NHS
Commissioning Board

NATIONAL HEALTH SERVICE COMMISSIONING BOARD

Annual Report & Accounts 2013–14

THE NHS CONSTITUTION
the NHS belongs to us all

National Health Service Commissioning Board

Annual Report & Accounts 2013–14

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is known as NHS England

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Chair's Introduction

Malcolm Grant
Chair

High quality care for all, now and for future generations

The creation of NHS England – one of the reforms made by the Health & Social Care Act 2012 – has opened up a new era in the leadership of the NHS. It is our responsibility to bring about continually improving health outcomes for individuals, communities and society as a whole, by investing the NHS budget strategically to ensure real value for money.

We were established in shadow form in October 2011 and assumed our formal statutory responsibilities in April 2013. These include stewardship of £96bn of public funds to provide comprehensive health and care services available to all, where there is clinical need and regardless of an individual's ability to pay. We are also custodians of the values of the NHS Constitution. We are 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.

Central to our role is the commissioning of health services. We commission some services directly (mainly specialised and primary care services), but allocate the majority of the resources we receive to clinical commissioning groups, who commission services at local level.

Launching the new NHS commissioning structure has involved one of the most ambitious and complex public sector reforms ever seen. Some 211 new clinical commissioning groups have now taken on their full responsibilities, and great progress has been made. I have been deeply impressed by the refreshing energy, enthusiasm and expertise of the local clinical leaders I have met and their determination to bring about long overdue improvement in the quality of services across the country, tackling inefficiency and outmoded working practices, all in the interests of ensuring that patients get the highest quality care. And all of this against the backcloth of unremitting increases in demand for NHS services at a time of acute financial stringency.

It has been a huge honour and responsibility to chair NHS England through this exceptional period, and I am grateful to all members of the NHS England Board for their dedication and commitment throughout the year. I am also profoundly grateful to all our staff who have worked so hard to make NHS England a success. The achievements outlined in this Annual Report are testament to their efforts and commitment.

Grateful thanks are due to Sir David Nicholson, our first Chief Executive, who retired at the end

of March 2014. Sir David played a leading role in steering the reforms that Parliament had prescribed, overcoming and managing the exceptional risks involved, and succeeding in creating a solid foundation on which we now must build a sustainable future for our NHS. Simon Stevens, an outstanding successor, brings great vision and experience to what is undoubtedly the most significant leadership role in healthcare in the world.

A note on our name: we adopted the name NHS England in April 2013 with the agreement of the Secretary of State for Health, although in statute we remain the National Health Service Commissioning Board. We use the name NHS England throughout this document.

Introduction by the Chief Executive

Simon Stevens
Chief Executive

This annual report describes NHS England's first full year of operation. It highlights the substantial work required to establish a new commissioning system for England from 1st April 2013. I want to add my personal thanks to all the staff of NHS England and its predecessor bodies who worked so diligently on this major transition. The result – unique in the western world – is that two thirds of our health service funding is now entrusted to local groups of family doctors and other clinicians.

Having taken up post as Chief Executive of NHS England on 1st April 2014, and five years into the longest period of austerity our health and social care services have faced since the Second World War, I am in no doubt that the NHS is at a defining moment. Looking out over the next five years, there is now a widespread sense across the NHS that 'more of the same' isn't sustainable. A growing and ageing population coupled with the increasing prevalence of obesity, dementia and multiple long-term conditions all mean that our patients' needs and preferences are changing. Legacy models of care are losing their relevance. New technologies are opening up new frontiers in diagnosis and treatment. Greater transparency about quality of care is rightly putting the most intense focus ever on care effectiveness, safety, patient experience and equity.

These challenges are quite well understood. The focus now needs to shift to developing solutions. As steward of nearly £100 billion of NHS funding, NHS England – in close partnership with local NHS clinical commissioning groups – exists to unleash more health and care 'bangs for the buck'. Our job is partly to catalyse and support improvement and creativity, as local communities develop new ways of future-proofing services. In doing so we aim at all times to "think like a patient, and act like a taxpayer".

We want to see an NHS that is more flexible, more adaptable, where national and local thinking converge to create different clinically and financially sustainable paths for particular communities. This will mean developing new commissioning approaches and accelerating the redesign of care delivery – using a combination of evidence from the NHS' past experiences, new local innovation, and learning from established international successes.

In doing so, we will seek actively to exploit the fundamental transformations now occurring in modern western medicine. The potential to use genetic science to develop personalised care. Using data to drive transparency, quality improvement and the move to more proactive and anticipatory care. The revolution in the role patients and communities will play in their own health and care. These are just a few of the

trends now sweeping across healthcare in the industrialised world.

So NHS England and our partners have an ambitious agenda ahead of us. In the autumn we will publish a Five Year Forward View for the NHS, which will set out our shared thinking in more detail and map out possible development paths for the NHS nationally and locally. We look forward to working with you, at a time when the stakes have never been higher for the NHS.

Annual Report

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Review of the Business

"The NHS belongs to the people. It is there to improve our health and wellbeing, supporting us to keep mentally and physically well, to get better when we are ill and, when we cannot fully recover, to stay as well as we can to the end of our lives. It works at the limits of science – bringing the highest levels of human knowledge and skill to save lives and improve health. It touches our lives at times of basic human need, when care and compassion are what matter most". **NHS Constitution**

What is NHS England?

The mission of NHS England is to deliver:

High quality care for all, now and for future generations.

The purpose of NHS England is to deliver improved health outcomes for England by:

- Allocating resources to clinical commissioning groups and supporting them to commission services on behalf of their patients according to evidence-based quality standards;
- Directly commissioning specialised care services, primary care services, healthcare for the armed forces and their families, healthcare for those in the justice system and a range of public health services; and,
- Achieving equal access to health services designed around the needs of the patient.

"One of the things I like most about working for NHS England is working in partnership with clinicians – CCG colleagues and National Clinical Directors. They have such a "can do" approach which is inspiring and will ensure transformational change happens."

Caroline Humphreys, Service Transformation Lead

NHS England is held to account for achievement of these purposes by Ministers and Parliament.

NHS England employed 15,291 staff (as at 31 March 2014) across the country; the majority supporting clinical commissioning groups or directly commissioning services. The organisation hosts 17 commissioning support units (as at 1 April 2014 – further consolidation is underway), NHS Improving Quality, the Sustainable Development Unit and a number of Clinical Senates and Networks.

"I have been struck by the extremely positive perspective of staff in NHS England and their absolute focus on patients, desire to add value and make a positive contribution to the NHS."

Annabel Johnson, Directorate Delivery Lead

Delivering on our Priorities: Progress to Date

NHS England is committed to putting patients at the heart of everything it does. NHS England works in partnership with a number of other NHS bodies including the Care Quality Commission, Monitor, the NHS Trust Development Authority, Public Health England, NICE, Health Education England and the Health & Social Care Information Centre, each of whom has distinctive responsibilities within the NHS.

Here are some of the ways in which NHS England has tried to make those ambitions reality:

- *NHS England's nursing directorate has championed Compassion in Practice across the NHS, embedding the 6 Cs of care, compassion, competence, communication, courage and commitment. There are now "caremakers" in all parts of the NHS – not only nurses, but doctors, commissioners, hospital porters and managers.*
- *The work to embed 7 day services was launched by Professor Sir Bruce Keogh who is now leading a review into how this is delivered. By the end of NHS England's first year the 111 service was commissioned and available across the whole of England taking a million calls a month.*
- *NHS England has continued its commitment to transparency throughout the year, making publicly available more indicators than ever before, including surgeon level information that show outcomes for patients in ten clinical areas, information about never events in hospitals and new data about general practices*
- *Patients are at the heart of what NHS England does, so making sure the NHS listens to their views and helping the public shape what is commissioned is vital. In its first year NHS England developed the Friends & Family Test so that patients can give actionable feedback at the point they receive care. The organisation is also pioneering a new approach to involving the public in the future of health and care called NHS Citizen.*
- *NHS England realises that making sure commissioners have the information they need to plan for care is vital. With its partners in the Health & Social Care Information Centre, NHS England has made care.data a priority, but there is more work needed on putting in the reassurance the public need about how their information is protected before the programme is rolled out. Meanwhile commissioning support units around the country have developed innovative and effective ways of providing timely information to commissioners.*

Improving Health Outcomes

Mandate Chapter One: Preventing people from dying prematurely

NHS England's ambition is for England to become one of the most successful European countries at preventing premature deaths. The Mandate states that about 20,000 lives a year could be saved if mortality rates in England were reduced to the lowest in Europe. The latest mortality data show a mixed picture. There are some encouraging trends in mortality; cancer survival rates, for example, have improved. However, it is known that it will take years of sustained effort to realise the goal of saving an additional 20,000 lives a year and that it is crucial to lay the right commissioning foundations. One of the key achievements in 2013–14 has been to shift the focus of commissioning towards outcomes rather than process. As part of the recent planning round, all clinical commissioning groups developed ambitions for improving outcomes across all five domains of the Outcomes Framework. NHS England has provided hands-on support as well as web-based tools designed to help clinical commissioning groups identify high-impact interventions. The organisation has also designed financial incentives for clinical commissioning groups, so that they are rewarded for achieving their planned reductions in premature mortality.

The majority of patient interactions with health services are through GP practices. Through the Prime Minister's Challenge Fund, more than seven million patients across the country will benefit from innovative pilot schemes that are trialling improvements to GP access.

Mandate Chapter Two: Enhancing quality of life for people with long term conditions

15 million people in England live with one or more long term conditions, and the Mandate from the Government asks NHS England to improve their quality of life. For some indicators the historic trend has been one of deterioration; for example, health related quality of life for people with long term conditions has improved, but the employment rate differential for people with long term conditions continues to widen, with a gap of 13.9% reported in quarter three of 2013–14. Turning this situation around requires long-term, united action across the health and social care system.

> ***"I'm inspired, motivated and driven to deliver for NHS England based on my experience of working in a supportive, positive and hardworking team committed to delivering a better NHS for and with patients. The first year of NHS England has been the best year of my working career so far."***
>
> Patricia Muramatsu, Senior Strategy Advisor

The Better Care Fund has potential to be a significant catalyst for service transformation, and NHS England has supported local systems through the planning process to develop five-year strategic plans to realise this potential. It is essential that plans are as robust as possible to deliver system-wide quality and efficiency, and NHS England will continue to work with local systems to improve the quality of plans. NHS England is part of a partnership that in 2013 identified 14 integrated care and support pioneer sites through a rigorous selection process. The learning from the experiences of these pioneers will inform how NHS England shapes its future national integration support work.

It is important that people with long term conditions are as involved in their care as possible. NHS England has made progress on delivery of the roll-out of personal health budgets which give people more control over the health care and services they require. All clinical commissioning groups have signed up to delivery of personal health budgets, and an Accelerated Development Programme has begun. Sites have now been chosen for piloting personal health budgets for people with mental health conditions.

For too long dementia has been an illness that went unnoticed until it was too late. NHS England is working to shift the way dementia care is organised and delivered in the UK so as to deliver better outcomes for people, and their carers, and help them live well with dementia. The number of people diagnosed and on the dementia register has risen by 8.4% in 2013–14 compared to 2012–13. The Planning Guidance published in December 2013 set clinical commissioning groups the challenge of achieving diagnosis rates of 67% by March 2015. NHS England is working with Public Health England and with the Department of Health to define best practice in post-diagnostic care. NHS England's Compassion in Practice agenda is particularly relevant, and there will be dementia training for people – nurses and others – working in hospital settings. There is a financial incentive (CQUIN) scheme to improve dementia and delirium care and there is also a directed enhanced service to encourage timely diagnosis.

Mandate Chapter Three: Helping people to recover from episodes of ill health

Over the last year NHS England has been working on a number of specific programmes to help people recover from episodes of ill health. These include the reviews of 7-day services and of urgent and emergency care, which will have enduring benefits for how services are delivered in future. By the end of 2013–14 the organisation had also ensured that NHS 111 was available across the whole of England, taking a million calls per month.

Information can be a powerful lever for change. It empowers citizens and patients to take more control of their care, and underpins improved decision making across provider and commissioner organisations. In 2013–14 NHS England has worked to extend the scope of data collection and publication into new areas, and to make that data more accessible. In summer 2013 consultant level outcomes data was published for 10 surgical specialties. This is the first time this information has been published at consultant level. This programme will be expanded in the coming year to cover other surgical and non-surgical areas.

> ***"I have worked in the NHS 'frontline' for 25 years. In my new role as a clinical director for NHS England (Wessex), I have been incredibly impressed at the talented and dedicated people who work 'behind the scenes' to drive improvements in care for our patients"***
>
> Dr Richard Jones, Clinical Director, Wessex Area Team

NHS England is committed to developing a modern data service to provide accurate and timely data linked across the patient journey. Following feedback from patients and national stakeholders the work to develop care.data was extended to allow for further engagement. This is an important project, and it is essential that the organisation listens to and acts upon views of patients and stakeholders. The phased roll out will now begin in Autumn 2014.

This section of the Mandate also included the specific requirement to introduce a process to ensure that NHS reconfigurations meet the four Secretary of State tests (1. clinically led, 2. have strong public engagement, 3. have a clear evidence base and 4. are consistent with patient choice). Guidance has been issued to commissioners advising how they should assure proposals against the four tests, and there is a Service Oversight Group in place with the specific remit to oversee a pipeline of reconfiguration schemes.

Mandate Chapter Four: Ensuring that people have a positive experience of care

As well as improving the clinical quality and outcomes for services, NHS England is improving the experience of care that people receive when they use health services. Recent data shows slight improvements in experience of hospital care and dental services (76.9% and 84% respectively), but slight falls in experience in GP and GP out of hours services (86.7% and 70.2% respectively).

In 2013–14 a key focus was on making rapid progress in measuring and understanding the experiences of patients. The Friends & Family Test has been rolled out for inpatient, accident & emergency and maternity services, and plans are in place for roll out to other services by March 2015. Response rates have increased for inpatient (27% to 35%) and accident & emergency services (10% to 19%). The net promoter score in January 2014 was 73 for inpatients and 54 for accident & emergency. Maintaining the access standards set out in the NHS Constitution is an important contributor to people's experience of the NHS.

We recognise the crucial role of commissioning in ensuring vulnerable people, including those with learning disabilities and autism, receive safe and appropriate care and are protected from harm. This includes ensuring full delivery of the Winterbourne View Concordat objectives. In 2013–14 the Joint Improvement Programme undertook a stocktake across all clinical commissioning groups and Local Authorities, and new data collections are in place to provide assurance on registers, care-coordination and discharge and transfer plans. The first quarterly data collection was published in March 2014, setting out the position at 31 December 2013: of a total of 2,577 patients, 260 have a transfer date, of which 172 are before 1 June 2014. This lack of progress was disappointing, and with partners across health and social care, NHS England has increased its efforts to escalate the urgency and priority of this programme.

> ***"NHS England in its first transformational year and my first year working in the NHS has shown, to quote Winston Churchill, "difficulties mastered are opportunities won". So here's to the second year!"***
>
> Clementine Chilvers, Administrative Assistant

The long term conditions programme includes an objective to improve the quality of life for older people with complex needs and end of life care. In February 2014 NHS England published guidance for commissioners and providers for integrated pathways for frail older people.

NHS England has given particular focus to improvement of the experience in maternity services and for children with special educational needs. On maternity, rates of stillbirths and babies dying within seven days of birth are higher in England than they should be; there is significant variability in the quality of care between trusts, and there are persistent inequalities in experiences. NHS England has begun responding to this challenge by introducing a Friends & Family Test in

maternity services, which in March 2014 showed a net promoter score of 67%. NHS England aims to build up from this position in the coming year through the established Strategic Clinical Networks, and in particular focus on improving the offer of a named midwife and improving early diagnosis and support for those with postnatal depression.

Developing joint care plans for children and young people with special education needs or disabilities and enabling them to use a personal health budget is primarily delivered through clinical commissioning groups, who have a duty to engage with local partners. NHS England has a role to support, lead and assure clinical commissioning groups through this process, and a more consistent and co-ordinated approach is needed for the coming year so that all eligible children and young people can benefit.

Digital technology has the power to transform healthcare for all. NHS England is committed to providing all citizens with access to medical records in general practice, available online from March 2015, and also to ensuring that everyone can book appointments and order repeat prescriptions online – as part of a broader initiative to enable patients and citizens to take more advantage of digital services in health and care. The Widening Digital Participation Programme has funded a series of initiatives showcasing innovation in digital inclusion to help 60,000 people become actively trained in digital skills with a further 100,000 reached.

Mandate Chapter Five: Treating and caring for people in a safe environment and protecting them from avoidable harm

Patients should be able to expect to be treated in a safe, clean environment, and to be kept from harm when they are using healthcare services. This involves high quality clinical care, ensuring that systems prevent error and harm, and developing a culture of learning from patient safety incidents. There is a lack of direct measures of harm patients suffer, and work is underway to develop a new measure. The rates of MRSA and C Difficile continued to fall during 2013–14.

NHS England is working with national and local partners to improve quality. In January the organisation launched the Patient Safety Alerting System, with seven alerts reported by the end of the financial year. NHS England has also put in place regular publication of never events data, from April 2014, and a surgical never events taskforce reported in February 2014.

Compassion in Practice, a system-wide programme for nurses, midwives and care staff to deliver higher quality compassionate care to improve physical and mental health and wellbeing outcomes, was published in December 2012, and throughout 2013–14 NHS England worked to embed the principles throughout the NHS. The 6Cs now have wide acceptance and reach throughout the nursing, midwifery and care staff workforce in the NHS across England. There are now 'caremakers' in all parts of the NHS, including nurses, doctors, commissioners, hospital porters and trust managers.

Throughout the year there has been a consistent increase in data submitted to the NHS Safety Thermometer, and this was matched with a decline in the incidence of 'harms' recorded – the number of patients harm free is now 93.6%, up from 92% last year.

Promoting Equality & Reducing Inequalities in Health Outcomes

Promoting equality and reducing health inequalities are a priority for NHS England, ensuring that every individual is able to access

and receive the highest quality of care according to their need.

To provide visible and robust leadership on equality and health inequalities issues, NHS England hosts the Equality and Diversity Council, which is working to ensure information is available so that NHS England can measure progress on tackling health inequalities.

To support clinical commissioning groups, NHS England published a Framework of Excellence, which identifies reducing health inequalities as a key priority for effective commissioning. The Commissioning Assembly's working group on Reducing Health Inequalities is developing a toolkit for clinical commissioning groups to tackle health inequalities locally.

Giving mental health the attention it deserves

The Mandate from the Government is very clear about the importance of treating mental and physical health in a co-ordinated way, and with equal priority. There is a long record of imbalance to redress: it is known that historically, people with mental health problems experience worse outcomes, and that those with physical problems often have mental health needs that go unrecognised.

In 2013–14 NHS England has been prioritising support for the commissioning system to put attention to mental health on a par with physical health, and to close the health gap between people with mental health problems and the population as a whole. The organisation also began work to improve the integration of physical health and mental health provision; so for instance, mental health assessments will include physical assessments, and mental health will be embedded into NHS Health Checks. The provision of care for those experiencing mental health crises has been another area of focus in 2013–14. NHS England has ensured its work is aligned with the Government's Mental Health Crisis Care Concordat.

The recent planning process set the challenge for clinical commissioning groups to develop plans to move towards genuine parity between physical and mental health. An important aspect of the programme is delivering the goal of 15% access to psychological therapies with a 50% recovery rate. NHS England has worked during 2013–14 to get the Improving Access to Psychological Treatment Programme on track, and has included intensive support for those clinical commissioning groups that face particular challenges. At quarter three of 2013–14 access was 11.5% and recovery 43.9%. NHS England recognises that continued focused effort is required to meet this standard and is incentivising improvement through the CQUIN and quality premium schemes. The Children & Young People Improving Access to Psychological Treatment Programme is on target to deliver 60% coverage by March 2015.

Employment of people with mental illness has improved during quarter three of 2013–14 – the gap in employment has reduced to 37% between those with mental illness and those without, but this illustrates the scale of the challenge to move towards genuine parity.

NHS Constitution Rights & Pledges

This Constitution sets out the principles and values of the NHS in England. It combines 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 that the NHS operates fairly and effectively.

Following publication of a revised version in March 2013, the NHS Constitution has been

promoted extensively via the NHS England website, the staff intranet, staff bulletins, NHS facing bulletins to NHS chief executives, nursing communities, medical directors and clinical commissioning groups as well as the allied health professions.

Timely access to services is a critical part of people's experience of care and all patients should receive high-quality care without unnecessary delay. Nationally, the NHS is making good progress across many key indicators, but NHS England is redoubling efforts to ensure standards are maintained.

Performance against these standards was strong for most of 2013–14, and the system coped well over the winter months. However, performance began to deteriorate in quarter four of 2013–14, with breaches of both referral to treatment and cancer standards. From April 2013 to January 2014 the NHS delivered the operational standard of 90% of admitted patients starting their treatment within 18 weeks, but the standard was not met in February and March 2014. The NHS is now performing 2,000 more operations a day than it was four years ago. The operational standard for non-admitted patients, of 95%, was met in every month of 2013–14.

It is vital cancer patients are diagnosed and treated quickly so they have the best possible chance of recovery. Figures for quarter four show the NHS has met and exceeded seven out of eight cancer waiting time standards. But there is variation, and national performance against one of the targets has dipped. NHS England is supporting local commissioners to work together with local providers where the standard is not being met to identify the issues to ensure patients are treated in a timely way.

The NHS Constitution pledges to provide patients with diagnostic tests within six weeks from referral. Timeliness of diagnosis and treatment is what patients expect; the vast majority get their tests promptly, with most patients waiting less than three weeks from referral. However, with more and more tests carried out every year, almost 56,000 more when compared to the same period last year, there is more work to do. NHS England continues to work with both commissioners and providers to ensure patients have prompt access to diagnostic tests.

The NHS continues to deliver a good service for patients against the national standard of a maximum four-hour wait in accident & emergency from arrival to admittance, transfer or discharge. The four hour access target was met in all four quarters of the year and for the year as a whole at 95.7%.

Becoming an Excellent Organisation

The creation of NHS England in April 2013 brought together staff from 162 legacy organisations. By March 2014 15,291 people were employed by NHS England (including in commissioning support units) in offices based around the country.

The staff barometer reflects the organisation's commitment to listen to all staff and to address the issues they raise. As a result, the Excellent Organisation Programme was developed with the aim of ensuring that NHS England is an organisation where people want to work and are inspired to give their best. The programme has focused on the areas that staff feel most strongly about: removing the obstacles to doing a great job; improving individual health and wellbeing; getting teams working across the whole organisation; developing internal communications and staff engagement; implementing agile working; developing the leadership community; and, accelerating

implementation of Performance Development Review.

Good joint working practices and interaction with NHS England's statutory partners, public and patient organisations and charities is vital to the successful implementation of policy across the NHS. To ensure the organisation's practices are as good as they can be, NHS England sought comprehensive 360 degree feedback from statutory partners, clinical commissioning groups, public and patient organisations and charities to understand their views, concerns and expectations. This showed that stakeholders were broadly satisfied with NHS England's performance in its first year of operation but highlighted the importance of collaboration in relationships, the need for more clarity and focus in certain areas, and the need to demonstrate action is being taken.

Looking Forward: Objectives for 2014–15

NHS England has three clear overarching objectives:

- Delivering high quality care for all now;
- Delivering high quality care for all, for the future; and,
- Developing the organisation.

Each of these objectives builds on the achievements of the first year as a fully operational organisation:

- They reflect NHS England's role as direct commissioners, as assurers of clinical commissioning group commissioning, and as a key player within the wider health and social care system;
- They contribute to the delivery of the mandate and the range of legal duties set out in the Health and Social Care Act (2012) and encompass the plans to embed quality and equality at the heart of everything that NHS England does; and,
- They will be taken forward in collaboration with partners, working across traditional boundaries to put the patient at the centre of the future NHS.

> ***"I was reminded that the NHS is a precious legacy that we should celebrate and protect and that the best dreams to have are the ones that help the dreams of other people come true too and that we should never be afraid to ask questions, we shouldn't be afraid to admit when we have made mistakes, and we shouldn't be afraid to ask for help".***
>
> Patient representative

To deliver on these overarching objectives NHS England has identified 31 business areas that together encompass the planned activity for the coming year. The full business plan, which can be downloaded from the NHS England website, describes these 31 business areas in more detail, sets out the things NHS England is committed to deliver and identifies the resource allocated to each area.

Taken together, these 31 business areas describe the organisational focus and outline how NHS England will help deliver the vision of high quality care for all, now and for future generations.

Simon Stevens
Accounting Officer

10 July 2014

Chief Financial Officer's Report

Paul Baumann
Chief Financial Officer

The Financial Statements for the year ending 31st March 2014 are presented later in this document. The Financial Statements have been prepared on the basis of a Direction issued by the Department of Health in accordance with the National Health Service Act 2006 (as amended) and show the performance of both the consolidated group covering the whole of the Commissioning System and of NHS England as the parent of the group. The group comprises NHS England and 211 clinical commissioning groups. A full list of the clinical commissioning groups can be found on the NHS England website.

The implementation of the ground-breaking Integrated Single Financial Environment – a financial accounting and reporting system covering all of the organisations concerned – has greatly facilitated this process.

NHS England had a revenue resource limit of £95,873m in 2013–14. The organisation is responsible for using this money wisely and fairly to secure the best possible outcomes for both patients and the taxpayer. As shown in Note 8 to the Financial Statements and later in this Report, the Group fulfilled all of the financial duties set out in the Mandate for 2013–14, covering revenue spending, administration costs and capital expenditure.

Operational Performance

The core measure for the financial performance of NHS commissioners is the Revenue Departmental Expenditure Limit (RDEL), which accounted for £95,213m of NHS England's available resources in 2013–14. This included £1,184m cumulative surplus brought forward from 2012–13. The plan was for in-year expenditure of £94,679m against this limit, thus reducing the end year surplus to £534m. Actual expenditure – before the net impact of the closedown of primary care trust and strategic health authority balance sheets ("legacy") – was £94,400m, an underspend of £279m (0.3%), taking the closing surplus to £813m.

This is shown in more detail in the table overleaf:

Financial performance against each area of activity – clinical commissioning groups and NHS England

Financial Performance 2013–14 – RDEL	Funding per Mandate	Expenditure		Surplus		Under/(over) spend against plan	
		Plan	Actual	Plan	Actual		
	£m	£m	£m	£m	£m	£m	%
Clinical commissioning groups	65,366	64,751	64,650	615	716	101	0.2%
Social care	859	859	859	0	0	0	0.0%
Direct commissioning	27,306	27,081	27,428	225	-122	-347	-1.3%
NHS England administration/central programmes	1,576	1,576	1,432	0	144	144	9.1%
Reserves & drawdown	106	412	30	-306	76	382	n/a
Financial Performance before legacy impacts	**95,213**	**94,679**	**94,400**	**534**	**813**	**279**	**0.3%**
Legacy 2012/13	0	0	-133	0	133	133	n/a
Total RDEL	**95,213**	**94,679**	**94,267**	**534**	**946**	**412**	**0.4%**

Note: definitions for each of the technical limits can be found in the Financial Statements later in this document

Across the 211 clinical commissioning groups, there was a small underspend of £101m (0.2% of allocation). Overall, clinical commissioning groups met the financial policy set out in the Planning Guidance of ending the year with a 1% cumulative surplus. However, the position by individual clinical commissioning group varied quite significantly, with carried forward surplus levels ranging from over 8% to deficits of more than 5%. A total of 19 clinical commissioning groups ended the year in deficit compared to a plan of nine. This is reflected in 19 regularity opinions from component auditors. All of these clinical commissioning groups are receiving close support under the clinical commissioning group assurance arrangements, and recovery plans are being agreed as part of the work on operational and strategic plans from 2014–15. Given the fact that 18 of the 19 deficits are in clinical commissioning groups whose current allocation is below target, NHS England has initiated steps to address this issue in the allocations for 2014–15 and 2015–16 (see below for more information on allocations).

Direct commissioning overspends were £347m (or 1.3% of allocation). The most significant area of overspend was specialised commissioning, where activity growth continued to run at an unaffordable rate and was compounded by issues associated with the disaggregation of primary care trust budget baselines. In recent months NHS England has significantly increased the resources focused on specialised commissioning and initiated a seven point strategic and operational programme to manage these pressures. The appointment of a dedicated Director of Specialised Commissioning and a subsequent reshaping of the organisation's approach to commissioning these services will better support this work.

Central budgets for NHS England running and programme costs were underspent by £144m (9.1%), mainly due to vacancies at the beginning of the year and delays to the programme to transform primary care support services, with consequent deferral of the related restructuring

costs, for which an additional budget had been provided in 2013–14.

The reserve releases reflect the fact that the bulk of the allowable surplus reduction (drawdown) in 2013–14 was held in reserve when operating plans were agreed, with a view to covering off risks in the organisation's first year of operation. £150m of these reserves were used to fund a second tranche of winter resilience money made available to frontline health services in addition to £250m provided by the Department of Health. After allowing for a small number of other unforeseen cost pressures, the remainder has been released to offset the pressures in specialised commissioning.

The "legacy" benefit of £133m represents the winding down of closing balance sheets of primary care trusts and strategic health authorities and represents a one-off net correction of 2.5% on the value attributable to the commissioning system.

In summary, whilst the overall surplus represents a small improvement over the plan, it nonetheless represents a net drawdown of historical surplus of nearly £400m and benefited from a number of one-time factors, that will not recur in future years. The outlook for the years ahead is therefore challenging.

Performance against Wider Financial Metrics

Within the Mandate, the Department of Health sets a number of technical financial targets, including the RDEL metrics described above, against which NHS England is expected to deliver. These limits are generally ring fenced which means that underspends in other areas cannot be used to support core patient services generally covered by RDEL.

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

Performance against key financial performance duties

Target	Limit	Actual	Under-spend	Target met
	£m	£m	£m	
Revenue Limits				
RDEL – general	95,065	94,205	860	✔
RDEL – ring-fenced for depreciation and operational impairment	148	62	86	✔
Total RDEL (see table above for detail)	**95,213**	**94,267**	**946**	
Annually Managed Expenditure limit for provision movements and other impairments	300	159	141	✔
Technical accounting limit (e.g. for capital grants)	360	93	267	✔
Total Revenue Expenditure	**95,873**	**94,519**	**1,354**	
Administration Costs (within overall revenue limits above)				
Total Administration Costs	2,016	1,898	118	✔
Capital Limit				
Capital expenditure contained within our Capital Resource Limit (CRL)	200	182	18	✔

Note: definitions for each of the technical limits can be found in the Financial Statements later in this document

In addition to the financial performance targets set out above, NHS England is committed to paying at least 95% of valid invoices within 30 days of receipt. The table in the Director's Report shows our performance for the year ending 31 March 2014. There has been a significant improvement in NHS England's performance in this area since last year, and the group as a whole achieved 96.6% and 99.3% compliance for non-NHS and NHS payments respectively when measured by value (94.7% and 92.0% by number of invoices).

Allocations

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

The NHS England Board decided in December 2012 to launch a fundamental review of allocation policy to ensure a holistic approach was taken across all commissioning areas of spend.

In December 2013, the Board decided to:

- Set allocation funding across commissioning areas in a way that left individual areas with broadly similar levels of efficiency challenge over the two years;
- Move to link allocation funding more directly to population, with funding expressed on the basis of £ per head;
- Adopt a new allocation formula for clinical commissioning groups, including a pace of change policy that targeted available investment at clinical commissioning groups below target but set a real terms funding growth at least for the first two years;
- Introduce an allocation formula for primary care funding for the first time; and,
- Adopt an adjustment for unmet need and inequalities of 10% for the clinical commissioning group formula and 15% for the primary care formula, using the SMR<75 mortality indicator for both.

Delivery against the Mandate in 2013–14 and fulfilling the Duty of Continuous Improvement in the Quality of Services

The first five chapters of the Mandate relate directly to the five domains of care in the NHS Outcomes Framework, and NHS England's actions against each are described earlier in this document in the Business Review. That narrative also describes how NHS England is fulfilling its legal duty to secure continuous improvement in the quality of healthcare services provided.

The following sections provide detail on how NHS England has tackled the objectives set by Government in the remainder of the Mandate, including actions taken.

Chapter Six: Freeing the NHS to Innovate

A key aspect of the reforms was to free up local commissioners so that they can focus on improving health outcomes and shaping local services to meet the needs of their particular communities. NHS England's role is to support and develop local commissioners to fulfil this role and provide appropriate and proportionate assurance.

The Commissioning Assembly has been an invaluable mechanism for learning, testing and sharing ideas. The national support centre of NHS England has been systematically gathering and responding to commissioner views and needs, particularly through providing tailored support and guidance as required.

NHS England worked with NHS Clinical Commissioners to gather views from clinical commissioning groups on how effective the organisation has been in this role. The report summarising the findings was published in November 2013. The report highlights the positive relationships being established between NHS England and clinical commissioning groups, and particularly through its assurance role. It also highlighted areas for future development including improving partnership working on NHS England direct commissioning, building mutual assurance as co-commissioners, and improving support for clinical commissioning groups. The NHS England business plan sets out the approach to tackling these issues in 2014–15.

NHS England clinical commissioning group and direct commissioning assurance frameworks will be used to review and monitor performance. For clinical commissioning groups this will include use of the updated CCG Outcome Indicator Set. The third clinical commissioning group assurance checkpoint has been completed, with the results reported to the Authorisation & Assurance Committee in May 2014.

In 2013–14 NHS England issued any qualified provider guidance to clinical commissioning groups and led a series of workshops for clinical commissioning groups, commissioning support units and area teams. The organisation has made good progress on the recommendations that fall to NHS England from the Fair Playing Field Review, including two year funding settlements, guidance on contract length flexibility in the standard contract and progression on pricing and currencies with Monitor. On choice, NHS England has put in place arrangements for choice to be offered in mental health services in 2014–15, but recognises further work is required to fully embed patient choice.

The National Tariff set for 2014–15 maintained relative stability and included minimal changes. NHS England plans to design new payment mechanisms aligned with wider policy objectives

in the longer term which will have scope for wider-ranging, more substantial changes that could be introduced from 2015–16 onwards.

Chapter Seven: The Broader Role of the NHS in Society

NHS England has been making progress on the objective to promote research in order to improve patient outcomes and to contribute to economic growth. The organisation has produced an organisational development plan to support short and long-term requirements of Academic Health Science Networks, with business plans approved and contracts signed by April 2014. The Academic Health Science Networks Assurance Group will produce quarterly reports, stakeholder communications and case studies. In December 2013 NHS England published a draft research strategy for consultation. It is anticipated that the final version will be published in the Autumn of 2014.

NHS England is a major delivery partner in the Prime Minister's Genome Programme, and is responsible for seven deliverables including supporting clinicians working in the relevant disease areas, undertaking data maturity assessments and collection and supply of DNA samples.

There is a new section in the NHS Standard Contract for providers relating to NHS Treatment Costs that states there must be due regard, as applicable, to NHS Treatment Costs Guidance.

During the course of 2013–14 NHS England has developed effective relationships with key partners, including the Department of Health, Monitor, the NHS Trust Development Authority, Healthwatch England, Public Health England, Health Education England, the Local Government Association, the National Institute for Health & Care Excellence and the Care Quality Commission. The organisation has gathered feedback from key partners and stakeholders, and while the findings show they are broadly satisfied with their relationship with NHS England these partners also feel that NHS England needs to go further to embed genuine collaboration into its working practices. The organisation also recognises the comments that NHS England could be easier to navigate and engage with. NHS England will take action on these views, and engaging in similar surveys in future years will allow the organisation to evaluate and benchmark the actions it takes.

Chapter Eight: Finance

Financial performance across the Commissioning System was strong throughout 2013–14. The system delivered a surplus of £813m, and around 85% of QIPP (Quality, Innovation, Productivity & Prevention) plans were delivered, with a value in excess of £1.7bn. Despite this strong performance, the financial outlook remains very challenging, and NHS England estimates that £30bn of further efficiencies will be required across the system in the next 5 years. This scale of savings will require sustained system wide transformation, and supporting the system to deliver this is a key priority.

NHS England has worked with commissioners to develop outline five year plans for clinical commissioning groups and the organisation as a direct commissioner. There will be monthly financial reporting against plans as part of the integrated performance management process. The organisation will also support the implementation of 2014–15 and 2015–16 QIPP plans.

Further detail is provided in the Chief Financial Officer's Report, earlier in this document.

Chapter Nine: Assessing Progress and Providing Stability

This chapter of the Mandate relates to the publication of information for directly commissioned services in a comparable way to clinical commissioning group commissioned services, and requires that progress is measured not simply by looking at absolute progress, but by looking at reductions in health inequalities and unjustified variation.

There are significant variations in health outcomes, and our level of understanding of these remains inadequate and hampered by poor data quality. NHS England is committed to systematically addressing these inequalities, and an assessment against its duties to reduce health inequalities is contained in the next section of this Report.

Section 7a

The Secretary of State for Health delegates to NHS England responsibility for commissioning certain public health functions through the NHS public health functions agreement 2014–15 (S7A agreement). The programmes that are commissioned by NHS England are:

- National Immunisation Programmes;
- National Screening Programmes;
- Children's public health services from pregnancy to age 5 (until 1st October 2015);
- Child Health Information Systems;
- Public health care for people in prison and other places of detention; and,
- Sexual assault services.

Governance arrangements for the programmes have been established through the NHS Public Health Functions Senior Oversight Group. The Group is chaired by the Department of Health Director General for Public Health and has senior membership from NHS England and Public Health England. Health Education England has also recently been invited to attend to strengthen partnership working for public health.

The main measures of how well NHS England performs these responsibilities are taken from the Public Health Outcomes Framework. The key deliverables for 2013–14 show that performance of these public health programmes was not affected by the transition to new responsibilities in April 2013.

A new agreement for 2014–15 has been signed by NHS England and the Department of Health. This agreement strengthens ambitions by NHS England to narrow health inequalities by reducing the range of variation.

Assessment of Duties to Reduce Health Inequalities

Health inequalities are the *'differences in health status or in the distribution of health determinants between different population groups'* (WHO Glossary). They are widespread in England and have been found, for example, based on geography, gender, some mental illnesses and other long term conditions, learning disabilities, ethnicity, status in society, religion and sexual orientation.

Health inequalities are also seen in the pronounced socio-economic gradient in the prevalence of all major long term conditions, in life expectancy and in healthy life expectancy. For example, on average in 2009–11, men in the most deprived areas of England have lives 9 years shorter than those in the least deprived areas and spend more of those shorter lives in ill-health (29% compared to 15%). The available data show that there are inequalities in both health outcomes and service experience that have endured over time, despite substantial investment in healthcare.

The Ethical Case

NHS England believes that health inequalities that are preventable by reasonable measures are unfair. Putting them right is a matter of social justice.

Reducing health inequalities is at the heart of NHS England's values; making sure 'everyone counts' forms a central part of NHS England's business plan.

NHS England is clear that its commitment to 'high quality care for all' cannot be achieved unless its commitment to reducing health inequalities exceeds its legal duties to do so.

The Legal Duties

The Health and Social Care Act 2012 introduced the first legal duties on health inequalities, with specific duties on NHS England to:

- Have regard to the need to reduce inequalities between patients in access to health services and the outcomes achieved;
- Exercise its functions with a view to securing that health services are provided in an integrated way, and are integrated with health-related and social care services, where it considers that this would improve quality and reduce inequalities in access to those services or the outcomes achieved;
- Include in an annual business plan an explanation of how it proposes to discharge its duty to have regard to the need to reduce inequalities;
- Include in an annual report an assessment of how effectively it discharged its duty to have regard to the need to reduce inequalities; and,
- Include in an annual report an assessment of how well clinical commissioning groups have discharged their duty to have regard to the need to reduce inequalities.

Assessment of NHS England's Performance Against the Health Inequalities Duties

The Secretary of State for Health set out in a letter in January 2014 the criteria for assessment relating to these duties. These provide a framework for embedding the duties within NHS England, from strategic direction downwards. Our actions relating to these criteria are summarised below:

Criterion of Assessment	Evidence
Has the organisation considered its potential impact on health inequalities strategically, and the application of the duty to its functions?	• Board development session (September 2013) – Board awareness of the health inequalities duties established; consideration of strategic implications • Board paper and Board discussion (December 2013) including approval of strategic priorities for NHS England's commitment to address health inequalities • Board consideration of health inequalities quantitative indicators (September and December 2013); establishment of (interim) health inequalities indicators • Embedded in Domain programmes of work, e.g. strategy for reducing premature mortality • Embedded in commissioning, e.g. primary care, direct commissioning
Has action been taken to ensure all staff subject to the duty are aware of it?	Assurance plan including: • Presentation on duties available on staff intranet to support staff members' awareness and implementation of duties • Communication sent to all staff, alerting them to duties and guidance presentation (October 2013) • Regard to health inequalities duties embedded in Project Management Office documentation providing wide reach into staff body and decision making processes (2013–14) • Awareness of legal duties is a key message in the Communication Plan for the Equality & Health Inequalities Team developed in 2013–14; implementation ongoing for the internal and external audiences • Guidance, e-learning package and training programme developed
Are appropriate governance arrangements in place?	• Governance arrangements for Equality & Health Inequalities Team and work tested by an independent audit (2013–14) • Equality and Health Inequalities identified as priority area and governance specified in review template (from 2013–14) • Board reporting specified in Board paper (December 2013) – annual stocktake on progress in addressing health inequalities and regular reporting mechanism established • Risks regarding work to address health inequalities identified and managed via committees of the Board • Revised governance for health inequalities being put in place for quarter one 2014–15 including alignment of business priorities and robust monitoring and reporting
Is there clear accountability at a sufficiently senior level?	• Executive Director identified as Senior Responsible Officer (September 2013) for progress on health inequalities and for reporting on this • Specified in Equality and Health Inequalities priority area review template (2013–14) • Assurance on health inequalities progress and risks provided through Board Assurance Framework and reported to NHS England Board (2013–14) • Equality & Diversity Council chaired by NHS England Chief Executive (2013–14 and ongoing) provides system leadership around health inequalities

Criterion of Assessment	Evidence
Is there an assurance process to ensure duties are being applied?	• Risks managed via Board Assurance Framework (2013–14) • Assurance through Business Plan on relevant deliverables (see deliverables 1.9 and 1.11) (2013–14) • Tested by independent audit (2013–14) of Equality & Health Inequalities Team, assurance and governance • Currently being strengthened via Equality and Health Inequalities Programme Board (first meeting quarter one 2014–15) • Self-assurance model for NHS England products, to be supported by externally chaired assurance board providing continuous improvement and learning from quarter one 2014–15 • EDC2 delivery across NHS organisations monitored and supported development (2013–14 and ongoing)
Is the approach being taken informed by evidence?	• NHS Outcomes Framework promoting equality and reducing inequalities in health evidence in the NHS England Performance Report (item 9) of September 2013 board papers. Evidence based decision making, e.g. in Domain 1 and in primary care
Are inequalities in access and outcomes being routinely monitored?	• Via Board reporting and Mandate Assurance (2013–14 and ongoing)
Are strategic partnership arrangements in place?	• NHS England has an established partnership with Public Health England focused on improving health outcomes and reducing health inequalities (2013–14 onwards) • Working with the Local Government Association and Public Health England a 'Health and Wellbeing System Improvement Programme and Partnerships Prospectus' published in June 2013 • Reducing health inequalities central to partnership agreement with Public Health England • Health inequalities considered as part of stakeholder analysis and has informed work programme of strategic partners (including voluntary sector partners) (2013–14 onwards)
Is progress in addressing health inequalities being maintained, including action on key priorities?	• Progress against Public Accounts Committee recommendations reported throughout 2013–14; suggestion that these have been implemented and can be closed being made to Public Accounts Committee • Domains' work programme • Primary care programme • Primary care strategic framework • Embedding of unmet need measure within resource allocation – quantum 15% for primary care and 10% for clinical commissioning group allocation (December 2013) • Board reports include updates on interim health inequalities measures
Has NHS England ensured clinical commissioning groups are capable of fulfilling their duties?	• *Framework of Excellence* (November 2013) and *Reducing Premature Mortality* (December 2013) support clinical commissioning groups in addressing health inequalities and make this central to planning • *Commissioning to Reduce Health Inequalities Toolkit* (due to be published in the second half of 2014) • A narrative outlining the plans for the above toolkit, including the legal duties for clinical commissioning groups, was published on the Commissioning Assembly website in January 2014 • Resource allocation to clinical commissioning groups (December 2013) – embedded unmet need measure (10% quantum)
Has NHS England put in place robust arrangements for assessment of clinical commissioning groups' fulfilment of their duties?	• Clinical commissioning group assurance process (2013–14 and ongoing) • Training programme for area teams developed – to be implemented 2014–15

Assessment of Public Involvement & Consultation

In accordance with the National Health Service Act 2006 (as amended) NHS England has a requirement to assess and report how effectively it has discharged its duty under Section 13Q of the Act (Public Involvement & Consultation by the Board).

This specifically relates to how individuals to whom services are being or may be provided are involved:

- In the planning of the commissioning arrangements by NHS England;
- In the development and consideration of proposals by NHS England for changes in the commissioning arrangements where the implementation of the proposals would have an impact on the manner in which the services are delivered to the individuals or the range of health services available to them; and,
- In decisions of NHS England affecting the operation of the commissioning arrangements where the implementation of the decisions would (if made) have such an impact.

Strong and genuine engagement with the public is one of the defining characteristics of NHS England.

Throughout its first full year of operation NHS England has been committed to ensuring patient and public participation in NHS England and the wider NHS. There has been engagement with patients, carers and the public, as well as the voluntary, social enterprise and community sectors through a number of workshops, events, scoping exercises and engagement exercises, including playing a key role in the NHS England AGM and the Health and Care Innovation Expo. Initiatives such as NHS Citizen, Patients and Information Open House, the Participation Academy, the Commitment to Carers and patient and public participation within specialised commissioning offer a forum for patients, the public and organisations to help NHS England to create the culture and conditions for health and care services to deliver the highest standard of care most effectively.

Support for Increased Patient & Public Participation

As a new organisation in its first year of operation, NHS England has focused its efforts on developing the processes and structures to support increased capacity for participation of patients and the public across all its work.

Understanding that participation should be fully embedded into the culture of NHS England, the Patient & Public Voice Team has provided advice and guidance to other NHS England teams throughout the year and fosters the link to health and care networks, allowing access to those difficult groups to reach.

Over the next year this work will be built upon by offering internal learning events, publishing 'how to' toolkits and building participation and engagement principles into the corporate induction process.

Publication of Transforming Participation in Health & Care Guidance

In September 2013, NHS England published *Transforming Participation in Health and Care*. This was developed with a wide range of stakeholders and partners to support commissioners to improve individual and public participation and to better understand and respond to the needs of the communities they serve.

Following the publication of the guidance, NHS England has continued to develop resources to support commissioners through a series of 'bite-sized guides' on a range of topics including principles for participation in commissioning, governance for participation, planning for participation, and budgeting for participation.

Recruitment of Patient & Public Voice in Governance

Throughout its first year of operation, NHS England has taken steps to ensure that the voices of patients and the public are heard at all levels.

Every level of the commissioning system will be informed by listening to those who use and care about services. Patient and public representatives have therefore been embedded into many of NHS England's governance structures, with the aim of ensuring that patient and public voice is integral to governance and not just an 'add on'. Where possible, these groups have multiple patient and public representatives to enable balance and diversity of perspective.

Involvement in governance includes the appointment of Non-Executive Members to the Board of NHS England, and representatives on many advisory groups covering areas such as clinical priorities, rare diseases and patient safety.

Productive Relationships

To ensure a wide and diverse range of voices are heard, NHS England works directly with patients and the public and also with the voluntary and community sector, Healthwatch England and the local healthwatch network. During its first year NHS England has established strong working relationships with the health and care voluntary sector strategic partner programme, in partnership with the Department of Health and Public Health England. This programme works with 22 partnerships (increased from 21 in 2013–14) across the breadth of the voluntary and community sector and, through the partners' networks, directly reaches over 350,000 voluntary and community sector organisations. Through the programme, NHS England is able to obtain initial insight from the voluntary sector into its work.

NHS England has also established strong working relationships with The Richmond Group, a coalition of 10 of the leading health and social care organisations in the voluntary sector, the National Association of Patient Participation, the Patients Association and many more.

NHS England works closely with Healthwatch England to ensure that the interests of patients and the public are at the heart of everything we do and that the voice of local healthwatch can be heard effectively by NHS England.

Co-producing NHS Citizen

NHS Citizen is a pioneering and co-produced approach to patient and public engagement in the health service. Launched in March 2014, it has been designed to bring the diversity of citizens' voices and views to bear on NHS England's decision making. It will provide a mechanism to respond quickly to issues raised by patients, carers and the general public, whilst working with citizens to solve some of the NHS's most pressing problems.

NHS Citizen seeks to involve people in both face-to-face and digital forums. Key figures to date include:

- A total of 12,916 hits on the webcasts;
- From October 2013 to 15 April 2014, 8,584 tweets sent by 1,121 participants;

- Personally speaking to over 300 people at design and development events and workshops; and,
- 596 people registered on the mailing list.

Further information about the development of NHS Citizen and how to get involved is available at www.nhscitizen.org.uk

During 2014, more public workshops will take place around the country to improve and strengthen the design of NHS Citizen.

NHS England Youth Forum

A new Youth Forum was established in March 2014, supported by the British Youth Council, to provide a specific mechanism to canvass the views of children and young people in order to challenge professionals on whether they are indeed prioritising the health issues that matter most to this group. The Forum was created based on feedback from young people.

Twenty young people have successfully been recruited to the Forum from all over the country, with membership open to children and young people between the ages of 11 and 18. Other age ranges have been invited to participate as appropriate in different work programme areas. Children and young people can find out more and get involved in the Youth Forum's discussions on the NHS England Youth Forum Facebook page.

Children's Takeover Day

Led by the Office of the Children's Commissioner, Takeover Day gives young people the chance to work with adults for the day and to be involved in experiencing and learning in ways that connect them with the world of work and raise their personal aspirations for the future. On Friday 22 November 2013 members of the Young People's Parliament from the Cooperative Academy of Leeds came to Quarry House, the headquarters of NHS England, and discussed their experiences of health services with National Directors from NHS England.

On 28 November 2013 young people really took over. Working with the Young People's Health Partnership, young people came from all over the country to participate in a day's workshop to explore their views and experiences of the NHS and concluded with a powerful presentation to the Executive Team.

To ensure that the recommendations of young people was taken on board, each of the Executive Team was asked to say a word, make a pledge or simply reflect on what they had heard on the day. These have subsequently been further developed with each of the Directors.

Participation Awards

In March 2014 NHS England hosted the inaugural Excellence in Participation Awards, showcasing exemplary practice in public and patient participation and insight. The Awards celebrate the outstanding contributions of people and organisations across the country who are transforming people's lives, improving health and care services and putting patients, carers and communities at the very heart of healthcare. They contribute to a culture of excellence and achievement across individual and public participation in health, which can then be celebrated and shared nationally. Winners were announced at Health Innovation EXPO 2014.

Digital Engagement

In addition to more traditional methods of engagement, NHS England has sought to involve patients and the public through digital methods over the last year. This has provided the opportunity for many people who cannot attend face to face events to have their voice heard and

has provided a wealth of feedback on different programmes and insight into commissioning.

Several face-to-face meetings, including work on NHS Citizen, the AGM in September 2013, the Open House, and all Board meetings have been live streamed to enable people to watch the proceedings. Twitter hashtags were established to enable people to follow the discussion and participate actively from afar. 'Tweet chats' have also been established for many of the programmes of work.

Some examples of the digital engagement methods used by NHS England include:

- **Websites:** Provision of information, guidance and user engagement (in the form of commenting facilities) via the main NHS England website. During 2013–14 the NHS England website was used by 1.5 million people viewing 3 million pages. The website also provides a professional networking platform which allows over 10,000 of our stakeholders to connect, ask questions and share best practice;
- **Social Media:** in addition to twitter NHS England also engages with users through the following platforms:
  - Flickr;
  - Pinterest;
  - Storify; and,
  - YouTube – 188 videos having had over 41,000 views in the last 12 months;
- **Consultations & Surveys:** NHS England has a dedicated platform for consultations and surveys. 130 consultations/surveys have been created on the NHS England hub this year, consulting in a variety of ways from registration forms to highly specialised consultations (e.g. urgent and emergency care review). 66,859 stakeholders have been reached through this channel; and,
- **E-bulletins:** Regular email bulletins are sent to approximately 76,000 users. These not only keep people informed of the progress of different programmes of work but also ensure that people are aware of forthcoming opportunities to participate.

A new digital health literacy programme was established in 2013–14 to help ensure that everyone in the community has access to digital platforms and the training they need to be involved.

Friends & Family Test

The introduction of the Friends & Family Test allows hospital trusts to gain real-time feedback on their services down to individual ward level and increases the transparency of NHS data to drive up choice and quality. This enables the NHS to record patient experience data and use this data to drive improvements.

The real strength of the Friends & Family Test lies in the follow up questions that can be attached to the initial question.

These provide a rich source of qualitative patient views that can be used locally to highlight and address concerns much more quickly than more traditional survey methods.

Involvement in Directly Commissioned Services

During this first year of operation there has been a significant focus on the development of patient and public voice in specialised commissioning, initially to develop the most appropriate models for national commissioning with a view to this

then being adapted for other national commissioning structures.

Over the forthcoming financial year this will be built upon within other areas of NHS England in partnership with patients and the public.

Specialised Commissioning

To ensure that patient and public voice was centred in the specialised commissioning model, a patient and public voice group was established from the outset to act as a transitional group to co-produce the model of engagement for specialised commissioning and to provide a powerful patient and public voice in the development of specialised commissioning during the first year of operation.

This developmental group has subsequently been replaced by an openly recruited Patient & Public Voice Assurance Group.

Communication and engagement within NHS England's specialised commissioning function covers a broad remit, including:

- **Public/Patient Voice in Governance:** Within the 75 Clinical Reference Groups that support specialised commissioning, 263 patient and public members have been recruited. Each Clinical Reference Group has representation from commissioners, clinicians, patient organisations and individual patients or carers as well as other stakeholders. Clinical Reference Groups are developing a strong culture of listening to patients. In addition, patient and public representatives have been recruited onto the Patient & Public Voice Specialised Services Assurance Group, the Clinical Priorities Advisory Group and the Rare Diseases Advisory Group, as well as regular patient and public voice involvement being facilitated in other forums;
- **Shaping Strategy & Policies:** Patient and public involvement has been facilitated in commissioning policies and strategies, including public workshops on specialised policies and specifications, and the ethical framework; and,
- **Supporting & Delivering Public Engagement:** Ensuring that a clear model of engagement is established when service change or review is underway including, but not limited to, formal public consultation.

A key focus since April 2013 has been to develop a web presence for specialised services, including individual pages for each of the 75 Clinical Reference Groups, to enable Clinical Reference Group members to access key documents.

Two examples of the more detailed work to involve patients and the public in specialised commissioning are:

- **Gender Identity Engagement:** Each of the Clinical Reference Groups have chosen to undertake patient involvement differently beyond governance positions; other stakeholders are able to register to receive updates and input their thoughts. Some have actively conducted additional engagement to ensure that patient and public views have been effectively included, for example, the Gender Identity Services Clinical Reference Group (C05).

  NHS England was committed from the outset to engaging effectively with members of the trans community, as well as with clinicians and other stakeholders, in the development of gender identity and gender dysphoria services.

  An initial workshop took place in June 2013 which helped NHS England start genuine dialogue with one of the most marginalised and hidden communities whose members face the greatest health inequalities in how

they access appropriate and safe services and receive support that is personalised to their needs. The design of the workshop ensured opportunities for an open and transparent dialogue between trans people, clinicians and NHS England, leading to agreement on an interim position and the process for a more in depth review of services beyond specialised services.

Further workshops have since brought together commissioners and providers of gender identity services with people from the trans community. Feedback from both of these workshops, the work of the Clinical Reference Group and ongoing dialogue have influenced the specification for gender identity services. A Gender Identity Network was also established, to provide an online forum where people can ask questions and share information with their peers.

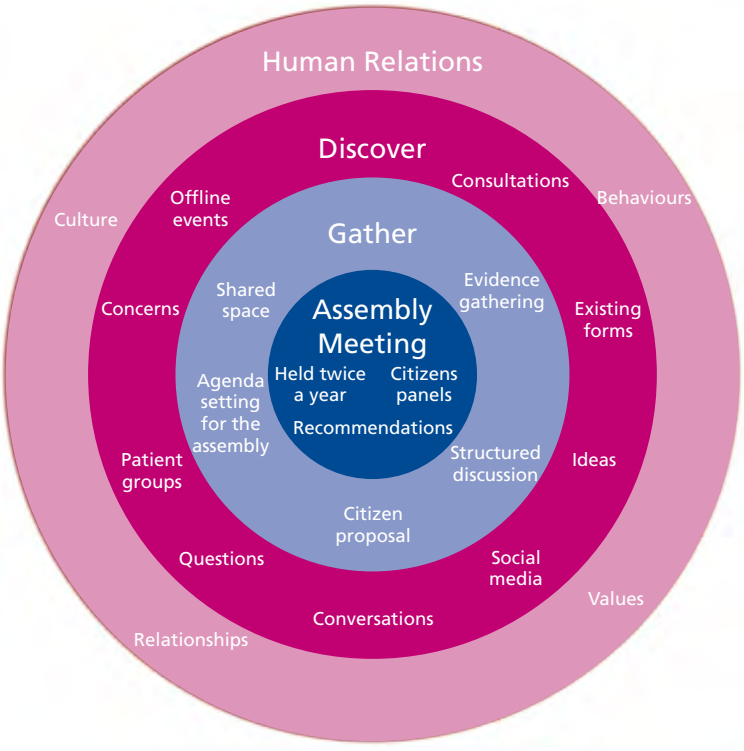
- **Congenital Heart Review:** As NHS England progresses with the national review of congenital heart services for children and adults, John Holden (Director of System Policy) is writing a regular blog to maximise transparency and ensure that those with an interest in the review are kept informed of progress and given the chance to get involved as appropriate.

The blog is published fortnightly on the NHS England website. It provides updates on a range of recent engagement activities and ongoing discussions with interested parties, including the Patients & Public Group, which brings together local and national charities with an independent chair. Announcements, agendas, meeting papers and minutes for the review are all published on the blog as soon as they are available.

Primary Care

Since April 2013 a key focus within primary care has been the development of the Enhanced Service for Patient Participation 2014–15, with the specific aim of strengthening the role of

The diagram below shows the current thinking on how NHS Citizen might work:



Patient Participation Groups within GP practices. In addition a Patient Participation Group Assurance Framework which includes a Quality Award Scheme for Patient Participation Groups was developed and piloted, and NHS England is exploring the possibility of linking this with other stakeholder quality schemes in future.

To build capacity in Patient Participation Groups and ensure they can be as effective as possible, NHS England worked directly with the National Association of Patient Participation during 2013-14.

2013–14 also saw the first steps towards making changes to the GP contract negotiation process between NHS England (via NHS Employers) and the British Medical Association's General Practitioner's Committee, as this is an area where there is minimal or no formal mechanism for involvement. It is envisaged that this will continue in 2014–15.

Health and Justice & Armed Forces Health

Based on the model for patient and public involvement developed within specialised commissioning, work has been undertaken over the last year to develop a model of participation for both health and justice and armed forces health commissioning. The approach to ensure open and transparent structures and processes, with patient and public voice at the heart of commissioning, is starting to be developed in partnership with service users and stakeholders.

The health and justice system presents a number of challenges to the patient and public voice agenda. NHS England is seeking to develop processes which are embedded into the organisation at all levels, and which ensure that the voices of patients from diverse and often hard-to-hear groups in secure settings are heard.

The organisation is therefore working to devise appropriate methods of participation for people who may not have access to digital and social media methods of engagement. The organisation is working with stakeholders to map current activity of engagement.

Similarly NHS England's armed forces health commissioners at both a national and an area team level have been working with the Patient & Public Voice Team to develop a participation model through workshops and focus groups to ensure that NHS England fully understands the culture around the armed forces and the best ways to engage with this population.

Involvement in Specific Programmes of Work

In addition to involvement in the services directly commissioned by NHS England, patient and public involvement has been at the heart of a number of other programmes of work since April 2013, which underpin commissioning at a national level and will directly affect patients and the public.

Some of these are detailed below, together with the impact the involvement of patients and the public has had:

Clinical Commissioning Group Authorisation

A number of lay assessors were appointed to support the authorisation of clinical commissioning groups prior to April 2013.

Their involvement strengthened the process by giving valuable perspectives of patients/carers during the review of evidence provided by clinical commissioning groups as well as at individual clinical commissioning group site visits.

The Keogh Review

Over 60 patient members were recruited to be part of the review teams.

This patient and public perspective was singled out for specific praise within the review process, recognising that having patient voice as part of the review teams had brought a different and vital dimension to the review.

The Call to Action

Patient and public involvement was critical to the 'Call to Action'.

Locally, NHS England area teams and pilot clinical commissioning groups were supported to involve patients and the public in their activities, and resources were subsequently developed.

Nationally a series of workshops was held to enable patients and the public, along with other stakeholders, to input into some of the key areas that need to be addressed in the NHS.

Following each event a 'thought leadership piece' was developed based on participant feedback. These were disseminated to clinical commissioning groups to help them involve their local communities in developing their five year strategic plans.

Primary Care Call to Action

Area teams and clinical commissioning groups have held various local engagement events specifically on the separate calls to action for primary care services: general practice (launched in August 2013); community pharmacy (December 2013); and NHS dental services (February 2014). These separate engagements cover the total £13 billion of primary care services directly commissioned by NHS England each year.

In some cases area teams have supplemented national materials with additional local material. For example, *'Transforming Primary Care in London'* was published in November 2013 and sets out the particular challenges and opportunities for primary care in London.

As well as local events, national stakeholder events took place in October 2013 for general practice and in March 2014 for community pharmacy, alongside online questionnaires.

Insight was also gathered from a review of responses to the GP Patient Survey and of complaints that NHS England has received directly from the public since April 2013. Children and young people also shared their experience of general practice services directly as part of Children's Takeover Day.

In addition, the Department of Health has been carrying out a national engagement exercise on how to improve services for vulnerable older people. NHS England will work with the Department to identify how best to support general practice to meet the issues identified.

In February 2014 NHS England published *'Improving General Practice – A Phase 1 Report'* which seeks to test emerging priorities and ambitions for general practice, and the work that has been started to support local communities in achieving these ambitions. The document explains how NHS England wants to explore further how national partners can help deliver the vision, and how NHS England seeks to remove barriers to local innovation.

A clear and consistent message from stakeholders was that "to do nothing" is not an option. Steps have already been taken to address some of the issues identified, both by the public and by the profession. This has been reflected in the reforms to the GP contract (and ongoing

reform to the national dental contract), and the approach taken to clinical commissioning group allocations published in December 2013.

Consideration is also being given to how improvements in access to general practice can be implemented through making best use of the Prime Minister's Challenge Fund, from April 2014, in addition to the steps that NHS England has already taken to enable patients to access services in ways that better reflect their needs and preferences.

New forms of collaborative commissioning with clinical commissioning groups for primary care services are also being explored to help tackle health inequalities and to provide a strategic focus on the specific needs of local communities.

Seven Day Services

The Seven Day Services Team used a workshop at the AGM and the plenary session to listen to patients' views. Some of the themes that emerged had a direct impact on the Team's thinking and on the *Summary of Initial Findings*, which was published by the NHS Services, Seven Days a Week Forum in December 2013.

This led to an extended and different engagement approach from that originally envisaged. For example, as a result of the AGM a final listening event was staged in Birmingham in November 2013, with more than 300 attendees from stakeholder groups.

One of the main messages from the AGM – that the co-ordination of services is of the utmost importance to users – had been clearly heard, and the event was used both to share the first stage findings and to take soundings about the next phase of work.

NHS England AGM

NHS England invited citizens to take part in a series of 'Talking Health' pre-AGM workshops: a real opportunity to demonstrate openly the values, behaviours and culture of transparency and participation that NHS England seeks to embody.

Over 200 people participated in the pre-AGM workshops and 400 people registered for the evening AGM meeting with the audience including patients, the public, clinicians and other NHS professionals.

Each workshop had a live twitter chat which enabled hundreds more people to contribute their ideas, experiences and opinions to the debates. One person tweeted, "Unfortunately I could not make @NHSEngland's #NHSAGM, but thanks to twitter, it feels like I've been there". There were more than 4,000 tweets using the workshop hashtags, with ongoing discussion of several workshop themes continuing well beyond the AGM. In the case of #EndofLifecare the twitter discussion continued for several days. An estimated 200,000 individual twitter accounts were reached.

Representatives of the NHS England Board attended each workshop and listened directly to what participants were saying. The key highlights from the discussions fed into the AGM public meeting, with strong themes around greater partnership working with patients and the public to meet the future challenges of the NHS.

The Future of Health

In November 2013 NHS England, University College London and the political information company, Dods, hosted the 'Future of Health' conference, bringing together more than 1,000 experts to hear the views of a "People's Panel". Led by Dr Martin McShane, the event enabled

senior health and care professionals to hear, first hand, from patients (especially those with long term conditions) what was important to them, and where often simple improvements could be made.

The People's Panel comprised 14 people with a wide range of long-term conditions and expertise in their own health and care. Their insight, experience and feedback formed a central theme and provided a reality check, making sure that people (patients, people who use services, carers and families) were at the centre of every conversation.

Future of Health recently won the Event of the Year category at the British Media Awards 2014.

The Informatics Services Commissioning Group

NHS England is a member of the Informatics Services Commissioning Group, which develops the informatics strategy for the health and social care system in England. From April 2014, the Group will be renamed the National Information Board.

NHS England hosted an Open House participation event on 21 January 2014 on behalf of the Group providing an opportunity to develop the informatics strategy in a transparent and participative way.

Patient leaders were involved in planning the event which was intended to move beyond information-giving to shaping and building strategy together. On the day, a range of stakeholders from across health and social care, including patients, carers and voluntary sector representatives, took part in facilitated discussions focusing on four different areas of informatics. Key themes were fed back and discussed with the Informatics Services Commissioning Group Leadership Group as the first item on their meeting agenda.

As with previous events such as NHS Citizen and the AGM, the digitally integrated approach (with live webcast and social reporting) greatly extended the reach of the meeting, generating over 1,628 individual connections to the webcast and through twitter 3.7 million impressions, 1,591 tweets and 378 participants, with #ISCG trending on the day of the event.

The insights and suggestions from this event have been used to inform the Informatics Services Commissioning Group Strategy and implementation of the relevant work programmes. Event participants were invited to continue to be involved in the design of an accountable and transparent approach to embedding participation in the ongoing work of the National Information Board, and also to maintain their involvement in different informatics work programmes.

The Commissioning of Wheelchair Services

Wheelchair services are not currently meeting people's needs in both adult and children's services, and this needs to change.

Sir David Nicholson made it his pledge for NHS Change Day 2014 to bring together people from across the country dedicated to improving services for people who use wheelchairs. A summit was held in February 2014 and included a range of service users, carers, commissioners, physiotherapists and many others.

An action plan to improve services has subsequently been developed from the feedback received on the day and is being implemented during 2014–15.

Engagement Activity to Inform the Accessible Information Standard

NHS England is developing a new information standard for accessible information. The 'accessible information standard' aims to ensure that disabled patients, service users and, where appropriate, carers, receive information in formats that they can understand, and appropriate communication support.

Engagement activity took place from mid-November 2013 until 21 February 2014 under the banner of 'making health and social care information accessible'. During this time over 1,000 people completed a survey and over 150 participated in a face-to-face workshop to share their experiences and to put forward suggestions for improvements with regards to accessible information and communication support.

The report of the engagement activity will be published in late spring/early summer 2014. The feedback received will be used to inform the development of the standard, which is due for submission to the Standardisation Committee for Care Information in summer 2014. There will be a formal, 12 week consultation on the draft specification for the accessible information standard. This is currently scheduled to take place over summer 2014.

Commitment to Carers

NHS England and NHS Improving Quality worked with stakeholders such as the Carers Trust, Carers UK, the Standing Commission for Carers, the Children's Society, the Department of Health and others to develop a set of shared aims to ensure that the NHS becomes dramatically better at involving patients and their carers, and empowering them to manage and make decisions about their own care and treatment.

A series of questions was asked through the NHS Improving Quality website and twitter feed, and stakeholder organisations were invited to post them onto their websites, newsletters and chat forums. The questions were also available through an online questionnaire, which was promoted through the above channels.

Twitter was utilised extensively, using the hashtag #NHSThinkCarer, which proved to be an effective medium to alert people to the questionnaire and gather their views.

A webinar was also held with the support of the Department of Health, which contributed to the understanding and identification of examples of good practice. Approximately 30 people contributed to this session, which generated rich discussion. In addition Dame Philippa Russell, the Chair of the Standing Commission for Carers, NHS England's national clinical directors and other professionals were asked to write blogs of their own individual experiences of caring, which were posted on NHS Improving Quality's blog. This helped to bring the participation exercise to a very personal level.

The participation exercise culminated in an event which took place in December 2013. Almost 90 stakeholders were involved, including carers, carer groups, third sector organisations, NHS England leaders, and health and social care professionals from a range of different sectors. The day was designed so delegates were able to reach a consensus on the priorities for action, and agree a range of commitments for NHS England to support and take forward.

The NHS England *Commitment to Carers* will be published in spring 2014.

Improving Patient Experience

NHS England has engaged with a number of patient leaders, including in a workshop held in

February 2014, to explore potential opportunities for patient leaders to participate in developing approaches to improve patient experience through commissioning.

This engagement has informed a programme designed to promote and support patient leaders to play a prominent role in defining, assessing and improving patient experience which will be initiated in 2014–15.

Regional & Area Activity

Within each region there has been extensive public and stakeholder engagement to inform area team and direct commissioning five year plans, as part of the Call to Action, between September 2013 and March 2014.

Activity included public events, online surveys and a series of tweet chats on subjects such as primary care, specialised services and promoting self-care

Sustainability Report

Introduction

Vision & Values

NHS England's mission is to deliver 'high quality care for all, now and for future generations'. Sustainability is at the heart and is central to delivering the vision and values.

Legislative Context

NHS England is required to report on its progress in delivering against sustainable development indicators both in its Annual Report and under the Greening Government Commitments. NHS England will ensure that it complies with its obligations under the Climate Change Act 2008, including the Adaptation Reporting Power, and the Public Services (Social Value) Act 2012.

Sustainable Development Strategy

The Sustainable Development Strategy for the NHS, Public Health and Social Care System was launched in January 2014.

NHS England and Public Health England fund the Sustainable Development Unit to ensure that the health, public health and care system fulfils its potential as a leading sustainable and low carbon service. The Sustainable Development Unit develops organisations, people, tools, policy and research which will help to promote sustainable development, to reduce carbon emissions and to adapt to climate change.

Energy

All of the energy use relating to NHS England's operations arises from occupation of rented office spaces. NHS Property Services is the landlord for the majority of the core estate, and in many cases buildings are occupied by multiple tenants. Once energy use data is available it will, by and large, be apportioned between NHS England and other building occupiers. Future reports will publish energy usage data for 2013–14.

NHS England is a tenant of the Department of Health at four properties, including at Quarry House in Leeds and Skipton House in London. Information for these properties will be reported in full by the Department of Health.

Greenhouse Gas Emissions

The majority of greenhouse gas emissions attributable to NHS England's activities are likely to come from energy used in the buildings the organisation occupies and from the business travel that staff undertake.

Greenhouse gas emissions information will be published in future annual reports.

Business travel makes a significant contribution to the greenhouse gas emissions from NHS England's activities.

Business Travel Policy: NHS England encourages staff to make every attempt "to identify options to eliminate the need to travel or minimise the number of miles travelled".

Agile Working: Business travel reduction is one of the performance indicators for the 'Excellent Organisation' programme. It is a priority to shape the culture of the business operations, estate, and ICT in order to encourage more flexible working patterns that are less dependent on fixed office locations and to reduce the impact of business travel.

Business Travel	NHS England (exc. CSUs & other hosted organisations)		CSUs & other hosted organisations		Total	
	Miles	tCO_2e	Miles	tCO_2e	Miles	tCO_2e
Road	5,238,604	1,758	8,461,345	2,663	13,669,949	4,421
Rail	10,642,836	840	988,981	78	11,631,817	918
Air	808,663	175	97,677	19	904,340	194
Total	**16,690,103**	**2,773**	**9,547,993**	**2,760**	**26,238,096**	**5,533**

tCO_2e = Equivalent tonnes CO_2

NHS Sustainability Day: Participation of NHS England in NHS Sustainability Day provided an opportunity to engage and enthuse staff in sustainability issues, and to begin to develop work to reduce the impact of business travel.

Waste & Water

NHS England has inherited waste disposal arrangements that differ from property to property across the estate. The organisation is cataloguing its facilities management arrangements and working with staff to reduce the waste arising from office operations.

The organisation is working with its various landlords to collate, and hence to be able to publish, water consumption information for 2013–14.

Procurement

NHS England's standard terms and conditions of contract, which are referenced on all purchase orders, have given consideration to sustainability. They include requirements for timely payment of sub-contractors and requirements for suppliers to give consideration to environmental factors and to act in accordance with all applicable law relating to the environment and the disposal of goods.

Climate Change Adaptation

NHS England co-produces both the National Heat Wave Plan and the Cold Weather Plan for England, working closely with Public Health England. The plans set out the scientific evidence and a case for change to protect population level health and improve individual health outcomes for vulnerable individuals.

Flooding has been a significant response function this year. NHS England has been actively engaged through its national, regional and area team emergency preparedness, resilience and response functions, supporting local health economies to maintain critical services and infrastructure and to ensure optimum outcomes for patients.

Health & Wellbeing

The benefit to individuals, NHS England and the broader economy that a healthy, committed and engaged workforce can create is at the core of the organisation's approach to employee health and wellbeing. Through the Organisational Development Strategy the organisation aims to develop NHS England into an excellent organisation and an exemplary employer, with a particular focus on the health and wellbeing of the people that work within the organisation.

Social Value

NHS England is also committed to ensuring that the Social Value Act becomes a reality in all communities and throughout the commissioning system. The Act represents a significant opportunity to transform the way that public money is spent.

Looking forward

In "Putting Patients First", the NHS England Business Plan for 2014–17, the organisation is committed to preparing a Corporate Social Responsibility Strategy and action plan. This will include sustainability plans across all of NHS England's work (the Sustainable Development Management Plan).

NHS England has published some data in this Sustainability Report. When it becomes available, data for 2013–14 will give the organisation the baseline against which future performance and achievements will be measured.

NHS England will develop a programme to reduce business travel and help make the business and home-to-work travel of staff more sustainable.

Building on the Equality, Diversity and Inclusion in the Workplace Strategy, NHS England will explore ways of using its position as a large employer to increase opportunities for work and skills development for people from local communities.

NHS England will increase the uptake of employee volunteering and enhance its impact in supporting health outcomes and in addressing health inequality.

Using sustainability and social value information accompanying the "Guidance for commissioners on the procurement of NHS-funded healthcare services" as a platform, NHS England will identify opportunities to further support commissioners to meet their obligations to delivering social value and the needs of local communities.

NHS England has inherited a variety of facilities management arrangements relating to the buildings that it occupies, including waste disposal arrangements. The organisation will work with facilities management contracts and with staff in all locations to reduce the waste arising from resources used in office operations.

NHS England will set out plans for adapting to climate change in its business operations and look for ways of achieving this in the services that it commissions.

With the NHS Business Services Authority, NHS England will take steps to consider the sustainability of its procurement, possibly including application of a tool to assist in identifying the impact on sustainability of each procurement process.

Governance

To inform the Corporate Social Responsibility Strategy development, NHS England will establish a reference group, drawing on its directorates, to look for ways of making social value and environmental sustainability an integral part of all business planning, policy development, strategy and commissioning. In future annual reports the organisation will publish its progress against the Corporate Social Responsibility Strategy and action plan, including sustainable development indicators.

Equality & Diversity Report

Introduction

NHS England employed 6,231 staff, as at 31 March 2014 (excluding commissioning support units). In addition, 9,060 commissioning support unit staff were employed under a hosting arrangement with the NHS Business Services Authority.

NHS England has developed an Equality, Diversity & Inclusion in the Workplace Strategy. At the core of this strategy is a fundamental belief that valuing staff for their individuality will create a culture in which talent, creativity and innovation can thrive.

On behalf of the NHS, NHS England refreshed the Equality Delivery System and launched an updated version, EDS2, in November 2013. EDS2 is a tool to support organisations to continuously improve their equality performance and to help meet the requirements of the public sector Equality Duty of the Equality Act 2010. EDS2 has four goals supported by eighteen outcomes. The four goals are:

- Better health outcomes;
- Improved patient access and experience;
- A representative and supported workforce; and,
- Inclusive leadership.

Further details on the Equality Delivery System can be found on the NHS England website.

In addition to its lead role, NHS England is also committed to implementing EDS2 as an organisation in its own right.

Equality Objectives

In accordance with the public sector Equality Duty, NHS England has set itself Equality Objectives for the period April 2014 to March 2016:

- NHS England will oversee and support the implementation of the Equality Delivery System (EDS2);
- By March 2015, NHS England will have developed an Accessible Information Standard to help disabled patients, service users and carers to receive accessible information and appropriate communication support when in contact with healthcare services, to be implemented by March 2016; and,
- NHS England is committed to implementing the Equality, Diversity and Inclusion in the Workplace Strategy 2013 to 2015, to ensure an engaged workforce that is more representative at all levels.

The Equality Objectives will help to ensure that NHS England's policy-making, decisions and activities are compliant with the public sector Equality Duty, and they will provide system leadership to clinical commissioning groups and other parts of the NHS.

Human Rights

The five FREDA principles (Fairness, Respect, Equality, Dignity, and Autonomy) have been developed to provide general principles to which the NHS should aspire. These principles lie at the heart of NHS England's values, processes and behaviours, and are reflected in the work carried out by the Equality & Diversity Council.

Organisational Gender Analysis

The gender analysis of NHS England's permanent employees, including the commissioning support units, as at 31 March 2014, was as follows:

	Female	Male	Total
NHS England Board	6	9	**15**
All Other Senior Managers	188	181	**369**
All Other Employees	10,009	4,898	**14,907**

Analysis

The equality make-up of the NHS England and commissioning support unit workforce, as at March 2014, is analysed in the following sections by eight protected characteristics.

There is currently no data field in the Electronic Staff Record (NHS national payroll and human resources system) to record gender re-assignment. This has been raised with the National ESR NHS Development team, within the Department of Health, which has advised on the plans to incorporate this data field into the ESR system during 2014–15, together with the amendment to the religion and belief fields to include the option of no belief.

NHS England

NHS England values the views of its workforce about their experience of working for the organisation and has carried out quarterly 'Staff Barometer' surveys.

Information on the composition of the workforce will help to inform the achievement of the key actions contained in the organisation's Equality, Diversity & Inclusion in the Workplace Strategy.

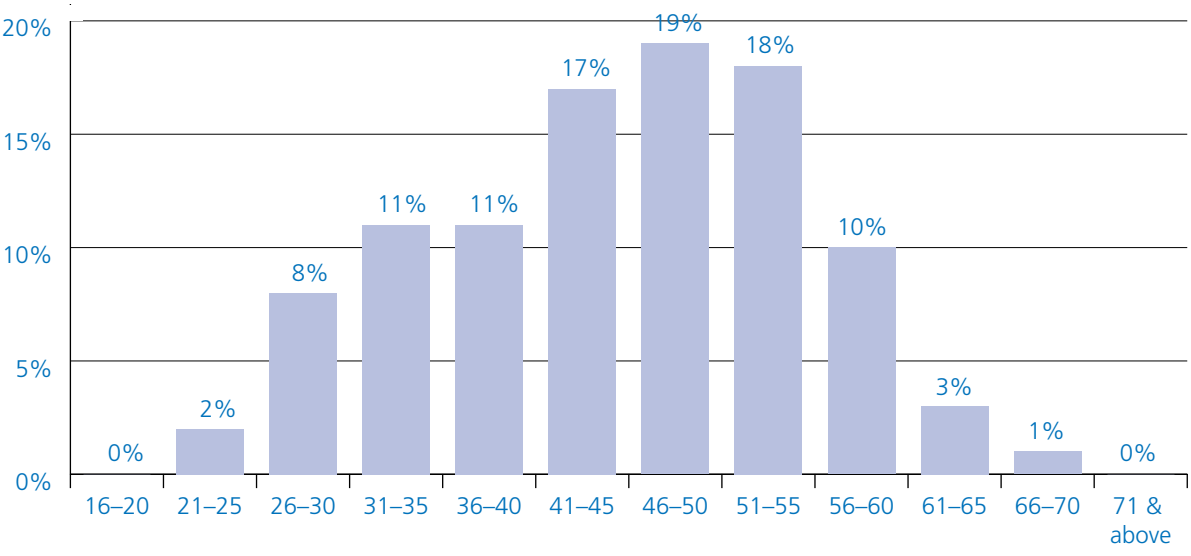
As required by the Equality Act 2010, NHS England published its Equality Information in January 2014. The organisation also stated how it would use that information to implement its Equality, Diversity & Inclusion in the Workplace Strategy and to help to develop workforce Equality Objectives. The strategy can be found on the NHS England website.

The following statistics reflect the NHS England core team, excluding commissioning support units which are covered later in this Report.

Age

Over half of NHS England's workforce is aged between 41 and 55 years.

NHS England workforce distribution by age



Disability

77% of NHS England staff have declared that they do not consider themselves to have a disability and 7% have declared that they do consider themselves to have a disability, with 6% having opted not to declare this information.

NHS England is committed to ensuring that disabled staff are supported to work within the organisation and will work with occupational health practitioners to ensure that it goes beyond its legal requirement to ensure that people can apply for and continue to work for the organisation when they consider themselves disabled.

	Disabled	Not Disabled	Undisclosed	Unknown	Total
Band 1	*	*	*	0.0%	**0.1%**
Band 2	0.6%	5.8%	0.7%	0.7%	**7.9%**
Band 3	0.7%	6.5%	0.8%	0.9%	**8.9%**
Band 4	0.9%	8.0%	0.8%	0.7%	**10.4%**
Band 5	0.9%	8.3%	0.7%	0.7%	**10.6%**
Band 6	0.6%	7.0%	0.4%	0.7%	**8.7%**
Band 7	0.8%	8.2%	0.5%	0.7%	**10.1%**
Band 8a	0.5%	7.9%	0.4%	0.9%	**9.8%**
Band 8b	0.5%	7.6%	0.4%	1.2%	**9.6%**
Band 8c	0.4%	4.8%	0.3%	0.7%	**6.2%**
Band 8d	*	4.7%	*	0.6%	**5.6%**
Band 9	0.3%	*	*	0.6%	**3.9%**
Unknown	0.4%	5.4%	0.7%	1.7%	**8.2%**
Total	**6.7%**	**77.1%**	**6.2%**	**10.0%**	**100.0%**

Notes:
Where there is risk of disclosure figures have been eliminated. Where small numbers occur in a category these have been suppressed by replacement with "*". Totals may not sum due to rounding.

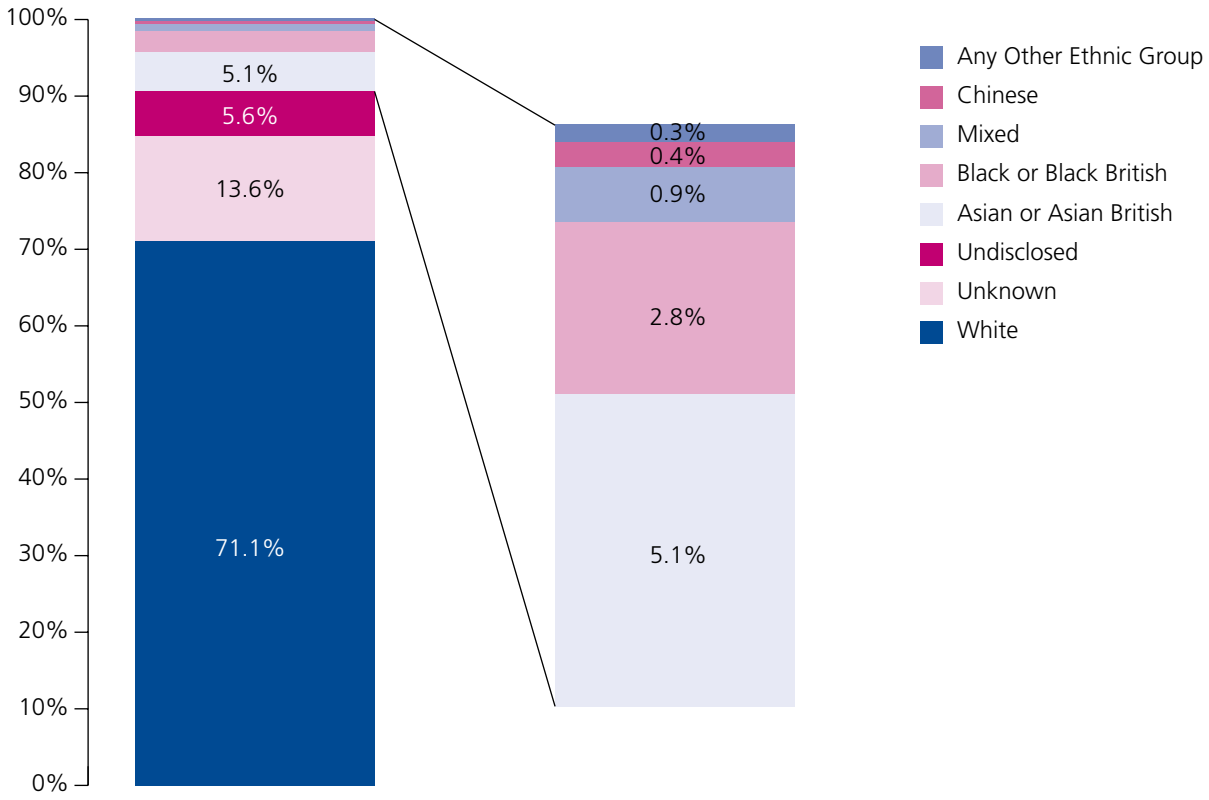
Ethnicity

Over two-thirds of the workforce consider themselves to be White. Of the workforce that consider themselves to be non-White, the majority consider themselves to be of Asian or Asian British ethnicity.

It is recognised that there is a significant number of staff whose ethnicity is unknown. Since NHS England inherited the majority of its staff in April 2013, the organisation has embarked upon a data improvement exercise to ensure that it has as much diversity data on staff as possible.

This work will continue in the future.

NHS England workforce distribution by ethnicity



Gender

Over two-thirds of the workforce are female.

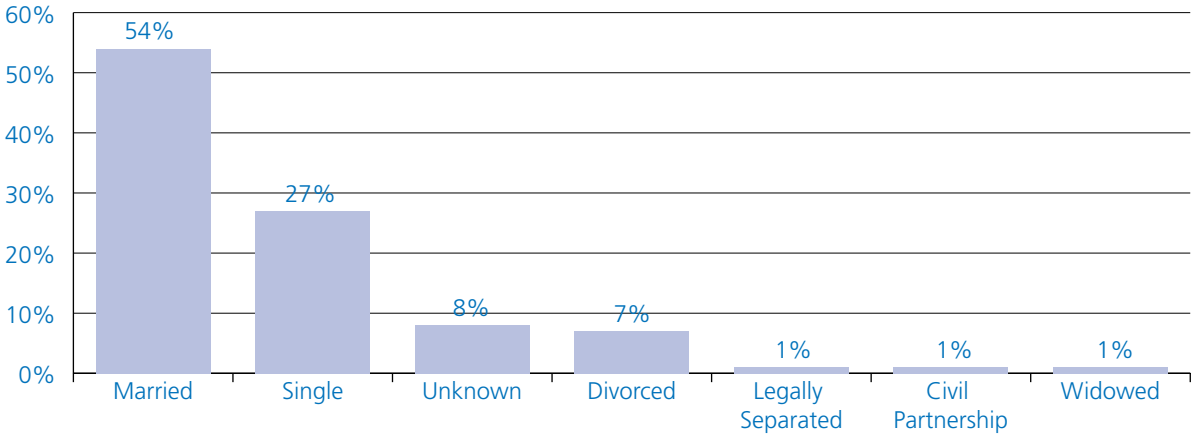
	Female	Male	Total
Band 1	*	*	**0.1%**
Band 2	6.0%	1.9%	**7.9%**
Band 3	7.5%	1.4%	**8.9%**
Band 4	9.0%	1.4%	**10.4%**
Band 5	*	*	**10.6%**
Band 6	6.8%	1.8%	**8.7%**
Band 7	7.3%	2.8%	**10.1%**
Band 8a	6.9%	2.9%	**9.8%**
Band 8b	6.6%	3.0%	**9.6%**
Band 8c	3.8%	2.3%	**6.2%**
Band 8d	3.7%	1.9%	**5.6%**
Band 9	*	*	**3.9%**
Unknown	3.8%	4.5%	**8.2%**
Total	**73.1%**	**26.9%**	**100.0%**

Notes:
Where small numbers occur in a category these have been suppressed by replacement with "*".
Totals may not sum due to rounding.

Marital Status

Over half of the workforce have declared that they are married or in a civil partnership.

NHS England workforce distribution by marital status

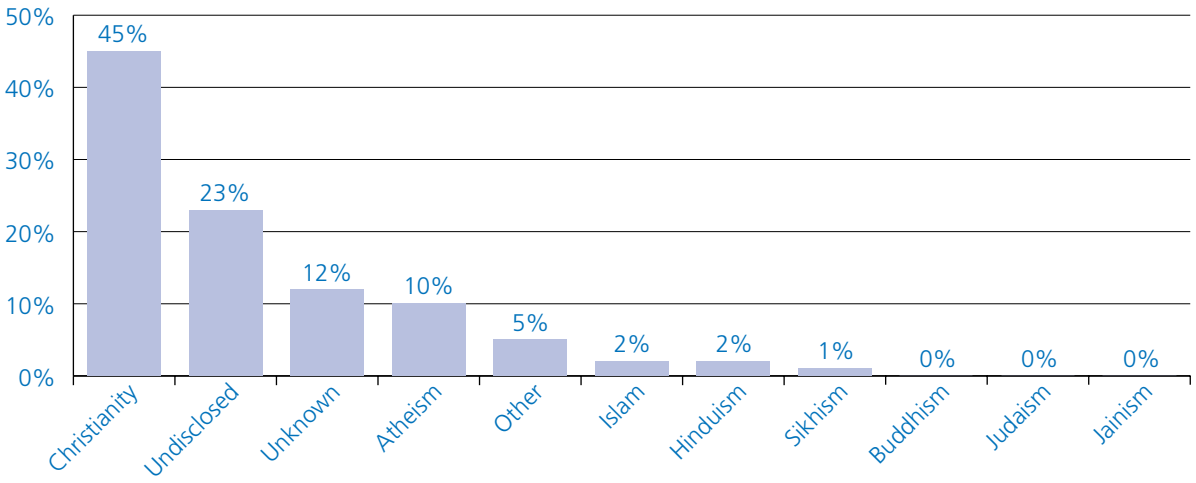


Pregnancy & Maternity

1.5% of the workforce are on either maternity or adoption leave.

Religion or Belief

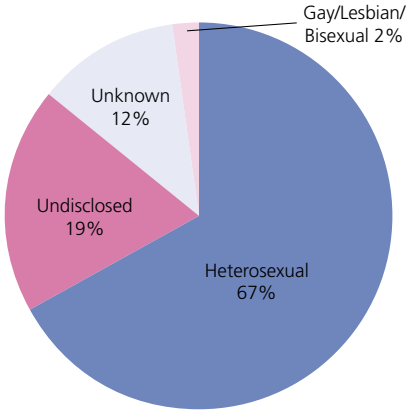
NHS England workforce distribution by religion or belief



Sexual Orientation

67% of the workforce has declared their sexual orientation as heterosexual, with 2% having declared their sexual orientation as gay, lesbian or bisexual. A large proportion (19%) of staff did not wish to disclose their sexual orientation.

NHS England workforce distribution by sexual orientation



Caveats & Clarifications

Data Source & Coverage: The data reported in this analysis is taken from Electronic Staff Record (NHS national payroll and human resources system) for NHS England staff. The extract reflects staff reported on the system as at 24th March 2014.

ESR data for NHS England staff does not include contractors, volunteers, or employees who are on secondment to NHS England but are paid by their parent organisation. Staff seconded out of the organisation but still paid by NHS England are included.

Commissioning Support Units

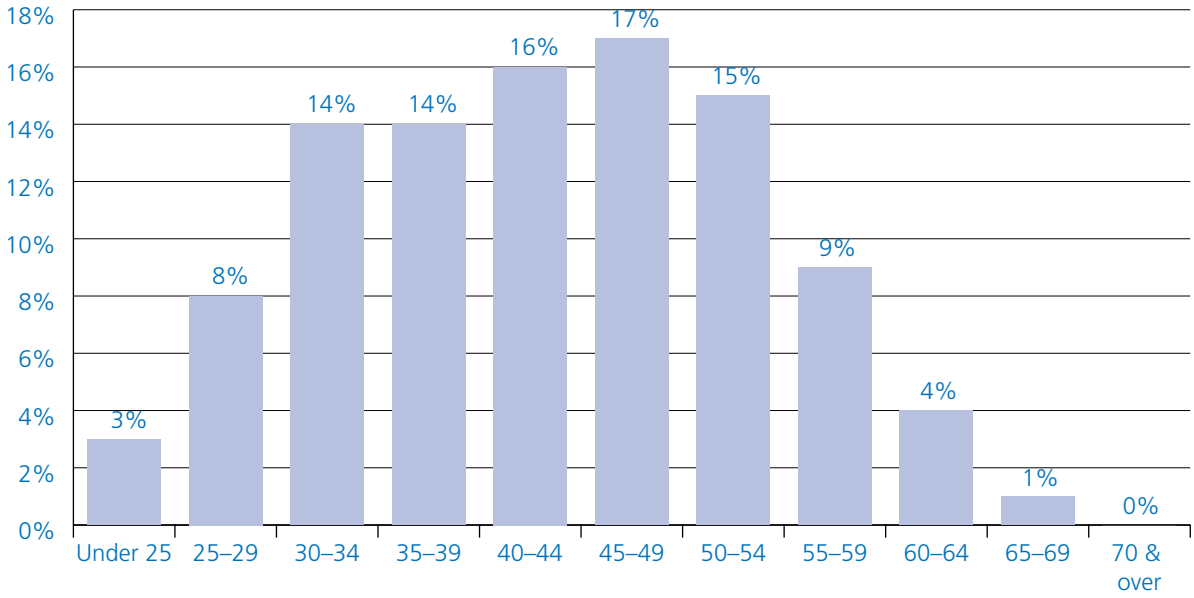
NHS England supports commissioning support units to aspire to having leadership and workforces that are diverse and reflective of their local communities.

The make-up of the commissioning support unit workforce is described below.

Age

Nearly half of commissioning support unit staff are aged between 40 and 54.

CSU workforce distribution by age



Disability

52% of CSU staff have declared that they do not consider themselves to have a disability and 2% have declared that they do consider themselves to have a disability, with 12% having opted not to declare this information.

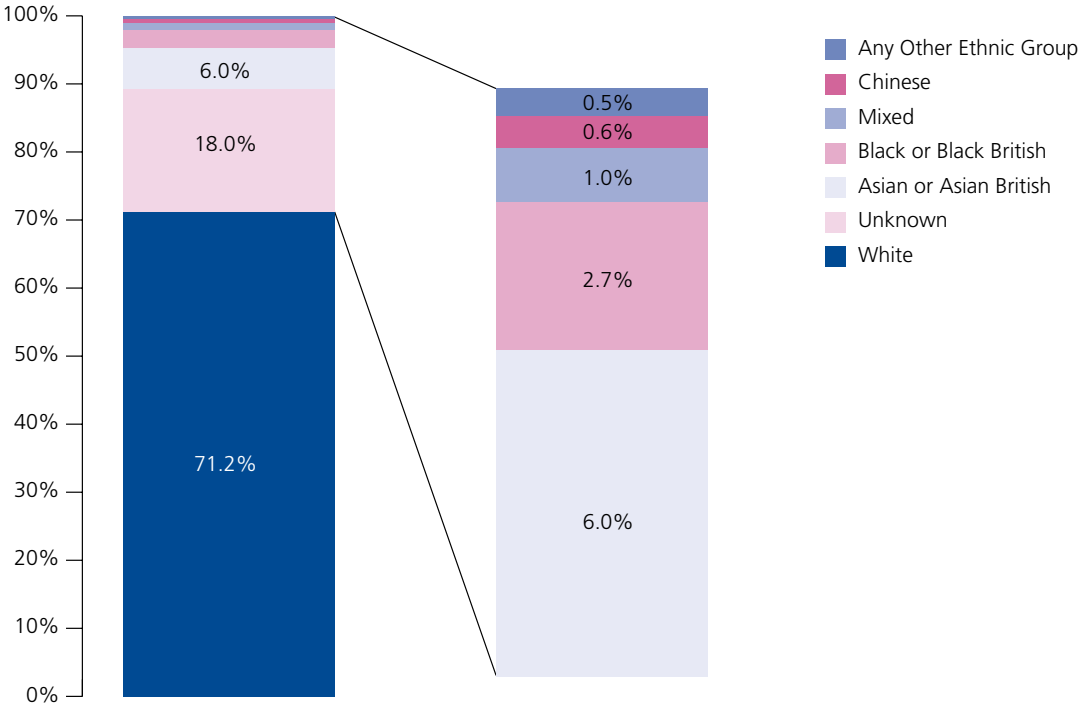
	Disabled	Not Disabled	Undisclosed	Unknown	Total
Band 1				0.0%	**0.0%**
Band 2	*	0.9%	0.1%	0.3%	**1.4%**
Band 3	0.2%	3.4%	0.7%	1.7%	**6.0%**
Band 4	0.3%	5.0%	1.2%	3.4%	**9.9%**
Band 5	0.4%	8.0%	1.9%	5.3%	**15.6%**
Band 6	0.6%	10.2%	2.3%	5.7%	**18.8%**
Band 7	0.3%	9.0%	2.1%	6.1%	**17.6%**
Band 8a	0.1%	6.4%	1.8%	4.2%	**12.5%**
Band 8b	0.1%	3.7%	1.0%	2.7%	**7.5%**
Band 8c	0.1%	2.2%	0.5%	1.9%	**4.6%**
Band 8d	*	1.4%	0.3%	1.2%	**2.9%**
Band 9	*	0.5%	0.1%	0.5%	**1.2%**
Consultants				0.0%	**0.1%**
Other					**0.0%**
Unknown	*	1.0%	0.2%	0.6%	**1.8%**
Total	**2.3%**	**51.7%**	**12.2%**	**33.8%**	**100.0%**

Notes:
Where there is risk of disclosure figures have been eliminated. Where small numbers occur in a category these have been suppressed by replacement with "*". Totals may not sum due to rounding. "Other" is Other Medical and Dental Staff.

Ethnicity

Over two-thirds of the workforce consider themselves to be White. Of the workforce that consider themselves to be non-White, the majority consider themselves to be of Asian or Asian British ethnicity.

CSU workforce distribution by ethnicity



Gender

Almost two-thirds of the CSU workforce are female.

	Female	Male	Total
Band 1		0.0%	**0.0%**
Band 2	1.1%	0.3%	**1.4%**
Band 3	4.9%	1.1%	**6.0%**
Band 4	7.5%	2.5%	**9.9%**
Band 5	9.8%	5.8%	**15.6%**
Band 6	12.2%	6.5%	**18.8%**
Band 7	11.3%	6.3%	**17.6%**
Band 8a	7.6%	4.9%	**12.5%**
Band 8b	4.2%	3.3%	**7.5%**
Band 8c	2.6%	2.0%	**4.6%**
Band 8d	1.6%	1.3%	**2.9%**
Band 9	0.5%	0.7%	**1.2%**
Consultants	0.0%	0.0%	**0.1%**
Other		0.0%	**0.0%**
Unknown	0.9%	0.9%	**1.8%**
Total	**64.2%**	**35.8%**	**100.0%**

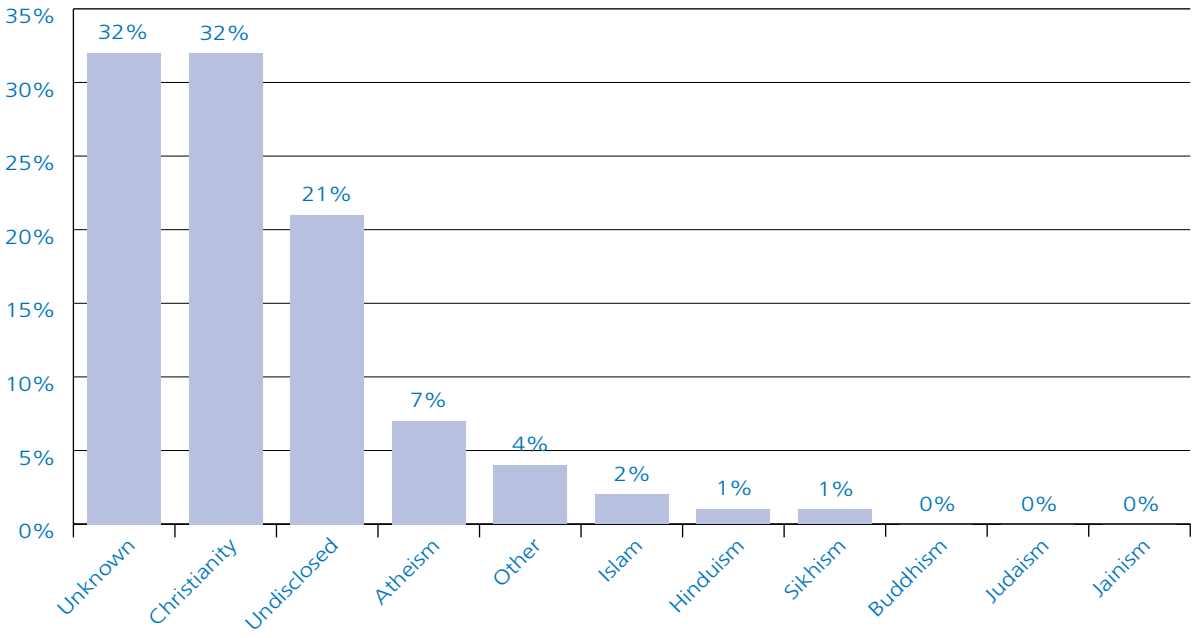
Notes:
The sum of classification totals may be greater than the total headcount of staff figure under that category due to individuals having more than one assignment.
"Other" is Other Medical and Dental Staff.

Marital Status, Pregnancy & Maternity

Information on marital status, pregnancy and maternity leave is not available in the Health & Social Care Information Centre's Provisional NHS Hospital & Community Health Service monthly workforce statistics.

Religion or Belief

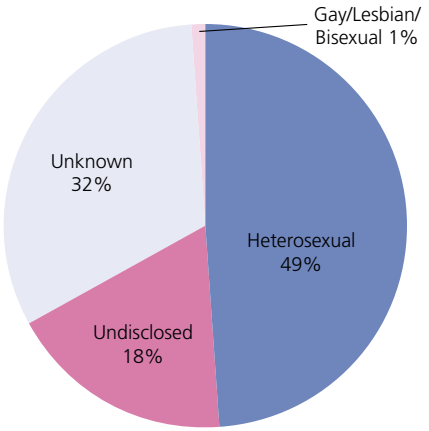
CSU workforce distribution by religion or belief



Sexual Orientation

49% of the workforce have declared their sexual orientation as heterosexual, with 1% having declared their sexual orientation as gay, lesbian or bisexual. A large proportion (18%) of staff did not wish to disclose their sexual orientation.

CSU workforce distribution by sexual orientation



Caveats & Clarifications

Data Source & Coverage: Source: Health and Social Care Information Centre, Provisional NHS Hospital & Community Health Service (HCHS) monthly workforce statistics. Copyright © 2014 Health and Social Care Information Centre. All rights reserved.

There were 9,413 commissioning support unit staff recorded in December 2013. These statistics relate to the contracted positions within English NHS organisations and may include those where the person assigned to the position is temporarily absent, for example on maternity leave.

Caveats: For the figures by pay band provided in tables, the sum of classification totals may be greater than the total headcount of staff figure under that category due to individuals having more than one assignment.

Principal Risks & Uncertainties

NHS England's risk management framework, processes and procedures are described in detail in the Governance Statement later in this document.

Significant risks, which are defined with reference to magnitude of impact and likelihood of occurrence, are escalated to the Board Assurance Framework. Members of the Executive Team take personal responsibility for monitoring these risks and mitigating actions.

The Executive Risk Management Group receives reports and presentations on risk status and maintains a view on changes in the organisation, Commissioning System and wider health system that may give rise to new risks or risk areas.

The Executive Risk Management Group reports to the Executive Team and via them to the Board.

The significant risks associated with the delivery of the 2014–15 to 2016–17 Business Plan, as recorded on the Board Assurance Framework, are summarised as follows:

	NHS England Board Assurance Framework Summary as at 12 June 2014				
	Risk Ref	Risk *High-level potential risks that are unlikely to be fully resolved and require ongoing control*	Current Gross RAG Status	When Mitigated RAG Status	Date by which RAG to be achieved
NHS-wide	Strategic				
	7	Urgent care	R	AR	31/03/2015
	2	Health inequalities and parity of esteem	AR	A	31/03/2015
	4	Strategy and service transformation	AR	A	31/03/2015
	19	Better Care Fund	AR	AG	30/09/2014
NHS England	Strategic				
	3	Funding for policy commitments and unavoidable cost pressures	R	R	31/03/2015
	9	Specialised services	R	AR	30/09/2014
	5	Relationship with patients and the public	AR	A	30/04/2015
	11	Commissioning support services	A	A	01/05/2015
	Operational				
NHS-wide	1	Major quality problems	R	AR	31/03/2015
	15	Major emergency	AR	A	31/03/2015
	8	NHS 111 service	A	A	12/06/2014
	12	Information and data sharing	AR	A	31/03/2015
	17	Genomics	AR	AG	31/12/2014
	18	Referral-to-treatment time	R	A	31/03/2015
NHS England	Operational				
	16	Information for contracting and performance monitoring	R	AR	31/03/2015
	10	Primary care support services	R	A	31/03/2015
	14	Organisational capacity and capability	R	A	31/03/2015
	6	Poor customer service delivery of complaints	AR	A	30/09/2014
	13	Revalidation	AR	AG	31/07/2015

Updated details of our rolling risk assessment are presented in public at each Board meeting, the papers for which are available on the NHS England web site.

Directors' Report

Directors' Report

Board Membership

The Board combines a wide range of experience and expertise.

Malcolm Grant is Chair, and other Non-executive Members throughout the financial year, and up to the date of signing this Report, were: Victor Adebowale; Margaret Casely-Hayford; Ciaran Devane; Moira Gibb; and, Ed Smith. Naguib Kheraj was a Non-executive Member until 10 December 2013.

On 31 March 2014 David Nicholson retired from the post of Chief Executive, and on 1 April 2014 Simon Stevens took up appointment. The National Health Service Act 2006 (as amended) requires that the Chief Executive also be the Accounting Officer. The Chief Executive is an Executive Member of the Board.

Other Executive Members of the Board throughout the financial year, and up to the date of signing this Report, were: Paul Baumann (Chief Financial Officer); Jane Cummings (Chief Nursing Officer); and, Bruce Keogh (National Medical Director).

Members of the Audit & Risk Assurance Committee throughout the financial year, and up to the date of signing this Report, were Ed Smith (Chair) and Moira Gibb. Naguib Kheraj was a member until 10 December 2013.

Full details of all the Committees and Sub-committees of the Board, their membership, attendance, etc., can be found in the Governance Statement.

Details of Members' declared interests can be found in the Remuneration Report.

Future Developments

Having now been in full operation for a year, and with the appointment of a new Chief Executive, NHS England has commenced an organisational stocktake to ensure the structures and processes that have developed to date are fit for purpose and appropriate for the future.

At the date of signing this report work is ongoing, but decisions that have been announced to date and which are now being implemented include:

- The Operations Directorate will be retitled the Commissioning Operations Directorate, and will also incorporate most of the functions of the Commissioning Development Directorate. Barbara Hakin will lead this Directorate as National Director: Commissioning Operations; and,
- The current Policy Directorate will be renamed the Commissioning Strategy Directorate, and will include those elements of the current Commissioning Development Directorate that are not moving to Commissioning Operations. Ian Dodge has been appointed to this post following open competition.

The next phase of the review will focus on the operation of the current regional and area teams, and how their operation and connection with the national support centre can be enhanced.

In addition, the Department of Health recently appointed three new Non-executive Members who will join the Board in the near future.

Significant Events after the Reporting Period

There have been no significant events since the balance sheet date that the Board consider to require inclusion in the Annual Report or an adjustment to the Annual Accounts.

Research & Development

Details of research and development activity during 2013–14 can be found in the Strategic Report.

Employee Consultation

NHS England has entered into formal partnership working arrangements with a number of trade unions/staff associations.

An NHS England National Partnership Forum involving representation from each of the trade unions/staff associations and senior HR professionals from NHS England is co-chaired by the NHS England Director of Human Resources and the UNISON National Officer aligned to NHS England.

In addition NHS England operates a number of routes to engage its employees directly.

Disabled Employees

NHS England's employment policies are applied equally to all protected characteristic groups, including people who consider they have a disability.

The overarching Equality, Diversity & Inclusion in the Workplace Strategy, approved by the Board in December 2013 and supplemented by the public duty arising from the Equality Act 2010, articulates NHS England's commitment to fairness, dignity, inclusion and respect.

Where job applicants consider themselves to have a disability and meet the essential requirements for a role, NHS England recruitment processes ensure that these applicants are given full consideration for the role.

NHS England achieves its requirements to make reasonable adjustments within the workplace to support employees who either consider themselves to be disabled or may develop a disability or long-term condition during their employment. Professional occupational health advice and support is accessible in this regard.

Equality and diversity training is part of the suite of statutory and mandatory training that all NHS England employees are required to undertake on an annual basis and this includes awareness of issues and requirements pertaining to disability and working with colleagues and patients that may consider themselves to have a disability.

All learning, development and promotion prospects are freely and equally accessible to all employees, including those who may consider themselves to have a disability. NHS England adopts a blended approach to learning, ensuring greater accessibility via a variety of delivery methods and locations for learning and development activities.

Sickness Absence

Sickness absence for the period 1 April 2013 to 31 December 2013 was as follows:

	FTE Days Available	FTE Days Lost to Sickness Absence	Average Sick Days per FTE
NHS England	911,347	25,769	4.77
Commisioning support units	1,753,409	45,106	4.34
Total parent	**2,664,756**	**70,876**	**4.49**
CCGs	1,813,095	40,356	3.76
Consolidated Group	**4,477,851**	**111,232**	**4.19**

NHS England adopted formal guidance in respect of the management of employee attendance supported by the provision of occupational health professional advice and expertise and a 24 hour confidential employee assistance programme.

Work has continued during 2013–14, in partnership with the recognised trade unions, to develop a full policy on supporting attendance at work to replace the interim guidance and arrangements currently in operation.

An appropriate approach to managing short-term absence is in operation, with a return to work interview expected to be completed following every period of absence for every employee. Balancing these robust arrangements with appropriate support and professional occupational health advice has meant that NHS England has maintained comparatively low levels of staff absence during the year. This will be an area for continued focus during 2014–15 as part of the overall approach to increasing productivity and efficiency.

Pension Liabilities

The policy on accounting for pensions can be found at note 1.7 to the Financial Statements, and details of the pension schemes to which NHS England has contributed, together with the amount of employer contributions, are detailed in note 3 to the Financial Statements.

Details of Directors' pension entitlements are contained in the Remuneration Report.

Payment of Suppliers

The Better Payment Practice Code requires organisations to aim to pay all valid invoices by the due date or within 30 days of receipt of a valid invoice, whichever is later.

Performance against the target, over the financial year, was as follows:

NHS England	2013–14		6 month period to 31 March 2013	
	Number	£'000	Number	£'000
Non-NHS Payables				
Total Non-NHS trade invoices paid in the year	807,815	10,249,434	3,868	45,924
Total Non-NHS trade invoices paid within target	785,296	10,120,244	3,378	38,676
Percentage of non-NHS trade invoices paid within target	97.21%	98.74%	87%	84%
NHS Payables				
Total NHS trade invoices paid in the year	39,873	80,491,383	n/a	n/a
Total NHS trade invoices paid within target	37,064	80,216,348	n/a	n/a
Percentage of NHS trade invoices paid within target	92.96%	99.66%	n/a	n/a

Consolidated Group	2013–14		6 month period to 31 March 2013	
	Number	£'000	Number	£'000
Non-NHS Payables				
Total Non-NHS trade invoices paid in the year	2,225,495	47,402,471	n/a	n/a
Total Non-NHS trade invoices paid within target	2,106,448	48,788,884	n/a	n/a
Percentage of non-NHS trade invoices paid within target	94.65%	96.60%	n/a	n/a
NHS Payables				
Total NHS trade invoices paid in the year	443,910	278,490,475	n/a	n/a
Total NHS trade invoices paid within target	408,377	276,473,861	n/a	n/a
Percentage of NHS trade invoices paid within target	92.00%	99.28%	n/a	n/a

Emergency Preparedness, Resilience & Response

We certify that NHS England has incident response plans in place, which are fully compliant with the NHS England Emergency Preparedness Framework 2013.

NHS England regularly reviews and makes improvements to its major incident plan and has a programme for regularly testing this plan, the results of which are reported to the Board.

Cost Allocation & Setting of Charges for Information

We certify that NHS England has complied with HM Treasury's guidance on cost allocation and the setting of charges for information.

Serious Untoward Incidents

Details of serious untoward incidents, including incidents of data loss and confidentiality breaches, can be found in the Governance Statement.

External Audit

The Financial Statements of NHS England (including the production of consolidated Financial Statements) are subject to audit by the Comptroller & Auditor General, using the National Audit Office.

The Financial Statements of clinical commissioning groups are audited by a range of firms appointed by the Audit Commission.

Payments to the National Audit Office for audit and non-audit services were as follows:

- Audit Services: £530,000 (6 months to 31 March 2013: £29,500);
- Further Assurance Services: £NIL (6 months to 31 March 2013: £NIL); and,
- Other Services: £NIL (6 months to 31 March 2013: £NIL).

Other Disclosures

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

NHS England has no, and has not had any, branches outside the UK.

Disclosure to Auditors

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

- So far as the member is aware, that there is no relevant audit information of which NHS England's external auditor is unaware; and,
- That the member has taken all the steps that they ought to have taken as a member in order to make themself 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 & Accounts, taken as a whole, is fair, balanced and understandable and provides the information necessary for stakeholders to assess the performance, strategy and business model of NHS England.

Simon Stevens
Accounting Officer

10 July 2014

Remuneration Report

Remuneration Report Contents

Remuneration & Terms of Service Committee Report

Role & Responsibilities

Updated terms of reference were approved by the Chair on behalf of the Board on 16 September 2013.

The purpose of the Committee is to:

- Approve the appropriate remuneration and terms of service for the Chief Executive, Directors and other Very Senior Managers and to consider some issues in relation to all staff employed by NHS England; and,
- Adhere to all relevant laws, regulations and policies in all respects including (but not limited to) determining levels of remuneration that are sufficient to attract, retain and motivate Executive Directors and senior staff whilst remaining cost effective.

The Committee does not deal with the appointment, terms of service or remuneration of the Chair and Non-executive Members, as the National Health Service Act 2006 (as amended) provides that the Secretary of State for Health will make these appointments, and deal with these matters.

In practice, these matters are handled by the Department of Health Public Appointments Team, on behalf of the Secretary of State.

Committee Composition & Attendance

Committee membership during the financial year and since the year end, and attendance at meetings during the financial year, were as follows:

Member	Meetings attended/eligible to attend (2013–14)		
	July	Nov	Mar
Malcolm Grant (Chair)	✓	✓	✓
Ciaran Devane	✓	✓	✓
Ed Smith	✓	✓	✓

The Chief Executive and/or a senior human resources professional attend meetings as appropriate, to advise the Committee.

During the year, the Chief Executive (Sir David Nicholson) attended a number of the meetings of the Committee, as did the National Director: Human Resources & Organisation Development. In addition, the Committee was supported in its work by Steven Keith, Regional Director of Human Resources & Organisation Development (South), until the appointment of Stephen Moir, Director of People, in July 2013. Paul Harrison, Director of Organisation Development, was also requested to attend the Committee on two occasions during 2013–14 to provide input and specific advice upon issues relating to talent management and employee engagement and feedback. All of these individuals were employed by NHS England.

The Committee is supported in its work by the Executive HR Sub-committee, whose primary aim is to consider and approve the appropriate remuneration, conditions and terms of service and HR policy issues for staff with the exception of National Directors. The work of the Sub-committee is carried out within the parameters set by the Remuneration & Terms of Service Committee, and within current agreed national frameworks. The Sub-committee has delegated powers to act on behalf of the Remuneration & Terms of Service Committee within the approved terms of reference.

Committee Effectiveness

The Committee meets as the need arises, and therefore does not operate a formal forward work programme planner, or undertake a formal assessment of its own effectiveness.

The Committee's Work

The Committee's main activities through the year have been:

- The appointment of the new Chief Executive (support in the process was provided by Odgers Berndtson, an executive search firm);
- Development of the performance and review process;
- Consideration of Very Senior Manager pay; and,
- Consideration of the secondment arrangements for the National Director: Transformation & Corporate Operations.

The Board does not have a specific policy for itself on equality, diversity and inclusion. It does however have an approach based on complying with the NHS England Equality, Diversity & Inclusion in the Workplace Strategy, which received public Board approval in December 2013. This is complemented by the organisations formal equality objectives as a public sector body.

Policy on Remuneration of Senior Mangers

The framework for the remuneration of Executive Directors is set by the Department of Health through the very senior managers' pay framework for arm's length bodies.

It is the policy of NHS England to pay salaries appropriate to recruit senior managers with the skills and abilities necessary for the effective running of a £96bn organisation while recognising the importance of demonstrating pay restraint at a time of considerable pressure on NHS finances.

The remuneration of Non-executive Members is set by the Department of Health upon appointment. All Non-executive Members are paid the same amount, except the Chair and Vice-chair, to reflect the equal time commitment expected from each Member. The Chair and Vice-chair are paid higher amounts to reflect the increased time commitment associated with their respective appointments. In the case of the Vice-chair, this includes his role as Chair of the Audit & Risk Assurance Committee.

Senior Managers Performance Related Pay

The performance related pay arrangements for Executive Directors are set out in the very senior managers' pay framework for arm's length bodies and follows guidance prescribed by the Department of Health and in-line with HM Treasury requirements.

Non-executive Members do not receive performance related pay.

Policy on Senior Managers' Contracts

Contracts of employment for senior managers are open-ended contracts, unless otherwise specified. Notice periods follow the provisions of the standard very senior manager contract of 6 months. Termination payments are only able to be authorised where contractual by NHS England's Remuneration and Terms of Service Committee. Any proposed special severance payment, i.e. non-contractual, requires formal approval from the Department of Health and HM Treasury.

Senior Managers Service Contracts

Name & Title	Date of Appointment	Unexpired Term at 31 March 2014	Notice Period	Provisions for Compensation for Early Termination	Other Details
Victor Adebowale *Non-executive Member*	1 July 2012	9 Months	None	None	Transferred from the NHS Commissioning Board Authority on 1 October 2012
Paul Baumann *Chief Financial Officer*	1 April 2013	n/a	6 months	Option to provide taxable pay in lieu of part or all of the notice period	Previously on secondment from London Strategic Health Authority
Margaret Casely-Hayford *Non-executive Member*	1 July 2012	2 Years 3 Months	None	None	Transferred from the NHS Commissioning Board Authority on 1 October 2012 Waived entitlement to remuneration
Jane Cummings *Chief Nursing Officer*	1 April 2013	n/a	6 months	Option to provide taxable pay in lieu of part or all of the notice period	Previously on secondment from North West Strategic Health Authority
Ian Dalton *Chief Operating Officer to 30 April 2013*	1 April 2013	n/a	6 months	Option to provide taxable pay in lieu of part or all of the notice period	Previously on secondment from North East Strategic Health Authority
Ciaran Devane *Non-executive Member*	1 January 2012	1 Year 9 Months	None	None	Transferred from the NHS Commissioning Board Authority on 1 October 2012
Moira Gibb *Non-executive Member*	1 July 2012	9 Months	None	None	Transferred from the NHS Commissioning Board Authority on 1 October 2012
Malcolm Grant *Chair*	31 October 2011	1 Year 7 Months	6 months	None	Transferred from the NHS Commissioning Board Authority on 1 October 2012 Up to 30 September 2013 his employer, University College London, recharged for the time spent on NHS England work (limited to the advertised remuneration) From 1 October paid via the NHS England payroll
Barbara Hakin *National Director: Commissioning Development to 30 April 2013, Chief Operating Officer from 1 May 2013*	1 April 2013	n/a	6 months	Option to provide taxable pay in lieu of part or all of the notice period	Previously on secondment from East Midlands Strategic Health Authority

Name & Title	Date of Appointment	Unexpired Term at 31 March 2014	Notice Period	Provisions for Compensation for Early Termination	Other Details
Tim Kelsey *National Director for Patients & Information*	2 July 2012	n/a	6 months	Option to provide taxable pay in lieu of part or all of the notice period	Transferred from the NHS Commissioning Board Authority on 1 October 2012
Naguib Kheraj *Non-executive Member to 10 December 2013*	1 July 2012	n/a	None	None	Transferred from the NHS Commissioning Board Authority on 1 October 2012 Waived entitlement to remuneration
Bill McCarthy *National Director: Policy to 30 June 2014*	1 April 2013	n/a	6 months	Option to provide taxable pay in lieu of part or all of the notice period	Previously on secondment from Yorkshire & the Humber Strategic Health Authority
Rosamond Roughton *National Director: Commissioning Development from 15 April 2013*	15 April 2013	n/a	6 months	Option to provide taxable pay in lieu of part or all of the notice period	
Ed Smith *Non-executive Member & Vice-chair*	9 November 2011	1 Year 8 Months	None	None	Transferred from the NHS Commissioning Board Authority on 1 October 2012
Simon Stevens *Chief Executive from 1 April 2014*	1 April 2014	n/a	6 months	Option to provide taxable pay in lieu of part or all of the notice period	
Jo-Anne Wass *National Director: Human Resources & Organisation Development to 31 March 2014*	1 June 2012	n/a	6 months	Option to provide taxable pay in lieu of part or all of the notice period	Transferred from the NHS Commissioning Board Authority on 1 October 2012
Secondments					
Bruce Keogh *National Medical Director*	1 April 2013	7 Months	12 months	None	Seconded from University College London Hospitals NHS Foundation Trust
David Nicholson *Chief Executive to 31 March 2014*	n/a	Nil	6 months	None	Seconded from the Department of Health
Karen Wheeler *National Director: Transformation & Corporate Operations from 1 April 2014*	1 April 2014	3 Years	3 months	None	Seconded from the Department of Health

Remuneration (including salary and pension entitlements)

Name & Title	2013–14					
	Salary & Fees (bands of £5,000) £000	Taxable Benefits (Rounded to the nearest £00) £	Annual Performance Related Bonuses (bands of £5,000) £000	Long-term Performance Related Bonuses (bands of £5,000) £000	All Pension Related Benefits (bands of £2,500) £000	Single Total Figure of Remuneration (bands of £5,000) £000
Victor Adebowale *Non-executive Member*	5 – 10	0	0	0	n/a	**5 – 10**
Paul Baumann *Chief Financial Officer*	205 – 210	10,800	0	0	25.0 – 27.5	**240 – 245**
Margaret Casely-Hayford *Non-executive Member*	0**	0	0	0	n/a	**0**
Jane Cummings *Chief Nursing Officer*	165 – 170	0	0	0	10.0 – 12.5	**175 – 180**
Ian Dalton *Chief Operating Officer to 30 April 2013*	15 – 20	0	0	0	(35.0) – (37.5)	**(15) – (20)**
Ciarán Devane *Non-executive Member*	5 – 10	0	0	0	n/a	**5 – 10**
Jim Easton *National Director: Transformation to 31 January 2013*	n/a	n/a	n/a	n/a	n/a	**n/a**
Moira Gibb *Non-executive Member*	5 – 10	0	0	0	n/a	**5 – 10**
Malcolm Grant *Chair*	60 – 65*	0	0	0	n/a	**60 – 65**
Barbara Hakin *National Director: Commissioning Development to 30 April 2013, Chief Operating Officer from 1 May 2013*	205 – 210	0	0	0	(75.0) – (77.5)	**130 – 135**
Tim Kelsey *National Director for Patients & Information*	180 – 185	16,200	0	0	42.5 – 45.0	**240 – 245**
Bruce Keogh *National Medical Director*	190 – 195	0	0	0	(7.5) – (10.0)	**180 – 185**
Naguib Kheraj *Non-executive Member to 10 December 2013*	0**	0	0	0	n/a	**0**
Bill McCarthy *National Director: Policy to 30 June 2014*	180 – 185	0	0	0	10.0 – 12.5	**195 – 200**
David Nicholson *Chief Executive to 31 March 2014*	210 – 215	14,200	#	0	37.5 – 40.0	**260 – 265**

Name & Title	Six Month Period to 31 March 2013					
	Salary & Fees (bands of £5,000) £000	Taxable Benefits (Rounded to the nearest £00) £	Annual Performance Related Bonuses (bands of £5,000) £000	Long-term Performance Related Bonuses (bands of £5,000) £000	All Pension Related Benefits (bands of £2,500) £000	Single Total Figure of Remuneration (bands of £5,000) £000
Victor Adebowale *Non-executive Member*	0 – 5	0	0	0	n/a	**0 – 5**
Paul Baumann *Chief Financial Officer*	100 – 105	0	0	0	12.5 – 15.0	**115 – 120**
Margaret Casely-Hayford *Non-executive Member*	0**	0	0	0	n/a	**0**
Jane Cummings *Chief Nursing Officer*	80 – 85	0	0	0	125.0 – 127.5	**205 – 210**
Ian Dalton *Chief Operating Officer to 30 April 2013*	105 – 110	0	5 – 10	0	17.5 – 20.0	**130 – 135**
Ciarán Devane *Non-executive Member*	0 – 5	0	0	0	n/a	**0 – 5**
Jim Easton *National Director: Transformation to 31 January 2013*	50 – 55	0	0	0	(2.5) – (5.0)	**45 – 50**
Moira Gibb *Non-executive Member*	0 – 5	0	0	0	n/a	**0 – 5**
Malcolm Grant *Chair*	30 – 35*	0	0	0	n/a	**30 – 35**
Barbara Hakin *National Director: Commissioning Development to 30 April 2013, Chief Operating Officer from 1 May 2013*	105 – 110	0	0	0	(15.0) – (17.5)	**90 – 95**
Tim Kelsey *National Director for Patients & Information*	90 – 95	0	0	0	42.5 – 45.0	**130 – 135**
Bruce Keogh *National Medical Director*	35 – 40	0	0	0	(10.0) – (12.5)	**25 – 30**
Naguib Kheraj *Non-executive Member to 10 December 2013*	0**	0	0	0	n/a	**0**
Bill McCarthy *National Director: Policy to 30 June 2014*	85 – 90	1,100	5 – 10	0	(17.5) – (20.0)	**70 – 75**
David Nicholson *Chief Executive to 31 March 2014*	40 – 45	0	0	0	25.0 – 27.5	**65 – 70**

Name & Title	2013–14					
	Salary & Fees (bands of £5,000) £000	Taxable Benefits (Rounded to the nearest £00) £	Annual Performance Related Bonuses (bands of £5,000) £000	Long-term Performance Related Bonuses (bands of £5,000) £000	All Pension Related Benefits (bands of £2,500) £000	Single Total Figure of Remuneration (bands of £5,000) £000
Rosamond Roughton *National Director: Commissioning Development from 15 April 2013*	165 – 170	0	0	0	72.5 – 75.0	**235 – 240**
Ed Smith *Non-executive Member & Vice-chair*	25 – 30	0	0	0	n/a	**25 – 30**
Jo-Anne Wass *National Director: Human Resources & Organisation Development to 31 March 2014*	155 – 160	0	0	0	(5.0) – (7.5)	**150 – 155**

* Until 30 September 2013 Malcolm Grant's employer (University College London) recharged for his time spend on NHS England work (limited to the advertised remuneration). From 1 October 2013 he has been paid via the NHS England payroll.

** Margaret Casely-Hayford and Naguib Kheraj have waived their entitlement to remuneration for their appointment.

Non-consolidated performance related pay for 2013–14 has yet to be decided. Any award will be paid in financial year 2014–15. For the performance year 2012–13 the value was £NIL.

n/a Non-executive Members do not receive pensionable remuneration, and therefore have no pension related benefits.

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

Pay Multiples

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 total banded remuneration of the highest paid Member of the NHS England Board in the financial year 2013–14 was £225,000 – £230,000. This was 6.47 times the median remuneration of the workforce, which was £35,154.

In 2013–14, no on-payroll employee received remuneration in excess of the highest-paid Member of the Board.

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

In 2012–13 most of the Members of the Board were employed on a secondment basis, including the Chief Executive. Many of the other staff were also seconded into the organisation. It was therefore decided that it would not be appropriate to include a pay multiple disclosure in the 2012–13 Remuneration Report. Consequently it is not possible to disclose comparative figures or changes in the pay multiple this year.

Name & Title	Six Month Period to 31 March 2013					
	Salary & Fees (bands of £5,000) £000	Taxable Benefits (Rounded to the nearest £00) £	Annual Performance Related Bonuses (bands of £5,000) £000	Long-term Performance Related Bonuses (bands of £5,000) £000	All Pension Related Benefits (bands of £2,500) £000	Single Total Figure of Remuneration (bands of £5,000) £000
Rosamond Roughton *National Director: Commissioning Development from 15 April 2013*	n/a	n/a	n/a	n/a	n/a	**n/a**
Ed Smith *Non-executive Member & Vice-chair*	10 – 15	0	0	0	n/a	**10 – 15**
Jo-Anne Wass *National Director: Human Resources & Organisation Development to 31 March 2014*	75 – 80	0	0	0	100.0 – 102.5	**175 – 180**

Payments to Past Senior Managers

No payments were made during the financial year to past senior managers.

Pension Benefits

Name & Title	Real increase in pension at age 60 (bands of £2,500) £000	Real increase in pension lump sum at aged 60 (bands of £2,500) £000	Total accrued pension at age 60 at 31 March 2014) (bands of £5,000 £000	Lump sum at age 60 related to accrued pension at 31 March 2014 (bands of £5,000) £000	Cash Equivalent Transfer Value at 31 March 2013 £000	Cash Equivalent Transfer Value at 31 March 2014 £000	Real increase in Cash Equivalent Transfer Value £000	Employer's contribution to partnership pension £00
Paul Baumann *Chief Financial Officer*	0.0 – 2.5	5.0 – 7.5	15 – 20	50 – 55	260	317	52	0
Jane Cummings *Chief Nursing Officer*	0.0 – 2.5	2.5 – 5.0	70 – 75	215 – 220	1,260	1,352	65	0
Barbara Hakin *Chief Operating Officer*	0.0 – (2.5)	(5.0) – (7.5)	70 – 75	220 – 225	n/a	n/a	n/a	0
Tim Kelsey *National Director for Patients & Information*	2.5 – 5.0	n/a	5 – 10	0	32	70	37	0
Bruce Keogh *National Medical Director*	0.0 – 2.5	0.0 – 2.5	75 – 80	235 – 240	1,748	1,857	70	0
Bill McCarthy *National Director: Policy to 30 June 2014*	0.0 – 2.5	2.5 – 5.0	65 – 70	200 – 205	1,129	1,213	60	0
David Nicholson *Chief Executive to 31 March 2014*	2.5 – 5.0	0	85 – 90	0	1,521*	1,662	35	0
Rosamond Roughton *National Director: Commissioning Development from 15 April 2013*	2.5 – 5.0	10.0 – 12.5	10 – 15	30 – 35	110	181	68	0
Jo-Anne Wass *National Director: Human Resources & Organisation Development to 31 March 2014*	0.0 – 2.5	0.0 – 2.5	45 – 50	145 – 150	748	795	31	0

Non-executive Members do not receive pensionable remuneration therefore there are no entries in respect of pensions for these Members.

* The CETV figure quoted for 2012–13 does not agree to the 2012–13 Remuneration Report due to the correction of an error in the disclosed value by the Principal Civil Service Pension Scheme.

Cash Equivalent Transfer Values

A cash equivalent transfer value 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 pension payable from the scheme. A cash equivalent transfer value 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 cash equivalent transfer value figures and the other pension details include the value of any pension benefits in another scheme or arrangement which the individual has transferred to the NHS Pension Scheme/Principal Civil Service 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. Cash equivalent transfer values are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries.

Real Increase in Cash Equivalent Transfer Value

This reflects the increase in cash equivalent transfer value effectively funded by the employer. It takes account of the increase in accrued pension due to inflation, contributions paid by the employee (including the value of any benefits transferred from another scheme or arrangement) and uses common market valuation factors for the start and end of the period.

Off-payroll Engagements (not subject to audit)

NHS England off-payroll engagements as of 31 March 2014, for more than £220 per day and that last longer than six months are as follows:

	Number
The number that have existed:	
• For less than one year at the time of reporting	577
• For between one and two years at the time of reporting	8
• For between two and three years at the time of reporting	0
• For between three and four years at the time of reporting	0
• For four or more years at the time of reporting	0
Total number of existing engagements as of 31 March 2014	**585**

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

	Number
Number of new engagements, or those that reached six months in duration, between 1 April 2013 and 31 March 2014	794
Number of the above which include contractual clauses giving NHS England the right to request assurance in relation to Income Tax and National Insurance obligations	310
Number for whom assurance has been requested:	
For whom assurance has been received	632
For whom assurance has not been received	130
Total number for whom assurance has been requested	**762**
Number of engagements terminated as a result of assurance not being received, or ended before assurance received	130

	Number
Number of off-payroll engagements of Board members and those that attend Board meetings, and/or senior officials with significant financial responsibility, during the financial year	4
Number of individuals that have been deemed " Board members and those that attend Board meetings, and/or senior officials with significant financial responsibility", during the financial year (this figure includes both off-payroll and on-payroll engagements)	326

Details of the four interim positions are as follows:

- **Regional Director of Finance:** Following the departure of the substantive post holder in 2013, the role has proved hard to fill substantively. A renewed search will be undertaken during 2014–15.
- **Director of Finance, Anglia CSU:** Due to changes within the region, a senior finance officer was required on a short term basis prior to the commissioning support unit partnering with another commissioning support unit. Financial responsibility is currently being integrated and passing to the partnership Executive Team.
- **Director of Finance, South London CSU:** Following the departure of the substantive post holder, an interim position was necessary due to the changes within the region and a consortium being formed with other commissioning support units. A decision has not yet been made concerning the permanent requirement of the consortium.
- **Director of Finance, Central Southern CSU:** The Director of Finance was seconded to another client organisation and therefore it was not possible to recruit for this post substantively. The seconded Director of Finance has now departed, the post has been confirmed as vacant, and the recruitment process has now commenced.

Simon Stevens
Accounting Officer

10 July 2014

Members' & Directors' Interests (not subject to audit)

Victor Adebowale	Non-executive Member
Chief Executive Officer & Company Secretary	Turning Point
Chancellor & Visiting Professor	University of Lincoln
Director	Leadership in Mind Ltd
Non-Executive Director	Three Sixty Action Ltd (ceased in year)
Non-Executive Director	Tomahawk Ltd
Chair	Collaborate Institute, London South Bank University
Chair	Urban Development
Board Member	English Touring Theatre
Board Member	National Standards Agency for Equalities
Commissioner	UK Commission for Employment & Skills

Paul Baumann	Chief Financial Officer
None	

Margaret Casely-Hayford	Non-executive Member
Director	British Retail Consortium
Secretary	Buy.Com Limited
Secretary	Cavendish Trustees Limited
Secretary	De Facto 1123 Limited
Secretary	Herbert Parkinson Limited
Secretary	JLP Scotland Limited
Secretary	John Lewis Car Finance Limited
Secretary	John Lewis Delivery Limited
Secretary	John Lewis Foundation
Secretary	John Lewis Partnership Pensions Trust
Secretary	John Lewis Partnerships plc
Secretary	John Lewis Partnerships Services Limited
Secretary	John Lewis Partnership Trust Limited
Secretary	John Lewis plc
Secretary	John Lewis Properties plc
Secretary	John Lewis PT Holdings Limited
Secretary	Jonelle Jewellery Limited
Secretary	Jonelle Limited
Secretary	JSL Custodian Trustee Limited
Secretary	Leckford Estate Limited
Secretary	Park One Management Limited
Secretary	Peter Jones Limited
Secretary	The Odney Estate Limited
Secretary	Waitrose Limited

Jane Cummings	Chief Nursing Officer
Trustee	Over the Wall (charity)

Ian Dalton	Chief Operating Officer to 30 April 2013
None	

Ciarán Devane	Non-executive Member
Chief Executive	Macmillan Cancer Support
Co-chair	National Cancer Survivors Initiative
Trustee	National Council for Voluntary Organisations
Trustee	Makaton Charity
Advisor	Advisory Council of the Cicely Saunders Institute

Moira Gibb	Non-executive Member
Non-executive Director	UK Statistics Authority
Chair	CityLit
Chair	Safeguarding Improvement Board, London Borough of Bexley
Chair	Social Work Reform Board (ceased in year)
Board Member	Achieving for Children, London Boroughs of Kingston & Richmond
Council Member	University of Reading

Malcolm Grant	Chair
Director	Genomics England Limited
President	The Council for Assisting Refugee Academics
President & Provost	University College London (to 30 September 2013)
Board Member	Higher Education Funding Council for England
Board Member	International Council on Global Competitiveness of Russian Universities (of the Russian Federation)
Board Member	University College London partners (ceased in year)
Board Member	University Grants Committee of Hong Kong
Governor	The Ditchley Foundation
Life Fellow	Clare College, Cambridge
Trustee	Somerset House

Barbara Hakin	National Director: Commissioning Development to 30 April 2013, Chief Operating Officer from 1 May 2013
None	
Family member is an employee of Ernst & Young (previously PwC)	

Tim Kelsey	National Director for Patients & Information
Trustee	Nuffield Trust
Partner is a Director of ZPB Limited, a health strategy company	

Bruce Keogh	National Medical Director
Fellow (previous Member of Council)	Royal College of Surgeons in England
Fellow & King James IV Professor	Royal College of Surgeons of Edinburgh
Fellow	Royal College of Physicians
Member & Past President	Society for Cardiothoracic Surgery in Great Britain & Ireland
Honorary Member & Past Secretary General	European Association for Cardiothoracic Surgery
Council Member	British Heart Foundation
Vice-Patron	The Poppy Factory
Honorary Fellow	Royal College of Surgeons in Ireland
Honorary Fellow	American College of Surgeons
Honorary Fellow	Royal College of Anaesthetists
Honorary Fellow	Royal College of General Practitioners
Honorary Member	British Society of Interventional Radiology
Honorary Member	Faculty of Medical Management & Leadership

Naguib Kheraj	Non-executive Member to 10 December 2013
Member	Investment Committee of the Wellcome Trust
Brother is a general practitioner	
Sister-in-law is Interim Medical Director, National Clinical Assessment Service	

Bill McCarthy	National Director: Policy to 30 June 2014
Employee (from 1 July 2014)	University of Bradford
Board Member	Hull York Medical School (ceased in year)
Council Member	University of York (ceased in year)
Wife is an employee of the Refugee Council and an ante-natal teacher	

David Nicholson	Chief Executive to 31 March 2014
Senior Fellow	University of Birmingham, Health Service Management
Honorary Fellow	Royal College of Physicians
Honorary Fellow	Royal College of General Practitioners
Wife is Chief Executive, Birmingham Children's Hospital NHS Foundation Trust	

Rosamond Roughton	National Director: Commissioning Development from 15 April 2013
Committee Member	Vincent Housing Association
Partner:	
• Is a Director of Mike Farrar Consulting Limited, a healthcare consultancy	
• Is a Director of Sport and Physical Activity@Work	
• Is a Non-executive Director of York Health Economics	
• Provides consultancy support to AMStrategy Limited	
• Is a Strategic advisor to Vanguard and CIPFA	

Ed Smith	Non-executive Member & Vice-chair
Pro Chancellor & Chair of Council	University of Birmingham
Member of Council & Treasurer	Royal Institute of International Affairs (Chatham House)
Non-executive Director	Department of Transport
Non-executive Director	Stamford Limited (until January 2014)
Chair	WWF-UK
Chair	British Universities & Colleges Sport Ltd
Member	WWF International Board
Panel Member	Competition & Markets Authority

Simon Stevens	Chief Executive from 1 April 2014
Non-executive Director	Commonwealth Fund

Jo-Anne Wass	National Director: Human Resources & Organisation Development to 31 March 2014
None	
Husband is an employee of NHS England	

Karen Wheeler	National Director: Transformation & Corporate Operations from 1 April 2014
None	

Non-executive Member Profiles (not subject to audit)

Professor Sir Malcolm Grant CBE

Chair

Sir Malcolm is a barrister and academic lawyer. He is currently a board member of the Higher Education Funding Council for England and of the University Grants Committee of Hong Kong. In addition, he serves as a UK Business Ambassador.

From 2003 to 2013 Sir Malcolm was the President and Provost of University College London. He has served as Chair of the Local Government Commission for England, of the Agriculture and Environmental Biotechnology Commission and the Russell Group.

Lord Victor Adebowale

Victor is currently Chief Executive and Company Secretary of Turning Point. He is a cross-bench peer and Visiting Professor and Chancellor at the University of Lincoln, a Fellow of the City & Guilds of London Institute, an associate member of the Health Service Management Centre at the University of Birmingham and of Cambridge University Judge Business School.

Victor is on the Board of English Touring Theatre, and is President of the International Association of Philosophy and Psychiatry. His previous roles included being the Chief Executive at Centre Point, the youth homelessness charity.

Margaret Casely-Hayford

Margaret is a Solicitor, and works as Director of Legal Services and Company Secretary at John Lewis Partnership plc. She also sits on the Policy Committee of the British Retail Consortium.

Margaret was previously a Government appointed Trustee of the Geffrye Museum and Special Trustee of Great Ormond Street Hospital Charity. Both of these appointments were held from 1999 to 2007.

Ciarán Devane

Ciarán is Chief Executive of Macmillan Cancer Support. He co-chairs the National Cancer Survivorship Initiative and is a Trustee of the National Council for Voluntary Organisations and the Makaton Charity.

Ciarán has been nominated to join the board of Social Finance, but has not yet taken up the role, and is on the Advisory Council of the Cicely Saunders Institute. He worked for ICI for eight years before joining Gemini Consulting.

Dame Moira Gibb

Dame Moira is a Civil Service Commissioner, a Non-executive Director of the UK Statistics Authority, Chair of City Lit Adult Education College and a member of the Council of Reading University. She also chairs a local authority improvement board and is a Non-executive Director of Achieving for Children.

Until December 2011 Dame Moira was Chief Executive of the London Borough of Camden and was a Director of the London Marathon from 2005 to 2011. Her career was in local government and social services and she chaired the Government Taskforce on the Social Work Profession in 2009.

Ed Smith CBE

Vice-chair

Ed is Pro-Chancellor and Chairman of Council at the University of Birmingham. In addition, he is Chairman of WWF-UK and a member of its International Board, Chairman of British Universities and Colleges Sport and a Member of Council and Treasurer of Chatham House. Ed is also a Board Member at the Department for Transport and is a Panel Member of the Competition and Markets Authority.

Ed is the former Global Assurance Chief Operating Officer and Strategy Chairman of PricewaterhouseCoopers (PwC). Before retiring he had a successful 30-year career with PwC, holding many leading board and top client roles in the UK and globally as a Senior Partner. He now holds board roles in education, sport, thought leadership and sustainable development, as well as a number of commercial interests.

Executive Director Profiles (not subject to audit)

Simon Stevens

Chief Executive from 1 April 2014

Simon has joined NHS England having spent the past decade leading health services in the United States, Europe, Brazil, India, China, Africa and the Middle East. Before that he ran the largest US health commissioning organisation for publicly-funded health care for millions of older Americans.

From 1997 to 2004, Simon was the British Prime Minister's Health Adviser at 10 Downing Street, and policy adviser to successive Health Secretaries at the UK Department of Health. Prior to that he held a number of senior NHS roles in the North East, London and on the South Coast – leading acute hospitals, mental health and community services, primary care and health commissioning. Simon joined the NHS through its Graduate Training Scheme in 1988.

Simon is a Member of the Board of Directors of the Commonwealth Fund, an international health philanthropy. He has previously served as a trustee of the Kings Fund and a director of the Nuffield Trust, as well as being a local councillor for Brixton and a visiting professor at the London School of Economics. His work on health care quality, new models of technology-enabled prevention, and international health reform is regularly published in leading international medical journals.

Paul Baumann

Chief Financial Officer

Paul joined NHS England from NHS London, where he was Director of Finance & Investment.

Paul joined NHS London, the Strategic Health Authority, in May 2007 as their first Director of Finance & Performance. Whilst at NHS London he oversaw a significant financial recovery programme for London's PCTs and Trusts and focused on the development of strategies to deliver long-term viability and sustainability across the London health economy.

Prior to working for NHS London Paul had 22 years of experience of international financial management and strategic leadership at Unilever, including finance directorships in Germany and Ireland and a global role as Vice President, Finance Excellence, in which he led the transformation of Unilever's finance function and the establishment of its Finance Academy.

Jane Cummings
Chief Nursing Officer

Jane joined NHS England from NHS North of England, where she was Chief Nurse.

Jane's key challenges at NHS North of England included the development and maintenance of new systems of performance management and strategic leadership for nursing. She was also the lead director for the Quality Framework.

While in the North West, Jane developed the Energise for Excellence nursing programme from which Compassion in Practice evolved.

Previously, as the national lead for emergency care, Jane led improvements in the quality of care provided in emergency departments, improved waiting times and delivered the four-hour target in A&E. In January 2005, she was appointed as the National Implementation Director for 'Choice' & 'Choose and Book'.

Jane worked for the NHS for a number of years as a nurse, specialising in emergency care, before moving into general management. She has held a variety of clinical and managerial roles including Director of Commissioning, Director of Nursing and Deputy Chief Executive.

Dame Barbara Hakin
Chief Operating Officer

Dame Barbara was appointed as interim Chief Operating Officer on 1 May 2013, following the resignation of Ian Dalton. Her substantive post is National Director: Commissioning Development.

Dame Barbara joined NHS England from East Midlands Strategic Health Authority, where she was Chief Executive. She was previously seconded to the Department of Health to oversee the development of the commissioning architecture of the NHS, and specifically the establishment and authorisation of clinical commissioning groups.

Prior to that, Dame Barbara was a PCT Chief Executive in Bradford. During this time she also held a broad range of national roles including Interim Director General of Commissioning in the Department of Health and Director of Primary Care in the Modernisation Agency.

Before moving into a full-time career in management in 2000, Dame Barbara was a GP in Bradford for over 20 years.

Tim Kelsey

National Director for Patients & Information

Tim joined NHS England from the Cabinet Office, where he was the first Executive Director of Transparency and Open Data.

Tim is a leading advocate of a popular knowledge revolution in public services and, in 2000, co-founded Dr Foster, a company that pioneered the publication of patient outcomes in healthcare. He is an internationally regarded expert in thinking differently about how digital and social media can transform the customer – and patient – experience in public services.

In 2007, Tim helped launch NHS Choices, the national online health information service, which now reports around 20 million unique users a month.

Before Dr Foster, Tim was a national newspaper journalist and a television reporter. He worked for the Independent and The Sunday Times, as well as Channel 4 and the BBC.

Professor Sir Bruce Keogh

National Medical Director

Sir Bruce joined NHS England from the Department of Health where he had been Medical Director of the NHS since 2007.

Previously Sir Bruce had enjoyed a distinguished career in surgery. He has been a British Heart Foundation senior lecturer and consultant in cardiothoracic surgery at the Hammersmith Hospital, a Consultant and Associate Medical Director for governance at the University Hospital Birmingham, Professor of Cardiac Surgery at University College London Hospitals and Director of Surgery at the Heart Hospital in London. He has been president of the Society for Cardiothoracic Surgery in Great Britain and Ireland, Secretary General of the European Association for Cardio-Thoracic Surgery and a director of the Society of Thoracic Surgeons in the US.

He has a long-standing interest in transparency and clinical outcomes, has chaired the board of NHS Choices and has served as a commissioner on both the Commission for Health Improvement and the Healthcare Commission.

Bill McCarthy

National Director: Policy to 30 June 2014

Bill was the Managing Director responsible for establishing NHS England.

Previously Bill has been Chief Executive at NHS Yorkshire & the Humber, and at City of York Council.

Between 2005 and 2007 Bill was a Director General at the Department of Health. Earlier posts in different parts of the public sector included Director of Planning and Performance at a teaching hospital.

Bill left NHS England on 30 June 2014 to take up the post of Deputy Vice Chancellor at the University of Bradford.

Rosamond Roughton

National Director: Commissioning Development

Prior to joining NHS England, Rosamond worked as the Programme Director for the development of the new commissioning architecture, working across the Department of Health and the NHS Commissioning Board Authority.

Previously, Rosamond spent four years as Director of Strategy at NHS Yorkshire & the Humber, following a period as a director at the Christie Hospital NHS Foundation Trust.

Rosamond's early career was spent in the Department of Health and HM Treasury.

Karen Wheeler CBE

National Director: Transformation & Corporate Operations from 1 April 2014

Karen joins NHS England from the Department of Health, where she was Director General: Information & Group Operations.

Karen joined the civil service in 2003, running a major change programme to create HM Court Service, an arms length body of the Ministry of Justice. She subsequently ran multiple change programmes in the Ministry of Justice, becoming Delivery Director for a major part of the department, including HM Court Service and many other arms length bodies.

In 2009, Karen joined the Cabinet Office to drive greater progress on digital delivery across government.

Before becoming a civil servant, Karen spent 15 years as a management consultant, initially with Andersen Consulting, working on large scale change programmes in different private sector organisations, including British Steel, Guinness, Societe Generale and North West Water.

Statements by the Accounting Officer

Statement of Accounting Officer's Responsibilities

The National Health Service Act 2006 (as amended) Schedule A1 Paragraph 15(4) states that the Chief Executive shall be the Accounting Officer of the National Health Service Commissioning Board (known as NHS England).

The responsibilities of the Accounting Officer, including responsibilities for the propriety and regularity of the public finances for which the Accounting Officer is answerable, for keeping proper accounting records (which disclose with reasonable accuracy at any time the financial position of the National Health Service Commissioning Board and enable them to ensure that the accounts comply with the requirements of the Accounts Direction) and for safeguarding the National Health Service Commissioning Board's assets (and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities), are set out in the Accounting Officer Appointment Letter, supported by *Managing Public Money* issued by HM Treasury.

Under the National Health Service Act 2006 (as amended), the Department of Health has directed the National Health Service Commissioning Board to prepare for each financial year financial statements in the form and on the basis set out in the Accounts Direction. The financial statements are prepared on an accruals basis and must give a true and fair view of the state of affairs of the National Health Service Commissioning Board and of its net expenditure, changes in taxpayers' equity and cash flows for the financial year.

In preparing the financial statements, the Accounting Officer is required to comply with the requirements of the *Government Financial Reporting Manual* issued by HM Treasury and in particular to:

- Observe the Accounts Direction issued by the Department of Health, including the relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis;
- Make judgements and estimates on a reasonable basis;
- State whether applicable accounting standards as set out in the *Government Financial Reporting Manual* issued by HM Treasury have been followed, and disclose and explain any material departures in the financial statements; and,
- Prepare the financial statements on a going concern basis.

For the financial year 1 April 2013 to 31 March 2014 Sir David Nicholson served as Accounting Officer. With his departure on 31 March 2014, and my appointment effective from 1 April 2014 it falls to me to sign this Annual Report & Accounts as the new Accounting Officer.

To the best of my knowledge and belief, the responsibilities set out in the relevant Accounting Officer Appointment Letters have been properly discharged.

Governance Statement

Governance Statement Contents

Introduction & Context

Simon Stevens
Chief Executive

The National Health Service Commissioning Board (since 1 April 2013 known as NHS England) was established as an Executive Non-Departmental Public Body on 1 October 2012, under provisions enacted in the Health & Social Care Act 2012 which amended the National Health Service Act 2006. The organisation inherited functions and assets from the NHS Commissioning Board Authority.

On 1 April 2013, when the National Health Service Commissioning Board took on its full powers, the organisation transformed from an organisation with a £60m expenditure in the previous six months to an organisation with an annual expenditure budget of £96.6bn.

NHS England hosts a number of other bodies (commissioning support units, NHS Improving Quality and the Sustainable Development Unit), all of which operate under their own names rather than the NHS Commissioning Board or NHS England name.

On 31 March 2014 Sir David Nicholson retired as Chief Executive and Accounting Officer, and I took up my appointment on 1 April 2014.

Changes to the NHS on 1 April 2013

From 1 April 2013 healthcare has been commissioned by 211 clinical commissioning groups, with guidance and support from NHS England via its national support centre, 27 area teams and four regional teams. The resulting split of commissioning sees approximately two thirds of commissioning undertaken by clinical commissioning groups and one third undertaken by NHS England (mainly for specialist and primary care services).

NHS England leads and oversees the commissioning of healthcare, and works closely with Monitor (which licenses NHS Foundation Trusts and acts as economic regulator of the sector), the NHS Trust Development Authority (which oversees NHS trusts) and the Care Quality Commission (which sets and maintains healthcare quality standards).

A range of support services are provided via commissioning support units, which are currently hosted by NHS England.

Other bodies, such as the NHS Health & Social Care Information Centre, NHS Business Services Authority, NHS Shared Business Services and McKesson, provide services to support the whole system. In addition, all commissioning system property is now owned and managed via two property companies, established and owned by the Department of Health (NHS Property Services Ltd and Community Health Partnerships Ltd).

Clinical Commissioning Groups

Clinical commissioning groups are clinically led. They need to demonstrate probity and governance commensurate with their considerable responsibilities for their patients' healthcare and taxpayers' money. This means ensuring that they have open, robust and transparent processes which will give the communities they service the confidence that, through the appropriate governance arrangements, they can demonstrate how they will play their part in ensuring that the services their patients receive are safe and delivered with care and compassion.

NHS England has three key roles in working with clinical commissioning groups:

- A development role to work with and support clinical commissioning groups to become the best they can be;
- An assurance role to ensure that as statutory organisations, clinical commissioning groups deliver the best possible services and outcomes for patients within their financial allocation; and,
- A co-commissioning role to ensure the direct commissioning undertaken by NHS England works across the care pathway for patients and supports the delivery of local outcomes.

Commissioning Support Units

To support the operation of clinical commissioning groups a number of commissioning support units were created.

As at 1 April 2014 there were 17 commissioning support units across the country. Their major customer base is clinical commissioning groups, although services are also provided to NHS England, NHS trusts and non-NHS organisations. Commissioning support units secure new work in competition with other non-NHS bodies.

Scope of Responsibility

This Statement is given in respect of the Annual Report & Accounts of the National Health Service Commissioning Board (known as NHS England and including all its hosted bodies), which consolidates the financial information of all clinical commissioning groups, in accordance with the requirements of the National Health Service Act 2006 (as amended). The following sections cover NHS England or clinical commissioning groups (collectively the Commissioning System).

As Accounting Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of NHS England's policies, aims and objectives, whilst safeguarding the public funds and assets for which I am personally responsible, in accordance with the responsibilities assigned to me in *Managing Public Money*. I also acknowledge my responsibilities as set out in my NHS Commissioning Board Accounting Officer appointment letter.

I am responsible for ensuring that NHS England is administered prudently and economically and that resources are applied efficiently and effectively, safeguarding financial propriety and regularity.

The formal relationship between NHS England and each clinical commissioning group is substantially different from the concept of a group in the commercial sector. Parliament has specified strictly limited rights of intervention by NHS England into each clinical commissioning group. Clinical commissioning groups are

independent membership organisations with significant autonomy. Each clinical commissioning group has an Accountable Officer who has been appointed by myself or my Accounting Officer predecessor.

I am responsible for ensuring that there is a high standard of financial management across the Commissioning System as a whole. Therefore, I have a responsibility to be satisfied that all clinical commissioning groups have in place adequate financial systems and procedures to promote the efficient and effective conduct of their business, ensure resources are administered prudently and economically and financial propriety and regularity is safeguarded.

I am also accountable for ensuring that expenditure across the Commissioning System is contained within limits set by the Department of Health.

Compliance with the UK Corporate Governance Code

Whilst the detailed provisions of the UK Corporate Governance Code are not mandatory for public sector bodies, compliance is considered to be good practice. This Governance Statement is intended to demonstrate NHS England's compliance with the principles set out in the UK Corporate Governance Code.

Certain provisions (A.1.3, C.3.7, D.2.4, E.2.1 and E.2.2) are not applicable to a public sector body, such as NHS England, and some (E.1.1, E.1.2 and E.2.4) have required interpretation in the public sector context.

For the financial year ended 31 March 2014, and up to the date of signing this statement, NHS England complied with the provisions set out in the Code, and applied the principles of the Code, subject to the above caveats, except as follows:

Code Provision		Exception
B.3.1	For the appointment of a chairman, the nomination committee should prepare a job specification, including an assessment of the time commitment expected, recognising the need for availability in the event of crises. A chairman's other significant commitments should be disclosed to the board before appointment and included in the annual report. Changes to such commitments should be reported to the board as they arise, and their impact explained in the next annual report.	Under the National Health Service Act 2006 (as amended) the Secretary of State appoints the Chair. The other elements of the provision are complied with.
B.5.2	All directors should have access to the advice and services of the company secretary, who is responsible to the board for ensuring that board procedures are complied with. Both the appointment and removal of the company secretary should be a matter for the board as a whole.	The appointment and removal of the Board Secretary is not reserved to the Board, but is undertaken by executive management.

Code Provision		Exception
B.7.1	All directors of FTSE 350 companies should be subject to annual election by shareholders. All other directors should be subject to election by shareholders at the first annual general meeting after their appointment, and to re-election thereafter at intervals of no more than three years. Non-executive directors who have served longer than nine years should be subject to annual re-election. The names of directors submitted for election or re-election should be accompanied by sufficient biographical details and any other relevant information to enable shareholders to take an informed decision on their election.	The arrangements for the appointment of Executive and Non-executive Members are laid down in the National Health Service Act 2006 (as amended). As a public body NHS England does not have shareholders, and therefore shareholder votes are not possible.
B.7.2	The board should set out to shareholders in the papers accompanying a resolution to elect a nonexecutive director why they believe an individual should be elected. The chairman should confirm to shareholders when proposing re-election that, following formal performance evaluation, the individual's performance continues to be effective and to demonstrate commitment to the role.	
D.2.1	The board should establish a remuneration committee of at least three, or in the case of smaller companies' two, independent non-executive directors. In addition the company chairman may also be a member of, but not chair, the committee if he or she was considered independent on appointment as chairman. The remuneration committee should make available its terms of reference, explaining its role and the authority delegated to it by the board. Where remuneration consultants are appointed, they should be identified in the annual report and a statement made as to whether they have any other connection with the company.	The Chair of the Remuneration & Terms of Service Committee is also the Chair of the Board. The other elements of the provision are complied with.

NHS England's Governance Framework

NHS England's *Corporate Governance Framework* describes the arrangements intended to provide a foundation of excellent governance, enabling the organisation to lead profound changes in the way NHS services will be planned, delivered and experienced.

The *Corporate Governance Framework* sets out the principles and methods NHS England adheres to in delivering its role and functions. It describes how NHS England operates, references matters reserved for Board decision, and other areas where the powers of the Board are delegated within NHS England.

These arrangements are reviewed annually to ensure they remain fit for purpose, enabling the organisation to do everything within its power to support the delivery of excellent NHS services.

During 2013–14, the *Corporate Governance Framework* was supported by a suite of documents that are reviewed at least annually, including:

- Standing Orders: detailing arrangements for the running of the Board and its Committees and Sub-committees;

- Standing Financial Instructions: detailing the overarching financial control environment and financial delegations;
- A Scheme of Delegation: detailing the delegations from the Board to specified Officers within the organisation; and,
- Commissioning Support Unit Operating Frameworks: detailing delegation of financial limits and functions within each commissioning support unit.

During 2014–15 Operating Frameworks will be rolled out to all Area and Regional Teams, National Directorates and other hosted bodies.

The Mandate

NHS England is accountable through its Board to the Secretary of State for Health for delivery of the Mandate. The Chair and Chief Executive of the Board meet the Secretary of State periodically to provide assurance on progress against Mandate objectives.

The Mandate sets the strategic direction for NHS England and ensures it is democratically accountable. The Mandate is the main basis of ministerial instruction to the NHS.

NHS England's progress against the Mandate is reviewed annually by Government, and an assessment is laid before Parliament. The Mandate Assessment by NHS England, included earlier in this document, is a key input to that process.

Framework Agreement with the Department of Health

The Agreement sets out the agreed roles and responsibilities of the two organisations and defines the critical elements of the relationship between us. It sets out how we will work in partnership to improve health outcomes for people in England, and how each party will discharge their accountability responsibilities effectively, based on delivering the Mandate, discharging statutory functions and providing assurance and seeking Government clearance where required. The Agreement recognises the autonomy and freedom of individual organisations to carry out their functions as they see fit, and the relationship of support and guidance which the NHS Commissioning Board has with clinical commissioning groups.

The Agreement covers NHS England's governance arrangements, audit, risk management, delegations and financial management, and human resources responsibilities, with reference to wider requirements applied to arm's length bodies across Government. The Agreement also includes the principles which underpin NHS England's partnership working with the Department of Health and other arm's length bodies, patients and the public, including commitment to the values in the NHS Constitution.

The Board

The National Health Service Act 2006 (as amended) requires that the Board consist of at least five Non-executive Members other than the Chair, and that the number of Executive Members is less than the number of Non-executive Members (including the Chair).

For most of 2013–14 the Board comprised the Chair, six other Non-executive Members and four Executive Members. Naguib Kheraj resigned as a Non-executive Member on 10 December 2013. From this date the Board operated with only six Non-executive Members (including the Chair).

The four Executive Members are the:

- Chief Executive;
- National Medical Director;

- Chief Nursing Officer; and,
- Chief Financial Officer.

The Chief Operating Officer, National Director: Commissioning Development, National Director: Human Resources & Organisation Development (up to 31 March 2014), National Director: Policy, National Director: Transformation & Corporate Operations (from 1 April 2014) and National Director for Patients & Information attend meetings of the Board to provide operational advice and support to the Board in the discharge of their responsibilities. These Directors are not voting members of the Board and do not bear the legal responsibility of an Executive Director.

Ian Dalton resigned as Deputy Chief Executive on 30 April 2013. The Board appointed Barbara Hakin (interim Chief Operating Officer) as interim Deputy Chief Executive from 1 April 2013.

The Board appointed Ed Smith as Vice-chair and Senior Independent Director from 12 April 2013.

The National Health Service Act 2006 (as amended) provides that all Non-executive Member appointments, including the Chair, are made by the Secretary of State for Health and that Executive Members are appointed by the Non-executive Members.

Board members bring a range of complementary skills and experience in areas such as finance, governance and health policy. New appointments take account of the skill sets already represented on the Board, recognising where gaps could be filled.

The role of the Board is to:

- Set the overall strategic direction of the NHS Commissioning Board, within the context of the NHS Mandate;
- Monitor performance against objectives;
- Provide effective financial stewardship;
- Ensure high standards of corporate governance and personal conduct; and,
- Promote effective dialogue between the NHS Commissioning Board, its partners, clinical commissioning groups, providers of healthcare and the communities the Commissioning System serves.

The Board held eight meetings in public over the course of 2013–14. At each of its meetings, the Board received reports on current issues that needed to be drawn to its attention from the Chief Executive, as well as from its Committees. It received regular performance reports against the mandate and other commitments, and considered strategic risks and their mitigations through the *Board Assurance Framework*. The Board oversaw the development and implementation of strategy across a range of areas and formally agreed key items such as planning guidance and allocations, and changes to the incentives and sanctions within the NHS Standard Contract.

The Board undertakes background briefing and early shaping work in development sessions in order for detailed papers then to be brought for discussion and decision in public. These development sessions are held each time the Board meets.

Board Effectiveness Assessment

The Board is currently in the process of appointing an external consultant to support it in undertaking an assessment of its effectiveness during our first year of full operation.

The assessment process will include:

- Individual interviews with each member of the Board;

- A paper based review of Board papers;
- Consideration of the Board Committee and Sub-committee structure; and,
- Observation of a Board meeting.

The output from the process will be presented back to the Board and will be used to agree an action plan and development plan.

Board Committees & Sub-committees

The National Health Service Act 2006 (as amended) provides that the Board may appoint such Committees and Sub-committees as it sees fit.

Each Committee or Sub-committee has a set of terms of reference. The terms of reference of Committees and Sub-committees appointed by the Board are formally approved by the Board.

Each Committee may appoint Sub-committees to support it in its work. The terms of reference of a Sub-committee so appointed are formally approved by the appointing Committee and reported to the Board.

Each Committee appointed by the Board has been asked to review its effectiveness and terms of reference, and provide an annual report to the Board.

A Committee Handbook was produced and approved by the Chair on behalf of the Board on 16 September 2013. This contains the approved terms of reference of each Committee appointed by the Board, as well as standard requirements applicable to all Committees (methods of attendance, support arrangements, requirement to report to the Board, requirement to establish a work programme, requirement to undertake an annual effectiveness review and report to the Board, urgent action process). A copy can be found on the NHS England website.

Committee Chairs present their approved minutes to the Board meeting following their approval (except the Remuneration & Terms of Service Committee, Efficiency Controls Committee and Finance & Investment Committee due to the confidential and/or sensitive nature of their business), together with a written summary of any meetings that have occurred, but for which approved minutes are not yet available.

A report on the work of the Audit & Risk Assurance Committee is the next section in this Statement. A report on the work of the Remuneration Committee is contained in the Remuneration Report. A report on the activity of each of the other Board Committees is contained in Annex C.

The Board and its Committee structure, during the financial year, was as follows:

Board								
Non-executive Membership	Meetings attended/eligible to attend (2013–14)							
	Apr	May	July	Sept	Nov	Dec	Jan	Mar
Professor Sir Malcolm Grant CBE (Chair)	✓	✓	✓	✓	✓	✓	✓	✓
Lord Victor Adebowale	✓	✓	✓	✓	✓	×	✓	✓
Margaret Casely-Hayford	✓	✓	×	✓	✓	✓	✓	✓
Ciaran Devane	✓	✓	✓	✓	✓	✓	✓	✓
Dame Moira Gibb	✓	✓	✓	✓	×	✓	✓	✓
Naguib Kheraj (to 10 December 2013)	✓	✓	✓	✓	×			
Ed Smith CBE	✓	✓	✓	✓	✓	✓	✓	✓
Executive Membership								
Sir David Nicholson CBE (Chief Executive to 31 March 2014)	✓	✓	✓	✓	✓	✓	✓	✓
Simon Stevens (Chief Executive from 1 April 2014)								
Paul Baumann (Chief Financial Officer)	✓	✓	✓	✓	✓	✓	✓	✓
Jane Cummings (Chief Nursing Officer)	✓	✓	✓	✓	✓	✓	✓	✓
Professor Sir Bruce Keogh (National Medical Director)	✓	✓	✓	✓	✓	✓	✓	✓

Audit & Risk Assurance Committee

Members:

- Ed Smith (Chair)
- Moira Gibb
- Naguib Kheraj (to 10 December 2013)

Remuneration & Terms of Service Committee

Members:

- Malcolm Grant (Chair)
- Ciaran Devane
- Ed Smith

Other Committees

- Authorisation & Assurance Committee (formerly the Clinical Commissioning Group Authorisation Sub-committee)
- Commissioning Support Committee (established 12 April 2013)
- Directly Commissioned Services Committee (established 12 April 2013)
- Efficiency Controls Committee (formerly the Procurement Controls Committee)
- Finance & Investment Committee (established 12 April 2013)
- Quality & Clinical Risk Committee (established 12 April 2013)
- Trust & Charitable Funds Committee (allowed for in Standing Orders but not required in year)

Audit & Risk Assurance Committee Report

Ed Smith CBE
Chair, Audit & Risk Assurance Committee

Throughout the year the Committee has been focused on the integrity of the annual financial reporting processes (including the impact of the legacy from the reorganisation of the NHS on 1 April 2013), governance arrangements, risk management processes and the effectiveness of internal controls.

In particular it focused on the work of internal audit, and the outcomes from internal audit work. This included how service auditor reporting would be provided to customers of commissioning support units, and the outcomes from that work.

The Committee also led an internal audit tender process, following which Deloitte LLP was appointed.

In forming its conclusion on the appropriateness of internal control arrangements, the Committee has been mindful of both the aspiration of NHS England to be an exemplar organisation and the magnitude of the undertaking implied by the establishment from scratch of a complex organisation at the heart of a newly created Commissioning Sector, operating with half of the management resource available to its predecessor organisations.

As such, it is clear that not all elements of a fully mature control environment were present at day one, but we have assured ourselves that progress with the necessary enhancements is progressing at speed, and we are confident that the improvements to date provide a sound foundation as we move into our second year of operation, while also providing assurance over the integrity of NHS England's accounts for 2013–14.

Role & Responsibilities

The Board approved renaming the Committee (previously the Audit Committee) as well as other minor changes to its terms of reference, on 15 May 2014.

The purpose of the Committee is to provide an independent and objective view of internal control by:

- Evaluating the effectiveness of NHS England's internal controls, including internal financial controls;

- Assessing NHS England's non-clinical risk management arrangements;
- Assessing the integrity of NHS England's financial reporting and satisfying itself that any significant financial judgements made by management are sound; and,
- Scrutinising the activities and performance of the internal and external auditors, including monitoring their independence and objectivity.

Clinical risk management is considered and monitored by the Quality & Clinical Risk Committee, and reported on to the Board by that Committee.

Committee Composition & Attendance

The Committee is comprised entirely of Non-executive Members. Membership during the financial year and since the year end, and attendance at meetings during the financial year, were as follows:

Membership	Meetings attended/eligible to attend (2013–14)				
	May	Jun	Sept	Dec	Feb
Ed Smith (Chair)	✓	✓	✓	✓	✓
Moira Gibb	✗	✓	✓	✓	✓
Naguib Kheraj (to 10 December 2013)	✓	✓	✓	✓	

The Committee does not have any Sub-committees.

Committee Effectiveness

The Committee has established a work plan for a rolling year forward, which is reviewed and updated at each meeting of the Committee.

During the year the Committee undertook an assessment of its effectiveness, utilising a checklist for Audit Committees produced by the National Audit Office. The outcome of the assessment, together with a proposed action plan, was reported to its April 2014 meeting.

The issues identified covered:

- The need for a formal process to request proposed additional items of business, for each agenda;
- The Committee does not have the authority to co-opt additional members, to provide specialist skills the Committee does not already have (a change to the Committee's terms of reference was approved by the Board on 15 May 2014 to include this);
- The need for a formal induction process for new members; and,
- In 2013–14 the Committee did not formally consider the draft Annual accounts before they were presented to the External Auditors for audit.

The Committee's Work

The Committee's main activities through the year have been:

- Monitoring the financial year end process for 2012–13 and 2013–14 including reviewing and recommending to the Accounting Officer for signature the Annual Report & Accounts, including this governance statement;
- Appointing Deloitte LLP as internal auditors, considering and approving their proposed internal audit programme, monitoring delivery against the plan and receiving and considering the Head of Internal Audit Opinion;
- Reviewing and approving a set of standards and a quality assessment process for Commissioners, developed by NHS Protect, in relation to fraud, bribery and corruption;

- Reviewing and approving a consultation process for a set of standards and a quality assessment process for Commissioners, developed by NHS Protect, in relation to security management;
- Monitoring delivery against the annual counter fraud plan;
- Reviewing the Board Assurance Framework and Risk Management Strategy & Policy; and,
- Receiving and considering other reports from management in accordance with its terms of reference, standing orders and standing financial instructions.

In addition the Audit Committee Chair ran two events for Audit Committee Chairs of clinical commissioning groups. These focused on the role of the Audit Committee and governance arrangements necessary to support the local governance statements, including sources of assurance and how service auditor reporting (particularly over commissioning support unit activity) would work.

The events were well received, providing an opportunity to share not just problems but also the solutions that some clinical commissioning groups had developed. It is planned to run these on a regular basis in the future.

Significant Issues Considered in Relation to the Financial Statements

The Committee considered the appropriateness of, and approved, the proposed accounting policies, in light of the significantly changed size and scope of the organisation. In addition, the Committee considered the critical accounting judgements and key sources of estimation uncertainty, and concluded that the estimates, judgements and assumptions used were reasonable based on the information available and that these had been used appropriately in applying the accounting policies.

Transition Legacy: Through the year the Committee monitored progress on closing down the transition from primary care trusts and strategic health authorities to the new system, and in particular the impact on accounting and operations within NHS England and clinical commission groups.

Management established a programme to manage inherited assets, and correctly allocate relevant items to clinical commissioning groups. The progress of the work was reported to each meeting, together with associated risks and issues.

Organisational Capacity: Throughout the year the Committee monitored management's plans to deliver the Annual Report, Governance Statement and Financial Statements.

The Governance Statement was considered at an early stage in drafting. In addition, the need to get sign off and handover of the Governance Statement from the outgoing to incoming Chief Executive was discussed and agreed with the outgoing Chief Executive.

The Committee considered progress reports from the external auditors at each of its meetings.

Management confirmed, and shared, their plans to utilise additional interim resource to support the delivery of year end.

System Capacity: Capacity within the wider Commissioning System to deliver good quality audited accounts, within the timescales that would allow for both NHS England and the Department of Health to produce and lay in Parliament pre-summer recess consolidated accounts, has been a key area of concern.

The capacity in Commissioning Support Units, as well as the outcome from internal audit work and service auditor reporting work was monitored, and the impact on clinical commissioning group governance statements and external auditor testing, was considered and additional contingent capacity put in place by management in case it was required.

External Audit

The Comptroller & Auditor General is the appointed external auditor for NHS England, in accordance with the National Health Service Act 2006 (as amended). The external audit is delivered by the National Audit Office.

The Audit Committee, via update reports presented by the National Audit Office to each meeting and discussion with both the National Audit Office and management, both at the meeting and outside the meeting, monitors the work of the National Audit Office. This includes consideration of any non-audit related work, and its potential impact on the independence of the National Audit Office.

In addition, the Committee received and considered the National Audit Office's Audit Planning Report and Reports to those Charged with Governance, issued after the interim audit and at the completion of the final audit. Particular focus was placed on considering the audit approach, including proposed timing of audit work, the findings from the audit work and management's responses to recommendations raised.

Through this process the effectiveness of the National Audit Office is constantly being monitored. A formal assessment of the effectiveness of external audit will be undertaken after the completion of the 2013–14 audit process.

Risk Management & Internal Control

The Committee takes an oversight role in relation to risk management process and procedures and internal control.

The Committee considered drafts of the Risk Management Strategy & Policy, and provided comment.

In addition, the Committee reviews the Board Assurance Framework and sources of assurance at each meeting, and considered the proposed changes to the Board Assurance Framework, providing comment for consideration by management.

The Committee oversees the internal control system, primarily through the consideration of the findings of internal audit and management's responses to those findings, and consideration of the sources of external assurance available, in relation to the Board Assurance Framework.

In addition the Committee considers any findings from the work of the external auditors and from counter fraud activity.

Internal Audit

As part of the tenders received from firms for the internal audit contract an indicative three year plan was requested. At the presentation stage firms were asked to present on their proposed plan, and to respond to questions from the panel.

Deloitte LLP, as the successful tenderer, spent time after the award of the contract engaging with all areas of NHS England to validate and refine their proposed plan, including discussions with members of the Committee and Board. The outcome of this process was presented to the Committee in June 2013, discussed and approved.

The same process of engagement across the organisation was utilised in developing the proposed 2014–15 internal audit plan, including individual engagement with Committee members. A draft proposed plan was presented to the April 2014 Committee meeting, with the final plan being approved at the June 2014 meeting.

In both cases the audit plan was referenced back to the strategic objectives of NHS England and the Board Assurance Framework, to ensure key areas of risk had been covered.

As part of the progress report to each Audit Committee, proposals for changes to the audit plan were presented, for Committee consideration and approval.

The effectiveness of internal audit is assessed on an on-going basis, by consideration of their progress reports, particularly focusing on the timing of the delivery of individual audits compared to the approved plan.

Via the progress reports presented to each meeting, the Committee considers all additional work Deloitte is delivering to NHS England, to ensure this does not put at risk the independence or effectiveness of the internal audit service.

A formal assessment of the effectiveness of internal audit was undertaken at the July 2014 meeting, following the completion of the 2013-14 plan.

Via the progress report presented to each meeting, the Committee monitors management's progress on delivering against recommendations raised by internal audit.

During the year there were some limited instances of delays in actioning recommendations, particularly within commissioning support units. The Committee accepted this reflected the considerable amounts of work required across NHS England to embed processes in a new organisation, and a focus on delivering key improvements (particularly for commissioning support units delivering improvements that would support the delivery of 'clean' service auditor reports to the clinical commissioning group customers).

The Committee is actively monitoring the number of overdue actions, to ensure they do not increase to an unacceptable position.

The Commissioning System Governance Framework

In the context of the legislative framework set out in the National Health Service Act 2006, as amended by the Health & Social Care Act 2012 and the National Health Service (Clinical Commissioning Groups) Regulations 2012, NHS England issued guidance (*Towards establishment: Creating responsive and accountable clinical commissioning groups*) to clinical commissioning groups to support them to develop effective governance arrangements. Within the parameters of this framework, clinical commissioning groups were afforded significant flexibility to determine the arrangements that they judged would best enable them to be effective organisations.

Towards establishment: Creating responsive and accountable clinical commissioning groups set out in particular:

- The steps GP practices were to take to establish the clinical commissioning group;

- Why good governance is essential for clinical commissioning groups;
- How to develop the clinical commissioning group's constitution, in order to enshrine the ways in which the organisation will operate, its processes and the committee structures, including the role of the governing body;
- How to develop robust arrangements for accountability, transparency and probity, including managing conflicts of interest;
- The key leadership roles in clinical commissioning groups and how they can be discharged; and,
- How to ensure effective governance where clinical commissioning groups adopt collaborative commissioning arrangements.

Clinical Commissioning Group Constitutions

Schedule 1A of the National Health Service Act 2006 (as amended) sets out the minimum requirements that must be included in a clinical commissioning group constitution. A model constitution was issued by NHS England during 2012 to help clinical commissioning groups develop something that was both locally driven and consistent with national requirements. This can be found on the NHS England website, and requires each clinical commissioning group constitution to address the following issues:

- The arrangements made by the clinical commissioning group for the discharge of its functions, including the role of the governing body, the appointment of any committees or sub-committees and the role of senior individuals such as the Chair, Accountable Officer and Chief Finance Officer;
- The procedures to be followed by the clinical commissioning group and its governing body in making decisions;
- How the clinical commissioning group deals with conflicts of interests, including the arrangements made to maintain, and grant public access to, registers of interests;
- The arrangements made by the clinical commissioning group for ensuring that there is transparency about the decisions of the group and of its governing body. This must include provision for meetings of governing bodies to be open to the public, except where the clinical commissioning group considers that it would not be in the public interest to permit members of the public to attend a meeting or part of a meeting; and,
- A description of the arrangements to secure patient and public involvement and consultation in relation to its commissioning functions and a statement of the principles it will follow in implementing these.

A copy of each clinical commissioning group's proposed constitution was submitted to NHS England, as part of their application for establishment.

Changes to a clinical commissioning group's constitution must be agreed with NHS England, and NHS England has implemented a process for assessing and agreeing changes to clinical commissioning group constitutions.

In addition, a national process for the review of clinical commissioning group constitutions has been put in place to ensure that on an ongoing basis, clinical commissioning group constitutions remain fit for purpose.

Each clinical commissioning group must publish its constitution.

Clinical Commissioning Group Authorisation

Through the authorisation process, NHS England gained assurance that individual clinical commissioning groups were able to commission healthcare safely, discharge responsibly their stewardship of their budget and exercise their functions in relation to improving quality, reducing inequality and being efficient, hence delivering better outcomes within their resources.

The authorisation process was built around six domains, as follows:

- Are patients receiving clinically commissioned, high quality services?
- Are patients and the public actively engaged and involved?
- Are clinical commissioning group plans delivering better outcomes for patients?
- Does the clinical commissioning group have robust governance arrangements?
- Are clinical commissioning groups working in partnership with others?
- Does the clinical commissioning group have strong and robust leadership?

Underpinning each domain were a range of detailed criteria.

Clinical Commissioning Group Assurance

An interim assurance process was published on 7 May 2013 which described quarterly checkpoints, underpinned by a nationally produced balanced scorecard that looked at quality of care, the NHS Constitution, improving health outcomes and finance. In addition, it outlined an annual assessment looking at organisational health and capability, to be focused around the six domains of clinical commissioning and a redefined set of criteria based on those used during authorisation.

The final proposal for clinical commissioning group assurance for quarter three 2013–14 onwards was published in November 2013, together with operational guidance which sets out in more detail the assurance process itself and identifies the key elements of assurance which are linked to the planning framework and which will be monitored on an in-year basis. The framework uses the same six domains that were adopted at authorisation.

The assurance process is undertaken by NHS England area teams who produce on a quarterly basis a report, by clinical commissioning group, summarising areas for development and notable practice. The quarterly report includes a clear assessment on whether NHS England is 'assured' or 'not assured' on the basis of the assurance domains.

Clinical commissioning groups will use their internal processes and structures to monitor their own delivery against statutory requirements, for example towards improving quality, reducing inequalities, and engaging patients and the public. NHS England's assessment of a clinical commissioning group's statutory compliance uses these internal assurances as the basis for the annual assurance assessment.

Where evidence indicates that these duties are not being met, further assurance is sought and support offered as needed. Where relevant, clear improvement trajectories are set out and are subject to further monitoring and discussion. In exceptional circumstances, NHS England may exercise its statutory intervention powers.

The NHS England national support centre is developing some tools to support clinical

commissioning groups in strengthening their governance:

- A self-assessment tool which will enable clinical commissioning group governing bodies to assess their governance efficiency and plan their organisational development; and,
- Case studies of five possible governance models currently used by strong clinical commissioning groups.

The assurance process is overseen at Board level by the Authorisation & Assurance Committee.

NHS England's Risk Management Framework

The key elements of NHS England's *Risk Management Strategy & Policy* are designed to identify and control risks whether strategic, financial, reputational, operational or relating to compliance or health and safety. The *Risk Management Strategy & Policy* was reviewed and updated in April 2013, and is being reviewed as part of the refresh of the *Board Assurance Framework*.

The *Risk Management Strategy & Policy* focuses on a no blame culture, but with clear risk ownership and accountability, seeking to identify improvements and learning from lessons highlighted through risk assessment, adverse events and public feedback.

NHS England employs a standardised methodology in the application of risk grading criteria, which helps to ensure a consistent approach to the prioritisation of risks and the effective targeting of resources.

A co-ordinated programme has been established to ensure effective risk management within NHS England, which includes:

- Directorate risk registers: a list of operational risks monitored and managed by each directorate from which high level (red or amber/red) risks are escalated via the corporate project management office to the Risk Advisory Group, and in turn to the Executive Risk Management Group where required;
- Major organisational programme risks: risks highlighted for the organisation's largest and most high risk projects; and,
- A list of strategic risks facing the delivery of the business plan set out in the *Board Assurance Framework*.

The Executive Risk Management Group supports these three elements. The group is tasked with managing the strategic risks and identifying the highest priority risks in the directorate risk registers and major organisational programme risk registers, so they can be escalated and brought to the attention of the Board, as necessary, for adding to the *Board Assurance Framework*.

The Board agrees the strategic risks that relate to its principal objectives. These form the *Board Assurance Framework*, which has been in use since the establishment of NHS England. It is based on NHS England's corporate objectives as agreed by the Board and is a high level document covering all NHS England's functions, which is reviewed and, if necessary, updated at each Board meeting.

A new *Board Assurance Framework*, including an improved format and new content, is under development. This has been developed in consultation with the Executive Risk Management Group and NHS England staff and reviewed by the Board. Work is being carried out

to ensure this new Framework contains links to all 2014–15 business plan priority areas. As the new *Board Assurance Framework* is developed, the Board will give further consideration to the risk appetite and the approach to risk mitigation it wishes to take for NHS England.

The corporate project management office supports Directorates by providing specialist advice on identifying and assessing risks and working with them to facilitate risk mitigation plans through training, education and other individual support.

Risk management is embedded in the activity of NHS England through:

- The Risk Management Strategy & Policy;
- The Executive Risk Management Group;
- The Risk Advisory Group;
- The Committee structures described in this report;
- Management processes (e.g. using a risk-based approach to help prioritise expenditure);
- The Board's Assurance Framework;
- CCG Assurance Framework (with effect from November 2013);
- Directly Commissioned Services Assurance Framework (with effect from November 2013);
- Risk management skills training including both risk assessments of various types and the mandatory and statutory training programme;
- Incident reporting frameworks (e.g. information governance, business continuity, patient safety and emergency preparedness, resilience and response; and,
- A policy on tackling fraud, bribery and corruption.

Quality & Clinical Risk

Responsibility for mitigating quality and clinical risks in the health system is systemic: no one organisation can be solely responsible for quality.

The primary duty on NHS England in respect of quality is to drive continuous improvement in the quality of services it provides to individuals. NHS England also has responsibility for assuring quality and managing clinical risk in the services it directly commissions, and for ensuring that clinical commissioning groups are assuring quality and managing clinical risk in their commissioned services.

The Board established a Quality & Clinical Risk Committee with overarching responsibility to provide assurance that robust systems and processes are in place to enable NHS England to:

- Fulfil its statutory duty to act with a view to securing continuous improvement in the quality of services provided to individuals; and,
- Identify and effectively manage any quality or clinical risks associated with performing statutory and non-statutory functions.

The Committee reviewed some processes in the year, such as the CCG Assurance Framework and Quality Surveillance Groups. The Committee will continue to seek assurance that processes, which are designed to enable NHS England to manage quality and clinical risk, are robust.

A full report on the work of the Committee is included at Annex C.6.

NHS England Directly Commissioned Services

NHS England assures the quality of, and manages clinical risks in, directly commissioned services in the following ways:

- NHS England area teams' routine contract management with providers, underpinned by data on the quality of services, enables them to assure the quality of commissioned services;
- For specialised commissioning, there is a series of quality dashboards which are updated quarterly;
- For general practice services, we use the GP High Level Indicators & Outcomes which are contained within an online web tool; and,
- Where there are significant concerns, these are on the whole dealt with locally, working with partners, including through Quality Surveillance Groups and using Risk Summits.

Overseeing NHS England's direct commissioning activities is the Directly Commissioned Services Committee. A full report on the work of the Committee is included at Annex C.3.

Clinical Commissioning Group Commissioned Services

NHS England ensures that clinical commissioning groups are assuring quality and managing clinical risks in their commissioning though:

- The CCG Assurance Framework, which includes at domain 1: 'Are patients receiving clinically commissioned, high quality services?'. Area Teams hold quarterly assurance conversations, and are prompted to probe:
  - Whether quality is a core focus of the board of the clinical commissioning group;
  - How far the board has discussions explicitly on quality;
  - How the clinical commissioning group is continuously monitoring quality of services and identifying potential action, and taking action; and,
  - Whether the clinical commissioning group is working with partners in sharing information and taking action, including through Quality Surveillance Groups.
- Data from the NHS England Quality Dashboard and the CCG Outcomes Indicator Set which inform their discussions on quality and outcomes; and,
- Involvement in Quality Surveillance Groups whereby NHS England can also ensure that clinical commissioning groups are identifying and managing clinical risk.

The Authorisation & Assurance Committee oversees how effectively area teams are assuring clinical commissioning groups. A full report on the work of the Committee is included at Annex C.1.

Public Stakeholder Involvement in Risk Management

We are committed to putting citizens at the heart of the NHS by ensuring that people have a voice in shaping and developing our NHS for future generations. This will implicitly involve citizens in shaping and delivering the organisation's responses to identified risks.

Actions related to stakeholder involvement are set out in detail in the Assessment of Public Involvement & Consultation section, earlier in this document.

The Internal Control Framework

The system of internal control is the set of processes and procedures in place in NHS England and each clinical commissioning group to ensure the Commissioning System delivers its policies, aims and objectives. It is designed to identify and prioritise the risks, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically.

The system of internal control allows risk to be managed to a reasonable level rather than eliminating all risk; it can therefore only provide reasonable and not absolute assurance of effectiveness.

Within NHS England, National Directors, Regional Directors, Area Directors and Hosted Body Managing Directors have responsibility for ensuring that their areas of responsibility are managed on the basis of demonstrable and evidenced compliance with the system of internal control. From 2014–15 this will be confirmed by the presentation of a Governance Assurance Statement. In support of this, an internal control framework is being developed, which will contain core assurance standards covering areas such as: planning & delivery; resource management; policy development; risk management; governance of clinical commissioning groups; and, direct commissioning.

Information Governance

The NHS Information Governance Framework sets the processes and procedures by which the NHS handles information about patients and employees, in particular personal identifiable information. The NHS Information Governance Framework is supported by an information governance toolkit, and the annual submission process provides assurances to NHS England, other organisations and to individuals that personal information is dealt with legally, securely, efficiently and effectively.

We place high importance on ensuring there are robust information governance systems and processes in place to help protect patient and corporate information. We have established an information governance management framework and are developing information governance processes and procedures in line with the information governance toolkit. We have required all staff to undertake annual information governance training and have implemented a staff information governance handbook to ensure staff are aware of their roles and responsibilities.

There are processes in place for incident reporting and investigation of serious incidents. We are developing information risk assessment and management procedures, and a programme will be established to fully embed an information risk culture throughout the organisation.

During the year Ed Smith (Non-executive Member) was a member of the Informatics Governance Assurance Review, chaired by the Department of Health. The review looked at existing arrangements relating to informatics programmes and made recommendations for change or improvement. The recommendations have implications system-wide but also create a clear distinction between internal and external issues, with an accepted model for managing cross-organisational information governance issues.

Pension Obligations

As an employer with staff entitled to membership of the NHS Pension Scheme, control measures

are in place to ensure all employer obligations contained within the scheme regulations are complied with. This includes ensuring that deductions from salary, employer's contributions and payments into the scheme are in accordance with the scheme rules, and that member pension scheme records are accurately updated in accordance with the timescales detailed in the regulations.

Equality, Diversity & Human Rights Obligations

Control measures are in place to ensure that NHS England complies with the required public sector equality duty set out in the Equality Act 2010. This is embedded in management processes as:

- A designated part of the gateway process, with a member of the equality and health inequalities team required to review documents prior to publication;
- Internal equality guidance which is available to enable policy makers to take account of equality considerations in order to identify, remove or minimise discriminatory practice against the nine characteristics; and,
- An equality impact assessment template to assist with the identification of discriminatory practice.

Sustainable Development Obligations

NHS England is required to report its progress in delivering against sustainable development indicators.

We are developing plans to assess risks, enhance our performance and reduce our impact, including against carbon reduction and climate change adaptation objectives. This includes establishing mechanisms to embed social and environmental sustainability across policy development, business planning and in commissioning.

We will ensure NHS England complies with its obligations under the Climate Change Act 2008, including the Adaptation Reporting power, and the Public Services (Social Value) Act 2012.

We are also setting out our commitments as a socially responsible employer.

Risk Assessment

NHS England Risks

Risks on the *Board Assurance Framework*, can be found in each set of public Board papers, on the NHS England web site, and a summary of the 2014–15 *Board Assurance Framework* risks is given in the Strategic Report, earlier in this document. The *Board Assurance Framework* summarises the organisation's assessment of the impact and likelihood of each risk, and provides details of sources of assurance and mitigating actions. Note: the descriptions in each case set out risks rather than statements of current fact.

The following risks on the 2013–14 *Board Assurance Framework*, related to specific transition and set up risks:

- **19. Transition – Transfer of Assets & Liabilities:** NHS England faces significant unforeseen liabilities and impairment of assets resulting from the significant structural changes;
- **21. Human Resources:** NHS England is unable to attract suitable candidates to fill key roles;

- **22. Procurement:** NHS England is restricted in the way it operates due to government procurement controls;
- **24. Transition – ICT:** NHS England's Information and Communications Technology (ICT) strategy implementation plan is delayed;
- **25. Organisational Culture:** NHS England fails to create a culture where there is a shared sense of purpose, clarity about our values and behaviours and how we work together and with others; and,
- **30. Immature Systems & Processes:** immature systems and governance processes in NHS England impede the delivery of a number of key objectives.

Clinical Commissioning Group Risks

The principal risks being managed by clinical commissioning groups, as declared in their governance statements, that have the potential to impact across part or all of the Commissioning System, are as follows:

- QIPP (delivery of saving schemes, acute provider activity exceeds plan);
- Not being able to develop value for money systems;
- Overspending on the prescribing budget;
- Failure to maintain financial statutory balance;
- Continuing Health Care claims;
- Inability to validate patient level invoices due to changes in legislation to patient identifiable data;
- Financial risks of legacy share arrangements;
- Lack of staff capacity;
- Commissioning support units (capacity and capability);
- Value for money for outsourced services;
- Impact of Better Care Fund;
- Delivery of NHS Constitution commitments and other key performance standards;
- Successful implementation of out of hospital strategy;
- Failure to engage and manage stakeholders; and,
- Effectiveness of multi-agency arrangements for safeguarding children and looked after adults.

Review of Economy, Efficiency & Effectiveness of the Use of Resources

The healthcare system is facing the challenge of significant and enduring financial pressures. People's need for services will continue to grow faster than funding, meaning that the Commissioning System has to innovate and transform the way it delivers high quality services, within the resources available, to ensure that patients, and their needs, are always put first.

Planning Guidance & Allocations to Clinical Commissioning Groups

In December 2013 NHS England published *Everyone Counts: Planning for Patients 2014–15 to 2018-19*, which sets out a bold framework within which commissioners will need to work with providers and partners in local government

to develop strong, robust and ambitious five year plans to secure the continuity of sustainable high quality care for all.

The planning guidance seeks:

- Strategic plans covering a five year period, with the first two years at operating plan level;
- An outcomes focused approach, with stretching local ambitions expected of commissioners, alongside credible and costed plans to deliver them;
- Citizen inclusion and empowerment, to focus on what patients want and need;
- More integration between providers and commissioners;
- More integration with social care, including co-operation with local authorities on better care fund planning; and,
- Plans to be explicit in dealing with the financial gap and risk and mitigation strategies.

In support of the planning guidance NHS England has issued allocations and running cost allowances for the next two years. In addition, the system has continuing obligations under the Quality, Innovation, Prevention & Productivity programme to deliver savings in future years.

NHS England Budget Setting

The timetable and approach to setting the NHS England budgets for 2014–15, for both running costs and the central programme budget, has been overseen by the Business Planning Committee. The entire process has been built around the structure of the NHS England business plan, and in particular the 31 individual priority initiatives.

The process has involved directorate draft budget submissions, a formal prioritisation challenge process with every national director, Business Planning Committee and Executive Team review and final savings challenges with national directors.

The process has achieved balanced budgets, which are designed to minimise the impact of necessary efficiency savings on the delivery of commitments and avoid redundancy costs. When considering restructuring, wherever possible staff are redeployed within NHS England, rather than assuming redundancy as the default option.

Cabinet Office Efficiency Controls

As part of the Government's control of expenditure NHS England is subject to expenditure controls, in the same way as Government Departments and other arms' length bodies. As a consequence business cases have had to be completed and approved before spending could occur in a range of areas. Initial approval is given by the Efficiency Controls Committee or the Finance & Investment Committee, depending on the area of spend. For spend above certain thresholds in certain categories, approval has also had to be sought from the Department of Health, and in some cases also Ministers, the Cabinet Office and/or HM Treasury.

Review of the Effectiveness of Governance, Risk Management & Internal Control

As Accounting Officer I have responsibility for reviewing the effectiveness of the systems for governance, risk management and internal control within NHS England.

Capacity to Handle Risk

NHS England is committed to providing high quality services in a safe and secure environment. NHS England offers leadership on risk management through a clear *Risk Management Strategy & Policy*.

As Chief Executive I have had responsibility for risk since 1 April 2014. Day to day responsibility for risk management processes within NHS England has been delegated to the National Director: Policy up to 31 March 2014 and to the National Director: Transformation & Corporate Operations from 1 April 2014, with National Directors taking responsibility for specific risk areas as follows:

- National Director: Policy to 31 March 2014, National Director: Transformation & Corporate Operations from 1 April 2014
  - Health & Safety
  - Information Governance
- National Director: Human Resources & Organisation Development to 31 March 2014, National Director: Transformation & Corporate Operations from 1 April 2014
  - Human Resource Management
  - Organisational Development
  - Workforce Equality, Diversity & Inclusion
- Chief Financial Officer
  - Financial

The remit of the National Director: Policy up to 31 March 2014, and the National Director: Transformation & Corporate Operations since 1 April 2014, includes the formal role of Senior Information Risk Officer. Regional Deputy Senior Information Risk Officers have been appointed to support the national Senior Information Risk Officer

NHS England employs a range of specialists to lead on the implementation of risk management strategies. These include the Social & Corporate Responsibility Manager, the Health & Safety Advisor and specialists in information governance, business continuity and emergency preparedness, resilience and response.

The responsibility for risk management is identified across all levels in NHS England – from Board members, through National Directors to all managers and staff.

The detailed arrangements for risk management are set out earlier in this Governance Statement, and my predecessor has certified that they operated effectively during 2013–14.

NHS England is committed to learning from good practice, and works closely with its internal auditors and external specialist bodies. We will continue to develop and enhance our approach to risk management to ensure it remains at the leading edge for a public sector body of our size and complexity.

Sources of Assurance

My review of the effectiveness of the systems for governance, risk management and internal control is informed by the work of the internal auditors. In addition, I have drawn on performance information available to me. My review is also informed by comments made by my predecessor, who was Accounting Officer for 2013–14, the external auditors (the National Audit Office) in their Reports to those Charged with Governance and other reports, including Value for Money Reviews.

The *Board Assurance Framework* itself provides me with evidence that the effectiveness of controls that manage risks to NHS England and the Commissioning System achieving their principal objectives have been reviewed.

I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the Board, the Audit & Risk Assurance Committee and the Quality & Clinical Risk Committee, and a plan to address weaknesses and ensure continuous improvement of the system is in place.

The following information highlights some of the key methods that I and the Board use to be assured the systems for governance, risk management and internal control are effective.

The Board

Board agendas are structured around the key risks and issues affecting the organisation.

The Board periodically reviews the governance framework to ensure it is fit for purpose and approves changes to the framework, Committee structures, Standing Orders, Standing Financial Instructions and the Scheme of Delegation as necessary. This saw new committee structures put in place in April 2013, as the organisation took on its full powers, and revisions to Standing Orders, Standing Financial Instructions and the Scheme of Delegation approved through the year.

The Board reviews the *Board Assurance Framework* at each meeting and receives regular reports from, particularly, the Audit & Risk Assurance Committee and Quality & Clinical Risk Committee, highlighting issues it needs to be aware of or consider.

The Audit & Risk Assurance Committee

A report on the work of the Audit & Risk Assurance Committee is contained earlier in this report. The work of the Committee is a key assurance mechanism for the Board and for me in relation to governance, non-clinical risk management and internal control within NHS England.

After each meeting of the Committee a report is presented to the Board, detailing key items and issues discussed and highlighting matters that the Board needs to consider.

The Quality & Clinical Risk Committee

A report on the work of the Quality & Clinical Risk Committee is contained at Annex C.6. The work of the Committee is a key assurance mechanism for the Board and for me in relation to quality and clinical risk management within NHS England.

After each meeting of the Committee a report is presented to the Board, detailing key items and issues discussed and highlighting matters that the Board needs to consider.

Internal Audit

Following completion of the planned audit work for the financial year for NHS England, the Head of Internal Audit issued an independent and objective opinion on the adequacy and effectiveness of NHS England's system of governance, risk management and internal control. The Head of Internal Audit's overall conclusion stated that:

Based on the summary provided above and in the context of the overall environment for NHS England for 2013–14, in my opinion the frameworks for governance and risk management have been adequate and effective in 2013–14.

With respect to the internal control environment significant effort has been focused on designing and implementing the structure through the 2013–14 year. On this basis and in my opinion the framework for internal control has been designed and evolved with the organisation, for the majority of areas, through the 2013–14 year. At 31 March 2014 the internal control system is largely in place although it has not been possible to test operating effectiveness in a number of areas. In addition, the following factors should be taken into consideration with respect to this assessment:

- *Given the immediacy of the set-up of NHS England not all core processes were designed, in place and operational at the start of the year. Significant effort has been invested over the course of the year to design and embed the processes and in particular the finance and HR processes have evolved over the course of the year although, at year end, there remain some actions to be completed.*
- *Some weaknesses in internal controls in core processes were identified and reported during the internal audit work completed during the year, which were assessed as being fundamental to the system of controls (Priority: Recommendations which are fundamental to the system of controls and upon which the organisation should take immediate action), including procurement, complaints management, payments, payroll, NHS Property Services: governance and relationship management and travel and expenses processes. Management actions have been agreed to address all of these observations, a significant number of which have been completed by year end. However, given the nature of the agreed management actions, some of which require a timeframe in excess of 12 months to implement, not all of these have been completed by year end. Where possible interim solutions have been put in place while activity remains focused on the implementation of the longer term actions.*
- *There were a number of areas of concern identified by NHS England management during the year for example with respect to transitional payroll, specialised commissioning allocations and invoice validation and the processes to account for legacy balances. Projects have been put in place to rectify the identified gaps the majority of which have completed during the year.*
- *There is significant reliance on third party providers of core services including:*
  - *NHS Shared Business Services for the Integrated Single Financial Environment and transaction processing and procurement services;*
  - *NHS Business Services Authority for human resources and procurement services;*

- *McKesson for payroll and travel and expenses transaction processing;*
- *Prop Co for building and estates management; and,*
- *The Health & Social Care Information Centre for data processing.*

The definition of the assurance requirements from these providers has evolved during the year such that the majority will provide a form of assurance at year end. There does however remain a requirement for continuing change with respect to understanding respective responsibilities in an environment where significant transaction processing is provided by a third party.

The Head of Internal Audit Opinion has been considered by the Audit & Risk Assurance Committee, in light of issues reported through the year from individual audit assignments. The Committee has concluded that the Head of Internal Audit Opinion is a balanced and fair assessment of the frameworks in place throughout the year and at the year end.

I concur with the judgement of the Audit & Risk Assurance Committee that progress towards the exemplary regime of internal controls required by an organisation of our significance to the NHS has accelerated as the year has progressed, and I am committed to ensuring that any remaining issues are resolved without delay.

Service Auditor Reports Issued

Commissioning support units provide a range of transactional services to NHS and non-NHS customers. These customers, as well as the Audit & Risk Assurance Committee, the Board and I, require assurance over the effectiveness of the control environment operated by each commissioning support unit and assurance on the adequacy and effectiveness of the key controls in operation.

Internal audit work is prepared for the specific purpose of providing assurance to NHS England. Therefore an internal audit report cannot be relied upon by, or provide assurance to, customers.

Service Auditor Reporting allows a service auditor (Deloitte LLP for commissioning support units) to independently review the control procedures defined by a service organisation to conclude on the design effectiveness and implementation (Type I) or design and operating effectiveness (Type II) of controls to achieve the related control objectives. The output of the review is a report comprising: a report by the directors of the service organisation concerning the control procedures of the service organisation; and a reasonable assurance report by the reporting accountants, explaining the scope of work carried out and giving their conclusion on relevant parts of the directors' report. Such reports provide an efficient way of providing assurance over relevant business process controls to multiple parties and are intended to be restricted to use by the service organisation, its customers and their auditors. Service Organisations, such as commissioning support units, can opt to commission either a Type I or Type II report. A Type I report involves an assessment of controls at a specific point in time. A Type II report involves the assessment of the operating effectiveness of controls over a specified time period.

NHS England has chosen to follow this approach so as to provide assurance in a cost effective and efficient manner for the NHS as a whole, where commissioning support unit activities are concerned, supporting the Value for Money agenda. This efficiency was achieved through economies of scale, central management and

reducing duplication with internal and external audit activity from multiple clinical commissioning groups.

Each commissioning support unit commissioned one or more service auditor reports with an equal mixture of Type I and Type II reports across the commissioning support units. The decision to select either a Type I and Type II report for the various business process areas was based on the maturity and readiness of processes for Service Auditor Reporting. The Type II reports were generally for the final three months of the financial year but in a few cases the period was six months. The majority of the Service Auditor Reports had one or more control objectives which could not be confirmed as having being met either from a control design or operating effectiveness perspective. This is reflective of the maturing control environments at commissioning support units. However, there were no reports which were fully qualified and no assurance given.

The commissioning support units are now focussing on addressing the design and operating effectiveness exceptions that were identified and prevented some of the control objectives from being met. The aim of the commissioning support units is to have no control objective exceptions in 2014–15.

Service Auditor Reports Received

NHS Shared Business Services has provided service auditor reports on the operation of:

- The Integrated Single Financial Environment and the financial processes it operates on behalf of the Commissioning System;
- Procurement processes for NHS England; and,
- Primary care service processes (payments to GPs and Opticians) operated on behalf of the Commissioning System.

The reports for 2013–14 confirmed the service descriptions provided by NHS Shared Business Services were fair, controls relating to control objectives were suitably designed and the controls tested operated effectively throughout the financial year.

NHS Business Services Authority has provided service auditor reports on the operation of prescription and dental payment processes operated on behalf of the Commissioning System. The dental report included a qualified opinion, on the basis that there were instances where user access controls and periodic user access reviews had not been operating as planned and, as a result, controls were not operating effectively to achieve the control objective. Otherwise, the reports for 2013–14 confirmed the service descriptions provided by the NHS Business Services Authority were fair, controls relating to control objectives were suitably designed and the controls tested operated effectively throughout the financial year.

The NHS Electronic Staff Record Programme has provided a service auditor report on the operation of the ESR payroll system platform and associated processes it operates on behalf of the NHS. The report for 2013–14 confirmed the service description provided by the NHS Electronic Staff Record Programme was fair, controls relating to control objectives were suitably designed and the controls tested operated effectively throughout the financial year.

Clinical Commissioning Groups

Some clinical commissioning groups were authorised with conditions, and a small minority also had legal directions put on them. By 1 April 2013, when clinical commissioning groups took on their statutory powers, 106 clinical

commissioning groups were fully authorised, 105 had conditions and 15 had legal directions.

All conditions imposed by NHS England on the authorisation of a clinical commissioning group must be kept under review, with the aim of removing conditions as soon as it is safe to do so. Since 1 April 2013 NHS England area and region teams have been working with clinical commissioning groups to support them in discharging their conditions or directions. The target is for all clinical commissioning groups to be fully authorised.

Reviews of conditions were carried out on a quarterly basis as part of the quarterly checkpoints within the clinical commissioning group assurance framework.

By 1 April 2014 192 clinical commissioning groups were fully authorised, 19 had remaining conditions (on average two and a half conditions per clinical commissioning group) and three of these had legal directions.

Commissioning Support Units

Each commissioning support unit has a management team led by a Managing Director, who is accountable for the business. Each finance function is led by a senior and experienced Director of Finance, with professional oversight from the CSU Transition Team within NHS England.

All commissioning support units have agreed Operating Frameworks in place that are linked to NHS England's *Standing Financial Instructions* and Scheme of Delegation.

During the hosting period the CSU Transition Team is working with commissioning support units to support their development and to provide assurance to the Commissioning Support Committee and Board on their financial and organisational viability. They provide assurance on the level of risk each commissioning support unit poses, through regular performance reports that include information on financial and operational issues.

There is a clear escalation process through the Director of CSU Transition to the Commissioning Support Committee in the event of concerns about viability, adherence to *Standing Financial Instructions* or suspected breaches of governance.

The escalation process process identified both Surrey & Sussex CSU and Anglia CSU as high risk and at risk of failure. The CSU Transition Team proposed interventions for each CSU, and the transition of services to other CSUs was managed in an orderly manner, with no loss of service to clients. The proposed interventions and progress on the transition of services was regularly reported to the Commissioning Support Committee.

Each commissioning support unit is expected to adhere to good governance procedures. They have internal governance leads and a programme of reporting to their management team. The CSU Transition Team undertakes regular assurance visits linked closely to strategic plans.

During the hosting period commissioning support units are subject to the same internal audit and counter fraud arrangements as the rest of NHS England. Details on service auditor reporting arrangements are provided earlier in this Statement.

Complaints

Internal audit completed a readiness assessment of complaints management to evaluate the control framework and to follow up on a previous internal audit, completed in 2012–13. The audit found considerable focus on improving

complaints management, and significant improvements had been made since the last audit in performance and customer satisfaction.

The audit found two areas where controls were not sufficiently robust to provide assurance that key risks were being managed. These were compliance with policy and regulations, and the limited functionality of the complaints management software system.

All the recommendations arising from the audit have been accepted by management, with the majority already recognised, and action plans have been developed. A procurement exercise to replace the current software system has commenced and will be completed in 2014–15.

Major Projects

The independent review into lessons from the introduction of NHS 111 made several recommendations that suggest senior leaders should oversee large and complex programmes in a systematic way. As a result of this, the executive team agreed a set of eight major programmes which are now subject to additional assurance and reporting above and beyond the standard performance assurance process managed by the corporate PMO.

This is an ongoing process with findings reported monthly to the executive team. Risks for the programmes are tracked and managed through directorate and corporate risk management processes, the risk advisory group and the executive risk management group.

Emergency Preparedness, Resilience & Response

The Health & Social Care Act 2012 places upon NHS funded organisations the duty to have an Accountable Emergency Officer with regard to emergency preparedness, resilience and response. Chief Executives of organisations commissioning or providing care on behalf of the NHS will designate the responsibility for emergency preparedness, resilience and response as a core part of the organisations governance and its operational delivery programmes. Barbara Hakin is designated the Accountable Emergency Officer for NHS England.

The role of NHS England is to ensure that the NHS in England is properly prepared to be able to deal with a range of potential disruptive threats to its operation and to take command of the NHS, as required, during emergency situations. Therefore the NHS needs to plan for, and respond to, a wide range of incidents, disruptive challenges or emergencies that could affect health or patient care.

During 2013–14 NHS England was involved in a number of exercises, which have helped to validate the plans in place and training provided. They also identified areas for improvement to work on.

As part of its annual programme, NHS England seeks assurance against the published core standards on the preparedness of NHS England and the NHS in England to respond to an emergency, and that there is resilience in relation to continuing to provide safe patient care. This process informs NHS England's assurance provided to the Department of Health in relation to emergency preparedness, resilience and response.

Assurance for 2013–14 focused on Category 1 responders as defined in the Civil Contingencies Act (2004). The assurance process was undertaken through local assessment by area teams with local health resilience partnership involvement and engagement, reviewed by regions, and regional peer review by the NHS England national emergency preparedness,

resilience and response team. In turn, the NHS England national emergency preparedness, resilience and response team's assessment was peer reviewed by the NHS England north region.

The assurance process identified a number of areas of good practice which enables NHS England to confirm that it and the NHS in England are prepared to respond to an emergency. The assurance process also identified areas for improvement that will further the emergency preparedness, resilience and response capabilities across the NHS in England, with the aim of ensuring full compliance with all the core standards. These areas will form the priorities of the emergency preparedness, resilience and response work programme for 2014–15.

Overall, assurance was gained via the processes undertaken in each region and area that NHS England and the NHS in England is ready to respond to an emergency.

Transition Legacy

Financial balances and contracts moved to new organisations under a legal asset transfer scheme. This has had to be amended during the financial year, as the data necessary to transfer balances accurately to clinical commissioning groups was not available in all cases. This has resulted in non-current assets, intangible assets, associated liabilities and provisions (excluding continuing health care) transferring to clinical commissioning groups and all other assets and liabilities for the commissioning system coming to NHS England.

Staff transferred to new organisations automatically at 1 April 2013, with circa 14,500 transferring into NHS England and the commissioning support units we host. A large number of these staff continued to be involved in closing down old organisations after their transfer, some for considerable periods of time. This has resulted in pressure on the ability of new organisations to perform effectively during their early months.

Finance

The restructuring of commissioning organisations into NHS England and clinical commissioning groups meant there was an opportunity to bring all financial transactions and reporting onto a single integrated financial platform (ISFE: Integrated Single Financial Environment).

The design, set up and implementation of a single financial environment presented major advantages, and has resulted in automatic consolidated financial reporting across all commissioning organisations. This has resulted in prompt month end reporting for management and allows good financial management throughout the year.

Implementing this major project, including all internal control procedures, across 211 clinical commissioning groups, the original 19 commissioning support units and NHS England itself (including its 27 area teams and four regions) has been an enormous challenge. Due to the start-up nature of the project it cannot be said that all desirable financial controls have been in place thoughout the financial year, as procedures and processes fit for the new structures have in many instances been designed through the year. This has resulted in an amount of inefficiency in the form of retrospective checking of transactions and manual mitigating controls, and this will need to be addressed in 2014–15.

However, all significant controls are now in place to provide assurance of a controlled financial environment, which allows NHS England and its

group to report reliably to Parliament and the tax payer.

Anti-Fraud Work

NHS Protect leads on work to identify and tackle crime across the health service. The aim is to protect NHS staff and resources from activities that would otherwise undermine their effectiveness and their ability to meet the needs of patients and professionals. Ultimately, this helps to ensure the proper use of valuable NHS resources and a safer, more secure environment in which to deliver and receive care.

NHS England has been working with NHS Protect over the last year to establish appropriate and efficient anti-fraud arrangements across its own activities and for the wider Commissioning System. In particular we have worked on embedding an anti-fraud culture by:

- Developing an anti-fraud, bribery & corruption policy;
- Working with NHS Protect to develop an e-learning package for staff across the Commissioning System to use as part of mandatory training on an annual basis; and,
- Running facilitated meetings, in collaboration with NHS Protect, with commissioning support units, area, regional and national directorate management teams to consider the anti-fraud, bribery and corruption responsibilities of senior managers, and areas of fraud risk in each business unit.

In addition we:

- Have worked with NHS Protect to develop and approve a set of anti-fraud standards for the Commissioning System (comparable to the standards already developed for providers), supported by a qualitative assessment process (comparable to that operated for providers);
- Have worked with NHS Protect to undertake an intelligence based assessment of likely areas of fraud risk within the Commissioning System, and are now working up a proactive fraud work plan to address the identified areas;
- Are working to conclude an agreement to implement significantly increased measures to detect and prevent prescription fraud and recoup sums not paid; and,
- Have established a reactive counter-fraud service, which has taken over all open cases attributable to NHS England from the old system, and is progressing them to closure.

Commissioning support units have developed/ maintained a counter fraud work programme, appropriate to the services they provide.

Human Resources

As a new organisation, NHS England had the challenge of not only designing a new organisational structure but populating this through both restricted and open competition. Addressing issues of redundancy mitigation meant that populating the core staffing structure for 1 April 2013 was challenging, and recruitment activity has continued throughout 2013–14. In addition to core staffing requirements, the 'lift and shift' transfer of primary care support services and the former NHS improvement bodies has resulted in significant

post transition workforce transformation programmes, which will continue into 2014–15.

Given the high volume of recruitment activity required throughout 2013–14, NHS England has not been able to achieve 100% staffing levels, and at times under-resourcing in some teams and hard to fill roles in particular professional areas, such as finance and communications, have created short-term capacity challenges.

To ensure that specific capacity gaps and capability deficits can be addressed, NHS England has utilised a number of off payroll workers during the year. The implementation of the Crown Commercial Services contingent labour one framework will standardise and enhance controls in this area, with greater cost control discipline to be applied during 2014–15 and any extension of contractors/interim workers to be carefully reviewed against budgeted establishment requirements and workforce planning needs.

Human resources governance arrangements for the establishment of all senior posts paid in excess of £100,000 per annum are carefully managed via the Executive HR Sub-committee, chaired by the Chief Executive, and reported to the Remuneration & Terms of Service Committee. The Committee also manages all redundancy business cases and ensures compliance with Department of Health and HM Treasury approvals processes in such matters.

Given the scale of transition, pragmatic decisions were reached with the recognised trade unions to implement a range of transitional and legacy human resources policies and procedures to ensure that day one operation could commence. During the course of the year, significant progress to establish NHS England human resources policies has taken place with key policies having been developed and approved.

Payroll

Payroll operations for day one were carefully managed via the workforce transition arrangements, resulting in the successful operation of payroll in April 2013. Whilst it was recognised that some payroll errors occurred during month one, the mitigation arrangements ensured that these were quickly rectified and reduced. During the following months, the payroll implementation programme led to a normalised service operation and business as usual payroll management being implemented.

Payroll service effectiveness has reached an accuracy rate in excess of 99% per month, with major reductions in the level of both supplementary and emergency payments required.

A Joint Operational Payroll User Group meets monthly, and quarterly ‘stocktake’ meetings occur between NHS England and McKesson.

As part of managing business travel and expense arrangements, the Crown Commercial Services let contract with Redfern is utilised to provide a travel booking system, to reduce costs and deliver efficiencies.

This approach has had variable levels of success during the year, in part because of transition arrangements and also because of initial manual processes involving paper based expenses claims systems. The management of such processes is being strengthened with the rapid deployment and roll out of the electronic staff record employee self-service and manager self-service functionality, along with electronic expenses processing during 2014–15.

Corporate Information & Communications Technology

The key activity over the past year for Corporate ICT has been to deploy the OpenService platform across the national support centres, regional and area team offices. Whilst there have been some technical and performance challenges, good progress has been made with over 80% of areas now live on OpenService.

During the process of deploying OpenService, a quantity of legacy data was securely transferred to the OpenService platform and, in addition, data bearing legacy assets follow an agreed secure process of cleansing and/or disposal. An internal audit review of the OpenService deployment gave an opinion of 'substantial assurance'.

Further work is taking place to improve the overall user experience and support offerings from Corporate ICT.

NHS Property Services & Community Health Partnerships

NHS Property Services Ltd and Community Health Partnership Ltd are two private companies created as a result of the NHS reorganisation to own and manage NHS property used and/or previously owned by commissioning organisations.

Transferring all property and then charging the appropriate organisations within the new system has proved a challenging exercise in 2013–14. Due to the lack of reliable data on which to bill organisations based on actual properties, NHS Property Services, Community Health Partnerships, the Department of Health and NHS England agreed a scheme which saw 2013–14 charges based on the original allocations made to budget holders within NHS England and clinical commissioning groups.

This process, whilst an improvement on attempting to bill on insufficiently documented actuals, has not been without its problems, and we expect to move to charging on actuals from 2014–15.

Data Quality

The Board receives an integrated performance report that covers finance and operational performance, for NHS England as well as the wider Commissioning System and NHS.

The data contained in the report is subject to significant scrutiny and review, both by management and constituent parts by various Groups and Board Committees.

During the year the internal auditors reviewed the processes for the production of the report, and provided an opinion of substantial assurance. In addition they have reviewed the detailed processes for producing and scrutinising financial information and provided recommendations for strengthening processes and procedures further.

The Board is confident that the information it is presented with has been through appropriate review and scrutiny, and continues to develop as the organisation matures.

Business Critical Models

NHS England recognises the importance of quality assurance across the full range of its analytical work.

In partnership with analysts in the Department of Health we have developed an approach that is fully consistent with the recommendations in Sir Nicholas Macpherson's review of quality assurance of government models. The framework includes a programme of mandatory workshops for NHS England analysts, which

highlights the importance of quality assurance across the full range of analytical work.

For business critical models, where an error would have a significant reputational, financial or patient care impact, we have agreed with the Department of Health a joint approach that audits the quality assurance strategy of the models. This is overseen by a joint committee of experienced analysts.

Discharge of Statutory Functions

During establishment, the arrangements put in place by NHS England and explained within the *Corporate Governance Framework* were developed with extensive expert external legal input, to ensure compliance with the all relevant legislation. That legal advice also informed the matters reserved for Board decision and the scheme of delegation.

In light of the Harris Review, NHS England has reviewed all of the statutory duties and powers conferred on it by the National Health Service Act 2006 (as amended) and other associated legislative and regulations. As a result, I can confirm that NHS England is clear about the legislative requirements associated with each of the statutory functions for which it is responsible, including any restrictions on delegation of those functions.

Responsibility for each duty and power has been clearly allocated to a lead National Director.

NHS England Data Security

We have submitted a satisfactory level of compliance with the information governance toolkit assessment for the national support centre and have improvement plans in place for all region and area teams to be compliant by 30 June 2014. Commissioning support units have all submitted information governance toolkit assessments that are satisfactory.

Serious untoward incidents involving personal data, as reported to the Information Commissioner's Office in 2013–14, relating to the NHS England national support centres, regional and area teams, were as follows:

Date of incident	Nature of incident	Paper or electronic information	Nature of data involved	Number of people potentially affected	Notification steps
6 January 2014	An area team unable to locate a box of Temporary Resident forms relating to patients who have attended a GP Surgery whilst visiting the locality (the forms have subsequently been located)	Paper	Personal Sensitive Data (patient)	1,000+	Logged as a reportable incident on the IG Toolkit. Information Commissioners Office responded and advised to undertake a review and establish lessons learnt

Serious untoward incidents involving personal data, as reported to the Information Commissioners Office in 2013–14, relating to commissioning support units, were as follows:

Date of incident	Nature of incident	Paper or electronic information	Nature of data involved	Number of people potentially affected	Notification steps
14 June 2013	An email that contained 400+ payslips from a commissioning support unit was sent to an ex-employee (external)	Electronic	Personal Sensitive Data (staff)	400+	Reported to the SIRO – CSU. Logged as a reportable incident on the IG Toolkit. Information Commissioners Office responded no further action required
1 December 2013	Unencrypted memory stick found on secure NHS premises containing personal confidential data from a commissioning support unit (external)	Electronic	Personal Confidential Data (patient)	80	Reported to the SIRO – CSU. Logged as a reportable incident on the IG Toolkit. Information Commissioners Office responded no further action required
30 January 2014	Pharmacy invoices found in a (secure) cupboard in the finance department of a commissioning support unit which contained sensitive personal data of patients (internal)	Paper	Personal Sensitive Data (patient)	1,000's	Reported to the SIRO – CSU. Logged as a reportable incident onto the IG Toolkit and onto STEIS. Investigation Pending
6 February 2014	Data file sent from a commissioning support unit to a Manager for Primary Care Intelligence at Cross City for Jiggins Lane Practice Patients. Upon opening the file it was noticed that it also contained Personal Confidential Data for another practice (external)	Electronic	Personal Confidential Data (patient)	Potentially over 1,000	Reported to the SIRO – CSU. Logged as a reportable incident on the IG Toolkit. Investigation Pending

The number of other personal data related incidents in 2013–14, was as follows:

Category	Nature of Incident	NHS England	Commissioning Support Units	Total
I	Loss of inadequately protected electronic equipment, devices or paper documents from secured NHS premises	15	0	15
II	Loss of inadequately protected electronic equipment, devices or paper documents from outside secured NHS premises	2	5	7
III	Insecure disposal of inadequately protected electronic equipment, devices or paper documents	2	0	2
IV	Unauthorised disclosure	27	11	38
V	Other	8	0	8

The Commissioning System Data Security

Details of individual incidents are included in the Governance Statement for each clinical commissioning group.

The total number of personal data related incidents in clinical commissioning groups during 2013–14, was as follows:

Category	Nature of Incident	Total
I	Loss of inadequately protected electronic equipment, devices or paper documents from secured NHS premises	58
II	Loss of inadequately protected electronic equipment, devices or paper documents from outside secured NHS premises	3
III	Insecure disposal of inadequately protected electronic equipment, devices or paper documents	2
IV	Unauthorised disclosure	36
V	Other	38

Conclusion

The governance arrangements appropriate to a £60m organisation are fundamentally different from those required to run a £96.6bn organisation, and we are committed to putting in place exemplary standards of governance, risk management and internal control.

Standards of risk management and governance have been strong from the start of the year and continually improving during the course of the year, as evidenced by the Head of Internal Audit Opinion, which informs my assessment.

As my predecessor, Sir David Nicholson, who was the Accounting Officer in the period April 2013 to March 2014 has identified, as a new organisation, the internal control processes and procedures one would expect in a mature, stable organisation were not all in place on 1 April 2013. Whereas arrangements in an established organisation would be well embedded and operating effectively throughout the year, this statement has described arrangements that have been developing and embedding over the financial year, and up to the date of signing this statement, and in some cases have therefore not operated effectively over the whole period.

Some processes and/or procedures have performed well, some have required improvement and some were missing and have been developed during the year. This process of refining and improving will continue during 2014–15, as the organisation moves towards a more steady state.

The consequence of this developing system of systematised internal control is that compensating controls have had to be maintained to provide a safe financial reporting environment. This has resulted in a significant burden on already stretched teams across NHS England and the wider Commissioning System. It is an enormous tribute to their professionalism

and dedication that the year end accounts for our first year of operation have been delivered to time, with universally unqualified true and fair opinions and with no significant changes to financial performance, and I would like to express my sincere gratitude to all concerned.

Simon Stevens
Accounting Officer

10 July 2014

Annual Accounts

The Certificate & Report of the Comptroller & Auditor General to the Houses of Parliament

I certify that I have audited the Financial Statements of the National Health Service Commissioning Board for the year ended 31 March 2014 under the Health & Social Care Act 2012. The Financial Statements comprise: the Group and National Health Service Commissioning Board 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 Report that is described in that Report as having been audited.

Respective Responsibilities of the Board, Accounting Officer and Auditor

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

Scope of the Audit of the Financial Statements

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

I am required to obtain evidence sufficient to give reasonable assurance that the expenditure and income recorded in the Financial Statements have been applied to the purposes intended by Parliament and the financial transactions recorded in the Financial Statements conform to the authorities which govern them.

Opinion on Regularity

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

Opinion on Financial Statements

In my opinion:

- The Financial Statements give a true and fair view of the state of the Group's and of the National Health Service Commissioning Board's affairs as at 31 March 2014 and of the Group's and the National Health Service Commissioning Board's net expenditure for the year then ended; and,
- The Financial Statements have been properly prepared in accordance with the Health & Social Care Act 2012 and Secretary of State directions issued thereunder.

Opinion on Other Matters

In my opinion:

- The part of the Remuneration Report to be audited has been properly prepared in accordance with Secretary of State directions made under the Health & Social Care Act 2012; and,
- The information given in the Strategic and Directors' Reports 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 part of the Remuneration Report to be audited are not in agreement with the accounting records and returns; or,
- I have not received all of the information and explanations I require for my audit; or,
- The Governance Statement does not reflect compliance with HM Treasury's guidance.

Report

I have no observations to make on these Financial Statements.

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

11 July 2014

Statement of Comprehensive Net Expenditure for the year ended 31 March 2014

	Note	Parent 2013–14 £000	Parent 6 months to 31 March 2013 £000	Consolidated Group 2013–14 £000	Consolidated Group 6 months to 31 March 2013 £000
Administration income and expenditure					
Other operating revenue	2	**(548,379)**	(208)	**(137,269)**	(208)
Employee benefits	3	**762,013**	11,850	**1,271,301**	11,850
Operating expenses	4	**1,908,355**	31,709	**938,860**	31,709
Net administration expenditure before interest		**2,121,989**	43,351	**2,072,892**	43,351
Programme income and expenditure					
Other operating revenue	2	**(1,568,315)**	0	**(1,706,099)**	0
Employee benefits	3	**108,899**	0	**257,767**	0
Operating expenses	4	**90,423,278**	0	**93,887,559**	0
Net programme expenditure before interest		**88,963,862**	0	**92,439,227**	0
Total income and expenditure					
Other operating revenue	2	**(2,116,694)**	(208)	**(1,843,368)**	(208)
Employee benefits	3	**870,912**	11,850	**1,529,068**	11,850
Operating expenses	4	**92,331,633**	31,709	**94,826,419**	31,709
Net operating expenditure before interest		**91,085,851**	43,351	**94,512,119**	43,351
Other losses	10	**27**	0	**715**	0
Finance costs		**6,092**	0	**6,150**	0
Net operating expenditure for the financial year		**91,091,970**	43,351	**94,518,984**	43,351
Net loss on transfers by absorption	6	**95,686**	5,963	**95,686**	5,963
Net operating expenditure for the financial year including absorption losses		**91,187,656**	49,314	**94,614,670**	49,314

Other comprehensive net expenditure

Items that will not be reclassified to net operating expenditure					
Impairments and reversals		**1,764**	0	**1,778**	0
Movements in other reserves		**0**	0	**(4,176)**	0
Total comprehensive net expenditure for the year		**91,189,420**	49,314	**94,612,272**	49,314

The notes on pages 137 to 172 form part of this statement.

All income and expenditure is derived from continuing operations.

Statement of Financial Position as at 31 March 2014

	Note	Parent 31 March 2014 £000	Parent 31 March 2013 £000	Consolidated Group 31 March 2014 £000	Consolidated Group 31 March 2013 £000
Non-current assets:					
Property, plant and equipment	10	**161,180**	3,509	**183,949**	3,509
Intangible assets	11	**7,860**	116	**8,805**	116
Trade and other receivables	13	**5,483**	0	**5,485**	0
Total non-current assets		**174,523**	3,625	**198,239**	3,625
Current assets					
Inventories	12	**454**	0	**1,715**	0
Trade and other receivables	13	**287,353**	15,902	**741,369**	15,902
Cash and cash equivalents	14	**391,990**	0	**424,044**	0
Total current assets		**679,797**	15,902	**1,167,128**	15,902
Total assets		**854,320**	19,527	**1,365,367**	19,527
Current liabilities					
Trade and other payables	15	**(2,728,264)**	(20,704)	**(6,753,949)**	(20,704)
Borrowings	16	**(1,006)**	(13,606)	**(4,129)**	(13,606)
Provisions	17	**(421,504)**	(31)	**(476,976)**	(31)
Total current liabilities		**(3,150,774)**	(34,341)	**(7,235,054)**	(34,341)
Total assets less net current liabilities		**(2,296,454)**	(14,814)	**(5,869,687)**	(14,814)
Non-current liabilities					
Trade and other payables	15	**(2,457)**	0	**(6,376)**	0
Other financial liabilities		**0**	0	**(25)**	0
Borrowings	16	**(3,015)**	0	**(4,377)**	0
Provisions	17	**(408,102)**	0	**(423,155)**	0
Total non-current liabilities		**(413,574)**	0	**(433,933)**	0
Net liabilities		**(2,710,028)**	(14,814)	**(6,303,620)**	(14,814)
Financed by taxpayers' equity					
General fund		**(2,710,192)**	(14,814)	**(6,298,186)**	(14,814)
Revaluation reserve		**164**	0	**337**	0
Other reserves		**0**	0	**(5,771)**	0
Total taxpayers' equity		**(2,710,028)**	(14,814)	**(6,303,620)**	(14,814)

The notes on pages 137 to 172 form part of this statement.

The financial statements on pages 132 to 172 were approved by the Board on 10 July 2014 and signed on its behalf by:

Simon Stevens
Accounting Officer

Parent Statement of Changes in Taxpayers' Equity for the year ended 31 March 2014

	General Fund £000	Revaluation Reserve £000	Other Reserves £000	Total Reserves £000
Balance at 1 April 2013	(14,814)	0	0	**(14,814)**
Transfer of assets and liabilities from closed NHS bodies as a result of the 1 April 2013 transition	(4,969,340)	1,928	0	**(4,967,412)**
Adjusted balance at 1 April 2013	(4,984,154)	1,928	0	**(4,982,226)**
Changes in taxpayers' equity for 2013–14				
Net operating expenditure for the financial year including absorption losses	(91,187,656)	0	0	**(91,187,656)**
Impairments and reversals	0	(1,764)	0	**(1,764)**
Net recognised expenditure for the financial year	(91,187,656)	(1,764)	0	**(91,189,420)**
Grant in aid	93,461,618	0	0	**93,461,618**
Balance at 31 March 2014	(2,710,192)	164	0	**(2,710,028)**

	General Fund £000	Revaluation Reserve £000	Other Reserves £000	Total Reserves £000
Balance at 1 October 2012	0	0	0	**0**
Changes in taxpayers' equity for 6 months to 31 March 2013				
Net operating expenditure for the financial year including absorption losses	(49,314)	0	0	**(49,314)**
Net recognised expenditure for the financial year	(49,314)	0	0	**(49,314)**
Grant in aid	34,500	0	0	**34,500**
Balance at 31 March 2013	(14,814)	0	0	**(14,814)**

Consolidated Statement of Changes in Taxpayers' Equity for the year ended 31 March 2014

	General Fund £000	Revaluation Reserve £000	Other Reserves £000	Total Reserves £000
Balance at 1 April 2013	(14,814)	0	0	**(14,814)**
Transfer of assets and liabilities from closed NHS bodies as a result of the 1 April 2013 transition	(5,131,017)	2,812	(9,947)	**(5,138,152)**
Adjusted balance at 1 April 2013	(5,145,831)	2,812	(9,947)	**(5,152,966)**
Changes in taxpayers' equity for 2013–14				
Net operating expenditure for the financial year including absorption losses	(94,614,670)	0	0	**(94,614,670)**
Impairments and reversals	0	(1,778)	0	**(1,778)**
Movements in other reserves	0	0	4,176	**4,176**
Release of reserves to the Statement of Comprehensive Net Expenditure	697	(697)	0	**0**
Net recognised expenditure for the financial year	(94,613,973)	(2,475)	4,176	**(94,612,272)**
Grant in aid	93,461,618	0	0	**93,461,618**
Balance at 31 March 2014	(6,298,186)	337	(5,771)	**(6,303,620)**

	General Fund £000	Revaluation Reserve £000	Other Reserves £000	Total Reserves £000
Balance at 1 October 2012	0	0	0	**0**
Changes in taxpayers' equity for 6 months to 31 March 2013				
Net operating expenditure for the financial year including absorption losses	(49,314)	0	0	**(49,314)**
Net recognised expenditure for the financial year	(49,314)	0	0	**(49,314)**
Grant in aid	34,500	0	0	**34,500**
Balance at 31 March 2013	(14,814)	0	0	**(14,814)**

Statement of Cash Flows for the year ended 31 March 2014

	Note	Parent 2013–14 £000	Parent 6 months to 31 March 2013 £000	Consolidated Group 2013–14 £000	Consolidated Group 6 months to 31 March 2013 £000
Cash flows from operating activities					
Net operating expenditure for the financial year		**(91,091,970)**	(43,351)	**(94,518,984)**	(43,351)
Depreciation and amortisation	4	**35,043**	168	**44,419**	168
Impairments and reversals	4	**115,550**	0	**118,406**	0
Unwinding of discount	17	**6,092**	0	**6,095**	0
Loss on disposal		**27**	0	**715**	0
Movement due to transfers by modified absorption		**(4,434,624)**	(12,617)	**(4,632,122)**	(12,617)
Increase in inventories	12	**(454)**	0	**(1,715)**	0
Increase in trade & other receivables	13	**(276,936)**	(15,902)	**(730,952)**	(15,902)
Increase in trade & other payables	15	**2,675,593**	34,310	**6,702,325**	34,310
Less movements in payables relating to items not passing through the Statement of Comprehensive Net Expenditure		**0**	(15,368)	**0**	(15,368)
Provisions utilised	17	**(77,187)**	0	**(78,264)**	0
Increase in provisions	17	**42,724**	0	**114,428**	0
Net cash outflow from operating activities		**(93,006,142)**	(52,760)	**(92,975,649)**	(52,760)
Cash flows from investing activities					
Payments for property, plant and equipment		**(48,822)**	(1,471)	**(50,321)**	(1,471)
Payments for intangible assets		**(1,058)**	0	**(1,121)**	0
Net cash outflow from investing activities		**(49,880)**	(1,471)	**(51,442)**	(1,471)
Net cash outflow before financing activities		**(93,056,022)**	(54,231)	**(93,027,091)**	(54,231)
Cash flows from financing activities					
Grant in aid funding received		**93,461,618**	40,625	**93,461,618**	40,625
Net cash inflow from financing activities		**93,461,618**	40,625	**93,461,618**	40,625
Net increase/(decrease) in cash & cash equivalents		**405,596**	(13,606)	**434,527**	(13,606)
Cash & cash equivalents at the beginning of the financial year	16	**(13,606)**	0	**(13,606)**	0
Cash & cash equivalents at the end of the financial year	14	**391,990**	(13,606)	**420,921**	(13,606)

Notes to the Financial Statements

1. Statement of Accounting Policies

These financial statements have been prepared in accordance with the 2013–14 Government Financial Reporting Manual (FReM) issued by HM Treasury. The accounting policies contained in the FReM apply International Financial Reporting Standards (IFRS) as adapted or interpreted for the public sector context. Where the FReM permits a choice of accounting policy, the accounting policy which is judged to be most appropriate to the particular circumstances of NHS England for the purpose of giving a true and fair view has been selected. The particular policies adopted by NHS England are described below. They have been applied consistently in dealing with items considered material to the accounts.

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

The 2013–14 Annual Report & Accounts includes two departures from the FReM, which have been agreed with HM Treasury and the Department of Health:

- Transfer of assets and liabilities from organisations that closed on 1 April 2013, as a result of their abolition under the Health & Social Care Act 2012, have been made using a modified form of absorption accounting, under which the net gain or loss on absorption is debited or credited to the general fund rather than to the Statement of Comprehensive Net Expenditure; and,
- All assets and liabilities from organisations that closed on 1 April 2013 that were allocated to a successor organisation falling within the NHS England group have been recorded by the parent, with the exception of non-current assets, inventories and their closely-related liabilities (meaning those specific liabilities which represent the financing or similar liabilities incurred in the purchase or leasing of those non-current assets). Such items have been accounted for by the relevant clinical commissioning group.

1.1 Operating Segments

Income and expenditure items are analysed in the Operating Segments note (note 9) 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 9.

1.2 Accounting Convention

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

1.3 Basis of Consolidation

These accounts comprise the results of the NHS England statutory entity (referred to as "the Parent") as well as the consolidated position of NHS England and its 211 related clinical commissioning groups. Transactions between entities included in the consolidation are eliminated.

Commissioning support units (CSUs) form part of NHS England and provide services to clinical commissioning groups (CCGs). Commissioning support unit results are included within the Parent accounts.

1.4 Comparative Information

The comparative information provided in these financial statements relates to the six month period ended 31 March 2013, NHS England's initial period of operation.

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. Parliament has demonstrated its commitment to fund the Department of Health for the foreseeable future via the latest Spending Review and the passing of the Health & Social Care Act 2012. In the same way, the Department of Health has demonstrated commitment to the funding of NHS England, with funding flows for the 2014–15 financial year having already commenced. It is therefore considered appropriate to adopt the going concern basis for the preparation of these financial statements.

1.6 Revenue Recognition

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

Other operating revenue in respect of fees, charges and services is recognised when the service is rendered and the stage completion of the transaction at the end of the reporting period can be measured reliably, and it is probably that economic benefit associated with the transaction will flow to the group. Income is measured at fair value of the consideration receivable. Where income is received for a specific activity which is to be delivered in the following financial year, that income is deferred.

1.7 Employee Benefits

Recognition of short-term benefits – retirement benefit costs:

Most past and present employees are covered by the provisions of the NHS Pension Scheme. The scheme is an unfunded, defined benefit scheme that covers NHS employers, general practitioners and other bodies allowed under the direction of the Secretary of State for Health in England and Wales. The scheme is not designed to be run in a way that would enable NHS bodies to identify their share of the underlying assets and liabilities. Therefore, the scheme is accounted for as if it were a defined contribution scheme. The cost recognised in these accounts represents the contributions payable for the year. Details of the benefits payable under these provisions can be found on the NHS Pensions website.

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

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

1.8 Administration & Programme Expenditure

The Statement of Comprehensive Net Expenditure is analysed between administration and programme expenditure, as defined by HM Treasury. In addition to the costs of running NHS England, administration costs in the consolidated accounts include the running costs associated with the commissioning functions of clinical commissioning groups. Administration costs are those that do not relate directly to the provision of front-line services.

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

1.9 Value Added Tax

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

1.10 Property, Plant & Equipment

1.10.1 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.

1.10.2 Valuation of Property, Plant & Equipment

All property, plant and equipment is measured initially at cost, representing the cost directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management. All assets are measured subsequently at fair value. Revaluations of property, plant and equipment are performed with sufficient regularity to ensure that carrying amounts are not materially different from those that would be determined at the end of the reporting period. Fair values are determined as follows:

- Land and non-specialised buildings: market value for existing use; and,
- Specialised buildings: depreciated replacement cost, modern equivalent asset basis.

Where an asset has been revalued, the accumulated depreciation at the date of revaluation is eliminated against the gross carrying amount of the asset and the net amount restated to the revalued amount of the asset.

Properties in the course of construction for service or administration purposes are carried at cost, less any impairment loss. Cost includes professional fees but not borrowing costs, which are recognised as immediately as an expense as allowed by IAS 23 for assets held at fair value. Assets are revalued and depreciation commences when they are brought into 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 fair value. This is in accordance with FReM requirements as these assets have short useful lives or low values or both.

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

1.10.3 Subsequent Expenditure

Where subsequent expenditure enhances an asset beyond its original specification, the directly attributable cost is capitalised. Where subsequent expenditure restores the asset to its original specification, the expenditure is capitalised and any existing carrying value of the item replaced is charged to operating expenses.

1.11 Intangible Non-current Assets

Intangible non-current assets are non-monetary assets without physical substance that are capable of sale separately from the rest of the group's business or arise from contractual or other legal rights. They are recognised only when it is probable that future economic benefits will flow to, or service potential be provided to, the group; where the cost of the asset can be measured reliably; and where the cost is at least £5,000.

Intangible non-current assets acquired separately are initially recognised at fair value. 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 fair value by reference to an active market, or, where no active market exists, at replacement cost if the asset is not yet available for use or amortised replacement cost if it is, as a proxy for fair value.

1.12 Research & 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; and,
- The ability to reliably measure the expenditure attributable to the intangible asset during its development.

The amount initially recognised for internally generated intangible assets is the sum of the expenditure incurred from the date when the criteria for recognition are initially met. Where no internally-generated intangible asset can be recognised, the expenditure is recognised in the period in which it is incurred.

1.13 Depreciation, Amortisation & 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 & machinery	5	10
Transport equipment	5	10
Information technology	2	10
Furniture & fittings	5	10
Computer software: purchased	2	5
Licences & trademarks	2	5
Development expenditure (internally generated)	2	5

A revaluation decrease that does not result from a loss of economic value or service potential is recognised as an impairment charged to the revaluation reserve to the extent that there is a balance on the reserve for the asset being impaired and, thereafter, to expenditure. Impairment losses that arise from a clear consumption of economic benefit are taken to expenditure. Where an impairment loss subsequently reverses, the carrying amount of the asset is increased to the revised estimate of the recoverable amount but capped at the amount that would have been determined had there been no initial impairment loss. The reversal of the impairment loss is credited to expenditure to the extent of the decrease previously charged there and thereafter to the revaluation reserve.

1.14 Leases

Leases are classified as finance leases when substantially all the risks and rewards of ownership are transferred to the lessee. All other leases are classified as operating leases.

Property, plant and equipment held under finance leases are initially recognised at the inception of the lease at fair value or, if lower, at the present value of the minimum lease payments, with a matching liability for the lease obligation to the lessor. Lease payments are apportioned between finance charges and reduction of the lease obligation to achieve a constant rate of interest on the remaining balance of the liability. Finance charges are recognised in the Statement of Comprehensive Net Expenditure.

Operating lease payments are recognised as an expense on a straight-line basis over the lease term. Lease incentives are recognised initially as a liability and subsequently as a reduction of rentals on a straight-line basis over the lease term.

Contingent rentals are recognised as an expense in the period in which they are incurred.

Where a lease is for land and buildings, the land and building components are separated and individually assessed as to whether they are operating or finance leases.

1.15 Inventories

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

1.16 Cash & 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 3 months or less from the date of acquisition and are readily convertible to known amounts of cash with insignificant risk of change in value.

In the Statement of Cash Flows, cash and cash equivalents are shown net of bank overdrafts that are repayable on demand and that form an integral part of cash management. Cash, bank and overdraft balances are recorded at current values.

1.17 Provisions

Provisions are recognised when there exists a present legal or constructive obligation as a result of a past event, it is probable that the group will be required to settle the obligation, and a reliable estimate can be made of the amount of the obligation. The amount recognised as a provision is the best estimate of the expenditure required to settle the obligation at the end of the reporting period, taking into account the risks and uncertainties. Where a provision is measured using the cash flows estimated to settle the obligation, its carrying amount is the present value of those cash flows using HM Treasury's discount rates.

Provisions are subject to three separate discount rates according to the expected timing of cashflows:

- A short term rate of minus 1.90% (2012–13: minus 1.80%) is applied to expected cash flows in a time boundary of between 0 and up to and including 5 years from the Statement of Financial Position date;
- A medium term rate of minus 0.65% (2012–13: minus 1.00%) is applied to the time boundary of after 5 and up to and including 10 years; and,
- A long-term rate of 2.20% (2012–13: 2.20%) is applied to expected cashflows exceeding 10 years.

All percentages are in real terms.

1.18 Clinical Negligence Costs

The NHS Litigation Authority operates a risk pooling scheme under which NHS England and clinical commissioning groups pay an annual contribution to the NHS Litigation Authority, which in turn settles all clinical negligence claims. The contribution is charged to expenditure. Although the NHS Litigation Authority is administratively responsible for all clinical negligence cases, the liability rests with the individual body concerned.

1.19 Non-clinical Risk Pooling

NHS England and clinical commissioning groups participate in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the individual body concerned pays an annual contribution to the NHS Litigation Authority and, in return, receives assistance with the cost of claims arising. The annual membership contributions, and any excesses payable in respect of particular claims, are charged to operating expenses when they become due.

1.20 Contingent Liabilities & 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; or,
- 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 IAS 37 are stated at discounted amounts.

1.21 Financial Assets

Financial assets are recognised on the Statement of Financial Position when the group becomes party to the financial instrument contract or, in the case of trade receivables, when the goods or services have been delivered. Financial assets are de-recognised when the contractual rights have expired or the asset has been transferred. Financial assets are initially recognised at fair value. Fair value is determined by reference to quoted market prices where possible, otherwise by valuation techniques.

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

At the Statement of Financial Position date, the group assesses whether any financial assets are impaired. Financial assets are impaired, and impairment losses recognised, if there is objective evidence of impairment as a result of one or more events which occurred after the initial recognition of the asset and which have an impact on the estimated future cash flows of the asset. For financial assets carried at amortised cost, the amount of the impairment loss is measured as the difference between the asset's carrying amount and the present value of the revised future cash flows discounted at the asset's original effective interest rate. The loss is recognised in the Statement of Comprehensive Net Expenditure.

1.22 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.

1.23 Losses & Special Payments

Losses and special payments are items that Parliament would not have contemplated when it agreed funds or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way each individual case is handled. Further information can be found on the HM Treasury website. Losses and special payments are disclosed in note 23.

1.24 Transfer of Functions

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

As outlined in Note 1, assets and liabilities transferred from organisations closed on 1 April 2013, as a result of their abolition under the Health & Social Care Act 2012, have been accounted for through a modified form of absorption accounting, with corresponding gains or losses debiting or crediting the general fund rather than the Statement of Comprehensive Net Expenditure. This treatment represents an HM Treasury agreed FReM departure, with all other transfers being accounted for in line with the FReM.

1.25 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 2013–14.
The application of the Standards as revised would not have a material impact on the accounts in 2013–14, were they applied in that year:

- IAS 17 Leases – subject to consultation
- IAS 18 Revenue Recognition – subject to consultation
- IAS 27 Separate Financial Statements – expected to be effective in 2014–15
- IAS 28 Investments in Associates and Joint Ventures – expected to be effective in 2014–15
- IFRS 9 Financial Instruments – subject to consultation
- IFRS 10 Consolidated Financial Statements – expected to be effective in 2014–15
- IFRS 11 Joint Arrangements – expected to be effective in 2014–15
- IFRS 12 Disclosure of Interests in Other Entities – expected to be effective in 2014–15
- IFRS 13 Fair Value Measurement – expected to be effective in 2015–16

1.26 Significant Accounting Policies & Material Judgements

Estimates and the underlying assumptions are reviewed on a regular basis by the group's senior management. Areas of significant judgement made by management are:

- IAS 37 Provisions – judgement is applied in arriving at the best estimate of the amount of the obligation. The amount recognised as a provision is the best estimate of the expenditure required to settle the obligation at the end of the reporting period, taking into account the risks and uncertainties; and,
- IAS 36 Impairments – management makes judgement on whether there are any indications of impairments to the carrying amounts of the group's assets.

2. Other Operating Revenue

	Parent				Consolidated Group			
			2013–14	6 months to 31 March 2013			2013–14	6 months to 31 March 2013
	Admin £000	Programme £000	Total £000	Total £000	Admin £000	Programme £000	Total £000	Total £000
Recoveries in respect of employee benefits	**118**	**77**	**195**	0	**1,554**	**211**	**1,765**	0
Prescription fees and charges	**49**	**465,552**	**465,601**	0	**51**	**470,682**	**470,733**	0
Dental fees and charges	**0**	**683,583**	**683,583**	0	**0**	**683,583**	**683,583**	0
Education, training and research	**5,627**	**285,354**	**290,981**	0	**8,841**	**290,494**	**299,335**	0
Charitable and other contributions to revenue expenditure: non-NHS	**90**	**46**	**136**	0	**495**	**1,544**	**2,039**	0
Non-patient care services to other bodies	**497,247**	**99,485**	**596,732**	0	**48,404**	**189,914**	**238,318**	0
Other revenue	**45,248**	**34,218**	**79,466**	208	**77,924**	**69,671**	**147,595**	208
Total other operating revenue	**548,379**	**1,568,315**	**2,116,694**	208	**137,269**	**1,706,099**	**1,843,368**	208

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

All prior year revenue was administration.

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

3. Employee Benefits & Staff Numbers

3.1 Employee Benefits

Parent	2013–14					6 months to 31 March 2013		
	Permanent Employees £000	Permanent CSU Employees £000	Other £000	CSU Other £000	Total £000	Permanent Employees £000	Other £000	Total £000
Salaries and wages	243,770	332,986	43,504	127,894	**748,154**	1,721	9,743	**11,464**
Social security costs	22,619	28,050	3	19	**50,691**	171	0	**171**
Employer contributions to NHS Pension scheme	30,701	40,263	4	23	**70,991**	215	0	**215**
Termination benefits	1,076	0	0	0	**1,076**	0	0	**0**
Gross employee benefits expenditure	298,166	401,299	43,511	127,936	**870,912**	2,107	9,743	**11,850**
Less recoveries in respect of employee benefits	0	0	0	(195)	**(195)**	0	0	**0**
Total net employee benefits	298,166	401,299	43,511	127,741	**870,717**	2,107	9,743	**11,850**

	Charged to Administration Budgets £000	Charged to Programme Budgets £000	Total £000
Of which:			
Parent excluding CSU	295,106	46,571	**341,677**
CSU	466,907	62,328	**529,235**
Gross employee benefits expenditure	762,013	108,899	**870,912**

Consolidated Group	2013–14					6 months to 31 March 2013		
	Permanent Employees £000	Permanent CSU Employees £000	Other £000	CSU Other £000	Total £000	Permanent Employees £000	Other £000	Total £000
Salaries and wages	706,383	332,986	136,966	127,894	**1,304,229**	1,721	9,743	**11,464**
Social security costs	64,441	28,050	35	19	**92,545**	171	0	**171**
Employer contributions to NHS Pension scheme	88,448	40,263	28	23	**128,762**	215	0	**215**
Other pension costs	0	0	18	0	**18**	0	0	**0**
Termination benefits	3,514	0	0	0	**3,514**	0	0	**0**
Gross employee benefits expenditure	862,786	401,299	137,047	127,936	**1,529,068**	2,107	9,743	**11,850**
Less recoveries in respect of employee benefits	(1,560)	0	(10)	(195)	**(1,765)**	0	0	**0**
Total net employee benefits	861,226	401,299	137,037	127,741	**1,527,303**	2,107	9,743	**11,850**

	Charged to Administration Budgets £000	Charged to Programme Budgets £000	Total £000
Of which:			
Parent excluding CSU	295,106	46,571	**341,677**
CSU	466,907	62,328	**529,235**
CCG	509,288	148,868	**658,156**
Gross employee benefits expenditure	1,271,301	257,767	**1,529,068**

Commissioning support units are part of NHS England and provide services to clinical commissioning groups. The employment contracts or secondment of almost all of these staff are held for NHS England on a "hosted basis" by the NHS Business Services Authority.

All prior year staff costs were charged to administration budgets.

3.2 Average Number of People Employed

	2013–14					6 months to 31 March 2013		
	Permanently Employed Number	CSU Employed Number	Other Number	CSU Other Number	Total Number	Permanently Employed Number	Other Number	Total Number
Total parent	5,321	8,313	917	1,829	**16,380**	45	242	**287**
Total consolidated group	15,658	8,313	2,274	1,829	**28,074**	45	242	**287**

NHS England had a relatively short set-up phase in the period before it commenced the undertaking of its full commissioning duties, on 1 April 2013. As a result, at the start of the 2013–14 financial year, a higher than normal number of substantive posts were filled by employees that did not have a permanent contract of employment with NHS England. Over the course of the year, those substantive posts have largely transferred to permanent employees. In addition to this, the organisation undertakes from time to time certain short-term projects where the best value for money option is that they be delivered by non-permanent staff. This option is taken only where existing resources can not meet the additional demand, or where specialist skills are required.

The commissioning support units within the group also undertake certain short-term projects where staffing decisions such as those described above are considered appropriate. In addition to this, some of the services that the commissioning support units provide are seasonal and from time to time need to be supplemented by additional resources. This includes supporting clinical commissioning groups in their financial planning and delivery of their processes around year end.

3.3 Exit Packages Agreed in the Financial Year

	Parent 2013–14			Consolidated Group 2013–14		
	Compulsory Redundancies Number	Other Agreed Departures Number	Total Number	Compulsory Redundancies Number	Other Agreed Departures Number	Total Number
Less than £10,000	30	0	**30**	59	15	**74**
£10,001 to £25,000	54	0	**54**	72	12	**84**
£25,001 to £50,000	58	0	**58**	66	6	**72**
£50,001 to £100,000	49	1	**50**	57	5	**62**
£100,001 to £150,000	10	0	**10**	11	0	**11**
£150,001 to £200,000	5	0	**5**	8	0	**8**
Over £200,001	1	0	**1**	1	0	**1**
Total	207	1	**208**	274	38	**312**
Total cost (£000)	8,689	59	**8,748**	10,565	801	**11,366**

There were no exit packages in the 6 months to 31 March 2013.

Analysis of other agreed departures

	Parent		Consolidated Group	
	Number	£000	Number	£000
Voluntary redundancies including early retirement contractual costs	1	59	6	203
Mutually agreed resignations (MARS) contractual costs	0	0	5	105
Early retirements in the efficiency of the service contractual costs	0	0	1	23
Contractual payments in lieu of notice	0	0	26	470
Total	**1**	**59**	**38**	**801**

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 will not necessarily match the total number in the table above, which will be the number of individuals.

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

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

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

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

3.4 Pension Costs

The group participates in the NHS Pension Scheme as noted in the accounting policies (note 1.7) and note 3.4.1. Additionally there are transactions within the group related to the Local Government Pension Scheme (note 3.4.2) and the Principal Civil Service Pension Scheme (note 3.4.3).

3.4.1 NHS Pension Scheme

Full actuarial (funding) valuation

The NHS Pension Scheme is an unfunded, multi-employer defined benefit scheme. Individual NHS bodies are therefore unable to identify their shares of the underlying scheme assets and liabilities. The scheme was actuarially valued as at 31 March 2004. Details can be found on the pension scheme website.

The purpose of the valuation is to assess the level of liability in respect of the benefits due under the Scheme (taking into account its recent demographic experience), and to recommend the contribution rates to be paid by employers and scheme members. The last such valuation, which determined current contribution rates, was undertaken as at 31 March 2004. The latest valuation was conducted as at 31 March 2012 and published in June 2014. The conclusion from the 2014 valuation was that the scheme had accumulated a notional deficit of £10.3 billion against the notional assets as at 31 March 2012. The contribution recommendations will influence rates from 1 April 2015.

Accounting valuation

A valuation of the scheme liability is carried out by the scheme actuary as at the end of the reporting period by updating the results of the full actuarial valuation.

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

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

Scheme provisions

The NHS Pension Scheme provides defined benefits, which are summarised below. This list is an illustrative guide only, and is not intended to detail all the benefits provided by the scheme or the specific conditions that must be met before these benefits can be obtained:

- The scheme is a "final salary" scheme. Annual pensions are normally based on 1/80th for the 1995 section and of the best of the last three years pensionable pay for each year of service, and 1/60th for the 2008 section of reckonable pay per year of membership. Members who are practitioners as defined by the Scheme Regulations have their annual pensions based upon total pensionable earnings over the relevant pensionable service;
- With effect from 1 April 2008 members can choose to give up some of their annual pension for an additional tax free lump sum, up to a maximum amount permitted under HM Revenue & Customs 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;
- 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 statement of comprehensive

net expenditure at the time the entity commits itself to the retirement, regardless of the method of payment; and,

- Members can purchase additional service in the scheme and contribute to money purchase AVC's run by the scheme's approved providers or by other Free Standing Additional Voluntary Contributions (FSAVC) providers.

3.4.2 Local Government Pension Scheme

Within the group there are clinical commissioning groups 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 clinical commissioning groups published accounts.

3.4.3 Principal Civil Service Pension Scheme

The Principal Civil Service Pension Scheme is an unfunded multi-employer defined benefit scheme. As such, NHS England is unable to identify its share of the underlying assets and liabilities. The scheme actuary valued the scheme as at 31 March 2007. Details can be found in the Annual Report & Accounts of the Cabinet Office: Civil Superannuation on the Civil Service website.

The scheme actuary reviews employer contributions usually every four years following a full scheme valuation. The contribution rates are set to meet the cost of the benefits accruing during 2013–14 to be paid when the member retires and not the benefits paid during this period to existing pensioners.

4. Operating Expenses

	Parent				Consolidated Group			
			2013–14	6 months to 31 March 2013			2013–14	6 months to 31 March 2013
	Admin £000	Programme £000	Total £000	Total £000	Admin £000	Programme £000	Total £000	Total £000
Operating expenses – cash								
Services from CCGs	**1,089**	**53,232**	**54,321**	0	**0**	**0**	**0**	0
Services from Foundation Trusts	**1,617**	**9,017,494**	**9,019,111**	0	**2,863**	**34,885,407**	**34,888,270**	0
Services from other NHS Trusts	**90**	**5,520,476**	**5,520,566**	0	**1,460**	**25,426,005**	**25,427,465**	0
Services from other NHS bodies	**1,885**	**469,599**	**471,484**	0	**1,788**	**492,525**	**494,313**	0
Purchase of healthcare from non-NHS bodies	**7,625**	**1,599,480**	**1,607,105**	0	**13,483**	**10,173,262**	**10,186,745**	0
General dental services and personal dental services	**3**	**3,083,890**	**3,083,893**	0	**3**	**3,079,683**	**3,079,686**	0
Prescribing costs	**0**	**5,275**	**5,275**	0	**315**	**8,029,603**	**8,029,918**	0
Pharmaceutical services	**0**	**2,093,820**	**2,093,820**	0	**0**	**2,101,665**	**2,101,665**	0
General ophthalmic services	**19**	**517,834**	**517,853**	0	**19**	**523,237**	**523,256**	0
Primary care services	**272**	**7,266,093**	**7,266,365**	0	**3,539**	**7,586,547**	**7,590,086**	0
Supplies and services – clinical	**319**	**75,731**	**76,050**	0	**320**	**174,357**	**174,677**	0
Supplies and services – general	**67,369**	**296,840**	**364,209**	25,498	**91,451**	**477,693**	**569,144**	25,498
Non executive members	**187**	**0**	**187**	60	**49,034**	**909**	**49,943**	60
Consultancy services	**46,748**	**9,997**	**56,745**	888	**73,983**	**54,934**	**128,917**	888
Establishment	**146,960**	**92,792**	**239,752**	1,270	**197,101**	**143,765**	**340,866**	1,270
Transport	**7,486**	**1,561**	**9,047**	1,056	**8,555**	**11,079**	**19,634**	1,056
Premises	**141,514**	**111,134**	**252,648**	1,463	**189,854**	**324,558**	**514,412**	1,463
Audit fees	**530**	**0**	**530**	30	**19,062**	**0**	**19,062**	30
Other non statutory audit expenditure	**3,792**	**136**	**3,928**	58	**8,384**	**321**	**8,705**	58
Other professional fees excl. audit	**16,680**	**4,187**	**20,867**	73	**28,067**	**10,263**	**38,330**	73
Grants to other public bodies	**53,583**	**700**	**54,283**	0	**53,623**	**39,164**	**92,787**	0
Clinical negligence	**0**	**0**	**0**	0	**291**	**13**	**304**	0
Research and development (excluding staff costs)	**733**	**157**	**890**	0	**4,252**	**8,813**	**13,065**	0
Education and training	**14,587**	**102,398**	**116,985**	1,102	**26,550**	**108,763**	**135,313**	1,102
Funding to group bodies	**1,261,901**	**59,995,373**	**61,257,274**	0	**0**	**0**	**0**	0
Other expenditure	**1,425**	**32,994**	**34,419**	74	**23,012**	**78,310**	**101,322**	74
Total operating expenses – cash	**1,776,414**	**90,351,193**	**92,127,607**	31,572	**797,009**	**93,730,876**	**94,527,885**	31,572
Operating expenses – non cash								
Impairments and reversals of receivables	**334**	**10,375**	**10,709**	0	**1,184**	**20,099**	**21,283**	0
Inventories written down	**0**	**0**	**0**	0	**0**	**0**	**0**	0
Depreciation	**13,333**	**20,684**	**34,017**	114	**18,437**	**24,104**	**42,541**	114
Amortisation	**267**	**759**	**1,026**	0	**603**	**1,275**	**1,878**	0
Impairments and reversals of property, plant and equipment	**106,010**	**0**	**106,010**	0	**107,633**	**1,075**	**108,708**	0
Impairments and reversals of intangible assets	**9,540**	**0**	**9,540**	23	**9,579**	**117**	**9,696**	23
Provisions	**2,457**	**40,267**	**42,724**	0	**4,415**	**110,013**	**114,428**	0
Total operating expenses – non cash	**131,941**	**72,085**	**204,026**	137	**141,851**	**156,683**	**298,534**	137
Total operating expenses costs	**1,908,355**	**90,423,278**	**92,331,633**	31,709	**938,860**	**93,887,559**	**94,826,419**	31,709

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

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

All expenditure in the 6 month comparative period was incurred as administration cost.

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

5. Fees & Charges

		Parent			Consolidated Group		
				2013–14			2013–14
	Note	Fees & Charges Income £000	Full Cost of Service £000	Surplus/ (Deficit) £000	Fees & Charges Income £000	Full Cost of Service £000	Surplus/ (Deficit) £000
Dental		683,583	(3,083,893)	**(2,400,310)**	683,583	(3,079,686)	**(2,396,103)**
Prescription		465,601	(2,093,820)	**(1,628,219)**	470,733	(2,101,665)	**(1,630,932)**
Total fees & charges	2, 4	1,149,184	(5,177,713)	**(4,028,529)**	1,154,316	(5,181,351)	**(4,027,035)**

The fees and charges information in this note is provided in accordance with section 5.4.28 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.

There were no fees and charges to disclose as comparatives for the prior 6 month period.

6. Net Loss on Transfer by Absorption

Transfers as a result of reorganisation fall to be accounted for by use of absorption accounting in line with the Government Financial Reporting Manual, issued by HM Treasury. The Government Financial Reporting Manual does not require retrospective adoption, so prior year transactions (which have been accounted for under merger accounting) have not been restated. Absorption accounting requires that entities account for their transactions in the period in which they took place, with no restatement of performance required when functions transfer within the public sector. Where assets and liabilities transfer, the gain or loss resulting is recognised in the Statement of Comprehensive Net Expenditure, and is disclosed separately from operating expenditure.

Other transfers of assets and liabilities within the Department of Health group are accounted for in line with IAS 20 and similarly give rise to income and expenditure entries.

	Parent		Consolidated Group	
	2013–14 £000	6 months to 31 March 2013 £000	2013–14 £000	6 months to 31 March 2013 £000
Transfer of property plant and equipment	**(60,611)**	390	**(60,611)**	390
Transfer of intangibles	**8,356**	139	**8,356**	139
Transfer of cash and cash equivalents	**0**	6,125	**0**	6,125
Transfer of receivables	**0**	6	**0**	6
Transfer of payables	**(43,403)**	(12,623)	**(43,403)**	(12,623)
Transfer of provisions	**(28)**	0	**(28)**	0
Net loss on transfers by absorption	**(95,686)**	(5,963)	**(95,686)**	(5,963)

7. Operating Leases

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 in place for these properties, the transactions involved do convey the right of the group to use property assests. 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.

Accordingly the payments made in 2013–14 are disclosed as minimum lease payments in the buildings category in note 7.1. 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 7.2. It is expected that the payments recognised in 2013–14 would continue to be minimum lease payments in 2014–15.

The group does not act as a lessor.

7.1 Payments Recognised as an Expense

	Parent			Consolidated Group		
	Buildings £000	Other £000	Total £000	Buildings £000	Other £000	Total £000
Minimum lease payments	148,552	1,014	**149,566**	366,219	2,131	**368,350**
Contingent rents	0	3	**3**	0	26	**26**
Sub-lease payments	0	0	**0**	0	0	**0**
Total payments recognised as an expense	148,552	1,017	**149,569**	366,219	2,157	**368,376**

There were no operating leases in the prior 6 month period.

7.2 Future Minimum Lease Payments

	Parent			Consolidated Group		
	Buildings £000	Other £000	Total £000	Buildings £000	Other £000	Total £000
Payable:						
No later than one year	133	511	**644**	11,318	1,351	**12,669**
Between one and five years	133	448	**581**	15,959	1,110	**17,069**
After five years	0	0	**0**	21,326	6	**21,332**
Total future minimum lease payments	266	959	**1,225**	48,603	2,467	**51,070**

There were no operating leases in the prior 6 month period.

8. NHS England Group Financial Performance

The Pursuit of Excellence: The First Mandate to NHS England, 2013–14 – 2014–15 published by the Secretary of State for Health under section 13A of the National Health Service Act 2006 (as amended), 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 2013–14 and certain additional expenditure controls to which NHS England must adhere. These stem from budgetary controls that HM Treasury applies to the Department of Health. Those limits, and NHS England's performance against them, are set out in the tables below.

	Revenue Departmental Expenditure Limit		Annually-Managed Expenditure	Technical	Total
	Non ring-fenced £000	Ring-fenced £000	£000	£000	£000
Limit	95,065,000	148,000	300,000	360,000	**95,873,000**
Actual expenditure	94,204,885	61,840	159,472	92,787	**94,518,984**
Surplus	860,115	86,160	140,528	267,213	**1,354,016**

	Capital Resource Limit £000
Limit	200,000
Actual expenditure	181,525
Surplus	**18,475**

NHS England is required to spend no more than £2,016,000,000 of its Revenue Departmental Expenditure Limit mandate on matters relating to administration. The actual amount spent on administration matters in 2013–14 was £1,897,641,000 as set out below.

	Adminstration Limit £000
Net administration costs before interest	2,072,892
Less:	
Administration expenditure covered by AME/Technical funding	(175,251)
Administration costs relating to RDEL	**1,897,641**
RDEL Administration expenditure limit	2,016,000
Underspend	**118,359**

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

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

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

9. Operating Segments

Consolidated Group	Clinical Commissioning Groups £000	Direct Commissioning £000	NHS England £000	Other £000	Intra-group Eliminations £000	NHS England Group Total £000
Income	(1,167,521)	(1,522,573)	(30,137)	(681,187)	1,558,089	**(1,843,329)**
Gross expenditure	65,851,811	28,951,023	1,474,099	1,643,469	(1,558,089)	**96,362,313**
Total net expenditure	64,684,290	27,428,450	1,443,962	962,282	0	**94,518,984**

Reconciliation back to SoCNE	
Revenue departmental expenditure limit	94,266,725
Annually managed expenditure	159,472
Technical expenditure	92,787
Net operating expenditure for the financial year	**94,518,984**

Reconciliation back to Statement of Comprehensive Net Expenditure	
Net operating expenditure for the financial year	94,518,984
Net loss on transfer by absorption	95,686
Net operating expenditure for the financial year including absorption losses	**94,614,670**

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

The activities of each segment are defined as follows:

- Clinical Commissioning Groups – clinically led groups that are responsible for commissioning healthcare services as defined in the Health & Social Care Act 2012;
- Direct Commissioning – the services commissioned by NHS England (via area teams) as defined in the Health & Social Care Act 2012;
- NHS England – the central administration of the organisation and centrally managed programmes; and,
- Other – includes commissioning support units, social care, national reserves, technical accounting items and legacy balances.

Multiple transactions take place between reportable segments, all of which are eliminated upon consolidation as shown in the "Intra-group eliminations" column. Information on total assets and liabilities and net assets and liabilities is not separately reported to the Chief Operating Decision Maker and thus, in accordance with IFRS 8, does not form part of this disclosure.

Segmental information for the prior year is not shown because the information is not available, due to changes in the organisation structure.

10. Property, Plant & Equipment

10.1 Parent 2013–14

	Buildings Excluding Dwellings £000	Assets Under Construction & Payments on Account £000	Plant & Machinery £000	Transport Equipment £000	Furniture & Fittings £000	Information Technology £000	Total £000
Cost or valuation at 1 April 2013	0	0	0	0	0	3,623	**3,623**
Transfer of assets from closed NHS bodies as a result of the 1 April 2013 transition	71,278	3,348	21,873	77	12,573	166,635	**275,784**
Adjusted cost or valuation at 1 April 2013	71,278	3,348	21,873	77	12,573	170,258	**279,407**
Addition of assets under construction and payments on account	0	6,464	0	0	0	0	**6,464**
Additions purchased	0	0	105	0	150	76,530	**76,785**
Reclassifications	0	(3,505)	0	0	(39)	4,611	**1,067**
Disposals other than by sale	0	0	0	0	0	(90)	**(90)**
Impairments charged	(1,659)	0	(16,998)	(45)	(11,398)	(77,674)	**(107,774)**
Transfer (to)/from other public sector body	(49,650)	0	(17)	0	0	980	**(48,687)**
Cost or valuation at 31 March 2014	19,969	6,307	4,963	32	1,286	174,615	**207,172**
Depreciation at 1 April 2013	0	0	0	0	0	114	**114**
Disposals other than by sale	0	0	0	0	0	(63)	**(63)**
Charged during the year	0	0	136	5	320	33,556	**34,017**
Transfer (to)/from other public sector body	9,092	0	2,347	0	0	485	**11,924**
Depreciation at 31 March 2014	9,092	0	2,483	5	320	34,092	**45,992**
Net book value at 31 March 2014	10,877	6,307	2,480	27	966	140,523	**161,180**
Asset financing:							
Owned	8,992	6,307	221	27	966	140,523	**157,036**
Held on finance lease	0	0	2,259	0	0		**2,259**
PFI contracts	1,885	0	0	0	0	0	**1,885**
Net book value at 31 March 2014	10,877	6,307	2,480	27	966	140,523	**161,180**

Disposals other than by sale (net £27k) relate to legacy assets transferred to NHS England. These have been written off and accounted for as a loss on disposal.

Revaluation reserve balance for property, plant & equipment

	Buildings £000	Assets under Construction & Payments on Account £000	Plant & Machinery £000	Transport Equipment £000	Furniture & Fittings £000	Information Technology £000	Total £000
Balance at 1 April 2013	0	0	0	0	0	0	**0**
Transfer of assets from closed NHS bodies as a result of the 1 April 2013 transition	174	0	826	16	299	608	**1,923**
Adjusted balance at 1 April 2013	174	0	826	16	299	608	**1,923**
Impairments	(34)	0	(826)	(16)	(287)	(601)	**(1,764)**
Balance at 31 March 2014	140	0	0	0	12	7	**159**

10.2 Parent for the 6 Months to 31 March 2013

	Information Technology £000	Total £000
Cost or valuation at 1 October 2012	0	**0**
Additions purchased	3,233	**3,233**
Transfer (to)/from other public sector body	390	**390**
Cost or valuation at 31 March 2013	3,623	**3,623**
Depreciation at 1 October 2012	0	**0**
Charged during the year	114	**114**
Depreciation at 31 March 2013	114	**114**
Net book value at 31 March 2013	3,509	**3,509**

10.3 Consolidated Group 2013–14

	Buildings Excluding Dwellings £000	Assets Under Construction & Payments on Account £000	Plant & Machinery £000	Transport Equipment £000	Furniture & Fittings £000	Information Technology £000	Total £000
Cost or valuation at 1 April 2013	0	0	0	0	0	3,623	**3,623**
Transfer of assets from closed NHS bodies as a result of the 1 April 2013 transition	72,555	3,365	32,280	126	16,486	181,296	**306,108**
Adjusted cost or valuation at 1 April 2013	72,555	3,365	32,280	126	16,486	184,919	**309,731**
Addition of assets under construction and payments on account	0	7,121	0	0	0	0	**7,121**
Additions purchased	7	0	786	0	393	79,310	**80,496**
Reclassifications	4	(3,522)	(64)	81	(123)	4,691	**1,067**
Disposals other than by sale	(4)	0	(566)	0	(72)	(312)	**(954)**
Impairments charged	(1,659)	0	(17,703)	(56)	(11,591)	(78,931)	**(109,940)**
Transfer (to)/from other public sector body	(49,650)	0	(17)	0	0	980	**(48,687)**
Cost or valuation at 31 March 2014	21,253	6,964	14,716	151	5,093	190,657	**238,834**
Depreciation at 1 April 2013	0	0	0	0	0	114	**114**
Disposals other than by sale	0	0	(88)	0	0	(151)	**(239)**
Impairments charged	0	0	(168)	0	2	712	**546**
Charged during the year	87	0	2,276	36	1,374	38,767	**42,540**
Transfer (to)/from other public sector body	9,092	0	2,347	0	0	485	**11,924**
Depreciation at 31 March 2014	9,179	0	4,367	36	1,376	39,927	**54,885**
Net book value at 31 March 2014	12,074	6,964	10,349	115	3,717	150,730	**183,949**
Asset financing:							
Owned	8,998	6,964	8,131	115	3,717	150,730	**178,655**
Held on finance lease	1,191	0	2,218	0	0	0	**3,409**
PFI contracts	1,885	0	0	0	0	0	**1,885**
Total at 31 March 2014	12,074	6,964	10,349	115	3,717	150,730	**183,949**

Disposals other than by sale (net £715k) relate to legacy assets transferred to the NHS England group. These have been written off and accounted for as a loss on disposal.

Revaluation reserve balance for property, plant & equipment

	Buildings £000	Assets Under Construction & Payments on Account £000	Plant & Machinery £000	Transport Equipment £000	Furniture & Fittings £000	Information Technology £000	Total £000
Balance at 1 April 2013	0	0	0	0	0	0	**0**
Transfer of assets from closed NHS bodies as a result of the 1 April 2013 transition	174	0	1,092	17	395	1,129	**2,807**
Adjusted balance at 1 April 2013	174	0	1,092	17	395	1,129	**2,807**
Impairments	(34)	0	(834)	(16)	(293)	(601)	**(1,778)**
Release to general fund	0	0	(110)	0	(66)	(521)	**(697)**
Balance at 31 March 2014	140	0	148	1	36	7	**332**

10.4 Consolidated Group for the 6 Months to 31 March 2013

	Information Technology £000	Total £000
Cost or valuation at 1 October 2012	0	**0**
Additions purchased	3,233	**3,233**
Transfer (to)/from other public sector body	390	**390**
Cost or valuation at 31 March 2013	3,623	**3,623**
Depreciation at 1 October 2012	0	**0**
Charged during the year	114	**114**
Depreciation at 31 March 2013	114	**114**
Net book value at 31 March 2013	3,509	**3,509**

11. Intangible Non-current Assets

11.1 2013–14

	Parent				Consolidated Group			
	Computer Software: Purchased £000	Licences & Trademarks £000	Development Expenditure (internally generated) £000	Total £000	Computer Software: Purchased £000	Licences & Trademarks £000	Development Expenditure (internally generated) £000	Total £000
Cost or valuation at 1 April 2013	139	0	0	**139**	139	0	0	**139**
Transfer of assets from closed NHS bodies as a result of the 1 April 2013 transition	9,117	219	628	**9,964**	10,313	304	1,236	**11,853**
Adjusted cost or valuation at 1 April 2013	9,256	219	628	**10,103**	10,452	304	1,236	**11,992**
Additions purchased	1,057	0	0	**1,057**	1,100	0	21	**1,121**
Reclassifications	(262)	(177)	(628)	**(1,067)**	(231)	(208)	(628)	**(1,067)**
Disposals other than by sale	0	0	0	**0**	(79)	0	0	**(79)**
Impairments charged	(9,540)	0	0	**(9,540)**	(9,701)	0	0	**(9,701)**
Transfer (to)/from other public sector body	9,317	0	0	**9,317**	9,317	0	0	**9,317**
Cost or valuation at 31 March 2014	9,828	42	0	**9,870**	10,858	96	629	**11,583**
Amortisation at 1 April 2013	23	0	0	**23**	23	0	0	**23**
Disposals other than by sale	0	0	0	**0**	(79)	0	0	**(79)**
Impairments charged	0	0	0	**0**	(5)	0	0	**(5)**
Charged during the year	1,021	5	0	**1,026**	1,537	38	303	**1,878**
Transfer (to)/from other public sector body	961	0	0	**961**	961	0	0	**961**
Amortisation at 31 March 2014	2,005	5	0	**2,010**	2,437	38	303	**2,778**
Net book value at 31 March 2014	7,823	37	0	**7,860**	8,421	58	326	**8,805**
Purchased	7,823	37	0	**7,860**	8,421	58	326	**8,805**
Net book value at 31 March 2014	7,823	37	0	**7,860**	8,421	58	326	**8,805**

Revaluation reserve balance for intangible non-current assets

	Parent				Consolidated Group			
	Computer Software: Purchased £000	Licences & Trademarks £000	Development Expenditure (internally generated) £000	Total £000	Computer Software: Purchased £000	Licences & Trademarks £000	Development Expenditure (internally generated) £000	Total £000
Balance at 1 April 2013	0	0	0	**0**	0	0	0	**0**
Transfer of assets from closed NHS bodies as a result of the 1 April 2013 transition	5	0	0	**5**	5	0	0	**5**
Adjusted balance at 1 April 2013	5	0	0	**5**	5	0	0	**5**
Balance at 31 March 2014	5	0	0	**5**	5	0	0	**5**

11.2 6 months to 31 March 2013

	Parent				Consolidated Group			
	Computer Software: Purchased £000	Licences & Trademarks £000	Development Expenditure (internally generated) £000	Total £000	Computer Software: Purchased £000	Licences & Trademarks £000	Development Expenditure (internally generated) £000	Total £000
Cost or valuation at 1 October 2012	0	0	0	**0**	0	0	0	**0**
Transfer (to)/from other public sector body	139	0	0	**139**	139	0	0	**139**
Cost or valuation at 31 March 2013	139	0	0	**139**	139	0	0	**139**
Amortisation 1 October 2012	0	0	0	**0**	0	0	0	**0**
Charged during the year	23	0	0	**23**	23	0	0	**23**
Amortisation at 31 March 2013	23	0	0	**23**	23	0	0	**23**
Net Book Value at 31 March 2013	116	0	0	**116**	116	0	0	**116**

12. Inventories

Parent	Drugs £000	Consumables £000	Other £000	Total £000
Balance at 1 April 2013	0	0	0	**0**
Transfer of assets from closed NHS bodies as a result of the 1 April 2013 transition	60	99	29	**188**
Adjusted balance at 1 April 2013	60	99	29	**188**
Additions	0	26	340	**366**
Inventories recognised as an expense in the period	(60)	(22)	(18)	**(100)**
Balance at 31 March 2014	0	103	351	**454**

Consolidated Group	Drugs £000	Consumables £000	Other £000	Total £000
Balance at 1 April 2013	0	0	0	**0**
Transfer of assets from closed NHS bodies as a result of the 1 April 2013 transition	60	300	785	**1,145**
Adjusted balance at 1 April 2013	60	300	785	**1,145**
Additions	0	203	3,098	**3,301**
Inventories recognised as an expense in the period	(60)	(213)	(2,458)	**(2,731)**
Balance at 31 March 2014	0	290	1,425	**1,715**

There were no inventory transactions in the 6 months to 31 March 2013.

13. Trade & Other Receivables

	Parent				Consolidated Group			
	31 March 2014		31 March 2013		31 March 2014		31 March 2013	
	Current £000	Non-current £000	Current £000	Non-current £000	Current £000	Non-current £000	Current £000	Non-current £000
NHS receivables: revenue	**84,128**	**1,440**	0	0	**150,714**	**1,440**	0	0
NHS prepayments and accrued income	**3,594**	**0**	0	0	**161,532**	**0**	0	0
Non-NHS receivables: revenue	**61,623**	**0**	14,103	0	**209,128**	**0**	14,103	0
Non-NHS prepayments and accrued income	**69,478**	**964**	5	0	**137,097**	**964**	5	0
Provision for the impairment of receivables	**(10,709)**	**0**	0	0	**(21,284)**	**1**	0	0
VAT	**9,842**	**0**	0	0	**18,733**	**0**	0	0
Other receivables	**69,397**	**3,079**	1,794	0	**85,449**	**3,080**	1,794	0
Total trade & other receivables	**287,353**	**5,483**	15,902	0	**741,369**	**5,485**	15,902	0
Total current and non-current		**292,836**		15,902		**746,854**		15,902

Intra-government receivables

	Parent				Consolidated Group			
	31 March 2014		31 March 2013		31 March 2014		31 March 2013	
	Current £000	Non-current £000	Current £000	Non-current £000	Current £000	Non-current £000	Current £000	Non-current £000
Balances with:								
Other central government bodies	**70,152**	**0**	15,726	0	**72,998**	**0**	15,726	0
Local authorities	**2,722**	**0**	0	0	**45,550**	**0**	0	0
Total of balances with government bodies:	**72,874**	**0**	15,726	0	**118,548**	**0**	15,726	0
Balances with NHS bodies	**87,722**	**1,440**	45	0	**312,246**	**1,440**	45	**0**
Bodies external to government	**126,757**	**4,043**	131	0	**310,575**	**4,045**	131	0
Total trade & other receivables	**287,353**	**5,483**	15,902	0	**741,369**	**5,485**	15,902	0

14. Cash & Cash Equivalents

	Parent £000	Consolidated Group £000
Balance at 1 April 2013	0	0
Net change in year	391,990	420,921
Balance at 31 March 2014	**391,990**	**420,921**
Made up of:		
Cash with the Government Banking Service	330,013	358,537
Cash in hand	61,977	65,507
Cash and cash equivalents in Statement of Financial Position	**391,990**	**424,044**
Bank overdraft: Government Banking Service	0	(3,123)
Total bank overdrafts	**0**	**(3,123)**
Balance at 31 March 2014	**391,990**	**420,921**

Included within cash in hand above is £59.68m held on behalf of NHS England by the NHS Business Services Authority and £2.28m in respect of the NHS Institute of Innovation & Improvement currently held by Department of Health. The consolidated group balance also includes £1.83m within Horsham & Mid Sussex CCG in relation to pooled budgets for Mental Health, Learning Difficulties and Telecare.

For details of the bank overdrafts see note 16.

15. Trade & Other Payables

	Parent				Consolidated Group			
	31 March 2014		31 March 2013		31 March 2014		31 March 2013	
	Current £000	Non-current £000	Current £000	Non-current £000	Current £000	Non-current £000	Current £000	Non-current £000
NHS payables: revenue	**717,364**	**0**	0	0	**1,620,541**	**0**	0	0
NHS payables: capital	**0**	**0**	0	0	**193**	**0**	0	0
NHS accruals and deferred income	**156,016**	**0**	0	0	**548,201**	**0**	0	0
Non-NHS payables: revenue	**453,151**	**2,440**	8,895	0	**1,024,813**	**2,440**	8,895	0
Non-NHS payables: capital	**1,410**	**0**	429	0	**2,736**	**0**	429	0
Non-NHS accruals and deferred income	**1,289,489**	**17**	11,036	0	**3,328,829**	**863**	11,036	0
Social security costs	**6,113**	**0**	192	0	**12,205**	**0**	192	0
Tax	**6,677**	**0**	0	0	**13,517**	**0**	0	0
Payments received on account	**(46)**	**0**	0	0	**169**	**0**	0	0
Other payables	**98,090**	**0**	152	0	**202,745**	**3,073**	152	0
Total trade & other payables	**2,728,264**	**2,457**	20,704	0	**6,753,949**	**6,376**	20,704	0
Total current and non-current		**2,730,721**		20,704		**6,760,325**		20,704

Prior year liabilities does not include bank overdraft of £13,606k as this is now shown in the borrowings note (note 16).

Intra-government payables

	Parent				Consolidated Group			
	31 March 2014		31 March 2013		31 March 2014		31 March 2013	
	Current £000	Non-current £000	Current £000	Non-current £000	Current £000	Non-current £000	Current £000	Non-current £000
Balances with:								
Other central government bodies	**86,801**	**0**	8,929	0	**98,622**	**0**	8,929	0
Local authorities	**131,133**	**0**	0	0	**267,291**	**0**	0	0
Total of balances with government bodies	**217,934**	**0**	8,929	0	**365,913**	**0**	8,929	0
Balances with NHS bodies	**873,381**	**0**	988	0	**2,168,935**	**0**	988	**0**
Bodies external to government	**1,636,949**	**2,457**	10,787	0	**4,219,101**	**6,376**	10,787	0
Total trade & other payables	**2,728,264**	**2,457**	20,704	0	**6,753,949**	**6,376**	20,704	0

16. Borrowings

	Parent				Consolidated Group			
	31 March 2014		31 March 2013		31 March 2014		31 March 2013	
	Current £000	Non-current £000	Current £000	Non-current £000	Current £000	Non-current £000	Current £000	Non-current £000
Bank overdrafts:								
Government banking service	**0**	**0**	13,606	0	**3,123**	**0**	13,606	0
Total overdrafts	**0**	**0**	13,606	0	**3,123**	**0**	13,606	0
Private finance initiative liabilities:								
Main liability	**199**	**3,015**	0	0	**199**	**3,015**	0	0
Total private finance initiative liabilities	**199**	**3,015**	0	0	**199**	**3,015**	0	0
Finance lease liabilities	**807**	**0**	0	0	**807**	**1,362**	0	0
Total borrowings	**1,006**	**3,015**	13,606	0	**4,129**	**4,377**	13,606	0
Total current and non-current		**4,021**		13,606		**8,506**		13,606

Repayment of principal falling due

	Parent		Consolidated Group	
	31 March 2014	31 March 2013	31 March 2014	31 March 2013
Within 1 year	**1,006**	13,606	**4,129**	13,606
Between one and five years	**701**	0	**821**	0
After five years	**2,314**	0	**3,556**	0
Total borrowings	**4,021**	13,606	**8,506**	13,606

17. Provisions

	Parent				Consolidated Group			
	31 March 2014		31 March 2013		31 March 2014		31 March 2013	
	Current £000	Non-current £000	Current £000	Non-current £000	Current £000	Non-current £000	Current £000	Non-current £000
Pensions relating to other staff	**0**	**0**	0	0	**88**	**0**	0	0
Restructuring	**3,563**	**92**	31	0	**5,597**	**2,254**	31	0
Redundancy	**1,516**	**0**	0	0	**1,516**	**0**	0	0
Equal pay	**30**	**118**	0	0	**30**	**118**	0	0
Legal claims	**3,497**	**37**	0	0	**3,616**	**39**	0	0
Continuing care	**362,310**	**406,869**	0	0	**402,774**	**415,517**	0	0
Other	**50,588**	**986**	0	0	**63,355**	**5,227**	0	0
Total provisions	**421,504**	**408,102**	31	0	**476,976**	**423,155**	31	0
Total current and non-current		**829,606**		31		**900,131**		31

Parent	Pensions Relating to Other Staff £000s	Restructuring £000s	Redundancy £000s	Equal Pay £000s	Legal Claims £000s	Continuing Care £000s	Other £000s	Total £000s
Balance at 1 April 2013	0	31	0	0	0	0	0	**31**
Transfer of assets from closed NHS bodies as a result of the 1 April 2013 transition	0	8,953	12,304	30	10,856	762,911	62,864	**857,918**
Adjusted balance at 1 April 2013	0	8,984	12,304	30	10,856	762,911	62,864	**857,949**
Arising during the year	0	156	0	0	1,466	115,889	2,338	**119,849**
Utilised during the year	0	(92)	0	0	0	(77,042)	(53)	**(77,187)**
Reversed unused	0	(5,421)	(10,788)	118	(8,788)	(38,671)	(13,575)	**(77,125)**
Unwinding of discount	0	0	0	0	0	6,092	0	**6,092**
Change in discount rate	0	0	0	0	0	0	0	**0**
Transfer (to) from other public sector body	0	28	0	0	0	0	0	**28**
Balance at 31 March 2014	0	3,655	1,516	148	3,534	769,179	51,574	**829,606**
Expected timing of cash flows:								
Within one year	0	3,563	1,516	30	3,497	362,310	50,588	**421,504**
Between one and five years	0	92	0	118	37	370,042	244	**370,533**
After five years	0	0	0	0	0	36,827	742	**37,569**
Balance at 31 March 2014	0	3,655	1,516	148	3,534	769,179	51,574	**829,606**

Consolidated Group	Pensions Relating to Other Staff £000s	Restructuring £000s	Redundancy £000s	Equal Pay £000s	Legal Claims £000s	Continuing Care £000s	Other £000s	Total £000s
Balance at 1 April 2013	0	31	0	0	0	0	0	**31**
Transfer of assets from closed NHS bodies as a result of the 1 April 2013 transition	0	8,953	12,304	30	10,856	762,911	62,759	**857,813**
Adjusted balance at 1 April 2013	0	8,984	12,304	30	10,856	762,911	62,759	**857,844**
Arising during the year	88	4,413	0	0	1,587	164,328	21,108	**191,524**
Utilised during the year	0	(181)	0	0	0	(77,111)	(972)	**(78,264)**
Reversed unused	0	(5,393)	(10,788)	118	(8,788)	(38,671)	(13,574)	**(77,096)**
Unwinding of discount	0	0	0	0	0	6,092	3	**6,095**
Change in discount rate	0	0	0	0	0	0	0	**0**
Transfer (to) from other public sector body	0	28	0	0	0	0	0	**28**
Balance at 31 March 2014	88	7,851	1,516	148	3,655	817,549	69,324	**900,131**
Expected timing of cash flows:								
Within one year	88	5,597	1,516	30	3,616	402,774	63,355	**476,976**
Between one and five years	0	2,254	0	118	39	377,948	5,227	**385,586**
After five years	0	0	0	0	0	36,827	742	**37,569**
Balance at 31 March 2014	88	7,851	1,516	148	3,655	817,549	69,324	**900,131**

£47,370k is included in the provisions of the NHS Litigation Authority as at 31 March 2014 in respect of clinical negligence liabilities of NHS England (31 March 2013: £nil).

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 omission of the NHS to pay for historical cases of such care and hence its responsibility for reimbursing patients and their families for costs incurred.

Other provisions relate mainly to onerous contract liabilities.

18. Contingencies

Contingent liabilities

	31 March 2014	
	Parent £000	Consolidated Group £000
Employment tribunals	983	983
NHSLA LTPS excess liability as notified by NHSLA	17	17
LTPS	0	10
Continuing healthcare	84,651	121,356
NHSLA employee liability claim	11	13
Legal claims	0	2
Under-utilised property lease liabilities	0	336
Contractual dispute	0	3,800
Net value of contingent liabilities	**85,662**	**126,517**

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.

Further information relating to the nature of continuing healthcare liabilities is given in note 17.

There were no contingent liabilities in the prior 6 month period ending 31 March 2013.

19. Commitments

19.1 Capital Commitments

	Parent		Consolidated Group	
	31 March 2014 £000	31 March 2013 £000	31 March 2014 £000	31 March 2013 £000
Property, plant and equipment	**14,921**	1,300	**18,063**	1,300
Intangible assets	**0**	0	**0**	0
Total	**14,921**	1,300	**18,063**	1,300

19.2 Other Financial Commitments

NHS England has entered into non-cancellable contracts (which are not leases, private finance initiative contracts or other service concession arrangements). The most significant contracts relate to a number of independent sector treatment and other healthcare centres and a contract with NHS Shared Business Services for the provision of an accounting system and related services.

	Parent		Consolidated Group	
	31 March 2014 £000	31 March 2013 £000	31 March 2014 £000	31 March 2013 £000
In not more than one year	**99,880**	15,867	**159,271**	15,867
In more than one year but not more than five years	**86,326**	30,760	**134,921**	30,760
In more than five years	**282**	0	**28,059**	0
Total	**186,488**	46,627	**322,251**	46,627

20 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 NHS England in undertaking its activities.

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

20.1 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 and therefore has low exposure to currency rate fluctuations.

20.2 Interest Rate Risk

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

20.3 Credit Risk

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

20.4 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.

20.5 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.

21. 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 211 clinical commissioning groups whose accounts are consolidated within these Financial Statements. These bodies are regarded as related parties with which the Parent has had various material transactions during the year; those transactions are disclosed in those entities' financial statements.

The following individuals hold director positions within NHS England and during the year NHS England has transacted with other organisations to which the directors are connected. Details of these relationships and transactions are set out below.

Name and Position in NHS England	Related party	Nature of relationship	Payments to Related Party £000	Receipts from Related Party £000	Amounts owed to Related Party £000	Amounts due from Related Party £000
Professor Sir Malcom Grant – Chair	University College London (UCL)	Non-executive; Former President and Provost	951	0 0	5	0
Sir David Nicholson – Chief Executive to 31 March 2014	Birmingham Children's Hospital	Wife is Chief Executive	161,955	0	2,818	1
Tim Kelsey – National Director	ZPB Ltd	Partner is a Director	20	0	0	0
Lord Victor Adebowale – Non-executive Member	Turning Point	CEO and Company Secretary	511	0	113	0
Ciaran Devane – Non-executive Member	Macmillan Cancer Support	Chief Executive	1	66	0	47
Dame Moira Gibb – Non-executive Member	Achieving for Children, London Boroughs of Kingston and Richmond	Board Member	0	21	0	0
	University of Reading	Council Member	6	0	0	0
Ed Smith – Non-executive Member	University of Birmingham	Chair of Council	235	0	9	0
Naguib Kheraj – Non-executive Member (to 10 December 2013)	Wellcome Trust	Member of the Investment Committee	2	0	0	0

The Department of Health is regarded as a related party. During the year NHS England has had a significant number of material transactions with entities for which the Department is regarded as the parent Department.

For example:

- NHS Foundation Trusts;
- NHS Trusts;
- NHS Litigation Authority; and,
- NHS Business Services Authority.

In addition, NHS England has had a number of material transactions with other government departments and other central and local government bodies. Most of these transactions have been with Local Authorities in respect of joint enterprises.

22. Events after the end of the Reporting Period

There are no events after the reporting period which will have a material effect on the Financial Statements of NHS England.

The date the Financial Statements were authorised for issue by the Accounting Officer is included at the foot of the Statement of Financial Position.

23. Losses & Special Payments

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

The total number of NHS England losses and special payments cases, and their total value, are detailed below.

23.1 Losses

	Parent		Consolidated Group	
	2013–14 Total Number of Cases	2013–14 Total Value of Cases £'000	2013–14 Total Number of Cases	2013–14 Total Value of Cases £'000
Administrative write-offs	1	120,183	1	120,183
Fruitless payments	1	23	11	539
Cash losses	1	1	4	3
Claims abandoned	0	0	1	1
Total losses	**3**	**120,207**	**17**	**120,726**

Bookkeeping loss – Impairment of assets following NHS reorganisation

The group has recorded impairments related to property, plant and equipment totalling £120.2 million. The majority of this number related to impairment of assets transferred to the group from the entities that closed on 1 April 2013, primarily primary care trusts. The transition required NHS England to examine the accounting records related to the transferred assets, as provided by 161 entities from which the assets came. Where information was not sufficient to enable the organisation to capitalise assets previously held on primary care trust balance sheets, an impairment has been recorded. Government accounting guidelines surrounding the transition required that such impairments be recorded in the receiving entity. There is no evidence that any assets were lost during the transition.

Reversal of receivable balances following NHS reorganisation

The 1 April 2013 transfer of accounting balances from the abolished strategic health authorities and primary care trusts to receiver organisations included the transfer of working capital balances, predominantly payables and receivables, at the value recorded in the audited accounts of the strategic health authorities and primary care trusts. As per standard accounting practice, these balances incorporated a number of accounting estimates (such as holiday pay accruals and the discounting of long term receivables and payables) made in good faith based on the best available information at the point the 2012–13 accounts were produced and audited. As would be the case in a standard year where no transfer had taken place, many of these balances required adjustment in the subsequent accounting period (the 2013–14 financial year) when more accurate information, such as an invoice, became available.

Whilst technical accounting adjustments of this nature are routine and do not represent losses, in some instances the working papers supporting the balances transferred did not contain sufficient information to establish the precise nature of individual balances. As such, whilst the available evidence suggests technical accounting adjustments have taken place, for a proportion of the receivable balances transferred NHS England is unable to demonstrate the adjustments made are of a technical accounting nature and are not the write-down of irrecoverable debts. In light of this, whilst the total value of transferred receivables reversed to Comprehensive Net Expenditure is not a loss (hence its non-inclusion within the tabular Losses Statement that forms part of this note), it is disclosed here for transparency. NHS England reversed £179,456k of receivable balances previously recorded in the audited accounts of strategic health authorities and primary care trusts and transferred to it on 1 April 2013 under the provisions of the Health & Social Care Act 2012.

23.2 Special Payments

	Parent		Consolidated Group	
	Total Number of Cases 2013–14	Total Value of Cases 2013–14 £'000	Total Number of Cases 2013–14	Total Value of Cases 2013–14 £'000
Compensation payments	0	0	9	10
Ex gratia payments	1	3	14	15
Total special payments	**1**	**3**	**23**	**25**

24. Entities within the Consolidated Group

NHS England acts as the Parent of the group comprising 211 clinical commissioning groups whose accounts are consolidated within these Financial Statements.

A full list of the clinical commissioning groups can be found on the NHS England website.

Annexes

Annex A: Business Model

The National Health Service Act 2006 (as amended) defines the duty of NHS England as being, jointly with the Secretary of State, to:

…continue to promote in England of a comprehensive health service designed to secure improvement:

- *In the physical and mental health of the people of England; and,*
- *In the prevention, diagnosis and treatment of physical and mental illness,*

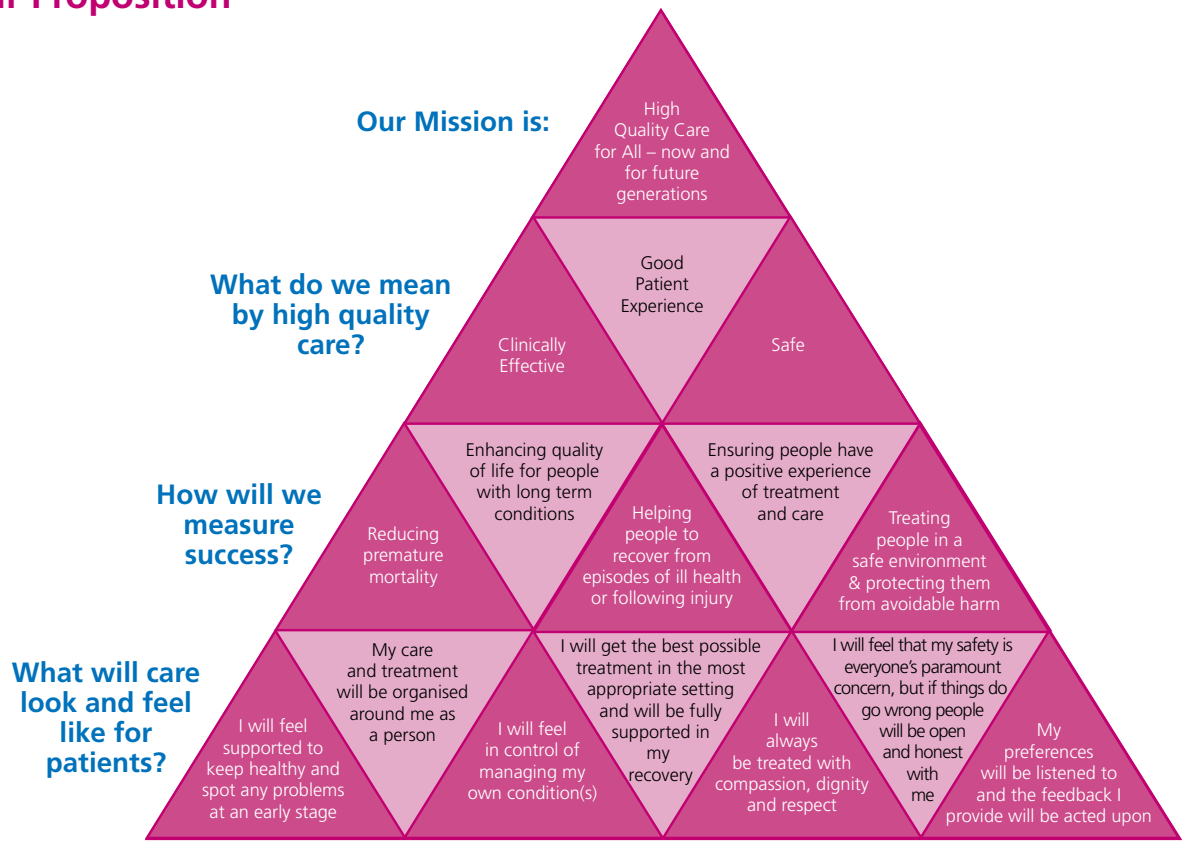
…except in relation to the part of the health service that is provided in pursuance of the public health functions of the Secretary of State or local authorities.

The Mandate sets the strategic direction for NHS England and is the main basis of ministerial instruction to the NHS.

A refreshed Mandate from the Government to NHS England, issued in November 2013, sets out the ambitions for the health service for April 2014 to March 2015. It sets out 25 objectives for NHS England structured around five main areas where Government expects, and NHS England aspires, to make improvements:

- Preventing people from dying prematurely;
- Enhancing quality of life for people with long-term conditions;
- Helping people to recover from episodes of ill health or following injury;
- Ensuring that people have a positive experience of care; and,
- Treating and caring for people in a safe environment and protecting them from avoidable harm.

Our Proposition



Annex B: 2013–14 Business Plan Deliverables

Chapter One: Preventing People from Dying Prematurely

2013–14 Business Plan Deliverable		Status
1.1	Clinical leadership will underpin all of our work to ensure sufficient focus on outcomes. We will produce vision statements for each Outcomes Framework domain by May 2013 setting out the high level approach the commissioning system will take to improve outcomes and reduce health inequalities	Completed
1.2	We will produce and embed single operating models for all directly commissioned services by June 2013. These will deliver improved outcomes by driving up standards in mental and physical health service provision and address unwarranted variation in current practice. At least 80% of direct commissioning intentions delivered to time by April 2014	Completed
1.3	Our oversight and leadership of the commissioning system will ensure robust planning and delivery of outcomes improvements that make sense locally and take account of health inequalities. At least 80% of outcomes improvements identified in clinical commissioning group plans delivered by April 2014	Completed
1.4	Our 10 year strategy will develop a framework for sustainable improvements in outcomes and addressing health inequalities over the medium term. Strategic documents will be published throughout 2013–14	Completed
1.5	We will undertake an Urgent and Emergency Care Review, to develop National Medical national framework that will enable clinical commissioning groups Director to commission high quality urgent and emergency care services across NHS England for April 2015. The first stage of the Review is to publish high level principles in 2013	Continuing – on track
1.6	We will deliver a range of programmes throughout 2013–14 that will support rapid diffusion and adoption of innovative practices and ideas to support outcomes improvement	Continuing – on track
1.7	We will produce a range of support tools and guidance to help commissioners throughout 2013–14 and beyond. For each product, we will ensure there is a direct connection to improving outcomes	Completed
1.8	We will use financial incentives to reward improvements in outcomes. The Quality Premium will be paid to clinical commissioning groups that in 2013–14 improve or achieve high standards of quality for four key measures in the NHS Outcomes Framework	Completed
1.9	We will publish a strategy for promoting equality and reducing health inequalities by March 2014. Our aim for each domain is to deliver interventions that offer maximum gain to those who are most in need and to demonstrate parity between physical and mental health care	Completed
1.10	We will measure improvements both at domain level for each of the five Outcomes Framework domains and at individual indicator level where data is available. Our aim is to deliver measurable progress on each area by March 2015	Continuing – on track
1.11	We will assess health inequalities across a range of dimensions both at domain level for each of the five Outcomes Framework domains and at individual indicator level where data allows. Our aim is to deliver continuing progress on each indicator. We will also broaden our understanding of health inequalities across the breadth of the Framework and identify the measurable progress which we can expect to make on health inequalities across the Framework	Continuing – on track
2.1	The actions set out in the overarching objective relating to all five domains of the outcomes framework all apply to this objective which focuses specifically on domain one (preventing people from dying prematurely)	Completed
2.2	Our clinical vision for domain one (published in May 2013) will set out the approach the commissioning system will take to improve outcomes and tackle inequalities in relation to mortality. This will focus particularly on prevention and earlier diagnosis of illness	Completed
2.3	Addressing premature mortality will be a focus of all directly commissioned services	Continuing – on track
2.4	As set out in Everyone Counts, there will be a particular focus on earlier diagnosis, improving management in community settings, improving acute and mental health services, and preventing recurrence after an acute event	Continuing – on track

2013–14 Business Plan Deliverable		Status
3.1	We will comply with NICE guidance and standards in our direct commissioning activity. Building on the authorisation process we will support and assure clinical commissioning groups to meet NICE requirements through their commissioning and contracting arrangements on an on-going basis	Continuing – on track
3.2	We will improve outcomes through our role as commissioners of screening and immunisation services, and of health intervention services for children 0-5 years	Continuing – on track
3.3	As commissioners of primary care in England, we will develop the GP contract to support improvements in outcomes, including risk stratification, earlier diagnosis and roll-out of health checks	Completed
3.4	We will develop new measures for mental health access and outcomes that aim to reintegrate mental and physical wellbeing during 2013–14. These will be used by clinical commissioning groups to understand and tackle variation locally	Continuing – delayed
3.5	We will measure health and wellbeing of the NHS workforce through the staff friends and family test and staff sickness absence rates on an on-going basis	Continuing – on track

Chapter Two: Enhancing Quality of Life for People with Long Term Conditions

2013–14 Business Plan Deliverable		Status
4.1	The actions set out in the overarching objective relating to all five domains of the outcomes framework all apply to this objective which focuses specifically on domain two (enhancing the life for people with long term conditions)	Completed
5.1	We are developing information, advocacy and support services to empower use of information as a means of managing health. We will launch the Customer Services Platform, a public facing multi-channel customer response service spanning health and social care, by November 2013	Continuing – delayed
5.2	80% of clinical commissioning groups will be commissioning to support patients' participation and decisions over their own care or will have a plan to do so by December 2013. This includes information and support for self-management, personalised care planning and shared decision making within normal service planning and commissioning	Continuing – delayed
5.3	The Health Online Programme will improve the way in which people interact with health services, including online access to key elements of the care process. 100,000 citizens will be trained in basic online skills to boost health literacy by April 2014	Continuing – delayed (Procurement Issues)
5.4	The re-launch of Choose & Book will make e-referrals available to patients and health professionals for all secondary care referrals by 2015	Continuing – delayed
5.5	Personalised budgets will provide a route for people to have more control over managing their health. Personal health budgets will be offered to those who would benefit by March 2015. 100% of clinical commissioning groups will be able to deliver personal health budgets, including direct payments, for people receiving NHS continuing health care by April 2014	Continuing – on track
5.6	We will encourage collective and collaborative participation in the NHS by establishing the Civil Society Assembly. Feedback from the voluntary/community sector and Civil Society Assembly demonstrates over 80% are satisfied with the involvement of patients and the public in the planning and commissioning of services by NHS England	Completed
5.7	We will use the reported experience of people to assess whether they feel they are being supported to manage their conditions (outcomes framework indicator 2.1)	Completed
6.1	We will continue the roll out of telehealth and telecare towards the 3 million by March 2017 ambition set out in Innovation Health & Wealth	Continuing – on track
6.2	We will improve online access to primary care. 50% of practices will offer the facility to order repeat prescriptions and to book appointments by April 2014 with 100% achieving this by March 2015. 100% of practices will have the technical capability to allow people to access their records by April 2014 and 100% will be offering this option to patients by March 2015	Continuing – delayed

2013–14 Business Plan Deliverable		Status
6.3	We will have a new NHS e-referrals service operational by December 2013 and 100% of referrals will be made electronically by March 2017	Continuing – delayed
7.1	As set out in Everyone Counts, the integration of the provision of services, including where appropriate the pooling of budgets to reflect local need, is an explicit requirement in local area planning. Integrated care proposals will be implemented in every Health & Wellbeing Area by April 2014	Completed
7.2	We will publish a common purpose framework for integrated care with national partners by May 2013	Completed
7.3	We will measure progress in this area through the new outcomes framework indicator on patient experience of integrated care (indicator 4.9 – currently under development)	Continuing – on track
8.1	Everyone Counts emphasised the importance of dementia diagnosis and care. We are collecting and assuring plans for improving dementia diagnosis rates and will monitor delivery throughout the year. The clinical commissioning group plans will demonstrate ambition for significant improvements in dementia diagnosis rates	Completed
8.2	As part of our nursing strategy Compassion in Practice we will publish a range of tools and resources aimed at supporting the nursing contribution to the dementia challenge. These resources will be published between April and July 2013	Completed
8.3	Our clinical vision for domain two of the outcomes framework will be published in May 2013. This will include how the commissioning system can work to deliver improved outcomes for dementia	Completed
8.4	A portion of the CQUIN payment from commissioners to providers will be linked specifically to improving dementia care	Completed
8.5	Through direct commissioning of general practice, we will provide appropriate incentives and rewards for improving dementia services, including a direct enhanced services for dementia	Completed

Chapter Three: Helping People to Recover from Episodes of Ill Health

2013–14 Business Plan Deliverable		Status
9.1	We will ensure that all NHS funded patients will have the opportunity to leave feedback in real time on any service by 2015	Continuing – on track
9.2	We will publish outcomes data for all major services by March 2015. Our starting point will be the ten surgical specialties set out in Everyone Counts which will be published in Summer 2013	Continuing – on track
9.3	A modern data service, care.data in physical and mental health services and social care will be established to ensure infrastructure is in place to support collection, storage, validation and presentation of care data: • 95% of trusts will be using the NHS number as the prime identifier in clinical correspondence by January 2015; • 75% of GP practices will be providing the full extract to care.data by September 2013; and, • 75% of hospital trusts will be providing patient level prescribing data to care.data by December 2015	Continuing – delayed
9.4	We will collect a core set of clinical data from GP practices for 2013–14	Continuing – delayed
9.5	Mental health trust providers will achieve 100% completion of the mental health minimum data set, and will publish regular information on key indicators (use of mental health act, physical health assessments and treatments as well as the results of peer accreditation and national audits with the early focus on safety in medicines and services for people with schizophrenia) in 2013–14	Completed

2013–14 Business Plan Deliverable		Status
10.1	We will introduce service change and reconfiguration policy and guidance, which will be implemented from April 2013. This will ensure that the four tests are appropriately applied in all service reconfiguration. We will receive systematic assurance by: • Each clinical commissioning group providing confirmation it has carried out a clinically-led quality impact assessment; • Use of local metrics and intelligence such as views of patients and staff, and other more clinically based tools such as the NHS Safety Thermometer; and, • A line of sight on the clinical assurances that there has been no clinically inappropriate reduction in the availability of local services	Completed
10.2	We will identify with the Local Government Association opportunities for closer alignment and integration to inform service reconfiguration	Continuing – on track
10.3	We will identify and publish evidence-based optimum clinical pathways to support local reconfigurations	Continuing – on track
11.1	Everyone Counts sets out the requirements on clinical commissioning groups to ensure sufficient emphasis on care for those with mental health issues	Completed
11.2	We will oversee the roll out of Improving Access to Psychological Therapy, towards the Mandate objective for improving timely access for at least 15% of adults, with a recovery rate of 50% by March 2015	Continuing – on track
11.3	From 2014–15, the Quality Premium paid to clinical commissioning groups for delivery of improved outcomes will include Mental Health measures	Completed
11.4	We will measure improvement against indicator 1.5 and 1.7 in the Outcomes Framework – excess under 75 mortality for those with a serious mental illness, and excess under 60 mortality rate in adults with a learning disability (indicator under development). During 2013–14, we will develop improved measures relating to parity of esteem	Continuing – delayed
11.5	We will work with partners to develop better mental health informatics and new measures for mental health access and outcomes that aim to support reintegration of mental and physical wellbeing during 2013–14. These will be used by clinical commissioning groups to understand and tackle variation locally	Continuing – delayed

Chapter Four: Ensuring that People have a Positive Experience of Care

2013–14 Business Plan Deliverable		Status
12.1	We will ensure delivery of all of the actions set out in the Winterbourne View concordat in 2013–14	Continuing – delayed
12.2	We will deliver all of the actions set out in the response to the Francis Report	Continuing – on track
12.3	We will work to ensure that the views of vulnerable people, their families and carers are routinely used in the planning and delivery of services	Continuing – on track
12.4	We will support clinical commissioning groups to improve outcomes across the full range of the NHS Outcomes Framework and act proactively, with our support when appropriate, should they identify or anticipate a quality or safety issue in a provider. That includes wider system responses, such as acting on the Winterbourne View and Francis reports	Continuing – on track
13.1	The majority of indicators within the NHS Outcomes Framework relate directly or indirectly to older people. Our domain visions we will ensure that there is sufficient emphasis and focus on older populations	Completed
13.2	Our objectives in relation improving diagnosis and care for dementia services set out above will also support this objective	Continuing – on track
13.3	We will support a delivery framework and enablers that promotes person centred co-ordinated care which addresses physical and mental health comorbidity and frailty	Continuing – on track
13.4	We will use the common purpose framework to continue pioneering greater integrated working between health and social care and physical and mental health	Continuing – on track

2013–14 Business Plan Deliverable		Status
13.5	We will begin implementation of 70% of the actions set out in Compassion in Practice by April 2014	Continuing – delayed (Unable to measure)
13.6	We will deliver Leadership Academy core programmes to 2,000 staff by March 2014	Completed
14.1	The Friends & Family Test will be introduced for 100% of acute hospital inpatients and accident and emergency patients from April 2013 and for women who have used maternity services from October 2013. Our aim is that there will be a 30% improvement in trust scores by 2014–15	Continuing – on track
14.2	We will use financial incentives to reward performance in relation to the Friends & Family Test. In 2013–14, a portion of CQUIN funding will be linked specifically to the Test	Completed
14.3	The Quality Premium will be paid to clinical commissioning groups that in 2013–14 improve or achieve high standards of quality for four key measures in the NHS Outcomes Framework. One of these measures relates to Friends & Family Test	Completed
14.4	We will measure improvements against domain four indicators of the outcomes framework which relate to patient experience of NHS services. Our aim is to deliver measurable progress on each area by March 2015	Continuing – on track
15.1	The Friends & Family Test will be introduced for women who have used maternity services from October 2013. We will use this, and indicator 4.5 of the Outcomes Framework (improving women and their families experience of maternity services) to assess overall progress against this objective	Completed
15.2	We will host the Strategic Clinical Network for children and maternity services. In 2013–14 we will work to ensure these networks are developing arrangements to support local health systems to improve choice and outcomes	Completed
15.3	We will for the first time have a National Clinical Director for Maternity & Women's Health to lead on clinical service improvement, reducing variation and generating information for the public on maternity services	Completed
16.1	Our vision statement for domain two will be published May 2013 will include how the system we will deliver improved outcomes and reduced inequalities for children and young adults with special education needs or disabilities	Completed
16.2	Personalised budgets will be offered to children and young people who would benefit by March 2015	Continuing – on track
17.1	We will uphold the NHS Constitution in both our direct commissioning, and oversight of clinical commissioning group functions. Everyone Counts sets out the expectations on clinical commissioning groups for continued delivery of the NHS Constitution. NHS England, through its area teams, will oversee clinical commissioning group delivery of the NHS Constitution rights and pledges on an on-going basis, providing additional support and intervention where required	Continuing – on track
17.2	We will fulfil our duty to promote the NHS Constitution and seek sustained improvement through a coordinated, system-wide approach. We are working with partners and stakeholders to co-develop and implement a joint system-wide strategy for promoting and embedding the Constitution, including appropriate means of monitoring progress and impact. This strategy will be available by September 2013	Continuing – delayed
17.3	We will develop new measures for mental health access and outcomes that aim to reintegrate mental and physical wellbeing. These will be used by clinical commissioning groups to understand and tackle variation locally	Continuing – delayed

Chapter Five: Treating and Caring for People in a Safe Environment and Protecting them from Avoidable Harm

2013–14 Business Plan Deliverable		Status
18.1	The actions set out in the overarching objective relating to all five domains of the Outcomes Framework all apply to this objective which focuses specifically on domain five (treating and caring for people in a safe environment and protect them from avoidable harm)	Continuing – on track

2013–14 Business Plan Deliverable		Status
18.2	Quality surveillance groups will be operational in every region from April 2013. They will bring together local commissioners regulators and other bodies to provide multi agency surveillance and response to quality and safety issues in all areas of healthcare	Completed
18.3	We are introducing a zero tolerance approach to MRSA infections. We expect all cases will involve a Post Infection Review to identify why an infection occurred, and how future cases can be avoided. Reducing the incidence of MRSA and Clostridium Difficile infections will be one of the national measures used to calculate the Quality Premium for clinical commissioning groups	Continuing – on track
18.4	CQUIN payment by commissioners when providers deliver a level of quality over and above that stipulated in the NHS Standard Contract. A portion of the CQUIN funding will be linked specifically to improvement against the NHS Safety Thermometer	Completed
18.5	All area teams will implement primary care quality assurance for all contractor service	Continuing – on track

Chapter Six: Freeing the NHS to Innovate

2013–14 Business Plan Deliverable		Status
19.1	Everyone Counts sets out the framework by which we expect local health systems to plan. Our aim is to provide the freedom and support for clinical commissioning groups to develop their own priorities through their input into the joint Health & Wellbeing Strategy	Completed
19.2	We have asked each clinical commissioning group to identify local priorities against which it will make progress during the year – these will form part of our assurance of each clinical commissioning group when determining if the clinical commissioning group should be rewarded through the Quality Premium	Completed
19.3	We will support the development of commissioning support units nationally through on-going robust assurance processes. A future development strategy will be published in November 2013, and commissioning support units will be externalised and viable by March 2016. We will measure progress through clinical commissioning group feedback on commissioning support unit services	Continuing – on track
19.4	We will assess how we are doing against this objective through comprehensive 360 degree feedback from national and local partners and stakeholders. We will aim to deliver positive overall feedback on our development support and tools, resources and guidance provided to clinical commissioning groups	Completed
20.1	A Choice & Competition Framework and supporting documents will be published by July 2013. This will set out guidance for how clinical commissioning groups can use choice and competition as levers to improve standards of care. This will include guidance in relation to the use of any qualified provider contracts	Continuing – delayed
20.2	NHS England is working in partnership with Monitor to develop a long term strategy for NHS pricing. This will expand the scope of the pricing where feasible and consistent with improving outcomes	Continuing – on track

Chapter Seven: The Broader Role of the NHS in Society

2013–14 Business Plan Deliverable		Status
21.1	We will establish a new Industry Council to identify and work through issues of mutual interest to NHS England and the UK life sciences industry, where this will generate benefits for patients and taxpayers, and support economic growth in the UK	Continuing – on track
21.2	We will establish Academic Health Science Networks from April 2013 to bring together expertise in research, education, information, dissemination and implementation methods and innovation to translate research into practice	Completed
21.3	Our flexible procurement programme for genomics will be in place by March 2014. It will throughput sequence 100,000 genomes in UK in the next three years	Continuing – delayed
21.4	We will develop an R&D strategy to set out the key areas of focus for our activities related to research	Continuing – delayed

2013–14 Business Plan Deliverable		Status
21.5	We will establish a system to involve all NHS commissioners of healthcare in setting national R&D priorities	Continuing – on track
21.6	We will establish mechanisms to increase participation in research both by NHS organisations, and NHS patients	Continuing – on track
22.1	Partnership agreements have been established for seven key national partners. These will be enacted from April 2013. In addition, we will consider whether this approach would offer a sensible way forward for formalising our relationships with other strategic partners	Continuing – on track
22.2	We will work closely with partners on key quality and safety issues through Quality Surveillance Groups from April 2013	Completed
22.3	We are facilitating joined up planning locally. Everyone Counts sets out the requirements on clinical commissioning groups and area teams to work with local partners to develop a joint Health & Wellbeing Strategy	Completed
22.4	We will ensure that there is a capable system of safeguarding linked Chief Nursing to quality assurance	Continuing – on track
22.5	We will continue and we worked with Public Health England and the Local Government Association to issue benchmarking support packs for each health and wellbeing area – setting out performance and variation against the NHS, adult social care and public health outcomes frameworks to inform joint strategies	Completed
22.6	We will conduct further exercises in each region to ensure incident Chief Operating response plans and reporting arrangements are alignment with key Officer partner agencies, and implement findings	Continuing – on track
22.7	We will publish an updated NHS Pandemic Influenza Guidance in Chief Operating preparation for the cross government Pandemic Influenza Exercise	Completed
22.8	We will carry out comprehensive 360 degree feedback from national and local partners and stakeholders to measure our success	Completed

Chapter Eight: Finance

2013–14 Business Plan Deliverable		Status
23.1	Our oversight and leadership of the commissioning system will ensure robust planning and financial management. We will assure clinical commissioning groups' QIPP plans as part of the planning process, and monitor clinical commissioning groups' financial performance throughout the year. Our annual assessment of clinical commissioning groups will include an assessment of financial performance. We will apply the same approach to direct commissioning activity	Completed
23.2	We will review NHS allocations methodology to ensure it is as fair as possible and consistent with our objectives. This will be completed by September 2013	Completed
23.3	We will develop a range of tools and guidance to support clinical commissioning groups deliver transformational change in relation to their QIPP objectives. The first tranche of six of these resources will be published by September 2013	Completed
23.4	We will use financial incentives to reward good financial performance. A clinical commissioning group will not receive the Quality Premium reward if it has overspent its approved Resource Limit in 2013–14	Completed

Chapter Nine: Assessing Progress and Providing Stability

2013–14 Business Plan Deliverable		Status
24.1	As stated above, we will publish outcomes data for all major services, both directly commissioned and clinical commissioning group commissioned by March 2015. Our starting point will be the 10 surgical specialties set out in Everyone Counts which will be published in summer 2013	Continuing – on track

Annex C.1: Authorisation & Assurance Committee Report

Role & Responsibilities

The Committee was renamed (previously the Clinical Commissioning Group Authorisation Sub-committee) and new terms of reference approved by the Chair on behalf of the Board on 16 September 2013.

The purpose of the Committee is to provide oversight and assurance of clinical commissioning group capacity and capability and how NHS England ensures that the appropriate support is given to clinical commissioning groups and standards are met.

Committee Composition & Attendance

Committee membership during the financial year and since the year end, and attendance at meetings during the financial year, were as follows:

Membership	Meetings attended/eligible to attend (2013–14)		
	July	October	January
Victor Adebowale (Chair)	✓	✓	✓
Ciaran Devane	×	✓	✓
Naguib Kheraj (to 10 December 2013)	✓	✓	
Chief Financial Officer or designated deputy	✓	D	D
Chief Operating Officer or designated deputy	✓	×	✓
National Medical Director (NMD) or Chief Nursing Officer (CNO) or designated deputy	CNO	NMD	CNO
National Director: Commissioning Development or designated deputy	✓	D	✓

D = Designated deputy attended

The Committee does not have any formal Sub-committees.

An Assurance Oversight Group and CCG Assurance Working Group have been established to discharge the management functions that support the Committee.

Committee Effectiveness

The Committee has established a work plan for the year forward, which is reviewed and updated at each meeting of the Committee.

The Committee has undertaken an assessment of its effectiveness, the outcome of which will be reported to the Board in the Committee's annual report to the Board.

The Committee's Work

The Committee's main activities through the year have been:

- Consideration of the results of the interim quarter 1 and quarter 2 assurance process and consideration of quarter 3 assurance conversations;
- Considering and agreeing proposals to remove/vary conditions to authorisation, and the removal/variation of directions;
- Development of clinical commissioning group assurance process and recommending to the Board for approval;
- Consideration of whether the assurance process has been applied consistently and fairly across the country; and,
- Consideration of the role of Area Teams in developing CCGs.

Annex C.2: Commissioning Support Committee Report

Role & Responsibilities

The establishment of the Committee was approved by the Board on 12 April 2013, together with its terms of reference.

The purpose of the Committee is to oversee assurance and development of commissioning support units.

The Committee has full delegated authority from the Board to decide how commissioning support units are governed, developed and assured during their transition to full independence.

Committee Composition & Attendance

Committee membership during the financial year and since the year end, and attendance at meetings during the financial year, were as follows:

Membership	Meetings attended/eligible to attend (2013–14)					
	April	June	September	November	January	March
Moira Gibb (Chair)	✓	✓	✓	✓	✓	✓
Margaret Casely-Hayford	✓	✓	✓	✓	×	✓
Ed Smith	✓	✓	✓	✓	✓	✓
Chief Financial Officer or designated deputy	×	D	✓	✓	D	D
National Director: Commissioning Development or designated deputy	✓	✓	✓	✓	✓	✓
National Director: Human Resources & Organisation Development or designated deputy (to 31 March 2014)	×	✓	✓	✓	✓	×
National Director for Patients & Information or designated deputy	×	✓	✓	D	×	✓
Director of CSU Transition Programme	✓	✓	✓	✓	✓	✓
Director of Commissioning Support Services, Strategy & Market Development	✓	✓	✓	✓	✓	✓

The Committee does not have any Sub-committees.

Committee Effectiveness

The Committee has established a work plan for the year forward, which is reviewed and updated at each meeting of the Committee.

The Committee will undertake an assessment of its effectiveness, the outcome of which will be reported to the Board in the Committee's annual report to the Board.

The Committee's Work

The Committee's main activities through the year have been:

- Establishing a balanced scorecard and escalation and intervention process to oversee the assurance, governance and financial arrangements for commissioning support units;
- Shaping the strategy for the development of the market for commissioning support, published in June 2013, to ensure that all commissioners can choose to get access to high quality, affordable support;
- Supporting the transition arrangements in Surrey & Sussex and in Anglia to ensure clinical commissioning groups in those areas could continue to source services from viable commissioning support providers;
- Contributing to the launch of the Lead Provider Framework for commissioning support services. This will accredit the best suppliers in the market for clinical commissioning groups and NHS England to source support from at a faster pace than having to undertake full procurement; and,
- Contributing to the development of the strategy to move commissioning support units out of the NHS England hosting arrangement by the end of 2016 into a shortlist of autonomous forms.

Annex C.3: Directly Commissioned Services Committee Report

Role & Responsibilities

The establishment of the Committee was approved by the Board on 12 April 2013, together with its terms of reference.

The purpose of the Committee is to oversee the delivery of directly commissioned services within the overall strategy set by NHS England, including assurance of the direct commissioning functions in NHS England.

Committee Composition & Attendance

Committee membership during the financial year and since the year end, and attendance at meetings during the financial year, were as follows:

Membership	Meetings attended/eligible to attend (2013–14)		
	July	October	January
Malcolm Grant (Chair)	✓	✓	✓
Victor Adebowale	✓	×	×
Chief Executive		✓	×
Chief Financial Officer or designated deputy	D	×	✓
Chief Nursing Officer or designated deputy	D	×	×
Chief Operating Officer or designated deputy	✓	✓	✓
National Director: Commissioning Development or designated deputy		D	✓
National Director: Policy or designated deputy		×	×
National Director for Patients & Information or designated deputy	×	×	D
National Medical Director or designated deputy	D	×	✓
Director of Commissioning (Corporate)	✓	✓	✓
Regional Director: North	✓	×	✓
Clinical Commissioning Group Representative		✓	✓

D = Designated deputy attended

The Committee does not have any formal Sub-committees.

The Committee is supported in its work by the:

- Clinical priorities advisory group;
- Armed forces oversight group;
- Health and justice oversight group;
- Primary care oversight group;
- Public health oversight group;
- Specialised commissioning oversight group; and,
- Primary care support services task and finish group (from January 2014): a time limited group established to provide oversight of the transformation programme.

The oversight groups:

- Oversee national agreements with other parties;
- Ensure quality standards are defined;
- Agree priorities and resources;

- Assure that services are being delivered to quality standards within agreed budgets;
- Assure that appropriate planning is in place; and,
- Assure that the NHS Commissioning Board has the capacity and capability to commission well.

Committee Effectiveness

The Committee has established a work plan for the year forward, which is reviewed and updated at each meeting of the Committee.

The Committee keeps its performance and effectiveness under constant review, and as a consequence has adjusted its way of working and terms of reference during the year.

The Committee's Work

The key issues considered during the year by the Committee were:

- The six functional areas required to enable NHS England to discharge its duties plus the terms of reference to reflect these key areas;
- The function of the clinical priorities advisory group and the oversight groups. It was agreed that the clinical priorities advisory group and the oversight groups would not be regarded as Sub-committees;
- The endorsement of the recommendations of the clinical priorities advisory group for formal adoption by NHS England at each meeting;
- The receipt of detailed reports at each meeting on each of the five areas that are directly commissioned by NHS England: specialised services; primary care; public health; health and justice; and, armed forces and their families;
- The receipt of regular updates with regards to the public health Section 7a agreement, and consideration of the proposed arrangements for strengthening the governance for public health;
- The endorsement of proposals for negotiating improvements to the general dental services contracts and the personal dental services agreements for 2014–15;
- The specific primary care support services oversight arrangements and agreement to request two additional attendees (Ciaran Devan and Jo-Anne Wass) for a time-limited period;
- A summarised report on the key deliverables on specialised services and assurance that the plan is fully developed and resourced;
- An update on the Prime Minister's Challenge Fund for General Practice and acknowledgement that work is underway to secure the pilot sites and support; and,
- The progress made with liaison and diversion services was noted and confirmation was given that approval (subject to a number of caveats) was given outside of the Committee that NHS England should take lead responsibility from 1 April 2014.

Annex C.4: Efficiency Controls Committee Report

Role & Responsibilities

The Committee was renamed (previously the Procurement Controls Committee) and new terms of reference approved by the Chair on behalf of the Board on 16 September 2013.

The purpose of the Committee is to approve expenditure on activities relating to NHS England's functions, as set out in the National Health Service Act 2006 (as amended), and the Health & Social Care Act 2012 utilising, where appropriate, the delegated limits set out in Standing Financial Instructions for members in attendance (the Committee has no delegated budgetary authority of its own).

Committee Composition & Attendance

Committee membership during the financial year and since the year end, and attendance at meetings during the financial year, were as follows:

Membership	Meeting attendance (2013–14)	
	Could have	Did
Chief Executive (Chair to 16 September 2013)	16	0
Chief Financial Officer (Chair from 16 September 2013)	39	27
Audit Committee Chair	39	15
National Director: Human Resources & Organisation Development (to 31 March 2014)	39	19
National Director: Policy	39	30
Director of Financial Control (from 16 September 2013)	23	15

The Committee does not have any Sub-committees.

Committee Effectiveness

The Committee meets weekly, and has a standard agenda which is not cyclical in nature. It therefore does not operate a formal forward work programme planner.

The Committee is in the process of reviewing how it operates, given the significant increase in workload over the financial year. This includes the potential to use an electronic workflow management system to support development, review and approval of business cases. The outcome of the review will be reported to the Board once complete.

The Committee's Work

The Committee's main activities through the year have been the review and approval (or not) of business cases, and where necessary associated single tender action forms, for expenditure subject to Cabinet Office Efficiency Controls.

Annex C.5: Finance & Investment Committee Report

Role & Responsibilities

The establishment of the Committee was approved by the Board on 12 April 2013, together with its terms of reference.

The purpose of the Committee is to:

- Scrutinise financial planning and performance for NHS England and the wider commissioning sector, reviewing areas of concern and reporting to the Board as appropriate;
- Approve and agree changes to the financial policy framework for the commissioning sector;
- Approve expenditure on activities relating to NHS England's functions, as set out in the National Health Service Act 2006 (as amended) and the Health & Social Care Act 2012 utilising, where appropriate, the delegated limits set out in Standing Financial Instructions in the following categories:
  - Capital expenditure across the commissioning sector;
  - Revenue contracts that will be accounted for as capital expenditure across the commissioning sector;
  - PFI contract expenditure across the commissioning sector;
  - Reconfigurations;
  - NHS England income generation;
  - NHS England leases or managed service agreements whether accounted as revenue or capital; and,
  - NHS England expenditure financed by borrowing, however sourced;
- Approve NHS England financial policies.

Committee Composition & Attendance

Committee membership during the financial year and since the year end, and attendance at meetings during the financial year, were as follows:

Membership	Meetings attended/eligible to attend (2013–14)									
	10 June	1 July	31 July	2 Sept	30 Sept	18 Nov	2 Dec	13 Jan	3 Feb	7 Mar
Moira Gibb (Chair)	✓	✓	✗	✓	✓	✓	✓	✓	✓	✓
Ed Smith	✓	✗	✓	✓	✓	✓	✓	✓	✓	✓
Chief Financial Officer	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Chief Operating Officer (to December 2013)	✓	✗	✓	✗	✗	✗	✗			
National Director: Policy	✓	✓	✓	✗	✓	✓	✓	✓	✓	✗
Regional Director: Midlands & East (from January 2014)								✓	✓	✓

The Committee does not have any Sub-committees.

Committee Effectiveness

The Committee has established a work plan for the year forward, which is reviewed and updated at each meeting of the Committee.

The Committee will undertake an assessment of its effectiveness, the outcome of which will be reported to the Board in the Committee's annual report to the Board.

The Committee's Work

The Committee's main activities through the year have been:

- Reviewing and approving the financial policy framework for the commissioning sector;
- Considering NHS England's medium-term financial strategy, in relation to both revenue and capital, and making recommendations to the Board;
- Reviewing and recommending the overall annual revenue and capital budgets to the Board for approval, and then monitoring spend during the year;
- Monitoring the in-year financial performance of the commissioning sector;
- Approving capital allocations for 2013–14 and 2014–15;
- Considering and approving NHS England financial policies; and,
- Approving business cases on behalf of the Board.

Key investment approvals taken during the year included:

- **Royal National Orthopaedic Hospital:** the Committee approved the decision to issue a letter of support for the Phase 1 PFI redevelopment of the hospital;
- **Relocation from Maple Street to Skipton House:** the Committee reviewed the business case for the move of London-based staff from Maple Street to Skipton House;
- **Health & Justice Information Service:** the Committee approved the strategic outline case and gave authority to proceed to outline business case;
- **111 Telephony Infrastructure Re-procurement:** the Committee approved the process for the re-procurement of these services, when the current contract expires in March 2015;
- **Acquisition of Barnet & Chase Farm Hospitals NHS Trust by Royal Free London NHS Foundation Trust:** the Committee approved the proposal to sign the Heads of Terms for the acquisition and an urgent action of the Board was recommended to that effect;
- **Primary Care Support Services:** the Committee reviewed and discussed the work being done on developing the business case for the transformation of primary care services prior to the final business case being submitted to the Board for consideration;
- **Eltham Community Hospital Stage 2 LIFT Business Case:** the Committee approved the business case subject to conditions; and,
- **NHS e-referrals Telephone Appointment Line Business Case:** the Committee delegated authority for assurance of the full business case to the Chief Financial Officer, who then sought urgent action of the Board for its final approval.

Annex C.6: Quality & Clinical Risk Committee Report

Role & Responsibilities

The establishment of a Quality & Clinical Risk Committee was approved by the Board, at its meeting on 12 April 2013. The Committee met for the first time in September 2013.

The purpose of the Committee is to provide assurance that robust systems and processes are in place to enable NHS England to:

- Fulfil its statutory duty to act with a view to securing continuous improvement in the quality of services provided to individuals; and,
- Identify and manage effectively any quality or clinical risks associated with performing statutory and non-statutory functions.

Committee Composition & Attendance

Committee membership during the financial year and since the year end, and attendance at meetings during the financial year, were as follows:

Membership	Meetings attended/eligible to attend (2013–14)			
	Sept	Oct	Dec	Feb
Sir Cyril Chantler (Independent Chair)	✓	✓	✓	✓
Victor Adebowale	✗	✗	✗	✓
Ciaran Devane	✓	✓	✓	✓
Chief Nursing Officer	✓	✗	✓	✗
National Medical Director	✗	✓	✓	✓
Regional Director: Midlands & East	✓	✗	✗	✓
Deputy Medical Director	✓	✓	✓	✓
Deputy Chief Nursing Officer	✓	✓	✗	✗
NHS Commissioning Assembly Chair	✓	✗	✗	✗
NHS Commissioning Assembly Quality Working Group Chair	✓	✓	✗	✓
NICE Representative	✗	✓	✓	✓
Academy of Royal Medical Colleges Representative	✓	✗	✓	✓
Public & Patient Voices Representative			✓	✓
External Expert in Quality Measurement	✓	✓	✓	✓

The Committee does not have any Sub-committees.

Committee Effectiveness

The Committee has established a work plan for the year forward, which is reviewed and updated at each meeting of the Committee.

The Committee will undertake an assessment of its effectiveness, the outcome of which will be reported to the Board in the Committee's annual report to the Board.

The Committee's Work

The key issues considered during the year by the Committee were:

- **The Process of Medical Revalidation:** the Committee assessed the key risks associated with the process of medical revalidation and made recommendations to the Board on actions that should be taken to mitigate these;

- **The Operation of Quality Surveillance Groups:** the Committee considered the role of Quality Surveillance Groups in identifying and mitigating quality/clinical risks, and made recommendations on actions that could be taken to strengthen the effectiveness of the network, enabling risks in the system to be identified more easily;
- **The Proposal to ask NHS England Area Teams and Clinical Commissioning Groups to Set Levels of Ambition for Improving Outcomes:** the Committee concluded that this approach would be an important step forward in enabling NHS England to fulfil its statutory duty in relation to driving continuous quality improvement;
- **Board Assurance Framework:** the Committee provided some initial advice on the revision of the Board Assurance Framework and on the quality/clinical risks included. It committed to engaging with the Audit Committee on the revision of the Board Assurance Framework and management of the quality/clinical risks identified on the Board Assurance Framework, on an ongoing basis;
- **Preparation for Winter Pressures:** the Committee had a brief, verbal update on the plans put in place to help A&E departments sustain their performance over winter. They concluded that the processes put in place appeared to be robust. This topic would be considered in summer to consider how well the processes worked for winter 2013 and to make recommendations based on that for winter 2014;
- **Patient Safety:** the Committee considered how NHS England was executing its responsibilities in terms of patient safety and made recommendations on those actions that could be taken to improve the functioning of some patient safety systems;
- **Role of Quality Measurement in Driving Continuous Quality Improvement and Identifying Quality/Clinical Risks:** the Committee concluded that NHS England should devise a strategy to align all the activity underway within NHS England, to maximise efforts to improve quality in different areas;
- **Dealing with Risk:** the Committee invited the Head of Internal Audit to present on approaches to risk management, in order to understand better the role of the Committee in NHS England's overall risk management structure;
- **CCG Assurance Framework:** the Committee considered the framework used to assure clinical commissioning group commissioning, and made recommendations on how this could be strengthened; and,
- **Quality in Primary Care:** the Committee considered the actions underway to improve quality in primary care and made additional recommendations on what more NHS England could do to improve quality.

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