NHS England

Our 2018/19

Annual Report

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

HC 2293

THE NHS CONSTITUTION
the NHS belongs to us all

NHS England

Annual Report and Accounts 2018/19

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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Contents

A view from Lord David Prior, Chair **7**

About NHS England **9**

Performance Report **13**

Chief Executive's overview 14
How we measure performance 16
Performance analysis 17
How we supported the wider NHS 33
Involving patients and the public 44
Sustainability 48
Chief Financial Officer's report 53
Our priorities for 2019/20 57

Accountability Report **59**

Corporate governance report 61
Remuneration and staff report 107
Parliamentary accountablity and audit report 135

Annual Accounts **143**

Notes to the financial statements 149

Appendices **191**

Appendix 1: How we have delivered against the Government's mandate to the NHS 192
Appendix 2: Equality 196
Appendix 3: Reducing health inequalities 197
Appendix 4: List of acronyms used in our annual report 200

A view from Lord David Prior, Chair

Healthcare systems in all developed countries are under growing pressure from ageing populations and slowing economic growth. That is true whether systems are funded publicly, privately, or a mixture of the two.

The NHS has not been immune.

Over the coming decade, the NHS will inevitably need to look after more people, with greater needs, as a result of our growing and ageing population. Remarkably over this period, the number of people over 85 is projected to increase from 1.3 million to 2 million and one in five of all newborn boys and nearly one in three of all newborn girls will now live to be centenarians.

Against this backdrop, the NHS remains one of Britain's proudest achievements:

- The latest GP patient survey showed that the vast majority of people are positive about their GP care – with eight out of ten patients rating their overall experience of their GP surgery as good – and that confidence and trust in GPs and healthcare professionals remains extremely high at 95.6%.
- For the first time last year, the NHS in England carried out more than two million checks on people who feared they might have cancer. Cancer survival is at an all-time high with new figures showing 10,000 more patients living for at least 12 months after diagnosis than five years earlier.
- 1.44 million people were referred to NHS mental health therapy services in the past year with more people than ever moving into recovery.
- Nearly 800,000 more people were seen and treated within four hours in Accident and Emergency (A&E), over 2,000 a day on average.
- Half a million extra people received planned treatment in 2018/19 than in 2017/18, an increase of 2.8%.
- In December, the 100,000th genome was sequenced through our world-leading 100,000 Genomes Project.

This has all been achieved within a constrained budget by historic standards and has only been possible because of significant year-on-year improvements in NHS productivity. A recent study by the University of York's respected Centre for Health Economics has calculated that NHS productivity has been growing at more than double that achieved by the rest of the UK economy over the last 12 years, meaning more care and treatments for patients and better value for taxpayers. The Office of National Statistics (ONS) reported that in the last year, NHS productivity growth in England was 3%. This is a remarkable tribute to our hard-working NHS staff.

But the hard work of our staff on its own is not enough. Simply putting more pressure on the existing service risks breaking the system. We have to face the facts: waiting times are going up and pressure on A&E departments is rising. It is too difficult to see a GP and health inequalities are too great. So, we have to change. Not incrementally but fundamentally, though not in a chaotic, adversarial, destructive way. The last thing we want is another ideological, top down, politically inspired reorganisation.

As the internationally respected surgeon and healthcare expert Lord Darzi said, "Simply demanding more for less or promising more money without a plan for better care isn't good enough".

This is the true achievement of the NHS Long Term Plan that was published in January and backed by the Government's revenue funding settlement of 3.4% annual real terms growth over the next five years. The Plan sets out a journey of transformational change – going with the grain of the NHS – focused on patient need, it has been clinically and locally led.

What are these changes?

- The NHS will have a renewed focus on helping people remain healthy, with a particular emphasis on reducing health inequalities. It cannot be right that people from deprived backgrounds die 10 years earlier than the rest of the population.
- The NHS will redirect more of its growing resources into primary care, community care and mental health, a very significant change from the last 20 years.
- The NHS will join up its services and integrate them much more closely with social care and other public services. Partnership, trusting relationships and cooperation will be more important than competition, fragmentation and organisational autonomy.
- The NHS will change its culture to make it a much better employer. In particular, we will improve the opportunities for people from Black, Asian and Minority Ethnic (BAME) backgrounds.
- The NHS will embrace the digital and data age, empowering patients and freeing up more time for clinicians to spend with patients who have complex conditions.
- The NHS will become the most innovative health system in the world making new science and new clinical technologies available to its patients.
- The NHS will re-double its efforts to reduce waste and unwarranted variation, and improve operational performance.

To realise these changes, the NHS must have a realistic and well-funded capital investment programme and proper funding for social care and public health.

Over the last 70 years the NHS has become integral to British society, the glue that holds us together. The Long Term Plan strengthens that glue not by reinforcing the status quo but by recognising the changing demands of our patients, the vital importance of our people and the extraordinary power of new science and technology.

Lord David Prior,
Chair of NHS England

About NHS England

NHS England is an executive non-departmental public body which leads and oversees the commissioning of healthcare provision in England. We are mandated to improve the country's health and wellbeing by arranging the provision of high quality care in a way that meets the needs of an evolving population, and that is sustainable into the future.

The Department of Health and Social Care (DHSC) entrusts NHS England with NHS funding in England. In 2018/19 we had a funding allocation of £114 billion to commission health care services, both directly and via the 195[1] Clinical Commissioning Groups (CCGs). Most of the services we commission directly are specialised and primary care services.

NHS England allocates the majority of the funding it receives to CCGs and supports them to commission services on behalf of their patients according to evidence-based quality standards. Together CCGs account for £75.6 billion of total commissioning expenditure.

Further detail about how we oversee the commissioning system is presented from page 92.

The Government's mandate to the NHS

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

Each year, the Government sets out its expectations of us and the funding we will receive, in the form of a mandate which is laid before Parliament. This mandate sets the direction for the NHS, describes the Government's healthcare priorities and helps to ensure the NHS is held accountable to Parliament and the public.

The Government's mandate to the NHS for 2018/19 can be viewed on the DHSC website[2] and the report from page 192 shows how we have delivered against it for 2018/19.

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 we can account for how we have discharged our functions, both to Parliament and the public. The Board is supported by committees which undertake detailed scrutiny in their respective areas of responsibility and provide it with regular reporting and formal assurance. In 2018/19, NHS England changed its committee structures to work more closely with NHS Improvement. Further details about our Board, its committees and membership are presented from page 61.

1 The number of CCGs reduced from 207 to 195 on 01 April 2018 as a result of mergers.
2 https://www.gov.uk/Government/uploads/system/uploads/attachment_data/file/601188/NHS_Mandate_2017-18_A.pdf

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. As a custodian of the values of the NHS Constitution, NHS England is 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.

Our values, aligned to this constitution, inspire us and are integral to everything we do:

- working together for patients;
- respect and dignity;
- commitment to quality of care;
- compassion;
- improving lives, and;
- everyone counts.

Further information about our values and the NHS Constitution can be found on the NHS England website[3].

How we operate

During 2018/19 NHS England strengthened its joint working arrangements with NHS Improvement to bring the two organisations as closely together, in strategic and operational terms, as is permitted under the legislation governing our activities.

In 2019/20 NHS England and NHS Improvement are moving to a single leadership model under the overall leadership of the Chief Executive Officer (CEO) of NHS England and a single Chief Operating Officer (COO) who will also be the CEO of NHS Improvement.

New National Director roles have been created, reporting to the CEO, which will operate across both organisations.

Integrated regional teams have been created, led by regional directors with a single reporting line to the COO. They are responsible for the performance of all NHS organisations in their region in relation to quality, finance and operational performance. National teams provide expertise, support and intervention – all in line with strategies agreed at the NHS Executive Group.

NHS England and NHS Improvement have, at the Prime Minister's invitation, developed proposals for primary legislation to support implementation of the NHS Long Term Plan. These proposals include establishing a single body responsible for all the functions of NHS England and NHS Improvement.

3 www.england.nhs.uk/about/

NHS England supports and relies upon local healthcare professionals making decisions about services in partnership with their patients and communities. NHS England's teams continue to work closely with CCGs, GP practices, local authorities and Health and Wellbeing Boards. In 2018/19, regional teams continued to strengthen their collaboration with Sustainability and Transformation Partnerships (STPs) and Integrated Care Systems (ICSs) across the country, with staff aligning their roles to STP and ICS footprints and working closely with their leadership.

Clinicians are essential to the work of NHS England. We have 28 national clinical directors and associate national clinical directors, each providing leadership in their respective fields. For further information about the national clinical directors please visit our website[4].

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), NHS Property Services Ltd. (NHSPS) and Primary Care Support England (PCSE) provided by Capita. Additionally, NHS England hosts NHS Interim Management and Support (NHS IMAS) and sponsors the Sustainability Unit on behalf of the NHS.

NHS England also oversees Commissioning Support Units (CSUs). The CSU staff group are employed by the NHS BSA, but they are formally a part of NHS England.

CSU activities are included in our Report and Accounts except where otherwise indicated.

Detail on how we assure the activity of our organisation is presented in this Annual Report from page 80. For further information about how we operate please visit our website[5].

4 https://www.england.nhs.uk/about/structure/ncd/
5 www.england.nhs.uk/about/

Performance Report

Simon Stevens
Accounting Officer
3 July 2019

Chief Executive's overview

In July 2018 the NHS marked its 70th anniversary. At its best our National Health Service is the practical expression of a shared commitment – across our nation, and across the generations. It is a remarkable testament to the care and professionalism of the 1.3 million staff of the NHS that public support for our health service is in fact even stronger now than at its founding.

But seventy years ago Aneurin Bevan predicted that the Health Service "must always be changing, growing and evolving" so that "it must always appear to be inadequate". As the Chair's report on page 7 and the performance report from page 17 set out, the past year has continued to see both progress and pressure across the frontline of NHS care.

We have, for example, seen cancer outcomes continuing to improve, with breast cancer death rates down nearly a fifth over the last five years. Mental health services have continued to expand, with the male suicide rate now at a 31 year low. Better joint working between hospitals, and community and social care has helped patients get back home and freed up inpatient beds across England - equivalent to opening four new fully-staffed hospitals.

But we have also seen workforce pressures intensify – with an estimated 100,000 vacancies across the NHS – matched by continuing increases in the number of patients needing emergency and planned care. And while the ONS report that NHS productivity has been rising three times faster than the rest of the economy, investment in modern buildings and equipment has been tightly constrained; the value of capital investment per staff member having fallen 17% since the start of the decade.

It is against that backdrop that the importance of the NHS's five year funding settlement announced last summer should be seen. Covering the period 2019/20 to 2023/24, it is only the second time in the NHS's history that we have multiyear funding certainty.

It has enabled us to chart a practical, phased and widely supported plan for the decade ahead. The NHS Long Term Plan published in January 2019 is now being developed into detailed local implementation programmes, that will see comprehensive gains in the big 'killers and disablers' affecting people's health, as well as further action in every part of the country to redesign and integrate care.

As we do so, a number of challenges confront us in the year ahead. We need to intensify work across the NHS to increase staff availability and better support our current workforce including nursing and primary care. Trusts and CCGs are being called on to manage day-to-day performance while also mobilising for wider service improvement. And the NHS must continue to play its part in contingency arrangements for Brexit, recognising our principal dependency on the effectiveness of the Government's work to secure transport and supply logistics.

At the same time we are bringing NHS England and NHS Improvement together under shared leadership, and asking our staff to save a further 20% of our organisational cost. We are reshaping our support and intervention model relative to frontline NHS organisations, promoting a culture of improvement as well as performance. And we need to agree with Government the investment in important areas not covered in the NHS's five year revenue settlement which will be critical contributors to the success of the NHS Long Term Plan.

Finally, while our core role is of course leadership and stewardship of the NHS itself, we also recognise our responsibility to contribute to some of the wider issues facing our country. Whether that be action to reduce air pollution, address youth violence, cut health inequalities or tackle childhood obesity, in the year ahead the NHS commits once again to fully play our part.

Simon Stevens

CEO of NHS England, and Accounting Officer

How we measure performance

The NHS Constitution sets out the rights of patients, public and staff. NHS England measures and monitors performance against a wide range of core constitutional performance standards to track delivery; for example, on waiting times for diagnostic tests and treatment. Where performance is found to be off track, NHS England works through its local teams to provide the necessary support to local organisations to deliver the best and improving care for patients. We publish statistics relating to these core constitutional standards on the NHS England website[6] every month.

NHS England also routinely monitors performance and delivery of the key commitments detailed in the NHS Five Year Forward View. In addition, we have a statutory obligation to assess the performance of CCGs using a range of measures to create a balanced judgement of their effectiveness. The table below shows the number of CCGs receiving each rating in 2018/19 compared to 2017/18[6a]. Further detail is provided in the 'Assurance of the commissioning system' section on page 92.

	2018/19	**2017/18**
Outstanding	24	20
Good	102	100
Requires Improvement	58	69
Inadequate	11	18
TOTAL[6b]	**195**	**207**

As the NHS moves to a more systems-based approach to delivering care through the functions of STPs and ICSs, the way that we measure and monitor performance is evolving. During 2018/19, NHS England and NHS Improvement have worked to bring together its data and insights into a single platform, the Population Health and Performance Management Dashboard. This incorporates data from monthly reporting, RightCare, Model Hospital, Getting It Right First Time (GIRFT) and many other sources to give a single source of information about the performance of a Region, an STP, a CCG or a hospital, creating clarity about where the opportunities for improvement lie. This approach has been piloted in a small number of health systems and, as stated in the NHS Long Term Plan, will be rolled out to all ICSs and STPs during 2019/20.

6 https://www.england.nhs.uk/statistics/statistical-work-areas/combined-performance-summary/
6a The full data set is available at https://www.england.nhs.uk/commissioning/regulation/ccg-assess/iaf/
6b In April 2018, 18 CCGs merged, forming six CCGs

Performance Analysis: Next Steps on the NHS Five Year Forward View priorities

The commitments set out in the NHS Five Year Forward View, are now beginning to bear fruit and this, as well as the practical experience of how to bring about large scale change, has informed the NHS Long Term Plan. This report provides analysis on the following priority areas: Urgent and emergency care page 17, Primary care page 19 Cancer page 20, Mental health page 22 and integrating care locally page 24, and includes other major work programmes designed to address the country's health and care needs. These additional priorities concentrate on Learning disabilities page 25, Diabetes page 27, Maternity page 28, Elective care page 31 and Digital transformation page 41. Together, our work programmes encapsulate the objectives set out in the Government's mandate to us for 2018/19 and are underpinned by work on funding and efficiency, strengthening our workforce and patient safety, all of which are addressed throughout this document.

Further information on our performance against the mandate is available on page 192.

Urgent and emergency care

During 2018/19, delivering the urgent and emergency care reform agenda has enabled the service to respond to demand by improving access to advice for patients, outside of hospital, improve care pathways within hospitals, and enabled timely discharge into the community.

NHS 111 received 5.1% more calls in 2018/19, and answered 1.7% additional calls within 60 seconds against the previous year, with 52.7% of all calls receiving clinical advice up from 48.4% in 2017/18. NHS 111 online is now available across the country, online[7] or via the mobile app.

Evening and weekend appointments are now available across the country seven days a week including bank holidays. We have increased the number of Urgent Treatment Centres (UTCs) and there are now 113 locations across England, with appointments bookable through NHS 111.

The expansion in same day emergency care services (SDEC) has supported an 11.9% increase in emergency patients being treated and returning home on the same day during 2018/19.

£145 million capital investment was provided to 81 schemes across the country, delivering upgrades to emergency departments and improved facilities to support the delivery of new care models such as SDEC.

In 2018/19 there has been a particular focus on supporting long stay patients (21 days or more), who are often frail and elderly, to safely leave hospital. This reduces the risk of harm and helps to free up beds, allowing other patients to be admitted. The number of patients in hospital with long lengths of stay (21 days or more) has reduced, releasing 2,111 beds.
In addition, delayed transfers of care have reduced by 15.9% compared to last year. This was supported by the investment from Government of £240 million to local authorities for adult social care to help reduce pressure on the NHS by enabling patients to be discharged in to the community or back into their own homes.

7 https://111.nhs.uk/

Demand for urgent and emergency care services increased in comparison to the previous year with nearly 25 million A&E attendances in 2018/19 (4.1%). Emergency admissions via A&E also increased compared to the previous year with nearly 300,000 more admissions (6.8%).

The four hour A&E performance metric was 88% and slightly below the 88.3% performance achieved in 2017/18, against the 95% target. The summer of 2018 was the joint hottest on record, with the Government issuing hot weather warnings in May, June and July. The heat contributed to increased demand, impacting upon performance. Despite lower overall performance, 780,000 more people were treated *within* four hours compared to last year.

The winter period, always the most challenging for the NHS, with outbreaks of flu, respiratory and gastrointestinal illnesses, saw an increase of over 400,000 attendances (5.1%). Despite this increased demand, 380,000 more patients were seen within four hours, with improved performance at 85.4% compared to 85% last winter.

Whilst there was an increase in ambulance arrivals, ambulance services worked with hospitals to significantly reduce ambulance handover delays, with winter 2018/19 data showing 10% and 22% reductions in 30 minute and 60 minute handover delays respectively, as compared to winter 2017/18.

Ambulance trust performance has improved in 2018/19 against all six new response time standards introduced by the Ambulance Response Programme (ARP). All ambulance trusts now regularly achieve the category 1 standards for those patients needing the most urgent care with an average national improvement of 1 minute (12.3%) against last year's performance.

Action for the year ahead includes:

- Expanding SDEC with the aim of delivering 30% of non-elective admissions via SDEC by March 2020.
- Undertaking a clinically-led Clinical Standards Review.
- Raising the ambition to further reduce long stay bed occupancy to 40%, hereby reducing the risk of harm to patients and ensuring better outcomes and increased capacity within the system.
- Continuing the roll out and designation of UTCs.
- Continuing to deliver Integrated Urgent Care by further developing our Clinical Assessment Service, improving patient triage.
- A stronger focus on effective use of data through daily reporting of the Emergency Care Data Set

For further information please see the urgent and emergency care pages of the NHS England website[8].

8 https://www.england.nhs.uk/urgent-emergency-care/

Primary care

The Primary Care Programme continues to support the delivery of the General Practice Forward View (GPFV). The programme increases investment in primary care services, and the number of people working in primary care, and supports improvements to access, services and premises. Responses to the GP Patient Survey give a patient's view on how primary care is performing. In 2018, responses to the survey (published in August) remained positive overall, with 83.8% rating their experiences as good, or very good.

We remain on track to deliver an additional £2.4 billion investment by 2021, investing £12 billion per annum in general practice, as set out in the GPFV. Investing in upgrading primary care facilities has continued, with 133 schemes completed in 2018/19 in addition to the 974 schemes completed over the last two years. There are currently a further 712 active schemes which are on track to be completed.

Since 1 October 2018, everyone across the country has been able to access general practice appointments in the evenings and weekends. This means that patients can see a doctor, nurse or other member of the practice team at a time that is convenient to them - providing an estimated nine million additional appointments per year. This was delivered ahead of the March 2019 commitment.

We have made progress with developing Primary Care Networks (PCNs), with groups of GP practices coming together with community multidisciplinary teams to deliver integrated primary care. We have achieved substantial PCN coverage and from April 2019, CCGs will be required to commit £1.50 per head of population to develop and maintain PCNs. We also remain committed to improving the working environment for GPs. Support for practices to implement at least two of the high impact 'Time for Care' actions continues. This has allowed for over 475,000 hours of GP and administrative time to be released for more productive use.

Recruitment of young UK doctors into GP training reached a record high. Recruitment of GPs from overseas has been stepped up, but is affected by the relatively limited pool of suitably qualified EEA doctors with sufficient language skills; competition from other countries worldwide that are actively recruiting and working to retain healthcare professionals; and uncertainty about the UK's exit from the European Union (EU). We are looking at countries where qualifications and experience are most closely equivalent to the UK. We have a pipeline of over 300 doctors who are currently working through our Induction and Refresher scheme; this scheme supports and assesses all new international doctors joining the NHS for the first time, those returning from overseas who trained or worked here previously, and domestic doctors who wish to return to work in general practice.

We have also made significant progress in expanding the number of non-GP staff working within the wider general practice workforce. The target growth for the wider workforce in general practice is 5,000 by September 2020 which has now been exceeded, having grown by over 5,321 Full Time Equivalents (FTEs) at the end of September 2018.

The largest increase has been seen in staff with direct patient care responsibilities, including clinical pharmacists and paramedics.

Cancer

Considerable progress has been made in delivering world class cancer care as set out in Next Steps on the NHS Five Year Forward View. Cancer survival is the highest it has ever been, with the most recent one year survival at 72.8%, over 10 percentage points higher than in 2001.

We aim to save more lives by increasing public awareness of cancer, driving earlier and faster diagnosis and providing access to the best treatments. In 2018/19, 53.7% of all cancers were diagnosed at an early stage, when patients have a greater chance of curative treatment, and patients reported a high level of satisfaction with their experience of treatment and care through the National Cancer Patient Experience Survey – the highest on record.

2018/19 saw intentionally steep increases in the number of referrals made for suspected cancer across all tumour types, with a 14.1% increase in the number of referrals seen within two weeks compared to the previous year. Across the year, both May and September 2018 saw historic monthly rates of growth of over 20%. This significant growth in demand helps move us towards delivery of the 75% early diagnosis target in the NHS Long Term Plan. The NHS responded well, with significant growth in activity and an 8.5% increase in the number of patients starting treatment within 62 days of urgent referral: in 2018/19 we saw more patients within 62 days of urgent referral: in 2018/19 we saw more patients within 62 days of urgent referral than ever before. However, rising demand has made it challenging to meet cancer waiting time standards and work is underway to ensure diagnostic capacity and associated staffing is in place to meet additional demand.

We invested over £200 million in the transformation of cancer services, led by Cancer Alliances, in 2017/18 and 2018/19. Alliances have implemented models for earlier and faster diagnosis, including timed diagnostic pathways for lung, prostate and colorectal cancer; multidisciplinary diagnostic centres for people with vague symptoms; targeted lung health check pilots and the use of faecal immunochemical tests (FIT) to improve the early detection of colorectal cancer.

Cancer Alliances also led the roll out of personalised care for people with cancer, including follow up pathways for breast cancer patients that have been designed to meet individual needs. Patients are empowered to manage their care, with follow-up that suits their needs and direct access to specialist advice whenever required rather than attending multiple follow up clinic appointments. More patients are receiving holistic assessments and care planning and support workers were introduced in many Trusts to support clinical staff and patients.

The £130 million Radiotherapy Modernisation Programme was completed this year, providing funding for over 80 new or upgraded radiotherapy machines, plus new treatment planning systems across England. New radiotherapy service specifications were published, which will establish eleven Radiotherapy Networks across the country by 2020, ensuring everyone has access to high-quality, modern treatment.

New treatments with promising results are being made available on the NHS. In December, the first patient received Proton Beam Therapy at the Christie in Manchester. We also began delivering Chimeric Antigen Receptor T Cell (CAR-T) Therapy treatment to children and young people up to 25 years old with B cell acute lymphoblastic leukaemia (ALL) that is refractory, in relapse post-transplant, or in second or later relapse. NHS cancer patients are amongst the first in Europe to benefit from this revolutionary treatment.

Action for the year ahead includes:

- Modernise cancer screening and increase uptake, starting with the implementation of more effective and accessible tests for bowel and cervical cancer screening from summer 2019 and 2020 respectively. Take forward the recommendations from Professor Sir Mike Richards' independent review of cancer screening, due in Summer 2019.
- Offer all boys aged 12–13 vaccination against Human papillomavirus (HPV)-related diseases from September 2019.
- Prepare for full implementation of the new 28-day faster diagnosis standard, to be monitored from April 2020, to ensure patients receive their diagnosis or "all clear" within 28 days of urgent referral for suspected cancer.
- Begin establishment of Rapid Diagnostic Centres, which will bring together diagnostic kit and expertise in one place for faster access to tests and results for patients, starting with one Centre in each Cancer Alliance by 2020.
- Establish 11 Radiotherapy networks to ensure equal access to the best treatment planning regardless of where patients live by 2020.
- Ensure all patients who finish breast cancer treatment move to a personalised follow up pathway from 2020 and continue to make personalised follow up available for people with colorectal and prostate cancers.
- Begin offering whole genome sequencing to all children with cancer from 2019.
- Complete testing of a world-first Quality of Life Metric, to track and respond to the long-term impact of cancer, and begin roll out.

The NHS Long Term Plan sets ambitious commitments to further improve survival and quality of care for everyone with cancer. Over the next ten years we will continue to transform cancer outcomes, so that from 2028 an extra 55,000 people each year will survive for five years or more following their cancer diagnosis and 75% of cancers will be diagnosed at an early stage.

Mental health

Putting mental health on an equal footing with physical health is at the heart of NHS England's plans to transform mental health services. To reinforce this, NHS England published updated requirements in 2018/19, requiring CCGs to ensure their investment in mental health rises at a faster rate than overall health funding. Latest data shows that *all* CCGs met the Mental Health Investment Standard in 2018/19, marking the first time this has been met everywhere in the country.

Significant progress has been made on the recommendations included in the Five Year Forward View for Mental Health, published in February 2016. Access to mental health services for people requiring psychological therapies, for children and young people with eating disorders, and for individuals requiring Early Intervention in Psychosis has improved. All access, recovery and referral to treatment time (RTT) targets are either being met or are on track to be achieved as expected by 2020/21.

We have also invested in a range of mental health services to further improve the service offering, including:

- Investing £170 million in children and young people's mental health services, with the programme on track to ensure an extra 35,000 children and young people can access services this year, with all STPs planning to achieve the commitment to see 70,000 more children and young people nationally by 2020/21.
- By year end, NHS England had opened 224 new children and young people's Tier 4 inpatient beds, making good progress on delivering improvements in local access, reducing travel distances, out of area placements and overall a more efficient distribution of the inpatient capacity nationally. The net position is an additional 109 new beds against the original baseline when taking into account beds which have closed.
- Opening 109 new beds since July 2017 for children and young people's Tier 4 inpatient mental health services in areas of greatest geographical challenge, which will help to minimise hospital stays and eliminate inappropriate use of beds in paediatric and adult wards. There are also plans for a further 40 new beds in 2019.
- Investing £42.7 million to enable new and expectant mothers experiencing mental health difficulties to access specialist perinatal mental health community services in every part of the country by April 2019. Across Quarter 1 and 2 this year, 4,450 additional women had accessed services. We are on track to support an additional 30,000 women each year to access specialist perinatal care by 2020/21.
- Investing in four new, eight-bedded Mother and Baby Units (MBUs) to provide specialist perinatal care in areas with particular access issues, and the number of beds in existing MBUs is increasing as well.
- Further progress has been made in 2018/19 to reduce inappropriate Out of Area Placements, and local areas have trajectories in place to eliminate them by 2020/21. This has been supported by a cumulative gross investment of £26 million in Crisis Resolution and Home Treatment Teams (CRHTTs), enabling intensive home treatment to be offered as an alternative to an acute inpatient admission.

- We remain on track to deliver our commitment that half of A&Es will achieve 'Core 24' standards including mental health liaison teams by 2020/21, supported by an investment of £13 million.
- Investing £4.8 million with 21 local areas for Individual Placement and Support services, £3.6 million with eight STPs for suicide prevention and reduction initiatives, and £3.3 million with three areas for piloting Specialist Community Forensic Teams.

We are also rolling out a programme to provide psychological therapies for people with Long Term Conditions, after pilot areas demonstrated a reduction in the need for hospitals, GPs and A&E.

The national standard for dementia diagnosis rate has been consistently achieved since July 2016. Across England, it reached 67.9% at the end of October 2018, achieving the ambition that at least two-thirds (66.7%) of people living with dementia receive a formal diagnosis.

Our seven most digitally advanced Mental Health Trusts (known as Global Digital Exemplars) are partnering with other Mental Health Trusts to share their approach to digitising mental health services, including record sharing, online therapy, and electronic patient medicines administration.

Action for the year ahead includes:

- Further progress towards achieving the 2020/21 access and RTT ambitions for children and young people (including eating disorders), adults with common mental illness and perinatal mental health services.
- Mobilising the system to deliver service expansions outlined in the NHS Long Term Plan.
- Supporting further partnership development as the system transitions to more integrated ways of working.

For further information, please see the mental health pages of the NHS England website[9].

9 https://www.england.nhs.uk/mental-health/

Integrating care locally

ICSs are local collaborations for improving access and outcomes, and for reducing health inequalities, within a defined share of NHS resources. Their purpose is twofold:

- To implement integrated care models that address the wider determinants of health and that provide more proactive and joined up care for people with complex needs;
- To create shared local responsibility for improving services, for managing the total available NHS resources more efficiently and effectively, and for implementing system-wide changes that are needed to achieve these goals.

There have been two waves of ICSs. The first group of ten included two systems with devolution agreements and were announced in June 2017: Bedfordshire, Luton and Milton Keynes; Berkshire West; Buckinghamshire; Dorset; Frimley; Greater Manchester (devolution deal), Lancashire and South Cumbria; South Yorkshire and Bassetlaw; Nottinghamshire and; Surrey Heartlands (devolution deal). This grew to 14 in May 2018, with the addition of: Gloucestershire, Suffolk and North East Essex, North Cumbria and West Yorkshire and Harrogate.

Building on the learning from the new care models programme which supported fifty vanguards to test whole population approaches to delivering care, the ICSs have begun to design and implement integrated service models, which meet the needs of their populations. They have also spread PCNs, enabling integrated multidisciplinary neighbourhood teams of primary care, community care, secondary care, social care, mental health and voluntary sector staff to come together to deliver a wider range of preventative, personalised care and support. For people with urgent medical needs, systems have increased access to same-day appointments by more flexibly deploying nurses, pharmacists, therapists and other staff.

In systems like North Cumbria, South Yorkshire and Bassetlaw, and Dorset, primary and community hubs are already providing enhanced services for people who would otherwise require a hospital stay. In York, for example, a programme of proactive community-based health coaching has resulted in significant reductions in acute emergency hospital admissions (-18%), hospital bed days (-20%) and A&E visits (-26%), for patients accessing the new service. In West Berkshire, patients who have a range of pain symptoms were being referred to outpatient clinics, waiting between seven and nine months. Now they are being seen in four weeks because GPs, consultants, radiologists, physiotherapists and psychologists have come together to better assess patients and direct them to the most appropriate care setting first time.

This collaboration between hospitals, GP practices, community and local government services are enabling care closer to home and reductions in avoidable trips to hospital. Increasingly, these collaborations are widening to include other agencies such as fire services, housing associations and voluntary organisations. By broadening their partnerships, ICSs are also beginning to tackle the wider determinants of health and wellbeing. For example, the 'Run-a-Mile Challenge' in which children, teachers and others commit to run a mile a day regularly, and community-led creative activities which connect people back into their communities, are helping to reduce social isolation.

Action for the year ahead includes:

- ICSs and STPs will continue with the roll out and develop PCNs, bringing together GP practices and community teams to create expanded multi-disciplinary teams. Each PCN will appoint a named accountable Clinical Director.
- As one of the cornerstones of the NHS Long Term Plan, more STPs will graduate to become ICSs and achieve the goal of full ICS coverage across the whole of England by 2021.
- Each ICS/STP will create a partnership board, drawn from and representing commissioners, trusts, primary care networks, local authorities, the voluntary and community sector and other partners; and appoint a non-executive chair.
- ICSs and STPs will develop system implementation plans for their delivery of the NHS Long Term Plan, engaging all system partners, including health, patients, local government and the voluntary sector.

Learning disabilities and/or autism

In 2015 NHS England, the Local Government Association (LGA) and the Association of Directors of Adult Social Services (ADASS) published Building the Right Support, a national plan to reduce the number of people with learning disabilities, autism or both living in long stay specialist hospitals by 35-50% and ensure they received the right care in the right setting, close to home.

The number of people with learning disabilities, autism or both living in these facilities as at April 2019 was 2,245; this is a decrease of 22% from the March 2015 total of 2,890. There have been over 6,760 discharges to the community since March 2015, including 745 people who had previously been in hospital for over five years, resulting in over 500 beds being decommissioned.

We have also been working to prevent avoidable admissions, and the number of people receiving community / pre-admission Care (Education) and Treatment Reviews (C(E)TRs) continues to increase. In total, 1,600 pre-admission C(E)TRs were undertaken in 2018/19, with 82% of these leading to a decision not to admit into inpatient care. There was a 56% increase in the number of pre-admission C(E)TRs conducted between 2016/17 and 2017/18, and a further 46% increase in 2018/19. Whilst continuing to support people to live in the community, those people that need specialist inpatient care must receive the best possible care and treatment, with the least use of seclusion, long-term segregation and restraint practice.

During 2018/19, we invested a further £22 million to accelerate progress; this included additional investment in crisis and community teams, as well as targeted work with children and young people. In addition, as part of the reconfiguration of services now underway, in 2018/19 NHS England transferred £53 million to support local commissioners to invest more in community-based initiatives.

Commissioned by Healthcare Quality Improvement Partnership (HQIP) and led by the University of Bristol, the Learning Disabilities Mortality Review (LeDeR) Programme continued to roll out a review process for the deaths of people with learning disabilities. 1,540 reviews have been completed up to March 2019.

People with learning disabilities often have poorer physical and mental health than other people and die 15-20 years younger compared to those without a learning disability. Annual Health Checks can identify undiagnosed health conditions early, ensure the appropriateness of ongoing treatments, promote and improve uptake of preventative care (e.g. through screening and immunisation), and establish trust and continuity of care. The NHS is committed to ensure more people with a learning disability receive an Annual Health Check. The STOMP project (Stop Over Medicating People) tackles inappropriate prescribing of psychotropic medication. Now over 340 organisations who support people with learning disabilities, autism, or both have signed a STOMP Pledge, supporting thousands of people. In 2018/19 the STOMP programme was expanded to Supporting Treatment and Appropriate Medication in Paediatrics (STOMP-STAMP). The initiative aims to make sure that children and young people with a learning disability, autism or both are only prescribed the right medication, at the right time and for the right reasons.

In October 2018, NHS England led a call on health, education and social care organisations to adopt a new scheme to ask, listen to and act on concerns raised by people with learning disabilities and autism to help address health inequalities.

'Ask Listen Do'[10] supports organisations to learn from and improve the experiences of people with a learning disability, autism or both, their families and carers when giving feedback, raising a concern or making a complaint. It also makes it easier for people, families and paid carers to give feedback, raise concerns and complain.

2018/19 has been an important year of sustained progress with continued commitment to achieving what needs to be done if we are to help people to lead longer, happier, healthier lives. The NHS Long Term Plan commits to reducing the number of people in specialist inpatient hospitals by 50% by March 2024, so for every million adults, there will be no more than 30 people with a learning disability and/or autism cared for in an inpatient unit. For children and young people, no more than 12 to 15 children with a learning disability, autism, or both per million, will be cared for in an inpatient facility. This will be supported by increased investment in community services for autistic people and people with a learning disability.

Action for the years ahead includes:

Over the next five years NHS England and NHS Improvement will:

- Work with partners to bring hearing, sight and dental checks to children and young people with a learning disability, autism or both in special residential schools.
- Introduce keyworkers for children and young people with the most complex needs.
- Test and implement the most effective ways to reduce autism diagnosis waiting times.
- Introduce a 'digital flag' in patient records to support staff in making (reasonable) adjustments to care for people with a learning disability or autism, improving patient experience.

10 https://www.england.nhs.uk/learning-disabilities/about/ask-listen-do/

Diabetes

Diabetes is a leading cause of premature mortality, resulting in over 22,000 additional deaths each year. Having diabetes doubles an individual's risk of cardiovascular disease (heart attacks, heart failure, angina, strokes). There are also significant inequalities in the incidence of Diabetes, with people from south Asian and black ethnic groups having up to a six-fold greater chance of developing Type 2 diabetes than people from white ethnic groups.

The NHS Diabetes Prevention Programme (NHS DPP) is the world's first nationwide Type 2 diabetes prevention programme. We have exceeded our mandate commitment to have up to 80,000 people on active programmes during 2018/19, with 104,939 having received an initial assessment. This means we have also delivered a year early on the NHS Five Year Forward View target of 100,000 people on the programme by 2019/20.

A significant development was the appointment of the new NHS DPP Provider Framework; a key project enabling us to improve our service offer and continue delivering the NHS DPP for three more years. Under this new Provider Framework, we will enable digital routes of access to the NHS DPP for the first time, widening access for participants, and further supporting our work to target the present inequalities in Type 2 diabetes.

We have delivered a wide range of projects to target variation and drive improvement in the management and care of people living with diabetes. To support this, across the NHS, we have recruited 500 additional staff, covering a range of roles, including: diabetes specialist nurses, podiatrists, consultants and support staff. Recruitment challenges have led to local teams looking at alternative ways to resource projects, for instance by upskilling their existing workforce. Further, whilst offers of education for people with diabetes remain high, we believe levels of uptake can be improved. Therefore we also funded digital services, widening access and choice, which will also be of benefit to working age populations.

During 2018/19 we delivered:

- 41 new or expanded multidisciplinary footcare teams, reducing the risk of people with ulcers or other diabetes foot disease from having an amputation;
- 30 new or expanded diabetes inpatient specialist nurse teams, reducing the length of hospital stays for people with diabetes by helping to reduce medication errors and advising on effective treatment;
- 133 CCGs offering expanded numbers of structured education places to support people newly diagnosed with diabetes to understand how to look after themselves well; and
- 108 CCGs supporting GPs, practice nurses and people with diabetes to understand how to increase the number of people who achieve the diabetes treatment targets (Hba1c, blood pressure and cholesterol) and so reduce the risks of complications.

Action for the year ahead includes:

- Commence roll out of digital diabetes prevention services to widen access, providing coverage of up to 45% of England this year.
- Increase capacity of the NHS DPP as we work towards supporting up to 200,000 individuals per annum by 2023/24.
- Complete in-service testing of Healthy Living for People with Diabetes (HeLP Diabetes), a digital self-management service for people living with Type 2 diabetes, and commence early phases of national roll-out.
- Ensure patients with Type 1 diabetes, who meet certain clinical guidelines, will have access to flash glucose monitoring devices.

Maternity

Our work to implement The National Maternity Review: Better Births[11] has continued to make good progress into its third year.

All 44 Local Maternity Systems (LMS) are implementing local plans to improve maternity care, bringing together providers, commissioners, Maternity Voice Partnerships and others to transform maternity care across STP footprints.

We continue to make progress towards the ambition to reduce stillbirths, neonatal deaths, maternal deaths and brain injuries at birth by 20% by 2020 and by 50% by 2025. One of several initiatives supporting this aim is the Saving Babies' Lives Care Bundle (SBLCB)[12]. The second version, published in March 2019, includes a new element to support a reduction in pre-term births. An independent evaluation[13] of the SBLCB showed that stillbirths fell by a fifth at the maternity units where implementation was evaluated. The 2019/20 NHS Planning Guidance and Standard Contract require providers to fully implement it.

Another key initiative to drive safer, more personalised care is continuity of carer. Over 10,500 women were placed on to continuity of carer pathways by March 2019, where they can expect to have the same midwife or small team of midwives providing their care throughout the whole maternity journey - pregnancy, birth and postnatally, which evidence shows improves outcomes.

100 Community Hubs have been established around England. They act as a one-stop shop, enabling women and families to access services under one roof. There are also now over 100 Maternity Voices Partnerships bringing together women and families, along with midwives, obstetricians, and local commissioners who work together to review and co-design maternity services.

Perinatal mental health services have continued to improve. By March 2019, there were specialist perinatal mental health community services in every STP area of England supported by £60 million investment, four new Mother and Baby units with an overall total of 19 units across England and over 400 new specialist staff recruited for community services. Over 13,000 additional women were cared for by these services in 2018/19.

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11 https://www.england.nhs.uk/publication/better-births-improving-outcomes-of-maternity-services-in-england-a-five-year-forward-view-for-maternity-care/
12 https://www.england.nhs.uk/wp-content/uploads/2016/03/saving-babies-lives-car-bundl.pdf
13 https://www.mamaacademy.org.uk/wp-content/uploads/2018/07/Evaluation-of-the-implementation-of-the-Saving-Babies-Lives-Care-Bundle-....pdf

We continue our goal of ensuring maternity is at the forefront of a digital NHS. 40,000 women were offered access to their maternity digital care record, following investment in 21 pilot sites across England. We have redesigned the Maternity Services Dataset, which is now live and a new Maternity Services Dashboard went live in August 2018, enabling every maternity provider to monitor and benchmark their performance to improve care.

Action for the year ahead includes:

- LMSs will produce plans to meet the maternity and neonatal elements[14] of the NHS Long Term Plan by the autumn.
- We will continue to roll out continuity of carer, so that 35% of women are placed on to continuity of carer pathways by March 2020 and most women receive it by 2021.
- New national guidance on postnatal care will be made available to LMSs, to support their improvement plans.
- The Maternity Transformation Workforce Strategy will be implemented, including increasing midwifery training places by 650 in 2019/20 and up to 1,000 places for a period of three years thereafter, while also improving the supply of the obstetrics and gynaecology consultant workforce and supporting the Neonatal Critical Care Review.

Stroke

The 2007 ten-year National Stroke Strategy ran until 2017. To continue to build on the success of the Strategy, and following engagement with the voluntary sector and clinical and patient experts, we established the National Stroke Programme Board in spring 2018, co-chaired by the chief executive of the Stroke Association. The board developed strategic objectives which have been the foundation for the focus on stroke as a clinical priority area for the NHS Long Term Plan. These support improvements in workforce and rehabilitative care alongside service integration and reconfiguration to improve patient outcomes. This board has now become the National Stroke Programme Delivery board reporting to the CVD-Respiratory Programme.

The National Stroke Programme was launched in January 2019. It included key milestones for improvement in stroke care over the next decade. Early action to March 2019 has included:

- Analytical work to identify the first new sites to carry out mechanical thrombectomy.
- Developing a new Commissioning for Quality and Innovation (CQUIN) scheme to improve access to six month post-stroke reviews, which is now in place.
- Establishing service development funding to implement an Atrial Fibrillation (AF) patient optimisation demonstrator programme focused on areas with the greatest health inequalities which will support primary care to increase rates of anticoagulation in people with AF to reduce their risk of stroke. It is forecast that by 2020 this programme will save up to 200 lives and prevent almost 700 strokes across 21 selected CCGs.

14 https://www.longtermplan.nhs.uk/online-version/chapter-3-further-progress-on-care-quality-and-outcomes/a-strong-start-in-life-for-children-and-young-people/maternity-and-neonatal-services/

We continue to fund the Sentinel Stroke National Audit Programme (SSNAP), and are establishing an expert group to review its provision, to ensure it supports programme delivery, including a renewed focus on stroke rehabilitation. From the latest SSNAP data (to December 2018) we can see marked improvement in processes of care over the NHS Five Year Forward View period.

- Brain scans initiated within one hour of hospital arrival are up from 47% to 55%.
- Timely swallow screening has increased from 72% to 77%.
- In hospital, 85% of patients are cared for primarily on a specialist unit.
- Delivery of Early Supported Discharge is up from 33% to 38%.
- On discharge 95% of patients are now receiving a joint health and social care plan, up from 88%.

Thrombectomy continues to be rolled out nationally through specialised commissioning teams with the focus being to develop sustainable safe services to deliver annually increasing numbers of thrombectomies to more people. Working from the baseline in 2016/17 with 450 thrombectomy procedures being recorded (mostly through research), we have commenced a development and implementation plan to increase access to thrombectomy for people who suffer an ischaemic stroke. In 2018/19 circa 1,100 thrombectomies were performed representing an increase of 59% from 2016/17. In 2019/20 we anticipate this number increasing to 2,000 thrombectomies being offered, with more in the subsequent years.

The major limiting factor in the implementation of thrombectomy services has been the lack of trained Interventional Neuroradiologists. To address the shortage of these specialists NHS England has embarked on a collaborative programme that will offer training to clinicians from other specialties. This is being done through a credential programme and is being jointly produced and endorsed by the Royal College of Radiologists, Health Education England, the General Medical Council and NHS England.

Further roll out of thrombectomy is focussing on those geographical areas where patients suffering a stroke will not be able to access a service within the six hour window from onset of symptoms. The implementation of these solutions will ensure equitable access across the country.

Thrombolysis rates have improved from 11% to 12%, and six month follow-up reviews have increased from 29% to 31%. New initiatives designed this year aim to accelerate future improvement in these areas to improve rates to the target levels. To this end we have engaged with ICSs and STPs throughout the year, to ensure that an evidence-based strategic approach is taken to developing reconfigured services in the form of Integrated Stroke Delivery Networks. These draw together patient care from the pre-hospital phase through to early supported discharge and beyond into the community.

Action for the year ahead includes:

- Deliver a suite of supporting guidance/tools to optimise delivery of Integrated Stroke Delivery Networks and linked service improvements from identification of stroke to ongoing rehabilitation.
- Support and monitor the implementation and impact of the community CQUIN for six month post stroke reviews.
- Develop criteria, evaluation processes and subsequently confirm Rehabilitation pilot sites to maximise the quality of impact evidence that can be secured from go live in 2020.
- Transfer hosting of the stroke educational framework to HEE and commence significant development work to underpin staff skills development and sustainable recruitment.

Elective care

The Elective Care Transformation Programme is supporting local clinicians and commissioners to change how patients are referred into services, to increase access and improve the quality of care provided.

The Elective Care Development Collaborative (ECDC) supports frontline delivery by spreading knowledge and expertise and helping to improve system capability through published products such as handbooks. Initial work in gastroenterology and musculoskeletal (MSK) has broadened out to include dermatology, ophthalmology, cardiology, urology, ENT, gynaecology, respiratory, general surgery, general medicine, radiology, neurology and endoscopy.

First Contact Practitioner (FCP) provides direct access for patients with back pain, arthritis and other MSK conditions, to physiotherapists with enhanced skills based in GP practices. This was piloted in 41 of 42 STPs and interim findings showed that: 97% of patients were likely or very likely to recommend FCPs to friends or family; 69% received advice on self-care or exercise; and, the number of blood tests and medication prescriptions dropped. FCPs are being rolled out more widely, with a minimum of three mobilised sites per STP next year.

The Elective Care Community of Practice is a key resource for CCGs/ICSs/STPs and providers, and had more than 1,000 members at the end of March 2019. It supports the creation, expansion and exchange of knowledge about elective care practice.

The Consultant to Consultant Good Practice Guide supports health economies to manage the increasing number of consultant to consultant referrals in elective care and reduce waiting times.

Capacity alerts help providers to move demand between neighbouring trusts, so that it is more evenly shared, reducing longer waiting times. 19 sites went live with the rollout of capacity alerts via the NHS e-Referral System. Initial evaluation results show that pilot sites showed a reduction in referrals to providers with the longest waiting times, by up to 38%. Further development of the framework will support continued mobilisation of capacity alerts and patient choice in future.

High Impact Intervention (HII) for Ophthalmology was implemented nationally, delivering timely assessment and follow-up of those most at risk of sight loss due to chronic eye conditions. By March 2019, 84% of hospital eye services had started or completed implementation, and 81% of CCGs had begun a review of eye health service capacity within their area.

Partly as a result of the work described above, during 2018/19, the number of GP referrals for elective care decreased by 0.4%. This reduction against anticipated demand represents a significant achievement in redesigning pathways across primary and secondary care and implementing interventions across the elective care pathway, reducing avoidable demand and ensuring that patients are referred to the most appropriate healthcare setting, first time.

The NHS England mandate for 2018/19 was to contain the size of the waiting list at the March 2018 level and to halve the number of over 52-week waiters. Rapid growth in both areas during the first half of the year was followed by a steady decrease achieved during the latter part of the year. The total size of the waiting list increased from 4.1 million in March 2018 to 4.33 million in March 2019.

Several areas of focus are supporting elective performance:

- Ongoing productivity improvements in outpatients.
- Intensive support for waiting list management in providers, and appropriate demand and capacity planning.
- Demand management work to constrain clock starts and referral growth.
- Appropriate targeted usage of the Independent Sector.

The number of patients waiting more than 52 weeks has decreased from a peak of 3,517 in June 2018 to the latest published figure of 1,154 for March 2019 and is a reduction of 58.11% on the position at March 2018, thereby achieving the 2018/19 mandate commitment.

Action for the year ahead include:

- Aim to ensure that no patient will wait more than 52 weeks for treatment, and actions taken on waiting lists growth.
- Ensure that patients waiting six months or longer are offered the option of care at an alternative provider.
- Implement agreed standards as set out in the Clinical Standards Review to be published in spring 2019.
- Ensure that no more than 1% of patients should wait six weeks or more for a diagnostic test.
- Ensure patients will have direct access to MSK First Contact Practitioners, with roll out to three mobilised sites in every STP.
- Continued mobilisation of Capacity Alerts as a demand management tool to support GPs and patients with choice at point of referral.
- Provide patients with the choice of a virtual outpatient appointment, where this is clinically appropriate, helping to reduce the long-term growth of outpatient attendances and avoid up to 30 million hospital visits a year within five years.

How we supported the wider NHS

Emergency Preparedness, Resilience and Response (EPRR)

NHS England responded to a range of potential threats to patient and public safety during the year, drawing on its considerable experience and expertise in EPRR.

The EPRR team mobilised a comprehensive health response to the nerve agent attack in Salisbury and subsequent incident in Amesbury. For a number of weeks there was significant focus and expert support provided to Salisbury Hospital. Tragically there was one fatality, but all other affected patients were successfully treated for exposure to the nerve agent Novichok. The NHS was able to draw on the skills and experiences acquired during the initial incident to deal with the second. Learning from these events is being incorporated into national guidance.

Extreme weather featured in the work of the EPRR team during 2018/19, with the extreme cold bringing the 'Beast from the East'. We saw a number of organisations experience difficulty getting staff into work, and transporting patients. NHS England worked with the Ministry of Defence (MoD) to provide assistance for some staff to get to work and to mobilise district nursing staff, and help to get essential medicines into pharmacies and patients homes. This was followed in the summer by soaring temperatures, triggering a national heatwave.

In July 2018, NHS England was made aware of an issue relating to the management of NHS clinical waste in the North of England. The Environment Agency confirmed that a company holding contracts with 53 NHS Trusts (and a small number of primary care organisations) was significantly over its permitted waste storage levels at the majority of its sites in England. With the likelihood of Environment Agency action being taken against this company, the NHS had to prepare for a possible disruption to collections of clinical waste, which in turn could have impacted on patient services. Working alongside colleagues in NHS Improvement and the affected sites, NHS England established an EPRR incident management team which managed the successful implementation of contingency measures and transfer of waste services to alternative providers. This meant NHS patient services were protected without interruption during this period. In December 2018, NHS organisations moved to new waste management contractors.

In September 2018, the national EPRR team supported the response to the first two (unrelated) cases of Monkeypox diagnosed in the UK. Building on the previous work of our High Consequence Infectious Disease (HCID) Programme Board, those affected were successfully treated at HCID units across the NHS. The learning from these cases has informed our ongoing work to develop the UK's health response to outbreaks of infectious diseases posing a high threat.

The EPRR team worked to support the NHS through several other NHS supplier related issues which had the potential to impact NHS services for patients, including the sale of a national provider of domiciliary care and a temporary national shortage of Epipen adrenalin injectors.

The outcomes of the EPRR annual assurance demonstrate substantial compliance with the Core Standards for EPRR, providing assurance that NHS England and the NHS in England is prepared to respond to an emergency, and has resilience in relation to the continued provision of safe patient care.

EPRR and Exiting the European Union

This work has included developing contingency plans for a No Deal scenario and contributing to workstreams that will implement any changes resulting from a deal between the UK and EU.

In preparation for EU Exit, we established an EU Exit team, working on behalf of NHS England and NHS Improvement to provide operational advice, specialist expertise and information to inform Government and NHS preparations for a range of scenarios including a No Deal scenario. Following changes to Government planning assumptions in December 2018, the joint NHS team has focussed on preparations for a No Deal EU Exit, under a single EU Exit Strategic Commander and EU Exit Executive Group.

Our programme followed four phases of work:

1. Testing DHSC and Government planning assumptions: We have supported DHSC specialist workstreams focusing on diagnosing NHS-specific impacts and contributing to contingency plans and guidance to inform local planning.
2. Make ready the health and care system: NHS England with NHS Improvement helped shape and disseminate the EU Exit Operational Readiness Guidance which was published by the DHSC in December 2018. Since then we have published a wide range of system-facing communications and guidance which can be found on our webpage[15]. We have delivered a series of regional events outlining national preparedness and local actions required plus other stakeholder events with independent providers, STP/ICS leads, Royal Colleges and key partners of the NHS.
3. Assurance of system preparation: Regional teams conducted local temperature check and Board assurance exercises to ensure that actions set out in the operational readiness guidance have been completed including identification of EU Exit Senior Responsible Officers (SROs) and supporting teams in place in each of the circa 400 NHS organisations.
4. Transition to incident(s) response: The NHS EU Exit response has been organised alongside existing EPRR processes and procedures. We developed our National Co-ordination Centre (NCC) working closely with regional EU Exit leads to gather intelligence from and disseminate information to the system. Part of the NCC is a Commercial Procurement Cell based in NHS Improvement to support the commercial, legal and contractual aspects of supplier changes as required in NHS organisations. The NCC was receiving situation reports from trusts and commissioners and was ready to extend operational hours to run multiple shifts and provide weekend cover as necessary. In addition, for each of the workstreams with a clinical interface we have established and tested Shortage Response Groups of subject matter experts and clinicians to advise on incident handling. Following the further extension to the Article 50 period, to 31 October 2019, necessary preparations for all EU Exit scenarios have been continuing, though with adjusted timescales. In the event of No Deal, not withstanding NHS preparations, the impact will critically depend on the adequacy of the continuing transport infrastructure, which is not itself under NHS or DHSC control.

15 https://www.england.nhs.uk/eu-exit/

Life sciences and innovation

Innovation and research are core to the NHS. Research active organisations often provide higher quality care for all patients, not only those involved in research. In 2018/19 our work on research focused on two areas: i) increasing the efficiency of research undertaken in the NHS to ensure the maximum number of people in England can participate in research studies, and ii) ensuring the research undertaken in the NHS answers questions that are important to patients and NHS staff.

This year, we therefore implemented two programmes to improve the efficiency of research - one to provide an equitable approach to non-commercial research that incurs excess treatment costs across the country and the other to improve efficiency of commercial contract research through standardising the study costing across the country. Less than a year after these policies were first proposed in our "12 actions to support research in the NHS"[16], we have undertaken a public consultation which supported these policies, implemented the new excess treatment costs process in full and field tested the new approach to commercial contract research.

In terms of ensuring the research undertaken in the NHS meets the needs of the NHS, we have for the first time this year worked with clinicians and managers within NHS England and the broader NHS to describe the areas in which we seek further research and innovation and published these on the NHS England website. We collaborated with National Institute for Health Research (NIHR) to develop 11 new research projects to start addressing our highest priority research needs in areas (such as depression in the over 65s in acute care, digital 111 and digital technologies in diabetes management).

On innovation, our work aims to increase the pipeline of proven innovations that meet the NHS' needs and to increase uptake and spread of these innovations across the NHS. In 2018/19 we worked with 484 innovators through our Clinical Entrepreneurs, Small Business Research Initiative (SBRI), Test Beds and National Innovation Accelerator (NIA) programmes, who together are developing or testing 442 products and have attracted £222 million of inward investment. On supporting uptake and spread of innovation, over 300,000 patients have had access to new innovations this year ranging from digital tools to reduce medication errors to heart scans that reduce the need for interventional procedures (through the Academic Health Science Network (AHSN) national programmes and Innovation and Technology Payment). For example, 39,160 patients have benefitted during 2018/19 from the use of Endocuff, a device that improves detection rates in patients undergoing bowel cancer tests (up from 656 patients in 2017/18), through support from the Innovation and Technology Payment programme. Additionally, AHSNs have supported 4,770 NHS organisations to use mobile Electrocardiogram (ECG) devices to improve detection of AF and 109 centres to provide 'ESCAPE-Pain programmes (Enabling Self-management and Coping with Arthritic Pain through Exercise)' to manage joint pain, reduce medications, surgery and improve quality of life.

16 https://www.england.nhs.uk/publication/12-actions-to-support-and-apply-research-in-the-nhs/

Action for the year ahead includes:

- Launching the national umbrella organisation for health innovation, The Accelerated Access Collaborative (AAC), within NHS England and NHS Improvement. This will build a simpler single innovation system that will apply across England, bringing together horizon scanning, national and regional advice to innovators and a simplified set of national innovation programmes.
- Development of a funding mandate for cost-saving devices, diagnostics and digital products by March 2020.
- Enabling people to register their interest in participating in research on the NHS App by 2020.

Personalised care

Providing people with choice and control over their care, treatment and support can improve outcomes and experience. Personalised Care can also deliver efficiency savings through approaches that support people to stay well and manage their own conditions better. Over the last 12 months we have expanded the rollout of the Comprehensive Model for Personalised Care to deliver on our commitment to supporting people to manage their own health in a way that matters to them.

The Comprehensive Model has been co-produced with people with lived experience and a wide range of stakeholders and brings together six evidence-based and inter-linked components, each of which is defined by a standard, replicable delivery model.

The components are:

- Shared decision making.
- Personalised care and support planning.
- Enabling choice, including legal rights to choice.
- Social prescribing and community-based support.
- Supported self-management.
- Personal Health Budgets (PHBs) and integrated health and social care personal budgets.

Building on the work already taking place in the Integrated Personal Commissioning demonstrator sites, we extended the programme in 2018/19 to cover a third of the country. We have supported CCGs to deliver over 925,000 personalised care interventions, including 54,143 PHBs, meeting the Mandate commitment of 50-100,000 two years early. We have agreed that PHBs should be the default for people receiving homebased Continuing Healthcare (CHC), expanding the model to other groups, and increasing the number of joint budgets with social care. We have consulted on expanding the legal right to have a PHB to further groups. Further rights for Section 117 aftercare[17] and for people who access wheelchair services will be tabled by Government at the next appropriate legislative opportunity in 2019/20.

17 Section 117: Some people who have been in hospital under certain sections of the 1983 Mental Health Act can get free aftercare when they leave hospital. This is known as Section 117 aftercare, and is provided to help prevent people's mental health conditions from deteriorating and avoid re-admittance to hospital. For more information, see: https://www.nhs.uk/conditions/social-care-and-support-guide/care-after-a-hospital-stay/mental-health-aftercare/

We also delivered over 89,000 Personal Maternity Care Budgets (PMCBs), which is significantly above our 2018/19 commitment.

More than 260,000 personalised care and support plans have been created by people with long term conditions and over 138,000 patient activation measurement assessments have been completed.

We have supported CCGs to assess their approach against our Patient Choice framework resulting in 100% completed assessments. 87% reported compliance against the nine minimum legal and contractual standards of choice, and 13% put in place improvement plans. As part of the Comprehensive Model, we have also scaled up our approach to shared decision making and social prescribing.

We have worked with our NHS, Local Government and Voluntary Sector partners during the year to continue to bring about improvements in end of life care through improved identification, planning and service design.

Action for the year ahead includes:

- Continue the work to increase personal health budget numbers, including supporting CCGs to prepare for the introduction of new legal rights.
- Support PCNs to increase the number of Social Prescribing link workers and set up the social prescribing academy.
- Continue to embed the personalised care model in more areas with continued support from the best performing ICSs as part of our demonstrator programme.

See our website for more information on Universal Personalised Care.[18]

Public and patient contact and complaints

It is important that the NHS listens to our patients, carers and the public, and makes the experience of complaining and providing feedback as easy as possible, in order to make improvements to services.

Throughout 2018/19 we have undertaken the following activities to improve complaint handling and learning from customer feedback:

- We provided complaints handling training to around 1,100 dentists, GPs and practice managers across primary care.
- Having worked with the Picker Institute during the design phase, and following a wide-reaching pilot, we published a model survey to measure complainants' experiences across health and social care, building on the Parliamentary and Health Service Ombudsman (PHSO) 'My Expectations'. A toolkit supporting the survey was published on the NHS England website and we have since started to survey our own complainants.
- We completed a peer review process of all our complaints teams, working in conjunction with local Healthwatch and complaints advocacy services, to help identify good practice and where improvements could be made to our complaints handling.

18 Universal Personalised Care: Implementing the Comprehensive Model (2019): https://www.england.nhs.uk/wp-content/uploads/2019/01/universal-personalised-care.pdf .

- We continue to improve the way we identify and share learning from complaints at both a national and local level. We identified the themes and trends from complaints which have progressed to the PHSO and fed this information back to relevant teams in NHS England.
- People with a learning disability, autism (or both) and their families often face additional difficulties in raising concerns or making complaints about health, education and social care services. NHS England continues to work with individuals, carers, families, key stakeholders (including our own complaints team), and providers to help remove some of the barriers to complaining, by applying and embedding the principles of Ask Listen Do.
- We worked with partners, most notable the General Dental Council, on a number of initiatives to promote effective complaints handling in primary dental care.

Action for the year ahead includes:

- We will continue to use intelligence from patient and public feedback and complaints to ensure that we continuously improve our services and share this information at both a national and local level;
- We will continue to deliver our complaints handling training for GPs, dentists, and practice managers, and;
- We will work to deliver a high quality and timely complaints service in line with the new system architecture as set out in the NHS Long Term Plan.

Headlines by contact type

General enquiry cases:

- 122,021 General Enquiries received in 2018/19.
- 91.22% of enquiries were resolved within three working days.

Freedom of Information (FOI) requests:

- 2,326 FOI requests were received in 2018/19.
- 81.21% of requests were responded to within the target of 20 working days.

Concerns:

- 7,967 concerns were recorded in 2018/19.
- 86.16% of concerns were responded to within the target of 10 working days.

Complaints:

- We recorded 6,395 complaints in 2018/19.
- 88.3% of complaints were acknowledged within the target of three working days, and 54.95% were resolved within the target 40 days.

Parliamentary and Health Service Ombudsman

The table below shows activity relating to complaints managed by NHS England which were closed by the PHSO between 1 April 2018 and 31 March 2019. Some of these complaints will have been received by NHS England prior to 1 April 2018 (but have since progressed to the Parliamentary and Health Service Ombudsman after 1 April 2018 hence included in these figures).

All recommendations relating to Partially Upheld or Upheld complaints were accepted and implemented.

	Upheld	Partially Upheld	Not Upheld	Discontinued Or Other	Total Cases
Number of Cases	1	12	15	53	81

KPI performance

	Target	2017/18	Q1	Q2	Q3	Q4	2018/19
General enquiries							
No. of cases received		103,919	30,824	31,529	28,807	30,861	122,021
Resolved within 3 working days	95%	98.24%	88.57%	88.52%	93.3%	94.1%	91.2%
FOI							
No. of cases received	-	2,772	555	585	572	614	2,326
Resolved within 20 working days	80%	85.38%	83.42%	80.34%	76.57%	84.34%	81.2%
Concerns							
No. of cases received		9,585	1,686	2,214	1,840	2,227	7,967
Resolved within 10 working days	80%	79.7%	75.6%	88.2%	91.7%	87.5%	86.2%
Complaints							
No. of cases received		6,432	1,706	1,531	1,557	1,710	6,511
Acknowledged within 3 working days	100%	94.6%	83.2%	86.9%	92.9%	90.1%	88.3%
Resolved within 40 working days	90%	59.3%	53.6%	51.0%	58.3%	56.8%	55.0%
Median response time (working days)	< 40	39	40	40	40	40	40
Admin Closures[18]							
No. of cases received		10,878	2,475	2,329	1,945	2,374	9,122

Who contacted us

The table below shows the types of people who contacted us:

	2017/18	2018/19
Caller type		
Member of the public	95%	94%
NHS Staff	4%	5%
Other	1%	1%

'Other' includes MPs/Parliament, HM Prisons and Probation service personnel, journalists and people who did not wish to identify themselves.

Contact method

The table below shows the ways people contacted us:

	2017/18	2018/19
All Cases		
Phone	74%	67%
Email	25%	31%
Post	1%	2%
Complaints		
Phone	43%	39%
Email	48%	51%
Post	9%	10%

Complaints by service area

The table below shows proportion of complaints concerning each service:

	2017/18	2018/19
Service area		
GP Surgery	71%	73%
Dental Surgery	15%	16%
Pharmacy	4%	4%
Commissioning		2%
Prison or Detention		1%
Other	11%	4%

Service areas attracting 1% or less of the total number of complaints have been grouped as 'other'. This includes ophthalmic services, services in the detained estate, specialised services and complaints about NHS England.

Delivering value for money

In 2018/19 NHS England and CCGs delivered £3 billion of productivity and efficiency improvements, changing the way that we commission services, procure drugs and medical devices, and driving productivity in order to help meet the additional demands for health care at the front line. This included approximately £600 million of savings delivered through the RightCare programme, which works to ensure all CCGs commission in line with the highest-performing areas. For example, some CCGs have reformed CVD services to increase the detection and management of AF and/or hypertension to reduce the risk of stroke and heart disease within the population.

Working alongside the DHSC, NHS England agreed a new voluntary medicines pricing scheme with the pharmaceutical industry that is estimated will save £744 million from the NHS medicines bill in England in 2019. The scheme is designed to ensure that the branded medicines bill stays within affordable limits, whilst also supporting innovation, delivering growth in branded medicines spend as well as faster access and uptake of the best new medicines.

During 2018/19 NHS England led the development of an innovative procurement process for alternatives to the NHS's most costly drug, Adalimumab, used to treat serious conditions such as rheumatoid arthritis, inflammatory bowel disease and psoriasis. The deal with a range of manufacturers has helped deliver £100 million of savings since rollout commenced in December 2018 and we expect to save a further £230 million in 2019/20 as increasing numbers of Adalimumab prescriptions are replaced with biosimilar equivalents. More broadly, across the whole range of complex medications where biosimilar alternatives are available, we have saved £440 million in 2018/19 by ensuring that, where clinically appropriate, clinicians are prescribing the optimal drug.

In 2018/19 NHS England has laid the groundwork for reducing the number of clinically inappropriate procedures undertaken through the Evidence Based Interventions programme. As a consequence of reducing clinically ineffective or inappropriate and harmful procedures, we have saved circa £25 million in 2018/19 and expect to save £120 million per annum by 2021. In addition, we have continued to focus on driving down spending on areas of low priority prescribing, and during the year spend on these products has reduced by over £50 million.

Digital transformation

Progress on the digital strategy for the NHS has continued. The major programmes are digitising the provision of health and care services; giving people the tools they need to help manage their own health more effectively; integrating the datasets each different part of the NHS creates; and providing a platform that supports greater innovation in the use of digital technology and data across the service.

Provider Digitisation

The first cohort of providers have made significant progress and we expect them to pass through the accreditation process towards the end of 2019. Our Global Digital Exemplars (GDEs) have demonstrated that they can use technology to reduce avoidable patient harm such as medication errors, sepsis and falls.

The GDEs and 'Fast Followers' (FF) have also continued the development of "blueprints" and the first tranche of these was published in January 2019. More than 60 individual blueprints are now available for a range of digital capabilities, clinical processes and settings. By describing the key challenges and lessons learnt from the exemplars, they are helping other organisations replicate the GDEs successes more quickly and cost effectively. To date, GDEs and FFs have benefited from £214 million of central investment.

To support wider investment across the rest of the country we also launched the Health Systems Led Investment (HSLI) programme in July 2018. Over the next three years this will give STPs access to central funding to help deliver their digital strategies. Proposals for the 2018/19 allocation were completed by each STP/ICS in September 2018 and, following a final assurance process, £89 million was distributed to support these local projects by the end of March 2019. Alongside this the Carter programme led by NHS Improvement awarded to 13 Trusts (11 Acute, 2 Mental Health) to deploy ePrescribing systems. This amounted to £16 million in 2018/19

and is helping ensure that all providers have digital systems in place to improve the safety of medicines prescribing and administration, which is a major source of avoidable patient harm and unnecessary cost across the country.

Local Health and Care Records

The Local Health and Care Record (LHCR) programme is working with five regional programmes to integrate health and social care datasets and create a single end-to-end view of their population's healthcare records and needs. Each one comprises multiple STPs and ICSs and together they cover around 40% of the population in England. The programmes are delivered at a local level whilst enabling the economies of scale associated with doing things once in a single region. To date, £18 million has been distributed between the five regional programmes and a second wave of investment is currently underway.

LHCRs will form a core part of the technology and data infrastructure required to develop successful STPs and ICSs. They will make sure clinicians and healthcare professionals have access to a full and accurate record of their patient's history, helping them to deliver better care and avoid unnecessary repetition of key information. By bringing together a range of datasets from primary and secondary care providers as well as social care information they will also form the basis of new models of proactive care and population health management, which is an essential part of our wider ICS strategy. Doing so will help the NHS and care services direct their resources towards people who need it most before they become unwell, or as soon as possible at the onset of a specific condition such as diabetes or heart disease.

Digital Primary Care

The GP Connect project is enabling better access to and sharing of GP data, to agreed standards, for direct care. It has continued to make progress on developing a set of national standards and APIs (interfaces) for exchange of information primarily between GP Systems. The project is collaborating with the main GP clinical system suppliers and key NHS stakeholders to define and implement standards. Viewing and accessing records and appointment management was available to the NHS from two GP system suppliers from June 2019.

GP IT Futures is replacing the current GP Systems of Choice (GPSoC) contract and will facilitate the delivery of new technologies that support the GPFV and NHS Long Term Plan. It is supporting new entrants to the GP IT marketplace to drive greater competition and encouraging a wider range of solutions from small-to-medium sized organisations. Between January and April 2019 the new catalogue was developed and launched as a beta release, and the new framework will launch formally in July.

The GP Data for Secondary Uses Programme addresses how the health system collects information about patients from primary care to improve care. The programme is developing a new GP dataset standard and has been working closely with clinical stakeholder groups within the profession to define what data should be made available for secondary uses. The new standard is formally defined by an Information Standards Notice (ISN). Pre-testing of ISN materials and wider stakeholder engagement is underway.

The GP Payments Calculation Futures programme is simplifying the general practice payment system and reducing the administrative burden upon practices. It is focused on the Calculating Quality Reporting Service (CQRS) contract, managed by NHS Digital on NHS England's behalf. NHS England has invoked the CQRS contract extension option to secure service from July 2018 to August 2020.

Empower the Person

2018/19 saw progress in how we use digital services to empower people to manage their own health and care. This included redesigning and re-platforming the NHS website (retiring the old NHS Choices name) to make it more accessible on mobile devices, lowering the reading age, making content more action-orientated and introducing new services such as a pharmacy finder. Visits to the site increased to between 40 and 50 million a month.

We delivered against the commitment to launch an NHS App to provide a consistent universal digital offer across the country. Over a third of GP practices were connected by March 2019. Alongside the NHS App, NHS login also went live, providing safe and secure online patient identity verification, and we began including other digital services. NHS 111 Online was provided across 100% of all CCGs by January, and the NHS Apps Library had its millionth visitor in March 2019. To provide better digital access for people and staff, free public NHS WiFi was installed across virtually the entire NHS primary and secondary care estate (over 90% by end of March 2019). Our widening digital participation programme had 14 live pathfinders across the country piloting different ways to embed digital into healthcare; one of which has led to a 13% increase in first time attendance for breast screening through social media platforms. For more information on how we are empowering people, visit nhs.uk/transformation

NHSX

NHSX will launch formally in July 2019. NHSX is bringing together expertise from across NHS England, NHS Digital NHS Improvement and DHSC to drive forward the digital transformation described in the NHS Long Term Plan. It provides a welcome opportunity to improve the clarity of leadership, coordination and decision making across national bodies, with consequent benefits for timely decision making and programme delivery.

Involving patients and the public

During 2018/19, we continued to take steps to ensure that the views and experiences of patients, carers and members of the public informed our work, involving a wide range of people as part of events and focus groups, as Patient and Public Voice (PPV) Partner members of our committees, and capturing views through surveys and social media.

We also continued to support our established forums, providing a way for groups which may otherwise be 'seldom heard' to input into our decision making, including the NHS Youth Forum and Older People's Sounding Board, and to progress with the NHS Citizen programme. We have also continued to use our relationships with the Voluntary, Community and Social Enterprise (VCSE) sector to reach diverse communities and capture different voices.

These activities support our established processes to ensure and assure consideration of our section 13Q duty (NHS Act 2006) to involve the public in commissioning, through our Patient and Public Participation Policy[19] and frameworks[20] for each area of direct commissioning responsibility. In Autumn 2019, we will again publish a 'Public Participation Dashboard' which provides a 'snapshot' of practice across six indicators, including legal duties, feedback and good practice. This includes commentary from each of our direct commissioning Oversight Groups on the section 13Q duty specifically.

A focus for our public participation during the latter part of this year has been to ensure people were able to influence the development of the NHS Long Term Plan[21]. This work will continue into 2019/20 and beyond, particularly focusing on supporting STPs and ICSs to involve communities in local implementation. During autumn / winter 2018 we worked with our established networks, and undertook additional targeted engagement with 'seldom heard' groups and those that experience health inequalities, in addition to events with stakeholders and an online survey available to the public. For further information about engagement in the NHS Long Term Plan visit the 'Developing the NHS Long Term Plan' webpage[22].

Information about our public participation approaches, opportunities and support is available on our Involvement Hub[23].

19 https://www.england.nhs.uk/publication/patient-and-public-participation-policy/
20 https://www.england.nhs.uk/participation/resources/docs/
21 https://www.longtermplan.nhs.uk/
22 https://www.longtermplan.nhs.uk/about/helping-develop-the-nhs-long-term-plan/
23 https://www.england.nhs.uk/participation/

Empowering People and Communities Taskforce

In early 2018 the Empowering People and Communities Taskforce was established for a year, with one of its key objectives being to ensure patient and public participation within the work of all our priority areas, and with a particular focus on seldom heard voices and health inequalities. As well as leading on the Public Participation Dashboard (see above) and principles for engagement with the VCSE sector (see below), during 2018, detailed workshops took place with a wide group of internal and external stakeholders looking at several NHS England priority areas including cancer, mental health, personalisation, and frailty. Recommendations on each topic were made to the NHS England Board, directly influencing content within the NHS Long Term Plan and changing the way programmes are delivered.

Engaging children and young people in the NHS Long Term Plan

2018/19 has been another eventful year for the NHS Youth Forum, with one of the highlights being members' active engagement in the development of the NHS Long Term Plan, through discussions at the Health and Care Innovation EXPO and two dedicated webinars in September 2018.

This engagement was complemented by additional engagement with 'seldom heard' young people led by the British Youth Council (who also host the NHS Youth Forum on behalf of NHS England). Young people were engaged during five face-to-face sessions in the Midlands and the South West and surveys were completed by young people aged 12 to 25. Respondents included young people who had experience of the criminal justice system, the care system, exclusion from school, and/or drug/alcohol misuse, and those who were carers, refugees or asylum seekers, and with a learning disability. Findings were shared with workstream leads, enabling young people's views to directly influence the NHS Long Term Plan.

The NHS Youth Forum were invited to present their findings at a Developing Integrated Care for Children and Young People event in October 2018 in London, with a significant number of high profile delegates.

Since the publication of the NHS Long Term Plan, the British Youth Council and NHS England continue to work closely with the NHS Youth Forum to support the development of the key objectives outlined and ensure children and young people's voices continue to be embedded in taking forward this work.

NHS England Older People's Sounding Board

NHS England has continued its partnership with Age UK delivering the NHS England Sounding Board. This group of older people have diverse experiences and backgrounds. Work during 2018/19 has included directly influencing NHS England's actions on dementia care planning, transport to hospital, frailty and the Integrated Care Provider (ICP) contract consultation, and informing the cancer programme's engagement strategies, as well as a number of agenda items to inform collaborative work with NHS Digital.

The group also contributed to the NHS Long Term Plan, with discussion focused on three key areas: ageing well, mental health, and primary care. Cross-cutting themes included: a strong voice for ensuring a continued focus on holistic care; the value of carers to the health and care system; the role of communities and the voluntary sector; and the continued importance of integrating health and care across organisational boundaries.

NHS Citizen – engaging families in the Learning from Deaths programme

Throughout 2018/19, NHS England has continued to work with bereaved families to develop guidance for NHS Trusts on how to engage with families following the death of a loved one. A wide range of stakeholders, including family members, carers, voluntary sector organisations and health professionals were involved in this work, and their collective insights, experiences and feedback shaped the guidance. Coproduction of the guidance was overseen by a steering group that included bereaved family members and voluntary sector representation. The guidance, along with complementary information for bereaved families, was published in July 2018 with the endorsement of NHS England, NHS Improvement and the Care Quality Commission (CQC).

Toolkit for carers of people in secure services

Coproduced with carers, and developed in response to their experiences of involvement in secure services, in Spring 2018 we launched Carers Support and Involvement in Secure Mental Health Services – a Toolkit[24]. It was developed in partnership with the National Specialised Mental Health team, carers, service users and staff working in specialised mental health services. Implementation of the toolkit is being driven by inclusion in the Secure Mental Health Service Specification and is being supported by the Royal College of Psychiatrists' Quality Network for Forensic Mental Health Services (QNFMHS) through their standards and peer review process.

Engagement with the VCSE Sector

Recognising the importance of good engagement with VCSE organisations, in November 2018, the NHS England Board approved new principles[25] which outline a more inclusive approach to working with the sector and our expectations from organisations that engage with us.

Building on these principles, we continue to work closely with the VCSE Health and Wellbeing Alliance (HW Alliance), the partnership between VCSE organisations and the health and care system, supported by the DHSC, Public Health England (PHE) and NHS England, to provide a voice and improve health and wellbeing for all communities.

This year, the HW Alliance has continued to have a significant role in contributing the voice of those who face the greatest health inequalities to inform national policy and decision-making, particularly through engagement on the NHS Long Term Plan. Between July-September 2018, the HW Alliance ran twelve engagement events, either on a national or regional level, reaching over 150 VCSE organisations.

A list of the HW Alliance partners and further information can be found on the NHS England website[26].

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24 https://www.england.nhs.uk/publication/carer-support-and-involvement-in-secure-mental-health-services/
25 https://www.england.nhs.uk/wp-content/uploads/2018/11/09-pb-28-11-2018-third-progress-report-from-the-empowering-people-communities-taskforce.pdf#page=15
26 https://www.england.nhs.uk/hwalliance/

NHS Assembly

The NHS Long Term Plan made the commitment that: "We will build on the open and consultative process that this plan is built on, and strengthen the ability of patients, professionals and the public to contribute, by establishing an NHS Assembly in early 2019."

Following a national campaign to recruit members of the Assembly, Dr Clare Gerada and Professor Sir Chris Ham were appointed as co-chairs (one clinical and one non-clinical).

The nationally advertised opportunity to join the Assembly resulted in almost 500 people registering their interest in becoming a member. The result is a diverse membership of 56 individuals drawn from across the health and care sectors, who serve as a "guiding coalition" supporting the successful implementation of the Long Term Plan. The membership, who are connected into their local communities either as frontline staff, patient activists, or clinical and system leaders, bring a breadth and depth of experience, demonstrating what can be achieved through innovative ways of working and helping to think through policy challenges in order to make real the big-ticket improvements we want to see delivered.

The NHS Assembly first came together in April 2019 and will meet four times a year. The Assembly will be informed by wider engagement, including with existing networks whose role it is to promote the voices and views of patients, staff, clinicians and others, which will bring greater insight to support Assembly discussions.

Sustainability

The NHS Long Term Plan describes the importance of ensuring that the NHS leads by example by reducing its impact on the environment, and recognises that the NHS faces a significant challenge to deliver the Climate Change Act 2008 target of 34% by 2020 and 51% by 2025. To support this, and sustainability more broadly, we continue to deliver on the commitments set out in our Sustainable Development Management Plan (SDMP) (2018-2020)[27], to reduce emissions, air pollution and waste, and thereby support sustainable development.

Our primary landlord, NHS Property Services (NHS PS), is making progress with the availability and accuracy of their data, moving us closer to a position to be able to baseline energy use across the majority of our sites. We continue to see good progress regarding paper usage, seeing a 17% reduction in pages printed and copied per Whole Time Equivalent (WTE) over 12 months.

Our sustainability performance is summarised below.

Sustainability Report

Scope

The reporting of greenhouse gas emissions, water and waste in this sustainability report 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[28].

Reporting for multi-occupancy buildings

Within this report NHS England and CSUs report on their proportion of occupied buildings. Where NHS England is a tenant of DHSC or the Department of Work and Pensions (DWP), energy, waste and water information will be reported within their annual report. This will be published on their respective websites[29],[30].

Provision of data

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. This year NHS PS have been able to provide data for electricity, gas and water consumption and cost for each site during 2018/19. Where accurate data has not been available they have made an estimation based on the building size and the performance of other properties occupied by NHS England and the CSUs. Sites have been estimated based on historic performance for that site or based on averages calculated for that type of property. For the purposes of the table below, all scope 2 emissions have been wholly or partially estimated.

NHS PS has also been able to provide partial data for waste collected from our sites; estimates have not been made where data is unavailable. NHS PS are working to improve their data collection ability.

27 https://www.england.nhs.uk/about/sustainable-development/
28 www.england.nhs.uk/ccg-details
29 https://www.gov.uk/Government/organisations/department-of-health-and-social-care
30 www.gov.uk/Government/organisations/department-for-work-pensions

Greenhouse Gas Emissions

Figures for scope 2 emissions in 2016/17 were estimated using the formula for typical usage based on the Chartered Institute of Building Services Engineers in the absence of any actual data. Figures for 2017/18 and 2018/19 have been calculated using actual and estimated data from our landlord, NHS PS. Due to the different methods used to collate the data, it is not possible to draw any conclusions between 2016/17 and the other two financial years. The reduction in scope 2 emissions between this year and last year is due to a reduction in the amount of office space occupied.

			2016/17	2017/18	2018/19
Scope 1 emissions[31]	Non-financial indicators (tCO2e)	Emissions from organisation-owned fleet vehicles	173	177	151
	Total Scope 1 (tCO2e)		173	177	151
	Financial indicators	Expenditure on official business travel	£244,063	£237,732	£219,618
Scope 2 emissions[32]	Non-financial indicators[33] (tCO2e)	Electricity	4,638	5,764*	4,972
		Gas	1,439	2,284*	1,748
	Total Scope 2 (tCO2e)		6,077	8,048*	6,720
	Related use (kWh)[34]	Electricity	10,428,527	14,992,535*	9,330,438
		Gas	7,709,202	12,401,131*	9,502,588
Scope 3 emissions[35]	Non-financial indicators (tCO2e)	Car travel	3,501	2,934	3,735
		Rail Travel	1,520	1,926	1,651
		Air Travel (domestic only)	28*[36]	34	45
	Total Scope 3 (tCO2e)		5,049*[37]	4,894	5,431
		Total (tCO2e)	**11,299***[38]	**13,118***	**12,303**

*Figures have been re-stated.

31 Scope 1 emissions arise from organisation owned and operated vehicles, plant and machinery.
32 Scope 2 emissions arise from the consumption of purchased electricity, heat, steam and cooling.
33 The figures for 2017/18 have been restated to reflect both an error in the calculation formula used and some discrepancies in the area of space occupied at several buildings which have come to light since publication of the original report.
34 The figures for 2017/18 have been restated for the reasons described in the above note.
35 Scope 3 emissions arise from official business travel by vehicles not owned by the organisation. Per person, the figures are lower than the previous year.
36 This figure was previously reported incorrectly and has been restated accurately.
37 Total has been updated to reflect the change in footnote 43.
38 Total has been updated to reflect the change in footnote 43.

Water

To estimate the figures for water consumption in 2016/17, we used the Construction Industry Research and Information Association figure for average water consumption per m2 of 'net internal area' of office space occupied. Since 2017/18, NHS PS has provided water data, as described above. Because the 2016/17 figures have been estimated using a different method, it is not possible to compare it with most recent years. The reduction in consumption during 2018/19 is due to the reduction of office space we occupied, compared with 2017/18.

		2016/17	2017/18	2018/19
Non-financial indicators (m3)	**Water used**	49,469	61,580	54,024
Financial indicators (cost of purchase of water)	**Cost of water used**	£179,503	£283,192*	£295,860

*Figure has been restated from the 2017/18 Sustainability Report

Waste

Figures for previous years were calculated using estimations from the best data available at the time. Figures for this financial year have been provided by NHS PS and estimations have been made using the data available. It is not possible to make any meaningful comparisons between this year and previous years.

It should be noted that no data was available for 60 of the 117 sites NHS PS reported against. This is because they do not manage the waste arrangements on these sites and are not provided with any data. Therefore, the data presented below, for 2018/19, is based only on the data available.

		2016/17	2017/18	2018/19
Non-financial indicators (tonnes)	**Total waste**	493	515	365
	Waste sent to landfill[39]	288	301	12
	Waste recycled/ reused	194	203	305
	Waste incinerated	11	11	48
Financial indicators (cost of waste disposal)	**Total waste**	£129,953	£135,585	£250,582
	Waste sent to landfill	£52,387	£54,658	-
	Waste recycled/ reused	£71,607	£74,710	-
	Waste incinerated	£5,959	£6,217	-

39 Previous years report the figure for general waste in this category whereas this year, NHS PS were able to identify the amount of general waste diverted from landfill.

The data NHS PS receives from their waste management providers contains a category for 'general waste'. In 2018/19 their providers were able to report that 96% of 'general waste' was diverted away from landfill. In previous years, the 'general waste' category didn't provide any further detail. For our annual reports, general waste has previously been categorised as 'waste sent to landfill'. This difference in reporting between the two years means that the amount of waste in each category appears significantly different.

The total cost of waste removal was £250,582 although we are no longer provided with a breakdown of costs associated with each waste stream.

ICT waste

As part of the roll-out of new technology during this financial year, we had a significant amount of ICT waste. This was all recycled or reused using corporate schemes who commit zero waste to landfill.

NHS England emissions from business travel per WTE

	2016/17	2017/18	2018/2019
tCO2e per WTE	0.583	0.552	0.515

The NHS Long Term Plan commits the NHS to cutting business miles and fleet air pollutant emissions by 20% by 2023/24. Accordingly, this is an area of continued focus for NHS England. Further information on conversion factors for greenhouse gas reporting can be found on the Government's website[40].

Sustainable procurement

We continue to place great emphasis on investing in our commercial experts. All new entrants to the Commercial and Procurement team undergo training and awareness on sustainable procurement. Thematically-focused awareness sessions are also offered to internal and Arm's Length Body (ALB) procurement colleagues, as per need.

All new procurements with an expected contract value over £150K are subject to our Sustainability Impact Assessment, which is embedded into our Commercial Value Risk Matrix and allows us to identify and manage sustainability risk alongside commercial risk.

As committed to in last year's report, we launched our Supplier Code of Conduct which aims to consolidate commercial, sustainability and social value expectations of our suppliers and introduce a system of regular reporting. The Code is applicable to all new contracts that are expected to exceed £150K in value and 12 months in duration. Building on the established relationships with our existing strategic suppliers, we have started negotiating the Supplier Code of Conduct to be retrospectively included in six supplier relationships representing about one fifth of our strategic spend.

40 https://www.gov.uk/Government/publications/greenhouse-gas-reporting-conversion-factors-2018

As we continue to roll out the implementation of our Third Party Assurance Framework, we will transfer knowledge, visibility and management of sustainability impacts to the rest of the organisation, which will share the responsibility and help establish a better understanding of our opportunities. As our commercial processes mature, our ability to manage risk and ensure resilience across our supply chain increases.

Our sustainable procurement programme is aligned with the Government's Flexible Framework for sustainable procurement.

Climate change adaptation

With PHE and others, we continue to produce a national Heatwave Plan[41] each year. This is intended to protect the population from heat-related harm to health. We also contribute to the Cold Weather Plan[42], which gives advice to help prevent the major avoidable effects on health during periods of cold weather in England.

We also contributed to the second National Adaptation Programme (2018-2023)[43], which sets out what the Government and others will be doing over the next five years to be ready for the challenges of climate change.

The Sustainable Development Unit (SDU)

The SDU plays a pivotal role in embedding the principles of sustainable development into the way in which the NHS, public health and social care system in England works; delivering high quality care for this and future generations. The Unit is jointly funded by NHS England and PHE.

A significant proportion of our health and wellbeing is determined by the quality of the environment we live in. The SDU supports the NHS to lead by example, in reducing its own impacts on the environment. This work is currently focussed on tackling air pollution, plastics, waste and the delivery of the UK's targets on carbon reduction.

During this year, the SDU has contributed to the NHS Long Term Plan, re-stating the NHS' commitment to delivering carbon targets in line with the UK Government Climate Change Act 2008.

This year the SDU published a Natural Resources Footprint for the health and care system. The report shows that the health and social care system has reduced its carbon emissions by 19% since 2007, despite a 27% increase in activity. Since 2010 the sector has cut its water footprint by 21% and only 15% of NHS waste now goes directly to landfill, with 23% of waste recycled.

This year saw the first year of the Sustainable Health and Care Campaign, commissioned on behalf of the sector by the SDU, including a national sustainability week, and in November an awards programme to recognise best practice.

The SDU is actively engaged with partner organisations, establishing board-approved plans and ensuring alignment with the United Nations' Sustainable Development Goals.

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41 https://assets.publishing.service.gov.uk/Government/uploads/system/uploads/attachment_data/file/711503/Heatwave_plan_for_England_2018.pdf

42 https://assets.publishing.service.gov.uk/Government/uploads/system/uploads/attachment_data/file/748492/the_cold_weather_plan_for_england_2018.pdf

43 https://www.gov.uk/Government/publications/climate-change-second-national-adaptation-

Chief Financial Officer's Report

The financial statements for the year ending 31 March 2019 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 195 CCGs.

NHS England was required to limit its revenue spending to £114,087 million in 2018/19. We are responsible for using this money wisely and fairly to secure the best outcomes for both patients and taxpayers. As shown later in this report, the group has again fulfilled all of the financial requirements set out in its mandate from central government, covering revenue spending, administration costs and capital expenditure.

Operational performance

Compared to its plan for the year, the NHS England group has delivered a managed underspend of £651 million (0.6% as a percentage of allocation)[44]. This is in addition to a £265 million planned underspend intended to offset anticipated deficits in the provider sector, giving an overall managed underspend for the NHS England group of £916 million.

Financial performance - Revenue Department Expenditure Limit (RDEL) general (non-ring-fenced)

Financial performance	2018/19				2017/18		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		Under/ (over) spend against plan		Under/ (over) spend against plan	
	Plan	Actual												
	£m	£m	£m	%	£m	%	£m	%	£m	%	£m	%	£m	%
CCGs	84,384	84,534	(150)	(0.2)%	(213)	(0.3)%	154	0.2%	(15)	(0.0)%	70	0.1%	89	0.1%
Direct Commissioning	24,791	24,481	310	1.3%	223	0.9%	296	1.2%	82	0.3%	(12)	(0.0)%	(365)	(1.4)%
NHS England Admin/ Central Progs/ Other	4,446	3,690	756	17.0%	960	23.2%	452	13%	532	28.5%	226	13.5%	602	30.5%
Total	**113,621**	**112,705**	**916**	**0.8%**	**970**	**0.9%**	**902**	**0.9%**	**599**	**0.6%**	**285**	**0.3%**	**326**	**0.3%**

Note 1: Historic CHC claims administered on behalf of CCGs included in "other"

44 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.

CCGs have continued to manage their finances well. Collectively they have taken appropriate action to absorb a number of unanticipated cost pressures outside of their control, including those arising from GP pay awards and generic drug prices. Despite these pressures, CCGs as a group have delivered efficiency savings of 2.9% of their allocations, and significantly fewer CCGs have ended the year with an overspend (33 in 2018/19 compared to 75 in 2017/18).

Most of the underspend in Direct Commissioning comes from Specialised Commissioning, reflecting improvements in financial management over the last three years.

NHS England took action early in 2018/19 to make savings in central spending to cover the emerging overspends in NHS providers. Underspends against central budgets include savings from vacancy control and income from GP rates rebates and counter fraud receipts. In addition, during the year NHS England held back investment that could otherwise have been deployed to fund transformation.

Performance against wider financial metrics

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

2018/19 Performance against key financial performance duties

Revenue Limits	Target				
	Mandate Limit £m	Actual £m	Underspend £m	Target met	Underspend as % of Mandate
RDEL - general	113,621	112,705	916	✓	0.8%
RDEL - ring-fenced for depreciation and operational impairment	166	132	34	✓	20.5%
Annually Managed Expenditure limit for provision movements and other impairments	100	(19)	119	✓	119.0%
Technical accounting limit (e.g. for capital grants)	200	48	152	✓	76.0%
Total Revenue Expenditure	**114,087**	**112,866**	**1,221**		**1.1%**
Administration costs (within overall revenue limits above)					
Total administration costs	**1,821**	**1,588**	**233**	✓	**12.8%**
Capital limit					
Capital expenditure contained within our Capital Resource Limited (CRL)	**254**	**221**	**33**	✓	**13.0%**

Allocations

NHS England has responsibility for allocating NHS funding agreed with the DHSC as part of our Mandate. We are required 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. Consistent with these duties, significant improvements to the formulae through which resources are distributed to CCGs were implemented in 2019/20, on the basis of recommendations from the independent Advisory Committee on Resource Allocation.

In June 2018 the Government announced a long-term revenue funding settlement for the NHS, to increase the NHS annual budget by £20.5 billion in real terms by 2023/24. The Government also committed to provide additional recurrent funding until 2023/24 to meet the anticipated cost pressure to the NHS in England resulting from increases to the employer contribution rate for the NHS England Pension scheme.

This revenue funding settlement has given NHS England the opportunity to set allocations for the health system over an extended period, providing greater planning certainty and allowing local systems to develop more robust and sustainable plans to implement the NHS Long Term Plan.

In January 2019, the NHS England Board approved allocations for the five years from 2019/20 to 2023/24. These were comprised of firm allocations for the first three years and indicative allocations for the final two.

Our approach to the distribution of funding was based upon the following key considerations:

- Funding a realistic and sustainable level of activity.
- Appropriately funding price pressures, including the impact of pay awards and changes in tariff prices.
- Protecting funding for the implementation of existing NHS Five Year Forward View commitments, particularly in respect of mental health, primary care and cancer services.
- Reducing running costs, whilst also prioritising funding for transformation and service development.
- Ensuring that CCGs have access to sufficient resources to meet the NHS Long Term Plan commitments that spending on mental health, and on primary medical and community health services, will grow as a share of overall NHS revenue spending.

Future financial sustainability

Putting the NHS back onto a sustainable financial path is a key priority and is essential to allowing the NHS to deliver the service improvements set out in the NHS Long Term Plan, which set out five key tests and the approach to meeting them:

1. The NHS (including providers) will return to financial balance.
2. The NHS will achieve cash-releasing productivity growth of at least 1.1% a year, with all savings reinvested in frontline care.
3. The NHS will reduce the growth in demand for care through better integration and prevention.
4. The NHS will reduce variation across the health system, improving providers' financial and operational performance.
5. The NHS will make better use of capital investment and its existing assets to drive transformation.

To support delivery of these tests we have made a number of changes to the NHS financial framework. We have updated the Market Forces Factor. We are increasingly moving away from activity-based payments through the progressive rollout of the blended payment model. The control total regime and the Provider Sustainability Fund will be abolished, with future financial support being allocated on the basis of delivery against agreed, multi-year recovery plans, showing significant year-on-year improvements in sustainability and financial performance. Further reforms to the financial framework will support the further development of ICSs, where commissioners and providers will make shared decisions about both financial sustainability and service transformation.

Matthew Style

Acting Chief Financial Officer

Our priorities for 2019/20

Building on the foundation established by the NHS Five Year Forward View, the NHS Long Term Plan, published in January 2019, states how increased funding, announced in June 2018, will be used over the next 10 years.

Our focus for 2019/20 was set out in the Annual Planning Guidance to the NHS[45] and supported by the Government's Mandate to NHS England and NHS Improvement for 2019/20.

45 https://www.england.nhs.uk/publication/preparing-for-2019-20-operational-planning-and-contracting/

Accountability Report

Simon Stevens
Accounting Officer
3 July 2019

The **Accountability Report** sets out how we meet key accountability requirements to Parliament. It comprises three key sections:

The Corporate Governance Report sets out how we have governed the organisation during 2018/19, 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 and starts from page 61.

The Remuneration and Staff Report sets out our remuneration policies for non-executive directors and 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 and starts from page 107.

The Parliamentary Accountability and Audit Report brings together key information to support accountability to Parliament, including a summary of fees and charges, contingent liabilities and the Certificate and Report of the Comptroller and Auditor General to the House of Commons. The report starts from page 135.

Corporate Governance Report

Directors' Report

The Board

The NHS England Board is composed of the Chair, six non-executive directors and five voting executive directors. These arrangements comply with the requirements of the National Health Service Act 2006 (as amended) that the Board should consist of at least five non-executive directors, other than the Chair, and that the number of voting executive directors is less than the number of non-executive directors (including the Chair). A number of non-voting executive directors also regularly attend Board meetings. In May 2018, the Boards of NHS England and NHS Improvement committed to deliver a new model of joint working, involving shared national director roles and alignment of national functions and integrated regional teams with new regional geographies. To support this closer alignment, the two Boards approved a new joint Board governance framework in November 2018. This new framework has been designed to enable the Boards to have full oversight of both organisations and together be able to support and challenge the delivery of ICSs and the NHS Long Term Plan. The new governance framework operated in an advisory capacity alongside the existing governance framework between 1 January to 31 March 2019, before being formally adopted in 2019/20.

Roles and responsibilities

The Board is the senior decision making structure in NHS England. To support its strategic leadership to the organisation it:

- sets the overall direction of NHS England, within the context of the NHS mandate;
- approves the business plan 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 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 and;
- promotes effective dialogue between NHS England, NHS Improvement, Government departments, other ALBs, partners, CCGs, providers of healthcare and communities served by the commissioning system.

Appointment

The Chair, Vice Chair and non-executive directors are appointed by the Secretary of State for Health and Social Care; executive directors are appointed by the Board. Board members bring a range of complementary skills and experience in areas such as the PPV, finance, governance and health policy. Any new appointments take account of the skills already represented on the Board and recognise where there are gaps that could be filled.

There were several changes in Board membership during the year. Professor Sir Malcolm Grant's appointment as Chair came to an end on 30 October 2018. Lord David Prior was appointed Chair on 31 October 2018. Three non-executive Directors left NHS England during the year, Professor Sir John Burn on 30 June 2018, Lord Victor Adebowale and Dame Moira Gibb on 31 December 2018. One new non-executive director, Professor Sir Munir Pirmohamed, was appointed to NHS England on 1 January 2019. Following the departure of Paul Baumann CBE on 18 November 2018, Matthew Style was appointed as acting Chief Financial Officer, with Julian Kelly taking on the role permanently from 1 April 2019. Following the retirement of Jane Cummings CBE, Ruth May was appointed joint Chief Nursing Officer with NHS Improvement, joining NHS England on 7 January 2019.

Register of Members' Interests

As part of NHS England's commitment to openness and transparency in its work and decision making, a Register of Members' Interests, drawing together Declarations of Interest made by all Board and executive members, is maintained. This is open to public scrutiny and is published on NHS England's website. The register is reviewed at each Board meeting and may be viewed on our website[46].

Board and executive members are required to notify and record any interests relevant to their role on the Board. In addition, members of the Board and the executive 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 2018/19 with other organisations to which an individual holding a director position within NHS England is connected, are set out in Note 17 on page 187 of the Annual Accounts.

NHS England Board Members

The names of NHS England Board members, both non-executive and executive (voting and non-voting), are noted below. Full details, including biographies and photographs, may be viewed on our website[47].

Board meeting attendance

The agenda, papers and the minutes of NHS England Board meetings held in public, are published on the NHS England website[48]. The agenda and papers from Board meetings held in private are made available one year after the meeting, where this does not compromise commercial or other confidentiality requirements.

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46 www.england.nhs.uk/about/whos-who/reg-interests/
47 https://www.england.nhs.uk/about/board/members/
48 www.england.nhs.uk/about/whos-who/board-meetings/.

During 2018/19, the Board met in common with the board of NHS Improvement on four occasions in public/private to discuss, amongst other matters, closer working.

Member	Job Title	Number of eligible meetings attended during the year[49]	Comments
Professor Sir Malcolm Grant	Chair	5/5	Until 31 October 2018
Lord David Prior	Chair	4/4	Appointed 31 October 2018
David Roberts CBE	Vice-Chair	9/9	
Lord Victor Adebowale	Non-Executive Director	5/6	Until 31 December 2018
Wendy Becker	Non-Executive Director	6/9	
Professor Sir John Burn	Non-Executive Director	2/2	Until 30 June 2018
Professor Sir Munir Pirmohamed	Non-Executive Director	1/3	Appointed 01 January 2019
Dame Moira Gibb	Non-Executive Director	6/6	Until 31 December 2018
Noel Gordon	Non-Executive Director	9/9	
Michelle Mitchell	Non-Executive Director	8/9	
Joanne Shaw	Non-Executive Director	8/9	
Richard Douglas (non-voting)	Associate Non-Executive Director	9/9	
Simon Stevens	Chief Executive	9/9	
Matthew Swindells	Deputy Chief Executive	9/9	Previously National Director: Operations & Information (non-voting) until 01 September 2018
Paul Baumann CBE	Chief Financial Officer	5/5	Until 18 November 2018
Matthew Style	Acting Chief Financial Officer	4/4	Interim 19 November 2018 to 31 March 2019
Professor Jane Cummings CBE	Chief Nursing Officer	6/6	Until 31 December 2018
Ruth May	Chief Nursing Officer	3/3	Appointed 07 January 2019
Professor Stephen Powis	National Medical Director	8/9	
Ian Dodge (non-voting)	National Director: Strategy & Innovation	9/9	
Emily Lawson (non-voting)	National Director: Transformation & Corporate Operations	9/9	

49 Includes meetings in common with NHS Improvement

Board diversity

NHS England had eight non-executive directors including one associate non-executive member (non-voting) as at 31 March 2019, three of whom were female and five were male. Of the seven members of NHS England's Executive Group as at 31 March 2019, five were male and two were female. More detail on the diversity of the NHS England Board is included in the Remuneration Report, at page 111.

Board performance

The NHS England Board regularly reviews its performance and works together to improve its effectiveness, although an independent review has not been conducted during 2018 given the advent of closer working with NHS Improvement. Work will now continue to further develop the Board's forward agenda as well as the Board's role in nurturing the culture of NHS England through its continuing transformation.

Board Committees

The Board has been supported in its assurance and oversight of the organisation by five committees up to the end of the year. This allows 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 and based on the correct information.

As noted above, a new joint Board governance framework has been agreed by the Boards of NHS England and NHS Improvement. As a result of this, during Quarter 4 of 2018/19, the Board implemented a new committee structure in shadow format to extend working in common with NHS Improvement below board level. This resulted in support to the Board from five committees, two to be held independently and three to be held in common with NHS Improvement's corresponding committees. In addition, three sub-committees of one of these committees meeting in common have been created, again to meet in common with NHS Improvement's corresponding sub-committees. Meeting in common in this way allows the two organisations to meet at the same time, with shared agendas and papers whilst retaining separate committees that can take decisions on behalf of each individual organisation. NHS England and NHS Improvement have made a commitment to transform the way we work to provide a single system view, single messaging and shared leadership to support and enable integrated care across England, whilst ensuring that both organisations continue to respect the statutory commissioner or provider responsibilities that can be discharged only by NHS England or NHS Improvement.

All the above committees and sub-committees form part of NHS England's formal governance structure, with each providing a report to the Board (or, in the case of the sub-committees, to the relevant committee) following every meeting, ensuring that the Board is kept informed of how it has discharged its delegated responsibilities. Additionally, each committee provides the Board with an annual report covering a review of the activities in the previous year, a summary of the priorities for the coming year, a self-assessment of its effectiveness, and a review of the terms of reference. The Accounting Officer (Chief Executive), 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 (Chief Executive) reserve and exercise the right to attend meetings of all committees and sub-committees. In addition, all non-executive directors have a standing invitation to attend and participate in any of the Board committee or sub-committee meetings.

NHS England Board governance framework and committees effective between 1 April 2018 and 31 March 2019

NHS England Board				
Strategic HR & Remuneration Committee Chair: Professor Sir Malcolm Grant (1 Apr-30 Oct) Chair: Lord David Prior (31 Oct-31 Mar)	**Audit and Risk Assurance Committee** Chair: Joanne Shaw	**Investment Committee** Chair: Moira Gibb	**Commissioning Committee** Chair: Wendy Becker	**Specialised Services Commissioning Committee** Chair: Noel Gordon
Main responsibilities				
Advise the Board on Board and organisational development. Approve remuneration and terms of service for the Chief Executive and National Directors.	Provide an independent and objective view of internal control, governance and risk management - including overview of internal and external audit services, governance, risk management and financial reporting.	Receive assurance and agree recommendations on business cases for activities related to NHS England's functions, on behalf of the Board. Make decisions on reconfiguration proposals requiring Board sign-off (in accordance with delegated powers). Oversee the assurance of reconfigurations.	Advise on development & implementation of strategy for the commissioning sector. Agrees commissioning priorities & resource allocation. Monitor and challenge the delivery of service performance, quality and financial outcomes. Oversee development of the commissioning system.	Advise the Board on development & implementation of strategy for specialised commissioning. Agree specialised commissioning priorities & work programmes. Monitor and challenge the delivery of priorities and work programmes.

New NHS England Board governance framework and committees

The new Board and Committees framework held advisory meetings only between 1 Jan to 31 March 2019 to prepare for formal commencement from 1 April 2019.

NHS England Board				
NHS England only Board Committee	**NHS England Board Committee with some business being run as a committee-in-common with NHS Improvement**	**Committees operating as a committee-in-common with NHS Improvement**		
Statutory Commissioning Committee Chair: Wendy Becker	**Audit and Risk Assurance Committee** Chair: Joanne Shaw	**Delivery, Quality and Performance Committee** Chair: David Prior	**Strategic HR and Remuneration Committee** Chair: David Prior	**Strategy Committee** Chair: David Prior
Main responsibilities				
Make decisions on the exercise of statutory powers in respect of CCGs under section 14 of the NHS Act 2006. Agree and approve individual CCG and commissioner allocations.	Provide an independent and objective view of internal control, governance and risk management - including overview of internal and external audit services, governance, risk management and financial reporting.	Review financial and operational performance of the NHS. Review the delivery and impact of the NHS Long Term Plan. Oversee the implementation and delivery of the new NHS financial framework.	Work with NHS Improvement to ensure that the organisations have: • a single formal and transparent remuneration policy • policies and practices to ensure that their people are properly recruited, engaged and motivated, diverse, performing and developed NHS England only: • approves the appointment, remuneration and terms of service for the Chief Executive and members of the Executive group, in line with the DHSC and ALB Pay Framework and Government decisions on public sector pay arising from the recommendations of the Senior Salaries Review Body	Provide overall strategic oversight, advice and leadership to the NHS. Provide strategic oversight for delivery of the Long-Term Plan.

Committees operating as a committee-in-common with NHS England		
Digital Committee Chair: Noel Gordon	**People Committee** Chair: Michelle Mitchell	**Quality Committee** Chair: Joanne Shaw
Details of these committees are provided overleaf		

In addition, two advisory groups supported the Boards:

Advisory Group	Chair	Responsibilities
Joint Finance Advisory Group (NHS Improvement and NHS England)	Chair: Non-Executive Director of either NHS Improvement or NHS England	The group has no executive responsibility and has been formed to ensure that both organisations are working from a common understanding of the financial targets and financial performance of the entire health system.
Joint Transition Advisory Group (NHS Improvement and NHS England)[50]	Chair: Joanne Shaw, Non-Executive Director, NHS England	The group had no executive responsibility and was formed to oversee the integration of NHS England and NHS Improvement.

Delivery, Quality and Performance Committee's sub-committees

Sub- committees of the Delivery, Quality and Performance Committee		
Operating as a committee-in-common with NHS Improvement		
Digital Committee Chair: Noel Gordon	**People Committee** Chair: Michelle Mitchell	**Quality Committee** Chair: Joanne Shaw
Main responsibilities		
Advise on the delivery of digital commitments of the NHS Long Term Plan, alignment of technology initiatives and spend to ensure they are focused on NHS Long Term Plan commitments. Provide assurance on the alignment of ALBs accountabilities and responsibilities for cross cutting digital initiatives, managing NHS organisations and ALBs implementation and operation of digital initiatives.	Oversee the implementation of the key recommendations from the People Plan. Support and advise on new talent management arrangements. Support challenge and advise on initiatives for workforce improvement. Oversee the delivery of best practice support for all workforce issues. **NHSE only responsibilities:** Support, challenge and advise on the delivery of the primary care commitments set out in the NHS Long Term Plan, the primary care networks contract and continuing commitments in the GPFV to strengthen the workforce across primary and community care, including training, recruitment, support and retention of medical, clinical and non-clinical staff. Support, challenge and advise on the development of integrated multi-disciplinary teams working across primary and community settings, including dentistry, community pharmacy and optometry.	Consider issues in relation to three areas of quality – safety, clinical effectiveness and patient experience – in relation to all NHS services. **NHSE only responsibility:** Review reports on the quality of care delivered by the NHS from the integrated regional teams based on data and information from local and regional surveillance and activities. Review reports bringing together data and information on national and/or strategic importance relating to NHS England's statutory duties and services directly commissioned. Review reports on specific NHS England-led national programmes and initiatives relevant to quality, including quality improvement programmes and transformation programmes.

50 This group was disbanded in March 2019 and the oversight provided by this group has been assumed into other committees.

Audit and Risk Assurance Committee (ARAC)

Role of the Committee

The Committee 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 has met five times. 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)	5/5	
Wendy Becker	4/4	
Gerry Murphy	5/5	Non-executive Chair of DHSC's Audit Committee
Professor Sir John Burn	0/2	Left NHS England 30 June 2018
Michelle Mitchell	1/1	Appointed to Committee 01 January 2019
Professor Sir Munir Pirmohamed	0/1	Appointed to Committee 01 January 2019

Committee attendees

Additional attendees are invited to attend meetings to assist with committee business. For 2018/2019, these have included National Directors, Director of Governance and Legal, representatives from the National Audit Office (NAO), Deloitte LLP (internal auditors) and DHSC.

Principal activities during the year

The Committee has provided progress reports to the Board on its key duties, which include:

- 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.
- Agreeing the internal audit plan for 2018/19 and reviewing progress.
- Reviewing issues with the delivery of Primary Care Services (Capita).
- Assessing the integrity of NHS England's financial reporting.
- Considering and approving the NHS England Final Annual Report and Accounts for 2017/18.
- Considering reports provided by the NAO that relate to 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.

- Considering progress with implementing internal audit recommendations.
- Overseeing the organisation's arrangements for counter fraud.
- Reviewing Cyber security issues and the implementation of the General Data Protection Regulations (GDPR).
- Reviewing the status of planning for EU Exit.

Planned activities during the coming year

In the coming year, the Committee will:

- Consider areas for review by internal audit and approve the 2019/20 plan of work and then review the audit work during the year.
- Consider the 2018/2019 Annual Internal Audit Report and Head of Internal Audit opinion.
- Consider and approve the NHS England Final Annual Report and Accounts for 2018/19.
- Review the NHS England Economic Crime Strategy.
- Review updates from the NAO on progress with their audit work.
- Consider corporate risks and the status of internal audit recommendations.
- Oversee other risk areas such as cyber security, primary care assurance and third party assurance.
- Review the developing governance arrangements between NHS England and NHS Improvement.

The Committee met in joint session with the NHS Improvement ARAC for the first time on 27 February 2019, and discussed which aspects of Committee business they might consider in future joint session.

Commissioning Committee

Role of the Committee

The Committee provided advice to the Board on the development and implementation of strategy for the commissioning sector, agreed commissioning priorities and allocated resources, and received assurance that performance, quality and financial outcomes are delivered, including financial performance monitoring. It also oversaw assurance and development of the commissioning system, including CCGs.

Committee members

The Committee met seven times during the financial year 2018/19. 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
Wendy Becker (Chair)	7/7	
Lord Victor Adebowale	4/7	Until 31 December 2018
Noel Gordon	6/7	
Michelle Mitchell	6/7	
Paul Baumann CBE	5/5	Left NHS England 18 November 2018
Professor Jane Cummings CBE	5/7	Left NHS England 31 December 2018
Ian Dodge	7/7	
Professor Stephen Powis	6/7	
Simon Stevens	5/7	
Matthew Style	2/2	Member from 19 November 2018
Matthew Swindells	7/7	
Richard Barker	4/7	
CCG representative	5/7	

Committee attendees

Additional attendees were invited to attend meetings to assist with committee business.

For 2018/19, these included the Director of Primary Care, the Director of Strategic Finance, the Director of Commissioning Policy Group and the Director of Financial Planning and Delivery.

Principal activities during the year

Over the year, the Committee focussed on its three core areas:

- Delivery of the main system transformation programmes:
  - Next Steps on the NHS Five Year Forward View[51] priorities including cancer; mental health and dementia; urgent and emergency care; primary care; and the NHS' ten-point efficiency plan with NHS Improvement.
  - STPs and ICSs.
- In-year performance and finance:
  - assurance of financial and service performance, both within NHS England and across the commissioning system.
- Oversight of the commissioning system and its development:
  - CCG improvement, assessment and assurance processes ensuring that CCGs meet their statutory duties.
  - 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.

Planned activities during the coming year

As part of the new Board governance framework, the Commissioning Committee has been disbanded, with its remit being transitioned to the new Delivery, Quality and Performance Committee (and its sub-committees: Quality, People and Digital), which will meet in common with NHS Improvement's Delivery, Quality and Performance Committee (and sub-committees).

51 https://www.england.nhs.uk/wp-content/uploads/2017/03/NEXT-STEPS-ON-THE-NHS-FIVE-YEAR-FORWARD-VIEW.pdf

Specialised Services Commissioning Committee

Role of the Committee

The Committee provided 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 covered health and justice, armed forces and sexual assault services commissioning.

Committee members

The Committee met five times during the financial year. The following table details core membership and the number of meetings attended by each member (although some members were not able to attend the whole of each meeting):

Member	Number of eligible meetings attended during the year	Comment
Noel Gordon (Chair)	5/5	
Michelle Mitchell	5/5	
Paul Baumann CBE	4/4	Left NHS England 18 November 2018
Ian Dodge	4/5	
Matthew Style	0/1	Member from 19 November 2018
Matthew Swindells	3/3	Member from 1 September 2018
John Stewart	5/5	
Simon Stevens	1/5	
Professor Stephen Powis	2/5	
Dame Moira Gibb	3/5	

Committee attendees

Additional attendees were invited to meetings to assist with committee business. For 2018/19, these have included: Director of Strategy and Policy, Specialised Commissioning; Medical Director, Specialised Commissioning; Finance Director, Specialised Commissioning; Clinical Programmes Director, Specialised Commissioning; and Director of Health & Justice, Armed Forces and Sexual Assault Referral Centres.

Principal activities during the year

Over the year, the Committee:

- Oversaw the development and, in some areas, implementation of:
  - revised strategic priorities for Specialised Commissioning, including alignment to the NHS Long Term Plan;
  - health and justice commissioning in England;
  - a new model of care for gender identity services;
  - the Genomic Medicine Service;
  - a focus on improving value by reducing variation;
  - healthcare commissioning for armed forces and their families;
  - proposals for decommissioning of specialised services, including obsolete services;
  - Chimeric Antigen Receptor T-cell Therapy (CAR-T) into the NHS in England;
  - an approach to horizon scanning for new technologies, including with closer links to National Institute for Health and Care Excellence (NICE);
  - opportunities provided by off-label medication usage; and
  - re-evaluation of health technologies for specialised services.
- Oversaw Specialised Commissioning's approach to NHS England's clinical priority areas – cancer, mental health and learning disabilities – and specific service reviews – such as the congenital heart disease review.
- Reviewed and agreed the routine commissioning of new treatments.
- Provided assurance and oversight for:
  - the Cancer Drugs Fund;
  - specialised commissioning financial plans for 2018/19;
  - operational decisions taken by NHS England's Specialised Commissioning Oversight Group (SCOG);
  - operational decisions made by the Specialised Commissioning Patient and Public Voice Assurance Group;
  - operational decisions taken by the Health & Justice Oversight Group and the Armed Forces Oversight Group.

Planned activities during the coming year

As part of the new Board governance framework, the Specialised Services Commissioning Committee has been disbanded, with the majority of its remit being transitioned to the new Delivery, Quality and Performance Committee and sub-committees, which will meet in common with NHS Improvement's Delivery, Quality and Performance Committee and sub-committees. Some decisions of the committee will now reside with the Board and/or Statutory Committee.

Investment Committee

Role of the Committee

The 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 twice during the year. In addition, it carried out its function by correspondence in July and November 2018. 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)	2/2	
Wendy Becker	2/2	
Paul Baumann CBE	2/2	Left NHS England on 18 November 2018
Matthew Style	0/0	Member from 19 November 2018
Ian Dodge	1/2	
Matthew Swindells	1/2	

Committee attendees

Additional attendees were invited to attend meetings to assist with committee business.

For 2018/19, these have included Director of Operations and Delivery, Head of Project Appraisals Unit and Chair of the OGSCR.

Principal activities during the year

During 2018/19, the Committee has:

- Approved investment cases relating to the Diabetes Prevention Programme, the National Ambulance Resilience Unit (NARU) and the General Practice Payment Calculation Futures (GPPCF) programme.
- Received an update on the Transformation Fund allocation.
- Reviewed the pipeline of service change and reconfiguration proposals presented by the OGSCR.

Planned activities during the coming year

As part of the new Board governance framework, the Investment Committee has been disbanded, with most of its decision making moving to the Executive Resource and Investment Group and some being transitioned to the new Delivery, Quality and Performance Committee, which will meet in common with NHS Improvement's Delivery, Quality and Performance Committee.

Strategic Human Resources (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. It also approves the appointment, remuneration and terms of service for the Chief Executive and members of the Executive group, in line with the DHSC and ALB 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, as these matters fall within the responsibilities of the Secretary of State for Health and Social Care under the National Health Service Act 2006 (as amended).

Committee members

The Committee met twice during the year. In addition, it carried out its function by correspondence in July, October, November and March. 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 CBE	1/2
Wendy Becker	2/2

Committee attendees

Additional attendees are invited to attend meetings to assist with committee business.

For 2018/19, these have included:

- Chief Executive.
- National Director: Transformation and Corporate Operations.
- Acting People and Organisation Development Director.

Principal activities during the year

Over the year the Committee has received reports assuring it about the implementation of the revised DHSC and ALB 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. It has focussed on workforce diversity and inclusion, overall staff experience and engagement and progress with talent management across NHS England. The committee has also considered the proposals for the closer working arrangements with NHS Improvement, in particular considering the appointments of members of the new NHS Executive Group.

Planned activities during the coming year

During the coming year, the Committee will be renamed the Strategic HR, Nominations and Remuneration committee and hold its meetings in common with the NHS Improvement Nominations and Remuneration Committee. It will continue to focus primarily on reviewing organisational development plans, particularly in light of the closer working with NHS Improvement. The Committee will review the approach to appraisal and talent management. The Committee will continue to review progress with workforce diversity and inclusion and overall staff experience and engagement throughout the year ahead.

Board disclosures

Disclosure of personal data-related incidents

As at 31 March 2019, a total of 13 Notifiable incidents had occurred relating to the loss of personal sensitive data in NHS England and CSUs. All incidents are logged, and a full investigation undertaken.

NHS Digital updated the Data Security and Protection (DSP) incident reporting process guidance following the introduction of the GDPR in May 2018.

The 'Guide to the Notification of Data Security and Protection Incidents' was released in September 2018. This sets out the reporting requirements for NHS organisations where a potential or actual incident may lead to a personal data breach defined under the Data Protection Act 2018 and GDPR. The new scoring criteria references the circumstances where notification to the Information Commissioner's Office (ICO) may not be necessary, and has resulted in a reduction in the number of incidents classified as notifiable.

Unless otherwise stated in the tables on the following pages, remedial actions were implemented for all incidents and the ICO kept informed as appropriate.

Summary of incident	Organisation	Date of incident	Nature of incident	Number of individuals affected	How patients were informed	Lessons Learned
Subject Access Request (SAR) response lost - sent recorded delivery via Royal Mail but was not received by the applicant. (ref: IGI/19491)	NHSE	03/05/2018	Lost in transit	1	In writing	Correct procedure was followed, incident caused by Royal Mail - outside of NHS England's control.
In responding to an individual's request for access to their medical records, limited clinical documents relating to 2 other patients were incorrectly disclosed in (ref: IGI/19478)	NHSE	08/05/2018	Disclosed in error	2	Duty of candour process is ongoing, based on the finding of the review of the service, communication will be sent to those impacted.	Training needs were identified and a review of the team process was actioned. The team were to be more vigilant when redacting cases and the redactor was to make an additional check to the documents.
Email containing details of 281 patients sent to and accessed by former GP practice employee. (ref: IGI/19500)	NHSE	10/05/2018	Disclosed in error	281	N/A – incident occurred under previous data protection legislation prior to the introduction of GDPR.	Reviewing internal procedures for bulk emails and starter and leaver processes.
In responding to an individual's request for access to their medical records, limited clinical documents relating to 4 other patients were incorrectly disclosed in (ref: DSP/1686)	NHSE	04/07/2018	Disclosed in error	4	Duty of candour process is ongoing, based on the finding of the review of the service, communication will be sent to those impacted.	Following a previous similar incident, the previous actions taken were deemed insufficient to prevent a repeat incident. As such, NHS England reviewed its redaction process upon review of health record requests and made alterations that now include a three-step process that aims to eliminate the incidences of misfiles occurring.
West Midlands Performer Team forwarded investigation e-mail to a GP who was an alleged perpetrator of the allegation. (ref: DSP/3494)	NHSE	04/09/2018	Disclosed in error	2	In writing	The team developed a Standard Operating Procedure (SOP) to mitigate against the risk of future repeated incidents.
North complaints team sent SAR response to incorrect recipient. (ref: DSP/4702)	NHSE	06/09/2018	Disclosed in error	1	In writing	Reviewed SAR process and procedure to ensure consistent approach across regions.
13 medical records delivered to incorrect GP practice and opened by practice staff. (ref: IGI/19302)	PCSE	12/04/2018	Mis-delivered medical records	13	N/A - incident occurred under previous data protection legislation prior to the introduction of GDPR.	This was caused by individual courier error. The courier has received full re-training in the delivery process including the use of the tracking device and an emphasis on tag checking as a final measure.
21 medical records delivered to incorrect GP practice and opened by practice staff. (ref: IGI/19419)	PCSE	01/05/2018	Mis-delivered medical records	21	N/A - incident occurred under previous data protection legislation prior to the introduction of GDPR.	Warehouse error. Sacks are now sorted, separated and correctly labelled before being delivered.
27 medical records delivered to incorrect GP practice and opened by practice staff. (ref: IGI/19442)	PCSE	02/05/2018	Mis-delivered medical records	27	N/A - incident occurred under previous data protection legislation prior to the introduction of GDPR.	This was the first incident of its type for the Reading service centre. Warehouse staff have had a retraining session with the centre manager detailing and highlighting the Capita process and the courier has been reminded of the need for diligence when delivering records.

Summary of incident	Organisation	Date of incident	Nature of incident	Number of individuals affected	How patients were informed	Lessons Learned
76 medical records delivered to incorrect GP practice and opened by practice staff. (ref: IGI/19565)	PCSE	10/05/2018	Mis-delivered medical records	76	N/A - incident occurred under previous data protection legislation prior to the introduction of GDPR.	Warehouse staff to ensure labels are securely attached to tags. Individual courier in this specific case has received refresher training and been reminded to contact the control centre if there is any uncertainty about a delivery.
19 medical records delivered to incorrect GP practice and opened by practice staff. (ref: IGI/19563)	PCSE	17/05/2018	Mis-delivered medical records	19	N/A - incident occurred under previous data protection legislation prior to the introduction of GDPR.	Courier error. Due to limited space the courier picked up the wrong sack and compounded the delivery error due to similarity with the stop ID. Practice names are now being printed on tags.
Cervical screening letters sent to an old NHS office for over three years. The letters were shredded by the new tenants and therefore never reached the patients. (ref: IGI/19335)	PCSE	19/04/2018	Disclosed in error	Circa 2000	N/A - data subjects unknown	PCSE are reviewing policies and procedures to ensure clear guidance is provided to staff regarding the decommissioning of sites and redirection of mail and reviewing methods of communication to ensure all stakeholders are informed of the decommissioning of sites in a timely manner.
Patient identifiable information shared with CCG Clinical Lead without redaction.	CSU	05/04/2018	Disclosed in error	1	In writing by CSU Caldicott Guardian.	Staff to ensure appropriate processes are followed to mitigate against the risk of future repeated incidents.

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 2019 was published on our website[52] in May 2019.

Statement of disclosure to auditors

Each member of the Board at the time the Directors' Report is approved on 31 March 2019 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 confirms that the Annual Report and Accounts for 2018/19, taken as a whole, is fair, balanced and understandable and provides the information necessary for stakeholders.

52 www.england.nhs.uk/safeguarding/slavery-human-trafficking-statement

Statement of Accounting Officer's responsibilities

Under the National Health Service Act 2006 (as amended), the Secretary of State for Health and Social Care (with the consent of HM Treasury) has directed NHS England to prepare, for each financial year, a statement of accounts in the form and on the basis set out in the Accounts Direction. The accounts are prepared on an accruals basis and must give a true and fair view of the state of affairs of NHS England and of its income and expenditure, Statement of Financial Position and cash flows for the financial year. In preparing the accounts, the Accounting Officer is required to comply with the requirements of the Government Financial Reporting Manual (HM Treasury, December 2018)[53] and in particular to:

- observe the Accounts Direction issued by the DHSC, including the relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis;
- make judgements and estimates on a reasonable basis;
- state whether applicable accounting standards, as set out in the Government Financial Reporting Manual, have been followed and disclose and explain any material departures in the financial statements;
- prepare the financial statements on a going concern basis; and
- confirm that the Annual Report and Accounts as a whole is fair, balanced and understandable and take personal responsibility for the Annual Report and Accounts and the judgements required for determining that it is fair, balanced and understandable.

The National Health Service Act 2006 (as amended) schedule A1 paragraph 15(4) states that the Chief Executive shall be the Accounting Officer of the National Health Service Commissioning Board (known as NHS England). The responsibilities of the Accounting Officer, including responsibilities for the propriety and regularity of the public finances for which the Accounting Officer is answerable, for keeping proper records and for safeguarding NHS England's assets, are set out in Managing Public Money (HM Treasury, July 2013, as amended March 2018)[54].

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

53 https://www.gov.uk/government/publications/government-financial-reporting-manual-2018-to-2019
54 https://www.gov.uk/government/publications/managing-public-money

Governance Statement

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

As Accounting Officer, I have responsibility 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 94 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 providers of NHS-funded care, nor for the DHSC'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 and Social Care for delivery of the annual mandate. The mandate sets the strategic direction for NHS England and helps ensure the NHS is accountable to Parliament and the public. 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 report on how we have delivered against the mandate objectives during 2018/19 can be found on page 192.

In addition, there is a framework agreement between NHS England and DHSC which sets out the mechanisms through which the relationship is jointly managed and the ways in which we work in partnership.

Governance arrangements and effectiveness

Governance framework

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

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

As part of implementing best practice, an assessment is undertaken each year against the Corporate Governance in central Government departments: Code of good practice 2017 (HM Treasury). NHS England is compliant against the provisions of the code, with the following exceptions[55]:

Ref	Code provision	Exception
3.6	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 ARAC.
4.3 **4.4** **4.5**	Terms of reference for the Nominations Committee.	There is no Nominations Committee (see above). The specific code provisions are handled by the Strategic HR and Remuneration Committee.
4.7	Through the Board Secretariat, the Department provides the necessary resources for developing the knowledge and capabilities of Board members, including access to its operations and staff.	This responsibility is shared between the Chair, Chief Executive's Office and Board Secretary.
4.11	The Board Secretary's responsibilities include: Arranging induction and professional development of Board Members.	This responsibility is shared between the Chair, Chief Executive's office and Board Secretary.
5.5	The Head of Internal Audit is periodically invited to attend Board meetings, where key issues are discussed relating to governance, risk management, or control issues across the department and its ALBs.	The Head of Internal Audit routinely attends meetings of the ARAC.

Board arrangements

Information on our Board and its Committees is set out from page 61.

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

Closer working with NHS Improvement

We will continue to embed our new operating model, with NHS Improvement, within the two organisations. We created a single NHS Executive Group chaired by NHS England's CEO, including membership of all national directors across both organisations.

In 2019/20 NHS England and NHS Improvement are moving to a single leadership model under the CEO of NHS England and single COO who will also be the CEO and Accounting Officer of NHS Improvement. The single COO post covering both NHS England and NHS Improvement and reporting directly to the CEO of NHS England.

The CEO of NHS England will hold responsibility for overall leadership of the NHS in England. The COO will be responsible for the operational delivery of the NHS Long Term Plan. The seven Regional Directors, the National Director for Emergency and Elective Care and the National Director of Improvement will report directly to the COO.

As set out on page 10, new national director roles, reporting to the CEO of NHS England, have been created and we will continue to appoint to these positions over the coming year.

Seven regional teams now carry out the functions of both NHS England and NHS Improvement in each of their local areas, supporting local systems to provide more joined up and sustainable care for patients. With responsibility for the quality, financial and operational performance of all NHS organisations in their region, they draw on the expertise and support of the national teams to improve services for patients, as well as supporting local transformation by developing the identity of STPs and ICSs.

Working in a more integrated way, at all levels of our health and care services, will deliver better outcomes for patients, better value for taxpayers and better job satisfaction for our staff.

Harris Review

Having regard to the wider implications of the Harris Review[56], 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 (as amended). This provides clarity about the legislative requirements 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 director and the register is regularly reviewed by the Director of Governance and Legal. Throughout 2018/19, NHS England has been using and updating this register to inform and capture the new operating model, to ensure that statutory duties and powers remain a priority for the new directorates.

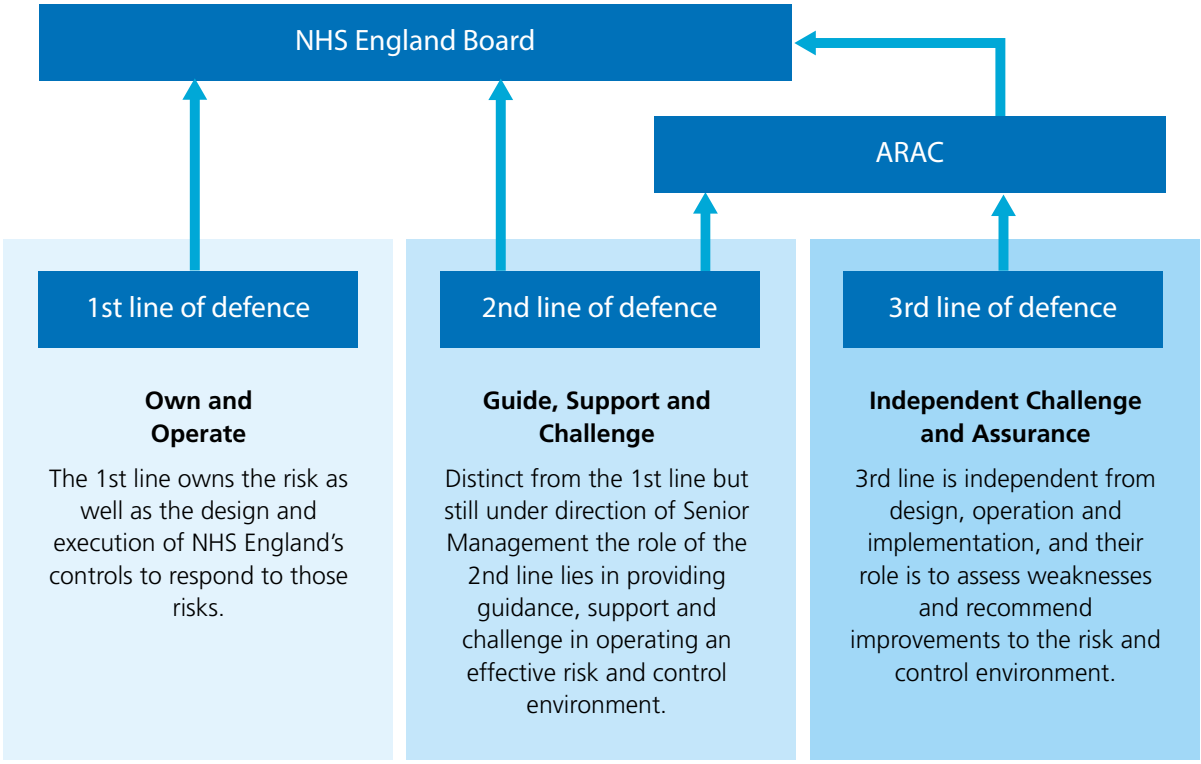
56 www.gov.uk/government/publications/independent-review-into-delegation-of-approval-functions-under-the-mental-health-act-1983

Corporate assurance

The NHS England Corporate Assurance Framework, set out below, provides for continuous and reliable assurance on organisational stewardship and the management of the major risks to organisational success and delivery of improved, cost effective, public services.

For the framework NHS England has adopted the Three Lines of Defence model, illustrated overleaf. This provides the mechanism for NHS England's employees to manage risk and control as well as provide assurance over the delivery of services.

Assurance activity	What is it?	What Value does it give?
Organisational Change framework	Guidelines for assessing and implementing major changes across NHS England.	Provides a consistent approach to thinking about the impact of organisational change, including people, infrastructure, financial and legal issues.
Risk Management framework	The approach to managing risk, including tools and methodologies for identifying, assessing, documenting and reporting risk.	Provides a consistent approach across the organisation, allowing identification of cross-directorate risks and challenges. Provides a way for managers to identify risks with a route of escalation to those accountable.
SFI's, Standing Orders & Scheme of Delegation	Fulfil the dual role of protecting NHS England's interests and protecting officers from possible accusation that they have acted less than properly.	Designed to ensure that NHS England's financial transactions are carried out in accordance with the law and Government policy in order to achieve probity, accuracy, economy, efficiency and effectiveness.
Programme Management framework	The policies, tools, methodology and resources that provide an approach to managing, controlling and assuring the delivery of projects and programmes in the NHS England portfolio.	Provides staff with a framework to manage, control and deliver projects and programmes. Provides the organisation with consistency of reporting and monitoring, confidence of delivery of outcomes, to enable decision-making and better resource control.
3rd Party Assurance framework	Guidelines for the assurance required for managing 3rd party contracts.	Ensures directorates responsible for major contracts assign a Contract Manager and put arrangements in place to monitor supplier performance. Obtains assurance over the services provided.
Corporate Policy framework	The methodology and approach for creating, maintaining and amending policies.	Provides an approach to help ensure policy documents are not developed in isolation, so they are balanced against the priorities of the organisation.



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

During 2018/19, the corporate governance team has worked with teams across the organisation to embed controls and underpin processes including:

- Obtaining regular management assurance from all senior managers, budget holders, Senior Responsible Owners and directors to confirm their compliance with the organisation's policies and processes.
- As set out in NHS England's Standards of Business Conduct, an annual attestation was implemented requiring all decision making staff to confirm they have complied with the requirements of the Standards of Business Conduct policy.
- Delivering substantial improvement in the timely completion of management actions arising from internal audit reviews.
- The introduction of electronic platforms for staff declarations and assurance certifications.
- Further training on the electronic platforms for administering risk and internal audit actions.

Management Assurance

Management assurance processes form a critical part of our control processes. All staff above Band 9 (including off-payroll workers (OPW) covering a substantive position), ESMs and all other budget holders are required to provide assurance of compliance with controls and accountability requirements. The assurance certification process is undertaken at mid-year and year-end. During 2018/19 we have seen a further increase in response rates, with a mid-year overall response rate of 91% and year-end rate of 84% compared to 86% and 85% in 2017/18).

We have seen an increased number of responses confirming non-compliance to a broader range of questions during this cycle. However, having reviewed the management information available, we consider that we have more considered and higher quality responses, rather than a decrease in compliance.

During 2018/19 we undertook a pilot of a new Management Assurance Framework, which is designed to reduce reliance on our third line of defence and strengthen our second through enabling management to perform an evidence-based evaluation of the effectiveness of NHS England's key controls for an agreed set of priority areas.

Oversight of NHS England's priorities and related programmes

Throughout 2018/19, the NHS England Board has been provided with regular updates on the implementation of the priorities and programmes that were committed to in Next Steps on the NHS Five Year Forward View. Matters relating to individual programmes were also considered within the formal committees of the Board, including the Specialised Commissioning Committee and the Commissioning Committee.

In addition, ARAC considers the outcomes of internal audit reviews of programmes and the Executive Risk Management Group (ERMG) reviews NHS England's corporate risks which can include causes, consequences, controls and actions relating to individual programmes.

Underpinning the above corporate governance arrangements, individual programme boards and oversight groups meet frequently, with the attendance of representatives from national and regional teams, each with responsibility for delivery of their particular programme, for example Urgent & Emergency Care, Primary Care etc.

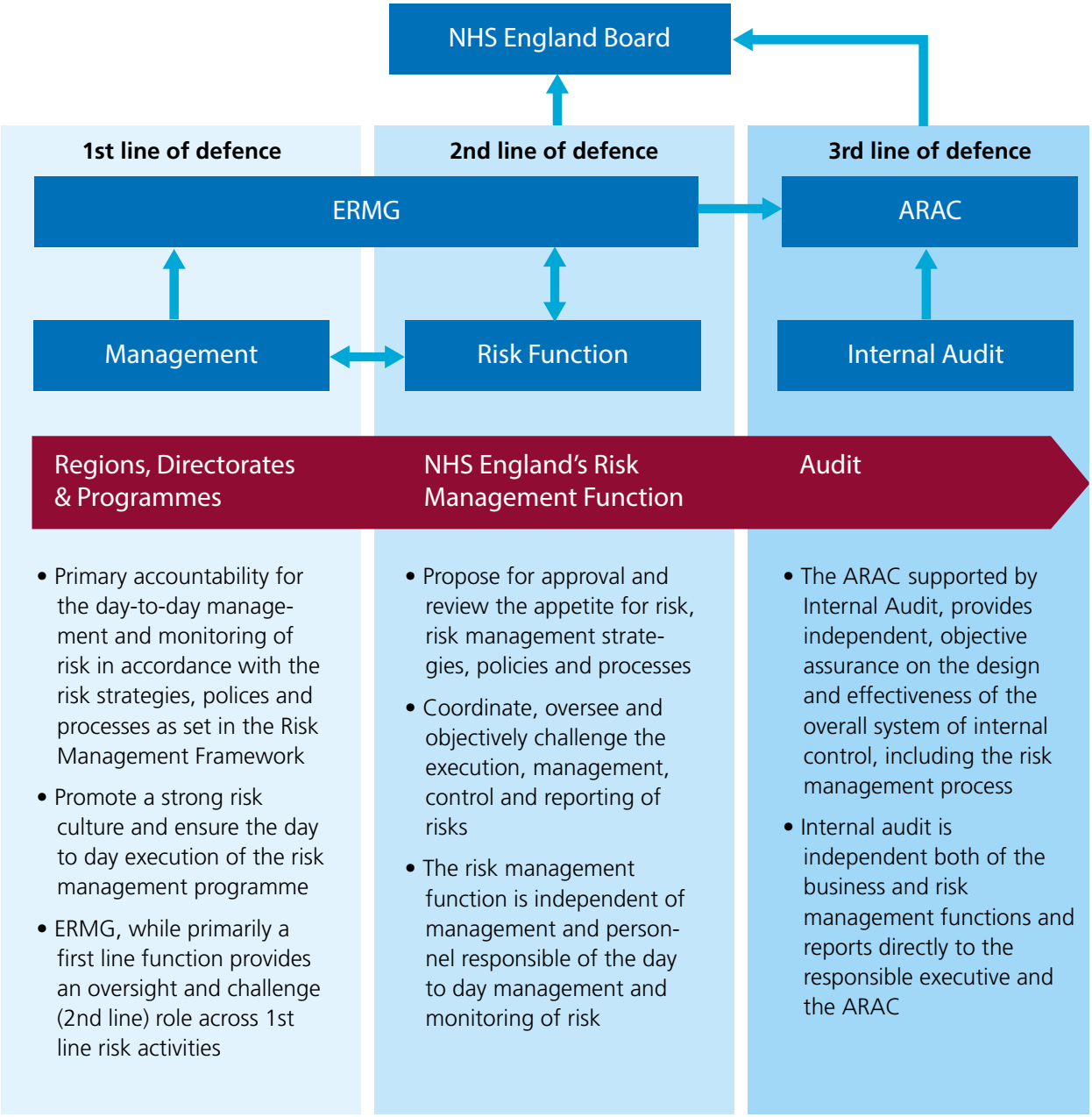
The Deputy Chief Executive Officer (DCEO) held quarterly assurance meetings with each of the regional teams, in addition to conducting regular detailed appraisals of the various national priority programmes. In future the COO will do the same.

Assuring the quality of data and reporting

At each meeting, the Board received reports covering finance and operational performance for NHS England and the wider commissioning system. This performance information is subject to scrutiny by both management and the Commissioning Committee (continued by the Delivery, Quality and Performance Committee in Common, from 1 April 2019). The Board is confident that the data presented in these performance reports has been through appropriate review and scrutiny, and that it continues to develop with changing organisational needs.

Managing risk

NHS England employees follow a single process for identifying and managing risks that may threaten delivery of services and achievement of objectives. The framework mirrors the three lines of defence of our overarching assurance framework. ARAC is responsible for reviewing the establishment and maintenance of an effective system of governance, risk management and internal control, covering all of NHS England's activities.



Our ERMG is responsible for providing assurance to the ARAC that the executive team are managing risks across the organisation. ERMG oversees implementation of NHS England's risk management framework, reviews all risks escalated to it, and considers which risks should be managed through the Corporate Risk Register (CRR) and associated processes.

NHS England has strengthened CRR management processes through the development of robust risk analysis, improving the reporting format, and by ensuring consistent quality of reporting led by the accountable risk owners. This is overseen by ARAC and regularly reported to the Board.

NHS England is now in the process of preparing a joint risk register with NHS Improvement to allow the two organisations to manage those risks which they consider are best managed together, and during 2019/20 will introduce a common risk management framework.

During 2018/19, the CRR included:

Risk description	Potential impact	Key mitigation(s) in place included
EU Exit: Services commissioned or needing to be commissioned by NHS England are continued to be delivered with minimal impact on NHS services and patients.	In a no deal Brexit scenario, the NHS is dependent on the UK Government having secured appropriate supply continuity and transport logistics.	- Regular meetings with DHSC (responsible for leading EU Exit planning) policy workstreams, DHSC EU Exit team and with other ALBs (chaired by DHSC). - Establishment of a single EU exit function across NHS England and NHS Improvement with Directors leading work-streams. - Workstream leads are brought together in the 'EU Exit Oversight Group'.
Transforming Primary Care: We continue to work to secure additional general practice services and invest in new ways of improving primary care for patients.	Service availability for patients and demand impacts on other services could be affected.	- GPFV, monitored through the Primary Care Oversight Group. - Work with NHS Digital on replacement IT systems for general practice. - Delivery of a multi-year pipeline of investment in estates and technology infrastructure.
Joint Working: Joint working with NHS Improvement delivers the planned benefits to patients, services and staff.	Possible disruption to critical 'business as usual' activities.	- Shared set of system priorities covering key functions and capabilities. - Joint Working Programme. - Joint Staff Engagement Programme (Project 70).
Primary care **"back office" support services.**	Underperforming primary care support services have a potential impact on the efficiency and effectiveness of our frontline services.	- Standard operating procedures. Contract monitoring. Incident and complaint management arrangements. - Independent expert supporting and monitoring of the service line. - Governance arrangements amended to ensure greater stakeholder involvement.

Risk description	Potential impact	Key mitigation(s) in place included
Inequalities: NHS England continues to demonstrate through its systems, processes and programmes actions to deliver its statutory duties.	Missed opportunities for patients and population health improvement.	- Review process to support Equality and Health Inequalities completion with directorates. - Working directly with the National Director for Operations and Information to ensure Equality and Health Inequalities considerations are being applied to regions and local Directors in a systematic way and potential risks identified locally and managed and supported nationally. - Reporting to the Board and also as part of the Annual Reporting process on actions to reduce health inequalities.
Learning Disabilities: Scale and Delivery of Building the Right Support ambitions - NHS England commitments of 35%-50% reduction in inpatients for people with often complex needs.	Reliance on inpatients support with often complex needs.	- Programme undertakes regular assurance meetings with regions to understand progress and identify where recovery actions are required against performance below expected. - Programme regularly monitors progress via the performance and delivery board. - 'Virtual team working' across system to manage dependencies on social care, housing and workforce.

Risk Appetite

The risk appetite of NHS England is grounded in the NHS Constitution. The NHS Constitution sets out rights, to which patients, public and staff are entitled, and pledges which the NHS is committed to achieve, together with responsibilities, which the public, patients and staff owe to one another to ensure the NHS operates fairly and effectively.

NHS England will minimise avoidable risks to patient safety in the delivery of quality care.

NHS England has a low "risk appetite" with regards to meeting its obligations under the National Health Service Act 2006 (as amended) and in relation to operational performance and financial duties.

Innovation - in the form of technology, integration of services, new models of care and new ways of working - NHS England is prepared to accept moderate to high risk in these areas, where this does not entail risks in any of the above areas, and where rapid cycle monitoring is in place to enable swift corrective action.

In striving to improve the health and wellbeing of the public, NHS England will tolerate low to moderate reputational risk where necessary.

Categories of risk, along with NHS England's previously stated tolerances, are summarised in the table below:

Category of Risk	Tolerance
Patient Safety	No tolerance
Regulatory	Low
Operational Performance	Low
Finance	Low
Reputational	Low to Moderate
Innovation	Moderate to High

Whistleblowing

Arrangements are in place to support whistleblowing for NHS England staff and for those employed by external organisations. Our internal whistleblowing policy 'Voicing your Concerns for Staff' is accessible via our staff intranet and on our website[57]. Emily Lawson, National Director of Transformation and Corporate Operations, is the 'Freedom to Speak Up' (FTSU) guardian for staff in NHS England, and Lord David Prior, Chair of NHS England, is the Board lead. The FTSU network currently consists of 40 FTSU Guardians, of whom seven (18%) have reported a BAME background.

NHS England received three internal whistleblowing concerns during 2018/19, all of which were investigated in accordance with our policy. CSUs reported an additional concern which is being investigated under the CSU's Raising a Concern Policy.

Whistleblowing in primary care

NHS England has been a 'Prescribed Person' for primary care services under the Public Interest Disclosure Order 1999 since April 2016. This allows whistleblowers working in primary medical services, dental services, ophthalmic services and pharmaceutical services to disclose information to NHS England in addition to, 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[58]. This activity is overseen by designated regional whistleblowing leads reporting into the Corporate Governance team.

Under the statutory protection afforded to workers who raise such concerns, whistleblowing is the term used when a worker provides information to their employer or a prescribed person concerning wrongdoing.

57 https://www.england.nhs.uk/wp-content/uploads/2016/09/voicing-concerns-staff-policy.pdf
58 https://www.england.nhs.uk/publication/external-whistleblowing-policy/

To gain the statutory protection under the legislation, the worker making the disclosure must reasonably believe:

- that the disclosure is in the public interest; and
- it falls into one of the following categories:
  - Criminal offence.
  - Breach of any legal obligation.
  - Miscarriage of justice.
  - Endangering someone's health and safety.
  - Damage to the environment.
  - Covering up wrongdoing in the above categories.

NHS England's role as a Prescribed Person

Where concerns are raised to us by primary care workers about these issues, we are required to produce annual reports of the disclosures of information made to us, but without identifying the workers concerned or their employers.

NHS England is committed to assigning any concerns raised for further investigation, and supporting individuals that have suffered fiscal or professional detriment as a result of whistleblowing. This includes signposting whistleblowers to the correct organisation responsible for dealing with their concerns.

Qualifying disclosures received by NHS England during 2018/19 and action taken

Between 1 April 2018 and 31 March 2019, 70 whistleblowing disclosures were made to us relating to primary care organisations.

The table below summarises how we dealt with the disclosures:

Signposted to an alternative body	Investigated – no remedial action required	Investigated and action taken during 2018/19	Under investigation	No investigation required
3	5	3	53	6

As the result of these investigations we have agreed changes with primary care providers designed to improve services delivered to patients. These include:

- Improved record keeping and management processes.
- Implementation of multi-agency contract management meeting to address quality issues.

Clinical assurance

Assuring the quality of services

The quality of commissioned services is assessed periodically by the CQC. It is also assured at the local and regional levels as appropriate through the lead CCG, NHS England's Director of Commissioning Operations (DCO) teams, regional teams and through the national Quality Assurance Group (QAG).

Membership of the QAG, which reports to the Executive Group, and in future to the Quality Committee, includes the Regional Medical Directors and Regional Chief Nurses, some of whom hold joint posts with NHS Improvement.

The QAG discusses quality risks and issues of national importance within NHS England's remit and agrees national action to mitigate and manage these. In 2018/19 the group has:

- Shared learning and intelligence between regional and national teams relating to quality risks/issues. For example, sharing learning and insight into: specific system and operational issues; from the review of the system's response into events at North Middlesex University Hospitals; from CAMHS Tier 4 Suicide quality summit and suicide investigation reports; and from the Learning Disability Mortality Review Programme.
- Continued to develop learning and improvement in three specific areas covering: prevention of future death reports; independent investigations into mental health homicides; and wider patient safety issues, under coroner's regulation 28[59]. On the latter we undertook detailed retrospective analysis of a wider range of regulation 28 reports to identify trends and are developing actions to address these. On all areas we have established closer working with NHS Improvement to ensure system oversight of learning and actions.
- Strengthened joint working between NHS England and NHS Improvement. For example, through the members holding joint posts who also sit on NHS Improvement's National Quality Committee and the continued work of the joint Patient Safety Group (a sub-group of the QAG).
- Contributed to the development of national policy and ensured operational alignment with this. For example: contributed to the National Quality Board review into aligning NHS England and NHS Improvement quality assurance and governance functions; worked through NHS England's role and fit with regards to the health and social care regulators' Emerging Concerns Protocol[60] and on the national policy for sharing person identifiable information.
- Provided feedback on national consultations regarding key pieces of work. For example, in March 2018 responded to the national consultation on 'Facing the Facts, Shaping the Future: A draft health and care workforce strategy for England to 2027'.
- Used clinical leadership to draw attention across the system to specific quality issues such as: Improving prescribing behaviours for Sodium Valporate in at-risk groups, ensuring system readiness to an alternative supply of Intravenous Immuno-Globulin and circulated the Medicines and Healthcare products Regulatory Agency (MHRA) safety alert on biopsy equipment.

59 The Coroners (Investigations) Regulations 2013 http://www.legislation.gov.uk/uksi/2013/1629/pdfs/uksi_20131629_en.pdf

60 Those who have signed the protocol include: Local Government and Social Care Ombudsman, Care Quality Commission, General Medical Council, General Pharmaceutical Council, Health and Care Professions Council, Health Education England, Nursing and Midwifery Council and Parliamentary and the Health Service Ombudsman. For the full list of those signed up to the Emerging Concerns Protocol please visit: https://www.cqc.org.uk/sites/default/files/20181112_emerging-concerns-protocol.pdf

Assurance of the commissioning system

Specialised commissioning

Specialised services support people with a range of rare and complex conditions. They often involve treatments provided to patients with rare cancers, genetic disorders or complex medical conditions or surgical needs. They deliver cutting-edge care and are a catalyst for innovation, supporting pioneering clinical practice in the NHS.

During 2018/19, the NHS England Board, through the Specialised Services Commissioning Committee (SSCC), set the strategic direction for specialised commissioning and provided assurance over quality, performance and value for money. The SSCC also assured decisions made by the SCOG, which had operational oversight of the £17.7 billion specialised commissioning budget. The Clinical Priorities Advisory Group (CPAG) made formal recommendations on the commissioning position of treatments and interventions for adoption, or otherwise. SCOG endorsed CPAG recommendations for prioritisation and the SSCC made the final decision. For in-year agreed service developments, SCOG made decisions and SSCC was informed.

Other direct commissioning

NHS England has a statutory duty to directly commission non-specialised healthcare services (primary care, public health commissioning, armed forces and health and justice commissioning). We discharge this duty through our central and regional teams, and in the case of primary medical care services through CCGs, ensuring that:

- healthcare services are planned locally and effectively, based on the needs of the population;
- services are secured to meet the population's needs; and
- the quality of healthcare is monitored.

Within the context of planning and securing services, specific annual objectives are agreed to meet the needs of the population.

Quality monitoring and delivery assurance is overseen by specific oversight groups, which individually reported to the Commissioning Committee and in future will report to the Delivery, Quality and Performance Committee. We target our resources to focus national oversight on the areas of greatest priority and risk. The three oversight groups for public health, armed forces and health and justice focus on key strategies, with regular reports on quality, performance and finance. The Primary Care Oversight Group focuses on key operational matters, with detailed operational discussions being held by the Primary Care Delivery Oversight Group. The Commissioning Committee receives regular reports, along with in depth reviews of specific areas on a rotating basis.

During 2018/19, direct commissioning for non-specialised services accounted for £7.34 billion of total commissioning expenditure (this excludes delegated expenditure by CCGs on primary medical care which totalled £5.64 billion).

Co-commissioning of primary medical services

As of 1 April 2019, 184 CCGs have delegated arrangements for primary medical services (96%). Of the remaining seven CCGs, two (1%) have a joint commissioning arrangement with NHS England and five CCGs (3%) are operating under the 'greater involvement' model.

NHS England's Board has committed to support CCGs to take on the delegated model in future, and additional delegation arrangements have now been agreed with seven CCGs to be taken forward during 2019/20. Additionally, delegation agreements have been made with several newly-merged CCGs, replacing their previous agreements.

STPs

STPs were established in 2016 and are a mechanism for driving partnership working across localities to deliver health and social care integration.

Over the last year, STPs have strengthened their leadership and governance arrangements, enabling collective decision making to best meet the population need for their geographies. In many instances, commissioning functions have been streamlined to drive efficiencies and reduce variations across geographical footprints.

Over the last year, two systems have received a 'deep dive diagnostic' to support the alignment of all system partners on the actions required to deliver services to meet local populations' health needs. In addition, all STPs and ICSs have received a high-level diagnostic to arm them with system-wide insight into the quality, operational performance and financial opportunities for their populations.

Commissioning capability programme

NHS England established a programme to use a place-based approach to support commissioning leadership teams across health systems to deliver on the Next Steps on the NHS Five Year Forward View. This year saw the launch of the NHS Long Term Plan and the programme supports an overarching expectation to break down traditional barriers between organisations to ensure a more coordinated, sustainable and integrated approach.

Through a tailored approach, the programme has specifically supported strong leadership development and sustainable system planning across CCG, STP and ICS leadership teams as key drivers to effective system transformation with a core focus across three modules:

- Delivering Today's Challenges (focussed on developing CCG leadership and sustainability performance). To date, 46 local health and care systems have progressed through the programme including 84 individual CCGs.
- Preparing for the future: supporting aspiring ICSs (targeted at STP leadership teams). 10 STPs have participated in the programme resulting in the development of clear roadmaps to support their future journey to ICS status.
- Population Health Management (equipping ICSs with the capabilities to implement proactive anticipatory care models). Four ICS sites are completing this module of work which will allow them to have much greater insight into their patient level data allowing for effective care design decisions to be made.

In addition, NHS Clinical Commissioners have developed a buddying and action learning offer to complement the programme and support the sharing of best practice and built a peer to peer network for leadership development.

Commissioning Support Units (CSUs)

There are five CSUs, with a combined workforce of 6,700 people providing essential support to a range of organisations, primarily to CCGs, but increasingly also to local authorities, NHS Trusts as well as ICSs and STPs. Being reliant on income for services delivered, CSUs have to be responsive to the needs of their local health system as well as delivering against national priorities. They continued to secure new work in competition with the commercial sector, demonstrating both resilience and quality of delivery. Their ability to perform to a high standard was confirmed again in year as they successfully secured places on national procurement frameworks following independent scrutiny of both the quality and efficiency of services they deliver.

During the year CSUs have delivered on local health system priorities, supported the emerging STPs and the ICSs. As an integral part of the NHS, CSUs have delivered national priorities such as a population health management dashboard, CHC cost reduction, waiting list initiatives and leading on transformation of local health systems. They have also been at the forefront of the NHS response to the challenges of cyber security threats, providing protection to primary care services and helping to avert potential disruption. CSUs have achieved independent cyber security accreditation and they are continuing to develop systems to combat new threats.

The Managing Director within each CSU is accountable for ensuring their CSU adheres to appropriate governance processes and NHS England receives a monthly signed statement of assurance from each CSU. In 2018/19, CSUs once again met all financial targets, meaning they will have achieved a balanced budget position every year since they were established in 2013.

During 2018/19 CSUs have worked closely with NHS England to evaluate their offering and develop a future strategy in the context of the evolving STP / ICS landscape. During 2019/20 CSUs will focus greater resources on supporting STPs and ICSs in the work they are doing across their systems. CSUs will work with National and Regional Directors to support local system development and productivity improvement for ICSs, STPs and Primary Care Networks.

Clinical Commissioning Groups (CCGs)

In 2018/19, there were 195 CCGs each of which is an independent statutory membership organisation with an appointed accountable officer. CCGs are clinically led and responsible for commissioning high quality healthcare services for their local communities. NHS England is accountable for assuring the commissioning system and has a statutory duty to assess the performance of each CCG every year to determine how well it has discharged its functions.

NHS England allocates a large proportion of the funding it receives from the DHSC to CCGs and supports them to commission services on behalf of their patients.

In turn, CCGs are required to demonstrate probity and good governance in managing their finances and performance. Together, CCGs are responsible for about 60% of the NHS budget.

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

CCG Improvement and Assessment Framework (IAF)

NHS England's CCG IAF was introduced in 2016/17 to align key national objectives and priorities and inform the way we manage our relationships with CCGs. It was recognised in 2016 that the NHS could only deliver on the NHS Five Year Forward View commitments through place-based partnerships spanning across CCGs, local government, providers, patients, communities, and the voluntary and independent sectors. Therefore, the IAF includes indicators that are beyond the scope of CCGs' direct control, reflecting the importance of tasks-in-common for the benefit of patients and communities.

The 2018/19 framework continued the principles of focusing on a manageable number of the highest priorities facing the NHS and reaching beyond CCGs. A small number of indicators were retired, and new indicators ensured alignment with NHS Improvement's Single Oversight Framework for NHS providers, supporting the development of integrated system working, and with the joint planning guidance published in February 2018.

NHS England and NHS Improvement have worked together to develop a new approach to oversight, starting with a transitional year in 2019/20, that will provide a consistent means of reviewing and supporting system-level performance. Legislation still requires an annual performance assessment to be carried out at individual CCG level.

NHS England has the option of using its statutory powers, conferred by section 14Z21 of the National Health Service Act 2006 (as amended), to support CCG improvement where a CCG is failing or is at risk of failing to discharge its functions. Details of CCG directions can be found on the NHS England website[61].

NHS England also supports improvement through its special measures regime, which is an internal management approach to CCGs facing the most significant challenge in the areas of financial and operational performance. There are two routes by which a CCG enters special measures: a rating of inadequate at the annual year-end assessment or an in-year assessment by the relevant regional director that there are significant issues with a CCG's leadership, quality and/or financial performance.

61 https://www.england.nhs.uk/commissioning/regulation/ccg-assess/directions/

18 CCGs assessed as inadequate at the 2017/18 yearend were placed in special measures and two CCGs entered the regime during 2018/19. Eight CCGs exited the regime during 2018/19, including those from the finalised 2017/18 year-end process.

When a CCG enters special measures, a tailored support package is put in place that is delivered through local networks, delivery partners or intensive support teams. The CCG must develop an improvement plan which is agreed with and overseen by NHS England.

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

CCG annual reports

CCGs published their individual annual reports via their websites in June 2019. A list of CCGs and links to their websites can be found on the NHS England website.

A review of the CCG governance statements found that the primary focus of comments from CCG internal auditors over the year was in the areas of 'quality and performance' and 'finance, governance and control', with the majority of control issues raised relating to delivery of performance targets in secondary care and achievement of financial balance. This matches issues highlighted by those CCGs in their earlier "exception" reports.

Other assurance

Cyber and data security

NHS England continues to work with Government agencies including NHS Digital, the National Cyber Security Centre, and external suppliers of data and systems to NHS England (including but not limited to Atos and BT), to ensure that we are aware of the latest threats and that our information is handled and stored safely and securely.

To mitigate the risks associated with cyber attacks, NHS England has instructed its IT suppliers to implement security patches in a timely and controlled manner, and we are working closely with our IT partners to address issues as they arise that could prevent the timely application of security patches and updates.

NHS England Corporate ICT provides support to the EPRR team, making communication flows and IT advice available in the event of a substantial attack. In addition to corporate activity, NHS England is working with other system partners to ensure that a robust approach is taken on cyber security across the service.

System-wide approach to cyber security

NHS England has worked to develop a target operating model for the cyber security programme that encompasses NHS Improvement, NHS Digital, and DHSC, whilst also taking account of planned changes to the operations of NHS England and NHS Improvement.

The cyber security programme operates through six workstreams, which are:

1. Establishing a Clear Contractual & Regulatory Framework.
   NHS England has continued to help to drive a clear contractual framework across the system, through the NHS Standard Contract for providers and the publication of an addendum to the GP IT Operating Model for primary care. The Standard Contract,

addendum, and new legislation, such as the GDPR and the Network Information Systems (NIS) regulations, have enabled the NHS to address issues such as the use of unsupported systems, and business continuity planning in NHS organisations. NHS England will continue to work with partners to promote awareness of and enforce the regulations. The 10 National Data Guardian (NDG) recommendations are integral to the new Data Security Protection Toolkit (DSPT) that NHS England has been promoting since the introduction of the DSPT In April 2018. NHS England has been active in escalating issues highlighted by the interim DSPT submissions made by providers in October 2018, and will continue to address issues raised in the full annual DSPT submissions made at the end of March 2019.

2. Addressing Infrastructure Weakness
   Work to evaluate the £61 million capital funding allocated in 2017/18 has been undertaken and a range of "local interventions" have been promoted across the system. Further cyber security funding of £150 million was announced by the Government for the next three years and NHS England has worked to develop a system to evaluate and identify key areas for priority investment. A cross-system group has been established to identify threats and risks and to ensure appropriate allocation and use of cyber security funding, to address the key threats and vulnerabilities across the system. The ongoing schedule of onsite assessments has been used to inform the decision-making process, with 50 additional assessments completed this year, and a programme of re-assessments planned to evaluate progress toward the certification standard of Cyber Essentials Plus. A pilot Cyber Essentials Plus accelerator scheme was undertaken to assess costs and requirement to achieve certification; the pilot will inform the Government's investment decisions for the coming year.

3. Communications & Engagement
   NHS England has continued to promote Board level engagement in cyber security through support of the NHS Digital board awareness training programme, and the continued use of the NHS England board framework. The framework has been promoted to trust and STP boards, at CCG events, to audit groups, and to incident response and business continuity partners.

   A Cyber Security Steering Group has been established. NHS Digital runs a 'Data Security Centre (DSC) Associates' scheme, and the programme has identified existing networks that can be coordinated to extend the 'cyber champions' network.

4. Building Local Performance and Boosting Capability
   The NHS continued to promote the development of the performance and capability of local organisations through a range of activities, including onsite assessments, Cyber Essentials Plus accelerator pilot, CSU deep dives and audit, and an internal audit of the 22 Chief Information Officer (CIO) recommendations. A range of metrics has been used to develop a "2 x 2" matrix of cyber security risk impact and the ability of organisations to address those risks. The 2 x 2 matrix has been used to focus intervention activities undertaken by NHS Digital DSC and the outcome of the interventions have then been used to develop a plan to target capital investment.

5. Improve Threat Surveillance and Incident Response
   Following feedback from the system-wide cyber incident exercise that was held in December 2017, the ALB Cyber Security Handbook has been merged with the DHSC incident handbook to provide a consolidated single approach which has been promoted at

regional events, exercises and workshops. A set of standard scenarios has been developed by NHS Digital and PHE that can be used by various organisations to run local cyber incident exercises. A communications protocol has been developed and agreed between ALBs, to ensure clear ownership and approval for messaging in pre-incident situations. A series of drills has been completed to rehearse and refine elements of the Cyber Incident Handbook; feedback from the drills has been collated to improve current processes and to update the handbook ahead of the next system-wide exercise.

NHS Digital has defined and implemented changes to the Care Computer Emergency Response Team's (CareCERT) "Collect" portal, to ensure it better meets the needs and requirements of the whole system, including primary care and GP IT suppliers, and continues to be a valuable source of communication and assurance during any future incidents.

NHS England has worked with the DHSC, NHS Digital and the CQC to use available threat intelligence to identify key areas of risk and to address those risks using the NIS Regulations.

6. Local Health and Care Records – Cyber security workstream
   As part of the move to ICSs, the Local Health and Care Records (LHCR) initiative looks to provide the longitudinal care record to support up joined up care but also the use of data for actionable insight. NHS England established a working group with DHSC, NCSC and NHS Digital on defining the cyber security standards needed for these local health and care records.

   We have developed a draft cyber framework for LHCR localities and will be undertaking "risk-tree" sessions with them to ensure that potential threat vectors have been considered.

Information Governance (IG)

Work continues to provide and assure an effective IG framework that ensures NHS England remains legally compliant in relation to data protection, records management and information security activities. Work is underway to develop an integrated IG operating model across NHS England and NHS Improvement, with a single Data Protection Officer now providing and assuring a corporate service across both organisations.

NHS England has achieved operational compliance with new data protection legislation, following the implementation of its GDPR readiness programme. We have delivered standardised processes and systems, a new corporate privacy notice and expanded IG policies, supported by an intensive communications campaign. Work continues to enhance compliance through ongoing engagement and a new IG assurance function. As the new laws became effective, the ICO carried out a voluntary audit to assess the compliance of NHS England's IG framework and governance arrangements. The outcome and any recommendations from the audit will form the basis for the NHS England IG action plan for 2019/20.

NHS England is working with NHS Digital to assign responsibilities pertaining to the governance of data for commissioning purposes. This aims to streamline national data access processes so that CCGs can make informed commissioning decisions based on high-quality and timely intelligence. This will support them to undertake population health management and, ultimately, improve outcomes for citizens in line with the NHS Long Term Plan.

Business critical models

NHS England recognises the importance of quality assurance across the full range of its analytical work and has an approach that is consistent with the recommendations in Sir Nicholas Macpherson's review of quality assurance of Government analytical models (2013).

NHS England analysts are expected to ensure consistent performance and quality assurance across their analytical work. For business critical models, where an error would have a significant patient care or other impact, NHS England operates a register of business critical models and audit of the quality assurance strategy associated with them, overseen by a committee of experienced analysts. To date all relevant NHS England models in the register have passed.

Business critical models operated by NHS England include:

Name of model	Type
Commissioner Finance Model (previously High level allocations model)	Allocation
CCG, primary medical care and specialised allocation model	Allocation
CVD treatment of high risk conditions	Forecasting
Referral-to-treatment ready reckoner, and associated Point of Delivery conversion file	Forecasting

During 2019/20 NHS England will work with NHS Improvement, to build on our joint experience and business critical models.

Service auditor reporting and third party assurances

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

During 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.

We have continued to work with Capita on improvements to the control environment. The interim Type II report issued to cover the first half of 2018/19 showed improvement compared to 2017/18. The year end Type II report confirmed this improvement although it still includes exceptions.

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; and
- 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 the 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 the ARAC.

The Head of Internal Audit opinion for 2018/19 is set out from page 105.

External Audit

During the year, the ARAC has worked constructively with the NAO Director responsible for Health, and his team. The work of external audit sits outside of NHS England's governance arrangements but independently informs NHS England's consideration and evaluation of controls, governance and risk. The work of external audit is monitored by the 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.

The Certificate and Report of the Comptroller and Auditor General is set out from page 139.

Control issues

During 2018/19 we have worked to build controls into management processes previously identified as requiring improvement:

Improving control processes for off-payroll workers

During 2018/19 we have further embedded our enhanced control processes for off-payroll workers, which were introduced in April 2017. These processes are based on using the Electronic Staff Record (ESR) as a single means of managing workforce information.

We have also commissioned further assurance work to ensure compliance with HM Revenue and Customs (HMRC) requirements and are expanding the work to include clinical off-payroll workers in advisory roles.

Strengthening establishment controls

Refinements were made to the electronic system used at NHS England giving each department access to their establishment. Reconciliation work has taken place between budget holders, management accountants and the Workforce Systems team to ensure data is accurate and cross-checked. As a result, there is now greater assurance around processes for maintaining the establishment, enhanced with the changes enabled via the ESR when personnel join or depart.

Managing third party contracts

Historic issues with some third-party contracts have led to strengthened contract management. These ensure maximum value and confirm that all delivery requirements are consistently being delivered with issues identified proactively and resolved as soon as they arise.

Extensive work, utilising Government Commercial Operating Standard methodologies has been undertaken over the last two years to identify contracts that require specific assurance, assign specific responsibility for contract ownership and management and develop supporting guidance and training. This work has been informed and supported by targeted internal audit reviews of third party assurance.

The Commercial team used a risk based approach to ensure that the highest value and highest impact contracts were reviewed first by a dedicated central team of experienced contract managers who engage with the relevant third party. The management of other, non-strategic, third party contracts is assigned to contract owners and managers across NHS England.

Over 100 contract managers and owners, covering 80% of non-strategic contracts, have been assigned to embed the redesigned processes and achieve Government Commercial Function contract management qualifications.

Primary Care Support England (PCSE) cervical screening incident

As part of the PCSE contract, Capita provides administrative support for the National Cervical Screening Programme by producing and sending around 9 million invitation, reminder and result letters to women each year.

On 17 October 2018, PCSE informed NHS England and PHE that a number of cervical screening invitation and reminder letters had not been sent to women inviting them to make a routine cervical screening appointment.

Following investigation of this incident, it was confirmed that 51,319 items of screening correspondence (screening invitation, letters and reminder letters) in total were not sent in 2017 and 2018. Investigations have concluded that this was due to the correct process for uploading, organising and checking letter files not being properly followed within PCSE.

NHS England declared this as a serious incident and set up a clinically-led multiagency incident panel to assess any risk or harm to the women affected.

Following the investigation, NHS England concluded that the potential harm from this incident has been minimised because a 'failsafe in the system operated as expected'. However, the impact on individuals will not be known for some time as women go through the whole screening process. The clinical recommendation from PHE is to undertake a full audit of screening outcomes for the women affected in nine months.

As part of a regular audit, Capita's Primary Care Support unit identified that emails had been sent to three of their email addresses that they thought were no longer being used. Some of these emails related to administrative aspects of screening. They also identified letters scanned into their IT systems which they may not have actioned due to incorrect technical configurations between their systems.

NHS England, Public Health England and Capita have since then been working together through a clinically-led incident panel to ensure every individual's case is reviewed, so that appropriate action can be taken. There is no current evidence that this incident has led to harm.

Other PCSE service issues

The PCSE contract with Capita came into effect on the 1 September 2015. As was confirmed by the NAO report[62] and again at the Public Accounts Committee, NHS England's management of the primary care support services contract with Capita has already saved the taxpayer £60 million. Capita has sought to consolidate services previously delivered from numerous local offices using different systems into a national standard service delivered to primary care contractors. PCSE has amalgamated delivery centres across the country so that there are now

62 https://www.nao.org.uk/report/nhs-englands-management-of-the-primary-care-support-services-contract-with-capita/

four major sites processing all activity across England. This is a complex task that continues to require careful management.

Recognised issues including updates to the performers list; administration of GP pensions; movement of records; and, timely payments have been a key focus for performance improvement under the contractual agreements in place with Capita, and there have been improvements in the last year. However, there is more to achieve in the coming year.

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

Allocations

NHS England is responsible for allocating funding for the NHS provided by the Government. We are required 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.

The Government has confirmed, alongside the NHS Long Term Plan, that annual funding for NHS England will grow by £33.9 billion in cash terms by 2023/24. In 2019/20 NHS England's funding will increase by 3.6% in real terms (adjusted for 2018/19 pay funding).

In January 2019 the NHS England Board approved allocations for the commissioning sector for the next five years, 2019/20 to 2023/24, with firm allocations for the first three years and indicative allocations for the final two.

Our approach to allocations is based upon:

- funding a realistic and sustainable level of activity for each commissioning stream;
- appropriately funding commissioning streams for price pressures, including the impact of 2018/19 pay awards and the impact of putting £1 billion of the Provider Sustainability Fund (PSF) into urgent and emergency care prices;
- protecting funding for the implementation of existing NHS Five Year Forward View commitments, particularly in respect of mental health, primary care and cancer services. We also allocate sufficient funds to meet the NHS Long Term Plan commitments to increase spending on mental health and primary medical and community health services.
- reducing running costs, whilst also prioritising funding for transformation and service development; and
- maintaining a prudent central provision given additional risks the Government is now requiring NHS England to manage.

Allocations to local areas are developed using statistical formulae, so that funding reflects local healthcare need and helps to reduce health inequalities. Based on advice from the independent Advisory Committee on Resource Allocations, we have made a number of improvements to the formulae including new or refreshed formulae for community services and mental health need, and changes to the health inequalities adjustment to make it more responsive to extreme health inequalities and unmet need.

We have continued to deliver on our previously established principle that no CCG should be more than 5% below the target "fair share" level of funding calculated using the updated formula. Over the five-year period we will continue to redistribute resources to bring those CCGs furthest from their target allocation closer to that level.

Financial Framework

The NHS Long Term Plan set out a number of reforms to the financial framework to deliver the five financial tests set by the Government as part of the long term financial settlement. These reforms will help to ensure that all organisations are able to deliver financial balance by the end of the five-year settlement and will drive the continued productivity and integration necessary to ensure sustainability in the medium and long term.

The key changes are:

- Reforms to the payment system, in particular the introduction of a blended payment model for urgent and emergency care activity in 2019/20, which will move funding away from activity-based payments over time ensure a majority of funding is population-based. This will make it easier to redesign care across providers, support the move to more preventive and anticipatory care models, and reduce transaction costs.
- Measures to re-set the financial framework for NHS providers including transferring £1 billion from the PSF into national prices and creating a new £1.05 billion Financial Recovery Fund (FRF) to support systems' and organisations' efforts to make all NHS services sustainable. As a result of this funding, we expect by 2023/24 no trust to be reporting a deficit.

Financial performance monitoring

In 2018/19 the financial position across the commissioning system has been reported monthly using the Integrated Single Financial Environment (ISFE) reporting system.

This has enabled a detailed monthly review by NHS England local offices, regional and national finance leadership teams, and the Chief Financial Officer. Regular updates on the overall financial position have been presented to the Executive Group, the Commissioning Committee and the NHS England public Board.

Individual CCG and direct commissioning financial performance is monitored against key performance indicators, with a focus on the underlying financial position of organisations and the presentation of any risks and mitigations, in addition to the reported forecast and year-to-date position. At critical points in the year the national team undertakes 'deep dives' with regional finance teams where organisational financial performance is analysed in greater detail.

Quarterly financial performance information for the commissioning sector at an organisational level is published on NHS England's website.

NHS England and NHS Improvement have continued to work more closely together in aligning financial performance monitoring across both the commissioner and provider sectors. At all levels the two organisations have been coming together to jointly assess the combined financial and operational position across local systems and the NHS as a whole, resulting in joint reporting and discussion at Board level.

NHS England central programme costs

In 2017/18 we agreed two-year allocations for our central programme resources and transformation funding. These baselines allocations were updated for 2018/19.

Most of this resource has been made available for direct investment to deliver on the priorities and objectives outlined in Next Steps on the NHS Five Year Forward View, in collaboration with STP areas, and focusing on priorities such as Urgent and Emergency Care, Primary Care, Cancer and Mental Health. The remaining available funding covers a variety of other operational commitments and charges for depreciation.

Cabinet Office efficiency controls

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

Counter fraud

NHS England investigates allegations of fraud related to our functions, where these are not undertaken by the NHS Counter Fraud Authority (NHSCFA), in addition to ensuring that appropriate anti-fraud arrangements are in place.

NHS England established its own in-house team of Counter Fraud Specialists to investigate allegations of fraud and conduct fraud awareness activities. 2018/19 was the NHS England Counter Fraud team's first full year of operation and the change in delivery model has already enhanced the effectiveness of the response.

ARAC receives regular updates regarding the counter fraud function, proactive counter fraud work and the outcome of reactive investigations. ARAC also receives a report at least annually against the Standards for Commissioners: Fraud, Bribery and Corruption. The Director of Financial Control has day-to-day operational responsibility for the NHS England counter fraud function, and the Chief Financial Officer provides executive support and direction.

The NHSCFA undertakes an annual high-level estimate of the potential scale of fraud affecting the whole of the NHS. Its Strategic Intelligence Assessment for 2017/18[63a] was recently published and reduced the estimated value of fraud from £1.29 billion to £1.27 billion which NHSCFA together with its partners have responsibility for tackling. Whilst this reduction is relatively small, the assessment records a £90 million reduction in estimated prescription, optical and dental exemption fraud.

A number of initiatives continue to tackle the fraud risk in primary care, including the Prescription Exemption Checking Service, the Dental Benefit Eligibility Checking Service and other contractor focussed services managed by NHSBSA on behalf of NHS England. These schemes are designed to have a significant deterrent impact but also resulted in net recoveries of £28 million in 2018/19.

63a Report is published on the Counter Fraud Authority website: https://cfa.nhs.uk/about-nhscfa/corporate-publications

The continued cooperation with key partners and development of the counter fraud service in the coming years will further safeguard NHS England's resources.

On 14 May 2019, the NAO published their "Investigation into penalty charge notices in healthcare"[63b]. The report highlights the loss to the NHS as a result of people incorrectly claiming exemption from paying prescription and dental charges was around £212m in 2017/18, concluding it is important that the NHS can reclaim these funds and deter fraud. Whilst recognising NHSBSA's efforts in reducing fraud (with an estimated reduction of £50m in prescription fraud between 2012/13 and 2016/17), the NAO found eligibility rules set by Government and Parliament are complicated and difficult to understand, with a need for a simpler system or better real time checking to not disadvantage vulnerable people.
NHS England are continuing to work with NHSBSA and DHSC to improve public awareness and understanding. A communications campaign to raise public awareness of eligibility and penalty charges 'check before you tick' took place in 2018, with further campaigns planned for 2019. NHSBSA are already piloting real-time exemption checking in pharmacies with the intention to roll this out further in the future.

Head of Internal Audit opinion

In the context of the overall environment for NHS England for 2018/19, in my opinion, the framework for governance and risk management has substantially been adequate and effective in 2018/19.

The overall opinion is supported by my view in each of the areas of governance, risk management and internal control. Each of these areas is covered in more detail within my full report. It is however important that the overall opinion is considered within the context of the environment that NHS England has operated in during the year to 31 March 2019.

With respect to the internal control environment, significant effort and progress has been made in addressing weaknesses identified in previous years, for example, non-clinical off payroll workers and recruitment, and the second line of defence has been strengthened with the introduction of the management assurance framework. On this basis, the framework for internal control has been appropriately implemented in the organisation through the 2018/19 year, except for the need to address the areas highlighted below; all of which NHS England are aware of:

1. The management of clinical off-payroll workers
2. Primary Care Support England Services
3. Third Party; Business Critical Models; and Project and Programme Management Frameworks
4. Primary Care Services Oversight
5. Continuing Healthcare

63b https://www.nao.org.uk/report/investigation-into-healthcare-penalty-charge-notices/

In my view, taking into account the internal audit work under taken during the year and the changes which the organisation continues to undergo, the design of the internal control framework provides a substantially adequate and effective foundation for the year to take the organisation forward, except for these areas.

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

This opinion takes into account other relevant information brought to the attention of internal audit. It has not been limited by any shortfall in resources, absence of skills, or any significant limitation of scope of internal audit activity which would adversely affect the ability to form an opinion. It can only be reasonable in the sense that no opinion can ever be absolute and is a reflection of the evidence available.

This opinion is a key element of the assurance framework which the Accounting Officer needs to inform his annual Governance Statement, however it in no respect detracts from the Accounting Officer's personal responsibility for risk management, governance and control processes.

Overall summary

Over the year we have continued to build on our approach to governance, risk and internal controls. We welcome the acknowledgement of the improvements made in the management of non-clinical off-payroll workers and our strengthened management assurance processes. We are committed to delivering improvements in the areas highlighted in the audit opinion.

During 2019/20 we will continue to develop our approach to governance frameworks internal controls and oversight of specific services particularly in the context of our joint working arrangements with NHS Improvement.

Remuneration and Staff Report

Staff report - NHS England

Our People

As at 31 March 2019, NHS England directly employed 6,520 people[64]. Of these, 4,752 people were permanently employed on recurrent, open-ended contracts of employment, based around the country within seven directorates. A further 1,768 people were employed on payroll on fixed term contracts of employment and 853 individuals were engaged in an off-payroll capacity which includes agency staff and secondees. (Subject to Audit)

Breakdown of number of people employed by directorate

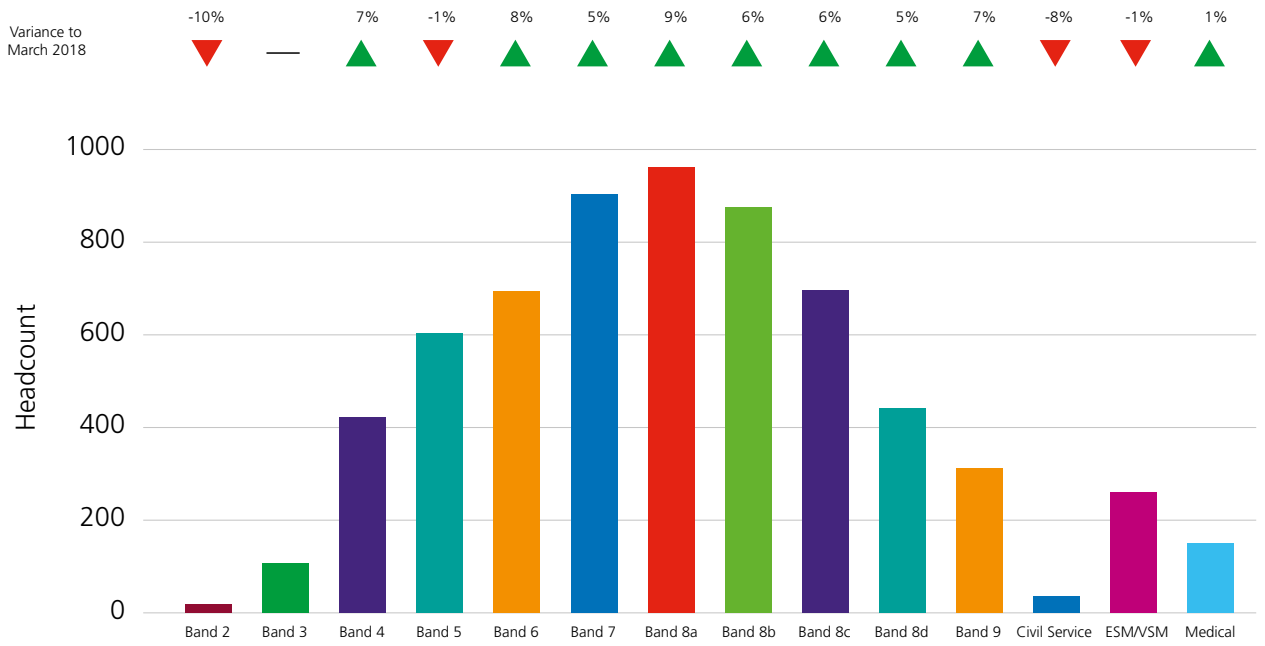
Member		No of people employed
Operations and Information - Central		1041
Operations and Information - London		579
Operations and Information - Midlands & East		1,131
Operations and Information - North		1,179
Operations and Information - South		918
Finance, Commercial and Specialised Commissioning:		495
of which..	*Finance*	181
	Specialised Commissioning	314
Medical		110
Nursing		176
Strategy and Innovation		312
Transformation & Corporate Operations		561
Chair and Chief Executive's Office		18
Total		**6,520**

Detail on staff numbers and costs for NHS England and the Consolidated Group, including CSUs, are presented from page 118.

64 CSU staff are employed via the NHS BSA and therefore not included in this analysis. The analysis of CSU staff is presented from page 117

All staff by pay band

NHS England has seen an increase in permanent and fixed term headcount of 5.9% since 2017/18 as we continue to reduce reliance on more expensive agency and contract labour and deliver our national programmes. The biggest increases in headcount can be seen at band 8a (salary range £42,414 - £49,969 per annum), band 8b (salary range £49,242 - £59,964 per annum and band 8d (salary range £70,206 - £85,333 per annum)[65].



The following organisational activities have been undertaken to ensure the ongoing advancement of our people to enable the continued delivery of the Next Steps on the NHS Five Year Forward View. Our Joint Working Programme with NHS Improvement has been designed to strengthen our joint working relationship and deliver a new operating model to ensure that collectively we can add greater value to the NHS.

Improving our workforce diversity and inclusion

We continue to work towards embedding the six ambitions of the Diversity and Inclusion Strategy across the organisation:

Individual	Organisation
I can make full use of my skills, experience and abilities	We have accurate data to support leadership accountability
I have equal opportunities for career progression	We tap into the lived experience of our staff
I am respected, valued and feel safe to be myself at work	Valuing diversity and supporting inclusion is part of the way we work

Giving permission:
Pilot on small scale, evaluate, improve.

Impact:
#real people camapign – sustainable change

Ownership:
Co-design with staff networks, regions and directorates

65 The term 'senior manager' (within this report) denotes all staff remunerated at or above the pro-rata salary of £84,507 per annum. This includes the top tier of Band 8d, where 163 of our 442 Band 8d staff are remunerated in the top tier. This is consistent with the definition used within Cabinet Office and HM Treasury returns.

Using the six ambitions as a focal point, we have enabled teams to retain ownership of the diversity and inclusion agenda, giving them permission to test out new ways of working and keeping them focused on developing practical actions that will help to improve the working lives of real people. Several teams are testing and piloting interventions on a small scale, evaluating them closely and then rolling the successful ideas out more widely.

A number of regional and central teams are participating in Reverse Mentoring programmes with the aim of supporting an improved understanding of the lived experience of staff from under-represented groups. The Strategy and Innovation directorate have completed a BAME positive action pilot and are now rolling out the programme to a wider cohort of staff.
A Diversity and Inclusion Leadership (DIL) programme has been developed, supporting 16 staff to complete stretch assignments, combined with in depth workshops on the subject of disability, race, LGBT+, Carers and Gender equality. It is envisaged that graduates from the DIL programme will use the knowledge they gain to become Diversity Innovators and share the learning they have gained with their teams.

Our staff network chairs and executive committee members continue to provide support to staff, influence policy development and hold the organisation to account. Staff networks across NHS England and NHS Improvement are enabling employees across both organisations to join as members, resulting in a total of eight networks. The offer to staff includes support from the BAME staff network; LGBT+ network, Disability and Wellbeing Network (DAWN), Carers, Muslim, Christian and Mental Health First Aid staff networks.

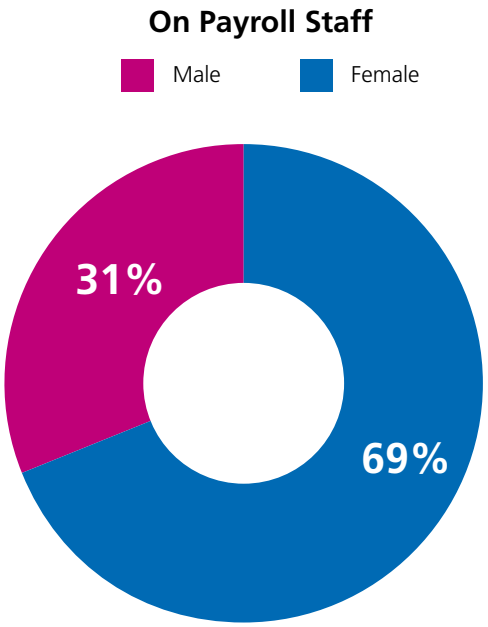
Recruitment and retention of disabled persons

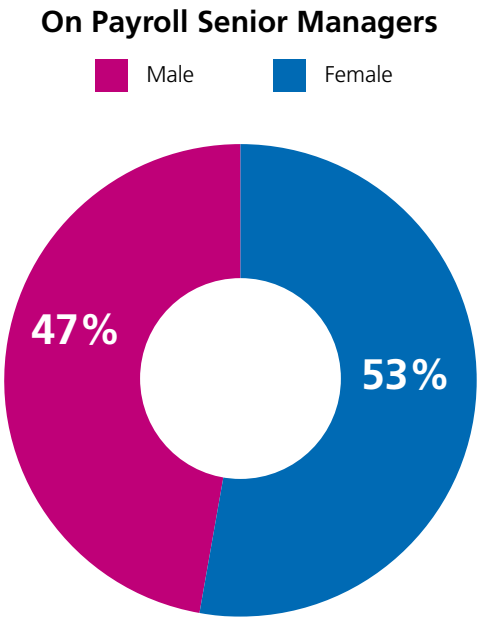
As a Disability Confident Employer, recognised by the Department for Work and Pensions, NHS England continues to work towards fulfilling our commitments to employ more disabled staff, and support disabled staff to work, develop and progress. Disabled staff voices have been sought out to improve conditions at work via three Disability and Wellbeing Network Staff Survey Focus Groups in 2018. Our major disability focus in 2018/19 has been on improving the provision of reasonable adjustments. This was in close collaboration with our active DAWN network which continues to grow year-on-year, and now includes three sub groups focused on Autism; Deaf and Hard of Hearing; and Mental Health.

We have continued to work with our DAWN network to support employees within the workplace and strive to ensure that all decisions relating to employment practices are objective, free from bias and based solely upon work criteria and individual merit. These principles are reinforced within our Equality, Diversity and Inclusion in the Workplace; and Recruitment and Selection and Flexible Working policies.

All staff by gender and senior managers by gender

The gender proportions of the total on payroll workforce and on payroll senior managers has remained constant over the year (all staff 2017/18: 31% male, 69% female; senior managers





2017/18: 47% male, 53% female). The gender diversity of Board members is set out on page 64.

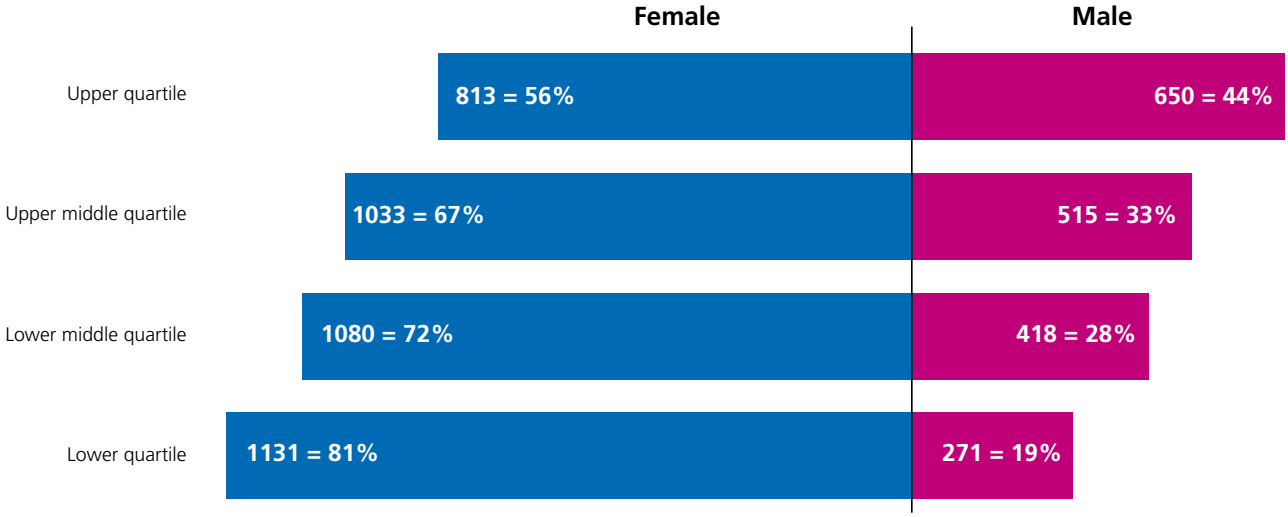
Gender pay gap

51% of the population of England are women, and 55% of NHS England's upper quartile senior staff are women. However, 81% of employees in the lower quartile are female. A significant driver of the pay gap therefore is a consequence of having a lower proportion of men in lower pay bands relative to their share of the population.

Based on the Government's methodology, using snap shot data as of 31 March 2018, NHS England had a mean gender pay gap of 19% calculated as the percentage difference between the average hourly salary for men and the average annual salary for women. The median gender pay gap of 22% is calculated as the percentage difference between the mid-point hourly salaries for men and women.

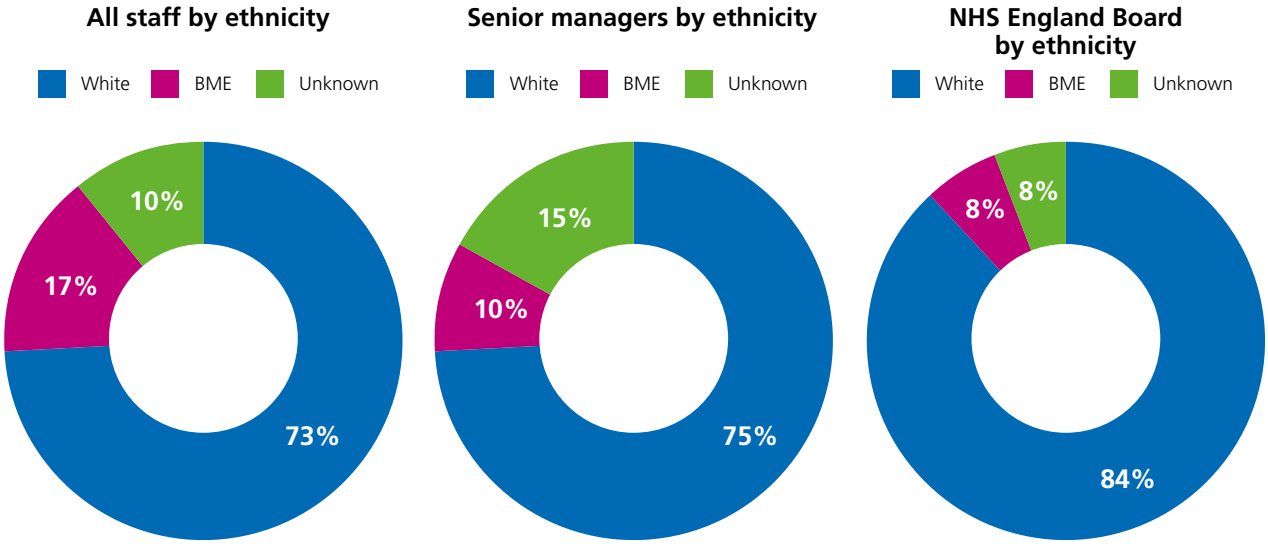
The mean gender pay gap compares favourably to March 2017, when we had a mean gender pay gap of 21%, however we have seen an increase of 1% in the median gender pay gap in comparison to March 2017.

The proportion of males and females in each pay quartile are detailed below:



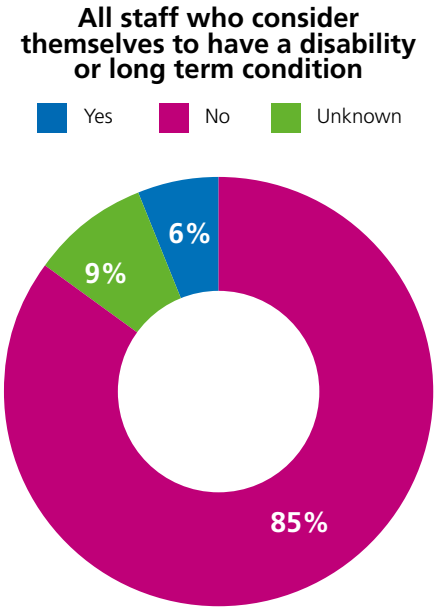
Working in partnership with our recognised trade unions and our Women's Network we continue to drive diversity and inclusion. Activities over the last 12 months include a refreshed flexible working policy which has resulted in a steady increase in the uptake of flexible working since the policy was launched; a demonstrable commitment to ensure that the NHS England and NHS Improvement Joint Working programme provides an opportunity to address gender equality in our workforce; and the formation of a Gender Pay group that has taken the lead role in identifying and supporting further initiatives to improve NHS England's and NHS Improvement's position with regard to gender pay. The group comprises representatives from the HR and Organisational Development (OD) group, trade unions and the Women's Network.

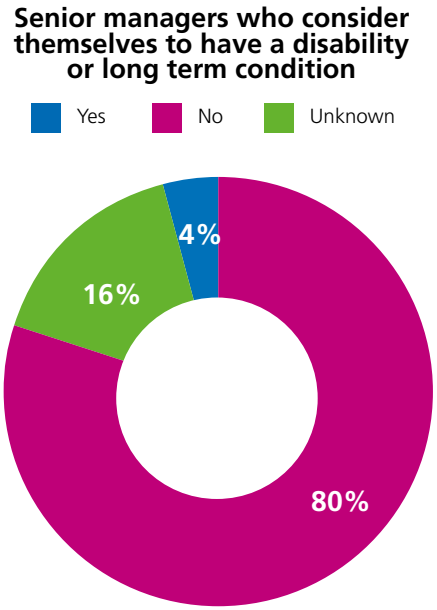
All staff by ethnicity and senior managers by ethnicity



The proportion of people employed by NHS England that consider themselves to be from a BAME heritage has increased by 1% over the year for all staff and for senior managers, with an increase of 2% at Board level (2017/18: 16% all staff, 9% senior managers and 6% NHS England board). We use the annual publication of the Workforce Race Equality Standard (WRES) data return as a driver for improvements in the working lives of BAME staff.

Following completion of interviews with Senior BAME Managers, NHS England produced the 'What Helps and What Hinders' report which provides a BAME-led perspective on the actions we need to take to improve race equality in the organisation. Following a national BAME Staff Network conference which was supported by our CEO, Chairs and over 160 staff, our Senior BAME Co-design group will continue to work with senior leaders to develop a 10-year action plan. This plan will mirror the national Model Employer guidance developed by the WRES team, to ensure that we work towards equal representation of BAME staff at the most senior pay bands.





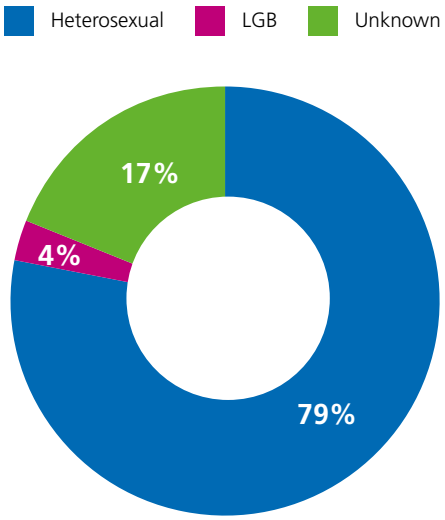
All staff who consider themselves to have a disability or long term condition and senior managers

We have continued to work closely with the DAWN staff to close the gaps in this workforce diversity data and encourage people to self-classify. This year an additional 2% of all staff and 1% of senior managers have chosen to disclose whether they have a disability or long-term condition (2017/18: 11% all staff, 18% senior managers). The proportion of our people disclosing a disability or long-term condition has remained constant.

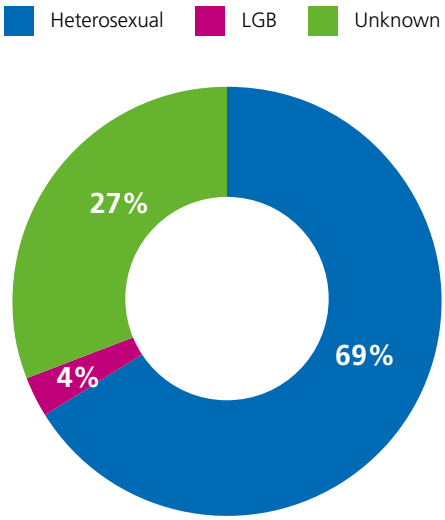
All staff by sexual orientation and senior managers by sexual orientation

Disclosure rates relating to sexual orientation have increased by 2% during the year for all staff, in line with the increase in the number of staff reporting that they are LGBT+ (2017/18: 3% all staff, 4% senior managers). This rise in disclosure rates reflects the positive work that has been done in conjunction with our LGBT+ network to build trust and confidence with our LGBT+ workforce.

All staff by sexual orientation



Senior managers by sexual orientation



As a Stonewall Workplace Equality Champion, we continue to embed LGBT+ inclusion. NHS England's Stonewall Workplace Equality Index 2019 result is 113th out of 445 organisations, a rise of 61 places since 2018. This strong progress reflects increased organisational ownership of an LGBT+ action plan, which in 2019/20 will be jointly owned with NHS Improvement. Progress is particularly strong around our active LGBT+ Network who have raised the visibility of LGBT+ staff and developed Trans and Bi Ally/Awareness training for staff. We have also secured a national rainbow NHS70 logo to celebrate the history of LGBT+ equality in the NHS. Organisationally we strive to embed LGBT+ inclusion across workforce data collection and making the facilities in our office environments more gender-inclusive.

Talent management and development

During the year we extended our talent management process from 8c and above to encompass staff at pay bands 8a and 8b, increasing the employee population involved in recorded talent development conversations by 97% in comparison to previous year.

Our stretch assignment service has continued to expand throughout the year, providing increased opportunities for staff to build their capabilities. 218 stretch assignments were placed by the service and of these 95 were successfully completed, representing a 64% increase in comparison to the previous year.

Our coaching and mentoring service continues to provide support to various national workstreams including: work with public and patient voice representatives; the line management and senior Line Management Development Programmes (LMDP); mentors to

support senior BAME talent; and, our work on gender equality. The service has continued to grow and there are currently 136 coaches on the register (2017/18:86) and 132 mentors (2017/18:79). We have increased the number of BAME coaches to 17% and BAME mentors to 12%. 11% of our mentors have disclosed a disability or long-term health condition compared to 7% in 2017/18. The proportion of coaches with a disability has remained at 7%. The coaching and mentoring service continues to engage with all staff networks to understand how coaching and mentoring can support their members and to inform them about the service offer. Recognising the need to increase in-house capability, we continue to develop our coaches at the Institute of Leadership Management (ILM) level 5 and level 7.

Line management development programme

The LMDP continues to play an important role in our strategy to ensure consistently high standards of people management practice that fully align with NHS values and behaviours. The LMDP has entered its third year of operation with over 1,967 employees having participated in the programme since August 2016 and a further 84 ESM colleagues having completed the programme.

Evaluation of the LMDP remains positive with feedback from delegates, teams and delegate's line managers continuing to evidence shifts in line management knowledge, skills and positive behaviours. The programme has delivered coherent and consistent standards of good management capability and skills; improved staff engagement and has contributed towards making NHS England a better place to work.

Apprenticeships

NHS England has embraced apprenticeships as an opportunity to build capabilities and improve the diversity of our workforce. Apprenticeships are offered to people of all ages, backgrounds, pay bands and across roles where the eligibility criteria are met. Our Apprenticeship Scheme was launched in May 2017 and we currently have 56 apprentices taking qualifications ranging from Level 2 Business Administration to Level 7 Senior Leader Master's Degree. Over £71,000 of the apprenticeship levy has been used to support these posts.

Workplace health, safety and wellbeing

In May 2018 we published our 'Mental Health in the Workplace Strategy' which details our proactive approach to tackling mental ill health within NHS England; it serves as our response to the 'Thriving at Work' Stevenson / Farmer Review and enables us to meet our 'Mindful Employer' commitments by October 2019.

We have trained 916 people in Mental Health First Aid since 2014, of whom 631 are employed by NHS England. In October 2018 we introduced Mental Health Aware, a half day course specifically promoted to those employed within leadership positions, and to date 69 senior managers have attended the course.

Staff engagement and experience

Staff survey

We have continued to address key themes emerging from our annual staff survey throughout the course of the year. As well as working with regions and directorates to develop and embed local action plans, we have invested in the development of organisation-wide initiatives to improve staff experience. We have introduced a Respect at Work contacts scheme, a new mediation service, trained more mental health first aiders (MHFA), increased opportunities to attend our LMDP and one-day workshops, and further developed our internal coaching and mentoring programmes. In the light of closer working with NHS Improvement work has taken place to make such offers accessible to staff across both organisations, as well as in-year "temperature checks" on the HR processes being used.

A key focus of our work this year has also been on the development of the staff survey itself. In preparation for our new operating model, we have engaged with stakeholders from across NHS England and NHS Improvement to agree a set of principles to underpin a new staff survey approach.

Staff engagement groups

We have more than 25 local staff engagement groups operating across NHS England. They feed into the national network to share best practice across the organisation. Our staff engagement groups contribute to the development of our people policies and are more widely engaged in staff affecting issues impacting the organisation. Over the last year we have also continued to build on the success of our staff recognition scheme.

Facility time

Facility time is paid time off for union representatives to carry out Trade Union (TU) activities. The information below relates to Trade Union facility time within NHS England.

a) TU representative – the total number of employees who were TU representatives during the relevant period.

Number of employees who were relevant union officials during the relevant period	FTE employee number
27	25.93

b) Percentage of time spent on facility time (duties and activities) - How many employees who were TU representatives officials employed during the relevant period spent a) 0%, b) 1%-50%, c) 51%-99% or d) 100% of their working hours on facility time.

Percentage of time	Number of employees
0%	5
1-50%	22
51%-99%	0
100%	0

c) Percentage of pay bill spent on facility time - The figures requested in the first column of the table below will determine the percentage of the total pay bill spent on paying employees who were TU representatives for facility time during the relevant period.

Figures	Figures
Provide the total cost of facility time	£74,231.98
Provide the total pay bill	£385,617,880.95
Provide the percentage of the total pay bill spent on facility time, calculated as: (total cost of facility time ÷ total pay bill) x 100	0.02%

d) Paid TU activities - As a percentage of total paid facility time hours, how many hours were spent by employees who were TU representatives during the relevant period on paid TU activities.

Figures	Figures
Time spent on paid TU activities as a percentage of total paid facility time hours calculated as: (total hours spent on paid TU activites by TU representatives during the relevan period ÷ total paid facility time hours) x 100	22.7%

Our improvement and change activities

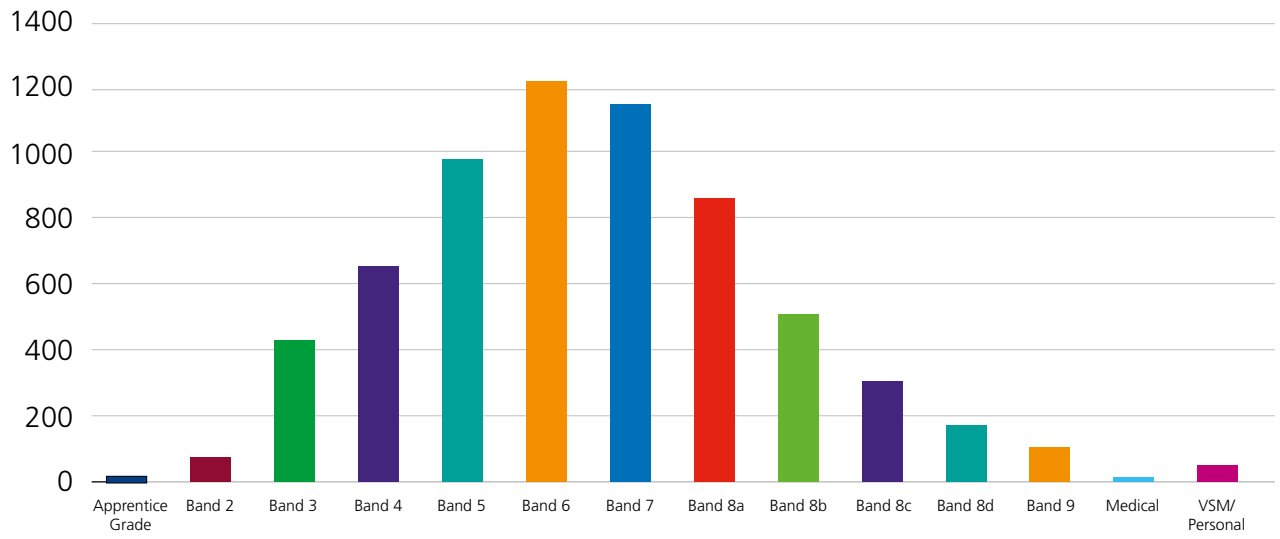
Organisational change programmes

Within the context of the NHS Long Term Plan, NHS England and NHS Improvement are coming together with a new shared operating model. At the same time we are implementing a 20% cut in our running costs. Substantial organisational design work has been undertaken to enable both organisations to achieve this. In December 2018 we announced a number of the appointments to our new senior team, and appointments to ESM roles were announced in March 2019. The organisation-wide redesign process will be completed by December 2019.

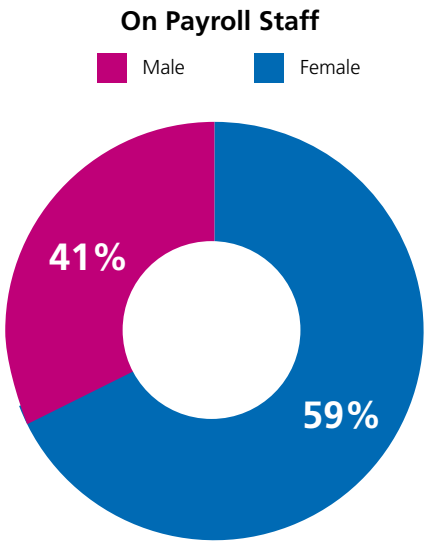
Staff report - CSUs

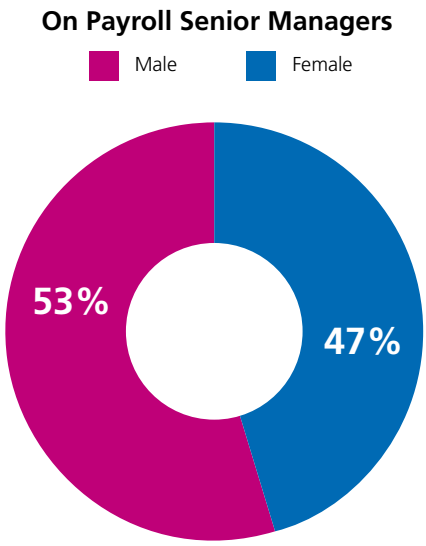
As at 31 March 2019, CSUs directly employ a total 6614 people. Of these 6138 people were permanently employed on recurrent, open-ended contracts of employment, based around the country within the five separate organisations. In addition, a further 476 people were employed on payroll on fixed term contracts of employment.

All CSU staff by pay band



All CSU staff by gender and CSU senior managers by gender





Employee benefits and staff numbers (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	2018/19				
	Permanently employed number	CSU employed number	Other number	CSU other number	Total number
Total	5,866	6,056	794	344	**13,060**
Of the above: Number of whole time equivalent people engaged on capital projects	-	-	-	-	-

Parent	2017/18				
	Permanently employed number	CSU employed number	Other number	CSU other number	Total number
Total	5,278	6,095	871	482	**12,726**
Of the above: Number of whole time equivalent people engaged on capital projects	-	-	-	-	-

Employee benefits

Parent	2018/19				
	Permanent employees £000	CSU employees £000	Other £000	CSU other £000	Total £000
Employee benefits					
Salaries and wages	308,102	242,344	49,765	31,343	**631,554**
Social security costs	34,967	25,739	114	-	**60,820**
Employer contributions to NHS Pension scheme	39,358	30,828	14	1	**70,201**
Other pension costs	-	-	-	-	-
Apprenticeship Levy	1,537	948	-	-	**2,485**
Termination benefits	4,012	2,721	-	-	**6,733**
Gross employee benefits expenditure	**387,976**	**302,580**	**49,893**	**31,344**	**771,793**
Less: Employee costs capitalised	-	-	-	-	-
Net employee benefits excluding capitalised costs	**387,976**	**302,580**	**49,893**	**31,344**	**771,793**
Less recoveries in respect of employee benefits	(592)	-	-	-	**(592)**
Total net employee benefits	**387,384**	**302,580**	**49,893**	**31,344**	**771,201**

Parent	2017/18				
	Permanent employees £000	CSU employees £000	Other £000	CSU other £000	Total £000
Employee benefits					
Salaries and wages	270,694	235,163	50,833	43,572	**600,262**
Social security costs	31,139	25,140	17	1	**56,297**
Employer contributions to NHS Pension scheme	34,980	30,198	24	1	**65,203**
Other pension costs	-	-	-	-	-
Apprenticeship Levy	1,357	1,329	-	-	**2,686**
Termination benefits	257	4,943	-	-	**5,200**
Gross employee benefits expenditure	**338,427**	**296,773**	**50,874**	**43,574**	**729,648**
Less: Employee costs capitalised	-	-	-	-	-
Net employee benefits excluding capitalised costs	**338,427**	**296,773**	**50,874**	**43,574**	**729,648**
Less recoveries in respect of employee benefits	(162)	-	-	-	**(162)**
Total net employee benefits	**338,265**	**296,773**	**50,874**	**43,574**	**729,486**

Average number of people employed

Consolidated Group	2018/19				
	Permanently employed number	CSU employed number	Other number	CSU other number	Total number
Total	24,011	6,056	2,680	344	**33,091**
Of the above: Number of whole time equivalent people engaged on capital projects	-	-	1	-	1

Consolidated Group	2017/18				
	Permanently employed number	CSU employed number	Other number	CSU other number	Total number
Total	22,408	6,095	2,725	482	**31,710**
Of the above: Number of whole time equivalent people engaged on capital projects	-	-	-	-	-

Employee benefits

Consolidated Group	2018/19				
	Permanent employees £000	CSU employees £000	Other £000	CSU other £000	Total £000
Employee benefits					
Salaries and wages	1,142,091	242,344	188,425	31,343	**1,604,203**
Social security costs	125,319	25,739	686	-	**151,744**
Employer contributions to NHS Pension scheme	144,486	30,828	553	1	**175,868**
Other pension costs	60	-	-	-	**60**
Apprenticeship Levy	3,439	948	-	-	**4,387**
Termination benefits	10,481	2,721	-	-	**13,202**
Gross employee benefits expenditure	**1,425,876**	**302,580**	**189,664**	**31,344**	**1,949,464**
Less: Employee costs capitalised	-	-	(51)	-	**(51)**
Net employee benefits excluding capitalised costs	**1,425,876**	**302,580**	**189,613**	**31,344**	**1,949,413**
Less recoveries in respect of employee benefits	(7,151)	-	(430)	-	**(7,581)**
Total net employee benefits	**1,418,725**	**302,580**	**189,183**	**31,344**	**1,941,832**

Consolidated Group	2017/18				
	Permanent employees £000	CSU employees £000	Other £000	CSU other £000	Total £000
Employee benefits					
Salaries and wages	1,046,741	235,163	194,512	43,572	**1,519,988**
Social security costs	116,284	25,140	317	1	**141,742**
Employer contributions to NHS Pension scheme	134,388	30,198	242	1	**164,829**
Other pension costs	18	-	-	-	**18**
Apprenticeship Levy	2,824	1,329	-	-	**4,153**
Termination benefits	7,436	4,943	-	-	**12,379**
Gross employee benefits expenditure	**1,307,691**	**296,773**	**195,071**	**43,574**	**1,843,109**
Less: Employee costs capitalised	-	-	-	-	**-**
Net employee benefits excluding capitalised costs	**1,307,691**	**296,773**	**195,071**	**43,574**	**1,843,109**
Less recoveries in respect of employee benefits	(6,793)	-	(82)	-	**(6,875)**
Total net employee benefits	**1,300,898**	**296,773**	**194,989**	**43,574**	**1,836,234**

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

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

Sickness absence

From 1 January 2018 to 31 December 2018, the average number of sick days taken by whole time equivalent employees increased by 0.3 days against the previous year.

Sickness absence for the period 1 January to 31 December 2018 was as follows:

	Whole time equivalent days available	Whole time equivalent days lost to sickness absence	Average sick days per whole time equivalent
NHS England	2,169,943	47,333	4.9
CSUs	2,230,730	68,879	6.9

Exit packages, severance payments and off-payroll engagements

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 £9 million during the financial year, a decrease of £18 million since 2017/18 (2017/18: £27 million).
Across the group, there was a total spend of £64 million on consultancy services during the period, against £85 million the previous year.

Expenditure on contingent labour, including agency staff and secondees, is given in the Annual Accounts on page 118: Employee Benefits and Staff Numbers under the 'other' column.
Net expenditure for NHS England and CSUs in this area was £81 million in 2018/19, against £94 million in 2017/18. Across the group, there was a total spend of £221 million on contingent labour during the year, against £239 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 102.

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. To reduce 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.

The following tables identify off-payroll workers[66] engaged by NHS England as at March 2019.

66 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 2,800 appraisers

Table 1: Off-payroll engagements longer than six months

Off-payroll engagements as at 31 March 2019, covering those earning more than £245 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 2019	560	58	618
Of which, the number that have existed:			
for less than one year at the time of reporting	185	51	236
for between one and two years at the time of reporting	276	7	283
for between 2 and 3 years at the time of reporting	49	0	49
for between 3 and 4 years at the time of reporting	19	0	19
for 4 or more years at the time of reporting	31	0	31

All existing off-payroll engagements, outlined above, have been subject to a risk-based assessment as to whether assurance is required that the individual is paying the right amount of tax and, where necessary, assurance has been sought.

Table 2: New off-payroll engagements

New off-payroll engagements or those that reached six months in duration, between 1 April 2018 and 31 March 2019, for more than £245 per day and that last longer than six months are as follows:

	NHS England	CSUs	Total
Total number of new engagements, or those that reached six months in duration, between 1 April 2018 and 31 March 2019	252	101	353
Of which:			
Number assessed as caught by IR35	114	70	184
Number assessed as NOT caught by IR35	138	31	169
Number engaged directly (via PSC contracted to department) and are on departmental payroll	0	0	0
Number of engagements reassessed for consistency / assurance purposes during the year	30	34	64
Number of engagements that saw a change to IR35 status following the consistency review	30	0	30

Table 3: Off-payroll board member/senior official engagement

Off-payroll engagements of Board members and/or senior officials with significant financial responsibility, between 1 April 2018 and 31 March 2019 are shown in the table below:

	NHS England (number)	CSUs (number)	Total (number)
Number of off-payroll engagements of Board members, and/or senior officers with significant financial responsibility, during the financial year	0	0	0
Total number of individuals on payroll and off-payroll that have been deemed "Board members, and/or, senior officials with significant financial responsibility", during the financial year.	267	40	307

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 61.

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 payments would first have to be scrutinised and approved by the Executive HR Sub-Committee before being considered by the DHSC and HM Treasury. Details of exit packages agreed over the year are detailed in the following tables. All contractual severance payments were subject to full external oversight by DHSC.

Exit packages agreed during the year: Compulsory redundancies

Parent	2018/19			2017/18		
	Compulsory redundancies number	Other agreed departures number	Total number	Compulsory redundancies number	Other agreed departures number	Total number
Less than £10,000	23	8	31	13	10	23
£10,001 to £25,000	20	-	20	8	22	30
£25,001 to £50,000	20	-	20	12	26	38
£50,001 to £100,000	26	-	26	8	15	23
£100,001 to £150,000	15	-	15	1	4	5
£150,001 to £200,000	17	-	17	1	4	5
Over £200,001	-	-	-	-	-	-
Total	**121**	**8**	**129**	**43**	**81**	**124**
Total cost (£000)	**7,640**	**37**	**7,677**	**1,453**	**3,628**	**5,081**

Consolidated Group	2018/19			2017/18		
	Compulsory redundancies number	Other agreed departures number	Total number	Compulsory redundancies number	Other agreed departures number	Total number
Less than £10,000	82	47	129	56	78	134
£10,001 to £25,000	67	33	100	48	61	109
£25,001 to £50,000	43	11	54	28	46	74
£50,001 to £100,000	52	13	65	24	33	57
£100,001 to £150,000	31	1	32	5	5	10
£150,001 to £200,000	29	1	30	19	5	24
Over £200,001	4	-	4	2	-	2
Total	**308**	**106**	**414**	**182**	**228**	**410**
Total cost (£000)	**16,246**	**2,327**	**18,573**	**7,983**	**6,946**	**14,929**

Exit packages agreed during the year: Other agreed departures

Parent	2018/19		2017/18	
	Other agreed departures		Other agreed departures	
	number	£000	number	£000
Voluntary redundancies including early retirement contractual costs	-	-	72	3,539
Contractual payments in lieu of notice	8	37	9	89
Exit payments following Employment Tribunals or court orders	-	-	-	-
Total	**8**	**37**	**81**	**3,628**

Consolidated Group	2018/19		2017/18	
	Other agreed departures		Other agreed departures	
	number	£000	number	£000
Voluntary redundancies including early retirement contractual costs	12	661	82	3,875
Mutually agreed resignations (MARS) contractual costs	19	584	48	1,423
Early retirements in the efficiency of the service contractual costs	1	10	4	386
Contractual payments in lieu of notice	72	1,055	92	1,162
Exit payments following Employment Tribunals or court orders	1	14	2	100
Non-contractual payments requiring HM Treasury approval	1	3	-	-
Total	**106**	**2,327**	**228**	**6,946**

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

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

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

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

Where NHS England and CCGs have agreed early retirements, the additional costs are met by NHS England or the 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 Report includes the disclosure of 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 Directors' Report at page 75.

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 2018/19 was £220,000- £225,000 (2017/18: £215,000-£220,000). This was 5.42 times the median remuneration of the workforce, which was £41,034 (2017/18: £40,428: 5.38). During 2018/19 the Chief Executive Officer (Simon Stevens) voluntarily took a £20,000 per annum pay cut for the fifth year in a row.

In 2018/19, one employee received pro-rata remuneration in excess of the highest-paid member of the Board (2017/18: 2). This employee is employed on a part time basis. Remuneration ranged from £6,453 - £225,000 (2017/2018: £6,844 (part time salary) to £220,430).

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

Policy on remuneration of senior managers

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

It is the policy of NHS England to pay salaries that are appropriate to recruit senior managers with the necessary skills, capability and experience necessary for the effective running of a more than £113 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, with final decisions being made by the DHSC ALB Remuneration Committee and HM Treasury, where appropriate.

Performance related pay

The performance related pay arrangements for national (executive) directors are set out in the ESM pay framework for ALBs, they follow guidance prescribed by DHSC and are in line with HM Treasury requirements. As a local policy decision, since its inception, NHS England does not currently allocate any funding for PRP non-consolidated bonus payments. In recognition of the current economic climate and the need to provide effective system leadership for the NHS, the decision was taken by the Strategic HR and Remuneration Committee not to allocate funds for PRP non-consolidated bonus payments for 2018/19.

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 DHSC Governance and Assurance Committee. Any proposed non-contractual special severance payment requires formal approval from DHSC and HM Treasury. No payments were made to any senior manager to compensate for loss of office.

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

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 Officer	1 April 2014	6 months	Option to provide taxable pay in lieu of part or all of the notice period	
Matthew Swindells Deputy Chief Executive	30 May 2016	6 months		
Paul Baumann CBE Chief Financial Officer	14 May 2012	6 months		Left NHS England on 18 November 2018
Professor Jane Cummings CBE Chief Nursing Officer	1 April 2013	6 months		Left NHS England on 31 December 2018
Ian Dodge National Director: Strategy	7 July 2014	6 months		
Emily Lawson National Director: Transformation and Corporate Operations	1 November 2017	6 months		
Professor Stephen Powis National Medical Director	1 March 2018	6 months		
Matthew Style Acting Chief Financial Officer	19 November 2018	6 months		
Ruth May Chief Nursing Officer	7 January 2019	6 months		

With NHS Improvement we jointly appointed Ruth May as Chief Nursing Officer with effect from 7 January 2019 and continue to jointly appoint Jennifer Howells, Regional Director – South West and Anne Eden, Regional Director – South East. These positions are recognised by both organisations as senior leadership roles, with Ruth May, Jennifer Howells and Anne Eden being members of the executive team at NHS Improvement and disclosed in the NHS Improvement Annual Report and Accounts.

Senior manager salary and pension entitlement 2018/19 (subjected to audit)

Name and Title	(a) Salary[67] (bands of £5,000)	(b) Benefits in kind (taxable) to nearest £100	(c) Performance pay and bonuses (bands of £5,000)	(d) Long term performance pay and bonuses (bands of £5,000)	(e) All pension-related benefits[68] (bands of £2,500)	(f) TOTAL (a to e) (bands of £5,000)
	£000	£s	£000	£000	£000	£000
Simon Stevens Chief Executive Officer[69]	190-195	0	0	0	42.5-45.0	235-240
Matthew Swindells Deputy Chief Executive[70]	205-210	0	0	0	0	205-210
Paul Baumann CBE Chief Financial Officer[71]	130-135 (pro-rata)	0	0	0	0	130-135 (pro-rata)
Professor Jane Cummings CBE Chief Nursing Officer[72]	140-145 (pro-rata)	0	0	0	0	140-145 (pro-rata)
Ian Dodge National Director: Strategy[73]	165-170	0	0	0	37.5-40.0	205-210
Emily Lawson National Director: Transformation and Corporate Operations[74]	190-195	0	0	0	0	190-195
Professor Stephen Powis National Medical Director	220-225	0	0	0	0	220-225
Matthew Style Acting Chief Financial Officer[75]	55-60 (pro rata)	0	0	0	10-12.50 (pro rata)	70-75 (pro rata)
Ruth May Chief Nursing Officer[76]	40-45 (pro rata)	0	0	0	2.5-5.0 (pro rata)	40-45 (pro rata)

Note: Taxable expenses and benefits in kind are expressed to the nearest £100.

67 The salaries disclosed are inclusive of the 2018 ESM Pay Award. Although this was not implemented within the 2018/19 reporting period, approval was received before the date the accounts were authorised for issue under IAS 10 Events after the Reporting Period and have therefore been included for disclosure. This is excluding Professor Stephen Powis as he attracts Medical & Dental Terms and Conditions.

68 The 2018 ESM Pay Award has not been included in the calculation of all pension-related benefits. This is due to approval for payment of the Pay Award being received outside of the 2018/19 reporting period.

69 On joining NHS England on 1 April 2014, Simon Stevens voluntarily reduced his pay by 10% from the substantive rate of pay for the post of Chief Executive, which would normally be within the range £210,000–£215,000. Mr Stevens has continued with this voluntary reduction in pay throughout 2018/19.

70 Matthew Swindells' took on the position title of Deputy Chief Executive from 01 September 2018.

71 Paul Baumann CBE left on 18 November 2018. The full year equivalent salary is £210,000-£215,000.

72 Professor Jane Cummings CBE continued to receive an additional responsibility allowance during 2018/19 for covering the London regional director role up until her retirement on 31 December 2018. The full year equivalent salary is £185,000-£190,000.

73 Ian Dodge took on the position title of National Director: Strategy and Innovation from 1 July 2017. This was not disclosed in the 2017/18 audited accounts, therefore is retrospectively being reported.

74 Emily Lawson continued to receive an additional responsibility allowance during 2018/19 that recognised extra duties in relation to the PCS service.

75 Matthew Style commenced in post on 19 November 2018. The full year equivalent salary is £160,000-£165,000. Mr Style chose to have Childcare Voucher deductions made from his salary via salary sacrifice. The full year equivalent salary remains at £160,000-£165,000 when taking into account the salary being sacrificed.

76 Ruth May was jointly appointed with NHS Improvement on 7 January 2019. The cost for the remuneration figures disclosed is wholly met by NHS Improvement. The full year equivalent salary is £175,000 to £180,000.

Senior manager salary and pension entitlement 2017/18 (subjected to audit)

Name and Title	(a) Salary (bands of £5,000)	(b) Benefits in kind (taxable) rounded to nearest £100	(c) Performance pay and bonuses (bands of £5,000)	(d) Long term performance pay and bonuses (bands of £5,000)	(e) All pension-related benefits (bands of £2,500)	(f) TOTAL (a to e) (bands of £5,000)
	£000	£s	£000	£000	£000	£000
Simon Stevens Chief Executive Officer[77]	190-195	0	0	0	45.0-47.5	235-240
Paul Baumann CBE Chief Financial Officer	205-210	0	0	0	0	205-210
Professor Jane Cummings CBE Chief Nursing Officer[78]	175-180 (pro-rata - allowance only)	0	0	0	0	175-180 (pro-rata allowance only)
Professor Sir Bruce Keogh National Medical Director[79]	155-160 (pro-rata)	0	0	0	0	155-160 (pro-rata)
Ian Dodge National Director: Strategy	165-170	0	0	0	37.5-40.0	205-210
Matthew Swindells National Director: Operations and Information[80]	205-210	0	0	0	0	205-210
Karen Wheeler CBE National Director: Transformation and Corporate Operations[81]	35-40 (pro-rata)	0	0	0	27.5-30.0 (pro-rata)	65-70 (pro-rata)
Emily Lawson National Director: Transformation and Corporate Operations[82]	90-95 (pro-rata)	0	0	0	0	90-95 (pro-rata)
Professor Stephen Powis National Medical Director[83]	15-20 (pro rata)	0	0	0	0	15-20 (pro rata)

77 On joining NHS England on 1 April 2014, Simon Stevens voluntarily reduced his pay by 10% from the substantive rate of pay for the post of Chief Executive, which would normally be within the range £210,000–£215,000. Mr Stevens has continued with this voluntary reduction in pay throughout 2017/18.

78 Professor Jane Cummings CBE commenced receipt of an additional responsibility allowance from 15 September 2017 for covering the London regional director role. The figures shown reflect this part year receipt of the allowance. The full year equivalent salary is £185,000-£190,000.

79 Professor Sir Bruce Keogh received an overpayment of £42,818 paid in error between 1 April 2015 and 31 January 2016, and this was fully recovered in the 2017/18 financial reporting period. The amount of the overpayment is not included in the total remuneration figures disclosed. Professor Sir Bruce Keogh retired on 28 January 2018. The full year equivalent salary is £190,000-£195,000.

80 Matthew Swindells was pro-rata previous year as he did not join the post until 30 May 2016. There has also been a pay award which has increased his salary into the next salary band.

81 Karen Wheeler was seconded from DHSC and her salary recharged to NHS England. As such, she was subject to the terms and conditions of her employing organisation. Karen Wheeler left NHS England on 30 June 2017. The full year equivalent salary is £155,000-£160,000.

82 Emily Lawson joined NHS England on 1 November 2017, replacing Karen Wheeler. The FTE salary is £190,000-£195,000. This includes an 8% additional responsibility allowance that recognises extra duties in relation to the PCS service. However, an additional amount of £10,876.92, relating to days worked prior to commencement on 1 November 2017, is included in the pro rata salary disclosed but not in the FTE salary.

83 Professor Stephen Powis joined NHS England on 1 March 2018, replacing Professor Sir Bruce Keogh. The full year equivalent salary is £215,000-£220,000.

Pension benefits as at 31 March 2019 (subjected to audit)

Name and Title	Real increase in pension at pension age (bands of £2,500)	Real increase in pension lump sum at pension age (bands of £2,500)	Total accrued pension at pension age at 31 March 2019 (bands of £5,000)	Lump sum at pension age related to accrued pension at 31 March 2019 (bands of £5,000)	Cash Equivalent Transfer Value at 31 March 2018 [84]	Real Increase in Cash Equivalent Transfer Value	Cash Equivalent Transfer Value at 31 March 2019	Employers contribution to partnership pension
	£000	£000	£000	£000	£000	£000	£000	£000
Simon Stevens Chief Executive Officer	2.5-5.0	(2.5)-0	35-40	55-60	529	85	658	0
Matthew Swindells National Director: Operations and Information[85]	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Paul Baumann CBE Chief Financial Officer[86]	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Professor Jane Cummings CBE Chief Nursing Officer[87]	(10)-(12.5)	97.50-100	65-70	370-375	1,669	0	0	0
Ian Dodge National Director: Strategy	2.5-5.0	N/A	10-15	N/A	113	35	176	0
Emily Lawson National Director: Transformation and Corporate Operations[88]	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Professor Stephen Powis National Medical Director[89]	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Matthew Style Acting Chief Financial Officer[90]	0-2.5	N/A	5-10	N/A	23	1	50	0
Ruth May Chief Nursing Officer	0-2.5	0-2.5	60-65	190-195	1,112	34	1,317	0

84 As per previous submissions, the column Cash Equivalent Transfer Value at 01 April 2018 is the uninflated value whereas the real Increase in CETV is the employer funded increase.
85 Matthew Swindells chose not to be covered by the NHS Pension arrangements during the reporting year.
86 Paul Baumann chose not to be covered by the NHS pension arrangements during the reporting year.
87 Professor Jane Cummings CBE re-joined the NHS Pension Scheme from 1 November 2018 to 31 December 2018, when she retired.
88 Emily Lawson chose not to be covered by the NHS Pension arrangements during the reporting year.
89 Professor Stephen Powis chose not to be covered by the NHS Pension arrangements during the reporting year.
90 Matthew Style commenced in post on 19 November 2018, therefore the Pension Benefits disclosed are pro-rata for the period 19 November 2018 to 31 March 2019.

Cash equivalent transfer values (CETV) (subjected to audit)

A CETV is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time.

The benefits valued are the member's accrued benefits and any contingent spouse's (or other allowable beneficiary's) pension payable from the scheme.

A CETV is a payment made by a pension scheme or arrangement to secure pension benefits in another pension scheme or arrangement when the member leaves a scheme and chooses to transfer the benefits accrued in their former scheme.

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

The CETV figures and the other pension details include the value of any pension benefits in another scheme or arrangement which the individual has transferred in 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 or contributions paid by the employee (including the value of any benefits transferred from another scheme or arrangement) and uses common market valuation factors for the start and end of the period.

Policy on remuneration of non-executive directors

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

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

Non-executive director service contracts

Name and Title	Date of Appointment	Unexpired Term at 31 March 18	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	0 months	6 months	None	Left NHS England on 31 October 2018
Lord David Prior Chair	31 October 2018	43 months	6 months	None	
David Roberts CBE Vice-Chair	1 July 2014, reappointed to a second term on 1 July 2018	27 months	None	None	Waived entitlement to remuneration
Lord Victor Adebowale CBE Non-executive director	1 July 2012, reappointed to a second term on 1 January 2015	0 months	None	None	Left NHS England 31 December 2018
Professor Sir John Burn Non-executive director	1 July 2014	0 months	None	None	Left NHS England 30 June 2018
Dame Moira Gibb Non-executive director	1 July 2012, reappointed to a second term on 1 January 2015	0 months	None	None	Left NHS England 31 December 2018
Noel Gordon Non-executive director	1 July 2014, reappointed to a second term on 1 July 2018	27 months	None	None	
Wendy Becker Non-executive director	1 March 2016	11 months	None	None	Waived entitlement to remuneration from September 2016.
Michelle Mitchell OBE Non-executive director	1 March 2016	11 months	None	None	
Joanne Shaw Non-executive director	1 October 2016	18 months	None	None	
Richard Douglas CB Associate Non-executive director	1 March 2018	11 months	None	None	
Professor Sir Munir Pirmohamed Non-executive director	1 January 2019	33 months	None	None	

Non-executive director remuneration (including salary entitlements)

Salaries and allowances 2018/19 (subjected to audit)

Name of non-executive director	2018/19					
	A: Salary (bands of £5,000	**B: Benefits in kind (taxable)** Rounded to nearest £100	**C: Performance pay and bonuses** (bands of £5,000)	**D: Long term performance pay and bonuses** (bands of £5,000)	**E: All pension-related benefits[91]** (bands of £2,500)	**F: TOTAL (A to E)** (bands of £5,000)
	£000	**£s**	**£000**	**£000**	**£000**	**£000**
Professor Sir Malcolm Grant Chair[92]	35-40 (pro-rata)	0	0	0	N/A	35-40 (pro-rata)
Lord David Prior Chair[93]	25-30 (pro-rata)	0	0	0	N/A	25-30 (pro-rata)
David Roberts CBE Vice-Chair[94]	0	0	0	0	N/A	0
Lord Victor Adebowale CBE[95]	5-10	0	0	0	N/A	5-10
Wendy Becker[96]	0	0	0	0	N/A	0
Professor Sir John Burn[97]	0-5 (pro-rata)	0	0	0	N/A	0-5 (pro-rata)
Dame Moira Gibb[98]	5-10 (pro-rata)	0	0	0	N/A	5-10 (pro-rata)
Noel Gordon	5-10	0	0	0	N/A	5-10
Michelle Mitchell OBE	5-10	0	0	0	N/A	5-10
Joanne Shaw	25-30	0	0	0	N/A	25-30
Richard Douglas CB[99] Associate non-voting	5-10	0	0	0	N/A	5-10
Professor Sir Munir Pirmohamed[100]	0-5 (pro-rata)	0	0	0	N/A	0-5 (pro-rata)

91 Non-executive directors do not receive pensionable remuneration, and therefore have no pension related benefits.

92 Professor Sir Malcolm Grant's unpaid leave overpayment of £3,188 reported in 2017/18 was recovered in 2018/19. The overpayment recovery is not included in the total remuneration figures disclosed. Professor Sir Malcolm Grant left on 31 October 2018. The full year equivalent salary is £60,000-65,000.

93 Lord David Prior joined NHS England on 31 October 2018 as Chair, to replace Professor Sir Malcolm Grant, however was paid from the incorrect start date of 1 November 2018 leading to an underpayment of £169.35, which will be paid in 2019/20. In 2018/19 pension deductions of £3,281.25 were taken in error from Lord David Prior; these pension deductions will be refunded in full during the 2019/20 financial year. The underpayments are not included in the total remuneration figures disclosed. The full year equivalent salary is £60,000-£65,000.

94 David Roberts CBE has waived his entitlement to non-executive director remuneration. David Roberts CBE is also an associate (non-voting) non-executive director at NHS Improvement.

95 Lord Victor Adebowale CBE left on 31 December 2018. The full year equivalent salary is £5,000-£10,000.

96 Wendy Becker waived her entitlement to non-executive director remuneration from the 1 September 2016. In 2016/17 pension deductions were taken in error from Wendy Becker, initially these were planned to be refunded in 2017/18, the actual refund was processed in 2018/19. Wendy Becker also received an incorrect tax refund in 2018/19, this refund was recovered in year.

97 Professor Sir John Burn left on 30 June 2018. The full year equivalent salary is £5,000-£10,000.

98 Dame Moira Gibb left 31 December 2018. The full year equivalent salary is £5,000-£10,000.

99 Richard Douglas CB is a non-executive director at NHS Improvement.

100 Professor Sir Munir Pirmohamed joined on 1 January 2019. Due to an error with onboarding, Sir Munir Pirmohamed did not receive remuneration for the period 1 January 2019 to 31 May 2019 leading to an underpayment of £3,284.60, which will be paid in 2019/20. The underpayments are not included in the total remuneration figures disclosed. The full year equivalent salary is £5,000-£10,000.

Salaries and allowances 2017/18

Name of non-executive director	2017/18					
	A: Salary (bands of £5,000)	**B: Benefits in kind (taxable)** Rounded to nearest £100	**C: Performance pay and bonuses** (bands of £5,000)	**D: Long term performance pay and bonuses** (bands of £5,000)	**E: All pension-related benefits[101]** (bands of £2,500)	**F: TOTAL (A to E)** (bands of £5,000)
	£000	**£s**	**£000**	**£000**	**£000**	**£000**
Professor Sir Malcolm Grant Chair[102]	55-60 (pro-rata)	0	0	0	N/A	55-60 (pro-rata)
David Roberts CBE Vice-Chair[103]	0	0	0	0	N/A	0
Lord Victor Adebowale CBE	5-10	0	0	0	N/A	5-10
Wendy Becker[104]	0	0	0	0	N/A	0
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[105]	5-10	0	0	0	N/A	5-10
Joanne Shaw[106]	25-30	0	0	0	N/A	25-30
Richard Douglas CB From 1 March 2018 Associate non-voting[107]	0-5 (pro-rata)	0	0	0	N/A	0-5 (pro-rata)

101 Non-executive directors do not receive pensionable remuneration, and therefore have no pension related benefits.

102 Professor Sir Malcolm Grant chose to take six weeks unpaid leave from 12 February 2018 to 23 March 2018. This period of unpaid leave is included in the pro rata salary disclosed. During the period of unpaid leave an overpayment of £3,188 was paid in error to Professor Sir Malcolm Grant which will be subject to recovery in 2018/19. The overpayment is not included in the total remuneration figures disclosed. The full year equivalent salary is £60,000-£65,000.

103 David Roberts CBE has waived his entitlement to non-executive director remuneration. David Roberts CBE also covered the role of Chair for the six-week period of unpaid leave taken by Professor Sir Malcolm Grant, to which he waived his entitlement to remuneration. David Roberts CBE is also an associate (non-voting) non-executive director at NHS Improvement.

104 Wendy Becker waived her entitlement to non-executive director remuneration from the 1 September 2016. In 2016/17 pension deductions were taken in error from Wendy Becker, initially these were planned to be refunded in 2017/18, the actual refund will now be made in 2018/19. The underpayment is not included in the total remuneration figures disclosed.

105 Pension contributions were taken in error from Michelle Mitchell during 2016/17. These were discovered and fully refunded in 2017/18. The underpayment is not included in the remuneration figures disclosed.

106 Joanne Shaw received a gross overpayment of £4,379 during the reporting periods 2016/17 and 2017/18, due to the incorrect payment of a High Cost Allowance. This has been fully recovered in the 2017/18 reporting period. The overpayment is not included in the remuneration figures disclosed.

107 Richard Douglas joined NHS England as an Associate non-voting NED on 1 March 2018. The full year equivalent salary is £5,000-£10,000. Richard Douglas is a non-executive director at NHS Improvement.

Parliamentary accountability and audit report

All elements of this report are subject 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 of 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 and are therefore subject to special control procedures compared to the generality of payments. They are divided into different categories, which govern the way that individual cases are handled.

Details of any losses and special payments relating to CCGs can be found within individual CCG annual reports which are published on CCG websites. A list of CCGs, along with links to their websites, can be found on the NHS England website.[108]

Losses and special payments

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

Losses

	Parent				Consolidated Group			
	Total number of cases 2018/19	Total value of cases 2018/19	Total number of cases 2017/18	Total value of cases 2017/18	Total number of cases 2018/19	Total value of cases 2018/19	Total number of cases 2017/18	Total value of cases 2017/18
	Number	£000	Number	£000	Number	£000	Number	£000
Administrative write-offs	-	-	31	358	50	885	314	20,749
Fruitless payments	54	161	44	6	79	325	86	15
Stores losses	-	-	-	-	2	1	7	4
Bookeeping losses	66	5	71	5	69	19	71	5
Cash losses	-	-	-	-	12	19	8	468
Claims abandoned	70,770	4,565	1	34	70,776	4,600	2	43
Total	**70,890**	**4,731**	**147**	**403**	**70,988**	**5,849**	**488**	**21,284**

108 www.england.nhs.uk/ccg-details

2018/19 Disclosure: Administrative write offs

Included within Administrative write-off in the group is a loss declared by NHS Devon CCG (280k) of write off of receivables and by NHS Swindon CCG (170k), a write off a risk stratification tool due to obsolescence.

2018/19 Disclosure: Fruitless payments

NHS Swindon CCG recognised a receivable of £150k as part of the solvent closure of SEQOL. Initial indications from the administration process were that the CCG would receive a refund once all liabilities had been settled and tax positions had been declared. SEQOL ceased to operate in September 2016 and as we are now at the end of 2018/19 the likelihood of the CCG receiving a distribution is low and so NHS Swindon CCG are impairing the debt.

2018/19 Disclosure: Claims Abandoned

For the first time included within total losses are penalty charge notices issued by NHS BSA on behalf of NHS England to individuals who obtained exemptions for prescription or dental charges for which it was subsequently confirmed that they were not eligible. The National Health Service Act 2006 (as amended) entitles the NHS to issue such notices. In some exceptional circumstances "easements" are offered to specific patients (e.g. for vulnerable individuals) such that the penalty charge notices are not pursued for payment. The number and value of easements issued in 2018/19 are considered to be "claims abandoned". However, given no individual easement exceeds £300,000 they are included solely within the total number and value of losses in the table. The 2017/18 comparatives have not been restated on materiality grounds which explains the significant increase in the number of losses year-on-year.

Easements were also issued in prior years to 2018/19 following the introduction of penalty charge notices. In previous years they were not classified as "claims abandoned" in the Parliamentary accountability and audit report and were not therefore recorded as losses in the report. The presentational change has arisen as a result of review of disclosure requirements in this area.

2017/18 Disclosure: Admin Write Offs

Included within Administrative write offs in the group is a loss declared by NHS Horsham and Mid Sussex CCG (£7,305k), NHS Crawley CCG (£5,106k) and NHS Brighton & Hove CCG (£1,393k) relating to contract payments to providers which have been deemed to be irrecoverable.

The value also includes a receivables impairment in Nene CCG (2017/18 £2,658k) for outstanding debt with a local authority.

2017/18 Disclosure: Cash Losses

NHS Newham CCG declared a cash loss of £383k which relates to payments made in financial years 2014/15 to 2016/17 by a third party on behalf of the CCG through a contracting arrangement. There have been no further such payments.

Special payments

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

	Parent				Consolidated Group			
	Total number of cases 2018/19	Total value of cases 2018/19	Total number of cases 2017/18	Total value of cases 2017/18	Total number of cases 2018/19	Total value of cases 2018/19	Total number of cases 2017/18	Total value of cases 2017/18
	Number	£000	Number	£000	Number	£000	Number	£000
Compensation payments	1	1	5	30	7	192	10	95
Extra Contractual Payments	1,083	300	6,950	3,839	1,088	432	6,961	5,373
Ex Gratia Payments	1	1	1	5	23	99	11	46
Extra Statutory Extra Regulatory Payments	-	-	-	-	2	22	-	-
Special Severance Payments Treasury Approved	-	-	-	-	1	3	-	-
Total	**1,085**	**302**	**6,956**	**3,874**	**1,121**	**748**	**6,982**	**5,514**

2017/18: Extra contractual payments

Included within extra contractual payments in the parent is a loss for £3 million to meet the expected cost of compensation payments in respect of operational issues with the delivery of Primary Care Support Services. Claims are reviewed on an individual basis and cover items such as claims for interest and charges, claims relating to lost earning as a result of issues with the National Performers List and other payment delays.

In 2016 Guildford and Waverley CCG ran a procurement process for the Surrey Children's Community Health Service on behalf of itself, five other CCGs, NHS England (together the "NHS Commissioners") and Surrey County Council.

The procurement process was challenged and, following legal advice and a mediation process, the parties involved agreed on an out of court settlement and a total payment of £1.560 million has been made in 2017/18 on behalf of all of NHS commissioners. As an organisation NHS England paid £220,000 of the settlement sum.

Cost allocation and setting of charges

NHS England certifies that it has complied with HM Treasury guidance on cost allocation and the setting of charges. The following provides details of income generation activities whose full cost exceeded £1 million or was otherwise material:

2018/19		Parent			Consolidated Group		
	Note	Income £000	Full cost £000	Surplus (deficit) £000	Income £000	Full cost £000	Surplus (deficit) £000
Dental	2 & 4	856,384	(2,919,876)	(2,063,492)	856,384	(2,919,876)	(2,063,492)
Prescription	2 & 4	583,809	(1,943,531)	(1,359,722)	591,960	(10,171,990)	(9,580,030)
Total fees & charges		**1,440,193**	**(4,863,407)**	**(3,423,214)**	**1,448,344**	**(13,091,866)**	**(11,643,522)**

2017/18		Parent			Consolidated Group		
	Note	Income £000	Full cost £000	Surplus (deficit) £000	Income £000	Full cost £000	Surplus (deficit) £000
Dental	2 & 4	807,333	(2,944,521)	(2,137,188)	807,333	(2,944,521)	(2,137,188)
Prescription	2 & 4	567,594	(1,942,072)	(1,374,478)	575,963	(10,467,886)	(9,891,923)
Total fees & charges		**1,374,927**	**(4,886,593)**	**(3,511,666)**	**1,383,296**	**(13,412,407)**	**(12,029,111)**

The fees and charges information in this note is provided in accordance with section 3.2.12 of the Government Financial Reporting Manual. It is provided for fees and charges purposes and not for 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[109] are a contribution to the cost of pharmaceutical services including the supply of drugs. In 2017/18, the NHS prescription charge for each medicine or appliance dispensed was £8.60, and in 2018/19 it was £8.80. However, around 90% of prescription items[110] are dispensed free each year where patients are exempt from charges. In addition, patients who were eligible to pay charges could purchase pre-payment certificates at £29.10 for three months or £104.00 for a year. A number of other charges were payable for wigs and fabric supports.

Those who are not eligible for exemption are required to pay NHS dental charges[111] which fall into three bands depending on the level and complexity of care provided. In 2017/18, the charge for Band 1 treatments was £20.60, for Band 2 was £56.30 and for Band 3 was £244.30. In 2018/19, the charge for Band 1 treatment was £21.60, for Band 2 was £59.10 and for Band 3 was £256.50.

109 https://www.gov.uk/government/speeches/nhs-prescription-charges-from-april-2017
https://www.gov.uk/government/speeches/nhs-prescription-charges-from-1-april-2018

110 https://digital.nhs.uk/data-and-information/publications/statistical/prescriptions-dispensed-in-the-community/prescriptions-dispensed-in-the-community-england---2007---2017

111 https://www.parliament.uk/business/publications/written-questions-answers-statements/written-statement/commons/2018-03-12/HCWS537/

Certificate and Report of the Comptroller and Auditor General to the House of Commons

Opinion on financial statements

I certify that I have audited the financial statements of the NHS Commissioning Board for the year ended 31 March 2019 under the Health and Social Care Act 2012. The financial statements comprise: the Group and Parent Statements of Comprehensive Net Expenditure, Financial Position, Cash Flows, Changes in Taxpayers' Equity; and the related notes. These financial statements have been prepared under the accounting policies set out within them. I have also audited the information in the Remuneration and Staff Report and the Parliamentary Accountability and Audit Report that is described in that report as having been audited.

In my opinion:

- the financial statements give a true and fair view of the state of the group's and of NHS Commissioning Board's affairs as at 31 March 2019 and of the group's and the parent's net operating costs for the year then ended; and
- the financial statements have been properly prepared in accordance with the Health and Social Care Act 2012 and Secretary of State directions issued thereunder.

Opinion on regularity

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

Basis of opinions

I conducted my audit in accordance with International Standards on Auditing (ISAs) (UK) and Practice Note 10 'Audit of Financial Statements of Public Sector Entities in the United Kingdom'. My responsibilities under those standards are further described in the Auditor's responsibilities for the audit of the financial statements section of my certificate. Those standards require me and my staff to comply with the Financial Reporting Council's Revised Ethical Standard 2016. I am independent of the NHS Commissioning Board in accordance with the ethical requirements that are relevant to my audit and the financial statements in the UK. My staff and I have fulfilled our other ethical responsibilities in accordance with these requirements. I believe that the audit evidence I have obtained is sufficient and appropriate to provide a basis for my opinion.

Conclusions relating to going concern

I am required to conclude on the appropriateness of management's use of the going concern basis of accounting and, based on the audit evidence obtained, whether a material uncertainty exists related to events or conditions that may cast significant doubt on the group's and the NHS Commissioning Board's ability to continue as a going concern for a period of at least twelve months from the date of approval of the financial statements. If I conclude that a material uncertainty exists, I am required to draw attention in my auditor's report to the related disclosures in the financial statements or, if such disclosures are inadequate, to modify my opinion. My conclusions are based on the audit evidence obtained up to the date of my auditor's report. However, future events or conditions may cause the entity to cease to continue as a going concern. I have nothing to report in these respects.

Responsibilities of the Board and the Accounting Officer for the financial statements

As explained more fully in the Statement of Accounting Officer's Responsibilities, the Board and the Accounting Officer are responsible for the preparation of the financial statements and for being satisfied that they give a true and fair view.

Auditor's responsibilities for the audit of the financial statements

My responsibility is to audit, certify and report on the financial statements in accordance with the Health and Social Care Act 2012.

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. Reasonable assurance is a high level of assurance, but is not a guarantee that an audit conducted in accordance with ISAs will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in the aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of these financial statements.

As part of an audit in accordance with ISAs, I exercise professional judgment and maintain professional scepticism throughout the audit. I also:

- identify and assess the risks of material misstatement of the financial statements, whether due to fraud or error, design and perform audit procedures responsive to those risks, and obtain audit evidence that is sufficient and appropriate to provide a basis for my opinion. The risk of not detecting a material misstatement resulting from fraud is higher than for one resulting from error, as fraud may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal control.
- obtain an understanding of internal control relevant to the audit in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the group's and the NHS Commissioning Board's internal control.
- evaluate the appropriateness of accounting policies used and the reasonableness of accounting estimates and related disclosures made by management.

- evaluate the overall presentation, structure and content of the financial statements, including the disclosures, and whether the consolidated financial statements represent the underlying transactions and events in a manner that achieves fair presentation.
- obtain sufficient appropriate audit evidence regarding the financial information of the entities or business activities within the Group to express an opinion on the consolidated financial statements. I am responsible for the direction, supervision and performance of the group audit. I remain solely responsible for my audit opinion.

I communicate with those charged with governance regarding, among other matters, the planned scope and timing of the audit and significant audit findings, including any significant deficiencies in internal control that I identify during my audit.

In addition, I am required to obtain evidence sufficient to give reasonable assurance that the income and expenditure reported in the financial statements have been applied to the purposes intended by Parliament and the financial transactions conform to the authorities which govern them.

Other information

The Board and the Accounting Officer are responsible for the other information. The other information comprises information included in the annual report, other than the parts of the Accountability Report described in that report as having been audited, the financial statements and my auditor's report thereon. My opinion on the financial statements does not cover the other information and I do not express any form of assurance conclusion thereon. In connection with my audit of the financial statements, my responsibility is to read the other information and, in doing so, consider whether the other information is materially inconsistent with the financial statements or my knowledge obtained in the audit or otherwise appears to be materially misstated. If, based on the work I have performed, I conclude that there is a material misstatement of this other information, I am required to report that fact. I have nothing to report in this regard.

Opinion on other matters

In my opinion:

- the 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;
- in the light of the knowledge and understanding of the group and the parent and its environment obtained in the course of the audit, I have not identified any material misstatements in the Performance Report or the Accountability Report; and
- the information given in 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; or
- the financial statements and the parts 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; or
- I have not received all of the information and explanations I require for my audit; or
- the Governance Statement does not reflect compliance with HM Treasury's guidance.

Report

I have no observations to make on these financial statements.

Gareth Davies 10 July 2019

Comptroller and Auditor General

National Audit Office | 157-197 Buckingham Palace Road | Victoria, London, SW1W 9SP

Annual Accounts

Simon Stevens
Accounting Officer
3 July 2019

Statement of comprehensive net expenditure for the year ended 31 March 2019

		Parent		Consolidated Group	
			Re-presented		Re-presented
	Note	2018/19	2017/18	2018/19	2017/18
		£000	£000	£000	£000
Income from sale of goods and services	2	(1,916,960)	(1,949,718)	(1,993,191)	(1,893,869)
Other operating income	2	(3,636)	(89,026)	(111,019)	(289,406)
Total operating income		**(1,920,596)**	**(2,038,744)**	**(2,104,210)**	**(2,183,275)**
Staff costs	3	771,793	729,648	1,949,413	1,843,109
Purchase of goods and services	4	113,094,005	109,170,258	112,496,829	108,641,524
Depreciation and impairment charges	4	117,401	90,184	132,065	103,315
Provision expense	4	(28,953)	(3,240)	(3,024)	49,562
Other operating expenditure	4	277,547	200,419	394,160	309,271
Total operating expenditure		**114,231,793**	**110,187,269**	**114,969,443**	**110,946,781**
Net operating expenditure		**112,311,197**	**108,148,525**	**112,865,233**	**108,763,506**
Finance expense	11	533	(1,089)	644	(1,263)
Net expenditure for the year		**112,311,730**	**108,147,436**	**112,865,877**	**108,762,243**
Other (gains)/losses		-	-	33	143
Total net expenditure for the year		**112,311,730**	**108,147,436**	**112,865,910**	**108,762,386**
Other comprehensive net expenditure					
Items which will not be reclassified to net operating costs					
Actuarial (gain)/loss in pension schemes		-	-	871	(850)
Sub total		-	-	871	(850)
Comprehensive net expenditure for the year		**112,311,730**	**108,147,436**	**112,866,781**	**108,761,536**

The Group has applied IFRS 15 in the financial year. Under the transition method chosen, comparatives have not been restated, except for a presentational change in the categorisation of income (see note 2 for further details).

The notes on pages 149 to 190 form part of this statement.

Statement of financial position as at 31 March 2019

		Parent		Consolidated Group	
		31 March 2019	31 March 2018	31 March 2019	31 March 2018
	Note	£000	£000	£000	£000
Non-current assets					
Property, plant and equipment	6	393,207	350,557	433,679	390,371
Intangible assets	7	3,516	4,857	8,615	11,256
Trade and other receivables	8	-	-	538	443
Other financial assets	8	-	-	554	554
Total non-current assets		**396,723**	**355,414**	**443,386**	**402,624**
Current assets					
Inventories		37,027	28,102	48,932	36,911
Trade and other receivables	8	206,923	243,143	966,282	1,008,482
Cash and cash equivalents	9	188,941	144,765	205,488	165,745
Total current assets		**432,891**	**416,010**	**1,220,702**	**1,211,138**
Total assets		**829,614**	**771,424**	**1,664,088**	**1,613,762**
Current liabilities					
Trade and other payables	10	(4,527,004)	(3,850,294)	(10,598,850)	(9,381,168)
Provisions	12	(30,693)	(71,857)	(135,082)	(177,931)
Total current liabilities		**(4,557,697)**	**(3,922,151)**	**(10,733,932)**	**(9,559,099)**
Total assets less current liabilities		**(3,728,083)**	**(3,150,727)**	**(9,069,844)**	**(7,945,337)**
Non-current liabilities					
Trade and other payables	10	(26)	(26)	(4,535)	(3,285)
Provisions	12	(22,204)	(11,151)	(41,886)	(26,221)
Total non-current liabilities		**(22,230)**	**(11,177)**	**(46,421)**	**(29,506)**
Total assets less total liabilities		**(3,750,313)**	**(3,161,904)**	**(9,116,265)**	**(7,974,843)**
Financed by taxpayers' equity and other reserves					
General fund		(3,750,313)	(3,161,904)	(9,110,735)	(7,970,187)
Revaluation reserve		-	-	34	37
Other reserves		-	-	(5,564)	(4,693)
Total taxpayers' equity		**(3,750,313)**	**(3,161,904)**	**(9,116,265)**	**(7,974,843)**

The notes on pages 149 to 190 form part of this statement.

The financial statements on pages 144 to 148 were approved by the Board on 27 June 2019 and signed on its behalf by: Simon Stevens, Accounting Officer.

Statement of changes In taxpayers equity for the year ended 31 March 2019

Parent	General fund £000	Revaluation reserve £000	Other reserves £000	Taxpayers equity £000
Changes in taxpayers' equity for 2018/19				
Balance at 1 April 2018	**(3,161,904)**	**-**	**-**	**(3,161,904)**
Impact of applying IFRS 9 to Opening Balances	(1,983)	-	-	(1,983)
Impact of applying IFRS 15 to Opening Balances	-	-	-	-
Restated balance at 1 April 2018	**(3,163,887)**	**-**	**-**	**(3,163,887)**
Changes in taxpayers' equity for 2018/19				
Total Net Expenditure for the financial year	(112,311,730)	-	-	**(112,311,730)**
Comprehensive net expenditure for the year	**(112,311,730)**	-	-	**(112,311,730)**
Grant in Aid	111,725,304	-	-	111,725,304
Balance at 31 March 2019	**(3,750,313)**	-	-	**(3,750,313)**

Parent	General fund £000	Revaluation reserve £000	Other reserves £000	Taxpayers equity £000
Changes in taxpayers' equity for 2017/18				
Balance at 1 April 2017	**(2,537,555)**	-	-	**(2,537,555)**
Changes in taxpayers' equity for 2017/18				
Total Net Expenditure for the financial year	(108,147,436)	-	-	(108,147,436)
Comprehensive net expenditure for the year	**(108,147,436)**	-	-	**(108,147,436)**
Grant in Aid	107,523,087	-	-	107,523,087
Balance at 31 March 2018	**(3,161,904)**	-	-	**(3,161,904)**

Consolidated Group	General fund £000	Revaluation reserve £000	Other reserves £000	Taxpayers equity £000
Changes in taxpayers' equity for 2018/19				
Balance at 1 April 2018	**(7,970,187)**	**37**	**(4,693)**	**(7,974,843)**
Impact of applying IFRS 9 to Opening Balances	55	-	-	55
Impact of applying IFRS 15 to Opening Balances	-	-	-	-
Restated balance at 1 April 2018	**(7,970,132)**	**37**	**(4,693)**	**(7,974,788)**
Changes in taxpayers' equity for 2018/19				
Total Net Expenditure for the financial year	(112,865,910)	-	-	(112,865,910)
Movements in other reserves	-	-	(871)	(871)
Transfers between reserves	3	(3)	-	-
Comprehensive net expenditure for the year	**(112,865,907)**	**(3)**	**(871)**	**(112,866,781)**
Grant in Aid	111,725,304	-	-	111,725,304
Balance at 31 March 2019	**(9,110,735)**	**34**	**(5,564)**	**(9,116,265)**

Consolidated Group	General fund £000	Revaluation reserve £000	Other reserves £000	Taxpayers equity £000
Changes in taxpayers' equity for 2017/18				
Balance at 1 April 2017	**(6,730,907)**	**42**	**(5,543)**	**(6,736,408)**
Changes in taxpayers' equity for 2017/18				
Total Net Expenditure for the financial year	(108,762,386)	-	-	(108,762,386)
Movements in other reserves	-	-	850	850
Transfers between reserves	5	(5)	-	-
Release of reserves to the Statement of Comprehensive Net Expenditure	14	-	-	14
Comprehensive net expenditure for the year	**(108,762,367)**	**(5)**	**850**	**(108,761,522)**
Grant in Aid	107,523,087	-	-	107,523,087
Balance at 31 March 2018	**(7,970,187)**	**37**	**(4,693)**	**(7,974,843)**

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

The notes on pages 149 to 190 form part of this statement.

Statement of cash flows for the year ended 31 March 2019

	Note	Parent		Consolidated Group	
		2018/19 £000	2017/18 £000	2018/19 £000	2017/18 £000
Cash flows from operating activities					
Net expenditure for the financial year		(112,311,730)	(108,147,436)	(112,865,910)	(108,762,243)
Depreciation and amortisation	4	117,401	90,184	131,524	103,293
Impairments and reversals	4	-	-	541	22
Non-cash movements arising on application of new accounting standards		(1,983)	-	55	-
Other non cash adjustments[1]		-	-	(223)	(173)
(Gain)/Loss on disposal		-	-	32	-
Unwinding of discount	11	533	(1,089)	588	(1,306)
Change in discount rate	12	(461)	(227)	(275)	(291)
(Increase)/decrease in inventories		(8,925)	(17,508)	(12,021)	(19,563)
(Increase)/decrease in trade & other receivables	8	36,220	(5,229)	42,105	(46,582)
Increase/(decrease) in trade & other payables	10	680,851	550,937	1,205,728	1,213,633
Provisions utilised	12	(1,692)	(5,581)	(24,902)	(30,294)
Increase/(decrease) in provisions	12	(28,491)	(3,013)	(2,595)	49,853
Net cash outflow from operating activities		**(111,518,277)**	**(107,538,962)**	**(111,525,353)**	**(107,493,651)**
Cash flows from investing activities					
Payments for property, plant and equipment		(161,824)	(101,031)	(164,579)	(131,634)
Payments for intangible assets		(1,027)	(2,214)	(1,826)	(4,242)
Proceeds from disposal of assets: property, plant and equipment		-	-	140	1,265
Proceeds from disposal of assets: intangible assets		-	-	-	-
Net cash outflow from investing activities		**(162,851)**	**(103,245)**	**(166,265)**	**(134,611)**
Net cash outflow before financing activities		**(111,681,128)**	**(107,642,207)**	**(111,691,618)**	**(107,628,262)**
Cash flows from financing activities					
Grant in aid funding received		111,725,304	107,523,087	111,725,304	107,523,087
Capital element of payments in respect of finance leases		-	-	(88)	(85)
Net cash inflow from financing activities		**111,725,304**	**107,523,087**	**111,725,216**	**107,523,002**
Net increase/(decrease) in cash & cash equivalents		**44,176**	**(119,120)**	**33,598**	**(105,260)**
Cash & cash equivalents at the beginning of the financial period	9	144,765	263,885	163,096	268,356
Cash & cash equivalents at the end of the financial year	9	**188,941**	**144,765**	**196,694**	**163,096**

The notes on pages 149 to 190 form part of this statement.

There is no separate disclosure under IAS 7 for cash and non cash movements for financing activities because the values are immaterial.

1 Other non cash adjustments comprise a non cash credit on lease charges of £12k (2017/18 £5k charge) and a pensions credit of £211k (2017/18 £178k credit).

Notes to the financial statements

1. Statement of accounting policies

These financial statements have been prepared in a form directed by the Secretary of State under Schedule 1(A), paragraph 15(2) of the Health and Social Care Act 2012 and in accordance with the 2018/19 DHSC Group Accounting Manual (DHSC GAM) issued by the Department of Health & Social Care and comply with HM Treasury's Financial Reporting Manual 2018/19 (FReM). The accounting policies contained in the DHSC GAM apply International Financial Reporting Standards (IFRS) as adapted or interpreted for the public sector context. Where the DHSC GAM permits a choice of accounting policy, the accounting policy which is judged to be most appropriate to the particular circumstances of NHS England for the purpose of giving a true and fair view has been selected. The particular policies adopted by NHS England are described below. They have been applied consistently in dealing with items considered material to the accounts.

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

Exchange gains and losses on monetary items (arising on settlement of the transaction or on retranslation at the Statement of Financial Position date) are recognised in the Statement of Comprehensive Net Expenditure in the period in which they arise.

1.1 Operating segments

Income and expenditure are analysed in the Operating Segments note (note 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 of property, plant and equipment, intangible assets, and certain financial assets and financial liabilities.

1.3 Basis of consolidation

These accounts comprise the results of the NHS England statutory entity as well as the consolidated position of NHS England and its 195 related CCGs. Transactions between entities included in the consolidation are eliminated.

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 2018. In the current year the parent and group have applied IFRS 9 and IFRS 15. As per the HMT FReM the cumulative catch up method has been applied and comparatives for prior years have not been restated.

1.5 Going concern

NHS England's financial statements are produced on a going concern basis. NHS England is supply-financed and draws its funding from the Department of Health & Social Care. Parliament has demonstrated its commitment to fund the Department of Health & Social Care for the foreseeable future via the latest Spending Review and the passing of the Health and Social Care Act 2012. In the same way, the Department of Health & Social Care has demonstrated commitment to the funding of NHS England (with funding flows for the 2019/20 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 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 transition to IFRS 15 has been completed in accordance with paragraph C3 (b) of the Standard, applying the Standard retrospectively recognising the cumulative effects at the date of initial application.

In the adoption of IFRS 15 a number of practical expedients offered in the Standard have been employed. These are as follows:

- As per paragraph 121 of the Standard NHS England will not disclose information regarding the performance obligations part of a contract that has an original expected duration of one year or less.
- NHS England is to similarly not disclose information where revenue is recognised in line with the practical expedient offered in paragraph B16 of the Standard where the right to consideration corresponds directly with value of the performance completed to date.
- The FReM has mandated the exercise of the practical expedient offered in C7(a) of the Standard that requires NHS England to reflect the aggregate effect of all contracts modified before the date of initial application.

The main source of funding for NHS England is grant-in-aid from the Department of Health & Social Care. NHS England is required to maintain expenditure within this allocation. The Department of Health & Social Care also approves a cash limit for the period. NHS England

is required to draw down cash in accordance with this limit. Grant-in-aid is drawn down and credited to the general fund. Grant-in-aid is recognised in the financial period in which it is received.

Revenue in respect of services provided is recognised when (or as) performance obligations are satisfied by transferring promised services to the customer, and is measured at the amount of the transaction price allocated to that performance obligation.

IFRS 15 is applicable to revenue in respect of dental and prescription charges in line with the adaptation in IFRS 15 which states that the definition of a contract includes revenue received under legislation and regulations. Revenue for these charges is recognised when the performance event occurs e.g. the issue of a prescription or payment for dental treatment.

Where income is received for a specific performance obligation that is to be satisfied in the following year, that income is deferred.

Other operating revenue is recognised when the service is rendered and the stage completion of the transaction at the end of the reporting period can be measured reliably, and it is probable that the economic benefit associated with the transaction will flow to the group. Income is measured at fair value of the consideration receivable.

The value of the benefit received when NHS England accesses funds from the Government's apprenticeship service are recognised as income in accordance with IAS 20, Accounting for Government Grants. Where these funds are paid directly to an accredited training provider, non-cash income and a corresponding non-cash training expense are recognised, both equal to the cost of the training funded.

1.8 Employee benefits

Recognition of short-term benefits - retirement benefit costs:

Past and present employees are covered by the provisions of the NHS Pensions Schemes. The schemes are unfunded, defined benefit schemes that cover NHS employers, general practitioners and other bodies allowed under the direction of the Secretary of State in England and Wales. The schemes are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying assets and liabilities. Therefore, the schemes are accounted for as if they were a defined contribution scheme; the cost recognised in these accounts represents the contributions payable for the year. Details of the benefits payable under these provisions can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions.

For early retirements other than those due to ill health, the additional pension liabilities are not funded by the scheme. The full amount of the liability for the additional costs is charged to expenditure at the time the organisation commits itself to the retirement, regardless of the method of payment.

The schemes are subject to a full actuarial valuation every four years and an accounting valuation every year.

Salaries, wages and employment related payments, including payments arising from the apprenticeship levy, are recognised in the period in which the service is received from employees. The cost of leave earned but not taken by employees at the end of the period is recognised in the financial statements to the extent that employees are permitted to carry forward leave into the following year.

1.9 Other expenses

Other operating expenses are recognised when, and to the extent that, the goods or services have been received. They are measured at the fair value of the consideration payable.

1.10 Value Added Tax

Most of the activities of the group are outside the scope of value added tax (VAT). Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of non-current assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

1.11 Property, Plant and Equipment Recognition

Property, plant and equipment is capitalised if:

- it is held for use in delivering services or for administrative purposes
- it is probable that future economic benefits will flow to, or service potential will be supplied to, the group
- it is expected to be used for more than one financial year
- the cost of the item can be measured reliably; and either
- the item cost at least £5,000, or
- collectively, a number of items have a total cost of at least £5,000 and individually have a cost of more than £250, where the assets are functionally interdependent, they have broadly simultaneous purchase dates, are anticipated to have simultaneous disposal dates and are under single managerial control.

Where an asset includes a number of components with significantly different asset lives, the components are treated as separate assets and depreciated over their individual useful economic lives.

Measurement of property, plant and equipment

All property, plant and equipment is measured initially at cost, representing the cost directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management. Assets that are held for their service potential and are in use are measured subsequently at their current value in existing use.

IT equipment, transport equipment, furniture and fittings, and plant and machinery that are held for operational use are valued at depreciated historical cost as a proxy for current value in existing use. This is in accordance with FReM requirements as these assets have short useful lives or low values or both.

Balances held in the Revaluation reserve relate to balances inherited as at 1st April 2013. In line with our accounting policy, no further revaluation gains have been recognised.

Subsequent expenditure

Where subsequent expenditure enhances an asset beyond its original specification, the directly attributable cost is capitalised. Where subsequent expenditure restores the asset to its original specification, the expenditure is capitalised and any existing carrying value of the item replaced is charged to operating expenses.

1.12 Intangible non-current assets

Intangible non-current assets are non-monetary assets without physical substance that are capable of sale separately from the rest of the group's business or arise from contractual or other legal rights. They are recognised only when it is probable that future economic benefits will flow to, or service potential be provided to, the group; where the cost of the asset can be measured reliably; and where the cost is at least £5,000.

Intangible non-current assets acquired separately are initially recognised at cost. Software that is integral to the operation of hardware is capitalised as part of the relevant item of property, plant and equipment. Software that is not integral to the operation of hardware is capitalised as an intangible asset.

Following initial recognition, intangible assets are carried at depreciated historic cost as a proxy for current value in existing use.

1.13 Research and development

Expenditure on research is not capitalised: it is recognised as an operating expense in the period in which it is incurred.

Internally generated assets are recognised if, and only if, all of the following have been demonstrated:

- the technical feasibility of completing the intangible asset so that it will be available for use
- the intention to complete the intangible asset and use it
- the ability to sell or use the intangible asset
- how the intangible asset will generate probable future economic benefits or service potential
- the availability of adequate technical, financial and other resources to complete the intangible asset and sell or use it
- the ability to reliably measure the expenditure attributable to the intangible asset during its development

The amount initially recognised for internally generated intangible assets is the sum of the expenditure incurred from the date when the criteria for recognition are initially met. Where no internally generated intangible asset can be recognised, the expenditure is recognised in the period in which it is incurred.

1.14 Depreciation, amortisation and impairments

Freehold land, assets under construction, investment properties, stockpiled goods and assets held for sale are neither depreciated nor amortised.

Otherwise, depreciation or amortisation, as appropriate, is charged to write off the costs or valuation of property, plant and equipment and intangible non-current assets, less any residual value, on a straight line basis over their estimated remaining useful lives. The estimated useful life of an asset is the period over which economic benefits or service potential is expected to be obtained from the asset. Estimated useful lives and residual values are reviewed each year end, with the effect of any changes recognised on a prospective basis. Assets held under finance leases are depreciated over the shorter of the lease term and the estimated useful life.

Depreciation/amortisation is charged as follows:

	Minimum life (years)	Maximum life (years)
Buildings excluding dwellings	5	20
Plant and machinery	5	10
Transport equipment	5	10
Information technology	2	10
Furniture and fittings	5	10
Computer software: purchased	2	5
Licences and trademarks	2	5
Development expenditure (internally generated)	2	5

A revaluation decrease that does not result from a loss of economic value or service potential is recognised as an impairment charged to the revaluation reserve to the extent that there is a balance on the reserve for the asset being impaired and, thereafter, to expenditure. Impairment losses that arise from a clear consumption of economic benefit are taken to expenditure. Where an impairment loss subsequently reverses, the carrying amount of the asset is increased to the revised estimate of the recoverable amount but capped at the amount that would have been determined had there been no initial impairment loss. The reversal of the impairment loss is credited to expenditure to the extent of the decrease previously charged there and thereafter to the revaluation reserve.

1.15 Government grants

Government grant funded assets are capitalised at their fair value on receipt, with a matching credit to income. Deferred income is recognised only where conditions attached to the grant preclude immediate recognition of the gain.

1.16 Non-current assets held for sale

Non-current assets are classified as held for sale if their carrying amount will be recovered principally through a sale transaction rather than through continuing use. This condition is satisfied once both of the following criteria are met:

- the asset is available for immediate sale in its present condition subject only to terms which are usual and customary for such sales; and
- the sale is highly probable.

Non-current assets held for sale are measured at the lower of their previous carrying amount and fair value less costs to sell. Fair value is open market value including alternative uses.

The profit or loss arising on disposal of an asset is the difference between the sale proceeds and the carrying amount and is recognised in the statement of comprehensive net expenditure. On disposal, the balance for the asset in the revaluation reserve is transferred to retained earnings.

Property, plant and equipment that is to be scrapped or demolished does not qualify for recognition as held for sale. Instead, it is retained as an operational asset and its economic life is adjusted. The asset is de-recognised when it is scrapped or demolished.

1.17 Leases

Leases are classified as finance leases when substantially all the risks and rewards of ownership are transferred to the lessee. All other leases are classified as operating leases.

Property, plant and equipment held under finance leases are initially recognised at the inception of the lease at fair value or, if lower, at the present value of the minimum lease payments, with a matching liability for the lease obligation to the lessor. Lease payments are apportioned between finance charges and reduction of the lease obligation to achieve a constant rate of interest on the remaining balance of the liability. Finance charges are recognised in the statement of comprehensive net expenditure.

Operating lease payments are recognised as an expense on a straight line basis over the lease term. Lease incentives are recognised initially as a liability and subsequently as a reduction of rentals on a straight line basis over the lease term.

Contingent rentals are recognised as an expense in the period in which they are incurred.

Where a lease is for land and buildings, the land and building components are separated and individually assessed as to whether they are operating or finance leases.

1.18 Inventories

Inventories are valued at the lower of cost and net realisable value, and are utilised using the First in First Out method of inventory controls.

1.19 Cash and cash equivalents

Cash is cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours. Cash equivalents are investments that mature in three months or less from the date of acquisition and are readily convertible to known amounts of cash with insignificant risk of change in value.

In the statement of cash flows, cash and cash equivalents are shown net of bank overdrafts that are repayable on demand and that form an integral part of cash management. Cash, bank and overdraft balances are recorded at current values.

1.20 Provisions

Provisions are recognised when there exists a present legal or constructive obligation as a result of a past event, it is probable that the group will be required to settle the obligation, and a reliable estimate can be made of the amount of the obligation. The amount recognised as a provision is the best estimate of the expenditure required to settle the obligation at the end of the reporting period, taking into account the risks and uncertainties. Where a provision is measured using the cash flows estimated to settle the obligation, its carrying amount is the present value of those cash flows using HM Treasury's discount rates.

Provisions are subject to three separate discount rates according to the expected timing of cashflows:

- A nominal short term rate of 0.76 percent (2017/18: minus 2.42 percent in real terms) is applied to inflation adjusted expected cash flows up to and including 5 years from Statement of Financial Position date.
- A nominal medium-term rate of 1.14% (2017/18: minus 1.85 percent in real terms) is applied to inflation adjusted expected cash flows over 5 years up to and including 10 years from the Statement of Financial Position date.
- A nominal long-term rate of 1.99% (2017/18: minus 1.56 percent in real terms) is applied to inflation adjusted expected cash flows over 10 years and up to and including 40 years from the Statement of Financial Position date.

All 2018/19 percentages are expressed in nominal terms with 2017/18 being the last financial year that HM Treasury provided real general provision discount rates.

1.21 Clinical negligence costs

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

1.22 Non-clinical risk pooling

The NHS England group participates in the Property Expenses Scheme and the Liabilities to Third Parties scheme. Both are risk pooling schemes under which NHS England and CCGs pay an annual contribution to NHS Resolution and, in return, receive assistance with the cost of claims arising. The annual membership contributions, and any excesses payable in respect of particular claims, are charged to operating expenses when they become due.

1.23 Contingent liabilities and contingent assets

A contingent liability is:

- A possible obligation that arises from past events and whose existence will be confirmed only by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the organisation.
- A present obligation that is not recognised because it is not probable that a payment will be required to settle the obligation or the amount of the obligation cannot be measured sufficiently reliably.

A contingent liability is disclosed unless the possibility of a payment is remote.

A contingent asset is a possible asset that arises from past events and whose existence will be confirmed by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the organisation. A contingent asset is disclosed where an inflow of economic benefits is probable.

Where the time value of money is material, contingent liabilities that are required to be disclosed under IAS37 are stated at discounted amounts.

1.24 Financial assets

Financial assets are recognised on the statement of financial position when the group becomes party to the financial instrument contract or, in the case of trade receivables, when the goods or services have been delivered. Financial assets are de-recognised when the contractual rights have expired or the asset has been transferred and the group has transferred substantially all of the risks and rewards of ownership or has not retained control of the asset.

As available for sale financial assets, the group's investments are measured at fair value. With the exception of impairment losses, changes in value are taken to the revaluation reserve. Accumulated gains or losses are recycled to the consolidated statement of net comprehensive expenditure on de-recognition.

Financial assets are classified into the following categories: financial assets at amortised cost, financial assets at fair value through other comprehensive income, and financial assets at fair value through profit and loss. The classification is determined by the cash flow and business model characteristics of the financial assets, as set out in IFRS 9, and is determined at the time of initial recognition.

1.24.1 Financial assets at amortised cost

Financial assets measured at amortised cost are those held within a business model whose objective is to hold financial assets in order to collect contractual cash flows and where the cash flows are solely payments of principal and interest. This includes most trade receivables, loans receivable, and other simple debt instruments.

After initial recognition, these financial assets are measured at amortised cost using the effective interest method, less any impairment. The effective interest rate is the rate that exactly discounts estimated future cash receipts through the life of the financial asset to the gross carrying amount of the financial asset.

1.24.2 Financial assets at fair value through other comprehensive income

Financial assets measured at fair value through other comprehensive income are those held within a business model whose objective is achieved by both collecting contractual cash flows, and selling financial assets and where the cash flows are solely payments of principal and interest.

1.24.3 Financial assets at fair value through profit and loss

Financial assets measured at fair value through profit or loss are those that are not otherwise measured at amortised cost or fair value through other comprehensive income. This includes derivatives and financial assets acquired principally for the purpose of selling in the short term.

1.24.4 Impairment

For all financial assets measured at amortised cost or at fair value through other comprehensive income (except equity instruments designated at fair value through other comprehensive income), lease receivables and contract assets, NHS England recognises a loss allowance representing expected credit losses on the financial instrument.

NHS England adopts the simplified approach to impairment, in accordance with IFRS 9, and measures the loss allowance for trade receivables, contract assets and lease receivables at an amount equal to lifetime expected credit losses. For other financial assets, the loss allowance is measured at an amount equal to lifetime expected credit losses if the credit risk on the financial instrument has increased significantly since initial recognition (stage 2), and otherwise at an amount equal to 12-month expected credit losses (stage 1).

HM Treasury has ruled that central Government bodies may not recognise stage 1 or stage 2 impairments against other Government departments, their executive agencies, the Bank of England, Exchequer Funds, and Exchequer Funds' assets where repayment is ensured by primary legislation. NHS England therefore does not recognise loss allowances for stage 1 or stage 2 impairments against these bodies. Additionally, the DHSC provides a guarantee of last resort against the debts of its ALBs and NHS bodies (excluding NHS charities), and NHS England does not recognise loss allowances for stage 1 or stage 2 impairments against these bodies.

For financial assets that have become credit impaired since initial recognition (stage 3), expected credit losses at the reporting date are measured as the difference between the asset's gross carrying amount and the present value of the estimated future cash flows discounted at the financial asset's original effective interest rate. Any adjustment is recognised in profit or loss as an impairment gain or loss.

1.25 Financial liabilities

Financial liabilities are recognised in the statement of financial position when the group becomes party to the contractual provisions of the financial instrument or, in the case of trade payables, when the goods or services have been received. Financial liabilities are de-recognised when the liability has been discharged; that is, the liability has been paid or has expired.

Financial liabilities are initially recognised at fair value.

After initial recognition, financial liabilities are measured at amortised cost using the effective interest method. The effective interest rate is the rate that exactly discounts estimated future cash payments through the life of the asset to the net carrying amount of the financial liability. Interest is recognised using the effective interest method.

1.26 Accounting standards that have been issued but have not yet been adopted

The FReM does not require the following Standards and Interpretations to be applied in 2018/19, these are applicable for accounting periods starting on or after 1 January 2019. These Standards are still subject to HM Treasury FReM adoption, with IFRS 16 being for implementation in 2020/21, and the Government's implementation date for IFRS 17 still subject to HM Treasury consideration.

IFRS 14 Regulatory Deferral Accounts (not applicable to Department of Health & Social Care group bodies).

IFRS 16 Leases – Application required for accounting periods beginning on or after 1 January 2019, but not yet adopted by the FReM: early adoption is not therefore permitted.

IFRS 17 Insurance Contracts – Application required for accounting periods beginning on or after 1 January 2021, but not yet adopted by the FReM: early adoption is not therefore permitted.

IFRIC 23 Uncertainty over Income Tax Treatments – Application required for accounting periods beginning on or after 1 January 2019.

IFRS 16 Leases

IFRS 16 – Leases replaces IAS 17 - Leases, IFRIC 4 - Determining whether an arrangement contains a lease and SIC 27 - Evaluating the substance of transactions involving the legal form of a lease and introduces a single, on-statement of financial position lease accounting model for lessees.

Currently, the NHS England parent and the CCGS (the group) recognises operating lease expenses on a straight-line basis over the term of the lease, and recognises assets and liabilities only to the extent that there is a timing difference between actual lease payments and the expense recognised. Under IFRS 16 it will recognise a right-of-use asset representing its right to use the underlying asset and a lease liability representing its obligation to make lease payments for any operating leases it assesses fall under IFRS 16. There are recognition exemptions for short-term leases and leases of low-value items.

In addition, the group will no longer recognise provisions for operating leases that it assesses to be onerous. Instead, the group will include the payments due under the lease in its lease liability with any appropriate assessment for impairments in the right of use asset.

The group has assessed that there is no significant impact on its current finance leases due to the immaterial value on the statement of financial position, and no significant impact on the limited transactions it undertakes as a lessor because IFRS 16 has not substantially changed the accounting arrangements for lessors.

IFRS 16 is effective for periods beginning on or after 1 January 2019 but under the requirements of the FReM NHS England group will not adopt it until 1 April 2020. NHS England has estimated the impact of initial application as described below. The actual impact may change however because;

a) The value and nature of the leases that the group holds at the time of implementation may change,

b) Processes and controls to identify and account for right of use assets under IFRS 16 are not yet finalised.

Impact

Note 5 contains details of operating lease expenditure at 31 March 2019. An assessment of the nature of leases within other indicates that these comprise mainly low value office items that would fall under the short term lease or low value lease exemptions in IFRS 16 and therefore, this expense will continue to be treated as straight line operating expenditure.

The most significant impact will be that the group will need to recognise right of use assets and lease liabilities for any buildings currently treated as operating leases that meet the recognition criteria in IFRS 16. At 31 March 2019 the future minimum lease payments amounted to £345 million and this means that the nature of this expense will change from being an operating lease expense to depreciation and interest expense.

Transition

The NHS England parent and the CCGs apply the FReM and therefore will recognise the cumulative effect of adopting the standard at the date of initial application as an adjustment to the opening retained earnings with no restatement of comparative balances.

IFRS 16 does not require entities to reassess whether a contract is, or contains, a lease at the date of initial application. HMT have interpreted this to mandate this practical expedient and therefore the group will apply IFRS 16 to contracts identified as a lease under IAS 17 or IFRIC 4 at 1 April 2020. However during the 2019/20 financial year the NHS England core department, CSUs and CCGs will be encouraged to review material contracts to ensure they have been correctly treated under IAS 17.

The group will utilise three further practical expedients under the transition approach adopted;

a) The election to not make an adjustment for leases for which the underlying asset is of low value,

b) The election to not make an adjustment to leases where the lease terms ends within 12 months of the date of application,

c) The election to use hindsight in determining the lease term if the contract contains options to extend or terminate the lease.

Other accounting standards issued but not yet adopted

Full assessments of the impact of the remaining standards issued but not yet adopted will be completed by NHS England in due course following any relevant guidance issued in the Government Financial Reporting Manual.

2. Operating income

	Parent		Consolidated Group	
		Re-presented		Re-presented
	2018/19	2017/18	2018/19	2017/18
	Total £000	Total £000	Total £000	Total £000
Income from sale of goods and services (contracts)				
Education, training and research[2]	483	165,237	13,624	177,657
Non-patient care services to other bodies[3]	384,599	409,392	274,915	326,041
Prescription fees and charges[4]	583,809	567,594	591,960	575,963
Dental fees and charges	856,384	807,333	856,384	807,333
Other Contract income	91,093	-	248,727	-
Recoveries in respect of employee benefits	592	162	7,581	6,875
Total Income from sale of goods and services	**1,916,960**	**1,949,718**	**1,993,191**	**1,893,869**
Other operating income				
Rental revenue from operating leases	-	-	232	267
Charitable and other contributions to revenue expenditure: non-NHS	237	410	2,839	2,695
Non cash apprenticeship training grants revenue	90	24	349	98
Other non contract revenue	3,309	88,592	107,599	286,346
Total other operating income	**3,636**	**89,026**	**111,019**	**289,406**
Total operating income	**1,920,596**	**2,038,744**	**2,104,210**	**2,183,275**

2 NHS England, the Parent, has assessed major income sources as part of the implementation of IFRS15. In prior years income from Health Education England in respect of GP training has been shown under education, training and research. Our assessment shows that NHS England is acting as an agent in this transaction and therefore from 2018/19 have accounted for the funding received on a net basis. Prior year comparatives totalling £142,727k have not been restated.

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 In line with the adaptation in the HMT Financial Reporting Manual prescription fees and charges and dental fees and charges are treated as revenue arising from a contract and accounted for under IFRS15.

The Parent and the Group have applied IFRS 15 in 2018/19. In line with the transition method specified in note 1.4 comparatives have not been restated. Balances for 2017/18 have however been reclassified as revenue arising from a contract for prescription fees and charges, dental fees and charges, and recoveries in respect of employee benefits in line with their classification in 2018/19 under IFRS 15.

2.1 Disaggregation of revenue

We disaggregate our revenue from contracts with customers by the nature of the revenue. This is shown in note 2. Note 2.1 provides the disaggregation in line with our operating segments reported in note 16.

Parent	CCG Total £000	Direct commissioning Total £000	NHS England Total £000	Other Total £000	I/co eliminations Total £000	Total £000
Income from sale of goods and services (contracts)						
Education, training and research	-	-	163	321	-	**484**
Non-patient care services to other bodies	-	4,087	3,628	458,148	(81,263)	**384,600**
Prescription fees and charges	-	583,809	-	-	-	**583,809**
Dental fees and charges	-	856,384	-	-	-	**856,384**
Other contract income	-	18,527	49,600	23,716	(752)	**91,091**
Recoveries in respect of employee benefits	-	-	592	-	-	**592**
Total Income from sale of goods and services	**-**	**1,462,807**	**53,983**	**482,185**	**(82,015)**	**1,916,960**

Consolidated Group	CCG Total £000	Direct commissioning Total £000	NHS England Total £000	Other Total £000	I/co eliminations Total £000	Total £000
Income from sale of goods and services (contracts)						
Education, training and research	13,558	-	163	321	(418)	**13,624**
Non-patient care services to other bodies	466,341	4,087	3,628	458,148	(657,288)	**274,916**
Prescription fees and charges	8,151	583,809	-	-	-	**591,960**
Dental fees and charges	-	856,384	-	-	-	**856,384**
Other contract income	176,721	18,527	49,600	23,716	(19,839)	**248,725**
Recoveries in respect of employee benefits	11,679	-	592	-	(4,689)	**7,582**
Total Income from sale of goods and services	**676,450**	**1,462,807**	**53,983**	**482,185**	**(682,234)**	**1,993,191**

3. Employee benefits

	Parent		Consolidated Group	
	2018/19	2017/18	2018/19	2017/18
	Total £000	Total £000	Total £000	Total £000
Employee benefits				
Salaries and wages	631,554	600,262	1,604,203	1,519,988
Social security costs	60,820	56,297	151,744	141,742
Employer contributions to NHS Pension scheme	70,201	65,203	175,868	164,829
Other pension costs	-	-	60	18
Apprenticeship Levy	2,485	2,686	4,387	4,153
Termination benefits	6,733	5,200	13,202	12,379
Gross employee benefits expenditure	**771,793**	**729,648**	**1,949,464**	**1,843,109**
Less: Employee costs capitalised	-	-	(51)	-
Gross employee benefits excluding capitalised costs	**771,793**	**729,648**	**1,949,413**	**1,843,109**
Less recoveries in respect of employee benefits	(592)	(162)	(7,581)	(6,875)
Net employee benefits	**771,201**	**729,486**	**1,941,832**	**1,836,234**

Staff numbers can be found in the Accountability report on page 118.

The Apprenticeship levy scheme was introduced from 6 April 2017. This is a tax payable on pay bills above £3 million. For 2018/19 NHS England, CSUs and 154 CCGs (2017/18 125 CCGs) are required to contribute to the levy.

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 is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2019, is based on valuation data as 31 March 2018, updated to 31 March 2019 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 latest actuarial valuation undertaken for the NHS Pension Scheme was completed as at 31 March 2016. The results of this valuation set the employer contribution rate payable from April 2019. The Department of Health and Social Care have recently laid Scheme Regulations confirming that the employer contribution rate will increase to 20.6% of pensionable pay from this date.

The 2016 funding valuation was also expected to test the cost of the Scheme relative to the employer cost cap set following the 2012 valuation. Following a judgment from the Court of Appeal in December 2018 Government announced a pause to that part of the valuation process pending conclusion of the continuing legal process.

3.2.2 Scheme provisions

The NHS Pension Scheme provided defined benefits, which are summarised below. This list is an illustrative guide only, and is not intended to detail all the benefits provided by the Scheme

or the specific conditions that must be met before these benefits can be obtained:

- The Scheme is a "final salary" scheme. Annual pensions are normally based on 1/80th for the 1995 section and of the best of the last three years pensionable pay for each year of service, and 1/60th for the 2008 section of reckonable pay per year of membership. Members who are practitioners as defined by the Scheme Regulations have their annual pensions based 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 super annuation schemes. These schemes are immaterial to the group financial statements and therefore have not been disclosed separately. Full disclosures are available in the underlying CCGs published accounts.

3.2.4 Principal Civil Service Pension Scheme

Past and present employees are covered by the provisions of the Principal Civil Service Pension Scheme (PCSPS) and the Civil Servant and Other Pension Scheme (CSOPS). These schemes are unfunded, defined benefit schemes covering civil servants. The schemes are not designed in a way that would enable employers to identify their share of the underlying scheme assets and liabilities. Therefore, the schemes are accounted for as though they were defined contribution schemes: the cost to [the entity] of participating in a scheme is taken as equal to the contributions payable to the scheme for the accounting period.

For defined contribution schemes, such as Civil Service partnership pensions, NHS England recognises the contributions payable for the year.

NHS England recognises the full cost of benefits paid under the Civil Service Compensation Scheme, including the early payment of pensions.

4. Operating expenses

	Parent		Consolidated Group	
	2018/19 Total £000	2017/18 Total £000	2018/19 Total £000	2017/18 Total £000
Purchase of goods and services – cash				
Services from other CCGs and NHS England	26,171	19,475	-	-
Services from foundation trusts	12,197,211	11,859,158	46,028,030	44,044,652
Services from other NHS trusts	5,694,154	5,651,306	25,128,222	24,684,323
Provider Sustainability Fund (Sustainability Transformation Fund 2017/18)[5]	2,450,000	1,800,000	2,450,000	1,800,000
Services from Other WGA bodies[6]	9,949	6,718	57,612	55,477
Purchase of healthcare from non-NHS bodies	1,319,697	1,226,871	13,734,227	13,095,600
Purchase of social care	(30)	-	647,354	599,274
General dental services and personal dental services	2,919,876	2,944,521	2,919,876	2,944,521
Prescribing costs	19,449	46,541	8,236,936	8,560,895
Pharmaceutical services	1,924,082	1,895,531	1,935,054	1,906,991
General ophthalmic services	543,097	547,518	553,598	556,015
GP primary care services[7]	1,075,268	1,654,779	8,526,114	8,274,354
Supplies and services – clinical	143,937	57,150	210,021	131,245
Supplies and services – general	379,961	356,249	897,109	820,880
Consultancy services	8,699	26,611	64,143	85,476
Establishment	176,861	172,747	388,180	368,988
Transport	12,112	10,974	63,144	44,826
Premises	81,903	96,225	430,893	392,345
Audit fees	300	300	10,301	10,402
Other non statutory audit expenditure[8]	-	-	3,034	1,927
Other professional fees	35,225	26,799	98,945	65,212
Legal fees	7,844	19,030	21,429	47,187
Education and training	57,974	120,308	92,258	150,834
Funding to group bodies[9]	84,010,175	80,631,423	-	-
Total purchase of goods and services - cash	**113,093,915**	**109,170,234**	**112,496,480**	**108,641,424**
Other operating expenditure – cash				
Chair and Non Executive Members	139	130	50,768	53,201
Grants to other bodies	60,466	63,629	82,108	85,347
Clinical negligence	-	-	219	189
Research and development (excluding staff costs)	1,297	238	15,235	11,856
Other expenditure	13,156	42,124	35,506	42,356
Other operating expenditure - cash	**75,058**	**106,121**	**183,836**	**192,949**
Total operating expenses - cash	**113,168,973**	**109,276,355**	**112,680,316**	**108,834,373**
Depreciation and impairment charges – non cash items				
Depreciation	115,098	85,341	127,106	97,308
Amortisation	2,303	4,843	4,418	5,985
Impairments and reversals of property, plant and equipment	-	-	541	22
Total depreciation and impairment charges	**117,401**	**90,184**	**132,065**	**103,315**
Provision expense – non cash items				
Change in discount rate	(461)	(227)	(275)	(291)
Provisions	(28,492)	(3,013)	(2,749)	49,853
Total provision expense	**(28,953)**	**(3,240)**	**(3,024)**	**49,562**
Purchase of goods and services - non cash				
Non cash apprenticeship training grants	90	24	349	100
Total purchase of goods and services - non cash	**90**	**24**	**349**	**100**
Other operating expenditure – non cash items				
Expected credit loss on receivables	2,650	-	7,660	19,774
Inventories consumed	199,839	94,298	202,664	96,548
Total other operating expenditure	**202,489**	**94,298**	**210,324**	**116,322**
Total operating expenses - non cash	**291,027**	**181,266**	**339,714**	**269,299**
Total operating expenses	**113,460,000**	**109,457,621**	**113,020,030**	**109,103,672**

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

5 In 2018/19 and 2017/18 NHS England has allocated expenditure through the Provider Sustainability Fund (formally Sustainability and Transformation Fund) for provider support, in line with the NHS England mandate.

6 Services from other WGA bodies comprises expenditure with the DHSC, DHSC ALBs and NHS Blood and Transplant.

7 The reductions in GP primary care expenditure in 2018/19 in the NHS England parent account, compared to 2017/18 are due to the ongoing 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.

8 In both financial years NHS England purchased no Non Audit services from NAO. Details of CCG non audit expenditure can be found in the underlying individual CCG accounts.

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

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 2018/19 and 2017/18 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 2018/19 would continue to be minimum lease payments in 2019/20.

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	2018/19			2017/18		
	Buildings £000	Other £000	Total £000	Buildings £000	Other £000	Total £000
Payments recognised as an expense						
Minimum lease payments	68,076	1,261	**69,337**	78,042	2,087	**80,129**
Contingent rents	-	-	-	-	-	-
Total	**68,076**	**1,261**	**69,337**	**78,042**	**2,087**	**80,129**

Consolidated Group	2018/19			2017/18		
	Buildings £000	Other £000	Total £000	Buildings £000	Other £000	Total £000
Payments recognised as an expense						
Minimum lease payments	345,259	2,841	**348,100**	322,075	3,969	**326,044**
Contingent rents	-	1,533	**1,533**	-	27	**27**
Total	**345,259**	**4,374**	**349,633**	**322,075**	**3,996**	**326,071**

5.1.2 Future minimum lease payments

Parent	2018/19			2017/18		
	Buildings £000	Other £000	Total £000	Buildings £000	Other £000	Total £000
Payable:						
No later than one year	37,340	930	**38,270**	31,303	1,214	**32,517**
Between one and five years	56,394	234	**56,628**	59,956	274	**60,230**
After five years	3,414	-	**3,414**	4,257	-	**4,257**
Total	**97,148**	**1,164**	**98,312**	**95,516**	**1,488**	**97,004**

Consolidated Group	2018/19			2017/18		
	Buildings £000	Other £000	Total £000	Buildings £000	Other £000	Total £000
Payable:						
No later than one year	79,819	1,613	**81,432**	66,190	2,154	**68,344**
Between one and five years	138,658	856	**139,514**	116,578	943	**117,521**
After five years	35,838	-	**35,838**	27,771	2	**27,773**
Total	**254,315**	**2,469**	**256,784**	**210,539**	**3,099**	**213,638**

6. Property, plant and equipment

Parent 2018/19	Buildings excluding dwellings £000	Assets under construction and payments on account £000	Plant & machinery £000	Transport equipment £000	Information technology £000	Furniture & fittings £000	Total £000
Cost or valuation at 1 April 2018	**404**	**-**	**1,062**	**211**	**551,866**	**7,510**	**561,053**
Additions purchased	-	-	-	418	155,610	1,655	**157,683**
Reclassifications	(183)	-	(32)	-	280	-	**65**
Disposals	-	-	-	-	(27,925)	(312)	**(28,237)**
Cost or valuation at 31 March 2019	**221**	**-**	**1,030**	**629**	**679,831**	**8,853**	**690,564**
Depreciation 1 April 2018	**38**	**-**	**289**	**23**	**206,963**	**3,183**	**210,496**
Reclassifications	-	-	-	-	-	-	**-**
Disposals	-	-	-	-	(27,925)	(312)	**(28,237)**
Charged during the year	44	-	198	40	113,522	1,294	**115,098**
At 31 March 2019	**82**	**-**	**487**	**63**	**292,560**	**4,165**	**297,357**
Net Book Value at 31 March 2019	**139**	**-**	**543**	**566**	**387,271**	**4,688**	**393,207**
Asset financing:							
Owned	139	-	543	566	387,271	4,688	**393,207**
Total at 31 March 2019	**139**	**-**	**543**	**566**	**387,271**	**4,688**	**393,207**

Parent 2017/18	Buildings excluding dwellings £000	Assets under construction and payments on account £000	Plant & machinery £000	Transport equipment £000	Information technology £000	Furniture & fittings £000	Total £000
Cost or valuation at 1 April 2017	**2,292**	**676**	**1,940**	**32**	**414,408**	**6,902**	**426,250**
Additions purchased	-	-	501	179	159,077	707	**160,464**
Reclassifications	-	(676)	(162)	-	937	(99)	**-**
Disposals	(1,888)	-	(1,217)	-	(22,556)	-	**(25,661)**
Cost or valuation at 31 March 2018	**404**	**-**	**1,062**	**211**	**551,866**	**7,510**	**561,053**
Depreciation 1 April 2017	**1,889**	**-**	**1,394**	**18**	**145,459**	**2,056**	**150,816**
Reclassifications	-	-	-	-	-	-	**-**
Disposals	(1,888)	-	(1,217)	-	(22,556)	-	**(25,661)**
Charged during the year	37	-	112	5	84,060	1,127	**85,341**
At 31 March 2018	**38**	**-**	**289**	**23**	**206,963**	**3,183**	**210,496**
Net Book Value at 31 March 2018	**366**	**-**	**773**	**188**	**344,903**	**4,327**	**350,557**
Asset financing:							
Owned	366	-	773	188	344,903	4,327	**350,557**
Total at 31 March 2018	**366**	**-**	**773**	**188**	**344,903**	**4,327**	**350,557**

6. Property, plant and equipment

Consolidated Group 2018/19	Buildings excluding dwellings £000	Assets under construction and payments on account £000	Plant & machinery £000	Transport equipment £000	Information technology £000	Furniture & fittings £000	Total £000
Cost or valuation at 1 April 2018	**2,567**	**312**	**17,223**	**327**	**613,141**	**17,156**	**650,726**
Addition of assets under construction and payments on account	-	65	-	-	-	-	**65**
Additions purchased	14	-	35	418	167,581	2,964	**171,012**
Reclassifications	(362)	293	(32)	-	(9)	157	**47**
Disposals	-	(140)	(99)	(3)	(28,854)	(312)	**(29,408)**
Impairments charged	-	-	-	-	(248)	-	**(248)**
Cost or valuation at 31 March 2019	**2,219**	**530**	**17,127**	**742**	**751,611**	**19,965**	**792,194**
Depreciation 1 April 2018	**394**	**-**	**8,951**	**139**	**242,425**	**8,446**	**260,355**
Reclassifications	(11)	-	-	-	(26)	35	**(2)**
Disposals	-	-	(67)	(3)	(28,854)	(313)	**(29,237)**
Impairments charged	-	-	-	-	(44)	337	**293**
Charged during the year	209	-	1,857	40	122,551	2,449	**127,106**
At 31 March 2019	**592**	**-**	**10,741**	**176**	**336,052**	**10,954**	**358,515**
Net Book Value at 31 March 2019	**1,627**	**530**	**6,386**	**566**	**415,559**	**9,011**	**433,679**
Asset financing:							
Owned	1,627	530	5,620	566	415,559	9,011	**432,913**
Held on finance lease	-	-	766	-	-	-	**766**
Total at 31 March 2019	**1,627**	**530**	**6,386**	**566**	**415,559**	**9,011**	**433,679**

Consolidated Group 2017/18	Buildings excluding dwellings £000	Assets under construction and payments on account £000	Plant & machinery £000	Transport equipment £000	Information technology £000	Furniture & fittings £000	Total £000
Cost or valuation at 1 April 2017	**4,046**	**2,579**	**17,849**	**148**	**470,190**	**16,275**	**511,087**
Addition of assets under construction and payments on account	-	148	-	-	-	-	**148**
Additions purchased	353	-	517	179	167,642	1,217	**169,908**
Reclassifications	57	(1,117)	183	-	(236)	(171)	**(1,284)**
Disposals	(1,889)	(1,298)	(1,326)	-	(24,433)	(165)	**(29,111)**
Impairments charged	-	-	-	-	(22)	-	**(22)**
Cost or valuation at 31 March 2018	**2,567**	**312**	**17,223**	**327**	**613,141**	**17,156**	**650,726**
Depreciation 1 April 2017	**2,084**	**-**	**8,309**	**134**	**175,046**	**6,176**	**191,749**
Reclassifications	1	-	-	-	(951)	-	**(950)**
Disposals	(1,889)	-	(1,302)	-	(24,412)	(149)	**(27,752)**
Impairments charged	-	-	-	-	-	-	**-**
Charged during the year	198	-	1,944	5	92,742	2,419	**97,308**
At 31 March 2018	**394**	**-**	**8,951**	**139**	**242,425**	**8,446**	**260,355**
Net Book Value at 31 March 2018	**2,173**	**312**	**8,272**	**188**	**370,716**	**8,710**	**390,371**
Asset financing:							
Owned	1,783	312	7,421	188	370,716	8,710	**389,130**
Held on finance lease	390	-	851	-	-	-	**1,241**
Total at 31 March 2018	**2,173**	**312**	**8,272**	**188**	**370,716**	**8,710**	**390,371**

7. Intangible non-current assets

Parent 2018/19	Computer software: purchased £000	Licences and trademarks £000	Development expenditure (internally generated) £000	Total £000
Cost or valuation at 1 April 2018	**15,466**	**8**	**1,973**	**17,447**
Additions purchased	1,027	-	-	**1,027**
Reclassifications	-	-	(65)	**(65)**
Disposals	(9,010)	-	-	**(9,010)**
Transfer (to)/from other public sector body	-	-	-	-
At 31 March 2019	**7,483**	**8**	**1,908**	**9,399**
Amortisation 1 April 2018	**12,208**	**8**	**374**	**12,590**
Reclassifications	-	-	-	-
Disposals	(9,010)	-	-	**(9,010)**
Charged during the year	1,999	-	304	**2,303**
Transfer (to) from other public sector body	-	-	-	-
At 31 March 2019	**5,197**	**8**	**678**	**5,883**
Net Book Value at 31 March 2019	**2,286**	**-**	**1,230**	**3,516**
Asset financing:				
Owned	2,286	-	1,230	**3,516**
Total at 31 March 2019	**2,286**	**-**	**1,230**	**3,516**

Parent 2017/18	Computer software: purchased £000	Licences and trademarks £000	Development expenditure (internally generated) £000	Total £000
Cost or valuation at 1 April 2017	**20,672**	**8**	**349**	**21,029**
Additions purchased	590	-	1,624	**2,214**
Reclassifications	-	-	-	-
Disposals	(5,796)	-	-	**(5,796)**
Transfer (to)/from other public sector body	-	-	-	-
At 31 March 2018	**15,466**	**8**	**1,973**	**17,447**
Amortisation 1 April 2017	**13,186**	**8**	**349**	**13,543**
Reclassifications	-	-	-	-
Disposals	(5,796)	-	-	**(5,796)**
Charged during the year	4,818	-	25	**4,843**
Transfer (to)/from other public sector body	-	-	-	-
At 31 March 2018	**12,208**	**8**	**374**	**12,590**
Net Book Value at 31 March 2018	**3,258**	**-**	**1,599**	**4,857**
Asset financing:				
Owned	3,258	-	1,599	**4,857**
Total at 31 March 2018	**3,258**	**-**	**1,599**	**4,857**

Consolidated Group 2018/19

	Computer software: purchased £000	Licences and trademarks £000	Development expenditure (internally generated) £000	Total £000
Cost or valuation at 1 April 2018	**25,179**	**8**	**3,609**	**28,796**
Additions purchased	1,826	-	-	**1,826**
Reclassifications	18	-	(65)	**(47)**
Disposals	(9,224)	-	-	**(9,224)**
Upward revaluation gains	-	-	-	-
Impairments charged	-	-	-	**-**
At 31 March 2019	**17,799**	**8**	**3,544**	**21,351**
Amortisation 1 April 2018	**16,647**	**8**	**885**	**17,540**
Reclassifications	2	-	-	**2**
Disposals	(9,224)	-	-	**(9,224)**
Charged during the year	3,880	-	538	**4,418**
At 31 March 2019	**11,305**	**8**	**1,423**	**12,736**
Net Book Value at 31 March 2019	**6,494**	**-**	**2,121**	**8,615**
Asset financing:				
Owned	6,494	-	2,121	**8,615**
Total at 31 March 2019	**6,494**	**-**	**2,121**	**8,615**

Consolidated Group 2017/18

	Computer software: purchased £000	Licences and trademarks £000	Development expenditure (internally generated) £000	Total £000
Cost or valuation at 1 April 2017	**27,143**	**8**	**2,573**	**29,724**
Additions purchased	2,617	-	1,625	**4,242**
Reclassifications	1,273	-	11	**1,284**
Disposals	(5,854)	-	(600)	**(6,454)**
Impairments charged	-	-	-	**-**
At 31 March 2018	**25,179**	**8**	**3,609**	**28,796**
Amortisation 1 April 2017	**15,597**	**8**	**1,405**	**17,010**
Reclassifications	950	-	-	**950**
Disposals	(5,805)	-	(600)	**(6,405)**
Upward revaluation gains	-	-	-	-
Charged during the year	5,905	-	80	**5,985**
At 31 March 2018	**16,647**	**8**	**885**	**17,540**
Net Book Value at 31 March 2018	**8,532**	**-**	**2,724**	**11,256**
Asset financing:				
Owned	8,532	-	2,724	**11,256**
Total at 31 March 2018	**8,532**	**-**	**2,724**	**11,256**

8. Trade and other receivables

	Parent				Consolidated Group			
	Current 2018/19 £000	Non-current 2018/19 £000	Current 2017/18 £000	Non-current 2017/18 £000	Current 2018/19 £000	Non-current 2018/19 £000	Current 2017/18 £000	Non-current 2017/18 £000
NHS receivables: revenue	48,684	-	49,853	-	100,583	-	123,989	-
NHS prepayments	10,805	-	10,359	-	217,589	-	219,877	-
NHS accrued income	17,477	-	29,417	-	120,132	-	125,090	-
NHS Non contract receivables	-	-	-	-	3,415	-	-	-
NHS contract assets	-	-	-	-	485	-	-	-
Non-NHS and other WGA receivables: revenue	34,813	-	62,481	-	251,116	326	225,799	-
Non-NHS and other WGA prepayments	64,311	-	62,283	-	144,897	209	163,777	440
Non-NHS and other WGA accrued income	23,638	-	15,803	-	98,634	-	131,674	-
Non-NHS and other WGA Non contract receivables	-	-	-	-	8,085	-	-	-
Non-NHS contract assets	-	-	-	-	201	-	-	-
Expected credit loss allowance-receivables	(3,391)	-	(1,279)	-	(20,289)	-	(29,438)	-
VAT	8,962	-	8,564	-	24,113	-	23,350	-
Other receivables and accruals	1,624	-	5,662	-	17,321	3	24,364	3
Total	**206,923**	**-**	**243,143**	**-**	**966,282**	**538**	**1,008,482**	**443**
Other financial assets	-	-	-	-	-	554	-	554
Total current and non current	**206,923**		**243,143**		**967,374**		**1,009,479**	

8.1 Impact of application of IFRS 9 on financial assets at 1 April 2018

	Parent				Consolidated Group			
	Receivables £000	Cash at bank £000	Other financial assets £000	Total £000	Receivables £000	Cash at bank £000	Other financial assets £000	Total £000
Carrying values under IAS 39 as at 31 March 2018								
Financial assets held at amortised cost (loans & receivables and held to maturity investments)	157,554	144,765	5,662	**307,981**	606,551	165,745	24,921	**797,217**
Total at 31 March 2018 under IAS 39	**157,554**	**144,765**	**5,662**	**307,981**	**606,551**	**165,745**	**24,921**	**797,217**
Carrying values under IFRS 9 as at 1 April 2018								
Financial assets measured at amortised cost	159,537	144,765	5,662	**309,964**	606,496	165,745	24,921	**797,162**
Total at 1 April 2018 under IFRS 9	**159,537**	**144,765**	**5,662**	**309,964**	**606,496**	**165,745**	**24,921**	**797,162**
Effect of implementation of IFRS 9 as at 1 April 2018								
Other changes (ECL adj through reserves)	(1,983)	-	-	**(1,983)**	55	-	-	**55**
Change in carrying amount	**(1,983)**	**-**	**-**	**(1,983)**	**55**	**-**	**-**	**55**

8.2 Movement in loss allowances due to application of IFRS 9

	Parent			Consolidated Group		
	Receivables £000	Other financial assets £000	Total £000	Receivables £000	Other financial assets £000	Total £000
Impairment and provisions allowances under IAS 39 as at 31st March 2018						
Financial assets held at amortised cost	(1,279)	-	**(1,279)**	(29,438)	-	**(29,438)**
Financial assets held at fair value through other comprehensive income	-	-	-	-	-	-
Total at 31st March 2018	**(1,279)**	**-**	**(1,279)**	**(29,438)**	**-**	**(29,438)**
Loss allowance under IFRS 9 as at 1st April 2018						
Financial Assets measured at amortised cost	(3,262)	-	**(3,262)**	(29,383)	-	**(29,383)**
Financial assets held at fair value through other comprehensive income	-	-	-	-	-	-
Total at 1st April 2018	**(3,262)**	**-**	**(3,262)**	**(29,383)**	**-**	**(29,383)**
Change in loss allowance arising from application of IFRS 9	**(1,983)**	**-**	**(1,983)**	**55**	**-**	**55**

9. Cash and cash equivalents

	Parent		Consolidated Group	
	2018/19	**2017/18**	**2018/19**	**2017/18**
	£000	**£000**	**£000**	**£000**
Balance at 1 April 2018	144,765	263,885	163,096	268,356
Net change in year	44,176	(119,120)	33,598	(105,260)
Balance at 31 March 2019	**188,941**	**144,765**	**196,694**	**163,096**
Made up of:				
Cash with the Government Banking Service	96,978	58,465	113,253	78,845
Cash with commercial banks	-	-	-	26
Hosted cash/cash in hand	89,810	86,300	90,082	86,874
Current investments	2,153	-	2,153	-
Cash and cash equivalents as in statement of financial position	**188,941**	**144,765**	**205,488**	**165,745**
Bank overdraft: Government Banking Service	-	-	(8,794)	(2,649)
Total bank overdrafts	**-**	**-**	**(8,794)**	**(2,649)**
Balance at 31 March 2019	**188,941**	**144,765**	**196,694**	**163,096**

For details of bank overdraft see note 10.

Included within hosted cash/cash in hand above is £89.8 million (2017/18 £86.3 million) held on behalf of NHS England by the NHS BSA.

Current investments within cash and cash equivalents include cash held in solicitor commercial escrow accounts that is not available for use by the group.

10. Trade and other payables

	Parent				Consolidated Group			
	Current 2018/19 £000	Non-current 2018/19 £000	Current 2017/18 £000	Non-current 2017/18 £000	Current 2018/19 £000	Non-current 2018/19 £000	Current 2017/18 £000	Non-current 2017/18 £000
NHS payables: revenue	528,945	-	645,415	-	1,227,807	-	1,394,629	-
NHS payables: capital	15,368	-	24,013	-	767	-	114	-
NHS accruals	2,288,229	-	1,633,777	-	2,957,898	-	2,200,725	-
NHS deferred income	375	-	649	-	205	-	199	-
NHS contract liabilities	124	-	-	-	6,574	-	-	-
Non-NHS and other WGA payables: revenue	150,252	-	144,477	-	1,071,135	-	975,487	-
Non-NHS and other WGA payables: capital	43,860	-	39,356	-	47,608	-	41,763	-
Non-NHS and other WGA accruals	1,144,291	-	1,033,456	-	4,382,565	-	3,945,570	-
Non-NHS and other WGA deferred income	983	-	2,926	-	15,666	762	19,713	73
Non-NHS contract liabilities	2,125	-	-	-	2,125	-	-	-
Social security costs	7,693	-	7,407	-	21,912	-	20,305	-
VAT	-	-	-	-	375	-	316	-
Tax	20,190	-	19,980	-	33,796	-	31,642	-
Payments received on account	108	-	7	-	722	-	88	-
Other payables and accruals	324,461	26	298,831	26	820,780	2,850	747,847	2,188
Total	**4,527,004**	**26**	**3,850,294**	**26**	**10,589,935**	**3,612**	**9,378,398**	**2,261**
Other financial liabilities								
Bank overdraft - Government Banking Service	-	-	-	-	8,794	-	2,649	-
Finance lease liabilities	-	-	-	-	121	828	121	917
Other financial liabilities - other	-	-	-	-	-	95	-	107
Total	**-**	**-**	**-**	**-**	**8,915**	**923**	**2,770**	**1,024**
Total trade & other payables (current)	**4,527,004**		**3,850,294**		**10,598,850**		**9,381,168**	
Total trade & other payables (non-current)		**26**		**26**		**4,535**		**3,285**
Total trade & other payables (current and non-current)		**4,527,030**		**3,850,320**		**10,603,385**		**9,384,453**

11 Finance costs

	Parent		Consolidated Group	
	2018/19	2017/18	2018/19	2017/18
	£000	£000	£000	£000
Interest				
Interest on obligations under finance leases	-	-	36	39
Interest on late payment of commercial debt	-	-	12	3
Other interest expense	-	-	4	1
Total interest	**-**	**-**	**52**	**43**
Other finance costs	-	-	4	-
Provisions: unwinding of discount	533	(1,089)	588	(1,306)
Total finance costs	**533**	**(1,089)**	**644**	**(1,263)**

12 Provisions

Parent	Current 2018/19 £000	Non-current 2018/19 £000	Current 2017/18 £000	Non-current 2017/18 £000
Restructuring	576	-	486	-
Redundancy	-	-	201	-
Legal claims	978	945	1,769	564
Continuing care	21,853	-	33,634	-
Other	7,286	21,259	35,767	10,587
Total	**30,693**	**22,204**	**71,857**	**11,151**
Total current and non-current	**52,897**		**83,008**	

	Restructuring £000	Redundancy £000	Legal claims £000	Continuing care £000	Other £000	Total £000
Balance at 1 April 2018	**486**	**201**	**2,333**	**33,634**	**46,354**	**83,008**
Arising during the year	550	-	27	5,765	15,131	**21,473**
Utilised during the year	(167)	-	(280)	(564)	(681)	**(1,692)**
Reversed unused	(293)	(201)	(177)	(16,390)	(32,903)	**(49,964)**
Unwinding of discount	-	-	57	(321)	797	**533**
Change in discount rate	-	-	(37)	(271)	(153)	**(461)**
Balance at 31 March 2019	**576**	**-**	**1,923**	**21,853**	**28,545**	**52,897**
Expected timing of cash flows:						
Within one year	576	-	978	21,853	7,286	**30,693**
Between one and five years	-	-	945	-	16,090	**17,035**
After five years	-	-	-	-	5,169	**5,169**
Balance at 31 March 2019	**576**	**-**	**1,923**	**21,853**	**28,545**	**52,897**

Consolidated Group	Current 2018/19 £000	Non-current 2018/19 £000	Current 2017/18 £000	Non-current 2017/18 £000
Restructuring	1,395	-	1,389	-
Redundancy	1,696	-	2,826	-
Legal claims	3,525	945	2,274	564
Continuing care	64,730	8,603	80,296	6,224
Other	63,736	32,338	91,146	19,433
Total	**135,082**	**41,886**	**177,931**	**26,221**
Total current and non-current	**176,968**		**204,152**	

	Restructuring £000	Redundancy £000	Legal claims £000	Continuing care £000	Other £000	Total £000
Balance at 1 April 2018	**1,389**	**2,826**	**2,838**	**86,520**	**110,579**	**204,152**
Arising during the year	1,465	1,822	2,465	41,762	49,375	**96,889**
Utilised during the year	(1,033)	(2,084)	(584)	(14,955)	(6,246)	**(24,902)**
Reversed unused	(426)	(868)	(269)	(39,668)	(58,253)	**(99,484)**
Unwinding of discount	-	-	57	(224)	755	**588**
Change in discount rate	-	-	(37)	(102)	(136)	**(275)**
Balance at 31 March 2019	**1,395**	**1,696**	**4,470**	**73,333**	**96,074**	**176,968**
Expected timing of cash flows:						
Within one year	1,395	1,696	3,525	64,730	63,736	**135,082**
Between one and five years	-	-	945	8,603	25,939	**35,487**
After five years	-	-	-	-	6,399	**6,399**
Balance at 31 March 2019	**1,395**	**1,696**	**4,470**	**73,333**	**96,074**	**176,968**

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 arising in 2018/19 in the parent include provisions for pension disputes (£8 million) and dilapidations (£4.2 million). Within the reversed unused amount in the parent is the reversal of the breast screening provision arising in 2017/18 following further assessment of the liability to NHS England.

The NHS Resolution financial statements disclose a provision of £47,605,694 as at 31 March 2019 in respect of clinical negligence liabilities and employment liability scheme of NHS England (31 March 2018: £68,476,936).

13. Contingencies

	Parent		Consolidated Group	
	2018/19	2017/18	2018/19	2017/18
	£000	£000	£000	£000
Contingent liabilities				
Employment tribunal	276	163	411	163
NHS Resolution employee liability claim	14	3	18	20
Continuing healthcare	-	-	14,581	13,603
Local authority - package recharges	-	-	-	171
Legal claims	8,966	14,991	8,966	14,991
NHS Resolution legal claims	-	-		2
Pension claims	-	7,070	-	7,070
Her Majesty's Revenue and Customs	-	-	1,794	1,113
West Wakefield Health and Wellbeing Ltd potential VAT liability	-	-	685	685
Other - service issues	-	1,500	-	1,500
Contract disputes with NHS bodies	-	-	-	1,958
Other	-	34	1,150	1,090
Net value of contingent liabilities	**9,256**	**23,761**	**27,605**	**42,366**

	Parent		Consolidated Group	
	2018/19	2017/18	2018/19	2017/18
	£000	£000	£000	£000
Contingent assets				
Legal cases	4,424	1,138	4,424	1,138
Potential recoveries re disrupted services	-	103	-	103
Potential rate rebates	-	-	532	407
Net value of contingent assets	**4,424**	**1,241**	**4,956**	**1,648**

Seven Sussex CCGs are jointly taking steps to enforce the terms of a parent company guarantee submitted as part of the non-emergency patient services contract which was terminated with effect from 31st March 2017. The position remains that due to the inherent uncertainties regarding the claim, it is not possible to give an accurate quantification of the precise financial consequences of the legal steps initiated but it is considered that these will not have a material impact on the future reported position of the CCGs.

Contingent liabilities are those for which provisions have not been recorded as there is a possible obligation depending on uncertain future events, or a present obligation where payment is not probable or the amount cannot be measured reliably. Contingent assets are those where a possible asset arises from a past event and whose existence will be confirmed only by the occurrence or non occurrence of an uncertain future event not wholly within the control of the entity. These are disclosed only when the inflow of economic benefit is probable.

14. Commitments

14.1 Capital commitments

	Parent		Consolidated Group	
	2018/19	2017/18	2018/19	2017/18
	£000	£000	£000	£000
Property, plant and equipment	16,351	38,061	16,455	38,833
Total	**16,351**	**38,061**	**16,455**	**38,833**

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	
	2018/19	2017/18	2018/19	2017/18
	£000	£000	£000	£000
In not more than one year	190,150	133,292	266,785	229,469
In more than one year but not more than five years	528,346	406,477	616,174	616,635
In more than five years	-	40,252	74,819	69,614
Total	**718,496**	**580,021**	**957,778**	**915,718**

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.

c) Care UK contract for Prison Healthcare.

In the group account the most significant commitment relates to:

a) An indemnity given by NHS Trafford CCG to NHS Property Services in relation to the Altrincham Hub.

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 SFIs and policies agreed by the CCG Governing Bodies. 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 2018/19	CCGs £000	Direct commissioning £000	NHS England £000	Other £000	Intra-group eliminations £000	NHS England group total £000
Income	(851,031)	(1,462,807)	(54,286)	(485,519)	749,433	**(2,104,210)**
Gross expenditure	85,415,387	25,984,756	3,826,387	493,023	(749,433)	**114,970,120**
Total net expenditure	**84,564,356**	**24,521,949**	**3,772,101**	**7,504**	**-**	**112,865,910**
Revenue resource expenditure						
Revenue departmental expenditure limit						112,836,816
Annually managed expenditure						(19,405)
Technical expenditure						48,499
Total net expenditure						**112,865,910**
Reconciliation back to SoCNE						
Total net expenditure for the year						112,865,910
Net (gain)/loss on revaluation of intangibles						-
Actuarial (gain)/loss in pension schemes						871
Comprehensive net expenditure for the year						**112,866,781**

Consolidated Group 2017/18	CCGs £000	Direct commissioning £000	NHS England £000	Other £000	Intra-group eliminations £000	NHS England group total £000
Income	(986,284)	(1,563,636)	(27,875)	(504,964)	899,484	**(2,183,275)**
Gross expenditure	82,232,658	25,821,470	3,307,317	483,700	(899,484)	**110,945,661**
Total net expenditure	**81,246,374**	**24,257,834**	**3,279,442**	**(21,264)**	**-**	**108,762,386**
Revenue resource expenditure						
Revenue departmental expenditure limit						108,689,363
Annually managed expenditure						18,107
Technical expenditure						54,916
Total net expenditure						**108,762,386**
Reconciliation back to SoCNE						
Net operating expenditure for the financial year						108,762,386
Net loss on transfer by absorption						-
Movements in other reserves						(850)
Net operating expenditure for the financial year including absorption losses						**108,761,536**

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:-

Clinical Commissioning Groups - 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 commissioning support units, national reserves, technical accounting items and legacy balances.

Multiple transactions take place between reportable segments, all of which are eliminated upon consolidation as shown in the "Intra-group eliminations" column. Information on total assets and liabilities and net assets and liabilities is not separately reported to the Chief Operating Decision Maker and thus, in accordance with IFRS 8, does not form part of this disclosure.

17. Related party transactions

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 195 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 Department of Health & Social Care, as the parent of NHS England, is regarded as a related party. During the year NHS England has had a significant number of material transactions with entities for which the Department is regarded as the parent Department.

For example:

- NHS Foundation Trusts;
- NHS Trusts;
- NHS Litigation Authority;
- NHS Business Services Authority;
- NHS Property Services;
- NHS Health Education England;
- NHS Shared Business Services (DH Equity Investment).

In addition, NHS England has had a number of significant transactions with other Government departments and their agencies including HMRC, Ministry of Justice and Her Majesty's Prison and Probation Service. No related party transactions were noted with key management personnel other than the compensation paid to them which can be found in the Remuneration Report on pages 126 to 134.

Following a review of disclosure requirements under IAS24, transactions with organisations with which NHS England board members also hold key management roles are not separately disclosed.

18. Events after the end of the reporting period

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

In March 2018, NHS England announced jointly with Monitor and NHS Trust Development Authority (NHS Improvement) to plan to work in a more integrated way to deliver better outcomes for patients, whilst improving performance and efficiency. During 2018/19, NHS England, Monitor, and NHS TDA published a joint leadership structure which came fully into effect on 1 April 2019 and the organisations are continuing to collaborate on an effective model of joint working but the underlying legal entities of NHS England, Monitor and NHS TDA will remain in place. This has no impact on NHS England's accounts and no adjustments have been made as a result.

From 1 April 2018 a further 14 CCGs commenced delegated commissioning arrangements, taking the total number operating under this initiative to 178. From 1 April 2019 a further 10 CCGs will commence delegated comissioning arrangements, taking the total number operating under the initiative to 184.

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.

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

19. Financial performance targets

The Mandate: A mandate from the Government to NHS England: April 2018 to March 2019 published by the Secretary of State under section 13A of the National Health Service Act 2006, and the associated Financial Directions as issued by the Department of Health, set out NHS England's total revenue resource limit and total capital resource limit for 2018/19 and certain additional expenditure controls to which NHS England must adhere. These stem from budgetary controls that HM Treasury applies to DHSC. Those limits were revised in May 2019 and NHS England's performance against those limits is set out in the tables below:

	2018/19						2017/18
	Revenue departmental expenditure limit			Annually-managed expenditure	Technical	Total	Total
	Non-ringfenced £000	Ringfenced £000	Total RDEL £000	£000	£000	£000	£000
Mandate limit	113,620,948	166,000	113,786,948	100,000	200,000	114,086,948	110,001,997
Actual expenditure	112,704,751	132,065	112,836,816	(19,405)	48,499	112,865,910	108,762,386
Surplus	**916,197**	**33,935**	**950,132**	**119,405**	**151,501**	**1,221,038**	**1,239,611**

	2018/19 Capital resource limit £000	2017/18 Capital resource limit £000
Limit	254,000	247,000
Actual expenditure	221,232	227,806
Surplus	32,768	19,194

NHS England is required to spend no more than £1,820,561,000 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 2019 was £1,587,848,031 as set out below:

Administration limit:	2018/19 £000	2017/18 £000
Net administration costs before interest	1,589,925	1,592,980
Less:		
Administration expenditure covered by AME/Technical funding	(2,077)	(10,476)
Administration costs relating to RDEL	1,587,848	1,582,504
RDEL Administration expenditure limit	1,820,561	1,805,000
Underspend	**232,713**	**222,496**

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

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

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

20. Entities within the Consolidated Group

NHS England acts as the Parent of the group comprising 195 CCGs (2017/18: 207 CCGs) whose accounts are consolidated within these Financial Statements.

From the 1st of April 2019 this became 191 CCGs with the merger of 6 CCGs creating 2 new CCGs as per the below:

Merging CCGs	New CCGs
NHS Southern Derbyshire CCG NHS North Derbyshire CCG NHS Erewash CCG NHS Hardwick CCG	NHS Derby & Derbyshire CCG
NHS North, East, West Devon CCG NHS South Devon and Torbay CCG	NHS Devon CCG

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

The parent entity of NHS England is the Department of Health & Social Care.

The largest group of entities for which group accounts are drawn up and of which NHS England is a member is the Department of Health & Social Care 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 the strategic direction for NHS England, describes the Government's healthcare priorities and the contribution NHS England is expected to make within its allocated budget. It also helps to ensure the NHS is held accountable to Parliament and the public.

The 2018/19 mandate maintained the approach set out in the 2017/18 mandate and maintained the direction and deliverables of the NHS Five Year Forward View.

Against the backdrop of continued rising levels of demand and a growing ageing population, NHS England managed to deliver the overwhelming majority of what it was mandated by the Government to achieve in 2018/19. Given the challenges faced, this demonstrates the dedication of NHS staff and increased NHS productivity to continue to deliver in many priority areas.

We will continue to respond to and confront these challenges in 2019/20 as NHS England and NHS Improvement drive forward implementation and delivery of the first year of the NHS Long Term Plan and the Clinical Review of Standards. For the first time in 2019/20 the Government's mandate forms part of the Accountability Framework which sets a single, common set of 2019/20 objectives for NHS England and NHS Improvement.

The progress and achievement in delivering the mandate in 2018/19 provides a good basis for meeting the ambitions set in next year's Accountability Framework.

The 2018/19 mandate set out deliverables against seven overarching objectives. Of the 62 deliverables set out in our mandate, 55 (89%) are assessed as on track. The following summarises progress against each of these objectives in 2018/19:

Objective 1: Through better commissioning, improve local and national health outcomes, and reduce health inequalities

- In July 2018, NHS England published the results of the CCG improvement and assessment framework for 2017/18. Independent assessments of CCG performance were also published on indicators relating to cancer, maternity, dementia, mental health, learning disabilities and diabetes. CCG performance is regularly updated and published on the MyNHS website including for these clinical priority areas.In 2018/19 we treated more patients than ever before within 18 weeks of referral – with 14.3 million patients surpassing the previous record set in 2016/17 by 84,952
- During 2018/19 we made good progress to embed health inequalities considerations across our corporate priority areas including cancer, mental health, diabetes and learning disabilities.

Objective 2: To help create the safest, highest quality health and social care service

- In primary care there has been continued reductions in antibiotic prescribing with all 195 CCGs beginning to deliver reductions towards the 2020/21 target.
- Through the Maternity Transformation Programme, Local Maternity Systems (LMS) are delivering their plans for safer and more personalised maternity care, in line with the Better Births vision and in order to meet national safety ambitions. In 2018/19, all LMS worked towards full implementation of the Saving Babies' Lives Care Bundle. Stillbirths fell by a fifth at the maternity units where implementation was evaluated. A second iteration of the Care Bundle was published in March 2019 including an additional element to reduce pre-term births. LMS began to implement continuity of carer, with the aim that one fifth of women had the same midwife or small team of midwives caring for them during pregnancy, birth and postnatally by March 2019. LMS are ensuring all women have personalised care plans by 2021 and can make choices about their maternity care. This is supported by learning from the Maternity Pioneers, who implemented initiatives to improve choice and deliver personalised care to over 96,000 women by March 2019.
- We have supported CCGs to deliver over 925,000 personalised care interventions, including 54,143 Personal Health Budgets, meeting the commitment of 50-100,000 two years early.
- The NHS has made considerable progress in delivering world class cancer care. We have seen an exceptional increase in demand in referrals made for suspected cancer; the service has responded well with significant growth in activity including an 8.5% increase in the number of patients starting treatment within 62 days of urgent referral. Furthermore 53.7% of all cancers were diagnosed at an early stage and, as the commitments of the NHS Long Term Plan are delivered, we expect to see a continued increase.
- We recognise the challenge we have in meeting cancer waiting times standards due to increased demand and are providing nearly £134 million funding in 2019/20 to our 19 Cancer Alliances to prioritise activity on earlier diagnosis and increased survival, and to improve and sustain operational service performance for patients. Through the Clinically-led Review of Standards, we are ensuring cancer waiting times standards are fit-for-purpose and support the achievement of our longer-term ambitions on diagnosis and survival.

Objective 3: To balance the NHS budget and improve efficiency and productivity

- The NHS set out to deliver a breakeven financial position overall across the commissioner and provider sectors for 2018/19. We worked with NHS Improvement to achieve a balanced plan and agreed a joint programme of actions to achieve this.
- NHS England has delivered an additional managed underspend of £651 million above the planned £265 million underspend resulting in a total resource underspend for the commissioning sector of £916 million.
- As the implementation of a new operating model for joint working between NHS Improvement and NHS England progressed, we worked together to balance the position, led by strong aligned governance arrangements at executive and non-executive level.

- In 2018/19 NHS England and CCGs delivered £3 billion of productivity and efficiency improvements, changing the way that we commission services, procure drugs and medical devices, and drive productivity in order to help meet the additional demands for health care at the front line. This included approximately £600 million of savings delivered through the RightCare programme.

Objective 4: To lead a step change in the NHS in preventing ill health and supporting people to live healthier lives

- We have continued to develop and invest in a series of prevention programmes. Significant examples include diabetes and tuberculosis as well as focussed work in areas such as cardiovascular disease and Atrial Fibrillation.
- We have exceeded our mandate commitment to have up to 80,000 people on the Diabetes Prevention Programme during 2018/19, with almost 105,000 having received an initial assessment. This means we have also delivered a year early on the NHS Five Year Forward View target of 100,000 people on the programme by 2019/20.
- Our action has reduced the sale of sugar-sweetened beverages across the NHS, from 15.6% in July 2017, to 7.4% in June 2018.
- The Healthy New Towns programme has worked with 10 housing developments involving over 50,000 homes to develop 10 principles, first published in 2018, for integrating health into the design, development and management of new places. The full learning from the programme will be published in the coming months.
- 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 has been met each month since July 2016.

Objective 5: To maintain and improve performance against core standards

- Against continued growth in demand, attendances and admissions there has been improved performance in some areas.
- The winter period saw an increase of over 464,000 patients (5.0%) for November 2018 to March 2019. Despite this increased demand, 380,000 more patients were seen within four hours, with performance at 85.4% compared to 85.0% last winter.
- In elective care the number of patients waiting more than 52 weeks has decreased by 58% to 1,154 in March 2019 from March 2018, thereby achieving the 2018/19 mandate commitment.
- In 2018/19 we treated more patients than ever before within 18 weeks of referral – with 14.3 million patients surpassing the previous record set in 2016/17 by 84,952.
- The number of patients in hospital with long lengths of stay (21 days or more) has reduced, releasing 2,012 beds as at March 2019 compared to the 2017/18 baseline. In 2018/19 delayed transfers of care reduced by 15.9%.
- Ambulance trust performance has improved in 2018/19 against all six new response time standards introduced by the Ambulance Response Programme. All ambulance trusts now regularly achieve the category 1 standards for those patients needing the most urgent care with an average national improvement of 1 minute (12.3%) against last year's performance.

Objective 6: To improve out-of-hospital care

- NHS England has met the mandate requirement on access to enhanced GP services – we are offering evening and weekend appointments across the country seven days a week including bank holidays
- Good progress is being made against all the mental health mandate deliverables. Latest data shows that all CCGs met the Mental Health Investment Standard in 2018/19, marking the first time this has been met everywhere in the country. We are on track to meet all access and waiting time standards for mental health services, with work ongoing to ensure the NHS Five Year Forward View ambitions are met in 2020/21. Almost 70% of people in England experiencing a first episode in psychosis were treated with NICE approved care package within two weeks of referral in January 2019.
- We have increased the number of people with learning disabilities, autism or both being cared for in the community rather than specialist inpatient services. The total number of people in inpatient units fell by 22% from March 2015 to March 2019. This includes 765 people who had previously been in hospital for over five years, resulting in over 570 beds being decommissioned. As part of the NHS Long Term Plan, we have committed to reducing the number by 50% by March 2024.

Objective 7: To support research, innovation and growth and to support the Government's implementation of EU Exit in regards to health and care.

- NHS England is working with Genomics England and other partners to align efforts to support genomics to be embedded into routine care as part of the NHS Long Term Plan.
- Good progress is being made in relation to the rollout of new technologies in the NHS. The NHS App continues to be tested and rolled-out to GP practices with plans for full coverage in 2019.
- 16.2 million patients (27% of patients in England) are now registered for one or more online services. National data also shows the number of general practices to have at least 10% of patients registered for one or more online services is 93%. In March 2019, 1.2 million transactions for appointment booking/cancelling occurred and there were 3.2 million online repeat prescription transactions.
- 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, with partners, has developed two health-led employment trials which went live in May 2018 and had involved more than 4,300 people by March 2019.
- NHS England and NHS Improvement established a single EU Exit function, working closely with DHSC to prepare the NHS for EU Exit under any scenario. We jointly issued Operational Readiness Guidance for local NHS organisations in December 2018. NHS England and NHS Improvement have held regional events to support local preparations and have continued to publish a wide range of system-facing communications. We have set up National Co-ordination Centre, Regional Coordination Centre and Commercial and Procurement Cell structures to gather intelligence from and disseminate information to the health system. We continue to test Government planning assumptions to ensure that national plans take account of the needs of the health and care sector and so that local leaders have the information they need to prepare for EU Exit under any scenario.

Appendix 2: Equality

Meeting our Public Sector Equality Duty (PSED)

NHS England has continued to prioritse action to meet the PSED and the associated equality duties. Our latest comprehensive report[1] describes the action being taken across NHS England to support compliance with the Equality Act 2010 and progress against our PSED. Our equality objectives are supported by key targets, and progress is set out in our latest update[2].

Our equality objectives for 2016 to 2020, set out below, address our role as an NHS system leader and our own role as an employer:

1: To improve the capability of NHS England's commissioners, policy staff and others to understand and address the legal obligations under the PSED and duties to reduce health inequalities set out in the Health and Social Care Act 2012.

2: To improve disabled staff representation, treatment and experience in the NHS and their employment opportunities within the NHS.

3: To improve the experience of Lesbian, Gay, Bisexual and Transgender People (LGBT) patients and improve LGBT staff representation.

4: To reduce language barriers experienced by individuals and specific groups of people who engage with the NHS, with specific reference to identifying how to address issues in relation to health inequalities and patient safety.

5: To improve the mapping, quality and extent of equality information in order to better facilitate compliance with the PSED in relation to patients, service-users and service delivery.

6: To improve the recruitment, retention, progression, development and experience of the people employed by NHS England to enable the organisation to become an inclusive employer of choice.

In January 2019, we published the NHS Long Term Plan and an associated Equality and Health Inequalities Impact Assessment. NHS England's second gender pay report[3] was published in March 2019. Further information can be found on page 110 of our Staff Report.

1 NHS England response to the specific equality duties of the Equality Act 2010: April 2018 - March 2019
2 https://www.england.nhs.uk/about/equality/objectives-16-20/
3 https://www.england.nhs.uk/publication/nhs-england-gender-pay-report/

Appendix 3: Reducing health inequalities

During 2018/19 NHS England has undertaken a range of work to address health inequalities, in line with the objectives set out in the Next Steps on the NHS Five Year Forward View, and more recently in the NHS Long Term Plan, and the criteria set by the Secretary of State.

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

Our strategic approach is to embed an understanding of the need to reduce health inequalities through our priority programmes and policies, to build insight into the impact of inequalities upon health and healthcare and support a coordinated, evidence-based approach in access to, and experience of, NHS services and health outcomes.

Partnership working is achieved in many ways, including the development and implementation of the Equality and Health Inequalities RightCare Packs[4] to support the work of CCGs and through the work of the NHS Equality and Diversity Council (EDC).

We have also established with the DHSC and PHE an oversight group that meets regularly to review progress, understand developments, and bring challenge on health inequalities.

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 (DHSC, 2015) set out 11 indicators identified for health inequalities assessment which have been used to guide reporting in 2018/19 using NHS Digital's data. Information and data on the indicators will be published on the NHS England website in July 2019. The framework supports our work with national clinical programmes in developing health inequalities measures within each work area to measure impact on health inequalities.

NHS England leads wider work on data monitoring and information standards in partnership with the DHSC and other key stakeholder organisations. In October 2018, the Information Standard on sexual orientation monitoring (SOM) was published, with 25 NHS Trusts agreeing to pilot the Standard to help inform implementation.

To support commissioners and providers to better understand inequalities in access, NHS England supported the refresh of the practical resource "Improving Access for all: reducing inequalities in access to general practice services". The Equality and Health Inequalities Analysis (EHIA) for the improving access to general practice services policy was published on NHS England's website in April and is tracked by CCGs.

The health inequalities indicator 106 for chronic ambulatory care sensitive conditions and urgent care sensitive conditions in the CCG IAF continues to help CCGs monitor and plan improvements in NHS equity performance and forms the basis of the EHI Right Care Packs. The EHI Right Care Packs support local healthcare systems to take systematic focused action on reducing health inequalities for their local diverse populations.

4 Equality and Health Inequality RightCare Packs - https://www.england.nhs.uk/rightcare/products/ccg-data-packs/equality-and-health-inequality-nhs-rightcare-packs/

Criterion 3: Utilise and develop the evidence of effective interventions to reduce health inequalities

Analysts at NHS England have been looking closely at the approaches some of the new care model vanguards have taken to identify patients at risk in their communities. The term used for this is 'risk stratification'. In 2018/19, we have also continued to increase the use of data and information to shape policy, drive improvement and assess progress in reducing health inequalities in cancer. In conjunction with DHSC, PHE, academics, charities and other stakeholders we have scoped unanswered and understudied questions on health inequalities. We took the evidence of effectiveness of interventions into account as a step to devise policies aimed at reducing those health inequalities. We will be developing this work further in 2019/20.

Criterion 4: Improve prevention, access and effective use of services for Inclusion Health groups

To deliver improvements in prevention and access to primary care medical services we published information that aims to make it easier for patients from Inclusion Health Groups to overcome the barriers to accessing healthcare.

In London, for example, 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. During 2018/19 we continued to support commissioners and providers to implement good homeless health practice; develop and promote clinical engagement in relation to homeless health and promote good homeless health practice to stakeholders and professional groups in London. The impact of this work is being evaluated locally to inform ongoing gap analysis and further work commissioners need to address in improving health access and outcomes for homeless people and rough sleepers.

Other work is being progressed in relation to other inclusion groups such as the appointment of an LGBT advisor and issues relating to access in conjunction with Gypsy and Roma communities.

Criterion 5: Continue its leadership of the health system to reduce inequalities, including assessing whether CCGs fulfil and report on their health inequalities duties in commissioning plans and annual reports

NHS England included in the 2018/19 CCG IAF a composite measure to help CCGs set priorities for tackling inequalities. This informs the headline national assessment of CCGs together with several other indicators.

Criterion 6: Continue to take action to reduce health inequalities as part of work to deliver, with partners, the NHS Five Year Forward View and the mandate to NHS England

Progress has been made to embed health inequalities considerations across our corporate priority areas, examples of which are set out below:

In Cancer, NHS England worked on the recommendations set out in the Cancer Strategy (2015) to ensure that patient experience is on a par with clinical effectiveness and safety. One of the specific areas is to increase Black, Asian and Minority Ethnic (BAME) representation in the Cancer Patient Experience Survey. As BAME people report a poorer experience of care for six out of the seven indicators in the cancer dashboard, a programme of projects was created – Equalities Cancer 2020 - to look at the actions that can be taken to address this.

In Mental Health, addressing equalities and health inequalities is one of the cross-cutting themes of the Five Year Forward View for Mental Health and several initiatives are underway to improve equitable access to services for groups with protected characteristics and people vulnerable to poor mental health. This includes equality issues in perinatal mental health service development, design, delivery and evaluation to meet the needs of underserved women and communities and the needs of BAME groups within wider mental health programmes.

In Learning Disabilities and Autism, we commissioned the LeDeR Programme. Through the learning from LeDeR reviews NHS RightCare has committed to reflecting the needs of people with a learning disability in the optimal pathways it produces.

In Diabetes, we are routinely monitoring take up and retention rates of the prevention programme, with analysis now being undertaken relating to the link between outcomes in BAME groups and social deprivation.

Appendix 4: List of acronyms used in our annual report

	Acronym used	Meaning
	A&E	Accident and Emergency
	AHSN	Academic Health Science Networks
	ADASS	Association of Directors of Adult Social Services
	ALB	Arm's Length Body
A	AF	Atrial Fibrillation
	ALL	Acute Lymphoblastic Leukaemia
	AME	Annually Managed Expenditure
	ARAC	Audit and Risk Assurance Committee
	ARP	Ambulance Response Programme
B	BAME	Black, Asian and Minority Ethnicities
	CareCERT	Care Computer Emergency Response Team
	CAR-T	Chimeric Antigen Receptor T Cell Therapy
	CEO	Chief Executive Officer
	CCG	Clinical Commissioning Group
	CETV	Cash Equivalent Transfer Value
	CHC	Continuing Healthcare
	CIO	Chief Information Officer
	COO	Chief Operating Officer
C	CPAG	Clinical Priorities Advisory Group
	CPI	Consumer Price Index
	CQC	Care Quality Commission
	CQRS	Calculating Quality Report Service
	CQUIN	Commissioning for Quality and Innovation
	CRHTT's	Crisis Resolution and Home Treatment Teams
	CSOPS	Civil Servant and Other Pension Scheme
	CRR	Corporate Risk Register
	CSU	Commissioning Support Unit
	DAWN	Disability and Wellbeing Network
	DCO	Director of Commissioning Operations
	DCEO	Deputy Chief Executive Officer
	DHSC	Department of Health and Social Care
D	DIL	Diversity and Inclusion Leadership
	DSC	Data Security Centre
	DSP	Data Security and Protection
	DSPT	Data Security Protection Toolkit
	DWP	Department of Work and Pensions

	Acronym used	Meaning
E	e-RS	e-referral system
	ECDC	Elective Care Development Collaborative
	EDC	Equality and Diversity Council
	ECG	Electrocardiogram
	EHIA	Equality and Health Inequalities Analysis
	EPRR	Emergency Preparedness, Resilience and Response
	ERMG	Executive Risk Management Group
	ESCAPE	Enabling Self-management and Coping with Arthritic Pain through Exercise
	ESM	Executive Senior Manager
	ESR	Electronic Staff Record
	EU	European Union
F	FCP	First Contact Practitioner
	FF	Fast Followers
	FIT	Faecal Immunochemical Tests
	FOI	Freedom of Information
	FReM	Financial Reporting Manual
	FRF	Financial Recovery Fund
	FSAVC	Free Standing Additional Voluntary Contributions
	FTE	Full Time Equivalent
	FTSU	Freedom to Speak Up
G	GAM	Group Accounting Manual
	GDPR	General Data Protection Regulation
	GIRFT	Getting It Right First Time
	GPFV	General Practice Forward View
	GPPCF	General Practice Payment Calculation Futures
	GPSoC	GP Systems of Choice
H	HCID	High Consequence Infectious Disease
	HII	High Impact Intervention
	HMRC	HM Revenue and Customs
	HQIP	Health Quality Improvement Partnership
	HR	Human Resources
I	IAF	Improvement and Assessment Framework
	ICO	Information Commissioners Office
	ICP	Integrated Care Provider
	ICS	Integrated Care System
	IFRS	International Financial Reporting Standards
	IG	Information Governance
	ILM	Institute of Leadership Management
	ISA	International Standards on Auditing
	ISFE	Integrated Single Financial Environment
	ISN	Information Standards Notice
L	LeDeR	Learning Disabilities Mortality Review
	LGA	Local Government Associations
	LGBT+	Lesbian, Gay, Bisexual, Trans +
	LHCR	Local Health Care Record
	LMDP	Line Management Development Programme
	LMS	Local Maternity Systems

	Acronym used	Meaning
M	MHFA	Mental Health First Aider
	MHRA	Medicines and Healthcare Products Regulator Agency
	MoD	Ministry of Defence
	MSK	Musculoskeletal
N	NAO	National Audit Office
	NARU	National Ambulance Resilience Unit
	NCC	National Co-Ordination Centre
	NGD	National Data Guardian
	NHS	National Health Service
	NHSCFA	NHS Counter Fraud Authority
	NHS DPP	The NHS Diabetes Prevention Programme
	NHS IMAS	NHS Interim Management and Support
	NHS BSA	NHS Business Services Authority
	NHS PS	NHS Property Services
	NHS SBS	NHS Shared Business Services
	NIA	National Innovation Accelerator
	NICE	National Institute for Health and Care Excellence
	NIHR	National Institute for Health Research
O	OD	Organisational Development
	OGSCR	Oversight Group for Service Change and Reconfiguration
	ONS	The Office of National Statistics
	OPW	Off-Payroll Workers
P	PCN	Primary Care Network
	PCSE	Primary Care Support England
	PCSPS	Principal Civil Service Pension Scheme
	PHB	Personal Health Budget
	PHE	Public Health England
	PHSO	Parliamentary and Health Service Ombudsman
	PPV	Patient and Public Voice
	PRP	Performance Related Pay
	PSED	Public Sector Equality Duty
	PSF	Provider Sustainability Fund
Q	QAG	Quality Assurance Group
	QNFMHS	Quality Network for Forensic Mental Health Services
R	RDEL	Revenue Department Expenditure Limit
	RPI	Retail Prices Index
	RTT	Referral to Treatment Time

	Acronym used	Meaning
S	SBLCB	Saving Babies Lives Care Bundle
	SBRI	Small Business Research Initiative
	SCOG	Specialised Commissioning Oversight Group
	SDEC	Same Day Emergency Care Services
	SDMP	Sustainable Development Management Plan
	SDU	Sustainable Development Unit
	SFI	Standing Financial Instructions
	SOM	Sexual Orientation Monitoring
	SROs	Senior Responsible Officers
	SSNAP	Sentinel Stroke National Audit Programme
	STP	Sustainability Transformation Partnership
T	TU	Trade Union
U	UTC	Urgent Treatment Centres
V	VAT	Value Added Tax
	VCSE	Voluntary, Community and Social Enterprise
W	WRES	Workforce Race Equality Standard
	WTE	Whole Time Equivalent

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