APPENDICES

APPENDIX 1: How we have delivered against the mandate

In its mandate to NHS England for 2015/16, the Government set us 25 objectives with an aim of providing the NHS with stability and continuity; it welcomed the Five Year Forward View and also asked for progress in mental health and in the integration of care across services. The preceding sections of this annual report set out NHS England's achievements against our corporate priorities; our work in all these areas contributes to progress against the 25 objectives in the Government's mandate. We have almost met the majority of these objectives in 2015/16. This annex highlights some of the progress we have made and some of the challenges.

The first of the objectives set by Government for NHS England was to demonstrate progress in the health outcome measures in its NHS Outcomes Framework. The latest data shows that the majority of measures are on a positive trajectory or stable. We have programmes in place to improve those areas where further progress needs to be made and we have developed the CCG Improvement and Assessment Framework to enable us to measure CCG performance on priority areas from 2016/17.

We have continued to make good progress in our work against the objective to become one of the most successful countries in Europe at preventing premature deaths. Initial modelling suggests we should exceed the ambition of avoiding an additional 30,000 additional premature deaths by 2020. We have taken important steps to improve cancer outcomes: including setting up a new cross-system National Cancer Transformation Board; helping the NHS to meet NHS Constitution standards on cancer and testing the new 28 day faster diagnosis standard. We have set up 23 Urgent and Emergency Care networks and are planning the staged delivery of the Urgent and Emergency Care review, including programmes to develop Seven Day Services in hospital care. We have also made progress on providing access to the electronic Summary Care Record: by March 2016 85 percent of NHS 111 service areas were using it and 63 percent of A&E departments had access to GP records.

An integrally linked mandate objective is to prevent ill health and improve access to treatment. As our Chief Executive states in his overview at the front of this report, sustained success for the NHS requires a radical upgrade in prevention and public health. There is a strong prevention element to CCG ambitions on reducing premature mortality,

the cancer strategy, the diabetes prevention programme and the tuberculosis strategy. Our NHS Diabetes Prevention Programme procurement is on track to deliver services to between 10,000 and 20,000 individuals in 2016/17, growing to 100,000 people a year over time. Work to support Public Health England's blood pressure strategy has continued to improve diagnosis and management of hypertension.

Another of NHS England's objectives is to make progress in improving patient experience: both in the measurement and understanding of patient experience and in taking action to improve it. We have made good progress in all areas. Improving experience of care is an integral feature of both the national plan for services for people with learning disability as published in October 2015, and the national maternity review as published in February 2016. Transforming care partnerships have worked with people with learning disabilities, their families and carers and stakeholders to agree implementation plans and service models based on person centred care and support. Improving maternity experience is a core part of the implementation programme for the maternity review, working in collaboration with the royal colleges and charitable groups. We have also made progress in improving children and young people's experience of care, building on the new inpatient survey. Training resources and commissioning guidance relating to complaints are in place. Use of the Friends and Family Test continues with 20 million pieces of feedback collected and acted upon as at end of March 2016.

The NHS Five Year Forward View stated that managing long term conditions is a central task for the NHS; it requires a partnership with patients so that the health and care system acts as one to provide integrated, connected care. This is a significant challenge: services need major redesign to deliver the best of person-centred care. We have a mandate objective to make measurable progress in making the NHS among the best in Europe at supporting people with ongoing health problems. Results from the NHS Outcomes Framework suggest that health related quality of life of people with long term conditions has remained stable, with over half of all patients (54 percent) reporting one or more long standing health condition, and 64 percent of those people reporting they received enough support from local services or organisations in the last six months to help them manage their condition. Our work here is interdependent with our mandate objectives on patient involvement, integration of health and care services and the quality of care especially for older people.

Increasing patient and carer involvement and choice and control is complex and requires changes in culture and systems and processes. Our work here is gaining momentum

as a result of the Support for Self-Management Programme. The roll out of PHB and other initiatives which feature care and support planning such as the Integrated Personal Commissioning programme, are also driving this agenda forward.

NHS England has made progress in achieving a significant increase in the use of technology to help people manage their health and care, another of our mandate objectives. We have supported CCGs to work with their local providers and local authorities, to develop plans – local digital roadmaps – as to how their local health and care economies will achieve the ambition of being paper free at the point of care by 2020. We have also seen further progress on patients' access to their health and care records, with over 95 percent of GPs able to offer patients access to their detailed health record. The use of digital services is increasing, and we are working to increase digital inclusion.

The second of NHS England's mission critical tasks is to lead and support a fundamental redesign of the way the NHS provides care, to make it more personal, co-ordinated and convenient. A central mandate objective is to see improvements in the way that care: is coordinated around the needs, convenience and choices of patients, their carers and families – rather than the interests of organisations that provide care. In support of this, progress on the New Care Models programme has been good and plans for 2016/17 are in place. We have also seen good progress and learning in the integrated care pioneers. Work has continued across a number of programmes to develop integrated care and is progressing as expected. Reporting suggests local delivery of Better Care Fund plans is progressing, pooled budgets have been established, and joint working relationships are generally strong. Delivery of the policy priorities set out within the 'national conditions' of the fund has been substantial, with significant progress made in key areas such as implementing seven day services that support discharge, and improving the sharing of data across health and social care.

Over the last year, NHS England has also made progress on improving children and young people's (CYP) health outcomes. This involves embedding CYP in NHS England's corporate priorities (including cancer, learning disabilities, mental health and diabetes), and there are also specific programmes and teams in place to take forward work in dedicated areas such as Special Educational Needs and Disability. Funding has been secured to develop a national child death database to improve the ability to identity and learn from preventable CYP deaths. In this period we have also strengthened national clinical leadership for CYP whilst embedding CYP in clinical network priority areas where appropriate.

The National Maternity Review has been completed and implementation planning is well underway. Implementation of the Review's recommendations will take a multi-organisational approach, with NHS England working with a number of key partners. The Review and the Saving Babies' Lives work align with and support the Secretary of State's national ambitions to halve the rates of stillbirths, neonatal and maternal deaths and intrapartum brain injuries in babies by 2030.

Progress is being maintained on action to reduce heath inequalities. This year has seen improved funding allocation formulae with closer alignment to population need and deprivation. There has also been continuity in the inclusion of the 'potential years of life lost' incentive within the quality premium for CCGs. This year has seen action taken to ensure that CCGs are following the requirements of the NHS Act 2006 in relation to having due regard to reduce health inequalities. Delivering the Forward View: NHS Planning Guidance for 2016/17-2020/21 also highlights reducing health inequalities as an area which needs to be addressed and asks CCGs to consider how they will assess and address their most important and highest cost preventable causes of ill health, to reduce healthcare demand and tackle health inequalities working closely with local authorities. The need to develop a high quality and agreed five year Sustainability and Transformation Plan (STP) is a key "must do" in pursuit of the triple aim – better health, transformed quality of care delivery, and sustainable finances. We intend the combined implementation of these initiatives will continue to drive progress.

An important and challenging objective is to put mental health on a par with physical health and narrow the health gap between people with mental health problems and the population as a whole. NHS England, on behalf of the NHS arm's length bodies, commissioned an independent taskforce to develop a Five Year Forward View for Mental Health, and we have made good progress in developing a major new programme to support implementation of the taskforce report. There are interdependencies with external factors such as data from NHS Digital and workforce support from Health Education England. These have been rate-limiting factors in some areas. However, we have delivered in important areas. CYP mental health funds for 2015/16 have been issued to CCGs following assurance of local transformation plans. The new waiting time standard for Improving Access to Psychological Therapies is being met, although local variation continues. Performance is steadily improving, with the access rate above the mandate commitment of 15 percent between October and December 2015. For liaison psychiatry, we have worked with DH and Mind to ensure that every community now has a refreshed Crisis Care Concordat local action plan in place.

There has been increased demand and corresponding pressures across both the planned and urgent care systems. While expected patient volumes were in line with those commissioned by CCGs from hospitals at the start of the year, hospital performance against the Constitution standards has shown an overall declining trend over the year, although there has been a significant improvement in some areas. We undertook considerable work alongside NHS Improvement to ensure that available capacity is identified and utilised, and work programmes such as the Emergency Care Improvement Programme supported Constitutional Standards. We worked to develop new work programmes including an A&E Improvement Plan for 2016/17, and a consolidated work programme with NHS Improvement for elective care services. There has been substantial focus on ensuring that commissioners agree operational plans for 2016/17 with the activity levels necessary in order that providers could meet the standards.

NHS England has demonstrated strong financial control of the budgets it oversees. We delivered the 2015/16 financial position across the commissioning system. We are also contributing significant planned underspends towards the overall DH group financial position. We collaborated with NHS Improvement during the 2016/17 planning round but there remains a significant risk to ensuring financial delivery within available resources in 2016/17. Progress has been made in mobilising national workstreams in response to the Five Year Forward View efficiency challenge, but the key challenge will be in ensuring that these are effectively embedded and delivered, including through the STPs to be developed by '44' local footprints.

APPENDIX 2: How we have acted to reduce health inequalities in 2015/16

Health inequalities cost lives, decrease the quality of life for many people and have financial consequences for the NHS. NHS England has made reasonable progress to reduce health inequalities this year, but more needs to be done and this will remain a high priority through implementing the Five Year Forward View. This appendix presents a summary of how we have met our legal duties with regard to health inequalities during 2015/16 against criteria set by the Secretary of State.

Criterion 1: An evidence-based strategic approach to reducing health inequalities based on sound governance, accountability and good partnership working

Response: Our strategy to reduce health inequalities is to embed a health inequalities "lens" in each of our main national health improvement goals, while ensuring that NHS funding is allocated so as to help support equal access for equal need across geographies, patient groups and health conditions. We build insight into how people access and experience NHS services and support a coordinated, evidence-based approach to helping reduce health inequalities. This is underpinned by the governance and accountability arrangements NHS England has in place for its major programmes of work, and our planning and assurance frameworks as detailed under Criterion 6.

The Equality and Health Inequalities Programme Board gives system-wide leadership to health inequalities within the organisation and is accountable to the NHS England Board through the Executive Group. For 2015/16, the programme board endorsed six key principles to reducing health inequalities and our Key Lines of Enquiry (KLOE) designed to strengthen how we support policy makers and managers across the organisation to consider and measure the impact of equality and health inequalities.

Criterion 2: Systematic focused action to reduce inequalities in access, outcomes and experience based on a defined and evolving set of metrics

Response: Following publication of the NHS Outcomes Framework, Indicators for Health Inequalities Assessment by DH in March 2015, inequality metrics against 11 indicators are now being developed by the Health and Social Care Information Centre (HSCIC) to inform and guide reporting in 2016/17.

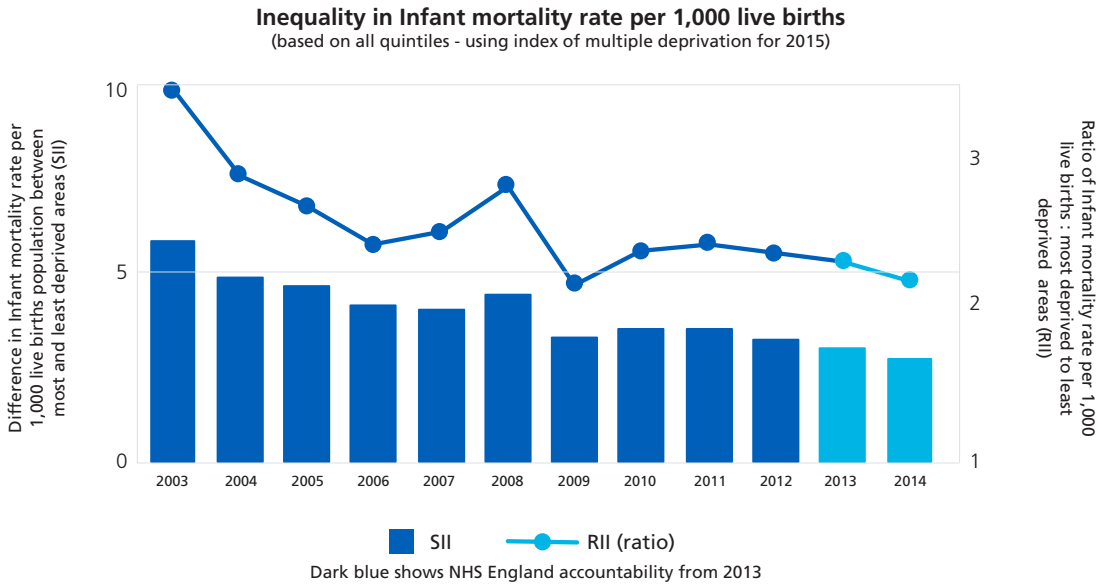
NHS England is also leading wider work on data monitoring information standards in partnership with DH and other key stakeholder organisations, overseen by a subgroup of the Equality Delivery Council (EDC). In March 2015, we published Monitoring Equalities and Health Inequalities to help NHS organisations improve local equity monitoring. This can be viewed at www.england.nhs.uk/about/gov/equality-hub/intelligence/.

Work continues to expand and improve the collection of data available to measure progress on equality and health inequalities. The information standard on sexual orientation is due to be piloted and the development, subject to sponsorship, of a unified information standard for all protected groups.

During 2015/16, there has been progress to report on key areas of inequalities, including continued reductions in cardiovascular disease and infant mortality. In some areas the existing inequality trend has remained constant and we have identified a number of areas where there have been challenges.

The following indicators show positive progress in reducing inequalities since 2013, or positive change from the previous trend[1]:

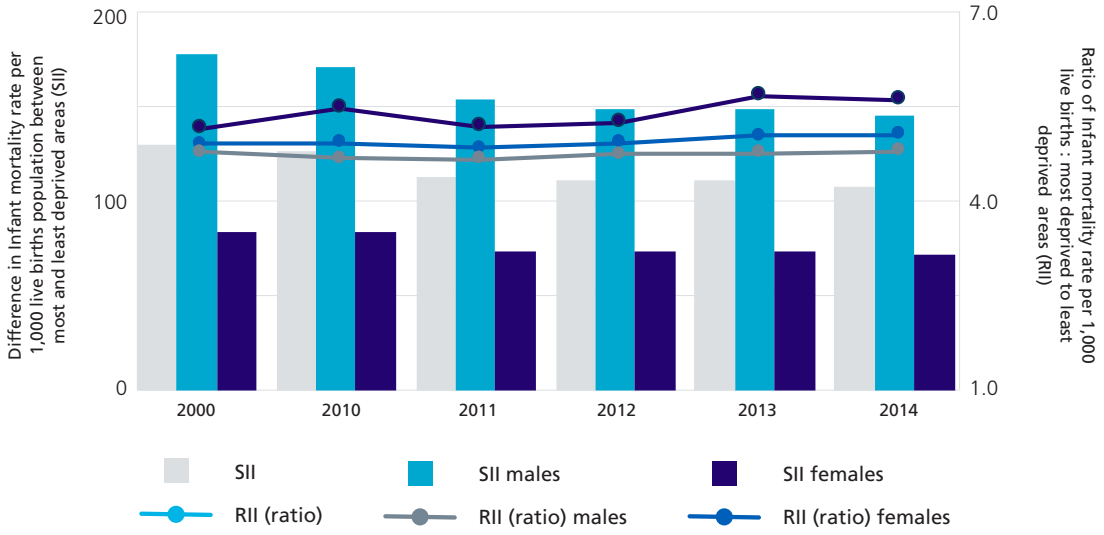
- Infant mortality by deprivation has narrowed, with the greatest gains seen amongst the most deprived cohort of the population.



1. Where the inequalities gap reduced by over 1 percent between 2013/14 and 2014/15 or a consistent decreasing trend.

- The under 75 mortality rate from cardiovascular disease by area deprivation has decreased[1].

Inequality in directly age standardised under 75 mortality from cardio vascular disease (under 75 CVD mortality) per 100k population (based on all deciles)



- The gap between those ethnic groups reporting the lowest scores for health-related quality of life for people with long-term conditions and white British people has narrowed.

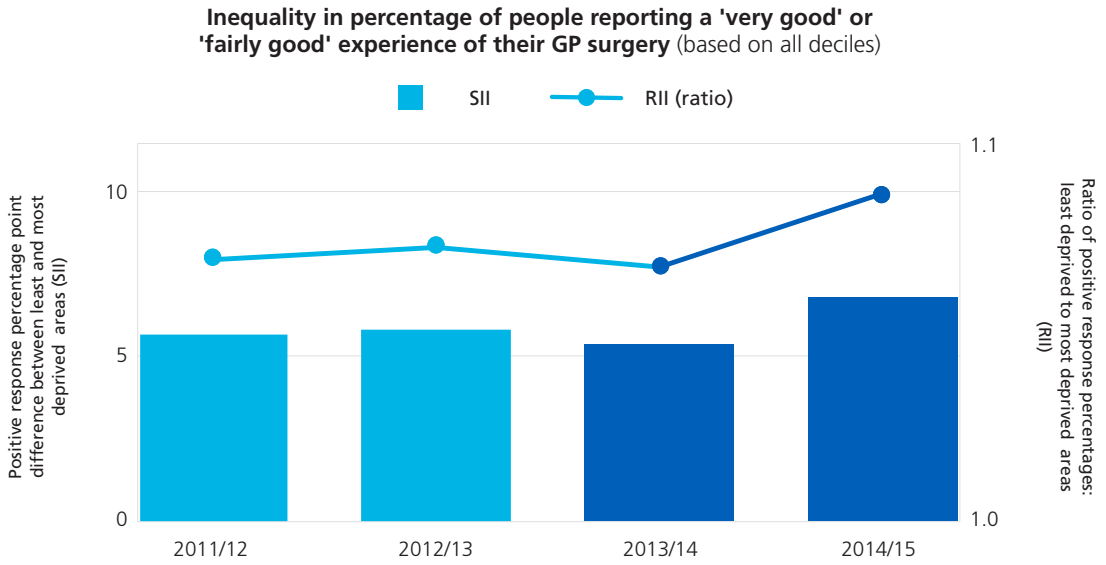
For the following indicators, the change in inequality gap by area deprivation since 2013 is consistent with previous flat trend[2]:

- Under 75 cancer mortality between 2013 and 2014.
- Health-related quality of life for people with long-term conditions.
- Potential Years of Life Lost (PYLL) for causes considered amenable to healthcare.

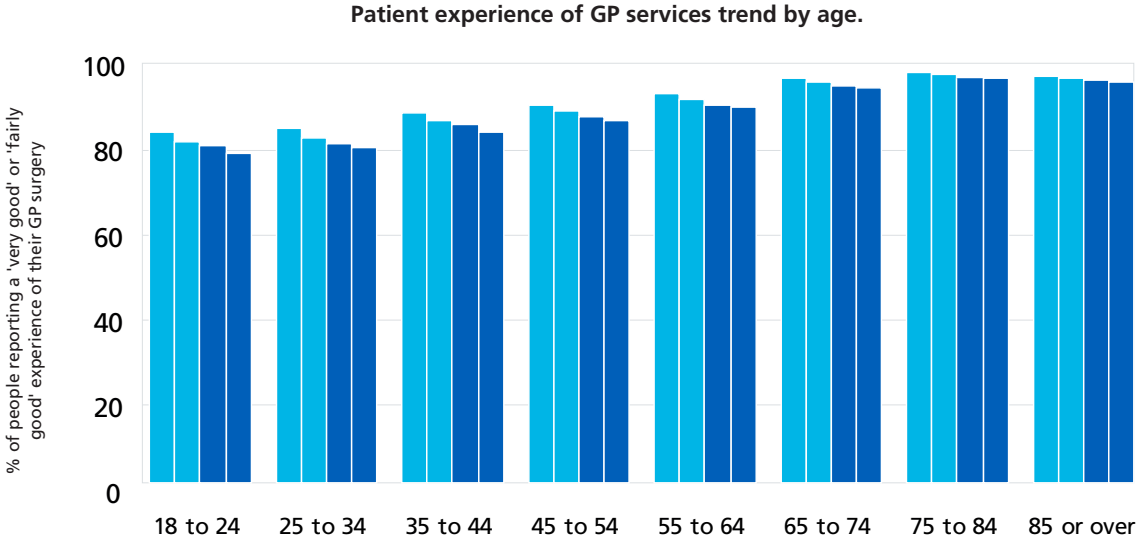
For the following indicators, the change in the inequality gap since 2013 shows poorer progress relative to previous flat or narrowing trend[3]:

- People who report[4] their experience of GP services as very good or fairly good – with an increase in the gap between areas of high and low deprivation.

1. Note that since overall CVD mortality has been reducing, the effect has been to increase the relative ratio.
2. Change in inequality gap between -1percent and +1percent between 2013/14 and 2014/15
3. Inequalities gap increased by over 1 percent between 2013/14 and 2014/15, or where there is a consistent increasing trend.
4. Source: https://gp-patient.co.uk/



- However, a high proportion of people report their experience of GP services as very good or fairly good across all groups as is illustrated by the age chart below.



- Emergency admissions for acute conditions that should not usually require hospital admission, by deprivation.

For the following indicators, only base year data (2013) is available and therefore it is too early to assess progress on reducing inequality:

- life expectancy at 75 for males
- life expectancy at 75 for females.

In 2016/17, we will increase the use of indicators to shape policy, drive improvement and assess progress in reducing inequalities. The new CCG Improvement and Assessment Framework for 2016/17 includes two health inequalities indicators, which align with Commissioning for Value packs to help CCGs set priorities for tackling inequalities and make improvements. We will continue to collaborate with DH and PHE to measure progress, and develop and implement evidence based interventions.

Criterion 3: Utilise and develop the evidence of effective interventions to reduce health inequalities

Response: In March 2015, the Equality and Health Inequalities programme board agreed a new single priority deliverable to achieve sustainable and measurable reductions in health inequalities ensuring improving health outcomes in England 2015-20.

Through the use and development of effective interventions, NHS England has made progress in a number of areas to address health inequality issues. These were presented in depth to the Board in November 2015 and work continues to strengthen our programme of work, including the Equality and Health Inequalities Hub that we share with PHE at www.england.nhs.uk/about/gov/equality-hub/resources/.

Criterion 4: Improve prevention, access and effective use of services for inclusion health groups and families on the Troubled Families programme

Response: Through the legacy of the research and evidence base of the National Inclusion Health Board, NHS England have continued to support and promote the Inclusion Health agenda. The Inclusion Health and Lived Experience sub group of the NHS Equality and Diversity Council (EDC) has been established with an agreed work plan and stated aim of supporting the council and its members to engage and work with people with lived experience to advance equity in access and improve health care experiences and outcomes for the most disadvantaged groups and those with protected characteristics by 2017, supporting healthcare commissioners and the wider system in this respect.

Criterion 5: Continue its leadership of the health system to reduce inequalities, including assessing and publishing on whether CCGs fulfil and report on their health inequalities duties in commissioning plans and annual reports

Response: Delivering the Forward View: NHS Shared Planning Guidance 2016/17 contained guidance for NHS Commissioners on Equality and Health Inequality Duties and set out requirements for all commissioners, including NHS England which has a statutory duty to make an annual assessment of each CCG's performance.

CCG Assurance Framework

Equality and health inequalities formed part of the assessment of the well-led component of the CCG Assurance Framework for 2015/16, alongside a number of other functions which require particular focus due to the complexity of the issues or degree of risk involved. These should be specific topics for discussion in assurance reviews and NHS England makes a risk-based assessment for CCGs when determining how much focus is required for each statutory function. The new CCG Improvement and Assessment Framework for 2016/17 will include two health inequalities indicators, which align with Commissioning for Value packs. This will further help CCGs to set priorities for tackling inequalities and make improvements.

CCG annual reports

Annual reporting guidance for CCGs was published in December 2015 and required NHS England regional teams to assure CCG annual reports for completeness, including whether the CCG had accurately reflected in its annual report how it has discharged its duty to reduce inequalities under section 14T of the Health and Social Care Act 2012.

Allocations

We have continued to develop our approach to ensure resources are effectively targeted to support commissioners to invest to meet the diverse needs of local people and reduce health inequalities, including through the provision of Commissioning for Value evidence packs, the Right Care Programme and the Quality Premium which provides an incentive for CCGs to reduce health inequalities and make improvements on Potential Years of Life Lost.

The Advisory Committee on Resource Allocation's recommendations for the CCG target allocations have been implemented, taking into account the latest evidence on the impact of resource distribution on reducing health inequalities. The formula from 2016/17 is detailed at www.england.nhs.uk/2016/04/allocations-tech-guide-16-17/.

Criterion 6: Continue to take action to reduce health inequalities as part of work to deliver, with partners, the Five Year Forward View and the mandate to NHS England

Response: NHS England's Business Plan for 2016/17 prioritises closing the gap for groups experiencing poorer health outcomes, a poorer experience of, and access to, healthcare. The Government's mandate to NHS England for 2016/17 also sets a specific objective on tackling health inequalities, underpinned by specific deliverables to be achieved in the short term, for the year 2016/17, and to be achieved in the long term, by 2020 or beyond. This requires NHS England to improve local and national health outcomes, particularly by addressing poor outcomes and inequalities, and through better commissioning.

The mandate also expects NHS England to demonstrate improvements against the NHS Outcomes Framework and work with CCGs to reduce variations in quality of care and outcomes at a local level, securing "measurable reductions in inequalities in access to health services, in people's experience of the health system, and across a specified range of health outcomes."

In December 2015, Delivering the Forward View: NHS Shared Planning Guidance 2016/17 - 2020/21, set out a list of national challenges – including how will you close the health and wellbeing gap – to help local systems define ambitions for their populations in their Sustainability and Transformation Plans (see page 29 for further detail). Local systems are asked how will they assess and address their most important and highest cost preventable causes of ill health, to reduce healthcare demand and tackle health inequalities working closely with local government.

This targeted attention to reducing inequalities in access to, experience of, and outcomes from healthcare services for all, will assist us to achieve sustainable and measurable reductions in health inequalities by 2020.

APPENDIX 3: Our sustainability report

The Five Year Forward View highlights the importance of a sustainable NHS in order to continue providing comprehensive, high quality care. The sustainable development strategy for the NHS, public health and social care system is led by the Sustainable Development Unit (SDU), and sets a vision and goals to aim for by 2020 to support sustainable development, reduce emissions, save money and improve the health and resilience of people and communities. The strategy can be viewed on the SDU's website at www.sduhealth.org.uk/policy-strategy/.

Within NHS England, this work is being taken forward as part of the Improving NHS England programme. Further information on this programme of work is given in our Staff Report.

This appendix covers NHS England and Commissioning Support Units (CSUs). Clinical Commissioning Groups (CCGs) report on sustainability within their individual annual reports which are due to be published on their websites in June 2016. A list of CCGs, and links to their websites, can be found on the NHS England website at www.england.nhs.uk/ccg-details/.

Reporting for multi-occupancy buildings and provision of data

NHS Property Services Ltd (NHS PS) is the landlord for the majority of the buildings we occupy, and they are responsible for providing building-related information required for this report. Due to acknowledged inaccuracies in the data provided from NHS PS, it has not been possible to include reporting for 2015/16 for the relevant areas of energy, waste and water in this annual report.

NHS PS recognise the shortfall in providing us with the data we need to fulfil our reporting obligations in this area, and will work with NHS England to improve the provision of all the required data for future years. We intend to work with them to establish accurate data for 2015/16 over the coming months and we will then publish it on our website at www.england.nhs.uk/publications/annual-report/.

Where NHS England is a tenant of DH, energy, waste and water information will be reported within their annual report. This will be published on their website at: www.gov.uk/government/organisations/department-of-health.

Greenhouse gas emissions

Energy, waste and water

All energy and water used, and waste produced, as a result of NHS England's operations arises from the occupation of rented office spaces.

Since the publication of our last annual report, more accurate data on occupancy levels for NHS England and CSUs during 2014/15 has been worked through with NHS PS Relevant figures have been restated in the tables below.

Data for 2015/16 will be published once accurate figures are available from NHS PS. This will include a comparison of our performance against 2014/15.

	Energy Restated data for 2014/15		
	NHS England	**CSUs**	**Total**
Electricity			
KWh	2,546,462	3,231,129	5,777,591
tCO2e	1,259	1,597	2,856
Gas			
kWh	2,613,703	2,503,010	5,116,713
tCO2e	483	463	946

	Water Restated data for 2014/15		
	NHS England	**CSUs**	**Total**
Water consumption (m3)	35,393	20,637	56,030

	Waste Restated data for 2014/15		
	NHS England	**CSUs**	**Total**
Total waste (tonnes)	1,608	765	2,373
Non-recycled (tonnes)	1,188	543	1,731
Recycled (tonnes)	420	222	642
Percentage recycled (%)	26%	29%	41%

Business travel

The focus of NHS England's business travel and expenses policy is on reducing unnecessary travel, as well as prioritising more sustainable forms of travel where it is required. We continue to invest in technology to support paper ight and travel free ways of working, alongside the need for us to work closely with local delivery partners. Overall, there has been a 15 percent decrease in carbon emissions arising from business travel during 2015/16:

	NHS England		CSUs		Total	
	2015/16	2014/15	2015/16	2014/15	2015/16	2014/15
Road travel						
Miles	4,974,652	4,759,417	7,303,406	11,368,462	12,278,058	16,127,879
tCO2e	1,525	1,493	2,218	3,544	3,743	5,037
Rail travel						
Miles	20,274,544	14,713,705	1,854,351	1,284,390	22,128,896	15,998,095
tCO2e	1,470	1,122	134	101	1,605	1,223
Air travel						
Miles	338,497	552,104	21,393	37,289	359,890	589,393
tCO2e	57	95	5	9	62	104
Total miles (Air, Road and Rail)	25,587,693	20,025,226	9,179,150	12,690,141	34,766,844	32,715,367
Total tCO2e (Air, Road and Rail)	3,052	2,710	2,357	3,654	5,410	6,364

We are also working to help our staff keep fit, reduce their carbon footprint and spend less time in their cars. In March 2016, we introduced a new cycle to work scheme for NHS England employees as a government backed salary sacrifice initiative.

From 2016/17, NHS England will be directly in scope to contribute to the target set for DH to reduce greenhouse gas emissions as set out in the Greening Government Commitments. This policy sets out our expectations that anyone travelling on behalf of NHS England will consider the impact that business travel can have on society and the environment, and reduce their travel wherever possible. More widely, the Greening Government Commitments also consider waste, water, paper and procurement.

Procurement

NHS England follows the Government Buying Standards and gives due consideration to the Public Services (Social Value) Act 2012. Sustainability is currently evaluated as part of the tender process, in line with the procurement strategy. NHS England's standard terms and conditions of contract, which are referenced on all purchase orders, have given consideration to sustainability. They include requirements for timely payment of sub-contractors and requirements for suppliers to give consideration to environmental factors and to act in accordance with all applicable law relating to the environment and the disposal of goods.

Climate change adaptation

In partnership with PHE and others, we produce a national Heatwave Plan and Cold Weather Plan for England each year. The purpose of these plans is to reduce the number of deaths and illness by raising public awareness and triggering actions in health, social care and other organisations to support people who have health, housing or economic circumstances that increase their vulnerability to extreme weather. The plans, and associated alerts, can be viewed on our website at: www.england.nhs.uk/ourwork/eprr/sw/.

Action has been taken to ensure that those policies with long term implications are robust in the face of changing weather, extreme events and sea-level rise from climate change.

Rural proofing

NHS England has collaborated with the Department for Environment, Food and Rural Affairs (DEFRA) and DH about Lord Cameron's 2015 independent rural proofing review into how the Government is making sure rural issues are included in our policies and programmes, and has shared developments with DEFRA in respect of relevant NHS policy developments. We will continue to work with DH to support the Government's response to Lord Cameron's review and the commitment to strengthen departmental rural proofing guidance by summer 2016.

APPENDIX 4: Register of Board members

Non-executive directors

	Designation	Start date	End date	Status	Term
Professor Sir Malcolm Grant	Chairman	31.10.11	30.10.18	Current	2
Lord Victor Adebowale	Non-executive Director	01.07.12	31.12.18	Current	2
Dame Moira Gibb	Non-executive Director; Chair - Investment Committee	01.07.12	31.12.18	Current	2
David Roberts	Non-executive Director; Chair - Commissioning Committee; Chair – Audit and Risk Assurance Committee.	01.07.14	30.06.18	Current	1
Noel Gordon	Non-executive Director; Chair - Specialised Commissioning Committee	01.07.14	30.06.18	Current	1
Professor Sir John Burn	Non-executive Director	01.07.14	30.06.18	Current	1
Wendy Becker	Non-executive Director	02.03.16	29.02.20	Current	1
Michelle Mitchell	Non-executive director	02.03.16	29.02.20	Current	1

Leavers

	Designation	Start date	End date	Term
Ed Smith	Non-executive Director; Deputy Chairman; Senior Independent Director; Chair - Audit & Risk Assurance Committee.	09.11.11	30.9.15	1
Sir Ciaran Devane	Non-executive Director	01.01.12	31.12.15	1
Margaret Casely-Hayford	Non-executive Director	01.07.12	31.03.16	1

Executive directors

	Designation	Start date	End date	Voting status
Simon Stevens	Chief Executive	01.04.14	N/A	
Paul Baumann	Chief Financial Officer	01.04.13	N/A	
Professor Jane Cummings	Chief Nursing Officer	01.04.13	N/A	
Professor Sir Bruce Keogh	National Medical Director	01.04.15	N/A	
Richard Barker	Interim National Director: Commissioning Operations	01.01.16	N/A	Non-voting
Ian Dodge	National Director: Commissioning Strategy	07.07.14	N/A	Non-voting
Karen Wheeler	National Director: Transformation and Corporate Operations	01.04.14	31.03.17	Non-voting; Secondment from Department of Health

Leavers

	Designation	Start date	End date	Term
Dame Barbara Hakin	National Director: Commissioning Operations	01.04.13	31.12.15	Non-voting
Tim Kelsey	National Director for Patients & Information	02.07.12	31.12.15	Non-voting

APPENDIX 5: Membership of Board committees and attendance

This table denotes membership of NHS England's Board and its committees. The Chair and Chief Executive reserve the right to attend meetings of all committees on an ad hoc supervisory basis. All meetings of NHS England's Board in 2015/16 were quorate.

	NHS England Board		Audit & Risk Assurance Committee		Investment Committee		Commissioning Committee		Specialised Commissioning Committee		Strategic HR and Remuneration Committee	
Non-executive directors	No. of meetings	No. of Eligible	No. of meetings	No. of Eligible	No. of meetings	No. of Eligible	No. of meetings	No. of Eligible	No. of meetings	No. of Eligible	No. of meetings	No. of Eligible
Professor Sir Malcolm Grant – Chair	8	9									3 Chair	3
Lord Victor Adebowale	8	9					7	10				
Dame Moira Gibb	9	9			8 Chair	8					1	1
Margaret Casely-Hayford	7	9							4	5		
David Roberts	8	9	6 Chair (from 01.10.15)	6			10 Chair	10			2	3
Noel Gordon	9	9	6	6	7	8	10	10	5 Chair	5		
Professor Sir John Burn	9								3	5		
Wendy Becker (from 1.3.16)	1	1	0	0								
Michelle Mitchell (from 1.3.16)	1	1							0	0		
Ed Smith (until 30.09.15)	3	3	4 Chair (from 30.09.15)	4	3	4						
Sir Ciaran Devane (until 31.12.15)	5	6									2	2
Executive directors												
Simon Stevens	9	9					8	10	5	5		
Paul Baumann	8	9			8	8	10	10	5	5		
Professor Jane Cummings	8	9					6	10				
Professor Sir Bruce Keogh	9	9					9	10	5	5		
Richard Barker (from 01.01.16)	2	3					2	3				
Ian Dodge	9	9			6	8	10	10	4	5		
Karen Wheeler	9	9										
Dame Barbara Hakin (until 31.12.15)	6	6					6	7	4	4		
Tim Kelsey (until 31.12.15)	5	6							4	4		

APPENDIX 6: Disclosure of personal data-related incidents

As at March 2016, a total of nine Serious Incidents Requiring Investigation (SIRIs) had occurred relating to the loss of personal sensitive data in NHS England and CSUs. All incidents are logged and a full investigation undertaken. Unless otherwise stated in the table opposite, 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 CSU and at the time of writing this report is still being investigated.

Key lessons learnt from the outcome of these SIRIs will be disseminated to NHS England, including CSU staff, by July 2016. This is in addition to mandatory training and items highlighting good practice in regular staff communications. Topics covered include: incident reporting; keeping information safe; confidentiality; records management; and data protection.

Clinical commissioning groups

Details of any incidents occurring in CCGs can be found within individual CCG annual reports and will be published on CCG websites in June 2016.

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

NHS England

Date of incident	Nature of incident	Paper	Electronic	Number of people potentially affected	Comments
May 2015	Email containing person identifiable data (staff) sent to incorrect recipients.		√	292	
March 2016	Email containing personal sensitive data (patient) was sent to an incorrect recipient in error.		√	1	Incident open – Investigation underway as at end March 2016.

Commissioning support units

Date of incident	Nature of incident	Paper	Electronic	Number of people potentially affected	Comments
June 2015	Bag containing an encrypted laptop and documents containing patient identifiable data was stolen from a staff member's car.	√	√	4	
June 2015	Bag containing electronic equipment and documents containing patient identifiable data stolen from a staff member's car overnight.	√	√	6	Remedial actions implemented and ICO kept informed of the investigation and provided with the report.
August 2015	Bag containing laptop and documents containing patient identifiable data left on train.	√	√	23	
October 2015	Personal sensitive data (patient) sent to another NHS organisation.		√	20	
October 2015	Personal sensitive data (patient) sent to another NHS organisation.		√	10,061	Remedial actions implemented and ICO kept informed of the investigation and provided with the report.
October 2015	Personal sensitive data (patient) sent to another NHS organisation.		√	470	
March 2016	Personal sensitive data (staff) disclosed in error.	√		1	Incident open – Investigation underway as at end March 2016.

APPENDIX 7: UK Corporate Governance Code Assessment

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

Provisions against which there are exceptions

Ref	Code Provision	Exception
B.3.1	For the appointment of a chairman, the nomination committee should prepare a job specification, including an assessment of the time commitment expected, recognising the need for availability in the event of crises. A chairman's other significant commitments should be disclosed to the board before appointment and included in the annual report. Changes to such commitments should be reported to the Board as they arise, and their impact explained in the next annual report.	Under the National Health Service Act 2006 (as amended) the Secretary of State for Health appoints the chair. The other elements of the provision are compliant.
B4.2	The Chairman should regularly review and agree with each director their training and development needs.	The Chairman is only required to conduct regular appraisals of the non-executive directors. The Chief Executive performs this role for other executive directors in consultation with the chair.
B.5.2	All directors should have access to the advice and services of the company secretary, who is responsible to the board for ensuring that board procedures are complied with. Both the appointment and removal of the company secretary should be a matter for the board as a whole.	There is a Board Secretary whose removal and appointment is not reserved to the Board, but is undertaken by executive management.
D.2.1	The Board should establish a remuneration committee of at least three, or in the case of smaller companies' two, independent non-executive directors. In addition the company chairman may also be a member of, but not chair, the committee if he or she was considered independent on appointment as chairman.	The Chair of the Strategic HR and Remuneration Committee is also the Chair of the Board. The other elements of the provision are compliant.

Provisions which are not applicable

B.2.1, B.2.2, B.2.3, B.2.4, B.7.1, B.7.2, C.3.7, D.1.1, D.1.2, D.1.3, D.2.3, D.2.4, E.1.1, E.1.2, E.2.1, E.2.2, E.2.3, E.2.4.

Assessment against the Corporate Governance in Central Government Departments: Code of Good Practice 2011 Compliance Checklist

Provisions against which there are exceptions

Ref	Code Provision	Exception
2.12	The Board collectively affirms and documents its understanding of the Department's purpose and documents its role and responsibilities in a Board Operating Framework.	The Board initiated a project to implement strengthened governance arrangements in December 2015, and, as part of this, received proposals for a revised Governance Manual in May 2016.
3.5e	Non-executive Board members form a Nominations and Governance Committee.	NHS England does not have a Nominations Committee as appointments of the executive and non-executive members are managed as required by the National Health Service Act 2006 (as amended). Governance issues are delegated to the Audit and Risk Assurance Committee.
3.13	The Board agrees and documents in its Board Operating Framework a de minimus threshold and mechanism for board advice on the operation and delivery of policy proposals.	The Board initiated a project to implement strengthened governance arrangements in December 2015, and as part of this, received proposals for a revised Governance Manual in May 2016
4.7	The terms of reference for the Nominations and Governance Committee include at least the four central elements.	There is no Nominations and Governance Committee (see Code 3.5e). The specific Code provisions a – d are handled by the Strategic Human Resources & Remuneration Committee, the terms of reference for which will be strengthened to reflect these specific duties.
4.10	Through the Board Secretariat, the Department provides the necessary resources for developing and updating the knowledge and capabilities of Board members, including access to its operations and staff.	This responsibility is shared between the Chair, Chief Executive's office and Board Secretary.
4.14f	The Board Secretary's responsibilities include: f) arranging induction and professional development of Board Members.	This responsibility is shared between the Chair, Chief Executive's office and Board Secretary.
5.7	The Head of Internal Audit is periodically invited to attend board meetings, where key issues are discussed relating to governance, risk management, or control across the department and its ALBs	The Head of Internal Audit routinely attends meetings at the Audit and Risk Assurance Committee.

Provisions which are not applicable

Section 1, 2.4, 2.5, 2.8d (Results Focus), 2.25,3.4a, 3.4b, 3.4c, 3.5h, 3.6, 3.7, 3.12, 3.17, 4.9, 4.12, 4.15, 4.16, 4.17, 5.10, 5.11 and 6.

Provisions against which improvement is planned for 2016/17

2.8f (and 5.8): Board setting of risk appetite and controls for managing risk.

4.1f: Formal evaluation of Board, committees and Board member's performance.

5.5: Board agenda setting.

APPENDIX 8: Key risks for the organisation

The following table details continuing and emerging risks for NHS England during 2015/16:

Financial sustainability of the NHS	The NHS continues to be subject to significant cost pressures which are not in the direct control of NHS England. We will work with DH and system leaders to drive out required efficiencies to secure future financial sustainability across the life of the spending review period.
Delivering transformational change	The NHS is delivering unprecedented and far-reaching change at pace, with an increasingly complex environment. We will prioritise and balance delivery of change alongside maintaining our operational business delivery.
Enabling Sustainability and Transformation Plans to deliver	All component organisations are accountable for delivery of clear, co-designed plans that deliver the scale of change that the system needs to deliver the aims of the Five Year Forward View. We need to provide the capability and capacity to assess and support planning, delivery and associated benefits.
Capacity of primary and urgent care	To meet the current and future demand for primary and urgent care we are putting in place new programmes of work, such as those to support general practice, to align capacity and ensure patients receive the required care, in a timely manner and in the right setting, thereby reducing pressures on A&E, primary and secondary care.
Specialised Services	As we seek to manage the specialised commissioning agenda, there is a threat of challenge from a range of bodies from those representing patients to pharmaceutical companies.
Commissioning support units	Our CSUs provide key support services to CCGs. If individual CSUs were to become unviable this could impact on the service provision to CCGs, and closedown costs will arise.
Cyber threats	We continue to engage across the health and care system to raise awareness of cyber threat and to develop our defence, detection and response capabilities. The sharing of information is essential to delivering an effective and efficient service and we will continually seek to improve our assurance.
Delivering our core business	We will continue to develop the leadership and delivery capability and capacity necessary to make sure we deliver changes across the NHS without detracting from implementing longer term, cross-system changes.

APPENDIX 9: List of acronyms used in our annual report

	Acronym used	Meaning
A	A&E	Accident and Emergency
	ACE	Accelerate, Coordinate and Evaluate
	ADASS	Association of Directors and Adult Social Services
	ARAC	Audit and Risk Assurance Committee
B	BME	Black, minority, ethnic
	BECS	Dental Benefit Eligibility Checking Service
C	CCG(s)	Clinical commissioning group(s)
	CDF	Cancer Drugs Fund
	CETV	Cash Equivalent Transfer Value
	CSU(s)	Commissioning support unit(s)
	CTR	Care Treatment Reviews
	CQC	Care Quality Commission
	CYP	Children and Young People
D	DH	Department of Health
	DfE	Department for Education
E	EDC	Equality Delivery Council
	EDS2	Equality Delivery System 2
	EPRR	Emergency preparedness, resilience and response
	ESR	Electronic Staff Record
F	FYFV	Five Year Forward View
	FFT	Friends and Family Test
G	GP	General Practice / General Practitioner
H	HEE	Health Education England
	HR	Human Resources
	HSCIC	Health and Social Care Information Centre

	Acronym used	Meaning
I	IAF	Improvement and assessment framework
	IAPT	Improving access to psychological therapies
	ICT	Information and communications technology
	IG	Information governance
	IPC	Integrated personal commissioning
	ISFE	Integrated Single Financial Environment
L	LGA	Local Government Association
N	NAO	National Audit Office
	NHS	National Health Service
	NHS BSA	NHS Business Services Authority
	NHS SBS	NHS Shared Business Services
	NICE	National Institute of Clinical Excellence
	NHS PS	NHS Property Services Limited
P	PAM	Patient Activation Measure
	PCS	Primary Care Service
	PECS	Prescription Eligibility Checking Service
	PHB	Personal Health Budget
	PHE	Public Health England
R	RDEL	Revenue Departmental Expenditure Limit
	RCGP	Royal College of General Practitioners
S	SCR	Summary Care Record
	SFI	Standing Financial Instructions
	SIRI	Serious Incidents Requiring Investigation
	SIRO	Senior Information Risk Owner
	STP	Sustainability and Transformation Plans
T	TCP(s)	Transforming Care Partnerships
U	UEC	Urgent and emergency care
V	VSM	Very Senior Manager
W	WRES	Workforce Race Equality Standard