ACCOUNTABILITY REPORT

Simon Stevens
Accounting Officer
8 July 2016

Directors' Report

The Board

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

Roles and responsibilities of the Board

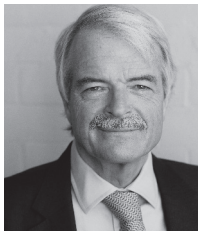
The Board is the senior decision-making structure in NHS England. It provides strategic leadership to the organisation and, in support of that, it:

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

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

NHS England's non-executive directors

NHS England's current non-executive directors are:



Chairman: Professor Sir Malcolm Grant CBE

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

Non-executive Director: Lord Victor Adebowale CBE

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

Non-executive Director from March 2016: Wendy Becker

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

Non-executive Director: Professor Sir John Burn

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

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

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

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

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

Non-executive Director from March 2016: Michelle Mitchell OBE

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

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

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

The following non-executive directors left during the year:

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

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

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

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

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

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

NHS England's Executive Group

Chief Executive: Simon Stevens

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

Chief Financial Officer: Paul Baumann

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

Chief Nursing Officer: Professor Jane Cummings

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

National Medical Director: Professor Sir Bruce Keogh

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

Interim National Director: Commissioning Operations: Richard Barker

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

National Director: Commissioning Strategy: Ian Dodge

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

National Director: Transformation & Corporate Operations: Karen Wheeler CBE

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

The following national directors left during the year:

National Director for Patients and Information: Tim Kelsey

(until 31 December 2015)

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

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

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

Register of Members' Interests

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

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

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

Disclosure of personal data-related incidents

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

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

Board Statement

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

Statement of Disclosure to Auditors

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

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

Our organisation and people

Staff report

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

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

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

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

Staff costs (subjected to audit)

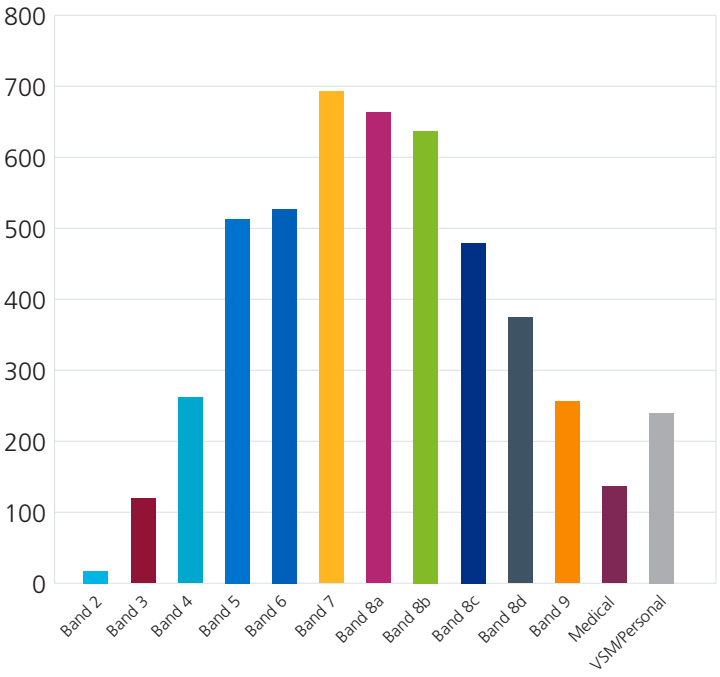
An analysis of staff costs is detailed in the Annual Accounts under Note 3: Employee Benefits and Staff Numbers.

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

Our people

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

All staff by payband



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

Senior manager by gender

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

All staff by gender

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

Senior manager by ethnicity

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

All staff by ethnicity

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

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

Senior manager by disability

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

All staff by disability

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

Senior manager by sexual orientation

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

All staff by sexual orientation

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

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

Organisational alignment and capability programme

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

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

The programme and consultation will close in 2016.

Improving NHS England during 2015/16

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

Developing our staff

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

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

Supporting diversity and inclusion

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

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

Staff policies

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

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

Our wellbeing (sickness absence)

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

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

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

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

Looking forward to 2016/17

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

Exit packages, severance payments and off-payroll engagement

Expenditure on consultancy and contingent labour (subjected to audit)

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

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

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

Off-payroll engagements

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

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

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

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

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

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

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

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

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

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

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

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

Exit packages including severance payments (subjected to audit)

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

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

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

Remuneration Report

Strategic HR and Remuneration Committee

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

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

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

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

Pay multiples (subjected to audit)

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

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

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

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

Policy on remuneration of senior managers

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

It is the policy of NHS England to pay salaries that are appropriate to recruit senior managers with the necessary skills, capability and experience necessary for the effective running of such a large organisation, whilst recognising the importance of demonstrating pay restraint at a time of considerable pressure on NHS finances. Recommending appropriate remuneration for executive directors is undertaken by the Strategic HR and Remuneration Committee of the Board, with final decisions being made by the DH arm's length bodies' Remuneration Committee.

Performance related pay

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

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

Policy on senior managers contracts

Contracts of employment for senior managers are open-ended contracts, unless otherwise specified. Notice periods generally follow the provisions of the VSM contract of employment, as applied by NHS England, of six months contractual notice. Termination payments are only able to be authorised where these are contractual and, subject to the value involved, may still require further approval from the DH Governance and Assurance Committee. Any proposed non-contractual special severance payment requires formal approval from DH and HM Treasury.

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

Senior managers service contracts (not subject to audit)

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

Secondments

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

Salaries and allowances 2015/16 (subjected to audit)

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

1. Richard Barker took up post from 1 January 2016, replacing Dame Barbara Hakin who retired on 31 December 2015. The figures shown reflect this part year adoption as a National Director position.
2. An overpayment was made to Professor Sir Bruce Keogh, which is subject to recovery in 2016. The amount of the overpayment is not included in the total remuneration figures disclosed.
3. On joining NHS England on 1 April 2014, Simon Stevens voluntarily reduced his pay by 10% from the substantive rate of pay for the post of Chief Executive Officer, which would normally pay within the range £210-215k. Simon Stevens has continued with this voluntary reduction in pay throughout 2015/16.
4. Karen Wheeler is seconded from DH and her salary recharged to NHS England. As such, she is subject to terms and conditions of her employing organisation. The non-consolidated bonus relates to 2014/15 but was paid in 2015/16. The bonus for 2015/16 is subject to moderation and any award will be paid 2016/17.

Salaries and allowances 2014/15

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

1.Professor Sir Bruce Keogh was seconded to NHS England from UCLH NHS Foundation Trust and his salary was paid by the organisation and recharged to NHS England. He transferred onto the NHS England payroll from 1 April 2015.
2. On joining NHS England on 1 April 2014, Simon Stevens voluntarily reduced his pay by 10% from the substantive rate of pay for the post of Chief Executive Officer, which would normally pay within the range £210–215k.
3. Karen Wheeler is seconded from DH and her salary recharged to NHS England. The non-consolidated bonus relates to 2013/14 but was paid in 2014/15. The bonus for 2014/15 is subject to moderation and any award will be paid in 2015/16.

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

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

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

Cash equivalent transfer values (subjected to audit)

A cash equivalent transfer value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member's accrued benefits and any contingent spouse's (or other allowable beneficiary's) pension payable from the scheme.

A CETV is a payment made by a pension scheme or arrangement to secure pension benefits in another pension scheme or arrangement when the member leaves a scheme and chooses to transfer the benefits accrued in their former scheme. The pension figures shown relate to the benefits that the individual has accrued as a consequence of their total membership of the pension scheme, not just their service in a senior capacity to which disclosure applies.

The CETV figures and the other pension details include the value of any pension benefits in another scheme or arrangement which the individual has transferred to the NHS Pension Scheme. They also include any additional pension benefit accrued to the member as a result of their purchasing additional years of pension service in the scheme at their own cost. CETVs are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries.

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

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

Real increase in CETV

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

Policy on remuneration of non-executive directors

The remuneration of non-executive directors is set by DH upon appointment. All non-executive directors are paid the same amount, except the Chair and Vice Chair, to reflect the equal time commitment expected from each non-executive. The Chair and Vice Chair are entitled to higher amounts to reflect the increased time commitment associated with their respective roles. In the case of the Vice Chair, this includes his role as the Chair of the Audit and Risk Assurance Committee. Some of the non-executive directors, including the Vice Chair, have opted to waive their contractual remuneration. Non-executive directors do not receive performance related pay or pensionable remuneration.

Salaries and allowances 2015/16 (subjected to audit)

	2015/16					
	(a) Salary (bands of £5,000)	(b) Benefits in Kind (taxable) rounded to nearest £100	(c) Performance pay and bonuses (bands of £5,000)	(d) Long term performance pay and bonuses (bands of £5,000)	(e) All pension-related benefits[1] (bands of £2,500)	(f) TOTAL (a to e) (bands of £5,000)
Name of non-executive director	£000	£s	£000	£000	£000	£000
Lord Victor Adebowale	5-10	0	0	0	n/a	5-10
Professor Sir John Burn	5-10	0	0	0	n/a	5-10
Margaret Casely-Hayford To 31 March 2016	5-10	0	0	0	n/a	5-10
Sir Ciarán Devane Until 31 December 2015	5-10	0	0	0	n/a	5-10
Dame Moira Gibb	5-10	0	0	0	n/a	5-10
Noel Gordon	5-10	0	0	0	n/a	5-10
Professor Sir Malcolm Grant Chair	60-65	0	0	0	n/a	60-65
David Roberts Vice Chair from October 2015[2]	0	0	0	0	n/a	0
Ed Smith Vice Chair until 30 September 2015	10-15	0	0	0	n/a	10-15
Wendy Becker From 1 March 2016	0-5	0	0	0	0	0-5
Michelle Mitchell From 1 March 2016	0-5	0	0	0	0	0-5

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

Salaries and allowances 2014/15

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

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

Statement of Accounting Officer's responsibilities

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

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

Under the National Health Service Act 2006 (as amended), the Secretary of State for Health (with consent of HM Treasury) has directed the National Health Service Commissioning Board to prepare, for each financial year, a statement of accounts in the form and on the basis set out in the Accounts Direction. The accounts are prepared on an accruals basis and must give a true and fair view of the state of affairs of the National Health Service Commissioning Board and of its net resource outturn, application of resources, changes in taxpayers' equity and cash flows for the financial year.

In preparing the accounts, the Accounting Officer is required to comply with the requirements of the Government Financial Reporting Manual and in particular to:

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

Governance Statement

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

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

As Accounting Officer, I have responsibility for the system of internal controls supporting and enabling the achievement of NHS England's aims and objectives, whilst safeguarding the public funds and assets for which I am personally responsible in accordance with Managing Public Money and as set out in my Accounting Officer appointment letter. This includes assurance of a number of organisations which are part of the wider commissioning system, including CCGs and the NHS Leadership Academy, and those organisations which NHS England hosts.

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

The Government's mandate to NHS England

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

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

Our purpose and role

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

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

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

Governance arrangements and effectiveness

Governance framework

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

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

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

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

Compliance with the UK Corporate Governance Code

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

The Board

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

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

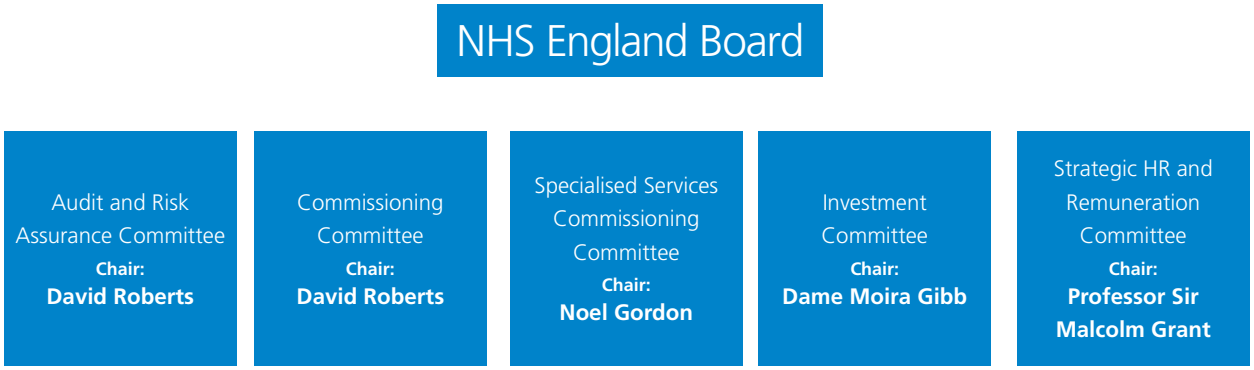
NHS England remains committed to transparency and regularly holds public Board meetings. Board papers, and the minutes of those meetings, are published on the

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

Board performance

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

Board committees



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

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

Audit and Risk Assurance Committee

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

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

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

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

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

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

Impact

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

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

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

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

Assurance statement

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

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

Risk management

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

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

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

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

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

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

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

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

Other sources of assurance

Internal control assurance framework

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

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

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

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

Assuring delivery of corporate priorities

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

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

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

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

Assuring quality and effective delivery of services

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

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

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

Meeting our duty to involve the public in commissioning

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

Whistleblowing

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

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

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

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

Harris Review

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

Data quality

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

Information governance, cyber and data security

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

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

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

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

Business critical models

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

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

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

Business critical models operated by NHS England

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

Service auditor reporting and third party assurances

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

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

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

Internal audit

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

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

The internal audit service, provided by Deloitte LLP, operates in accordance with the Public Sector Internal Audit Standards and to an annual internal audit plan approved by ARAC. Internal audit updates the plan to reflect changes in risk profile, and any revisions are reviewed and approved by ARAC. The internal audit service submits regular reports on the effectiveness of NHS England's systems of internal control and the management of key business risks, together with recommendations for improvement by management (including an agreed timetable for action). The status of audit recommendations is reported to each meeting of ARAC, which has placed strong emphasis on reducing overdue actions to acceptable levels during the past year.

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

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

External audit

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

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

Control issues

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

Strengthening establishment controls (on-payroll)

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

Improving control processes for off-payroll workers

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

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

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

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

Providing stronger controls around business travel and expenses

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

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

Improving procurement practices and compliance

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

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

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

Embedding strong programme and project management practice

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

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

NHS Shared Business Services incident

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

Assuring commissioning support units

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

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

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

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

Strengthening the management of conflicts of interest across the NHS

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

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

Supporting robust information governance, cyber and data security

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

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

Assurance of the commissioning system

NHS direct commissioning

Specialised Commissioning

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

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

Non-specialised commissioning

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

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

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

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

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

Clinical commissioning groups

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

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

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

Assurance

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

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

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

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

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

CCG Annual Reports

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

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

Co-commissioning

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

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

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

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

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

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

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

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

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

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

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

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

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

Commissioning support units (CSUs)

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

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

Assurance

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

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

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

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

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

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

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

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

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

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

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

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

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

Allocations, planning and in-year performance monitoring

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

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

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

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

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

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

NHS England central programme costs

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

Cabinet Office efficiency controls

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

Investment Committee

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

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

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

Counter fraud

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

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

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

Head of Internal Audit opinion

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

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

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

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

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

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

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

Overall summary

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

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

Parliamentary accountability and audit report

All elements of this report are subjected to audit.

Remote contingent liabilities

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

Notation of gifts over £300,000

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

Regularity of expenditure: Losses and special payments

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

Losses

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

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

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

Special payments†

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

Cost allocation and setting of charges for information

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

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

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

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

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

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

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

Long-term expenditure trends

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

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

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

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

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

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

Respective responsibilities of the Board, Accounting Officer and auditor

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

Scope of the audit of the financial statements

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

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

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

Opinion on regularity

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

Opinion on financial statements

In my opinion:

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

Opinion on other matters

In my opinion:

- the parts of the Remuneration and Staff Report and the Parliamentary Accountability and Audit Report to be audited have been properly prepared in accordance with Secretary of State directions made under the Health and Social Care Act 2012; and
- the information given in the Performance Report for the financial year for which the financial statements are prepared is consistent with the financial statements.

Matters on which I report by exception

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

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

12 July 2016

Sir Amyas C E Morse
Comptroller and Auditor General
National Audit Office
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Victoria
London
SW1W 9SP

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

Introduction

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

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

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

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

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

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

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

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

Structure of this report

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

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

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

Pressures facing NHS England

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

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

How NHS England has addressed these pressures in-year

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

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

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

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

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

Financial Audit in 2015/16

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

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

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

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

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

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

NHS England plans to address financial sustainability

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

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

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

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

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

Conclusion and future audit work

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

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

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

12 July 2016

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