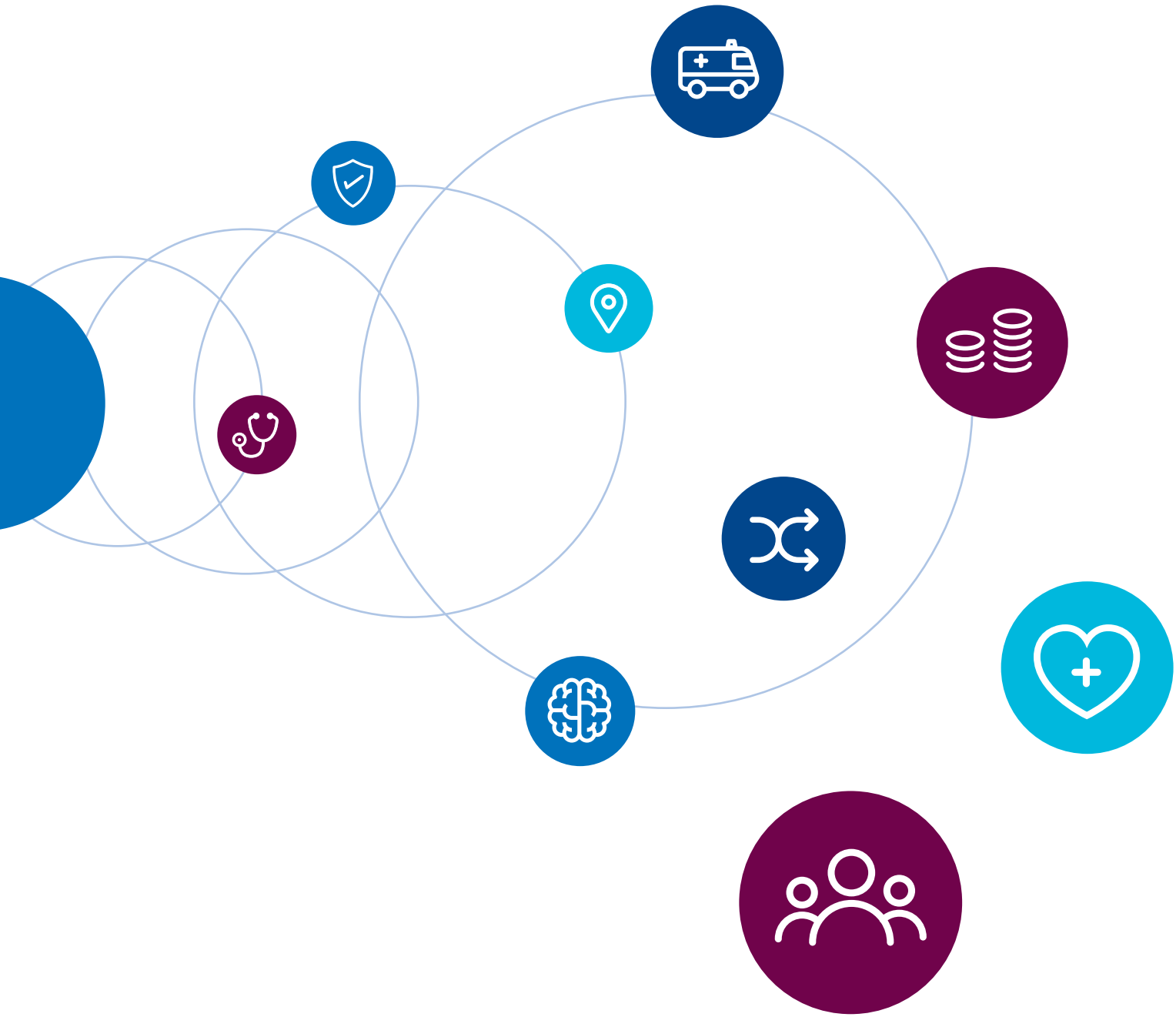
NHS England

ANNUAL REPORT

2016/17



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 2016/17

NHS England is legally referred to as the National Health Service Commissioning Board. Presented to Parliament pursuant to the National Health Service Act 2006 (as amended by the Health and Social Care Act 2012).

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A welcome by Professor Sir Malcolm Grant, Chair

We care passionately about the NHS, the institution that makes the public most proud to be British. In this, NHS England's fourth annual report, we set out the work we have done to ensure the NHS continues to provide comprehensive, high quality health care, free to all where there is clinical need, regardless of ability to pay.

We are an independent organisation, at arms-length from government, committed to putting patients at the heart of everything we do and ensuring they receive the best health care available, something that remains challenging at a time of continued financial constraint. It is pleasing that this year's British social attitudes survey suggests public satisfaction with the NHS remains higher than in all but three of the past 30 years, but it is of concern that separate surveys suggest increasing worry for its future.

The Government sets out what it expects from NHS England in its annual mandate, and once again it backed our transformation programme (the Five Year Forward View), designed to secure a sustainable future for the NHS. This plan was devised in partnership with the other arms length bodies that lead the health and care system.

At the end of the financial year we published an update on that vision for improvement. Whereas in 2014 we argued why the NHS needed to change, the Next Steps on the NHS Five Year Forward View[1] described what would change over the next two years and how. It marks the next phase in NHS England's and our partners' work, moving from charting a strategic direction for the NHS to a more focused role delivering the priorities set out in the plan.

Much of this change will need to be delivered locally by the NHS working in partnership with local authorities. Substantial effort has gone into supporting this local planning, including the formation of 44 Sustainability and Transformation Partnerships (STPs) covering every part of England.

1. https://www.england.nhs.uk/five-year-forward-view/.

And as we require the local NHS to work much more closely together, so too are we forming closer bonds with our national arms length partners. Over the course of the year we have made several joint appointments with NHS Improvement including Chief Nurses for London (Oliver Shanley) and South (Sue Doheny), a Chief Clinical Information Officer (Keith McNeil), and National Directors for Cancer (Cally Palmer), Mental Health (Claire Murdoch) and Urgent and Emergency Care (Pauline Philip).

Only by working together to transform the NHS can we meet the challenge of rising public demand and expectations, which has put huge pressure on our GP and hospital services, making it hard to meet the high service standards enshrined in the NHS Constitution. Once again this will be a focus for the NHS over the coming year.

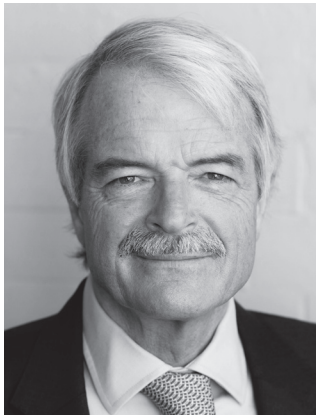
It is a privilege to chair the Board of NHS England, and I am delighted to welcome two new members to the already impressive team. Joanne Shaw, a qualified accountant and former Chair of the National Audit Office (NAO) Audit Committee, joined us in October 2016 and is now Chair of the NHS England Audit and Risk Assurance Committee. On the executive team, we welcomed Matthew Swindells as National Director: Operations and Information. He has over 25 years of health care experience, including as a trust chief executive, a senior policy advisor to the Secretary of State for Health and a senior advisor to the Prime Minister.

In the next few months we will be saying goodbye to two influential national directors. Karen Wheeler has done much to establish NHS England, a relatively new organisation with a complex and critical remit. When he retires, Professor Sir Bruce Keogh will have served the NHS as Medical Director for a decade; he will be a huge loss to NHS England, and we thank him for his service.

The team in NHS England continue to do an impressive job in addressing the wider needs of the NHS and patients. 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.

I would also like to extend the Board's thanks to all who work in the NHS. Numbers of front line staff are growing and more is being done to bring the NHS workforce up to capacity but doctors, nurses, midwives, paramedics, therapists, scientists and other clinical and non-clinical staff remain under huge pressure to meet public expectation and cope with ever increasing numbers of patients with increasingly complex needs. The response of NHS staff, alongside other emergency services, to the recent tragic events in Manchester and London, was deeply impressive under the most challenging circumstances.

In this context it is notable that NHS staff remain positive and supportive of the NHS; the most recent staff survey showed a five year high in engagement scores. As the NHS continues to adapt to new challenges, it will be critical that NHS England and local NHS leaders engage and empower all staff to enable them to play their full part in the essential transformation we know will secure improved health and care for the future.



Professor Sir Malcolm Grant, Chair of NHS England

About us

NHS England is an executive non-departmental public body which plans and funds the NHS, so as to improve health and well-being, secure high quality care and ensure the future NHS is sustainable. We had a funding allocation of £107 billion in 2016/17, which was used to commission health care services both directly by NHS England and by 209 local Clinical Commissioning Groups (CCGs) on behalf of the patients, citizens and taxpayers of England.

NHS funding is 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).

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. This sets the direction for the NHS, and helps ensure it is held accountable to Parliament and the public. The Government's mandate to the NHS for 2016/17 can be viewed at http://www.gov.uk/government/publications/nhs-mandate-2016-to-2017.

An assessment of how we have delivered against the mandate for 2016/17 is presented in Appendix 1 from page 236.

How we are governed and managed

NHS England is governed by a Board which provides strategic leadership to the organisation and is responsible for ensuring that it is able to account to Parliament and the public for how it has discharged its functions. The Board is supported by a number of committees which provide it with regular reporting and formal assurance. Further detail about our Board, its committees and membership is presented from page 85.

NHS England allocates a large proportion of the funding it receives from the Department of Health (DH) to CCGs and supports them to commission services on behalf of their patients according to evidence-based quality standards. Together they account for £76.5 billion of total commissioning expenditure. Further detail about how we oversee the commissioning system is presented from page 132.

Our values and the NHS Constitution

The NHS Constitution establishes the principles and values of the NHS in England and unites patients and staff in a shared ambition for high quality care. NHS England is a custodian 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.

Further information about our values and the NHS Constitution can be found on our website at www.england.nhs.uk/about/.

How we operate

As an organisation, we operate through our central teams and four regional teams[2], working closely with partner organisations that provide regulatory and support services to the health and care system, including NHS Improvement and the Care Quality Commission.

Our regional teams also work closely with other organisations to discharge their responsibilities, such as CCGs, local authorities, health and wellbeing boards and GP practices. To oversee the delivery of NHS funded services - and the continuous improvements to the quality of treatment and care - we both support and rely upon local healthcare professionals making decisions about services in partnership with their patients and communities. Further information about how we operate can be found on our website at www.england.nhs.uk/about/.

The work of NHS England is supported by a number of NHS and third party organisations including NHS Digital, NHS Business Services Authority (NHS BSA), NHS Shared Business Services (NHS SBS) and NHS Property Services Ltd. Additionally, we hosted NHS Interim Management and Support during the year and sponsored the Sustainability Unit, on behalf of the NHS. We also oversee Commissioning Support Units (CSUs), whose staff are employed via the NHS BSA.

Detail on how we assure the activity of our organisation is presented in this annual report from page 115.

2. In April 2017, NHS England's South region was split to create two regions covering both the South West and South East of England. This split will enable closer engagement with STPs, CCGs and providers to deliver the next steps of the Five Year Forward View.

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. A report on our customer contact and complaints during 2016/17 is presented from page 241.

PERFORMANCE REPORT

Simon Stevens
Accounting Officer
3 July 2017

Chief Executive's Overview

Increasing treatment and care for a growing and aging population mean that pressures on the NHS in 2016/17 were arguably greater than they have ever been. But on most objective measures, treatment outcomes are far better – and public satisfaction higher – than ten or twenty years ago. And as reflected in the NHS Five Year Forward View, there is now an underlying consensus about how care needs to evolve to help 'future proof' the NHS.

In 2016/17 NHS England made good progress in the first phase of implementing agreed national blueprints for cancer, mental health, maternity, learning disabilities and GP services, backed by targeted initial investment. Cancer survival is at a record high, and the first ever waiting times targets for mental health treatments were introduced and met, as was the new dementia diagnosis target. Patient experiences of care remained strong, as reflected in national patient surveys.

The first phase of fundamental care redesign under way through integrated 'vanguard' new care models began to show results, with the rate of per person emergency hospitalisation growth slowing by up to two-thirds. CCGs' work to constrain inappropriate demand meant that the growth rate in referrals to hospital, and the growth in the waiting list for routine operations, both also fell by two-thirds compared with the year before. NHS England produced strong financial performance during 2016/17, with a managed underspend of £902 million, beating our goal of £800 million, and substantially up on our 2015/16 managed underspend of £599 million.

However, despite increased acute hospital beds, delays in being able to discharge patients needing community health, home care or care home places put A&E waiting times under pressure. Last winter was particularly difficult. The NHS was also confronted with some difficult choices within its available funding – for example about the relative priority of ending years of relative neglect of primary care and mental health versus increasing investment in non-urgent elective procedures. While the NHS and

the Government remain committed to short waits, our new mandate for 2017/18 recognises these trade-offs mean that further improvements in waiting times will have to be phased.

For the year ahead we have detailed our plans and approach in our Next Steps on the NHS Five Year Forward View, available at https://www.england.nhs.uk/five-year-forward-view/next-steps-on-the-nhs-five-year-forward-view/.

It necessarily takes as its starting point the current legislative framework, and the current funding the NHS has been allocated. Future decisions on both are for government and Parliament. The Next Steps plan sets out clear accountabilities for delivering local goals and key national milestones – including better A&E performance, improvements in cancer, mental health and primary care services, and local financial control totals supported by action on major efficiency programmes.

Of course significant risks to delivery remain, such as workforce supply and staff support, the hospital bed occupancy challenge, the resilience of GP services and social care, capital requirements and residual financial gaps. NHS England and NHS Improvement are working with the Department of Health and local health partners to help address these. Doing so will require continued acts of unparalleled leadership across the NHS, at a time of leadership renewal and change. Above all the NHS only succeeds thanks to the dedication and professionalism of our staff.

A fair conclusion from the NHS' recent history is therefore that we have a viable and agreed strategic direction, and progress has been made. But we have a Health Service under real pressure from inescapably rising demand within a tight funding envelope.

Over the last seven decades of the NHS' life, growth in NHS funding has closely followed the ups and downs of wider economic cycles. Since the recession of 2008 the economic picture has again become more challenging. Despite real terms protection, NHS funding growth is much slower than either the historic long term trend or the Office for Budget Responsibility's forecast of what will be needed going forwards.

Next year the NHS turns 70. The Health Service's founding principles of care for all, on the basis of need not ability to pay have stood the test of time. That is unsurprising because the case for the NHS is straightforward. It does a good job for individual patients, offering high quality care for an ever-expanding range of conditions. It reduces insecurity for families, especially at times of economic uncertainty and dislocation, because access to care is not tied to your job or your income. And as one of the world's most cost-effective health systems, it directly contributes to the success of the British economy.

We are determined to play our part in ensuring that it does so in as strong a position as possible. There can be little doubt that that is what our patients, staff and taxpayers all want to see.

Simon Stevens, Chief Executive

Performance Analysis

How we have delivered against our corporate priorities for 2016/17

Our Business Plan for 2016/17 was published on 31 March 2016 and set out our 10 business priorities for the year, detailing how we will improve health and secure high quality healthcare for the people of England, now and for future generations. The priorities reflect the main themes of the mandate and are grouped under themes which embody the agenda of the Five Year Forward View (FYFV): improving health, transforming care and controlling costs.

Improving health – closing the health and wellbeing gap

The 2016/17 business plan set out four priorities under the improving health gap:

	See further detail on page
Improving the quality of care and access to cancer treatment	20
Upgrading the quality of care and access to mental health and dementia services	24
Transforming care for people with learning disabilities	28
Tackling obesity and preventing diabetes	31

Throughout 2016/17, work on achieving these priorities was driven forward through a strong focus on prevention, delivering care more locally, and empowering patients to take more control over their own care and treatment. An emphasis on dissolving the divides between physical and mental health, health and social care, and prevention and treatment underlies each of the priorities under the Improving Health section.

Transforming care – closing the care and quality gap

NHS England focused on five main priority areas throughout 2016/17 geared towards closing the care and quality gap:

	See further detail on page
Strengthening primary care services	33
Redesigning urgent and emergency care services	36
Providing timely access to high quality elective care	39
Ensuring high quality and affordable specialised care	45
Transforming commissioning: new care models	48

2016/17 has seen increased focus on personalised and co-ordinated health services for patients. NHS England has made demonstrable progress in the integration of primary and acute care to bring services together for local populations that are integrated around the patient. Significant investment has been made in priority services, improving care as well as the patient experience.

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

The FYFV set out a roadmap and financial strategy for the period to 2020/21. Resolute action on efficiency is now required to secure the sustainable services we require for the future.

	See further detail on page
Delivering value and financial sustainability through a step change in efficiency	58
Developing leading edge science and innovation	61
Transforming care through harnessing information and technology	65
Developing the capability and infrastructure for transformational change	See Accountability Report
Patients and the public	248

Throughout 2016/17 NHS England has worked with NHS Improvement to implement the recommendations of the Carter Review[3], delivering trust deficit reduction plans and reducing spending on agency staff, as well as working to ensure the delivery of our contribution to the NHS efficiency target. We have recently published in Next Steps on the NHS Five Year Forward View a more detailed efficiency blueprint for the coming years in the form of a 10 point plan for implementation across the NHS.

We have worked with our partners, patients, and local communities on developing new ways of delivering services, making better use of technology, further developing leadership and supporting scientific research and innovation.

3. Operational productivity and performance in English NHS acute hospitals: unwarranted variations https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/499229/Operational_productivity_A.pdf.

Cancer

Our 2016/17 commitments:
In April 2016, we will launch an integrated cancer dashboard of outcomes. By March 2017, we will agree an approach for collecting data on long term quality of life for inclusion in the dashboard.
From September 2016, we will begin to roll out a national system of Cancer Alliances.
By December 2016, we will develop a plan for a modern national radiotherapy network, with a revised radiotherapy service specification.
From April 2016, we will support NHS providers and NHS Improvement to achieve the 62-day maximum wait from receipt of urgent GP referral to start of first treatment.
By March 2017, in five local health economies, we will develop and test a new waiting times standard of 28 days from referral to definitive diagnosis, for roll out from early 2017/18.

More people are being treated for cancer than ever before and the standard of care has risen. The latest survival figures show an estimated 7,000+ more people surviving cancer after successful NHS cancer treatment compared to three years prior. Early diagnosis and prompt intervention are the best defence against the disease and give the greatest chance of cure. Over 1.7 million urgent referrals for investigation were made by GPs during the year and the proportion of cases diagnosed as an emergency fell to one in five, the lowest ever recorded.

We are upgrading radiotherapy equipment to create a modern, sustainable service over two years backed by a £130 million investment. The first 23 hospitals have received new or upgraded equipment in 2017, and over 50 new radiotherapy machines in at least 34 hospitals will be rolled out over the next 18 months, subject to HM Treasury approval of the capital business case.

We have established 16 Cancer Alliances and three cancer vanguard sites to lead local implementation of the recommendations of the independent Cancer Taskforce, which recommended an upgrade in prevention, a focus on earlier diagnosis, improved patient experience, better care, extra investment and reformed commissioning. Alliances will take a whole population, whole pathway approach to improving outcomes across their geographical 'footprints', building on their relevant STPs.

They are the 'cancer work stream' of STPs. Alliances have developed delivery plans for implementation of independent cancer taskforce recommendations locally.

In 2016/17, the NHS met seven out of the eight cancer waiting times standards. In 2016/17, 119,798 patients referred urgently by their GP with cancer received treatment within 62 days, an increase of 5,902 (5.2%) on 2015/16. However, this equated to national performance for the full year of 82%, against a target of 85%. NHS England and NHS Improvement are working with NHS providers and CCGs to improve speed of care during 2017/18. A national Performance and Delivery Group will oversee implementation of regionally driven recovery plans.

We launched 30 projects across the country to test more efficient pathways to speed the diagnosis of cancer. These included increasing the number of patients who receive a test at their first appointment, managing patients in the most clinically appropriate and efficient manner and increasing the amount of testing that can be processed immediately on site. The work was supported by the National Diagnostics Capacity Fund announced in May 2016.

We began testing a new standard that patients should receive a diagnosis or ruling out of cancer within 28 days in five test sites across the country.

We launched a new integrated Cancer Dashboard in May 2016 to provide a single, high level measure of patient outcomes in local areas to help improve the speed and quality of services. We also commissioned research on the best way of introducing a Quality of Life indicator for cancer patients, working with Macmillan Cancer Support.

East Lancashire Hospitals NHS Trust: Faster Diagnosis for Suspected Cancer Patients

East Lancashire Hospitals NHS Trust (ELHT) has been chosen by NHS England as one of the five test sites developing the 28 day standard.

ELHT receives a high number of referrals for suspected lung and upper gastrointestinal (GI) (oesophageal and gastric) cancers, but less than a third of these will turn out to have cancer.

The trust is working in partnership with local CCGs to test the policy and explore the service changes needed to meet the 28 day target. Initially this will be for patients referred by their GP with suspected lung cancers and upper GI cancers.

Redesigning pathways is crucial. Since November 2016 the trust has been testing and evaluating ways to shorten the pathway initially for patients referred with suspected lung cancer on a two week wait referral into the trust. From January 2017, the trust has been reviewing the pathway for upper GI.

ELHT is making two key changes to the pathways which lung and upper GI cancer patients go through.

For lung cancer patients the trust has created a 'virtual clinic'. When a patient is referred by their GP with suspected lung cancer, a Lung Physician and a Consultant Radiologist conduct a 'virtual clinic' to view the GP letter, x-ray and CT scan results (if available) and decide the next steps before the patient attends their first outpatient appointment. Clinicians are speedily brought together in the virtual clinic and can agree the next steps much quicker and diagnostic tests can be requested earlier. This results in the first outpatient appointment being more effective and efficient.

For upper GI cancer patients the trust is working closely with colleagues in the Endoscopy and Radiology Units to look at the feasibility of booking patients in for a CT scan who need one within two to three days of having their scope. This will lead to a faster diagnosis.

TrueNTH UK Supported Self-Management and Follow-Up

Five NHS trusts are participating in the TrueNTH Supported Self Management and Follow Up Care Project, which was set up to develop and test a new model of follow up care for prostate cancer focusing on self management and remote monitoring.

Men who are identified as suitable to take part in the project do not have to attend clinic appointments unless they have a Prostate Specific Antigen (PSA) rise or other significant issue that requires face-to-face intervention by the clinical team. Instead, they have access to a computer system to support them to self manage aspects of their care. They are monitored remotely by the clinical team via the system and have access to a support worker. They are also invited to attend a workshop to give them the confidence to self manage aspects of their care.

Between June 2014 and December 2016 over 2,000 men were enrolled on the new model of follow up care and 191 workshops were delivered. Feedback from patients and clinical teams has been very positive.

An evaluation is now underway to compare the new model of follow up care with clinic based follow up care. The final evaluation report will be available in August 2017.

Mental health and dementia

Our 2016/17 commitments:
Develop and implement a new national implementation programme for mental health to 2020/21, building on the recommendations of the independent Mental Health Taskforce and the Dementia Implementation Plan.
From April 2016, at least 50 percent of people experiencing a first episode of psychosis should commence treatment with a National Institute for Health and Care Excellence (NICE) approved care package within two weeks of referral, with the aim of increasing to 60 percent over the next five years.
By April 2016, we will work with mental health providers to ensure that 75 percent of people referred to psychological therapies begin treatment within six weeks, and 95 percent within 18 weeks, securing a minimum of 50 percent recovery rate from treatment, with the aim of increasing access to 25 percent over the next 5 years.
From April 2016, maintain a minimum of two-thirds diagnosis rates for people with dementia, whilst agreeing an affordable implementation plan to deliver more consistent access to effective treatment and support.
By March 2017, we will support CCGs to begin implementing plans to improve crisis care for all ages, including investing in places of safety.
By March 2017, we will work with partners to increase provision of high quality mental health care for children and young people to ensure an extra 70,000 have access by 2020, including prevention and early intervention.
By March 2017, we will set out how areas will ensure that children and young people with an eating disorder commence treatment with NICE approved care within clear waiting times for both urgent and routine cases.

We made progress in improving the care of people with mental health problems who in the past have received poorer services than people with physical health problems, suffered worse outcomes and endured stigma and discrimination.

We published the Five Year Forward View for Mental Health by an independent taskforce in February 2016 which recommended new investment in crisis care, psychological therapies, liaison services, children's services and suicide prevention. In July 2016 we published an implementation plan to help an extra one million people receive support, backed by extra investment rising to £1 billion annually by 2020/21. In February 2017, to mark the anniversary of the publication of the Five Year Forward View for Mental Health, we published the One Year On report, which highlights the progress made in the first year of the programme.

We introduced a waiting time standard for a first episode of psychosis from April 2016 to ensure at least 50% of patients are treated within two weeks of referral. The latest performance data (March 2017) show 73.7% of patients were treated within two weeks.

The waiting time standards for psychological therapies under the Improving Access to Psychological Therapies (IAPT) programme were consistently met. The programme has expanded significantly, providing help to more than 3.5 million people since 2008. In February 2017, 89.3% of people began treatment within six weeks of referral to the programme against the 75% standard, and 98.7% within 18 weeks against the 95% standard. The Children and Young People IAPT programme is a shared responsibility with HEE. In 2016/17 the programme worked with services covering 90% of 0-18 year olds in England.

In November 2016 we invited bids from acute hospitals to increase the proportion providing 24/7 liaison psychiatry services in A&E departments from 10 to 20%, with £30 million of funding over two years from within the additional investment set out above. Our ambition is to raise the proportion to 50% by 2020/21.

We achieved the NHS mandate commitment on dementia that two-thirds of those with the condition will be diagnosed. This ambition has been met and sustained since July 2016 and the National Estimated Diagnosis Rate was 68% in March 2017[4].

We are committed to reducing the number of people suffering mental health issues who are taken to police cells as places of safety. We announced 88 projects in autumn 2016 to improve access to health-based places of safety and community-based alternatives. Police figures show the use of police cells fell sharply in 2015/16, accounting for 1,764 (8%) of all Section 136 detentions, down from 3,996 (17%) the previous year. Data for 2016/17 confirming further progress will be available in the autumn of 2017.

We worked to improve early access to care for children with eating disorders. We launched a National Quality Improvement and Accreditation Network for Community Eating Disorder Services and supported CCGs to establish 61 Community Eating Disorder teams to improve early access to National Institute for Health and Care Excellence (NICE) concordat care for children and young people.

We supported CCGs to create Children and Young People's Mental Health Local Transformation Plans setting out how local areas will improve access to services.

4. The level of dementia in the over 65 population that we use to assess the rate of diagnosis uses the Cognitive Function and Ageing Study estimate.

In April 2016, the NAO recognised the progress we had made in setting priorities and national leadership and we are working to overcome the challenges it identified. These included implementing access and waiting times standards, building workforce capacity and capability, and better integration of mental and physical health. ('Mental health services: preparations for improving access', NAO, April 2016).

Stockport CCG - Improved Dementia Diagnosis Service

Stockport CCG had a dementia diagnosis rate of 40% and large increases in waiting times and referrals to memory services, with a need to improve post-diagnostic support.

The CCG implemented a shared care pathway where the management of stable patients with dementia was conducted in primary care with support from a memory service. This meant that there was early recognition and initial diagnosis in primary care with final diagnosis and medication initiation via the memory service. Additional resources were brought in from the third sector to support this pathway.

As a result of this action, the diagnosis rate increased dramatically to over 72% by summer 2016. Additionally, waiting times for memory services were reduced, with 95% of referred patients being diagnosed within 6 weeks and all patients now receiving two dementia reviews each year.

Durham and Darlington Children's and Young Person's Mental Health Services Crisis, Liaison & Intensive Home Treatment Team

The Durham and Darlington Children's and Young Person's Mental Health Services Crisis, and Liaison team (CYPMHS) conducted 1833 assessments between May 2014 and March 2017. Of these around 85% of presentations were seen for assessment in less than three hours therefore greatly relieving the strain on front-line emergency services and offering faster access to mental health care for the patients.

The CYPMHS crisis and liaison team have an open-access service that offers telephone support as well as access to other health professionals including the children's workforce and an out-of-hours response.

The initial comprehensive mental health and risk assessment appointment aims to commence within one hour (four hour maximum) of the referral being received by the service. This is followed up by intensive support within the home, or appropriate setting, for up to 72 hours or until the risks are contained.

Updated information for the service covering the period May 2014 to March 2017 showed that overnight paediatric bed use reduced by approximately 1032 admissions, A&E attendances reduced by around 600 as well as a reduction in waiting times.

40% of CYPMHS crisis assessments now take place in community settings.

Learning Disabilities

Our 2016/17 commitments:
During 2016/17 we will increase the number of people with a learning disability living in homes in the community and reduce the numbers in hospital, to achieve an overall reduction of 35-50 percent by 2020.
During 2016/17 we will increase the number of people with a learning disability who are registered with, and known to, a GP.
During 2016/17 we will increase the number of people with a learning disability having an annual health check.
During 2016/17 we will strengthen the monitoring of the quality of services accessed by people with a learning disability and their mortality rates.
During 2016/17, we will help NHS employers to employ more people with learning disabilities. We will also set an example ourselves by finding good opportunities to include people with learning disabilities within NHS England.

In 2015 we announced that we would reduce the number of people with learning disabilities, autism or both living in long stay specialist hospitals and ensure they received the right care in the right setting, close to home.

Between March 2016 and March 2017 we reduced the number of people living in specialist hospitals from 2,750 to 2,510.

We are now working to deliver a further reduction of around 35% from the March 2017 total over the next two years and we are working with partners such as local government to tackle the barriers to progress identified by the NAO in their recent report. ('Local support for people with a learning disability', NAO, March 2017).

The public consultation relating to the future of secure services in the North West ended at the end of February 2017, and it has been confirmed that a decision has been made to close the Mersey Care Whalley site (formerly known as Calderstones Partnership NHS Foundation Trust), re-providing services in a better way.

To ensure people do not stay in hospital longer than they need we are investing in a whole range of services and support, including a family based initiative to provide support to people in their own homes. Called the Shared Lives model, this provides a carefully matched carer to share their lives with someone with a learning disability.

People with a learning disability suffer poor physical health and die on average 16-25 years earlier than the rest of the population. During 2016/17 we began rolling out the local mortality reviews of all deaths of people with a learning disability, in order to understand and act on these differences. We have worked with 13 organisations to improve the quality of health services and co-design and implement Always Events®[5] and develop two further NHS Quality Checking toolkits, giving seven in total, allowing people with a learning disability to assess the quality of services they use.

As a key step towards reducing the mortality gap, we strengthened the learning disability annual health check process by providing a new standardised template. We also commissioned the Royal College of General Practitioners, Mencap and the National Development Team for Inclusion (NDTI) to support people to receive an annual health check.

In 2016/17 we launched the STOMP project (Stop Over Medicating People) to tackle inappropriate prescribing of psychotropic medication. The Royal Colleges of GPs and Psychiatrists and the Royal Pharmaceutical Society have launched projects of work to support STOMP.

We are improving systems to ensure people with learning disabilities are identified on GP records and their needs met by, for example, exploring using a flag on Summary Care Records to ensure reasonable adjustments can be made.

We are committed to improving employment opportunities for people with learning disabilities in the NHS. The NHS Learning Disability Employment Initiative is designed to support and increase the number of people with learning disabilities employed by the NHS.

At March 2017, 113 NHS organisations had pledged to employ more people with a learning disability, exceeding the original target of 100. Of these 36 were already employing people with a learning disability, with others offering internships or planning to do so in 2017/18.

5. Always Events® are described as "aspects of the patient experience that are so important to patients and families that health care providers must perform them consistently for every patient, every time". The learning disability programme has been working with a number of services to co-produce Always Events® with people with a learning disability and their families as a basis of an improvement programme for that service.

People with a learning disability are employed by the NHS England Learning Disabilities programme, which published guidance for NHS Employers and commissioned a more accessible version of the NHS Jobs application form. In November 2016 NHS England participated in the learning disability work experience week organised by Mencap.

Case study

David from Cambridgeshire is someone who left hospital with all the right standards in place. The Intensive Support Team (IST) assisted with David's move from a community hospital to supported living. For the last two years, David has lived in his own place and works at a charity shop three days a week and two days a week at an allotment.

David organises his week to get everything done including shopping, cooking, cleaning and going to the gym. Through regular planning meetings, David was involved in developing his own goals and had increased access to the community without staff and took part in problem solving sessions and was able to address concerns and anxieties, and work out other ways of coping. David went from having 24-hour staff support to having no staff and has been supported to attend education courses in order to get a paid job. He would like to work in car sales. In his own words, David said he "now lives in the real world."

Diabetes and obesity

Our 2016/17 commitments:
By April 2016 we will have the first contracts in place locally for the delivery of diabetes prevention services.
By March 2017 we will have made available to at least a further 10,000 people at high risk of developing Type 2 diabetes support to help modify their diet, control their weight and become more physically active through the prevention programme.

Rising rates of obesity have been accompanied by a rapid increase in Type 2 diabetes. The numbers affected are projected to increase to over 4 million by 2030, causing widespread suffering and putting an immense burden on the NHS.

Since April 2016, the NHS Diabetes Prevention Programme (NHS DPP) has been rolled out to 27 areas, covering nearly half of England's population. The programme targets people at high risk with help to modify their diet, control their weight and become more physically active. The aim is to slow the rise in incidence of the disease and reduce the burden of heart, stroke, kidney, eye and foot problems (and associated mortality) related to it.

The first 27 areas to join the programme began to refer people to the new services between June and December, and at the end of March 2017, total referrals stood at over 30,000, exceeding the 10,000 target set in the NHS mandate.

Building on the success of the NHS DPP in 2016/17, we have expanded the programme for 2017/18 in 13 new STP areas. NHS DPP Framework providers bid through a competitive process during February 2017 and contracts were awarded in March 2017.

For people with Type 1 diabetes, we are working with partners to develop an online resource to support self-management. It will aim to ensure that when someone is newly diagnosed, they have a single, online point of access all of the information and support they need to manage their condition.

In December 2016, we announced £40 million Transformation Funding for Diabetes Treatment and Care and invited CCGs to submit bids. The funds are available to improve multi-disciplinary foot care teams, increase diabetes inpatient specialist nursing capacity, increase the achievement of NICE-recommended treatment targets and improve access to structured education.

Luis, age 40, South London

It was a routine appointment to see the GP which led to 40 year old Luis, from South London, being told his blood sugar levels were high. It's also where he first heard about the Healthier You NHS Diabetes Prevention Programme. After meeting with the Healthier You team and taking another blood test, which confirmed he was at risk of developing Type 2 diabetes, Luis signed up to the programme.

"Because of my medical history, I wasn't that surprised when I learned I might be at risk of developing Type 2 diabetes", said Luis: "I've had cancer before, and my dad has Type 1 diabetes. I have a young family and I'm young too. I want to take good health with me into my old age so I can be involved in my children's lives."

"I was playing basketball twice a week for two hours and I also used to swim about a kilometre every week. So I was quite fit, but my GP advised me to stop playing and exercising for a period of time due to a different health issue."

"This has meant that my cholesterol and sugar levels have shot up in the past 18 months."

However thanks to the Healthier You programme, Luis has recently been told that he can start to be more active again and says "The changes we're making are achievable and sustainable. It's not about dieting and eating less, it's about healthy alternatives and small lifestyle changes...I really do feel better!"

Primary care

Our 2016/17 commitments:
By the end of March 2017, as part of our commitment towards achieving a seven day NHS, we will offer ongoing evening and weekend access to general practice for at least 20 percent of people across England.
By the end of March 2017, we will have accelerated investment in primary care estates and rolled out workforce measures to improve return to work processes for doctors working in general practice, which contributes to securing 5,000 doctors by 2020.
By the end of March 2017, we will conclude contract negotiations for 2017/18 for general practice and pharmacy, and develop an alternative contract option for general practice as part of the new care models programme.

Primary care services are the bedrock of the NHS. They receive around 300 million patient visits a year, which account for most of the contact that patients have with the NHS. But a growing, ageing population and the rise of people with multiple conditions requires both more capacity and new ways of providing care. To meet the rising demand, in April 2016 we set out a multi-billion pound investment and reform plan, the General Practice Forward View, to improve access to general practice services, to invest in new forms of provision, and to increase the workforce.

The GP Access Fund has continued to improve patient access to general practice services, with over 17 million patients (30% of the country) in over 2,500 practices benefiting. We are building on this by providing additional funding to CCGs to commission and fund extra capacity across England to ensure sufficient routine and same-day appointments are provided at evenings and weekends to meet local demand, alongside effective access to urgent and other care services.

The Estates and Technology Transformation Fund is a multi-million pound, multi-year investment in GP buildings. In 2016/17 198 schemes were completed, 169 were in delivery and 656 were in the identified pipeline for potential investment subject to due diligence checks and approval. These schemes are in addition to 560 schemes already completed by the end of 2015/16.

In February 2017, along with the Government and the British Medical Association's General Practice Committee, we reached agreement on changes to the general practice contract in England to benefit patients and GPs. The new contract, to take effect from April 2017, will see investment of around £238 million going into the contract for 2017/18.

A new £30 million national General Practice Development programme has been established, supporting practices to develop new ways of meeting demand and improving the experience for patients.

Over 1,000 practices are able to access support to help them develop under the new £40 million Practice Resilience Programme.

To support the workforce, we now have an easier route to return to practice for doctors who have left general practice, for a career break or to raise a family, through the Induction and Refresher scheme. We have also supported the recruitment of GP trainees to areas where there have traditionally been shortages, through the Targeted Enhanced Recruitment Scheme.

In January 2017 we launched the NHS GP Health Service, a new confidential service which offers support to those suffering stress or mental health issues.

These measures will help us meet the challenges to increasing the GP workforce identified in the NAO report published in January 2017 'Improving patient access to general practice'.

An additional 491 clinical pharmacists were recruited to 650 practices across the country by December 2016. Applications for the next phase of the Clinical Pharmacy Scheme have now been considered; as a result over 200 more pharmacists will be supporting over 700 practices. The number is expected to rise to 1,500 by 2020, backed by an extra investment of £112 million. Roll-out has also begun of mental health therapists working in primary care.

Increasing the number of doctors in general practice

NHS England and Health Education England's revamped Induction and Refresher scheme to attract family doctors back to practice makes it easier than ever to return to the profession.

The first time Dr Frances Clement tried to come back to general practice after a 10-year break she was faced with bureaucracy and gave up in frustration. But thanks to the revamped scheme to attract GPs back, she has returned to work as a salaried GP in Derbyshire, having been supported and funded through retraining.

The 49 year old, who now works seven sessions a week for Royal Primary Care in Chesterfield, admitted: "I'm absolutely delighted by what I have achieved. It's obviously the right thing for me at my stage in life. But if you had asked me two years ago, I would not have been able to imagine how I would be able to make this choice." From gaining a place on the Induction and Refresher scheme to starting her current job took only 11 months.

The newly-simplified GP I&R scheme aims to make it easier for GPs to return to practice after taking time to have children, work abroad or following a change in profession. The hope is to attract an extra 500 doctors into the NHS through this scheme by 2020/21.

Estates and Technology Transformation Fund

More than £320,000 is being invested into Roxbourne Medical Centre at South Harrow, Middlesex. A ground floor extension will provide a new wing to the practice, consisting of additional consulting, rehabilitation and clinical support space. It will be used primarily as a community cardiopulmonary rehabilitation unit.

With major housing developments underway in the area there is potential for an increased list size and requirement for additional clinical space. It is the intention of the practice to work with the local hospital-based cardiology and respiratory teams to develop and run a rehabilitation service for Harrow patients to aid recovery and prevent further admissions.

Urgent and emergency care

Our 2016/17 commitments:
By March 2017 we will deliver the integrated urgent care model described above to at least 20 percent of the country, offering a single all hours telephone number (111) for all urgent care needs, with access to a clinician and, where possible, to an individual's health records when required.
By March 2017 the emergency ambulance service will provide a 999 response that best meets a patient's clinical needs.
By March 2017, we will support hospitals to roll out seven day emergency hospital services to 25 percent of the population, across nine parts of the country. These services will comply with the four clinical standards that have been identified as having the most impact.

Demands on the urgent and emergency care service have been rising steeply for years. Many patients are uncertain about where to get help and how to choose between GP urgent care, the A&E department, the emergency ambulance service and NHS 111.

Next Steps on the Five Year Forward View, published in March 2017, set out our plans to improve the system to provide a modern responsive service to deliver the right care to patients in the right place at the right time.

We have introduced reforms to the NHS 111 service which will allow patients, whenever their condition requires it, to speak directly to a clinician and/or be directly booked into an appointment with the service that is right for them. In the past, callers may have had their symptoms assessed by call handlers to determine their severity before being signposted to their GP or A&E for further advice or treatment. Now, clinicians will give advice and either complete on the phone or refer to the most appropriate point of care. Patients will increasingly have direct access to a greater range of more senior clinicians. This is already the case for 30% of callers, up from 22%, and will continue to increase.

We are trialling changes to the emergency ambulance service, to help meet rising demand from a population with changing needs and expectations. The changes are aimed at reducing wasted journeys to patients with less serious conditions and involve providing callers to 999 with telephone advice, treatment at the scene, or conveyance to hospital or elsewhere, as clinically appropriate. This means ambulance staff will be able to allocate calls more accurately and deliver the right resource to the right patient at the right time, with improvements in efficiency and performance.

We developed a set of 10 clinical standards to improve the quality of emergency care, four have been prioritised as most likely to have the greatest impact in tackling variation in quality and safety and experience of hospital care and improve patient flow through a hospital. The four priorities to be met, whatever the day of the week, are: being assessed by a specialist consultant soon after admission to hospital; having necessary tests promptly; having emergency treatments without delay; and being reviewed by specialists daily in high dependency areas. In early 2017 more patients should be receiving care that meets these standards seven days a week. By November 2017 the standards should be met for all patients at all times in five urgent specialist services – major trauma, paediatric intensive care, hyperacute stoke, emergency vascular surgery and STEMI heart attacks.

The Next Steps on the Five Year Forward View sets out an expectation that Trusts and CCGs will be in line with the Government's 2017/18 mandate to the NHS, ensure that:

1. in or before September 2017 over 90% of emergency patients are treated, admitted or transferred within 4 hours. This compares with 89.1% for 2016/17

2. the majority of trusts meet the 95% standard in March 2018, and the goal that

3. the NHS overall returns to the 95% standard within the course of 2018.

During winter 2016/17, hospital inpatient beds actually increased, but elective capacity fell as a result of sharp increases in 'delayed transfers of care'. The single most important operational dependency for improved A&E waiting times in 2017/18 will therefore be the extent to which additional social care investment helps hospitals free up inpatient beds for emergency patients. By the end of 2017/18, all trusts will have implemented co-located primary care streaming into their emergency departments to support treatment of minors. Thus far 98 trusts have had capital funding made available to them to support any capital development needed to implement this service in time for winter 2017/18. Hospitals will speed up the assessment process and ensure that patients are able to return home as soon as possible and if home is not the best place for their immediate care, they will be transferred promptly to the most appropriate care setting for their needs. We will standardise access to 'Urgent Treatment Centres' through booked appointments via NHS 111. These facilities will be open 12 hours a day, staffed by clinicians, with access to simple diagnostics.

Urgent Response Assess at Home pathway

A patient with Multiple Sclerosis was admitted to hospital with a broken leg; as a result, she had high care needs and was not to put weight through her leg for 6-12 weeks whilst it healed.

Hospital therapists liaised with the community Urgent Response team who booked a 'discharge to assess pathway', which included equipment and a home care package.

When the patient arrived home, it was identified that the equipment was unsuitable for her environment and that three carers were needed for each visit. An urgent therapy assessment at home facilitated more suitable equipment that reduced the care package back to two carers and re-enablement subsequently reduced this further to one carer visiting twice a day.

This pathway helped the patient's rapid discharge from hospital as well as helping to prevent further crisis or re-admission to hospital or a care home as well as more appropriate commissioning of lower intensity longer term care. Overall, patients on this pathway are discharged from hospital sooner with a 25% reduction in long term care needs. 20% of patients are independent within 6 weeks.

Elective care

Our 2016/17 commitments:
By April 2016 we will begin to implement the maternity review.
By March 2017 we will ensure that commissioners are commissioning the care needed to achieve recovery of the NHS Constitution standards for elective care and support providers and NHS Improvement to help hospitals deliver them.
By March 2017 we will have set out significant improvement in the patient referral process and patient journey to better meet patient needs, deliver genuine choice and manage demand for elective care, for wider adoption by providers and commissioners.

The number of patients treated by the NHS continues to rise and during 2016/17 there was substantial progress made in slowing the rate of referral into hospital care. Referral growth fell by two-thirds compared with 2015/16. However, capacity constraints in acute hospitals linked to extended emergency inpatients stays meant hospitals struggled to expand their elective operations. The combined effect of these two variables – much better CCG demand management but with hospital capacity constrained – was that waiting lists rose, but by two-thirds less than in 2015/16. At the end of March 2017, 90.3% of all patients on the waiting list for non-urgent treatment had been waiting less than 18 weeks, compared to the 92% standard.

The number of treatment episodes (Referral to Treatment [RTT] pathways) completed each day increased by 4.7% in 2016/17 compared with 2015/16.

In 2016/17 we added resources to the regions to support elective care redesign and published a demand management guide, listing actions CCGs should consider implementing locally, particularly to reduce unnecessary outpatient appointments. These include peer review of referrals, shared decision making and alternatives such as group or nurse-led consultations.

We designed new ways to deliver specialist care and tested them in pilot sites as part of the Elective Care Rapid Testing Programme. We are now providing further support to new vanguard sites.

Renal e-clinics in Tower Hamlets

Tower Hamlets Together has created a single pathway from primary to secondary care, with rapid access to specialist advice provided by consultant led e-clinics which has transformed the way the renal outpatient service is delivered.

GPs refer patients to an e-clinic, which is run by a community based nephrologist, who reviews patient notes and provides advice back to the GP via the EMIS web system. E-clinics are coupled with an education package with clear guidelines for GPs and multi-disciplinary teams on how to manage this process. In a six week pilot phase across 19 practices in Tower Hamlets, 50% of referrals were managed without the need for an outpatient appointment.

Tower Hamlets have successfully enabled joint access to patient records, which is a key factor in the success of this model. Though this has been done in renal services, the principles can be applied to other specialities. Local transformation teams are currently working to spread this model across all other specialities in the health system.

Bedford Musculoskeletal disorders (MSK) Referral Management Centre

Bedford Referral Management Centre (RMC) has implemented a model where 95% of all musculoskeletal disorders (MSK) referrals go through the RMC. Referrals are triaged by extended scope physiotherapists within 24 hours, and trust consultants are also integrated into this hub, enabling shared decision making for major surgery. The remaining 5% of referrals not managed through the hub equates to 18% of secondary care activity.

Benefits from this model are numerous; for instance, up to 30% of GP decisions are changed so that the patient receives the most appropriate treatment and is not routinely directed to secondary care. It also shows a significant difference in performance between providers that are contracted by the RMC and those that are not (92% vs. 83% RTT performance for Trauma and Orthopaedics respectively). Contracted providers are able to direct referrals to the right consultant, reducing the risk of a referral being rejected or an inappropriate referral being made.

Bedfordshire CCG is now among the 10 CCGs in the country with the lowest inpatient activity per 1,000 of population and has seen a more significant decrease in inpatient activity than similar, benchmarked CCGs. Finally, there has been an improved utilisation of community care through this initiative.

Maternity care

Following the launch of the National Maternity Review Report 'Better Births' in February 2016, we established the Maternity Transformation Programme (MTP) to ensure all women get high quality maternity care regardless of their circumstances or where they live. The MTP will give women greater control and more choice, as well as making care safer, by providing information and support based around their needs and circumstances, and those of their babies.

As recommended in Better Births we have brought local providers, commissioners and other stakeholders together by forming 44 Local Maternity Systems (LMS), based on STP geographies, across England. These LMS will ensure that by October 2017 every part of England has a plan in place to implement Better Births. A LMS resource pack to support implementation of Better Births was published in March 2016.

From January 2017 early adopters have been working to implement key elements of Better Births including improved postnatal care, choice, personal care planning, safer care, continuity of carer, electronic patient records, bringing services together and closer to users through community hubs and new models of care co-designed with service users.

In May 2016 NHS England established seven Maternity Choice Pioneers who are working to extend the choices available to women including through the introduction of Personal Maternity Care Budgets (PMCBs). All of the pioneers have now launched their PMCBs. By March 2017, 81 women had benefited from a PMCB and by the end of 2017/18 10,000 women will have been offered a PMCB.

In February 2016 the Maternal and Neonatal Health and Safety collaborative was launched and the 44 Trusts who are taking part in wave 1 were announced. The collaborative will work with providers and commissioners to improve clinical practices, reduced unwarranted variation and support delivery of the Secretary of State's ambition to halve neonatal mortality, still-birth, serious brain injury and maternal mortality by 2030. During 2016/17 we supported the roll out of the Saving Babies Lives Care bundle which sets out evidence based priorities and actions for reducing still-birth. Over 90% of all NHS Maternity Providers are implementing activity across all four elements of the care bundles to reduce smoking in pregnancy, better detect foetal growth restriction, raise awareness of reduced foetal movement and effective foetal monitoring during labour.

In December 2016 we provided £2 million to CCGs with the highest rates of smoking at time of delivery to invest in proven interventions to reduce smoking during pregnancy.

In August 2016 the specialist perinatal mental health community services development fund was launched to promote service development and quality improvement and increase the availability of high-quality care for women and families. 20 proposals have been selected for wave 1 covering 90 CCGs and all four NHS regions. In 2017/18 we will set out further plans to expand specialised perinatal mental health services including additional Mother and Baby Unit capacity.

Birmingham and Solihull United Maternity and Newborn Pathway (BUMP) Early Adopter

Birmingham and Solihull United Maternity and Newborn Pathway (BUMP) is one of seven maternity Early Adopters which are being supported to test key recommendations from Better Births, the report of the National Maternity Review.

BUMP focuses on providing women with a single point of access with midwives as their first point of contact. This will ensure that women are supported by a midwife throughout their journey and helped to make informed choices about their care.

The service aims to increase the number of women choosing to give birth in midwifery led units or home births. It also aims to provide a multidisciplinary community maternity team which will provide continuity of carer to women and their families and increase provision of community antenatal care. This will help to improve outcomes in areas such as infant mortality, experience of care and the ability to deliver care closer to home.

BUMP is working to create a single maternity Electronic Patient Record for all pregnant women and to commission new care providers to enhance the portfolio of providers.

North East London Choice and Personalisation Pioneer

Waltham Forest, as part of the North East London Pioneer project, have increased their choice offer to women in each part of the maternity pathway by introducing a new provider, Neighbourhood Midwives, who offer a continuity of carer model to women on a standard pathway. The Maternity Choice and Personalisation Pioneer programme will work with Waltham Forest and Neighbourhood Midwives to understand the learning from this in relation to pricing, commissioning, outcomes and the local maternity system and will share this learning through the wider maternity transformation.

Specialised care

Our 2016/17 commitments:
By January 2017, we will articulate and communicate the overall strategic vision and strategy for specialised commissioning over the next five years.
By March 2017 we will implement new arrangements for the Cancer Drugs Fund.
During 2016/17 we will continue to invest in Proton Beam Therapy which will see the first patient treated in the UK in August 2018.
By March 2017 we will have completed at least seven national service reviews to improve value and quality for patients.
During 2016/17 we will give CCGs stronger leadership of collaborative commissioning of specialised services.
During 2016/17 we will embed an Integrated Quality Surveillance Programme for specialised services and cancer services and establish a rolling programme of peer reviews for services where there are variations in quality of care.
By March 2017 we will have developed and delivered a new high cost drugs and devices procurement approach.
By March 2017, as part of our ongoing Improving Value programme, we will have delivered Quality, Innovation, Productivity and Prevention (QIPP) project plans for national schemes that will deliver benefits in the 2017/18 contracting round.

The demand for new, innovative and often expensive treatments is rising rapidly. To meet these challenges, we have developed and tested a new strategic framework which sets out our overall vision for specialised commissioning, in line with the FYFV.

Following consultation, we implemented a new process for prioritising new investments in specialised services and strengthening clinical leadership and patient and public involvement through a refreshed clinical reference group structure for the six National Programmes of Care: internal medicine, cancer, mental health, trauma, women and children, and blood and infection.

We implemented a new operating model for the Cancer Drugs Fund (CDF), working with the National Institute for Health and Care Excellence (NICE), under which 25 drugs treating 42 indications are currently being accessed by patients. This has been effective in containing spend in the total CDF budget.

The first Proton Beam Therapy Centre in England is due to open in 2018, in line with the prime ministerial commitment, and in the meantime we are continuing to fund treatment overseas for those patients who are clinically appropriate.

Our programme of National Service Reviews has included congenital heart disease services, specialised children and adult mental health services, medium and low secure adults' mental health services and perinatal mental health services

During 2016/17 the National Oversight Group (NOG) for High Secure Hospital Services has focused on the work of the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT) which inspected secure hospitals last year and compliance with the Mental Health Act 1983 Code of Practice; paying particular attention to the number and circumstances around patients being in long term segregation and seclusion. This work continues into 2017/18 with the reporting arrangements to NOG changing to reflect this key area. The review into the High Security Psychiatric Services (arrangements for Safety and Security) Directions 2013 continues and we expect to consult on the revisions later this year. This work is being led by the Department of Health, working with colleagues at the high security hospitals and NHS England, with the aim of ensuring the Directions reflect more contemporary clinical and security best practice.

In December 2016, we announced an expansion of the HIV prevention programme to provide access to Pre-Exposure Prophylaxis through a large scale clinical trial.

To help tackle variations in care across the country, we have established an Integrated Quality Surveillance Programme under which 200 peer reviews have been completed to support providers to meet published standards in specialised services and cancer services.

We have developed a new approach for procuring high cost devices which is on target to deliver substantial savings through economies of scale. We are implementing a new national approach to purchasing medical technology devices with all hospitals using a single national online catalogue. This means the NHS national purchasing clout secures substantial savings allowing us to reinvest substantial resources in patient care. We also reshaped the Identification Rules (IR) for specialised services to more accurately reflect the content of the Specialised Service manual and supporting service specification. Business intelligence reporting has been developed to facilitate discussion with STPs about specialised commissioning in their area.

Rolling out new oral treatments for Hepatitis C

The largest single investment in new treatments in the year was for new oral Hepatitis C treatments. We now have evidence that this investment and the approach to manage access through operational delivery networks who prioritise those in greatest need has reduced deaths and liver transplants within the first year of introduction. By end of March 2017 we are on target to have treated approximately 16,000 patients, which amounts to more than 10% of the total infected population. Since we have followed NICE guidance to focus on those at greatest clinical need, this has led to a rapid reduction in death rates (by 11%) and a reduction in transplantation for Hepatitis C Virus of 50%.

Transforming commissioning: new care models

The national bodies are committed to enabling new care models and are working together to deliver the following:
During 2016/17 we will track progress in the vanguards using clear national and local measures.
During 2016/17 we will support the design and delivery of the sustainability and transformation planning process to enable the spread of new care models.
By June 2016, we will have developed and published common frameworks for MCPs, PACS and enhanced health in care homes.
During 2016/17, we will start testing new payment approaches, including whole population budgets, as well as approaches to gain and risk share that align financial incentives across local health systems.
By September 2016, we will work with the vanguards to co-produce frameworks for the new organisational forms that will help other areas to deliver new care models.
By March 2017 we will be testing a new contract for MCPs and PACS, for use in 2017/18.
Over 2016/17, we will enable and support MCPs and PACS, as well as Greater Manchester and the North East, to contribute to system-wide changes in 15 to 20 percent of the country.
During 2016/17, we will work with 10 new towns and developments to 'design in' health and healthy environments, and to create health services delivered making the most of technology and patient engagement.

NHS England has worked closely with other health sector bodies including NHS Improvement, Care Quality Commission (CQC), Health Education England (HEE), National Institute for Health and Care Excellence (NICE) and Public Health England (PHE), to develop solutions to the multiple challenges the NHS faces by transforming the way care is delivered, following the strategy set out in the FYFV.

As part of this effort, the programme was launched in March 2015 to develop new ways of working that will act as blueprints for the future. The new care models (NCM) programme received £148 million of funding in 2016/17 to bring together best practice and support the development and spread of new models of care.

A further £100 million transformation funding has been allocated to existing vanguards for 2017/18 to demonstrate implementation of the new approaches at scale, support their spread and ensure the wider NHS learns from their experience.

The vanguards are led by front line clinicians, managers and patients and are testing new approaches by creating networks of care, breaking down the barriers between hospital, community services, primary and social care.

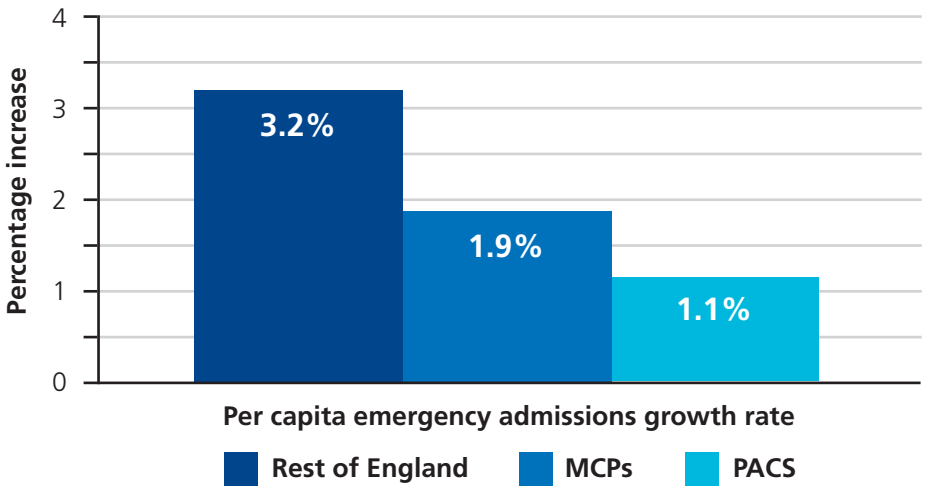
Vanguards have aligned their work to published frameworks for the multispecialty community provider (MCP), integrated primary and acute care system (PACS), and enhanced health in home care vanguards, whilst continuing to respond to the needs of their local communities.

We have worked intensively with vanguards, including those in Greater Manchester and the North East, to develop new arrangements for commissioning and assuring services under the MCP model last published in February 2017. A draft version of the contract was published in December 2016 for a period of engagement, and we will shortly publish an updated version of the contract which is ready for use by commissioners to help inform the early stages of their procurement processes.

We have been working closely with a number of vanguard areas across the country to co-develop a whole population budget methodology, which will focus on outcomes rather than activity, and incentivise prevention. An initial version of the 'Whole population models of provision establishing integrated budgets handbook' will be published in the coming months for a period of public engagement and feedback.

Compared to their 2014/15 baseline both PACS and MCP vanguards have seen lower growth in emergency hospital admissions and emergency inpatient bed days than the rest of England. Given sample sizes and duration it is important not to over-interpret the data currently available. However, comparing the most recent twelve months for which complete data are available (January-December 2016) with the twelve months prior to the vanguard funding commencing (the year to September 2015), per capita emergency admissions growth rates were: PACS vanguards 1.1%, MCP vanguards 1.9%, versus the non-vanguard rest of England which was 3.2%.

MCP and PACS vanguards have seen lower growth in per capita emergency hospital admissions than the rest of England



NB: This chart compares the most recent 12 months for which complete data is available (January-December 2016) with the twelve months prior to the vanguards commencing (the year to September 2015).

Alternatively taking the full financial year April 2014-March 2015 before the vanguards were selected as the baseline period, per capita emergency admissions growth rates were: PACS 1.7%, MCPs 2.7% and rest of England 3.3%. Vanguards such as Morecambe Bay, Northumberland and Rushcliffe are reporting absolute reductions in emergency admissions per capita. As intended, the benefit has been greatest for older people. The Care Homes vanguards are also reporting lower growth in emergency admissions than the rest of England, and meaningful savings from reducing unnecessary prescribing costs.

The New Care Models programme has continued to support the 25 integrated care pioneer sites that are testing new ways of joining up health and social care services across England. We started work with a further cohort of 22 small district general hospitals to test new ways of improving their quality, efficiency, and effectiveness in order to sustain smaller local district hospitals in their communities.

We supported the National Association of Primary Care to develop the Primary Care Home (PCH) model, which is being tested in 92 'community of practice' sites covering a total population of around four million. The programme is aimed at developing a new model of primary health care for a population of 30,000 to 50,000 centred around the needs of local communities, with multidisciplinary teams delivering personalised and comprehensive care.

East and North Hertfordshire CCG Vanguard - Enhanced health in care home

East and North Hertfordshire CCG vanguard (enhanced health in care home) has employed pharmacists to work with GPs, care home staff and other healthcare professionals to provide in depth medicine reviews for residents. Improved IT also means they can now access patients' records using laptops in the care home, allowing a more thorough review alongside each resident's care plan and medicines record. Working with 25 care homes, the vanguard has already seen over 901 patients and reviewed the use of 8,183 medicines. 1,015 medicines have been stopped, including 198 which could have increased the risk of falls. The direct cost savings are estimated to be around £160,000 or £181 per patient.

Fylde Coast Local Health Economy

Fylde Coast Local Health Economy vanguard (multispecialty community provider) has created a new 'extensive care service' which brings together different health professionals who offer dedicated, targeted support for older patients with multiple conditions. National vanguard funding means the care model is being rolled out across the entire Fylde Coast with every GP practice able to refer eligible patients. Early indications from their figures show a 13% reduction in A&E attendances, 25% reduction in non-elective admissions and 18% reduction in outpatient appointments. Most notably, there has been a 37% fall in planned visits to hospital among patients receiving support.

The Better Together Vanguard

In mid-Nottinghamshire, the Better Together vanguard (integrated primary and acute care system) includes a total of eight joined-up community teams who work with patients, their families and carers to provide physical, mental and social care support to ensure people are cared for at home wherever possible. The vanguard has reported a reduction in acute bed days and reductions in long term admissions to care homes. They have also reported a 5.4% reduction in avoidable patient attendances for 18-79 year olds and 20.5% for patients aged 80 years and above (compared to 2015/16).

Healthy New Towns

We supported 10 demonstrator sites to form partnerships across the NHS, local government and housebuilders to produce detailed delivery plans that re-think how health and care services can be delivered and shape the health of their communities. We helped them design new care models and engage patients in developing them, embed health-improving interventions in the technical town planning process and pilot new models to support people to lead healthier lives.

The ten sites formed collaboratives to address common problems and share expertise – focusing on the built environment, new care models, community engagement and evaluation – and we are inviting global innovators to enter a competition to design a practical healthy new town.

Transforming commissioning: Personalisation and choice

Our 2016/17 commitments:
By October 2016 we will develop a detailed strategy and delivery plan to ensure we are able to meet the mandate commitment to increase the number of personal health budgets and integrated personal budgets to between 50-100,000 by 2020/21.
By June 2016 we will launch a programme to improve choice for women during maternity, in at least three test sites.
By March 2017 we will promote and support the implementation of a Choice Commitment to improve choice in end of life care.
By March 2017 we will develop a robust operational structure to enable national roll out of Integrated Personal Commissioning.

The NHS is moving from a 'one size fits all' approach to care which is increasingly personalised to the individual. Since September 2014, people with long term complex conditions who receive NHS Continuing Healthcare (CHC) have had a legal right to have a Personal Health Budget (PHB), enabling them to tailor the care they receive to better meet their needs.

We have been implementing Integrated Personal Commissioning (IPC) in Demonstrator sites since April 2015, a new model of care for people with complex needs that includes blending health and social care funding and offering people integrated personal budgets that give them more control over how resources are used for their care. In 2016/17, we extended the roll-out of IPC through an additional set of early adopter sites and also across Greater Manchester, so that 40 CCGs are now actively implementing IPC.

In 2016/17, we made personal health budgets available to a wider range of other people who would benefit from personalised services, such as people who use wheelchairs, mental health services, and end of life care services, people with a learning disability, and children and young people.

By the end of March 2017, 15,811 people were benefiting from a personal health budget; more than double the number in September 2015. Since November 2016, every CCG in England has been working towards robust trajectories for the number of personal health budgets they will deliver, putting us firmly on track to achieve the mandate commitment of 50,000 to 100,000 by 2020/21.

To support this delivery, we have published a comprehensive set of practical delivery support materials for IPC and PHB, including the IPC Operating Model and these have been co-developed with key stakeholders across the system.

In May 2016, we established seven Maternity Choice and Personalisation Pioneers, involving 36 CCGs, to improve choice and control for women in maternity, including through Personal Maternity Care Budgets (PMCBs). By the end of March 2017, 81 women were benefitting from a PMCB, and Pioneers are putting in place plans to provide 10,000 PMCBs by March 2018.

Following the DH's July 2016 response to the Review of Choice in End of Life Care, we launched a national programme to promote the changes necessary for the NHS to meet the Government's End of Life Care commitment of consistently high quality, personalised care, and are developing PHBs in End of Life Care in five areas with the aim of promoting their adoption across the country.

In August 2016, NHS England and NHS Improvement jointly published 'Securing Meaningful Choice: Choice Planning and Improvement Guide', a self-assessment framework for CCGs to improve patients' choice over where and how they receive their care. CCGs have begun to adopt the guide, and we are now working with a range of CCGs to demonstrate improvements and the resultant benefits to patients and the NHS as we aim to ensure that all CCGs are fully compliant with choice standards by March 2019.

Personal health budgets improving end of life care in Warrington

NHS Warrington CCG is working with a local hospice to offer personal health budgets (PHBs) to people receiving end of life care within the hospice, as well as those who choose to remain at home.

Hospice staff identify suitable recipients for PHBs through the Fast Track funding process and have been trained to co-develop personalised support plans and identify health outcomes with patients.

Four months into the pilot, 17 people have received PHBs, which have been used for a range of services to support health outcomes, such as pain management and mental health care. Traditionally, the home care and support package consists of four visits per day and three overnight stays. All recipients of PHBs in the pilot have opted for alternative care and support to this traditional offer, with a fully tailored package and plan put in place that includes services and support the individual may be accessing in the community.

Each of the PHBs has resulted in a more efficient use of resources. Work is now in progress to offer PHBs to people not accessing the hospice service, in order to secure equity of access and support across the locality.

Seeing the financial benefits of Integrated Personal Commissioning in the South West

North, East and West (NEW) Devon has been part of the Integrated Personal Commissioning (IPC) programme since 2015, and joined the programme as a fully-fledged demonstrator site in 2016.

Strong links have been made into local Transforming Care and Special Educational Needs and Disability (SEND) programmes as well as with other associated programmes such as the Better Care Plan, the Success Regime and with Integrated Care Exeter. Here, IPC is seen as the foundation for the development of new models of care to support people with long-term conditions and complex needs.

NEW Devon is working towards making personal health budgets (PHBs) a routine offer for patients within Continuing Healthcare (CHC), and for jointly funded packages of care. The PHB 'offer' will be extended to cover people with mental health problems, learning disabilities and autism plus people with multiple long term conditions.

NEW Devon's work with around 100 people eligible for CHC who are in receipt of a PHB has built local confidence that PHBs improve health outcomes and deliver services more efficiently. NEW Devon has estimated that traditional health and care spending for these people would have been around £7.3 million in 2016/17, and that the provision of PHBs has resulted in efficiencies of around £1.3 million (20%).

Commissioning development

Our 2016/17 commitments:
During 2016/17 we will continue to oversee integration of health and social care through the Better Care Fund.
During 2016/17 we will support the roll out of full co-commissioning of primary care to the majority of CCGs.
During 2016/17 we will enable CCGs to have stronger leadership and influence of collaborative commissioning of specialised services.
By April 2017, we will ensure that every commissioner has access to excellent commissioning support, including leading edge business intelligence and analytics, through completing the nationwide roll out of the Lead Provider Framework.

Strong commissioning is vital to the future of the NHS and we have worked to ensure it continues to evolve with the changing role of CCGs.

A key objective is integration of health and social care. The Better Care Fund was established in 2013/14 to provide a partially pooled budget for the NHS and local government. In 2016/17, the third year of its operation, the budget for the Better Care Fund rose to £5.9 billion. Of 150 Health and Wellbeing Boards, voluntary contributions to 119 were more than the minimum.

Through the roll out of delegated commissioning, CCGs take on responsibility for commissioning primary care services to promote and develop integration, aligned to wider CCG plans and STPs for improving health services. We have seen benefits in terms of improved quality of care, improved access to primary care, greater local ownership of development of primary care services, increased clinical leadership and more local decision making, greater involvement of patients and a more sustainable primary care service for the future.

Progress on the roll out of delegated commissioning is set out on page 135 of this annual report.

We have strengthened support services for NHS commissioners through the Lead Provider Framework which was established to drive up the quality of services and the value for money for taxpayers. At the end of March 2017, 109 CCGs had launched procurements for external support worth over £480 million, including population health analytical solutions, demand management and capacity planning support, and ICT transformation.

Financial sustainability

Our commitments for 2016/17:
By November 2016 we will roll out RightCare to the first wave of 60 CCGs, followed by the remaining 150 CCGs starting in December 2016.
By March 2017 we will achieve planned reductions in spending through RightCare, and ensure NHS England's contribution to the overall efficiency agenda across other programmes.
During 2016/2017 we will drive the transformation of services by rolling out new methods of assessing value in investment and developing payment systems and tariff structures.

The NHS faces very significant challenges in terms of controlling costs and improving care in order to achieve financial sustainability, as highlighted by the NAO in their report, Financial sustainability of the NHS, published in November 2016.

The RightCare programme, which compares performance across the country in order to reduce unwarranted variation and secure the best value for money, is a key part of this drive.

In 2016/17 we rolled out NHS RightCare to all 209 CCGs in England. Each CCG has agreed a timeline for identifying planned savings under the programme, based on comparing their performance with ten similar health economies, and will report against them. Typically, it takes around nine months for a first cycle of change but there are already examples of positive progress and tangible improvements to outcomes and value. One such example is Slough CCG, which introduced a new complex care case management service that has reduced targeted demand on A&E by 24% and non-elective admissions by 17%.

The RightCare approach is focused on capturing opportunities to reduce unwarranted variation and increase value, securing agreement among stakeholders for change and a plan of action, and reaching agreement on measures to monitor its impact on a quarterly basis to 2020.

Cumbria CCG's Pain Management Service

The NHS RightCare Commissioning for Value 'Where to Look' pack highlighted musculoskeletal (MSK) services as one of Cumbria CCG's key opportunities for improvement, with the pain service as a key component. Cumbria CCG had a high spend for back pain injections compared to their most similar 10 CCGs.

The CCG brought key players together to design an optimal care pathway and the outcome was the persistent physical symptom management service (PPSS). It was introduced in April 2016 and offers GPs a single point of access to a biopsychosocial symptoms management service, whatever the patients' diagnosis. Early evaluation shows the new service is helping to improve access, has high patient and GP satisfaction, and highlights a reduction in drug prescribing. There is also a positive improvement on core measures for IAPT, depression and quality of life outcomes.

North Kirklees CCG over the counter medicines

As a wave 1 CCG, North Kirklees used Commissioning for Value data as a starting point to identify areas of unwarranted variation in the local health economy. One area that was quickly prioritised for action and capable of yielding improvements was prescription of analgesia.

The data identifying unwarranted variation was reviewed by the clinical strategy group. This was essential in driving clinical engagement, and provided an opportunity for a wide range of clinicians in the geography to challenge, understand and ultimately buy into the view that there was an opportunity to improve prescribing spend. The group also reviewed evidence of where similar CCGs had introduced successful interventions, including over-the-counter (OTC) schemes.

A number of clinically-led interventions were developed, with an OTC scheme approved as a priority to drive better value quickly. The CCG led a campaign aimed at encouraging patients to not ask for cheaper, generic medicines such as ibuprofen or paracetamol on prescription therefore linking the associated costs and savings to other services where the funding could be better used such as community nurses, breast cancer treatment and cataract operations.

In 2017/18 we will be progressing the 10 point plan for efficiency, which has been published as part of the Next Steps on the NHS Five Year Forward View document and forms the blueprint for implementation of the joined up national and local efficiency improvement initiatives required to ensure financial sustainability over the coming years. Further detail is included in the CFO report on page 75.

The NHS and, where appropriate, local councils have come together in 44 areas across England to develop joint plans for health and care, strengthen local leadership and agree how to improve services within the total resources available, focusing on the needs of the populations they serve rather than of individual organisations. STPs represent a shift in how the NHS commissions and delivers services, with the focus on closer integration of health and social care and place-based planning.

The plans vary in their levels of detail and ambition, reflecting the strength and length of local relationships. Regional and local teams will work with the STP leadership teams to ensure they develop and implement good quality plans, with the aim of making services easier to access, keeping people healthier for longer, reducing avoidable demand growth for acute hospital care and promoting co-operation between health and social care.

Science and innovation

Our 2016/17 commitments:
During 2016/17 we will continue to develop our strategy for a Personalised Medicine service, encompassing underpinning diagnostic services.
During 2016/17 we will deliver the NHS contribution to 100,000 Genomes project.
During 2016/17 we will continue central funding of the Small Business Research Initiative and seek external investment and experience to promote products for priority areas.
During 2016/17 we will support our Academic Health Science Networks to help drive the uptake of innovation in the NHS at local and regional level.
During 2016/17 we will continue to sponsor Healthcare UK, the international brand for the UK healthcare industry, jointly with the DH and UK Trade and Investment.
During 2016/17 we will produce a research plan, developed with our partners, setting out our programme of work to identify research priorities, help increase patient recruitment into trials, and continue to address concerns about excess treatment costs.
By January 2017 we will deliver interim results on the innovations being trialled in the seven real world test beds we have established for evaluating new technologies and approaches that offer better care at the same or lower overall cost.

Our continued investment in science and innovation has contributed to UK economic growth and supported the NHS in its aims of improving patient outcomes and experience. We have taken the first step in defining how we will commission future research to meet the needs of the NHS and set the groundwork for delivering radically different diagnostics of cancer and rare diseases which will positively impact the treatment of thousands of patients.

Personalised medicine

Across the world, scientific discoveries and technological advances in genomics, informatics, analytics and bio-nanotechnology are transforming our ability to more precisely diagnose illness and target treatment of disease.

The concept of tailoring interventions is not new, but never before has it been possible to identify the underlying cause of disease, predict how each of our bodies will respond to specific interventions, or determine which of us is at risk of developing an illness.

In September 2016, we published Improving Outcomes through Personalised Medicine which sets out our intention to support the NHS to embed genomic medicine into routine care, to lay the foundations for personalised treatments and interventions.

100,000 Genomes

By the end of 2016/17, the 13 NHS Genomic Medicine Centres established to collect samples and engage patients and family members in the programme had collected over 25,000 rare disease and over 4,000 cancer samples. Over 20,000 whole human genomes have been sequenced. By sequencing the genomes in these samples not only can we better understand these diseases, but we can also target specific treatments at the patients who will benefit most from them. The main cancer programme of the project is live and multi-disciplinary teams have been set up to handle the return of sequencing data and the validation of results. This is a world leading project, preparing the NHS to embed genomics as part of routine NHS care where it is clinically and cost effective to do so.

Test beds

Since announcing the seven test beds in January 2016, the programme has facilitated the formation of seven public-private partnerships, in which NHS organisations have partnered with around 40 digital technology companies. A conservative estimate is that the programme has leveraged £15 million (this is about three times more than the £5.1 million NHS England has invested).

All seven test beds have transitioned from design and mobilisation in year 1 to delivery in year 2; for example Lancashire and Cumbria Innovation Alliance is testing digital tools (wearables and sensors) with 1,600 people living with a long term condition identified through their redesigned vanguard patient pathways. The programme will be developing tools for others to use.

National Innovation Accelerator

The scheme supports individuals to develop innovations for the NHS. It recruited a further eight fellows in 2016/17, bringing the total to 25. The themes pursued by the new fellows were prevention, earlier intervention and long-term condition management.

The initial cohort of 17 fellows, appointed in 2015/16, have secured £20 million of additional funds to support the development of their ideas. These include digital health innovations which focus on reducing health inequalities, such as Patients Know Best, an online patient engagement system which empowers patients to take control of their medical records, MyCOPD, providing online rehabilitation for patients with Chronic Obstructive Lung Disease at home, and DrDoctor, an online platform allowing patients to book and cancel appointments. These innovations are being evaluated and rolled out in 419 NHS organisations.

Exemplar Clinical Pathways

In late 2015 NHS England began work with the Academy of Medical Colleges, to co-develop exemplar Clinical Pathways. The Pathways demonstrate how personalised medicine approaches could be built into the diagnosis and treatment of significant diseases. The work of the Academy culminated in Roundtable meetings throughout the following year, which brought together key stakeholders including academia, NHS, industry and research funders.

The first Roundtable mapped out a high-level clinical pathway for monogenic diabetes, which accounts for 2-3% of patients diagnosed with diabetes before 30 years of age, and is an area where personalised clinical pathways are not yet widely implemented.

The second Roundtable addressed clinical pathways for cardiovascular disease, including Familial Hypercholesterolaemia, and inherited cardiac conditions, Hypertrophic Cardiomyopathy and Long QT Syndrome. They can lead to serious consequences including heart disease and sudden cardiac death, and so there are tangible benefits to implementing a stratified approach to these patient pathways.

The Academy made recommendations covering commissioning; awareness; education and training; and health economics; addressing the challenges to implementation and the practical steps required to put these pathways into practice.

The reports were published in October 2016, and are being used to support NHS England's programmes of work to build the evidence base, encourage clinical change in the NHS and build the appetite for the introduction of personalised medicine approaches.

The benefits are: earlier and more precise diagnosis; better prognosis; identification of predisposition markers to predict disease before onset / symptoms'; better disease prevention; avoidance of adverse drug reactions; and more precise assessment of the likely clinical effectiveness of treatment and avoidance of futile prescribing.

Information and technology

Our 2016/17 commitments:
By June 2016 local health communities will develop roadmaps setting out the steps to be taken to achieve a paper-free NHS.
By March 2017 we are incentivising CCGs and providers to make 80 percent of relevant elective referrals electronically using NHS e-Referrals, up from 50 percent today.
By March 2017 we will ensure 10 percent of patients are registered for primary care services online.
By March 2017 all ambulance trusts, all community pharmacies, NHS 111 and two-thirds of A&E departments will have access to patients' Summary Care Records.
By March 2017 we will publish five new scorecards about hospital quality on the MyNHS website.
By March 2017 we will publish revised national data on mental health and learning disabilities.

During 2016/17 we aligned the Personalised Health and Care 2020 information strategy with the Five Year Forward View to ensure that information technology is delivering the right capabilities at the right time to help deliver improved health, improved care, and improved efficiency. In June 2016, 73 Local Digital Roadmap footprints were developed to set out the steps to achieve a paper-free NHS. These have now been aligned with the 44 STPs, to ensure that the ten domains of activity in the national IT strategy are delivering support to the service developments described in the STPs.

In September 2016 we announced the first 12 Global Digital Exemplar acute trusts. These organisations are the most advanced IT hospitals in the NHS and have committed to work to become world class exemplars from which the rest of the NHS can learn.

Development of the NHS e-Referral system for elective referrals is continuing. The user interface has been improved and a facility introduced to flag specialties within hospitals where waiting times are particularly long. The bi-monthly Hospital Activity Data shows utilisation currently at 54% and the programme has been charged with increasing this to 100% by October 2018.

As of January 2017, 95% of GPs offer patients online appointment booking, repeat prescriptions and access to their Summary Care Record. Overall, 10.4 million people are now registered for online services, exceeding the 10% target set out in the NHS England Business Plan. 9 million have registered for repeat prescriptions, and 5 million for their summary information record. In January 2017, 1.1 million appointments were booked or changed online and 1.9 million repeat prescriptions were ordered online.

As at March 2017, 100% of NHS 111 and 92% of ambulance trusts could access extended patient data through the Summary Care Record (SCR). 85% of A&E departments have access to GP records, which is significantly more than forecast in the NHS England Business Plan. It is estimated that 40% of urgent treatment centres are enabled to access SCR or a local care record sharing service. These combined developments ensure safer clinical care, improved speed in transitioning care between services and an improved patient experience.

The national mental health services dataset is being updated to better capture data to monitor improvement across the service. Key performance measures are published quarterly in the FYFV Mental Health Dashboard, with the first dashboard published in October 2016.

The roll-out of free Wi-Fi to GP surgeries for patients and professionals has started and as of March 2017 covered approximately 1,000 surgeries in 20 CCG areas.

NHS Patient Online - Hugh's story

Hugh is visually impaired, registered blind. He also has asthma and a number of different health conditions.

Before Hugh had online access to his patient records he managed his healthcare in a "very random and unprivate way." He had to ask people to read things to him, and didn't feel very in control of what he was doing when having to use the telephone system to book appointments.

Hugh's GP receptionist spoke to him about Patient Online and typed the login information to Patient Online into Hugh's laptop for him, to keep it confidential.

Hugh is able to access the system by listening to it through his smartphone or laptop, and a screen reader. Listening through his earphones keeps his information completely confidential.

Patient Online has made a huge difference to Hugh as he can directly read information through his talking device. It has helped him understand and stay in control of his healthcare.

"It just frees you from having to ask anybody else for help, you can do it for yourself and I think that's so important when you're managing your own health - that it's something that you're in control of, that you're reading, it's your information and ultimately it's about you managing your own health and being a good patient.

I think Patient Online is the best thing I've used in terms of accessing information about my healthcare…"

How we supported the wider NHS

Emergency preparedness, resilience and response

NHS England responded to a number of potential threats to patient and public safety during the year, drawing on its considerable experience in emergency preparedness, resilience and response (EPRR).

We tested EPRR plans for a series of scenarios including chemical attacks and the treatment of burns victims. Following the 2014-16 outbreak of Ebola in West Africa, we continued to develop the UK's health response to outbreaks of infectious disease posing a high threat.

We made sure the NHS continued to deliver safe care during the 2016 junior doctors' industrial dispute, working with key partners through our national incident control centre.

In July 2016, we worked closely with Public Health England to ensure the safe treatment of over 100 victims of an e-coli outbreak in the south west of England, associated with contaminated salad leaves.

In November 2016, the EPRR team were instrumental in ensuring more than 50 people injured in a train crash in Croydon received an NHS emergency response.

The resilience capability of the NHS has been clearly demonstrated in a number of incidents in recent months. March 2017 saw the first mass casualty terror attack on UK soil for many years, when a vehicle was driven into tourists along Westminster Bridge in London killing and injuring members of the public.

In Manchester in May 2017, members of the public were killed and injured by a suicide bomber in a terrorist attack at a music concert at the Arena, with many of those affected being children and young people.

In early June 2017, three men drove a vehicle into crowds on London Bridge and launched a knife attack on people in the Borough Market area. Once again, as a result of this atrocity members of the public were killed and injured.

A raging fire ripped through Grenfell Tower block in North Kensington, London in June 2017, resulting in significant injuries and loss of life. A number of people were transferred to hospital as part of the rescue operation, with many more seeking advice and treatment for the effects of smoke inhalation.

All 999 services, including health, responded to this series of exceptional incidents with dedication, professionalism and bravery – both in the immediate deployment of emergency resources and in delivering the ongoing healthcare requirements for many of the individuals affected. The importance of our investment in specialist trauma centres and networks was reinforced during these events. The EPRR team led co-ordination of the immediate health response, ensuring access to NHS services for all those affected by this tragic event. The team also participated in the wider cross-government response for victims who experienced such traumatic and life changing events.

Equality and Meeting our Public Sector Equality Duty

We are committed to ensuring that all those using the NHS have fair and equitable access to high quality services that are appropriate and in proportion to their needs. In addition we have a specific focus on those with protected characteristics (by reason of age, membership of disadvantaged groups or living in disadvantaged areas).

We trained more than 150 commissioners, policy leads, managers and other staff in their Public Sector Equality Duty and their duty to reduce health inequalities, and are continuing to roll out the programme and evaluate its success. An assessment of how we have acted to address health inequalities, as required by the Health and Social Care Act 2012, is set out in Appendix 4 from page 256.

As leaders of the NHS Equality and Diversity Council (EDC), we have worked to promote equality as a system leader throughout the NHS. See Appendix 4 for more information.

Our report detailing the work we have done to promote equality under the Equality Act 2010, and setting out our objectives for 2016-20, can be viewed at www.england.nhs.uk/about/equality/.

Inclusion health and lived experience

An inclusion health and lived experience sub group of the EDC was set up to help improve access to, and outcomes of, healthcare services for disadvantaged groups, people with lived experience of inequalities and those with protected characteristics.

In 2016/17 we:

- delivered a 'Quick Wins' programme targeting barriers to primary care
- strengthened the capacity of EDC member organisations to identify and address health inequalities
- produced leaflets explaining the new principles designed to make it easier for patients from Inclusion Health groups to register with GP practices
- organised a presentation to demonstrate the power of lived experience to improve the planning, commissioning and delivery of integrated health care, ensuring the voice of the marginalised is heard, to the Heads of Digital Inclusion, Equality and Health Inequalities at Expo 2016.

Community Languages Information Standard

We are committed to reducing language barriers for individuals and groups who need NHS services but may suffer worse access or outcomes or whose safety may be at risk because of communication difficulties. A scoping exercise on the development of a community languages information standard has been created for consultation. The intention is to ensure alignment with interpreting and translation principles. Moving forward, during 2017/18 we plan to consult further and assess next steps subject to sponsorship and resources being available.

Unified Information Standard

We commenced work to develop a scoping exercise to examine how to map the quality and extent of equality information cross-system to enable compliance with the Pubic Sector Equality Duty (PSED) in relation to patients, services users and services. This work to scope how to develop a Unified Information Standard will be completed in 2017/18. As part of our work to develop a Unified Information Standard, we are considering how best to address definitional issues around the monitoring of protected characteristics.

Workforce Race Equality Standard

The NHS Workforce Race Equality Standard (WRES) mandates the NHS to tackle less favourable treatment of black and minority ethnic staff. Our first report on the WRES, published in June 2016 showed gaps in the progression and treatment of BME staff compared with their white counterparts. In London, 69% of NHS trusts had a higher proportion of BME staff complaining of being harassed, bullied or abused by patients, relatives or members of the public. All trusts in London reported lower proportions of BME staff who felt their employer offered equal opportunities for career progression compared to elsewhere in England.

We have challenged NHS trusts and independent providers to meet their WRES commitments. To ensure a consistent approach, trusts are required to demonstrate that they are collecting data against the nine WRES indicators, analysing for evidence of discrimination, and implementing action plans to close the gaps in line with their Public Sector Equality Duty.

The WRES has become part of the 'well led' domain of CQC inspections. The 2016 WRES report was published in the first quarter of 2017 and included workforce data from the NHS staff survey. We will use this data to identify good practice and drive improvement. The programme will require sustained effort over several years.

Workforce Disability Equality Standard

We introduced the Workforce Disability Equality Standard (WDES) to improve the representation, treatment and experience of disabled staff in the NHS and to promote the theme of 'disability as an asset'. Employing people with lived experience of disability or long term health conditions helps the NHS to increase the quality of its services and attract diverse talent. The WDES will be mandated in England from April 2018.

Sustainability

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 http://www.sduhealth.org.uk/policy-strategy/. Our sustainability report is presented in Appendix 5 from page 264.

Our priorities for 2017/18

Our continuing contribution to delivering the FYFV is set out in Next Steps on the Five Year Forward View, published in March 2017.

As an annex to the Next Steps document, we published 'NHS England Funding and Resource 2017-19' which sets out how we will, through the distribution of funding and our people, support the next steps on the NHS Five Year Forward View to transform local health and care systems.

Over the past two years, national improvement blueprints have been developed with key partners for urgent and emergency care, cancer, mental health, primary care, learning disabilities, and maternity. 2017/18 will support the delivery and implementation of these key priorities and work will continue on accelerating service redesign locally through STPs and Accountable Care Systems.

Chief Financial Officer's Report

The financial statements for the year ending 31 March 2017 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 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 £106,528 million in 2016/17. We are 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 has again fulfilled all of the financial duties set out in its mandate from central government, covering revenue spending, administration costs and capital expenditure.

Although not legally responsible for securing financial balance across the NHS or for ensuring that the DH meets its overall Revenue and Capital Departmental Expenditure Limits, the NHS England Group has, in addition to meeting its own financial duties, held back the risk reserve specified in the NHS Planning Guidance for 2016/17 and ultimately deployed it to help offset provider deficits.

Operational performance

The NHS England Group has delivered a managed underspend of £902 million (0.9% as a percentage of allocation) against its £105,702 million budget set for in-year operational expenditure.[6]

The most significant factor in this underspend is the release of the system risk reserve. As set out in the 2016/17 NHS Planning Guidance, commissioners were required to hold a 1% risk reserve, created by setting aside the monies they would otherwise have spent during the year. This was intended to be released for investment in FYFV transformational priorities to the extent that evidence emerged of risks across the system not arising or being effectively mitigated through other means.

6. The core measure for the financial performance of NHS commissioners included here is the non-ring-fenced Revenue Departmental Expenditure Limit (RDEL), or general RDEL.

In the event, however, the position across the provider sector has been such that NHS England has been unable to allow the 1% non-recurrent monies to be spent, and therefore all CCGs and NHS England direct commissioning teams were required to release their share of the reserve to the bottom line. This was delivered in full, resulting in a contribution of £799 million (of which £707 million is included in CCG positions and £92 million in direct commissioning) towards our overall surplus of £902 million.

The key features of the 2016/17 financial position are shown in more detail in the following table and set in the context of the pattern of small managed underspends delivered in the three previous years since the creation of NHS England and CCGs:

Financial performance

	2016/17				2015/16		2014/15		2013/14	
	Expenditure		Under/(over)spend against plan		Under/(over)spend against plan		Under/(over)spend against plan		Under/(over)spend against plan	
	Plan	Actual								
	£m	£m	£m	%	£m	%	£m	%	£m	%
CCGs	76,630	76,476	154	0.2%	(15)	0.0%	70	0.1%	89	0.1%
Direct commissioning	25,610	25,314	296	1.2%	82	0.3%	(12)	0.0%	(365)	-1.4%
NHS England Admin/ Central Progs/ Other	3,312	2,874	439	13.2%	340	21.4%	193	12.2%	679	34.4%
Historic continuing healthcare claims administered on behalf of CCGs	150	137	13	8.6%	192	67.7%	33	35.4%	(77)	0.0%
Total	**105,702**	**104,800**	**902**	**0.9%**	**599**	**0.6%**	**285**	**0.3%**	**326**	**0.3%**

The figures above are on a non-ring-fenced Revenue Departmental Expenditure Limit (RDEL), or general RDEL.

2016/17 has been a year of unprecedented challenges for NHS commissioners. The creation of the risk reserve in 2016/17 has placed significant pressure on the commissioning system, requiring an increase in the level of savings that commissioners needed to make from an average of 2.2% of allocations in 2015/16 to 3.0% of allocations in 2016/17 plans. In addition, the NHS England Group has absorbed a number of material financial pressures this year, including most significantly a £190 million increase in the rates set by DH for funded nursing care. NHS England's systematic process for continuous evaluation of financial exposure enabled us to identify the level of commissioner risks from the start of the year and take appropriate mitigating action both with individual CCGs and in relation to central budgets.

In general, CCGs have risen well to the challenge. Commissioner efficiencies delivered by CCGs have risen from £1.5 billion in 2015/16 to £2.0 billion in 2016/17, and the measures to improve CCG resilience, which we commenced in 2015/16, were further developed and widely deployed in 2016/17. The majority of CCGs delivered their planned financial position in addition to the release of the risk reserve. 24 CCGs reported further underspends totalling £17 million, and there was a £34 million underspend against the budget set for Quality Premium. However, 85 CCGs reported operating overspends totalling £607 million, leading to an aggregate overspend of £556 million (0.7%) before allowing for the reserve release.

Within direct commissioning, specialised services teams achieved an underspend of £58 million on their operational performance, reflecting the significant programme of measures undertaken over the last two years to improve management processes and controls. In addition, a new approach to prioritisation and financial management of drugs within the Cancer Drugs Fund (CDF) was introduced in July 2016, which has been effective in containing spend within the total CDF budget, contrasting with the £126 million overspend in the previous financial year.

In the light of the operational finance risks identified at the start of the year we took early action to reduce the programme and running cost expenditure of NHS England directorates while freezing contingencies and banking a number of small one-off gains. This led to a combined underspend of £439 million. However, it should be noted that most of these variances relate to non-recurrent budgets and income available to NHS England in 2016/17, and the recurrent elements have generally already been reflected in reduced central budgets for 2017/18. We have now largely completed the programme to deal with historic claims in relation to continuing healthcare, with expenditure in the year slightly below the amount set aside in our plans.

Performance against wider financial metrics

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

£150 million of the total £237 million savings against the administration limit are relevant to the general RDEL limit, the remainder being depreciation-related. This underspend has helped to offset the significant operational pressures highlighted above while maximising funding available for frontline services.

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

Revenue Limits	**Target**				
	Mandate limit	**Actual**	**Underspend**	**Target met**	**Underspend as a % of mandate**
	£m	**£m**	**£m**		
RDEL - general	105,702	104,800	902	√	0.9%
RDEL - ring-fenced for depreciation and operational impairment	166	96	70	√	42%
Annually Managed Expenditure limit for provision movements and other impairments	300	(308)	608	√	202.6%
Technical accounting limit (e.g. for capital grants)	360	71	289	√	80.4%
Total Revenue Expenditure	**106,528**	**104,659**	**1,869**		**1.8%**
Administration costs (within overall revenue limits above)					
Total administration costs	**1,832**	**1,595**	**237**	√	**12.9%**
Capital limit					
Capital expenditure contained within our Capital Resource Limit (CRL)	**260**	**227**	**33**	√	**12.7%**

Allocations

NHS England has responsibility for the allocation of NHS funding agreed with the 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.

In December 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. As reported last year, these allocations were intended to achieve the following goals:

- 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 and £2.86 billion for 2017/18, of which £1.8 billion is deployed to support provider sustainability and the remainder for transformation in other key areas, prioritised within the FYFV.
- Greater equity of access, by bringing allocated funding closer to target levels, with no CCGs more than 5% under target for CCG commissioned services and no CCG areas more than 5% 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 and
- 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.

Subject to minor adjustments, mainly to reflect specific changes to commissioning responsibilities between CCGs and NHS England, the decisions made by the Board have been reconfirmed in relation to 2017/18 and 2018/19.

Future financial sustainability

The FYFV 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.

The 2015 Spending Review provided additional real-terms funding of £8.4 billion to reduce an estimated £30 billion resource gap by 2020/21 and provide resources for sustainability and transformation investments. In parallel with this, the NHS has been developing and implementing STPs across 44 local areas to demonstrate how commissioners and providers, and local authority partners can work together to deliver the goals set out in the Forward View within the resources available to each locality.

A 10 point plan for efficiency has also been published as part of the Next Steps on the NHS Five Year Forward View document and forms the blueprint for implementation of the joined up national and local efficiency improvement initiatives required to ensure financial sustainability over the coming years. In this context, NHS England and NHS Improvement will work closely together and with other arm's length bodies to support concerted action in the following areas:

1. Freeing up hospital bed capacity
2. Improving staff productivity, including further action on temporary labour costs
3. Leveraging the NHS's procurement opportunities
4. Securing best value from medicines and pharmacy
5. Reducing avoidable demand and meeting demand more appropriately
6. Reducing unwarranted variation in clinical quality and efficiency
7. Action on estates, infrastructure, capital and clinical support services
8. Cutting the cost of corporate services and administration
9. Improving cost recovery from non-UK residents
10. Ensuring financial accountability and discipline in all NHS organisations.

The profile of funding growth in the Spending Review settlement means that 2017/18 and 2018/19 present a particular challenge for local health economies in balancing the significant and growing operational pressures facing the service with the need to invest confidently in transformational programmes in the key priority areas set out in the Next Steps document. In many places this will involve difficult choices on where to invest and disinvest, and partners in every STP area will need to use the 10 point efficiency plan to build on and substantially accelerate progress made in 2016/17, if they are to square this very challenging circle.

Long term expenditure trends from the establishment of NHS England in 2013/14 are set out below, detailing expenditure on CCGs, direct commissioning and NHS England's central programme and running costs. The increase in central costs is driven by the establishment of £1.8 billion deployed to support provider sustainability within the Sustainability and Transformation Fund (STF).

Financial performance - RDEL general (non-ring-fenced)

	Expenditure				Expenditure (%increase)		
	2013/14 £m	2014/15 £m	2015/16 £m	2016/17 £m	2014/15 %	2015/16 %	2016/17 %
CCGs	65,427	66,775	72,259	76,476	2.1%	8.2%	5.8%
Direct commissioning	27,407	29,364	26,687	25,314	7.1%	-9.1%	-5.1%
NHS England Admin/ Central Progs/ Other	1,294	1,387	1,245	2,874	7.2%	-10.2%	130.8%
Historic continuing healthcare claims administered on behalf of CCGs	77	61	92	137	-21.2%	50.9%	49.5%
Total RDEL - general	**94,205**	**97,587**	**100,283**	**104,800**	**3.6%**	**2.8%**	**4.5%**

ACCOUNTABILITY REPORT

Simon Stevens
Accounting Officer
3 July 2017

The purpose of the Accountability Report is to set out how we meet key accountability requirements to Parliament. It comprises three key sections:

Corporate Governance Report

This explains how NHS England has been governed during 2016/17, including membership and organisation of our governance structures and how they support achievement of our objectives. The report includes the Directors' Report, the Statement of Accounting Officer's Responsibilities and the Governance Statement. The Corporate Governance Report is set out from page 85.

Remuneration and Staff Report

This sets out our remuneration policies for non-executive directors and the executive directors and how these policies have been implemented for the reporting period, including salary information and pension liabilities. It also provides further detail on remuneration and staff. The Remuneration and Staff Report is set out from page 144.

Parliamentary Accountability and Audit Report

This brings together key information to support accountability to Parliament, including a summary of fees and charges, remote contingent liabilities and the Certificate and Report of the Comptroller and Auditor General to the House of Commons. The Parliamentary Accountability and Audit Report is set out from page 171.

Corporate Governance Report

Directors' Report

The Board

The NHS England Board consists of a Chair, 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.

These 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).

Roles and responsibilities

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, partners, CCGs and providers of healthcare and communities served by the commissioning system.

Appointment

Board members bring a range of complementary skills and experience in areas such as the patient and public voice, 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. The Chair and non-executive directors are appointed by the Secretary of State for Health; executive members are appointed by the Board. One new non-executive director, Joanne Shaw, was appointed to the NHS England Board in October 2016.

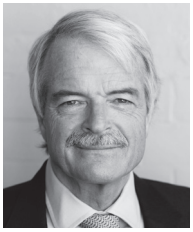
Register of Members' Interests

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. The register of interests is a public document which is open to public scrutiny and is published on NHS England's website. The register is reviewed on a monthly basis. This may be viewed at www.england.nhs.uk/about/whos-who/reg-interests/.

Board members are required to notify and 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 and abstain from related Board discussion as required.

Details of related party transactions, where NHS England has transacted during 2016/17 with other organisations, to which an individual holding a director position within NHS England is connected, are set out in Note 17 of the Annual Accounts.

NHS England's non-executive directors



Chairman: Professor Sir Malcolm Grant CBE

Skills and experience: 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, Global Chair of the PLuS Alliance, a director of Genomics England Ltd and a UK Business Ambassador.

Appointed to the Board: 31 October 2011
(Reappointed to second term from 31 October 2015)

Term expires: 30 October 2018

Committee membership: Strategic HR and Remuneration Committee (Chair). In addition, the Chair reserves and exercises the right to attend meetings of all committees.

Vice-Chair: David Roberts

Skills and experience: David Roberts became 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.

Appointed to the Board: 1 July 2014

Term expires: 30 June 2018

Committee membership: Commissioning Committee (Chair); Audit and Risk Assurance Committee (interim Chair until 30 September 2016); Strategic HR and Remuneration Committee.

Lord Victor Adebowale CBE

Skills and experience: Victor Adebowale is currently Chief Executive and company secretary of Turning Point. He is a crossbench peer and Visiting Professor and Chancellor at the University of Lincoln, a Fellow of the City and Guilds of London Institute, and an associate member of the Health Service Management Centre at the University of Birmingham. He is a director of Leadership in Mind and a Director of IOCOM. Victor is Chair of youth charity Urban Development, Chair of Social Enterprise UK, and Chair of Collaborate CIC. He is a non-executive director of the Co-Operative Group and sits on the Board of Governors for the London School of Economics and on the Board of The Social Investment Partnership. Victor 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.

Appointed to the Board: 1 July 2012
(Reappointed to second term from 1 January 2015)

Term expires: 31 December 2018

Committee membership: Commissioning Committee.

Wendy Becker

Skills and experience: 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 Great Portland Estates Plc, a member of the finance committee of the Oxford University Press, the Deputy Chairman of Cancer Research UK, and a Trustee of the Prince's Trust and the Design Museum. She holds a BA in Economics from Dartmouth College and an MBA from Stanford's Graduate School of Business. She completed a nine year term as a non executive director of Whitbread Plc during this year.

Appointed to the Board: 1 March 2016

Term expires: 29 February 2020

Committee membership: Audit and Risk Assurance Committee; Investment Committee (with effect from 1 June 2016).

Professor Sir John Burn

Skills and experience: 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-off 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. He was knighted for services to medicine and healthcare in 2010.

Appointed to the Board: 1 July 2014

Term expires: 30 June 2018

Committee membership: Specialised Services Commissioning Committee.

Dame Moira Gibb

Skills and experience: Moira Gibb is Chair of Skills for Care and 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.

Appointed to the Board: 1 July 2012
(Reappointed to second term from 1 January 2015)

Term expires: 31 December 2018

Committee membership: Investment Committee (Chair); Strategic HR and Remuneration Committee.

Noel Gordon

Skills and experience: Formerly an economist and a banker, Noel spent most of his career in consultancy until his retirement in 2012 including, 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 Chairman of NHS Digital, and of the Healthcare UK Advisory Board. He is a member of the Life Sciences Industrial Strategy Board of the DH, 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 UserVoice.org.

Appointed to the Board: 1 July 2014

Term expires: 30 June 2018

Committee membership: Specialised Services Commissioning Committee (Chair); Commissioning Committee; Audit and Risk Assurance Committee (until May 2016).

Michelle Mitchell OBE

Skills and experience: 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 and 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 and the Global Not for Profit Leaders programme at Harvard Business School.

Appointed to the Board: 1 March 2016

Term expires: 29 February 2020

Committee membership: Specialised Services Commissioning Committee.

Joanne Shaw

Skills and experience: Joanne Shaw joined the Board in October 2016. She is a qualified accountant and has chaired the audit committees of the NAO and the Money Advice Service. Her experience in the health sector includes: acute and primary care; urgent care; commissioning; remote and digital health assessment, advice and information; medicines; and prevention. She is currently Deputy Chair of Nuffield Health and Chair of the British Equestrian Federation. As past Chair of NHS Direct, Joanne has a strong interest in the use of mobile and digital channels for health and medicines. In her professional roles and in her writing for health publications she is known for advocating partnership between patients and health professionals and supporting people to make better-informed choices about their health.

Appointed to the Board: 1 October 2016

Term expires: 30 September 2020

Committee membership: Audit and Risk Assurance Committee (Chair).

NHS England's executive group

Chief Executive: Simon Stevens

Skills and experience: 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.

Appointed to the Board: 1 April 2014 (Voting)

Board Committee membership: The Chief Executive reserves and exercises the right to attend meetings of all committees.

Chief Financial Officer: Paul Baumann

Skills and experience: 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 joined the NHS as the first Director of Finance and Investment of NHS London in 2007 following a 22 year career in international financial management at Unilever Plc. Paul is also executive lead for Devolution. Paul is a Fellow of the Chartered Institute of Management Accountants.

Appointed to the Board: 14 May 2012 (Voting)

Chief Nursing Officer: Honorary Professor Jane Cummings

Skills and experience: Professor Jane Cummings is the executive lead for maternity, patient experience, learning disability, equalities and for patient and public participation at NHS England, and is the professional lead for nursing and midwifery in England. Jane has been awarded Doctorates by Edge Hill University and Bucks New University, and is a visiting professor at Kingston University and St George's, University of London.

Appointed to the Board: 1 April 2013 (Voting)

National Medical Director: Professor Sir Bruce Keogh

Skills and experience: Professor Sir Bruce Keogh is NHS England's Medical Director and professional lead for NHS doctors. He is responsible for promoting clinical leadership, quality and innovation. 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 (CHI) and the Healthcare Commission. He was knighted for services to medicine in 2003.

Appointed to the Board: 1 April 2013 (Voting)

National Director: Commissioning Strategy: Ian Dodge

Skills and experience: Ian Dodge joined NHS England in July 2014. During 2016/17 his directorate led 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.

Appointed to the Board: 7 July 2014 (non-voting)

National Director for Operations and Information: Matthew Swindells

Skills and experience: Matthew Swindells joined NHS England in May 2016 from the Cerner Group and his role as Senior Vice President for Population Health and Global Strategy. He has over 25 years' experience in health care services and senior roles include Chief Information Officer at the DH, Senior Policy Advisor to the Secretary of State for Health, Principal Adviser in the Prime Minister's Office of Public Service Reform and Chief Executive of the Royal Surrey County Hospital. He is visiting professor and Chair of the advisory committee in the School of Health Management at the University of Surrey and Member of the Editorial Board for the Journal of Population Health Management.

Appointed to the Board: 30 May 2016 (non-voting)

National Director: Transformation and Corporate Operations: Karen Wheeler CBE

Skills and experience: 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 has executive oversight of CSUs.

Appointed to the Board: 1 April 2014 (non-voting)

The following member of the Executive Group served for part of the year:

Interim National Director: Commissioning Operations: Richard Barker

Skills and experience: 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 CCGs 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.

Appointed to the Board: 1 January 2016 to 30 May 2016 (non-voting)

Board meeting attendance

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 at www.england.nhs.uk/about/whos-who/board-meetings/. In addition 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.

Member	Number of eligible meetings attended during the year	Comment
Professor Sir Malcolm Grant (Chair)	6/6	
David Roberts (Vice-Chair)	6/6	
Lord Victor Adebowale	5/6	Absence agreed with Chair
Wendy Becker	5/6	Absence agreed with Chair
Professor Sir John Burn	6/6	
Dame Moira Gibb	6/6	
Noel Gordon	6/6	
Michelle Mitchell	5/6	
Joanne Shaw	3/3	Appointed October 2016
Simon Stevens	6/6	
Paul Baumann	6/6	
Professor Jane Cummings	6/6	
Professor Sir Bruce Keogh	6/6	
Matthew Swindells	5/5	Appointed 30 May 2016
Ian Dodge	6/6	
Karen Wheeler	6/6	
Richard Barker	1/1	Member until 30 May 2016

Board diversity

NHS England had nine non-executive directors as at 31 March 2017, four of whom were female and five were male. Of the seven members of NHS England's executive group as at 31 March 2017, five were male and two were female.

Board performance

The Board had planned to undertake a review of its performance as part of a development session in the autumn of 2016; however changes to Board membership during the year meant this was deferred. Following discussion with the Chair, the Board has arranged for an external review, similar to that undertaken in 2014/15, to be undertaken during 2017/18.

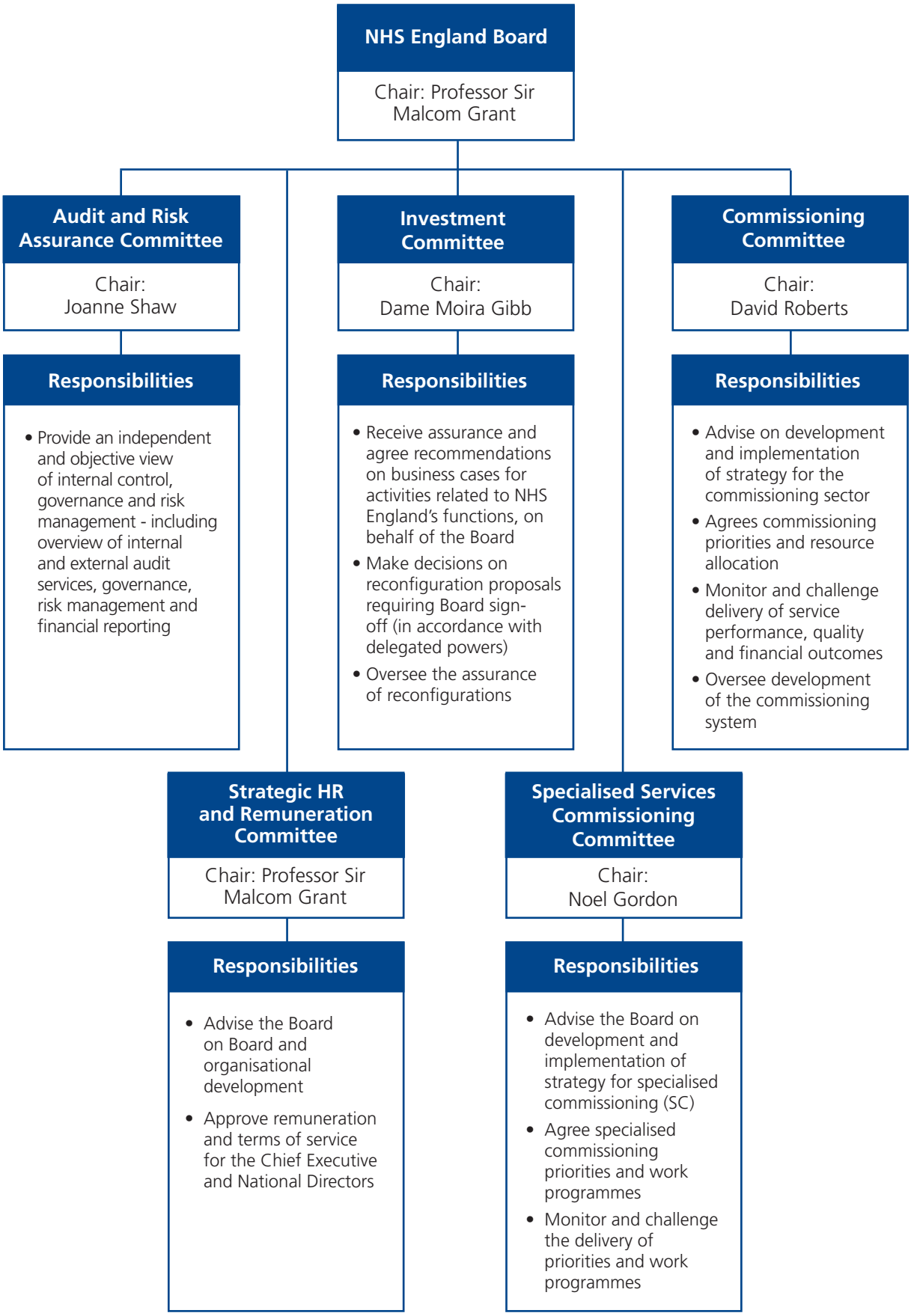
Board committees

The Board is supported by five committees which underpin the Board's assurance and oversight of the organisation. The 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.

Every committee provides a report to the Board following each meeting, ensuring the Board is kept informed of how the committees have discharged their delegated responsibilities. In addition, each committee provides the Board with an annual report covering their effectiveness, a review of the activities in the previous year, a summary of the priorities for the coming year and a review of the terms of reference. The Accounting Officer, as well as being a member of the Board, is similarly informed of each committee's activities through discussions with the relevant Chair.

The Chair and Accounting Officer reserve and exercise the right to attend meetings of all committees. In addition, all non-executive directors have a standing invitation to attend and participate in any of the Board committees' meetings.

NHS England Board and Committees



Audit and Risk Assurance Committee

Role of the Committee

The Audit and Risk Assurance Committee (ARAC) provides independent and objective assurance to the Board on how NHS England manages its system of internal control, governance and risk management. This includes an overview of internal and external audit services and financial reporting.

Committee members

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

Member	Number of eligible meetings attended during the year	Comment
Joanne Shaw (Chair)	3/3	Appointed October 2016
David Roberts	5/5	Interim Chair until 30 September 2016
Wendy Becker	4/5	Absence agreed with Chair
Noel Gordon	1/1	Member until end May 2016
Gerry Murphy	4/4	Non-executive Chair of the Department of Health's Audit and Risk Committee and member since June 2016

Committee attendees

Additional attendees are invited to attend meetings to assist with committee business. For 2016/17, these have included:

- Chief Financial Officer
- National Director: Transformation and Corporate Operations
- Director of Financial Control
- Director of Governance
- Director of Finance and Assurance (CSU Transition Team)
- Head of Internal Audit (Deloitte)
- Director responsible for Health at the National Audit Office (NAO)
- Chief Executive, NHS Protect

Principal activities during the year

The Committee has provided regular progress reports to the Board on its key duties which included:

- reviewing the organisation's risk profile and the management and mitigation of current and emerging risks, and ensuring that all corporate risks have an accountable national director and delegated risk owner
- evaluating the effectiveness of NHS England's control environment
- assessing the integrity of NHS England's financial reporting and satisfying itself that any significant financial judgements made by management were sound
- considering relevant reports from the Comptroller and Auditor General (NAO) on NHS England's accounts and the achievement of value for money
- commissioning and receiving internal audit reports on the adequacy of internal control systems, risk management and corporate governance
- reviewing the activities of internal and external auditors, including monitoring their independence and objectivity
- oversight of the organisation's arrangements for counter fraud.

Planned activities during the coming year

In 2017/18, the Committee will:

- consider areas for review by Internal Audit, approve the 2017/18 plan of work and monitor delivery against that plan and any continuing work from 2016/17
- continue to receive updates from National Directors on key control priorities and outstanding internal audit actions and key risks in their respective Directorates
- consider a refresh of the NHS England Economic Crime Strategy which will reflect any changes in the counter fraud landscape and priorities, and review and approve the proactive Counter Fraud Plan for 2017/18
- review the plan for delivery of the 2017/18 Annual Report and Accounts
- review updates from the NAO on progress with their audit work
- receive a governance report at each meeting to include consideration of corporate risks, updates to the governance manual and the status of Internal Audit recommendations
- oversee other key areas such as reporting against the Government's mandate to the NHS and delivery of NHS England corporate priorities.

Commissioning Committee

Role of the Committee

The Committee provides advice to the Board on the development and implementation of strategy for the commissioning sector, agrees commissioning priorities and allocation of resources, and receives assurance that performance, quality and financial outcomes are delivered, including financial performance monitoring. It also oversees assurance and development of the commissioning system.

Committee members

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

Member	Number of eligible meetings attended during the year	Comment
David Roberts (Chair)	9/9	
Lord Victor Adebowale	9/9	
Noel Gordon	7/9	
Simon Stevens	8/9	
Paul Baumann	8/9	
Professor Jane Cummings	7/9	
Professor Sir Bruce Keogh	9/9	
Ian Dodge	9/9	
Matthew Swindells	8/8	Member since June 2016
Richard Barker	1/1	Interim National Director: Commissioning Operations until 30 May 2016

Committee attendees

Additional attendees are invited to attend meetings to assist with committee business. For 2016/17, these have included:

- Director of Primary Care
- Director of Commissioning Development
- Director of Financial Planning and Delivery
- Regional Director (North)
- CCG representative

Principal activities during the year

Over the year, the Committee has focussed on:

- delivery of the main system transformation programmes, including urgent and emergency care reform, GP Forward View, RightCare, new care models, self care and self management, personal health budgets and pharmacy reform
- operational planning for 2017/18 and beyond
- overseeing STP plans
- overseeing the allocations process and agreeing the approach to CCG allocation adjustments for 2017/18
- assurance of financial and service performance, both within NHS England and across the commissioning system
- oversight of the development of a single integrated assurance process across NHS England and NHS Improvement for novel contracts
- CCG improvement, assessment and assurance processes ensuring that CCGs meet their statutory duties

- maintaining oversight on behalf of NHS England of: the commissioning system and its development, including the continued development of NHS England's commissioning strategy and setting out NHS England's expectations of the commissioning system in delivering the FYFV
- agreeing recommendations for CCGs taking on the delegation of primary medical care commissioning functions on behalf of the Board as well as the process and decision criteria for CCG mergers
- oversight of devolution programmes and related decision making.

Planned activities during the coming year

The Committee agenda in 2017/18 will continue to be based around the three strands set out above, but with a strong focus on the main elements outlined in Next Steps on the NHS Five Year Forward View particularly:

- the priority transformation programmes for urgent and emergency care, cancer, primary care and mental health
- the integration of care locally through STPs, Accountable Care Systems and new care models
- the NHS 10 point efficiency plan.

Specialised Services Commissioning Committee

Role of the Committee

The Committee provides advice to the Board on the development and implementation of NHS England's strategy for commissioning of prescribed specialised services, providing assurance of quality, performance and value for money.

Committee members

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

Member	Number of eligible meetings attended during the year	Comment
Noel Gordon (Chair)	8/8	
Professor Sir John Burn	5/8	
Michelle Mitchell	4/6	Member since May 2016
Professor Sir Bruce Keogh	7/8	
Paul Baumann	8/8	
Ian Dodge	5/8	
Matthew Swindells	0/5	Member since July 2016
John Stewart	8/8	Director of Specialised Commissioning
Simon Stevens	5/8	

Committee attendees

Additional attendees have been invited to attend meetings to assist with committee business. For 2016/17, these have included:

- Clinical Director for Specialised Commissioning
- Director of Strategy and Policy, Specialised Commissioning

Principal activities during the year

Over the year, the Committee has:

- overseen the development and implementation of:
  - a new strategic framework for specialised services, setting out expectations for delivering the FYFV and taking it forward through STPs
  - a new prioritisation process for new drugs and treatments
  - service reviews, including for high cost drugs and devices
- overseen the launch of the joint consultation with NICE on technology appraisals[7] and a consultation on NHS England's policies on service developments and individual funding requests
- reviewed and agreed the routine commissioning of 33 new treatments
- provided assurance and oversight for:
  - the new Cancer Drugs Fund
  - specialised commissioning financial plans for 2016/17 and 2017/18
  - operational decisions taken by NHS England's Specialised Commissioning Oversight Group (SCOG).

7. Changes to the arrangements for evaluating and funding drugs and other health technologies appraised through NICE's Technology Appraisal and Highly Specialised Technologies programme.

Planned activities during the coming year

The Committee's priority for 2017/18 will be to continue supporting the implementation of the strategic framework for specialised services. This will require the Committee to:

- provide assurance on how specialised commissioning is supporting improvements in patient care in relation to NHS England's priorities, particularly for mental health, learning disabilities and cancer
- provide assurance on financial control for specialised services and on achieving specialised services efficiency savings for 2016/17 to 2020/21
- oversee the implementation of place-based commissioning of specialised services where appropriate
- oversee ongoing work around data and information, including implementation of RightCare for specialised commissioning
- consider which new treatments will be routinely commissioned by NHS England for 2017/18 and 2018/19, taking advice from the Clinical Priorities Advisory Group (CPAG) and SCOG
- oversee the Medicines Value Programme, which aims to identify potential opportunities to maximise value from medicines.

Investment Committee

Role of the Committee

The Investment Committee scrutinises and approves significant and/or multi-year expenditure on high cost activities relating to NHS England's functions, including those relating to capital expenditure. It receives assurance and agrees recommendations on high value business cases on behalf of the Board.

The Committee also oversees the assurance of service change and reconfigurations and has delegated powers to make decisions on those requiring Board sign-off, supported by advice from the Oversight Group for Service Change and Reconfiguration (OGSCR).

Committee members

The Committee met eight times during the year. In addition, it carried out its function by correspondence once in April 2016 and held a specific conference call to address an investment decision in October 2016.

The following table details core membership and the number of meetings attended by each member:

Member	Number of eligible meetings attended during the year	Comment
Dame Moira Gibb (Chair)	8/8	
Wendy Becker	5/7	Member since June 2016
Paul Baumann	8/8	
Ian Dodge	6/8	
Matthew Swindells	5/5	Member since September 2016

Committee attendees

Additional attendees are invited to attend meetings to assist with committee business. For 2016/17, these have included:

- Director of Strategic Finance
- Director of Financial Planning and Delivery
- Director of Financial Control
- Director of Operations and Delivery.

Principal Committee activities during 2016/17:

- Provided overall assurance on the Transformation Fund for 2017/18 and 2018/19, and approved a number of investment cases using Best Possible Value methodology for investment decision making. This has included proposals for allocating funding for Wave 1 new care model vanguard sites, and approving investment in a number of successful bidders for transformation funding from priority programmes such as cancer, mental health, diabetes and learning disabilities.
- Regularly reviewed the pipeline of service change and reconfiguration proposals presented by the OGSCR. The Committee has made decisions on a number of reconfiguration proposals in advance of consultation, assessing quality and financial implications and ensuring compliance with applicable national guidance, legislation and best practice.
- Approved other capital and non-clinical revenue expenditure business cases, in line with Standing Financial Instructions (SFIs), and agreed the business as usual capital budget across the commissioning sector for 2017/18 and 2018/19.

Planned activities during the coming year

In 2017/18, the Investment Committee will continue to scrutinise and approve expenditure on activities relating to NHS England functions within limits set in the SFIs. In particular, the Committee will support transformation by approving investments and continuing to oversee the assurance of service change and reconfiguration proposals to support STP footprints.

Strategic HR and Remuneration Committee

Role of the Committee

The 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 members of the executive group in line with the DH and arm's length bodies' pay framework and Government decisions on public sector pay arising from the recommendations of the Senior Salaries Review Body.

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 Services Act 2006, as amended by the Health and Social Care Act 2012.

Committee members

The Committee met twice during the year. The following table details core membership and the number of meetings attended by each member:

Member	Number of eligible meetings attended during the year
Professor Sir Malcolm Grant (Chair)	2/2
Dame Moira Gibb	2/2
David Roberts	2/2

Committee attendees

Additional attendees are invited to attend meetings to assist with committee business. For 2016/17, these have included:

- Chief Executive
- National Director: Transformation and Corporate Operations
- National Director: Operations and Information
- Chief People Officer
- Regional Director of People and Organisation Development (London).

Principal activities during the year

Over the year the Committee has focused on NHS England's approach to talent management, improving workforce diversity, staff engagement and experience within NHS England and action plans to further enhance these areas. Other activities have included reviewing NHS England's talent management outcomes, progress with improving workforce race equality and diversity and scrutinising NHS England's staff experience and engagement outcomes and plans to improve in this area.

Additionally, the Committee approved outcomes from the annual appraisal of the Chief Executive and his voluntary decision to continue with a 10% reduction in base pay for 2016/17. The Committee also received reports assuring it about the implementation of the revised DH and arm's length bodies Executive and Senior Manager (ESM) pay framework and approved decisions relating to the targeted allocation of consolidated and non-consolidated pay awards to this group of senior staff for the financial year.

Planned activities during the coming year

During the coming year, the Committee will focus primarily on reviewing organisational development plans and the alignment of NHS England's support for and enablement of Next Steps on the NHS Five Year Forward View and STP across the system. The Committee will continue to review progress with talent management, workforce diversity and inclusion, and overall staff experience and engagement throughout the year ahead. Finally, the Committee will make decisions in respect of the Chief Executive's annual appraisal and pay and any issues pertaining to National Directors.

Board Disclosures

Disclosure of personal data-related incidents

During 2016/17, 18 Serious Incidents Requiring Investigation (SIRI) had occurred relating to the loss or disclosure of personal sensitive data in NHS England and Commissioning Support Units (CSUs). All were logged and a full investigation undertaken, with details set out from in Appendix 6 from page 273. Unless otherwise stated, remedial actions were implemented for all incidents and the Information Commissioner's Office kept informed as appropriate.

Slavery and Human Trafficking

NHS England fully supports the Government's objectives to eradicate modern slavery and human trafficking. Our Slavery and Human Trafficking Statement for the financial year ending 31 March 2017 was published on our website at www.england.nhs.uk/ourwork/safeguarding in May 2017.

Statement of Disclosure to Auditors

Each 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.

Board statement

The Board is responsible for preparing and approving the Annual Report and Accounts for 2016/17, and confirm that, taken as a whole, it is fair, balanced and understandable.

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 (HMT).

Under the National Health Service Act 2006 (as amended), the Secretary of State for Health (with consent of HMT) 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 (HMT, December 2016)[8] and in particular to:

- observe the Accounts Direction issued by the DH, 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.

The Accounting Officer confirms that the annual report and accounts as a whole is fair, balanced and understandable, and takes personal responsibility for the annual report and accounts and the judgements required for determining that it is fair, balanced and understandable.

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

8. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/577272/2016-17_Government_Financial_Reporting_Manual.pdf.

Governance Statement

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

As Accounting Officer, I have responsibility 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 those organisations which NHS England hosts. My responsibilities in relation to the assurance of CCGs are set out from page 133 of this Annual Report.

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 NHS Trusts, NHS Foundation Trusts or other providers of NHS-funded care, nor for the DH's 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.

A framework agreement between NHS England and DH additionally 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 the DH and other organisations, patients and the public, including commitment to the values in the NHS Constitution. The framework agreement can be viewed at: https://www.gov.uk/government/publications/framework-agreement-between-dh-and-nhs-england.

Governance arrangements and effectiveness

Governance framework

The governance framework includes the Standing Orders, Standing Financial Instructions, Scheme of Delegation, Risk Management Framework and three lines of defence model. Separate operating frameworks exist for each CSU.

The Governance and Assurance Project (GAP), reporting to the Chief Executive and ARAC, was launched in January 2016. Its purpose has been to improve the assurance and control environment with the organisation, addressing National Audit Office (NAO) and internal audit recommendations and strengthening management accountabilities. The project delivered its objectives and ended in March 2017.

Compliance with the UK Corporate Governance Code

NHS England's arrangements generally comply with the best practice described in the UK Corporate Governance Code (2016). 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 from page 278.

Board arrangements

Information on our Board and its Committees is set out from page 95.

Harris Review

Having regard to the wider implications of the Harris Review[9], which recommended an explicit assurance that all statutory duties and powers are understood and complied with, NHS England maintains a register of all of the statutory duties and powers conferred on it by the National Health Service Act 2006 and Health and Social Care Act 2012. This provides clarity about the legislative requirements and subsequent changes associated with each of the statutory functions for which it is responsible, including any restrictions on delegation of those functions. Responsibility for each duty and power has been clearly allocated to a national and/or regional director and the register is regularly reviewed by the Director of Governance and Head of Legal Services.

9. www.gov.uk/government/publications/independent-review-into-delegation-of-approval-functions-under-the-mental-health-act-1983.

Other sources of assurance

Internal control assurance framework

Over the past year we have worked with our internal and external auditors to strengthen our assurance framework. Each directorate and region has a designated director-level lead – reporting directly to respective national and regional directors and linking with the governance, audit and risk teams – with responsibility for ensuring risk management, audit actions and other assurance activities are carried out, approved by the relevant senior director and reported and escalated on a regular basis. This provides increased focus and accountability, and improved communication, at operating unit level across the organisation.

Over the past twelve months we have strengthened our governance team whilst making a number of changes to controls and underpinning processes including:

- obtaining regular management assurance from all senior managers, budget holders, Senior Responsible Owners for programmes and directors to confirm their compliance with the organisation's policies and processes
- the introduction of an improved risk management framework and review process and introducing a three lines of defence model
- more timely completion of internal audit actions
- compliance with requirements of travel, expenses and permanent staff establishment controls
- improving adherence to project and programme management controls
- compliance with established processes for business cases, authorisation and appointment for on and off-payroll workers.

These changes will be further incorporated into business as usual processes during 2017/18.

Management assurance

Management assurance processes introduced at the end of 2015/16, now form an important part of our control processes. All staff above Band 9 and all budget holders are required to provide assurance of compliance with controls and accountability requirements. This process strengthens formal accountabilities. Year-end assurance certifications were issued in April 2017 and returns confirm that the work carried out during the year on improving financial controls, commercial disciplines and new off-payroll worker processes has resulted in substantially increased compliance. Areas to focus on in the next return period relate to budget holders, training and returns, and increasing response rates. Implementation of this work continues into the 2017/18 financial year further addressing audit recommendations.

Assuring delivery of corporate priorities and related programmes

This year we implemented new assurance arrangements for our major corporate programmes, including six-monthly stocktakes which reported to the Corporate Executive Group, Executive Group and ARAC.

The Corporate Executive Group (a sub-group of the Executive Group) scrutinises NHS England's corporate delivery and informs Board performance reporting.

The NHS England portfolio includes other programmes, such as those forming our contribution to the Government Major Projects Portfolio, and informatics programmes within the Paperless 2020 'Driving Digital Maturity' portfolio overseen by the Digital Delivery Board.

Assuring the quality of data and reporting

The Board receives reports at each meeting covering finance and operational performance for NHS England as well as the wider commissioning system and NHS. The data contained in these reports is subject to scrutiny by both management and Board committees. Revised risk management and assurance certification processes provide additional assurance. 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 changing organisational needs.

Managing risk

In response to audit recommendations an enhanced risk management framework, aligned with the three lines of defence model and strategic challenges identified by the Board, was introduced in December 2016. This will be implemented during 2017/18 through national, directorate and regional levels supported by automated data collection.

All national and regional teams are required to identify, manage and report risks at the appropriate level and escalate, where appropriate, to the Executive Risk Management Group (ERMG) to be considered for inclusion in the Corporate Risk Register. The register has been redesigned in-year to align with the Board's strategic challenges, which are reviewed every six months, and improve consolidation and reporting. Regional oversight enables escalation of the risks affecting CCGs in their locality into NHS England as required via the regional process. This is further validated against the CCG annual reports. Risks on the register are bought to the attention of the Corporate Executive Group, the Board or one of its committees as appropriate.

The Corporate Risk Register is a regular agenda item for ARAC, where the organisation's risk profile is discussed and national directors attend to discuss key risks and issued in their respective parts of the organisation.

Key risks from the Corporate Risk Register, derived on the basis of potential high risk and probability, are:

System efficiency savings and financial sustainability

The NHS continues to be subject to significant cost pressures relating to its funding levels, not all of which are in the direct control of NHS England. We will work with DH and system leaders to support required efficiencies and seek to secure future financial sustainability across the life of the spending review period.

Supporting Sustainability and Transformation Partnership (STP) plans to transform local health economies

The commissioning system needs to secure high quality, comprehensive services within its financial envelope. STPs are being supported to deliver the scale of change that the system needs to deliver the aims of the FYFV. We need to provide the capability and capacity to support planning, and ensure STPs will deliver successful transformation.

Transforming primary care

Transformation in general practice and pharmacy is critical to the delivery of the FYFV and STP plans. We are working through delivery of the General Practice Forward View to increase the number of GPs and other staff, improve access to services and invest in new ways of improving primary care for patients.

Protecting NHS information

We continue to engage across the health and care system to raise awareness of cyber threat, develop our defence, detection and response capabilities and guard against data misuse. The sharing of information is essential to delivering an effective and efficient service and we will continually seek to improve our assurance.

Operational performance

NHS England, in partnership with NHS Improvement and DH, will work to support delivery of key services taking account of NHS Constitution standards on urgent and emergency care, given changing demographics and increasing demand for these services.

The following risks disclosed in our 2015/16 Annual Report are now mitigated to a lower level of risk maintained at directorate level and are no longer listed on the Corporate Risk Register:

- Cancer Drugs Fund. Now subject to an effective cost control mechanism (see CFO report on page 75)
- CSUs. Any loss of business and subsequent loss of income remains a risk, but arrangements such as risk pooling and engagement across national delivery are in place to seek to manage the risk. Further information is set out in the annual report from page 136.

Assuring the quality of services

The Quality Assurance Group provides assurance to the Executive Group, via the Corporate Executive, that mechanisms are in place to identify, manage and escalate quality concerns/issues arising from commissioned services where necessary, specific issues are escalated directly to the Executive Group. This provides a forum to discuss quality issues within NHS England's remit which require national action, considering reports from each region based on outputs from Quality Surveillance Groups, risk summits, patient complaints, safety incidents, CCG assurance conversations, and routine interactions with commissioners and providers and:

- share intelligence between regional and national teams related to quality risks/issues
- develop and publish NHS England's Serious Incident Escalation Process
- establish the Serious Incident Desk to strengthen NHS England's national coordination and management of serious incidents
- strengthen NHS England's processes for responding to and learning from Coroners Prevention for Future Deaths (Regulation 28) Reports.

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 is accessible via our staff intranet and website. The National Director: Transformation and Corporate Operations is the 'Freedom to Speak Up' guardian for staff in NHS England, and Professor Sir Malcolm Grant, Chair of NHS England, is the Board lead.

NHS England has been a Prescribed Person for primary care services under the provisions within the Small Business, Enterprise and Employment Act 2015, since April 2016. This allows whistleblowers working in primary medical services, dental services, ophthalmic services and local pharmaceutical services to disclose information to NHS England in addition or as an alternative to their own employer. Information on how staff from primary care organisations can raise a concern with us is set out on our website at www.england.nhs.uk/ourwork/whistleblowing/. This activity is overseen by designated regional whistleblowing leads reporting in to the central governance team. Formal reporting commences in April 2017, and will form part of the annual report, but interim arrangements are in place.

During 2016/17, NHS England received 127 external whistleblowing concerns which can be listed under the following themes:

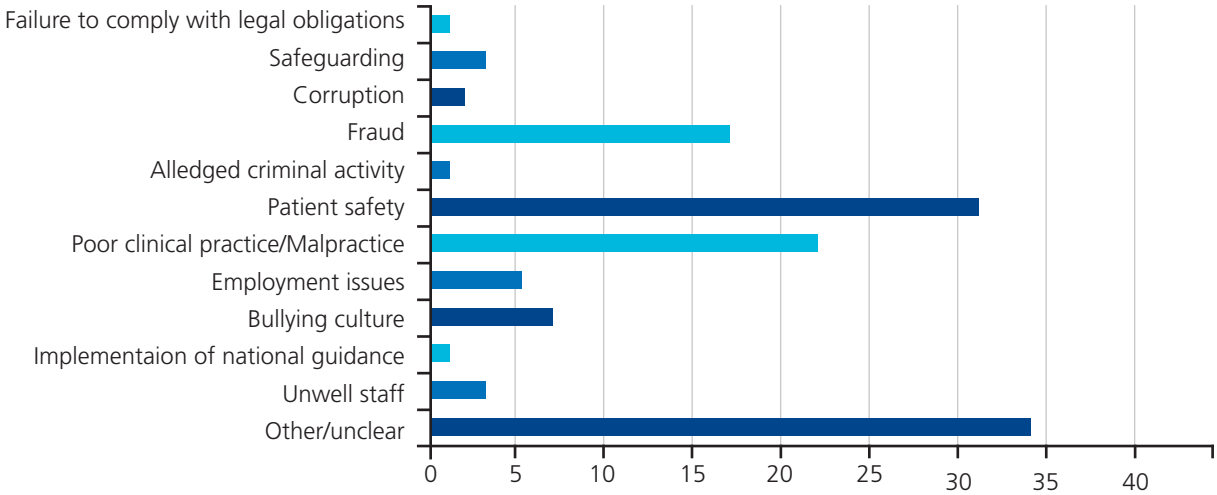


Table of external whistleblowing cases April 2016-March 2017

In the same period, NHS England received four internal whistleblowing concerns, all of which were investigated in accordance with our internal policy. CSUs reported an additional seven concerns which are being investigated under the CSU Raising a Concern Policy. Key themes were: treatment of staff, fraud and behaviours, systems and processes.

Cyber and data security

In July 2016, the National Data Guardian for Health and Care, Dame Fiona Caldicott, published a review into data security, consent and opt-out. It set out ten data security standards that organisations need to follow. A key recommendation is that every organisation should demonstrate clear ownership and responsibility for data security, just as it does for clinical and financial management and accountability.

NHS England already has arrangements in place to protect its information and systems and is working with DH, NHS Improvement and NHS Digital, to take forward the cyber-agenda on a system-wide level following the National Data Guardian Review. In driving forward a system-wide approach, new governance and oversight arrangements have been introduced.

We recognise the importance of embedding this agenda across the service and have implemented a number of activities during 2016/17 which align with the review recommendations and its focus on people, process and technology aspects.

These include:

- including data security standards in key contracts such as the GMS and NHS Standard Contract
- cyber readiness of Data Service for Commissioners Regional Offices (DSCROs) (staff embedded with CSUs, and responsible for handling patient data needed for commissioning)
- embedding end-to-end processes in regional teams (e.g. establishing 'cyber-champions' as key leads) in conjunction with regional leads for incident handing
- embedding cyber requirements within service specifications for primary care services and practice agreements
- providing the NHS England Board with accredited training on cyber and related responsibilities
- establishing a CCG Internal Audit Chair expert group to help develop a toolkit of audit requirements to raise awareness and assurance of the cyber risk.

Approximately 100 countries were hit by the WannaCry ransomware cyber-attack in May 2017. Although the NHS was not specifically targeted, the consequences of such a wide ranging attack were felt across the NHS from GP practices to hospitals. NHS England worked with NHS Digital, NHS Improvement, the National Crime Agency, the National Cyber Security Centre and others to respond to the attack to ensure that patients could continue to use the NHS whilst recovery actions were carried out.

Staff across the NHS worked tirelessly to minimise the disruption to patients, and the majority of immediate recovery actions were completed within a week. Since the attack we have conducted a review of cyber security to ensure the readiness of the NHS to respond to any further threats of this kind.

Information Governance

An Information Governance (IG) operating model and framework has been developed setting out arrangements for the provision of a high quality and effective Information Governance service for NHS England. IG assurance has been strengthened for CSUs through various mechanisms including governance and assurance meetings, monthly compliance statements and an annual independent audit of their IG toolkit assessment. Work is also underway to:

- determine a process for monitoring compliance in general practice with the IG toolkit
- understand the IG assurance mechanisms that are in place and determine the adequacy for other directly commissioned services including specialised commissioning, armed forces healthcare, and secondary dental care
- understand the commissioning responsibilities, data flows and data controllership for health and justice healthcare.

NHS England continues to implement assurance processes to ensure that the collection and provision of data to commissioners is managed appropriately, that only the minimum amount of data is used to support commissioning requirements and that data is being processed safely and securely by staff who understand their responsibilities to protect patient confidentiality. Working closely with NHS Digital, we are also reviewing the processing activities undertaken by CCGs and their support organisations, to ensure that they meet the high standards required to manage patient information for commissioning purposes.

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)[10]. NHS England analysts take part in workshops to ensure consistent performance and quality assurance across the full range of analytical work.

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

10. www.gov.uk/government/publications//review-of-quality-assurance-government-models/.

Service auditor reporting and third party assurances

NHS England relies on a number of third party providers (such as NHS Shared Business Services, NHS Business Services Authority, NHS Digital and Capita) to provide a range of transactional processing services ranging from finance to data processing. Our requirements for the assurance provided by these organisations have been reviewed and strengthened over the past year 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. Service providers are requested to address any control weaknesses identified during the ISAE 3402 reporting process within an appropriate timescale.

An adverse audit report was received for Capita and a remedial plan has been agreed for implementation by September 2017.

Internal audit

NHS England's internal audit service plays a crucial role in the independent 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 key business risks.

Our internal audit service, provided by Deloitte LLP, operates in accordance with 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 Head of Internal Audit opinion for 2016/17 is set out from page 141 of this Annual Report.

External audit

During the year, ARAC has worked constructively with the NAO's Director responsible for Health and his 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 ARAC 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.

Control issues

During 2016/17 we have worked to build further controls into a number of management processes identified as requiring improvement:

Strengthening establishment controls

We have addressed previous control issues by strengthening existing processes, controls and resources to manage the on and off-payroll establishment of NHS England. A new workflow system has been introduced 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 the new workflow involving both finance and human resources teams.

Improving control processes for off-payroll workers

We initiated a dedicated project which has operated during the 2016/17 year to review and improve management and control processes around off-payroll workers. A refreshed off-payroll workers policy has been approved and associated processes redesigned and strengthened. This includes links to the ESR system to provide a single means for managing all our NHS England workforce information, for both employees and off-payroll workers sourced through the Crown Commercial Service frameworks.

A workflow system for approvals containing additional commercial and assurance checkpoints has also been built as part of these strengthened processes. The revised approach will be in operation from April 2017 and implemented across the whole organisation as part of business as usual arrangements between April and July 2017.

This strengthened approach will ensure systematic adherence to our existing policy in that no off-payroll worker can be added to the ESR system unless appropriate approvals are in place, including HM Revenue and Customs compliance.

In addition, arrangements have been established for off-payroll workers engaged on an ad-hoc basis for their specific medical expertise (e.g. medical appraisers, clinical advisers and lay Chairs) to ensure they are engaged through a robust contractual arrangement and that numbers are reportable alongside the ESR data. This will be implemented during the first quarter of the 2017/18 financial year.

Providing stronger controls around business travel and expenses

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

The Business Travel and Expenses policy has been reviewed, and additional controls, enhancing management assurance of activity and spend each month, have been implemented to the satisfaction of auditors.

Improving procurement practices and compliance

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 planning. The new team is building a procurement pipeline for 2017/18 as part of wider business planning. Assurance has been strengthened through an improved approvals arrangement 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 all 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. Decisions on business cases for £1million and above, single tender actions and any retrospective applications are made 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 and assurance. Whilst progress has been recognised, there remains a significant programme of work to be delivered to underpin further improvements in this area and this will continue, and be subject to audit, throughout 2017/18.

Primary Care Commissioning

NHS England has accountability for the contract management of primary care service providers, including those delegated to CCGs. During the year PCSS issues have impacted the ability to fully discharge the relevant accountabilities. In addition, the framework for obtaining assurance over delegated responsibilities for primary care has remained in development.

Strengthening the management of conflicts of interest across the NHS

NHS England has continued to work with partners to strengthen the way that conflicts of interest are managed in the NHS, building on the work developed in 2015/16. 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:

- **A cross NHS approach:** The cross system task and finish group, chaired by Professor Sir Malcolm Grant and set up in 2015/16, developed a set of rules that are to be applied consistently across the health system – across all national bodies and agencies including arm's length bodies, professional regulators, local commissioners and NHS providers. The group developed proposals that were put out for consultation in the autumn. Following consideration by the NHS England Board, new guidelines for managing conflicts of interest in the NHS were published in February 2017 and can be accessed at https://www.england.nhs.uk/ourwork/coi/.
- **Strengthening NHS England's internal policy:** Work has been undertaken to revise NHS England's procedures to implement the findings of the group, and bring them into line with wider good practice. A revised Standards of Business Conduct policy has been approved by the NHS England Board and will be implemented from Q2 of 2017/18.

- **Strengthening conflicts of interest management in CCGs:**

  - In June 2016, we published revised statutory guidance on managing conflicts of interest for CCGs. This was accompanied by a series of practical templates and toolkits.

  - In 2017/18 we will provide further advice and support on conflicts of interest management to CCGs specifically addressing further developments in care models and integrated care organisations.

  - In April 2016, we published the findings of the 2015/16 co-commissioning conflicts of interest audit. From 2016/17, CCGs are required to complete an annual audit of conflicts of interest management.

  - We have also included a conflicts of interest indicator in the CCG Improvement and Assessment Framework (IAF) to assess compliance with the statutory guidance. Each CCG is given a rating as to whether they meet the indicator criteria and this is made available to the public via MyNHS.

  - NHS England has continued its programme of training for CCGs. This includes tailored training for over 100 CCG lay members to support them in managing conflicts of interest in line with the guidance.

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 117.

NHS Shared Business Services incident

NHS England was notified of a serious incident in March 2016 when NHS Shared Business Services, who previously provided primary care support services to NHS England in three geographical areas, reported a backlog of c709,000 unprocessed documents relating to patients. Management of the incident, repatriation and review of the documentation by registered GPs has taken place during the 2016/17 year and will continue in 2017/18. Associated patient-related issues are now being followed up appropriately through a clinical review process which will determine whether any harm has been caused. The NAO has conducted an investigation into the incident and published its findings in June 2017.

The Information Commissioner's Office (ICO) continue to investigate the incident. In February 2017 an information governance incident occurred involving financial data which has been reported to the police for investigation. GPs received payment for reviewing documentation totalling £2.5 million.

Detail on Losses and Special Payments incurred as a result of this incident are set out on page 172.

Primary Care Support Services contract

A seven-year contract to provide primary care support services (PCSS) was awarded to Capita in September 2015, to provide transformational improvements to the service and drive £40 million per annum operating cost savings. After a few months of successful service, Capita implemented service changes which led to major issues in the operational services. These issues emerged during the summer of 2016, causing significant backlogs, delays and other issues which had serious impacts for many primary care users and their patients. The service issues included a significant increase in information governance issues, largely through failings in the new PCSS courier arrangements.

NHS England rapidly escalated its service management arrangements to scrutinise Capita's performance, hold it to account for making recovery and drive improvements. Contractual levers have been deployed, including requiring recovery plans across five of the PCS service lines. Capita have implemented their agreed recovery plans, which included significant additional and improved resources, upgrading of training and procedures, improved communication with and support to users and stakeholders, and much strengthened operational management. They also significantly improved their IG capability and assurance arrangements. NHS England has also provided significant help from service experts, to assist the service recovery.

Although recovery has been much slower than hoped, services have steadily recovered and backlogs have progressively been cleared. Most services have been largely recovered to business as usual, though some backlogs and recovery work will continue through to the end of June 2017. A list of the related information governance incidents is included at page 273 of this Annual Report.

Assurance of the commissioning system

NHS direct commissioning

NHS England has a statutory duty to directly commission certain 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 its national and 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.

As a single organisation, we are careful to target our resources to focus national oversight on the areas of greatest risk. The three Oversight Groups for public health, armed forces and health and justice focus on key strategic issues, with regular reports on quality, performance and finance. The Primary Care Oversight Group focuses on strategic and key operational matters, with detailed operational discussions held by the Primary Care Delivery Oversight Group. The Commissioning Committee receives regular reports, and also in depth reviews of specific areas. Over the coming year, we will be strengthening our national assurance of delivery of the key general practice commitments set out in the Next Steps Five Year Forward View.

In total, direct commissioning for non-specialised services accounts for £9.9 billion of total commissioning expenditure (these figures do not include funding that is delegated to CCGs for primary medical care).

Specialised commissioning

NHS England is also responsible for the direct commissioning of specialised services for people who have rare and complex conditions. Specialised services cover a range of services from renal dialysis and secure inpatient mental health services, through to treatments for rare cancers and life threatening genetic disorders. Specialised services often deliver cutting edge care, using new drugs and technologies to improve patient outcomes.

The Specialised Services Commissioning Committee provides advice to the Board on the development and implementation of NHS England's strategy for commissioning of prescribed specialised services, providing assurance of quality, performance and value for money. The Committee also assures decisions made by the Specialised Commissioning Oversight Group which has operational oversight of specialised commissioning and the Clinical Priorities Oversight Group (CPAG) which makes recommendations on the commissioning position of treatments and interventions for adoption, or otherwise, by NHS England.

In total, direct commissioning for specialised services accounts for £15.4 billion of total commissioning expenditure.

Clinical Commissioning Groups

NHS England is accountable for overseeing and assuring the commissioning system to ensure that it is working effectively. In particular with regard to the 209 CCGs, NHS England has a statutory duty to performance assess each CCG every year to determine how well it has discharged its functions during that year. 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 the 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 £76.5 billion of total commissioning expenditure.

Overall, this ensures that CCGs are delivering the best outcomes for their patients and have a high standard of financial management, administering resources prudently and economically and safeguarding financial propriety and regularity. Parliament has also provided for specified limited rights of intervention by NHS England into CCG functions.

CCG Improvement and assessment

NHS England published the new CCG Improvement and Assessment Framework (IAF) for 2016/17 to fully align with the FYFV, NHS Shared Planning Guidance and STPs. It supports a number of tasks including implementation of the FYFV to drive improvements in health and care, restoration and maintenance of financial balance, and the delivery of core access and quality standards.

Legislation requires an annual performance assessment to be carried out at an individual CCG level. The three areas with which the CCG IAF aligns recognise that wider system working is necessary for the longer term sustainability of the NHS.

The IAF focuses on a manageable number of the highest priorities facing the NHS and, as a dynamic tool, will be refreshed over time so that the assessment of CCGs continually focuses on the greatest emerging and actionable opportunities. It provides a greater focus on assisting improvement alongside NHS England's statutory assessment function and closely aligns NHS England's operational and national policy teams to diagnose issues, set out what good and outstanding look like and apply the most effective support and resources to help CCGs achieve this.

NHS England also has the option of using its statutory powers, conferred by section 14Z21 of the NHS Act 2006 (as amended) to support CCG improvement where a CCG is failing or is at risk of failing to discharge its functions. At the year-end assessment of CCGs in 2015/16 those rated as inadequate, and not already under direction, had directions applied to ensure a strong focus on improvement.

Details of CCG directions can be found on the NHS England website at www.england.nhs.uk/commissioning/ccg-assess/directions/.

In July 2016, as part of the actions taken to strengthen NHS financial and operational performance, NHS Improvement and NHS England announced that a number of Trusts and nine CCGs were being placed in a new regime of special measures. NHS England's special measures is an internal management approach to CCGs under direction, to enable more intensive support for improvement.

60 CCGs have been reported to the Secretary of State under Section 30 of the Local Audit and Accountability Act 2014 due to forecasting that expenditure would exceed income during the financial year.

CCG annual reports

CCGs publish their individual annual reports via their websites. A list of CCGs, and links to their websites, can be found on the NHS England website at www.england.nhs.uk/ccg-details/.

A review of the 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 in earlier exception reports.

Co-commissioning of primary medical services

Since April 2015, CCGs have had the opportunity to assume greater responsibility for general practice commissioning via one of three co-commissioning models: greater involvement; joint commissioning and delegated commissioning.

NHS England's Board has committed to support the majority of CCGs to migrate to full delegation by 1 April 2017. Giving CCGs more control and say over primary medical services is part of a wider strategy to support the development of place-based commissioning and new care models.

In 2016/17, 114 CCGs implemented delegated arrangements, 70 CCGs joint arrangements and 25 CCGs the 'greater involvement' model. Following joint work between NHS England, CCGs and NHS Clinical Commissioners, a further 62 CCGs will be taking forward full delegation during 2017/18 representing 85% coverage.

Where NHS England has delegated functions to CCGs, NHS England retains overall responsibility for the Primary Medical Services function and is therefore responsible for obtaining assurance that the terms of the delegation agreement are being complied with. It has been agreed that a framework will be developed to achieve this.

Commissioning Support Units

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 SFIs. Any management actions are managed through the CSU's finance director, with oversight by the CSU's leadership team and the central CSU Transition Team. Progress is then reported to ARAC. The Commissioning Committee also receives regular information on CSU assurance, performance and risk.

All CSUs make monthly returns to the CSU Transition team as part of an operational assurance dashboard, which includes a governance assurance statement covering issues such as compliance with SFIs. CSU Managing Directors provide assurance of compliance with controls and accountability requirements.

CSUs have internal management assurance frameworks, governance controls and processes in place which are reviewed by the CSU Transition team 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 more detail. This provides a focus on issues of strategy, delivery and compliance, providing 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 and any exceptions relating to the processes CSUs operate for their customers are reported via service auditor reports.

Further to completion of the 2016/17 year-end Service Auditor Reporting process, with the exception of North East London, all CSUs met the final reporting deadline of 28 April 2017.

Of the 10 final reports issued, six were given an 'Except for opinion' (where one or more control objectives could not be confirmed as having being met either from a control design or operating effectiveness perspective) and four a 'No Qualifications' opinion (where it was concluded that controls were suitably designed and operating to provide reasonable assurance that the stated control objectives were achieved throughout the period).

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

Allocations

The Chief Financial Officer report provides an update on how we are progressing our responsibility to allocate NHS funds and our ongoing plan to secure future financial sustainability. Please see page 75.

Operational planning

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.

To support the STP process and help to drive partnership working, in late 2016, NHS England, together with NHS Improvement, significantly streamlined the annual NHS planning and contracting round to provide greater certainty and stability, simplify processes, and support partnership and transformation, with two year operational plans, underpinned by two-year pricing arrangements and a two-year NHS Standard Contract. This was designed to provide greater stability and certainty for planning local health services, and allow NHS organisations to spend less of their time locked in adversarial and transactional relationships and devote more of their energies towards redesigning and delivering better, more efficient care.

Through the planning process, NHS organisations have been tasked to deliver individual CCG and NHS provider organisational control totals, and achieve local system financial control totals, implement local STP plans and achieve local targets to moderate demand growth and increase provider efficiencies. The planning guidance also set the expectation that providers and commissioners need to have focus on efficiency in 2017/18 and 2018/19; and that the opportunities set out in the national efficiency programmes and embedded in STPs are further developed in operational plans and delivered by providers and commissioners working together.

The joint operational planning guidance set out the business rules for commissioners for 2017/18 and 2018/19. Following the 2016/17 planning round, 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 jointly with NHS Improvement to secure alignment of commissioner and provider plans.

As in 2016/17, we are setting aside a risk reserve to manage system wide risks and hence manage the overall financial performance of the NHS. In 2016/17 this was comprised of 1% of commissioner allocation set aside at the start of the year. For 2017-19 the risk reserve will be made up as follows:

- CCGs are to set aside 0.5% of their allocation
- 0.5% of the local CQUIN will be held in reserve by providers
- NHS England will hold £200 million in reserve centrally.

The risk reserve will again be held until such time as we can be confident that the NHS is on track to meet its financial targets for the year.

The planning guidance for 2017/19 also set out that NHS England would use the Best Possible Value (BPV) framework approach, developed to ensure we extract the best possible value for every pound spent through our investment decisions, to assess all transformation investment decisions and run a single coordinated process to minimise the administrative burden on local areas who would be applying for funding. In December 2016 we launched this single coordinated application process for national programmes including mental health, cancer, diabetes and learning disabilities.

Financial performance monitoring

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, 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 continued its focus during 2016/17 on improving the financial resilience of CCGs, progressing a work programme to deliver effective mechanisms to detect deteriorating financial performance earlier and take robust action where required.

NHS England central programme costs

NHS England's internal business planning process was launched in October 2016. This was designed to align with the system planning guidance and years two and three of STPs, as well as addressing issues inherent with one year planning by allocating funding to programmes for two years, rather than the single year allocated previously.

The corporate aims and priorities were agreed by the Executive Group and remained consistent with the approach in 2016/17. In submissions for programme funding, the leads for corporate priorities were asked to specify the outcomes that they will deliver over the period, demonstrate how these outcomes support the FYFV and NHS England's mandate, and to set out clearly how they plan to move from national strategy and planning towards regional and local delivery.

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.

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 contracts Deloitte LLP to provide accredited counter fraud specialists and undertake counter fraud work proportionate to its risks. ARAC receives regular updates regarding the development of the counter fraud function, the progress against the proactive work plan and reactive investigations. The Director of Financial Control is delegated the day-to-day operational responsibility for the NHS England counter fraud function, and the Chief Financial Officer also provides executive support and direction.

NHS England approved an Economic Crime Strategy in 2016/17 which details its approach to tackling fraud, bribery and corruption until 2020. The strategy describes its counter fraud function, including its strategic and annual proactive counter fraud work plans, as well as its reactive strategy. 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 ensure compliance with the Standards for Commissioners: Fraud, bribery and corruption. NHS England was quality assessed against the standards in 2016/17 and is taking appropriate action in relation to the recommendations made by NHS Protect. ARAC receives a report at least annually against each of the standards.

A number of initiatives have continued to tackle the fraud risk in primary care, including significant extension of the Prescription Exemption Checking Service, the Dental Benefit Eligibility Checking Service and others managed by NHS BSA on behalf of NHS England. These schemes have led to net recoveries of £21.7 million in 2016/17, with further development planned for 2017/18. The recoveries received demonstrate that the current initiatives are producing results, as well as creating an expected deterrent effect. The continued development of the counter fraud service in the coming years aims to amplify this effect.

Head of Internal Audit opinion

My Head of Internal Audit has informed me that, based on the internal audit work undertaken during 2016/17 and in the context of the overall environment for NHS England for 2016/17, in his opinion the frameworks for governance and risk management have been adequate in 2016/17; however a number of the actions implemented through the Governance and Assurance Project (GAP) need to continue to be embedded during 2017/18 in accordance with the plans in place.

With respect to the internal control environment, significant effort has been focussed on implementing the structures designed in 2013/14, 2014/15 and 2015/16, albeit that some structures, for example 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 2016/17.

At 31 March 2017, 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.

In addition, the Head of Internal Audit reports that the following factors should be taken into consideration with respect to the assessment:

- The internal audit work for 2016/17 has focussed on assessing the operational effectiveness of the core processes. A readiness assessment was performed in relation to off-payroll workers during 2016/17, given the process has been re-designed during the financial year.

- 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[11]. These include primary medical care commissioning; performers concerns follow-up; cancer drugs fund; procurement; RightCare; cancer programme; mental health programme; safeguarding; learning disabilities programme; CSU general controls; risk management; travel and expenses and performance appraisal. Management actions have been agreed to address all of these observations. However, given the nature of the agreed management actions, not all of these have been completed by year end. Where possible interim solutions have been put in place whilst activity remains focussed on the implementation of the agreed actions.

- There were a number of areas of concern previously identified by NHS England management, for example with respect to NHS SBS, procurement, off-payroll workers and individual projects. Projects have remained in place to rectify the identified gaps or management has requested that the internal audit team complete additional work in these areas.

- There remains significant reliance on third party providers of core services including:

  - NHS SBS for the Integrated Single Financial Environment (ISFE), transaction processing, procurement and payroll services

  - NHS BSA for human resources and procurement services

  - Capita for Primary Care Support Services

  - NHS Digital for data processing.

11. Priority 1 - Recommendations which are fundamental to the system of controls and upon which the organisation should take immediate action.

The understanding of the assurance requirements from these providers has further evolved during the year. Additional assurance reports have been obtained for 2016/17, for example with the receipt of a Service Auditor Report from NHS Digital and Capita. There does however remain a requirement to continue to understand respective responsibilities in an environment where significant reliance is placed on third parties.

Overall summary

Over this year we have made significant progress through a dedicated project to strengthen our approach to governance, assurance and controls and to address a number of audit recommendations, highlighting areas requiring attention.

We welcome the acknowledgement of this progress by our auditors, and during the coming year we will continue to sustain the outcomes of this work – particularly around commercial disciplines, third party assurance, contract management and risk – by ensuring that the relevant frameworks are fully and consistently implemented across the organisation.

Remuneration and Staff Report

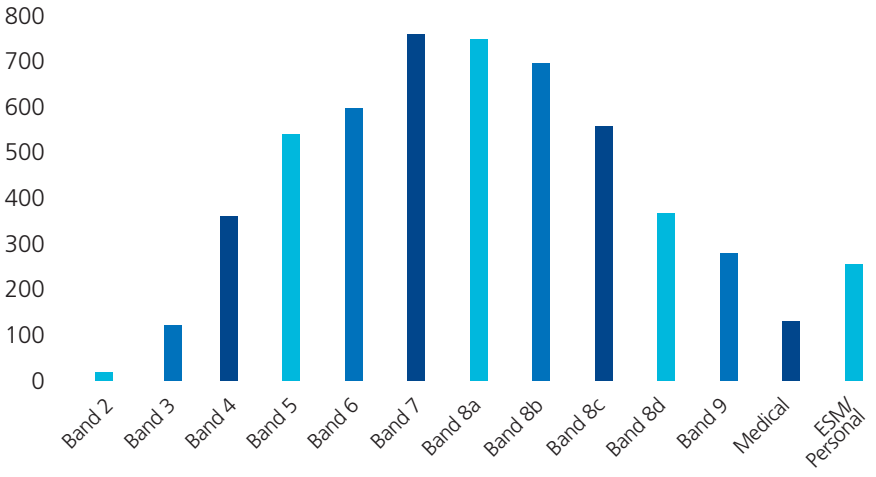
Our organisation and people

As at 31 March 2017, NHS England directly employed 5,400 people[12]. Of these, 4,503 people were permanently employed on recurrent, open-ended contracts of employment, based around the country within seven directorates. In addition, a further 897 people were employed on payroll on fixed term contracts of employment:

Member	Number of people employed
Chair and Chief Executive's Office	17
Commissioning Strategy	321
Finance	192
Medical	356
Nursing	214
Operations and Information (including regional teams)	3,669
Specialised Commissioning	146
Transformation and Corporate Operations	485
Total	5,400

Detail on staff numbers and costs for NHS England and the Consolidated Group, including CSUs, are presented from page 152.

All staff by pay band[13]



Band 2	20	0.4%
Band 3	122	2.3%
Band 4	362	6.7%
Band 5	536	9.9%
Band 6	591	10.9%
Band 7	760	14.1%
Band 8a	748	13.9%
Band 8b	698	12.9%
Band 8c	553	10.2%
Band 8d	368	6.8%
Band 9	271	5.0%
Medical	125	2.3%
ESM/Personal	246	4.6%
Grand total	5,400	100.0%

12. Commissioning Support Unit staff are not directly employed by NHS England and are therefore not included in this analysis. Given NHS England is responsible for overseeing CSUs, staff numbers and expenses are reflected within the financial statements in this report.

13. The term 'senior manager' denotes all staff remunerated at or above the pro-rata salary of £78,629 per annum. This is consistent with the definition used within Cabinet Office and HM Treasury returns.

NHS England has seen an increase in headcount of 7% since 2015/16, as we have reduced usage of temporary and contract labour, with the biggest increases between Bands 6 to 8c (salary range £26,302 - £68,484 per annum).

All staff by gender

	Head count	Percentage
Female	3,738	69%
Male	1,662	31%
Total	5,400	100%

Senior managers by gender

	Head count	Percentage
Female	415	51%
Male	394	49%
Total	809	100%

These proportions are largely unchanged from 2015/16.

All staff by ethnicity

	Head count	Percentage
White	3,988	74%
BME	763	14%
Unknown	649	12%
Total	5,400	100%

Senior managers by ethnicity

	Head count	Percentage
White	589	73%
BME	67	8%
Unknown	153	19%
Total	809	100%

The proportion of people employed by NHS England that consider themselves to be from a black or minority ethnic (BME) heritage has increased by 3% over the year (2015/16: 11% all staff, 5% senior managers). This is a consequence of focussed effort to improve our workplace diversity and inclusion, in line with the Public Sector Equality Duty and NHS England's response to the Workforce Race Equality Standard (WRES) for the NHS. The organisation has worked in close partnership with the NHS England BME staff network to achieve these improvements.

All staff who consider themselves to have a disability or long term condition

	Head count	Percentage
No	4,479	83%
Yes	292	5%
Unknown	629	12%
Total	5,400	100%

Senior managers who consider themselves to have a disability or long term condition

	Head count	Percentage
No	610	75%
Yes	32	4%
Unknown	167	21%
Total	809	100%

We have worked closely with the NHS England Disability and Wellbeing Network (DAWN) staff to close the gaps in our workforce diversity data and encourage people to self-classify, and 2.5% more staff have chosen to disclose whether they have a disability or long term condition this year (2015/16: 14.5% all staff, 24% senior managers). The percentage of staff disclosing a disability or long term condition has remained constant (2015/16: 5.2% all staff, 4% senior managers).

All staff by sexual orientation

	Head count	Percentage
Heterosexual	4,140	77%
LGB	151	3%
Unknown	1,109	21%
Total	5,400	100%

Senior managers by sexual orientation

	Head count	Percentage
Heterosexual	519	64%
LGB	22	3%
Unknown	268	33%
Total	809	100%

The number of people choosing not to disclose their sexuality has decreased by 3% across the workforce and by 3.5% at senior manager level this year (2015/16: 24% all staff, 36.5% senior managers)[14]. 1% more staff now report that they are lesbian, gay or bisexual (2015/16: 1.65% all staff, 1.9% senior managers).

14. It is not possible to record whether staff members classify themselves as transgender on the NHS electronic staff record (ESR), this is a national functionality restriction within ESR and not something that NHS England is able to address locally. The above figures total 101 due to rounding.

Our people commitments

We have continued to shape and strengthen our capabilities, processes and infrastructure during the year to ensure that NHS England can recruit, retain, recognise and develop a diverse range of people with the right capabilities and values to deliver our business plan. Progress made in each of our 'People Commitment' areas is detailed below.

Talent management and development

We have continued to build talent and capability at all levels across the organisation to ensure that our people are able to contribute their maximum potential to delivery of the NHS Five Year Forward View. During the year, we expanded the number of interventions on offer to support talent development - including job shadowing, coaching, mentoring, and a series of internal stretch assignments being offered, working closely with our staff networks to directly communicate these opportunities. Shaped with the insight we have obtained from our BME senior leaders and BME Staff Network, we have built talent plans at a regional and directorate level that fully reflect our agreed approach to improving diversity and inclusion, and to enable us to best use our available talent to support, lead and contribute to the delivery of our priorities and meet our challenges.

In August 2016, we strengthened leadership development and line manager capability with the launch of a new Line Management Development Programme which is underpinned by a set of line management standards. 192 managers have since benefitted from attending the programme.

We supported the Government's target to deliver three million apprenticeships by 2020 through the launch of our new 'Skills 4 Success' programme. We will be able to offer a range of high quality apprenticeship qualifications to both existing staff and new recruits to secure a highly skilled, diverse and talented workforce that is fit for the future and meets our existing and future skills gaps.

Improving our workforce diversity and inclusion

We recognise that people are increasingly keen to work for organisations that give them both the opportunity and freedom to be themselves. Our four staff diversity networks continue to grow with over 500 members: the BME network, the Lesbian, Gay, Bisexual, Trans + network, DAWN and the Women's Development Network. These networks provide opportunity for our people to influence change, gather feedback and present their views on the topics that are most important to them including policy and staff development, raising awareness and celebrating diversity.

A Diversity and Inclusion Group, led by a member of the NHS England Board, was established during 2016 to bring key partners and stakeholders, including our trade unions, together to help create a fairer and more inclusive workforce for NHS England.

We achieved an improved ranking in the Stonewall Workplace Equality Index in 2017, moving up 16 places, as a result of improvements made in networking groups, career development, training and community engagement.

In October 2016, we were awarded Disability Confident Employer status by the Department for Work and Pensions in recognition of our commitment to recruiting and retaining disabled people and people with health conditions for their skills and talent.

Our Work Experience Policy, which forms part of our commitment to equality, diversity and inclusion in the work place, was launched in September 2016 and provides a range of opportunities to students and those in vulnerable and under-represented groups. In November 2016, as part of the Mencap's learning disability work experience week, we hosted two work experience candidates with learning disabilities, both of whom spent time with the Chief Executive and his private office.

Workplace health, safety and wellbeing

In December 2016, we were accredited with the Health@Work Workplace Wellbeing Charter, in recognition of the significant and wide-ranging work we have undertaken to create a workplace where the physical, mental and emotional health and safety of our colleagues is supported and improved.

During 2016/17, we trained a further 289 of our people as Mental Health First Aiders (MHFA). We also continue to hold regular events and raise awareness of mental health by supporting national campaigns and awareness days including Time to Talk, Mental Health Awareness Week and World Suicide Prevention Day.

As part of the wider NHS Healthy Workforce Programme, we piloted a number of new initiatives during the year to better support the mental and physical health of our colleagues. Successes include the launch of a Weight Watcher voucher scheme in June 2016, resulting in 101 people signing up to completing a 12 week programme to successfully lose weight, and the issuing of a further 69 bikes under the cycle to work scheme since 1 April 2016.

In 2016/17, the average number of sick days taken by whole time equivalent employees decreased by 1.1 days against the previous year.

Sickness absence for the period April 2016 to March 2017 was as follows:

	Whole time equivalent days available	Whole time equivalent days lost to sickness absence	Average sick days per whole time equivalent
NHS England	1,734,735	23,990	5.0
CSUs	2,261,173	39,120	6.3
Total Parent	**3,995,908**	**63,109**	**5.8**
CCGs	6,002,681	102,502	6.2
Consolidated Group	**9,998,589**	**165,611**	**6.0**

Staff engagement and experience

We externally commissioned a short 'pulse' staff survey in May 2016, followed by a full 'census' staff survey in October 2016 to enhance analysis and reporting of employee engagement within NHS England. Our overall response rate for the census survey was 71%, a +4% positive improvement in our response rate since the previous survey. Overall employee engagement scores are up +10% over the past three years.

Staff engagement groups have been established across the organisation, working with our leadership teams to address issues raised in the staff survey. A national staff engagement group brings together the learning from these local groups, chaired by a member of the Board.

We have built on the success of our staff recognition scheme 'Everyone Counts Awards', and this recognised 34 colleagues who have gone the extra mile and been a true advocate of our values and behaviours.

Our improvement and change activities

Workforce systems

In April 2016, a Workforce Systems Team was appointed to ensure staff were better equipped to access and record information around their employment and provide the organisation with a sharper picture of key people trends and people analytics to support evidence based decision-making and our ambition to become an employer of choice.

Organisational change programmes

As we continue to transform the organisation, our National Partnership Forum with the recognised Trade Unions representing NHS England staff, enables us to inform, involve and consult with colleagues across the business on our future plans.

In 2016, a significant piece of work was undertaken to ascertain how digital functions might best be structured to support the development and delivery of national strategies on information, technology and data investment. As a result of this review, 29 of our people transferred to NHS Digital - the national provider of information, data and IT systems for commissioners, analysts and clinicians in health and social care.

Looking forward to 2017/18

Our approach to People and Organisation Development for 2017/18 will focus upon talent management and development, creating a diverse and inclusive workplace, culture and employee engagement, and health, wellbeing and safety at work.

Staff numbers and costs (subjected to audit)

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

Average number of people employed

Parent	2016/17				
	Total number	Permanent employed number	CSU employed number	Other number	CSU other number
Total	**12,649**	**4,696**	**6,111**	**1,019**	**823**
Of the above:					
Number of whole time equivalent people engaged on capital projects	**8**	**-**	**8**	**-**	**-**

Parent	2015/16				
	Total number	Permanent employed number	CSU employed number	Other number	CSU other number
Total	**14,365**	**4,693**	**7,373**	**1,056**	**1,243**
Of the above:					
Number of whole time equivalent people engaged on capital projects	**-**	**-**	**-**	**-**	**-**

Consolidated Group

	2016/17				
	Total number	Permanent employed number	CSU employed number	Other number	CSU other number
Total	**31,017**	**20,909**	**6,111**	**3,174**	**823**
Of the above:					
Number of whole time equivalent people engaged on capital projects	**12**	**3**	**8**	**1**	**-**

Consolidated Group

	2015/16				
	Total number	Permanent employed number	CSU employed number	Other number	CSU other number
Total	**30,535**	**18,807**	**7,373**	**3,112**	**1,243**
Of the above:					
Number of whole time equivalent people engaged on capital projects	**-**	**-**	**-**	**-**	**-**

Employee Benefits

Parent

Employee benefits	Permanent employees £000	Permanent CSU employees £000	Other £000	CSU other £000	Total £000
	2016/17				
Salaries and wages	236,642	233,052	60,888	70,550	**601,132**
Social security costs	27,285	24,933	7	5	**52,230**
Employer contributions to NHS pensions scheme	31,278	29,501	25	6	**60,810**
Termination benefits	(395)	7,201	-	-	**6,806**
Gross employee benefits expenditure	**294,810**	**294,687**	**60,920**	**70,561**	**720,978**
Less: Employee costs capitalised	-	(196)	-	-	**(196)**
Net employee benefits excluding capitalised costs	**294,810**	**294,491**	**60,920**	**70,561**	**720,782**
Less recoveries in respect of employee benefits	(8)	-	-	-	**(8)**
Total net employee benefits	**294,802**	**294,491**	**60,920**	**70,561**	**720,774**

Parent

Employee benefits	Permanent employees £000	Permanent CSU employees £000	Other £000	CSU other £000	Total £000
	2015/16				
Salaries and wages	231,571	272,986	70,435	105,303	**680,295**
Social security costs	22,149	23,230	12	16	**45,407**
Employer contributions to NHS pensions scheme	30,381	34,611	13	18	**65,023**
Termination benefits	4,271	12,816	-	-	**17,087**
Gross employee benefits expenditure	**288,372**	**343,643**	**70,460**	**105,337**	**807,812**
Less: Employee costs capitalised	-	-	-	-	**-**
Net employee benefits excluding capitalised costs	**288,372**	**343,643**	**70,460**	**105,337**	**807,812**
Less recoveries in respect of employee benefits	(390)	(588)	-	(237)	**(1,215)**
Total net employee benefits	**287,982**	**343,055**	**70,460**	**105,100**	**806,597**

Consolidated Group

Employee benefits	Permanent employees £000	Permanent CSU employees £000	Other £000	CSU other £000	Total £000
	2016/17				
Salaries and wages	946,796	233,052	240,222	70,550	**1,490,620**
Social security costs	105,015	24,933	199	5	**130,152**
Employer contributions to NHS pensions scheme	121,997	29,501	172	6	**151,676**
Termination benefits	2,243	7,201	-	-	**9,444**
Gross employee benefits expenditure	**1,176,051**	**294,687**	**240,593**	**70,561**	**1,781,892**
Less: Employee costs capitalised	(130)	(196)	(116)	-	**(442)**
Net employee benefits excluding capitalised costs	**1,175,921**	**294,491**	**240,477**	**70,561**	**1,781,450**
Less recoveries in respect of employee benefits	(4,990)	-	(93)	-	**(5,083)**
Total net employee benefits	**1,170,931**	**294,491**	**240,384**	**70,561**	**1,776,367**

Consolidated Group

Employee benefits	Permanent employees £000	Permanent CSU employees £000	Other £000	CSU other £000	Total £000
	2015/16				
Salaries and wages	857,565	272,986	239,893	105,303	**1,475,747**
Social security costs	78,416	23,230	115	16	**101,777**
Employer contributions to NHS pensions scheme	110,439	34,611	187	18	**145,255**
Termination benefits	6,061	12,816	-	-	**18,877**
Gross employee benefits expenditure	**1,052,481**	**343,643**	**240,195**	**105,337**	**1,741,656**
Less: Employee costs capitalised	-	-	-	-	**-**
Net employee benefits excluding capitalised costs	**1,052,481**	**343,643**	**240,195**	**105,337**	**1,741,656**
Less recoveries in respect of employee benefits	(4,129)	(588)	-	(194)	**(4,911)**
Total net employee benefits	**1,048,352**	**343,055**	**240,195**	**105,143**	**1,736,745**

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

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 £18 million during the financial year, a decrease from £25 million in 2015/16. Across the group, there was a total spend of £101 million on consultancy services during the period, against £113 million the previous year.

Expenditure on contingent labour, including agency staff and secondees, is given on page 154. Net expenditure for NHS England and CSUs in this area was £131 million in 2016/17, against £176 million in 2015/16. Across the group, there was a total spend of £311 million on contingent labour during the year, against £346 million the previous year.

Further detail on efficiency controls, and steps we have taken to improve procurement practices and compliance within NHS England during the year, can be found in our Governance Statement from page 114.

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, 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.

In September 2016, a project was established to design and deliver a more effective end-to-end process to manage our off-payroll workers and provide associated assurances to better manage, control and report engagements and apply required governance. The following tables identify off-payroll workers[15] engaged by NHS England as at March 2017.

15. 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 2,400 appraisers.

Off-payroll engagements longer than six months

Off-payroll engagements as at 31 March 2017, 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 2017	345	169	514
Of which, the number that have existed:			
for less than one year at the time of reporting	83	66	149
for between one and two years at the time of reporting	114	72	186
for between two and three years at the time of reporting	85	19	104
for between three and four years at the time of reporting	63	12	75
for four 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

New off-payroll engagements between 1 April 2016 and 31 March 2017, 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 2016 and 31 March 2017	193	184	377
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	118	112	230
Number for whom assurance has been requested	193	184	377
Of which:			
assurance has been received	178	174	352
assurance has not been received	15	10	25
engagements terminated as a result of assurance not received being	0	0	0

	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	1	1
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	251	37	288

Off-payroll engagements of Board members and/or senior officials with significant financial responsibility between 1 April 2016 and 31 March 2017 are shown in the table above. There has been one off-payroll senior officer engagement with significant financial responsibility in the financial year. An interim Director of Finance was appointed between 5 April and 30 September 2016 at South East CSU under exceptional circumstances whilst the future of the CSU was being determined.

Further detail on commercial approvals, and steps we have taken to improve procurement practices and compliance within NHS England during the year, can be found in our Governance Statement from page 114.

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 the DH and HM Treasury.

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

Exit packages agreed during the year:

Parent

	2016/17			2015/16		
	Compulsory redundancies number	Other agreed departures number	Total number	Compulsory redundancies number	Other agreed departures number	Total number
Less than £10,000	12	9	**21**	38	8	**46**
£10,001 to £25,000	34	15	**49**	67	42	**109**
£25,001 to £50,000	46	16	**62**	57	46	**103**
£50,001 to £100,000	16	12	**28**	51	31	**82**
£100,001 to £150,000	7	8	**15**	18	22	**40**
£150,001 to £200,000	13	2	**15**	14	7	**21**
Over £200,001	-	-	**-**	6	4	**10**
Total	**128**	**62**	**190**	**251**	**160**	**411**
Total cost (£000)	**6,372**	**2,919**	**9,291**	**13,203**	**9,572**	**22,775**

Consolidated Group

	2016/17			2015/16		
	Compulsory redundancies number	Other agreed departures number	Total number	Compulsory redundancies number	Other agreed departures number	Total number
Less than £10,000	31	28	**59**	51	24	**75**
£10,001 to £25,000	49	37	**86**	90	56	**146**
£25,001 to £50,000	63	31	**94**	64	51	**115**
£50,001 to £100,000	23	18	**41**	56	35	**91**
£100,001 to £150,000	12	9	**21**	20	22	**42**
£150,001 to £200,000	16	3	**19**	14	9	**23**
Over £200,001	1	1	**2**	6	4	**10**
Total	**195**	**127**	**322**	**301**	**201**	**502**
Total cost (£000)	**9,057**	**4,878**	**13,935**	**14,543**	**10,630**	**25,173**

Exit packages agreed during the year: Other agreed departures

Parent

	2016/17		2015/16	
	Other agreed departures number	£000	Other agreed departures number	£000
Voluntary redundancies including early retirement contractual costs	56	2,854	156	9,440
Contractual payments in lieu of notice	6	64	3	37
Exit payments following Employment Tribunals or court orders	-	-	1	95
Total	**62**	**2,919**	**160**	**9,572**

Consolidated Group

	2016/17		2015/16	
	Other agreed departures number	£000	Other agreed departures number	£000
Voluntary redundancies including early retirement contractual costs	69	3,696	160	9,681
Mutually agreed resignations (MARS) contractual costs	-	-	1	170
Early retirements in the efficiency of the service contractual costs	1	48	-	-
Contractual payments in lieu of notice	53	1,061	36	648
Exit payments following Employment Tribunals or court orders	4	70	2	97
Non-contractual payments requiring HMT approval	-	3	2	34
Total	**127**	**4,878**	**201**	**10,630**

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 NHS England.

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

Where NHS England and CCGs have agreed early retirements, the additional costs are met by NHS England or the CCG and not by the NHS Pension Scheme, and are included in the tables. Ill-health retirement costs are met by the NHS Pension Scheme and are not included in the tables.

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

Remuneration Report

Strategic HR and Remuneration Committee

Detail on the role and activity of the Strategic HR and Remuneration Committee is given in our Director's Report at page 109.

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 2016/17 was £205,000 - £210,000 (2015/16: £205,000-£210,000). This was 5.35 times the median remuneration of the workforce, which was £38,812 (2015/16: £38,300: 5.42).[16]

In 2016/17, two employees received remuneration in excess of the highest-paid member of the Board (2015/16: 0). Remuneration ranged from £1,452 to £220,430. (2015/2016: £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.

16. This year's calculation is based on more robust information and updated methodology and is therefore not directly comparable with last year's data.

Policy on remuneration of senior managers

The framework for the remuneration of Executive Directors is set by DH through the Executive and Senior Managers (ESM) 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 for the effective running of a £107 billion 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 and HMT, where appropriate.

Performance related pay

The performance related pay arrangements for national (executive) directors are set out in the ESM pay framework for arm's length bodies and follows guidance prescribed by DH and are in-line with HMT requirements. As a local policy decision, since its inception, NHS England does not currently allocate any funding for performance related pay (PRP) non-consolidated bonus payments. In recognition of the current economic climate and the need to provide effective system leadership for the NHS, the decision was taken by the Strategic HR and Remuneration Committee not to allocate funds for PRP non-consolidated bonus payments for 2016/17.

Secondees are subject to the terms and conditions of their employing organisation.

Policy on senior managers contracts

Contracts of employment for senior managers are open-ended and recurrent, unless otherwise specified. Notice periods follow the provisions of the ESM contract of employment, as applied by NHS England, 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 HMT.

No payments were made to any senior manager 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
Simon Stevens Chief Executive	1 April 2014	6 months	Option to provide taxable pay in lieu of part or all of the notice period	
Paul Baumann Chief Financial Officer	14 May 2012	6 months		
Professor Jane Cummings Chief Nursing Officer	1 April 2013	6 months		
Professor Sir Bruce Keogh National Medical Director	1 April 2015	6 months		
Richard Barker Interim National Director: Commissioning Operations	1 January 2016	6 months		Acting up in role during the period 01 April - 30 May 2016
Ian Dodge National Director: Commissioning Strategy	7 July 2014	6 months		
Matthew Swindells National Director: Operations and Information	30 May 2016	6 months		

Secondments

Name and Title	Date of Appointment	Unexpired Term at 31 March 2017	Provisions for Compensation for Early Termination	Other Details
Karen Wheeler National Director: Transformation and Corporate Operations	1 April 2014	3 months	N/A	3 year secondment from the Department of Health, with the option to extend for 2 further years.

Senior manager salary and pension entitlement 2016/17 (subjected to audit)

	2016/17					
	(a) Salary (bands of £5,000)	(b) Benefit in kind (taxable) rounded to the 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 (bands of £2,500)	(f) TOTAL (a to e) (bands of £5,000)
Name and Title	**£000**	**£s**	**£000**	**£000**	**£000**	**£000**
Simon Stevens Chief Executive[17]	190-195	0	0	0	42.5-45.0	235-240
Paul Baumann Chief Financial Officer	205-210	0	0	0	45.0-47.5	250-255
Professor Jane Cummings Chief Nursing Officer	165-170	0	0	0	22.5-25.0	190-195
Professor Sir Bruce Keogh National Medical Director[18]	190-195	0	0	0	0	190-195
Richard Barker National Director: Commissioning Operations[19]	25-30 (pro-rata)	0	0	0	5.0-7.5 (pro-rata)	35-40 (pro-rata)
Ian Dodge National Director: Commissioning Strategy	165-170	0	0	0	37.5-40.0	205-210
Matthew Swindells National Director: Operations and Information[20]	170-175 (pro-rata)	0	0	0	0	170-175 (pro-rata)
Karen Wheeler National Director: Transformation and Corporate Operations[21]	155-160	0	10-15	0	50-52.5	215-220

17. On joining NHS England on 01 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. Mr Stevens has continued with this voluntary reduction in pay throughout 2016/17.
18. Professor Sir Bruce Keogh received an overpayment of £42,818 paid in error between 1 April 2015 and 31 January 2016, this was initially planned for recovery in 2016, actual recovery will not be commencing until 2017/18. Professor Sir Bruce Keogh chose not to be covered by the NHS pension arrangements during the reporting year.
19. Richard Barker was in post from 01 January-30 May 2016, replacing Dame Barbara Hakin who retired on 31 December 2015. The figures shown reflect this part year adoption as a National Director for the period April-May 2016. The full year salary equivalent is within the range £175k-£180k.
20. Matthew Swindells joined in the post of National Director from 30 May 2016, his full-time earnings were within the range £200k-£205k.
21. Karen Wheeler is seconded from DH and her salary recharged to NHS England. The non-consolidated bonus relates to 2015/16. The bonus is subject to moderation and any award paid the following financial year.

Senior manager salary and pension entitlement 2015/16

	2015/16					
	(a) Salary (bands of £5,000)	(b) Benefit in kind (taxable) rounded to the 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 (bands of £2,500)	(f) RESTATED TOTAL (a to e) (bands of £5,000)
Name and Title	**£000**	**£s**	**£000**	**£000**	**£000**	**£000**
Simon Stevens Chief Executive[22]	190-195	0	0	0	40.0-42.5	230-235
Paul Baumann Chief Financial Officer	205-210	0	0	0	22.5-25.0	230-235
Professor Jane Cummings Chief Nursing Officer	165-170	0	0	0	2.5-5.0	170-175
Professor Sir Bruce Keogh National Medical Director[23]	190-195	0	0	0	2.5-5.0	195-200
Richard Barker National Director: Commissioning Operations from 1 January 2016[24]	40-45 (pro-rata)	0	0	0	0.0-2.5 (pro-rata)	45-50 (pro-rata)
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[25]	155-160 (pro-rata)	0	0	0	-	155-160 (pro-rata)
Tim Kelsey National Director for Patients and Information to 31 December 2015[26]	135-140 (pro-rata)	0	0	0	27.5-30.0 (pro-rata)	165-170 (pro-rata)
Karen Wheeler National Director: Transformation and Corporate Operations[27]	155-160	0	10-15	0	70-72.5	235-240

22. On joining NHS England on 1 April 2014, Simon Stevens voluntarily reduced his pay by 10% from the substantive rate of pay for the post of Chief Executive, which would normally pay within the range £210,000–£215,000. Mr Stevens has continued with this voluntary reduction in pay throughout 2015/16.
23. Professor Sir Bruce Keogh received an overpayment of £42,818 paid in error between the 1 April 2015 and 31 January 2016, this was initially planned for recovery in 2016, actual recovery will not be commencing until 2017/18. The amount of the overpayment is not included in the total remuneration figures disclosed.
24. 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. The full year salary equivalent is within the range £175,000-£180,000. Richard Barker was underpaid by £3,500 between January and May 2016, this was addressed in August 2016. The value of overpayment during the 2015/16 reporting period was £2,100 as a result, the total remuneration figure for Mr Barker is different from the value in the 2015/16 audited accounts.
25. Dame Barbara Hakin retired on 31 December 2015, the full year equivalent salary is within the range £205,000 – £210,000
26. Tim Kelsey left the organisation on 31 December 2015, the full year equivalent salary is within the range £180,000-£185,000
27. 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.

Pension benefits as at 31 March 2017 (subjected to audit)

Name and Title	Real increase in pension at pension (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 2017 (bands of £5,000) £000	Lump sum at pension age related to accrued pension at 31 March 2017 (bands of £5,000) £000	Cash equivalent transfer value at 31 March 2016[28] £000	Cash equivalent transfer value at 31 March 2017 £000	Real increase in cash equivalent transfer value £000	Employers contribution to partnership pension £000
Simon Stevens Chief Executive	2.5-5.0	0	25-30	55-60	403	470	33	0
Paul Baumann Chief Financial Officer	2.5-5.0	7.5-10.0	20-25	70-75	431	508	38	0
Professor Jane Cummings Chief Nursing Officer	2.0-2.5	5.0-7.5	75-80	230-235	1,492	1,577	42	0
Professor Sir Bruce Keogh National Medical Director[29]	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Richard Barker Interim National Director: Commissioning Operations[30]	2.5-5.0	7.5-10.0	65-70	200-205	1,282	1,371	44	0
Ian Dodge National Director Commissioning Strategy	2.5-5.0	N/A	5-10	N/A	47	78	15	0
Matthew Swindells National Director: Operations and Information[31]	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Karen Wheeler National Director: Transformation and Corporate Operations	2.5-5.0	0	55-60	0	1,089	1,151	51	0

28. As per previous submissions, the column Cash Equivalent Transfer Value at 31 March 2016 is the uninflated value whereas the real increase in CETV is the employer funded increase.
29. Professor Sir Bruce Keogh chose not to be covered by the NHS pension arrangements during the reporting year.
30. Richard Barker took up post from 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 2016/17.
31. Matthew Swindells joined in the post of National Director from 30 May 2016. He is not a member of the NHS Pension Scheme.

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.

Real increase in CETV

This reflects the increase in CETV effectively funded by the employer. It does not include the increase in accrued pension due to inflation, 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 included his role as the Chair of ARAC. Some of the non-executive directors, including the Vice-Chair, have opted to waive their contractual remuneration. Non-executive directors did not receive PRP or pensionable remuneration.

Non-executive director service contracts

Name and Title	Date of Appointment	Unexpired Term at 31 March 2017	Notice Period	Provisions for Compensation for Early Termination	Other Details
Professor Sir Malcolm Grant Chair	31 October 2011, reappointed to a second term on 31 October 2015	19 months	6 months	None	
David Roberts Vice Chair	1 July 2014	15 months	None	None	Waived entitlement to remuneration
Lord Victor Adebowale Non-executive director	1 July 2012, reappointed to a second term on 1 January 2015	21 months	None	None	
Professor Sir John Burn Non-executive director	1 July 2014	15 months	None	None	
Dame Moira Gibb Non-executive director	1 July 2012, reappointed to a second term on 1 January 2015	21 months	None	None	
Noel Gordon Non-executive director	1 July 2014	15 months	None	None	
Wendy Becker Non-executive director	1 March 2016	35 months	None	None	Waived entitlement to remuneration from September 2016
Michelle Mitchell Non-executive director	1 March 2016	35 months	None	None	
Joanne Shaw Non-executive director	1 October 2016	42 months	None	None	

Non-executive director remuneration (including salary entitlements)

Salaries and allowances 2016/17 (subjected to audit)

	2016/17					
	(a) Salary (bands of £5,000)	(b) Benefit in kind (taxable) rounded to the 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[32] (bands of £2,500)	(f) TOTAL (a to e) (bands of £5,000)
Name of non-executive director	**£000**	**£s**	**£000**	**£000**	**£000**	**£000**
Professor Sir Malcolm Grant Chair	60-65	0	0	0	n/a	60-65
David Roberts[33] Vice Chair	0	0	0	0	n/a	0
Lord Victor Adebowale	5-10	0	0	0	n/a	5-10
Wendy Becker[34]	0-5	0	0	0	n/a	0-5
Professor Sir John Burn	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
Michelle Mitchell	5-10	0	0	0	n/a	5-10
Joanne Shaw[35] From 1 October 2016	10-15	0	0	0	n/a	10-15

32. Non-executive directors do not receive pensionable remuneration, and therefore have no pension related benefits.
33. David Roberts has waived his entitlement to non-executive director remuneration.
34. Wendy Becker waived her entitlement to non-executive director remuneration from 1 September 2016. NHS England has made employer pension contributions and pension deductions have been taken in error during the reporting period, this has resulted in an underpayment of £200 to Wendy Becker, which will be subject to full refund in 2017/18. The underpayment is not included in the total remuneration figures disclosed.
35. Joanne Shaw is Chair of the Audit and Risk Assurance Committee. Joanne Shaw received an overpayment of £2,600 paid in error during 2016/17, which will be subject to recovery in 2017/18. NHS England has made employer pension contributions and pension deductions have been taken in error during the reporting period, this has resulted in an underpayment of £900 to Joanne Shaw, which will be subject to full refund in 2017/18. Neither the underpayment nor overpayment are included in the total remuneration figures disclosed.

Salaries and allowances 2015/16

	2015/16					
	(a) Salary (bands of £5,000)	(b) Benefit in kind (taxable) rounded to the 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[36] (bands of £2,500)	(f) TOTAL (a to e) (bands of £5,000)
Name of non-executive director	**£000**	**£s**	**£000**	**£000**	**£000**	**£000**
Professor Sir Malcolm Grant Chair	60-65	0	0	0	n/a	60-65
David Roberts[37] Vice Chair from October 2015	0	0	0	0	n/a	0
Lord Victor Adebowale	5-10	0	0	0	n/a	5-10
Wendy Becker[38] From 1 March 2016	0-5	0	0	0	0	0-5
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 Ciaran 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
Michelle Mitchell From 1 March 2016	0-5	0	0	0	0	0-5
Ed Smith Vice Chair until 30 September 2015	10-15	0	0	0	n/a	10-15

36. Non-executive directors do not receive pensionable remuneration, and therefore have no pension related benefits.
37. David Roberts has waived his entitlement to non-executive director remuneration.
38. NHS England has made employer pension contributions and pension deductions were taken from Wendy Becker in March 2016, this has resulted in an underpayment of less than £100 to Wendy Becker, which will be subject to full refund in 2017/18. The underpayment is not included in the total remuneration figures disclosed.

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, are stated in the tables overleaf.

Details of any losses and special payments relating to CCGs can be found within individual CCG annual reports which are published on CCG websites. A list of CCGs, and links to their websites, can be found on the NHS England website at www.england.nhs.uk/ccg-details.

Losses and special payments

Losses

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

	Parent				Consolidated Group			
	Total number of cases 2016/17	Total value of cases 2016/17	Total number of cases 2015/16	Total value of cases 2015/16	Total number of cases 2016/17	Total value of cases 2016/17	Total number of cases 2015/16	Total value of cases 2015/16
	Number	£000	Number	£000	Number	£000	Number	£000
Administrative write-offs	126	245	168	809	341	9,464	387	11,875
Fruitless payments	38	233	4	916	90	849	40	1,434
Stores losses	-	-	75	19	-	-	78	19
Book Keeping Losses	-	-	6	4,071	-	-	7	4,071
Constructive loss	-	-	-	-	-	-	-	-
Cash losses	-	-	-	-	3	1	7	2
Claims abandoned	1	338	-	-	2	339	1	1
Total	**165**	**816**	**253**	**5,815**	**436**	**10,653**	**520**	**17,402**

2016/17: Claims abandoned

NHS England issued a loan to a GP practice under the provisions of s96 NHS Act 2006 in 2015/16. Due to a change in circumstances of the GP practice the loan is deemed to be irrecoverable and has therefore been written off in the current financial year.

Special payments

	Parent				Consolidated Group			
	Total number of cases 2016/17	Total value of cases 2016/17	Total number of cases 2015/16	Total value of cases 2015/16	Total number of cases 2016/17	Total value of cases 2016/17	Total number of cases 2015/16	Total value of cases 2015/16
	Number	£000	Number	£000	Number	£000	Number	£000
Compensation payments	-	-	2	2	10	410	10	95
Extra contractual Payments	7,330	2,451	1	13	7,341	2,974	4	239
Ex gratia payments	-	-	2	101	14	228	12	162
Special severance payments	-	-	-	-	1	3	2	34
Total	**7,330**	**2,451**	**5**	**116**	**7,366**	**3,615**	**28**	**530**

The parent case extra contractual payments are to support repatriation of clinical correspondence to GP practices. This in relation to the NHS Shared Business Services incident identified in the previous year and referred to in the 2015/16 Annual Report.

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 information is provided in accordance with 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. The following provides details of income generation activities whose full cost exceeded £1 million or was otherwise material:

		Parent			Consolidated Group		
2016/17	Noted	Income £000	Full cost £000	Surplus (deficit) £000	Income £000	Full cost £000	Surplus (deficit) £000
Dental	2 & 4	776,812	(2,909,509)	(2,132,697)	776,812	(2,909,509)	(2,132,697)
Prescription	2 & 4	547,961	(1,997,166)	(1,449,205)	554,935	(10,526,846)	(9,971,911)
Total fees & charges		**1,324,773**	**(4,906,675)**	**(3,581,902)**	**1,331,747**	**(13,436,355)**	**(12,104,608)**

		Parent			Consolidated Group		
2015/16	Noted	Income £000	Full cost £000	Surplus (deficit) £000	Income £000	Full cost £000	Surplus (deficit) £000
Dental	2 & 4	743,843	(3,314,086)	(2,570,243)	743,843	(3,313,160)	(2,569,317)
Prescription	2 & 4	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)**

The fees and charges information in this note is provided for fees and charges purposes as per the FReM and not for IFRS 8 purposes. The financial objective of prescription and dental charges is to collect charges only from those patients that are eligible to pay.

Prescription charges are a contribution to the cost of pharmaceutical services including the supply of drugs. In 2016/17, the NHS prescription charge for each medicine or appliance dispensed was £8.40. However, around 90% of prescriptions items were dispensed free as patients were exempt from charges. In addition, patients who were eligible to pay charges could purchase pre-payment certificates at £29.10 for three months or £104.00 for a year. A number of other charges were payable for wigs and fabric supports[39].

Those who are not eligible for exemption are required to pay NHS dental charges which fall into three bands depending on the level and complexity of care provided. In 2016/17, the charge for Band 1 treatments was £19.70, for Band 2 was £53.90 and for Band 3 was £233.70[40].

39. Further details on prescription charges are set out in the Ministerial announcement of 11 March 2016 at www.parliament.uk/business/publications/written-questions-answers-statements/written-statement/Commons/2016-03-11/HCWS607/.
40. Further details are set out in the Ministerial announcement of 11 March 2016 at https://www.parliament.uk/business/publications/written-questions-answers-statements/written-statement/Commons/2016-03-11/HCWS606/.

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

Opinion on financial statements

In my opinion the financial statements:

- give a true and fair view of the state of the NHS Commissioning Board's and the NHS Commissioning Board group's affairs as at 31 March 2017 and of the NHS Commissioning Board's net operating cost and the NHS Commissioning Board group's net operating costs for the year then ended; and
- have been properly prepared in accordance with the Health and Social Care Act 2012 and Secretary of State directions issued thereunder.

Opinion on regularity

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

Basis of opinions

I have audited the financial statements of the NHS Commissioning Board for the year ended 31 March 2017 under the Health and Social Care Act 2012. The NHS Commissioning Board parent consists of the NHS Commissioning Board. The NHS Commissioning Board group consists of the NHS Commissioning Board parent and 209 clinical commissioning groups. The financial statements comprise the parent's and group's 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.

The basis of my regularity opinion is the regularity framework which comprise the Health and Social Care Act 2012, Managing Public Money and applicable law.

Overview of my audit approach

Matters significant to my audit

I consider the following areas of particular audit focus to be those areas that had the greatest effect on my overall audit strategy, the allocation of resources in my audit and directing the efforts of the audit team in the current year.

I have also set out how my audit addressed these specific areas in order to support the opinion on the financial statements as a whole and any comments I make on the results of my procedures should be read in this context.

This is not a complete list of all risks identified by my audit but only those areas that had the greatest effect on my overall audit strategy, allocation of resources and direction of effort.

The areas of focus were discussed with the Audit and Risk Assurance Committee; their report on matters that they considered to be significant is set out on pages 98-100.

Risk	My response
Management Override of control: International Standard on Auditing (UK and Ireland) 240 The auditor's responsibilities relating to fraud in an audit of financial statements states that there is a risk in all entities that management override controls to perpetrate fraud. The standard requires that auditors perform audit procedures to address this risk in the following areas: • Significant or unusual transactions including the Sustainability and Transformation Fund (The Fund) The Fund was introduced during 2016-17, with NHS England making £1.8 billion available to support NHS providers during the year, subject to meeting certain financial and operational performance targets. I considered that there was an incentive for manipulation of results at a local provider level to gain access to the Fund, and that this could manifest itself in NHS England's financial statements in the form of clinical commissioning groups making discretionary payments to NHS providers to enable them to meet their control totals and access the Fund. This would benefit the whole local health economy. • Manual Journal Entries • Bias in accounting estimates	I responded to the significant risk of management override of control, focusing my work on the areas considered to be at most risk based on the nature of the NHS Commissioning Board's activities. **Significant unusual transactions** I performed procedures to identify significant unusual transactions. The only such transactions identified related to the Sustainability and Transformation Fund (the Fund). I have liaised regularly with auditors of clinical commissioning groups during the audit and also requested specific assurances from them on this issue as part of audit completion processes. I also performed analytical procedures on component financial data to identify payments of this nature. My work has not identified any instances of discretionary payments made which resulted in NHS providers securing monies from the Fund. **Manual Journal Entries** I used data analytics to identify manual journals with particular risk characteristics which may be indicative of management override of controls. I performed a high level review of those journals which displayed two or more of the risk characteristics, and detailed testing was performed on those journals deemed of interest from the initial review. No instances of management override were found from this work. **Bias in accounting estimates** I reviewed accounting estimates made in the production of the financial statements for evidence of bias. Due to the nature of NHS Commissioning Board's operations, there are no accounting estimates made which present a high risk of management bias, and none was identified during my work. I am satisfied that this risk has not materialised.

Application of materiality

I applied the concept of materiality in both planning and performing my audit, and in evaluating the effect of misstatements on my audit and on the financial statements. This approach recognises that financial statements are rarely absolutely correct, and that an audit is designed to provide reasonable, rather than absolute, assurance that the financial statements are free from material misstatement or irregularity. A matter is material if its omission or misstatement would, in the judgement of the auditor, reasonably influence the decisions of users of the financial statements.

Based on my professional judgement, I determined overall materiality for the NHS Commissioning Board's financial statements at £1.023 billion and for the NHS Commissioning Board's group at £1.024 billion, which is approximately 1% of gross expenditure. I chose this benchmark as I consider this to be the principal consideration for users in assessing the NHS Commissioning Board's financial performance. There has been no change to the prior year in the methodology for determining materiality.

In conducting the audit, for the NHS Commissioning Board's financial statements, in determining the level of testing to undertake, we applied a performance materiality at £767 million and for the NHS Commissioning Board's group at £768 million. This is the amount set by the auditor at a level not higher than 75% of materiality to reduce to an appropriately low level the probability that the aggregate of uncorrected and undetected misstatements exceeds materiality for the financial statements as a whole.

As well as quantitative materiality there are certain matters that, by their very nature, would if not corrected influence the decisions of users, for example, any errors reported in the Accountability Report. Assessment of such matters would need to have regard to the nature of the misstatement and the applicable legal and reporting framework, as well as the size of the misstatement.

I applied the same concept of materiality to my audit of regularity. In planning and performing audit work in support of my opinion on regularity and evaluating the impact of any irregular transactions, I took into account both quantitative and qualitative aspects that I consider would reasonably influence the decisions of users of the financial statements.

I agreed with the Audit and Risk Assurance Committee that I would report to it all uncorrected misstatements identified through my audit in excess of £250,000, as well as differences below this threshold that in my view warranted reporting on qualitative grounds.

Total unadjusted audit differences reported to the Audit and Risk Assurance Committee would increase net assets by £8,351k.

Scope of my audit

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 and parent's circumstances and have been consistently applied and adequately disclosed;
- the reasonableness of significant accounting estimates made by the Accounting Officer; and
- the overall presentation of the financial statements.

In addition I read all the information and non-financial information in the Performance Report and Accountability 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 and report.

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.

Group audit approach

Other than the NHS Commissioning Board parent, no other components were identified as significant in the context of ISA 600. All 209 clinical commissioning groups have been thus identified as either a sampled non-significant component (in which case component auditors are requested to perform a number of further procedures on the consolidated data for the group audit), or a non-significant component (where component auditors are only required to perform limited procedures for the group audit).

I audited the full financial information of the NHS Commissioning Board parent. I also audited the NHS Commissioning Board group including the consolidation process, taking assurance over the 209 clinical commissioning groups from component auditors who audited this financial information on my behalf. This work covered substantially all of the group's assets and net expenditure. Both the procedures performed at group level, and the assurance provided over the financial information of sampled non-significant and non-significant components have provided the evidence necessary for my opinion on the group's financial statements as a whole.

Other matters on which I report

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 and Accountability 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;
- the financial statements and the part of the Remuneration and Staff Report and the Parliamentary Accountability and Audit Report disclosures to be audited are not in agreement with the accounting records and returns;
- 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.

Responsibilities of the Accounting Officer for the financial statements

As explained more fully in the Statement of Accounting Officer's Responsibilities, the Accounting Officer is responsible for the preparation of the NHS Commissioning Board's and NHS Commissioning Board group's financial statements and for ensuring they give a true and fair view.

Auditor's responsibilities for the audit of the financial statements

My responsibility is to audit and express an opinion 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.

Report

I have no observations to make on these financial statements.

Sir Amyas C E Morse **17 July 2017**
Comptroller and Auditor General
National Audit Office
157-197 Buckingham Palace Road
Victoria
London
SW1W 9SP

ANNUAL ACCOUNTS

Simon Stevens
Accounting Officer
3 July 2017

Statement of comprehensive net expenditure for the year ended 31 March 2017

		Parent		Consolidated Group	
		2016/17	2015/16	2016/17	2015/16
	Note	£000	£000	£000	£000
Income from sale of goods and services	2	(650,390)	(805,644)	(565,444)	(614,770)
Other operating income	2	(1,534,046)	(1,612,189)	(1,677,010)	(1,577,738)
Total operating income		**(2,184,436)**	**(2,417,833)**	**(2,242,454)**	**(2,192,508)**
Staff costs	3	720,782	807,812	1,781,450	1,741,656
Purchase of goods and services	4	106,122,171	101,462,103	104,988,385	100,469,547
Depreciation and impairment charges	4	75,719	69,222	89,508	79,586
Provision expense	4	(205,479)	(144,196)	(171,937)	(124,006)
Other operating expenditure	4	112,964	73,411	222,556	228,561
Total operating expenditure		**106,826,157**	**102,268,352**	**106,909,962**	**102,395,344**
Net operating expenditure		**104,641,721**	**99,850,519**	**104,667,508**	**100,202,836**
Finance expense	11	(8,218)	(11,587)	(8,030)	(11,400)
Net expenditure for the year		**104,633,503**	**99,838,932**	**104,659,478**	**100,191,436**
Other (gains)/losses		-	(1)	(10)	(2)
Net (gain)/loss on Transfer by Absorption[1]		4,003	-	-	-
Total net expenditure for the year		**104,637,506**	**99,838,931**	**104,659,468**	**100,191,434**
Other comprehensive expenditure					
Items which will not be reclassified to net operating costs					
Net (gain) on revaluation of intangible assets	7	-	-	(540)	-
Actuarial (gain)/loss on pension schemes		-	-	1,024	(3,533)
Sub total		-	-	484	(3,533)
Comprehensive net expenditure for the year		**104,637,506**	**99,838,931**	**104,659,952**	**100,187,901**

1. The net gain on absorption is eliminated on consolidation as the transfer of functions was between NHS England (the parent) and a CCG on 1 April 2016.

The following presentational changes have been made in line with the HM Treasury's Financial Reporting Manual 2016/17 (FReM):

- Income and Expenditure streams are no longer categorised between administration and programme
- Finance expenses are separately disclosed below operating expenditure
- Operating expenditure has now been split into different categories.

The format has been applied to prior year figures to ensure year on year comparability.

The notes on pages 189 to 234 form part of this statement.

Statement of financial position as at 31 March 2017

		Parent		Consolidated Group	
	Note	31 March 2017 £000	31 March 2016 £000	31 March 2017 £000	31 March 2016 £000
Non-current assets:					
Property, plant and equipment	6	275,434	205,433	319,338	246,200
Intangible assets	7	7,486	12,862	12,714	18,590
Trade and other receivables	8	-	-	291	179
Other financial assets	8	-	278	540	278
Total non-current assets		**282,920**	**218,573**	**332,883**	**265,247**
Current assets:					
Inventories		10,594	150	17,348	5,237
Trade and other receivables	8	237,914	269,733	962,052	853,387
Cash and cash equivalents	9	263,885	261,740	284,835	283,543
Total current assets		**512,393**	**531,623**	**1,264,235**	**1,142,167**
Total assets		**795,313**	**750,196**	**1,597,118**	**1,407,414**
Current liabilities					
Trade and other payables	10	(3,239,950)	(2,520,172)	(8,142,409)	(7,267,679)
Provisions	12	(81,869)	(304,730)	(159,750)	(376,996)
Total current liabilities		**(3,321,819)**	**(2,824,902)**	**(8,302,159)**	**(7,644,675)**
Total assets less current liabilities		**(2,526,506)**	**(2,074,706)**	**(6,705,041)**	**(6,237,261)**
Non-current liabilities					
Trade and other payables	10	-	(2,440)	(4,927)	(6,538)
Provisions	12	(11,049)	(107,353)	(26,440)	(117,107)
Total non-current liabilities		**(11,049)**	**(109,793)**	**(31,367)**	**(123,645)**
Total assets less total liabilities		**(2,537,555)**	**(2,184,499)**	**(6,736,408)**	**(6,360,906)**
Financed by taxpayers' equity and other reserves					
General fund		(2,537,555)	(2,184,523)	(6,730,907)	(6,356,524)
Revaluation reserve		-	24	42	137
Other reserves		-	-	(5,543)	(4,519)
Total taxpayers' equity		**(2,537,555)**	**(2,184,499)**	**(6,736,408)**	**(6,360,906)**

The notes on pages 189 to 234 form part of this statement.

The financial statements on pages 184 to 188 were approved by the Board on 3 July 2017 and signed on its behalf by:

Simon Stevens
Accounting Officer

Statement of changes in taxpayers' equity for the year ended 31 March 2017

Parent	General fund	Revaluation reserve	Other reserves	Taxpayers' equity
	£000	£000	£000	£000
Changes in taxpayers' equity for 2016/17				
Balance at 01 April 2016	**(2,184,523)**	**24**	**-**	**(2,184,499)**
Changes in taxpayers' equity for 2016/17				
Total net expenditure for the financial year	(104,637,506)	-	-	(104,637,506)
Transfers between reserves	24	(24)	-	-
Net recognised expenditure for the financial year	**(104,637,482)**	**(24)**	**-**	**(104,637,506)**
Grant in Aid	104,284,450	-	-	104,284,450
Balance at 31 March 2017	**(2,537,555)**	**-**	**-**	**(2,537,555)**

	General fund	Revaluation reserve	Other reserves	Taxpayers' equity
	£000	£000	£000	£000
Changes in taxpayers' equity for 2015/16				
Balance at 01 April 2015	**(2,702,964)**	**24**	**-**	**(2,702,940)**
Changes in taxpayers' equity for 2015/16				
Total 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)**

Consolidated Group

	General fund	Revaluation reserve	Other reserves	Taxpayers' equity
	£000	£000	£000	£000
Changes in taxpayers' equity for 2016/17				
Balance at 01 April 2016	**(6,356,524)**	**137**	**(4,519)**	**(6,360,906)**
Changes in taxpayers' equity for 2016/17				
Total net expenditure for the financial year	(104,659,468)	-	-	(104,659,468)
Net gain/(loss) on revaluation of intangible assets	-	540	-	540
Total revaluations against revaluation reserve	**-**	**540**	**-**	**540**
Movements in other reserves	-	-	(1,024)	(1,024)
Transfers between reserves	635	(635)	-	-
Net recognised expenditure for the financial year	**(104,658,833)**	**(95)**	**(1,024)**	**(104,659,952)**
Grant in Aid	104,284,450	-	-	104,284,450
Balance at 31 March 2017	**(6,730,907)**	**42**	**(5,543)**	**(6,736,408)**

	General fund	Revaluation reserve	Other reserves	Taxpayers' equity
	£000	£000	£000	£000
Changes in taxpayers' equity for 2015/16				
Balance at 01 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)**

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

The notes on pages 189 to 234 form part of this statement.

Statement of cash flows for the year ended 31 March 2017

		Parent		Consolidated Group	
		2016/17	2015/16	2016/17	2015/16
	Note	£000	£000	£000	£000
Cash flows from operating activities					
Net operating costs for the financial year		(104,633,503)	(99,838,931)	(104,659,478)	(100,191,434)
Depreciation and amortisation	4	75,719	69,222	87,948	79,250
Impairments and reversals	4	-	-	1,560	336
Other non cash adjustments[2]		-	-	81	26
Movement due to transfers by absorption		(320)	-	-	-
(Gain)/loss on disposal		-	(1)	-	(2)
Unwinding of discount	11	(8,605)	(12,217)	(8,501)	(12,092)
Change in discount rate	4	342	384	255	341
(Increase)/decrease in inventories		(10,444)	28	(12,111)	(2,993)
(Increase)/decrease in trade & other receivables	8	32,097	(34,802)	(109,039)	(82,478)
Increase/(decrease) in trade & other payables	10	729,359	(72,516)	877,480	341,833
Provisions utilised	12	(104,761)	(98,821)	(127,475)	(117,862)
Increase/(decrease) in provisions	12	(205,821)	(144,580)	(172,192)	(124,347)
Net cash outflow from operating activities		**(104,125,937)**	**(100,132,234)**	**(104,121,472)**	**(100,109,422)**
Cash flows from investing activities					
Payments for property, plant and equipment		(144,322)	(77,555)	(160,865)	(91,998)
Payments for intangible assets		(1,523)	(9,308)	(2,030)	(12,178)
Proceeds from disposal of assets: property, plant and equipment		-	185	168	189
Proceeds from disposal of assets : intangible assets		-	-	540	-
Loans to other bodies		-	(278)	-	(278)
Net cash outflow from investing activities		**(145,845)**	**(86,956)**	**(162,187)**	**(104,265)**
Net cash outflow before financing activities		**(104,271,782)**	**(100,219,190)**	**(104,283,659)**	**(100,213,687)**
Cash flows from financing activities					
Grant in aid funding received		104,284,450	100,357,372	104,284,450	100,357,372
Capital element of payments in respect of finance leases		(10,523)	(5,921)	(10,606)	(6,000)
Net cash inflow from financing activities		**104,273,927**	**100,351,451**	**104,273,844**	**100,351,372**
Net increase (decrease) in cash & cash equivalents		**2,145**	**132,261**	**(9,815)**	**137,685**
Cash & cash equivalents at the beginning of the financial period	9	261,740	129,479	278,171	140,486
Cash & cash equivalents at the end of the financial year		**263,885**	**261,740**	**268,356**	**278,171**

2. Other non cash adjustments comprise a non cash charge to reflect a discount on future lease charges of £25k (2015/16 £26k) and a pension charge of £56k.

The notes on pages 189 to 234 form part of this statement.

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 2016/17 Department of Health Group Accounting Manual (DH GAM) issued by the DH and comply with HM Treasury's Financial Reporting Manual 2016/17 (FReM). The accounting policies contained in the DH GAM apply International Financial Reporting Standards (IFRS) as adapted or interpreted for the public sector context. Where the DH GAM permits a choice of accounting policy, the accounting policy which is judged to be most appropriate to the particular circumstances of NHS England for the purpose of giving a true and fair view has been selected. The particular policies adopted by NHS England are described below. They have been applied consistently in dealing with items considered material to the accounts.

The functional and presentational currency is pounds sterling and figures are expressed in pounds thousands unless expressly stated. Two sets of figures are presented - the first relating to NHS England itself (the Parent) and a second set of consolidated figures (Consolidated Group). The entities making up the Consolidated Group are declared in Note 20.

1.1 Operating segments

Income and expenditure are analysed in the Operating segments note (note 16) 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 16.

1.2 Accounting convention

These accounts have been prepared under the historical cost convention, modified to account for the revaluation to fair value of property, plant and equipment, intangible assets, certain financial assets and financial liabilities.

1.3 Basis of consolidation

These accounts comprise the results of the NHS England statutory entity as well as the consolidated position of NHS England 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, as they are not separate legal entities.

1.4 Comparative information

The comparative information provided in these financial statements is for the year ended 31 March 2016.

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 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 2017/18 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 Transfer of functions

As public sector bodies within a Departmental Boundary are deemed to operate under common control, business reconfigurations are outside the scope of IFRS 3 Business Combinations. When functions transfer between two public sector bodies (except for transfers between government departments) the FReM requires the application of 'absorption accounting'. Absorption accounting requires that entities account for their transactions in the period in which those transactions took place. Where assets and liabilities transfer, the gain or loss resulting is recognised in the Statement of Net Comprehensive Expenditure, and is disclosed separately from operating costs.

1.7 Revenue recognition

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.

1.8 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 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.

1.9 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 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.

1.15 Inventories

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

1.16 Cash and cash equivalents

Cash is cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours. Cash equivalents are investments that mature in 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.

1.17 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 2.70 percent (2015/16: minus 1.55 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 1.95 percent (2015/16: minus 1 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 (2015/16: minus 0.80 percent) is applied to expected cashflows exceeding 10 years

All percentages are in real terms.

1.18 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 legal liability rests with the group.

1.19 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.

1.20 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 contributions of CCGs are charged to operating income in year in the NHS England parent account.

1.21 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.

1.22 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.

1.23 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.

1.24 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 2016/17. Full assessments of the impact of these standards will be completed by NHS England in due course following the issue of relevant interpretations and guidance in the FReM.

IFRS 9 Financial Instruments (application from 1 January 2018)
IFRS 14 Regulatory Deferral Accounts (not applicable to DH group bodies)
IFRS15 Revenue for Contract with Customers (application from 1 January 2018)
IFRS 16 Leases (application from 1 January 2019)
IFRS 17 Insurance Contracts (application from 1 January 2021)

1.25 Significant accounting policies and material judgement

Estimates and the underlying assumptions are reviewed on a regular basis by the group's senior management. Areas of 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		Consolidated Group	
	2016/17 Total £000	2015/16 Total £000	2016/17 Total £000	2015/16 Total £000
Income from sale of goods and services				
Education, training and research	187,119	219,353	202,158	230,956
Non-patient care services to other bodies[3]	463,271	586,291	362,849	383,512
Rental revenue from operating leases	-	-	437	302
Total Income from sale of goods and services	**650,390**	**805,644**	**565,444**	**614,770**
Other operating income				
Recoveries in respect of employee benefits	8	1,215	5,084	4,911
Prescription fees and charges	547,961	517,769	554,935	523,539
Dental fees and charges	776,812	743,843	776,812	743,843
Charitable and other contributions to revenue expenditure: non-NHS	631	406	2,889	3,291
Continuing Healthcare risk pool contributions[4]	100,000	250,000	-	-
Other revenue	108,634	98,956	337,290	302,154
Total other operating income	**1,534,046**	**1,612,189**	**1,677,010**	**1,577,738**
Total operating income	**2,184,436**	**2,417,833**	**2,242,454**	**2,192,508**

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

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

3. Employee benefits and staff numbers

3.1 Employee benefits

	Parent		Consolidated Group	
	2016/17 Total £000	2015/16 Total £000	2016/17 Total £000	2015/16 Total £000
Employee benefits				
Salaries and wages	601,132	680,295	1,490,620	1,475,747
Social security costs	52,230	45,407	130,152	101,777
Employer contributions to NHS Pension scheme	60,810	65,023	151,676	145,255
Termination benefits	6,806	17,087	9,444	18,877
Gross employee benefits expenditure	**720,978**	**807,812**	**1,781,892**	**1,741,656**
Less: Employee costs capitalised	(196)	-	(442)	-
Net employee benefits excluding capitalised costs	**720,782**	**807,812**	**1,781,450**	**1,741,656**
Less recoveries in respect of employee benefits	(8)	(1,215)	(5,083)	(4,911)
Total net employee benefits	**720,774**	**806,597**	**1,776,367**	**1,736,745**

Staff numbers can be found in the Accountability Report on page 152.

3.2 Pension costs

As described in Note 1.8 past and present employees are covered by the provisions of the NHS Pensions Scheme. 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 follows:

3.2.1 Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This 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 scheme liability as at 31 March 2017, is based on valuation data as 31 March 2016, updated to 31 March 2017 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

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

Full actuarial (funding) valuation

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the schemes (taking into account their recent demographic experience), and to recommend contribution rates payable by employees and employers.

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

The Scheme Regulations allow for the level of contribution rates to be changed 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.

3.2.2 Scheme provisions

The NHS Pension Scheme provides 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 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.

3.2.3 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 CCGs published accounts.

3.2.4 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 2007. 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		Consolidated Group	
	2016/17 Total £000	2015/16 Total £000	2016/17 Total £000	2015/16 Total £000
Other costs				
Services from CCGs	21,970	50,867	-	-
Services from Foundation Trusts	11,170,819	10,292,599	42,196,636	39,256,513
Services from other NHS Trusts	5,132,890	5,242,515	23,785,519	23,891,223
Sustainability and Transformation Fund[5]	1,800,000	-	1,800,000	-
Services from Other WGA bodies[6]	9,231	5,753	44,872	11,200
Purchase of healthcare from non-NHS bodies	1,201,954	1,118,429	13,025,524	12,552,868
General dental services and personal dental services[7]	2,909,509	3,314,086	2,909,509	3,313,160
Prescribing costs	14,794	158	8,534,616	8,557,135
Pharmaceutical services	1,982,372	2,094,255	1,992,230	2,105,899
General ophthalmic services	545,981	534,857	554,399	542,339
Primary care services[8]	3,771,509	5,263,459	7,971,342	7,797,894
Supplies and services – clinical	33,418	87,788	110,059	176,716
Supplies and services – general	503,973	673,242	959,624	1,116,785
Chair and lay membership body and governing body members	141	133	52,454	50,178
Consultancy services	18,353	25,051	101,264	112,964
Establishment	161,978	188,515	316,281	333,443
Transport	9,891	11,185	33,318	24,437
Premises	71,493	178,626	371,719	411,186
Audit fees	315	335	13,599	14,018
Other non statutory audit expenditure[9]	-	1,098	1,865	3,412
Other professional fees excl. services provided by external audit	50,552	50,758	125,764	105,961
Grants to other public bodies	76,007	56,564	106,760	108,659
Clinical negligence	-	58	338	373
Research and development (excluding staff costs)	549	686	12,937	13,400
Education and training	112,153	115,969	140,245	142,395
Funding to group bodies[10]	76,599,016	72,212,559	-	-
Other expenditure	35,884	15,077	41,726	43,085
Total operating expenses - cash	**106,234,752**	**101,534,622**	**105,202,600**	**100,685,243**
Operating expenditure - non cash				
Impairments and reversals of receivables	2	809	6,514	9,994
Impairment of loan	278	-	278	-
Inventories written down	103	83	1,549	2,871
Depreciation	70,903	64,534	82,091	73,795
Amortisation	4,816	4,688	5,857	5,455
Impairments and reversals of property, plant and equipment	-	-	1,154	336
Impairments and reversals of intangible assets	-	-	406	-
Change in discount rate	342	384	255	341
Provisions[11]	(205,821)	(144,580)	(172,192)	(124,347)
Total operating expenses - non cash	**(129,377)**	**(74,082)**	**(74,088)**	**(31,555)**
Total operating expenses	**106,105,375**	**101,460,540**	**105,128,512**	**100,653,688**

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

5. In 2016/17 NHS England has allocated expenditure through the Sustainability and Transformation Fund for provider sustainability support, in line with the 2016/17 NHS England mandate.
6. Services from other WGA bodies comprises expenditure from the Department of Health and other Department arm's length bodies.
7. There has been a significant fall in dental services due to the improved allocation of costs between primary care and secondary dental services.
8. The reductions in primary care expenditure in 2016/17 and 2015/16 in the NHS England parent account are due to the switch in budget from NHS England to those CCGs who have taken delegated commissioning responsibilities. This also results in an increase in group funding to those CCGs who have assumed delegated commissioning responsibilities.
9. In both financial years NHS England purchased no Non Audit services from the National Audit Office (NAO). Details of CCG non audit expenditure can be found in the underlying individual CCG accounts.
10. Funding to group bodies is shown above and represents cash funding drawn down by the CCGs. These balances are eliminated on consolidation.
11. Provision costs have been reduced in 2016/17 and 2015/16 by the ongoing reassessment of required provision values, particularly for legacy continuing healthcare. See note 12 for further details.

5. Operating leases

5.1 As lessee

The group has arrangements in place with NHS Property Services Ltd 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 IFRIC 4 'Determining whether an arrangement contains a lease' and determined that the arrangements are (or contain) leases. Work is on-going with NHS Property Services to determine the future minimum lease payments.

Accordingly the payments made in 2016/17 and 2015/16 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 2016/17 would continue to be minimum lease payments in 2017/18.

Within the group a small number CCGs act as a lessor. Details of these arrangements can be found in the underlying CCG accounts.

5.1.1 Payments recognised as an expense

Parent

	2016/17			2015/16		
	Buildings £000	Other £000	Total £000	Buildings £000	Other £000	Total £000
Payments recognised as an expense						
Minimum lease payments	50,358	1,182	**51,540**	153,732	1,477	**155,209**
Contingent rents	-	-	-	-	-	**-**
Total	**50,358**	**1,182**	**51,540**	**153,732**	**1,477**	**155,209**

Consolidated Group

Payments recognised as an expense						
Minimum lease payments	288,065	3,305	**291,370**	347,592	3,846	**351,438**
Contingent rents	-	36	**36**	-	34	**34**
Total	**288,065**	**3,341**	**291,406**	**347,592**	**3,880**	**351,472**

5.1.2 Future minimum lease payments

Parent

	2016/17			2015/16		
	Buildings £000	Other £000	Total £000	Buildings £000	Other £000	Total £000
Payable:						
No later than one year	17,189	1,086	**18,275**	14,107	1,071	**15,178**
Between one and five years	32,078	2,206	**34,284**	33,042	2,459	**35,501**
After five years	327	-	**327**	108	365	**473**
Total	**49,594**	**3,292**	**52,886**	**47,257**	**3,895**	**51,152**

Consolidated Group

Payable:						
No later than one year	35,707	2,144	**37,851**	25,267	2,232	**27,499**
Between one and five years	83,277	3,085	**86,362**	65,014	3,933	**68,947**
After five years	29,297	15	**29,312**	27,652	385	**28,037**
Total	**148,281**	**5,244**	**153,525**	**117,933**	**6,550**	**124,483**

6. Property, plant and equipment

Parent 2016/17	Buildings excluding dwellings	Assets under construction and payments on account	Plant and machinery	Transport equipment	Information technology	Fixtures and fittings	Total
	£000	£000	£000	£000	£000	£000	£000
Cost or valuation at 1 April 2016	**12,027**	**447**	**4,404**	**32**	**316,324**	**3,579**	**336,813**
Addition of assets under construction and payments on account	-	229	-	-	-	-	**229**
Additions purchased	396	-	190	-	138,485	3,524	**142,595**
Reclassifications	-	-	-	-	1,757	(113)	**1,644**
Disposals	(10,131)	-	(2,654)	-	(31,833)	(73)	**(44,691)**
Impairments charged	-	-	-	-	-	-	**-**
Transfer (to)/from other public sector body	-	-	-	-	(10,325)	(15)	**(10,340)**
Cost or valuation at 31 March 2017	**2,292**	**676**	**1,940**	**32**	**414,408**	**6,902**	**426,250**
Depreciation at 1 April 2016	**10,521**	**-**	**3,645**	**13**	**116,218**	**983**	**131,380**
Reclassifications	-	-	-	-	114	(113)	**1**
Disposals	(10,131)	-	(2,654)	-	(31,833)	(73)	**(44,691)**
Charged during the year	1,499	-	403	5	67,730	1,266	**70,903**
Transfer (to)/from other public sector body	-	-	-	-	(6,770)	(7)	**(6,777)**
At 31 March 2017	**1,889**	**-**	**1,394**	**18**	**145,459**	**2,056**	**150,816**
Net Book Value at 31 March 2017	**403**	**676**	**546**	**14**	**268,949**	**4,846**	**275,434**
Asset financing:							
Owned	403	676	546	14	268,949	4,846	**275,434**
Total at 31 March 2017	**403**	**676**	**546**	**14**	**268,949**	**4,846**	**275,434**

Parent 2015/16

	Buildings excluding dwellings	Assets under construction and payments on account	Plant and machinery	Transport equipment	Information technology	Fixtures 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**
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**

Consolidated Group 2016/17

	Buildings excluding dwellings	Assets under construction and payments on account	Plant and machinery	Transport equipment	Information technology	Fixtures and fittings	Total
	£000	£000	£000	£000	£000	£000	£000
Cost or valuation at 1 April 2016	**13,441**	**2,475**	**20,626**	**151**	**352,837**	**11,967**	**401,497**
Addition of assets under construction and payments on account	-	837	-	-	-	-	**837**
Additions purchased	736	-	334	-	148,535	4,456	**154,061**
Reclassifications	-	(733)	252	-	2,142	(17)	**1,644**
Disposals	(10,131)	-	(2,920)	(3)	(32,095)	(127)	**(45,276)**
Impairments charged	-	-	(443)	-	(1,229)	(4)	**(1,676)**
Cost or valuation at 31 March 2017	**4,046**	**2,579**	**17,849**	**148**	**470,190**	**16,275**	**511,087**
Depreciation at 1 April 2016	**10,613**	**-**	**9,146**	**104**	**131,560**	**3,874**	**155,297**
Reclassifications	-	-	-	-	114	(113)	**1**
Disposals	(10,131)	-	(2,787)	(3)	(32,095)	(102)	**(45,118)**
Impairments charged	-	-	(338)	-	(184)	-	**(522)**
Charged during the year	1,602	-	2,288	33	75,651	2,517	**82,091**
At 31 March 2017	**2,084**	**-**	**8,309**	**134**	**175,046**	**6,176**	**191,749**
Net book value at 31 March 2017	**1,962**	**2,579**	**9,540**	**14**	**295,144**	**10,099**	**319,338**
Asset financing:							
Owned	1,692	2,579	8,604	14	295,144	10,099	**318,132**
Held on finance lease	270	-	936	-	-	-	**1,206**
Total at 31 March 2017	**1,962**	**2,579**	**9,540**	**14**	**295,144**	**10,099**	**319,338**

Consolidated Group 2015/16

	Buildings excluding dwellings	Assets under construction and payments on account	Plant and machinery	Transport equipment	Information technology	Fixtures 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)**
Impairments charged	-	-	-	-	-	-	-
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	-	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**

7. Intangible non-current assets

Parent 2016/17	Computer software: purchased	Licences and trademarks	Development expenditure (internally generated)	Total
	£000	£000	£000	£000
Cost or valuation at 1 April 2016	**20,526**	**8**	**1,893**	**22,427**
Additions purchased	1,523	-	-	**1,523**
Reclassifications	(100)	-	(1,544)	**(1,644)**
Disposals	(520)	-	-	**(520)**
Transfer (to)/from other public sector body	(757)	-	-	**(757)**
At 31 March 2017	**20,672**	**8**	**349**	**21,029**
Amortisation at 1 April 2016	9,208	8	349	**9,565**
Reclassifications	(1)	-	-	**(1)**
Disposals	(520)	-	-	**(520)**
Charged during the year	4,816	-	-	**4,816**
Transfer (to)/from other public sector body	(317)	-	-	**(317)**
At 31 March 2017	**13,186**	**8**	**349**	**13,543**
Net book value at 31 March 2017	**7,486**	**-**	**-**	**7,486**
Asset financing:				
Owned	7,486	-	-	**7,486**
Total at 31 March 2017	**7,486**	**-**	**-**	**7,486**

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 at 1 April 2015	7,292	8	38	**7,338**
Reclassifications	25	-	-	**25**
Disposals other than by sale	(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**

Consolidated Group 2016/17	Computer software: purchased	Licences and trademarks	Development expenditure (internally generated)	Total
	£000	£000	£000	£000
Cost or valuation at 1 April 2016	**26,168**	**8**	**4,117**	**30,293**
Additions purchased	2,030	-	-	**2,030**
Reclassifications	(100)	-	(1,544)	**(1,644)**
Disposals	(549)	-	(540)	**(1,089)**
Upward revaluation gains	-	-	540	**540**
Impairments charged	(406)	-	-	**(406)**
At 31 March 2017	**27,143**	**8**	**2,573**	**29,724**
Amortisation at 1 April 2016	10,427	8	1,268	**11,703**
Reclassifications	(1)	-	-	**(1)**
Disposals	(549)	-	-	**(549)**
Charged during the year	5,720	-	137	**5,857**
At 31 March 2017	**15,597**	**8**	**1,405**	**17,010**
Net book value at 31 March 2017	**11,546**	**-**	**1,168**	**12,714**
Asset financing:				
Owned	11,546	-	1,168	**12,714**
Total at 31 March 2017	**11,546**	**-**	**1,168**	**12,714**

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 at 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**

8. Trade and other receivables

	Parent				Consolidated Group			
	Current	Non-current	Current	Non-current	Current	Non-current	Current	Non-current
	2016/17	2016/17	2015/16	2015/16	2016/17	2016/17	2015/16	2015/16
	£000	£000	£000	£000	£000	£000	£000	£000
NHS receivables: revenue	46,492	-	48,686	-	127,601	-	107,199	-
NHS prepayments	6,273	-	1,969	-	213,712	-	182,696	-
NHS accrued income	6,885	-	18,586	-	78,193	-	57,888	-
Non-NHS and other WGA receivables: revenue	75,105	-	111,978	-	247,794	-	281,513	-
Non-NHS and other WGA prepayments	76,340	-	74,845	-	171,803	161	124,399	179
Non-NHS and other WGA accrued income	17,859	-	16,080	-	96,709	130	94,716	-
Provision for the impairment of receivables	(997)	-	(13,373)	-	(15,049)	-	(29,780)	-
VAT	8,990	-	9,249	-	24,670	-	19,172	-
Other receivables and accruals	967	-	1,713	-	16,619	-	15,584	-
Total	**237,914**	**-**	**269,733**	**-**	**962,052**	**291**	**853,387**	**179**
Other financial assets	-	-	-	278	-	540	-	278
Total current and non current	**237,914**	**-**	**270,011**	**-**	**962,883**	**-**	**853,844**	**-**

9. Cash and cash equivalents

	Parent		Consolidated Group	
	2016/17	2015/16	2016/17	2015/16
	£000	£000	£000	£000
Balance at 1 April 2016	261,740	129,479	278,171	140,486
Net change in year	2,145	132,261	(9,815)	137,685
Balance at 31 March 2017	**263,885**	**261,740**	**268,356**	**278,171**
Made up of:				
Cash with the Government Banking Service	193,173	162,759	213,635	183,936
Hosted cash/cash in hand	70,712	98,981	71,200	99,607
Cash and cash equivalents as in statement of financial position	**263,885**	**261,740**	**284,835**	**283,543**
Bank overdraft: Government Banking Service	-	-	(16,479)	(5,372)
Total bank overdrafts	**-**	**-**	**(16,479)**	**(5,372)**
Balance at 31 March 2017	**263,885**	**261,740**	**268,356**	**278,171**

For details of bank overdraft see note 10.

Included within hosted cash/cash in hand above is £70.7 million (2015/16 £98.9m) held on behalf of NHS England by the NHS Business Services Authority.

10. Trade and other payables

	Parent				Consolidated Group			
	Current	Non-current	Current	Non-current	Current	Non-current	Current	Non-current
	2016/17	2016/17	2015/16	2015/16	2016/17	2016/17	2015/16	2015/16
	£000	£000	£000	£000	£000	£000	£000	£000
NHS payables: revenue	492,491	-	520,136	-	1,143,087	-	1,260,410	-
NHS payables: capital	3,323	-	482	-	1,088	-	884	-
NHS accruals	1,149,796	-	242,516	-	1,700,133	-	742,649	-
NHS deferred income	1,654	-	955	-	687	-	200	-
Non-NHS and Other WGA payables: revenue	162,420	-	243,082	2,440	988,834	-	1,048,435	2,440
Non-NHS and Other WGA payables: capital	613	-	4,952	-	2,401	-	9,364	-
Non-NHS and Other WGA accruals	1,115,898	-	1,215,237	-	3,620,281	-	3,742,406	-
Non-NHS and Other WGA deferred income	5,042	-	4,545	-	19,073	360	11,947	580
Social security costs	7,504	-	5,869	-	19,662	-	15,297	-
VAT	-	-	-	-	519	-	290	-
Tax	6,738	-	6,237	-	17,185	-	15,860	-
Payments received on account	65	-	108	-	170	-	288	-
Other payables and accruals	294,406	-	265,530	-	612,689	3,464	403,634	2,357
Total	**3,239,950**	**-**	**2,509,649**	**2,440**	**8,125,809**	**3,824**	**7,251,664**	**5,377**
Other financial liabilities								
Bank overdraft - Government Banking Service	-	-	-	-	16,479	-	5,372	-
Finance lease liabilities	-	-	10,523	-	121	1,002	10,643	1,085
Other financial liabilities - other	-	-	-	-	-	101	-	76
Total	**-**	**-**	**10,523**	**-**	**16,600**	**1,103**	**16,015**	**1,161**
Total trade and other payables (current)	**3,239,950**		**2,520,172**		**8,142,409**		**7,267,679**	
Total trade and other payables (non-current)		**-**		**2,440**		**4,927**		**6,538**
Total trade and other payables (current and non-current)		**3,239,950**		**2,522,612**		**8,147,336**		**7,274,217**

11. Finance costs

	Parent		Consolidated Group	
	2016/17	2015/16	2016/17	2015/16
	£000	£000	£000	£000
Interest				
Interest on obligations under finance leases	379	569	422	614
Interest on late payment of commercial debt	8	-	33	15
Other interest expense	-	-	16	2
Total interest	**387**	**569**	**471**	**631**
Other finance costs	-	61	-	61
Provisions: unwinding of discount	(8,605)	(12,217)	(8,501)	(12,092)
Total finance costs	**(8,218)**	**(11,587)**	**(8,030)**	**(11,400)**

12. Provisions

Parent

	Current	Non-current	Current	Non-current
	2016/17	2016/17	2015/16	2015/16
	£000	£000	£000	£000
Restructuring	522	-	317	223
Redundancy	1,147	-	6,956	-
Legal claims	930	-	1,267	428
Continuing care	54,261	822	278,345	80,653
Other	25,009	10,227	17,845	26,049
Total	**81,869**	**11,049**	**304,730**	**107,353**
Total current and non-current	**92,918**		**412,083**	

	Restructuring	Redundancy	Legal claims	Continuing care	Other	Total
	£000	£000	£000	£000	£000	£000
Balance at 1 April 2016	**540**	**6,956**	**1,695**	**358,998**	**43,894**	**412,083**
Arising during the year	476	74	-	9,941	4,753	**15,244**
Utilised during the year	(56)	(4,137)	(192)	(94,171)	(6,205)	**(104,761)**
Reversed unused	(473)	(1,743)	(595)	(210,663)	(7,591)	**(221,065)**
Unwinding of discount	35	(1)	32	(9,777)	1,106	**(8,605)**
Change in discount rate	-	(2)	(10)	755	(401)	**342**
Transfer (to) from other public sector body under absorption	-	-	-	-	(320)	**(320)**
Balance at 31 March 2017	**522**	**1,147**	**930**	**55,083**	**35,236**	**92,918**
Expected timing of cash flows:						
Within one year	522	1,147	930	54,261	25,009	**81,869**
Between one and five years	-	-	-	822	4,674	**5,496**
After five years	-	-	-	-	5,553	**5,553**
Balance at 31 March 2017	**522**	**1,147**	**930**	**55,083**	**35,236**	**92,918**

Consolidated Group

	Current	Non-current	Current	Non-current
	2016/17	2016/17	2015/16	2015/16
	£000	£000	£000	£000
Restructuring	825	-	3,028	244
Redundancy	2,481	-	7,348	-
Legal claims	1,392	2	1,443	446
Continuing care	87,817	8,213	321,890	86,770
Other	67,235	18,225	43,287	29,647
Total	**159,750**	**26,440**	**376,996**	**117,107**
Total current and non-current	**186,190**		**494,103**	

	Restructuring	Redundancy	Legal claims	Continuing care	Other	Total
	£000	£000	£000	£000	£000	£000
Balance at 1 April 2016	**3,272**	**7,348**	**1,889**	**408,660**	**72,934**	**494,103**
Arising during the year	501	1,543	442	38,031	44,274	**84,791**
Utilised during the year	(1,282)	(4,444)	(210)	(108,956)	(12,583)	**(127,475)**
Reversed unused	(1,701)	(1,963)	(749)	(232,665)	(19,905)	**(256,983)**
Unwinding of discount	35	(1)	32	(9,701)	1,134	**(8,501)**
Change in discount rate	-	(2)	(10)	661	(394)	**255**
Balance at 31 March 2017	**825**	**2,481**	**1,394**	**96,030**	**85,460**	**186,190**
Expected timing of cash flows:						
Within one year	825	2,481	1,392	87,817	67,235	**159,750**
Between one and five years	-	-	2	8,213	11,467	**19,682**
After five years	-	-	-	-	6,758	**6,758**
Balance at 31 March 2017	**825**	**2,481**	**1,394**	**96,030**	**85,460**	**186,190**

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.

The NHS Litigation Authority financial statements disclose a provision of £71,795,033 as at 31 March 2017 in respect of clinical negligence liabilities of NHS England (31 March 2016: £66,589,000).

13. Contingencies

	Parent		Consolidated Group	
	2016/17	Restated 2015/16	2016/17	Restated 2015/16
	£000	£000	£000	£000
Contingent liabilities				
Employment tribunal	863	1,157	863	1,157
NHSLA employee liability claim	12	15	31	24
Continuing healthcare	-	-	13,695	16,631
Local authority - package recharges	-	-	532	-
Legal claims	5,526	8,051	5,526	8,073
NHS Litigation Authority legal claims	-	-	3	-
NHS Property Services	-	-	-	3,270
Employee pension[12]	250	1,800	250	1,800
Other employee related litigation	103	155	103	155
Other employee related issues	-	600	-	600
Older people Sec 117 recharges	-	-	-	1,320
Responsible commissioner dispute	-	-	615	370
Her Majesty's Revenue and Customs	-	-	832	42
West Wakefield Health & Wellbeing Ltd potential VAT liability	-	-	685	-
Other - service issues	15,000	-	15,000	-
Risk share	-	-	392	-
Contract disputes with NHS bodies	-	-	3,712	1,000
Other	-	-	1,259	-
Net value of contingent liabilities	**21,754**	**11,778**	**43,498**	**34,442**

	Parent		Consolidated Group	
	2016/17	Restated 2015/16	2016/17	Restated 2015/16
	£000	£000	£000	£000
Contingent assets				
Legal cases	3,913	1,015	3,913	1,015
Potential recoveries re disrupted services	10,000	-	10,000	-
Net value of contingent assets	**13,913**	**1,015**	**13,913**	**1,015**

12. Further review of the 2015/16 contingent liabilities has confirmed that £1.8 million of the £1.96 million shown as "Other employee related litigation" was not in fact a legal case. Therefore the 2015/16 reported value has been extracted and included in the "Employee Pension" line.

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.

14. Commitments

14.1 Capital commitments

	Parent		Consolidated Group	
	2016/17	2015/16	2016/17	2015/16
	£000	£000	£000	£000
Property, plant and equipment	2,675	332	2,855	429
Total	**2,675**	**332**	**2,855**	**429**

14.2 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	
	2016/17	2015/16	2016/17	2015/16
	£000	£000	£000	£000
In not more than one year	125,920	80,368	224,440	165,778
In more than one year but not more than five years	421,921	371,819	657,291	563,988
In more than five years	80,304	219,796	146,228	321,811
Total	**628,145**	**671,983**	**1,027,959**	**1,051,577**

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.

15. Financial instruments

15.1 Financial risk management

Financial reporting standard IFRS 7 requires disclosure of the role that financial instruments have had during the period in creating or changing the risks a body faces in undertaking its activities.

Because NHS England is financed through parliamentary funding, it is not exposed to the degree of financial risk faced by business entities. Also, financial instruments play a much more limited role in creating or changing risk than would be typical of listed companies, to which the financial reporting standards mainly apply. NHS England has limited powers to borrow or invest surplus funds and financial assets and liabilities are generated by day-to-day operational activities rather than being held to change the risks facing the CCG in undertaking its activities.

Treasury management operations are carried out by the finance department, within parameters defined formally within the NHS England standing financial instructions and policies agreed by the Governing Body. Treasury activity is subject to review by the NHS England internal auditors.

15.1.1 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.

15.1.2 Interest rate risk

NHS England does not have any borrowings that are subject to interest rate risk.

15.1.3 Credit risk

Because the majority of NHS England revenue comes from parliamentary funding, NHS England has low exposure to credit risk. The maximum exposure as at the end of the financial year is in receivables from customers, as disclosed in the trade and other receivables note.

15.1.4 Liquidity risk

NHS England is required to operate within revenue and capital resource limits, which are financed from resources voted annually by Parliament.

NHS England draws down cash to cover expenditure, as the need arises. NHS England is not, therefore, exposed to significant liquidity risks.

15.1.5 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.

16. Operating segments

Consolidated Group 2016/17	CCGs	Direct commissioning	NHS England	Other	Intra-group eliminations	NHS England group total
	£000	£000	£000	£000	£000	£000
Income	(1,089,513)	(1,547,506)	(56,051)	(646,165)	1,096,781	(2,242,454)
Gross expenditure	77,710,491	26,907,600	2,992,480	388,132	(1,096,781)	106,901,922
Total net expenditure	**76,620,978**	**25,360,094**	**2,936,429**	**(258,033)**	**-**	**104,659,468**

Revenue resource expenditure	
Revenue departmental expenditure limit	**104,896,663**
Annually managed expenditure	**(307,842)**
Technical expenditure	**70,647**
Total net expenditure	**104,659,468**

Consolidated Group 2015/16	CCGs	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**
Total net expenditure	**100,191,434**

The reportable segments disclosed within this note reflect the current structure of NHS England with the activities of each reportable segment reflecting the remit of the organisation. These operating segments are regularly reported to the NHS England Board of Directors for financial management and decision making purposes.

The activities of each segment are defined as follows:-

CCGs - clinically led groups that are responsible for commissioning healthcare services as defined in the Health and Social Care Act 2012.

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 IFRS 8, does not form part of this disclosure.

17. 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 1.3 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.

2016/17

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 Malcom Grant - Chair	Cancer Research	Family member is an employee	110	170	-	156
Professor Sir Malcom Grant - Chair	University of York	Chancellor	45	-	5	-
Lord Victor Adebowale - Non-executive director	Turning Point	Chief Executive Officer and Company Secretary	1,138	-	16	-
Lord Victor Adebowale - Non-executive director	IOCOM	Non-executive director	12	-	-	-
Lord Victor Adebowale - Non-executive director	Co-operative Society	Board member	4	-	-	-
Professor Sir John Burn - Non-executive director	Newcastle University.	Professor of Clinical Genetics	261	16	-	-
Professor Sir John Burn - Non-executive director	Newcastle Hospitals NHS Foundation Trust	Honorary Consultant Clinical Geneticist	392,627	7	3,124	-
Professor Sir John Burn - Non-executive director	Advisory Board to Astra Zeneca	Member	-	23	-	2
Professor Sir John Burnn - Non-executive director	Health Education England	Genomics Advisory Board, member	11,558	176,426	516	19,444
Dame Moira Gibb - Non-executive director	Skills for Health	Chair	216	-	42	-
Dame Moira Gibb - Non-executive director	University of Reading	Council member	3	-	-	-
Noel Gordon - Non-executive director	Uservoice.org	Chairman of Board of Trustees	142	-	24	-
Noel Gordon - Non-executive director	NHS Digital	Chair	2,644	-	8,251	-
Noel Gordon - Non-executive director	Age UK	Member	26	-	5	-
Noel Gordon - Non-executive director	University of Warwick, Audit and Risk Committee	Member	97	-	-	-

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
David Roberts - Non-executive director	Henley Business School, University of Reading	Member, Strategy Board	3	-	-	-
Wendy Becker - Non-executive director	Cancer Research UK	Deputy Chairman	110	170	-	156
Wendy Becker - Non-executive director	SAID School Business Advisory Body, Oxford University	Member	25	-	-	-
Wendy Becker - Non-executive director	BUPA association	Member	16	-	-	-
Joanne Shaw - Non-executive director	Nuffield Health	Deputy Chair and Governor	2,558	-	435	-
Joanne Shaw - Non-executive director	Imperial College Healthcare Trust	Family member is Non Executive Director	326,335	-	704	29
Ian Dodge - National director	Institute of Global Health Innovation, Imperial College London	Adjunct Professor	193	1	-	-
Professor Sir Bruce Keogh - National director	Cancer research UK	Company member	110	170	-	156
Matthew Swindells - National director	Royal College of General Practitioners	Member of Research and Surveillance Centre Advisory Board	757	-	492	-

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
- NHS Business Services Authority, and
- NHS Property Services.

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 on pages 161-170.

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 Malcom Grant - Chair	University College London (UCL)	Non-executive, former President and Provost	673	-	114	-
Professor Sir Malcom Grant - Chair	UCL Partners	Ex Board member	4,132	-	274	-
Professor Sir Malcom Grant - Chair	Genomics England Ltd	Director	53	-	-	-
Professor Sir Malcom Grant - Chair	Cancer Research	Family member is an employee	222	368	-	77
Professor Sir Malcom 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	-	-	-
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	Panel	130	-	-	-
Dame Moira Gibb - Non-executive director	Skills for Health	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	-	-	-
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	-

2015/16 continued...

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 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	-

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 DH is regarded as the parent Department.

For example:

- NHS Foundation Trusts
- NHS Trusts
- NHS Litigation Authority
- NHS Business Services Authority, and
- NHS Property Services

In addition, NHS England had only 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 on page 161-170.

18. Events after the end of the reporting period

The Accounts were authorised for issue by the Accounting Officer on the date of the Audit Certificate of the Comptroller & Auditor General.

There are no adjusting events after the reporting period which will have a material effect on the financial statements of NHS England.

From 1 April 2017 a further 62 CCGs commenced delegated commissioning arrangements, taking the total number operating under this initiative to 174. These arrangements were first introduced in 2014/15 as part of the NHS 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 those CCGs and a corresponding increase in funding to those CCGs.

19. Financial performance targets

The mandate: A mandate from Government to NHS England: April 2016 to March 2017 published by the Secretary of State under section 13A of the National Health Service Act 2006, and the associated Financial Directions as issued by the DH, set out NHS England's total revenue resource limit and total capital resource limit for 2016/17 and certain additional expenditure controls to which NHS England must adhere. These stem from budgetary controls that HM Treasury applies to the DH. Those limits were revised in March 2017 and NHS England's performance against those revised limits is set out in the tables below.

	2016/17					2015/16
	Revenue departmental expenditure limit		Annually managed expenditure	Technical	Total	Total
	Non ringfenced	Ringfenced				
	£000	£000	£000	£000	£000	£000
Mandate limit	105,702,000	166,000	300,000	360,000	**106,528,000**	**102,205,000**
Actual expenditure	104,800,435	96,228	(307,842)	70,647	**104,659,468**	**100,191,434**
Surplus	**901,565**	**69,772**	**607,842**	**289,353**	**1,868,532**	**2,013,566**
Revenue resource limit (excluding planned surplus c/f into 2016/17 of £497m)						**101,708,000**[13]
2015/16 Surplus (excluding planned surplus c/f)	**599,127**	**76,421**	**553,960**	**287,058**		**1,516,566**

	2016/17	2015/16
	Capital resource limit	Capital resource limit
	£000	£000
Limit	260,000	300,000
Actual expenditure	226,875	176,142
Surplus	**33,125**	**123,858**

13. The above table has been slightly amended from the 2015/16 accounts presentation, as there is no required surplus within the 2016/17 revenue resource limit.

NHS England is required to spend no more than £1,832,000,000 of its Revenue Departmental Expenditure Limit mandate on matters relating to administration in the full year. The actual amount spent on RDEL administration matters to 31st March 2017 was £1,595,463,000 as set out below.

	2016/17	2015/16
Administration limit:	**£000**	**£000**
Net administration costs before interest	1,609,025	1,652,709
Less:		
Administration expenditure covered by AME/Technical funding	(13,562)	(3,855)
Administration costs relating to RDEL	1,595,463	1,648,854
RDEL administration expenditure limit	1,832,000	1,862,000
Underspend	**236,537**	**213,146**

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

Annually Managed Expenditure 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 Treasury approval.

There are clear rules governing the classification of certain types of expenditure as Annually Managed Expenditure or Departmental Expenditure Limit.

20. Entities within the Consolidated Group

NHS England acts as the Parent of the group comprising 209 CCGs whose accounts are consolidated within these Financial Statements.

From the 1st of April 2017 this became 207 CCGs with the merger of NHS Central Manchester CCG, NHS North Manchester CCG and NHS South Manchester CCG to form NHS Manchester CCG.

A full list of the CCGs can be found on the NHS England website.

The parent entity of NHS England is the DH.

The largest group of entities for which group accounts are drawn up and of which NHS England is a member is the DH Group.

Copies of the accounts can be obtained from www.gov.uk/government/publications.

APPENDICES

Appendix 1: How we have delivered against the Government's mandate to the NHS

The Government mandate to NHS England sets out the Government's priorities for the NHS, the contribution NHS England is expected to make as well as the budget allocated to achieve this. In its mandate to NHS England for 2016/17, the Government set us seven objectives to 2020 with associated deliverables to be achieved in 2016/17. We have made good progress against the mandate objectives in 2016/17 under challenging circumstances.

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 seven objectives in the Government's mandate.

This annex highlights some of the progress we have made against the specific mandate deliverables, the challenges we have faced and how we have worked to address them this year.

Objective 1: Through better commissioning, improve local and national health outcomes, particularly by addressing poor outcomes and inequalities.

- Good progress has been made with the development of the CCG Improvement and Assessment Framework. The framework has been published and an overall assessment for 2016/17 will be published in June 2017. Assessments for each of the six clinical areas have been made and published as planned.

Objective 2: To help create the safest, highest quality health and social care service

- Good progress is being made on the rollout of the four clinical priority standards for seven day services. The maternity transformation programme is up and running, and progress in relation to maternity safety is being made through a dedicated work stream which has invested £8 million in a maternity safety fund. Work to support the Government's ambitions in relation to anti-microbial resistance and prescribing is on track with the development of new commissioning incentives and indicators to measure progress.

- Work streams to deliver personal health budgets and increase patient choice in relation to maternity and end of life care are making good progress. More than 12,000 people are now in receipt of personal health budgets and seven maternity pioneers have been launched to deepen and widen the choices available to pregnant women.

- As the NHS continued to expand access to cancer services so as to improve early diagnosis, patient volumes increased and performance against the 62 day standard from urgent GP referral to first definitive treatment was 81.9% in January 2017 against a standard of 85%. March 2017 figures showed 1.1% of patients waiting six weeks or more from referral for a diagnostic test, this is an improvement from 1.7% in March 2016. NHS England is working closely with NHS Improvement to support Trusts to improve and progress is being made from a very challenging position. For example endoscopy test performance has improved significantly over the last year. The redesigned Cancer Drugs Fund is being delivered on budget and a new approach to the Fund has been successfully launched.

Objective 3: To balance the NHS budget and improve efficiency and productivity

- The financial position of the NHS continues to be very challenging. Despite these challenges NHS England has managed to deliver financial balance in the commissioning system in line with plans for this year. In addition a £902 million managed underspend in the commissioning system was used to support the financial position in the provider sector. This compares with a goal of producing £800 million managed underspend so representing strong financial performance by NHS England. NHS England continues to work collaboratively with NHSI in relation to efficiency savings, trust deficit reduction plans and reducing spend on agency staff.

- Good progress has been made on rolling out the RightCare programme to all CCGs, NHS England has ensured that all CCGs have a local estate strategy in place.

Objective 4: To lead a step change in the NHS in preventing ill health and supporting people to live better lives

- NHS England continues to work with the DH and other partners to support implementation of the Government's child obesity action plan. To support these aims NHS England has included a childhood obesity indicator in the CCG Improvement and Assessment Framework.

- The Diabetes Prevention Programme, the most ambitious programme of its type in the world, has far exceeded the mandate target of 10,000 referrals with more than 30,000 people having been referred to the programme. NHS England has also consulted on approaches to reduce the prevalence of sugar sweetened drinks in NHS premises.

- Dementia remains a big challenge for the NHS and society as a whole. The aim of maintaining a minimum diagnosis rate of two-thirds for people with dementia is being met, and an evidence-based treatment pathway guide has been published to support clinicians.

Objective 5: To maintain and improve performance against core standards

- As noted above waiting times have been under pressure for a number of years and these continued to intensify in 2016/17, in the context of increasing demand and the tough financial position the NHS currently faces. At February 2017, 90% of patient pathways were completed within 18 weeks, which is below the 92% standard, as delayed emergency patient discharges affected hospitals ability to further expand their routine surgery during 2016/17. However progress is being made in reducing demand growth from GP referrals and this has seen a significant reduction in their growth rate in 2016/17, by around two-thirds compared with 2015/16.

- The ambulance response programme has made considerable progress and full roll out of the new system will happen soon. Urgent and Emergency networks have been implemented and now cover 100% of England.

Objective 6: To improve out-of-hospital care

- Over 17 million patients (30% of the registered population) are benefitting from extended access through the GP access fund. GP practice-level data on quality and access to services has been published on My NHS and will continue to be updated.

- Greater integration of health and social care is a key priority for NHS England. Implementation of Better Care Fund plans has taken place across the country and NHS England has worked closely with a number of areas to develop health proposals as part of their devolution plans.

- Delayed transfers of care continue to be a challenge for both the NHS and social care services which are facing unprecedented financial constraints. A programme has been established to support activity to reduce delayed transfers of care, and assessment of progress is being carried out, with further targeted support planned for the most challenged areas.

- Good progress is being made against all of the mental health deliverables set out in the mandate. This includes improving access to treatment for psychosis, to talking therapies and the quality of crisis care. At January 2017, 76.2% of people starting treatment with an early intervention in psychosis service did so within two weeks of referral. In December 2016, 89.4% of people completed a course of talking therapies treatment in six weeks and 98.5% within 18 weeks. Good progress is being made on implementation of the mental health taskforce recommendations. In relation to learning disabilities there has been an increase in the number of people being cared for in the community rather than in-patient services. The total number of people in in-patient units between January 2016 and March 2017 has reduced from 2,800 to 2,510. There have been 1,670 discharges from in-patient care to community settings in 2016/17.

Objective 7: To support research, innovation and growth

- Progress has been made in setting up an NHS England Research team and a research plan has been published. The 100,000 genomes project is making progress with over 25,000 rare disease samples and over 4,000 cancer samples collected. However the programme faces challenges in relation to meeting the 2020 target of delivery of 90,000 genome sequences. The flow of cancer samples from Genomics Medicine Centres remains below trajectory. NHS England and Genomics England are working with the Genomic Medicine centres to increase patient recruitment.

- Good progress is being made in relation to the rollout of new technologies in the NHS. There has been an increase in patients actively accessing NHS services online, with over 15% of the patient population now registered for online services. There has also been a significant increase in the number of patients accessing and using their electronic health record. Over half a million patients are now signed up to access their detailed health record.

- NHS England continues to support the Government's ambition to reduce the impact of ill health and disability on people's ability to work. NHS England has worked with the Government to pilot health led employment trials which are testing new ways of delivering interventions in various care settings to support people back to work. NHS England is also working to improve the health of the NHS workforce through the healthy workforce programme and the general practice forward view. This has included an indicator on improving staff health and wellbeing in the national CQUIN indicators, providing a financial incentive to improve staff wellbeing within hospital trusts, and piloting staff wellbeing initiatives in a number of demonstrator sites across the NHS.

Appendix 2: Our customer contact and complaints report

Overview

Throughout 2016/17 we have undertaken the following activities to improve complaint handling and learning from customer feedback:

- Focused on ensuring that we deliver against our key performance indicators relating to complaints made direct to NHS England. We are now looking to balance timeliness with the quality of our response, and ensure consistency of approach across the organisation. We have developed a Quality Framework for Complaints, and have also started to roll out an internal peer review process. We are working in partnership with local advocacy providers and Health Watch to review complaints handled in each of our regions with the view to identify good practice and continuously improve the quality and timeliness of response.

- Worked with The Parliamentary and Health Service Ombudsman (PHSO) and Picker Institute to develop a model survey of complainants which can be used in all healthcare settings. This approach will help those using the survey to better understand the complainants' experience of making a complaint. The survey is being piloted in a number of provider settings across England and should be available for wider roll out later in 2017.

- Learning from complaints and customer feedback. One of the themes identified relates to the way in which patients are removed from GP practice lists. NHS England regional teams have been working to help practices better understand the relevant contractual rules and ensure that they are applying appropriate processes.

- Developed a free training programme on complaints for dental practices in England, which has been developed and run in partnership with the Dental Protection Society. The aim is to increase awareness of good practice in this area, increase confidence in the handling of complaints and ensure that patients and the public have access to a quality complaints service should they need to raise concerns about their care, treatment or services provided.

In 2017/18 we will be:

- Building on our work in 2016/17 with both the General Dental and Medical Councils to encourage local resolution in primary care complaints handling
- Working with the Medical Protection Society and Medical Defence Union to co-design and co-deliver complaints training for GP practices
- Continuing to implement our learning programme to ensure that information from complaints and other forms of feedback help inform local and national policies and procedures, and also working in conjunction with other stakeholders to identify themes and trends from customer feedback.

KPI performance

Case Volume and Associated KPI Measures 2016/17

	2015/16	Q1	Q2	Q3	Q4	2016/17
General Enquiries						
No. of cases received	110,839	24,703	25,351	25,767	25,195	101,016
Resolved within 3 working days (Target 95%)	95.9%	96.2%	96.2%	97.2%	95.8%	96.4%
Freedom of Information requests						
No. of cases received	2,681	644	622	657	699	2,622
Resolved within 20 working days (Target 80%)	88.6%	84.6%	84.2%	84.6%	81.4%	83.7%
Concerns[1]						
No. of cases received	6,043	1,774	1,457	1,250	3,743	8,224
Resolved within 10 working days (Target 80%)	86.9%	90.1%	82.4%	82.4%	85.1%	85.3%
Complaints						
No. of cases received	5,913	1,611	1,655	1,732	1,498	6,496
Acknowledged within 3 working days (Target 100%)	94.2%	95.3%	94.7%	96.3%	93.9%	95.1%
Resolved within 40 working days (Target 90%)	46.9%	48.7%	52.2%	48.0%	60.2%	52.1%
Admin Closures[2]						
No. of cases received	12,607	3,708	4,053	4,014	3,061	14,836

1. A concern is defined as an expression of dissatisfaction which has not been handled as a complaint.
2. Admin closure is where a case does not reach a conclusion such as where a complainant does not consent to an investigation or an investigation is not permitted under NHS policy.

Headlines by contact type

General enquiry cases

- We received 101,016 General Enquiries in 2016/17, down from 110,839 (-8.9%) in 2015/16.
- 96.4% of enquiries were resolved within 3 working days, up from 95.9% the previous year.

Freedom of Information (FoI) requests

- 2,621 Freedom of Information requests were received, down from 2,681 (-2.2%) in 2015/16.
- We responded to 83.7% of requests within the target of 20 working days in 2016/17, down from 88.6% the previous year but exceeding our target of 80%.

Complaints

- We recorded 6,496 complaints in 2016/17, up from 5,913 (+9.9%) the previous year.
- In 2016/17, 95.1% of complaints were acknowledged within the target 3 working days, and 52.1% resolved within the target 40 days. This was up from 94.2% and 46.9% respectively in 2015/16.

The table below shows activity relating to complaints managed by NHS England which were reported to the PHSO between 1 April 2016 and 31 March 2017. Some of these complaints will have been received by NHS England prior to 1 April 2016 (but will have progressed to the PHSO after 1 April 2016 hence included in these figures).

All recommendations relating to partially upheld or upheld complaints were accepted and implemented.

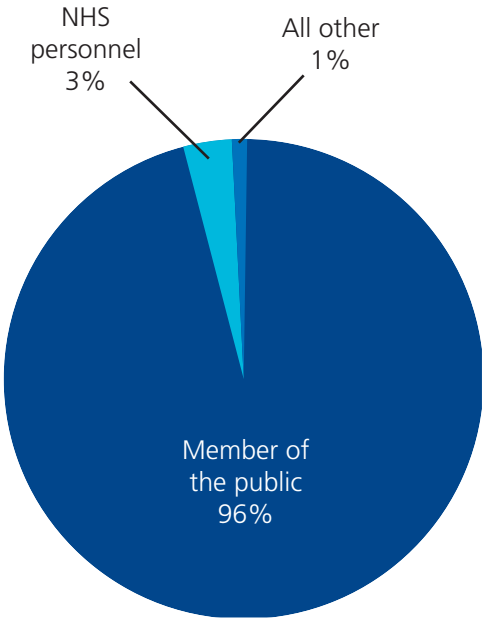
9% of the NHS England complaints considered by the PHSO in 2016/17 were upheld, 13% were partially upheld, 36% were not upheld and the remainder were discontinued or withdrawn.

Region	Upheld	Not Upheld	Partially Upheld	Discontinued Or Other	Total Cases
Midlands & East	2	18	5	18	43
South	2	10	7	7	26
London	3	6	3	7	19
North	6	15	2	17	40
Greater Manchester	1	3	2	4	10
National	0	3	1	10	14
Total	**14**	**55**	**20**	**63**	**152**

Who contacted us?

The majority of contacts came directly from members of the public (96%). NHS staff made up the second largest single group (3%), often making enquiries about NHS England or requesting information.

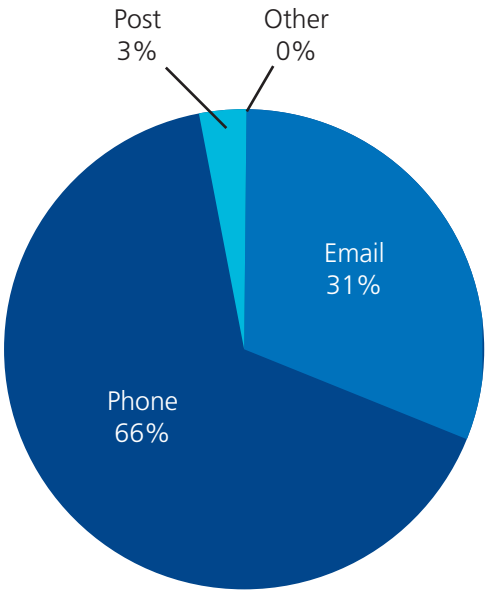
A small percentage (1%) of contact was made from other callers such as MPs/ parliamentary staff, Her Majesty's Prison Service personnel, journalists and people who did not wish to identify themselves.



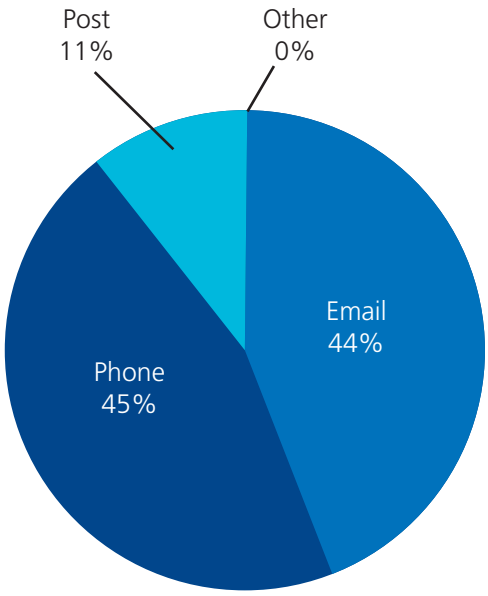
Caller type, 2016/17

Contact method

Two-thirds of all cases were received by telephone in 2016/17. A further 31% by email, and 3% post. For complaints, fewer than half were received by telephone; with 55% either by email or post.



Access channel (all case types), 2016/17

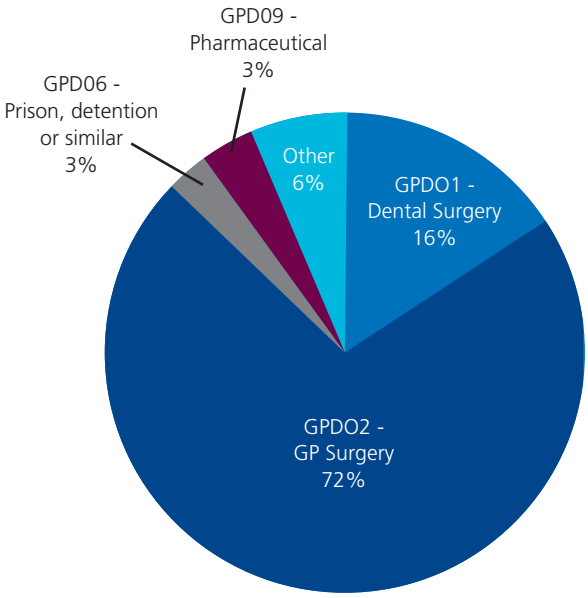


Access channel (complaints), 2016/17

Complaints by service area

In 2016/17, changes to the complaints categorisation were introduced. This was to improve the quality of statistics and provide context for the figures. However it also means that consistent comparisons between 2016/17 and previous years are not possible.

In 2016/17 nearly three quarters of complaints (72%) concerned GP surgeries, with a further 16% about dental surgeries. A smaller proportion was about pharmacies and prisons/detention centres (both 3%).



Service (complaints), 2016/17

Customer satisfaction

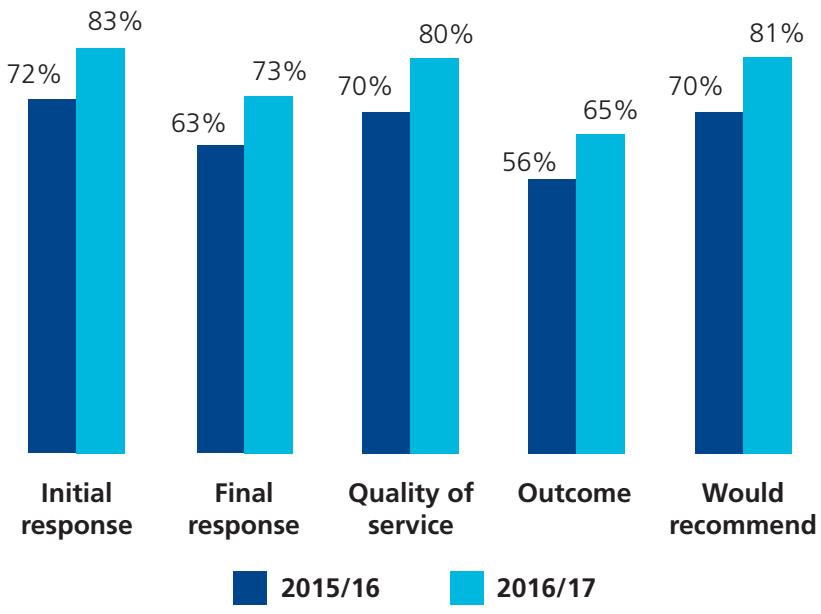
The Customer Contact Centre conducts an ongoing satisfaction survey among a sample of our customers. Customers are asked about their experience of using the service. Over the course of 2016/17, we interviewed 4,420 people about their experience.

All measures of satisfaction increased between 2015/16 and 2016/17.

Satisfaction with the length of time taken to receive an initial response was highest at 83%, compared with 72% the previous year. The lowest reported satisfaction was with the outcome of the case (65% compared with 56% the previous year).

As an overall measure of satisfaction with the service, customers are asked whether or not they would recommend it to friends or family with a similar issue. Again, satisfaction increased compared with the previous year, from 70% to 81%.

Comparison of survey results: 2016/17 with 2015/16



Appendix 3: How we have acted to involve patients and the public in 2016/17

Supporting commissioners to embed participation

We made significant progress in 2016/17 to embed patient and public participation in the work of NHS England under the umbrella of the NHS Citizen programme. Key successes during the year included the launch of our new online Involvement Hub (https://www.england.nhs.uk/participation) in September 2016 which attracted over 30,000 unique page views in its first three months.

New measures were introduced as part of the latest business planning round to ensure our priorities and programmes are well informed by the needs and wishes of patients and the public.

We refreshed our Policy for Patient and Public Participation (https://www.england.nhs.uk/publication/patient-and-public-participation-policy) and published updated Transforming Participation in Health and Care guidance (https://www.england.nhs.uk/participation/involvementguidance).

We have developed patient and public participation frameworks in collaboration with partners for each area of direct commissioning. The frameworks show the most effective ways to involve relevant communities in planning, buying and monitoring health services, and include sources of insight, case studies and good practice. The frameworks are available at: www.england.nhs.uk/participation/resources/docs/.

Progress on developing People Bank, a user-friendly way for people to register their interest in working with NHS England to improve health services, continued to be made in 2016/17, with a pilot successfully evaluated in October 2016. People Bank is now being developed further.

Opportunities to get involved in NHS England's work are promoted to patients and the public through a number of networks and a twice-monthly e-newsletter, 'In touch'.

Alongside People Bank, the support we offer to patient and public voice (PPV) partners who work with NHS England has been reviewed. Around 850 PPV partners work with us on a regular basis. In order to improve the experience and impact of PPV partners, we developed a new recruitment and welcome pack, along with an enhanced support package of training, coaching and mentoring opportunities. Responses to a survey of our PPV partners in December 2016 indicated that 54% thought that patient and public participation was valued by their group / committee to a great extent and a further 40% to some extent.

"We are a very active group and have not only been allowed but encouraged to be involved and input at the highest level. Our lived experience is very valued by the whole team."

"My views are always sought and listened to by other panel members and I feel I am influential in decision making. Bringing a non-clinical perspective has been enthusiastically received."

Looking forward to 2017/18, we will further develop internal reporting and assurance of participation, and seek greater consistency in participation practice. We will continue to strengthen our support offer to seek to enable anyone who wants to work with us to do so in a range of ways, including via social media, contributing to a consultation, attending a workshop or becoming a member of one of our groups, boards or committees.

NHS England is committed to fulfilling its duty under section 13Q of the NHS Act (as amended) to involve the public in relevant commissioning decisions. No successful legal proceedings were made against NHS England in respect of its section 13Q duty in 2016/17.

Supporting participation in Sustainability and Transformation Partnerships (STPs)

The development of STPs has highlighted the need for an effective place-based approach to health and care commissioning, with organisations joining together to engage with and seek to understand and meet the needs of their local populations. In September 2016, we published guidance for STPs to support this process and have subsequently developed a package of tailored support for STPs.

New care models

Over 2016/17 we have worked with the 50 vanguards to ensure that enabling people to manage their own long-term conditions and working in partnership with communities to promote healthy living and wellbeing are central within the design, implementation and spread of new care models. Our approaches have been embedded in the frameworks for multispecialty community providers (MCP), primary and acute care systems (PACS) and enhanced healthcare in care homes (EHCH) care models. We have also delivered three Masterclass events focusing on the 'how to' aspect of developing approaches that support people and communities to be empowered in managing their health and wellbeing.

We have initiated work with a network of 15 vanguards (nine MCP, six PACS) around a programme of accelerated support and learning. The network meets on a quarterly basis to share learning and receives tailored support to ensure effective partnership working with communities, and support for people with long-term conditions to self care. The network will share learning and best practice across the health and care system.

Outreach: working with networks and partner organisations

NHS England continues to support the successful operation of various networks to bring the patient voice into policy-making and commissioning. These include the Voluntary and Community Sector (VCS) Strategic Partners, who ensure that NHS England can hear from a wide range of VCS organisations, and the network of Patient and Public Involvement (PPI) lay members of CCGs.

The PPI Lay Members' Network works collaboratively with NHS Clinical Commissioners and CCG Audit and Finance lay member networks to support lay members in their roles. The lay networks have worked with non-executive directors to identify emerging good practice in STPs and to develop guidance for lay members, STPs, CCGs and NHS England.

The Youth Forum has gone from strength to strength in 2016/17, focussing on issues including young people's mental health and in December 2016 the Older People's Sounding Board was launched to voice the specific needs of this community.

We supported 15 community organisations to showcase the impact of public involvement on health services through our innovative community grant programme in 2016/17. The Involvement Hub includes resources produced by the community groups that received grants. Successful projects include a film from Healthwatch Norfolk about how it worked with partners to engage armed forces veterans, and a film from Rethink Mental Illness about how it has worked with mental health service users to develop improved care planning tools.

Self care

The self care programme is a Patient Supported Self-Management programme targeted at patients with long-term conditions to include peer support, care planning and self-management.

In 2016/17 we developed a national Commissioning for Quality and Innovation (CQUIN) incentive for community care providers to identify patients who would benefit from Personalised Care and Support Planning (PCSP), train staff to have conversations about PCSP, implement those conversations and measure the impact of the actions taken from the resulting personalised care and support plans.

In March 2017 we published a Patient Activation Measure (PAM) good practice guide which outlines the support offered from NHS England to sites using this tool to increase patients' knowledge, skills and confidence in managing their own health and care. We have secured 1.8 million licenses for the PAM and 1.3 million have been allocated to over 50 sites including local authorities and CCGs.

Community partnerships

The NHS Citizens' Active Communities Alliance now has a membership of over 400 organisations and individuals. It has become a source of networking and support for people and organisations interested in involving communities in health and care, especially around increasing volunteering opportunities.

In December 2016, the Department of Culture, Media and Sport and the NHS Confederation came together to deliver a £1.2 million programme of support to increase volunteering in the NHS. Working across ambulance trusts initially, and then spreading to other areas of the health service, the programme will support STP areas to increase volunteering activity that supports self care.

In addition to the Active Communities Alliance, a National Social Prescribing Network is now in place, supported by NHS England and led by the University of Westminster. The Network is specifically supporting organisations within health and care to build and develop social prescribing programmes. Social prescribing involves empowering individuals to improve their health and wellbeing and social welfare by connecting them to non-medical and community support services.

Insight and feedback from patients and staff

The Friends and Family Test (FFT) continuous feedback tool continued to attract a strong response with more than 13 million people rating their experience of care and treatment across the NHS during the year. On average, nine out of ten people said they would recommend the service to other people. This feedback, often coupled with comments from patients to explain their rating, highlights what is working well and what needs to be improved and it is helping to drive both large and small developments across many services.

Some of these benefits were showcased in the first national FFT Awards in Spring 2016 and shared across the NHS through a series of short films and case studies. Following that success, NHS England committed to continuing to recognise good practice in future years by creating several new FFT and Insight for Improvement categories under the umbrella of the annual national awards scheme operated by the non-profit Patient Experience Network.

The Maternity Challenge Fund was launched, providing £100,000 of funding for two projects – at University Hospitals of Morecambe Bay and Kingston Hospital NHS Foundation Trust - to explore the use of feedback to enhance the clinical and ward level experiences of women and their families. The initiative aligns with the Maternity Transformation Programme, which aims to make care safer and give women greater control and more choices. It also fits with NHS England's ongoing agenda to ensure that the NHS makes better use of insight information to give patients a say in decisions about their services. Following the success of the projects, a second round of the fund was launched in October 2016.

During the year, a national insight network was established to encourage greater use and sharing of patient and staff insight data as a foundation for service improvement work by providers and commissioners. By March 2017, there were more than 1,000 members, with monthly e-briefings introduced from December 2016. One of the initiatives delivered was the creation of a set of bite-size guides to insight. The first five were published during the year and were well received.

The Insight and Feedback Team also oversees a range of national surveys to help commissioners, providers and regulators understand the experiences of patients and NHS staff. These are broken down to trust and practice level, allowing comparisons between organisations and also tracking of progress over time.

In July 2016, the team published findings of the GP Patient Survey. It is the largest primary care survey in the world, in which more than two million people are invited to give detailed feedback on key issues like ease of making appointments, waiting times and quality of service. The 2016/17 survey results showed that patients' overall experience of their GP surgery (85.2% good) and overall experience of making an appointment at the surgery (73.4% good) have improved in the last year, arresting a decline from 2011/12 to 2014/15. Whilst these figures support recent policies focussing on improved access, there is evidently still room for improvement. The Cancer Patient Experience Survey was also published in July and the VOICES Survey of Bereaved People in April. The experience of cancer patients in England is generally positive. Asked to rate their overall care on a scale of 0 (very poor) to 10 (very good), 94% of respondents gave a rating of 7 or higher. For the majority of questions, including the overall rating of care, males were more positive about their experiences than females. White respondents were more positive about their experiences than other ethnic groups for the majority of questions, including overall rating of care. In 2015, three out of four bereaved people (75%) rated the overall quality of end of life care for their relative as outstanding, excellent or good; one out of 10 (10%) rated care as poor.

Seven out of 10 people (69%) rated hospital care as outstanding, excellent or good which is significantly lower compared with care homes (82%), hospice care (79%) or care at home (79%). In partnership with the Care Quality Commission, the team also contributed to delivery of the Adult Inpatients Survey in June and the Community Mental Health Survey in November.

In March 2017, the team announced findings from the largest ever survey of NHS staff across England, with more than 423,000 employees responding; about a third of the workforce and an increase of 124,000 on the previous year.

The team also carried out a review of PROMs (Patient Reported Outcome Measures), which assess how patients perceive their benefits from of a range of elective surgeries such as hip and knee replacements. The review is likely to bring some changes to how PROMs is carried out in future and these will be announced in 2017/18.

Increasing uptake of immunisation through engagement – Public Health Commissioning, Peterborough and Cambridgeshire

In Peterborough and Cambridgeshire, screening and immunisation rates were lower than the national average therefore commissioners wanted to understand the reasons so that they could take steps to improve uptake.

The commissioners worked in partnership with Public Health England, local authorities, Healthwatch, charities and CCGs to engage with local people and other stakeholders, including general practice, to find out more about why rates were low and what barriers might exist.

In Cambridgeshire, Healthwatch and charities such as Jo's Cervical Cancer Trust gathered public views on screening, using social media, outreach at existing events, and an online survey.

The information was analysed alongside other national and local data and on the basis of the findings, the partners secured funding to deliver a range of new actions. These included screening and immunisation awareness training for health professionals and community connectors, a cervical screening poster campaign and changes to how families are invited for immunisation. Uptake for the prenatal pertussis vaccine has increased from 47% to 79% with midwives rather than GPs offering the vaccine.

Embedding Patient Voice in the West Yorkshire Prisons Procurement Project

NHS England's health and justice commissioning team (North) is working with partners including WY-FI, a local third sector organisation, to engage with service users in the procurement of health services.

The project covered services in a high security prison, two adult male prisons, two female prisons, a young offenders' institution and a secure children's home. In addition to the benefits of developing partnerships between organisations, the project helped to break down the barriers between patients and professionals and to support patients to gain greater control of their own care. As 'experts by experience', service users contributed to an effective service level agreement between all parties and a procurement training pack for future use by experts by experience. There was a clear impact on project outputs from service user engagement such as scoring of the bid evaluations, specification design and healthcare models to meet the needs of the different groups of service users.

There were also benefits for the experts by experience themselves, who fed back that the process was empowering, confidence building, interesting and enjoyable. They also felt that their role had 'made a difference'.

Appendix 4: How we have acted to reduce health inequalities in 2016/17

Health inequalities cost lives, decrease the quality of life for many people and have financial consequences for the NHS. NHS England has continued to make reasonable progress to reduce health inequalities during 2016/17, but recognises that more still needs to be done and the reduction of health inequalities will remain a high priority through the implementation of the Next Steps on the NHS Five Year Forward View. This appendix presents a summary of how we have met our legal duties with regard to health inequalities during 2016/17, against criteria set by the Secretary of State for Health.

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

Our strategic approach is to embed health inequalities considerations in our priority programmes and policies, build insight into the impact of inequalities upon health and healthcare and support a coordinated, evidence-based approach to reducing health inequalities in both access to and experience of NHS services and health outcomes. This is underpinned by the governance and accountability arrangements that NHS England has in place for its major programmes of work, and our planning and assurance frameworks as detailed under Criterion 6. A core aspect of our work on inequality reduction is ensuring fairer distribution of NHS funding. In 2016/17 we used the primary care, local CCG services and specialised services funding allocations provisions to substantially improve equality of resource allocation across the NHS.

Our Programme Board for Equality and Health Inequalities provides leadership for this agenda, overseeing a programme of work which supports policy makers and managers across the organisation to consider, measure and reduce the impact of health inequalities.

The Equality and Health Inequalities Unit (EHIU) provides comprehensive advice, guidance and tools to assist policy makers, commissioners and managers to meet the legal duties for health inequalities and works to support and embed a systematic approach to reducing health inequalities across the organisation.

Throughout 2016/17 we achieved this through delivering a package of initiatives, including:

- Publication of new Equality and Health Inequalities (EHIA) screening and assessment tools which are embedded in NHS England's Policy Support Toolkit
- A programme of 16 webinars involving over 500 NHS England and CCG staff, focussing on specific programme areas (e.g. diabetes) as well as on data, intelligence and interventions to promote equality and tackle health inequalities
- Rollout of the Capability Building Training programme to over 142 staff to improve knowledge of our legal duties and capability in conducting EHIAs. Bespoke and customised training sessions were piloted by specialised commissioning teams in March 2017
- A programme of face-to-face surgeries were piloted in February and March 2017 to provide advice and support to managers, commissioners and policy officers who are conducting EHIAs and build an equality and health inequalities focus into their areas of work.

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

The NHS Outcomes Framework, Indicators for Health Inequalities Assessment (DH, 2015) set out 11 indicators identified for health inequalities assessment which have been used to guide reporting in 2016/17 using data available on NHS Digital's website. Analysis and data on the indicators can be found here, together with some analysis on IAPT services:

https://www.england.nhs.uk/about/gov/equality-hub/nhs-outcome-framework-health-inequalities-indicators/

https://www.england.nhs.uk/about/equality/equality-hub/increasing-access-to-psychological-therapies-services-analysis/.

A 'community of practice' for policy leads and analysts was established in March 2017 to support a robust and coherent approach to reporting.

NHS England leads wider work on data monitoring and information standards in partnership with the DH and other key stakeholder organisations, overseen by a subgroup of the Equality and Diversity Council (EDC). During the year, we commissioned and supported the development of an Information Standard on sexual orientation which is due to be published in Summer 2017. Our published Equality Objectives (2016-20) support and strengthen this work. Objective 5 commits to improve the mapping, quality and extent of equality information collected.

The 2016/17 CCG IAF include two health inequalities indicators. Mirrored in the NHS Outcomes Framework, these are designed to help CCGs monitor and plan improvements in NHS equity performance, using the markers of unplanned hospitalisation for chronic ambulatory care sensitive conditions and emergency admissions for urgent care sensitive conditions.

In October 2016, our resource pack Challenging Health Inequalities: Support for CCGs set out how to use these indicators to identify and tackle inequalities in the rate of avoidable hospital admissions and unplanned hospitalisation for urgent care-sensitive conditions between most and least deprived areas, locally and nationally. Interactive heat maps to visually explore this data can be viewed at: ccgtools.england.nhs.uk/inequalities/CCGEmergencyAdmissions/atlas.

Our development of data and tools is helping CCGs to identify priority neighbourhoods in which inequalities need to be addressed, consider appropriate interventions and actions to tackle unwarranted variation and deliver improved healthcare for local populations. Further information on interventions around social prescribing, self-management and integrated care, alongside case studies detailing their successful application by CCGs can be found in the RightCare Long Term Conditions Packs at www.england.nhs.uk/rightcare/. Work is underway to develop a RightCare Pack with a focus upon the intersectionality between health inequalities and protected and disadvantaged groups. This highlights approaches and interventions that have the potential to better address the needs of groups of people who share a protected characteristic.

In 2017/18, we will increase the use of data and information to shape policy, drive improvement and assess progress in reducing health inequalities. We will continue to collaborate with the DH and Public Health England to measure progress, and develop and implement evidence-based interventions.

Criterion 3: Utilise and develop the evidence of effective interventions to reduce health inequalities.

In August 2016, data was launched on the My NHS website (www.nhs.uk/service-search/scorecard/results/1172?metricGroupId=605&radiusInMile=0&recordsPerPage=10) highlighting the social inequalities in hospital admissions – which means far more poor people end up in hospital for preventable conditions than more affluent people – charting significant variation across England.

Data compiled by the University of York for NHS England highlighted that the performance of a CCG in tackling the social divide in these preventable hospital admissions, whilst indexed to deprivation, is also an indicator of how well the NHS is succeeding in delivering out-of-hospital services to deprived patients with complex long-term conditions.

The launch of these equity indicators is a key achievement which will help improve the coordination of care, reduce preventable hospitalisation and costly health emergencies associated with social deprivation. The EHIU and its analysts have built on this and commenced a programme of work with the University of York and wider stakeholders to invite, develop and gather evidence on equality and health inequality interventions, implemented in different localities and communities. Our Equality and Health Inequalities Resource Hub can be accessed at: www.england.nhs.uk/about/equality/equality-hub/resources/.

Criterion 4: Improve prevention, access and effective use of services for Inclusion Health groups.

During 2016/17, NHS England worked through the NHS Equality and Diversity Council (EDC) Inclusion Health/ Lived Experience sub group, along with the DH, Public Health England and key stakeholders from the community and voluntary sector. In March 2017, the sub group co-produced and published leaflets, complementing existing guidance for GP practices for registering patients. The aim was to make it easier for patients from Inclusion Health Groups to overcome barriers when accessing the healthcare they are entitled to. The leaflet is available on the NHS Choices website: http://www.nhs.uk/NHSEngland/AboutNHSservices/doctors/Pages/NHSGPs.aspx#register.

There are many good practice examples of commissioners tackling health inequalities for Inclusion Health Groups. In London, NHS England and CCGs established a pan-London programme to deliver 'Once for London' work to assist CCGs to plan for the needs of people who are homeless within their localities. They produced 'My right to access' healthcare cards, with 30,000 cards distributed across London. Details of the London Homeless Health Programme's work can be found at: www.healthylondon.org/homeless.

Further details of how we have acted to improve prevention, access and effective use of services for Inclusion Health Groups is set out in this annual report from page 70.

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.

As set out under Criterion 2, the 2016/17 CCG IAF includes two health inequalities indicators to help CCGs set priorities for tackling inequalities. These inform the headline assessment of CCGs together with 58 other indicators. CCG year end annual assessments will be published on NHS England's website and on the MyNHS site.

The links are:

https://www.england.nhs.uk/commissioning/ccg-assess/
https://www.nhs.uk/Service-Search/performance/search.

Further detail on the CCG IAF is set out from page 134 of this annual report.

The Five Year Forward View set out the need to address the health and wellbeing gap in all CCGs, narrowing – or at least preventing any further widening of – health inequalities. The Healthy Hastings and Rother programme is a good example of how one CCG is taking steps to tackle health inequalities. A summary of their activities can be found at:
www.hastingsandrotherccg.nhs.uk/about-us/plans-and-strategies/healthyhastingsandrother/.

In preparing their annual reports, CCGs are required to make an assessment of how they have met their legal duties for health inequalities. NHS England requires all CCG annual reports to be reviewed by NHS England regional teams prior to submission, and this includes consideration of how well CCGs have met this reporting duty.

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.

The Government's mandate to NHS England for 2016/17 set a specific long term objective on tackling health inequalities by 2020 as set out in Appendix 1 underpinned by specific deliverables to be achieved in year. The EHIU has assisted with delivering this commitment, providing expert support to staff in NHS England and CCGs and through developing a suite of resources in 2016/17.

The NHS Operational Planning and Contracting Guidance 2017/19 set out nine 'must do's, including mental health, primary care and cancer care as well as clear expectations on the role to be played by STPs.

All 44 STPs have outlined strategies for achieving the 'triple aim' set out in the FYFV and are in the process of developing delivery plans for the ambitions outlined. NHS England's EHIU have contributed to the development of an 'offer' to STPs, to be delivered in 2017/18, which builds upon the Unit's expert input in late 2016 to a series of workshops for STP leads on the legal duties. The EHIU has also worked with the EDC to produce a blog highlighting the need to consider equality and health inequalities when developing and implementing STPs. This can be viewed at: www.england.nhs.uk/2016/12/lucy-wilkinson/.

Independent analysis of a number of STPs across the country was presented to the EDC in January 2017, highlighting good practice in relation to equality and health inequalities:

- **North East London (NEL) STP** A comprehensive EHIA is in place for the STP plan, easily accessed from the STP website
- **Greater Manchester Transformation** A community organisation undertook an EHIA which was informed by a series of engagement meetings with people with experience of stark inequalities, and from protected and inclusion health groups and independently assured by a multi-agency Equality Advisory Group.

NHS England Business Plan for 2016/17

An analysis of how NHS England has delivered against our corporate priorities for 2016/17 is set out in our Performance Report. Much progress has been made to embed health inequalities considerations across these priority areas, examples of which are set out below. Information on where to find further information on each priority area is set out from page 13 of this annual report.

- **Diabetes** A pilot is being undertaken to enable providers to target individuals at risk of developing Type 2 diabetes, focusing on communities likely to be under-represented in accessing health services including BME communities who have a higher prevalence of Type 2 diabetes than the rest of the population. Through a further pilot, providers are adjusting their course content so that it meets the needs of people with learning disabilities.

- **The Maternity Transformation Programme** is working closely with Public Health England to ensure that prevention is embedded across the Programme. Public Health England will also deliver packages of evidence for application to drive improvements and reduce inequalities on priority topics for 2017/18, including smoking in pregnancy, drinking alcohol in pregnancy and perinatal and infant mental health. A key achievement has been additional support, secured to implement interventions recommended by NICE guidance for the 26 CCGs identified as having the highest rates of maternal smoking.

- **Primary Care** NHS England's planning and contracting guidance for 2017-2019 sets out funding and the trajectory to deliver improved access across England by March 2019. The guidance sets seven core requirements for commissioners and includes a specific requirement to address issues of inequalities in patients' experience of accessing general practice identified by local evidence and actions to resolve, put in place. To help understand the impact this could have on the inequalities agenda for patients, a work stream has been established as part of the Improving Access to General Practice Services Programme. NHS England has commissioned the production of an inequalities resource for general practice access, aimed at general practice providers and commissioners which will be available shortly on NHS England's website.

- **Vanguards** The vanguards are helping to tackle health inequalities in a number of ways, aiming to improve the physical, mental and social health and wellbeing of their local population. For example, Harrogate and rural district CCG is tackling health inequalities with the Warm and Well scheme which provides practical and financial support to alleviate the effects of cold homes and fuel poverty on the health and wellbeing of their most vulnerable patients. People supported by the project include the over-65s, people on low incomes, those receiving benefits, people with asthma or COPD or other long-term health conditions and disabilities including mental health.

- **Integrated Urgent Care** Steps have been taken this year to further improve the NHS 111 service for the deaf community by introducing Interpreter Now. Deaf people can go online and use Interpreter Now to call NHS 111 where they will be connected to a fully qualified interpreter who will relay the conversation. Deaf people can telephone NHS 111 in two ways. Firstly, via the NHS Choices website and secondly, by using the Interpreter Now App or via their website.

- **Cancer** Research evidence drawn from the Cancer Patient Experience Survey (CPES) has identified that people from BME communities are still experiencing a significantly poorer experience of care when using cancer services. NHS England undertook work in 2016/17 to identify approaches to reduce this inequality, including through commissioning. This has included a project to look at equality and health inequalities in cancer care for BME communities, the first face-to-face meeting of which was held and supported by the Patient Experience team in November 2016 with representatives from six CCGs. The meeting afforded opportunities to focus on the gaps that the CCGs had identified regarding the experience of the BME community and cancer care, to agree shared goals and promote experiential learning.

The focus that NHS England has placed in 2016/17 upon identifying inequalities with targeted attention on reducing inequalities in access to, experience of and outcomes from healthcare services will support NHS England and the wider system to achieve sustainable and measurable reductions in health inequalities by 2020.

Appendix 5: Our sustainability report

NHS England continues to develop our approach to sustainable development and this year published our first Sustainable Development Management Plan. The Sustainable Development Management Plan sets out our ambitions for the coming year, whilst we develop a longer-term Sustainable Development Management Plan to take us forward.

This appendix covers NHS England and CSUs only. CCGs report on sustainability within their individual annual reports which are published on their websites. 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

Within this report NHS England and CSUs will report on their proportion of occupied buildings.

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.

Where NHS England is a tenant of the Department of Work and Pensions, 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-for-work-pensions.

Provision of data

NHS Property Services Ltd (NHS PS) is the landlord for the majority of NHS England and CSU offices and we are reliant on them for the provision of utilities and waste data. Recognising that they are not in a position to provide accurate, actual data NHS PS has made the following statement for inclusion in this report:

"NHS Property Services Ltd (NHS PS) recognises the importance of being able to provide building-related information to those who occupy its buildings. Over the last 12 months NHS PS has been working hard to better understand the energy consumption and waste arising from the buildings for which it is landlord. This has included undertaking one of the largest hard and soft Facilities Management rationalisation programmes ever seen in England which has significantly reduced the number of contractors and which going forward will make data collection and management easier. NHS PS has also recently completed a full country-wide asset and condition survey of its entire estate which will provide the foundation for improved data collection and reporting over the coming year. We are currently evaluating the huge amounts of data that these surveys have produced and developing robust and complete consumption records will be a priority. To support this work NHS PS has commenced the process of recruiting additional resource to support our customers going forward."

For the purpose of reporting on energy, water and waste where data is not available, NHS England has used a methodology utilised by other arm's length bodies to make the best estimation possible. The method used for each estimate is included within the relevant section of this report. For consistency, we have applied this formula to both NHS England and CSUs, including previously reported figures which were based on partial data.

Due to the use of estimated figures, it's difficult to draw any conclusions about our performance in this area. However, due to estates rationalisation over recent financial years, we would expect to see a reduction in scope 2 emissions. Our Sustainable Development Management Plan outlines our intention to set a baseline and targets for ongoing reductions, when data becomes available from NHS PS. Scope 3 emissions are explored further in the Business Travel section on page 270.

Greenhouse Gas Emissions

NHS England *estimated

			2016/17	2015/16	2014/15
Scope 1 emissions[3]	Non-financial indicators (tCO2e)	Emissions from organisation-owned fleet vehicles	1	27	65
	Total Scope 1 (tCO2e)		**1**	**27**	**65**
	Financial indicators	Expenditure on official business travel	£419	£15,422	£35,003
Scope 2 emissions[4]	Non-financial indicators (tCO2e)	Electricity Gas	1,468* 1,112*	1,665* 1,261*	1,741* 1,319*
	Total Scope 2 (tCO2e)		**2,580***	**2,926***	**3,060***
	Related use (Kwh)	Electricity Gas	3,267,060* 2,475,819*	3,704,820* 2,807,559*	3,874,676* 2,936,278*
Scope 3 emissions[5]	Non-financial indicators (tCO2e)	Car travel Rail travel Air travel (domestic only)	1,356 1,475 25	1,498 1,470 26	1,428 1,122 38
	Total Scope 3 (tCO2e)		**2,856**	**2,995**	**2,588**
TOTAL (tCO2e)			**5,438***	**5,948***	**5,713***

3. Scope 1 emissions arise from organisation owned and operated vehicles, plant and machinery.
4. Scope 2 emissions arise from the consumption of purchased electricity, heat, steam and cooling. To estimate scope 2 emissions in the section, we have used a formula based on the typical usage figures from the Chartered Institute of Building Services Engineers (CIBSE) and the Net Internal Area (NIA) of space occupied.
5. Scope 3 emissions arise from official business travel by vehicles not owned by the organisation

CSUs *estimated

			2016/17	2015/16	2014/15
Scope 1 emissions	Non-financial indicators (tCO2e)	Emissions from organisation-owned fleet vehicles	35	87	1
	Total Scope 1 (tCO2e)		**35**	**87**	**190**
	Financial indicators	Expenditure on official business travel	£50,629	£113,512	£247,219
Scope 2 emissions	Non-financial indicators (tCO2e)	Electricity Gas	3,103* 2,351*	5,084* 3,852*	4,274* 3,239*
	Total Scope 2 (tCO2e)		**5,454 ***	**8,936***	**7,513***
	Related use (Kwh)	Electricity Gas	6,905,907* 5,233,383*	11,313,818* 8,573,753*	9,512,198* 7,208,463*
Scope 3 emissions	Non-financial indicators (tCO2e)	Car travel Rail travel Air travel (domestic only)	2,282 45 0	2,131 134 4	3,355 101 7
	Total Scope 3 (tCO2e)		**2,328**	**2,270**	**3,462**
TOTAL (tCO2e)			**7,817***	**11,292***	**11,164***

Total (NHS England and CSUs) *estimated

			2016/17	2015/16	2014/15
Scope 1 emissions	Non-financial indicators (tCO2e)	Emissions from organisation-owned fleet vehicles	36	114	255
	Total Scope 1 (tCO2e)		**36**	**114**	**255**
	Financial indicators	Expenditure on official business travel	£51,047	£128,934	£282,223
Scope 2 emissions	Non-financial indicators (tCO2e)	Electricity Gas	4,571* 3,464*	6,748* 5,114*	6,015* 4,558*
	Total Scope 2 (tCO2e)		**8,035***	**11,862***	**10,573***
	Related use (Kwh)	Electricity Gas	10,172,968* 7,709,202*	15,018,639* 11,381,312*	13,386,875* 10,144,741*
Scope 3 emissions	Non-financial indicators (tCO2e)	Car travel Rail travel Air travel (domestic only)	3,638 1,520 26	3,630 1,605 30	4,781 1,223 4
	Total Scope 3 (tCO2e)		**5,184**	**5,264**	**6,050**
TOTAL (tCO2e)			**13,255***	**17,240***	**16,877***

Water consumption

To estimate the figures for water consumption, we have used the Construction Industry Research and Information Association (CIRIA) figure for average water consumption per m^2 of Net Internal Area (NIA) of office space occupied.

NHS England *estimated

		2016/17	2015/16	2014/15
Non-financial indicators (m3)	Water used	16,709*	17,575*	18,380*
Financial indicators (cost of purchase of water)	Cost of water used	£60,631*	£63,771*	£66,695*

CSUs *estimated

		2016/17	2015/16	2014/15
Non-financial indicators (m3)	Water used	32,760*	53,670*	45,123*
Financial indicators (cost of purchase of water)	Cost of water used	£118,871*	£194,745*	£163,733*

NHS England *estimated

		2016/17	2015/16	2014/15
Non-financial indicators (m3)	Water used	49,469*	71,245*	63,504*
Financial indicators (cost of purchase of water)	Cost of water used	£179,503*	£258,515*	£230,428*

Waste

The waste figures have been estimated using the averages from partial data provided by NHS PS in 2015/16, multiplied by the NIA of space occupied.

CSUs *estimated

		2016/17	2015/16	2014/15
Non-financial indicators (tonnes)	Total waste	327*	535*	450*
	Waste sent to landfill	191*	313*	263*
	Waste recycled/reused	129*	211*	177*
	Waste incinerated	7*	12*	10*
Financial indicators (cost of waste disposal)	Total waste	£86,058*	£140,988*	£118,537*
	Waste sent to landfill	£34,692*	£56,836*	£47,785*
	Waste recycled/reused	£47,420*	£77,687*	£65,316*
	Waste incinerated	£3,946*	£6,465*	£5,436*

Total *estimated

		2016/17	2015/16	2014/15
Non-financial indicators (tonnes)	Total waste	493*	710*	633*
	Waste sent to landfill	288*	415*	370*
	Waste recycled/reused	194*	280*	250*
	Waste incinerated	11*	15*	14*
Financial indicators (cost of waste disposal)	Total waste	£129,953*	£187,155*	£166,821*
	Waste sent to landfill	£52,387*	£75,447*	£67,250*
	Waste recycled/reused	£71,607*	£103,126*	£91,921*
	Waste incinerated	£5,959 *	£8,582*	£7,650*

NHS England business travel

		2016/17	2015/16	2014/15
Miles	Rail	20,343,565	20,274,544	14,713,705
	Car use (scope 1 and 2)	4,564,382	4,974,652	4,759,417
	Domestic flights	100,068	103,051	151,535
	Non-domestic flights	144,930	235,446	400,569
	Total	**25,567,889**	**25,587,693**	**20,025,226**
tCO2e	Rail	1,475	1,470	1,122
	Car use (scope 1 and 2)	1,357	1,525	1,493
	Domestic flights	25	26	38
	Non-domestic flights	21	31	58
	Total	**2,878**	**3,053**	**2,710**

This year we have seen a small decrease in the amount of carbon emissions from business travel. This can be attributed mostly to a large decrease in the amount of carbon as result of non-domestic air travel. There was also a small decrease in carbon emissions from domestic air travel and business travel by car. Carbon emissions from rail travel remain the same as last year, as opposed to increases seen in previous years.

NHS England has a sustainable travel and expenses policy, which prioritises the use of technology to hold virtual meetings, followed by the use of public transport instead of more environmentally harmful modes of transport. We continue to develop IT, increasing the possibilities for colleagues to meet virtually (internally and externally) and we also encourage and support colleagues to cycle where possible, through the cycle to work scheme and cycle mileage rate.

Our Sustainable Development Management Plan sets out an ambitious aspiration to further reduce domestic air travel by 10% per FTE in the next financial year, and reduce overall carbon emissions from business travel by 10% per FTE against 2016/17 baseline figures.

Sustainable procurement

All commercial and procurement staff have received training on environmental, ethical and labour issues in procurement. Sustainability features in the recruitment of commercial employees, forms a key part of our induction for new entrants to the Commercial team and will be integrated into the commercial team members' personal development process.

Our Business Case approval process now includes a question on Social Value which must be considered before the budget for a proposed procurement is approved. This question is supported by explanatory narrative, which makes direct references to specific sustainability issues. Key contracts undergo an assessment of the sustainability risks that they may pose to NHS England with the view to implement relevant and proportionate mitigating actions, as necessary.

Our supplier registration process includes mandatory supplier classification questions, which capture the nature and ownership of new suppliers e.g. SMEs, Third Sector Organisations etc. This will help us understand how diverse our supply base is, to better target our efforts on increasing the proportion of under-represented supplier groups. Our next steps include consolidating our supplier engagement approach and sharing our ambition and objectives with key suppliers.

Sustainability is embedded within our commercial reporting framework (the Commercial Balanced Scorecard). Our Sustainable Procurement Programme is aligned with the Flexible Framework.

Climate change adaptation

Sustainable Development Unit (SDU) is jointly hosted by NHS England and Public Health England. The SDU Health Check 2017 was published on 26 January 2017. The health check demonstrated that overall organisations are cutting their carbon footprint and saving money through reducing energy use, but having less success in addressing water use and the increased costs from waste disposal. Progress in sustainable approaches to commissioning, procurement and across the social care sector is more difficult to measure and more needs to be done in this area. Sustainable development is increasingly becoming a core part of work. More organisations have board approved Sustainable Development Management Plans and are reporting annually on their work.

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.

Appendix 6: Disclosure of personal data-related incidents

As at 31 March 2017, a total of 18 Serious Incidents Requiring Investigation (SIRI) 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 tables below, remedial actions were implemented for all incidents and the Information Commissioner's Office (ICO) were kept informed as appropriate.

All IG incidents are assessed and managed according to NHS Digital's Checklist Guidance for Reporting, Managing and Investigating Information Governance and Cyber Security SIRI. NHS England continues to promote IG good practice through annual training and regular communications. Lessons learnt are disseminated to staff and where appropriate key themes / messages are incorporated into the NHS England's IG training module.

Details of any incidents occurring in CCGs can be found within individual CCG annual reports which are published on CCG websites. A list of CCGs, and links to their websites, can be found at: www.england.nhs.uk/ccg-details/.

NHS England

Date of incident	Nature of incident	Paper	Electronic	Number of people potentially affected	Comments
Sept 2016	A team received what was believed to be a blank dataset template. This email which contained personal sensitive data (patient) was forwarded to a team in an external organisation in error.		√	288	Incident closed. Remedial actions implemented and ICO confirmed no further action required.
Jan 2017	Personal sensitive data (patient) sent to a third party in error.	√		3	Incident closed. Remedial actions implemented and ICO confirmed no further action required.
Feb 2017	A document was uploaded to the NHS England website in error; this was a summary of pharmacy alerts that had occurred during a month period and contained personal sensitive data (patient).		√	1	Incident closed. Remedial actions implemented and ICO confirmed no further action required.

Primary Care Support England

The contract for providing primary care support services was awarded to Primary Care Support England (Capita) on behalf of NHS England in September 2015. Changes to this service have been implemented to move this to a nationally delivered solution instead of locally managed. 12 of the 18 incidents have occurred within the primary care service and a full rectification plan is in place which is monitored by NHS England.

Date of incident	Nature of incident	Paper	Electronic	Number of people potentially affected	Comments
April 2016	A summary record was found outside and returned to the local Medical Practice	√		1	Incident closed. Remedial actions implemented and the ICO confirmed no further action required.
Sept 2016	A bag of medical records, sealed individually in tamper-proof bags, was left outside a medical practice. The dispatching medical practice opened the bag to verify the contents.	√		Unknown quantity	Incident closed. Remedial actions implemented and the ICO confirmed no further action required.
Oct 2016	A medical record, sealed in a tamper-proof bag, was left outside a medical practice. The dispatching medical practice opened the bag to verify the contents.	√		1	Incident closed. Investigation underway as at end of March 2017 and the ICO did not investigate on this occasion.
Oct 2016	Medical record was sent to an incorrect individual.	√		1	Incident closed. Remedial actions implemented and the ICO confirmed no further action required.
Oct 2016	A bag of medical records individually sealed in tamper proof bags was incorrectly delivered to another medical practice. The practice opened the bag to verify the contents.	√		600	Incident closed. Remedial actions implemented and the ICO confirmed no further action required.

Date of incident	Nature of incident	Paper	Electronic	Number of people potentially affected	Comments
Oct 2016	PCSE was notified that a medical record in a sealed tamper proof bag was found outside a hospital. The hospital opened the bag to verify the contents.	√		1	Incident closed. Remedial actions implemented and the ICO confirmed no further action required.
Jan 2017	A medical record, sealed in a tamper-proof bag, was left outside a medical practice. The dispatching medical practice opened the bag to verify the contents.	√		1	Incident closed. Remedial actions being implemented and ICO confirmed no further action required.
Jan 2017	A medical record, sealed in a tamper-proof bag, was left outside a medical practice. The dispatching medical practice opened the bag to verify the contents.	√		1	Incident closed. Remedial actions being implemented and ICO confirmed no further action required.
Feb 2017	A bag of medical records individually sealed in tamper proof bags was incorrectly delivered to another medical practice. The practice opened the bag to verify the contents.	√		50	Incident closed. Remedial actions being implemented and ICO confirmed no further action required.
March 2017	A medical record sealed in a tamper-proof bag was found outside a medical practice and returned unopened to the practice.	√		1	Incident closed Remedial actions being implemented and ICO confirmed no further action required.
March 2017	A bag of medical records, individually sealed in tamper proof bags was incorrectly delivered to a pharmacy reception located within the same building as the intended medical practice. The Pharmacy opened the bag to verify the contents.	√		26	Incident closed. Remedial actions being implemented and ICO confirmed no further action required.
March 2017	Medical record was sent to an incorrect recipient, a third party organisation.	√		1	Incident closed. Remedial actions being implemented and ICO confirmed no further action required.

Commissioning Support Units

Date of incident	Nature of incident	Paper	Electronic	Number of people potentially affected	Comments
June 2016	Letter containing personal sensitive data (patient) was sent to an incorrect recipient.	√		10	Remedial actions implemented and the ICO confirmed no further action required.
July 2016	A CSU breached the contract in place with HSCIC for Hospital Episode Statistic (HES) record level data by sharing with a 3rd party.		√	100,000	Incident closed. Remedial actions implemented and the ICO did not investigate on this occasion.
Oct 2016	Following a Continuing Healthcare assessment, an outcome letter was sent to a patient's relative. The relative had not been involved in the assessment and does not have Lasting Power of Attorney (Health & Welfare).	√		1	Incident closed. Incident has been reported by the CCG as the responsible data controller.

Appendix 7: UK Corporate Governance Code Assessment

NHS England's arrangements generally comply with the best practice described in the UK Corporate Governance Code (2016). As part of implementing best practice, whilst it is not mandatory, an assessment of compliance against both the UK Corporate Governance Code and Corporate Governance in Central Government Departments: Code of Good Practice 2011 is undertaken each year.

A number of the provisions are not applicable, and others have required interpretation for the context in which NHS England operates. 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.

Compliance with the UK Corporate Governance Code (2016)

Provisions against which there are exceptions:

Ref	Code provision	Exception
A.4.1	The board should appoint one of the independent non-executive directors to be the senior independent director to provide a sounding board for the chairman and to serve as an intermediary for the other directors when necessary. The senior independent director should be available to shareholders if they have concerns which contact through the normal channels of chairman, chief executive or other executive directors has failed to resolve or for which such contact is inappropriate.	The appointment of a senior independent director is not a mandatory appointment. Currently NHS England has determined that this is not a requirement for our board.
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 NHS Act 2006 (as amended) the Secretary of State appoints the Chair. Other elements of this provision are met.
B.4.2	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 the other executives.

Ref	Code provision	Exception
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.	The appointment and removal of the board secretary 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 remuneration committee should make available its terms of reference, explaining its role and the authority delegated to it by the board. Where remuneration consultants are appointed, they should be identified in the annual report and a statement made as to whether they have any other connection with the company.	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 against which there are exceptions:

B.2.1, B.2.2, B.2.3, B.2.4, B.3.2, B.3.3, B.6.2, 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
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.
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 above). The specific code provisions a-d are handled by the Strategic Human Resources and Remuneration Committee.
4.10	Through the Board Secretariat, the Department provides the necessary resources for developing the knowledge and capabilities of board members, including access to its operations and staff.	This responsibility is shared between the Chair, 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 issues across the department and its ALBs.	The Head of Internal Audit routinely attends meetings of 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 2017/18:

4.1f – formal evaluation of Board, Committees and Board member performance – in view of the changes in non-executive members of the board during 2016/17 it was agreed to defer the formal evaluation of the board until 2017/18.

Appendix 8: List of acronyms used in our annual report

	Acronym used	Meaning
A	A&E	Accident and Emergency
	ARAC	Audit and Risk Assurance Committee
B	BME	Black, minority, ethnic
	BECS	Dental Benefit Eligibility Checking Service
C	CCG(s)	Clinical Commissioning Group(s)
	CETV	Cash Equivalent Transfer Value
	CSU(s)	Commissioning support unit(s)
	CTR	Care Treatment Reviews
	CQC	Care Quality Commission
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
	ESM	Executive Senior Manager
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
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

	Acronym used	Meaning
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 for Health and Care Excellence
P	PCS	Primary Care Service
	PECS	Prescription Eligibility Checking Service
	PHE	Public Health England
R	RDEL	Revenue Departmental Expenditure Limit
	RCGP	Royal College of General Practitioners
S	SFI	Standing Financial Instructions
	SIRI	Serious Incidents Requiring Investigation
	SIRO	Senior Information Risk Owner
	STP	Sustainability and Transformation Partnerships
T	TCP(s)	Transforming Care Partnerships
U	UEC	Urgent and emergency care
W	WRES	Workforce Race Equality Standard

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