NHS England

OUR 2014-15 ANNUAL REPORT

HEALTH AND HIGH QUALITY CARE FOR ALL, NOW AND FOR FUTURE GENERATIONS

THE NHS CONSTITUTION
the NHS belongs to us all

NHS ENGLAND

Annual Report and Accounts 2014-15

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WELCOME

BY MALCOLM GRANT, CHAIR

NHS England is responsible for the stewardship of £99 billion 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 custodians of the values of the NHS Constitution, committed to putting patients at the heart of everything we do, promoting transparency and accountability of our work to citizens, and ensuring the most efficient, fair and inclusive use of finite taxpayer resources.

It is our responsibility to 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.

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.

This annual report describes our second full year of operation. 2014-15 has been a very busy and successful year for us. We have matured as an organisation and begun to deliver real improvements for patients. This report outlines some of our most significant achievements. Of course, we have faced challenges too. Demand for services has continued to increase and we have faced intense pressure on services over the winter. It is in great measure thanks to the dedication and hard work of people across the service that the NHS has continued to maintain such high quality services and care for our patients.

One of the most significant events for us last year was the launch of the Five Year Forward View, which we published jointly with our arms-length body partners in October. It set out a vision for the future of healthcare in England that was universal, sustainable and free at the point of delivery, based around redesigned care, a new emphasis on prevention and a major drive to support the NHS's future sustainability.

The Five Year Forward View set out the challenges and opportunities facing health and care services in England and confirmed the broad consensus on ways to reduce health inequalities, improve the quality of care and ensure the future affordability of the NHS. All major political parties declared their backing for the strategic direction it set out, alongside wide support from stakeholders. It subsequently framed the debate about the future of the NHS during the general election and now has the enthusiastic backing of the new government.

It is truly a privilege to chair NHS England, and to be supported on the Board by such a fine team. We have been significantly strengthened during the year by the recruitment of three additional non-executive directors, Sir John Burn, Noel Gordon and David Roberts.

I am grateful to our Chief Executive, Simon Stevens, and to all of our directors, executive as well as non-executive, who have provided leadership at a pivotal time in the history of the NHS. They all join me in expressing our profound gratitude 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.

But – so far, so good.

I am conscious that all of those qualities are likely to be stretched to the limit by the challenges that lie ahead. The Five Year Forward View foresees an exacting programme of transformation for all parts of the NHS in England. There is a dawning sense of realism. It is now widely understood that the rate of increase in demand for our services runs well ahead of anticipated growth in GDP so that we cannot expect it to be matched by increases in funding. The status quo cannot hold. We need to carry through transformation rather than throwing yet more money at outdated models. Nobody should believe that this will be an easy process.

Transformation on this scale needs strength of purpose, unwavering commitment, and investment to support innovation and to release the entrepreneurial energies within the NHS, to bring care closer to people's homes and communities, and to support the empowerment of patients to better manage their own health through modern technologies.

INTRODUCTION

BY SIMON STEVENS, CHIEF EXECUTIVE

2014-15 was a year in which the Health Service responded – largely successfully – to wide-ranging operational pressures. But as importantly, it was a year in which patients' groups, caring professionals and national leaders came together to chart a shared direction for our country's NHS for the next five years.

The NHS Five Year Forward View sets us on a path for better health, more personalised care, and a financially sustainable Health Service. It argues that to succeed we're going to need broad based action on three fronts.

First, as a nation it's time to get our act together on prevention. Life expectancy is its highest ever. But smoking still explains half the inequality in life expectancy between rich and poor – and two thirds of smokers get hooked as kids. Binge drinking costs at least £5 billion a year. Poor diets and couch potato lifestyles are normalising obesity. So we'll need wide ranging action – as families, as the health service, as government, as industry.

But when people do actually need looking after – as millions will – our families deserve care that's more personal, more coordinated, more convenient, safe and reliable. So the second of our mission-critical tasks over the next five years is fundamental redesign of how services are provided. Blurring the old boundaries between GP and hospital care, physical and mental health services, health and social care. And one of the best ways of getting this personalisation and integration will be to give patients and their families more clout over the support they receive.

Prevention and care redesign will both help with our third major challenge which is putting the NHS' finances on a sustainable footing. But they're not a quick fix, and they won't be enough – we will need extra investment. We already have a lean and efficient health service compared with just about every other industrialised country. But like every other major nation, we also still have big quality and efficiency differences – between different parts of the country, between different hospitals, and between different local clinical commissioning groups. Tackling this won't be easy, and the Health Service will step up and play our part. This will be supported by the greater alignment now evident between the national leadership bodies of the NHS, the streamlining of functions between us, and the development of new ways of working with local services and the public.

2015-16 represents Year One of the Five Year Forward View. So, for the year ahead, NHS England has identified key commissioning priorities for improvement. These include cancer care, mental health, learning disabilities, and obesity and diabetes prevention. Our care redesign focus will be on primary care, urgent and emergency care, and maternity services. And we will be working with communities and frontline services across England to support a variety of new 'Vanguards'.

As we do so, huge thanks go to our Board, to NHS England's dedicated staff, and to all 1.4 million people working right across the Health Service, united in the common cause of providing high quality, responsive and compassionate care, in partnership with millions of families and their loved ones across this country.

STRATEGIC REPORT

A SNAPSHOT OF 2014-15

AROUND 340 MILLION GP CONSULTATIONS TOOK PLACE

NHS 111 RECEIVED 4.1 MILLION MORE CALLS THAN IN 2013-14

210,000 MORE EMERGENCY ADMISSIONS THAN IN 2013-14

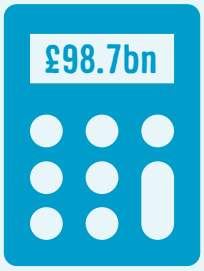
22.4m A&E ATTENDANCES – 600,000 MORE THAN IN 2013-14

ESTIMATES SUGGEST THAT £1 IN EVERY £10 OF NHS MONEY WAS SPENT ON DIABETES

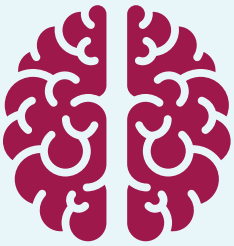
IN RESPONSE TO THE EBOLA OUTBREAK, NHS ENGLAND COMMISSIONED OVER £3.5M OF EQUIPMENT AND CARE IN THE NHS

LONG TERM HEALTH CONDITIONS ACCOUNTED FOR 70% OF THE HEALTH SERVICE BUDGET

OVER 300,000 ADMISSIONS WITH AN ALCOHOL-RELATED PRIMARY DIAGNOSIS OR EXTERNAL CAUSE



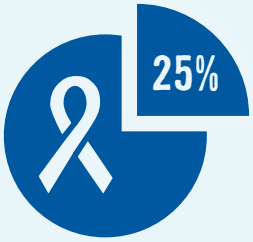
NHS ENGLAND'S COMMISSIONING BUDGET



MORE THAN 1/4 OF HOSPITAL INPATIENTS HAD DEMENTIA

MENTAL ILLNESS WAS THE SINGLE LARGEST CAUSE OF DISABILITY IN ENGLAND, COSTING THE ECONOMY ROUGHLY THE SAME AS THE NHS

85% OF PATIENTS RATED THEIR OVERALL EXPERIENCE AT THEIR GP SURGERY FAIRLY GOOD OR VERY GOOD



ABOUT 25% OF CANCERS WERE DIAGNOSED THROUGH A&E

BIRTHS CONTINUED TO RISE

THEY ARE UP BY ALMOST A QUARTER IN THE LAST DECADE, AND WERE AT THEIR HIGHEST IN 40 YEARS

PRIMARY SCHOOL CHILDREN WERE CLINICALLY OBESE

438 MILLION COMMUNITY PHARMACY VISITS FOR HEALTH-RELATED REASONS

PERFORMANCE IN 2014-15

The NHS successfully cared for millions of our fellow citizens in 2014-15.

It dealt with many more GP visits, 600,000 more A&E attendances, 210,000 more emergency admissions to hospital and 4.1 million more calls to NHS 111 than in the prior year.

But the NHS is under pressure. It faces a major challenge over the next five years to improve its productivity in order to meet rapidly growing demand from patients at a time when the nation's finances are under strain.

Funding the NHS

In October, the Five Year Forward View – published jointly by national leaders in health and care – set out the shared direction for the NHS over the next five years.

In response, the government announced in the Autumn Statement an additional £1.8 billion of funding for the English NHS for the current financial year (2015-16) – equivalent to a 1.6 per cent real terms increase. Along with £150 million of funding reprioritised from central programme budgets, this meant that almost £2 billion of additional funding was available for allocation in 2015-16.

The majority of these funds (£1.1 billion) were included in clinical commissioning group (CCG) allocations in order to increase the purchasing power of local commissioners. £450 million has been allocated to two transformation funds, in order to begin funding the transition to new models of care for the NHS as set out in the Five Year Forward View.

Overall the government has pledged to invest at least an additional £8 billion in real terms annually in the NHS by 2020-21. But this remains a demanding financial outlook, requiring substantial and sustained action to create the headroom to cope with rising demand and related financial pressures. There will be a new focus on prevention, on involving patients in their own care and on redesigning care. In part this will mean delivering more care locally, outside hospitals and in the community.

More investment in integrated care

The challenge of caring for an ageing population in the 21st century is profoundly different from that faced by the NHS at its inception in the mid-20th century. Older people with complex conditions need a different type of care, usually best delivered outside hospital.

This year will mark the first year of operation of the Better Care Fund. Pooled budgets worth £5.3 billion have been agreed between local authorities and local NHS commissioners which will support the integration of health and social care services. Local authorities will help the NHS, for example by reducing emergency hospital admissions, and NHS budgets will be used to help local authorities, for example by reducing permanent admissions to care homes.

All local plans for improved integration have been approved. The Better Care Fund support team, hosted by NHS England, is developing a programme of comprehensive support for implementation in 2015-16.

A fairer deal for local areas

Some areas have not historically received the amounts they are entitled to under the formula used to calculate the health needs of the populations covered by CCGs. In 2015-16, the number of CCGs that are more than five per cent below target allocations will be halved from 34 to 17 and next year (2016-17) it is hoped that all CCGs receiving less than their target funding could be brought to within five per cent of target.

The NHS Mandate

The NHS Mandate sets out the ambitions for the NHS. Most of the goals for 2014-15 were met or were close to being met. NHS England met its overriding financial duty to keep spending within the agreed budget set by government.

A full breakdown is in appendix 1.

Stronger primary care

Improving primary care access

In October 2013, the Prime Minister's Challenge Fund was established to help improve access to general practice and

stimulate innovative ways of providing primary care services. Since then NHS England has invested more than £150 million, enabling practices to extend opening hours into evenings and weekends and make better use of digital innovations, such as offering consultations over email, video links and smartphones.

57 schemes were launched in two waves across England. These will improve access to GPs for over 18 million patients in around 2,500 practices. The Prime Minister's Challenge Fund is also helping groups of practices come together with other primary care professionals to provide more integrated community services.

In addition, NHS England launched a separate £1 billion fund to help practices improve their buildings and harness technology over the next four years – to give them the physical space and technical ability to offer more appointments and improved care for, in particular, the frail elderly.

Expanding the GP workforce

A growing population, with a growing number of elderly and chronically sick patients, requires a growing number of GPs to provide necessary care. The government has also pledged to extend the range of NHS services, available over seven days a week by 2020. England therefore needs to expand its GP workforce.

In January 2014, NHS England announced a £10 million fund to boost recruitment. Initiatives to attract newly trained doctors to shortage areas include offering a further year of training in a related specialty, a national marketing campaign to highlight the opportunities of a career in general practice and pilot training hubs based in practices with the greatest workforce needs.

GPs considering retirement or a career break will be encouraged to consider part time working. Those returning from overseas or after a career break will be encouraged to re-join the NHS and help with costs will be offered in areas of greatest need.

The proposals are set out in Building the Workforce – the New Deal for General Practice, which was jointly produced with Health Education England, the Royal College of General Practitioners and the British Medical Association.

Access to hospital services

Unprecedented numbers of patients were treated by the NHS last year – for both urgent and planned care. There were 600,000 more attendances at A&E in England and 210,000 more emergency hospital admissions than in 2013-14. There were 4.1 million more calls to the NHS 111 urgent care telephone service.

Case study: **Learning from the Friends and Family Test**

At Hillingdon Hospital in London, patients staying in hospital commented about noise on wards at night-time disturbing their sleep. The management launched a "Comfort at night" campaign which resulted in wards having lights out or dimmed at night, extra pillows and blankets readily available, silent-closing waste bins, staff wearing quiet shoes and prior explanation given to patients likely to be woken during the night for medication or checks.

"Staff find the comments received as part of the FFT provide helpful insights about what really matters to patients"

Bev Hall
Deputy Director of Nursing

Waiting times for cancer consultations and for diagnostic tests came under pressure, driven in part by effective public health campaigns urging patients not to delay reporting symptoms, and public health interventions such as NHS England cancer screening. Early diagnosis has been proven to improve outcomes.

Despite these pressures, the NHS met its target that 92 per cent of patients should be waiting no more than 18 weeks for planned care from referral by a GP. The median wait for planned hospital care was just 10 weeks.

NHS hospitals missed their A&E target during the winter – that 95 per cent of patients should be seen and treated, admitted or discharged within four hours – but the position improved in the spring. Overall NHS A&E Services continued to meet this standard for more than 9 in 10 patients in England – the best performance measured by a major industrial country.

Better specialised services

The NHS provides a number of specialised services delivered in relatively few hospitals for comparatively small numbers of patients. Examples include renal services for patients with kidney failure, secure hospitals for people with mental health conditions, neonatal services for premature babies and care for rarer conditions such as uncommon cancers, burn injuries and genetic abnormalities. Spending on specialised services accounts for 14 per cent of the total NHS budget, approximately £13.8 billion.

Historically, there has been wide variation in how each region commissions specialised services resulting in inconsistencies in approach to quality standards, budget setting, performance management and access to services.

In April 2014 a specialised commissioning task force was established to make improvements. Significant progress has since been achieved in addressing the challenges and stabilising the financial pressures resulting from increased demand.

Among the key operational achievements is the start of a rolling programme of service reviews, which have so far delivered:

- New contracts for PET/CT scanning which will bring substantial savings for the NHS and improved access across the country.

- Targeted introduction of treatment with ground-breaking new drugs for patients at greatest risk of liver failure which can cure them of Hepatitis C.

- Benefits for parents and children from the roll out of new tests for inherited genetic disorders.

Making mental health a priority

Achieving parity of esteem

Mental illness is the single largest cause of disability in England. Three quarters of mental health problems in adult life start before the age of 18. People with severe mental illness die on average 15 to 20 years earlier than other people. Yet, in financial terms, mental health remains a poor relation within the NHS.

The Government has pledged to achieve parity of esteem for mental and physical health by 2020. In 2014-15, NHS England secured extra funding towards this. Over five years, this includes £1.25 billion to improve mental health services for children and young people, including perinatal services; an extra £30 million to improve access to eating disorder services and £30 million to improve access to liaison mental health services for people in general hospital who need psychiatric help. CCGs have been asked used to improve investment in these services across the country. A task force was launched to drive forward the transformation of services and develop a mental health strategy by 2020, in association with partners by experience and other experts.

Setting the first mental health waiting time standards

NHS England launched the first access and waiting time standards for mental health services. From April 2016, at least 50 per cent of patients with a first episode of psychosis should be treated within two weeks of referral, and 75 per cent of patients with anxiety or depression needing psychological therapies should have access to them within six weeks.

Significant progress has also been made in increasing the involvement of patients and the public. The Patient and Public Voice Assurance Group has been set up and around 200 patient and public members of the Clinical Reference Groups (CRGs) recruited to provide input on the needs patients and carers. The group will inform the planning, redesign and specification of specialised services.

Case study: **Easing anxiety for people with learning disabilities**

Effective communication with people with a learning disability is fundamental to good care and reduces anxiety and stress.

Devon Partnership NHS Trust won a grant from the Nursing Technology Fund to provide 136 iPads, with specialist apps tailored to the needs of people with a learning disability, helping reduce worry about their treatment and improving their experience.

A second grant will enable the Trust's nursing staff to carry out their administrative tasks on a mobile basis, so they can spend more time with patients.

"This technology will radically improve the care and support that we are able to provide"

Vanessa Moir
Clinical Nurse Specialist in learning disability services

Case study: **Personal Health Budgets**

Kevin is quadriplegic and requires 24 hour nursing care. When he left hospital following a tracheostomy it was assumed that he would need to stay in residential care to manage his ventilation. Instead, with a personal health budget, he can manage his care at home with his family.

Kevin and his wife employ a team of personal assistants who work with them, with the support of qualified nurses. The team is even able to help them take family holidays together.

"A nursing home was never going to be an option. I was more concerned about getting back to work, and on with my life"

Kevin

NHS England has made extra efforts to give a voice to those groups which are seldom heard. A national transgender network has been established to consult on a national policy for gender identity services. It has worked with the Royal College of Paediatrics and Child Health to engage children and young people in the provision of specialised services. In association with the organisation Rethink, NHS England has brought service users from secure mental health services together with staff and commissioners to drive new developments. Please refer to appendix 3 for information about public involvement in NHS England's work.

Hundreds of patients and other organisations had their say during a three month consultation on how specialised services should be provided in future. Guidance on how NHS England and CCGs will work together to commission the services in a more collaborative way has now been published.

Increasing the Cancer Drugs Fund

An extra £80 million was committed to the Cancer Drugs Fund in 2014-15, increasing the total budget to £280 million to buy additional treatments not fully approved by the National Institute for Health and Care Excellence (NICE). The Fund's budget will grow this year to £340 million.

Increasing provision of psychological therapy

Psychological therapy is the preferred treatment for many patients with anxiety and depression. More than three million people have been treated under the Improving Access to Psychological Therapies (IAPT) programme since its inception in 2008. More than 521,000 have recovered and over 100,000 had moved off sick pay and benefits by December 2014.

In the first three quarters of last year, over 582,000 started treatment and 138,000 recovered. Other groups such as armed forces veterans and those in custody are starting to benefit from the programme. Full figures for 2014-15 will be published in July 2015.

Increasing provision for children

Too many children and young people with mental health problems are being treated in hospitals and units far from home. In July 2014, a review of children and adolescent mental health services (Tier 4) revealed there were limited options for treatment, resulting in increased pressure on in-patient services and a small

number of young people having to travel long distances to find a place. NHS England took immediate action to increase the provision of specialist beds, overhaul the management of cases and, in consultation with patients and their families, improve access and discharge arrangements. Work is continuing to ensure the right type of services are available in the right place for these vulnerable young patients.

The Children and Young People's IAPT programme was extended to cover 68 per cent of the 0-19 population, exceeding its goal of 60 per cent by 2015. The programme also established a set of service standards.

NHS England published a report, Future in Mind, setting out how to make it easier for children and young people to get access to high quality mental health care when they need it.

Improving dementia care

A team of dementia 'ambassadors' has improved the diagnosis and care of people with dementia by providing support to GP practices and making regular information available to local commissioners. Dementia diagnosis rates are set to exceed 90 per cent of the goal this year against the ambition that two thirds of people with the condition should be able to have a diagnosis.

Improving services for people with learning disabilities

Around 2,600 people with learning disabilities and autism live at any one time in in-patient accommodation. Following the inexcusable events at Winterbourne View, NHS England is committed to ensuring that they receive the right care in the right setting, close to home. The announcement of a programme to close long stay hospital institutions has been widely supported.

More than 1,400 care and treatment reviews – the first step in transferring people to community settings – have been conducted and 600 people have been discharged. The rate of discharge is expected to increase this year.

Tackling obesity and diabetes

The rise in Type 2 diabetes is of national and global health concern. The numbers affected have soared in recent years, driven by the increase in obesity and sedentary lifestyles. In England, almost three million people are living with the condition and 7-9 million are at risk of becoming diabetic. It exacts a heavy human toll causing more than 100 amputations a week and 20,000 premature deaths a year.

This also places an immense but largely preventable burden on the NHS which faces costs of £10 billion a year caring for people affected.

In 2014 NHS England, working with Public Health England, launched the NHS Diabetes Prevention programme. Seven demonstrator projects have been launched, based on proven UK and international models, to support people to lose weight, take exercise and eat better. The programme aims to help reduce significantly the number of people developing Type 2 diabetes over the next decade.

Building a new relationship with patients and communities

Empowering patients

Virtually everyone is, or will be, a patient at some point in their lives, so it makes sense to support them to take more control over their own health when they want to.

NHS England has made it a priority to provide better information to people about conditions, treatments and the quality of local services. It has encouraged self care using online resources and peer-to-peer networks. It has also supported local commissioners offering personal care plans to patients with long term conditions, and direct control over health and social care budgets for eligible patients with complex needs.

NHS England launched the Realising the Value programme to support commissioning approaches to improve patient empowerment.

Engaging communities

The NHS Citizen programme puts citizens at the centre of the design process for NHS services. It was developed in 2014-15 to support direct citizen involvement in health care, whether as a patient, carer, staff member or volunteer, and is fundamental to the implementation of the Five Year Forward View. In 2015-16 NHS Citizen will be rolled out locally, and online innovations will be launched to broaden participation. Further details of public involvement are in appendix 3.

NHS England's Board has established a group to review how it can ensure patient and public participation in its own decision making.

NHS England will also work with clinical staff and other experts to support carers, create new options for volunteering, design ways for voluntary organisations to work alongside the NHS more easily and capitalise on the NHS's role as an employer to achieve wider health goals.

Devolving power and promoting autonomy

Devolving control of primary medical care

In order to create a local NHS, where decisions are taken as close to the front line as possible, CCGs, which currently buy local community and hospital services for their populations, were invited to take on a bigger role in the planning and funding of primary medical care. They were offered one of three graduated options – greater involvement in primary medical care commissioning, joint commissioning with NHS England or delegated commissioning in which they would take on full responsibility.

There was a strong response from CCGs. In April 2015, 63 took on full delegated responsibility for buying GP services and 86 opted for joint commissioning with NHS England. Giving CCGs more influence over the wider NHS budget will enable a shift in investment from hospital to community services and enable money to follow the patient.

The pace and scale of co-commissioning will now be expanded where appropriate to include specialised services. NHS England will also work with local authorities to strengthen joint commissioning for health and social care.

Devolved powers for Greater Manchester

Devolving decision making to local communities where appropriate is a principle of the Five Year Forward View. As an unprecedented first step, an in-principle agreement to move towards giving Greater Manchester devolved control over its £6 billion health and social care budget from April 2016 was negotiated between 10 local authorities, 12 CCGs and NHS England.

This would be the biggest pooled budget ever and means resources could be allocated more effectively and flexibly to meet local priorities and support investment in services outside of hospital.

Devolving control of individuals' care

Increasing the control patients have over their own care and treatment is a principle of the Five Year Forward View. Evidence shows it improves health and improves wise use of health services.

In July 2014, NHS England announced plans to give patients control over combined health and social care budgets for the first time in a scheme called Integrated Personal Commissioning (IPC).

Nine demonstrator sites were launched in April 2015 in the first wave of the programme to develop a new personalised commissioning approach. This will allow individuals to blend health and social care funding and direct how it is used.

The programme will support people with complex needs, including older people with long term conditions, children with disabilities and their families, people with learning disabilities, and people living with serious mental illness.

Reducing inequality

Health inequalities cost lives, decrease the quality of life for many and increase pressures on the NHS. Reducing inequalities is a key priority of the Five Year Forward View.

Deaths from cancer and heart disease under 75 have fallen since 2003. Cancer mortality has seen a faster improvement among men and a narrowing of the mortality gap with women. For cardiovascular disease there has been a downward trend in the gender gap of 24 per cent in the five years from 2008-13, although there was a small increase of three per cent in 2012-13. Taking years of life lost from all causes amenable to healthcare, this has seen a steady decrease and the gender gap has decreased overall by 18 per cent between 2008-13.

In 2014-15, NHS England introduced new formulae to allocate resources to CCGs and to primary care. To support action to reduce health inequalities, these include adjustments (of 10 per cent and 15 per cent respectively) to provide additional funding to address unmet needs.

In 2014-15, NHS England introduced several programmes to reduce health inequalities. These include:

- A programme to reduce stillbirth and early neonatal death by improving risk assessment and clinical management of pregnant women from economically deprived families, asylum seekers and black and ethnic minority groups.

- A programme to ensure there is a named accountable GP for every person over 75.

- A new scheme to reduce emergency admissions through better care and extended health checks for those aged 14 with learning disabilities.

NHS England has set four objectives for achievement by March 2016:

- To ensure at least 95 per cent of NHS Trusts and CCGs have implemented the Equality Delivery System (EDS2) to protect vulnerable patients in the community and provide a non-discriminatory environment for NHS staff.

- To embed equality at the heart of the CCG assurance scheme and the corporate governance statement.

- To ensure disabled patients, service users and carers have access to information they can understand under the Accessible Information Standard.

- To implement an equality, diversity and inclusion strategy for the NHS workforce and a new Workforce Race Equity Standard.

Improving safety

The safety of patients is paramount. NHS England has worked closely with the Department of Health and other partners to improve the safety of patients in response to Sir Robert Francis QC's report on Mid Staffordshire NHS Foundation Trust. It is delivering against its plans including setting up fifteen safety collaboratives across England to tackle the most pressing safety concerns.

Making better use of technology

Better use of data and technology has the power to improve choice and outcomes for patients, allow them to take more control, reduce the burden on frontline staff, increase accountability and support the NHS as an engine of science and economic growth. Modern digital communications are essential for modern, high quality, sustainable health care.

New digital services for patients

General practices can now offer a range of online services including booking appointments, ordering prescriptions and providing access to medical records. By April 2015, 97 per cent of practices had the technical capability to provide at least one of these, helping patients take more control of their health care.

NHS Choices, which provides online information and advice about health and care, launched the first digital mental health services library providing help for people with mental health problems. The range of assistance offered has been shown to improve outcomes. NHS Choices now has 45 million visits a month making it the largest online health resource in Europe. Of those, more than one in five (9.7 million) are to pages on depression.

New digital services for professionals

In an emergency, being able to share patient records between A&E departments, local ambulances and GP out of hours services helps medical staff provide safe, high quality care. By April 2015, more than a third of A&E departments were able to communicate a summary digital record in this way, exceeding the target set in the NHS Mandate. All clinical correspondence must now include the patient's NHS number, so that records can be shared by clinicians.

It is planned that all NHS providers will have comprehensive digital records by 2020. A total of £195 million extra capital was allocated under two technology funds last year for this purpose. A third fund, the Nursing Technology Fund, supported initiatives to improve the patient experience with digital communication.

Improved information on services

Better information about the performance of the NHS can help researchers and planners improve services by identifying where it is most efficient and effective. The care.data programme is an initiative to link hospital and GP records safely for this purpose, and has been developed over the last year in partnership with the public and clinical leaders. In 2015 it will be tested in more than 100 GP practices in England. The results will be scrutinised and a full evaluation carried out by the National Data Guardian before it is rolled out more widely.

Helping more people get online

Around 9.5 million people lack basic computer skills and 6.5 million have never been online. They tend to be older, poorer and are more likely to be disabled than the rest of the population. In 2014 more than 129,000 people, many among the most disadvantaged in society, received support to get online through the Widening Digital Participation programme run by the Tinder Foundation.

Priorities for the future

The National Information Board, established in April 2014 to bring together organisations from across the NHS, public health, clinical science, social care, local government and public representatives, will publish a set of road maps later this year setting out how technology will support delivery of the Five Year Forward View.

Improving transparency

Over seven million responses have been received through the Friends and Family Test (FFT) since it was launched in April 2013, and nine out of ten patients say they would recommend the services they have used. There is evidence that this feedback is being used to rapidly improve services. Scores for most NHS providers were published for the first time last year on NHS Choices. Separate ratings for individual hospital consultants in 12 surgical specialties were also included for the first time. This year ratings for the effectiveness of local commissioners will also be published at http://www.nhs.uk/mynhs

Supporting research

It is vital that the NHS is at the cutting edge of science. Last year NHS England launched a £300 million programme, in partnership with Genomics England Limited, to sequence the genomes of 100,000 patients by 2017 – making England the first country in the world to do so. Genomics has the potential to improve the prediction and prevention of disease, enable new and more precise diagnostic tests, and allow drugs and treatments to be personalised for patients with specific genetic variants.

In 2014-15, 11 genomic medicine centres were designated following an open competition and the first patients were recruited into the programme which moves to full mobilisation this year.

Our overarching plans for research are currently being reshaped in light of the Five Year Forward View and work continues to address the complex issue of excess treatment costs – when the associated costs of an experimental treatment or intervention in a clinical trial is higher than the existing treatment or intervention.

THE NEXT FIVE YEARS

The Five Year Forward View

The Five Year Forward View was published in October to wide acclaim. A copy of this can be found at www.england.nhs.uk/ourwork/futurenhs/ It set out a vision for the future of healthcare in England that was universal, sustainable and free at the point of delivery, based around redesigned care, a new emphasis on prevention and a major drive to support the NHS's future sustainability.

All major political parties declared their backing for the strategic direction it set out, alongside wide support from stakeholders. It subsequently framed the debate about the future of the NHS during the general election.

The Five Year Forward View set out the challenges and opportunities facing health and care services in England and confirmed the broad consensus on ways to reduce health inequalities, improve the quality of care and ensure the future affordability of the NHS.

It highlighted the need for a radical upgrade in prevention and public health to tackle obesity, smoking, alcohol and other major health risks.

It stressed the need to give patients greater control over their care, including the option of shared budgets combining health and social care.

It emphasised the need for the NHS to break down the barriers between GPs and hospitals, physical and mental health and between health and social care, so that in the future, more care is delivered locally but with some services in specialist centres.

Local health communities will be encouraged to choose from among a small number of radical new care delivery options and supported to implement them.

Joining up hospital and community services

The Vanguards programme for developing new models of care was announced in the wake of the Five Year Forward View. The aim is to redesign health and care systems by joining up hospitals, primary care, mental health, community nursing, pharmacy and social care. This will provide a seamless service which could, for example, mean fewer trips to hospital for cancer sufferers and specialists holding clinics in local surgeries for dementia patients. The programme is backed by a £200 million transformation fund.

In March 2015, the first wave of 29 vanguard sites were chosen to develop new care models linking hospital and community care which will serve as blueprints for the health and care system. For example, multispecialty community providers will incorporate some acute specialists such as consultant geriatricians, psychiatrists and paediatricians to provide integrated specialist services in out-of-hospital settings.

In May 2015, applicants were invited for further vanguard sites to develop new ways of delivering high quality acute care for patients. These new models may include greater use of clinical networks across nearby sites, joint ventures between NHS organisations, or the delivery of specialist single services across a number of different providers. As well as delivering better outcomes for patients, the aim is that they should also be more productive, making a fixed amount of resources go further and giving district general hospitals a path to long term sustainability.

In addition, we are now inviting areas covering five million people to become urgent and emergency care vanguards. These will ensure people with serious or life-threatening emergency needs are treated in hospitals with the very best expertise and facilities, but will also focus on developing convenient and technologically-enabled out of hospital services for people with urgent but non-life threatening needs.

A series of other initiatives will be launched this year to support the development of new technologies in partnership with the NHS. Innovators from the UK and around the world will also be offered radical opportunities to redesign health care provision in new towns and planned urban developments.

Improving patient outcomes

There is still too much variation in the NHS. Two thirds of services across health and social care deliver good or outstanding care, but that means that one in three require improvement.

In the most challenged areas, NHS England are introducing a new regime of support, the Success Regime, to help create the conditions for transformation. This new approach will work across whole health economies rather than focusing on individual organisations, strengthen leadership, introduce new care models and be overseen jointly by NHS England, Monitor and the NHS Trust Development Authority (TDA).

The first areas to benefit from the Success Regime, following national and regional assessment, are North Cumbria, Essex and Northern, Eastern and Western Devon.

More details on how the Success Regime will work, the first cohort of entrants and how the Success Regime board will make decisions about future areas is available at www.gov.uk/government/publications/five-year-forward-view-the-success-regime-a-whole-systems-intervention

Despite improvements in cancer care, England still has a poorer record on cancer outcomes than some other European countries. A task force has been established, chaired by the Chief Executive of Cancer Research UK, to deliver better outcomes.

Similar task forces have been established to improve outcomes in mental health, learning disabilities and maternity care.

Improving efficiency

NHS England set out its plans to help meet the demand and cost pressures arising by 2020-21 with the ambition of achieving an extra 2-3 per cent average annual net efficiency gain. Measures include increasing productivity within existing services (reducing waste, improving procurement, shortening length of stay), delivering care in the right setting (shifting care from hospital to the community, concentrating specialised services in centres of excellence), new ways of providing care and re-directing NHS spending (to prevention, early diagnosis). These plans are being developed and implemented with partners.

The NHS is taking steps to reduce over reliance on agency staff and curb their costs whilst ensuring a greater supply of NHS nurses through the successful national Return to Practice campaign, which has already supported over 1,300 experienced nurses to come back to the NHS. It is sharing best practice on staff retention and supporting efforts to provide NHS staff with more flexible working. It is also taking steps to curb spending on consultancy services.

Some of the required actions are a matter for individual organisations to lead: trusts are best placed to reduce staff sickness levels, for example. Other actions, such as levering the NHS's national clout to get the best pricing deals, are best taken at a national level, whilst some issues, such as the redesign of services or preventing ill-health, are best achieved through collective action: not just by partnering with other sectors, but by harnessing the energy of local communities and voluntary groups.

NHS England has already committed to a nationwide diabetes prevention programme. Continued support to help people stop smoking brings immediate benefits in addition to long-term decreases in the risk of cardiovascular disease and cancer. Similarly, reduction in alcohol misuse immediately reduces the risk of ending up in A&E, and reductions in the prevalence of hypertension and high cholesterol can help avoid hospitalisations.

Supporting people to manage their own health and healthcare can both improve outcomes and reduce costs. The Expert Patient programme, for example, suggests that at a typical investment of £400 per patient could save about £4,000 per year.

NHS England knows that a small number of patients consume a very large proportion of total resources. Increasingly, it is able to identify these patients before their health deteriorates using a mix of predictive software and professional judgment.

NHS England knows some areas achieve very different outcomes despite similar levels of expenditure, and vice versa. By benchmarking costs and outcomes across comparable areas, it can help commissioners understand how they could change spending patterns to achieve better overall value and where to target their improvement programmes. For example, Warrington CCG was helped to identify higher non-elective admissions compared to its peers, which in turn led to implementing decision aids and other clinical improvements that have held down admissions and saved £15 million per year.

There are also wide variations among providers on a whole raft of areas including length of stay, day case rates and new-to-follow up ratios. Costs for the same goods can vary by as much as 35 per cent between hospitals. In addition, estate efficiencies across the acute and mental health sectors could yield a gain of perhaps £1 billion per annum, with perhaps a further £1 billion one-off gain from the sale of surplus estate; some estimates even suggest figures up to £7.5 billion.

NHS England has reduced central administration costs by over a third in order to maximise funding for frontline services, including £700 million of reductions to Department of Health and NHS England central programmes. Nationally, it will continue to hold central administrative costs and budgets down to ensure that frontline services take priority.

PRIORITIES FOR 2015-16

NHS England supports delivery of the Five Year Forward View in its business plan for 2015-16 which is published at http://www.england.nhs.uk/about/business-plan/ and is summarised here:

1. Improving the quality of care and access to cancer treatment

NHS England will publish a new cancer strategy for England and support the NHS to meet cancer waiting times. It will support CCGs and GPs to improve early diagnosis and one-year survival rates, and work with Public Health England on cancer symptom awareness campaigns and in commissioning screening programmes.

NHS England will also tackle the inequalities in outcomes and experience of people with cancer in England, and work with partners to make progress in rolling out the cancer recovery package and wider cancer survivorship work.

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

NHS England will develop and implement access and waiting time standards, develop a national mental health strategy and work with Health Education England to deliver further transformation of child and adolescent health services. It will also reach and maintain the national dementia target diagnosis rate of 67 per cent and develop a five-year transformation plan to ensure good post-diagnostic services for people with dementia across England.

3. Transforming care for people with learning disabilities

NHS England will improve the independence, wellbeing and health of people with learning disabilities by continuing to roll out care and treatment reviews to manage discharges and prevent inappropriate admissions. The organisation will ensure annual health checks to support physical health, and extend the offer of personal budgets.

NHS England will also make sure that all young people with a learning disability leaving residential school have an education, health and care plan to support their transition to adult services. It will work with partners to develop a national framework to close inappropriate facilities and commission more appropriate local and community-based alternatives.

Building on preliminary work in 2014-15, NHS England will establish a national learning disability mortality review function in 2015-16 to inform how the organisation will shape future services and use reliable real-time data to track progress and inform learning disability work.

4. Tackling obesity and preventing diabetes

NHS England will continue to support interventions to help change the health-related behaviour of patients and staff, in line with NICE guidance, for smoking, alcohol, obesity and physical activity. It will have the new NHS Diabetes Prevention programme up and running and available to 10,000 at risk individuals, and will develop a plan to roll it out more widely in 2016-17, in partnership with Public Health England and Diabetes UK. It will work with the NHS and other employers to promote healthier workplaces and support staff health and wellbeing.

5. Redesigning urgent and emergency care services

NHS England will pilot a new payment model for urgent and emergency care in 2015-16, in preparation for wider changes in 2016-17 and beyond, in conjunction with Monitor. It will publish standards for urgent and emergency care networks and support their development as system leaders. It will arrange for patient records to be shared in emergencies (including end of life and advanced care plans) across the NHS 111 telephone advice service, the 999 ambulance service and hospital acute admissions.

6. Strengthening primary care services

NHS England will improve access to general practice, through Wave Two pilots of the Prime Minister's Challenge Fund, and by investing in primary care staffing and infrastructure. NHS England will invest in GP estates, IT and delivery of the 10 point GP workforce action plan to support better quality and a wider range of services, particularly in areas of greatest need. It will negotiate and agree the national contracts for primary care and have a plan for community urgent care ready for winter 2015-16.

7. Timely access to high quality elective care

NHS England will work with Monitor, TDA and CCGs to improve and sustain short waiting times for elective care, diagnostics and cancer services, nationally and locally. It will share results from the Efficient and Effective Care programme, including: increased use of shared decision making; routine personalised risk assessment in primary care; spread and

take up of enhanced recovery principles; and increased productivity (day case rates, Lean methodology, productive operating theatre). It will help CCGs and providers access expert help when they need it, to reduce variation and improve waiting list management, through the Elective Intensive Support team.

8. Ensuring high quality and affordable specialised care

NHS England will review its investment decisions on specialised services, as described above, and establish a rolling programme of priority service reviews to drive quality and value, including new models of provision. It will consider the specialised services needs of local populations and how to best incentivise local providers to deliver them.

9. Whole system change for future clinical and financial stability

NHS England can only succeed with these eight priorities, in both the short and long term, if the organisation helps ensure the NHS is financially sustainable. For 2015-16 the revised government mandate allocated an extra £1.83 billion to NHS England. This, along with a further £150 million of our own reallocated resources, has resulted in a total of £1.98 billion for frontline services. This will help the organisation further invest in primary care and kick start investment in new models of care. But the financial challenge remains substantial and will inevitably require broad-based and fundamental action by all parts of the NHS next year, and in the years to come.

10. Foundations for improvement

The organisation must build and invest in the foundations for improvement to happen. This includes building on existing work to use data and technology more effectively, encouraging and investing in the benefits of innovation and science, such as genomics, and building the capacity and organisational infrastructure across health and care systems.

Most critically, and underpinning all of our endeavours, is the need to ensure our work is based on a clear understanding of what the people NHS England serve need and want. So the organisation will continue to engage and involve our patients, their carers and families and, more broadly, our fellow citizens and communities, to ensure high quality health and care now and for future generations.

BUILDING CAPABILITY

Planning future NHS workforce

The NHS could not deliver without the dedication, skill and professionalism of the people who manage and provide the care for patients. The current pressures on the NHS affect all its staff, whether at the front line or in management and support roles. The requirements and new models of care of the Five Year Forward View will need changes in the workforce over the next few years which need to be scoped and planned now. Planning and managing those changes requires additional leadership and managerial capability to lead and improve individual organisations and local health systems. NHS England is working with Health Education England and partners to plan for these changes.

Aligning NHS England management and resources

At the start of the year, NHS England reshaped its management structure to create two new directorates: Commissioning Strategy and Transformation and Corporate Operations.

Commissioning Strategy leads on NHS strategy, the development of the commissioning system, and provides analytical capability and support for the new care model redesign programme.

The Transformation and Corporate Operations directorate was formed to improve NHS England's capability and organisational effectiveness. Through the organisational review, NHS England transformed specialised commissioning, and built more effective capability to support learning disability services and its Medical directorate.

The regional management structure consolidated local teams into four regional teams to oversee commissioning and provide leadership to local organisations working on the transformation agenda.

Emergency planning

The NHS has unprecedented experience in contingency planning and last year successfully responded to potential threats to patient and public safety, including these from the Ebola outbreak in West Africa, and industrial action by ambulance staff.

Improving efficiency

During 2014-15, NHS England has successfully prepared for the delivery of the necessary further 10 per cent saving in its running costs.

In addition there will be a major anticipated saving in 2015-16 in the cost of Primary Care Support (PCS) services, which provide administrative and back office functions for primary care contractors. The aim is to provide a modern sustainable service at 40 per cent lower cost.

Costs of the commissioning system overall will have fallen by over a third over the last three years.

Developing talent and performance

In 2014, NHS England brought in new talent from the NHS and wider health system to lead new programmes of work. It introduced more rigorous focus on managing talent to ensure there are effective succession plans for senior leadership roles, and implemented a new online performance appraisal system to ensure staff have personal goals aligned with NHS England's objectives.

Improving diversity

NHS England is committed to promoting equality and improving diversity to ensure its workforce is more representative and engaged. It has developed the Workforce Race Equality Standard (WRES) which requires that equality data is published and can be benchmarked, and mandated it in the 2015-16 NHS Contract.

Strengthening NHS leadership

The Five Year Forward View emphasised the importance of collaborative national leadership and local autonomy in the design and improvement of services.

The NHS Leadership Academy has successfully delivered leadership development to over 30,000 people in the last two and a half years, including over 10,000 nurses and midwives.

CHIEF FINANCIAL OFFICER'S REPORT

PAUL BAUMANN

The Financial Statements for the year ending 31 March 2015 are presented later in this document. The Financial Statements show the performance of both the consolidated group - covering the whole of the commissioning system - and NHS England as the parent of the group. The group comprises NHS England and 211† clinical commissioning groups (CCGs), consolidated through the Integrated Single Financial Environment, a financial accounting and reporting system covering all of the organisations concerned. A full list of CCGs can be found on the NHS England website.

NHS England had a revenue resource limit of £98,692 million in 2014-15. The organisation is responsible for using this money wisely and fairly to secure the best possible outcomes for both patients and taxpayers. As shown later in this report, the group fulfilled all of the financial duties set out in the Mandate for 2014-15, 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). The plan was for in-year expenditure of £98,032 million against this limit. Actual expenditure was £97,660 million, which represents a slight underspend equivalent to 0.4 per cent. When the ring-fenced depreciation element is excluded, the underspend falls to 0.3 per cent.

During the financial year, we have continued to improve our financial controls with a view to managing the risk of potential overspends and driving out savings wherever possible in order to contribute to overall NHS finances in what has been a financially challenging year across the system as a whole.

† NB. from 1 April 2015 there are 209 CCGs

The underspend reflects both our response to the Department of Health's request to defer any discretionary investments in the light of this wider financial position and a number of one-off factors this year (see below). However, it is clear that the underlying commissioning position is already showing significant signs of stress, and in the context of the Five Year Forward View ensuring future financial sustainability will be very challenging.

The key features of the 2014-15 financial position are shown in more detail in the following table:

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

	Expenditure		Under/(over spend) against plan	
	Plan £m	Actual £m	£m	%
Clinical commissioning groups	67,034	66,852	182	0.3%
Social Care	1,100	1,100	0	0.0%
Direct commissioning	28,293	28,275	18	0.1%
NHS England admin/central progs & others	1,605	1,433	172	10.7%
Total RDEL	**98,032**	**97,660**	**372**	**0.4%**
Of which:				
General	97,872	97,587	285	0.3%
Ring-fenced for depreciation and operational impairment	160	73	87	54.4%

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

Across the 211 CCGs, there was a small underspend of £182 million (0.3 per cent of allocation). This position benefitted from one-off items which have significantly contributed to the underspend.

Firstly, CCG's spending against legacy continuing healthcare claims in 2014-15 has been £156 million lower than the estimated level. Secondly, payments under the Quality Premium scheme for CCGs were £66 million lower than planned. In the absence of these specific factors, CCG performance as a whole would have been an overspend of £40 million (0.1 per cent of plan).

Limiting the underlying overspend to this level required significant deferral of investment, both by some CCGs seeking to minimise their own adverse variances to plan and by others in support of the overall NHS position. Taken together with an increase in the likely expenditure on continuing healthcare claims carried forward into the next financial year, this places an immediate financial pressure on the CCG position for 2015-16, and as a consequence, the 2015-16 planning round has been extremely challenging.

There is variation in individual CCG performance, although positive variation is not as wide as in 2013-14. Six CCGs underspent against plan by 2 per cent or more (2013-14: eleven), whilst eight CCGs overspent by a similar amount (2013-14: seven). All CCGs who have substantially underperformed against their plans are receiving intensive assurance support, and recovery plans are being agreed as part of the planning process for 2015-16.

Direct commissioning underspends were £18 million (or 0.1 per cent of allocation). Specialised commissioning overspent by £214 million due to ongoing activity growth above plan and overspends on the Cancer Drugs Fund. This has to some extent been offset by operational underspends elsewhere, but it has also been necessary to defer some planned investments in primary care. This will be more than compensated by the higher level of investment – both operational and transformational – planned for primary care services in 2015-16.

Central budgets for NHS England running and programme costs were held back to an underspend of £172 million (10.7 per cent), largely as a result of an internal review to drive out savings in anticipation of the structural rationalisation and reprioritisation implemented for 2015-16. In summary, whilst the overall surplus represents a small improvement over the plan, the position benefits from one-off items not expected

to recur in future years, savings in anticipation of reduced budgets in 2015-16 and deferral of investment which we will need to make good in future years if we are to deliver on the commitments to transformation contained in the Five Year Forward View.

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 ring-fenced, which means that underspends in other areas cannot be used to support core patient services covered by the general RDEL limit.

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

Performance against key financial performance duties

	Resource limit £m	Actual £m	Under spend £m	Target met
Revenue limits				
RDEL – general	97,872	97,587	285	✓
RDEL – ring-fenced for depreciation and operational impairment	160	73	87	✓
Annually managed expenditure limit for provisions movements and other impairments	300	(138)	438	✓
Technical accounting limit (e.g. for capital grants)	360	64	296	✓
Total revenue expenditure	98,692	97,586	1,106	
Administration costs (within overall revenue limits above)				
Total administration costs	2,142	1,780	362	✓
Capital Limit				
Capital expenditure contained within our capital resource limit (CRL)	270	189	81	✓

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

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.

In December 2013, the Board approved allocations for the commissioning sector for 2014-15 and 2015-16.

In December 2014, the Board revised the allocations for 2015-16, incorporating additional funding for frontline services and transformation amounting to £1.76 billion. As part of this, it was agreed that the extra frontline funding of £1.1 billion routed via CCGs would be used to move parts of the country furthest below their 'fair share' of NHS funding towards it at a faster pace than was possible under previously notified allocations. This improves the alignment of funding with population growth and need, and it also channels additional NHS purchasing power to geographies with substantial financial challenges in both the commissioner and provider sectors.

Future financial sustainability

The Five Year Forward View set out how, in the absence of further annual efficiencies in the NHS, a combination of growing demand from an ageing population, increases in the costs of running the NHS and constrained funding growth would produce a significant mismatch between resources available and what patients need.

As set out in our business plan for 2015-16, we are providing leadership to the NHS, in partnership with the Department of Health and other national NHS bodies, through an NHS-wide efficiency programme covering the period to 2020-21. This will enable individual organisations to realise their full potential for internal efficiency gains; it will also tackle the biggest opportunity areas, such as agency staffing costs, through concerted national action. Health economies will be supported to reduce the demand placed on NHS services and ensure that every pound of taxpayers' money achieves the maximum possible impact on outcomes for patients.

Success with this initiative will address the challenge of the future clinical and financial sustainability of the NHS, but more immediately, financial balance in 2015-16 will require commissioners and providers across the country to make rapid progress in implementing this ambitious efficiency programme.

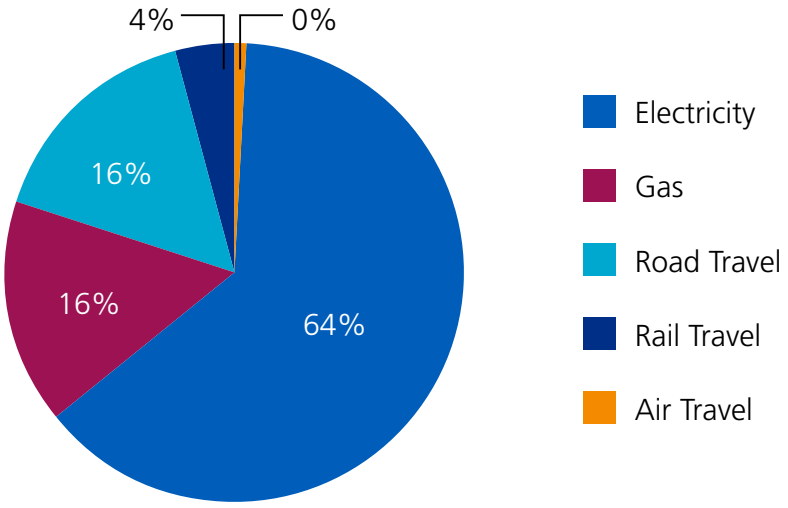
SUSTAINABILITY REPORT

The sustainable development strategy for the NHS, public health and social care system was launched in January 2014. Developed by organisations across the health and care system, and written by the Sustainable Development Unit (SDU), it sets out a vision and goals to aim for by 2020.

The SDU aims to ensure that the health, public health and care system support sustainable development, reduce emissions, save money and improve the health and resilience of people and communities.

Greenhouse Gas (GHG) emissions

The majority of greenhouse gas emissions attributable to NHS England's activities arise from electricity use across the estate . This is the first time we have full data related to GHG; this gives us a baseline to work from and an understanding of where we can make the most impact in GHG reductions.



Energy

Energy use relating to NHS England's operations arises from occupation of rented office spaces. NHS Property Services Ltd is the landlord for the majority of the core estate, and in many cases buildings are occupied by multiple tenants. Energy use data is apportioned between NHS England and other building occupiers.

Where no details are available for electric and/or gas consumption, NHS Property Services Ltd estimates the consumption figures using the average consumption figure from a sample of comparable buildings.

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	NHS England		CSUs		Totals	
	2014-15	2013-14	2014-15	2013-14	2014-15 Total	2013-14 Total
Electricity						
kWh	**25,378,042**	30,731,219	**18,194,155**	24,243,862	**43,572,197**	54,975,081
CO2 (tCO2e)	**12,273**	14,862	**8,799**	11,724	**21,072**	26,586
Cost (£)	**£3,558,191**	£3,666,371	**£2,560,301**	£2,690,322	**£6,118,492**	£6,356,694
Gas						
kWh	**12,517,865**	12,484,173	**16,459,433**	17,715,628	**28,977,298**	30,199,801
CO2 (tCO2e)	**2,303**	2,297	**3,029**	3,260	**5,332**	5,557
Cost (£)	**£882,795**	£746,845	**£683,062**	£716,241	**£1,565,857**	£1,463,087

Figures for CO2 have been calculated using 2014 DEFRA carbon conversion factors

tCO2e = Equivalent tonnes CO2

Business travel

NHS England has changed its working practices and is targeting a reduction in business travel and a shift towards more sustainable methods of travel. During 2014-15 there was an increase in travel miles due to the organisational change.

NHS England (excluding CSUs)	2014-15		2013-14	
	Miles	tCO2e	Miles	tCO2e
Road	4,759,417	1,493	5,238,604	1,758
Rail	14,713,705	1,122	10,642,836	840
Air	552,104	95	808,663	175
Total	**20,025,226**	**2,710**	**16,690,103**	**2,773**
Commissioning support units (CSUs)				
	2014-15		2013-14	
	Miles	tCO2e	Miles	tCO2e
Road	11,368,462	3,544	8,461,345	2,663
Rail	1,284,390	101	988,981	78
Air	37,289	9	97,677	19
Total	**12,690,141**	**3,654**	**9,548,003**	**2,760**
Grand total	**32,715,367**	**6,364**	**26,238,106**	**5,533**

tCO2e = Equivalent tonnes CO2

Waste

NHS Property Services Ltd have been able to provide partial waste data for the NHS England estate. Where data is missing, they have not provided an estimate in order not to affect the data integrity. Therefore, whilst the figures below are the best available they will be under-representative of the true totals.

NHS Property Services Ltd is building a revised business process for the collection of this data in the future.

	NHS England		CSUs		Totals	
	2014-15	2013-14	2014-15	2013-14	2014-15	2013-14
Total waste (tonnes)	1,608	1,489	765	841	**2,373**	**2,330**
Non-recycled (tonnes)	1,188	1,037	543	572	**1,731**	**1,610**
Recycled (tonnes)	420	452	222	269	**642**	**721**
Percentage recycled	26%	30%	29%	32%	**41%**	**31%**

Water

NHS Property Services have estimated water consumption from costs based on a conversion factor which represents the average of ten water company charges[†].

	NHS England		CSUs		Totals	
	2014-15	2013-14	2014-15	2013-14	2014-15	2013-14
Consumption (m3)	162,163	108,340	144,398	145,137	306,561	253,477

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 laws 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.

NHS England has been actively engaged through its central and regional emergency preparedness, resilience and response functions, supporting local health economies to maintain critical services and infrastructure and to ensure optimum outcomes for patients.

Simon Stevens
Accounting Officer
29 June 2015

[†] Where CSUs share a building with NHS England, the figures have been reported under NHS England

DIRECTORS' REPORT

THE BOARD

The NHS England Board consists of a Chair and eight non-executive directors and four voting executive directors. This complies with the requirements of the National Health Service Act 2006. Board members' profiles are below. A number of non-voting national directors regularly attend Board meetings, and the register of the Board membership in 2014-15 is set out at appendix 5. The role of the Board is to:

- Set the overall strategic direction of NHS England, within the context of the NHS Mandate.
- Monitor performance against business plan priorities.
- Provide effective financial stewardship.
- Ensure high standards of corporate governance and personal conduct.
- Promote effective dialogue between the NHS England, its partners, CCGs, providers of healthcare and the communities the commissioning system serves.

Board members bring a range of complementary skills and experience in areas such as finance, governance and health policy, and new appointments take account of the skills already represented on the Board and recognise where gaps could be filled. During 2014-15, three new non-executive voting directors were appointed by the Secretary of State for Health: David Roberts, Noel Gordon and Professor Sir John Burn and three new national directors were also appointed by the Board: Chief Executive Simon Stevens (voting), Karen Wheeler (non-voting) and Ian Dodge (non-voting).

NHS England's non-executive directors are:

Chairman: Professor Sir Malcolm Grant CBE

Sir Malcolm Grant is a barrister and a member of the Bench of Middle Temple. As an academic lawyer he specialised in planning, property and environmental law, and was Professor of Land Economy at Cambridge from 1991-2003. From 2003-13 he 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. He is currently a trustee of Somerset House, a director of Genomics England Ltd, a board member of the University Grants Committee of Hong Kong; and a UK Business Ambassador. He is Chancellor-Elect of the University of York.

Deputy Chairman and Chair of the Audit & Risk Assurance Committee: Ed Smith, CBE, FCA, CPFA

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

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

Dame Moira Gibb is Chair of Skills for Care and Chair of City Lit Adult Education College. She is a non-executive director of the UK Statistics Authority and a member of the Council of Reading University. She is a Civil Service Commissioner, chairs a local authority improvement board and is a non-executive director of Achieving for Children. Her career was in local government and social services and she was a Director of the London Marathon from 2005-11.

Non-executive Director: Noel Gordon

Noel Gordon was appointed in July 2014 and had been appointed Chair of the Specialised Commissioning Committee. Formerly an economist, Noel spent most of his career in consultancy until his retirement in 2014 including, for the last 16 years, with Accenture where he was global managing director of the Banking Industry Practice. He has extensive practical experience of driving fundamental innovations in transforming industries, and of big data, analytics and digital technologies. He is Chairman of the Board of Trustees of UserVoice.org.

Non-executive Director: David Roberts

David Roberts has many years of experience at board and executive level in retail and commercial banking in the UK and internationally. He is Chairman Elect of Nationwide Building Society and from 2010-14 he was Group Deputy Chairman of Lloyds Banking Group and Chairman of the Board Risk Committee. He held various senior management positions in Barclays during 1983 - 2006 culminating in Executive Director, member of the Group Executive Committee and Chief Executive, International Retail and Commercial Banking. He is a former non-executive Director of BAA plc and Absa Group SA, and was Chairman and Chief Executive of Bawag PSK AG, Austria's second largest retail bank.

Non-executive Director: Ciarán Devane

Ciarán Devane was educated at University College, Dublin and George Washington University, Washington DC and worked for ICI for eight years before becoming a management consultant. He was Chief Executive on Macmillan Cancer Support from 2007-14 and in January 2015 he joined the British Council as Chief Executive. Ciarán is a trustee of the National Council for Voluntary Organisations and is a director elect of the Board of Social Finance.

Non-executive Director: Margaret Casely-Hayford

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

Non-executive Director: Lord Victor Adebowale

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

Non-Executive Director: Professor Sir John Burn

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

NHS England's Executive Management Group

Chief Executive: Simon Stevens

Simon Stevens is NHS England's Accounting Officer and is answerable to Parliament for the performance of NHS England and delivery against the Mandate. He is responsible for the overall leadership of NHS England, for setting priorities to drive improvement and deliver improved outcomes and for over £100 billion of annual health service funding.

Chief Financial Officer: Paul Baumann

Paul Baumann is NHS England's Chief Financial Officer, providing system leadership to the NHS in delivering best value and financial sustainability. The Finance Directorate, under Paul's leadership, aims to provide a first class financial management service ensuring NHS England is well advised and provided with excellent financial services at all times. Paul is a Fellow of the Chartered Institute of Management Accountants.

National Medical Director: Sir Bruce Keogh

Sir Bruce Keogh is responsible for the clinical and professional leadership of doctors, dentists, pharmacists, scientists and allied health professionals; improving clinical outcomes and promoting innovation.

Chief Nursing Officer: Jane Cummings

Jane Cummings is the executive lead for patient safety, patient experience and the professional lead for nursing and midwifery in England. Since April 2014, Jane has also been the Senior Responsible Officer for Learning Disability at NHS England.

National Director: Commissioning Operations: Dame Barbara Hakin

Dame Barbara Hakin is the National Director responsible for overseeing operational delivery within NHS England, which includes responsibility for oversight of NHS England's directly commissioned services including: Specialised Services, Primary Care, Public Health, Health and Justice and services for the Armed Forces. She has responsibility, through the regional and local teams, for oversight, support and assurance of CCGs, as well as overseeing NHS England's CSUs.

National Director: Commissioning Strategy: Ian Dodge

Ian Dodge joined NHS England in July 2014. He is responsible for NHS England's commissioning support strategy, policy and analytical services and a number of delivery programmes. The directorate is leading work on NHS transformation and the Five Year Forward View. It has set up and is running the work on new care models and the vanguard programmes; and giving power to patients through rolling out personal budgets, integrated personalised commissioning and patient choice. The Directorate also runs the national Congenital Heart Disease review, leads NHS England's work on promoting science and innovation and hosts cross-system functions, such as the national NHS SDU, and promoting equality and tackling inequalities.

National Director for Patients & Information: Tim Kelsey

Tim Kelsey's role combines the functions of chief technology and information officer with responsibility for patient and public participation. He sets the strategy and policy outcomes to support patients and public and leads the engagement framework to ensure services are delivered with clear public involvement.

National Director: Transformation & Corporate Operations: Karen Wheeler

Karen Wheeler is responsible for the NHS England's strategic organisation development strategy, and for ensuring its corporate services are effective in supporting the organisation. She provides oversight and assurance of all NHS England's Business Plan priorities and major change programmes.

OUR ORGANISATION AND PEOPLE

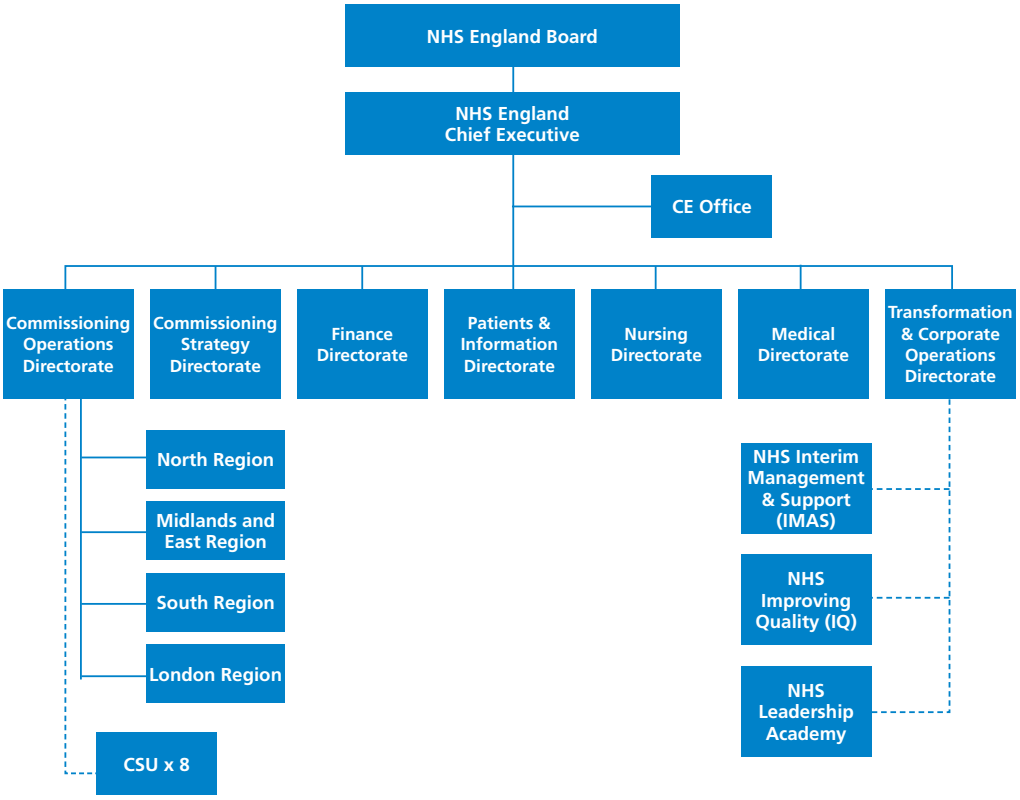
In March 2015, approximately 6,000 people were employed by NHS England based around the country. It hosted eight Commissioning Support Units which employ a further 10,000 staff, plus NHS Improving Quality, NHS Sustainable Development Unit and a number of clinical senates and networks.

NHS England's staff work in roles in support of commissioning, assurance, policy and strategy development and providing system leadership in collaboration with its national partners including the Care Quality Commission, Monitor, NHS TDA, Public Health England, NICE, Health Education England and the Health and Social Care Information Centre.

NHS England is committed to achieving equal access to health services designed around the needs of the patient. It upholds the NHS Constitution and shares in full the values enshrined within it of:

- Respect and dignity
- Commitment to the quality of care
- Compassion
- Improving lives
- Working together for patients
- Everyone counts

During 2014-15, NHS England reviewed its organisational functions and processes and implemented a revised management and regional structure, and delivered 10 per cent operating cost efficiencies.



Building NHS England capability and engagement

Over the last year, NHS England has addressed issues with its corporate services including creating a new in-house legal team, and improving its IT service. It has introduced formal talent management for business critical senior leadership roles, and launched work to develop our capabilities. It has also further developed engagement with staff, through the staff barometer, regular all staff briefings, and improved internal communications. Staff wellbeing has been made a priority, and the organisation's mental health first aider's network has attracted national recognition.

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 NHS England's Chief People Officer and the UNISON National Officer aligned to NHS England.

Sickness absence

Sickness absence for the period 1 January 2014 to 31 December 2014 was as follows:

	FTE-Days Available	FTE-Days Lost to Sickness Absence	Average Sick Days per FTE
NHS England	1,274,154	42,718	7.5
CSUs	1,841,394	55,575	6.8
Total Parent	**3,115,548**	**98,293**	**7.2**
CCGs	2,736,232	72,382	5.8
Consolidated Group	**8,967,327**	**268,967**	**6.8**

• FTE – full time equivalent

Enhanced sickness management arrangements, including managers directly reporting and recording absence, have been implemented this year, and have enabled NHS England to maintain comparatively low levels of staff absence during the year.

Health and safety

During 2014-15, NHS England has updated its health and safety policy, and established a formal health and safety committee, in consultation with trade union partners. It has also improved its safety management system through:

- Developing an intranet based portal accessible to all staff containing health and safety procedures, tools, information and guidance.

- Developing e-learning packages to support staff in their work. As at 1 April 2015, the health and safety awareness module has been successfully completed by 84 per cent of staff.

- Improving safety incident reporting. Between April 2014 and March 2015, NHS England recorded 34 incidents, a summary of which can be found within the health and safety portal. One incident was reportable to the Health and Safety Executive (HSE) under the Reporting of Incidents, Diseases and Dangerous Occurrences Regulations (RIDDOR). To date, this incident has not attracted HSE intervention.

How NHS England responded to its customers

Contacts and complaints

NHS England's Customer Contact Centre is the initial point of contact in NHS England for people who require advice about accessing primary care (GP, dental, optical and pharmacy services). The Contact Centre also

accepts complaints from patients who wish to complain to NHS England about primary care or the additional services that it commissions (health and justice, military health services and some specialised services) rather than the provider of a particular service.

The aim is to ensure that all complaints are investigated and a response is sent to the complainant within a mutually agreed timescale wherever possible. NHS England conducts regular customer satisfaction surveys to measure the effectiveness of the complaints handling procedure and ensure a quality, consistent approach. The results for the past year will also be published in the Annual Complaints report, which will be available online from summer 2015.

Although progress has been made to improve both responsiveness and the quality of complaints handling, more needs to be done. A new suite of key performance indicators (KPIs) and management controls were implemented in the early part of 2015 to ensure front line contact continually improves.

Using complaints to drive improvement

NHS England recognises the importance of using lessons learned during complaints investigation, as well as general feedback from patients, to drive improvement in the services it commissions. NHS England recently implemented a customer relationship management (CRM) system which will enable it to obtain insight into the patient experience, for example through monitoring complaints information to identify trends and patterns, facilitating the early detection of problems with a particular service or provider.

An analysis of the complaints received for the year ending 31 March 2015 along with examples of the changes instigated as a result of the lessons learned will be published in the annual complaints report.

Exit packages, severance payments and off payroll engagement

NHS England has made no special severance payments during 2014-15 and complies fully with its delegations and guidance from HM Treasury and the Department of Health. It has not supported any such payments within CCGs either in its grandparent role. NHS England operates internal controls in respect of such matters and any special severance payment business cases would first have to be reviewed and approved by the Executive HR Sub-Committee. No such approvals have been made.

However, in order to make cuts in NHS England's running costs, a number of posts were eliminated, and appropriate redundancy payments made, during 2014-15.

Details of payments made are contained in the following tables:

Parent

	2014-15			2013-14		
	Compulsory redundancies Number	Other agreed departures Number	Total Number	Compulsory redundancies Number	Other agreed departures Number	Total Number
Less than £10,000	78	40	118	30	-	30
£10,001 to £25,000	126	101	227	54	-	54
£25,001 to £50,000	78	147	225	58	-	58
£50,001 to £100,000	68	76	144	49	1	50
£100,001 to £150,000	21	26	47	10	-	10
£150,001 to £200,000	16	19	35	5	-	5
Over £200,001	24	20	44	1	-	1
Total	**411**	**429**	**840**	**207**	**1**	**208**
Total cost (£000)	**21,666**	**24,406**	**46,072**	**8,689**	**59**	**8,748**

Consolidated group

	2014-15			2013-14		
	Compulsory redundancies Number	Other agreed departures Number	Total Number	Compulsory redundancies Number	Other agreed departures Number	Total Number
Less than £10,000	86	48	134	59	15	74
£10,001 to £25,000	142	116	258	72	12	84
£25,001 to £50,000	94	155	249	66	6	72
£50,001 to £100,000	80	90	170	57	5	62
£100,001 to £150,000	28	30	58	11	-	11
£150,001 to £200,000	20	19	39	8	-	8
Over £200,001	29	20	49	1	-	1
Total	**479**	**478**	**957**	**274**	**38**	**312**
Total cost (£000)	**26,118**	**26,350**	**52,468**	**10,565**	**801**	**11,366**

Off-payroll engagements

Off-payroll engagements as of 31 March 2015, for more than £220 per day and that have lasted longer than six months are as follows:

	Number
The number that have existed:	
For less than one year at the time of reporting	298
For between one and two years at the time of reporting	207
For between two and three years at the time of reporting	2
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 2015	507

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 2014 and 31 March 2015	764
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	468
Number for whom assurance has been requested:	
For whom assurance has been received	527
For whom assurance has not been received	207
Number that have been terminated as a result of assurance not being received	0
Total number for whom assurance has been requested	734

	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	3
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 (N.B. this figure includes on-payroll as well as off-payroll engagements)	338

A payment of £470,000 was required by HM Treasury in respect of off-payroll workers during the financial year.

Board statement

The Board confirms that the Annual Report and 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.

Details of the directors

The details of the Directors are set out in the Board profile section and their interests are set out at appendix 8.

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.

Cost allocation and setting of charges for information

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

Disclosure of personal data-related incidents

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

Fraud

NHS England has a policy on Tackling Fraud Bribery and Corruption. This is due for review in June 2015. The organisation works closely with our local counter fraud specialist and NHS Protect to ensure all reactive investigative work is dealt with thoroughly and recoveries made where possible. NHS England aims to comply with security standards set out by NHS Protect.

Payment of suppliers

Whilst NHS England are not formal signatories to the Prompt Payment Code it abides by the principles on which it is based. This is evidenced by NHS England's strong performance in 2014-15 against the Better Payments Practice Code.

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:

Payment of suppliers - Better Payment Practice Code

	2014/15		2013/14	
	Number	£000	Number	£000
Parent				
Non NHS Payables				
Total Non-NHS trade invoices paid in the year	846,125	10,244,726	807,815	10,249,434
Total Non-NHS trade invoices paid within target	823,134	10,033,009	785,296	10,120,244
Percentage of Non-NHS trade invoices paid within target	97.28%	97.93%	97.21%	98.74%
NHS Payables				
Total Non-NHS trade invoices paid in the year	61,424	87,611,661	39,873	80,491,383
Total Non-NHS trade invoices paid within target	57,999	87,365,294	37,064	80,216,348
Percentage of Non-NHS trade invoices paid within target	94.42%	99.72%	92.96%	99.66%
Consolidated Group				
Non NHS Payables				
Total Non-NHS trade invoices paid in the year	2,710,613	21,151,859	2,267,883	18,982,771
Total Non-NHS trade invoices paid within target	2,605,797	20,523,067	2,147,274	18,321,392
Percentage of Non-NHS trade invoices paid within target	96.13%	97.03%	94.73%	96.52%
NHS Payables				
Total Non-NHS trade invoices paid in the year	816,823	135,819,461	437,384	127,020,913
Total Non-NHS trade invoices paid within target	778,798	134,962,474	401,574	125,308,277
Percentage of Non-NHS trade invoices paid within target	95.34%	99.37%	91.81%	98.65%

Emergency preparedness, resilience and response

NHS England certifies that it 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.

Statement of Disclosure to Auditors

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

- So far as the member is aware, there is no relevant audit information of which NHS England's external auditor is unaware.

- The member has taken all the steps that they ought to have taken as a member in order to make him or herself aware of any relevant audit information and to establish that NHS England's external auditor is aware of that information.

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.

EQUALITY AND DIVERSITY REPORT

NHS England is committed to equality and diversity, and complies with the required public sector equality duty set out in the Equality Act 2010. It published updated workforce equality data in January 2015. The link to the full report is here: http://www.england.nhs.uk/about/equality/

A more comprehensive NHS England workforce equality and inclusion data report will be produced on 1 July and this will be the new annual reporting date for workforce data.

Integral to meeting our legal responsibilities is the provision of 'system leadership' on equality. NHS England has demonstrated commitment to promoting equality and reducing health inequalities for all the communities it serves, in particular the re-establishment and leadership of the Equality and Diversity Council (EDC). In line with the Five Year Forward View commitment, NHS England has committed to help lead better focus on equality and diversity across the NHS.

NHS England's equality objectives

NHS England has set four equality objectives for the period April 2014 to March 2016:

- It will oversee and support the implementation of the refreshed Equality Delivery System (EDS2), or the original Equality Delivery System (EDS) so that by 31 March 2016 there is a minimum of 95 per cent implementation across all NHS Trusts, NHS Foundation Trusts, and CCGs across England.

- During 2014-15, it will help support CCGs to plan and commission for equality by embedding equality at the heart of key system levers identified by the Equality and Diversity Council, including the CCG assurance regime and the corporate governance statement.

- By March 2015, it 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.

- 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.

Key achievements during 2014-15

- As of 1 April 2015, two measures have been introduced to improve equality – the Workforce Race Equality Standard (WRES) and the EDS/2 have been mandated in the 2015-16 NHS Contract. These link with the CCG Assurance Framework and the Care Quality Commission (CQC) inspection regime. Currently 93 per cent of NHS organisations (including NHS England) are implementing the EDS or the refreshed EDS2.

Development of an equality and health inequalities hub on the NHS England website - https://www.england.nhs.uk/ourwork/gov/equality-hub/ including resources for EDS2 and WRES and examples of good practice.

- The NHS England Equality and Health Inequalities unit has held over 30 workshops on the Public Sector Equality Duty and EDS2 (in partnership with the Equality and Human Rights Commission), health inequalities duties and the WRES.

- NHS England has published a new information standard for accessible information and communication – ISB 1605 Accessible Information.

The Workforce Race Equality Standard (WRES)

The WRES is mandated in the NHS Standard Contract from 1 April 2015. The requirement for publication of data that is transparent and can be benchmarked will place appropriate focus upon ensuring that the gap between the treatment, opportunities and experience of Black and Minority Ethnic (BME) and White staff is closed and that NHS Boards are broadly representative of the communities they serve through the development and implementation of the WRES.

Accessible Information Standard

NHS England has published a new Information Standard for accessible information and communication – ISB 1605 Accessible Information. The standard aims to establish a clear and consistent framework, and provide direction to the health and adult social care system, such that disabled patients, service users, carers and parents receive accessible information (such as correspondence in easy read, braille or via email) and communication support (such as a British Sign Language (BSL) interpreter) at appointments. The development of this standard will have particular impact for people who have a learning disability, who are deaf, blind or deafblind, and/or who have some hearing or visual loss. Information about the project can be found at www.england.nhs.uk/accessibleinfo

Work is also underway to develop an information standard for sexual orientation monitoring, to introduce recording of the sexual orientation of patients/service users.

NHS England's summary assessment of meeting our legal duties with regard to health inequalities is included in appendix 2.

Simon Stevens
Accounting Officer
29 June 2015

REMUNERATION REPORT

Strategic HR and Remuneration Committee report

As part of the overall review of Board effectiveness, the focus and terms of reference for this Committee were revised and implemented in January 2014. The new Strategic HR and Remuneration Committee subsumes all the work of the previous Committee (the Remuneration and Terms of Service Committee) and reflects an expanded role:

- To provide the Board with assurance and oversight of all aspects of strategic people management and organisational development.

- To approve the appointment, remuneration and terms of service for the Chief Executive and national (executive) directors, and other very senior managers (VSMs).

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

Committee composition and attendance

Committee membership during the financial year and attendance at meetings during the financial year are shown in appendix 6.

During the year, the Chief Executive attended a number of the meetings of the Committee, as did the National Director: Transformation and Corporate Operations. In addition, the Committee was supported in its work by Stephen Moir, Chief People Officer. Paul Harrison, Director of Organisation Development, was also requested to attend the Committee on one occasion during 2014-15 to provide input and specific advice upon issues relating to talent management and organisation development initiatives.

Highlights of Board Committee reports for 2014-15 can be found in appendix 7.

The Committee's work

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

- Consideration of the remuneration and terms of appointment of national directors.

- Development and implementation of a talent management framework for senior leaders within NHS England.

- Consideration of NHS pay and severance terms arising from the 2015-16 NHS pay agreement, negotiated by the Department of Health.

- Reviewing progress with NHS England's performance and development review process.

- Consideration of the results of the NHS England staff satisfaction and engagement survey.

The Board has formally adopted an equality, diversity and inclusion in the workplace strategy for its workforce, and this is complemented by the organisation's formal equality objectives arising from the Equality Act 2010. In addition, NHS England has led the development of a new Workforce Race Equality Standard (WRES) for the NHS, which it will be applying to its own operations, along with the provisions of the NHS Equality Delivery System 2 (EDS2) framework to assess progress in respect of its workforce diversity performance.

Policy on remuneration of senior managers

The framework for the remuneration of national (executive) directors is set by the Department of Health through the VSMs pay framework for arm's length bodies.

It is the policy of NHS England to pay salaries that are appropriate to recruit senior managers with the necessary skills, capability and experience necessary for the effective running of a £99 billion organisation, whilst recognising the importance of demonstrating pay restraint at a time of considerable pressure on NHS finances. Recommending appropriate remuneration for national (executive) directors is undertaken by the Strategic HR and Remuneration Committee of the Board, with final decisions being made by the Department of Health's Arm's Length Bodies' Remuneration Committee.

Senior managers performance related pay

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

Policy on senior managers contracts (not audited)

Contracts of employment for senior managers are open-ended contracts, unless otherwise specified. Notice periods follow the provisions of the VSM contract of employment, as applied by NHS England, of six months contractual notice. Termination payments are only able to be authorised where these are contractual and, subject to the value involved, may still require further approval from the Department of Health's Governance and Assurance Committee.

Any proposed special severance payment, i.e. non-contractual, requires formal approval from the Department of Health and HM Treasury.

Name and title	Date of appointment	Unexpired term at 31 March 2015	Notice period	Provisions for compensation for early termination	Other details
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	
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	
Ian Dodge National Director: Commissioning Strategy	7 July 2014	n/a	6 months	Option to provide taxable pay in lieu of part or all of the notice period	
Barbara Hakin National Director: Commissioning Operations	1 April 2013	n/a	6 months	Option to provide taxable pay in lieu of part or all of the notice period	
Tim Kelsey National Director for Patients and Information	2 July 2012	n/a	6 months	Option to provide taxable pay in lieu of part or all of the notice period.	
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	Left NHS England on 30 June 2014
Rosamond Roughton Interim National Director: Commissioning Development to 31 July 2014	15 April 2013	n/a	6 months	Option to provide taxable pay in lieu of part or all of the notice period	Returned to substantive role as Director of NHS Commissioning, not a Board level position.
Simon Stevens Chief Executive Officer	1 April 2014	n/a	6 months	Option to provide taxable pay in lieu of part or all of the notice period	

Secondments					
Bruce Keogh National Medical Director	1 April 2013	n/a	12 months	n/a	Seconded from University College London Hospitals NHS Foundation Trust to 1 April 2015, thereafter employed by NHS England.
Karen Wheeler National Director: Transformation and Corporate Operations	1 April 2014	2 years	3 months	n/a	3 year secondment from the Department of Health

Policy on remuneration of non-executive directors

The remuneration of non-executive directors is set by the Department of Health upon appointment. All non-executive directors are paid the same amount, except the Chair and Vice-Chair, to reflect the equal time commitment expected from each non-executive. The Chair and Vice-Chair are paid higher amounts to reflect the increased time commitment associated with their respective roles. In the case of the Vice-Chair, this includes his role as the Chair of the Audit and Risk Committee. Some of the non-executive directors have opted to waive their contractual remuneration.

Non-executive directors performance related pay

Non-executive directors do not receive performance related pay.

Policy on non-executive director service contracts (not audited)

The terms of service of the non-executive directors is set by the Department of Health upon appointment.

Name and title	Date of appointment	Unexpired term at 31 March 2015	Notice period	Provisions for compensation for early termination	Other details
Malcolm Grant Chair	31 October 2011	7 months	6 months	None	
Victor Adebowale Non-executive Director	1 July 2012, reappointed to a second term on 1 January 2015	3 years, 9 months	None	None	
John Burn Non-executive Director	1 July 2014	3 years, 3 months	None	None	
Margaret Casely-Hayford Non-executive Director	1 July 2012	1 year, 3 months	None	None	Waived entitlement to remuneration between April and July 2014. Received remuneration from August 2014.
Ciaran Devane Non-executive Director	1 January 2012	9 months	None	None	
Moira Gibb Non-executive Director	1 July 2012, reappointed to a second term on 1 January 2015	3 years, 9 months	None	None	
Noel Gordon Non-executive Director	1 July 2014	3 years, 3 months	None	None	
David Roberts Non-executive Director	1 July 2014	3 years, 3 months	None	None	Waived entitlement to remuneration
Ed Smith Non-executive Director and Vice-Chair	9 November 2011	7 months	None	None	

Salaries and allowances

Senior manager remuneration (including salary and pension entitlements)

Salaries and allowances 2014-15 (audited)

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

* Professor Sir Bruce Keogh was seconded to NHS England from UCLH NHS Foundation Trust and his salary was paid by that organisation and recharged to NHS England. He transferred onto the NHS England payroll from 1 April 2015.

** Simon Stevens' salary entitlement is in the band £210-215 and he voluntarily decided to reduce his pay in 2014-15 to the band £190-195. It has been agreed that he will do so again in 2015-16.

*** Karen Wheeler is seconded from the Department of Health to NHS England and her salary is paid by that organisation and recharged to NHS England. The non-consolidated bonus relates to 2013-14 but was paid in 2014-15. The bonus for 2014-15 is subject to moderation and any award will be paid in 2015-16.

Salaries and allowances 2013-14 (audited)

Name and title	(a) Salary (bands of £5,000)	(b) Expense payments (taxable) Rounded to nearest £100	(c) Performance pay and bonuses (bands of £5,000)	(d) Long term performance pay and bonuses (bands of £5,000)	(e) All pension-related benefits (bands of £2,500)	(f) TOTAL (a to e) (bands of £5,000)
Paul Baumann Chief Financial Officer	205-210	10,800	0	0	25.0-27.5	240-245
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)
Barbara Hakin National Director: Commissioning Operations	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
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	0	37.5-40.0	260-265
Rosamond Roughton Interim National Director: Commissioning Development to 31 July 2014	165-170	0	0	0	72.5-75.0	235-240
Jo-Anne Wass National Director: Human Resources & Organisational Development to 31 March 2014	155-160	0	0	0	(5.0)-(7.5)	150-155

* Professor Sir Bruce Keogh was seconded to NHS England from UCLH NHS Foundation Trust and his salary was paid by that organisation and recharged to NHS England. He transferred onto the NHS England payroll from 1 April 2015.

Pension benefits (audited)

Name and title	Real increase in pension at age 60 (bands of £2,500)	Real increase in pension lump sum at age 60 (bands of £2,500)	Total accrued pension at age 60 at 31 March 2015 (bands of £5,000)	Lump sum at age 60 related to accrued pension at 31 March 2015 (bands of £5,000)	Cash equivalent transfer value at 31 March 2014 (£000)	Cash equivalent transfer value at 31 March 2015 (£000)	Real increase in cash equivalent transfer value (£000)	Employers contribution to partnership pension (£000)
Paul Baumann Chief Financial Officer	0-2.5	5.0-7.5	15-20	55-60	317	378	52	0
Jane Cummings Chief Nursing Officer	0-2.5	0-2.5	70-75	220-225	1352	1434	45	0
Ian Dodge National Director: Commissioning Strategy	0-2.5	n/a	0-5	n/a	0	15	15	0
Barbara Hakin National Director: Commissioning Operations	0-2.5	0-2.5	50-55	160-165	n/a	n/a	n/a	0
Tim Kelsey National Director for Patients & Information	2.5-5.0	n/a	5-10	n/a	70	108	36	0
Bruce Keogh National Medical Director	0-2.5	0-2.5	80-85	235-240	1857	n/a	n/a	0
Bill McCarthy National Director: Policy to 30 June 2014	(0)-(2.5)	(0)-(2.5)	65-70	200-205	1213	1247	0	0
Rosamond Roughton Interim National Director: Commissioning Development to 31 July 2014	0-2.5	0-2.5	10-15	30-35	181	201	5	0
Simon Stevens Chief Executive Officer	2.5-5.0	0-2.5	20-25	55-60	306	360	45	0
Karen Wheeler National Director: Transformation & Corporate Operations	2.5-5.0	n/a	45-50	n/a	809	930	57	0

Non-executive director remuneration (including salary entitlements)

Non-executive directors do not receive pensionable remuneration.

Salaries and allowances 2014-15 (audited)

Name and title	(a) Salary (bands of £5,000)	(b) Expense payments (taxable) Rounded to nearest £100	(c) Performance pay and bonuses (bands of £5,000)	(d) Long term performance pay and bonuses (bands of £5,000)	(e) All pension-related benefits (bands of £2,500)	(f) TOTAL (a to e) (bands of £5,000)
Victor Adebowale Non-executive Director	5-10	0	0	0	n/a	5-10
John Burn Non-executive Director from 1 July 2014	0-5	0	0	0	n/a	0-5
Margaret Casely-Hayford* Non-executive Director	5-10	0	0	0	n/a	5-10
Ciaran Devane Non-executive Director	5-10	0	0	0	n/a	5-10
Moira Gibb Non-executive Director	5-10	0	0	0	n/a	5-10
Noel Gordon Non-executive Director from 1 July 2014	5-10	0	0	0	n/a	5-10
Malcolm Grant Chair	60-65	0	0	0	n/a	60-65
David Roberts** Non-executive Director from 1 July 2014	0	0	0	0	n/a	0
Ed Smith Non-executive Director & Vice-Chair	25-30	0	0	0	n/a	25-30

* Margaret Casely-Hayford waived her Non-executive Member remuneration between April and July 2014, but received remuneration from August 2014.

** David Roberts has waived his Non-executive Member remuneration.

Salaries and allowances 2013-14 (audited)

Name and title	(a) Salary (bands of £5,000)	(b) Expense payments (taxable) Rounded to nearest £100	(c) Performance pay and bonuses (bands of £5,000)	(d) Long term performance pay and bonuses (bands of £5,000)	(e) All pension-related benefits (bands of £2,500)	(f) TOTAL (a to e) (bands of £5,000)
Victor Adebowale Non-executive Director	5-10	0	0	0	n/a	5-10
Margaret Casely-Hayford* Non-executive Director	0	0	0	0	n/a	0
Ciaran Devane Non-executive Director	5-10	0	0	0	n/a	5-10
Moira Gibb Non-executive Director	5-10	0	0	0	n/a	5-10
Malcolm Grant** Chair	60-65	0	0	0	n/a	60-65
Naguib Kheraj*** Non-executive Director to 10 December 2013	0	0	0	0	n/a	0
Ed Smith Non-executive Director & Vice-Chair	25-30	0	0	0	n/a	25-30

* Margaret Casely-Hayford waived her Non-executive Director remuneration.
** Between 1 April 2013 and September 2013 Malcolm Grant's employer (University College London) recharged for his time spent on NHS England work (limited to the advertised remuneration). From 1 October 2013 he has been paid via NHS England's payroll.
*** Naguib Kheraj waived his Non-executive Director remuneration.
n/a Non-executive Directors do not receive pensionable remuneration, and therefore have no pension related benefits

Cash Equivalent Transfer Values

A Cash Equivalent Transfer Value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member's accrued benefits and any contingent spouse's pension payable from the scheme. A CETV is a payment made by a pension scheme or arrangement to secure pension benefits in another pension scheme or arrangement when the member leaves a scheme and chooses to transfer the benefits accrued in their former scheme. The pension figures shown relate to the benefits that the individual has accrued as a consequence of their total membership of the pension scheme, not just their service in a senior capacity to which disclosure applies. The CETV figures and the other pension details include the value of any pension benefits in another scheme or arrangement which the individual has transferred to the NHS pension scheme. They also include any additional pension benefit accrued to the member as a result of their purchasing additional years of pension service in the scheme at their own cost. CETVs are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries.

Real increase in CETV

This reflects the increase in CETV effectively funded by the employer. It 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.

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 banded remuneration of the highest paid member of the Board in the financial year 2014-15 was £205,000 to £210,000 (2013-14: £225,000 – £230,000). This was 5.66 times (2013-14: 6.47) the median remuneration of the workforce, which was £36,666 (2013-14: £35,154).

In 2014-15, no employees received remuneration in excess of the highest-paid member of the Board (2013-14: 0).

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

Simon Stevens
Accounting Officer
29 June 2015

STATEMENT OF THE ACCOUNTING OFFICER

Statement of the 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:

- 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.

- Prepare the Financial Statements on a going concern basis.

ANNUAL GOVERNANCE STATEMENT

Introduction and context

NHS England[†] is an executive non-departmental public body which leads and oversees the commissioning of healthcare to improve health and well-being, secure high quality care and ensure the future NHS is sustainable. In 2014-15 we oversaw an annual expenditure of £99 billion, which was used to commission health care services both directly by NHS England and by the 211 clinical commissioning groups (CCGs).

This Annual Governance Statement covers NHS England's NHS corporate leadership role, its role in directly commissioning health services and its oversight and assurance of the commissioning system, including CCGs.

As Accounting Officer, I have responsibility for the system of internal controls supporting and enabling the achievement of NHS England's aims and objectives, whilst safeguarding the public funds and assets for which I am personally responsible in accordance with Managing Public Money and as set out in my Accounting Officer appointment letter. This includes assurance of the organisations which are part of the wider commissioning system, including CCGs, the NHS Leadership Academy and those organisations which NHS England hosts, namely commissioning support units (CSUs), NHS Improving Quality (IQ) and NHS Interim Management and Support (IMAS).

This is our second full year of operation, and the organisation continues to develop to ensure that we can use our commissioning and leadership role to drive significant change in the NHS, given the increasing demand for its service and the likelihood of constrained resource growth in the foreseeable future.

[†] The legal title of the organisation is the NHS Commissioning Board

Following my appointment on 1 April 2014, I put in place an Organisational Alignment and Capability programme to ensure that NHS England has the capability and organisational structure to deliver against a challenging agenda. On 23 October 2014 we launched the NHS Five Year Forward View, which was developed with those partner organisations which share responsibility for delivering and overseeing health and care services, namely Public Health England, Monitor, Health Education England, the Care Quality Commission and the NHS Trust Development Authority (TDA). Patient groups, clinicians and independent experts provided their advice to create a collective view of how the health service needs to change over the next five years, if it is to close the widening gaps in the health of the population, quality of care and the funding of services. Our Business Plan for 2015-16 focusses our resources on the delivery of ten key priorities supporting delivery of this Five Year Forward View and is published on the NHS England website.

Statutory background

NHS England is accountable, through its Board, to the Secretary of State for Health for delivery of the Mandate. The Mandate sets the strategic direction for NHS England, ensures it is democratically accountable and is the main basis of ministerial instruction to the NHS. The Chair of the Board and Chief Executive meet the Secretary of State regularly to provide assurance on progress against Mandate objectives, and our progress is reviewed annually by Government and an assessment given to Parliament.

A Framework Agreement between NHS England and the Department of Health sets out the agreed roles and responsibilities of the two organisations and the critical elements of our relationship. It covers arrangements for NHS England's governance, audit, risk management, delegations and financial management and human resources responsibilities, with reference to wider requirements applied to organisations across government. This also encompasses the principles which underpin our partnership working with the Department of Health and other organisations, patients and the public, including commitment to the values in the NHS Constitution.

Our purpose and role

NHS England, in addition to its leadership and commissioning oversight role, directly commissions £28 billion of healthcare services, mainly in specialised and primary care services.

As an organisation we operate through our central team and four regional teams, working closely with partner organisations that provide regulatory and support services to the health and care system. We also host other bodies – CSUs, NHS IQ, NHS IMAS – and we fund and sponsor the NHS Leadership Academy, on behalf of the NHS.

Our work is also supported by a number of third party organisations, including the NHS Health and Social Care Information Centre (HSCIC), NHS Business Services Authority (BSA), NHS Shared Business Services (SBS) and NHS Property Services Ltd. Governance and assurance arrangements for these relationships have been strengthened during 2014-15, and this process will continue during 2015-16.

The commissioning system

The NHS budget is entrusted to NHS England which shares, with the Secretary of State for Health, the legal duty to promote a comprehensive health service. It oversees the delivery of NHS services, including continuous improvement of the quality of treatment and care, through healthcare professionals making decisions about services based on the needs of their communities. NHS England allocates resources to CCGs and supports them to commission services on behalf of their patients according to evidence-based quality standards.

Clinical commissioning groups

NHS England is accountable for overseeing and assuring the commissioning system, and in particular the 211 CCGs[†], to ensure that it is working effectively. The CCGs are independent membership organisations, each of which has an appointed Accountable Officer. They are clinically led and responsible for commissioning high quality healthcare services for their local communities. Parliament has specified limited rights of intervention by NHS England into each CCG. NHS England allocates a large proportion of the funding it receives from the Department of Health to these groups who, in turn, are responsible for demonstrating probity and good governance in managing their finance and performance. Together they account for £67 billion of the commissioning funds. NHS England's role is to ensure that they deliver the best outcomes for their patients and have a high standard of financial management which ensures that resources are administered prudently and economically, with financial propriety and regularity being safeguarded. Further detail on assurance of the commissioning system is given on page 105.

[†] A merger took place on 1 April 2015 which reduced the number of CCGs to 209

Direct commissioning

NHS England directly commissions £28 billion of predominantly specialised and primary care healthcare services. This work also includes healthcare for the armed forces and their families, healthcare for those in the justice system and a range of public health services.

Health care services for those in secure and detained settings include provision for some 85,000 people in prisons, 1.4 million people per year in police custody and courts and those in immigration removal centres, secure children's homes and young offender institutions. Healthcare services are also provided for around 250,000 serving personnel in the armed forces and their families, and for 2.5 million veterans.

The public health services currently include national immunisation and screening programmes, public health for those in secure or detained settings, child health information services and public health services for children aged 0-5 years. Over 11 million flu vaccinations were commissioned and delivered between September 2014 and January 2015.

Commissioning support units

CSUs were established to provide support for CCGs, and on the basis that CCGs will buy back office and support services from CSUs. They provide a range of high quality, efficient support services (such as analysis, information, procurement, contracting, HR administration and financial services) to CCGs and other NHS organisations. At the start of the year there were 17 CSUs but, through consolidation and restructuring as CCGs sought efficiencies, the number reduced to eight by 1 April 2015.

Governance arrangements and effectiveness

Governance framework

The governance framework is clearly set out in Standing Orders, Standing Financial Instructions, a Scheme of Delegation and Commissioning Support Unit Operating Frameworks. To strengthen governance arrangements within the organisation a Director of Governance and Assurance was appointed with effect from 1 April 2015. He will support the Board in ensuring that current arrangements are appropriate for an organisation of the size and complexity of NHS England, that the recently amended board committee structure is operating effectively and underpinned by appropriate executive arrangements and governance

documentation, and that the framework continues to evolve in line with the organisation's function and operating arrangements.

Compliance with the UK Corporate Governance Code

NHS England's arrangements generally comply with the best practice described in the UK Corporate Governance Code and the Corporate Governance in Central Government Departments: Code of Good Practice 2011 (HM Treasury and Cabinet Office). An assessment has indicated a few exceptions which are shown in appendix 9.

The Board

The Board arrangements comply with The National Health Service Act 2006 (as amended) requirements that the Board consists of at least five non-executive directors other than the Chair, and that the number of executive directors is less than the number of non-executive directors (including the Chair). The Chair and non-executive directors are appointed by the Secretary of State; executive members are appointed by the Board. Details of all Board members, meetings held and attendance, are set out in appendix 6.

To extend the range of skills and experience available to the Board, and also to provide more non-executive time to support its work, three new non-executive members were appointed to the Board on 1 July 2014: David Roberts, Noel Gordon and Professor Sir John Burn. One of these appointments was to fill a vacated post.

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

Roles and responsibilities of the Board

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

- Sets the overall strategic direction of NHS England, within the context of the NHS Mandate.
- Approves the business plan which is designed to achieve NHS England's strategic objectives.

- Determines which decisions it will make and which it will delegate to the Executive Group via the Scheme of Delegation.

- Monitors the performance of NHS England against the business plan and holds the NHS England Executive Group to account for that performance and for the proper running of the organisation (including operating in accordance with legal and government requirements).

- Ensures high standards of corporate governance and personal conduct.

- Monitors the performance of the group against core financial and operational objectives.

- Provides effective financial stewardship.

- Promotes effective dialogue between NHS England, its partners, CCGs and providers of healthcare and the communities served by the commissioning system.

All Board members are required to record annually any interests relevant to their role on the Board. The register of interests is a public document which is open to public scrutiny at NHS England's offices in London and also on the organisation's website.

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

Board performance

The Board regularly reviews its performance and works to improve its effectiveness. To this end, it carried out an assessment of its effectiveness. It concluded that the Board had been effective in establishing the organisation, creating an experienced and diverse Board supported by an able executive team. It also noted that the Board had overseen the introduction of a wide variety of new financial and other processes to

[†] The Independent Review into Self-inflicted Deaths in Custody of 18-24 year olds. The Review began on the 1 April 2014, chaired by Lord Toby Harris. The purpose of the Review was to make recommendations to reduce the risk of future self-inflicted deaths in custody.

support the operation of the organisation. The Board identified areas for further development on areas such as risk management and talent development which will be taken forward as part of the work programme for the coming year.

Board committees

The Board is supported by a number of committees which support the Board's assurance and oversight of the organisation. The Board committee structure helps the Board to spend a significant proportion of its time on strategic decision-making whilst obtaining proper assurance that decisions across the organisation have been made based on the correct information. Committee chairs report to the Board on their activities following each meeting of that committee.

During the year the Board re-evaluated the committee structure and decided to reduce the number of committees to better reflect the organisation's core business and decision making. The new committee structure ran in shadow form for the final quarter of the year and became fully operational from 1 April 2015, as shown in appendix 4.

Audit & Risk Assurance Committee

The Committee provides assurance to the Board on how NHS England manages its risks. It ensures that the system of internal control, governance and risk management is effective. Between April and July 2014 the Committee operated with two members, but this was strengthened through the addition of two further non-executive Directors in July, David Roberts and Noel Gordon. The Chairman provided regular progress reports to the Board on its key duties which included:

- Commissioning and receiving reports from the internal auditors on the adequacy of NHS England's internal control systems.

- Considering all relevant reports from the Comptroller and Auditor General, NHS England's external auditor, including reports on NHS England's accounts and achievement of value for money.

- In-depth review of the organisation's risk profile and reporting to the Board on managing and mitigating current and emerging risks.

- Ensuring that all corporate risks and mitigations have an accountable Board member and delegated risk owner.

- Evaluating the effectiveness of NHS England's control environment.

- Oversight of the organisation's arrangements for counter fraud.

- Assessing the integrity of NHS England's financial reporting and satisfying itself that any significant financial judgements made by management were sound.

- Scrutinising the activities and performance of the internal and external auditors, including monitoring their independence and objectivity.

In 2014-15, to deliver better assurance within CCG Audit Committee arrangements, the Chairman of the Audit & Risk Assurance Committee ran events for CCG Audit Committee Chairs which, alongside broader communication and discussion, focussed on:

- Development of risk management and assurance frameworks.

- Changes to local audit arrangements.

- Conflicts of interests – particularly in relation to developing co-commissioning arrangements.

Impact

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

It has had robust discussions about the resources needed to execute the internal control system and year end processes, which have led to effective prioritisation and the acquisition of additional resources.

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

Finally the Committee and executive colleagues had successful engagement with CCG Audit Committee chairs to ensure guidance was both given and received on delivering the necessary assurances to, and by, CCGs.

Assurance statement

Internal audit

The Committee confirms it has fulfilled its duties in respect of monitoring the provision of internal audit services, including the approval of an appropriate risk based programme of work for 2014-15.

Counter fraud

The Committee confirms it has fulfilled its duties in respect of monitoring the provision of counter fraud services, including the approval of an appropriate programme of work for 2014-15 and future years.

External audit and financial reporting

The Committee confirms it has fulfilled its duties in respect of the external audit and the Annual Report and Accounts.

Governance

The Committee confirms it has fulfilled its duties in respect of considering and monitoring the governance arrangements for the organisation for 2014-15.

Risk management

Risk management in NHS England is led by the National Director: Transformation and Corporate Operations. Our Risk Management Strategy and 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.

During the past year, the Risk Management Policy and Process Guide, which sets out the corporate standards to assist staff to identify, analyse, evaluate and control risks (whether strategic, financial, reputational and/or operational), was updated.

Risk management is embedded in the activity of the organisation through:

- The Risk Management Strategy and Policy.
- The Executive Risk Management Group.

- The Committee structures described in this report.
- Management processes (e.g. using a risk-based approach to help prioritise expenditure).
- The CCG Assurance Framework.
- The generation of a whistleblowing policy.
- Incident reporting frameworks (e.g. information governance and emergency preparedness, resilience and response).
- A policy on tackling fraud, bribery and corruption.

All national and regional teams within NHS England are required to identify, manage and report risks which are captured on a regular basis and escalated to the Corporate Risk Register where appropriate. The Executive Risk Management Group reviews and manages the strategic risks and identifies the highest priority risks in the directorate risk registers, so that they can be escalated and brought to the attention of the Board as necessary.

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

Responsibility for mitigating quality and clinical risks in the health system is systemic: no one organisation can be solely responsible for quality. The Care Quality Commission, NICE, professional regulator Monitor and the NHS TDA each have their roles. The primary duty on NHS England in respect of quality is to drive continuous improvement in the quality of services it directly commissions, and to ensure that CCGs are appropriately assuring quality and managing clinical risk in their commissioned services. Risk management responsibility for this is embedded in the roles of the new Commissioning and Specialised Commissioning Committees.

There is a core set of risks on the Corporate Risk Register which have continued from last year including quality, delivery of urgent and emergency care, major emergency, service transformation, relationship with the patients and public, finances and NHS England capability and capacity.

Additional risks have emerged during the year and have been given greater focus and regular attention. These include: primary care capacity; information sharing governance and security; and commissioning support. Appendix 10 lists the key risks from the Corporate Risk Register, which can be found in full in the most recent performance report in the Board paper section of the organisation's website.

Considerable management attention, through monthly executive reviews, has been focused on the areas which remain high risk even after our mitigation actions, in particular:

- Financial sustainability of the NHS, given that most of the cost drivers and pressures are not within NHS England's direct control. This is a primary driver of the Five Year Forward View, and work is under way to scope and plan the NHS England contribution towards the £22 billion.

- The capacity of primary care, which is insufficient to meet projected needs, and without necessary growth will result in downstream pressures on A&E, secondary care and targets. We are working with HEE to ensure that primary care workforce is developed to meet future demands.

- The changes needed to urgent and emergency care local arrangements, to ensure they can continue to deliver acceptable standards of service and meet A&E targets. Work is underway to implement the agreed new standards for urgent and emergency care in collaboration with the local health organisations which need to effect the changes.

- The need to reform our approach to provision of specialised services, to ensure we can deliver quality standards within available resources, given increasing costs and expectations of specialised treatments and services

All of these areas are included as explicit priorities within our 2015-16 Business plan, and arrangements for managing the plans which will

mitigate the risks will be assured through our delivery assurance of those priorities.

We have specifically reviewed, with the Audit and Risk Assurance Committee, our management of the risks associated with our internal organisation change programme, and our capacity and capability to take forward the additional work for the Five Year Forward View. The Board was assured that mitigations were in hand.

The Audit and Risk Assurance Committee has suggested the appointment of a Chief Risk Officer to further strengthen NHS England's focus and management of risks; this role will be fulfilled by the Director of Governance and Assurance from 1 April 2015.

During 2015-16 the Board plans to re-evaluate the level of risk that it regards as acceptable.

Sources of assurance

Internal control assurance framework

NHS England's assurance framework was not fully developed throughout 2014-15, but we continue to implement a more systematic approach for demonstrating compliance with the organisation's system of internal control. Internal Audit reports have shown good progress, but more work remains to be done to embed controls in the organisation. National and Regional Directors, CSU Managing Directors and hosted body Chief Executives have formally certified their compliance with internal policies and controls in an end-year Assurance Statement. By signing it, each director is confirming compliance, for their area(s) of responsibility, with the requirements and standards outlined in the Assurance Statement, which includes adherence to key governance policies, arrangements for health and safety, managing counter fraud and information governance. During 2015-16, the assurance will be reviewed quarterly, and supported with appropriate evidence.

The end of year Assurance Statements were completed and submitted by senior managers in April. The Corporate Assurance team have reviewed the statements; they do not reveal any individually significant issues for attention other than areas already included under Control Issues later in this document.

Assuring delivery

During the year we have had systematic and routine tracking and reporting of delivery commitments. This covers:

- Assurance of delivery against Mandate commitments, which is reported to the Board and to the Department of Health.
- Reporting on progress of delivery of all business plan commitments listed in NHS England's Business Plan.
- Formal assurance and reporting of our major change programmes.

In all cases, reporting feeds into the Board performance reports, and risks and issues are escalated through executive committees, and as necessary to the Board or Audit & Risk Assurance Committee for scrutiny.

NHS England has more to do to embed this work into reporting and assurance mechanisms and will be providing more systematic and robust governance of programmes, alongside assurance of our 2015-16 Business Plan priority objectives, to assure and report on our delivery during 2015-16.

Assuring quality of services

The Quality and Clinical Risk Committee was established in 2013 to provide assurance to the Board in respect of quality and clinical risk, and was chaired by Prof Sir Cyril Chantler. The purpose of the Committee was to provide assurance that robust systems and processes were 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.
- Identify and effectively manage any quality or clinical risks associated with performing statutory and non-statutory functions.

The Committee met four times in 2014 (February, April, June and September). The Committee audited a number of items related to both of the duties on NHS England given above in respect of quality, and provided written reports to the Board, providing assurance that risks were being adequately managed, and making recommendations as to the

actions that could be taken to strengthen the mitigation of quality/clinical risks inherent in performing NHS England's duties where appropriate.

With regards to managing quality and/or clinical risks, the Committee audited and made recommendations to the Board on the operation of Quality Surveillance Groups, handling patient complaints in the NHS, specific functions concerned with patient safety, the operation of the Local Supervising Authority in England, and the process of medical revalidation.

The Committee also considered topics related to improving the quality of services provided to individuals, such as NHS England's strategy for primary care and the use of incentives, tools and levers in the NHS. At its last meeting in September 2014 the Committee considered progress against Domain 1 of the NHS Outcomes Framework.

New arrangements for oversight and assurance of quality of services, and management of related risks, embed this important assurance into the routine executive processes. Significant quality risks will continue to be escalated to the Board as necessary.

Public involvement and consultation

NHS England has made progress on public involvement and engagement in order that it becomes embedded in our work. Policy teams (supported by advice from the patient participation team) are required to make arrangements for public involvement in the planning and development of commissioning arrangements. The NHS Citizen programme is building a national approach to citizen engagement and accountability. NHS England is targeting areas for development and areas of good practice to share across the organisation. Work is underway with each of the oversight groups to further develop the models of engagement across each area. In particular specialised commissioning are deploying a model of engagement with patient and public involvement built in at every governance level, and assured by a strategic Patient and Public Voice Assurance Group.

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 by various Board committees. The Board is confident that the information it is presented with has been through appropriate review and scrutiny, and that it continues to develop with organisational needs.

Business critical models

NHS England recognises the importance of quality assurance across the full range of its analytical work. Mechanisms are in place to ensure that wider government recommendations are adopted into our analysis work. Where an error might 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 models. This is overseen by a joint committee of experienced analysts.

Information governance, cyber and data security

Given previous inconsistency in compliance and assurance at local and regional level, NHS England has continued to strengthen its data and information governance (IG) processes systems and structures. It has improved IG oversight and assurance through establishing a National Information Governance Steering Group, which regularly reviews assurance and risks across NHS England centre and regions, CSUs and other hosted organisations. Additional IG resource has been brought into regional teams, to improve compliance and reporting, As a result, the assessment of IG compliance, through a single organisation-wide submission of the Information Governance Toolkit on 31 March 2015, achieved a satisfactory level.

In addition to testing compliance, the toolkit has been used to report and alert Department of Health and the Information Commissioner's Office to any breaches occurring by NHS organisations and enables speedy coordination of investigation and response. All NHS England incidents have been reported, investigated and escalated appropriately. Themes and trends are monitored, from which mitigating actions and preventative measures are put in place to minimise recurrence.

Regular lessons learned bulletins are issued as part of an internal communication campaign on data breaches.

NHS England has recently developed and implemented an information asset management system to enable risk assessments to be carried out based on mapping data flows for every significant information asset.

NHS England is increasing focus on cyber risk as the organisation increasingly relies on electronic channels and communication for all core business activity.

It has adopted the Cabinet Office (10 steps to cyber security) approach to ensure cyber security is integrated within the broader IG and business continuity management arrangements.

A series of cyber awareness campaigns have been undertaken within NHS England, and cyber awareness modules have been included within the on-line IG training module to be rolled out in 2015-16. Where appropriate, cyber related information sharing with CSUs will be undertaken.

Newly implemented gateway processes for reviewing Information and Communication Technology (ICT) security are used for ICT and digital projects, and provide assurance that cyber security requirements are built in to new systems and services.

Work is also underway with the Department of Health and Health and Social Care Information Centre (HSCIC) to improve communications, for the reporting of incidents and for on-going assurance responses across the commissioning system and NHS organisations.

Service auditor reporting

NHS England has a range of methods for assuring our relationship with third party organisations providing services, with lead national directors having responsibility for the relationship and service provision, and formal customer-supplier performance oversight arrangements. In addition Service Auditor Reports have been commissioned to review the control procedures.

Internal audit

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

- Auditing the application of risk management and the internal control framework.
- Reviewing key systems and processes.
- Providing advice to management on internal control implications of proposed and emerging changes.
- Being available to guide managers and staff on improvements in internal controls.
- Focusing audit activity on the key business risks.

The internal audit service, provided by Deloitte LLP, operates in accordance with the Public Sector Internal Audit Standards and to an internal audit plan. Internal audit updates the plan to reflect changes in risk profile, and the revised plan is reviewed and approved by the Audit & Risk Assurance Committee. The internal audit service submits regular reports on the effectiveness of NHS England's systems of internal control and the management of key business risks, together with recommendations for improvement by management (including an agreed timetable for action). The status of internal audit recommendations are reported to each meeting of the Audit & Risk Assurance Committee.

The planned audit programme this year has placed a strong focus on the organisation's core internal control mechanisms (such as finance, human resources, procurement, information technology, programme and project management) and its support of the CCGs through CSUs and wider commissioning arrangements.

External audit

During the year NHS England's Audit and Risk Assurance Committee has worked constructively with the National Audit Office's Audit Director and his team. The work of external audit sits outside NHS England's governance arrangements but independently informs NHS England's consideration and evaluation of controls, governance and risk. The work of external audit is monitored by the Committee through regular progress reports.

Board and committees

The Board and its committees are part of NHS England's formal governance, and the committees provide the Board with regular reporting and formal assurance. Their role and activities are described in the previous section on roles and responsibilities of the Board.

Control issues

During 2014-15, NHS England has made significant progress evolving its system of internal control to address the areas for improvement set out in last year's Annual Governance Statement. The Head of Internal Audit recognises in his report to the Accounting Officer significant improvements, particularly in the areas of financial control and IT. Progress continues to be made in respect of obtaining assurance from third party providers around the many services that are provided to NHS England, and work will continue to improve this over the coming year.

During 2014-15 a number of areas were identified in which internal controls required further strengthening. Internal audit were asked to review these areas as part of their wider audit programme and provide recommendations and advice on improvements that could be made.

The main areas of concern were:

Establishment control: An audit in the last six months of 2014-15 highlighted where internal arrangements need to change to provide effective control. In response, new establishment control arrangements have been implemented from 1 May 2015. They include changes for the executive human resources sub-committee and working arrangements between NHS England and its HR shared service provider, the NHS Business Services Authority (BSA), to provide greater oversight and reporting.

Off payroll workers: An audit at the end of 2014-15 highlighted where internal arrangements need to be improved and strengthened, to tighten controls and management of off payroll workers. Work is underway to implement establishment control arrangements for off payroll workers and to tighten related procedures and controls, and this programme will be implemented during 2015-16.

Travel and expenses: A follow up audit was undertaken in 2014-15. A number of changes were made as a result of the first audit, including updating the business travel and expenses policy, to improve the organisation's understanding of the requirements. The organisation also moved from a manual to electronic expenses system (from September 2014), which has improved management information, identifies non-compliance and records evidence for claims. Further improvements are also planned in the management of travel requisitions through our nominated supplier.

Procurement: A Procurement Improvement Programme (PIP) was established in June 2014 immediately following the completion of an internal audit report setting out the need for improved procurement practices and compliance. The programme has made progress on a baseline review of the procurement function, publication of guidance on efficiency controls and development of a non-clinical procurement strategy. The remaining work to improve the process will be completed during 2015-16.

Legal services: During the course of the year, a new legal services team was recruited and established to form a robust internal legal service and reduce dependency on and cost of externally procured legal advice. Further work is in hand to improve procedures across the organisation, informed by a recent internal audit report, to ensure all legal spend is adequately controlled.

Programme and project management: Audits over the last year have indicated variations across major programmes in the standards of governance, programme management, capability and delivery effectiveness. The organisation has started to establish more systematic review and assurance processes, focusing initially on major programmes. It has also introduced standards to apply to all major programmes and projects and set up a major programmes assurance group to oversee implementing these standards.

In addition arrangements are underway to develop a flexible project resource pool, to provide internal skilled resources to support effective management of major programmes and projects, and to ensure standards and good practice are applied. This will also reduce costs and use of external contractors.

Third party assurances

NHS England relies on a number of third party providers (such as NHS SBS, NHS BSA, NHS Property Services Ltd and the HSCIC) to provide a range of transactional processing services ranging from finance to data processing. The assurance provided by these organisations has been audited during this year and plans subsequently identified – for both the long and short term – to continue to improve both the processes and understanding.

Information incidents

In 2014-15, there were six serious untoward incidents in relation to data loss which were reported as set out below:

Date of incident	Nature of incident	Paper or electronic information	Nature of data involved	Number of people potentially affected	Notification steps and outcome
NHS England (national support centre, region and area teams) incidents					
01-Jul-14	Email containing patient identifiable data sent to incorrect recipients	Electronic	Personal sensitive data (patient)	41	Logged as a reportable incident on the IG Toolkit. Full Investigation undertaken and remedial actions implemented. No harm done – information contained within NHS and deleted.
02-Oct-14	Patient identifiable data was not removed from spreadsheet prior to being emailed to clinical commissioning group by an NHS Trust	Electronic	Personal sensitive data (patient)	20,000	Incident logged. Full investigation undertaken, ICO responded and remedial actions implemented. No harm done – information contained within NHS and deleted.
Commissioning support unit incidents					
01-Jun-14	Staff identifiable data of clinical commissioning groups disclosed to an external organisation in error	Electronic	Personal sensitive data (staff)	369	Incident logged. Full investigation undertaken and no further action required. No harm done – information contained within NHS and deleted.
24-Sep-14	Patient identifiable data uploaded onto a portal shared by the clinical commissioning group and commissioning support unit	Electronic	Personal sensitive data (patient)	1	Incident logged. Full investigation undertaken and ICO responded no further action required. No harm done – information contained within NHS and deleted.
15-Oct-14	Staff identifiable information disclosed internally in error	Electronic	Personal sensitive data (staff)	363	Incident logged. Full investigation undertaken, ICO responded and no further action required. No harm done – information contained within NHS and deleted.
23-Feb-15	Personal sensitive data sent out to an external organisation	Electronic	Personal sensitive data (patient)	100,000	Incident logged. Full investigation undertaken. No data was compromised and no further action required.

Investigations into the two larger scale incidents confirmed that no personal data had been compromised. After each incident, formal reviews are undertaken and lessons are captured and communicated through guidance and targeted communications.

Assurance of the commissioning system

Clinical commissioning groups

CCGs are independent organisations, each with its own governing body. Through the authorisation process to establish CCGs, NHS England gained assurance that individual CCGs 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. It was based on six domains of assurance.

CCGs 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, and NHS England's assessment of a CCGs 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. This power was used once during the year for Barnet CCG.

As part of the assurance process in 2014-15, NHS England has produced a quarterly report, by CCG, summarising areas for development. The quarterly report includes an assessment on whether NHS England is 'assured' or 'not assured' on the basis of the six assurance domains, and details the agreed actions for improvement. An annual letter to the CCG governing body summarises assurance discussions throughout the year and identifies any agreed improvement required and ambitions for further development.

NHS England has recognised that there have been a number of changes since CCGs were first authorised, and in March 2015 it produced a new CCG Assurance Framework 2015-16 setting out a new approach to assurance that reflects the maturity of the CCGs and a changed commissioning environment. The Framework strengthens the focus on a CCG's track record and ongoing performance in delivering improvements for patients, and will continue to assess a CCGs capability as well as ensuring its fitness to take on additional roles and responsibilities under the co-commissioning agenda.

This new Framework also acknowledges that CCGs have different starting positions, with different populations and challenges, requiring different leadership responses. Some are operating in an extremely difficult environment, within challenged health economies or with legacy financial issues.

The organisation gains assurance about the use of financial resources by commissioners (within the bounds of the 2012 Act, and recognising the freedoms allowed to GP-led commissioners) through the business planning process, followed up by the in-year monitoring process. The annual planning guidance specifies the financial business rules within which commissioners operate.

In year, the financial position is reported on a monthly basis. Individual variances from a CCGs plan are evaluated against business rules, and related risks and mitigations are also reported. Finance reports are reviewed with the Chief Financial Officer on a monthly basis and presented regularly at executive group meetings. Board Committees receive monthly finance reports with supporting narrative and review the relevant risks and available mitigations. The full Board regularly receives financial performance reports, and quarterly financial performance information is published on the NHS England website.

Commissioning support units

Each CSU produces an annual business plan which is reviewed on submission and monitored throughout the year. They are subject to an in-year assurance programme which regularly reports on their risk, viability, development and compliance with NHS England's Standing Financial Instructions. NHS England acts upon any exceptions reported in Service Auditor Reports, and any management actions are managed through the CSUs Finance Director and tracked until completion. Progress is then reported to the Audit & Risk Assurance Committee.

All CSUs completed an Assurance Statement in April. These have been reviewed and support the further strengthening in 2015-16 regarding procurement and Standing Financial Instructions (SFIs). NHS England has concluded that there is a need to review the application of SFIs by CSUs and has asked that the Procurement Improvement Programme include the findings in its current work to improve compliance.

NHS direct commissioning

In 2013-14 specialised commissioning was not delivering within its budget allocation, and a formal review was instituted. Progress has been made to address some of the historical challenges and financial pressures facing specialised services. A turnaround task force was set up and, as a result, there has been better control of expenditure in specialised commissioning.

The Specialised Services Commissioning Committee has been established to monitor progress on these changes, and to scrutinise and track quality and effectiveness of commissioning, and management of risks.

Changes to the commissioning landscape

During the year, NHS England has been progressing a number of developments which evolve local commissioning arrangements:

- Moving direct commissioning of primary care into co-commissioning arrangements with CCGs.

- Combining local health and social care budgets through the Better Care Fund.

- New partnership arrangements with CCGs and local authorities in Greater Manchester (GM), proposed to take full effect from April 2016.

These changes to commissioning arrangements and plans have been managed through formal change programmes. The new arrangements with CCGs are integrated with our existing oversight arrangements and assured through our commissioning committees. They will be operational in 2015-16.

With regard to GM devolution, appropriate forms of delegation and/or co-commissioning will be used to give the NHS and local government partners in the city region control over the £6 billion health and social care budgets relating to their population. It is a core principle of the devolution process, as agreed in the Memorandum of Understanding signed in February 2015, that health services in GM remain part of the NHS, governed by the NHS Constitution, and with ongoing accountability through NHS England to the Department of Health. We are currently working with the GM Devolution programme board to develop the detailed arrangements by which this can be achieved, including the scale and scope of budgetary delegation, the entities to which responsibility will be devolved or with whom it will be shared, and the accountability and assurance arrangements which will apply to this. It is envisaged that these changes will take place in April 2016 following a period of validation through operation in shadow form from October 2015.

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

As part of its programme of work, and as set out in the Business Plan for 2015-16, NHS England will be providing leadership to the NHS, in partnership with the Department of Health and other national NHS bodies, so that individual organisations can realise their own internal efficiency gains, whilst supporting optimisation of the whole system and reducing the demand placed on the NHS as a whole. It is developing plans with our NHS partners to support further improvements in both operational efficiency in the provider sector and allocative efficiency in the commissioner sector.

Planning guidance and allocations

In December 2014, NHS England, Monitor, the NHS TDA, the Care Quality Commission, Public Health England and Health Education England came together to issue the joint guidance called 'The Forward View into action: planning for 2015-16', co-ordinating and establishing a firm foundation for longer term transformation of the NHS, while building on the direction set out in the Five Year Forward View.

The guidance is backed by the additional financial allocations for healthcare commissioners announced in the Autumn Statement.

NHS England central programme costs

Central programme costs are subject to scrutiny at the planning stage through a 'review and challenge' process between senior finance officials, including the Chief Financial Officer, the national director: Transformation and Corporate Operations and the relevant national director, and through this process budgets are decided. Individual expenditure items are subject to further scrutiny and approval process in line with Standing Financial Instructions and Government Efficiency Controls.

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 arm's length bodies. As a consequence, business cases are approved before spending can occur in a range of areas, in order to ensure best value for money and that efficiency is being maximised. Depending on the area of expenditure, approval is given by the Efficiency Controls executive or the Investment Committee. For expenditure above certain thresholds in certain categories, approval is also sought from the Department of Health, and in some cases also Ministers, the Cabinet Office and/or HM Treasury.

Counter fraud

NHS England has invested in increased counter fraud capability during 2014-15. It has established an enhanced local counter fraud function covering reactive and proactive counter fraud work. In addition to this investment in its own capability in both deterring and detecting fraud it is working closely with a number of other bodies, including NHS Protect, to establish appropriate and efficient anti-fraud arrangements across the wider commissioning system, and to comply with the standards set out by NHS Protect.

We have delivered a number of anti-fraud initiatives in 2014-15 including work to reduce the fraudulent claiming of prescription charge exemptions through the exemption checking service.

During 2015-16 the policy on Tackling Fraud Bribery and Corruption will be reviewed to further strengthen activity in this area.

Head of Internal Audit opinion

I have relied upon the following annual opinion of the Head of Internal Audit when preparing this Governance Statement:

"Based on the summary provided above and in the context of the overall environment for NHS England for FY2014/15, in my opinion the frameworks for governance and risk management have been adequate and effective in 2014/15.

With respect to the internal control environment significant effort has been focussed on implementing the structures designed through the FY2013/14 year, albeit that some structures, for example procurement and off payroll workers, remained in the design stage during the year. On this basis and in my opinion the framework for internal control has evolved and been implemented within the organisation, for the majority of areas, through the FY2014/15 year. At 31 March 2015 the majority of the internal control framework is in place although internal audit work has identified areas of non-compliance with the designed framework, a small number of areas where the design of the internal control framework remains ongoing and opportunities to improve the design of some areas of the internal control framework. All of the recommendations raised by internal audit have been accepted by management, actions have been agreed to address these and considerable focus has been placed on the implementation of the actions in a timely manner.

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

- Given the evolution of NHS England most core processes were designed and in place at 1 April 2014 although it had not been possible to test the operating effectiveness during the FY2013/14 year. The internal audit work for FY2014/15 has focussed largely on assessing the operational effectiveness of the core processes. However, there remain some core processes where readiness assessments were undertaken during FY2014/15 including off payroll workers and procurement.

- 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[1]. These include project and programme management, payroll, off payroll

workers, establishment control, payments and travel and expenses processes. Management actions have been agreed to address all of these observations, a significant number of which have been completed by year end. However, given the nature of the agreed management actions, some of which require a timeframe in excess of 12 months to implement, not all of these have been completed by year end. Where possible interim solutions have been put in place whilst activity remains focussed 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 procurement, off payroll workers, specialised commissioning and individual projects. Projects have been put in place to rectify the identified gaps or management have requested that we complete additional work in these areas.

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

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

  - BSA for human resources and procurement services;

  - McKesson for payroll and travel and expenses transaction processing;

  - NHS Property Services for building and estates management; and

  - HSCIC for data processing.

The understanding of the assurance requirements from these providers has evolved during the year with a specific piece of work commissioned from internal audit to understand the current assurance arrangements and the short and long term requirements to address any gaps identified. This enabled a set of assurances to be obtained for the FY2014-15 year and should provide the foundations for a robust assurance base for the FY2015-16 year. There does however remain a requirement for continuing change with respect to understanding respective responsibilities in an environment where significant transaction processing is provided by a third party."

Conclusion

During 2013-14, the organisation was in its first year of existence and still putting in place core operational process and controls some of which were insufficient, with the organisation relying heavily on internal audit to provide assurance. During the past year, 2014-15, it has initiated projects to redesign some core processes, streamline and improve their effectiveness, and to build more effective controls, especially in respect of HR service, establishment controls, payroll, and procurement. This work is progressively enabling the organisation to move to more effective reliance on internal controls rather than internal audit. While progress is underway, more work remains to be done in 2015-16.

Good progress has also been made to strengthen assurance and oversight of commissioning, through the new Board committee structure and realigned internal directorate structures. This work continues to be a key priority within the 2015-16 business plan.

Simon Stevens
Accounting Officer
29 June 2015

CERTIFICATE OF THE COMPTROLLER AND AUDITOR GENERAL

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

I certify that I have audited the financial statements of the NHS Commissioning Board for the year ended 31 March 2015 under the Health and Social Care Act 2012. The financial statements comprise: the Group and Parent Statements of Comprehensive Net Expenditure, Financial Position, Cash Flows, Changes in Taxpayers' Equity; and the related notes.

These financial statements have been prepared under the accounting policies set out within them. I have also audited the information in the Remuneration 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 and Social Care Act 2012. I conducted my audit in accordance with International Standards on Auditing (UK and Ireland). Those standards require me and my staff to comply with the Auditing Practices Board's Ethical Standards for Auditors.

Scope of the audit of the financial statements

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

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

Opinion on regularity

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

Opinion on financial statements

In my opinion:

- the financial statements give a true and fair view of the state of the group's and of the NHS Commissioning Board's affairs as at 31 March 2015 and of the group's and the parent's net expenditure for the year then ended; and

- the financial statements have been properly prepared in accordance with the Health and Social Care Act 2012 and Secretary of State directions issued thereunder.

Opinion on other matters

In my opinion:

- the part of the Remuneration Report to be audited has been properly prepared in accordance with Secretary of State directions made under the Health and Social Care Act 2012; and

- the information given in the Strategic Report and the Director's Report for the financial year for which the financial statements are prepared is consistent with the financial statements.

Matters on which I report by exception

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

- adequate accounting records have not been kept or returns adequate for my audit have not been received from branches not visited by my staff; or

- the financial statements and the 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 and Auditor General

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

1 July 2015

ANNUAL ACCOUNTS

STATEMENT OF COMPREHENSIVE NET EXPENDITURE FOR THE YEAR ENDED 31 MARCH 2015

		Parent		Consolidated Group	
		2014-2015	2013-2014	2014-2015	2013-2014
	Note	£000	£000	£000	£000
Administration Income and Expenditure					
Other operating revenue	2	(478,039)	(548,379)	(141,378)	(137,269)
Employee benefits	3.1	707,608	762,013	1,289,438	1,271,301
Operating expenses	4	1,668,188	1,908,355	689,469	938,860
Net administration expenditure before interest		**1,897,757**	**2,121,989**	**1,837,529**	**2,072,892**
Programme Income and Expenditure					
Other operating revenue	2	(1,876,904)	(1,568,315)	(2,014,531)	(1,706,099)
Employee benefits	3.1	210,815	108,899	437,590	257,767
Operating expenses	4	97,118,466	90,423,278	97,321,163	93,887,559
Net programme expenditure before interest		**95,452,377**	**88,963,862**	95,744,222	**92,439,227**
Total Income and Expenditure					
Other operating revenue	2	(2,354,943)	(2,116,694)	(2,155,909)	(1,843,368)
Employee benefits	3.1	918,423	870,912	1,727,028	1,529,068
Operating expenses	4	98,786,654	92,331,633	98,010,632	94,826,419
Net operating expenditure before interest		**97,350,134**	**91,085,851**	**97,581,751**	**94,512,119**
Other losses		-	27	-	715
Finance costs		4,200	6,092	4,263	6,150
Net operating expenditure for the financial year		**97,354,334**	**91,091,970**	**97,586,014**	**94,518,984**
Net loss on transfers by absorption	6	-	95,686	-	95,686
Net operating expenditure for the financial year including absorption losses		**97,354,334**	**91,187,656**	**97,586,014**	**94,614,670**
Other Comprehensive Net Expenditure					
Impairments and reversals		-	1,764	-	1,778
Movements in other reserves		19,484	-	21,649	(4,176)
Total comprehensive net expenditure for the year		**97,373,818**	**91,189,420**	**97,607,663**	**94,612,272**

The notes on pages 125 to 180 form part of this statement.

All income and expenditure is derived from continuing operations

STATEMENT OF FINANCIAL POSITION AS AT 31 MARCH 2015

		Parent		Consolidated Group	
		31 March 2015	31 March 2014	31 March 2015	31 March 2014
	Note	£000	£000	£000	£000
Non-current assets					
Property, plant and equipment	8	196,607	161,180	231,659	183,949
Intangible assets	9	6,224	7,860	9,849	8,805
Trade and other receivables	11	4,043	5,483	4,222	5,485
Total non-current assets		**206,874**	**174,523**	**245,730**	**198,239**
Current assets					
Inventories	10	178	454	2,244	1,715
Trade and other receivables	11	230,888	287,353	766,866	741,369
Cash and cash equivalents	12	129,479	391,990	150,045	424,044
Total current assets		**360,545**	**679,797**	**919,155**	**1,167,128**
Total assets		**567,419**	**854,320**	**1,164,885**	**1,365,367**
Current liabilities					
Trade and other payables	13	(2,584,030)	(2,728,264)	(6,910,966)	(6,753,949)
Borrowings	14	(5,921)	(1,006)	(15,605)	(4,129)
Provisions	15	(312,482)	(421,504)	(379,177)	(476,976)
Total current liabilities		**(2,902,433)**	**(3,150,774)**	**(7,305,748)**	**(7,235,054)**
Non-current assets less net current liabilities		**(2,335,014)**	**(2,296,454)**	**(6,140,863)**	**(5,869,687)**
Non-current liabilities					
Trade and other payables	13	(2,568)	(2,457)	(8,894)	(6,376)
Other financial liabilities		-	-	(51)	(25)
Borrowings	14	(10,523)	(3,015)	(11,683)	(4,377)
Provisions	15	(354,835)	(408,102)	(368,886)	(423,155)
Total non-current liabilities		**(367,926)**	**(413,574)**	**(389,514)**	**(433,933)**
Assets less liabilities		**(2,702,940)**	**(2,710,028)**	**(6,530,377)**	**(6,303,620)**
Financed by taxpayers' equity					
General fund		(2,702,964)	(2,710,192)	(6,522,485)	(6,298,186)
Revaluation reserve		24	164	160	337
Other reserves		-	-	(8,052)	(5,771)
Total taxpayers' equity		**(2,702,940)**	**(2,710,028)**	**(6,530,377)**	**(6,303,620)**

The notes on pages 125 to 180 form part of this statement.

The financial statements on pages 120 to 124 were approved by the Board on 29 June 2015 and signed on its behalf by:

Simon Stevens

Accounting Officer

STATEMENT OF CHANGES IN TAXPAYERS' EQUITY FOR THE YEAR ENDED 31 MARCH 2015

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

PARENT	General fund £000	Revaluation reserve £000	Total reserves £000
Balance at 1 April 2013	**(14,814)**	**-**	**(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	(4,967,412)
Adjusted balance at 1 April 2013	**(4,984,154)**	**1,928**	**(4,982,226)**
Changes in taxpayers' equity for 2013-14			
Net operating expenditure for the financial year	(91,187,656)		(91,187,656)
Impairments and reversals	-	(1,764)	(1,764)
Net recognised expenditure for the financial year	**(91,187,656)**	**(1,764)**	**(91,189,420)**
Grant in Aid	93,461,618	-	93,461,618
Balance at 31 March 2014	**(2,710,192)**	**164**	**(2,710,028)**

CONSOLIDATED GROUP

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

CONSOLIDATED GROUP

	General fund £000	Revaluation reserve £000	Other reserves £000	Total reserves £000
Balance at 1 April 2013	**(14,814)**	**-**	**-**	**(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	(94,614,670)	-	-	(94,614,670)
Impairments and reversals	-	(1,778)	-	(1,778)
Movements in other reserves	-	-	4,176	4,176
Release of reserves to the Statement of Comprehensive Net Expenditure	697	(697)	-	-
Net recognised expenditure for the financial year	**(94,613,973)**	**(2,475)**	**4,176**	**(94,612,272)**
Grant in Aid	93,461,618	-	-	93,461,618
Balance at 31 March 2014	**(6,298,186)**	**337**	**(5,771)**	**(6,303,620)**

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

The notes on pages 125 to 180 form part of this statement.

STATEMENT OF CASH FLOWS FOR THE YEAR ENDED 31 MARCH 2015

		Parent		Consolidated Group	
		2014-2015	2013-2014	2014-2015	2013-2014
	Note	£000	£000	£000	£000
Cash flows from operating activities					
Net operating costs for the financial year		(97,354,334)	(91,091,970)	(97,586,014)	(94,518,984)
Depreciation and amortisation	4	47,456	35,043	55,030	44,419
Impairments and reversals	4	18,210	115,550	19,131	118,406
Other non cash adjustments*		(4,021)	-	(3,995)	
Movement due to transfers by modified absorption		-	(4,434,624)	-	(4,632,122)
Loss on disposal		-	27	-	715
Unwinding of discount	15	3,010	6,092	3,012	6,095
Finance costs		(12,298)	-	(12,235)	-
(Increase)/decrease in inventories	10	276	(454)	(529)	(1,715)
(Increase)/decrease in trade & other receivables	11	57,905	(276,936)	(24,234)	(730,952)
Increase/(decrease) in trade and other payables**	13	(150,143)	2,675,593	148,929	6,702,325
Provisions utilised	15	(68,430)	(77,187)	(88,865)	(78,264)
Increase/(decrease) in provisions	15	(84,571)	42,724	(53,980)	114,428
Net cash outflow from operating activities		**(97,546,940)**	**(93,006,142)**	**(97,543,750)**	**(92,975,649)**
Cash flows from investing activities					
Payments for property, plant and equipment		(94,092)	(48,822)	(111,762)	(50,321)
Payments for intangible assets		(1,759)	(1,058)	(5,163)	(1,121)
Payments for other financial assets		-	-		-
Proceeds from disposal of assets held for sale: property, plant and equipment		2,386	-	2,424	-
Proceeds from disposal of assets held for sale: intangible assets		26	-	26	-
Net cash outflow from investing activities		**(93,439)**	**(49,880)**	**(114,475)**	**(51,442)**
Net cash outflow before financing activities		**(97,640,379)**	**(93,056,022)**	**(97,658,225)**	**(93,027,091)**
Cash flows from financing activities					
Grant in aid funding received		97,380,906	93,461,618	97,380,906	93,461,618
Capital element of payments in respect of finance leases		(3,038)	-	(3,116)	-
Net cash inflow (outflow) from financing activities		**97,377,868**	**93,461,618**	**97,377,790**	**93,461,618**
Net increase (decrease) in cash & cash equivalents		**(262,511)**	**405,596**	**(280,435)**	**434,527**
Cash & Cash Equivalents at the Beginning of the Financial Year	12	391,990	(13,606)	420,921	(13,606)
Cash & Cash Equivalents at the end of the financial year	**12**	**129,479**	**391,990**	**140,486**	**420,921**

The notes on pages 125 to 180 form part of this statement.

*Other non cash adjustments relate to derecognition of legacy lease creditors £(4,021)k. In the consolidated group accounts there is a non cash charge to reflect a discount on future lease charges of £26k.

** Consolidated group includes adjustment of Local Authority Pension Liability of £(2,281)k and £114k correction of Partially Completed Spells transferred to NHS England at 31 March 2013.

1. STATEMENT OF ACCOUNTING POLICIES

These financial statements have been prepared in accordance with the 2014-15 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 comparative amounts include two departures from the FReM, which were 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 and Social Care Act 2012, were 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 were 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, expenditure, depreciation and other material items are analysed in the Operating Segments note (note 19) 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 19.

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). The CSU results are included within the Parent accounts.

1.4 Comparative information

The comparative information provided in these financial statements is for the year ended 31 March 2014.

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 for the foreseeable future via the latest Spending Review and the passing of the Health and Social Care Act 2012. In the same way, the Department has demonstrated commitment to the funding of NHS England, with funding flows for the 2015-16 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 (DH). NHS England is required to maintain expenditure within this allocation. The DH also approves a cash limit for the period. NHS England is required to draw down cash in accordance with this limit. Cash drawn down is credited to the general fund. Grant in Aid is recognised in the financial period in which it is received.

Other operating revenue in respect of fees, charges and services is recognised when the service is rendered and the stage completion of the transaction at the end of the reporting period can be measured reliably, and it is probable that economic benefit associated with the transaction will flow to the Group. Income is measured at fair value of the consideration receivable. Where income is received for a specific activity which is to be delivered in the following financial year, that income is deferred.

1.7 Employee benefits

Recognition of short-term benefits - retirement benefit costs:

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 in England and Wales. The scheme is not designed to be run in a way that would enable NHS bodies to identify their share of the underlying assets and liabilities. Therefore, the scheme is accounted for as if it were a defined contribution scheme; the cost recognised in these accounts represents the contributions payable for the year. Details of the benefits payable under these provisions can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions.

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

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

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

1.8 Administration and programme expenditure

The Statement of Comprehensive Net Expenditure is analysed between administration and programme expenditure, as defined by HM Treasury. In addition to the costs of running NHS England, administration costs in the consolidated accounts include the running costs associated with the commissioning functions of 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 and equipment

Recognition

Property, plant and equipment is capitalised if:

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

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

Valuation of property, plant and equipment

All property, plant and equipment is measured initially at cost, representing the cost directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management. All assets are measured subsequently at 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.

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 and development

Expenditure on research is not capitalised: it is recognised as an operating expense in the period in which it is incurred.

Internally-generated assets are recognised if, and only if, all of the following have been demonstrated:

- The technical feasibility of completing the intangible asset so that it will be available for use.
- The intention to complete the intangible asset and use it.
- The ability to sell or use the intangible asset.

- How the intangible asset will generate probable future economic benefits or service potential.
- The availability of adequate technical, financial and other resources to complete the intangible asset and sell or use it.
- The ability to reliably measure the expenditure attributable to the intangible asset during its development.

The amount initially recognised for internally generated intangible assets is the sum of the expenditure incurred from the date when the criteria for recognition are initially met. Where no internally-generated intangible asset can be recognised, the expenditure is recognised in the period in which it is incurred.

1.13 Depreciation, amortisation and impairments

Freehold land, assets under construction, investment properties, stockpiled goods and assets held for sale are neither depreciated nor amortised.

Otherwise, depreciation or amortisation, as appropriate, is charged to write off the costs or valuation of property, plant and equipment and intangible non-current assets, less any residual value, on a straight-line basis over their estimated remaining useful lives. The estimated useful life of an asset is the period over which economic benefits or service potential is expected to be obtained from the asset. Estimated useful lives and residual values are reviewed each year end, with the effect of any changes recognised on a prospective basis. Assets held under finance leases are depreciated over the shorter of the lease term and the estimated useful life.

Depreciation/amortisation is charged as follows:

	Minimum Life (Years)	Maximum Life (Years)
Buildings excluding dwellings	5	20
Plant & 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 Government grants

Government grant funded assets are capitalised at their fair value on receipt, with a matching credit to income. Deferred income is recognised only where conditions attached to the grant preclude immediate recognition of the gain.

1.15 Non-current assets held for sale

Non-current assets are classified as held for sale if their carrying amount will be recovered principally through a sale transaction rather than through continuing use. This condition is satisfied once both of the following criteria are met:

- the asset is available for immediate sale in its present condition subject only to terms which are usual and customary for such sales; and
- the sale is highly probable.

Non-current assets held for sale are measured at the lower of their previous carrying amount and fair value less costs to sell. Fair value is open market value including alternative uses.

The profit or loss arising on disposal of an asset is the difference between the sale proceeds and the carrying amount and is recognised in the Statement of Comprehensive Net Expenditure. On disposal, the balance for the asset in the revaluation reserve is transferred to retained earnings.

Property, plant and equipment that is to be scrapped or demolished does not qualify for recognition as held for sale. Instead, it is retained as an operational asset and its economic life is adjusted. The asset is de-recognised when it is scrapped or demolished.

1.16 Leases

Leases are classified as finance leases when substantially all the risks and rewards of ownership are transferred to the lessee. All other leases are classified as operating leases.

Property, plant and equipment held under finance leases are initially recognised at the inception of the lease at fair value or, if lower, at the present value of the minimum lease payments, with a matching liability for the lease obligation to the lessor. Lease payments are apportioned between finance charges and reduction of the lease obligation to achieve a constant rate of interest on the remaining balance of the liability. Finance charges are recognised in the Statement of Comprehensive Net Expenditure.

Operating lease payments are recognised as an expense on a straight-line basis over the lease term. Lease incentives are recognised initially as a liability and subsequently as a reduction of rentals on a straight-line basis over the lease term.

Contingent rentals are recognised as an expense in the period in which they are incurred.

Where a lease is for land and buildings, the land and building components are separated and individually assessed as to whether they are operating or finance leases.

1.17 Inventories

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

1.18 Cash and cash equivalents

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

1.19 Provisions

Provisions are recognised when there exists a present legal or constructive obligation as a result of a past event, it is probable that the Group will be required to settle the obligation, and a reliable estimate can be made of the amount of the obligation. The amount recognised as a provision is the best estimate of the expenditure required to settle the obligation at the end of the reporting period, taking into account the risks and uncertainties. Where a provision is measured using the cash flows estimated to settle the obligation, its carrying amount is the present value of those cash flows using HM Treasury's discount rates.

Provisions are subject to three separate discount rates according to the expected timing of cashflows:

- a short term rate of minus 1.50 per cent (2013-14: minus 1.90 per cent) 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 1.05 per cent (2013-14: minus 0.65 per cent) is applied to the time boundary of after 5 and up to and including 10 years; and
- a long-term rate of 2.20 per cent (2013-14: 2.20 per cent) is applied to expected cashflows exceeding 10 years.

All percentages are in real terms.

1.20 Clinical negligence costs

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

1.21 Non-clinical risk pooling

NHS England participates in the Property Expenses Scheme and the Liabilities to Third Parties scheme. Both are risk pooling schemes under which the clinical commissioning group 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.

1.22 Continuing healthcare risk pooling

In 2014-15 a risk pool scheme has been introduced by NHS England for continuing healthcare claims, for claim periods prior to 31 March 2013. Under the scheme clinical commissioning groups contribute annually to a pooled fund, which is used to settle the claims.

1.23 Contingent liabilities and contingent assets

A contingent liability is:

- a possible obligation that arises from past events and whose existence will be confirmed only by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the organisation, 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.

1.24 Financial assets

Financial assets are recognised on the Statement of Financial Position when the group becomes party to the financial instrument contract or, in the case of trade receivables, when the goods or services have been delivered. Financial assets are de-recognised when the contractual rights have expired or the asset has been transferred. Financial assets are initially recognised at fair value. Fair value is determined by reference to quoted market prices where possible, otherwise by valuation techniques.

As available for sale financial assets, the group's investments are measured at fair value. With the exception of impairment losses, changes in value are taken to the revaluation reserve. Accumulated gains or losses are recycled to the Consolidated Statement of Net Comprehensive Expenditure on de-recognition.

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

At the Statement of Financial Position date, the group assesses whether any financial assets are impaired. Financial assets are impaired, and impairment losses recognised, if there is objective evidence of impairment as a result of one or more events which occurred after the initial recognition of the asset and which have an impact on the estimated future cash flows of the asset. For financial assets carried at amortised cost, the amount of the impairment loss is measured as the difference between the asset's carrying amount and the present value of the revised future cash flows discounted at the asset's original effective interest rate. The loss is recognised in the Statement of Net Comprehensive Expenditure.

1.25 Financial liabilities

Financial liabilities are recognised in the Statement of Financial Position when the group becomes party to the contractual provisions of the financial instrument or, in the case of trade payables, when the goods or services have been received. Financial liabilities are de-recognised when the liability has been discharged; that is, the liability has been paid or has expired.

Financial liabilities are initially recognised at fair value.

After initial recognition, financial liabilities are measured at amortised cost using the effective interest method. The effective interest rate is the rate that exactly discounts estimated future cash payments through the life of the asset to the net carrying amount of the financial liability. Interest is recognised using the effective interest method.

1.26 Losses and 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: www.hm-treasury.gov.uk. Losses and special payments are disclosed in note 22.

1.27 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 Net Comprehensive 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 and 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.

1.28 Accounting standards that have been issued but have not yet been adopted

The Treasury FReM does not require the following Standards and Interpretations to be applied in 2014-15. The application of the Standards as revised would not have a material impact on the accounts in 2014-15, were they applied in that year:

IFRS 9 Financial Instruments - effective from 2018-19

IFRS 13 Fair Value Measurement - effective from 2015-16

IFRS 14 Regulatory Deferral Accounts - effective from 2016-17

IFRS 15 Revenue for Contract with Customers - effective from 2017-18

1.29 Significant accounting policies and material judgements

Estimates and the underlying assumptions are reviewed on a regular basis by the group's senior management. Areas of significant judgement made by management are:

IAS37 Provisions - judgement is applied in arriving at the best estimate of the amount of the obligation. The amount recognised as a provision is the best estimate of the expenditure required to settle the obligation at the end of the reporting period, taking into account the risks and uncertainties.

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

2. OTHER OPERATING REVENUE

PARENT

	2014-15			2013-14		
	Total £000	Admin £000	Programme £000	Total £000	Admin £000	Programme £000
Recoveries in respect of employee benefits	**570**	530	40	**195**	118	77
Prescription fees and charges	**501,009**	-	501,009	**465,601**	49	465,552
Dental fees and charges	**716,014**	-	716,014	**683,583**	-	683,583
Education, training and research	**267,614**	6,509	261,105	**290,981**	5,627	285,354
Charitable and other contributions to revenue expenditure: non-NHS	**478**	443	35	**136**	90	46
Non-patient care services to other bodies *	**685,629**	428,062	257,567	**596,732**	497,247	99,485
Continuing Healthcare risk pool contributions **	**94,434**	-	94,434	**-**	-	-
Other revenue	**89,195**	42,495	46,700	**79,466**	45,248	34,218
Total other operating revenue	**2,354,943**	**478,039**	**1,876,904**	**2,116,694**	**548,379**	**1,568,315**

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

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

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

CONSOLIDATED GROUP

	2014-15			2013-14		
	Total £000	Admin £000	Programme £000	Total £000	Admin £000	Programme £000
Recoveries in respect of employee benefits	**3,415**	2,590	825	**1,765**	1,554	211
Prescription fees and charges	**503,940**	-	503,940	**470,733**	51	470,682
Dental fees and charges	**716,014**	-	716,014	**683,583**	-	683,583
Education, training and research	**280,807**	10,659	270,148	**299,335**	8,841	290,494
Charitable and other contributions to revenue expenditure: non-NHS	**2,278**	1,295	983	**2,039**	495	1,544
Non-patient care services to other bodies	**368,116**	49,766	318,350	**238,318**	48,404	189,914
Other revenue	**281,339**	77,068	204,271	**147,595**	77,924	69,671
Total other operating revenue	**2,155,909**	**141,378**	**2,014,531**	**1,843,368**	**137,269**	**1,706,099**

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

3. EMPLOYEE BENEFITS AND STAFF NUMBERS

3.1 EMPLOYEE BENEFITS

PARENT	2014-15					2013-14				
	Permanent Employees £000	Permanent CSU Employees £000	Other £000	CSU Other £000	Total £000	Permanent Employees £000	Permanent CSU Employees £000	Other £000	CSU Other £000	Total £000
Employee benefits										
Salaries and wages	252,387	315,880	56,663	135,946	**760,876**	243,770	332,986	43,504	127,894	**748,154**
Social security costs	23,847	26,562	74	30	**50,513**	22,619	28,050	3	19	**50,691**
Employer contributions to NHS Pension scheme	32,449	38,727	20	40	**71,236**	30,701	40,263	4	23	**70,991**
Termination benefits	30,109	6,038	-	-	**36,147**	1,076	-	-	-	**1,076**
Gross employee benefits expenditure	**338,792**	**387,207**	**56,757**	**136,016**	**918,772**	**298,166**	**401,299**	**43,511**	**127,936**	**870,912**
Less recoveries in respect of employee benefits	(162)	(407)	-	-	**(569)**	-	-	-	(195)	**(195)**
Total net employee benefits	**338,630**	**386,800**	**56,757**	**136,016**	**918,203**	**298,166**	**401,299**	**43,511**	**127,741**	**870,717**
Less: Employee costs capitalised	-	(349)	-	-	**(349)**	-	-	-	-	**-**
Net employee benefits excluding capitalised costs	**338,630**	**386,451**	**56,757**	**136,016**	**917,854**	**298,166**	**401,299**	**43,511**	**127,741**	**870,717**

	Charged to administration budgets £000	Charged to programme budgets £000	Total Gross employee benefits expenditure £000	Charged to administration budgets £000	Charged to programme budgets £000	Total Gross employee benefits expenditure £000
Of which:						
Parent excluding CSU	337,303	58,246	**395,549**	295,106	46,571	**341,677**
CSU	370,654	152,569	**523,223**	466,907	62,328	**529,235**
Gross employee benefits expenditure	**707,957**	**210,815**	**918,772**	**762,013**	**108,899**	**870,912**
Less Employee costs capitalised	(349)	-	(349)	-	-	-
Net Employee Benefits excluding Capitalised costs	**707,608**	**210,815**	**918,423**	**762,013**	**108,899**	**870,912**

CONSOLIDATED GROUP	2014-15					2013-14				
	Permanent Employees £000	Permanent CSU Employees £000	Other £000	CSU Other £000	Total £000	Permanent Employees £000	Permanent CSU Employees £000	Other £000	CSU Other £000	Total £000
Employee benefits										
Salaries and wages	796,666	315,880	199,106	135,946	**1,447,598**	706,383	332,986	136,966	127,894	**1,304,229**
Social security costs	73,141	26,562	209	30	**99,942**	64,441	28,050	35	19	**92,545**
Employer contributions to NHS Pension scheme	100,319	38,727	188	40	**139,274**	88,448	40,263	28	23	**128,762**
Other pension costs	-	-	-	-	**-**	-	-	18	-	**18**
Termination benefits	34,525	6,038	-	-	**40,563**	3,514	-	-	-	**3,514**
Gross employee benefits expenditure	**1,004,651**	**387,207**	**199,503**	**136,016**	1,727,377	**862,786**	**401,299**	**137,047**	**127,936**	1,529,068
Less recoveries in respect of employee benefits	(3,009)	(407)	-	-	**(3,416)**	(1,560)	-	(10)	(195)	**(1,765)**
Total net employee benefits	**1,001,642**	**386,800**	**199,503**	**136,016**	1,723,961	**861,226**	**401,299**	**137,037**	**127,741**	1,527,303
Less: Employee costs capitalised	-	(349)	-	-	**(349)**	-	-	-	-	**-**
Net employee benefits excluding capitalised costs	**1,001,642**	**386,451**	**199,503**	**136,016**	1,723,612	**861,226**	**401,299**	**137,037**	**127,741**	1,527,303

	Charged to administration budgets £000	Charged to programme budgets £000	Total Gross employee benefits expenditure £000	Charged to administration budgets £000	Charged to programme budgets £000	Total Gross employee benefits expenditure £000
Of which:						
Parent excluding CSU	337,303	58,246	**395,549**	295,106	46,571	**341,677**
CSU	370,654	152,569	**523,223**	466,907	62,328	**529,235**
CCG	581,830	226,775	**808,605**	509,288	148,868	**658,156**
Gross employee benefits expenditure	**1,289,787**	**437,590**	1,727,377	**1,271,301**	**257,767**	1,529,068
Less employee costs capitalised	(349)	-	**(349)**	-	-	**-**
Net employee benefits excluding capitalised costs	**1,289,438**	**437,590**	1,727,028	**1,271,301**	**257,767**	1,529,068

Commissioning support units (CSUs) 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.

3.2 AVERAGE NUMBER OF PEOPLE EMPLOYED

PARENT

	2014-15					2013-14				
	Total Number	Perm employed Number	CSU Employed Number	Other Number	CSU Other Number	Total Number	Perm employed Number	CSU Employed Number	Other Number	CSU Other Number
Total	**16,562**	**5,525**	**8,220**	**1,128**	**1,689**	**16,380**	**5,321**	**8,313**	**917**	**1,829**
Of the above:										
Number of whole time equivalent people engaged on capital projects	**7**	**0**	**2**	**0**	**5**	**-**	**-**	**-**	**-**	**-**

CONSOLIDATED GROUP

	2014-15					2013-14				
	Total Number	Perm employed Number	CSU Employed Number	Other Number	CSU Other Number	Total Number	Perm employed Number	CSU Employed Number	Other Number	CSU Other Number
Total	**30,642**	**17,763**	**8,220**	**2,970**	**1,689**	**28,074**	**15,658**	**8,313**	**2,274**	**1,829**
Of the above:										
Number of whole time equivalent people engaged on capital projects	**13**	**1**	**2**	**5**	**5**	**-**	**-**	**-**	**-**	**-**

3.3 EXIT PACKAGES AGREED IN THE FINANCIAL YEAR

PARENT

	2014-15			2013-14		
	Compulsory redundancies Number	Other agreed departures Number	Total Number	Compulsory redundancies Number	Other agreed departures Number	Total Number
Less than £10,000	78	40	118	30	-	30
£10,001 to £25,000	126	101	227	54	-	54
£25,001 to £50,000	78	147	225	58	-	58
£50,001 to £100,000	68	76	144	49	1	50
£100,001 to £150,000	21	26	47	10	-	10
£150,001 to £200,000	16	19	35	5	-	5
Over £200,001	24	20	44	1	-	1
Total	**411**	**429**	**840**	**207**	**1**	**208**
Total cost (£000)	**21,666**	**24,406**	**46,072**	**8,689**	**59**	**8,748**

CONSOLIDATED GROUP

	2014-15			2013-14		
	Compulsory redundancies Number	Other agreed departures Number	Total Number	Compulsory redundancies Number	Other agreed departures Number	Total Number
Less than £10,000	86	48	134	59	15	74
£10,001 to £25,000	142	116	258	72	12	84
£25,001 to £50,000	94	155	249	66	6	72
£50,001 to £100,000	80	90	170	57	5	62
£100,001 to £150,000	28	30	58	11	-	11
£150,001 to £200,000	20	19	39	8	-	8
Over £200,001	29	20	49	1	-	1
Total	**479**	**478**	**957**	**274**	**38**	**312**
Total cost (£000)	**26,118**	**26,350**	**52,468**	**10,565**	**801**	**11,366**

PARENT

	2014-15 Other agreed departures		2013-14 Other agreed departures	
	Number	£000	Number	£000
Voluntary redundancies including early retirement contractual costs	429	24,406	1	59
Total	**429**	**24,406**	**1**	**59**

CONSOLIDATED GROUP

	2014-15 Other agreed departures		2013-14 Other agreed departures	
	Number	£000	Number	£000
Voluntary redundancies including early retirement contractual costs	450	25,527	6	203
Mutually agreed resignations (MARS) contractual costs	-	-	5	105
Early retirements in the efficiency of the service contractual costs	1	11	1	23
Contractual payments in lieu of notice	26	803	26	470
Exit payments following Employment Tribunals or court orders	1	9	-	-
Total	**478**	**26,350**	**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 the NHS England.

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

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

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

3.4 Pension costs

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

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

3.4.1 Full actuarial (funding) valuation

A valuation of the scheme liability is carried out annually by the scheme actuary as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and are accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2015, is based on valuation data as 31 March 2014, updated to 31 March 2015 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

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

Full actuarial (funding) valuation

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the scheme (taking into account its recent demographic experience), and to recommend the contribution rates.

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

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

3.4.2 Scheme provisions

The NHS Pension Scheme 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. From 2011-12 the Consumer Price Index (CPI) has been used and replaced the Retail Prices Index (RPI).

- Early payment of a pension, with enhancement, is available to members of the Scheme who are permanently incapable of fulfilling their duties effectively through illness or infirmity. A death gratuity of twice final year's pensionable pay for death in service, and five times their annual pension for death after retirement is payable;

- For early retirements other than those due to ill health the additional pension liabilities are not funded by the scheme. The full amount of the liability for the additional costs is charged to the employer.

- Members can purchase additional service in the Scheme and contribute to money purchase AVC's run by the Scheme's approved providers or by other Free Standing Additional Voluntary Contributions (FSAVC) providers.

3.4.3 Local Government Pension Scheme

Within the group there are 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.

3.4.4 Principal Civil Service Pension Scheme

The Principal Civil Service Pension Scheme is an unfunded multi-employer defined benefit scheme. As such, NHS England is unable to identify its share of the underlying assets and liabilities. The scheme actuary valued the scheme as at 31 March 2007. Details can be found in the Annual Report & Accounts of the Cabinet Office: Civil Superannuation on the Civil Service website.

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

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

4. OPERATING EXPENSES

PARENT

	2014-15			2013-14		
	Admin £000	Programme £000	Total £000	Admin £000	Programme £000	Total £000
Other costs						
Services from CCGs	3,913	73,071	76,984	1,089	53,232	54,321
Services from Foundation Trusts	842	9,624,137	9,624,979	1,617	9,017,494	9,019,111
Services from other NHS Trusts	677	5,970,603	5,971,280	90	5,520,476	5,520,566
Services from other NHS bodies*	472	28,978	29,450	1,885	469,599	471,484
Purchase of healthcare from non-NHS bodies	-	2,277,953	2,277,953	7,625	1,599,480	1,607,105
General dental services and personal dental services	-	3,113,516	3,113,516	3	3,083,890	3,083,893
Prescribing costs	-	3,024	3,024	-	5,275	5,275
Pharmaceutical services	-	2,121,624	2,121,624	-	2,093,820	2,093,820
General ophthalmic services	-	523,299	523,299	19	517,834	517,853
Primary care services	60	7,264,373	7,264,433	272	7,266,093	7,266,365
Supplies and services – clinical	562	73,794	74,356	319	75,731	76,050
Supplies and services – general	48,264	335,299	383,563	67,369	296,840	364,209
Chair and lay membership body and governing body members	169	-	169	187	-	187
Consultancy services	30,080	13,826	43,906	46,748	9,997	56,745
Establishment	104,743	94,023	198,766	146,960	92,792	239,752
Transport	8,455	2,388	10,843	7,486	1,561	9,047
Premises	69,301	147,106	216,407	141,514	111,134	252,648
Audit fees	355	-	355	530	-	530
Other non statutory audit expenditure**	-	-	-	3,792	136	3,928
Other professional fees excl. audit	19,054	24,941	43,995	16,680	4,187	20,867
Grants to other public bodies	31,451	200	31,651	53,583	700	54,283
Clinical negligence	51	-	51	-	-	-
Research and development (excluding staff costs)	846	1,915	2,761	733	157	890
Education and training	10,422	99,326	109,748	14,587	102,398	116,985
Funding to group bodies	1,289,472	65,396,012	66,685,484	1,261,901	59,995,373	61,257,274
Other expenditure	513	1,930	2,443	1,425	32,994	34,419
Total operating expenses - cash	**1,619,702**	**97,191,338**	**98,811,040**	**1,776,414**	**90,351,193**	**92,127,607**
Operating expenditure - non cash						
Impairments and reversals of receivables	467	10,675	11,142	334	10,375	10,709
Inventories written down	-	88	88	-	-	-
Depreciation	13,215	28,814	42,029	13,333	20,684	34,017
Amortisation	4,865	562	5,427	267	759	1,026
Impairments and reversals of property, plant and equipment	15,766	1,911	17,677	106,010	-	106,010
Impairments and reversals of intangible assets	531	2	533	9,540	-	9,540
Change in discount rate	-	(12,298)	(12,298)	-	-	-
Provisions	13,642	(98,605)	(84,963)	2,457	40,267	42,724
Other expenditure***	-	(4,021)	(4,021)	-	-	-
Total operating expenses - non cash	**48,486**	**(72,872)**	**(24,386)**	**131,941**	**72,085**	**204,026**
Total operating expenses	**1,668,188**	**97,118,466**	**98,786,654**	**1,908,355**	**90,423,278**	**92,331,633**

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

Provision costs have been reduced in 2014-15 by the ongoing reassessment of required provision values, particularly for Continuing Healthcare. See note 15 for further details.

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

*Services from other NHS bodies comprises expenditure from the Department of Health and other Department Arm's Length Bodies.

**In 2014-15 other non statutory audit expenditure has been reclassified to other professional fees.

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

CONSOLIDATED GROUP

	2014-15			2013-14		
	Admin £000	Programme £000	Total £000	Admin £000	Programme £000	Total £000
Other costs						
Services from Foundation Trusts	5,005	36,847,583	36,852,588	2,863	34,885,407	34,888,270
Services from other NHS Trusts	4,177	25,680,878	25,685,055	1,460	25,426,005	25,427,465
Services from other NHS bodies	494	32,959	33,453	1,788	492,525	494,313
Purchase of healthcare from non-NHS bodies*	-	11,577,570	11,577,570	13,483	10,173,262	10,186,745
General dental services and personal dental services	-	3,114,073	3,114,073	3	3,079,683	3,079,686
Prescribing costs	-	8,216,012	8,216,012	315	8,029,603	8,029,918
Pharmaceutical services	-	2,132,112	2,132,112	-	2,101,665	2,101,665
General ophthalmic services	-	527,709	527,709	19	523,237	523,256
Primary care services	3,022	7,683,683	7,686,705	3,539	7,586,547	7,590,086
Supplies and services – clinical	564	165,905	166,469	320	174,357	174,677
Supplies and services – general	77,517	522,111	599,628	91,451	477,693	569,144
Chair and lay membership body and governing body members	51,788	878	52,666	49,034	909	49,943
Consultancy services	64,454	93,460	157,914	73,983	54,934	128,917
Establishment	154,311	183,025	337,336	197,101	143,765	340,866
Transport	9,783	13,634	23,417	8,555	11,079	19,634
Premises	129,747	325,313	455,060	189,854	324,558	514,412
Audit fees	18,306	26	18,332	19,062	-	19,062
Other non statutory audit expenditure**	2,791	103	2,894	8,384	321	8,705
Other professional fees excl. audit	52,635	42,312	94,947	28,067	10,263	38,330
Grants to other public bodies	31,736	53,060	84,796	53,623	39,164	92,787
Clinical negligence	367	24	391	291	13	304
Research and development (excluding staff costs)	1,908	12,045	13,953	4,252	8,813	13,065
Education and training	24,025	111,400	135,425	26,550	108,763	135,313
Other expenditure	1,752	24,139	25,891	23,012	78,310	101,322
Total operating expenses - cash	**634,382**	**97,360,014**	**97,994,396**	**797,009**	**93,730,876**	**94,527,885**
Operating expenditure - non cash						
Impairments and reversals of receivables	868	12,379	13,247	1,184	20,099	21,283
Inventories written down	-	88	88	-	-	-
Depreciation	17,181	31,698	48,879	18,437	24,104	42,541
Amortisation	5,081	1,070	6,151	603	1,275	1,878
Impairments and reversals of property, plant and equipment	15,827	2,771	18,598	107,633	1,075	108,708
Impairments and reversals of intangible assets	531	2	533	9,579	117	9,696
Change in discount rate	(2)	(12,233)	(12,235)	-	-	-
Provisions	15,601	(70,605)	(55,004)	4,415	110,013	114,428
Other expenditure***	-	(4,021)	(4,021)	-	-	-
Total operating expenses - non cash	**55,087**	**(38,851)**	**16,236**	**141,851**	**156,683**	**298,534**
Total operating expenses	**689,469**	**97,321,163**	**98,010,632**	**938,860**	**93,887,559**	**94,826,419**

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.

Provision costs have been reduced in 2014-15 by the ongoing reassessment of required provision values, particularly for Continuing Healthcare. See note 15 for further details.

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

* In 2013-14 clinical commissioning groups classified a proportion of their expenditure on Non NHS healthcare to services with NHS bodies. Improved coding has led to the year on year increase in this expenditure category, along with a significant increase in the funding for the purchase of social care and from independent providers.

**In 2014-15 other non statutory audit expenditure has been reclassified to other professional fees.

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

5. FEES AND CHARGES

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

2013-14		Parent			Consolidated Group		
	Note	Income £000	Full cost £000	Surplus (deficit) £000	Income £000	Full cost £000	Surplus (deficit) £000
Dental	2 & 4	683,583	(3,083,893)	(2,400,310)	683,583	(3,079,686)	(2,396,103)
Prescription	2 & 4	465,601	(2,099,095)	(1,633,494)	470,733	(10,131,583)	(9,660,850)
Total fees & charges		**1,149,184**	**(5,182,988)**	**(4,033,804)**	**1,154,316**	**(13,211,269)**	**(12,056,953)**

The fees and charges information in this note is provided in accordance with section 5.4.16 of the Government Financial Reporting Manual. It is provided for fees and charges purposes and not for IFRS 8 purposes. The financial objective of prescription and dental charges is to collect charges only from those patients that are eligible to pay. In 2014-15 initiatives such as "The Prescription Checking Service", "Anti Fraud Communication Campaigns" and the introduction of penalty charge notices have resulted in a greater number of fees collected from patients who are eligible to pay for prescriptions and dental care.

Prescription charges are a contribution to the cost of pharmaceutical services including the supply of drugs. The disclosure has been restated for 2013-14 to include the prescribing costs (drugs) that are incurred primarily by clinical commissioning groups.

6. NET GAIN/(LOSS) ON TRANSFER BY ABSORPTION

Transfers as part of a 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 costs.

Prior year transactions represent the transfer of assets and liabilities as per the table below. There have been no further transfers in 2014-15.

	Parent		Consolidated Group	
	2014-15 £000	2013-14 £000	2014-15 £000	2013-14 £000
Transfer of property plant and equipment	-	(60,611)	-	(60,611)
Transfer of intangibles	-	8,356	-	8,356
Transfer of cash and cash equivalents	-	-	-	-
Transfer of receivables	-	-	-	-
Transfer of payables	-	(43,403)	-	(43,403)
Transfer of provisions	-	(28)	-	(28)
Net loss on transfers by absorption	**-**	**(95,686)**	**-**	**(95,686)**

7. OPERATING LEASES

7.1 As lessee

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

Although formal signed leases are not typically in place for these properties, the transactions involved do convey the right of the group to use property assets. The group has considered the substance of these arrangements under IFRIC 4 'Determining whether an arrangement contains a lease' and determined that the arrangements are (or contain) leases. Substantial progress has been made in 2014-15 to confirm future minimum lease payments.

Accordingly the payments made in 2014–15 and 2013-14 are disclosed as minimum lease payments in the buildings category in note 7.1.1. However in the absence of formal contracts it is not possible to confirm minimum lease payments for future years and hence no disclosure is made for these buildings in note 7.1.2. It is expected that the payments recognised in 2014–15 would continue to be minimum lease payments in 2015-16.

The group does not act as a lessor.

7.1.1 PAYMENTS RECOGNISED AS AN EXPENSE

PARENT

	2014-15			2013-14		
	Buildings £000	Other £000	Total £000	Buildings £000	Other £000	Total £000
Payments recognised as an expense						
Minimum lease payments	118,870	1,735	120,605	148,552	1,014	149,566
Contingent rents	-	-	-	-	3	3
Total	**118,870**	**1,735**	**120,605**	**148,522**	**1,017**	**149,569**

CONSOLIDATED GROUP

	2014-15			2013-14		
	Buildings £000	Other £000	Total £000	Buildings £000	Other £000	Total £000
Payments recognised as an expense						
Minimum lease payments	318,005	3,845	321,850	366,219	2,131	368,350
Contingent rents	-	32	32	-	26	26
Total	**318,005**	**3,877**	**321,882**	**366,219**	**2,157**	**368,376**

7.1.2 FUTURE MINIMUM LEASE PAYMENTS

PARENT

	2014-15			2013-14		
	Buildings £000	Other £000	Total £000	Buildings £000	Other £000	Total £000
Payable:						
No later than one year	102,218	1,839	104,057	133	511	644
Between one and five years	7,436	2,110	9,546	133	448	581
After five years	6,623	-	6,623	-	-	-
Total	**116,277**	**3,949**	**120,226**	**266**	**959**	**1,225**

CONSOLIDATED GROUP

	2014-15			2013-14		
	Buildings £000	Other £000	Total £000	Buildings £000	Other £000	Total £000
Payable:						
No later than one year	112,326	3,260	115,586	11,318	1,351	12,669
Between one and five years	33,409	4,459	37,868	15,959	1,110	17,069
After five years	26,593	225	26,818	21,326	6	21,332
Total	**172,328**	**7,944**	**180,272**	**48,603**	**2,467**	**51,070**

8. PROPERTY, PLANT AND EQUIPMENT

PARENT 2014-15

	Buildings excluding dwellings £000	Assets under construction & payments on account £000	Plant & machinery £000	Transport equipment £000	Information technology £000	Furniture and fittings £000	Total £000
Cost or valuation at 1 April 2014	**19,969**	**6,307**	**4,963**	**32**	**174,615**	**1,286**	**207,172**
Addition of assets under construction and payments on account		744					744
Additions purchased	-	-	262	-	97,688	1,416	99,366
Reclassifications	-	(6,156)	-	-	3,585	(20)	(2,591)
Disposals other than by sale	-	-	-	-	(9,431)	(116)	(9,547)
Impairments charged	(1,886)	-	(61)	-	(14,593)	(1,137)	(17,677)
Cost or valuation at 31 March 2015	**18,083**	**895**	**5,164**	**32**	**251,864**	**1,429**	**277,467**
Depreciation 1 April 2014	**9,092**	**-**	**2,483**	**5**	**34,092**	**320**	**45,992**
Disposals other than by sale	-	-	-	-	(7,045)	(116)	(7,161)
Impairments charged	-	-	-	-	-	-	-
Charged during the year	5,229	-	1,281	-	35,427	92	42,029
At 31 March 2015	**14,321**	**-**	**3,764**	**5**	**62,474**	**296**	**80,860**
Net Book Value at 31 March 2015	**3,762**	**895**	**1,400**	**27**	**189,390**	**1,133**	**196,607**
Purchased	3,762	895	1,400	27	189,390	1,133	196,607
Total at 31 March 2015	**3,762**	**895**	**1,400**	**27**	**189,390**	**1,133**	**196,607**
Asset financing:							
Owned	-	895	411	27	189,390	1,133	191,856
Held on finance lease	3,762	-	989	-	-	-	4,751
Total at 31 March 2015	**3,762**	**895**	**1,400**	**27**	**189,390**	**1,133**	**196,607**

Revaluation Reserve Balance for Property, Plant & Equipment	Buildings £000	Assets under construction & payments on account £000	Plant & machinery £000	Transport equipment £000	Information technology £000	Furniture and fittings £000	Total £000
Balance at 1 April 2014	**140**	**-**	**-**	**-**	**7**	**12**	**159**
Revaluation gains	-	-	-	-	-	-	-
Impairments	-	-	-	-	-	-	-
Release to general fund	(140)	-	-	-	-	-	(140)
Other movements	-	-	-	-	-	-	-
At 31 March 2015	**-**	**-**	**-**	**-**	**7**	**12**	**19**

PARENT 2013-14

	Buildings excluding dwellings £000	Assets under construction & payments on account £000	Plant & machinery £000	Transport equipment £000	Information technology £000	Furniture & fittings £000	Total £000
Cost or valuation at 1 April 2013	**-**	**-**	**-**	**-**	**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	166,635	12,573	275,784
Adjusted cost or valuation at 1 April 2013	**71,278**	**3,348**	**21,873**	**77**	**170,258**	**12,573**	**279,407**
Addition of assets under construction and payments on account	-	6,464	-	-	-	-	6,464
Additions purchased	-	-	105	-	76,530	150	76,785
Reclassifications	-	(3,505)	-	-	4,611	(39)	1,067
Disposals other than by sale	-	-	-	-	(90)	-	(90)
Impairments charged	(1,659)	-	(16,998)	(45)	(77,674)	(11,398)	(107,774)
Transfer (to)/from other public sector body	(49,650)	-	(17)	-	980	-	(48,687)
Cost or valuation at 31 March 2015	**19,969**	**6,307**	**4,963**	**32**	**174,615**	**1,286**	**207,172**
Depreciation at 1 April 2013	**-**	**-**	**-**	**-**	**114**	**-**	**114**
Adjusted depreciation 1 April 2013	**-**	**-**	**-**	**-**	**114**	**-**	**114**
Disposals other than by sale	-	-	-	-	(63)	-	(63)
Charged during the year	-	-	136	5	33,556	320	34,017
Transfer (to)/from other public sector body	9,092	-	2,347	-	485	-	11,924
At 31 March 2014	**9,092**	**-**	**2,483**	**5**	**34,092**	**320**	**45,992**
Net book value at 31 March 2014	**10,877**	**6,307**	**2,480**	**27**	**140,523**	**966**	**161,180**
Purchased	10,877	6,307	2,480	27	140,523	966	161,180
Total at 31 March 2014	**10,877**	**6,307**	**2,480**	**27**	**140,523**	**966**	**161,180**
Asset financing:							
Owned	8,992	6,307	221	27	140,523	966	157,036
Held on finance lease	-	-	2,259	-	-	-	2,259
PFI contracts	1,885	-	-	-	-	-	1,885
Total at 31 March 2014	**10,877**	**6,307**	**2,480**	**27**	**140,523**	**966**	**161,180**

Revaluation Reserve Balance for Property, Plant & Equipment	Buildings excluding dwellings £000	Assets under construction & payments on account £000	Plant & machinery £000	Transport equipment £000	Information technology £000	Furniture & fittings £000	Total £000
Balance at 1 April 2013	**-**	**-**	**-**	**-**	**-**	**-**	**-**
Transfer of assets from closed NHS bodies as a result of the 1 April 2013 transition	174	-	826	16	608	299	1,923
Adjusted balance at 1 April 2013	**174**	**-**	**826**	**16**	**608**	**299**	**1,923**
Impairments	(34)	-	(826)	(16)	(601)	(287)	(1,764)
At 31 March 2014	**140**	**-**	**-**	**-**	**7**	**12**	**159**

CONSOLIDATED GROUP 2014-15

	Buildings excluding dwellings £000	Assets under construction & payments on account £000	Plant & machinery £000	Transport equipment £000	Information technology £000	Furniture and fittings £000	Total £000
Cost or valuation at 1 April 2014	**21,253**	**6,964**	**14,716**	**151**	**190,657**	**5,093**	**238,834**
Addition of assets under construction and payments on account	-	2,604	-	-	-	-	2,604
Additions purchased	66	-	4,056	-	109,421	4,056	117,599
Reclassifications	(1,097)	(6,781)	1,144	-	3,448	695	(2,591)
Disposals other than by sale	(7)	-	(4)	-	(10,162)	(138)	(10,311)
Impairments charged	(1,886)	-	(237)	-	(15,028)	(1,284)	(18,435)
Reversal of impairments	-	-	-	-	16	-	16
Cost or valuation at 31 March 2015	**18,329**	**2,787**	**19,675**	**151**	**278,352**	**8,422**	**327,716**
Depreciation 1 April 2014	**9,179**	**-**	**4,367**	**36**	**39,927**	**1,376**	**54,885**
Reclassifications	(58)	-	65	-	(27)	20	-
Disposals other than by sale	(7)	-	(4)	-	(7,751)	(125)	(7,887)
Impairments charged	-	-	(39)	-	220	(1)	180
Charged during the year	5,244	-	2,894	31	39,823	887	48,879
At 31 March 2015	**14,358**	**-**	**7,283**	**67**	**72,192**	**2,157**	**96,057**
Net Book Value at 31 March 2015	**3,971**	**2,787**	**12,392**	**84**	**206,160**	**6,265**	**231,659**
Purchased	3,971	2,787	12,392	84	206,160	6,265	231,659
Total at 31 March 2015	**3,971**	**2,787**	**12,392**	**84**	**206,160**	**6,265**	**231,659**
Asset financing:							
Owned	171	2,787	10,297	84	206,160	6,265	225,764
Held on finance lease	3,800	-	2,095	-	-	-	5,895
Total at 31 March 2015	**3,971**	**2,787**	**12,392**	**84**	**206,160**	**6,265**	**231,659**

Revaluation Reserve Balance for Property, Plant & Equipment	Buildings £000	Assets under construction & payments on account £000	Plant & machinery £000	Transport equipment £000	Information technology £000	Furniture and fittings £000	Total £000
Balance at 1 April 2014	**140**	**-**	**148**	**1**	**7**	**36**	**332**
Revaluation gains	-	-	-	-	-	-	-
Impairments	-	-	-	(1)	(1)	(36)	(38)
Release to general fund	(140)	-	-	-	-	-	(140)
Other movements	-	-	-	-	-	-	-
At 31 March 2015	**-**	**-**	**148**	**-**	**6**	**-**	**154**

CONSOLIDATED GROUP 2013-14

	Buildings excluding dwellings £000	Assets under construction & payments on account £000	Plant & machinery £000	Transport equipment £000	Information technology £000	Furniture & fittings £000	Total £000
Cost or valuation at 1 April 2013	**-**	**-**	**-**	**-**	**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	181,296	16,486	306,108
Adjusted cost or valuation at 1 April 2013	**72,555**	**3,365**	**32,280**	**126**	**184,919**	**16,486**	**309,731**
Addition of assets under construction and payments on account	-	7,121	-	-	-	-	7,121
Additions purchased	7	-	786	-	79,310	393	80,496
Reclassifications	4	(3,522)	(64)	81	4,691	(123)	1,067
Disposals other than by sale	(4)	-	(566)	-	(312)	(72)	(954)
Impairments charged	(1,659)	-	(17,703)	(56)	(78,931)	(11,591)	(109,940)
Transfer (to)/from other public sector body	(49,650)	-	(17)	-	980	-	(48,687)
Cost or valuation at 31 March 2015	**21,253**	**6,964**	**14,716**	**151**	**190,657**	**5,093**	**238,834**
Depreciation at 1 April 2013	**-**	**-**	**-**	**-**	**114**	**-**	**114**
Adjusted depreciation 1 April 2013							
Disposals other than by sale	-	-	(88)	-	(151)	-	(239)
Impairments charged	-	-	(168)	-	712	2	546
Charged during the year	87	-	2,276	36	38,767	1,374	42,540
Transfer (to)/from other public sector body	9,092	-	2,347	-	485	-	11,924
At 31 March 2014	9,179	-	4,367	36	39,927	1,376	54,885
Net book value at 31 March 2014	**12,074**	**6,964**	**10,349**	**115**	**150,730**	**3,717**	**183,949**
Purchased	12,074	6,964	10,349	115	150,730	3,717	183,949
Total at 31 March 2014	**12,074**	**6,964**	**10,349**	**115**	**150,730**	**3,717**	**183,949**
Asset financing:							
Owned	8,998	6,964	8,131	115	150,730	3,717	178,655
Held on finance lease	1,191	-	2,218	-	-	-	3,409
PFI contracts	1,885	-	-	-	-	-	1,885
Total at 31 March 2014	**12,074**	**6,964**	**10,349**	**115**	**150,730**	**3,717**	**183,949**

Revaluation Reserve Balance for Property, Plant & Equipment	Buildings £000	Assets under construction & payments on account £000	Plant & machinery £000	Transport equipment £000	Information technology £000	Furniture & fittings £000	Total £000
Balance at 1 April 2013	**-**	**-**	**-**	**-**	**-**	**-**	**-**
Transfer of assets from closed NHS bodies as a result of the 1 April 2013 transition	174	-	1,092	17	1,129	395	2,807
Adjusted balance at 1 April 2013	**174**	**-**	**1,092**	**17**	**1,129**	**395**	**2,807**
Impairments	(34)	-	(834)	(16)	(601)	(293)	(1,778)
Release to general fund	-	-	(110)	-	(521)	(66)	(697)
At 31 March 2014	**140**	**-**	**148**	**1**	**7**	**36**	**332**

9. INTANGIBLE NON-CURRENT ASSETS

PARENT 2014-15

	Computer Software: Purchased £000	Licences & Trademarks £000	Development Expenditure (internally generated) £000	Total £000
Cost or valuation at 1 April 2014	**9,828**	**42**	**-**	**9,870**
Additions purchased	1,410	-	349	1,759
Reclassifications	2,625	(34)	-	2,591
Disposals other than by sale	(125)	-	-	(125)
Impairments charged	(533)	-	-	(533)
At 31 March 2015	**13,205**	**8**	**349**	**13,562**
Amortisation 1 April 2014	**2,005**	**5**	**-**	**2,010**
Disposals other than by sale	(99)	-	-	(99)
Charged during the year	5,386	3	38	5,427
At 31 March 2015	**7,292**	**8**	**38**	**7,338**
Net Book Value at 31 March 2015	**5,913**	**-**	**311**	**6,224**
Purchased	5,913	-	311	6,224
Total at 31 March 2015	**5,913**	**-**	**311**	**6,224**

REVALUATION RESERVE BALANCE FOR INTANGIBLE ASSETS

	Computer Software: Purchased £000	Licences & Trademarks £000	Development Expenditure (internally generated) £000	Total £000
Balance at 1 April 2014	**5**	**-**	**-**	**5**
At 31 March 2015	**5**	**-**	**-**	**5**

PARENT 2013-14

	Computer Software: Purchased £000	Licences & Trademarks £000	Development Expenditure (internally generated) £000	Total £000
Cost or valuation at 1 April 2013	**139**	**-**	**-**	**139**
Transfer of assets from closed NHS bodies as a result of the 1 April 2013 transition	9,117	219	628	9,964
Adjusted cost or valuation at 1 April 2013	**9,256**	**219**	**628**	**10,103**
Additions purchased	1,057	-	-	1,057
Reclassifications	(262)	(177)	(628)	(1,067)
Impairments charged	(9,540)	-	-	(9,540)
Transfer (to)/from other public sector body	9,317	-	-	9,317
At 31 March 2014	**9,828**	**42**	**-**	**9,870**
Amortisation at 1 April 2013	**23**	**-**	**-**	**23**
Adjusted amortisation 1 April 2013	**23**	**-**	**-**	**23**
Charged during the year	1,021	5	-	1,026
Transfer (to)/from other public sector body	961	-	-	961
At 31 March 2014	**2,005**	**5**	**-**	**2,010**
Net book value at 31 March 2014	**7,823**	**37**	**-**	**7,860**
Owned	7,823	37	-	7,860
Total at 31 March 2014	**7,823**	**37**	**-**	**7,860**

REVALUATION RESERVE BALANCE FOR INTANGIBLE ASSETS

	Computer Software: Purchased £000	Licences & Trademarks £000	Development Expenditure (internally generated) £000	Total £000
Balance at 1 April 2013	-	-	-	-
Transfer of assets from closed NHS bodies as a result of the 1 April 2013 transition	5	-	-	5
Adjusted balance at 1 April 2013	**5**	**-**	**-**	**5**
At 31 March 2014	**5**	**-**	**-**	**5**

CONSOLIDATED GROUP 2014-15

	Computer Software: Purchased £000	Licences & Trademarks £000	Development Expenditure (internally generated) £000	Total £000
Cost or valuation at 1 April 2014	**10,858**	**96**	**629**	**11,583**
Additions purchased	4,394	-	769	5,163
Reclassifications	2,679	(88)	-	2,591
Disposals other than by sale	(223)	-	-	(223)
Impairments charged	(533)	-	-	(533)
At 31 March 2015	**17,175**	**8**	**1,398**	**18,581**
Amortisation 1 April 2014	**2,437**	**38**	**303**	**2,778**
Disposals other than by sale	(197)	-	-	(197)
Charged during the year	5,808	(30)	373	6,151
At 31 March 2015	**8,048**	**8**	**676**	**8,732**
Net Book Value at 31 March 2015	**9,127**	**0**	**722**	**9,849**
Owned	9,127	-	722	9,849
Total at 31 March 2015	**9,127**	**-**	**722**	**9,849**

REVALUATION RESERVE BALANCE FOR INTANGIBLE ASSETS

	Computer Software: Purchased £000	Licences & Trademarks £000	Development Expenditure (internally generated) £000	Total £000
Balance at 1 April 2014	**5**	**-**	**-**	**5**
At 31 March 2015	**5**	**-**	**-**	**5**

CONSOLIDATED GROUP 2013-14

	Computer Software: Purchased £000	Licences & Trademarks £000	Development Expenditure (internally generated) £000	Total £000
Cost or Valuation at 01 April 2013	**139**	**-**	**-**	**139**
Transfer of assets from closed NHS bodies as a result of the 1 April 2013 transition	10,313	304	1,236	11,853
Adjusted Cost or Valuation at 01 April 2013	**10,452**	**304**	**1,236**	**11,992**
Additions purchased	1,100	-	21	1,121
Reclassifications	(231)	(208)	(628)	(1,067)
Disposals other than by sale	(79)	-	-	(79)
Impairments charged	(9,701)	-	-	(9,701)
Transfer (to) from other public sector body	9,317	-	-	9,317
Cost or Valuation at 31 March 2014	**10,858**	**96**	**629**	**11,583**
Amortisation at 01 April 2013	**23**	**-**	**-**	**23**
Adjusted Amortisation at 01 April 2013	**23**	**-**	**-**	**23**
Disposals other than by sale	(79)	-	-	(79)
Impairments charged	(5)	-	-	(5)
Charged during the year	1,537	38	303	1,878
Transfer (to) from other public sector body	961	-	-	961
Amortisation at 31 March 2014	**2,437**	**38**	**303**	**2,778**
Net Book Value at 31 March 2014	**8,421**	**58**	**326**	**8,805**
Owned	8,421	58	326	8,805
Total at 31 March 2014	**8,421**	**58**	**326**	**8,805**

REVALUATION RESERVE BALANCE FOR INTANGIBLE ASSETS

	Computer Software: Purchased £000	Licences & Trademarks £000	Development Expenditure (internally generated) £000	Total £000
Balance at 1 April 2013	**-**	**-**	**-**	**-**
Transfer of assets from closed NHS bodies as a result of the 1 April 2013 transition	5	-	-	5
Adjusted balance at 1 April 2013	**5**	**-**	**-**	**5**
At 31 March 2014	**5**	**-**	**-**	**5**

10. INVENTORIES

PARENT 2014-15

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

2013-14

	Drugs £000	Consumables £000	Other £000	Total £000
Balance at 1 April 2013	**-**	**-**	**-**	**-**
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	-	26	340	366
Inventories recognised as an expense in the period	(60)	(22)	(18)	(100)
At 31 March 2014	**-**	**103**	**351**	**454**

CONSOLIDATED GROUP 2014-15

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

2013-14

	Drugs £000	Consumables £000	Other £000	Total £000
Balance at 1 April 2013	**-**	**-**	**-**	**-**
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	-	203	3,098	3,301
Inventories recognised as an expense in the period	(60)	(213)	(2,458)	(2,731)
At 31 March 2014	**-**	**290**	**1,425**	**1,715**

11. TRADE AND OTHER RECEIVABLES

	Parent				Consolidated Group			
	Current 2014-15 £000	Non-current 2014-15 £000	Current 2013-14 £000	Non-current 2013-14 £000	Current 2014-15 £000	Non-current 2014-15 £000	Current 2013-14 £000	Non-current 2013-14 £000
NHS receivables: Revenue	39,516	-	84,128	1,440	87,810	-	150,714	1,440
NHS prepayments and accrued income	7,978	-	3,594	-	229,294	-	161,532	-
Non-NHS receivables: revenue	87,156	-	61,623	-	237,034	-	209,128	-
Non-NHS prepayments and accrued income	97,765	964	69,478	964	203,911	1,143	137,097	964
Provision for the impairment of receivables	(12,476)	-	(10,709)	-	(22,822)	-	(21,284)	1
VAT	9,578	-	9,842	-	18,923	-	18,733	-
Other receivables	1,371	3,079	69,397	3,079	12,716	3,079	85,449	3,080
Total	**230,888**	**4,043**	**287,353**	**5,483**	**766,866**	**4,222**	**741,369**	**5,485**
Total current and non current	**234,931**		**292,836**		**771,088**		**746,854**	

11.1 INTRA-GOVERNMENT AND OTHER BALANCES

	Parent				Consolidated Group			
	Current 2014-15 £000	Non-current 2014-15 £000	Current 2013-14 £000	Non-current 2013-14 £000	Current 2014-15 £000	Non-current 2014-15 £000	Current 2013-14 £000	Non-current 2013-14 £000
Balances with:								
· Other Central Government bodies	59,705	-	70,152	-	71,818	-	72,998	-
· Local Authorities	7,066	-	2,722	-	128,795	-	45,550	-
Total of Balances with Government Bodies	**66,771**	**-**	**72,874**	**-**	**200,613**	**-**	**118,548**	**-**
Total of balances with NHS bodies:	**47,493**	**-**	**87,722**	**1,440**	**317,104**	**-**	**312,246**	**1,440**
· Bodies external to Government	116,624	4,043	126,757	4,043	249,149	4,222	310,575	4,045
Total balances at 31 March 2015	**230,888**	**4,043**	**287,353**	**5,483**	**766,866**	**4,222**	**741,369**	**5,485**

12. CASH AND CASH EQUIVALENTS

	Parent		Consolidated Group	
	2014-15 £000	2013-14 £000	2014-15 £000	2013-14 £000
Balance at 1 April 2014	391,990	-	420,921	-
Net change in year	(262,511)	391,990	(280,435)	420,921
Balance at 31 March 2015	**129,479**	**391,990**	**140,486**	**420,921**
Made up of:				
Cash with the Government Banking Service	67,084	330,013	81,321	358,537
Cash with Commercial banks	-	-	-	-
Cash in hand	62,395	61,977	68,724	65,507
Cash and cash equivalents as in statement of financial position	**129,479**	**391,990**	**150,045**	**424,044**
Bank overdraft: Government Banking Service	-	-	(9,559)	(3,123)
Total bank overdrafts	**-**	**-**	**(9,559)**	**(3,123)**
Balance at 31 March 2015	**129,479**	**391,990**	**140,486**	**420,921**

For details of bank overdraft see note 14.

Included within cash in hand above is £62.39m held on behalf of NHS England by the NHS Business Services Authority.

13. TRADE AND OTHER PAYABLES

	Parent				Consolidated Group			
	Current 2014-15 £000	Non-current 2014-15 £000	Current 2013-14 £000	Non-current 2013-14 £000	Current 2014-15 £000	Non-current 2014-15 £000	Current 2013-14 £000	Non-current 2013-14 £000
NHS payables: revenue	570,212	-	717,364	-	1,326,756	-	1,620,541	-
NHS payables: capital	1,372	-	-	-	156	-	193	-
NHS accruals and deferred income	118,525	-	156,016	-	638,637	-	548,201	-
Non-NHS payables: revenue	416,138	2,440	453,151	2,440	1,044,847	2,440	1,024,813	2,440
Non-NHS payables: capital	6,056	-	1,410	-	11,214	-	2,736	-
Non-NHS accruals and deferred income	1,261,837	128	1,289,489	17	3,532,832	709	3,328,829	863
Social security costs	6,897	-	6,113	-	14,580	-	12,205	-
VAT	-	-	-	-	-	-	-	-
Tax	7,553	-	6,677	-	15,641	-	13,517	-
Payments received on account	24	-	(46)	-	560	-	169	-
Other payables	195,416	-	98,090	-	325,743	5,745	202,745	3,073
Total	**2,584,030**	**2,568**	**2,728,264**	**2,457**	**6,910,966**	**8,894**	**6,753,949**	**6,376**
Total payables (current and non-current)	**2,586,598**		**2,730,721**		**6,919,860**		**6,760,325**	

13.1 INTRA-GOVERNMENT AND OTHER BALANCES

	Parent				Consolidated Group			
	Current 2014-15 £000	Non-current 2014-15 £000	Current 2013-14 £000	Non-current 2013-14 £000	Current 2014-15 £000	Non-current 2014-15 £000	Current 2013-14 £000	Non-current 2013-14 £000
Balances with:								
· Other Central Government bodies	96,572	-	86,801	-	172,164	-	98,622	-
· Local Authorities	270,021	-	131,133	-	559,725	-	267,291	-
Total of Balances with Government Bodies	**366,593**	**-**	**217,934**	**-**	**731,889**	**-**	**365,913**	**-**
Balances with NHS bodies:	**690,109**	**-**	**873,381**	**-**	**1,965,549**	**-**	**2,168,935**	**-**
· Bodies external to Government	1,527,328	2,568	1,636,949	2,457	4,213,528	8,894	4,219,101	6,376
Total balances at 31 March 2015	**2,584,030**	**2,568**	**2,728,264**	**2,457**	**6,910,966**	**8,894**	**6,753,949**	**6,376**

14. BORROWINGS

	Parent				Consolidated Group			
	Current 2014-15 £000	Non-current 2014-15 £000	Current 2013-14 £000	Non-current 2013-14 £000	Current 2014-15 £000	Non-current 2014-15 £000	Current 2013-14 £000	Non-current 2013-14 £000
Bank overdrafts:								
· Government banking service	-	-	-	-	9,559	-	3,123	-
Total overdrafts	**-**	**-**	**-**	**-**	**9,559**	**-**	**3,123**	**-**
Private finance initiative liabilities:								
· Main liability	-	-	199	3,015	-	-	199	3,015
Total private finance initiative liabilities	**-**	**-**	**199**	**3,015**	**-**	**-**	**199**	**3,015**
Finance lease liabilities	**5,921**	**10,523**	**807**	**-**	**6,046**	**11,683**	**807**	**1,362**
Total	**5,921**	**10,523**	**1,006**	**3,015**	**15,605**	**11,683**	**4,129**	**4,377**
Total current and non-current	**16,444**		**4,021**		**27,288**		**8,506**	

14.1 Repayment of principal falling due

	Parent				Consolidated Group			
	Department of Health 2014-15 £000	Other 2014-15 £000	Total 2014-15 £000	Total 2013-14 £000	Department of Health 2014-15 £000	Other 2014-15 £000	Total 2014-15 £000	Total 2013-14 £000
Within one year	-	5,921	5,921	1,006	-	15,605	15,605	4,129
Between one and five years	-	10,523	10,523	701	-	11,022	11,022	821
After five years	-	-	-	2,314	-	661	661	3,556
Total	**-**	**16,444**	**16,444**	**4,021**	**-**	**27,288**	**27,288**	**8,506**

15. PROVISIONS

PARENT

	Current 2014-15 £000	Non-current 2014-15 £000	Current 2013-14 £000	Non-current 2013-14 £000
Restructuring	1,062	223	3,563	92
Redundancy	9,506	-	1,516	-
Equal pay	25	-	30	118
Legal claims	1,519	428	3,497	37
Continuing care	276,435	328,860	362,310	406,869
Other	23,935	25,324	50,588	986
Total	**312,482**	**354,835**	**421,504**	**408,102**
Total current and non-current	**667,317**		**829,606**	

	Restructuring £000	Redundancy £000	Equal Pay £000	Legal Claims £000	Continuing Care £000	Other £000	Total £000
Balance at 1 April 2014	**3,655**	**1,516**	**148**	**3,534**	**769,179**	**51,574**	**829,606**
							-
Arising during the year	-	9,298	-	44	48,219	5,096	62,657
Utilised during the year	(2,136)	(275)	(122)	(835)	(61,745)	(3,317)	(68,430)
Reversed unused	(120)	(975)	-	(744)	(142,630)	(2,759)	(147,228)
Unwinding of discount	(105)	(57)	(1)	(43)	3,125	91	3,010
Change in discount rate	(9)	(1)	-	(9)	(10,853)	(1,426)	(12,298)
Balance at 31 March 2015	**1,285**	**9,506**	**25**	**1,947**	**605,295**	**49,259**	**667,317**
Expected timing of cash flows:							
Within one year	1,062	9,506	25	1,519	276,435	23,935	312,482
Between one and five years	223	-	-	428	299,280	16,408	316,339
After five years	-	-	-	-	29,580	8,916	38,496
Balance at 31 March 2015	**1,285**	**9,506**	**25**	**1,947**	**605,295**	**49,259**	**667,317**

CONSOLIDATED GROUP

	Current 2014-15 £000	Non-current 2014-15 £000	Current 2013-14 £000	Non-current 2013-14 £000
Pensions relating to other staff	77	-	88	-
Restructuring	3,659	223	5,597	2,254
Redundancy	10,156	-	1,516	-
Equal pay	25	-	30	118
Legal claims	1,578	446	3,616	39
Continuing care	316,593	341,080	402,774	415,517
Other	47,089	27,137	63,355	5,227
Total	**379,177**	**368,886**	**476,976**	**423,155**
Total current and non-current	**748,063**		**900,131**	

	Pensions Relating to Other Staff £000	Restructuring £000	Redundancy £000	Equal Pay £000	Legal Claims £000	Continuing Care £000	Other £000	Total £000
Balance at 1 April 2014	**88**	**7,851**	**1,516**	**148**	**3,655**	**817,549**	**69,324**	**900,131**
Arising during the year	17	3,106	10,728	-	113	84,368	25,441	123,773
Utilised during the year	-	(5,567)	(1,014)	(122)	(848)	(69,207)	(12,107)	(88,865)
Reversed unused	(28)	(1,394)	(1,016)	-	(844)	(167,378)	(7,093)	(177,753)
Unwinding of discount	-	(105)	(57)	(1)	(43)	3,130	88	3,012
Change in discount rate	-	(9)	(1)	-	(9)	(10,789)	(1,427)	(12,235)
Balance at 31 March 2015	**77**	**3,882**	**10,156**	**25**	**2,024**	**657,673**	**74,226**	**748,063**
Expected timing of cash flows:								
Within one year	77	3,659	10,156	25	1,578	316,593	47,089	379,177
Between one and five years	-	223	-	-	446	311,500	18,221	330,390
After five years	-	-	-	-	-	29,580	8,916	38,496
Balance at 31 March 2015	**77**	**3,882**	**10,156**	**25**	**2,024**	**657,673**	**74,226**	**748,063**

£49,054k is included in provisions for NHS Litigation Authority as at 31 March 2015 in respect of clinical negligence liabilities of NHS England (31 March 2014: £47,370k)

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 cases of such care and hence its responsibility for reimbursing patients and their families for costs incurred.

"Other" provisions include; • Miscellaneous Legacy provisions inherited under the Health and Social Care Reforms (April 2012) including onerous contracts, property related provisions, partially completed spells, and ISTC costs. • Dilapidations • Stranded costs in relation to CSU transformation • Referral To Treatment provisions

16. CONTINGENCIES

	Parent		Consolidated Group	
	2014-15 £000	2013-14 £000	2014-15 £000	2013-14 £000
Contingent liabilities				
Employment Tribunal	300	983	300	983
NHSLA employee liability claim	-	11	2	13
Continuing Healthcare	-	84,651	16,338	121,356
Legal Claim	2,388	-	2,402	2
NHSLA - LTPS	21	17	21	17
Learning Disabilities Disputed Cases	-	-	457	-
Service transformation costs	-	-	466	-
Contractual dispute	-	-	2,400	3,800
LTPS	-	-	-	10
Under-utilised property lease liabilities	-	-	336	336
NHS Property Services	-	-	2,963	-
Retrospective Social Care claims	-	-	710	-
Other employee related litigation	-	-	5	-
Net value of contingent liabilities	**2,709**	**85,662**	**26,400**	**126,517**

	Parent		Consolidated Group	
	2014-15 £000	2013-14 £000	2014-15 £000	2013-14 £000
Contingent assets				
Legal Claims	917	-	917	-
NHS Property Services	-	-	1,408	-
Net value of contingent assets	**917**	**-**	**2,325**	**-**

Contingent liabilities are those for which provisions have not been recorded as there is a possible obligation depending on uncertain future events, or a present obligation where payment is not probable or the amount cannot be measured reliably.

In 2014-15 the parent liability in respect of continuing healthcare claims is recognised wholly as provision (see note 15) rather than as a provision and a contingent liability element. This is due to greater certainty in 2014-15 as to the estimate of the total liability.

17. COMMITMENTS

17.1 CAPITAL COMMITMENTS

	Parent		Consolidated Group	
	2014-15 £000	2013-14 £000	2014-15 £000	2013-14 £000
Property, plant and equipment	-	14,921	10	18,063
Intangible assets	-	-	66	-
Total	**-**	**14,921**	**76**	**18,063**

The significant movement in capital commitments is due to the recognition of Renal ISTC commitments onto the Statement of Financial Position as a Finance Lease

17.2 OTHER FINANCIAL COMMITMENTS

NHS England had entered into non-cancellable contracts (which are not leases, private finance initiative contracts or other service concession arrangements) which expire as follows:

	Parent		Consolidated Group	
	2014-15 £000	2013-14 £000	2014-15 £000	2013-14 £000
In not more than one year	82,523	99,880	141,859	159,271
In more than one year but not more than five years	23,403	86,326	69,367	134,921
In more than five years	-	282	26,144	28,059
Total	**105,926**	**186,488**	**237,370**	**322,251**

The most significant contracts relate to a number of independent sector treatment centres and a contract with NHS Shared Business Services for the provision of an accounting system and related services.

18. FINANCIAL RISK MANAGEMENT

18.1 Financial risk management

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

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

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

18.1.1 Currency risk

NHS England is principally a domestic organisation with the great majority of transactions, assets and liabilities being in the UK and sterling based. NHS England has no overseas operations. NHS England therefore has low exposure to currency rate fluctuations.

18.1.2 Interest rate risk

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

18.1.3 Credit risk

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

18.1.4 Liquidity risk

NHS England is required to operate within revenue and capital resource limits, which are financed from resources voted annually by Parliament. NHS England draws down cash to cover expenditure, as the need arises. NHS England is not, therefore, exposed to significant liquidity risks.

18.1.5 Financial instruments

As the cash requirements of NHS England are met through the Estimate process, financial instruments play a more limited role in creating and managing risk than would apply to a non-public sector body. The majority of financial instruments relate to contracts to buy non-financial items in line with NHS England's expected purchase and usage requirements and NHS England is therefore exposed to little credit, liquidity or market risk.

19. OPERATING SEGMENTS

CONSOLIDATED GROUP 2014-15	Clinical commissioning groups £000	Direct commissioning £000	NHS England £000	Other £000	Intra-group eliminations £000	NHS England group total £000
Income	(1,156,271)	(1,558,362)	(26,341)	(849,134)	1,434,200	(2,155,908)
Gross expenditure	68,073,434	30,933,696	1,402,938	766,054	(1,434,200)	99,741,922
Total net expenditure	**66,917,163**	**29,375,334**	**1,376,597**	**(83,080)**	**-**	**97,586,014**
Revenue resource expenditure (note 23)						
Revenue departmental expenditure limit						97,659,757
Annually managed expenditure						(137,591)
Technical expenditure						63,848
Net operating expenditure for the financial year						**97,586,014**
Reconciliation back to SoCNE						
Net operating expenditure for the financial year						97,586,014
Net loss on transfer by absorption (note 6)						-
Net operating expenditure for the financial year including absorption losses						**97,586,014**

CONSOLIDATED GROUP 2013-14	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**	**-**	**94,518,984**
Revenue resource expenditure (note 23)						
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 SoCNE						
Net operating expenditure for the financial year						94,518,984
Net loss on transfer by absorption (note 6)						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 of Directors for financial management and decision making purposes.

The activities of each segment are defined as follows:-

Clinical commissioning groups - clinically led groups that are responsible for commissioning healthcare services as defined in the Health and Social Care Act 2012.
Direct Commissioning - the services commissioned by NHS England (via Area Teams) as defined in the Health and Social Care Act 2012.
NHS England - the central administration of the organisation and centrally managed programmes.
Other - includes commissioning support units, 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.

20. RELATED PARTY TRANSACTIONS

Details of related party transactions with individuals are as follows:

Related party transactions associated with the Parent are disclosed within this note. As disclosed in note 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.

2014-15

Name and Position in NHS England	Related Party	Nature of Relationship	Payments to related party £000	Receipts from related party £000	Amounts owed to related party £000	Amounts due from related party £000
Professor Sir Malcolm Grant - *Chair*	University College London (UCL)	Non-executive, former President and Provost	560	-	-	-
Professor Sir Malcolm Grant - *Chair*	UCL Partners	Ex Board member	5,583	-	1,346	-
Professor Sir Malcolm Grant - *Chair*	Cancer Research	Family member is a staff member	72	167	-	47
Professor Sir Malcolm Grant - *Chair*	University of York	Chancellor-elect	92	-	-	-
Victor Adebowale - *Non-Executive Director*	Turning Point	Chief Executive Officer and Company Secretary	2,192	-	-	-
Victor Adebowale - *Non-Executive Director*	Tomahawk Ltd, subsidiary of Three Sixty Action Ltd, collaborative software and IT innovation – now operating as THP Innovate	Non-executive director	38	-	-	-
John Burn - *Non-Executive Director*	Newcastle University.	Professor of Clinical Genetics	80	-	-	-
John Burn - *Non-Executive Director*	Newcastle Hospitals NHS Foundation Trust	Honorary Consultant Clinical Geneticist	510,801	-	-	2,342
John Burn - *Non-Executive Director*	Health Education England	Genomics Advisory Board	8,579	234,065	135	30,683
Margaret Casely-Hayford - *Non-Executive Director*	Metropolitan Police Corruption Investigation Oversight Panel	Member	7	-	-	1,083
Moira Gibb - *Non-Executive Director*	Skills for Health	Chair	28	-	-	-
Ed Smith - *Non-Executive Director*	PWC	Retired Senior Partner	1,133	-	-	-
Ed Smith - *Non-Executive Director*	University of Birmingham	Pro Chancellor and Chair of Council	448		59	-
Ed Smith - *Non-Executive Director*	Crown Commercial Services	Non-Executive Chairman	2	-	-	-
Jane Cummings - *National Director*	Macmillan Cancer Support	Director and Trustee	-	141	10	178
Bruce Keogh - *National Director*	Royal College of Surgeons in England (previous Member of Council)	Fellow	141	-	-	-

2014-15 (CONT)

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
Bruce Keogh - *National Director*	Royal College of General Practitioners	Honorary Fellow	457	-	-	-
Bruce Keogh - *National Director*	Faculty of Medical Management and Leadership	Honorary Member	117	-	-	-
Bruce Keogh - *National Director*	British Heart Foundation	Council	-	31	-	5
Bruce Keogh - *National Director*	Cancer research UK	Company Member	72	167	-	47
Barbara Hakin - *National Director*	Ernst and Young	Family member is an employee	3,327	-	-	-
Barbara Hakin - *National Director*	NHS Trust Development Authority	Son works for TDA	5,014	195	-	94
Tim Kelsey - *National Director*	ZPB	Partner is a director, this is a health strategy company	15	-	24	-
Rosamond Roughton - *National Director*	Mike Farrar Consulting Limited	Partner is a director	2	-	-	-
Rosamond Roughton - *National Director*	York Health Economics	Partner is a non-executive director	63	-	-	-

2013-14

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	-	5	-
Sir David Nicholson *Chief Executive to 31 March 2014*	Birmingham Children's Hospital	Wife is Chief Executive	161,955	-	2,818	1
Tim Kelsey *National Director*	ZPB Ltd	Wife is a Director	20	-	-	-
Lord Victor Adebowale *Non Executive Director*	Turning Point	CEO and Company Secretary	511	-	113	-
Ciaran Devane *Non Executive Director*	Macmillan Cancer Support	Chief Executive	1	66	-	47
Dame Moira Gibb *Non Executive Director*	Achieving for Children, London Boroughs of Kingston and Richmond	Board Member	-	21	-	-
	University of Reading	Council Member	6	-	-	-
Ed Smith *Non Executive Director*	University of Birmingham	Chair of Council	235	-	9	-
Naguib Kheraj *Former Non-Executive Director to 10 December 2013*	Wellcome Trust	Member of the Investment Committee	2	-	-	-

The Department of Health, as the parent of NHS England, is regarded as a related party. During the year NHS England has had a significant number of material transactions with entities for which the Department is regarded as the parent Department.

For example:

• NHS Foundation Trusts; • NHS Trusts; • NHS Litigation Authority and • NHS Business Services Authority.

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

The compensation paid to key management personnel can be found in the remuneration report on pages 74 to 77.

21. EVENTS AFTER THE END OF THE REPORTING PERIOD

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

NHS England recently announced details of the clinical commissioning groups approved to take on greater delegated responsibility or to jointly commission services from 1 April 2015. The new primary care co-commissioning arrangements are part of series of changes set out in the NHS Five Year Forward View. 63 clinical commissioning groups have been approved under delegated commissioning arrangements which means that the clinical commissioning groups will assume full responsibility for contractual GP performance management, budget management, and the design and implementation of local incentive schemes from 1st April 2015. This will result in a switch in expenditure from NHS England to those clinical commissioning groups.

The date the financial statements were authorised for issue by the Accounting Officer is included at the bottom of the Certificate and Report of the Comptroller and Auditor General to the Houses of Parliament report.

22. LOSSES AND SPECIAL PAYMENTS

Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way that individual cases are handled.

22.1 LOSSES

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

	Parent				Consolidated Group			
	Total Number of Cases 2014-15 Number	Total Value of Cases 2014-15 £000	Total Number of Cases 2013-14 Number	Total Value of Cases 2013-14 £000	Total Number of Cases 2014-15 Number	Total Value of Cases 2014-15 £000	Total Number of Cases 2013-14 Number	Total Value of Cases 2013-14 £000
Administrative write-offs	38	29,352	1	120,183	151	32,377	1	120,183
Fruitless payments	-	-	1	23	11	6	11	539
Stores losses	58	92	-	-	58	92	-	-
Book Keeping losses	-	-	-	-	3	3	-	-
Cash losses	-	-	1	1	1	3	4	3
Claims abandoned	-	-	-	-	-	-	1	1
Total	**96**	**29,444**	**3**	**120,207**	**224**	**32,481**	**17**	**120,726**

2014-15 Disclosure: Administrative write off

In 2014-15 a further impairment review was conducted on assets transferring from legacy organisations - resulting in a write off of £26,365k

In 2013-14 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.

2013-14 Disclosure: 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.

22.2 SPECIAL PAYMENTS

	Parent				Consolidated Group			
	Total Number of Cases 2014-15 Number	Total Value of Cases 2014-15 £000	Total Number of Cases 2013-14 Number	Total Value of Cases 2013-14 £000	Total Number of Cases 2014-15 Number	Total Value of Cases 2014-15 £000	Total Number of Cases 2013-14 Number	Total Value of Cases 2013-14 £000
Compensation payments	1	1	-	-	21	55	9	10
Extra contractual payments	-	-	-	-	28	145	-	-
Ex gratia payments	1	3	1	3	31	123	14	15
Total	**2**	**4**	**1**	**3**	**80**	**323**	**23**	**25**

A fine of £470K was levied by the Treasury in respect of 2 off payroll workers. This value was deducted from the Department of Health funding allocation and a memorandum note has been made in the Losses register.

23. FINANCIAL PERFORMANCE TARGETS

The Mandate: A mandate from Government to NHS England: April 2014 to March 2015 published by the Secretary of State under section 13A of the National Health Service Act 2006, and the associated Financial Directions as issued by the Department of Health, set out NHS England's total revenue resource limit and total capital resource limit for 2014-15 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.

	2014-15						2013-14
	Revenue Departmental Expenditure Limit			Annually-managed expenditure	Technical	Total	Total
	Non ring-fenced £000	Ring-fenced £000	Total £000	£000	£000	£000	£000
Mandate Limit	98,339,000	160,000	98,499,000	300,000	360,000	99,159,000	95,873,000
Actual expenditure	97,586,828	72,929	97,659,757	(137,591)	63,848	97,586,014	94,518,984
Surplus	**752,172**	**87,071**	**839,243**	**437,591**	**296,152**	**1,572,986**	**1,354,016**
Revenue resource limit (excluding planned surplus c/f into 2015/16 of £467m and £534m in 13/14)	97,872,000	160,000	98,032,000	300,000	360,000	98,692,000	95,339,000
Surplus (excluding planned surplus c/f)	**285,172**	**87,071**	**372,243**	**437,591**	**296,152**	**1,105,986**	**820,016**

	2014-15 Capital resource limit £000	2013-14 Capital resource limit £000
Limit	270,000	200,000
Actual expenditure	189,212	181,525
Surplus	**80,788**	**18,475**

NHS England is required to spend no more than £2,142,000,000 of its Revenue Departmental Expenditure Limit mandate on matters relating to administration. The actual amount spent on administration matters in 2014-15 was £1,780,114,000 as set out below.

Administration Limit	2014-15 £000	2013-14 £000
Net administration costs before interest	1,837,530	2,072,892
Less:		
Administration expenditure covered by AME/Technical funding	(57,416)	(175,251)
Administration costs relating to RDEL	1,780,114	1,897,641
RDEL Administration expenditure limit	2,142,000	2,016,000
Underspend	**361,886**	**118,359**

The various limits of expenditure set out in the tables 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 AME closely and inform HM Treasury if they expect AME to rise above forecast. Any increase requires Treasury approval.

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

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. From the 1st of April 2015 this became 209 clinical commissioning groups with the merger of Gateshead CCG, Newcastle North and East CCG and Newcastle West CCG to form Newcastle Gateshead CCG.

A full list of the clinical commissioning groups can be found on the NHS England website.

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

APPENDICES

APPENDIX 1

How we have delivered against the Mandate

The Government's Mandate for 2014-15 set 25 objectives for NHS England. The following summarises progress made against each one, highlighting key achievements and setting out where further work is needed.

Objective 1: Improvement against the NHS Outcomes Framework

Over the last twelve months we have strived to make progress against all domains of the NHS Outcomes Framework. Latest data from the framework shows 48 metrics with data available from 2013 onwards. Of these, notable progress has been made against 40 per cent, a further 40 per cent have remained fairly static and deterioration shown in 20 per cent. It can take several years for actions to positively impact on health outcomes. Over the past year we have continued to develop the system architecture to support quality – we have worked with NICE to develop the library of NICE quality standards for use by commissioners and providers; we have been building and improving the National Clinical Audit programme and we have enabled local commissioners to measure and prioritise outcomes, using the CCG outcomes indicator set and supporting atlas tool. We have also progressed work in specific areas according to an analysis of indicators in the framework. An analysis of PYLL (potential years of life lost) identified sepsis and AKI (acute kidney injury) as clinical priorities where improvements in care would have the greatest impact on reducing premature mortality. Consequently, as part of wider work programmes, we have introduced national financial incentive payments (Commissioning for Quality and Innovation measures) for 2015-16, incentivising the timely identification and treatment of sepsis, and improvements in the follow up and recovery for individuals who have sustained AKI.

Objective 2: Preventing premature mortality

The requirement to take action to prevent people from dying prematurely is embedded in everything we do. It will take time to see the impact of our work programmes on outcomes but we have delivered a strong set of actions over the past year – highlights include: convening a cancer task force, who have already published an interim report; for stroke, we have developed two specific cases for acute stroke service reconfigurations - West Midlands and Manchester who are taking this work further; we have continued to support Public Health England (PHE) on symptom awareness campaigns and work with them to deliver the section 7a agreement; we have also supported PHE publish a TB strategy in October 2014 which includes proposals to implement latent TB screening across England.

Objective 3: Preventing ill health and improving access to treatment

Progress has been made preventing ill health as we continue to strengthen diagnosis in primary care and work in partnership with Public Health England on the prevention agenda. Investing in prevention will reap benefits in years to come. For diabetes we have launched a diabetes prevention programme, including identifying seven demonstrator sites to work with to co-design the programme. We also contributed to a PHE initiative as they published the Healthier Lives: Diabetes Atlas, a tool to drive improvements in diabetes care and iron out variation. In terms of improving access to treatment, the Prime Minister's Challenge Fund has progressed with sites leading the way in testing innovative ways of increasing access and delivering wider transformational change in general practice. In total there are now 57 pilots covering over 18 million population (a third of the country) in around 2,500 practices that will benefit from improved access and transformational change at local level. A wide variety of innovative ideas are being tested including extended opening hours, more ways for patients to access services and new services to better support patients with complex needs.

Objective 4: Supporting people with long term conditions

Supporting people with long-term conditions is an area where we have made good progress over the last year but there is significant challenge. The Five Year Forward View notes that long-term conditions (LTC) are now a central task of the NHS and caring for these needs, requires a partnership with patients over the long term rather than providing single, unconnected episodes of care. Results from the 2014 GP Patient Survey are that over half of all patients (54.0 per cent) have one or more long standing health conditions and, of these patients, 63.7 per cent say they received enough support from local services or organisations in the last six months to help them manage their condition, so further progress is needed. Specific actions delivered this year include publication of healthy ageing guide, devised with Age UK to support older people living with frailty; we have also co-produced with experts including patients, carers, commissioners and health and care professionals three handbooks to provide practical support for good LTC management which in turn focus on risk stratification and case finding; personalised care and support planning; and multidisciplinary team working.

Objective 5: Improving involvement of people with long- term conditions and their carers

Good progress has been made across this objective with a focus on self-management, personal care plans, personal health budgets and support for carers. A national NHS young carers event was held and health leaders at the event made pledges for action leading to NHS England hosting a round table looking at the mental health needs of young carers, as well as the impact of caring for a parent or sibling with mental health needs. A personalised care and support planning handbook was published January 2015, giving guidance for commissioners and practitioners – however, personalised care plans are not yet available to all patients with LTC. To fulfil the objective, work is taking place with partners to focus on delivering this for individuals who would most benefit. And as of September 2014, 90 per cent of CCGs confirmed that they were in a position to deliver personal health budgets to patients who would benefit from having one; we will continue to support the remaining CCGs to deliver this.

Objective 6: Use of technology

Increasing the use of technology is an area where we have made particular progress this year. The use of the NHS number in clinical correspondence has increased (it is now used in 97.6 per cent of trusts); and summary care records are now available to a third of all NHS 111 providers, A&E departments and ambulance trusts. The Patient Online programme has also shown improvement – GP practices with which 97 per cent of patients in England are registered have now enabled electronic booking of appointments for their patients and 96 per cent have enabled electronic repeat prescriptions ordering. Currently 98 per cent of practices have the technical capability to offer access to GP patient record records online, although evidence shows that more work is needed to ensure that GP practices make this access a reality for patients.

Objective 7: Integration

Integration is a challenging area but strong work programmes and these go beyond the requirements set out in the Mandate. There are four main strands to our work on integration: the Better Care Fund (BCF), Integrated Personal Commissioning (IPC), the Integrated Care Pioneers and the medium term plans set out in the Five Year Forward View. The BCF is on track with nearly all plans being fully approved and support in place for their implementation, although we recognise that developing robust plans for BCF has proved challenging and this workstream in particular has benefitted from strong cross-government working, which we aim to continue in the coming year. 11 second wave integrated care pioneers were formally announced in January and a revised support package has been co-developed and is being implemented. IPC gives patients control over their combined health and social care budgets and nine demonstrator sites went live from April 2015 in the first wave of the programme. Finally, from the Five Year Forward View, the New Care Models programme has started with 29 local vanguard sites announced who will prototype new approaches for care design and delivery, developed to meet the needs of local populations.

Objective 8: Dementia

Throughout this period NHS England has used a five part dementia recovery plan to improve diagnosis of and care for people with dementia (the five parts comprise regional support to CCGs; improving data; proactive communications; intensive clinical support; and use and further development of financial incentives). This is evidenced through the planning and assurance processes, the financial levers established to incentivise improvement, improved and more regular data and benchmarking tools for commissioners. Intensive activity has seen provisional data show the diagnosis rate rise to 61.6 per cent by the end of March against the two-thirds dementia diagnosis ambition; NHS England expects to have met the ambition early in 2015-16 but data will not be available until September to confirm this. Work has also progressed on post-diagnosis treatment through the dementia enhanced service, with more planned in the coming year.

Objective 9: Transparency of information

Whilst there have continued to be delays to the delivery of the Care. Data programme, we can point to significant successes in the publication of data. For example, consultant level outcome data across 12 different specialities has been published for the first time and in one publically accessible place: myNHS, alongside publication of hospital quality and patient safety indicators. A rolling programme of over 30 clinical audits has been commissioned and good progress has been made developing a CCG and refining the GP scorecards. All the work to date on the Friends and Family Test is paying dividends we have recorded more than 7 million pieces of feedback since its launch and has been successfully implemented in all services where it is appropriate.

Objective 10: Reconfiguration of services

We continue to work in line with the service change and reconfiguration policy and national guidance to ensure that the four tests are appropriately applied in all service reconfiguration. The four tests are: i) strong public and patient engagement; ii) consistency with current and prospective need for patient choice; iii) a clear clinical evidence base and iv) support for proposals from clinical commissioners.

Objective 11: Mental health (parity of esteem)

There has been a lot of focus and profile on mental health this year with good progress been made during the year. Adult IAPT has improved and we forecast the 15 per cent access target will be achieved at the end of Q4 (+/- 0.5 per cent). A five year vision for mental health access standards to achieve greater parity was published in October 2014; The Children and Young Peoples Mental Health task force report Future in Mind was published in March 2015; access and waiting time standards have been developed; implementation of choice in mental health has begun and will be further embedded throughout the year; the friends and family test was rolled out for mental health in December. A mental health task force has been set up to develop a five year all-age national strategy for mental health". In December 2014, every CCG signed a declaration to work with the police and social services to improve local mental health crisis interventions, and followed this up in the spring with agreed joint action plans. Department of Health also committed an additional £40 million funding boost for mental health services during 2014-15.

Objective 12: Action in response to the Francis report

We are working closely with Department of Health and other partners to ensure that we fulfil our role in the system-wide response to the Francis report. Until a decision has been made on the transfer of patient safety functions, we will continue to fulfil our existing system leadership role and ensure progress is maintained. Achievements in year include launching the Sign up to Safety campaign, a joint campaign between Department of Health and NHS England with a three year objective to reduce avoidable harm by 50 per cent and save 6,000 lives; we have also been developing NHS-wide approach to 'always events', supporting organisations to develop a culture of what is always done and give clear expectations of those delivering care. Objective 19 outlines progress made against patient safety and objective 15 patient experience, both of which are linked to delivery of this objective.

Objective 13: Safeguarding

There is an organisational focus on transforming care for people with learning disabilities because we know there is more work to be done, but there are strong actions in place and progress is being made. More than 1,400 care and treatment reviews – the first step in transferring people to community settings – have been conducted and 600 people have been discharged. This is fewer than initially intended but the rate of discharge is expected to increase this year. In November 2014, Sir Stephen Bubb published Winterbourne View – Time for Change which set out proposals for changing the approach to health and social care for people with learning disabilities and complex behaviour. In January 2015, NHS England, with system partners, published its response to this report, including commitments to create a single delivery programme across the system. In terms of broader safeguarding, work is progressing well with particular emphasis on child sex exploitation, the Mental Capacity Act and the organisation PREVENT.

Objective 14: Quality of caring, especially for older people and at the end of life

On end of life care, significant activity with cross-system partners has taken place. NHS England's Actions for End of Life Care has now been published, we have contributed to the Health Select Committee inquiry into end of life care, the Department of Health choice review, the NHS England palliative care funding review, the PHE palliative care dataset consultation, and other cross cutting work.

Objective 15: Improve patient experience

We are committed to continually improving patient experience. Since its start in April 2013, over seven million responses have been received through the Friends and Family Test (FFT). Some examples of how feedback through FFT has improved services are by introducing a patient passport; improving A&E waiting areas; giving maternity care assistants additional training to support mothers with breastfeeding; purchasing tinted drinking glasses so people with visual impairments can see them more easily and the recruitment of a physical health nurse to work within an adult mental health unit. We have also been developing an insight strategy providing commissioners with practical approaches in how to gain insight from their patients.

Objective 16: Improving maternity and early years care

Action continues to be taking to deliver the children and young peoples pledge, with a model for integrated care from pregnancy through to the transition into adult healthcare being developed. NHS Improving Quality (IQ) have carried out in-depth analysis on perinatal mental health with a focus on postnatal depression and work has taken place on the choice and named midwife agenda. However, we recognise that more progress is needed and this has led to a major review of the commissioning of NHS maternity services being announced in March 2015. The review is expected to be completed by the end of the year and will include models of care and improving the ability of mothers to make informed choices about their care.

Objective 17: Supporting children and young people with Special Educational Needs (SEN) and disabilities

CCGs have a responsibility to support children and young people with SEN and disabilities; NHS England needs to get the balance right between giving CCGs their autonomy, offering support and gaining assurance on how well CCGs are delivering against this responsibility. We have supported CCGs prepare for delivering this objective, working with the Council for disabled children who have issued guidance to CCGs. We also published a suite of commissioning guidance in September covering: outcomes focused working; joint commissioning; Education, Health and Care Plans; local offer, designated medical officer and information sharing. We recognise that more can be done to support CCGs to deliver against this objective and will continue to work with the Department for Education, Department of Health and CCGs to do this.

Objective 18: NHS Constitution

Overall, provider performance against the NHS constitutional standards has continued to deteriorate over the second half of 2014-15 especially for the delivery of A&E and ambulance standards, although the position improved in the spring. We have seen increased demand and corresponding pressures across both the elective and urgent care systems and these issues have led to a special focus on 2015-16 plans to ensure systems have undertaken appropriate demand and capacity planning. Despite these pressures, the NHS met its target that no more than 92 per cent of patients should be waiting from than 18 weeks from referral by a GP.

Objective 19: Improving patient safety and reducing avoidable harm

We continue to deliver strongly on the Patient Safety programme and until the Department of Health's planned transfer of patient safety functions, we will continue to fulfil our existing system leadership role and ensure progress is maintained. Highlights over the past year include publication of patient safety data on NHS Choices and MyNHS, including information on open and honest reporting, healthcare associated infections and cleanliness and compliance with patient safety alerts. We have also established 15 safety collaboratives covering every part of England that bring together providers, commissioners, patients and others from across an area to tackle key safety priorities, and form clusters to share learning on pressure ulcers, medication safety, acute kidney injury, sepsis and mental health safety.

Objective 20: Strengthening local autonomy

Good progress is being made on primary care commissioning and co-commissioning and we will continue to work with Greater Manchester to develop their ambitious plans to improve health and social care across Greater Manchester involving NHS England, 12 NHS CCGs, 15 NHS providers and 10 local authorities. During the past year two CCGs have been issued with directions and conditions after their initial authorisation period. Overall, of the 209 CCGs in England there are 16 conditions remaining across eight CCGs at Q3 of 2014-15. There are two CCGs where directions remain, with directions issued to Barnet CCG earlier in the year.

Objective 21: Choice, competition and pricing

Work on mental health choice continues to progress. We are now monitoring impact, including through repeating the Patient Choice Survey with Monitor. We have also launched work to improve choice in maternity services, underpinned by a commitment in the Five Year Forward View. We continue to provide case advice and the Lead Provider Framework for commissioning support is improving commissioners' procurement support. A voluntary option has been developed for the 2015-16 tariff and we have worked with Monitor to publish plans on reforming the NHS payment system to support delivery of the Five Year Forward View.

Objective 22: Research to improve outcomes and contribute to growth

Progress is still needed to fully deliver this objective, in particular in the element that refers specifically to research, and not to the objective in the round, where progress is being made. Excess Treatment Costs (ETC) remains a difficult issue not fully addressed and our overarching plans for research also need to be reshaped, particularly in light of the Five Year Forward View. We have been working with Department of Health on this. However, progress has been made in other areas – for example, the creation of the new NHS genomic medicine centres will play a key role in bringing together researchers, NHS clinicians and trainees to work as part of Genomic England's clinical interpretation partnership on whole genome data. We have established 11 NHS genomic medicine centres in England and a second wave are planned, enabling the mapping of 100,000 genomes by 2017. We are investing significant resources in growth and innovation in the NHS, including £20 million in 2014-15 and in 2015-16 in the small business research initiative. This year also sees the establishment of test bed sites and systems, trialling integrated innovative packages in clinical settings.

Objective 23: Making partnership work a success

We work in partnership across all our programmes and relationships continue to evolve and improve. Examples of strong partnership over the past year includes the preparation work with partners to plan for Through the Gate across secure estate in conjunction with the National Offender Management service, PHE and Department of Health. The simplified generic common service specification for veterans' services has also been agreed, and the healthcare model for Immigration Removal Centres (IRC) transitioned to NHS England in September 2014. We recognise that more needs to be done to demonstrate progress against other areas of the objective and will continue to engage and work with partners in the coming year, including relevant government departments.

Objective 24: Financial management and Quality, Innovation, Productivity and Prevention

The Chief Financial Officer's Report within the main body of this report provides a detailed assessment against this objective.

Objective 25: Measurement of outcomes, including inequalities

A continued focus is required to ensure that a sustainable reduction in health inequalities (HI) is achieved, as despite increases in life expectancy in recent years in both the most and least deprived areas in England, there has been little change in inequality in life expectancy across the social gradient. Against this challenging background we have led a system wide approach to reducing inequalities including: the adjustment for unmet need in target allocations for CCG and primary care; the 2014-15 and 2015-16 CCG Assurance Frameworks include equality and heath inequalities; we have asked CCGs to set locally agreed ambitions to reduce HI from 2015-16 onwards; and the NHS Outcomes Framework for 2015-16 will also include HI assessed indicators.

APPENDIX 2

How we have acted to reduce health inequalities

NHS England's summary assessment of meeting our legal duties with regard to health inequalities.

Health inequalities costs lives, decreases the quality of life for many people and has a cost to the NHS. NHS England and the wider NHS have made reasonable progress in recent years in reducing health inequalities, but more remains to be done and NHS England will ensure it remains a high priority in implementing the Five Year Forward View (FYFV).

	Secretary of State criteria for health inequalities assessment 2014-15	Summary response
1	Are governance and accountability arrangements for health inequalities appropriate and in use?	To ensure delivery of our aims and objectives for reducing health inequalities, NHS England uses: • governance and accountability against all programmes of work; and • planning and assurance frameworks. NHS England also has: • the Mandate, with an objective to reduce health inequalities; • the FYFV which has tackling health inequalities at its core; • business plan; • the NHS planning guidance; and • the Equality and Health Inequalities Programme Board (E&HIPB).
2	Does the organisation have a strategic and evidenced-based approach to identifying clear goals, priorities and actions that are most likely to lead to measureable reductions in health inequalities?	In March 2015 the E&HIPB agreed a new single priority deliverable for reducing health inequalities, which has seven supporting objectives to help the E&HI team deliver the work. This is: 'Achieve sustainable and measurable reductions in health inequalities ensuring improving health outcomes in England 2015-20.'

Secretary of State criteria for health inequalities assessment 2014-15		Summary response
3	Is the organisation working collaboratively with partners, including at a local level and with individuals where appropriate, to help reduce health inequalities?	NHS England co-produced the 'Five Year Forward View' and 'Planning Guidance for 2015-16' with other key NHS organisations including NHS Trust Development Agency (NTDA), Monitor, Health Education England (HEE), PHE and the Care Quality Commission (CQC). Both documents contain references to health inequalities and the actions that NHS England plans to take. The National Equality & Diversity Council (EDC) has an interest and strong links to Health Inequalities. The NHS England Chief Executive chairs this Council and it is attended by senior representatives from partner organisations. We strive to work collaboratively throughout all of our work programmes. This is illustrated by: **Reducing inequalities – meeting our duties** In partnership with PHE we have delivered a series of regional workshops for CCGs and their local partners to refresh awareness on legal duties. **Urgent and Emergency Care Review** We are working collaboratively with previously mentioned organisations to consider how each area of work can address key health inequalities through: • Clinical Models and Standards Groups; • Delivery Groups; and • Commissioning Assembly Working Group on Urgent and Emergency Care – this is a forum which allows us to work collaboratively with our commissioner partners at a local level. **GP Contract** We work across the organisation and with Government to identify priorities for changes to GP contracts, keeping in mind the legal duties to reduce health inequalities. We then work with NHS Employers to identify those changes that could be agreed with the British Medical Association (BMA) General Practitioners Committee. The agreement is only accepted once NHS England and Government are in agreement. **Primary Care Services** We have been working with the contracts team and Inequalities leads to draft a briefing to clarify the rules and regulations around migrant access to primary care services. NHS England regions and CCGs need to ensure a consistent approach across the country in relation to migrants registering with a general practice. In addition, a voluntary sector organisation has been commissioned to draft a patient and public facing leaflet in relation to this work. **Health and Justice** The 10 Health and Justice commissioning leads for NHS England have partnered with prisons, police forces, local authorities, clinical commissioning groups and service user and victims organisations to ensure the improvement of patient healthcare in the criminal justice system to support reduction of health inequalities and offending behaviour. **Continuing Health Care (CHC)** There is partnership work with the NHS CHC group which includes key charities such as Alzheimers UK, Parkinson's UK, Spinal Injuries Association and Marie Curie Care. In particular they focus on the following: • assessment and decision making that its lawful, of high quality and timely; • transition is well managed when funding streams change; • training; • fast track; and • care and support planning.

Secretary of State criteria for health inequalities assessment 2014-15		Summary response
4	Is there an assurance process to ensure the health inequalities duties are being applied across all relevant functions?	The 2015-16 planning guidance contains an annex on 'Guidance for NHS Commissioners on Equality and Health Inequality Duties'. This sets out requirements and expectations for all commissioners, including NHS England. The E&HIPB have agreed for 2015-16, key questions for all programme boards to use, so they can test how their work is focused on reducing health inequalities. 1. How have you considered equality and health inequalities and the need to give due regard to the Public Sector Equality Duty? For example evidence of an equality and health inequalities analysis. 2. What action will you take to address the identified E&HI priorities? 3. How will you know what progress you are making in addressing E&HI? 4. What are the key risks/opportunities for achieving your E&HI priorities? 5. What evidence is there of improved outcomes? How will you record this?
5	Are inequalities in access and outcomes being routinely monitored? In 2014-15, I hope to see action to ensure that progress made over the last decade or so is maintained, particularly in the following areas: a) Reduction in absolute inequalities in CVD mortality under 75 years for men and women b) Reduction in absolute inequalities in cancer mortality under 75 years for men and women c) Reduction in inequalities in infant mortality	The latest available data demonstrates improvements in reducing health inequalities over time for a number areas. They also show that we need to maintain progress on reducing health inequalities. This will be supported by the inclusion, for the first time, in 2015-16, of health inequality assessed indicators within the NHS Outcomes Framework. The latest available data shows: • there has been a steady decrease in the potential years of life lost (PYLL) from causes considered amenable to healthcare, although this has levelled off between 2012-13. The absolute gap between males and females remains, but the gap has seen an overall decrease from 2008 to 2013 of 18%; • continued progress has been maintained in reducing inequality in the under 75 mortality rate from CVD between the most and least deprived people in England (2013); • healthy life expectancy (HLE) for males has slightly increased between 2009-10 and 2011-12, whilst for females it has slightly decreased. However there has been a 2% decrease in inequality for female HLE from 2009-10 to 2010-12, whilst for male HLE there has been a 1% increase; • reductions in infant mortality from 2000-12 across all-age groups of mothers, with the greatest improvement seen for mothers from 20 to 24 and mothers under 20; • Cardio Vascular Disease (CVD) mortality for people under 75 has been going down. There is also a downward trend in the absolute gap between male and female mortality from CVD for under 75 year olds since 2003, although there was a small increase in the absolute gap in 2012 compared to 2013. In addition there has been a downward trend in the slope index of inequality in the under 75 mortality rate from CVD since 2009; and • Cancer mortality for people under 75 has seen a steady fall since 2003, with a faster improvement for men and a narrowing of the mortality gap with women although there was a small increase in the absolute gap in 2012 compared to 2013. We do recognise that this progress is not the same for all people. Evidence from national cancer surveys shows that the experience and outcomes for cancer for people from black and minority ethnic communities are often not as good as for other individuals. To address this we have made it a priority in our 2015-16 business plan. We will look to address unwarranted variation across the country, drawing on patient experience and particularly focusing on the outcomes and experience of older people, children and young people, from black and minority ethnic communities, and people with a learning disability.
6	Is progress in addressing health inequalities being maintained across key priorities, such as reducing premature mortality?. Are the actions identified by the Inclusion Health work being considered and put into action where appropriate?	To make sure actions from the Inclusion Health work are being put into action, we are: • involved with the Hepatitis C Homeless Task force, Chaired by Professor Graham Foster, London. The Task force aims to improve Hepatitis C (HCV) services for homeless people in the UK. This links to the prevention of people dying prematurely, and more specifically the under 75 mortality rate from liver disease and premature deaths of people with a serious mental illness; • working with Open Doors and the National Sex Workers Network to improve healthcare access and outcomes for sex workers across England; • supporting regional partnerships who work with tackling issues of healthcare access for vulnerable migrant communities across England; • supporting the work of the Gypsy Traveller Inclusion Health group and the Faculty of Inclusion Health on addressing ongoing concerns facing inclusion health groups; and • working with Primary Care commissioners and Contracts managers on promotion and implementation of the standards developed by The Faculty of Homeless and Inclusion Health. This has resulted in better understanding of the issues facing GP services working with Inclusion Health groups.

Secretary of State criteria for health inequalities assessment 2014-15		Summary response
7	Has NHS England ensured CCGs are capable of fulfilling their duties with regard to health inequalities?	The 2014-15 CCG assurance process is structured around: 1. Are patients receiving clinically commissioned, high quality services? 2. Are patients and the public actively engaged and involved? 3. Are CCG plans delivering better outcomes for patients? 4. Does the CCG have robust governance arrangements? 5. Are CCGs working in partnership with others? 6. Does the CCG have strong and robust leadership? These are supported with three cross cutting themes: a) Equality and health inequalities; b) Better Care Fund; and c) Parity of esteem. This design allows for broader conversations to take place which has driven a greater focus on reducing inequalities, improving health outcomes and, a wider understanding of local relationships and organisational health. At the end of their assurance meetings, area teams (now known as regional teams) produce a quarterly report summarising areas for development and notable practice, and are shared with the CCG for comment. Each CCG is rated as 'assured', 'assured with support' or 'not assured' for each of the six assurance domains.
8	Has NHS England put in place robust arrangements for assessment and publication of CCGs fulfilment of their duties with regard to health inequalities?	As a key component of quarterly assurance conversations a CCG is required to demonstrate: • a comprehensive insight into their populations health needs, and be able to describe how, through their own commissioning and wider collaboration, that they are meeting the inequality challenge for their population; and • a focus on the outcomes of the Equality Delivery System (EDS/EDS2), including better patient access to services and wider choice, and a better patient experience. CCGs have a duty to prepare an annual report for each financial year which includes their fulfilment of their duties with regard to both promoting equality and reducing health inequalities. This requirement is included in the guidance to CCGs on annual reports. Promoting equality and reducing health inequalities will continue to be a main theme for CCGs to reduce local health and healthcare inequalities and improve outcomes for health and wellbeing through their plans.

APPENDIX 3

Public involvement in our work

NHS England is committed to ensuring that patients, carers and other stakeholders have an opportunity to influence and shape all the NHS services which we commission.

On specialised services, we hold regular public consultations and engagement events about changes in national policies and specifications. NHS England supports a number of service-specific networks to ensure that we work in partnership with service users, and we have embedded patient and carer voice into our specialised services governance processes, including 75 clinical reference groups and the Clinical Priorities Advisory Group which makes recommendations on the commissioning of new services, treatments and technologies.

NHS England supports a Patient and Public Voice Assurance group, a strategic body of patient/public representatives, ensuring robust patient engagement in our work. Patients and the public are also represented on the Specialised Services Oversight group and the Clinical Priorities Advisory Group (CPAG) which makes recommendations on the commissioning of new services, treatments and technologies. It considers which of these should be prioritised for investment.

For further information about getting involved: https://www.england.nhs.uk/commissioning/spec-services/get-involved/

In respect of primary care services, an NHS Citizen workshop in March 2015 explored approaches to developing citizen voice in commissioning GP services.

National strategy and policy for commissioning GP services in 2014-15 was influenced by the 'Call to Action' carried out in the previous year, where the public and other stakeholders were asked for their ideas on the future development of general practice.

The 2015-16 contract for General Medical Services and the associated enhanced services have been informed by public engagement, particularly in the areas of care planning and public participation. We work with the National Association for Patient Participation to support their network of patient participation groups that operate in GP surgeries. We have linked directly to PPGs as a route to patient involvement in primary care, both at local level and in national programmes such as Patient Online.

We have developed practical toolkits to support communication and involvement in the procurement of GP services.

In dental commissioning, we have engaged on new national commissioning guides produced for four key dental service areas. We used digital engagement and partnership work with children and young people's charities to get a voice from children and young people on orthodontics. This will influence how dental services are commissioned in future in relation to citizen voice in national governance and patient involvement in procurement and monitoring of dental contracts.

On Health in Justice and Armed Forces Commissioning, we have worked with voluntary sector organisations, service users and stakeholders to embed a model of participation into their ongoing work in commissioning health in justice and health services for members of the armed forces. This has included developing service user participation in governance.

APPENDIX 4

Changes to the Board Committee structure during 2014-15

During the year changes were made to the Committee structures supporting the Board and its work. The mapping of responsibilities is shown below:

APPENDIX 5
Register of Board members

Non-executive Directors

Forenames	Surname	Designation	Start Date	End Date	Status	Term
Malcom	Grant	Chairman	31.10.11	30.10.15	Current	1
Ed	Smith	Non-Executive Director, Deputy Chairman, Senior Independent Director, Chair - Audit & Risk Assurance Committee	09.11.11	08.11.15	Current	1
Ciarán	Devane	Non-Executive Director	01.01.12	31.12.15	Current	1
Victor	Adebowale	Non-Executive Director	01.07.12	31.12.18	Current	2
Moira	Gibb	Non-Executive Director, Chair - Investment Committee	01.07.12	31.12.18	Current	2
Margaret	Casely-Hayford	Non-Executive Director	01.07.12	30.06.16	Current	1
David	Roberts	Non-Executive Director, Chair - Commissioning Committee	01.07.14	30.06.18	Current	1
Noel	Gordon	Non-Executive Director, Chair - Specialised Commissioning Committee	01.07.14	30.06.18	Current	1
John	Burn	Non-Executive Director	01.07.14	30.06.18	Current	1

Executive Directors

Forenames	Surname	Designation	Start Date	End Date	Comment
Simon	Stevens	Chief Executive	01.04.14	N/A	N/A
Paul	Baumann	Chief Finance Officer	01.04.13	N/A	N/A
Jane	Cummings	Chief Nursing Officer	01.04.13	N/A	N/A
Bruce	Keogh	National Medical Director	01.04.13	N/A	Seconded from UCH, London
Ian	Dodge	National Director: Commissioning Strategy	07.07.14	N/A	Non-Voting
Barbara	Hakin	National Director: Commissioning Operations	01.04.13	N/A	Non-Voting
Tim	Kelsey	National Director for Patients & Information	02.07.12	N/A	Non-Voting
Karen	Wheeler	National Director: Transformation and Corporate Operations	01.04.14	31.03.17	Non-Voting; Seconded from DH

Leavers

Executive Directors

Forenames	Surname	Designation	Start Date	End Date	Comment
Rosamond	Roughton	National Director: Commissioning Development	15.04.13	31.07.14	Changes to Board structure
Bill	McCarthy	National Director: Policy	01.04.13	30.06.14	Changes to Board structure

APPENDIX 6

Summary of Board membership of Committees

Board Committee membership and attendance (April – November 2014)

	Audit Committee	Authorisation & Assurance Committee	Commissioning Support Committee	Directly Commissioned Services Committee	Finance and Investment Committee	Efficiency Controls Committee	Quality & Clinical Risk Committee*	Remuneration Committee
Sir Malcolm Grant Chairman				Chair				Chair
Simon Stevens Chief Executive				✓				A
Lord Victor Adebowale Non-Executive Director		Chair		✓			✓	
John Burn Non-Executive Director								
Margaret Casely-Hayford Non-Executive Director			✓	✓				
Ciarán Devane Non-Executive Director		✓		✓			✓	✓
Dame Moira Gibb Non-Executive Director	✓		Chair		Chair			
Noel Gordon Non-Executive Director	✓				✓			
David Roberts Non-Executive Director	✓							
Ed Smith Non-Executive Director	Chair		✓		✓	✓		✓
Paul Baumann Chief Financial Officer	A	✓	✓	✓	✓	Chair		
Jane Cummings Chief Nursing Officer		✓		✓			✓	
Ian Dodge ND: Commissioning Strategy			✓		✓			
Sir Bruce Keogh National Medical Director		✓		✓			✓	
Dame Barbara Hakin ND: Commissioning Operations		✓	✓	✓	✓			
Tim Kelsey ND: Patients & Information			✓	✓				
Bill McCarthy ND: Policy				✓	✓	✓		
Rosamond Roughton ND: Commissioning Development		✓	✓	✓				
Karen Wheeler ND: Transformation & Corporate Operations	A		✓	✓		✓		A

* Committee chaired by an external member - Professor Sir Cyril Chantler.

A in attendance

Board Committee membership and attendance (November 2014 – March 2015)

	Audit & Risk Assurance Committee	Investment Committee	Commissioning Committee	Specialised Commissioning Committee	Strategic HR & Remuneration Committee
Sir Malcolm Grant Chairman					Chair
Simon Stevens Chief Executive			✓	✓	A
Lord Victor Adebowale Non-Executive Director			✓		
John Burn Non-Executive Director				✓	
Margaret Casely-Hayford Non-Executive Director				✓	
Ciarán Devane Non-Executive Director					✓
Dame Moira Gibb Non-Executive Director		Chair			
Noel Gordon Non-Executive Director	✓	✓	✓	Chair	
David Roberts Non-Executive Director	✓		Chair		✓
Ed Smith Non-Executive Director	Chair	✓			✓
Paul Baumann Chief Financial Officer	A	✓	✓	✓	
Jane Cummings Chief Nursing Officer			✓		
Ian Dodge ND: Commissioning Strategy		✓	✓	✓	
Sir Bruce Keogh National Medical Director			✓	✓	
Dame Barbara Hakin ND: Commissioning Operations			✓	✓	
Tim Kelsey ND: Patients & Information				✓	
Karen Wheeler ND: Transformation & Corporate Operations	A				A

A in attendance

Attendance at Board meetings

		15-May 14	03-Jul 14	18-Sep 14 AGM	19-Sep 14	06-Nov 14	17-Dec 14	29-Jan 15	26-Mar 15
Professor Sir Malcolm Grant	Chairman	√	√	√	√	√	√	√	√
Ed Smith	Non Executive Director and Deputy Chairman	√	√	√	√	√	√	√	√
Ciarán Devane	Non Executive Director	√	√	√	√	√	√	Apols	√
Lord Victor Adebowale	Non Executive Director	√	√	√	√	Apols	√	√	√
Margaret Casely-Hayford	Non Executive Director	√	√	√	√	√	√	√	√
Dame Moira Gibb	Non Executive Director	√	√	√	√	√	√	√	√
Professor Sir John Burn	Non Executive Director		Apols	√	√	√	√	√	√
Noel Gordon	Non Executive Director		√	√	√	√	√	√	√
David Roberts	Non Executive Director		Apols	√	√	√	Apols	√	√
Simon Stevens	Chief Executive	√	√	√	√	√	√	√	√
Sir Bruce Keogh	National Medical Director	Apols	√	√	√	√	√	√	√
Jane Cummings	Chief Nursing Officer	√	√	√	√	√	√	√	√
Paul Baumann	Chief Financial Officer	√	√	√	√	√	√	√	√
Ian Dodge	National Director: Commissioning Strategy	√	√	√	√	√	√	√	√
Dame Barbara Hakin	National Director: Commissioning Operations	√	√	√	√	√	√	√	√
Karen Wheeler	National Director: Transformation and Corporate Operations	√	√	√	√	√	√	√	√
Tim Kelsey	National Director for Patients and Information	√	√	√	√	√	√	√	√
Bill McCarthy	National Director: Policy	√							
Rosamond Roughton	Interim National Director: Commissioning Development	√	√						
Key: **Bold type - Voting Director**	No of members present √	9/10	11/13	13/13	13/13	12/13	12/13	12/13	13/13
Regular type - Non-voting Director	Quorate	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes

APPENDIX 7

Highlights of relevant Board committee reports 2014-15

Investment Committee (formerly Finance and Investment Committee)

The purpose of this Committee is to:

i. scrutinise financial planning and performance for NHS England and the wider commissioning sector, reviewing areas of concern and reporting to the Board as appropriate
ii. approve and agree changes to the financial policy framework for the commissioning sector
iii. approve expenditure on activities relating to NHS England functions within the limits set in the Standing Financial Instructions.

During 2014-15, the Committee monitored the in-year financial performance of the commissioning sector each month, including financial performance of CCGs, direct commissioning and central NHS England running and programme costs. The risk-adjusted financial position was also scrutinised by the Committee.

The Committee received updates and made recommendations to the Board as appropriate on topics including the progress of the National Tariff for 2015-16, development of 2015-16 allocations for the commissioning sector, the financial modelling underpinning the Five Year Forward View and the development and approval of financial plans for the commissioning sector. More recently the committee has provided oversight of the use of funding available to progress the Five Year Forward View priorities, including the Primary Care Infrastructure Fund and the Vanguard Transformation Fund, relating to new models of care.

There were a number of approvals relating to revenue expenditure, capital expenditure, reconfigurations and other contracts as set out in the Committee's terms of reference.

Strategic HR and Remuneration Committee (formerly Remuneration Committee)

The Committee is responsible for setting the remuneration and terms and conditions of employment for the Chief Executive and national directors of NHS England and other very senior managers (VSMs), as well as maintaining an overview of strategic human resource (HR) and organisational development (OD) issues for the organisation and the approval of employment policies.

Audit and Risk Assurance Committee

A description of the Audit and Risk Assurance Committee is contained in the Governance Statement.

APPENDIX 8

Register of Board members' and directors' interests

Professor Sir Malcolm Grant	Chairman
Non-executive, Former President and Provost	University College London
Director	Genomics England Ltd
Chancellor-elect	University of York
President	The Council for Assisting Refugee Academics
Trustee	Somerset House
UK Business Ambassador	
Honorary Member	Royal Institution of Chartered Surveyors
Honorary Member	Royal Town Planning Institute
Consultant Editor	Encyclopaedia of Planning Law and Practice
Board Member	University Grants Committee of Hong Kong
Board Member	International Council on Global Competitiveness of Russian Universities (of the Russian Federation)
Member	International Advisory Board, Moscow Institute of Physics and Technology
Montgomery Fellow	Dartmouth College, USA
Presidential Advisor	Arizona State University, USA
Life Fellow	Clare College Cambridge
Bencher	Middle Temple
Fellow	Academy for the Social Sciences
Member	HSBC Philanthropic and Community Investment Oversight Committee
Member	FCO Diplomatic Excellence Panel

Simon Stevens	Chief Executive
Director	Commonwealth Fund

Ed Smith	Non-Executive Director
Pro Chancellor & Chair of Council	University of Birmingham
Member	Competition & Markets Authority
Non-Executive Chairman	Crown Commercial Services
Lead Non-Executive Director	Department of Transport
Treasurer	Chatham House
Advisory Board Member	Social Value Portal
Chairman	Caterham School

Lord Victor Adebowale	Non-Executive Director & Deputy Chairman
Chief Executive Officer & Company Secretary	Turning Point
Non-Executive Director	Tomahawk Ltd
Director	Leadership in Mind Ltd
Chair	Urban Development
Chair	Collaborative Institute at London South Bank University
Board Member	National Standards Agency for Equalities
Patron	2020 Health
Chancellor & Visiting Professor	University of Lincoln

Professor Sir John Burn MD	Non-Executive Director
Professor of Clinical Genetics	Newcastle University
Honorary Consultant Clinical Geneticist	Newcastle Hospitals NHS Foundation Trust
Chairman & Shareholder	QuantuMDx Group Ltd
Member	Science Advisory Committee, Genomics England
Member	Genomics Advisory Board, Health Education England
Board Member	Human Variome Project International
Member	Advisory Board to Astra Zeneca on the use of Lynparza (olaparib) in hereditary breast/ovarian cancer

Margaret Casely-Hayford	Non-Executive Director
Chair	Action Aid UK
Member	Metropolitan Police Corruption Investigation Oversight Panel

Ciarán Devane	Non-Executive Director
Chief Executive	British Council
Non-Executive Director	Social Finance Ltd
Trustee	National Council for Voluntary Organisations

Dame Moira Gibb	Non-Executive Director
Civil Service Commissioner	
Director	Achieving for Health
Non-Executive Director	UK Statistics Authority
Chair	CityLit
Chair	Skills for Health
Council Member	University of Reading
Associate	Signs of Safety Innovation Project

Noel Gordon	Non-Executive Director
Director	Allen International
Chairman of Board of Trustees	Uservoice.org
Member	Advisory Committee on Innovative Medicines
Member	Development Board, Age UK

David Roberts	Non-Executive Director
Chairman Elect & Non-Executive Director (from 01.09.14)	Nationwide Building Society
Non-Executive Director	Campion Wilcocks Ltd
Governor	Dr Challoner's Grammar School, Amersham
Member	Strategy Board, Henley Business School, University of Reading

Paul Baumann	Chief Financial Officer
None	

Jane Cummings	Chief Nursing Officer
Trustee	Over the Wall
Director & Trustee	Macmillan Cancer Support

Ian Dodge	National Director: Commissioning Strategy
Adjunct Professorship	Institute of Global Health Innovation, Imperial College London

Sir Bruce Keogh	National Medical Director
Fellow	Royal College of Surgeons in England
Fellow	Royal College of Surgeons of Edinburgh – King James IV Professor
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 & Past Secretary General	European Association for Cardiothoracic Surgery
Member & Past President	Society for Cardiothoracic Surgery in Great Britain and Ireland
Honorary Member	British Society of Interventional Radiology
Honorary Member	Faculty of Medical Management and Leadership
Council Member	British Heart Foundation
Vice-Patron	The Poppy Factory
Company Member	Cancer Research UK
Trustee	The Healing Foundation
Chair	Ex-Fide Fiducia Trust

Dame Barbara Hakin	National Director: Commissioning Operations
None	
Family member is an employee of Ernst & Young	Family member is an employee of Ernst & Young
Family member works at NHS Trust Development Authority	Family member works at NHS Trust Development Authority

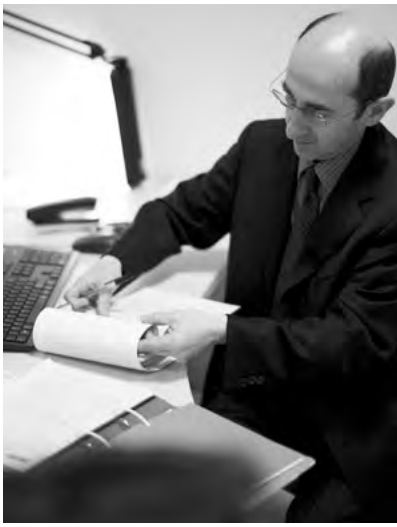
Tim Kelsey	National Director for Patients and Information
None	
Wife is a Director of ZPB, a health strategy company	Wife is a Director of ZPB, a health strategy company

Karen Wheeler	National Director: Transformation & Corporate Operations
None	

APPENDIX 9

NHS England Compliance Assessment against the UK Corporate Governance Code (September 2012) and Corporate Governance in Central Government Departments: Code of Good Practice 2011 during 2014-15

Compliance against both the UK Corporate Governance Code (September 2012) and Corporate Governance in Central Government Departments: Code of Good Practice 2011 is considered to be good practice but is not mandatory for NHS England. A number of provisions are not applicable, and others have required interpretation for the context in which NHS England operates. As NHS England operates in a "comply or explain" regime, set out below is a summary of the provisions which are not applicable, those against which there is an exception and those where improvement is planned.



Compliance with the UK Corporate Governance Code

Provisions against which there are exceptions:		
Ref	**Code Provision**	**Exception**
B.3.1	For the appointment of a chairman, the nomination committee should prepare a job specification, including an assessment of the time commitment expected, recognising the need for availability in the event of crises. A chairman's other significant commitments should be disclosed to the board before appointment and included in the annual report. Changes to such commitments should be reported to the board as they arise, and their impact explained in the next annual report.	Under the National Health Service Act 2006 (as amended) the Secretary of State appoints the Chair.
B4.2	The Chairman should regularly review and agree with each Director their training and development needs.	The Chairman is only required to conduct regular appraisals of the Non-executive Directors. The Chief Executive performs this role for other executive directors.
B.5.2	All Directors should have access to the advice and services of the company secretary, who is responsible to the board for ensuring that board procedures are complied with. Both the appointment and removal of the company secretary should be a matter for the board as a whole.	There is a Board Secretary whose removal and appointment is not reserved to the Board, but is undertaken by executive management, in consultation with the Chairman.
D.2.1	The Board should establish a remuneration committee of at least three, or in the case of smaller companies' two, independent non-executive directors. In addition the company chairman may also be a member of, but not chair, the committee if he or she was considered independent on appointment as chairman.	The Chair of the Remuneration & Terms of Service Committee is also the Chair of the Board. The other elements of the provision are compliant.

Provisions which are not applicable:

B.2.1, B.2.2, B.2.3, B.2.4, B.7.1, B.7.2, C.3.7, D.1.1, D.1.2, D.1.3, D.2.3, D.2.4, E.1.1, E.1.2, E.2.1, E.2.2, E.2.3, E.2.4.

Provisions against which further work is planned for 2015-16:

B.5.1 Access to independent professional advice for directors and non-executive directors

B.6.1 Performance evaluation of Board committees

Compliance with the Corporate Governance in Central Government Departments: Code of Good Practice 2011

Provisions against which there are exceptions:		
Ref	**Code Provision**	**Exception**
2.12	The Board collectively affirms and documents its understanding of the Department's purpose and documents its role and responsibilities in a Board Operating Framework.	It is proposed that the Board devises a Board Operating Framework to guide its operation (see Code 3.13).
	The Chairman should regularly review and agree with each Director their training and development needs.	The Chairman is only required to conduct regular appraisals of the Non-executive Directors. The Chief Executive performs this role for other executive directors.
	All Directors should have access to the advice and services of the company secretary, who is responsible to the board for ensuring that board procedures are complied with. Both the appointment and removal of the company secretary should be a matter for the board as a whole.	There is a Board Secretary whose removal and appointment is not reserved to the Board, but is undertaken by executive management, in consultation with the Chairman.
3.5e	Non-Executive Board Members form a Nominations & Governance Committee.	NHS England does not have a Nominations Committee as appointments of the executive and Non-executive members are managed as required by the National Health Service Act 2006 (as amended). Governance issues are delegated to the Audit & Risk Assurance Committee.
3.13	The Board agrees and documents in its Board Operating Framework a de minimus threshold and mechanism for board advice on the operation and delivery of policy proposals.	It is proposed that the Board devises a Board Operating Framework to guide its operation.
4.7	The terms of reference for the Nominations and Governance Committee include at least the four central elements.	There is no Nominations & Governance Committee (see Code 3.5e). The specific Code provisions a – d are handled by the Strategic Human Resources & Remuneration Committee, the terms of reference for which will be strengthened to reflect these specific duties.
4.10	Through the Board Secretariat, the Department provides the necessary resources for developing and updating the knowledge and capabilities of Board members, including access to its operations and staff.	This responsibility is shared between the Chairman and Chief Executive's Office and Board Secretariat.
4.14f	The Board Secretary's responsibilities include: f) arranging induction and professional development of Board Members.	This responsibility is shared between the Chairman and Chief Executive's Office and Board Secretariat.
5.12	The Board and Accounting Officer are supported by an Audit & Risk Assurance Committee comprising at least three members.	For first quarter of 2014-15, the Audit & Risk Assurance Committee operated with only two Non-executive Directors. A third Non-executive Director was appointed in July 2014.

Provisions which are not applicable:

Section 1, 2.4, 2.5, 2.8d (Results Focus), 3.4a, 3.4b, 3.5h, 3.6, 3.7, 3.12, 3.17, 4.9, 4.12, 4.15, 4.16, 4.17

Provisions against which further work is planned for 2015-16:	
2.8	Review Board Operating Framework

APPENDIX 10

Key risks for the organisation

Financial sustainability of NHS	The NHS is subject to significant cost pressures which are not within the direct control of NHS England. We need to work with DH and system leaders to drive significant efficiencies and manage or mitigate avoidable pressures.
Capacity of primary care	There is a need to expand the capacity and capability of primary care to meet demographic needs, to avoid further downstream pressures on A&E, secondary care, and targets. We need to work with Health Education England (HEE) to develop the workforce to meet future demands.
Winter resilience and emergency care	Changing demographics and increasing demand are impacting the NHS's ability to meet A&E targets and deliver appropriate access to high quality urgent care services. We need to ensure changes are made to the urgent and emergency care system, to improve its ability to manage requirements.
Commissioning support	CSUs provide critical support to CCGs. If CSUs become unviable, CCGs would lose necessary support, and unnecessary closedown costs will arise, reducing the resource available for service provision.
Litigation risks	There is an increase in the threat of challenge and litigation from various interested parties. We are working to ensure consistency of approach and decision making by enhancing our suite of policies and rolling out focussed national training.
Manchester devolution	We are working with partners in Greater Manchester to ensure risks are managed and system change is effectively coordinated as part of the devolution agreement.
Cyber and data security	Given the increasing reliance on electronic channels, and the need to share information across the wide and complex health and care system, we need to continue to develop effective defences against data loss and cyber attacks
NHS England capability and capacity	Given the increasing pressures on NHS England to provide leadership to achieve wholesale system change across the NHS, future sustainability and deliver the vision of the Five Year Forward View, NHS England needs to build its own capabilities and effectiveness.

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