ACCOUNTABILITY REPORT

Simon Stevens
Accounting Officer
3 July 2017

The purpose of the Accountability Report is to set out how we meet key accountability requirements to Parliament. It comprises three key sections:

Corporate Governance Report

This explains how NHS England has been governed during 2016/17, including membership and organisation of our governance structures and how they support achievement of our objectives. The report includes the Directors' Report, the Statement of Accounting Officer's Responsibilities and the Governance Statement. The Corporate Governance Report is set out from page 85.

Remuneration and Staff Report

This sets out our remuneration policies for non-executive directors and the executive directors and how these policies have been implemented for the reporting period, including salary information and pension liabilities. It also provides further detail on remuneration and staff. The Remuneration and Staff Report is set out from page 144.

Parliamentary Accountability and Audit Report

This brings together key information to support accountability to Parliament, including a summary of fees and charges, remote contingent liabilities and the Certificate and Report of the Comptroller and Auditor General to the House of Commons. The Parliamentary Accountability and Audit Report is set out from page 171.

Corporate Governance Report

Directors' Report

The Board

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

These arrangements comply with the National Health Service Act 2006 (as amended) which requires that the Board consists of at least five non-executive directors, other than the Chair, and that the number of executive directors is less than the number of non-executive directors (including the Chair).

Roles and responsibilities

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

- sets the overall direction of NHS England, within the context of the NHS mandate
- approves the business plan, which is designed to support achievement of NHS England's strategic objectives and monitors NHS England's performance against it
- holds NHS England's executive group to account for this performance and for the proper running of the organisation (including operating in accordance with legal and government requirements)
- determines which decisions it will make and which it will delegate to the executive group via the Scheme of Delegation
- ensures high standards of corporate governance and personal conduct
- monitors the performance of the group against core financial and operational objectives

- provides effective financial stewardship
- promotes effective dialogue between NHS England, government departments, other arm's length bodies, partners, CCGs and providers of healthcare and communities served by the commissioning system.

Appointment

Board members bring a range of complementary skills and experience in areas such as the patient and public voice, finance, governance and health policy. New appointments take account of the skills already represented on the Board and recognise where there are gaps that could be filled. The Chair and non-executive directors are appointed by the Secretary of State for Health; executive members are appointed by the Board. One new non-executive director, Joanne Shaw, was appointed to the NHS England Board in October 2016.

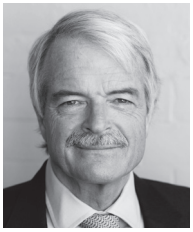
Register of Members' Interests

NHS England is committed to openness and transparency in its work and decision making. As part of that commitment, we maintain and publish a Register of Members' Interests which draws together Declarations of Interest made by Board members. The register of interests is a public document which is open to public scrutiny and is published on NHS England's website. The register is reviewed on a monthly basis. This may be viewed at www.england.nhs.uk/about/whos-who/reg-interests/.

Board members are required to notify and record any interests relevant to their role on the Board. In addition, members of the Board are required at the commencement of each Board meeting, and whenever relevant matters are raised, to declare any personal interest they may have in any business on the agenda and abstain from related Board discussion as required.

Details of related party transactions, where NHS England has transacted during 2016/17 with other organisations, to which an individual holding a director position within NHS England is connected, are set out in Note 17 of the Annual Accounts.

NHS England's non-executive directors



Chairman: Professor Sir Malcolm Grant CBE

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

Appointed to the Board: 31 October 2011
(Reappointed to second term from 31 October 2015)

Term expires: 30 October 2018

Committee membership: Strategic HR and Remuneration Committee (Chair). In addition, the Chair reserves and exercises the right to attend meetings of all committees.

Vice-Chair: David Roberts

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

Appointed to the Board: 1 July 2014

Term expires: 30 June 2018

Committee membership: Commissioning Committee (Chair); Audit and Risk Assurance Committee (interim Chair until 30 September 2016); Strategic HR and Remuneration Committee.

Lord Victor Adebowale CBE

Skills and experience: Victor Adebowale is currently Chief Executive and company secretary of Turning Point. He is a crossbench peer and Visiting Professor and Chancellor at the University of Lincoln, a Fellow of the City and Guilds of London Institute, and an associate member of the Health Service Management Centre at the University of Birmingham. He is a director of Leadership in Mind and a Director of IOCOM. Victor is Chair of youth charity Urban Development, Chair of Social Enterprise UK, and Chair of Collaborate CIC. He is a non-executive director of the Co-Operative Group and sits on the Board of Governors for the London School of Economics and on the Board of The Social Investment Partnership. Victor is President of the International Association of Philosophy and Psychiatry. His previous roles include being the Chief Executive at Centre Point, the youth homelessness charity, and membership of the United Kingdom Commission for Employment and Skills.

Appointed to the Board: 1 July 2012
(Reappointed to second term from 1 January 2015)

Term expires: 31 December 2018

Committee membership: Commissioning Committee.

Wendy Becker

Skills and experience: In her executive career, Wendy Becker had many years of experience leading consumer-related organisations, creating strategies and driving change. Wendy spent 15 years at McKinsey and Company in both San Francisco and London with nine years as a partner. She has held a number of senior roles in industry including as Chief Executive Officer of Jack Wills and as Global Chief Marketing Officer and member of the Executive Committee at Vodafone plc. Wendy is a non-executive director for Great Portland Estates Plc, a member of the finance committee of the Oxford University Press, the Deputy Chairman of Cancer Research UK, and a Trustee of the Prince's Trust and the Design Museum. She holds a BA in Economics from Dartmouth College and an MBA from Stanford's Graduate School of Business. She completed a nine year term as a non executive director of Whitbread Plc during this year.

Appointed to the Board: 1 March 2016

Term expires: 29 February 2020

Committee membership: Audit and Risk Assurance Committee; Investment Committee (with effect from 1 June 2016).

Professor Sir John Burn

Skills and experience: John Burn is a senior clinical geneticist and academic, based in Newcastle. He holds the NHS Endowed Chair in Clinical Genetics at Newcastle University, and conceived and helped to bring to fruition the Millennium Landmark Centre for Life in Newcastle. He is a distinguished academic, clinician, and clinical entrepreneur, as founder of two spin-off companies in the field of genetic diagnostics. He is Chairman of QuantuMDx Ltd, a medical device company developing point of care DNA testing for the developing world. He was knighted for services to medicine and healthcare in 2010.

Appointed to the Board: 1 July 2014

Term expires: 30 June 2018

Committee membership: Specialised Services Commissioning Committee.

Dame Moira Gibb

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

Appointed to the Board: 1 July 2012
(Reappointed to second term from 1 January 2015)

Term expires: 31 December 2018

Committee membership: Investment Committee (Chair); Strategic HR and Remuneration Committee.

Noel Gordon

Skills and experience: Formerly an economist and a banker, Noel spent most of his career in consultancy until his retirement in 2012 including, 16 years with Accenture where he was Global Managing Director of the Banking Industry Practice. He has extensive practical experience of driving fundamental innovations in transforming industries, and of big data, analytics, mobile and digital technologies. Noel is Chairman of NHS Digital, and of the Healthcare UK Advisory Board. He is a member of the Life Sciences Industrial Strategy Board of the DH, a non-executive director of the Payments Systems Regulator, a member of the Audit and Risk Committee of the University of Warwick, a member of the Development Board of Age UK, and Chairman of the Board of Trustees of UserVoice.org.

Appointed to the Board: 1 July 2014

Term expires: 30 June 2018

Committee membership: Specialised Services Commissioning Committee (Chair); Commissioning Committee; Audit and Risk Assurance Committee (until May 2016).

Michelle Mitchell OBE

Skills and experience: Michelle Mitchell is Chief Executive Officer of the Multiple Sclerosis Society UK. She is currently a Trustee of the MS International Federation. She was previously a Trustee of the King's Fund. Michelle is a Managing Member of the Progressive MS Alliance and has extensive voluntary sector experience at a leadership level. Before joining the MS Society, she was Director General for Age UK. Prior to that, Michelle was Chair of the Fawcett Society. Michelle has a BA in Economics, an MA in Politics and Administration and an International Executive Diploma from INSEAD. Michelle is an alumna of the Innovations in Government Programme at Harvard University JFK School and the Global Not for Profit Leaders programme at Harvard Business School.

Appointed to the Board: 1 March 2016

Term expires: 29 February 2020

Committee membership: Specialised Services Commissioning Committee.

Joanne Shaw

Skills and experience: Joanne Shaw joined the Board in October 2016. She is a qualified accountant and has chaired the audit committees of the NAO and the Money Advice Service. Her experience in the health sector includes: acute and primary care; urgent care; commissioning; remote and digital health assessment, advice and information; medicines; and prevention. She is currently Deputy Chair of Nuffield Health and Chair of the British Equestrian Federation. As past Chair of NHS Direct, Joanne has a strong interest in the use of mobile and digital channels for health and medicines. In her professional roles and in her writing for health publications she is known for advocating partnership between patients and health professionals and supporting people to make better-informed choices about their health.

Appointed to the Board: 1 October 2016

Term expires: 30 September 2020

Committee membership: Audit and Risk Assurance Committee (Chair).

NHS England's executive group

Chief Executive: Simon Stevens

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

Appointed to the Board: 1 April 2014 (Voting)

Board Committee membership: The Chief Executive reserves and exercises the right to attend meetings of all committees.

Chief Financial Officer: Paul Baumann

Skills and experience: Paul Baumann is NHS England's Chief Financial Officer, providing system leadership to the NHS in delivering best value and financial sustainability. The Finance Directorate, under Paul's leadership, aims to provide a first class financial management service, ensuring NHS England is well advised and provided with excellent financial services at all times. Paul joined the NHS as the first Director of Finance and Investment of NHS London in 2007 following a 22 year career in international financial management at Unilever Plc. Paul is also executive lead for Devolution. Paul is a Fellow of the Chartered Institute of Management Accountants.

Appointed to the Board: 14 May 2012 (Voting)

Chief Nursing Officer: Honorary Professor Jane Cummings

Skills and experience: Professor Jane Cummings is the executive lead for maternity, patient experience, learning disability, equalities and for patient and public participation at NHS England, and is the professional lead for nursing and midwifery in England. Jane has been awarded Doctorates by Edge Hill University and Bucks New University, and is a visiting professor at Kingston University and St George's, University of London.

Appointed to the Board: 1 April 2013 (Voting)

National Medical Director: Professor Sir Bruce Keogh

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

Appointed to the Board: 1 April 2013 (Voting)

National Director: Commissioning Strategy: Ian Dodge

Skills and experience: Ian Dodge joined NHS England in July 2014. During 2016/17 his directorate led the organisation's work on: NHS strategy; sustainability and transformation; planning and implementing the Five Year Forward View; vanguards and the new care models programme; giving power to patients through personalisation and choice; commissioning strategy and development; and prioritising science and innovation.

Appointed to the Board: 7 July 2014 (non-voting)

National Director for Operations and Information: Matthew Swindells

Skills and experience: Matthew Swindells joined NHS England in May 2016 from the Cerner Group and his role as Senior Vice President for Population Health and Global Strategy. He has over 25 years' experience in health care services and senior roles include Chief Information Officer at the DH, Senior Policy Advisor to the Secretary of State for Health, Principal Adviser in the Prime Minister's Office of Public Service Reform and Chief Executive of the Royal Surrey County Hospital. He is visiting professor and Chair of the advisory committee in the School of Health Management at the University of Surrey and Member of the Editorial Board for the Journal of Population Health Management.

Appointed to the Board: 30 May 2016 (non-voting)

National Director: Transformation and Corporate Operations: Karen Wheeler CBE

Skills and experience: Karen Wheeler is responsible for ensuring NHS England's governance, organisation and corporate services are effective and support staff to deliver their objectives. Karen oversees delivery of all NHS England's Business Plan priorities and major change programmes, and has executive oversight of CSUs.

Appointed to the Board: 1 April 2014 (non-voting)

The following member of the Executive Group served for part of the year:

Interim National Director: Commissioning Operations: Richard Barker

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

Appointed to the Board: 1 January 2016 to 30 May 2016 (non-voting)

Board meeting attendance

NHS England remains committed to transparency and regularly holds public Board meetings. Board papers, and the minutes of those meetings, are published on the NHS England website at www.england.nhs.uk/about/whos-who/board-meetings/. In addition arrangements exist to publish the agenda and papers from the private meetings one year after the meeting, where this does not compromise commercial or other confidentiality requirements.

Member	Number of eligible meetings attended during the year	Comment
Professor Sir Malcolm Grant (Chair)	6/6	
David Roberts (Vice-Chair)	6/6	
Lord Victor Adebowale	5/6	Absence agreed with Chair
Wendy Becker	5/6	Absence agreed with Chair
Professor Sir John Burn	6/6	
Dame Moira Gibb	6/6	
Noel Gordon	6/6	
Michelle Mitchell	5/6	
Joanne Shaw	3/3	Appointed October 2016
Simon Stevens	6/6	
Paul Baumann	6/6	
Professor Jane Cummings	6/6	
Professor Sir Bruce Keogh	6/6	
Matthew Swindells	5/5	Appointed 30 May 2016
Ian Dodge	6/6	
Karen Wheeler	6/6	
Richard Barker	1/1	Member until 30 May 2016

Board diversity

NHS England had nine non-executive directors as at 31 March 2017, four of whom were female and five were male. Of the seven members of NHS England's executive group as at 31 March 2017, five were male and two were female.

Board performance

The Board had planned to undertake a review of its performance as part of a development session in the autumn of 2016; however changes to Board membership during the year meant this was deferred. Following discussion with the Chair, the Board has arranged for an external review, similar to that undertaken in 2014/15, to be undertaken during 2017/18.

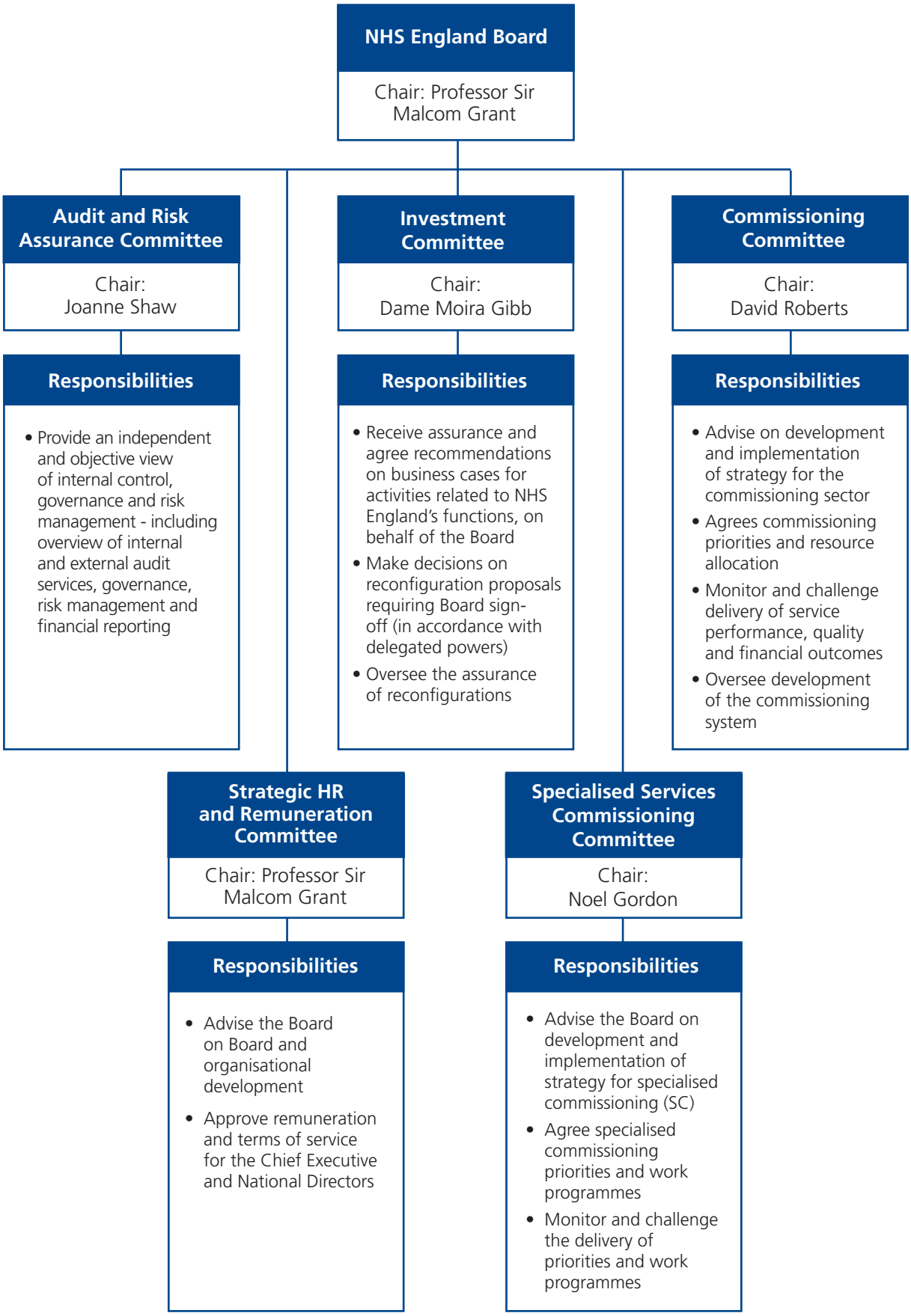
Board committees

The Board is supported by five committees which underpin the Board's assurance and oversight of the organisation. The committees are part of NHS England's formal governance structure and provide the Board with regular reporting and formal assurance. This helps the Board to spend a significant proportion of its time on strategic decision-making, whilst obtaining proper assurance that decisions across the organisation have been made effectively based on the correct information.

Every committee provides a report to the Board following each meeting, ensuring the Board is kept informed of how the committees have discharged their delegated responsibilities. In addition, each committee provides the Board with an annual report covering their effectiveness, a review of the activities in the previous year, a summary of the priorities for the coming year and a review of the terms of reference. The Accounting Officer, as well as being a member of the Board, is similarly informed of each committee's activities through discussions with the relevant Chair.

The Chair and Accounting Officer reserve and exercise the right to attend meetings of all committees. In addition, all non-executive directors have a standing invitation to attend and participate in any of the Board committees' meetings.

NHS England Board and Committees



Audit and Risk Assurance Committee

Role of the Committee

The Audit and Risk Assurance Committee (ARAC) provides independent and objective assurance to the Board on how NHS England manages its system of internal control, governance and risk management. This includes an overview of internal and external audit services and financial reporting.

Committee members

The Committee met five times during the year. The following table details core membership and the number of meetings attended by each member:

Member	Number of eligible meetings attended during the year	Comment
Joanne Shaw (Chair)	3/3	Appointed October 2016
David Roberts	5/5	Interim Chair until 30 September 2016
Wendy Becker	4/5	Absence agreed with Chair
Noel Gordon	1/1	Member until end May 2016
Gerry Murphy	4/4	Non-executive Chair of the Department of Health's Audit and Risk Committee and member since June 2016

Committee attendees

Additional attendees are invited to attend meetings to assist with committee business. For 2016/17, these have included:

- Chief Financial Officer
- National Director: Transformation and Corporate Operations
- Director of Financial Control
- Director of Governance
- Director of Finance and Assurance (CSU Transition Team)
- Head of Internal Audit (Deloitte)
- Director responsible for Health at the National Audit Office (NAO)
- Chief Executive, NHS Protect

Principal activities during the year

The Committee has provided regular progress reports to the Board on its key duties which included:

- reviewing the organisation's risk profile and the management and mitigation of current and emerging risks, and ensuring that all corporate risks have an accountable national director and delegated risk owner
- evaluating the effectiveness of NHS England's control environment
- assessing the integrity of NHS England's financial reporting and satisfying itself that any significant financial judgements made by management were sound
- considering relevant reports from the Comptroller and Auditor General (NAO) on NHS England's accounts and the achievement of value for money
- commissioning and receiving internal audit reports on the adequacy of internal control systems, risk management and corporate governance
- reviewing the activities of internal and external auditors, including monitoring their independence and objectivity
- oversight of the organisation's arrangements for counter fraud.

Planned activities during the coming year

In 2017/18, the Committee will:

- consider areas for review by Internal Audit, approve the 2017/18 plan of work and monitor delivery against that plan and any continuing work from 2016/17
- continue to receive updates from National Directors on key control priorities and outstanding internal audit actions and key risks in their respective Directorates
- consider a refresh of the NHS England Economic Crime Strategy which will reflect any changes in the counter fraud landscape and priorities, and review and approve the proactive Counter Fraud Plan for 2017/18
- review the plan for delivery of the 2017/18 Annual Report and Accounts
- review updates from the NAO on progress with their audit work
- receive a governance report at each meeting to include consideration of corporate risks, updates to the governance manual and the status of Internal Audit recommendations
- oversee other key areas such as reporting against the Government's mandate to the NHS and delivery of NHS England corporate priorities.

Commissioning Committee

Role of the Committee

The Committee provides advice to the Board on the development and implementation of strategy for the commissioning sector, agrees commissioning priorities and allocation of resources, and receives assurance that performance, quality and financial outcomes are delivered, including financial performance monitoring. It also oversees assurance and development of the commissioning system.

Committee members

The Committee met nine times during the year. The following table details core membership and the number of meetings attended by each member:

Member	Number of eligible meetings attended during the year	Comment
David Roberts (Chair)	9/9	
Lord Victor Adebowale	9/9	
Noel Gordon	7/9	
Simon Stevens	8/9	
Paul Baumann	8/9	
Professor Jane Cummings	7/9	
Professor Sir Bruce Keogh	9/9	
Ian Dodge	9/9	
Matthew Swindells	8/8	Member since June 2016
Richard Barker	1/1	Interim National Director: Commissioning Operations until 30 May 2016

Committee attendees

Additional attendees are invited to attend meetings to assist with committee business. For 2016/17, these have included:

- Director of Primary Care
- Director of Commissioning Development
- Director of Financial Planning and Delivery
- Regional Director (North)
- CCG representative

Principal activities during the year

Over the year, the Committee has focussed on:

- delivery of the main system transformation programmes, including urgent and emergency care reform, GP Forward View, RightCare, new care models, self care and self management, personal health budgets and pharmacy reform
- operational planning for 2017/18 and beyond
- overseeing STP plans
- overseeing the allocations process and agreeing the approach to CCG allocation adjustments for 2017/18
- assurance of financial and service performance, both within NHS England and across the commissioning system
- oversight of the development of a single integrated assurance process across NHS England and NHS Improvement for novel contracts
- CCG improvement, assessment and assurance processes ensuring that CCGs meet their statutory duties

- maintaining oversight on behalf of NHS England of: the commissioning system and its development, including the continued development of NHS England's commissioning strategy and setting out NHS England's expectations of the commissioning system in delivering the FYFV
- agreeing recommendations for CCGs taking on the delegation of primary medical care commissioning functions on behalf of the Board as well as the process and decision criteria for CCG mergers
- oversight of devolution programmes and related decision making.

Planned activities during the coming year

The Committee agenda in 2017/18 will continue to be based around the three strands set out above, but with a strong focus on the main elements outlined in Next Steps on the NHS Five Year Forward View particularly:

- the priority transformation programmes for urgent and emergency care, cancer, primary care and mental health
- the integration of care locally through STPs, Accountable Care Systems and new care models
- the NHS 10 point efficiency plan.

Specialised Services Commissioning Committee

Role of the Committee

The Committee provides advice to the Board on the development and implementation of NHS England's strategy for commissioning of prescribed specialised services, providing assurance of quality, performance and value for money.

Committee members

The Committee met eight times during the year. The following table details core membership and the number of meetings attended by each member:

Member	Number of eligible meetings attended during the year	Comment
Noel Gordon (Chair)	8/8	
Professor Sir John Burn	5/8	
Michelle Mitchell	4/6	Member since May 2016
Professor Sir Bruce Keogh	7/8	
Paul Baumann	8/8	
Ian Dodge	5/8	
Matthew Swindells	0/5	Member since July 2016
John Stewart	8/8	Director of Specialised Commissioning
Simon Stevens	5/8	

Committee attendees

Additional attendees have been invited to attend meetings to assist with committee business. For 2016/17, these have included:

- Clinical Director for Specialised Commissioning
- Director of Strategy and Policy, Specialised Commissioning

Principal activities during the year

Over the year, the Committee has:

- overseen the development and implementation of:
  - a new strategic framework for specialised services, setting out expectations for delivering the FYFV and taking it forward through STPs
  - a new prioritisation process for new drugs and treatments
  - service reviews, including for high cost drugs and devices
- overseen the launch of the joint consultation with NICE on technology appraisals[7] and a consultation on NHS England's policies on service developments and individual funding requests
- reviewed and agreed the routine commissioning of 33 new treatments
- provided assurance and oversight for:
  - the new Cancer Drugs Fund
  - specialised commissioning financial plans for 2016/17 and 2017/18
  - operational decisions taken by NHS England's Specialised Commissioning Oversight Group (SCOG).

7. Changes to the arrangements for evaluating and funding drugs and other health technologies appraised through NICE's Technology Appraisal and Highly Specialised Technologies programme.

Planned activities during the coming year

The Committee's priority for 2017/18 will be to continue supporting the implementation of the strategic framework for specialised services. This will require the Committee to:

- provide assurance on how specialised commissioning is supporting improvements in patient care in relation to NHS England's priorities, particularly for mental health, learning disabilities and cancer
- provide assurance on financial control for specialised services and on achieving specialised services efficiency savings for 2016/17 to 2020/21
- oversee the implementation of place-based commissioning of specialised services where appropriate
- oversee ongoing work around data and information, including implementation of RightCare for specialised commissioning
- consider which new treatments will be routinely commissioned by NHS England for 2017/18 and 2018/19, taking advice from the Clinical Priorities Advisory Group (CPAG) and SCOG
- oversee the Medicines Value Programme, which aims to identify potential opportunities to maximise value from medicines.

Investment Committee

Role of the Committee

The Investment Committee scrutinises and approves significant and/or multi-year expenditure on high cost activities relating to NHS England's functions, including those relating to capital expenditure. It receives assurance and agrees recommendations on high value business cases on behalf of the Board.

The Committee also oversees the assurance of service change and reconfigurations and has delegated powers to make decisions on those requiring Board sign-off, supported by advice from the Oversight Group for Service Change and Reconfiguration (OGSCR).

Committee members

The Committee met eight times during the year. In addition, it carried out its function by correspondence once in April 2016 and held a specific conference call to address an investment decision in October 2016.

The following table details core membership and the number of meetings attended by each member:

Member	Number of eligible meetings attended during the year	Comment
Dame Moira Gibb (Chair)	8/8	
Wendy Becker	5/7	Member since June 2016
Paul Baumann	8/8	
Ian Dodge	6/8	
Matthew Swindells	5/5	Member since September 2016

Committee attendees

Additional attendees are invited to attend meetings to assist with committee business. For 2016/17, these have included:

- Director of Strategic Finance
- Director of Financial Planning and Delivery
- Director of Financial Control
- Director of Operations and Delivery.

Principal Committee activities during 2016/17:

- Provided overall assurance on the Transformation Fund for 2017/18 and 2018/19, and approved a number of investment cases using Best Possible Value methodology for investment decision making. This has included proposals for allocating funding for Wave 1 new care model vanguard sites, and approving investment in a number of successful bidders for transformation funding from priority programmes such as cancer, mental health, diabetes and learning disabilities.
- Regularly reviewed the pipeline of service change and reconfiguration proposals presented by the OGSCR. The Committee has made decisions on a number of reconfiguration proposals in advance of consultation, assessing quality and financial implications and ensuring compliance with applicable national guidance, legislation and best practice.
- Approved other capital and non-clinical revenue expenditure business cases, in line with Standing Financial Instructions (SFIs), and agreed the business as usual capital budget across the commissioning sector for 2017/18 and 2018/19.

Planned activities during the coming year

In 2017/18, the Investment Committee will continue to scrutinise and approve expenditure on activities relating to NHS England functions within limits set in the SFIs. In particular, the Committee will support transformation by approving investments and continuing to oversee the assurance of service change and reconfiguration proposals to support STP footprints.

Strategic HR and Remuneration Committee

Role of the Committee

The Committee provides the Board with assurance and oversight of all aspects of strategic people management and organisational development, and it approves the appointment, remuneration and terms of service for the Chief Executive and members of the executive group in line with the DH and arm's length bodies' pay framework and Government decisions on public sector pay arising from the recommendations of the Senior Salaries Review Body.

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

Committee members

The Committee met twice during the year. The following table details core membership and the number of meetings attended by each member:

Member	Number of eligible meetings attended during the year
Professor Sir Malcolm Grant (Chair)	2/2
Dame Moira Gibb	2/2
David Roberts	2/2

Committee attendees

Additional attendees are invited to attend meetings to assist with committee business. For 2016/17, these have included:

- Chief Executive
- National Director: Transformation and Corporate Operations
- National Director: Operations and Information
- Chief People Officer
- Regional Director of People and Organisation Development (London).

Principal activities during the year

Over the year the Committee has focused on NHS England's approach to talent management, improving workforce diversity, staff engagement and experience within NHS England and action plans to further enhance these areas. Other activities have included reviewing NHS England's talent management outcomes, progress with improving workforce race equality and diversity and scrutinising NHS England's staff experience and engagement outcomes and plans to improve in this area.

Additionally, the Committee approved outcomes from the annual appraisal of the Chief Executive and his voluntary decision to continue with a 10% reduction in base pay for 2016/17. The Committee also received reports assuring it about the implementation of the revised DH and arm's length bodies Executive and Senior Manager (ESM) pay framework and approved decisions relating to the targeted allocation of consolidated and non-consolidated pay awards to this group of senior staff for the financial year.

Planned activities during the coming year

During the coming year, the Committee will focus primarily on reviewing organisational development plans and the alignment of NHS England's support for and enablement of Next Steps on the NHS Five Year Forward View and STP across the system. The Committee will continue to review progress with talent management, workforce diversity and inclusion, and overall staff experience and engagement throughout the year ahead. Finally, the Committee will make decisions in respect of the Chief Executive's annual appraisal and pay and any issues pertaining to National Directors.

Board Disclosures

Disclosure of personal data-related incidents

During 2016/17, 18 Serious Incidents Requiring Investigation (SIRI) had occurred relating to the loss or disclosure of personal sensitive data in NHS England and Commissioning Support Units (CSUs). All were logged and a full investigation undertaken, with details set out from in Appendix 6 from page 273. Unless otherwise stated, remedial actions were implemented for all incidents and the Information Commissioner's Office kept informed as appropriate.

Slavery and Human Trafficking

NHS England fully supports the Government's objectives to eradicate modern slavery and human trafficking. Our Slavery and Human Trafficking Statement for the financial year ending 31 March 2017 was published on our website at www.england.nhs.uk/ourwork/safeguarding in May 2017.

Statement of Disclosure to Auditors

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

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

Board statement

The Board is responsible for preparing and approving the Annual Report and Accounts for 2016/17, and confirm that, taken as a whole, it is fair, balanced and understandable.

Statement of Accounting Officer's responsibilities

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

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

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

In preparing the accounts, the Accounting Officer is required to comply with the requirements of the Government Financial Reporting Manual (HMT, December 2016)[8] and in particular to:

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

The Accounting Officer confirms that the annual report and accounts as a whole is fair, balanced and understandable, and takes personal responsibility for the annual report and accounts and the judgements required for determining that it is fair, balanced and understandable.

As far as the Accounting Officer is aware, there is no relevant audit information of which NHS England's external auditor is unaware, and the Accounting Officer has taken all the steps necessary to make himself aware of any relevant audit information and to establish that the external auditor is aware of that information.

8. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/577272/2016-17_Government_Financial_Reporting_Manual.pdf.

Governance Statement

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

As Accounting Officer, I have responsibility for the system of internal controls supporting and enabling the achievement of NHS England's aims and objectives, whilst safeguarding the public funds and assets for which I am personally responsible in accordance with Managing Public Money and as set out in my Accounting Officer appointment letter. This includes assurance of a number of organisations which are part of the wider commissioning system, including those organisations which NHS England hosts. My responsibilities in relation to the assurance of CCGs are set out from page 133 of this Annual Report.

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

The Government's mandate to NHS England

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

A framework agreement between NHS England and DH additionally sets out the mechanisms through which the accountability relationship is managed and also the ways in which DH and NHS England work in partnership. This includes the principles which underpin our partnership working with the DH and other organisations, patients and the public, including commitment to the values in the NHS Constitution. The framework agreement can be viewed at: https://www.gov.uk/government/publications/framework-agreement-between-dh-and-nhs-england.

Governance arrangements and effectiveness

Governance framework

The governance framework includes the Standing Orders, Standing Financial Instructions, Scheme of Delegation, Risk Management Framework and three lines of defence model. Separate operating frameworks exist for each CSU.

The Governance and Assurance Project (GAP), reporting to the Chief Executive and ARAC, was launched in January 2016. Its purpose has been to improve the assurance and control environment with the organisation, addressing National Audit Office (NAO) and internal audit recommendations and strengthening management accountabilities. The project delivered its objectives and ended in March 2017.

Compliance with the UK Corporate Governance Code

NHS England's arrangements generally comply with the best practice described in the UK Corporate Governance Code (2016). As part of implementing best practice, an assessment is undertaken each year against the code and the Corporate Governance in central government departments: Code of good practice 2011 (HM Treasury). The exceptions arising from this year's assessment are shown in Appendix 7 from page 278.

Board arrangements

Information on our Board and its Committees is set out from page 95.

Harris Review

Having regard to the wider implications of the Harris Review[9], which recommended an explicit assurance that all statutory duties and powers are understood and complied with, NHS England maintains a register of all of the statutory duties and powers conferred on it by the National Health Service Act 2006 and Health and Social Care Act 2012. This provides clarity about the legislative requirements and subsequent changes associated with each of the statutory functions for which it is responsible, including any restrictions on delegation of those functions. Responsibility for each duty and power has been clearly allocated to a national and/or regional director and the register is regularly reviewed by the Director of Governance and Head of Legal Services.

9. www.gov.uk/government/publications/independent-review-into-delegation-of-approval-functions-under-the-mental-health-act-1983.

Other sources of assurance

Internal control assurance framework

Over the past year we have worked with our internal and external auditors to strengthen our assurance framework. Each directorate and region has a designated director-level lead – reporting directly to respective national and regional directors and linking with the governance, audit and risk teams – with responsibility for ensuring risk management, audit actions and other assurance activities are carried out, approved by the relevant senior director and reported and escalated on a regular basis. This provides increased focus and accountability, and improved communication, at operating unit level across the organisation.

Over the past twelve months we have strengthened our governance team whilst making a number of changes to controls and underpinning processes including:

- obtaining regular management assurance from all senior managers, budget holders, Senior Responsible Owners for programmes and directors to confirm their compliance with the organisation's policies and processes
- the introduction of an improved risk management framework and review process and introducing a three lines of defence model
- more timely completion of internal audit actions
- compliance with requirements of travel, expenses and permanent staff establishment controls
- improving adherence to project and programme management controls
- compliance with established processes for business cases, authorisation and appointment for on and off-payroll workers.

These changes will be further incorporated into business as usual processes during 2017/18.

Management assurance

Management assurance processes introduced at the end of 2015/16, now form an important part of our control processes. All staff above Band 9 and all budget holders are required to provide assurance of compliance with controls and accountability requirements. This process strengthens formal accountabilities. Year-end assurance certifications were issued in April 2017 and returns confirm that the work carried out during the year on improving financial controls, commercial disciplines and new off-payroll worker processes has resulted in substantially increased compliance. Areas to focus on in the next return period relate to budget holders, training and returns, and increasing response rates. Implementation of this work continues into the 2017/18 financial year further addressing audit recommendations.

Assuring delivery of corporate priorities and related programmes

This year we implemented new assurance arrangements for our major corporate programmes, including six-monthly stocktakes which reported to the Corporate Executive Group, Executive Group and ARAC.

The Corporate Executive Group (a sub-group of the Executive Group) scrutinises NHS England's corporate delivery and informs Board performance reporting.

The NHS England portfolio includes other programmes, such as those forming our contribution to the Government Major Projects Portfolio, and informatics programmes within the Paperless 2020 'Driving Digital Maturity' portfolio overseen by the Digital Delivery Board.

Assuring the quality of data and reporting

The Board receives reports at each meeting covering finance and operational performance for NHS England as well as the wider commissioning system and NHS. The data contained in these reports is subject to scrutiny by both management and Board committees. Revised risk management and assurance certification processes provide additional assurance. The Board is confident that the information it is presented with has been through appropriate review and scrutiny, and that it continues to develop with changing organisational needs.

Managing risk

In response to audit recommendations an enhanced risk management framework, aligned with the three lines of defence model and strategic challenges identified by the Board, was introduced in December 2016. This will be implemented during 2017/18 through national, directorate and regional levels supported by automated data collection.

All national and regional teams are required to identify, manage and report risks at the appropriate level and escalate, where appropriate, to the Executive Risk Management Group (ERMG) to be considered for inclusion in the Corporate Risk Register. The register has been redesigned in-year to align with the Board's strategic challenges, which are reviewed every six months, and improve consolidation and reporting. Regional oversight enables escalation of the risks affecting CCGs in their locality into NHS England as required via the regional process. This is further validated against the CCG annual reports. Risks on the register are bought to the attention of the Corporate Executive Group, the Board or one of its committees as appropriate.

The Corporate Risk Register is a regular agenda item for ARAC, where the organisation's risk profile is discussed and national directors attend to discuss key risks and issued in their respective parts of the organisation.

Key risks from the Corporate Risk Register, derived on the basis of potential high risk and probability, are:

System efficiency savings and financial sustainability

The NHS continues to be subject to significant cost pressures relating to its funding levels, not all of which are in the direct control of NHS England. We will work with DH and system leaders to support required efficiencies and seek to secure future financial sustainability across the life of the spending review period.

Supporting Sustainability and Transformation Partnership (STP) plans to transform local health economies

The commissioning system needs to secure high quality, comprehensive services within its financial envelope. STPs are being supported to deliver the scale of change that the system needs to deliver the aims of the FYFV. We need to provide the capability and capacity to support planning, and ensure STPs will deliver successful transformation.

Transforming primary care

Transformation in general practice and pharmacy is critical to the delivery of the FYFV and STP plans. We are working through delivery of the General Practice Forward View to increase the number of GPs and other staff, improve access to services and invest in new ways of improving primary care for patients.

Protecting NHS information

We continue to engage across the health and care system to raise awareness of cyber threat, develop our defence, detection and response capabilities and guard against data misuse. The sharing of information is essential to delivering an effective and efficient service and we will continually seek to improve our assurance.

Operational performance

NHS England, in partnership with NHS Improvement and DH, will work to support delivery of key services taking account of NHS Constitution standards on urgent and emergency care, given changing demographics and increasing demand for these services.

The following risks disclosed in our 2015/16 Annual Report are now mitigated to a lower level of risk maintained at directorate level and are no longer listed on the Corporate Risk Register:

- Cancer Drugs Fund. Now subject to an effective cost control mechanism (see CFO report on page 75)
- CSUs. Any loss of business and subsequent loss of income remains a risk, but arrangements such as risk pooling and engagement across national delivery are in place to seek to manage the risk. Further information is set out in the annual report from page 136.

Assuring the quality of services

The Quality Assurance Group provides assurance to the Executive Group, via the Corporate Executive, that mechanisms are in place to identify, manage and escalate quality concerns/issues arising from commissioned services where necessary, specific issues are escalated directly to the Executive Group. This provides a forum to discuss quality issues within NHS England's remit which require national action, considering reports from each region based on outputs from Quality Surveillance Groups, risk summits, patient complaints, safety incidents, CCG assurance conversations, and routine interactions with commissioners and providers and:

- share intelligence between regional and national teams related to quality risks/issues
- develop and publish NHS England's Serious Incident Escalation Process
- establish the Serious Incident Desk to strengthen NHS England's national coordination and management of serious incidents
- strengthen NHS England's processes for responding to and learning from Coroners Prevention for Future Deaths (Regulation 28) Reports.

Whistleblowing

NHS England has policies and arrangements in place to enable whistleblowing for NHS England staff and staff in external organisations. Voicing your Concerns for Staff, our internal whistleblowing policy is accessible via our staff intranet and website. The National Director: Transformation and Corporate Operations is the 'Freedom to Speak Up' guardian for staff in NHS England, and Professor Sir Malcolm Grant, Chair of NHS England, is the Board lead.

NHS England has been a Prescribed Person for primary care services under the provisions within the Small Business, Enterprise and Employment Act 2015, since April 2016. This allows whistleblowers working in primary medical services, dental services, ophthalmic services and local pharmaceutical services to disclose information to NHS England in addition or as an alternative to their own employer. Information on how staff from primary care organisations can raise a concern with us is set out on our website at www.england.nhs.uk/ourwork/whistleblowing/. This activity is overseen by designated regional whistleblowing leads reporting in to the central governance team. Formal reporting commences in April 2017, and will form part of the annual report, but interim arrangements are in place.

During 2016/17, NHS England received 127 external whistleblowing concerns which can be listed under the following themes:

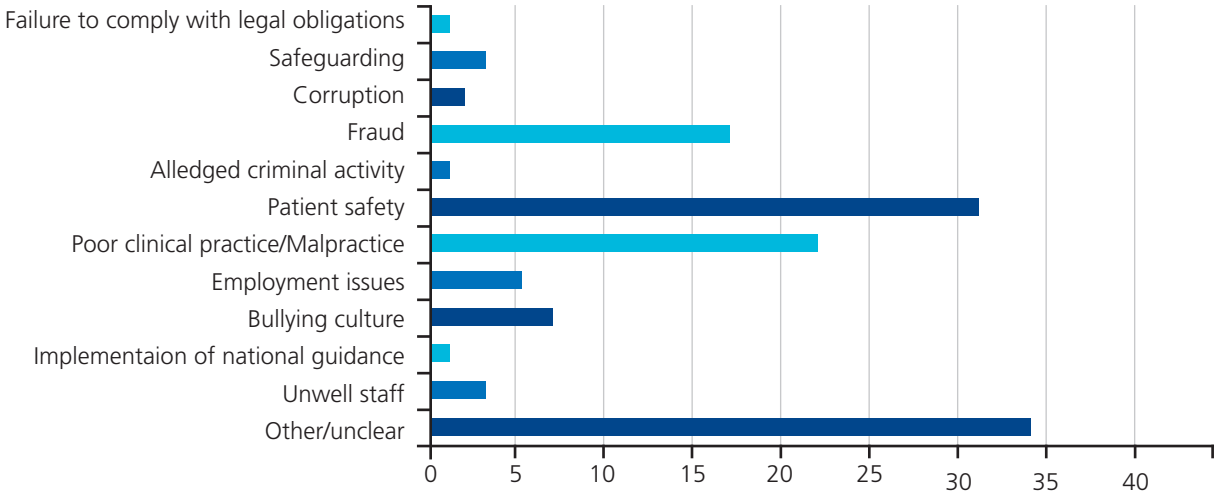


Table of external whistleblowing cases April 2016-March 2017

In the same period, NHS England received four internal whistleblowing concerns, all of which were investigated in accordance with our internal policy. CSUs reported an additional seven concerns which are being investigated under the CSU Raising a Concern Policy. Key themes were: treatment of staff, fraud and behaviours, systems and processes.

Cyber and data security

In July 2016, the National Data Guardian for Health and Care, Dame Fiona Caldicott, published a review into data security, consent and opt-out. It set out ten data security standards that organisations need to follow. A key recommendation is that every organisation should demonstrate clear ownership and responsibility for data security, just as it does for clinical and financial management and accountability.

NHS England already has arrangements in place to protect its information and systems and is working with DH, NHS Improvement and NHS Digital, to take forward the cyber-agenda on a system-wide level following the National Data Guardian Review. In driving forward a system-wide approach, new governance and oversight arrangements have been introduced.

We recognise the importance of embedding this agenda across the service and have implemented a number of activities during 2016/17 which align with the review recommendations and its focus on people, process and technology aspects.

These include:

- including data security standards in key contracts such as the GMS and NHS Standard Contract
- cyber readiness of Data Service for Commissioners Regional Offices (DSCROs) (staff embedded with CSUs, and responsible for handling patient data needed for commissioning)
- embedding end-to-end processes in regional teams (e.g. establishing 'cyber-champions' as key leads) in conjunction with regional leads for incident handing
- embedding cyber requirements within service specifications for primary care services and practice agreements
- providing the NHS England Board with accredited training on cyber and related responsibilities
- establishing a CCG Internal Audit Chair expert group to help develop a toolkit of audit requirements to raise awareness and assurance of the cyber risk.

Approximately 100 countries were hit by the WannaCry ransomware cyber-attack in May 2017. Although the NHS was not specifically targeted, the consequences of such a wide ranging attack were felt across the NHS from GP practices to hospitals. NHS England worked with NHS Digital, NHS Improvement, the National Crime Agency, the National Cyber Security Centre and others to respond to the attack to ensure that patients could continue to use the NHS whilst recovery actions were carried out.

Staff across the NHS worked tirelessly to minimise the disruption to patients, and the majority of immediate recovery actions were completed within a week. Since the attack we have conducted a review of cyber security to ensure the readiness of the NHS to respond to any further threats of this kind.

Information Governance

An Information Governance (IG) operating model and framework has been developed setting out arrangements for the provision of a high quality and effective Information Governance service for NHS England. IG assurance has been strengthened for CSUs through various mechanisms including governance and assurance meetings, monthly compliance statements and an annual independent audit of their IG toolkit assessment. Work is also underway to:

- determine a process for monitoring compliance in general practice with the IG toolkit
- understand the IG assurance mechanisms that are in place and determine the adequacy for other directly commissioned services including specialised commissioning, armed forces healthcare, and secondary dental care
- understand the commissioning responsibilities, data flows and data controllership for health and justice healthcare.

NHS England continues to implement assurance processes to ensure that the collection and provision of data to commissioners is managed appropriately, that only the minimum amount of data is used to support commissioning requirements and that data is being processed safely and securely by staff who understand their responsibilities to protect patient confidentiality. Working closely with NHS Digital, we are also reviewing the processing activities undertaken by CCGs and their support organisations, to ensure that they meet the high standards required to manage patient information for commissioning purposes.

Business critical models

NHS England recognises the importance of quality assurance across the full range of its analytical work. In partnership with analysts in DH, we have developed an approach that is fully consistent with the recommendations in Sir Nicholas Macpherson's review of quality assurance of government analytical models (2013)[10]. NHS England analysts take part in workshops to ensure consistent performance and quality assurance across the full range of analytical work.

For business critical models, where an error would have a significant reputational, financial or patient care impact, NHS England operates a joint approach with DH and other arm's length bodies which includes the maintenance of a register of business critical models and audit of the quality assurance strategy associated with them, overseen by a joint committee of experienced analysts. This committee reviews the quality assurance arrangements for business critical models, based on a self-reported template. Models are regularly reassessed and, to date, all relevant NHS England models in the register have passed.

Business critical models operated by NHS England

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

10. www.gov.uk/government/publications//review-of-quality-assurance-government-models/.

Service auditor reporting and third party assurances

NHS England relies on a number of third party providers (such as NHS Shared Business Services, NHS Business Services Authority, NHS Digital and Capita) to provide a range of transactional processing services ranging from finance to data processing. Our requirements for the assurance provided by these organisations have been reviewed and strengthened over the past year to ensure appropriate formal assurances are obtained to supplement responsibilities for relationship and service provision, and routine customer-supplier performance oversight arrangements.

During the year, service auditor reports have been specifically commissioned to provide assurance over the operation of our control environment, and we are working, where appropriate, with our suppliers to implement ISAE 3402 or similar standards to make sure that the relevant internal controls and control procedures operated by our service organisations have operated effectively. Service providers are requested to address any control weaknesses identified during the ISAE 3402 reporting process within an appropriate timescale.

An adverse audit report was received for Capita and a remedial plan has been agreed for implementation by September 2017.

Internal audit

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

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

Our internal audit service, provided by Deloitte LLP, operates in accordance with Public Sector Internal Audit Standards and to an annual internal audit plan approved by ARAC. Internal audit updates the plan to reflect changes in risk profile, and any revisions are reviewed and approved by ARAC. The internal audit service submits regular reports on the effectiveness of NHS England's systems of internal control and the management of key business risks, together with recommendations for improvement by management (including an agreed timetable for action).

The status of audit recommendations is reported to each meeting of ARAC, which has placed strong emphasis on reducing overdue actions to acceptable levels during the past year. The Head of Internal Audit opinion for 2016/17 is set out from page 141 of this Annual Report.

External audit

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

Control issues

During 2016/17 we have worked to build further controls into a number of management processes identified as requiring improvement:

Strengthening establishment controls

We have addressed previous control issues by strengthening existing processes, controls and resources to manage the on and off-payroll establishment of NHS England. A new workflow system has been introduced covering access to cost centres, change control and management of security passes and IT devices. Changes to the on-payroll establishment are formally approved and captured on the Electronic Staff Record (ESR) system, and effective controls are in place, based on the new workflow involving both finance and human resources teams.

Improving control processes for off-payroll workers

We initiated a dedicated project which has operated during the 2016/17 year to review and improve management and control processes around off-payroll workers. A refreshed off-payroll workers policy has been approved and associated processes redesigned and strengthened. This includes links to the ESR system to provide a single means for managing all our NHS England workforce information, for both employees and off-payroll workers sourced through the Crown Commercial Service frameworks.

A workflow system for approvals containing additional commercial and assurance checkpoints has also been built as part of these strengthened processes. The revised approach will be in operation from April 2017 and implemented across the whole organisation as part of business as usual arrangements between April and July 2017.

This strengthened approach will ensure systematic adherence to our existing policy in that no off-payroll worker can be added to the ESR system unless appropriate approvals are in place, including HM Revenue and Customs compliance.

In addition, arrangements have been established for off-payroll workers engaged on an ad-hoc basis for their specific medical expertise (e.g. medical appraisers, clinical advisers and lay Chairs) to ensure they are engaged through a robust contractual arrangement and that numbers are reportable alongside the ESR data. This will be implemented during the first quarter of the 2017/18 financial year.

Providing stronger controls around business travel and expenses

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

The Business Travel and Expenses policy has been reviewed, and additional controls, enhancing management assurance of activity and spend each month, have been implemented to the satisfaction of auditors.

Improving procurement practices and compliance

Improvements in the period up to year end have included the introduction of more effective business partnering, implementing new governance and assurance arrangements, and work to develop our strategic procurement, supplier relationship management and contract planning. The new team is building a procurement pipeline for 2017/18 as part of wider business planning. Assurance has been strengthened through an improved approvals arrangement which requires approval at two key stages of the commercial lifecycle - procurement strategy (including business case) and contract award - by the Commercial Executive Group, where the commitment exceeds £1 million or relates to a novel or contentious project, or the Commercial Panel in all other cases.

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

The effect so far has been a significant improvement in the quality and content of the business cases, speedier approvals and greater opportunities to deliver value for money savings. More effective contract management processes and tools are being developed and implemented to manage performance of contracts and related risk and assurance. Whilst progress has been recognised, there remains a significant programme of work to be delivered to underpin further improvements in this area and this will continue, and be subject to audit, throughout 2017/18.

Primary Care Commissioning

NHS England has accountability for the contract management of primary care service providers, including those delegated to CCGs. During the year PCSS issues have impacted the ability to fully discharge the relevant accountabilities. In addition, the framework for obtaining assurance over delegated responsibilities for primary care has remained in development.

Strengthening the management of conflicts of interest across the NHS

NHS England has continued to work with partners to strengthen the way that conflicts of interest are managed in the NHS, building on the work developed in 2015/16. The aim of this work is to strengthen and improve the consistency of the rules that NHS organisations, including NHS England itself, have in place to manage conflicts of interest, gifts and hospitality.

The core components of this work are as follows:

- **A cross NHS approach:** The cross system task and finish group, chaired by Professor Sir Malcolm Grant and set up in 2015/16, developed a set of rules that are to be applied consistently across the health system – across all national bodies and agencies including arm's length bodies, professional regulators, local commissioners and NHS providers. The group developed proposals that were put out for consultation in the autumn. Following consideration by the NHS England Board, new guidelines for managing conflicts of interest in the NHS were published in February 2017 and can be accessed at https://www.england.nhs.uk/ourwork/coi/.
- **Strengthening NHS England's internal policy:** Work has been undertaken to revise NHS England's procedures to implement the findings of the group, and bring them into line with wider good practice. A revised Standards of Business Conduct policy has been approved by the NHS England Board and will be implemented from Q2 of 2017/18.

- **Strengthening conflicts of interest management in CCGs:**

  - In June 2016, we published revised statutory guidance on managing conflicts of interest for CCGs. This was accompanied by a series of practical templates and toolkits.

  - In 2017/18 we will provide further advice and support on conflicts of interest management to CCGs specifically addressing further developments in care models and integrated care organisations.

  - In April 2016, we published the findings of the 2015/16 co-commissioning conflicts of interest audit. From 2016/17, CCGs are required to complete an annual audit of conflicts of interest management.

  - We have also included a conflicts of interest indicator in the CCG Improvement and Assessment Framework (IAF) to assess compliance with the statutory guidance. Each CCG is given a rating as to whether they meet the indicator criteria and this is made available to the public via MyNHS.

  - NHS England has continued its programme of training for CCGs. This includes tailored training for over 100 CCG lay members to support them in managing conflicts of interest in line with the guidance.

Embedding strong programme and project management practice

Work has been undertaken to improve the quality and frequency of reporting and assurance across major programmes delivering our corporate priorities. Further details can be found on page 117.

NHS Shared Business Services incident

NHS England was notified of a serious incident in March 2016 when NHS Shared Business Services, who previously provided primary care support services to NHS England in three geographical areas, reported a backlog of c709,000 unprocessed documents relating to patients. Management of the incident, repatriation and review of the documentation by registered GPs has taken place during the 2016/17 year and will continue in 2017/18. Associated patient-related issues are now being followed up appropriately through a clinical review process which will determine whether any harm has been caused. The NAO has conducted an investigation into the incident and published its findings in June 2017.

The Information Commissioner's Office (ICO) continue to investigate the incident. In February 2017 an information governance incident occurred involving financial data which has been reported to the police for investigation. GPs received payment for reviewing documentation totalling £2.5 million.

Detail on Losses and Special Payments incurred as a result of this incident are set out on page 172.

Primary Care Support Services contract

A seven-year contract to provide primary care support services (PCSS) was awarded to Capita in September 2015, to provide transformational improvements to the service and drive £40 million per annum operating cost savings. After a few months of successful service, Capita implemented service changes which led to major issues in the operational services. These issues emerged during the summer of 2016, causing significant backlogs, delays and other issues which had serious impacts for many primary care users and their patients. The service issues included a significant increase in information governance issues, largely through failings in the new PCSS courier arrangements.

NHS England rapidly escalated its service management arrangements to scrutinise Capita's performance, hold it to account for making recovery and drive improvements. Contractual levers have been deployed, including requiring recovery plans across five of the PCS service lines. Capita have implemented their agreed recovery plans, which included significant additional and improved resources, upgrading of training and procedures, improved communication with and support to users and stakeholders, and much strengthened operational management. They also significantly improved their IG capability and assurance arrangements. NHS England has also provided significant help from service experts, to assist the service recovery.

Although recovery has been much slower than hoped, services have steadily recovered and backlogs have progressively been cleared. Most services have been largely recovered to business as usual, though some backlogs and recovery work will continue through to the end of June 2017. A list of the related information governance incidents is included at page 273 of this Annual Report.

Assurance of the commissioning system

NHS direct commissioning

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

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

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

As a single organisation, we are careful to target our resources to focus national oversight on the areas of greatest risk. The three Oversight Groups for public health, armed forces and health and justice focus on key strategic issues, with regular reports on quality, performance and finance. The Primary Care Oversight Group focuses on strategic and key operational matters, with detailed operational discussions held by the Primary Care Delivery Oversight Group. The Commissioning Committee receives regular reports, and also in depth reviews of specific areas. Over the coming year, we will be strengthening our national assurance of delivery of the key general practice commitments set out in the Next Steps Five Year Forward View.

In total, direct commissioning for non-specialised services accounts for £9.9 billion of total commissioning expenditure (these figures do not include funding that is delegated to CCGs for primary medical care).

Specialised commissioning

NHS England is also responsible for the direct commissioning of specialised services for people who have rare and complex conditions. Specialised services cover a range of services from renal dialysis and secure inpatient mental health services, through to treatments for rare cancers and life threatening genetic disorders. Specialised services often deliver cutting edge care, using new drugs and technologies to improve patient outcomes.

The Specialised Services Commissioning Committee provides advice to the Board on the development and implementation of NHS England's strategy for commissioning of prescribed specialised services, providing assurance of quality, performance and value for money. The Committee also assures decisions made by the Specialised Commissioning Oversight Group which has operational oversight of specialised commissioning and the Clinical Priorities Oversight Group (CPAG) which makes recommendations on the commissioning position of treatments and interventions for adoption, or otherwise, by NHS England.

In total, direct commissioning for specialised services accounts for £15.4 billion of total commissioning expenditure.

Clinical Commissioning Groups

NHS England is accountable for overseeing and assuring the commissioning system to ensure that it is working effectively. In particular with regard to the 209 CCGs, NHS England has a statutory duty to performance assess each CCG every year to determine how well it has discharged its functions during that year. CCGs are independent membership organisations, each of which has an appointed Accountable Officer. They are clinically led and responsible for commissioning high quality healthcare services for their local communities.

NHS England allocates a large proportion of the funding it receives from the DH to CCGs and supports them to commission services on behalf of their patients according to evidence-based quality standards. In turn, CCGs are responsible for demonstrating probity and good governance in managing their finance and performance. Together they account for £76.5 billion of total commissioning expenditure.

Overall, this ensures that CCGs are delivering the best outcomes for their patients and have a high standard of financial management, administering resources prudently and economically and safeguarding financial propriety and regularity. Parliament has also provided for specified limited rights of intervention by NHS England into CCG functions.

CCG Improvement and assessment

NHS England published the new CCG Improvement and Assessment Framework (IAF) for 2016/17 to fully align with the FYFV, NHS Shared Planning Guidance and STPs. It supports a number of tasks including implementation of the FYFV to drive improvements in health and care, restoration and maintenance of financial balance, and the delivery of core access and quality standards.

Legislation requires an annual performance assessment to be carried out at an individual CCG level. The three areas with which the CCG IAF aligns recognise that wider system working is necessary for the longer term sustainability of the NHS.

The IAF focuses on a manageable number of the highest priorities facing the NHS and, as a dynamic tool, will be refreshed over time so that the assessment of CCGs continually focuses on the greatest emerging and actionable opportunities. It provides a greater focus on assisting improvement alongside NHS England's statutory assessment function and closely aligns NHS England's operational and national policy teams to diagnose issues, set out what good and outstanding look like and apply the most effective support and resources to help CCGs achieve this.

NHS England also has the option of using its statutory powers, conferred by section 14Z21 of the NHS Act 2006 (as amended) to support CCG improvement where a CCG is failing or is at risk of failing to discharge its functions. At the year-end assessment of CCGs in 2015/16 those rated as inadequate, and not already under direction, had directions applied to ensure a strong focus on improvement.

Details of CCG directions can be found on the NHS England website at www.england.nhs.uk/commissioning/ccg-assess/directions/.

In July 2016, as part of the actions taken to strengthen NHS financial and operational performance, NHS Improvement and NHS England announced that a number of Trusts and nine CCGs were being placed in a new regime of special measures. NHS England's special measures is an internal management approach to CCGs under direction, to enable more intensive support for improvement.

60 CCGs have been reported to the Secretary of State under Section 30 of the Local Audit and Accountability Act 2014 due to forecasting that expenditure would exceed income during the financial year.

CCG annual reports

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

A review of the CCG governance statements found that the primary focus of CCG internal auditors over the year was in the areas of finance, corporate governance, commissioning, information and communications technology, and clinical governance. This is in line with expectations and issues previously highlighted by CCGs in earlier exception reports.

Co-commissioning of primary medical services

Since April 2015, CCGs have had the opportunity to assume greater responsibility for general practice commissioning via one of three co-commissioning models: greater involvement; joint commissioning and delegated commissioning.

NHS England's Board has committed to support the majority of CCGs to migrate to full delegation by 1 April 2017. Giving CCGs more control and say over primary medical services is part of a wider strategy to support the development of place-based commissioning and new care models.

In 2016/17, 114 CCGs implemented delegated arrangements, 70 CCGs joint arrangements and 25 CCGs the 'greater involvement' model. Following joint work between NHS England, CCGs and NHS Clinical Commissioners, a further 62 CCGs will be taking forward full delegation during 2017/18 representing 85% coverage.

Where NHS England has delegated functions to CCGs, NHS England retains overall responsibility for the Primary Medical Services function and is therefore responsible for obtaining assurance that the terms of the delegation agreement are being complied with. It has been agreed that a framework will be developed to achieve this.

Commissioning Support Units

Each CSU produces an annual business and finance plan which is reviewed on submission and monitored throughout the year. They are subject to an in-year assurance programme which regularly reports on their risk, viability, development and compliance with SFIs. Any management actions are managed through the CSU's finance director, with oversight by the CSU's leadership team and the central CSU Transition Team. Progress is then reported to ARAC. The Commissioning Committee also receives regular information on CSU assurance, performance and risk.

All CSUs make monthly returns to the CSU Transition team as part of an operational assurance dashboard, which includes a governance assurance statement covering issues such as compliance with SFIs. CSU Managing Directors provide assurance of compliance with controls and accountability requirements.

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

CSUs have adopted the service auditor reporting approach to provide assurance to their customers and any exceptions relating to the processes CSUs operate for their customers are reported via service auditor reports.

Further to completion of the 2016/17 year-end Service Auditor Reporting process, with the exception of North East London, all CSUs met the final reporting deadline of 28 April 2017.

Of the 10 final reports issued, six were given an 'Except for opinion' (where one or more control objectives could not be confirmed as having being met either from a control design or operating effectiveness perspective) and four a 'No Qualifications' opinion (where it was concluded that controls were suitably designed and operating to provide reasonable assurance that the stated control objectives were achieved throughout the period).

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

Allocations

The Chief Financial Officer report provides an update on how we are progressing our responsibility to allocate NHS funds and our ongoing plan to secure future financial sustainability. Please see page 75.

Operational planning

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

To support the STP process and help to drive partnership working, in late 2016, NHS England, together with NHS Improvement, significantly streamlined the annual NHS planning and contracting round to provide greater certainty and stability, simplify processes, and support partnership and transformation, with two year operational plans, underpinned by two-year pricing arrangements and a two-year NHS Standard Contract. This was designed to provide greater stability and certainty for planning local health services, and allow NHS organisations to spend less of their time locked in adversarial and transactional relationships and devote more of their energies towards redesigning and delivering better, more efficient care.

Through the planning process, NHS organisations have been tasked to deliver individual CCG and NHS provider organisational control totals, and achieve local system financial control totals, implement local STP plans and achieve local targets to moderate demand growth and increase provider efficiencies. The planning guidance also set the expectation that providers and commissioners need to have focus on efficiency in 2017/18 and 2018/19; and that the opportunities set out in the national efficiency programmes and embedded in STPs are further developed in operational plans and delivered by providers and commissioners working together.

The joint operational planning guidance set out the business rules for commissioners for 2017/18 and 2018/19. Following the 2016/17 planning round, NHS England finance teams reviewed all CCG and direct commissioning plans to verify the extent to which they demonstrated achievement of these business rules, realism of savings plans and the value for money of any new investments. We also worked jointly with NHS Improvement to secure alignment of commissioner and provider plans.

As in 2016/17, we are setting aside a risk reserve to manage system wide risks and hence manage the overall financial performance of the NHS. In 2016/17 this was comprised of 1% of commissioner allocation set aside at the start of the year. For 2017-19 the risk reserve will be made up as follows:

- CCGs are to set aside 0.5% of their allocation
- 0.5% of the local CQUIN will be held in reserve by providers
- NHS England will hold £200 million in reserve centrally.

The risk reserve will again be held until such time as we can be confident that the NHS is on track to meet its financial targets for the year.

The planning guidance for 2017/19 also set out that NHS England would use the Best Possible Value (BPV) framework approach, developed to ensure we extract the best possible value for every pound spent through our investment decisions, to assess all transformation investment decisions and run a single coordinated process to minimise the administrative burden on local areas who would be applying for funding. In December 2016 we launched this single coordinated application process for national programmes including mental health, cancer, diabetes and learning disabilities.

Financial performance monitoring

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

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

NHS England has continued its focus during 2016/17 on improving the financial resilience of CCGs, progressing a work programme to deliver effective mechanisms to detect deteriorating financial performance earlier and take robust action where required.

NHS England central programme costs

NHS England's internal business planning process was launched in October 2016. This was designed to align with the system planning guidance and years two and three of STPs, as well as addressing issues inherent with one year planning by allocating funding to programmes for two years, rather than the single year allocated previously.

The corporate aims and priorities were agreed by the Executive Group and remained consistent with the approach in 2016/17. In submissions for programme funding, the leads for corporate priorities were asked to specify the outcomes that they will deliver over the period, demonstrate how these outcomes support the FYFV and NHS England's mandate, and to set out clearly how they plan to move from national strategy and planning towards regional and local delivery.

Cabinet Office efficiency controls

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

Counter fraud

NHS England is responsible for investigating allegations of fraud related to our functions and work, where this is not undertaken by NHS Protect, and for ensuring that appropriate anti-fraud arrangements are in place. NHS England contracts Deloitte LLP to provide accredited counter fraud specialists and undertake counter fraud work proportionate to its risks. ARAC receives regular updates regarding the development of the counter fraud function, the progress against the proactive work plan and reactive investigations. The Director of Financial Control is delegated the day-to-day operational responsibility for the NHS England counter fraud function, and the Chief Financial Officer also provides executive support and direction.

NHS England approved an Economic Crime Strategy in 2016/17 which details its approach to tackling fraud, bribery and corruption until 2020. The strategy describes its counter fraud function, including its strategic and annual proactive counter fraud work plans, as well as its reactive strategy. Training and education has continued through the year to raise fraud awareness amongst all staff. NHS England's policy on tackling fraud, bribery and corruption was reviewed during the year and communicated to all staff and is available on the public website. In addition to this, NHS England is working closely with a number of other bodies, including NHS Protect, to establish appropriate and efficient anti-fraud arrangements across the wider commissioning system, and to ensure compliance with the Standards for Commissioners: Fraud, bribery and corruption. NHS England was quality assessed against the standards in 2016/17 and is taking appropriate action in relation to the recommendations made by NHS Protect. ARAC receives a report at least annually against each of the standards.

A number of initiatives have continued to tackle the fraud risk in primary care, including significant extension of the Prescription Exemption Checking Service, the Dental Benefit Eligibility Checking Service and others managed by NHS BSA on behalf of NHS England. These schemes have led to net recoveries of £21.7 million in 2016/17, with further development planned for 2017/18. The recoveries received demonstrate that the current initiatives are producing results, as well as creating an expected deterrent effect. The continued development of the counter fraud service in the coming years aims to amplify this effect.

Head of Internal Audit opinion

My Head of Internal Audit has informed me that, based on the internal audit work undertaken during 2016/17 and in the context of the overall environment for NHS England for 2016/17, in his opinion the frameworks for governance and risk management have been adequate in 2016/17; however a number of the actions implemented through the Governance and Assurance Project (GAP) need to continue to be embedded during 2017/18 in accordance with the plans in place.

With respect to the internal control environment, significant effort has been focussed on implementing the structures designed in 2013/14, 2014/15 and 2015/16, albeit that some structures, for example off payroll workers, continued to remain in the design stage during the year. On this basis the framework for internal control has continued to evolve and be implemented within the organisation, for the majority of areas, through 2016/17.

At 31 March 2017, the majority of the internal control framework is in place although internal audit work has identified some specific continued areas of non-compliance with the designed framework, some areas where the design of the internal control framework remains ongoing and opportunities to improve the design of some areas of the internal control framework.

All of the recommendations raised by internal audit have been accepted by management, actions have been agreed to address these and considerable focus has been placed on the implementation of the actions in a timely manner.

In addition, the Head of Internal Audit reports that the following factors should be taken into consideration with respect to the assessment:

- The internal audit work for 2016/17 has focussed on assessing the operational effectiveness of the core processes. A readiness assessment was performed in relation to off-payroll workers during 2016/17, given the process has been re-designed during the financial year.

- Some weaknesses in internal controls in core processes were identified and reported during the internal audit work completed during the year, which were assessed as being fundamental to the system of controls[11]. These include primary medical care commissioning; performers concerns follow-up; cancer drugs fund; procurement; RightCare; cancer programme; mental health programme; safeguarding; learning disabilities programme; CSU general controls; risk management; travel and expenses and performance appraisal. Management actions have been agreed to address all of these observations. However, given the nature of the agreed management actions, not all of these have been completed by year end. Where possible interim solutions have been put in place whilst activity remains focussed on the implementation of the agreed actions.

- There were a number of areas of concern previously identified by NHS England management, for example with respect to NHS SBS, procurement, off-payroll workers and individual projects. Projects have remained in place to rectify the identified gaps or management has requested that the internal audit team complete additional work in these areas.

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

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

  - NHS BSA for human resources and procurement services

  - Capita for Primary Care Support Services

  - NHS Digital for data processing.

11. Priority 1 - Recommendations which are fundamental to the system of controls and upon which the organisation should take immediate action.

The understanding of the assurance requirements from these providers has further evolved during the year. Additional assurance reports have been obtained for 2016/17, for example with the receipt of a Service Auditor Report from NHS Digital and Capita. There does however remain a requirement to continue to understand respective responsibilities in an environment where significant reliance is placed on third parties.

Overall summary

Over this year we have made significant progress through a dedicated project to strengthen our approach to governance, assurance and controls and to address a number of audit recommendations, highlighting areas requiring attention.

We welcome the acknowledgement of this progress by our auditors, and during the coming year we will continue to sustain the outcomes of this work – particularly around commercial disciplines, third party assurance, contract management and risk – by ensuring that the relevant frameworks are fully and consistently implemented across the organisation.

Remuneration and Staff Report

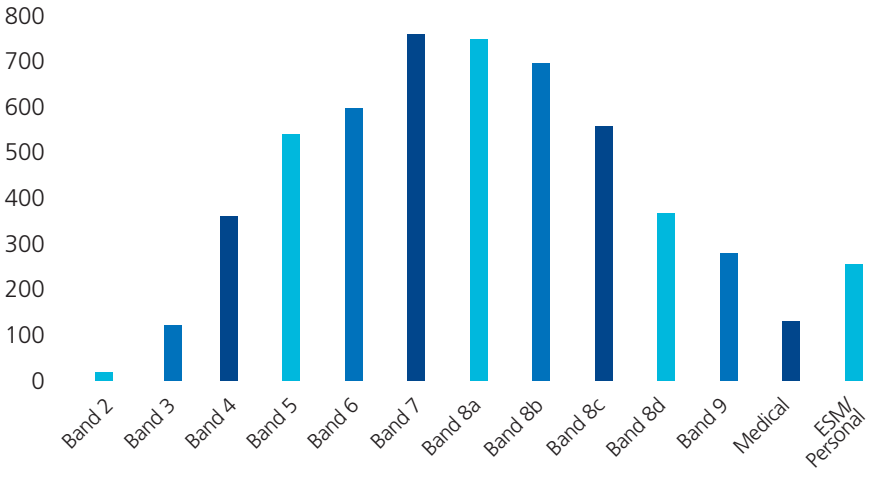
Our organisation and people

As at 31 March 2017, NHS England directly employed 5,400 people[12]. Of these, 4,503 people were permanently employed on recurrent, open-ended contracts of employment, based around the country within seven directorates. In addition, a further 897 people were employed on payroll on fixed term contracts of employment:

Member	Number of people employed
Chair and Chief Executive's Office	17
Commissioning Strategy	321
Finance	192
Medical	356
Nursing	214
Operations and Information (including regional teams)	3,669
Specialised Commissioning	146
Transformation and Corporate Operations	485
Total	5,400

Detail on staff numbers and costs for NHS England and the Consolidated Group, including CSUs, are presented from page 152.

All staff by pay band[13]



Band 2	20	0.4%
Band 3	122	2.3%
Band 4	362	6.7%
Band 5	536	9.9%
Band 6	591	10.9%
Band 7	760	14.1%
Band 8a	748	13.9%
Band 8b	698	12.9%
Band 8c	553	10.2%
Band 8d	368	6.8%
Band 9	271	5.0%
Medical	125	2.3%
ESM/Personal	246	4.6%
Grand total	5,400	100.0%

12. Commissioning Support Unit staff are not directly employed by NHS England and are therefore not included in this analysis. Given NHS England is responsible for overseeing CSUs, staff numbers and expenses are reflected within the financial statements in this report.

13. The term 'senior manager' denotes all staff remunerated at or above the pro-rata salary of £78,629 per annum. This is consistent with the definition used within Cabinet Office and HM Treasury returns.

NHS England has seen an increase in headcount of 7% since 2015/16, as we have reduced usage of temporary and contract labour, with the biggest increases between Bands 6 to 8c (salary range £26,302 - £68,484 per annum).

All staff by gender

	Head count	Percentage
Female	3,738	69%
Male	1,662	31%
Total	5,400	100%

Senior managers by gender

	Head count	Percentage
Female	415	51%
Male	394	49%
Total	809	100%

These proportions are largely unchanged from 2015/16.

All staff by ethnicity

	Head count	Percentage
White	3,988	74%
BME	763	14%
Unknown	649	12%
Total	5,400	100%

Senior managers by ethnicity

	Head count	Percentage
White	589	73%
BME	67	8%
Unknown	153	19%
Total	809	100%

The proportion of people employed by NHS England that consider themselves to be from a black or minority ethnic (BME) heritage has increased by 3% over the year (2015/16: 11% all staff, 5% senior managers). This is a consequence of focussed effort to improve our workplace diversity and inclusion, in line with the Public Sector Equality Duty and NHS England's response to the Workforce Race Equality Standard (WRES) for the NHS. The organisation has worked in close partnership with the NHS England BME staff network to achieve these improvements.

All staff who consider themselves to have a disability or long term condition

	Head count	Percentage
No	4,479	83%
Yes	292	5%
Unknown	629	12%
Total	5,400	100%

Senior managers who consider themselves to have a disability or long term condition

	Head count	Percentage
No	610	75%
Yes	32	4%
Unknown	167	21%
Total	809	100%

We have worked closely with the NHS England Disability and Wellbeing Network (DAWN) staff to close the gaps in our workforce diversity data and encourage people to self-classify, and 2.5% more staff have chosen to disclose whether they have a disability or long term condition this year (2015/16: 14.5% all staff, 24% senior managers). The percentage of staff disclosing a disability or long term condition has remained constant (2015/16: 5.2% all staff, 4% senior managers).

All staff by sexual orientation

	Head count	Percentage
Heterosexual	4,140	77%
LGB	151	3%
Unknown	1,109	21%
Total	5,400	100%

Senior managers by sexual orientation

	Head count	Percentage
Heterosexual	519	64%
LGB	22	3%
Unknown	268	33%
Total	809	100%

The number of people choosing not to disclose their sexuality has decreased by 3% across the workforce and by 3.5% at senior manager level this year (2015/16: 24% all staff, 36.5% senior managers)[14]. 1% more staff now report that they are lesbian, gay or bisexual (2015/16: 1.65% all staff, 1.9% senior managers).

14. It is not possible to record whether staff members classify themselves as transgender on the NHS electronic staff record (ESR), this is a national functionality restriction within ESR and not something that NHS England is able to address locally. The above figures total 101 due to rounding.

Our people commitments

We have continued to shape and strengthen our capabilities, processes and infrastructure during the year to ensure that NHS England can recruit, retain, recognise and develop a diverse range of people with the right capabilities and values to deliver our business plan. Progress made in each of our 'People Commitment' areas is detailed below.

Talent management and development

We have continued to build talent and capability at all levels across the organisation to ensure that our people are able to contribute their maximum potential to delivery of the NHS Five Year Forward View. During the year, we expanded the number of interventions on offer to support talent development - including job shadowing, coaching, mentoring, and a series of internal stretch assignments being offered, working closely with our staff networks to directly communicate these opportunities. Shaped with the insight we have obtained from our BME senior leaders and BME Staff Network, we have built talent plans at a regional and directorate level that fully reflect our agreed approach to improving diversity and inclusion, and to enable us to best use our available talent to support, lead and contribute to the delivery of our priorities and meet our challenges.

In August 2016, we strengthened leadership development and line manager capability with the launch of a new Line Management Development Programme which is underpinned by a set of line management standards. 192 managers have since benefitted from attending the programme.

We supported the Government's target to deliver three million apprenticeships by 2020 through the launch of our new 'Skills 4 Success' programme. We will be able to offer a range of high quality apprenticeship qualifications to both existing staff and new recruits to secure a highly skilled, diverse and talented workforce that is fit for the future and meets our existing and future skills gaps.

Improving our workforce diversity and inclusion

We recognise that people are increasingly keen to work for organisations that give them both the opportunity and freedom to be themselves. Our four staff diversity networks continue to grow with over 500 members: the BME network, the Lesbian, Gay, Bisexual, Trans + network, DAWN and the Women's Development Network. These networks provide opportunity for our people to influence change, gather feedback and present their views on the topics that are most important to them including policy and staff development, raising awareness and celebrating diversity.

A Diversity and Inclusion Group, led by a member of the NHS England Board, was established during 2016 to bring key partners and stakeholders, including our trade unions, together to help create a fairer and more inclusive workforce for NHS England.

We achieved an improved ranking in the Stonewall Workplace Equality Index in 2017, moving up 16 places, as a result of improvements made in networking groups, career development, training and community engagement.

In October 2016, we were awarded Disability Confident Employer status by the Department for Work and Pensions in recognition of our commitment to recruiting and retaining disabled people and people with health conditions for their skills and talent.

Our Work Experience Policy, which forms part of our commitment to equality, diversity and inclusion in the work place, was launched in September 2016 and provides a range of opportunities to students and those in vulnerable and under-represented groups. In November 2016, as part of the Mencap's learning disability work experience week, we hosted two work experience candidates with learning disabilities, both of whom spent time with the Chief Executive and his private office.

Workplace health, safety and wellbeing

In December 2016, we were accredited with the Health@Work Workplace Wellbeing Charter, in recognition of the significant and wide-ranging work we have undertaken to create a workplace where the physical, mental and emotional health and safety of our colleagues is supported and improved.

During 2016/17, we trained a further 289 of our people as Mental Health First Aiders (MHFA). We also continue to hold regular events and raise awareness of mental health by supporting national campaigns and awareness days including Time to Talk, Mental Health Awareness Week and World Suicide Prevention Day.

As part of the wider NHS Healthy Workforce Programme, we piloted a number of new initiatives during the year to better support the mental and physical health of our colleagues. Successes include the launch of a Weight Watcher voucher scheme in June 2016, resulting in 101 people signing up to completing a 12 week programme to successfully lose weight, and the issuing of a further 69 bikes under the cycle to work scheme since 1 April 2016.

In 2016/17, the average number of sick days taken by whole time equivalent employees decreased by 1.1 days against the previous year.

Sickness absence for the period April 2016 to March 2017 was as follows:

	Whole time equivalent days available	Whole time equivalent days lost to sickness absence	Average sick days per whole time equivalent
NHS England	1,734,735	23,990	5.0
CSUs	2,261,173	39,120	6.3
Total Parent	**3,995,908**	**63,109**	**5.8**
CCGs	6,002,681	102,502	6.2
Consolidated Group	**9,998,589**	**165,611**	**6.0**

Staff engagement and experience

We externally commissioned a short 'pulse' staff survey in May 2016, followed by a full 'census' staff survey in October 2016 to enhance analysis and reporting of employee engagement within NHS England. Our overall response rate for the census survey was 71%, a +4% positive improvement in our response rate since the previous survey. Overall employee engagement scores are up +10% over the past three years.

Staff engagement groups have been established across the organisation, working with our leadership teams to address issues raised in the staff survey. A national staff engagement group brings together the learning from these local groups, chaired by a member of the Board.

We have built on the success of our staff recognition scheme 'Everyone Counts Awards', and this recognised 34 colleagues who have gone the extra mile and been a true advocate of our values and behaviours.

Our improvement and change activities

Workforce systems

In April 2016, a Workforce Systems Team was appointed to ensure staff were better equipped to access and record information around their employment and provide the organisation with a sharper picture of key people trends and people analytics to support evidence based decision-making and our ambition to become an employer of choice.

Organisational change programmes

As we continue to transform the organisation, our National Partnership Forum with the recognised Trade Unions representing NHS England staff, enables us to inform, involve and consult with colleagues across the business on our future plans.

In 2016, a significant piece of work was undertaken to ascertain how digital functions might best be structured to support the development and delivery of national strategies on information, technology and data investment. As a result of this review, 29 of our people transferred to NHS Digital - the national provider of information, data and IT systems for commissioners, analysts and clinicians in health and social care.

Looking forward to 2017/18

Our approach to People and Organisation Development for 2017/18 will focus upon talent management and development, creating a diverse and inclusive workplace, culture and employee engagement, and health, wellbeing and safety at work.

Staff numbers and costs (subjected to audit)

Detail on staff numbers and costs for NHS England and the Consolidated Group, including CSUs, are presented in the following tables:

Average number of people employed

Parent	2016/17				
	Total number	Permanent employed number	CSU employed number	Other number	CSU other number
Total	**12,649**	**4,696**	**6,111**	**1,019**	**823**
Of the above:					
Number of whole time equivalent people engaged on capital projects	**8**	**-**	**8**	**-**	**-**

Parent	2015/16				
	Total number	Permanent employed number	CSU employed number	Other number	CSU other number
Total	**14,365**	**4,693**	**7,373**	**1,056**	**1,243**
Of the above:					
Number of whole time equivalent people engaged on capital projects	**-**	**-**	**-**	**-**	**-**

Consolidated Group

	2016/17				
	Total number	Permanent employed number	CSU employed number	Other number	CSU other number
Total	**31,017**	**20,909**	**6,111**	**3,174**	**823**
Of the above:					
Number of whole time equivalent people engaged on capital projects	**12**	**3**	**8**	**1**	**-**

Consolidated Group

	2015/16				
	Total number	Permanent employed number	CSU employed number	Other number	CSU other number
Total	**30,535**	**18,807**	**7,373**	**3,112**	**1,243**
Of the above:					
Number of whole time equivalent people engaged on capital projects	**-**	**-**	**-**	**-**	**-**

Employee Benefits

Parent

Employee benefits	Permanent employees £000	Permanent CSU employees £000	Other £000	CSU other £000	Total £000
	2016/17				
Salaries and wages	236,642	233,052	60,888	70,550	**601,132**
Social security costs	27,285	24,933	7	5	**52,230**
Employer contributions to NHS pensions scheme	31,278	29,501	25	6	**60,810**
Termination benefits	(395)	7,201	-	-	**6,806**
Gross employee benefits expenditure	**294,810**	**294,687**	**60,920**	**70,561**	**720,978**
Less: Employee costs capitalised	-	(196)	-	-	**(196)**
Net employee benefits excluding capitalised costs	**294,810**	**294,491**	**60,920**	**70,561**	**720,782**
Less recoveries in respect of employee benefits	(8)	-	-	-	**(8)**
Total net employee benefits	**294,802**	**294,491**	**60,920**	**70,561**	**720,774**

Parent

Employee benefits	Permanent employees £000	Permanent CSU employees £000	Other £000	CSU other £000	Total £000
	2015/16				
Salaries and wages	231,571	272,986	70,435	105,303	**680,295**
Social security costs	22,149	23,230	12	16	**45,407**
Employer contributions to NHS pensions scheme	30,381	34,611	13	18	**65,023**
Termination benefits	4,271	12,816	-	-	**17,087**
Gross employee benefits expenditure	**288,372**	**343,643**	**70,460**	**105,337**	**807,812**
Less: Employee costs capitalised	-	-	-	-	**-**
Net employee benefits excluding capitalised costs	**288,372**	**343,643**	**70,460**	**105,337**	**807,812**
Less recoveries in respect of employee benefits	(390)	(588)	-	(237)	**(1,215)**
Total net employee benefits	**287,982**	**343,055**	**70,460**	**105,100**	**806,597**

Consolidated Group

Employee benefits	Permanent employees £000	Permanent CSU employees £000	Other £000	CSU other £000	Total £000
	2016/17				
Salaries and wages	946,796	233,052	240,222	70,550	**1,490,620**
Social security costs	105,015	24,933	199	5	**130,152**
Employer contributions to NHS pensions scheme	121,997	29,501	172	6	**151,676**
Termination benefits	2,243	7,201	-	-	**9,444**
Gross employee benefits expenditure	**1,176,051**	**294,687**	**240,593**	**70,561**	**1,781,892**
Less: Employee costs capitalised	(130)	(196)	(116)	-	**(442)**
Net employee benefits excluding capitalised costs	**1,175,921**	**294,491**	**240,477**	**70,561**	**1,781,450**
Less recoveries in respect of employee benefits	(4,990)	-	(93)	-	**(5,083)**
Total net employee benefits	**1,170,931**	**294,491**	**240,384**	**70,561**	**1,776,367**

Consolidated Group

Employee benefits	Permanent employees £000	Permanent CSU employees £000	Other £000	CSU other £000	Total £000
	2015/16				
Salaries and wages	857,565	272,986	239,893	105,303	**1,475,747**
Social security costs	78,416	23,230	115	16	**101,777**
Employer contributions to NHS pensions scheme	110,439	34,611	187	18	**145,255**
Termination benefits	6,061	12,816	-	-	**18,877**
Gross employee benefits expenditure	**1,052,481**	**343,643**	**240,195**	**105,337**	**1,741,656**
Less: Employee costs capitalised	-	-	-	-	**-**
Net employee benefits excluding capitalised costs	**1,052,481**	**343,643**	**240,195**	**105,337**	**1,741,656**
Less recoveries in respect of employee benefits	(4,129)	(588)	-	(194)	**(4,911)**
Total net employee benefits	**1,048,352**	**343,055**	**240,195**	**105,143**	**1,736,745**

CSUs are part of NHS England and provide services to CCGs. The employment contracts or secondment of almost all of these are held for NHS England on a hosted basis by the NHS BSA.

Exit packages, severance payments and off-payroll engagement

Expenditure on consultancy and contingent labour (subjected to audit)

Expenditure on consultancy is detailed in the Annual Accounts under Note 4: Operating Expenses. NHS England and CSUs procured consultancy services worth £18 million during the financial year, a decrease from £25 million in 2015/16. Across the group, there was a total spend of £101 million on consultancy services during the period, against £113 million the previous year.

Expenditure on contingent labour, including agency staff and secondees, is given on page 154. Net expenditure for NHS England and CSUs in this area was £131 million in 2016/17, against £176 million in 2015/16. Across the group, there was a total spend of £311 million on contingent labour during the year, against £346 million the previous year.

Further detail on efficiency controls, and steps we have taken to improve procurement practices and compliance within NHS England during the year, can be found in our Governance Statement from page 114.

Off-payroll engagements

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

In September 2016, a project was established to design and deliver a more effective end-to-end process to manage our off-payroll workers and provide associated assurances to better manage, control and report engagements and apply required governance. The following tables identify off-payroll workers[15] engaged by NHS England as at March 2017.

15. Note that these tables do not include medical appraisers who perform ad hoc short engagements to support the medical revalidation process. Appraisers are selected from a total pool of around 2,400 appraisers.

Off-payroll engagements longer than six months

Off-payroll engagements as at 31 March 2017, covering those earning more than £220 per day and staying longer than six months are as follows:

	NHS England number	CSUs number	Total number
Number of existing engagements as of 31 March 2017	345	169	514
Of which, the number that have existed:			
for less than one year at the time of reporting	83	66	149
for between one and two years at the time of reporting	114	72	186
for between two and three years at the time of reporting	85	19	104
for between three and four years at the time of reporting	63	12	75
for four or more years at the time of reporting	0	0	0

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

New off-payroll engagements

New off-payroll engagements between 1 April 2016 and 31 March 2017, for more than £220 per day and that have lasted longer than six months are as follows:

	NHS England number	CSUs number	Total number
Number of new engagements, or those that reached six months in duration, between 1 April 2016 and 31 March 2017	193	184	377
Number of new engagements which include contractual clauses giving NHS England the right to request assurance in relation to income tax and National Insurance obligations	118	112	230
Number for whom assurance has been requested	193	184	377
Of which:			
assurance has been received	178	174	352
assurance has not been received	15	10	25
engagements terminated as a result of assurance not received being	0	0	0

	NHS England	CSUs	Total
Number of off-payroll engagements of board members, and/or senior officers with significant financial responsibility, during the financial year	0	1	1
Total number of individuals on payroll and off-payroll that have been deemed 'board members, and/or, senior officials with significant financial responsibility', during the financial year	251	37	288

Off-payroll engagements of Board members and/or senior officials with significant financial responsibility between 1 April 2016 and 31 March 2017 are shown in the table above. There has been one off-payroll senior officer engagement with significant financial responsibility in the financial year. An interim Director of Finance was appointed between 5 April and 30 September 2016 at South East CSU under exceptional circumstances whilst the future of the CSU was being determined.

Further detail on commercial approvals, and steps we have taken to improve procurement practices and compliance within NHS England during the year, can be found in our Governance Statement from page 114.

Exit packages including severance payments (subjected to audit)

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

Details of exit packages agreed over the year are detailed in the tables below and overleaf. All contractual severance payments were subject to full external oversight by DH.

Exit packages agreed during the year:

Parent

	2016/17			2015/16		
	Compulsory redundancies number	Other agreed departures number	Total number	Compulsory redundancies number	Other agreed departures number	Total number
Less than £10,000	12	9	**21**	38	8	**46**
£10,001 to £25,000	34	15	**49**	67	42	**109**
£25,001 to £50,000	46	16	**62**	57	46	**103**
£50,001 to £100,000	16	12	**28**	51	31	**82**
£100,001 to £150,000	7	8	**15**	18	22	**40**
£150,001 to £200,000	13	2	**15**	14	7	**21**
Over £200,001	-	-	**-**	6	4	**10**
Total	**128**	**62**	**190**	**251**	**160**	**411**
Total cost (£000)	**6,372**	**2,919**	**9,291**	**13,203**	**9,572**	**22,775**

Consolidated Group

	2016/17			2015/16		
	Compulsory redundancies number	Other agreed departures number	Total number	Compulsory redundancies number	Other agreed departures number	Total number
Less than £10,000	31	28	**59**	51	24	**75**
£10,001 to £25,000	49	37	**86**	90	56	**146**
£25,001 to £50,000	63	31	**94**	64	51	**115**
£50,001 to £100,000	23	18	**41**	56	35	**91**
£100,001 to £150,000	12	9	**21**	20	22	**42**
£150,001 to £200,000	16	3	**19**	14	9	**23**
Over £200,001	1	1	**2**	6	4	**10**
Total	**195**	**127**	**322**	**301**	**201**	**502**
Total cost (£000)	**9,057**	**4,878**	**13,935**	**14,543**	**10,630**	**25,173**

Exit packages agreed during the year: Other agreed departures

Parent

	2016/17		2015/16	
	Other agreed departures number	£000	Other agreed departures number	£000
Voluntary redundancies including early retirement contractual costs	56	2,854	156	9,440
Contractual payments in lieu of notice	6	64	3	37
Exit payments following Employment Tribunals or court orders	-	-	1	95
Total	**62**	**2,919**	**160**	**9,572**

Consolidated Group

	2016/17		2015/16	
	Other agreed departures number	£000	Other agreed departures number	£000
Voluntary redundancies including early retirement contractual costs	69	3,696	160	9,681
Mutually agreed resignations (MARS) contractual costs	-	-	1	170
Early retirements in the efficiency of the service contractual costs	1	48	-	-
Contractual payments in lieu of notice	53	1,061	36	648
Exit payments following Employment Tribunals or court orders	4	70	2	97
Non-contractual payments requiring HMT approval	-	3	2	34
Total	**127**	**4,878**	**201**	**10,630**

As a single exit package can be made up of several components each of which will be counted separately in this table, the total number of exit packages will not necessarily match the total number in the table above, which will be the number of individuals.

These tables report the number and value of exit packages agreed in the financial year. The expense associated with these departures may have been recognised in part or in full in a previous period.

Redundancy and other departure costs have been paid in accordance with the provisions of NHS England.

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

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

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

Remuneration Report

Strategic HR and Remuneration Committee

Detail on the role and activity of the Strategic HR and Remuneration Committee is given in our Director's Report at page 109.

Pay multiples (subjected to audit)

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

The banded remuneration of the highest paid member of the Board in the financial year 2016/17 was £205,000 - £210,000 (2015/16: £205,000-£210,000). This was 5.35 times the median remuneration of the workforce, which was £38,812 (2015/16: £38,300: 5.42).[16]

In 2016/17, two employees received remuneration in excess of the highest-paid member of the Board (2015/16: 0). Remuneration ranged from £1,452 to £220,430. (2015/2016: £143 to £210,000).

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

16. This year's calculation is based on more robust information and updated methodology and is therefore not directly comparable with last year's data.

Policy on remuneration of senior managers

The framework for the remuneration of Executive Directors is set by DH through the Executive and Senior Managers (ESM) pay framework for arm's length bodies.

It is the policy of NHS England to pay salaries that are appropriate to recruit senior managers with the necessary skills, capability and experience for the effective running of a £107 billion organisation, whilst recognising the importance of demonstrating pay restraint at a time of considerable pressure on NHS finances. Recommending appropriate remuneration for Executive Directors is undertaken by the Strategic HR and Remuneration Committee of the Board, with final decisions being made by the DH arm's length bodies' Remuneration Committee and HMT, where appropriate.

Performance related pay

The performance related pay arrangements for national (executive) directors are set out in the ESM pay framework for arm's length bodies and follows guidance prescribed by DH and are in-line with HMT requirements. As a local policy decision, since its inception, NHS England does not currently allocate any funding for performance related pay (PRP) non-consolidated bonus payments. In recognition of the current economic climate and the need to provide effective system leadership for the NHS, the decision was taken by the Strategic HR and Remuneration Committee not to allocate funds for PRP non-consolidated bonus payments for 2016/17.

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

Policy on senior managers contracts

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

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

Senior managers service contracts (not subject to audit)

Name and Title	Date of Appointment	Notice Period	Provisions for Compensation for Early Termination	Other Details
Simon Stevens Chief Executive	1 April 2014	6 months	Option to provide taxable pay in lieu of part or all of the notice period	
Paul Baumann Chief Financial Officer	14 May 2012	6 months		
Professor Jane Cummings Chief Nursing Officer	1 April 2013	6 months		
Professor Sir Bruce Keogh National Medical Director	1 April 2015	6 months		
Richard Barker Interim National Director: Commissioning Operations	1 January 2016	6 months		Acting up in role during the period 01 April - 30 May 2016
Ian Dodge National Director: Commissioning Strategy	7 July 2014	6 months		
Matthew Swindells National Director: Operations and Information	30 May 2016	6 months		

Secondments

Name and Title	Date of Appointment	Unexpired Term at 31 March 2017	Provisions for Compensation for Early Termination	Other Details
Karen Wheeler National Director: Transformation and Corporate Operations	1 April 2014	3 months	N/A	3 year secondment from the Department of Health, with the option to extend for 2 further years.

Senior manager salary and pension entitlement 2016/17 (subjected to audit)

	2016/17					
	(a) Salary (bands of £5,000)	(b) Benefit in kind (taxable) rounded to the nearest £100	(c) Performance pay and bonuses (bands of £5,000)	(d) Long term performance pay and bonuses (bands of £5,000)	(e) All pension-related benefits (bands of £2,500)	(f) TOTAL (a to e) (bands of £5,000)
Name and Title	**£000**	**£s**	**£000**	**£000**	**£000**	**£000**
Simon Stevens Chief Executive[17]	190-195	0	0	0	42.5-45.0	235-240
Paul Baumann Chief Financial Officer	205-210	0	0	0	45.0-47.5	250-255
Professor Jane Cummings Chief Nursing Officer	165-170	0	0	0	22.5-25.0	190-195
Professor Sir Bruce Keogh National Medical Director[18]	190-195	0	0	0	0	190-195
Richard Barker National Director: Commissioning Operations[19]	25-30 (pro-rata)	0	0	0	5.0-7.5 (pro-rata)	35-40 (pro-rata)
Ian Dodge National Director: Commissioning Strategy	165-170	0	0	0	37.5-40.0	205-210
Matthew Swindells National Director: Operations and Information[20]	170-175 (pro-rata)	0	0	0	0	170-175 (pro-rata)
Karen Wheeler National Director: Transformation and Corporate Operations[21]	155-160	0	10-15	0	50-52.5	215-220

17. On joining NHS England on 01 April 2014, Simon Stevens voluntarily reduced his pay by 10% from the substantive rate of pay for the post of Chief Executive Officer, which would normally pay within the range £210-215k. Mr Stevens has continued with this voluntary reduction in pay throughout 2016/17.
18. Professor Sir Bruce Keogh received an overpayment of £42,818 paid in error between 1 April 2015 and 31 January 2016, this was initially planned for recovery in 2016, actual recovery will not be commencing until 2017/18. Professor Sir Bruce Keogh chose not to be covered by the NHS pension arrangements during the reporting year.
19. Richard Barker was in post from 01 January-30 May 2016, replacing Dame Barbara Hakin who retired on 31 December 2015. The figures shown reflect this part year adoption as a National Director for the period April-May 2016. The full year salary equivalent is within the range £175k-£180k.
20. Matthew Swindells joined in the post of National Director from 30 May 2016, his full-time earnings were within the range £200k-£205k.
21. Karen Wheeler is seconded from DH and her salary recharged to NHS England. The non-consolidated bonus relates to 2015/16. The bonus is subject to moderation and any award paid the following financial year.

Senior manager salary and pension entitlement 2015/16

	2015/16					
	(a) Salary (bands of £5,000)	(b) Benefit in kind (taxable) rounded to the nearest £100	(c) Performance pay and bonuses (bands of £5,000)	(d) Long term performance pay and bonuses (bands of £5,000)	(e) All pension-related benefits (bands of £2,500)	(f) RESTATED TOTAL (a to e) (bands of £5,000)
Name and Title	**£000**	**£s**	**£000**	**£000**	**£000**	**£000**
Simon Stevens Chief Executive[22]	190-195	0	0	0	40.0-42.5	230-235
Paul Baumann Chief Financial Officer	205-210	0	0	0	22.5-25.0	230-235
Professor Jane Cummings Chief Nursing Officer	165-170	0	0	0	2.5-5.0	170-175
Professor Sir Bruce Keogh National Medical Director[23]	190-195	0	0	0	2.5-5.0	195-200
Richard Barker National Director: Commissioning Operations from 1 January 2016[24]	40-45 (pro-rata)	0	0	0	0.0-2.5 (pro-rata)	45-50 (pro-rata)
Ian Dodge National Director: Commissioning Strategy	160-165	0	0	0	45.0-47.5	205-210
Dame Barbara Hakin National Director: Commissioning Operations to 31 December 2015[25]	155-160 (pro-rata)	0	0	0	-	155-160 (pro-rata)
Tim Kelsey National Director for Patients and Information to 31 December 2015[26]	135-140 (pro-rata)	0	0	0	27.5-30.0 (pro-rata)	165-170 (pro-rata)
Karen Wheeler National Director: Transformation and Corporate Operations[27]	155-160	0	10-15	0	70-72.5	235-240

22. On joining NHS England on 1 April 2014, Simon Stevens voluntarily reduced his pay by 10% from the substantive rate of pay for the post of Chief Executive, which would normally pay within the range £210,000–£215,000. Mr Stevens has continued with this voluntary reduction in pay throughout 2015/16.
23. Professor Sir Bruce Keogh received an overpayment of £42,818 paid in error between the 1 April 2015 and 31 January 2016, this was initially planned for recovery in 2016, actual recovery will not be commencing until 2017/18. The amount of the overpayment is not included in the total remuneration figures disclosed.
24. Richard Barker took up post from 1 January 2016, replacing Dame Barbara Hakin who retired on 31 December 2015. The figures shown reflect this part year adoption as a National Director position. The full year salary equivalent is within the range £175,000-£180,000. Richard Barker was underpaid by £3,500 between January and May 2016, this was addressed in August 2016. The value of overpayment during the 2015/16 reporting period was £2,100 as a result, the total remuneration figure for Mr Barker is different from the value in the 2015/16 audited accounts.
25. Dame Barbara Hakin retired on 31 December 2015, the full year equivalent salary is within the range £205,000 – £210,000
26. Tim Kelsey left the organisation on 31 December 2015, the full year equivalent salary is within the range £180,000-£185,000
27. Karen Wheeler is seconded from DH and her salary recharged to NHS England. As such, she is subject to terms and conditions of her employing organisation. The non-consolidated bonus relates to 2014/15 but was paid in 2015/16. The bonus for 2015/16 is subject to moderation and any award will be paid 2016/17.

Pension benefits as at 31 March 2017 (subjected to audit)

Name and Title	Real increase in pension at pension (bands of £2,500) £000	Real increase in pension lump sum at pension age (bands of £2,500) £000	Total accrued pension at pension age at 31 March 2017 (bands of £5,000) £000	Lump sum at pension age related to accrued pension at 31 March 2017 (bands of £5,000) £000	Cash equivalent transfer value at 31 March 2016[28] £000	Cash equivalent transfer value at 31 March 2017 £000	Real increase in cash equivalent transfer value £000	Employers contribution to partnership pension £000
Simon Stevens Chief Executive	2.5-5.0	0	25-30	55-60	403	470	33	0
Paul Baumann Chief Financial Officer	2.5-5.0	7.5-10.0	20-25	70-75	431	508	38	0
Professor Jane Cummings Chief Nursing Officer	2.0-2.5	5.0-7.5	75-80	230-235	1,492	1,577	42	0
Professor Sir Bruce Keogh National Medical Director[29]	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Richard Barker Interim National Director: Commissioning Operations[30]	2.5-5.0	7.5-10.0	65-70	200-205	1,282	1,371	44	0
Ian Dodge National Director Commissioning Strategy	2.5-5.0	N/A	5-10	N/A	47	78	15	0
Matthew Swindells National Director: Operations and Information[31]	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Karen Wheeler National Director: Transformation and Corporate Operations	2.5-5.0	0	55-60	0	1,089	1,151	51	0

28. As per previous submissions, the column Cash Equivalent Transfer Value at 31 March 2016 is the uninflated value whereas the real increase in CETV is the employer funded increase.
29. Professor Sir Bruce Keogh chose not to be covered by the NHS pension arrangements during the reporting year.
30. Richard Barker took up post from 1 January 2016, replacing Dame Barbara Hakin who retired on 31 December 2015. The figures shown are the absolute values attributed to Richard Barker for 2016/17.
31. Matthew Swindells joined in the post of National Director from 30 May 2016. He is not a member of the NHS Pension Scheme.

Cash equivalent transfer values (subjected to audit)

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

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

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

Real increase in CETV

This reflects the increase in CETV effectively funded by the employer. It does not include the increase in accrued pension due to inflation, contributions paid by the employee (including the value of any benefits transferred from another scheme or arrangement) and uses common market valuation factors for the start and end of the period.

Policy on remuneration of non-executive directors

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

Non-executive director service contracts

Name and Title	Date of Appointment	Unexpired Term at 31 March 2017	Notice Period	Provisions for Compensation for Early Termination	Other Details
Professor Sir Malcolm Grant Chair	31 October 2011, reappointed to a second term on 31 October 2015	19 months	6 months	None	
David Roberts Vice Chair	1 July 2014	15 months	None	None	Waived entitlement to remuneration
Lord Victor Adebowale Non-executive director	1 July 2012, reappointed to a second term on 1 January 2015	21 months	None	None	
Professor Sir John Burn Non-executive director	1 July 2014	15 months	None	None	
Dame Moira Gibb Non-executive director	1 July 2012, reappointed to a second term on 1 January 2015	21 months	None	None	
Noel Gordon Non-executive director	1 July 2014	15 months	None	None	
Wendy Becker Non-executive director	1 March 2016	35 months	None	None	Waived entitlement to remuneration from September 2016
Michelle Mitchell Non-executive director	1 March 2016	35 months	None	None	
Joanne Shaw Non-executive director	1 October 2016	42 months	None	None	

Non-executive director remuneration (including salary entitlements)

Salaries and allowances 2016/17 (subjected to audit)

	2016/17					
	(a) Salary (bands of £5,000)	(b) Benefit in kind (taxable) rounded to the nearest £100	(c) Performance pay and bonuses (bands of £5,000)	(d) Long term performance pay and bonuses (bands of £5,000)	(e) All pension-related benefits[32] (bands of £2,500)	(f) TOTAL (a to e) (bands of £5,000)
Name of non-executive director	**£000**	**£s**	**£000**	**£000**	**£000**	**£000**
Professor Sir Malcolm Grant Chair	60-65	0	0	0	n/a	60-65
David Roberts[33] Vice Chair	0	0	0	0	n/a	0
Lord Victor Adebowale	5-10	0	0	0	n/a	5-10
Wendy Becker[34]	0-5	0	0	0	n/a	0-5
Professor Sir John Burn	5-10	0	0	0	n/a	5-10
Dame Moira Gibb	5-10	0	0	0	n/a	5-10
Noel Gordon	5-10	0	0	0	n/a	5-10
Michelle Mitchell	5-10	0	0	0	n/a	5-10
Joanne Shaw[35] From 1 October 2016	10-15	0	0	0	n/a	10-15

32. Non-executive directors do not receive pensionable remuneration, and therefore have no pension related benefits.
33. David Roberts has waived his entitlement to non-executive director remuneration.
34. Wendy Becker waived her entitlement to non-executive director remuneration from 1 September 2016. NHS England has made employer pension contributions and pension deductions have been taken in error during the reporting period, this has resulted in an underpayment of £200 to Wendy Becker, which will be subject to full refund in 2017/18. The underpayment is not included in the total remuneration figures disclosed.
35. Joanne Shaw is Chair of the Audit and Risk Assurance Committee. Joanne Shaw received an overpayment of £2,600 paid in error during 2016/17, which will be subject to recovery in 2017/18. NHS England has made employer pension contributions and pension deductions have been taken in error during the reporting period, this has resulted in an underpayment of £900 to Joanne Shaw, which will be subject to full refund in 2017/18. Neither the underpayment nor overpayment are included in the total remuneration figures disclosed.

Salaries and allowances 2015/16

	2015/16					
	(a) Salary (bands of £5,000)	(b) Benefit in kind (taxable) rounded to the nearest £100	(c) Performance pay and bonuses (bands of £5,000)	(d) Long term performance pay and bonuses (bands of £5,000)	(e) All pension-related benefits[36] (bands of £2,500)	(f) TOTAL (a to e) (bands of £5,000)
Name of non-executive director	**£000**	**£s**	**£000**	**£000**	**£000**	**£000**
Professor Sir Malcolm Grant Chair	60-65	0	0	0	n/a	60-65
David Roberts[37] Vice Chair from October 2015	0	0	0	0	n/a	0
Lord Victor Adebowale	5-10	0	0	0	n/a	5-10
Wendy Becker[38] From 1 March 2016	0-5	0	0	0	0	0-5
Professor Sir John Burn	5-10	0	0	0	n/a	5-10
Margaret Casely-Hayford To 31 March 2016	5-10	0	0	0	n/a	5-10
Sir Ciaran Devane Until 31 December 2015	5-10	0	0	0	n/a	5-10
Dame Moira Gibb	5-10	0	0	0	n/a	5-10
Noel Gordon	5-10	0	0	0	n/a	5-10
Michelle Mitchell From 1 March 2016	0-5	0	0	0	0	0-5
Ed Smith Vice Chair until 30 September 2015	10-15	0	0	0	n/a	10-15

36. Non-executive directors do not receive pensionable remuneration, and therefore have no pension related benefits.
37. David Roberts has waived his entitlement to non-executive director remuneration.
38. NHS England has made employer pension contributions and pension deductions were taken from Wendy Becker in March 2016, this has resulted in an underpayment of less than £100 to Wendy Becker, which will be subject to full refund in 2017/18. The underpayment is not included in the total remuneration figures disclosed.

Parliamentary accountability and audit report

All elements of this report are subjected to audit.

Remote contingent liabilities

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

Notation of gifts over £300,000

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

Regularity of expenditure: Losses and special payments

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

Details of any losses and special payments relating to CCGs can be found within individual CCG annual reports which are published on CCG websites. A list of CCGs, and links to their websites, can be found on the NHS England website at www.england.nhs.uk/ccg-details.

Losses and special payments

Losses

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

	Parent				Consolidated Group			
	Total number of cases 2016/17	Total value of cases 2016/17	Total number of cases 2015/16	Total value of cases 2015/16	Total number of cases 2016/17	Total value of cases 2016/17	Total number of cases 2015/16	Total value of cases 2015/16
	Number	£000	Number	£000	Number	£000	Number	£000
Administrative write-offs	126	245	168	809	341	9,464	387	11,875
Fruitless payments	38	233	4	916	90	849	40	1,434
Stores losses	-	-	75	19	-	-	78	19
Book Keeping Losses	-	-	6	4,071	-	-	7	4,071
Constructive loss	-	-	-	-	-	-	-	-
Cash losses	-	-	-	-	3	1	7	2
Claims abandoned	1	338	-	-	2	339	1	1
Total	**165**	**816**	**253**	**5,815**	**436**	**10,653**	**520**	**17,402**

2016/17: Claims abandoned

NHS England issued a loan to a GP practice under the provisions of s96 NHS Act 2006 in 2015/16. Due to a change in circumstances of the GP practice the loan is deemed to be irrecoverable and has therefore been written off in the current financial year.

Special payments

	Parent				Consolidated Group			
	Total number of cases 2016/17	Total value of cases 2016/17	Total number of cases 2015/16	Total value of cases 2015/16	Total number of cases 2016/17	Total value of cases 2016/17	Total number of cases 2015/16	Total value of cases 2015/16
	Number	£000	Number	£000	Number	£000	Number	£000
Compensation payments	-	-	2	2	10	410	10	95
Extra contractual Payments	7,330	2,451	1	13	7,341	2,974	4	239
Ex gratia payments	-	-	2	101	14	228	12	162
Special severance payments	-	-	-	-	1	3	2	34
Total	**7,330**	**2,451**	**5**	**116**	**7,366**	**3,615**	**28**	**530**

The parent case extra contractual payments are to support repatriation of clinical correspondence to GP practices. This in relation to the NHS Shared Business Services incident identified in the previous year and referred to in the 2015/16 Annual Report.

Cost allocation and setting of charges for information

NHS England certifies that it has complied with HM Treasury guidance on cost allocation and the setting of charges for information. The fees and charges information is provided in accordance with the Government Financial Reporting Manual. It is provided for fees and charges purposes and not for IFRS purposes.

The financial objective of prescription and dental charges is to collect charges only from those patients that are eligible to pay. The following provides details of income generation activities whose full cost exceeded £1 million or was otherwise material:

		Parent			Consolidated Group		
2016/17	Noted	Income £000	Full cost £000	Surplus (deficit) £000	Income £000	Full cost £000	Surplus (deficit) £000
Dental	2 & 4	776,812	(2,909,509)	(2,132,697)	776,812	(2,909,509)	(2,132,697)
Prescription	2 & 4	547,961	(1,997,166)	(1,449,205)	554,935	(10,526,846)	(9,971,911)
Total fees & charges		**1,324,773**	**(4,906,675)**	**(3,581,902)**	**1,331,747**	**(13,436,355)**	**(12,104,608)**

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

The fees and charges information in this note is provided for fees and charges purposes as per the FReM and not for IFRS 8 purposes. The financial objective of prescription and dental charges is to collect charges only from those patients that are eligible to pay.

Prescription charges are a contribution to the cost of pharmaceutical services including the supply of drugs. In 2016/17, the NHS prescription charge for each medicine or appliance dispensed was £8.40. However, around 90% of prescriptions items were dispensed free as patients were exempt from charges. In addition, patients who were eligible to pay charges could purchase pre-payment certificates at £29.10 for three months or £104.00 for a year. A number of other charges were payable for wigs and fabric supports[39].

Those who are not eligible for exemption are required to pay NHS dental charges which fall into three bands depending on the level and complexity of care provided. In 2016/17, the charge for Band 1 treatments was £19.70, for Band 2 was £53.90 and for Band 3 was £233.70[40].

39. Further details on prescription charges are set out in the Ministerial announcement of 11 March 2016 at www.parliament.uk/business/publications/written-questions-answers-statements/written-statement/Commons/2016-03-11/HCWS607/.
40. Further details are set out in the Ministerial announcement of 11 March 2016 at https://www.parliament.uk/business/publications/written-questions-answers-statements/written-statement/Commons/2016-03-11/HCWS606/.

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

Opinion on financial statements

In my opinion the financial statements:

- give a true and fair view of the state of the NHS Commissioning Board's and the NHS Commissioning Board group's affairs as at 31 March 2017 and of the NHS Commissioning Board's net operating cost and the NHS Commissioning Board group's net operating costs for the year then ended; and
- have been properly prepared in accordance with the Health and Social Care Act 2012 and Secretary of State directions issued thereunder.

Opinion on regularity

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

Basis of opinions

I have audited the financial statements of the NHS Commissioning Board for the year ended 31 March 2017 under the Health and Social Care Act 2012. The NHS Commissioning Board parent consists of the NHS Commissioning Board. The NHS Commissioning Board group consists of the NHS Commissioning Board parent and 209 clinical commissioning groups. The financial statements comprise the parent's and group's Statements of Comprehensive Net Expenditure, Financial Position, Cash Flows, Changes in Taxpayers' Equity, and the related notes. These financial statements have been prepared under the accounting policies set out within them.

I have also audited the information in the Remuneration and Staff Report and the Parliamentary Accountability and Audit Report that is described as having been audited.

The basis of my regularity opinion is the regularity framework which comprise the Health and Social Care Act 2012, Managing Public Money and applicable law.

Overview of my audit approach

Matters significant to my audit

I consider the following areas of particular audit focus to be those areas that had the greatest effect on my overall audit strategy, the allocation of resources in my audit and directing the efforts of the audit team in the current year.

I have also set out how my audit addressed these specific areas in order to support the opinion on the financial statements as a whole and any comments I make on the results of my procedures should be read in this context.

This is not a complete list of all risks identified by my audit but only those areas that had the greatest effect on my overall audit strategy, allocation of resources and direction of effort.

The areas of focus were discussed with the Audit and Risk Assurance Committee; their report on matters that they considered to be significant is set out on pages 98-100.

Risk	My response
Management Override of control: International Standard on Auditing (UK and Ireland) 240 The auditor's responsibilities relating to fraud in an audit of financial statements states that there is a risk in all entities that management override controls to perpetrate fraud. The standard requires that auditors perform audit procedures to address this risk in the following areas: • Significant or unusual transactions including the Sustainability and Transformation Fund (The Fund) The Fund was introduced during 2016-17, with NHS England making £1.8 billion available to support NHS providers during the year, subject to meeting certain financial and operational performance targets. I considered that there was an incentive for manipulation of results at a local provider level to gain access to the Fund, and that this could manifest itself in NHS England's financial statements in the form of clinical commissioning groups making discretionary payments to NHS providers to enable them to meet their control totals and access the Fund. This would benefit the whole local health economy. • Manual Journal Entries • Bias in accounting estimates	I responded to the significant risk of management override of control, focusing my work on the areas considered to be at most risk based on the nature of the NHS Commissioning Board's activities. **Significant unusual transactions** I performed procedures to identify significant unusual transactions. The only such transactions identified related to the Sustainability and Transformation Fund (the Fund). I have liaised regularly with auditors of clinical commissioning groups during the audit and also requested specific assurances from them on this issue as part of audit completion processes. I also performed analytical procedures on component financial data to identify payments of this nature. My work has not identified any instances of discretionary payments made which resulted in NHS providers securing monies from the Fund. **Manual Journal Entries** I used data analytics to identify manual journals with particular risk characteristics which may be indicative of management override of controls. I performed a high level review of those journals which displayed two or more of the risk characteristics, and detailed testing was performed on those journals deemed of interest from the initial review. No instances of management override were found from this work. **Bias in accounting estimates** I reviewed accounting estimates made in the production of the financial statements for evidence of bias. Due to the nature of NHS Commissioning Board's operations, there are no accounting estimates made which present a high risk of management bias, and none was identified during my work. I am satisfied that this risk has not materialised.

Application of materiality

I applied the concept of materiality in both planning and performing my audit, and in evaluating the effect of misstatements on my audit and on the financial statements. This approach recognises that financial statements are rarely absolutely correct, and that an audit is designed to provide reasonable, rather than absolute, assurance that the financial statements are free from material misstatement or irregularity. A matter is material if its omission or misstatement would, in the judgement of the auditor, reasonably influence the decisions of users of the financial statements.

Based on my professional judgement, I determined overall materiality for the NHS Commissioning Board's financial statements at £1.023 billion and for the NHS Commissioning Board's group at £1.024 billion, which is approximately 1% of gross expenditure. I chose this benchmark as I consider this to be the principal consideration for users in assessing the NHS Commissioning Board's financial performance. There has been no change to the prior year in the methodology for determining materiality.

In conducting the audit, for the NHS Commissioning Board's financial statements, in determining the level of testing to undertake, we applied a performance materiality at £767 million and for the NHS Commissioning Board's group at £768 million. This is the amount set by the auditor at a level not higher than 75% of materiality to reduce to an appropriately low level the probability that the aggregate of uncorrected and undetected misstatements exceeds materiality for the financial statements as a whole.

As well as quantitative materiality there are certain matters that, by their very nature, would if not corrected influence the decisions of users, for example, any errors reported in the Accountability Report. Assessment of such matters would need to have regard to the nature of the misstatement and the applicable legal and reporting framework, as well as the size of the misstatement.

I applied the same concept of materiality to my audit of regularity. In planning and performing audit work in support of my opinion on regularity and evaluating the impact of any irregular transactions, I took into account both quantitative and qualitative aspects that I consider would reasonably influence the decisions of users of the financial statements.

I agreed with the Audit and Risk Assurance Committee that I would report to it all uncorrected misstatements identified through my audit in excess of £250,000, as well as differences below this threshold that in my view warranted reporting on qualitative grounds.

Total unadjusted audit differences reported to the Audit and Risk Assurance Committee would increase net assets by £8,351k.

Scope of my audit

An audit involves obtaining evidence about the amounts and disclosures in the financial statements sufficient to give reasonable assurance that the financial statements are free from material misstatement, whether caused by fraud or error. This includes an assessment of:

- whether the accounting policies are appropriate to the group and parent's circumstances and have been consistently applied and adequately disclosed;
- the reasonableness of significant accounting estimates made by the Accounting Officer; and
- the overall presentation of the financial statements.

In addition I read all the information and non-financial information in the Performance Report and Accountability Report to identify material inconsistencies with the audited financial statements and to identify any information that is apparently materially incorrect based on, or materially inconsistent with, the knowledge acquired by me in the course of performing the audit. If I become aware of any apparent material misstatements or inconsistencies I consider the implications for my certificate and report.

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

Group audit approach

Other than the NHS Commissioning Board parent, no other components were identified as significant in the context of ISA 600. All 209 clinical commissioning groups have been thus identified as either a sampled non-significant component (in which case component auditors are requested to perform a number of further procedures on the consolidated data for the group audit), or a non-significant component (where component auditors are only required to perform limited procedures for the group audit).

I audited the full financial information of the NHS Commissioning Board parent. I also audited the NHS Commissioning Board group including the consolidation process, taking assurance over the 209 clinical commissioning groups from component auditors who audited this financial information on my behalf. This work covered substantially all of the group's assets and net expenditure. Both the procedures performed at group level, and the assurance provided over the financial information of sampled non-significant and non-significant components have provided the evidence necessary for my opinion on the group's financial statements as a whole.

Other matters on which I report

In my opinion:

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

Matters on which I report by exception

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

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

Responsibilities of the Accounting Officer for the financial statements

As explained more fully in the Statement of Accounting Officer's Responsibilities, the Accounting Officer is responsible for the preparation of the NHS Commissioning Board's and NHS Commissioning Board group's financial statements and for ensuring they give a true and fair view.

Auditor's responsibilities for the audit of the financial statements

My responsibility is to audit and express an opinion on the financial statements in accordance with the Health and Social Care Act 2012. I conducted my audit in accordance with International Standards on Auditing (UK and Ireland). Those standards require me and my staff to comply with the Auditing Practices Board's Ethical Standards for Auditors.

Report

I have no observations to make on these financial statements.

Sir Amyas C E Morse **17 July 2017**
Comptroller and Auditor General
National Audit Office
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