

PERFORMANCE REPORT

Simon Stevens
Accounting Officer
8 July 2016

CHIEF EXECUTIVE'S OVERVIEW

At times of national uncertainty and debate, the National Health Service continues to offer high quality care to the people of this country, unifying the nation through our mutual commitment to care for all, across the generations.

Our NHS Five Year Forward View, published in October 2014, set the shared strategic direction for the NHS, giving practical life to the 'Triple Aim' of improved health and redesigned high quality care, underpinned by sustainable financial stewardship. In moving to implement the Forward View, 2015/16 was a year of both progress and challenge.

NHS England's independent taskforces published widely supported national improvement blueprints for cancer care, mental health, and maternity services. We set a clear new direction for strengthened GP and primary care, and for redesigned urgent and emergency services. 'Vanguard' areas covering five million people got to work on our 'triple integration' agenda, joining up primary and specialist care, physical and mental health, and health and social care. We sponsored the novel 'Devo Manc' partnership between the NHS and local government for 2.8 million people in the North West. And we helped lead the national debate on one of our greatest public health threats – childhood obesity – and backed that with action by commissioning the world's first nationally-scaled diabetes prevention programme and wide-ranging new NHS staff health incentives.

NHS England's local teams and emergency preparedness experts led the operational response of the NHS to various 'civil contingencies', including strike action by junior doctors, flooding in Cumbria and the international outbreak of Ebola. This came as GP services, mental health providers, NHS hospitals and social care all faced sustained operational pressures, which in turn meant headline waiting times targets were often missed. Despite that, over the last year, no other major industrialised nation can claim to have cared for 9 out of 10 A&E patients within four hours, and provided 9 out of 10 planned hospital appointments and treatments within 18 weeks.

In November NHS England secured a frontloaded NHS funding settlement from the Government's Spending Review. This will kick start the Forward View, albeit that we also argued that success will inevitably depend on intensified prevention and public health, a well functioning social care system, and targeted revenue and capital funding for service transformation.

As set out on page 51, NHS England met each of the financial duties placed on us by Parliament in 2015/16, including once again balancing our budget of just over £100 billion. We are committed to playing our full part in the wider financial challenges facing the NHS, while recognising that – as laid out in the Governance Statement on page 81 – under the Health and Social Care Act 2012 NHS England is not itself legally empowered to oversee the financial performance of providers of NHS-funded care, or to manage the Department of Health's overall budget. In 2015/16 we contributed a £0.6 billion managed underspend to help offset substantial overspends elsewhere.

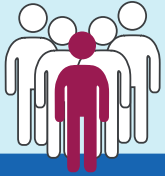
These pressures underscore the size of the challenge facing the NHS. In the year ahead we will therefore support NHS Improvement to 'reset' providers' 2016/17 financial deficits and operational performance. We will work with local communities and health and care leaders to agree and support viable local Five Year Forward View implementation plans, across all 44 'sustainability and transformation' areas. And we will get going on delivering our national improvement priorities – including primary care, urgent and emergency care redesign, cancer services and mental health.

While the outcome of the recent 'Brexit' vote may affect our operating and financial environment – at least over the short to medium term – it does not alter these critical tasks in front of us. Constancy of direction, consistency of leadership, and effectiveness of delivery are what the NHS now needs. That's what NHS England – working hand in glove with our partners – is committed to providing.



Simon Stevens, Chief Executive Officer

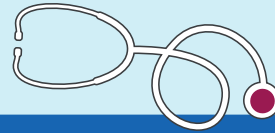
A snapshot of 2015/16



ONE FIFTH of the NHS workforce is of black or minority ethnic backgrounds



85% of patients rated their experience of their general practice as good



More than **5 MILLION** GP consultations took place each week



An increase of **176,427** urgent cancer referrals made by GPs

A new healthy workforce programme is now working to support **1.3 MILLION** NHS workers



10 HEALTHY new towns covering more than 76,000 new homes and 170,000 residents

350,000 more patients received consultant led care than in 2014/15



23 Urgent and emergency care networks now cover the whole of England



Cost of Type 2 diabetes is **£8.8 BILLION** a year

48 Transforming Care Partnerships support those with learning disabilities



GP Access Fund now covers over **18 MILLION** patients



Almost **23 MILLION** patients attended A&E

2.6 MILLION fewer prescriptions for antibiotics were prescribed by GPs



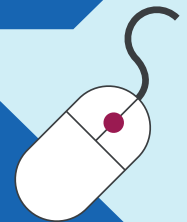
20 MILLION pieces of patient feedback have been received through the Friends and Family Test

Specialised Services budget was just under **£15 BILLION**

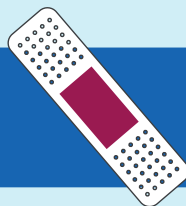
First wave of RightCare covers **19 MILLION** people

50 vanguards received **£131 MILLION** funding

Over **95%** of GPs can offer patients online access to their detailed health record



Over **1.7 MILLION** patient safety incidents were reported

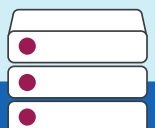


A **THIRD** of all prescriptions are now transmitted electronically



We received over **198,000** customer contacts from patients and the public

The UK now has **THE LARGEST** whole genome sequencing database in the world



Analysis of our performance in 2015/16

The NHS budget of £102 billion for 2015/16 was entrusted to NHS England which shares, with the Secretary of State for Health, the legal duty to promote a comprehensive health service in England in accordance with the NHS Act 2006 (as amended by the Health and Social Care Act 2012). NHS England oversees the delivery of NHS funded services – and the continuous improvements to the quality of treatment and care. In doing so, we both support and rely upon local healthcare professionals making decisions about services based on the needs of, and in partnership with, their patients and communities.

Performance in 2015/16

The NHS provided more than 5 million GP consultations each week, managed 2.9 percent more emergency admissions to hospital, and responded to 7.2 percent more calls to NHS 111 than in the previous year.

Almost 15 million patients received NHS care led by a consultant in 2015/16. Despite the increase in demand, 91.5 percent of patients on the waiting list at the end of March 2016 had been waiting for less than 18 weeks.

But with demand from patients continuing to rise, pressure on primary care, mental health, accident and emergency (A&E) and waits for operations, and budgets tightly constrained, the NHS faces a major challenge in the coming years.

Securing funding in 2015/16: planning for greater investment

In October 2014, national leaders in health and care published the Five Year Forward View setting out how the NHS is to meet the challenges ahead. It identified funding requirements for the NHS as an extra £8 billion to £21 billion by 2020/21, dependent on demand, productivity and support for service transformation. The Government responded by pledging to invest an additional £8.4 billion in real terms annually by 2020/21. The Five Year Forward View can be found on our website at www.england.nhs.uk/ourwork/futurenhs/.

In recognition of the immediate pressures faced by the NHS, the Government announced in the Autumn Statement in November 2015 that the revenue settlement would be frontloaded to provide £3.8 billion (3.7 percent) real terms growth in 2016/17, and £1.4 billion (1.3 percent) in 2017/18.

The financial outlook remains very challenging, and sustained action is needed to deliver the necessary efficiencies implied by this funding settlement. This will require a continuing focus on prevention, on involving patients in their own care, on a resilient social care system and on redesigning services.

More investment in transforming care

A key element of the focus on transforming care has been to establish a new Sustainability and Transformation Fund to stabilise NHS finances, in tandem with higher rates of efficiency growth, and to provide funding for transition to more effective models of care.

The fund is worth £2.14 billion in 2016/17, £1.8 billion of which will be deployed on sustainability to stabilise NHS operational performance. £340 million will be used for transformation to invest in new care models and facilitate progress with clinical priorities such as earlier cancer diagnosis, diabetes prevention and improved mental health, as set out in the Five Year Forward View.

The Sustainability and Transformation Fund will grow to £2.9 billion in 2017/18 and £3.4 billion in 2020/21, with an increasing proportion deployed on transformation.

More investment in primary care

All local commissioners have been given firm budgets for the next three years and indicative budgets for the final two years to allow them to plan how to use their purchasing power most effectively. Primary medical care, including GP services, which have been under particular pressure, has been allocated an above average increase. In addition, clinical commissioning groups (CCGs) have the option to top investment up further, especially where they have assumed greater responsibility for commissioning primary care services under the delegation and co-commissioning arrangements introduced last year.

The General Practice Forward View, published in April 2016, sets out a plan, backed by a multi-billion pound investment, to stabilise and transform general practice. It has been developed with Health Education England (HEE) and in discussion with the Royal College of General Practitioners (RCGP) and other GP representatives.

It commits to an extra £2.4 billion a year to support general practice services by 2020/21. This means spending will rise from £9.6 billion in 2015/16 to over £12 billion by 2021 – a 14 percent real terms increase. This investment will be supplemented by a one off five-year £500 million national sustainability and transformation package to support GP practices, and includes additional funds from local CCGs.

The plan also contains specific, practical and funded steps to grow and develop the workforce, drive efficiencies in workload and relieve demand, modernise infrastructure and technology, and support local practices to redesign the way modern primary care is offered to patients.

A fairer deal for local areas

Historically, some CCGs have received less funding than they have been entitled to under the formula used for calculating the health needs of their populations. In 2015/16, we halved the number of CCGs that were more than five percent below their target allocations, from 34 to 17. For 2016/17, we have taken actions to ensure that no CCG is now more than five percent below its fair share funding; similarly in 2016/17 the place based allocation, which considers CCG commissioned activity, primary medical care and specialised services together, is no more than five percent below target for any CCG area.

The Government's mandate to NHS England

The mandate sets out the goals for the NHS. Most of the goals for 2015/16 were met or close to being met. NHS England met its overriding financial duty to keep spending within the agreed budget set by government. Further detail is presented in Appendix 1.

Corporate priorities for 2015/16

We identified key priorities for improvement in 2015/16, following publication of the Five Year Forward View which were detailed in our business plan for 2015/16. They include some services which will require sustained action over years. They include cancer care, mental health, learning disabilities, obesity and diabetes prevention. The focus of our care redesign work was on primary care, urgent and emergency care (UEC), specialised services and the development of new, and more integrated, care models. Building the NHS of the Five Year Forward View: NHS England Business Plan 2015/16 can be viewed on our website at www.england.nhs.uk/publications/business-plan/.

A summary of progress against each of our corporate priorities is set out below. Detail on how we assure delivery against these objectives can be found in the Governance Statement.

Improving the quality of care and access to cancer treatment

The NHS provides a very high standard of cancer care. Our cancer outcomes have improved significantly over recent years, including our survival rates, which have never been higher. There are also more people being diagnosed with cancer and living with the condition. Current figures show that one in two people born after 1960 will be diagnosed with cancer in their lifetime, and it is expected that 3.4 million people will be living with cancer by 2030. However, we know that more work is required to ensure that everyone with cancer receives truly world-class care, support and treatment.

To chart the key improvements for the next five years, NHS England commissioned an independent Cancer Taskforce. Their report, *Achieving World-Class Cancer Outcomes* (July 2015) included 96 recommendations designed to achieve six goals: a radical upgrade in prevention; a drive for earlier diagnosis; improved patient experience; a transformation in care for those living with and beyond cancer; investment in modern high quality services; and reformed processes for commissioning, provision and accountability. This is available to read at www.england.nhs.uk/ourwork/cancer.

We have made a good start in implementing the recommendations in the report, led by the newly created National Cancer Transformation Board which includes representatives from NHS England, Public Health England (PHE), HEE, the Care Quality Commission (CQC), and NHS Improvement. Advice and challenge to the cancer programme is provided by a new National Cancer Advisory Group comprised of patient representatives, cancer charities and royal colleges.

We have begun to issue interim reports giving practical guidance on delivering earlier and faster cancer diagnosis based on learning from the first wave of 60 test sites under our Accelerate, Coordinate and Evaluate (ACE) programme. The first three reports cover variation in performance and practice on lung cancer pathways, direct referral by non GP primary cancer health professionals, and pharmacy training for early diagnosis of cancer. We have also recruited to six test sites for our next wave of activity to evaluate the impact of multidisciplinary diagnostic centres for investigation of symptoms of concern which do not map onto other pathways. These sites will go live in 2016/17.

We have also begun to develop rules for the new 28 Day Faster Diagnosis Standard for Cancer, which will ensure patients have their potential cancer diagnosed or ruled out within 28 days of a GP referral. In 2016/17, we will be recruiting five test sites across England to help us robustly roadtest the new standard.

During 2015/16, the volume of urgent GP referrals, where cancer was suspected, increased by 11.4 percent on 2014/15. This is 176,427 more patients being seen compared with 2014/15.

In 2015/16, 82.4 percent of patients began a first definitive treatment within 62 days from an urgent GP referral for suspected cancer against a target of 85 percent and prior year performance of 83.4 percent. As at the end of October 2015, 75 trusts were not meeting the 62 day cancer standard and were required to develop recovery plans. The plans have been assured, and high risk trusts are being reviewed each month on their progress. However, during 2015/16, the volume of patients on the 62 day pathway receiving a first definitive treatment for cancer increased by 6 percent compared with 2014/15.

During 2015/16, we consulted on substantial revisions to the Cancer Drugs Fund (CDF) so that from 2016/17 it will be used to test 'real world patient outcomes' from the most promising cancer therapies where clinical uncertainty exists at the time of its licensing. This will also ensure the CDF is managed within its expanded budget of £340 million.

We have now published an implementation plan outlining a wide range of specific steps designed to increase prevention, speed up diagnosis, improve the experience of patients and help people living with and beyond the disease. A new Cancer Waiting Times Delivery Group, formed jointly with NHS Improvement, has begun to tackle waiting times and specifically improve performance against the 62 day maximum wait from receipt of urgent GP referral to start of treatment.

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

A quarter of the population experience mental ill health at some point in their lives. Yet mental health services have historically lagged behind physical health services in funding growth, and many people have struggled to get the help they need, enduring worse outcomes than those with physical health problems and suffering stigma and discrimination. The human cost has rightly been seen as unacceptable, with wider economic benefits of improved mental health in the population also not fully realised.

The Five Year Forward View set out a vision of a reformed service that would provide better prevention, improved crisis care and early access to evidence based treatment, integrated services for mental and physical health, and new ways of delivering care coupled with routine outcome monitoring.

In 2015/16, we made progress towards making this a reality. We improved outcomes and increased access to evidence based psychological therapies with treatment success rates at record levels. We plan to further increase access to reach 25 percent (from the current 15 percent) of need by 2020/21 so that at least 600,000 more adults with anxiety and depression can receive care. Every CCG created a joint agency plan with local partners to improve care for children and young people and received a share of the new money allocated in the Autumn Statement 2014 and Spring Budget 2015.

We have extended the Children and Young People's Improving Access to Psychological Therapies (CYP IAPT) transformation programme to cover services working across 82 percent of 0-19 year olds, and we are on target for 100 percent coverage by 2018. The first referral to treatment time standard specifically for those under 18 years old with an eating disorder was published in August 2015. We worked with the Department for Education (DfE) to support a single point of contact pilot between the NHS and schools to improve access and referral pathways, including 27 CCGs and 255 schools.

The number of adults who recover following treatment under the IAPT programme continues to increase, with 167,320 recovering in the nine months to December 2015. This is a 33 percent increase on the same period in 2014/15. However, there is still a wide regional and sub-regional variation in both access and recovery rates.

In January 2016, the statistics showed that 84.3 percent of people referred to IAPT services began treatment within six weeks and 96.4 percent within 18 weeks.

We have taken steps to improve crisis care since the 2014 launch of the Crisis Care Concordat with the establishment of a major five year national improvement programme with the aim that people will be able to access high quality urgent and emergency mental health care 24 hours a day, seven days a week, 365 days of the year, in the same way as we expect for physical health care. The use of police cells under 'Section 136' arrangements at times of mental health crisis has more than halved in recent years, with further progress planned in 2016/17.

The mandate for 2015/16 required that a new access and waiting time standard was introduced this year to ensure that, by April 2016, more than 50 percent of people experiencing a first episode of psychosis commence treatment with a National Institute of Clinical Excellence (NICE) approved package of care within two weeks. The focus of work this year has been on ensuring system and workforce readiness to implement the new standard.

NHS England recognises that there are workforce issues and is working closely with HEE who are establishing a workforce strategy to support the mental health providers to deliver this standard.

The Prime Minister's challenge on dementia 2020 (February 2015) required that at least two thirds of the estimated number of people with dementia should be diagnosed. This target diagnosis rate was achieved in November 2015, and statistics show this has been maintained and improved over subsequent months, and the national estimated rate at the end of March 2016 is confirmed as 67.5 percent. We have developed a new evidence based care pathway for people living with dementia and their carers and established an expert group to help develop our approach to implementation.

In February 2016, we published the report of our independent Mental Health Taskforce, the Five Year Forward View for Mental Health for the NHS in England (February 2016) at www.england.nhs.uk/mentalhealth/taskforce/ which set out plans to transform mental health services by 2020/21. It proposed a three pronged approach to improving care through prevention, providing seven day access to treatment in a crisis and integrating physical and mental health care.

In response to the taskforce's call for extra investment we have pledged to help more than a million extra people and invest more than £1 billion pounds extra a year by 2020/21. This will fund increased access to the evidence based care set out as the key priorities in the taskforce report.

As described by the National Audit Office (NAO), successful implementation will require cross-system alignment and a Mental Health and Dementia Board across arm's length bodies has been established to bring together key partners in governing the programme as it develops.

Transforming care for people with learning disabilities

We committed to improving the lives of the 1.2 million people with learning disabilities last year, and significantly reducing the inequalities in health and care that they face.

In October 2015, we published Building the Right Support (October 2015) which is available to read at www.england.nhs.uk/learningdisabilities/natplan/. Developed jointly with our partners, the Local Government Association (LGA) and the Association of Directors of Adult Social Services (ADASS), and with active input from people who use the services and

their families, this is an ambitious three year national plan to develop community services and deliver our commitment to close outdated long stay hospitals and inpatient facilities.

Our plan gives commissioners a clear framework to develop more community services for people with a learning disability and/or autism with behaviour that challenges, and it aims to close 35-50 percent of inpatient care over the next three years, including Calderstones, the last remaining standalone learning disability hospital in England.

Six fast-track partnerships, supported by a total of £10 million funding, provided vital learning for the national plan and as a result there are now 48 Transforming Care Partnerships (TCPs) across the country, bringing together CCGs, local authorities and NHS England specialised commissioners. TCPs will be supported by £30 million transformation funding to make this plan a reality and give people and their families more choice and say in their care and support.

Alongside the national plan we published a new service model, which was tested by the fast track areas. This describes what good services should look like and gives people a clear picture of what they can expect from the services they use, while at the same time allowing partnerships the flexibility to design and commission services that meet the needs of people in their area. TCPs are learning from the impact which the fast tracks have achieved, and we are focused on accelerating this process.

Care and Treatment Reviews (CTRs) have been tested and rolled out across the country, designed to help reduce unnecessary admissions and lengthy stays in specialist hospitals.

We have worked with the Association of Directors of Children's Services and DfE to ensure that CTRs properly meet the needs of children who are inpatients and in 52 week residential school placements.

Over 2,000 CTRs have been carried out this year, helping to increase the number of people discharged from hospital. However, while the number of people still in hospital has been reduced by 6.4 percent to 2,615, progress needs to accelerate over the next year and beyond.

People with a learning disability and/or autism have poorer physical and mental health compared to others, and a lower life expectancy. As part of our commitment to address this, we began working with the University of Bristol to develop a new national learning

disability mortality review which will help us to understand why this is happening, address health inequalities and improve care.

We also finalised plans to support more people with a learning disability and/or autism to have better quality annual health checks, and worked to create easy to read learning disability tools and guidance to support the recruitment and employment of people with learning disabilities into the NHS.

Tackling obesity and preventing diabetes

Type 2 diabetes affects 2.8 million people in Britain, with a further 5 million at risk. The cost to the NHS of caring for those with Type 2 diabetes is £8.8 billion a year. In the Five Year Forward View we announced our ambition to become the first country in the world to implement a national, evidence based, diabetes prevention programme.

In 2015/16, we established a joint plan with PHE and Diabetes UK based around seven demonstrator sites to design the prevention programme, deliver behavioural interventions – supporting people to lose weight, take exercise and eat better – and guide its implementation.

Four providers of the programme were selected in March 2016 from 11 organisations invited to tender. Contracts to deliver services have been awarded in 10 areas, and a further 17 will go live this summer covering almost half the population of England. An initial cohort of CCGs is expected to join the programme by July 2016.

The programme is on track to deliver services making up to 20,000 places available to at-risk individuals in 2016/17, expanding to around 100,000 people a year over subsequent years.

As part of efforts to encourage healthier lifestyles, plans to create 10 NHS supported healthy new towns were announced in March 2016 covering more than 76,000 new homes and 170,000 residents.

We will also be developing a diabetes treatment programme in 2016/17 which will take into account recommendations from the 2015 NAO report to continue to improve services and performance.

Case study: Diabetes

Dorothy Hall (60) was dancing at her local club twice a week, doing about 3,000 steps a day, and thought she was getting her 5-a-day until a spot health check showed she was at high risk of Type 2 diabetes.

Dorothy was referred to the Just Beat It programme, run by Durham County Council and Durham's two CCGs. The scheme is one of seven demonstrator sites for the NHS Diabetes Prevention Programme. It includes six months of education and exercise, plus 18 months follow-up and support. The education focuses on eating 5-a-day, behaviour change and dealing with stress. Since being referred to the scheme, Dorothy has lost 3kg and 10cm off her waist.

"Getting support from the Just Beat It programme was excellent. Changing your diet and lifestyle isn't easy, so it was really good to always have someone to turn to for advice and support. There needs to be greater support to help people eat more healthily, and be more active, which is why I think the NHS Diabetes Prevention Programme is a magnificent initiative, and I would most definitely recommend it to everyone!"

Redesigning urgent and emergency care services

In November 2013, we published a review of urgent and emergency care which set out a new strategy: to provide people with urgent but non-life threatening needs with highly responsive, effective and personalised services outside of hospital and closer to their homes; and to provide people with more serious or life threatening emergency needs with rapid treatment in centres of excellence with the very best expertise and facilities to maximise their chances of survival and a good recovery.

Since the publication of the review, 23 UEC networks, covering the whole of England, have been established to lead implementation in their local area. In July 2015, eight vanguards were selected as early test beds for new initiatives, including a 24/7 mental health crisis response service, support for clinical decision making in urgent and emergency situations (such as by highlighting variation from best practice) and new outcome measures.

Across England, urgent and emergency care (UEC) services are under pressure. Rising demand from an ageing population, confusion among patients about where to get help, and pressure on general practice, all contribute to increasing the burden on A&E departments, emergency ambulances and the NHS 111 service. Almost 23 million patients attended A&E in 2015/16, an increase of 2.3 percent on the level of attendances in 2014/15.

In response to increasing demand and as part of NHS England's ongoing Urgent and Emergency Care Review, a new service model is being introduced, bringing together NHS 111, GP out of hours and clinical advice. This offers patients improved access to a new 24/7 urgent clinical assessment, advice and treatment service, and is being rolled out across England. The operational standard for A&E waiting times is that 95 percent of patients should be admitted, transferred or discharged within four hours of their arrival at an A&E department. In 2015/16, 91.9 percent of patients attending A&E were either admitted, transferred or discharged within four hours. Performance has varied across the country with the causes of poor performance being multi-factorial. While the increase in activity is one cause, there are a number of others that need to be addressed. Flow through the acute sector, delays in discharges linked to social care pressures, lack of available alternatives to A&E, system leadership and other factors contribute to performance to a greater or lesser extent across the country.

Emergency admissions over the past twelve months were up 2.9 percent on the preceding twelve month period, in line with expectations.

NHS Improvement, with support from NHS England, is developing a plan to support recovery of A&E performance in 2016/17. The plan focuses on ensuring that all health systems adopt five best practices drawing on the NHS England report on transforming UEC services, Safer, Faster, Better (August 2015) which can be read at www.ecip.nhs.uk/resource/safer-faster-better.

Access to patients' medical records is vital to enable clinicians to deliver the best care. Among patients registered with a GP, 96 percent now have an electronic Summary Care Record (SCR); with the patient's consent, clinicians can access these in 51 percent of A&E departments, 88 percent of NHS 111 service providers and 82 percent of ambulance services.

Reforms to the 999 ambulance service were tested in 2015/16 to improve performance by delivering help on the phone, face to face in the patient's home, or transport to hospital in the right vehicle with the right urgency, as appropriate. A pilot programme called Dispatch on Disposition gives 999 call handlers additional time to determine accurately when an emergency ambulance is needed in non-life threatening situations. This is being independently evaluated before a decision is made on national roll out.

Networks for acute stroke care are being developed in several areas across England, building on the published success of the London model.

Case study: Urgent and emergency care

A call came in to 111 from a daughter of an 86 year old patient who was in increasing pain and becoming very agitated. The call handler saw that there was a Special Patient Note stating the patient was for palliative care only. The call handler excluded any need for an emergency response and referred the patient to the specialist palliative nurse in the call centre. The nurse, with patient consent, was able to access the GP/community notes. The care plan

was clear that the patient wanted to die in the hospice where she had been an inpatient. The palliative care nurse assessed that the patient was in terminal agitation. She contacted the hospice who agreed to admit her. She was then able to arrange transport by one of Yorkshire Ambulance Service's dedicated palliative care ambulances to take her to the hospice, where she died peacefully, surrounded by her family, some 24 hours later.

Strengthening primary care services

Primary care services such as GP surgeries, pharmacies, dentists and opticians are the cornerstone of the NHS, providing vital health services to local communities. In 2015/16, the overall budget for primary care increased by 4.1 percent.

Most of the contact that patients have with the NHS is through their GP surgery, and more than eight out of ten patients rate their experience of GP services as good. But services are under real pressure with rising workloads and patients increasingly concerned about access to services.

Improvements in general practice infrastructure are vital in enabling the type of transformation that we all want to see. Work has been underway, and during 2015/16 NHS England has been leading a multi-million pound transformation fund to support primary care and general practice to make improvements in premises and technology. This is already having an impact in local GP surgeries, and investment will continue over the coming years with CCGs leading the way in developing plans for investment in line with their local digital and estates strategies.

In January 2015, a ten point Building the Workforce plan was published to increase recruitment to general practice, retain more doctors in practice and support more to return. As part of this, we introduced a revised scheme to provide doctors with a clearer and easier route to return to general practice, targeting locations with the greatest GP shortages and encouraging GPs to work in these areas. We also invested £31 million in an additional 400 clinical pharmacists in general practice as part of work to expand the primary care workforce. This has since been expanded as part of the General Practice Forward View to £112 million for 1,500 new clinical pharmacists in general practice by 2020. This plan can be read at www.england.nhs.uk/commissioning/primary-care-comm/gp-action-plan.

In April 2016 we published the General Practice Forward View which set out a multi-billion pound plan to support general practice by increasing the number of GPs and other staff, improving access to services and investing in new ways of improving primary care for patients.

The General Practice Forward View builds on this workforce investment, supporting the Government's commitment to increasing the number of doctors in general practice by 5,000 and other staff working in general practice by the same amount, by 2020.

The GP Access Fund (formerly the Prime Minister's Challenge Fund) was established to help improve access to general practice and stimulate innovative ways of providing primary care services. Since the programme launch in October 2013, NHS England is now managing 57 schemes covering over 18 million patients (30 percent of the country) in over 2,500 GP practices. Patients are benefitting from improved access and transformational change at a local level. This includes extended access to services, better care navigation and increased use of technology such as video consultation.

In 2015/16, a majority of CCGs took on greater responsibility for commissioning GP services as part of the co-commissioning agenda. This marks a critical step towards more joined up health commissioning and enabling the development of more integrated care for patients set out in the Five Year Forward View.

For the first time in 2015/16, a national service for pharmacists to provide the NHS influenza vaccine direct to patients was established. Half a million patients chose to take up their vaccination from their community pharmacy, twice the number in the previous year when access to the vaccine via local pharmacies was only available through local schemes.

Timely access to high quality elective care

Nearly 15 million patients started consultant-led treatment in the 12 months to March 2016, up 2.5 percent compared to the previous financial year. Of all patients on the waiting list at the end of March 2016, 91.5 percent had been waiting less than 18 weeks, compared to the 92 percent standard set under the NHS Constitution.

Over the last decade, waiting times have fallen dramatically. From the beginning of 2015/16, we have used a single waiting time measure, known as the incomplete standard. This standard focuses on all those patients whose treatment is still incomplete at the end of each month, rather than just on those treated in that particular month. The incomplete standard is that 92 percent of those still waiting to start treatment have been waiting less than 18 weeks. This change is intended to cut extended waits by ensuring hospitals are encouraged to, and not penalised for, treating patients that have waited longer than 18 weeks, as was the case with the former admitted and non-admitted standards.

We have continued to make strides in cutting long waits and the number of long wait patients treated per working day in the six months to March 2016 was a third higher than in the same period a year earlier, which as a proportion of all activity, was up from 7.4 percent to 9.7 percent. Patients waiting more than a year were over 5,000 in 2012 and are now down to within hundreds.

Despite continued pressure on waiting lists, the incomplete standard was met in most months of 2015/16 (it was just missed in December, January and March). Extra effort to maintain it will be needed as pressure on NHS capacity increases further.

To ensure maximum use of NHS capacity, a mechanism was established with NHS Improvement to support the transfer of patients from NHS trusts under the greatest pressure to those with available capacity, including the independent sector. A specific arrangement was put in place for endoscopy procedures which were under particular pressure.

Work is also underway to modernise the referral system to ensure it is effective, clinically-led and provides patients with a genuine choice over how and where to have their treatment.

We consolidated and simplified the advice on recording and reporting of waiting time data, with refreshed guidance for NHS trusts. We ensured consistent national messages were provided about the changes to the waiting time standard and provided support to improve demand and capacity planning.

In February 2016 Better Births, the national maternity review, was published. This is a five year plan for maternity services to make care safer and give women greater control and more choice. A key element of the plan is to ensure maternity care is centred on the woman, her baby and family, by providing access to information and support that is based around their needs and circumstances. The aim is to improve outcomes, particularly for vulnerable women, and reduce health inequalities.

Ensuring high quality and affordable specialised care

Specialised services include those for patients with rare conditions and those of very high cost. They often require specialised multidisciplinary teams working together to achieve the best outcomes and patient experience. Over the past three years, significant progress has been made in developing consistent national standards and gaining control of one of the most challenged budgets within the NHS – just under £15 billion in 2015/16. To the envy of many other countries, any patient who needs it can access these high quality, often world class treatments free at the point of use; be it for rare cancers, genetic diseases, infectious diseases such as hepatitis C or specialised medical or surgical conditions.

In 2015/16, for the first time, NHS England successfully balanced its specialised commissioning budget, whilst also continuing to expand services and treatments available.

However, as recent reports from the NAO point out, the rapidly rising demand for new, innovative but often expensive treatments, particularly drugs, means that the demand for specialised services continues to grow at a rate that is considerably more than other parts of the NHS. In addition, there continues to be variation in access, outcomes and cost for some specialised services.

To help address this, we are exploring the use of innovative approaches to commissioning high cost interventions, for example in rare diseases, such as the Managed Access Agreement successfully negotiated in December 2015 for elosulfase alfa for the ultra-rare Morquio A syndrome. This approach allows patients access to treatment at a substantially discounted cost, whilst they are monitored to see how the intervention has worked in practice before final funding decisions are taken.

Following significant engagement and consultation with industry and patient groups, we have also set out new arrangements for the CDF so that the most effective treatments can continue to be offered to patients, whilst stopping those that are less effective to ensure that new and more effective treatments can be added within the budget available.

Following consultation on the principles and process by which NHS England makes investment decisions, 23 additional clinical policies were approved in July 2015 as part of the annual prioritisation round. These include new treatments for Parkinson's disease, cystic fibrosis, HIV, prostate cancer and tuberculosis, as well as policies widening access to Proton Beam Therapy and a range of genetic tests that can help prevent breast and ovarian cancer. These new policies will help us to improve and extend thousands of lives for years to come through prevention, identification and treatment.

We know that we must continue to build on this progress and accelerate transformation – with specialised care embedded in patient pathways and more personalised care – whilst ensuring best value from the resources available. Under plans set out in the Five Year Forward View, in 2016/17 we are moving from the provision of treatments for individual services to population based allocation of specialised services budgets. To drive this agenda, collaborative commissioning committees are now established in all 10 commissioning hubs, and plans have been developed at a local level to identify those services that could benefit from closer collaboration between NHS England and CCGs. This will help to ensure that fair and timely decisions are made for patients and that the public get the best value from the services.

Whole system change for future clinical and financial stability

The Five Year Forward View set out a clear direction for the NHS but acknowledged that there is no one-size-fits-all answer to the multiple challenges the health care system faces. Its proposals were based on finding diverse solutions to diverse problems and creating partnerships between national and local organisations. This is a new approach for NHS

England which involves working more closely with other health sector bodies including NHS Improvement, CQC, HEE, NICE and PHE. These bodies have come together with NHS England in the Five Year Forward View Board, which is developing a strategy for the future.

The Spending Review for the NHS in England initiated three interdependent and essential tasks: to restore and maintain financial balance; to deliver core access and quality standards for patients; and to implement the Five Year Forward View.

The NHS Shared Planning Guidance, published in December 2015, asked every health and care system to come together to create its own ambitious local blueprint for accelerating implementation of the Forward View and to close these health, care and financial gaps by 2020/21.

As a result, neighbouring health and care services have come together to form 44 defined footprints – geographic areas, in which people and organisations are working together to develop robust plans to transform the way that care is delivered. These footprints will develop Sustainability and Transformation Plans (STPs), place-based, strategic plans built around the needs of local populations. They will help drive improvements in patient experience, health outcomes, and efficiency in the longer term whilst also securing affordable solutions to the NHS's more immediate challenges.

New care models

Since its launch in March 2015, the new care models programme has supported the establishment and growth of 50 vanguards and the ongoing development of 25 integrated care pioneers to lead on developing new care models that will act as blueprints for the NHS and an inspiration for the future of the health and care system.

By 2020, it is envisaged that at least half of the country will be covered by the new care models. Separately and together the 50 vanguards are designing and implementing new ways of working which are focused around the needs of patients, creating networks of care and breaking down the traditional barriers between hospital, community services, primary care and social care. Though no single model of care will work everywhere, they are identifying and testing out common needs and approaches, led by frontline clinicians, managerial staff and patients working with their local partners.

The vanguards were selected following a rigorous process involving a range of national NHS bodies, as well as the royal colleges, social care, clinicians, and patient representative groups.

In 14 areas, GP practices and partners in the community are working together as multispecialty community provider vanguards. They are focused on moving care out of hospital into the community, bringing care closer to where people live, ensuring their medical and social needs are looked at in a joined up way rather than in isolation.

In nine areas, hospital and community services, together with mental health and community care, have joined up as integrated primary and acute care system vanguards, creating a single organisation responsible for people's care, whatever they need.

In six areas, enhanced health in care home vanguards are joining up health, care, and rehabilitation services for elderly and frail populations. They include dedicated teams of physiotherapists, chiropodists and other clinicians and are working to harness new technology such as telehealth.

There are eight urgent and emergency care vanguards working to reduce pressure on A&E departments by delivering the recommendations of the 2015 UEC review faster than the rest of the NHS.

The 13 acute care collaboration vanguards are developing networks to share clinical expertise, joining up hospitals in different areas or selecting one NHS organisation to provide specialist care on different sites, whilst focusing specifically on reducing variation in care and efficiency.

The 50 vanguards received total funding of £131 million in 2015/16, and are supported by more than 1,000 GP practices and over 40 CCGs. The funding that vanguards received is helping them make the necessary change while establishing a robust governance structure around their individual programmes. Vanguards have been provided with support, including training, advice, and access to experts, which has helped to ensure the successful development of their new care models.

During 2015/16, the programme focused on the selection, development and growth of the new care models with increasing focus on spreading the new care models across the country and a rigorous approach to prioritisation of funding based on detailed assessment of value propositions submitted by each vanguard. In 2016/17, the programme is moving to the next phase of delivery to ensure quantifiable impact, and to support wider spread and the mainstreaming of new care models from 2017/18. Our work with the NHS Confederation, NHS Providers, NHS Clinical Commissioners, LGA and the RCGP is supporting this by spreading the learning from the vanguards with the wider NHS and care services.

Evaluation is at the heart of the programme in order to provide robust results and learning. Improvements in outcomes and the cost-effectiveness of changes made will be rapidly disseminated across the NHS and elsewhere. The new care models programme is complex in its breadth and depth, and combines experimental discovery with standardisation. This calls for an innovative, sophisticated and multi-faceted approach to measurement and evaluation.

The impact of the vanguards on health and wellbeing, care and quality, and efficiency, is being evaluated nationally using a set of national metrics: high level outcome indicators for each care model type are reported quarterly through a dashboard, comparing with a do-nothing baseline. Vanguards will report on progress against their plans against a set of local metrics and we will also be looking at a small set of common national enabler metrics showing progress towards the core components (such as multidisciplinary teams, integrated care records, and whole population budget). Information from measurement, reporting and local intelligence will be collated and synthesised. A Health Data Lab is being developed with the Health Foundation to strengthen our capability to measure the impact of NHS transformation programmes. This will provide selected vanguards with the capability to rapidly evaluate the impact of specific interventions, by comparing results in an intervention area against counterfactuals, such as matched controls.

Case study: Partnership working in the Isle of Wight

Isle of Wight's My Life a Full Life change programme brings together the CCG, Isle of Wight NHS Trust, Isle of Wight Council, the voluntary and independent sectors and the island's GP federation, One Wight Health. It followed significant consultation with residents about their priorities for health and social care.

Over the last five years, the island has established a central hub, which co-locates a range of services for early intervention and diversion of patients away from hospital admission where appropriate.

The hub includes 999 emergency calls operators; NHS 111 call handlers; paramedic clinical advisers; GP out of hours services; district nurses; social workers; pharmacists; Wightcare, who provide alarms for vulnerable people; occupational therapists; the charity Age

UK; and a crisis response team. It allows instant access to the patient's records from all the organisations involved.

The crisis response team is made up of district nurses, coronary care nurses, clinical assessors, paramedics, an occupational therapist, a social worker and an Age UK representative. The team provide wrap around care for people at risk of hospital admission, usually older people, and those with long term conditions and mental health needs.

Between April and December 2015, the crisis team saw 489 people, and spent an estimated £725,000 less than it would have done with a more traditional approach. Of those 489 people, just 58 were admitted to hospital, mostly due to complications of existing long term conditions.

Personalisation and choice

Patients are the focus of the NHS, but they have not always been involved in decisions about their treatment. The Five Year Forward View set out a commitment to ensure that when people need health services they will have greater control over where and how they receive care, and to move from a one-size-fits-all approach towards care personalised to each individual. NHS England has established a personalisation and choice programme dedicated to driving forward these plans, including giving choice to women over how they are cared for in pregnancy and childbirth and to people with terminal illnesses requiring end of life care.

A cost effective way of giving people control over their care is to provide them with a Personal Health Budget (PHB) to buy the services they need. This improves quality of life and reduces reliance on unplanned care. Building on learning in social care, from September 2014 people with long term, complex conditions who receive NHS Continuing Healthcare, or continuing care in the case of children, have had a legal right to have a PHB, and the number of people holding them has begun to increase. 4,700 patients took up the offer in the first half of 2015/16, a 60 percent increase on the previous year. Our target is to raise the number to 50,000-100,000 by 2020.

As highlighted in a recently published NAO report there is widespread support for personalised commissioning in social care. Building on this and the demand for greater integration for people with complex health and social care needs, in April 2015 we introduced Integrated Personal Commissioning (IPC) which blends health and social care funding together and gives people more choice and control over how this is used. Nine demonstrator sites have been established and are developing local processes with the national team. The IPC programme will be evaluated and learning shared across health and care community over the coming years.

Financial sustainability

During 2015/16, we completed our modelling of the NHS' impending challenge and, in December 2015, we built the impact of the Spending Review settlement into our allocations. We have mobilised key efficiency programmes within our scope that will help us in our objective of achieving financial sustainability, and have started work to develop an approach to measurement, evaluation and benefits realisation for each of our efficiency workstreams. We have initiated the development of a model and an approach to support

local systems in delivering financial sustainability, ahead of the STP process which will be the vehicle through which we will demonstrate routes to financial sustainability in every health economy around the country.

The RightCare programme is a core element of our efficiency programme. It has grown at a rapid rate throughout the year, having been rolled out to 65 local health economies covering 19 million people in 2015/16, with a launch to all remaining areas of England planned for the end of 2016.

RightCare is a proven improvement approach to tackling unwarranted variation and improving value. It has been tested successfully and has shown both to improve patient outcomes and to free up funds.

A series of Commissioning for Value and new focus packs have been published throughout the year to take a more detailed look at how treatment of numerous conditions vary across England. These have so far included cardiovascular disease, neurological conditions, respiratory, cancer and tumours, maternity and early years, mental health and dementia and musculoskeletal.

Case study: Ashford CCG

Demand for orthopaedic services in East Kent was increasing to the point of unsustainability. Ashford CCG wanted to ensure that it was making maximum use of available resources and that patients were receiving the best care. The CCG implemented the RightCare approach to achieve this.

RightCare identified that, compared to similar locations, a high proportion of Ashford's musculoskeletal patients were being referred directly to hospital. The RightCare approach found significant variation in rates of referrals by GPs.

The CCG introduced a new triage service, run by GPs and aimed at delivering the best pathway for patients. GPs received specialist support, and focus was placed on delivery of the 18 week wait target.

Outcomes for patients were improved, with more being seen in the right setting and, as a result of the reduced waiting times, far quicker than under previous arrangements. In its first 12 months of operation, the approach resulted in a reduction of 30 percent in referrals to secondary care, with annual savings of £1 million.

Foundations for improvement

Patient and public participation

In November 2015, we published our Patient and Public Participation Policy to embed the participation of patients and the public in all areas of our activity, supported by a 10 point action plan. The plan includes providing training, information and resources to help people make their voices heard and increase involvement in our decision making. This policy can be viewed at www.england.nhs.uk/ourwork/patients/ppp-policy/.

We are also introducing frameworks for participation in all of NHS England's areas of direct commissioning, and our NHS Citizen programme has paved the way for two way communication using online fora, social media and face to face events.

People's lives can be transformed when they are helped to manage their health, shape their care, and choose what is important to them. As part of our Self Care programme we will support the knowledge and confidence of people to manage their own health, using the Patient Activation Measure (PAM). This is a validated, evidence based survey tool that measures individuals' knowledge, skills and confidence to manage their own health, and the measure will be rolled out over the next five years to 1.8 million people, through key NHS change programmes, including the new care model vanguards and IPC demonstrator sites. By knowing the activation level of their population, health and care systems can begin to tailor their services in order to support people on a journey of activation, helping them lead better lives at a lower cost to the system.

In August 2015, we completed the final stage of the Friends and Family Test (FFT) rollout across the NHS. As at end of March 2016, this had provided 20 million pieces of feedback to the NHS. We are also working to ensure that our national patient and staff surveys continue to identify trends in experience of different demographic groups.

Case study: Wessex Community Voices: Partnership working with Healthwatch and the voluntary and community sector to influence the commissioning cycle

Wessex Community Voices was developed by NHS England in Wessex and the Wessex Healthwatch Partnership, including the voluntary and the community sector. It includes a training and support programme to develop public understanding of commissioning. The project developed a guide for staff about public and patient engagement, called Choosing and Buying Services Together including examples of how

the public can be involved at each stage of the commissioning cycle and participation techniques and methods. A Healthwatch worker also maintains a network of people able to contribute to commissioning work programmes, supports training, supports engagement with seldom heard individuals and groups, and provides independent evaluation of public consultations.

Case study: Sheffield CCG

In Sheffield CCG, the PAM is being integrated in general practice into the delivery of existing services for routine diabetes care. In the redesigned appointment system, clinical time is reallocated to offer a longer appointment to tailor discussion to the appropriate level of activation. This is helping to remove barriers to providing person-centred care, such as clinical availability/ time, training and delivering support relevant to the patients' needs. The PAM is an integral tool in ensuring that resources are allocated appropriately and patients receive care tailored to their needs.

"This person-centric approach will eventually liberate us from wasting time doing the wrong things, in the wrong way, and help healthcare professionals to shape our systems around what patients need at each stage of their life."

Dr Ollie Hart, a GP in Sheffield

Harnessing the information revolution

In April 2015, England became the first country in the world to enable its citizens to book GP practice appointments, order prescriptions and access their medical records online. By April 2016, over 95 percent of GPs were able to offer patients online access to their detailed health record.

This underpins our work to encourage better use of data and technology to extend patient choice, enable citizens to take more control, be more engaged in their own health and care, improve outcomes, and at the same time reduce the administrative burden on the NHS.

In February 2016, DH announced £4.2 billion of funding for NHS technology over the next five years, including £1.8 billion to create a paper free health and care system, following the publication in November 2014 of the National Information Board's strategy, which will support the transformation of care. This funding is underpinned by a benefits case with efficiencies mapped out over the next five years.

In September 2015, we launched guidance for CCGs on extending electronic health records and the development of local digital roadmaps to realise a paper free health and care system by 2020.

Over 17 million patients are able to use the Electronic Prescription Service, which allows them to collect medicines direct from the pharmacy without visiting their GP, or even have them delivered. A third of all prescriptions are now transmitted electronically.

A new E-Referrals system was launched in June 2015, which provides a safe and secure mechanism for patients and referrers to select a provider of their choice and convenient time and date for their appointment.

Over 96 percent of patients now have an electronic SCR, which can be accessed by health professionals with the patient's consent. Its use is increasing on occasions when urgent care is needed, with over 3 million views a year.

Case study: Learning from the Patient Online programme

The Swan Practice in Buckingham sees about 70 patients per day for tests and samples. Until recently, patients had to ring or visit the practice to get their results. Each call lasts approximately two minutes, but can easily take up more time when the patient wants the receptionist to read out the results.

Since August 2015, when the practice started offering online test results to their patients, the number of calls has dropped to 25 per day. This has freed up valuable time for both administrative and clinical staff.

Research and innovation

Genomics

NHS England is a major partner with Genomics England in the 100,000 Genomes Project, a £300 million scheme to collect and decode 100,000 human genomes – complete sets of people's genes. The project, which is looking at certain cancers and rare disorders, has the potential to improve the prediction and prevention of disease, introduce more precise diagnostic tests and lead to the development of new drugs and diagnostics.

In 2015/16 the number of NHS genomic medicine centres was increased from 11 to 13, ensuring equitable access to eligible participants, and 42 NHS trusts are now actively recruiting patients, with a further 50-60 planning to go live during the lifetime of the project. Some patients with rare diseases have received a diagnosis for the first time as a result of having their whole genome sequenced. This is a world leading project, which will result in the use of genomic technologies linked with deep clinical and diagnostic information being mainstreamed in the NHS.

Small Business Research Initiative

This £20 million investment programme is intended to speed up the adoption of new products by the NHS. In 2015/16, three competitions were held for companies to propose new technologies and ideas for improving UEC, the care of older people with multiple conditions and the care of children and adolescents with mental health problems.

258 applications were received, with 26 phase 1 companies being financially supported (up to £100,000 each) to test feasibility of the solutions to the NHS, and 18 companies were funded (up to £1 million each), for phase 2 from previous competitions, to produce their prototypes and test these in healthcare settings.

Test Beds

Seven real world NHS Test Beds were established in January 2016 for evaluating new technologies that offer better care at the same or lower overall cost. They will begin implementing their projects in 2016 and produce evidence of the impact and cost effectiveness of their innovations in 2018.

National Innovation Accelerator

This scheme, launched in January 2015, supports individuals to develop innovations for the NHS. Of 125 applications, 17 fellows were selected and joined the programme in July 2015.

By autumn 2015, 68 more organisations were using National Innovation Accelerator innovations than at the start of the programme. £8.35 million of external funding has been awarded to support further roll out, and six awards have been won. Another eight fellows will be recruited during the summer 2016.

Excess treatment costs

Research is an important core activity of the NHS that NHS England is keen to promote and support in line with its statutory responsibility. It also has a responsibility to ensure that the treatment costs of patients involved in non-commercial research funded by the Government and research charities are met. Anecdotal evidence suggests that the payment of these treatment costs, specifically treatment costs in excess of normal care (excess treatment costs) have become a point of friction between providers and commissioners, both of whom want to support research in the interests of healthcare for patients. This is despite the value of NHS excess treatment costs being small in the context of overall NHS funding.

NHS England worked with DH and other key stakeholders to develop an effective approach to address these issues. As a result, in November 2015 NHS England published new guidance to help clarify the rules and expectations. Development of a costing template, to bring greater transparency, is underway with stakeholders.

How we support the wider NHS

Commissioning

Commissioning is a key driver of quality and efficiency in the NHS. A large part of the funds NHS England receives, amounting to £73 billion, is allocated to the 209 CCGs who use it to buy hospital and other services for their local populations.

During 2015/16, nearly three quarters of CCGs took on an increased role in the commissioning of GP services, and 63 CCGs took on full delegated responsibility, to promote integration of hospital and primary care services.

NHS England provides support to CCGs to ensure they deliver the best outcomes for their patients and obtain the best value from their funds. To help them, commissioning support units (CSUs) were established in 2013 to offer data analysis and advice on procurement, service transformation, contracting, HR and financial management. With new business of £50 million in-year as part of a total income of £630 million, indications are that the CSUs are offering the services their customers seek.

Further detail on our assurance of the commissioning system is included in our Governance Statement from page 101.

Emergency preparedness, resilience and response

NHS England and the NHS in England have considerable experience in emergency preparedness, resilience and response (EPRR), and during the year we responded successfully to a number of potential threats to patient and public safety. We have also been involved in a number of key training and exercise events, to test the EPRR plans in place for a series of scenarios including significant widespread power loss, marauding terrorism, and infectious diseases. The impact of this work includes:

- leading the UK health response to suspected Ebola cases in people travelling back to the UK during the Ebola outbreak in West Africa, which was unprecedented in its scale, severity, and complexity
- working closely with local resilience forums following Storm Desmond, to ensure continued safe access to healthcare for patients. This storm caused large scale flooding and power interruption to the north of the UK – particularly Cumbria – requiring homes to be evacuated, and roads to be closed

- the establishment of a national incident control centre to assure the ongoing delivery of safe patient care during the industrial action undertaken by junior doctors, working closely with key partners.

Equality and health inequalities

NHS England is committed to ensuring fair and equitable access to high quality and appropriate health services which are planned and delivered in proportion to need, with a specific focus upon protected characteristics and disadvantaged groups and areas. Alongside this, we have a legal duty to promote equality under the Equality Act 2010. A report on how we have met the requirements of the specific duties of this Act is now available to read at

www.england.nhs.uk/wp-content/uploads/2016/02/nhse-specific-duties-equality-act.pdf.

Our priority for the year has been to promote equality as a system leader and in collaboration with other parts of the health system, achieved largely through our leadership of the NHS Equality and Diversity Council (EDC). Key achievements include:

- establishing a Quick Wins programme for 2016/17 to improve equity of access to services – and outcomes – for protected groups and people with lived experience of stark inequalities
- publishing new principles for registering patients with GP practices to make it easier for patients to access the healthcare they are entitled to – available to read at www.england.nhs.uk/commissioning/primary-care-comm/resource-primary/
- progressing a unified information standard for all protected groups, and piloting a similar standard on sexual orientation
- mandating the Workforce Race Equality Standard (WRES) and use of EDS2 – the equality delivery system for the NHS – through the NHS Standard Contract in April 2015.

Alongside this, lessons from the first year of the mandatory WRES are being used to develop a new Workforce Disability Equality Standard. In 2015/16, we commissioned primary research from Middlesex University to explore what issues and measures this should comprise, focusing on the experiences of staff with disabilities working within the NHS.

Appendix 2 sets out our assessment that in fulfilling our health inequalities duties in 2015/16 as required by the Health and Social Care Act 2012, we have made reasonable progress but more needs to be done.

Workforce Race Equality Standard

One fifth of the workforce is from a Black or Minority Ethnic (BME) background, but evidence suggests BME staff do not always experience equitable treatment compared to other staff and are not properly represented at senior management levels.

Since mandating the WRES through the NHS Standard Contract, we have worked with the CQC to embed the standard within its inspection programme for hospitals.

The WRES requires NHS organisations to demonstrate progress against a number of indicators of workforce race equality, including a specific indicator to address the low levels of BME Board representation. 82 percent of NHS provider organisations submitted their baseline data against the nine WRES indicators for 2015/16. The data has been analysed and was published in June 2016. Work on implementing the WRES across the NHS is on track and we expect to see the changes it seeks to achieve over the next few years.

Patient safety

The safety of patients is paramount, but healthcare inevitably carries risks. Understanding and managing these risks is vital to secure the best outcomes.

Staff are encouraged to report all patient safety incidents, whether minor or serious, and increasing numbers of reports are seen as a good sign of an improving safety culture. The National Reporting and Learning System is the most comprehensive database of patient safety information in the world, having amassed over 12 million reports since it was established in 2004. Over 1.7 million incidents were recorded in the last year, a pleasing increase of over 10 percent on the previous year, suggesting greater awareness and transparency around patient safety. Ten patient safety alerts were issued in 2015/16, based on these incident reports. This increase in incident reporting should not be taken as an indication of worsening patient safety, but rather as an increasing level of awareness of safety issues amongst healthcare professionals and a more open and transparent culture across the organisation.

New standards on invasive procedures were published in 2015 to reduce the incidence of Never Events – patient safety incidents that can be very serious but which are wholly preventable if national guidance and recommendations are followed.

15 Patient Safety Collaboratives have been developed in partnership with the Academic Health Science Networks (AHSNs) focused on local safety priorities in their areas.

Working with the Health Foundation, 231 patient safety and quality improvement experts were recruited to the Q initiative which is helping connect a critical mass of people highly skilled in quality and safety improvement.

A key source of learning is to study the care of people who died in hospital. We have commissioned the Royal College of Physicians to develop a standard way of doing this.

The rise of antimicrobial resistance poses a major threat to global health. We helped reduce the number of GP prescriptions for antibiotics by more than 2.6 million in 2015/16 compared with the previous year through the introduction of the antimicrobial resistance quality premium and will use similar levers to support this work in hospitals.

The Patient Safety domain and its statutory responsibilities transferred from NHS England to NHS Improvement on 1 April 2016.

Customer contact and complaints

We value feedback from patients and the public about the NHS services we provide and commission, and we use it to improve the quality of services.

In 2015/16, we received 198,100 contacts (including general contacts, complaints and Freedom of Information (Fol) requests, down 5 percent on the previous year. We will be publishing more detailed data on the breakdown between these areas in our customer contact annual report, which will be published on the NHS England website later this year.

We have set out to improve the quality of our customer contacts in a number of ways. We have restructured the contact centre and increased the number of staff answering calls; implemented a new case management system; developed a web portal for launch during 2016/17 and launched a British Sign Language video service for the deaf and hard of hearing. We expect these measures to improve access and performance further.

We have also implemented the Complaints Quality Framework in January 2016. This is a framework for complaints handling; its aim is to improve the quality and consistency of complaints handling across NHS England.

In the past year we centralised oversight of NHS England complaints which progress to the Parliamentary and Health Service Ombudsman (PHSO). This ensures a consistent quality of information sharing between NHS England and the PHSO, permits an overview of all cases in the system, and helps us understand any themes or trends emerging from these complaints. The number of cases referred to the PHSO over 2015/16 was as follows:

Cases referred to the PHSO by outcome and region

	Upheld	Not Upheld	Partially Upheld	Discontinued	Total Cases
North	2	4	2	0	8
Midlands and East	1	2	3	4	10
South	1	2	4	1	8
London	1	2	1	3	7
National	0	1	0	0	1
TOTAL	5	11	10	8	34

Sustainability

Our performance on sustainability is detailed in Appendix 3.

Our priorities for 2016/17

NHS England's continuing contribution to the delivery of the Five Year Forward View is set out in its business plan for 2016/17 and is summarised in this section.

 <p>1</p> <p>IMPROVING THE QUALITY OF CARE AND ACCESS TO CANCER TREATMENT</p>	 <p>2</p> <p>UPGRADING THE QUALITY OF CARE AND ACCESS TO MENTAL HEALTH AND DEMENTIA SERVICES</p>	 <p>3</p> <p>TRANSFORMING CARE FOR PEOPLE WITH LEARNING DISABILITIES</p>
 <p>4</p> <p>TACKLING OBESITY AND PREVENTING DIABETES</p>	 <p>5</p> <p>STRENGTHENING PRIMARY CARE SERVICES</p>	 <p>6</p> <p>REDESIGNING URGENT AND EMERGENCY CARE SERVICES</p>
 <p>7</p> <p>PROVIDING TIMELY ACCESS TO HIGH QUALITY ELECTIVE CARE</p>	 <p>8</p> <p>ENSURING HIGH QUALITY AND AFFORDABLE SPECIALISED CARE</p>	 <p>9</p> <p>TRANSFORMING COMMISSIONING</p>
 <p>10</p> <p>CONTROLLING COSTS AND ENABLING CHANGE</p>	<p>WE HAVE 10 PRIORITIES FOR 2016/17</p> <p>Our mission is to improve health and secure high quality healthcare for the people of England, now and for future generations.</p>	

Improving health – closing the health and wellbeing gap

- We will drive down waiting times for cancer treatment, increase diagnostic capacity and develop a modern national radiotherapy network, as recommended in the Cancer Taskforce report published in July 2015.
- For people with mental health problems, we will increase early intervention, shorten waits for treatment and expand crisis services, in line with the Mental Health Taskforce report, published in February 2016.
- We will increase the number of people with learning disabilities living in homes in the community in place of specialist inpatient units, so that they have a chance of a better life.
- We will roll out a national programme aimed at lowering the risk of developing Type 2 diabetes for individuals and slowing the rise in incidence of the disease.

Transforming care – closing the care and quality gap

- We will improve access to urgent and emergency care services by creating a single point of urgent telephonic contact through NHS 111, and we will support hospitals to extend emergency consultant cover and diagnostic services seven days a week.
- We will improve access to primary care and support GPs to extend services by widening the workforce, harnessing digital technology and increasing use of pharmacists.
- We will commit an extra £2.4 billion a year to support general practice services by 2020/21. This means spending will rise from £9.6 billion in 2015/16 to over £12 billion by 2020/21 – a 14 percent real terms increase.
- We will support hospitals to hold down waiting times for elective care, including through patient choice.
- We will tackle unwarranted variations in the cost of specialised services, implement a prioritisation framework and use our national leverage to improve outcomes and value for money.
- We will support the continued development of commissioning, encourage demonstrative integration of primary and acute care and plan for the spread of new care models.

Controlling costs and enabling change – closing the finance and efficiency gap

- We will work to ensure delivery of NHS England's contribution to the NHS efficiency challenge.
- We will roll out the RightCare programme to obtain the best value care by optimising spending across areas and specialties.
- We will support NHS Improvement to implement the recommendations of the Carter Review, deliver year on year trust deficit reduction plans, and reduce spending on agency staff.
- We will focus, with our partners, on making better use of technology, further developing leadership and supporting scientific research and innovation.
- We will involve the public by empowering patients and engaging communities, increasing patient choice and developing more personalised services in maternity and end of life care.

Chief Financial Officer's Report

The financial statements for the year ending 31 March 2016 are presented later in this document and show the performance of both the consolidated group – covering the whole of the commissioning system – and NHS England as the parent of the group. The group comprises NHS England and 209 clinical commissioning groups (CCGs), consolidated through the Integrated Single Financial Environment (ISFE), a financial accounting and reporting system covering all of the organisations concerned.

NHS England had a revenue resource limit of £101,708 million in 2015/16. The organisation is responsible for using this money wisely and fairly to secure the best possible outcomes for both patients and taxpayers. As shown later in this report, the group fulfilled all of the financial duties set out in the mandate for 2015/16, covering revenue spending, administration costs and capital expenditure. Although not legally responsible for ensuring financial balance across providers of NHS funded services, or for ensuring the Department of Health (DH) meets its overall Revenue and Capital Departmental Expenditure Limits; throughout 2015/16 NHS England has actively sought to maximise the contribution of the commissioning sector to the overall DH financial position in light of the scale of provider deficits.

Long term expenditure trends from the establishment of NHS England in 2013/14 are set out in the Parliamentary Accountability and Audit Report on page 115.

A full list of CCGs can be found on the NHS England website at:

www.england.nhs.uk/resources/ccg-directory/.

Operational performance

The core measure for the financial performance of NHS commissioners is the non-ringfenced Revenue Departmental Expenditure Limit (RDEL), or general RDEL. The plan was for in-year expenditure of £100,882 million against this limit, and actual expenditure was £100,283 million, which represents an underspend equivalent to 0.6 percent of planned expenditure.

The key features of the 2015/16 financial position are shown in more detail in the following table:

Financial performance 2015/16 – RDEL general (non-ringfenced)	Expenditure		Under/(over)spend against plan	
	Plan £m	Actual £m	£m	%
Clinical commissioning groups	72,244	72,259	(15)	0.0
Direct commissioning	26,769	26,687	82	0.3
NHS England/central programmes	1,585	1,245	340	21.4
Historic continuing healthcare claims administered on behalf of CCGs	284	92	192	67.7
Total RDEL – general	100,882	100,283	599	0.6

NHS England has generated an underspend of £599 million (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 in budget setting for 2016/17 to maximise funding available for frontline services and transformation in a year of exceptional challenge for the NHS.

At the year end, 62 CCGs reported underspends totalling £122 million against their annual plan, and 39 CCGs reported overspends totalling £151 million. The overall CCG position included a £13 million underspend on Quality Premium. 31 CCGs finished the year with cumulative deficits, 10 of which were unplanned. The measures to improve CCG resilience, which we have taken in 2015/16, have resulted in a reduction in the number and scale of significant overspends. Only four CCGs overspent by more than two percent (2014/15: eight percent), and the largest CCG overspend was five percent (2014/15: 10 percent).

In direct commissioning, specialised services teams achieved a small underspend (£14 million) on their operational performance, reflecting the significant programme of measures undertaken over the last two years to improve management processes and controls. At the end of 2015/16, three out of four regions balanced overall within their specialised allocations. However, despite this improved performance, when adding into

specialised commissioning the Cancer Drugs Fund (CDF), it overspent by £112 million in total due to overspends on the CDF of £126 million (37 percent) despite reprioritisations undertaken during the year. A new approach to prioritisation and financial management of drugs within the CDF will be introduced in July 2016 following the recent consultation process in partnership with the National Institute for Clinical Excellence (NICE). This is designed to provide access to potentially effective cancer drugs in a way which secures value for money and ensures that the fund remains within the agreed envelope of £340 million. These variances were offset by underspends in other areas of direct commissioning amounting to 1.6 percent.

Central programme and running costs underspent by £340 million, primarily due to reduced redundancy and transition costs, underspends on DH managed budgets hosted by NHS England, unplanned rates rebates, underspends on a number of directorate programme budgets and the freezing of contingencies. The bulk of these variances relate to non-recurrent budgets and income available to NHS England in 2015/16, and the recurrent elements have been reflected in reduced central budgets for 2016/17.

The other significant underspend in 2015/16 was on settlements relating to legacy continuing healthcare claims. This amounted to £192 million (on a general RDEL basis). In the light of experience in 2014/15 and 2015/16, the budget in 2016/17 has been reduced to reflect the likely levels of claim settlement.

Performance against wider financial metrics

Within the mandate, DH sets a number of technical financial targets, including the general RDEL metrics described above, against which NHS England is expected to deliver. These limits are ringfenced, which means that underspends in other areas cannot be used to support core patient services covered by the general RDEL limit.

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

	Target			Target met
	Mandate limit £m	Actual £m	Underspend £m	
Revenue limits				
RDEL – general	100,882	100,283	599	✓
RDEL – ringfenced for depreciation and operational impairment	166	89	77	✓
Annually Managed Expenditure limit for provision movements and other impairments	300	(254)	554	✓
Technical accounting limit (e.g. for capital grants)	360	73	287	✓
Total revenue expenditure	101,708	100,191	1,517	
Administration Costs (within overall revenue limits above)				
Total administration costs	1,862	1,649	213	✓
Capital Limit				
Capital expenditure contained within our Capital Resource Limit (CRL)	300	176	124	✓

Allocations

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

Following the outcome of the Spending Review in November 2015, the NHS England Board approved allocations for the commissioning sector for the next five years, 2016/17 to 2020/21, with firm allocations for the first three years and indicative allocations for the final two years.

These allocations were intended to achieve:

- faster progress towards our strategic goals, particularly through higher funding growth for GP services, increased operational and transformational investment in mental health and the establishment of a Sustainability and Transformation Fund of £2.14 billion for 2016/17, of which £1.8 billion is being deployed on sustainability to stabilise NHS operational performance, and £340 million for transformation to continue the vanguard programme and invest in other key areas, prioritised within the Five Year Forward View
- greater equity of access, by bringing allocated funding closer to target levels, with all CCGs no more than five percent under target for CCG commissioned services and all CCG areas no more than five percent under target for the total commissioning streams for their population
- closer alignment with population need through improved allocation formulae, including improvements to inequalities adjustments and a new sparsity adjustment for remote areas
- better visibility of projected total commissioning resources by locality to stimulate and support the development of place-based commissioning and stronger long term collaboration between commissioners and providers.

Future financial sustainability

The Five Year Forward View set out how, in the absence of further annual efficiencies in the NHS, a combination of growing demand from an ageing population, increases in the costs of running the NHS and constrained funding growth would produce a significant mismatch between the growth in resources available and the funding required to deliver what patients need. It estimated the incremental real annual funding requirement of the NHS at between £8 billion and £21 billion by 2020/21.

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. 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 is reflected in NHS cash funding growth from £101.0 billion in 2015/16 to £119.6 billion in 2020/21. In May 2016, we published a recap briefing for the Health Select Committee on technical modelling and scenarios for the Five Year Forward View which can be viewed at www.england.nhs.uk/ourwork/futurenhs/#related.

While this implies an efficiency requirement of £22 billion by 2020/21, the majority of these efficiencies are not cost reductions per se, but rather the more effective use of resources within a growing budget. Furthermore, the Spending Review assumes that around £7 billion of the total efficiencies will be delivered nationally, leaving £15 billion to be sourced locally. We expect that these local contributions will be delivered through a combination of actions by commissioners and providers. Commissioners will work with partners across their health economies to moderate the level of activity growth through care redesign, promotion of self care, investments in prevention, and the delivery of best possible value through programmes such as RightCare, whilst providers across the full range of NHS services will be supported to deliver a significant programme of operational efficiency improvement.

During 2015/16, NHS England has supported the mobilisation and implementation of key efficiency programmes within our scope. Throughout 2016/17, we will continue to ensure NHS England's contribution to the overall efficiency agenda by delivering our contribution to the closure of the finance and efficiency gap. STPs, drawn up by 44 geographical footprints, will be the vehicle through which we will demonstrate routes to financial sustainability in every health economy around the country.