NHS England

70 YEARS OF THE NHS 1948 - 2018

Our 2017/18 Annual Report

Health and high quality care for all, now and for future generations

HC 1238

THE NHS CONSTITUTION
the NHS belongs to us all

NHS England

Annual Report and Accounts 2017/18

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Contents

A Welcome by Professor Sir Malcolm Grant, Chair

70 years after the creation of the NHS, it is remarkable that as the latest research from the King's Fund shows, no fewer than 9 out of 10 people still back its founding principles. As an independent organisation, at arms-length from government, we work to ensure the continuance of those principles, putting patients at the heart of everything we do.

Following nine years of austerity funding, it is clear that significant further investment is required to maintain and improve NHS services. Serious investment will be essential if we are to ensure that the public receive the best health care available. It is therefore reassuring that the Prime Minister is committed to a long term plan for the NHS and for its future funding.

We will for our part continue to ensure that the funding allocated to the NHS is used in the best interests of patients, while also providing best value for the taxpayer. In this, our fifth annual report, we describe how NHS England has used public funds over the past year to provide the best health and care possible, using investment to maintain world class services for the whole population, ensuring it is well run, and supporting NHS staff in tough but worthwhile jobs.

World class

Everyone who watched BBC 2's "Hospital" will have seen the pressures on Queen's Medical Centre in Nottingham during the busiest winter months, and will also have seen ground-breaking reconstructive surgery on a cancer patient, enabling her jaw to regrow. Across England, ordinary hospitals continue to provide extraordinary care, including Salisbury Hospital where the skill and swift action of doctors and nurses saves the lives of two people attacked with an unknown, deadly chemical that no NHS clinician would ever expect to encounter.

Several initiatives in the last year have demonstrated both scale and pace: The national roll out of the Diabetes Prevention Programme with more than 150,000 referrals of people at risk of type 2 diabetes; the referral of nearly one million people to the world leading Improving Access to Psychological Therapies (IAPT) talking therapies programme, supporting the mental health of the nation, and 14 million people registered for GP Online services, allowing them to book appointments, order repeat prescriptions and access their health records in a manner fit for the 21st century.

Well run

Last year we described how services needed to be transformed if the NHS was to meet the challenge of rising public demand, which continues to put such huge pressure on our GP, community, mental health and hospital services. GPs, hospitals and local councils needed to work closer together to ensure that services are organised around patients, especially the most vulnerable. By developing new ways of working, services across England have become more effective in meeting the high standards enshrined in the NHS Constitution, and 10 areas in the country are now leading the way in formally adopting much more integrated systems of working, putting people and communities at the heart of care rather than the institutions that serve them.

As a board, we have also taken measures to devote more NHS funding to front line care by driving down spending on low value medicines and interventions and making deals with the pharmaceutical industry that provide the best medicines at reasonable prices. Those savings have enabled increased investment in primary care, with the result that more than half of the country now has access to evening and weekend GP appointments.

As we ask the NHS to work closer together and to eliminate waste, it is right that national organisations should lead the way.

In last year's report I wrote about joint appointments with NHS Improvement; this year we have gone further and have committed to working together as one team across both organisations wherever possible, aligning as joint teams where necessary and only working separately where legally essential. This is of fundamental importance in providing clear joined-up national leadership to both the commissioning and the provision of healthcare in England.

We have been pleased to welcome Professor Stephen Powis as the new National Medical Director, succeeding Sir Bruce Keogh. Stephen worked as Group Chief Medical Officer at the Royal Free Hospital as well as a Professor of Renal Medicine at University College London. He combines extensive experience of specialist medicine with a deep knowledge of how digital innovation can help improve care for patients and transform the work of staff. Amongst other priorities, he works alongside Jane Cummings, (Chief Nursing Officer for England until her retirement later in 2018), to lead on our work in supporting NHS staff, attracting new recruits, encouraging people to remain in the NHS and assisting those who wish to return to front line services.

We have also been pleased to welcome, as National Director for Transformation and Corporate Operations, Emily Lawson, who has extensive experience in organisational change, and who will lead for us in developing joint working with NHS Improvement.

Worthwhile

In what is my last foreword to an annual report after seven years as Chair, I would like to thank all members of the NHS England Board for their contribution to our success.

They have overseen the original setting up of NHS England and its continuing evolution today in leading the planning and running of healthcare in England. My thanks also to all of the teams at NHS England. Their work supporting the front line is rarely recognised – but this report aptly describes the impact they have had on improving the NHS.

Finally, and as always, I would like to add the Board's tribute and thanks to all those who provide the care and services which are the core of the NHS. Everyone can take real pride in the extraordinary achievements of the NHS in its first 70 years and look forward to its founding principles being steadfastly maintained well into the future.

Professor Sir Malcolm Grant,
Chair of NHS England

70 YEARS OF THE NHS 1948 - 2018

1948
Launch of the NHS, free care for all at point of delivery.

1953
DNA structure discovered, revolutionising the study of defective gene related diseases.

1962
First hip replacement operation – in 2018 around 75,000 hip operations performed.

1968
Measles vaccine introduced – previously half a million children caught the disease each year.

1978
World's first test tube baby was born – 5 million babies have been born though assisted reproduction worldwide.

1986
The world's first liver, heart and lung transplant is carried out.

1988
Breast and cervical screening introduced – 250,000 cancers and 5m cervical abnormalities detected over last 20 years.

1994
NHS Organ Donor Register is set up. More than 50,000 people are alive today due to organ transplants.

2002
The first successful gene therapy is carried out curing an 18-month-old boy of bubble boy disease (severe combined immunodeficiency, or SCID).

2007
First robotic arm used in surgery, to treat people with fast or irregular heartbeats.

2013
Abnormal aortic aneurysm (AAA) screening is rolled out for all men over the age of 65, saving the lives of thousands of older men.

2016
UK's first double hand transplant performed.

2017
£80million investment in thrombectomy, an innovation in stroke care to directly remove clots from the brain.

2018

About us

NHS England is an executive non-departmental public body which leads and oversees the planning, funding and delivery of healthcare provision in England. We are mandated to improve the country's health and wellbeing by arranging high quality care in a way that meets current demand, in a way that is sustainable into the future.

In 2017/18 we had a funding allocation of £110 billion to commission healthcare services, both directly and via the 207 Clinical Commissioning Groups (CCGs)[1].

NHS England allocates most of the funding it receives to CCGs and supports them to commission services on behalf of their patients. NHS England also undertakes direct commissioning of specialised, primary care and other services. Together they account for £105 billion of total commissioning expenditure.

Further detail about how we oversee the commissioning system is presented from page 68.

The Government's mandate to the NHS

NHS England shares with the Secretary of State for Health and Social Care the legal duty to promote a comprehensive health service in England, in accordance with the NHS Act 2006 (as amended by the Health and Social Care Act 2012).
Each year, the Government sets out its expectations of the service and the funding we will receive in the form of a mandate which is laid before Parliament. This mandate sets the direction for the NHS, describes the government's healthcare priorities and helps to ensure the NHS is accountable to Parliament and the public.

The Government's mandate to the NHS for 2017/18 can be viewed on the Department of Health and Social Care (DHSC) website[2] and the report in Appendix 1 shows how we have delivered against it.

How we are governed and managed

NHS England is governed by a Board which provides strategic leadership to the organisation and is responsible for ensuring that it is able to account to Parliament and the public for how it has discharged its functions. Primary legislation directly designates the Chief Executive Officer of NHS England as the Accounting Officer for the funds Parliament allocates to NHS England. The Board is supported by a number of committees which undertake detailed scrutiny in their respective areas of responsibility and provide regular reporting and formal assurance. Further detail about our Board, its committees and membership is presented from page 38.

1 In April 2018, 18 CCGs merged into six new CCGs. This builds on a history of joint working and further reduces the total number of CCGs to 195
2 www.gov.uk/government/uploads/system/uploads/attachment_data/file/601188/NHS_Mandate_2017-18_A.pdf

Our values and the NHS Constitution

The NHS Constitution establishes the principles and values of the NHS in England and unites patients and staff in a shared ambition for high quality care. As a custodian of the values of the NHS Constitution, NHS England is committed to putting patients at the heart of everything we do, promoting transparency and accountability of our work to citizens, and ensuring the most efficient, fair and inclusive use of finite taxpayer resources.

Further information about our values and the NHS Constitution can be found on the NHS England website[3].

How we operate

NHS England operates through its national and regional teams. We work closely with partner organisations that provide regulatory and support services to the health and care system, including NHS Improvement, the DHSC, NHS Digital, Public Health England (PHE) and the Care Quality Commission (CQC).

The organisation is focused on delivering in the priority areas as set out in the publication Next Steps on the Five Year Forward View[4].

During 2017/18 NHS England took steps in further streamlining its work by working ever more closely with NHS Improvement. Joint working between NHS England and NHS Improvement is now taking place at all levels, including appointments to joint system-wide Chief Clinical Information Officer and Chief Information Officer roles, a number of joint Regional Director of Nursing posts and, most recently, two joint Regional Directors in the South East and South West Regions who exercise leadership on behalf of both organisations. The joint working initiative has facilitated the creation of a single Urgent and Emergency Care programme under a joint national lead and the division of the country into seven urgent and emergency care patches.

In January 2018, NHS Improvement announced that David Roberts, NHS England's Vice Chair, had been invited to attend their Board as an Associate (non-voting) Non-Executive Director; similarly, Richard Douglas CB, Non-Executive Director and Chair of the NHS Improvement Audit Committee, was invited to attend NHS England's Board as an Associate (non-voting) Non-Executive Director in March 2018.

On 27 March 2018 and at our last Board meeting, NHS England made a joint announcement[5] with NHS Improvement regarding plans to work in a more integrated way and to deliver better outcomes for patients, whilst improving our performance and efficiency. This included plans for additional joint posts at national director level in the areas of medical, nursing and financial leadership.

3 www.england.nhs.uk/about/
4 www.england.nhs.uk/wp-content/uploads/2017/03/NEXT-STEPS-ON-THE-NHS-FIVE-YEAR-FORWARD-VIEW.pdf
5 www.england.nhs.uk/2018/03/nhs-england-and-nhs-improvement-working-closer-together/

NHS England's teams continue to work closely with CCGs, GP practices, local authorities and health and wellbeing boards. In 2017/18 regional teams strengthened collaboration with Sustainability and Transformation Partnerships (STPs) and Integrated Care Systems (ICSs) across the country, by aligning roles or embedding staff to STP and ICS footprints and working ever more closely with the STP and ICS leadership.

Clinicians are an essential feature of the work of NHS England, and we have 26 national clinical directors and associate national clinical directors providing leadership in their respective fields. For further information about the national clinical directors please visit our website[6].

The work of NHS England is further supported by a number of NHS and third party organisations including NHS Digital, NHS Business Services Authority (NHS BSA), NHS Shared Business Services (NHS SBS), NHS Property Services Ltd (NHS PS) and Primary Care Support England (Capita). Additionally, NHS England hosts NHS Interim Management and Support (NHS IMAS) and sponsors the Sustainability Unit on behalf of the NHS.

NHS England has statutory powers to provide commissioning support services to CCGs. To this end a number of Commissioning Support Units (CSUs) were formed in April 2013, hosted by NHS Business Services Authority but subject to oversight and direction by NHS England. CSUs' activities are included in our Report and Accounts except where otherwise indicated.

For further information about how we operate please visit our website[7].

6 www.england.nhs.uk/about/structure/ncd/
7 www.england.nhs.uk/about/

Performance Report

Simon Stevens
Accounting Officer
3 July 2018

Chief Executive's overview

Personally and on behalf of our Board, I want to start by paying tribute to Sir Malcolm Grant, who later this year stands down as NHS England's founding Chair. Malcolm has both shaped and driven NHS England's mission as the independent steward of the National Health Service, and champion of the patients we serve. He will be greatly missed.

As this Annual Report shows, the past year has again been one of both progress and pressure.

Genuine and measurable advances have been secured in many critical services. We've had upgrades to cancer radiotherapy treatment, and steadily improving cancer survival rates. Mental health services are expanding, particularly for new mums and for young people needing specialist care. More patients are able to see a GP after work or on a weekend. Fewer frail older people are stuck in hospital waiting to go home. More people are getting advice from an NHS 111 clinician. Fewer people with learning disabilities are living in inappropriate institutions. More A&E patients are being looked after within four hours. Further gains have been secured in efficiency, with action to drive out ineffective or wasteful prescribing and procurement. This has all been underpinned by continued financial discipline, as NHS England has balanced its books and met or exceeded all financial goals set by the Government for the fifth year in a row.

But there has also been intensifying and inescapable pressure in other important areas. GP workloads are up, but GP numbers down. There were longer waits last year for A&E and routine surgery, and a particularly difficult winter. And financial deficits continued in some local NHS organisations.

So in November I spoke publicly about what would be needed if, in our 70th year, we wanted to sustain a well-functioning National Health Service. I explained that the compound effect of funding and staffing constraints since the 2008 economic crash meant that GPs, community and mental health services, hospitals and social care were under increasing strain. While NHS productivity has been rising far faster than the rest of the economy, over the past five years cumulatively the NHS has operated with £27 billion less than had it been funded at its long term trend funding growth. We are now spending a third less per person on our health services than Germany, on a like-for-like basis.

Against this backdrop, the Prime Minister's important decision in June this year now provides the NHS with the welcome certainty of a five year funding settlement. Working with patient groups, clinicians, frontline NHS leaders and our wider partners, we will use this opportunity to frame a realistic but appropriately ambitious plan for health and care improvement for the next decade.

Because as we turn to the years ahead, it is not just a question of 'keeping the show on the road'. We also need to continue and accelerate the fundamental changes we're embarked on to 'future proof' the health service for generations ahead. In doing so we have three particular advantages to build on.

First, our health service staff are outstanding. The past year has once again shown not only their skill and dedication day in, day out, but also how NHS staff respond in the most extraordinary way at times of national emergency. Survivors and relatives of Grenfell Tower, and

victims of terrorism in Manchester and London all bear witness to the care and compassion of the nurses, therapists, doctors, care assistants and countless others who were there for them at their time of greatest need. And in a year when we also mark the 70th anniversary of the Empire Windrush, we are reminded that the NHS has over seven decades benefited from the professional commitment of generations of staff from Britain and also from overseas.

Second, the NHS's own reform programme is beginning to bear fruit. GPs and local Clinical Commissioning Groups have begun to develop alternatives to hospital referral for conditions that don't need it, and new outpatient referrals each day actually fell by 1.6% over the past year. 12.5 million people across England are now covered by early stage 'integrated' care, and where GPs, community services and hospitals are working most closely together, emergency hospitalisations per person are now growing at under half the rate of the rest of the country. 12% fewer people are being admitted to hospital as emergencies than would have been five years ago, thanks in part to better support at home.

Third, the British people want us to succeed. I joined the NHS on its 40th birthday in 1988, and thirty years later as we mark its 70th birthday, public support for and satisfaction with the NHS is higher now than it was then. That is a testament to the enduring popularity of the founding principle of an NHS there when you need it, regardless of ability to pay. But it is also a recognition of the fact that, while by no means perfect, for most people most of the time, the NHS provides high quality and steadily improving care.

Simon Stevens

CEO of NHS England, and Accounting Officer

Performance Analysis

Our business plan for 2017-19 was published on 6 April 2017 as part of the Next Steps on the NHS Five Year Forward View, with a further update being made on 29 March 2018.

Next Steps on the NHS Five Year Forward View outlines national priorities for the NHS, and this report provides analysis of the following priority areas: **Urgent and emergency care** (p.16); **Primary care** (p.18); **cancer** (p.19); **mental health** (p.20); and **integrating care locally** (p.22).

These priority areas encapsulate the objectives set out in the Government's mandate to us for 2017/18[8] and are underpinned by other national priority themes: funding and efficiency; harnessing technology and innovation; strengthening our workforce; and patient safety, all of which are addressed throughout this document. Further information on our performance against the mandate is available in appendix 1 on page 160.

Urgent and emergency care

A comprehensive urgent and emergency care programme has been delivered during 2017/18, covering GP urgent care, A&E departments, emergency ambulance services and NHS 111. This programme was developed to tackle the rising demands on urgent and emergency care, as well as clarify where patients can access services that best meet their urgent care needs.

Reforms are being introduced to NHS 111 which allow patients, whenever their condition requires it, to speak to a clinician as well as being able to book an appointment directly with a service that is right for them. NHS 111 online has been piloted and evaluated in a number of areas, with 34% of the population now able to access urgent and emergency care advice through this online portal. We aim to have NHS 111 online services in place across all areas this summer, with work being undertaken to develop greater integration with local services.

Record call volume is being successfully managed through NHS 111, and more patients than ever before are able to speak to a clinician about their urgent and emergency care needs when calling the service. 48.4% of calls now receive clinical input, which is expected to rise to half of all calls by the end of March 2019.

A number of strategies have continued to be developed to ease the pressure on hospitals, including extended access to primary care, with coverage of 55.4% of the population, and more Urgent Treatment Centres (UTC). There are now 85 UTCs that have been designated with the revised standard specification.

The recommendations of the Ambulance Response Programme have been implemented in mainland ambulance trusts across England.

By the end of March 2018, all eligible acute Trusts with Type 1 A&E had front-door clinical streaming services in place. This has resulted in more patients with minor illnesses being diverted to more appropriate services, helping to improve patient experience and health outcomes.

We have provided an additional £96.7 million to 105 Trusts to support the modification of their A&Es to separate serious medical and surgical cases from those needing urgent primary care treatments.

8 https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/692140/NHSE_Mandate__2017-18_revised.pdf

At the 'back door' of A&E 1,649 beds have been freed up as a result of reducing Delayed Transfer of Care (DToCs), and DToC delayed days have reduced consistently throughout the year. With the exception of December 2017, this is the lowest number of beds occupied DToC since August 2015. This means that there are now fewer patients occupying a hospital bed who could receive better and more appropriate care in their own home or a nursing or care home. This has been achieved through partnership working between health and social care at a local level, with 150 local council areas agreeing Better Care Fund (BCF) plans. In addition, there are now more assessments for patients' continuing healthcare needs taking place out of an acute hospital environment.

The NHS's plan for winter was more detailed and intensive than in previous years.

2017/18 performance was tracking the same as last year until December and January. Performance for February and March 2018 reflected much greater pressure, and as a result, year-end performance by hospitals on their four hour standard was at 88.4%, below 2016/17 performance of 89.1%. This downturn towards the end of the year reflected a more complex case mix, increased ambulance arrivals and the most severe flu season since 2010/11, with flu patients occupying over 2000 more beds at the peak than at the worst days in 2016/17. This was exacerbated by norovirus bed closures, which were up on the previous year. Bed occupancy, therefore, tracked higher than the same period last year.

Action for the year ahead includes:

- Continuing to focus developing NHS online, enhancing NHS 111, developing urgent treatment centres and completing the extension of extended access to GPs to the whole country.
- Continuing to develop patient streaming in A&E departments.
- Developing clinical pathways to optimise the use of emergency day care and identify more cohorts of patients who can be managed in this way.
- Reducing the number of patients whose length of stay exceeds 21 days (which amounts to around 20% of total bed occupancy), to create the capacity hospitals need.
- Working with Local Authorities and care home providers to help keep patients in their own homes and away from hospital unless really necessary.

In March 2018, the NAO published its report 'Reducing Emergency Admissions'. We have put in place a number of actions to address the recommendations made. In addition, jointly with NHS Improvement, we have requested local providers and commissioners to focus on reducing length of stay in the coming year, particularly for patients who have been waiting in hospitals over 21 days. A reduction in length of stay will support the increase in capacity required to manage the predicted emergency and elective demand over the course of the year.

For further information please see the urgent and emergency care pages of the NHS England website[9].

9 www.england.nhs.uk/urgent-emergency-care

Primary care

The Primary Care Programme continues to support the delivery of the General Practice Forward View (GPFV). The programme increases investment in primary care services, increases the number of people working in primary care and supports the improvement of access, services and premises. Responses to the GP Patient Survey give a patient view on how primary care is performing. In 2017, responses to the survey remained positive overall, with 84.8% rating their experience as good, and many would recommend their GP surgery to others (72.7%). However, the survey did reveal decreasing satisfaction with ability to contact their GP 'in-hours' and being able to get an appointment with a GP they prefer to see.

In response, we remain on track to deliver an additional £2.4 billion by 2021, increasing our investment in general practice to £12 billion per annum, as set out in the GPFV, with a particular focus on additional investment for primary care transformation. Investing in upgrading primary care facilities has continued, with 106 schemes completed in 2017/18 in addition to the 758 schemes previously completed. As well as this there are a further 972 active schemes at different stages of progress (427 in due diligence, 170 pre-project, and 375 in delivery).

We have surpassed the Government's Mandate commitment to achieve 40% access to evening and weekend appointments for general practice services, as more than half of the population are now able to access these extended services. The whole of the population will be able to access evening and weekend appointments by October 2018.

We continue to tackle challenges in GP retention and recruitment. In partnership with Health Education England, NHS England has a number of programmes that are seeking to maintain and increase numbers in line with the ambitions in the General Practice Forward View. These include a continued focus on boosting the number of new GPs and other professionals working in primary care. We now have the highest number of GP trainees ever recruited, as more than 770 additional GP trainees have commenced specialist training since 2015, bringing the current total to 3,157. Recruitment for the 2018 intake is now underway.

We have launched a programme to recruit international GPs to further strengthen our GP workforce. International GP recruitment has begun in the first three pilot sites in Lincolnshire, Essex and Cumbria. Humber Coast and Vale subsequently started during the latter stages of the pilots. The expanded recruitment programme is now also underway across 11 additional areas of the country, with further phases planned, and it is expected that the first candidates will be relocated to England by the Autumn. The GP Retention Scheme, offering financial and educational support to doctors who might otherwise leave the profession was launched in April 2017 and replaced the Retained Doctors 2016 scheme. There were 286 GPs being supported through these schemes at 31 March 2018, an increase of 80% since Sept 2015.

During 2017/18 nearly 34 million patients have benefitted from improved pharmacy services in a general practice setting. Against the current target of 2000 Full Time Equivalent (FTE) Clinical Pharmacists in post by 2020/21, as at March 2018 over 748 FTE Clinical Pharmacists were actively working in general practice, an increase of 550 since September 2015. Applications for a further 410 FTE Clinical Pharmacists have been approved to date.

Action for the year ahead includes:

- Actively encourage every practice to be part of a local primary care network, serving populations of at least 30,000 to 50,000.
- Ensure every practice implements at least two of the high impact 'time to care' actions.
- Continue to recruit and retain the primary care workforce via all available national and local initiatives.

For further information on our work with primary care, please see the primary care pages of the NHS England website[10].

Cancer

Progress continues to be made on delivering world class cancer services as set out in the Next Steps on Five Year Forward View. We are developing services that increase prevention, speed up diagnosis, improve the experience of patients and help people living with and beyond the disease. Cancer survival has never been higher. The latest figures published in November show one year survival at 72.3% for people diagnosed in 2015, amounting to a further 0.7% year-on-year increase.

We are shifting to earlier and faster diagnosis by increasing public awareness of the signs and symptoms of cancer, encouraging people to seek medical advice if they have concerns and making sure health services act swiftly to ensure rapid diagnosis. In 2017/18, we invested more than £37 million nationally through our Cancer Alliances to boost diagnostic services, including embedding the latest research on prostate diagnosis to avoid unnecessary biopsies and identify more cancers, and rolling out 'straight to test' pathways for colorectal cancer to speed up diagnosis and reduce the number of outpatient appointments. We also introduced ten new multidisciplinary rapid diagnostic and assessment centres to ensure patients with complex symptoms receive a rapid diagnosis.

We have continued to implement the largest radiotherapy upgrade programme in 15 years.

£46 million was spent in 2017/18 on 26 new radiotherapy machines in 21 hospitals and we are on track for 70 new / upgraded machines by Autumn 2018 at a cost of £130 million. We also consulted on a new radiotherapy service specification to ensure equity of access to the highest quality treatment across the country. The new specification will be rolled out in 2018/19.

In 2017/18, more than £18 million was spent nationally on additional capacity to support improvement against the 62-day Referral to Treatment Time (RTT) standard for cancer. Additional funding was made available to our Cancer Alliances by way of performance incentives for achievement of the RTT standard. During 2017/18, almost 140,000 patients received first treatments for cancer within 62 days of an urgent GP referral, 3% more than last year. Despite this progress, trusts remain short of their 85% target, and this will continue to be their focus so times are improved further in 2018/19.

10 https://www.england.nhs.uk/gp/

Fast track funding for the most promising new cancer drugs is being delivered by the new Cancer Drugs Fund, which has benefited nearly 15,700 patients since it opened in July 2016. 52 drugs across 81 different types of cancer have been made available, and around 5,000 patients have received treatment sooner due to new early access arrangements. There is a commitment from National Institute for Health and Care Excellence (NICE) to make a decision on cancer drugs within 90 days of their being licensed for use in England. In 2017/18, we have also invested more than £11 million through 10 of the 19 Cancer Alliances to transform personalised follow up after cancer treatment.

Action for the year ahead includes:

- Driving earlier and faster diagnosis through our Cancer Alliances, including implementing rapid diagnostic and assessment pathways for lung, prostate and colorectal cancer, and rolling out the use of low dose CT case finding for lung cancer.
- Introducing Faecal Immunotherapy Test (FIT) into the bowel cancer screening programme, and readying the system for the introduction of HPV screening in the cervical screening programme.
- Driving up standards in treatment and care, investing in radiotherapy equipment and networking and implementing personalised follow-up support.
- Enabling and reinforcing Cancer Alliances' leadership role to drive improvements for their populations and delivering a data, evidence and analysis service to ensure evidence based, local decision making.
- Making improvements to meet and sustain the 62 day referral-to-treatment standard and all other cancer waiting times standards, and deliver a new Cancer Waiting Times system.

For further information, please see the cancer pages of the NHS England website[11].

Mental health

Throughout 2017/18 we have been implementing the recommendations included in the Five Year Forward View for Mental Health (FYFV MH), published in February 2016, with more patients being seen and a number of other improvements.

Access to mental health services for people requiring psychological therapies has been improved for children and young people with eating disorders, and for individuals requiring early intervention in psychosis. All access targets are being met, and, where appropriate, are on track to be strengthened by 2020/21.

Integrating mental health services with the rest of our transformation agenda has been a key focus this year. £16.3 million was invested in 2017/18 in acute hospitals to support 74 areas to meet the 'Core 24' standard, which includes 24/7 mental health liaison teams as part of the commitment to invest £30 million by March 2019. 46% of acute hospitals are expected to meet the 'Core 24' standard by the end of 2018/19.

£48.7 million has been invested in 37 'early adopter' sites to progress the integration of

11 https://www.england.nhs.uk/cancer/

Improving Access to Psychological Therapies and Long term Conditions, to improve mental and physical health services. Early results from some of these sites show a marked decrease in use of primary and secondary care services.

We have also provided more physical health checks and interventions for patients with severe mental illnesses in secondary care, with 60% of people in inpatient settings and 42% in community mental health teams receiving this to date.

£18 million was also provided over the winter period to address mental health-related system pressures.

£18.6 million was invested in more than 20 areas in 2017/18 to develop perinatal community services. We comprehensively exceeded the target of 2,000 women being able to access specialist perinatal mental health services as 7,000 more women accessed specialist care in 2017/18.

New beds are helping to improve patient experience and reduce the travel for children and young people, and their families. An additional 113 have been implemented or re-purposed for specialist mental health services for children and adolescents (tier 4).

70 new or extended community eating disorder services have been funded and commissioned across the country.

The Mental Health Investment Standard was met both nationally and regionally in 2017/18, and we have required each CCG to meet the standard in 2018/19.

CCGs have continued to meet the dementia diagnosis standard, with a performance of 67.5% in 2017/18. A project to examine potential strategies to reduce unnecessary admissions and length of stay in acute hospitals for people with dementia has been established, and three STPs have been invited to participate. For further information, please see the mental health pages of the NHS England website[12].

We increased personalised care for people discharged from psychiatric hospitals who receive Section 117 aftercare under the Mental Health Act, working with more than 50 sites across England.

Action for the year ahead includes:

- Requiring all CCGs to increase investment in mental health services faster than the overall increase in their allocation this year.
- Expanding children and young people's mental health services so children and young people in need can access high quality care at the right time.
- Increasing access to the Individual Placement and Support Programme by 25% to support people with severe mental illness to gain and retain meaningful employment.

12 https://www.england.nhs.uk/mental-health/

Integrating care locally

Throughout the past year, STPs have provided a framework for all local health and care systems to identify shared challenges and solutions. STPs in every part of England are now addressing the Five Year Forward View's triple aim of improved health and wellbeing, transformed quality of care and sustainable finances – as well as the priority areas set out in Next Steps on the Five Year Forward View.

The most mature partnerships are evolving further to become 'Integrated Care Systems'. Commissioners and NHS providers, working closely with GP networks, local councils and others, voluntarily agree to take shared responsibility for how they use their collective resources for the benefit of local populations in ways which are consistent with the existing statutory framework. Integrated care systems are crucial to improving health and care locally by:

- Putting GPs and primary care at the heart of the populations they serve, through the use of networks to provide at-scale and comprehensive services.
- Supporting the integration of services within the NHS and between health and social care, with a particular focus on people at risk of developing acute illness and hospitalisation.
- Providing more care through redesigned community and home-based services, including partnerships with social care, the voluntary and community sector.
- Ensuring a greater focus on prevention of ill health and population health outcomes, in partnership with communities.

During 2017/18 we signed a memorandum of understanding with eight ICSs[13], setting out the expectations of delivery and resources and flexibilities that will be offered in recognition of their partnership working. This is complementary to the devolution agreements in place with Greater Manchester, Surrey Heartlands and London, with Greater Manchester and Surrey Heartlands playing a full role in the ICS programme. These systems have confirmed that the appropriate governance arrangements are in place to enable the release of delegated funding.

Further ICS areas were approved in June, so that 12.5 million people are now covered by this new way of working.

As the rest of the country moves in this direction, appropriate joint working with social care will be important, as described by the NAO in their study on the adult social care workforce.

For further information please see the system changes pages of the NHS England website[14].

13 https://www.england.nhs.uk/accountable-care-systems/
14 https://www.england.nhs.uk/systemchange/

Our priorities for 2018/19

Progress continues to be made on delivering the Five Year Forward View. The Next Steps on the NHS Five Year Forward View, published in 2017, set out key priority areas and 'NHS England Funding and Resources 2017-19', as an annex to the Next Steps, detailed how funding will be distributed and staff used to achieve the ambitions stated in the Next Steps. 'NHS England Funding Resource 2018/19' updates the annex and contains information about NHS England's funding in 2018/19.

Our priorities for 2018/19 are those set out in the Next Steps and focus on transforming urgent and emergency care, cancer, mental health, primary care and integrating care locally, so that in the NHS's 70th year we can continue to deliver world class healthcare now and for future generations.

Our plans for 2018/19 reinforce the role of STP and ICS leadership in population health, coordinating and strengthening the delivery of the Five Year Forward View across their respective geographies. To deliver excellent treatment and care, we rely upon local healthcare professionals, working in partnership with their patients and communities, to inform us of services they need. We will continue to empower these local areas so they can access the best and most appropriate services.

We will also concentrate on building an effective model of joint working with NHS Improvement. We will work in a much more streamlined way in order to set consistent expectations of commissioners and providers and deliver forms of support and oversight that best help local systems to meet shared goals.

How we supported the wider NHS

Emergency Preparedness, Resilience and Response (EPRR)

NHS England responded to a number of potential threats to patient and public safety during the year, drawing on its considerable experience and expertise in EPRR.

The resilience capability of the NHS has been clearly demonstrated throughout 2017/18, with a number of terror attacks across the UK for the first time in many years. The attacks at Westminster Bridge, Manchester Arena, London Bridge, Salisbury, Finsbury Park and Parson's Green have all required an emergency response from the NHS. The EPRR team led the coordination of the immediate health responses to these incidents and will continue to work towards improving future emergency responses. In the months since these occurred, there has been much focus on sharing invaluable learning from these incidents, to help ensure emergency preparedness for similar future incidents. The EPRR team continues to cooperate with partners in the wider cross-government response to the Grenfell Tower fire in June 2017.

Following the outbreak of Ebola in West Africa, our High Consequence Infectious Disease Programme Board has continued its work to develop the UK's health response to outbreaks of infectious diseases posing a high threat.

The global attack of the 'WannaCry' virus in May 2017 affected many NHS organisations and caused significant service disruption. The health response required to restore impacted NHS IT systems and ensure protection against future cyber attacks was led by the national EPRR team. A number of CCGs, GP practices and NHS Trusts were affected, with services disrupted. Expert teams in the CSUs were part of the first wave response to that attack, in many cases responding out of hours and across the weekend. Their work was instrumental in preventing the attack from spreading and had a positive impact on maintaining services. Since this cyber attack, the EPRR team has contributed to the development of plans for the NHS for its response to any future attack.

In October 2017, The National Audit Office published a report[15] that investigated the NHS's response to the WannaCry cyber attack. The investigation focused on the ransomware attack's impact on the NHS and its patients, why some parts of the NHS were affected; and how the DHSC and NHS national bodies responded to the attack.

The national breast cancer screening incident

On 2 May 2018, the Secretary of State for Health and Social Care informed the House of a serious incident in the national Breast Screening Programme in England, overseen by Public Health England, which resulted in thousands of women aged between 68 and 71 not being invited to their final breast screening appointment due to the misapplication of a computer algorithm dating back to 2009.

Public Health England has contacted 195,565 women registered with a GP in England who have been affected to offer them a screening appointment. Public Health England are leading

15 https://www.nao.org.uk/wp-content/uploads/2017/10/Investigation-WannaCry-cyber-attack-and-the-NHS.pdf

the incident response and NHS England has taken major steps with local areas to expand the capacity of screening services so that women who wish to be screened can be offered an appointment within six months.

Life sciences and innovation

NHS England has an important responsibility in promoting the opportunity for life sciences and innovation and supporting the spread of innovations. In 2017/18 we provided £37.9 million funding to Academic Health Science Networks (AHSN) to deploy innovation at pace and scale.

Over the last five years, the AHSNs estimate they have supported the spread of 332 innovations across 11,000 locations, benefiting 22 million patients.

The AHSNs have also: leveraged £330 million to improve health and support NHS, care and industry partners; supported contracts awarded to more than 450 Small and Medium-sized Enterprises (SMEs); and helped create more than 500 new jobs[16].

The Innovation and Technology Tariff (ITT) was launched in April 2017 to incentivise the adoption of transformational innovation in the NHS. Since the launch of the ITT:

- 56,382 patients are benefitting from being able to self-manage their severe or very severe Chronic Obstructive Pulmonary Disease (COPD) symptoms.
- Reusable angled episiotomy scissors have been used on over 6,625 occasions, reducing the likelihood of injuries to women in labour.
- 1,578 ventilation tubes that are specifically designed to reduce the incidence of Ventilator Associated Pneumonia are in use in hospitals.
- 13,748 devices that prevent injection of fluids into an artery are being used, improving patient safety.

At our Board in November, we published Twelve Actions to support and apply research in the NHS. We have undertaken significant engagement with key stakeholders and partner organisations to progress work on solving excess treatment costs, commercial contract research and NHS England's research needs. NHS England is working with the Office for Life Sciences and Department for Business, Energy and Industrial Strategy (BEIS) on the Review of the Innovation Landscape. The review provides an opportunity to simplify and enhance how we deploy proven innovations and will help to create the conditions for these to be generated in the first place.

We coordinate and lead the NHS response to the Life Sciences Industrial Strategy, a report from the Life Science sector and Professor Sir John Bell, and we are an active partner in the Accelerated Access Collaborative (AAC). The AAC is a partnership between Government, industry and the NHS, tasked with implementing proven and affordable innovations.

During 2017/18, NHS England created a stronger focus on life sciences and innovation by establishing a new dedicated life sciences and innovation group.

16 The Academic Health Science Networks, Impact Report 2017, May 2017; http://www.ahsnnetwork.com/wp-content/uploads/2017/06/AHSN-Network-Impact-Report-2017_Web_spreads.pdf

Personalised care

Evidence shows that supporting patients to be actively involved in their own care, treatment and support can improve their outcomes and experience. Personalised care can also potentially yield efficiency savings for the system through approaches that support people to stay well and manage their own conditions better. NHS England has made a commitment to involve patients and their carers by giving people the power to manage their own health and make informed decisions about their care and treatment and by supporting people to improve their health and give them the best opportunity to lead the life they want.

We delivered 28,040 Personal Health Budgets (PHBs) in 2017/18, significantly exceeding our target of 20,000. We are increasingly rolling out PHBs by default for people receiving continuing healthcare (CHC) and expanding local PHB offers to support people with learning disabilities. In July 2017, NAO published the findings of its investigation into NHS Continuing Healthcare. NHS England and the DHSC are working at providing more consistent access to CHC funding and supporting CCGs to make efficiency savings. We introduced an expanded Personal Wheelchair Budgets model to 18 CCGs and providers in 2017/18. We also delivered significantly in excess of our commitment of 10,000 Personal Maternity Care Budgets (PMCBs), supporting 18,905 pregnant women in their choice of maternity care.

More than 70,000 personalised care and support plans have been created by people with long term conditions in partnership with professionals through the Integrated Personal Commissioning Programme.

Patient activation describes the knowledge, skills and confidence a person has in managing their own health and care. During 2017/18, we have completed in the region of 47,000 Patient Activation Measurement assessments and around 70,000 since the programme began. This far exceeds the 50,000 commitment by March 2018, supporting more people to develop their knowledge, skills and confidence to manage their health, improving health outcomes and patient experience.

We also launched a national shared decision making collaborative, working with 13 CCGs to support people with MSK conditions to make more informed decisions about their care.

Meeting our Public Sector Equality Duty (PSED)

NHS England has developed a proactive response to the public sector equality duty and the associated specific equality duties. We have published a comprehensive report[17] which demonstrates that meaningful action is being taken across NHS England that supports compliance with the Equality Act 2010 generally and the PSED specifically. The report also lays a foundation for future developments and for an exploration of the interface between addressing the PSED and the health inequalities duties arising from the Health and Social Care Act 2012. It sets out how NHS England has embraced the requirement to publish equality objectives every four years and equality information annually. Our equality objectives are supported by key targets, and progress in relation to both the equality objectives and the targets are set out in our latest response to the specific equality duties[18].

NHS England's gender pay report[19] was published in March 2018. This complies with the

17 https://www.england.nhs.uk/about/equality/objectives-16-20/
18 https://www.england.nhs.uk/wp-content/uploads/2017/03/nhse-response-to-the-specific-equality-duties-of-the-equality-act-2010.pdf
19 https://www.england.nhs.uk/publication/nhs-england-gender-pay-report/

requirement to publish monitoring information in relation to gender pay gap. Further information can be found on page 79 of our staff report.

Our equality objectives for 2016 to 2020, set out below, address our role as an NHS system leader and our own role as an employer:

Equality objective 1: To improve the capability of NHS England's commissioners, policy staff and others to understand and address the legal obligations under the Public Sector Equality Duty and duties to reduce health inequalities introduced by the Health and Social Care Act 2012.

Equality objective 2: To improve disabled staff representation, treatment and experience in the NHS and their employment opportunities within the NHS.

Equality objective 3: To improve the experience of LGBT patients and improve LGBT staff representation.

Equality objective 4: To reduce language barriers experienced by individuals and specific groups of people who engage with the NHS, with specific reference to identifying how to address issues in relation to health inequalities and patient safety.

Equality objective 5: To improve the mapping, quality and extent of equality information in order to better facilitate compliance with the Public Sector Equality Duty in relation to patients, service-users and service delivery.

Equality objective 6: To improve the recruitment, retention, progression, development and experience of the people employed by NHS England to enable the organisation to become an inclusive employer of choice.

During 2019/20 we aim to engage with stakeholders to review our equality objectives in order to publish updated objectives by March 2020.

Sustainability

The Five Year Forward View describes the importance of a sustainable NHS to ensure the continued provision of wide-ranging, high quality care. The sustainable development strategy for the NHS, public health and social care is led by the Sustainable Development Unit (SDU) and describes the vision and goals to support sustainable development, reduce emissions, save money and improve the overall health and wellbeing of communities.

Our Sustainability report describes NHS England's progress and approach to sustainable development and is presented in Appendix 6 from page 177.

Maternity services

Despite the growing challenges faced by maternity services, as the complexities caused by age, weight and the number of co-morbidities of service users increases, the NHS continues to deliver improvements in the outcomes it achieves:

- Between 2010 and 2016 the NHS delivered a 14% reduction in stillbirth, a 6% reduction in neonatal death and a 17% reduction in maternal death.

- The CQC maternity experience survey, published in March 2018, showed improvements in most areas, including choice, emotional support, postnatal care, and with fewer women being left alone at a time that worried them.

Key Deliverables:

- By April 2017, 44 Local Maternity Systems (LMS) were formed, co-terminous with STP footprints, bringing together commissioners, providers and service users to provide local leadership and place-based planning for maternity.
- Over the past year, these LMS have set out proposals and have begun to implement Better Births, the national maternity review (launched in 2016), in their areas.
- To help them do this, every LMS has been provided a bespoke offer of support, setting out the guidance and assistance they can expect from a national and regional level, and from their local strategic clinical network. From a national perspective, support in 2017/18 has included the following publications:
    - Implementing Better Births: A resource pack for LMS (March 2017) provided advice to LMS on how to approach their initial plans for Implementing Better Births.
    - Implementing Better Births: Continuity of Carer (Dec 2017) sets out two models for implementing continuity of carer, and provides practical guidance to LMS on how to develop a continuity of carer model within their services.
- The Saving Babies' Lives care bundle (SBLCB) is now being implemented by the majority of maternity care providers and all will be implementing by March 2019. The evaluation of the SBLCB is expected in the summer of 2018.
- Every NHS trust with a maternity service is taking part in National Maternal and Neonatal Health Safety Collaborative, 44 Trusts recruited for Wave 1 (2017/18), 45 Trusts recruited for Wave 2 (2018/19) and 45 Trusts recruited for Wave 3 (2019/20).
- Personal Maternity Care Budgets featured in the FYFV Next Steps and had an April 2018 target for 10,000. The end of year figure was 19,241, exceeding this target by 92%.
- Decision Aids have been published to support the 'choice discussion' with women about place of birth.
- Perinatal mental health: On the 8 May 2018, NHS England announced that new and expectant mums will be able to access specialist perinatal mental health community services, in every part of the country, by April next year. We have also published perinatal mental health care pathways[20].

20 https://www.england.nhs.uk/publication/the-perinatal-mental-health-care-pathways/

Learning disabilities

In 2015 we announced that we would reduce the number of people with learning disabilities, autism or both living in long stay specialist hospitals by 35-50% and ensure they received the right care in the right setting, close to home. Since March 2015, we have reduced the number of people living in specialist hospitals by 18%. In the last year significant progress has been made; over 1,600 people have been discharged from hospital, including 180 people who had been in hospital for over 5 years or more. The programme has also been working to prevent avoidable admissions, and the number of people receiving community/pre-admission Care, Education and Treatment Reviews (CETRs) continues to improve, with 42% more pre-admission CETRs undertaken in 2017/18 than in 2016/17 and 79% of these leading to a decision not to admit into inpatient care.

Commissioned by Healthcare Quality Improvement Partnership (HQIP) on behalf of NHS England and led by the University of Bristol, the Learning Disabilities Mortality Review Programme continued to roll out a review process for the deaths of people with learning disabilities. In early May 2018, the University of Bristol published its annual report on this topic. The report found that, compared with the general population, the median age of death for people with a learning disability is 23 years younger for men and 29 years younger for women. The most common individual causes of premature death were pneumonia, sepsis and aspiration pneumonia; NHS England is feeding these early lessons into hospital and community services' work, including early detection of the symptoms of sepsis, pneumonia prevention, and the management of constipation and epilepsy, as well as developing work with RightCare to create optimal pathways for people with learning disabilities.

We remain committed to ensure more people with a learning disability receive an annual health check, and in 2017/18 the number of people who had an Annual Health Check increased by 10% in comparison with 2016/17.

In 2016/17 we launched the STOMP project (Stop Over Medicating People) to tackle inappropriate prescribing of psychotropic medication. Now over 230 organisations who support people with learning disabilities, autism or both have signed up to a STOMP Pledge, supporting over 55,000 people.

Elective care

The number of patients being referred for elective care by their GP has reduced by 1.6% this year, compared with a 1.5% increase in 2016/17.

Total referral growth in 2017/18 was at 0.3%, a reduction from 2% growth in 2016/17.

This reduction of demand represents a very significant achievement by primary care in redesigning pathways to avoid unnecessary hospital referrals and ensure that patients receive the care they need in the most appropriate location. Without this work, the impact on patients of hospital capacity constraints could have been much greater.

We continue to focus on reducing avoidable demand for elective care to ensure that patients who can have conditions treated in an alternative setting are not referred into hospital. In 2017/18, we have delivered:

- The Elective Care Development Collaborative (ECDR) to support improvements in the design of services, starting with gastroenterology and musculoskeletal (MSK)/orthopaedic services and progressing to diabetes, dermatology, ophthalmology and ear, nose and throat, cardiology, and urology. Our Elective Care Speciality Handbooks for MSK/orthopaedics and gastroenterology were published in November 2017. Further guides will be published in 2018/19.
- MSK triage to ensure that patients are seen by the most appropriate healthcare professional and, if required, a hospital consultant. By February 2018, 158 out of 197 CCGs had established compliant MSK triage services. We anticipate this increasing to 166 by the end of March 2018.
- Clinical peer review where GPs assess each other's new referrals to provide constructive feedback in a safe learning environment. By the end of March 2018 we anticipate that 35 CCGs, peer review, will have adopted this in at least half of their GP practices.
- Advice and guidance to support management of patients in a primary care setting where appropriate in lieu of outpatient referral. A non-mandated price structure has been developed and will undergo consultation through the NHS Improvement Tariff engagement process in early 2018/19.
- Capacity alerts via the e-referral system (e-RS) seeking to spread demand away from providers with the longest waiting times and help ensure the NHS is making best use of elective capacity across the country. Pilot sites have shown capacity alerts on e-RS can steer referrals, for certain specialties, from hospitals with limited capacity to those more able to meet the demand. National roll-out of capacity alerts is underway.

Chief Financial Officer's Report

The financial statements for the year ending 31 March 2018 are presented later in this document and show the performance of both the consolidated group - covering the whole of the commissioning system - and NHS England as the parent of the group. The group comprises NHS England and 207 CCGs, consolidated through the Integrated Single Financial Environment (ISFE), a financial accounting and reporting system encompassing all of the organisations concerned.

NHS England was required to limit its revenue spending to £110,002 million in 2017/18. We are responsible for using this money wisely and fairly to secure the best outcomes for both patients and taxpayers. As shown later in this report, the group has again fulfilled all of the financial duties set out in its mandate from central government, covering revenue spending, administration costs and capital expenditure.

Operational performance

The NHS England Group has delivered a managed underspend of £970 million (0.9% as a percentage of allocation) against its £109,536 million budget for in-year operational expenditure[21].

£640 million of this underspend came from the release of the system risk reserve and other contingencies. The system risk reserve was an amount set aside in our allocation in case of need across the NHS system. It was made up of the following elements:

- Half of the 1% non-recurrent investment planned by CCGs (£360 million).
- £200 million set aside centrally by NHS England.

A further £80 million was added to this reserve from other sources during the course of the year, and all three elements were released at the end of the financial year to offset overspends by hospitals and other NHS service providers.

For 2018/19 NHS England and CCGs will not be holding any national risk reserve beyond normal operating contingencies. £650 million has instead been allocated to expand the Provider Sustainability Fund from £1.8 billion this year to £2.45 billion next year and thereby enable the provider sector to plan for and deliver a balanced financial position.

21 The core measure for the financial performance of NHS commissioners included here is the non-ring-fenced Revenue Departmental Expenditure Limit (RDEL), or general RDEL.

The key features of the 2017/18 financial position are shown in more detail in the following table:

Financial performance - RDEL general (non-ring-fenced)

Financial performance	2017/18				2016/17		2015/16		2014/15		2013/14	
	Expenditure		Under/ (over) spend against plan		Under/ (over) spend against plan		Under/ (over) spend against plan		Under/ (over) spend against plan		Under/ (over) spend against plan	
	Plan	Actual										
	£m	£m	£m	%	£m	%	£m	%	£m	%	£m	%
CCGs	80,964	81,177	(213)	(0.3)%	154	0.2%	(15)	0.0%	70	0.1%	89	0.1%
Direct Commissioning	24,439	24,216	223	0.9%	296	1.2%	82	0.3%	(12)	0.0%	(365)	(1.4)%
NHS England Admin/ Central Progs/ Other	4,133	3,171	962	23.3%	439	13.2%	340	21.4%	193	12.2%	679	34.4%
Historical Continuing Healthcare Claims administered on behalf of CCGs	-	2	(2)	0.0%	13	8.6%	192	67.7%	33	35.4%	(77)	0.0%
Total	**109,536**	**108,566**	**970**	**0.9%**	**902**	**0.9%**	**599**	**0.6%**	**285**	**0.3%**	**326**	**0.3%**

CCG performance

CCGs have delivered an unprecedented level of efficiencies, equivalent to 3.1% of their allocations, and have generally performed well in taking appropriate action to manage unprecedented pressures. £349 million of CCG cost pressures relate to the impact of significant issues with generic drug pricing set by DHSC, which are outside the control of local NHS organisations. This pressure has been partially offset by an £80 million prior year rebate on Category M drugs which was passed back to CCGs at the end of the year for release as part of the system risk reserve (see above).

There were overspends in 124 CCGs, with 65 CCGs overspent by more than 1%. Releasing the 0.5% risk reserve reduced this to 75 CCGs with an overspend, and 57 with an overspend of more than 1%.

Most of the underspend in Direct Commissioning comes from Specialised Commissioning, reflecting improvements in financial management processes and controls over the last two years.

Management took action early in 2017/18 to cover the emerging overspends by CCGs, including the impact of the concessionary drug pricing pressures described above. Underspends against central budgets are a mixture of non-recurrent, central running and programme cost underspends, mainly due to vacancy management, and the deferral of some transformation expenditure. Whilst necessary to deliver our contribution to the overall NHS financial position in 2017/18, deferring expenditure on transformation priorities in particular is neither sustainable nor consistent with our Five Year Forward View ambitions.

£25 million of the central underspend relates to winter funding attributable to the provider sector but not allocated to individual organisations.

Performance against wider financial metrics

Within the Mandate, the DHSC sets a number of technical financial targets for the NHS England Group, including the core operational limit (general RDEL) described above. These limits are ringfenced, which means that underspends on the other revenue limits cannot be used to support core patient services covered by the general RDEL limit.

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

2017/18 Performance against key financial performance duties

	Target				
	Mandate Limit £m	Actual £m	Underspend £m	Target met	Underspend as % of Mandate
RDEL - general	109,536	108,566	970	✓	0.9%
RDEL - ring-fenced for depreciation and operational impairment	166	123	43	✓	25.9%
Annually Managed Expenditure limit for provision movements and other impairments	100	18	82	✓	82.0%
Technical accounting limit (e.g. for capital grants)	200	55	145	✓	72.5%
Total Revenue Expenditure	**110,002**	**108,762**	**1,240**		**1.1%**
Administration costs (within overall revenue limits above)					
Total administration costs	**1,805**	**1,583**	**222**	✓	**12.3%**
Capital limit					
Capital expenditure contained within our Capital Resource Limited (CRL)	**247**	**228**	**19**	✓	**7.8%**

Allocations

NHS England has responsibility for allocating NHS funding agreed with the DHSC as part of our Mandate. We are required to operate a transparent allocation process to ensure equal access for equal need. The Health and Social Care Act 2012 also requires NHS England to have regard to reducing inequalities in access to and outcomes from healthcare.

In December 2015 the NHS England Board approved allocations for the commissioning sector for the next five years, 2016/17 to 2020/21, with firm allocations for the first three years and indicative allocations for the final two.

The November budget set by Government made an additional £337 million available in the 2017 Mandate for the management of 'winter pressures' and confirmed that 2018/19 revenue for NHS England would grow by £1.6 billion over the 2015 Spending Review figure. The DHSC subsequently agreed to make available a further £540 million for 2018/19.

As set out in our Board paper on allocations in February 2018 we are using this funding to:

- ensure that existing care is funded, recognising the current deficits in the provider and CCG sectors;
- cover the additional costs of emergency care improvements and growth in line with Mandate commitments;
- build on the progress made in 2017/18 and protect investment in mental health, cancer services and primary care; and
- enable carefully chosen investments in other local and national priorities in line with available resources and agreed plans.

The Government has also committed to provide additional funding in 2018/19 to cover the impact of its recent announcements on pay rises for NHS staff.

Future financial sustainability

The 10-point plan for efficiency was published as part of the Next Steps on the NHS Five Year Forward View and forms the blueprint for implementing the joined up national and local efficiency improvement initiatives required to ensure financial sustainability over the coming years.

The ten areas of focus being pursued across the NHS are:

1. Freeing up hospital bed capacity.
2. Improving staff productivity, including further action on temporary labour costs.
3. Leveraging the NHS's procurement opportunities.
4. Securing best value from medicines and pharmacy.
5. Reducing avoidable demand and meeting demand more appropriately.
6. Reducing unwarranted variation in clinical quality and efficiency.
7. Action on estates, infrastructure, capital and clinical support services.
8. Cutting the cost of corporate services and administration.
9. Improving cost recovery from non-UK residents.
10. Ensuring financial accountability and discipline in all NHS organisations.

In 2018/19 local systems are expected to build on their success to date in implementing the priority efficiency programmes within the 10 Point Efficiency Plan. We expect all STPs to continue to identify and implement system-wide efficiency opportunities, such as reducing avoidable demand and unwarranted variation and sharing clinical support and back office functions.

The recently announced five-year funding settlement for the NHS, designed to support a 10-year strategy created on the platform of the Five Year Forward View, provides an important opportunity, in its 70th year, to put the NHS on a sustainable financial footing and create the foundations required to capture the opportunities of the decade ahead.

Paul Baumann

Chief Financial Officer

Accountability Report

Simon Stevens
Accounting Officer
3 July 2018

The **Accountability Report** sets out how we meet key accountability requirements to Parliament. It comprises three key sections:

The Corporate Governance Report sets out how we have governed the organisation during 2017/18, 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 and starts from page 38.

The Remuneration and Staff Report sets out our remuneration policies for non-executive directors and 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 and starts from page 76.

The Parliamentary Accountability and Audit Report brings together key information to support accountability to Parliament, including a summary of fees and charges, contingent liabilities and the Certificate and Report of the Comptroller and Auditor General to the House of Commons. The report starts from page 105.

Corporate Governance Report

Directors' Report

The Board

The NHS England Board is composed of the Chair, eight non-executive directors and four voting executive directors. These arrangements comply with the requirements of the NHS Act 2006 (as amended) that the Board should consist of at least five non-executive directors, other than the Chair, and that the number of executive directors should be less than the number of non-executive directors (including the Chair). A number of non-voting executive directors also regularly attend Board meetings.

Roles and responsibilities

The Board is the senior decision-making structure in NHS England. To support its strategic leadership to the organisation 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 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 and;
- promotes effective dialogue between NHS England, government departments, other arm's length bodies, partners, CCGs, providers of healthcare and communities served by the commissioning system.

Appointment

The Chair, Vice Chair and non-executive directors are appointed by the Secretary of State for Health and Social Care, and executive directors are appointed by the Board. Board members bring a range of complementary skills and experience in areas such as: the patient and public voice; finance; governance; and health policy.

Any new appointments take account of the skills already represented on the Board and recognise where there are gaps which could be filled.

Under the Health and Social Care Act 2012, Chief Executive Officer of NHS England also has direct accountability to Parliament as its Accounting Officer for the £110 billion of funding allocated to the NHS in 2017/18.

Following the retirement of Professor Sir Bruce Keogh, Professor Stephen Powis was appointed National Medical Director, joining NHS England on 1 March 2018. One new non-voting executive director, Emily Lawson, was appointed to NHS England in November 2017, replacing Karen Wheeler who returned to the Civil Service at the end of her secondment in June 2017.

In February 2018, NHS England and NHS Improvement confirmed their commitment to bringing about significantly better alignment between the work of the two organisations. Although there is a legal barrier to a shared Chair and Chief Executive, the formal appointment of at least some non-executive directors to both Boards would be possible with changes to the secondary legislation regulating the Trust Development Authority. As a first signal of this commitment, the role of Associate (non-voting) Non-Executive Director has been created, with David Roberts (Vice Chair of NHS England) attending the NHS Improvement Board, and Richard Douglas (Non-Executive Director at NHS Improvement) attending the NHS England Board on this basis.

In May 2018 the NHS England and NHS Improvement Boards announced a range of further steps towards joint working, including the creation of a number of new executive leadership posts operating across both organisations. In light of this, work is underway to review any changes to the operation of each board and its committees required to support effective collaboration between the two organisations.

Register of Members' Interests

As part of NHS England's commitment to openness and transparency in its work and decision making, a Register of Members' Interests, drawing together Declarations of Interest made by all Board and Executive Group members, is maintained. The register is reviewed at each Board meeting, is open to public scrutiny and is published on NHS England's website[22].

Board and Executive members are required to notify and record any interests relevant to their role on the Board. In addition, members of the Board and Executive Group 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 and Committee discussion where that is deemed to be appropriate.

Details of related party transactions are set out in Note 17 of the Annual Accounts.

NHS England Board Members

Full details of NHS England Board members, both Non-Executive and Executive, including biographies and photographs, are available on the NHS England website[23].

22 www.england.nhs.uk/about/whos-who/reg-interests/
23 https://www.england.nhs.uk/about/board/members/

Board meeting attendance

The agenda, papers and minutes of NHS England Board meetings held in public, are published on the NHS England website[24]. The agenda and papers from Board meetings held in private are made available one year after the meeting, where this does not compromise commercial or other confidentiality requirements.

Member	Job Title	Number of eligible meetings attended during the year	Comments
Professor Sir Malcolm Grant	Chair	6/6	
David Roberts	Vice-Chair	6/6	
Lord Victor Adebowale	Non-Executive Director	5/6	
Wendy Becker	Non-Executive Director	5/6	
Professor Sir John Burn	Non-Executive Director	6/6	
Dame Moira Gibb	Non-Executive Director	6/6	
Noel Gordon	Non-Executive Director	5/6	
Michelle Mitchell	Non-Executive Director	6/6	
Joanne Shaw	Non-Executive Director	5/6	
Richard Douglas	Associate (non-voting) Non-Executive Director	0/1	Appointed 5 March 2018
Simon Stevens	Chief Executive	6/6	
Paul Baumann	Chief Financial Officer	6/6	
Professor Jane Cummings	Chief Nursing Officer	6/6	
Professor Sir Bruce Keogh	National Medical Director	4/4	Retired 28 January 2018
Professor Stephen Powis	National Medical Director	2/2	Joined 29 January 2018 in an honorary capacity. Employed from 1 March 2018
Ian Dodge	National Director: Strategy & Innovation	6/6	
Matthew Swindells	National Director: Operations & Information	6/6	
Karen Wheeler	National Director: Transformation & Corporate Operations	1/1	Member until 30 June 2017
Emily Lawson	National Director: Transformation & Corporate Operations	3/3	Appointed 1 November 2017

24 www.england.nhs.uk/about/whos-who/board-meetings/

Board diversity

NHS England had nine non-executive directors as at 31 March 2018, four of whom were female and five were male. Of the 12 members of NHS England's Executive Group, as at 31 March 2018, five were female and seven male. Detail relating to the ethnic diversity of the NHS England Board is included in the Staff report, at page 80.

Board performance

The NHS England Board regularly reviews its performance and works together to improve its effectiveness. To this end, it carried out an assessment of its effectiveness during 2017, which sought the views of a wide range of internal and external stakeholders. This review concluded that the Board had been effective in: supporting a strong working partnership between the Chair and Chief Executive; emphasising the focus on delivery of the Five Year Forward View; and ensuring clarity on the next stage of development of NHS England. The review also noted that a number of new non-executive directors had joined the Board, which had strengthened its diversity of views and backgrounds. The Board actively seeks this diversity, which provides the necessary challenge and support to the Board and Executive team alike.

The Board effectiveness review also identified areas for further development, including: planning the Board's forward agenda; division of responsibilities between the Board and Board committees; and clarity on the nature of decisions required by Board papers.

The review also emphasised the Board's role in nurturing the culture of NHS England through its continuing transformation, and in securing senior executive succession to sustain the success of the organisation. A number of actions were agreed as a result of the Board effectiveness review, and these will be taken forward as part of the work programme for the coming year.

Board Committees

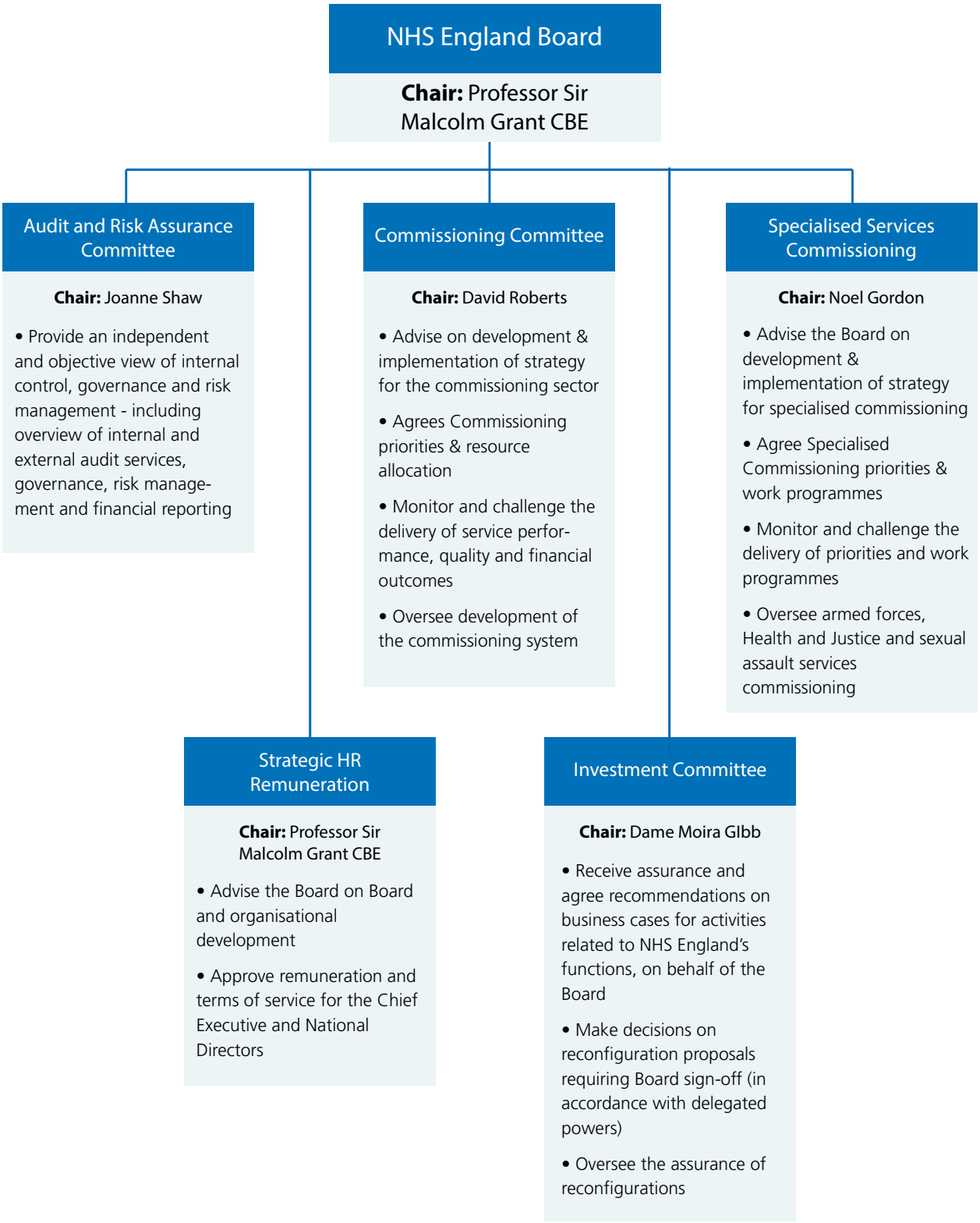
The Board is supported in its assurance and oversight of the organisation by five committees. This allows the Board to spend a significant proportion of its time on strategic decision-making, whilst obtaining proper assurance that decisions across the organisation have been made effectively based on the correct information.

The committees are part of NHS England's formal governance structure, with each providing a report to the Board following every meeting, ensuring the Board is kept informed of how they have discharged their delegated responsibilities. Additionally, each committee provides the Board with an annual report covering: a review of its activities in the previous year; a summary of the priorities for the coming year; a self-assessment of its effectiveness; and a review of its terms of reference.

The NHS England Chief Executive (Accounting Officer), as well as being a member of the Board, is similarly informed of each committee's activities through his personal participation and discussions with the relevant Committee Chair.

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

NHS England Board and Committees



Audit and Risk Assurance Committee (ARAC)

Committee members

The Committee has met five times. 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)	5/5	
David Roberts	4/4	Until 31 December 2017
Wendy Becker	5/5	
Gerry Murphy	5/5	Non-executive Chair of the Department of Health and Social Care's Audit Committee
John Burn	0/1	Joined January 2018

Committee attendees

Additional attendees are invited to attend meetings to assist with committee business. For 2017/2018, these have included National Directors, representatives from the National Audit Office (NAO), Deloitte LLP (internal auditors), DHSC and the NHS Counter Fraud Authority (NHSCFA).

Principal activities during the year

The Committee has provided progress reports to the Board on its key duties, which include:

- Assessing the integrity of NHS England's financial reporting.
- Considering and approving the NHS England Final Annual Report and Accounts for 2016/17.
- Considering reports provided by the NAO that relate to NHS England's accounts and the achievement of value for money.
- Agreeing the Internal Audit plan for 2017/18 and reviewing progress.
- Commissioning and receiving internal audit reports on the adequacy of internal control systems, risk management and corporate governance.
- Considering progress with implementing Internal Audit recommendations.
- Agreeing proposals for the future delivery of the Internal Audit service.
- Overseeing the organisation's arrangements for counter fraud, and agreeing plans for the delivery of a reactive counter fraud service.
- Reviewing issues with the delivery of Primary Care Services, described on page 67 of the Governance Statement.
- Reviewing Cyber security issues and the implementation of the General Data Protection Regulation (GDPR) regulations.
- Reviewing the organisation's risk profile, the management and mitigation of current and emerging risks and ensuring that all corporate risks have an accountable national director and delegated risk owner.

Planned activities during the coming year

In 2018/19, the Committee will:

- Consider and approve the NHS England Final Annual Report and Accounts for 2017/18.
- Review updates from the NAO on progress with their audit work.
- Consider the 2017/18 Annual Internal Audit Report and Head of Internal Audit opinion.
- Consider areas for review by Internal Audit and approve the 2018/19 plan of work and then review the audit work during the year.
- Consider corporate risks and the status of Internal Audit recommendations.
- Review the Economic Crime Strategy and proposals for the delivery of Proactive Counter Fraud work for 2018/19.
- Oversee other risk areas such as cyber security, primary care assurance, third party assurance and the developing governance arrangements between NHS England and NHS Improvement.

Commissioning Committee

Committee members

The Committee met 10 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)	9/10	Chair until 31 March 2018
Lord Victor Adebowale	6/10	
Noel Gordon	8/10	
Wendy Becker	3/4	Member since November 2017. Chair from 1 April 2018
Simon Stevens	9/10	
Paul Baumann	9/10	
Professor Jane Cummings	9/10	
Professor Sir Bruce Keogh	8/8	Member until 28 January 2018
Amanda Doyle (CCG representative)	9/10	
Ian Dodge	10/10	
Matthew Swindells	9/10	
Richard Barker	8/10	
Professor Stephen Powis	2/2	Joined 29 January 2018 in an honorary capacity. Employed from 1 March 2018
Michelle Mitchell	1/1	Member since 8 February 2018

Committee attendees

Additional attendees are invited to attend meetings to assist with committee business. For 2017/18, these have included:

- Chair of NHS England and other Non-Executive Directors.
- Director of Primary Care.
- Director of Commissioning Development.
- Director of Financial Planning and Delivery.
- Director of Strategic Finance.

Principal activities during the year

Over the year, the Committee has focussed on its three core areas:

- Delivery of the main system transformation programmes:
  - Next Steps on the Five Year Forward priorities including cancer; mental health and dementia; urgent and emergency care; learning disabilities; maternity; primary care; and the NHS's ten point efficiency plan with NHS Improvement.
  - STPs and ICSs.
- In year performance and finance:
  - Assurance of financial and service performance, both within NHS England and across the commissioning system.
- Oversight of the commissioning system and its development:
  - CCG improvement, assessment and assurance processes ensuring that CCGs meet their statutory duties.
  - 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.

Planned activities during the coming year

The Committee agenda in 2018/19 will continue to be based around the Next Steps on the Five Year Forward View and the other priorities set out above.

Specialised Services Commissioning Committee

Committee members

The Committee met six 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)	5/6	
Professor Sir John Burn	4/4	Member until 30 November 2017
Michelle Mitchell	6/6	
Dame Moira Gibb	1/1	Member since 8 February 2018
Simon Stevens	5/6	
Paul Baumann	6/6	
Professor Sir Bruce Keogh	5/5	Member until retirement from NHS England on 28 January 2018
Professor Stephen Powis	1/1	Joined 29 January 2018 in an honorary capacity. Employed from 1 March 2018
Ian Dodge	5/6	
Matthew Swindells	0/3	Member until 30 September 2017
John Stewart	6/6	

Committee attendees

Additional attendees have included the Chair of NHS England and others who have been invited to attend meetings to assist with committee business. For 2017/18, these have included: Director of Strategy and Policy, Specialised Commissioning; Medical Director, Specialised Commissioning; Finance Director, Specialised Commissioning; Operational Delivery Director, Specialised Commissioning; and Commercial Director, Specialised Commissioning.

Principal activities during the year

Over the year, the Committee has:

- Overseen the development and implementation of:
  - a set of strategic priorities for specialised services;
  - place-based commissioning of specialised services, building on the plans for STPs;
  - new approaches to service reviews and quality assurance;
  - proposals on improving performance and delivery assurance, alongside a strengthened approach to business intelligence;
  - a strategy for improving dialogue with patients and the public;
  - a framework for securing maximum value from medicines spend and related programme of action;

- a multi-year strategic approach to achieve affordable and accelerated hepatitis C elimination;
- refined commissioning policies, used to guide NHS England's decision making, including service development policy, Individual Funding Requests (IFR) policy and clinical trial policy;
- a review of health and justice commissioning in England;
- the approach to implementing the UK Strategy for Rare Diseases;
- a proposed new model of care for gender identity services.

- Overseen Specialised Commissioning's approach to NHS England's clinical priority areas – cancer, mental health and learning disabilities – and specific service reviews, such as the congenital heart disease review.
- Reviewed and agreed the routine commissioning of new treatments.
- Provided assurance and oversight for:
  - the Cancer Drugs Fund;
  - specialised commissioning financial plans for 2017/18 and 2018/19;
  - operational decisions taken by NHS England's Specialised Commissioning Oversight Group (SCOG);
  - the Specialised Commissioning Patient and Public Voice Assurance Group;
  - the Health & Justice Oversight Group and the Armed Forces Oversight Group.

Planned activities during the coming year

The Committee's priority for 2018/19 will be to continue supporting the implementation of the strategic priorities for specialised services, as well as overseeing new areas of responsibility. This will require the Committee to provide assurance to the Board on:

- Financial control for specialised services and on achieving specialised services efficiency savings for 2018/19 to 2020/21.
- How specialised commissioning is supporting improvements in patient care in relation to NHS England's priorities, particularly for mental health, learning disabilities and cancer.
- The continued implementation of priority programmes, such as: service reviews; place-based commissioning; strengthening assurance of performance and delivery; the medicines value programme and quality assurance.
- Which new treatments will be routinely commissioned by NHS England for 2018/19 and 2019/20, taking advice from the Clinical Priorities Advisory Group (CPAG) and SCOG.
- The roll out of a genomics service across the NHS.

Investment Committee

Committee members

The Committee met six times during the year. In addition, it carried out its function by correspondence in April, May, September and December 2017. 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)	6/6	
Wendy Becker	6/6	
Paul Baumann	5/6	
Ian Dodge	6/6	
Matthew Swindells	5/6	

Committee attendees

Additional attendees have included the Chair of NHS England and others invited to attend meetings to assist with committee business.
For 2017/18, these have included:

- Director of Strategic Finance.
- Director of Operations and Information.
- Acting Director, Specialised Commissioning.
- Head of Reconfiguration, London Region and Chair of the Oversight Group for Service Change and Reconfiguration (OGSCR).

Principal activities during the year

During 2017/18, the Committee has:

- Approved investment cases for use of the transformation fund across priority areas such as Mental Health and Diabetes, and agreed allocations to ICSs.
- Approved a number of business cases for revenue and/or capital expenditure.
- Reviewed the pipeline of service change and reconfiguration proposals presented by the OGSCR.
- Reviewed 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.

Planned activities during the coming year

In 2018/19, 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 from STPs.

Strategic HR and Remuneration Committee

Committee members

The Committee has 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	1/2
David Roberts	2/2
Wendy Becker	1/1 (member since November 2017)

Committee attendees

Additional attendees are invited to attend meetings to assist with committee business. For 2017/18, these have included:

- Chief Executive.
- Chief Financial Officer.
- National Director: Transformation and Corporate Operations.
- Acting People and Organisation Development Director.

Principal activities during the year

Over the year the Committee has received reports assuring it about the implementation of the revised DHSC 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. It has focussed on workforce diversity and inclusion, overall staff experience and engagement and progress with talent management across NHS England. The Committee has also considered the proposals for the alignment of NHS England's support for the enablement of Next Steps on the NHS Five Year Forward View. Discussion of the outcomes from the staff survey was also undertaken with the full Board.

Planned activities during the coming year

During the coming year, the Committee will continue to 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 STPs 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 pay and any issues pertaining to national directors.

Board disclosures

Disclosure of personal data-related incidents

During 2017/18, 37 Serious Incidents Requiring Investigation (SIRI) occurred relating to the loss or disclosure of personally sensitive data in NHS England and CSUs. All were logged and full investigations were undertaken, with details set out in Appendix 7 from page 184. Where appropriate, 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 2018 was published on our website[25] in May 2018.

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 about 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 himself 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 confirms that the Annual Report and Accounts for 2017/18, taken as a whole, is fair, balanced and understandable and provides the information necessary for stakeholders to assess the business model, strategy and performance of NHS England.

25 www.england.nhs.uk/ourwork/safeguarding/our-work/modern-slavery/

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 NHS England and enable them to ensure that the accounts comply with the requirements of the Accounts Direction) and for safeguarding NHS England'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[26] issued by HM Treasury (HMT) (Revised August 2015).

Under the National Health Service Act 2006 (as amended), the Secretary of State for Health and Social Care (with the consent of HMT) has directed NHS England 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 NHS England 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 2017)[27] and in particular to:

- observe the Accounts Direction issued by the DHSC, 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.

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 appropriate steps to make himself aware of any relevant audit information and to establish that the external auditor is aware of that information.

The Accounting Officer takes responsibility for, and confirms that, the Annual Report and Accounts 2017/18 as a whole is fair, balanced and understandable.

26 www.gov.uk/government/uploads/system/uploads/attachment_data/file/454191/Managing_Public_Money_AA_v2_-jan15.pdf

27 www.gov.uk/government/uploads/system/uploads/attachment_data/file/577262/2017-18_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 69 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 providers of NHS-funded care, nor for the DHSC'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 and Social Care for delivery of the annual mandate. The mandate sets the strategic direction for NHS England and helps ensure the NHS is accountable to Parliament and the public. 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 the Government via an assessment given to Parliament. A report on how we have delivered against the mandate objectives is given in Appendix 1 on page 160.

In addition, there is a framework agreement between NHS England and DHSC which sets out the mechanisms through which the relationship is jointly managed and the ways in which we work in partnership.

Governance arrangements and effectiveness

Governance framework

The governance manual brings together all the key strands of governance and assurance across NHS England, including: the Standing Orders; Standing Financial Instructions; Scheme of Delegation; Standards of Business Conduct policy; Risk Management Framework; and the Three Lines of Defence model. Separate operating frameworks exist for each CSU.

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

As part of implementing best practice, an assessment is undertaken each year against the Corporate Governance in central government departments: Code of good practice 2017 (HM Treasury). The exceptions arising from this year's assessment are shown in Appendix 8 from page 187.

Board arrangements

Information on our Board and its Committees is set out from page 38.

Closer working with NHS Improvement

As set out at page 39, on 24 March 2018, NHS England made a joint announcement with NHS Improvement regarding plans to work in a more integrated way and to deliver better outcomes for patients, whilst improving performance and efficiency. This followed a meeting in common of the boards of NHS England and NHS Improvement, on 24 May 2018, at which further steps towards joint working were agreed. Both boards are aware of the need to transact their own business with their own board members and mindful of the legislative framework within which they operate. So in the planning and design of all closer working arrangements, steps will be taken to ensure that potential institutional conflicts of interest are appropriately managed.

Harris Review

Having regard to the wider implications of the Harris Review[28], 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 NHS Act 2006 (as amended). This provides clarity about the legislative requirements associated with each of the statutory functions for which it is responsible, including any restrictions on delegation of those functions. Responsibility for each duty and power has been clearly allocated to a national director and the register is regularly reviewed by the Director of Governance and Head of Legal Services.

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

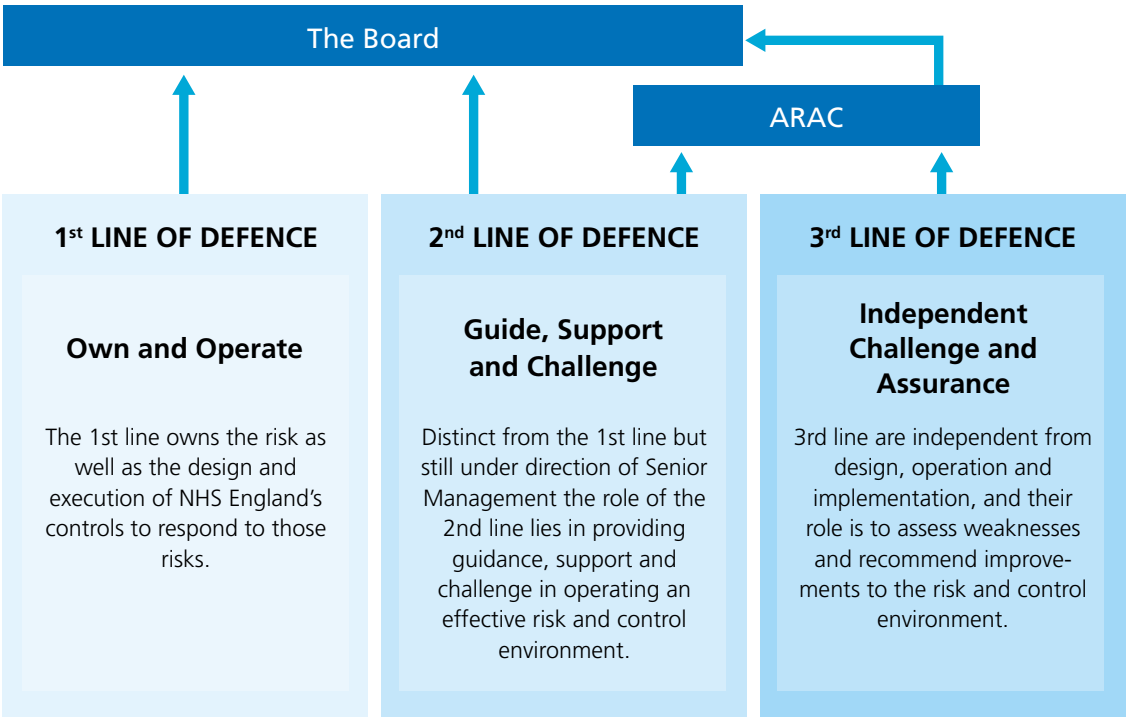
Corporate assurance

Assurance framework

The NHS England Corporate Assurance Framework, set out below, provides for continuous and reliable assurance on organisational stewardship and the management of the major risks to organisational success and delivery of improved, cost effective, public services.

Assurance activity	What is it?	What Value does it give?
Organisational Change Framework	Guidelines for assessing and implementing major changes across NHS England.	Provides a consistent approach to thinking about the impact of organisational change, including people, infrastructure, financial and legal issues.
Risk Management Framework	The approach to managing risk, including tools and methodologies for identifying, assessing, documenting and reporting risk.	Provides a consistent approach across the organisation, allowing identification of cross-directorate risks and challenges. Provides a way for managers to identify risks with a route of escalation to those accountable.
SFI's, Standing Orders & Scheme of Delegation	Fulfil the dual role of protecting NHS England's interests and protecting officers from possible accusation that they have acted less than properly.	Designed to ensure that NHS England's financial transactions are carried out in accordance with the law and Government policy in order to achieve probity, accuracy, economy, efficiency and effectiveness.
Programme Management Framework	The policies, tools, methodology and resources that provide an approach to managing, controlling and assuring the delivery of projects and programmes in the NHS England portfolio.	Provides staff with a framework to manage, control and deliver projects and programmes. Provides the organisation with consistency of reporting and monitoring, confidence of delivery of outcomes, to enable decision-making and better resource control.
3rd Party Assurance Framework	Guidelines for the assurance required for managing 3rd party contracts.	Ensures directorates responsible for major contracts assign a Contract Manager and put arrangements in place to monitor supplier performance. Obtains assurance over the services provided.
Corporate Policy Framework	The methodology and approach for creating, maintaining and amending policies.	Provides an approach to help ensure policy documents are not developed in isolation, so they are balanced against the priorities of the organisation.

For the framework NHS England has adopted the Three Lines of Defence model, illustrated overleaf. This provides the mechanism for NHS England's employees to manage risk and control as well as provide assurance over the delivery of services.



We work with the support of our internal and external auditors to strengthen and embed our assurance framework. Each directorate and region has designated leads with responsibility for ensuring that risk management, implementation of internal audit actions and other key assurance activities are carried out, and approved by the relevant senior director, including appropriate regular reporting and exception escalation processes. The leads report directly to respective national and regional directors and link with the governance, audit and risk teams. This provides increased focus, accountability and improved communication at operating unit level across the organisation.

During 2017/18, the corporate governance team has worked with teams across the organisation to embed controls and underpin processes including:

- Obtaining regular management assurance from all senior managers, budget holders, Senior Responsible Owners and directors to confirm their compliance with the organisation's policies and processes.
- An annual attestation implemented for year-end requiring all staff to confirm they have complied with the requirements of the Standards of Business Conduct policy.
- Delivering substantial improvement in the timely completion of management actions arising from internal audit reviews.
- The introduction of electronic platforms for administering risk and internal audit actions; this will be extended to include staff declarations and assurance certifications in early 2018/19.
- Improving adherence to project and programme management controls.

Management assurance

The management assurance processes form a critical part of our control processes. All staff above Band 9 (including off-payroll workers covering a substantive position), Senior Responsible Owners and all other budget holders are required to provide assurance of compliance with controls and accountability requirements. The assurance certification process is undertaken at mid-year and end of year. This year has shown a significant increase in response rates (86% and 85% respectively in 2017/18, compared to 69% and 70% in 2016/17). Further work is ongoing to ensure that systematic action is taken in response to statements of non-compliance and to triangulate this information with other sources of compliance data.

Oversight of NHS England's priorities and related programmes

During 2017/18 the NHS England Board was provided with regular updates on implementation of key commitments included in Next Steps on the NHS Five Year Forward View.

The National Director of Operations & Information holds quarterly review meetings with regions to assess delivery at a geographic level.

The Corporate Executive Group (a sub group of the Executive Group) receives performance information on NHS England's corporate delivery and business functions.

The NHS England portfolio of programmes includes those forming our contribution to the Government Major Projects Portfolio and informatics programmes within the Personalised Heath and Care 2020 portfolio, are overseen by the cross-system Digital Delivery Board.

Whistleblowing

NHS England has arrangements in place to support whistleblowing for staff in both NHS England and external organisations. 'Voicing your Concerns for Staff', our internal whistleblowing policy, is accessible via our staff intranet and website. Emily Lawson, National Director of Transformation and Corporate Operations, is the 'Freedom to Speak Up' (FTSU) guardian for staff in NHS England, and Professor Sir Malcolm Grant, Chair of NHS England, is the Board lead. The FTSU network currently consists of 37 FTSU Guardians, of which 19 (37%) have reported a BME background.

NHS England has been a 'Prescribed Person' for primary care services under the Public Interest Disclosure Order 1999 since April 2016. This allows whistleblowers working in primary medical services, dental services, ophthalmic services and local community pharmacy services to disclose information to NHS England in addition to, 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[29]. This activity is overseen by designated regional whistleblowing leads reporting into the corporate governance team. The formal 2017/18 report of 'qualifying disclosures' in line with the Department for BEIS Whistleblowing Prescribed Persons guidance[30] is given at Appendix 3 on page 168.

NHS England received three internal whistleblowing concerns during 2017/18, all of which were investigated in accordance with our policy. CSUs reported an additional four concerns which are being investigated under the CSU's Raising a Concern Policy.

29 www.england.nhs.uk/ourwork/whistleblowing/
30 www.gov.uk/government/uploads/system/uploads/attachment_data/file/604935/whistleblowing-prescribed-persons-guidance.pdf

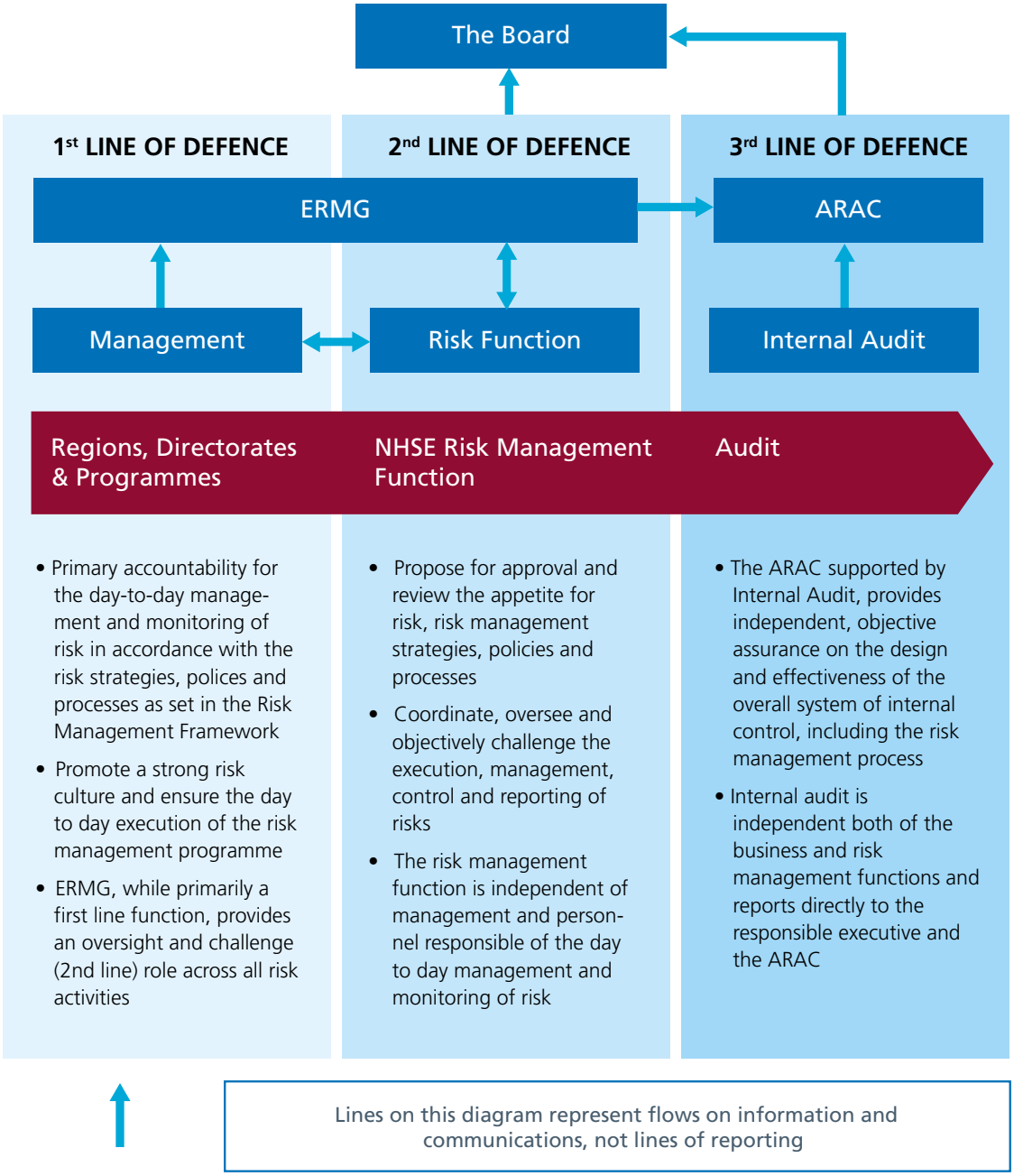
Assuring the quality of data and reporting

At each meeting, the Board receives reports covering finance and operational performance for NHS England and the wider commissioning system. This performance information is subject to scrutiny by both management and the Commissioning Committee.

The Board is confident that the data presented in these performance reports has been through appropriate review and scrutiny and that it continues to develop with changing organisational needs.

Managing risk

During 2017/18 we implemented an enhanced risk management framework to ensure that NHS England employees follow a single process for identifying and managing risks which threaten delivery of services and achievement of objectives. This framework mirrors the three lines of defence of our overarching assurance framework.



Our Executive Risk Management Group (ERMG) is responsible for providing assurance to the ARAC that the executive team are managing risks across the organisation. ERMG oversees implementation of NHS England's risk management framework and reviews those risks escalated to it.

ARAC is responsible for reviewing the establishment and maintenance of an effective system of governance, risk management and internal control, covering all of NHS England's activities.

NHS England's Board has responsibility for ensuring the delivery of the organisation's objectives, including its statutory functions. The Board identifies the strategic challenges to delivering these objectives and the principal risks it needs to manage. During 2017/18, the Corporate Risk Register included:

- System efficiency savings and financial sustainability – significant pressures remain relating to funding levels for the whole of the NHS. We will continue to work with DHSC and NHS Improvement to support the delivery of efficiencies and secure financial sustainability over the period of the spending review.
- Operational performance – the health system faces significant ongoing challenges in the delivery of NHS Constitution access standards. Through our regional teams, we are working with NHS Improvement and DHSC to support the most challenged systems.
- Cyber security – the NHS and NHS England itself faces the need to protect information and the delivery of patient services from the threat of sustained cyber attack.
- Protecting NHS information – we recognise that sharing appropriate information is essential to the delivery of an efficient and effective service and we are taking action to further assure our processes.
- Primary care support services – any poorly performing primary care support services have a potential impact on the efficiency and effectiveness of our front line services. We are working with the relevant third party provider to ensure improved service delivery.
- Transforming primary care – we continue to work to secure additional general practice services and invest in new ways of improving primary care for patients.
- Supporting STPs to transform local health economies – through our regional teams we are supporting the ongoing development of STPs to provide the capability and capacity to deliver successful transformation.

At the end of the year NHS England initiated work to improve the content and format of the Corporate Risk Register and to consider the implications for risk management of planned closer working with NHS Improvement. Management of existing risks and identification of new risks continue, and reporting to ARAC will resume once this review is completed. The board will also have an opportunity to consider NHS England's risk profile later in the year.

Risk appetite

Risk appetite is a balance of the amount and type of risk that the NHS England is prepared to take in pursuit of achieving its strategic vision in the Five Year Forward View with our partners.

In its approach to delivering the strategy set out in the Next Steps on the NHS Five Year Forward View, NHS England has made clear that whilst it understands it must live within the existing legal framework set by the NHS Act 2006 (as amended), it is striving to create new ways of working, integration of services and new models of care. Risk appetite is therefore identified as part of our approach. There are some risks which we are not prepared to take - notably those relating to patient safety - and some areas where our appetite is greater, particularly where this enables innovation.

Clinical assurance

Assuring the quality of services

The quality of commissioned services is assessed periodically by the CQC. It is also assured at the local and regional levels as appropriate through the lead CCG. Our Director of Commissioning Operations (DCO) teams, Regional teams and through the national Quality Assurance Group (QAG).

Membership of the QAG, which reports to the Executive Group, includes the Regional Medical Directors and Regional Chief Nurses, some of whom hold joint posts with NHS Improvement.

The QAG discusses quality risks and issues of national importance within NHS England's remit and agrees national action to mitigate and manage these. In 2017/18 the group has:

- Shared learning and intelligence between regional and national teams relating to quality risks/issues. For example, sharing learning from the major incidents that occurred in London and Manchester.
- Strengthened joint working between NHS England and NHS Improvement. For example, through the members holding joint posts who also sit on NHS Improvement's National Quality Committee and the continued work of the joint Patient Safety Group (a sub-group of the QAG).
- Overseen the development and publication in December 2017 of internal operational guidance for NHS England employees – 'Applying the Serious Incident Framework' – enabling teams to carry out existing duties with confidence in what often can be a challenging and complex area.
- Contributed to the development of national policy and ensured operational alignment with this. For example, contributed to the National Quality Board review of Quality Surveillance Groups (QSGs) and Risk Summits and implemented the resulting guidance published in July 2017.
- Provided feedback on national consultations regarding key pieces of work. For example, in March 2018 responded to the national consultation on 'Facing the Facts, Shaping the Future: A draft health and care workforce strategy for England to 2027'.
- Continued work to strengthen NHS England's internal processes for responding to and learning from Coroners' Regulation 28 Reports to Prevent Future Deaths, with plans to work with NHS Improvement to ensure system oversight of learning and actions from all relevant reports.
- Used clinical leadership to draw attention across the system to specific quality issues.

QSGs provide a network in every locality and region which systematically brings together different parts of the system (including commissioners and regulators) to share quality information, seek assurance and coordinate actions to drive quality improvements. Risk Summits also provide a mechanism for partners to come together, this time to give specific and focussed consideration to concerns raised, generally in relation to a single provider. There are currently 28 local QSGs, reporting to four regional QSGs, which in turn report to the national QAG. Quality risks and issues are identified and managed at the local level and escalated (if necessary) to the regional level (Regional QSGs) and/or national level (QAG).

Other assurance

Cyber and data security

NHS England continues to work with Government agencies such as NHS Digital, the National Security Centre and external suppliers of data and systems to NHS England (including but not limited to Atos and BT), to ensure that we are up to date with the latest threats and that our data is stored and protected appropriately. NHS Digital's Care Computer Emergency Response Team (CareCERT) offers advice and guidance to all health and social care organisations to respond to cyber security threats. Suppliers to NHS England have been informed that it is imperative that all security patches are implemented in a timely and controlled manner to assist in the negation of cyber attacks. NHS England Corporate ICT is also closely linked in with EPRR to ensure that any required communication flows and IT advice are available if required in the event of any substantial attack.

In addition to corporate activity, NHS England is actively leading work with other system partners to ensure that a robust approach is taken on cyber security across the service. Whilst NHS Improvement has a statutory role for Providers and CQC in regulation, there is a need for a coherent approach across the service with the use of levers, investment, regulation and engagement aligned. This includes:

Use of levers

- NHS England can help to drive appropriate behaviours as part of a clear contractual framework across the system - such as the NHS Standard Contract for providers or defining operating models for GP IT, where it has system wide responsibilities.
- Helping direct any investment DHSC makes available across the service to address infrastructure weaknesses in the service.
- Establishing board level leadership for commissioners on cyber-readiness whilst working in conjunction with NHS Improvement on providers.
- Preparing for the impact of a cyber security attack through the creation of the joint DHSC and NHS England 'Cyber Handbook' on improving preparedness for incident response and link into EPRR processes.

Establishing a clear contractual and regulatory framework

- With our input, DHSC has published the single 'Statement of Requirements', based on the data security standards that underpin the NHS England Standard NHS Contract requirements. This sets out expectations across Providers, CCGs and GP practices.

- The 10 Data Security Standards have been included in the NHS England GP IT Operating Model that is being updated to ensure that these are embedded into operational procedures of primary care. This operating model defines the accountabilities of CCGs on cyber readiness and also on GP practices for any equipment that they install. The adherence to the operating model will be captured through the Information Governance (IG) Toolkit and Primary Care Digital Maturity Assessment Tool.
- We are supporting sign up to CareCERT Collect to ensure that alerts are received and acted upon by local organisations. The purpose is to create a "closed-loop" to ensure that a positive response to an alert is received. NHS England and NHS Improvement will then follow up critical CareCERT alerts to confirm that organisations have taken the necessary action (as per National Data Guardian recommendations). There has been a specific focus driving uptake with 100% of Providers signed up.

Addressing infrastructure weaknesses

- £61 million capital funding was allocated to address critical vulnerabilities in Major Trauma Centres and Ambulance Trusts as part of the Government response to the National Data Guardian Review. NHS England has been leading on allocation of this fund during 2017/18 and working with system partners such as NHS Digital to ensure this is addressing key vulnerabilities identified through independent assessments.

Engaging with local leaders

- The National Data Guardian review recommended that NHS England and NHS Improvement should run engagement programmes on local leadership - recognising the critical role that local leadership plays in an organisation's cyber resilience. NHS England is already working with Health Education England, as part Building a Digital Ready Workforce to work with STPs on cyber-related readiness.
- We have engaged with CCG Audit Chairs on the assurances they need to seek as part of their role in oversight of strategic risks (such as cyber). These assurances include:
  - an accountable person on the CCG Board;
  - the Board being provided with assurance for the Data Security requirements for Primary Care IT and for Providers;
  - the undertaking of assurance reviews with regional teams with regard to:
    - the Implementation of High CareCERT alerts;
    - independent assessments undertaken with associated remediation plan;
    - data security training provision to all staff.
  - local cyber champions/leads are now in place within each of the NHS England regional teams. The intention is to create a wider network of cyber leads in conjunction with the Chief Clinical Information Officer (CCIO) and Chief Information officer (CIO) networks and working in partnership with the British Computer Society (BCS) so that we have a register of professionally qualified individuals.

Improving threat surveillance and incident response:

- The creation of the 'Cyber Handbook', developed jointly with DHSC and NHS England.

Information governance

Work has continued to embed the IG operating model and framework to ensure the provision of a high quality and effective IG service for NHS England.

A compliance programme has been established to ensure NHS England's readiness for the General Data Protection Regulation (GDPR) which came fully into force on 25 May 2018. NHS England has made necessary changes to systems, processes, policies and procedures, in line with new data protection law.

A Data Protection Officer has been appointed to provide advice and guidance to NHS England on compliance with its duties under the new regulation. An audit has also been conducted by Deloittes LLP, and affirmative action has been taken to address all recommended actions.

NHS England continues to work closely with CSUs to obtain assurance regarding their data processing activities. Independent audits were commissioned which identified a number of areas of good practice. Action plans are being implemented to address the recommendations that were provided to further improve compliance. NHS England worked closely with CSUs to ensure GDPR programmes were in place and to monitor progress towards full compliance by 25 May 2018.

NHS England continues to work closely with NHS Digital to implement assurance processes which will ensure that the collection and provision of data for commissioners is managed appropriately. A web based Population Health Management Information Governance Support tool is being developed to help organisations understand their legal basis for requesting data and will ensure that they are fully aware of the action they need to take to 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 DHSC, 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).

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 DHSC 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

NHS England has included in its Internal Audit programme for 2018/19 a review of business critical models in order to identify any other operational models, on which we rely, and to test their robustness.

Service auditor reporting and third party assurances

NHS England relies on a number of third party providers (such as NHS SBS, NHS BSA, 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 are reviewed every year. Appropriate formal assurances are obtained to supplement responsibilities for relationship or 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.

For 2017/18 we have enhanced the service auditor requirements for our contract with Capita. A report covering the design of the control environment, delivered in November 2017, demonstrated significant improvements; however, a further report covering how embedded those controls are, delivered in April 2018, returned a qualified opinion. We continue to work with Capita to improve the controls in place.

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.

During 2017/18 we undertook a formal competitive tendering exercise for the future provision of the internal audit service, which led to the reappointment of Deloitte LLP. Internal audit updates the plan to reflect changes in risk, 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, and during the year the timeliness of implementing recommendations has increased from 39% to 70%.

The Head of Internal Audit opinion for 2017/18 is set out from page 74 of this Annual Report.

External audit

During the year ARAC has worked constructively with the NAO 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 ARAC.

The Certificate and Report of the Comptroller and Auditor General is set out from page 109 of this Annual Report.

Control issues

During the year, we have worked to build further controls into a number of management processes identified as requiring improvement:

Strengthening establishment controls

An electronic system has been implemented across NHS England giving each department access to their establishment, and a standardised request form allows changes to be made as necessary. Reconciliation work has taken place between budget holders, management accountants and the Workforce Systems Team in order to ensure data is accurate and cross-checked. As a result, there is now far greater assurance around processes for maintaining the establishment, and a further audit will be undertaken during 2018/19.

Improving control processes for off-payroll workers

During 2017/18 we have further embedded our enhanced control processes for off payroll workers, which were introduced in April 2017. These processes are based on using the Electronic Staff Record (ESR) as a single means of managing workforce information. We have also commissioned further assurance work to ensure compliance with HMRC requirements.

Payroll services contract

Over the course of the last 12 months, NHS England and CSUs have experienced performance issues with the current payroll provision. The service is contracted with CGI under the RM887 framework and provided by a third party subcontractor, NHS Shared Business Services.

The service management of these issues has required the implementation of a service improvement plan with NHS SBS, leading to termination of the current contractual arrangements for delivery. This termination has allowed NHS England and the CSUs the opportunity to undertake a wider detailed review of the service and options for future delivery. The Board will consider these options in due course.

Improving procurement practices and compliance

Substantial investment has been made in both technology and working practices during 2017/18 to further refine and embed the business case and approval arrangements implemented in 2016/17 and thereby ensure that the efficiency and effectiveness of these processes is maximised. This work included significant amendments to the Standing Financial Instructions to implement enhancements identified from feedback and an ongoing programme of working closely with budget holders to develop effective procurement pipelines. The impact of these arrangements has been to increase accountability, aid effective planning and drive value for money. Progress continues to be made in improving adherence to prior approval requirements, and discipline in selection of designated service providers for specific categories of spend.

The existing contract management toolkit has been revised and enhanced to provide a suite of tools that will enable the effective management of contracts by contract managers across NHS England, with expert support provided by the commercial team as required. These revised arrangements, which ensure accountability through contracts being owned by defined individuals supported by training and dedicated commercial support, are being rolled out from April 2018.

NHS England's internal conflicts of interest policy

The Standards of Business Conduct policy was revised and reissued in June 2017 to reflect the new system wide guidance on conflicts of interest issued in February 2017. Further work is planned to ensure that the policy is applied consistently throughout all areas of the business.

Staff currently proactively submit the declarations required by the policy. An electronic platform will be introduced during 2018/19 which will enable us to prompt, deliver and monitor compliance with the standards set out in the policy more systematically.

Strengthening conflicts of interest management in CCGs

We have continued to support CCGs to strengthen their approach to conflicts of interest management. In June 2017, NHS England published revised statutory guidance on managing conflicts of interest for CCGs[31]. The statutory guidance was updated to ensure it was fully aligned with Managing Conflicts of Interest in the NHS[32], published in February 2017. NHS England has delivered further support and training this year to help CCGs to identify and manage conflicts of interest. This has included webinars and the roll out of an online conflicts of interest training package for CCGs. We are continuing to monitor CCGs' compliance with the statutory guidance through the CCG Improvement and Assessment Framework. CCGs are also required to undertake an annual internal audit of conflicts of interest.

Primary Care Commissioning

NHS England retains accountability for the commissioning and contract management of primary care service providers, even where it has delegated this to CCGs. The commitment to strengthen assurance arrangements of delegated CCGs was included in the planning guidance refresh published in February 2018 and the agreed framework for strengthening assurance over delegated responsibilities for primary care, which is due for publication shortly.

The requirements include:

- A self-reported assessment of CCG compliance with published primary medical care policies from each lead commissioner. This will be delivered through the Primary Care Activity Report collection process, which will run from the beginning of April 2018, with reporting expected around July 2018.
- Each CCG publishing a report covering the outcomes achieved through their delegated responsibilities and the way in which assurances have been gained locally. Scoping of the report requirements is underway.
- Delegated CCGs' to include an assessment of compliance against their delegated functions in their internal audit plans.

NHS Shared Business Services incident

In March 2016, NHS SBS, who previously provided primary care support services in three geographical areas, notified NHS England of a backlog of unprocessed clinical correspondence. During the investigation approximately 709,000 items of clinical correspondence were identified and needed to be individually reviewed. As of the 31 March 2018 reviews to establish the impact on patients had been completed on 99.96% of the 709,000 items. The NAO published a report, Investigation: clinical correspondence handling at NHS Shared Business Services[33] in June 2017, which led to a Public Accounts Committee (PAC) hearing in October 2017. The subsequent recommendations made by the Committee following that hearing have been implemented and were presented to the Public Accounts Committee on 26 March 2018. The Clinical Review process has identified one case where the patient did not receive treatment in a timely manner which affected their health. The Information Commissioner has been kept informed throughout.

31 www.england.nhs.uk/publication/managing-conflicts-of-interest-revised-statutory-guidance-for-ccgs-2017/
32 www.england.nhs.uk/publication/managing-conflicts-of-interest-in-the-nhs-guidance-for-staff-and-organisations/
33 www.nao.org.uk/wp-content/uploads/2018/02/Investigation-into-clinical-correspondence-handling-in-the-NHS.pdf

Primary Care Support England (PCSE) clinical correspondence incident

NHS England notified the PAC in October 2017 that it had learned of a further items of clinical correspondence that had not been appropriately redirected. NHS England identified a total of 423,784 items requiring repatriation. Items which required GP action were sent to the corresponding practices for assessment of whether there had been any actual harm to patients. As of the 31 March 2018 reviews to establish the impact on patients had been completed on 99.69% of the 423,784 items.

The NAO published a report on this matter, Investigation into clinical correspondence handling in the NHS[34] on 2 February 2018, to update on the NHS Shared Business Services incident and review the Primary Care Support clinical correspondence Incident. The PAC hearing took place in March 2018. No cases of patient harm as a consequence of this incident have been identified. Details of the related information governance incidents are included in Appendix 7 on page 184. The Information Commissioner has been kept informed throughout.

Other PCSE service issues

The PCSE contract with Capita came into effect on the 1 September 2015. As the NAO confirmed in its recent report, NHS England's management of the primary care support services contract with Capita[34a], in its first two years of operation the contract has saved the taxpayer £60 million. Since that time, Capita has sought to consolidate services previously delivered from numerous local offices using different systems into a national standard service delivered to primary care contractors. PCSE has amalgamated delivery centres across the country so that there are now four major sites processing all activity across England. This is a complex task that continues to require careful management to minimise the impact on stakeholders.

The contract is managed by a dedicated team within NHS England, with the focus on seeking assurance of service quality and obtaining value for money. Through close working relationships with Capita, progress has been made on identifying early performance issues and agreements are in place for rectification.

NHS England continues to work with national stakeholders to understand issues of concern and through the contract to bring a focus on key deliverables. We are aware of dissatisfaction expressed by national representative bodies, in relation to recognised issues such as updates to the performers list, administration of GP pensions[34b], movement of records and timely payments. All of these issues have been a key focus for performance improvement under the contractual agreements in place with Capita, and there have been improvements in the last year. However, both NHS England and PCSE know there is still more to achieve, and the ongoing focus in the coming year will be to ensure sustained delivery, and deal with the findings of the NAO report.

34 www.nao.org.uk/wp-content/uploads/2018/02/Investigation-into-clinical-correspondence-handling-in-the-NHS.pdf
34a https://www.nao.org.uk/wp-content/uploads/2018/05/NHS-England-management-of-the-primary-care-support-services-contract-with-capita.pdf
34b PCSE breached a statutory deadline (30 April 2017) to provide BSA with an up to date pensions record for GP pensions for the year 2015/16. The Pensions Regulator has been informed.

Assurance of the commissioning system

Specialised commissioning

Specialised services support people with a range of rare and complex conditions. They often involve treatments provided to patients with rare cancers, genetic disorders or complex medical or surgical conditions. They deliver cutting-edge care and are a catalyst for innovation, supporting pioneering clinical practice in the NHS.

The Specialised Services Commissioning Committee sets the strategic direction for specialised commissioning and provides assurance over quality, performance and value for money. The Committee also assures decisions made by the Specialised Commissioning Oversight Group (SCOG), which has operational oversight of the £16.6 billion specialised commissioning budget, and the Clinical Priorities Advisory Group (CPAG), which makes recommendations on the commissioning position of treatments and interventions for adoption, or otherwise, by NHS England.

Other direct commissioning

NHS England has a statutory duty to directly commission non-specialised healthcare services (primary care, public health commissioning, armed forces and health and justice commissioning). We discharge this duty through our central and regional teams, and in the case of primary medical care services through CCGs, ensuring that:

- healthcare services are planned locally and effectively, based on the needs of the population;
- services are secured to meet the population's needs;
- the quality of healthcare is monitored.

Within the context of planning and securing services, specific annual objectives are agreed to meet the needs of the population.

Quality monitoring and delivery assurance is overseen by specific oversight groups, which individually report to the Commissioning Committee. We target our resources to focus national oversight on the areas of greatest priority and risk. The three Oversight Groups for public health, armed forces and health and justice focus on key strategies, with regular reports on quality, performance and finance. The Primary Care Oversight Group focuses key operational matters, with detailed operational discussions being held by the Primary Care Delivery Oversight Group. The Commissioning Committee receives regular reports, along with in depth reviews of specific areas on a rotating basis.

During 2017/18, direct commissioning for non-specialised services accounted for £7.8 billion of total commissioning expenditure (this excludes delegated expenditure by CCGs on primary medical care which totalled £6.1 billion).

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. 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.

As of March 2018, 174 of the CCGs have delegated arrangements (representing 84% coverage), and 23 CCGs (11%) have joint commissioning arrangements.

NHS England's Board has committed to support the majority of CCGs to take on the delegated model in future, and additional delegation arrangements have now been agreed with 14 CCGs to be taken forward during 2018/19. Additionally, delegation agreements have been made with a number of newly-merged CCGs, replacing their previous agreements.

As of 1 April 2018, 178 CCGs have delegated arrangements for primary medical services (91%). In addition, 10 CCGs (5%) have a joint commissioning arrangement with NHS England and 7 CCGs (3.6%) are operating under the 'greater involvement' model.

Sustainability and Transformation Partnerships

As detailed in 'Next Steps on the Five Year Forward View' STPs are not statutory bodies. They supplement rather than replace the accountabilities of individual organisations, and the way STPs work will vary according to the needs of different parts of the country.

Place-based health and care systems are defined and assessed primarily by how they practically tackle their shared local health, quality and efficiency challenges. The success of STPs and their constituent organisations is determined by the results they are able to achieve.

In 2017/18 systems have strengthened their governance to include NHS bodies, local government and the third sector.

The most mature systems have put in place mechanisms for joint decision-making and collective risk sharing. They have also become more transparent, involving non-executive directors, lay members and other community representatives.

CCGs

NHS England is accountable for overseeing and assuring the commissioning system to ensure that it is working effectively. NHS England has a statutory duty to performance assess each of the 207 CCGs every year to determine how well it has discharged its functions. 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 DHSC to CCGs and supports them to commission services on behalf of their patients. In turn, CCGs are responsible for demonstrating probity and good governance in managing their finance and performance. Together they account for £81.2 billion of total commissioning expenditure.

Our assurance and oversight functions seek to ensure that CCGs are delivering the best outcomes for their patients and have a high standard of financial management, are 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's CCG Improvement and Assessment Framework (IAF) was introduced in 2016/17 to align key national objectives and priorities and inform the way we manage our relationships with CCGs. The 2017/18 framework builds on this work. It focuses on a manageable number of the highest priorities facing the NHS, but also acknowledges the rapidly changing environment required to transform the health and care system. It has been designed to align with NHS England's mandate and planning guidance to reach beyond CCGs and enable local health systems and communities to assess their own progress from ratings published on the MyNHS website.

The framework plays an important part in the continued delivery of the Five Year Forward View, as set out in the Next Steps document, helping to diagnose issues and apply the most effective support and resources. As STPs develop further, careful attention will be given to the alignment of STP metrics and the CCG IAF.

Legislation requires an annual performance assessment to be carried out at an individual CCG level. 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. Details of CCG directions can be found on the NHS England website[35].

In July 2017, 23 CCGs assessed as inadequate were placed in special measures. NHS England's special measures regime is an internal management approach to CCGs facing the most significant challenge in the areas of financial and operational performance. During 2017/18, 3 of these CCGs successfully exited the regime.

There are two routes by which a CCG would enter special measures: a rating of inadequate at the annual year-end assessment or an in-year assessment by the relevant regional director that there are significant issues with CCG's leadership, quality and/or financial performance.

When a CCG enters into special measures, a tailored support package is put in place that is delivered through local networks, delivery partners or intensive support teams. The CCG must develop an improvement plan which is agreed with and overseen by NHS England.

86 CCGs have been reported by their auditors 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.

Commissioning capability programme

A new Capability Programme has been introduced that uses a place-based approach to support CCG commissioning teams across health systems to deliver the Next Steps on the NHS Five Year Forward View. The programme is aligned to the IAF and uses existing assessment processes to build capabilities in managing the challenging issues facing commissioners today and to prepare for the future strategy in their local system. NHS England's regional teams work to target improvements in a number of key areas such as CCG leadership, financial planning, strategy development and delivery and innovation for new care models.

35 www.england.nhs.uk/ccg-details/

To ensure the programme builds from existing assessments and is of high quality, the initial focus is to support CCGs currently deemed inadequate (beginning with six local systems) with a 12-week intensive package that is bespoke to each system's context and challenges.

CCG annual reports

CCGs published their individual annual reports via their websites in June 2018. A list of CCGs and links to their websites can be found on the NHS England website[36].

A review of the CCG governance statements found that the primary focus of comments from 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.

Commissioning support units

The five CSUs each operate through an approved annual business and finance plan that sets out their intentions for the year. The plans themselves are developed by the CSUs but are reviewed by the NHS England CSU Team before receiving formal approval by NHS England.

Operational performance and adherence to plans are monitored through monthly returns by each CSU to the CSU Team as part of an operational assurance dashboard. The dashboard provides information to NHS England on aspects of CSU delivery and includes a governance assurance statement signed off by the Managing Director. This ensures NHS England receives assurance from the Managing Director every month of compliance by the CSU with NHS England SFIs, internal controls and gives a clear sight of accountability.

Each of the CSUs is also monitored on an ongoing basis through scrutiny of spending decisions through business case approval and use of off payroll workers. In addition there are two targeted governance meetings a year with each of the CSUs. These meetings test adherence to best practice and focus upon how governance can be enshrined throughout the organisation and wider. The first meeting consists of a detailed examination of the internal processes, systems and management assurance processes within the CSU. Each meeting is with their senior Executive Team, as well as officers with specific responsibilities. The meetings are documented, and evidence is provided to demonstrate the CSU approach. The second governance meeting focuses on specific issues that may have arisen from the first meeting or issues identified by NHS England in the year. This process has ensured NHS England and the CSUs have agreed and focused action plans in relation to any issues that may arise.

Management actions to rectify gaps are undertaken by the CSUs, led by the CSU Finance Director and Managing Director, overseen by the CSU Team. Where appropriate there are reports provided to ARAC and the Commissioning Committee. In 2017/18, CSUs will again meet all of their financial targets and finish the year in a balanced budget position.

CSUs have continued to use the service auditor reporting approach to provide assurance to their customers. Any exceptions relating to the processes CSUs operate for their customers are reported using this approach. The service auditor reporting approach demonstrates continuing improvements across CSUs.

36 www.england.nhs.uk/ccg-details/

CSUs continued to respond to the needs of CCGs and other customers. New work requirements and some existing contracts were put out to competition during the year. They have responded well to this challenge, winning contracts and demonstrating a high level of resilience when contract values have been reduced. They have also managed internal changes, where work has been taken in-house by some customers or where existing contracts have been awarded to an alternative CSU. The impact of this type of change has seen commissioning support providers consolidating their workforce numbers and developing innovative approaches to areas such as data analytics and transformational change.

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

Allocations

The Chief Financial Officer's report, on page 31, provides an update on how we are meeting our responsibility to allocate NHS funds and our ongoing plan to secure future financial sustainability.

NHS England gains assurance about the use of financial resources by commissioners (within the bounds of the NHS Act 2006 (as amended), and recognising the freedoms allowed to GP-led commissioners) through the annual planning process and the in-year monitoring process.

In late 2016 NHS England, together with NHS Improvement, significantly streamlined the annual NHS planning and contracting round 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.

The 2018/19 planning process has seen a limited update to these multi-year plans to reflect the additional funding provided by Government and any significant changes in activity and cost trends in individual health economies.

As well as being tasked to deliver individual CCG and NHS provider control totals, individual organisations are working together through STPs to develop system-wide plans that reconcile and explain how providers and commissioners will work together to improve services and manage within their collective budgets. NHS England and NHS Improvement have asked the most advanced integrated health systems to lead this process proactively and autonomously and have provided them with additional freedoms and flexibilities to enable them to do so.

Financial performance monitoring

In 2017/18 the financial position across the commissioning system has continued to be reported on a monthly basis using the Integrated Single Financial Environment (ISFE) reporting system. This enables a detailed monthly review by the Finance Leadership team and Chief Financial Officer, leading to regular updates to the Commissioning Committee and the Board.

Individual CCG and direct commissioning variances from the plan are rated against business rules, and analysis received from CCGs 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[37].

37 www.england.nhs.uk/publications/financial-performance-reports/

During 2017/18 NHS England and NHS Improvement have introduced a set of regular joint leadership meetings to enable improved monitoring of system wide financial performance.

NHS England central programme costs

Last year NHS England ran a two year business planning process and allocated funding to central programmes over two years. These allocations have been updated by exception where necessary.

Cabinet Office efficiency controls

As part of the Government's control of expenditure, NHS England is subject to specified expenditure controls.

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 specified categories (e.g. consultancy), approval is also sought from DHSC and for some cases this also requires approval from Ministers, the Cabinet Office and/or HMT. These arrangements are currently under review to ensure that they enable NHS England to operate efficiently and to recognise the strength of NHS England's internal processes.

Counter fraud

NHS England investigates allegations of fraud related to our functions, where these are not undertaken by the newly formed NHS Counter Fraud Authority (NHSCFA), in addition to ensuring that appropriate anti-fraud arrangements are in place. During 2017/18 NHS England contracted Deloitte LLP to provide accredited counter fraud specialists to investigate any cases of suspected fraud and undertake pro-active counter fraud work proportionate to its risks. During the year, NHS England established its own in-house team of Counter Fraud Specialists to investigate allegations of fraud and conduct fraud awareness activities. The NHS England Counter Fraud Team was fully operational by year end. It is anticipated that this change in delivery model will further enhance the effectiveness of the service.

ARAC receives regular updates regarding the development of the counter fraud function, progress against the proactive counter fraud work plan and the outcome of reactive investigations. The Director of Financial Control has day-to-day operational responsibility for the NHS England counter fraud function, and the Chief Financial Officer provides executive support and direction.

NHSCFA conducted a follow up assessment against the Standards for Commissioners: Fraud, Bribery and Corruption in 2017/18. Further improvements were recommended in a number of areas, and NHS England is taking appropriate action in relation to the NHSCFA's recommendations. ARAC receives a report at least annually against the standards.

The NHSCFA undertakes a periodic high-level estimate of the potential scale of fraud affecting the whole NHS. Its Strategic Intelligence Assessment for 2016/17 is due to be published shortly, but its latest Business Plan contained an unverified fraud estimate of £1.29 billion which NHSCFA together with its partners have responsibility for tackling.

Significant progress has been made in this area in recent years, and a number of initiatives continue to tackle the fraud risk in primary care, including the Prescription Exemption Checking Service, the Dental Benefit Eligibility Checking Service and others managed by NHSBSA on behalf of NHS England. These schemes are designed to have a significant deterrent impact but also resulted in net recoveries of £21.6 million in 2017/18. The continued development of the counter fraud service in the coming years will further safeguard NHS England's resources.

Head of Internal Audit opinion

The Head of Internal Audit reports that, based on the internal audit work undertaken and in the context of the overall environment for NHS England for 2017/18, the framework for governance has in his opinion been adequate in 2017/18. The design of the risk management framework at the year-end provides the foundation of a framework to take the organisation forward; however, there is a need to implement a number of actions for the risk management framework to form the basis of a robust framework for an organisation of the size, scale and complexity of NHS England. With respect to the internal control environment, significant effort and progress has been made in addressing outstanding internal audit actions. On this basis, the framework for internal control has been appropriately implemented in the organisation through the 2017/18 year, except for the need to address significant weaknesses in PCSE, third party assurance, conflicts of interest and off-payroll workers, all of which NHS England are aware of.

All of the recommendations raised by internal audit have been accepted by management; actions have been agreed to address these, and considerable focus continues to be placed on the implementation of the actions in a timely manner. For example, a detailed action plan and tracking mechanism has been established to oversee implementation progress for PCSE actions, and an Off-Payroll Workers (OPW) Process and Development Project has been established to address known issues in relation to IR35 compliance and oversee that key actions from our 2017/18 OPW report are being addressed.

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

- 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 in these areas. These include Grant Management, NHS Digital Governance, General Data Protection Regulations readiness, Third Party Assurance, PCSE, Travel and Expenses, conflicts of interest, risk management, procurement and Off-Payroll Workers. 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 identified by NHS England management, for example with respect to NHS SBS, PCSE, payroll and off payroll workers. Projects have remained in place to rectify the identified gaps, or management have requested that we 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; and
  - NHS Digital for data processing.

There remains a requirement to further embed the third party assurance framework to obtain assurance over the delivery of services.

Overall summary

Over this year we have continued to strengthen our approach to governance, assurance and controls. We welcome the acknowledgement of the improvements made to overall internal controls - especially the significant progress in the management of internal audit actions to ensure that recommendations are implemented in a timely manner - and we are committed to addressing the further improvements required in PCSE, off payroll workers and third party assurance.

We will be developing our approach to risk management in the coming months to ensure that it remains appropriate for our needs, and in the context of working with NHS Improvement we will consider and action as appropriate any modifications required to our governance arrangements.

Remuneration and Staff Report

Staff report - NHS England

As at 31 March 2018, NHS England directly employed 6,158 people[38]. Of these, 4,711 people were permanently employed on recurrent open-ended contracts of employment, based around the country within seven directorates. A further 1,447 people were employed on payroll on fixed term contracts of employment and 859 individuals were engaged in an off-payroll capacity which includes agency staff and secondees.

Breakdown of number of people employed by directorate

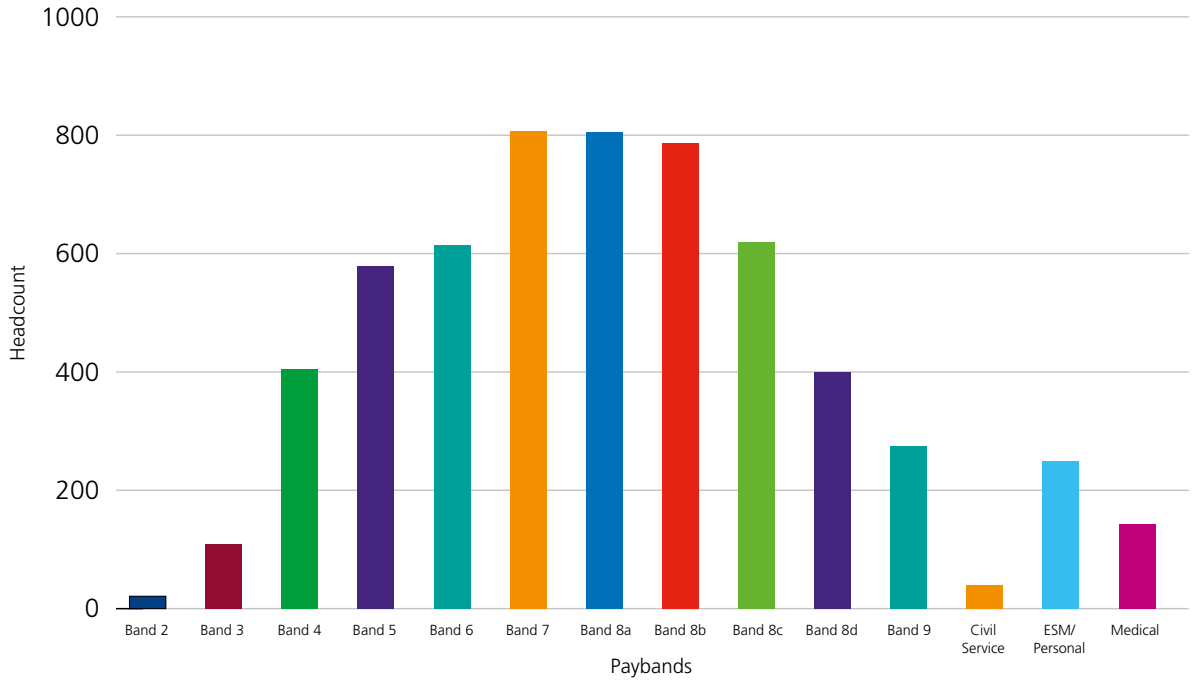
Member		No of people employed
Operations and Information - Central		907
Operations and Information - London		537
Operations and Information - Midlands & East		1,076
Operations and Information - North		1,147
Operations and Information - South		833
Finance, Commercial and Specialised Commissioning:		526
Finance	244	
Specialised Commissioning	282	
Medical		104
Nursing		242
Strategy and Innovation		274
Transformation & Corporate Operations		491
Chair and Chief Executive's Office		21
Total		**6,158**

Detail on staff numbers and costs for NHS England and the Consolidated Group, including CSUs, are presented from page 88.

38 Commissioning Support Unit staff are employed via the NHS Business Services Authority and therefore not included in this analysis. The analysis of Commissioning Support Unit staff is presented from page 86

All staff by pay band

At the same time as reducing our real terms running costs, NHS England has intentionally seen an increase in permanent and fixed term headcount of 14% since 2016/17 as we continue to reduce reliance on more expensive agency and contract labour and deliver our national programmes. The biggest increases in headcount can be seen at Bands 8a to 8c (salary range £40,428 - £69,168 per annum)



The term 'senior manager' denotes all staff remunerated at or above the pro-rata salary of £79,415 per annum (this includes the top tier of Band 8d; 189 of our 419 Band 8d staff are remunerated in the top tier). This is consistent with the definition used within Cabinet Office and HM Treasury returns.

Total On Payroll by Payband

Paybands	Headcount	% of workforce	Variance +/- from 2016/17
Band 2	21	0.3%	-0.1%
Band 3	106	1.7%	+0.6%
Band 4	395	6.4%	+0.3%
Band 5	608	9.9%	-
Band 6	645	10.5%	+0.4%
Band 7	858	13.9%	-0.2%
Band 8a	880	14.3%	+0.4%
Band 8b	829	13.5%	+0.6%
Band 8c	655	10.6%	+0.4%
Band 8d	419	6.8%	-
Band 9	292	4.7%	-0.3%
Civil Service	39	0.6%	-
ESM/ Personal	262	4.3%	-0.3%
Medical	149	2.4%	+0.1%
Total	**6,158**	**100%**	

Our people

Our people are integral to our success. In this section, we concentrate on the organisational activities undertaken to ensure the development of our people and our actions to support delivery of the Next Steps on the NHS Five Year Forward View.

Improving our workforce diversity and inclusion

We continue on our quest to achieve our workforce-related equality objective 'to improve the recruitment, retention, progression, development and experience of the people employed by NHS England to enable the organisation to become an inclusive employer of choice'.

Following the appointment of a new Head of Diversity, we have recruited a new diversity and inclusion team, and they have supported the development of a renewed Diversity and Inclusion strategy. This sets out actions and targets and lays out the plans to deliver across the four priority areas of culture change, targeted talent management, access and data.

We have continued to actively engage with, promote, support and encourage the work of our staff networks. Our existing networks – the Black and Minority Ethnic (BME) staff network; Lesbian, Gay, Bisexual, Trans + (LGBT+) network, Disability and Wellbeing Network (DAWN) and Women's Development network play a growing role in enabling staff to feel supported, engaged and heard. A new staff carer's network has been established during 2017/18. Staff networks continue to have a strong influence on our people policies and practices, for example DAWN's continued involvement in supporting improvements to our reasonable adjustments, the LGBT+ Network's support for language to be more trans-and-non-binary gender sensitive, and the BME network's support for development of BME focused talent management programmes. Furthermore, networks have collaborated, as part of the Equality Impact Assessment and Insight processes, to ensure that core people policies such as Flexible Working and Supporting Employee Performance are more inclusive of under-represented groups.

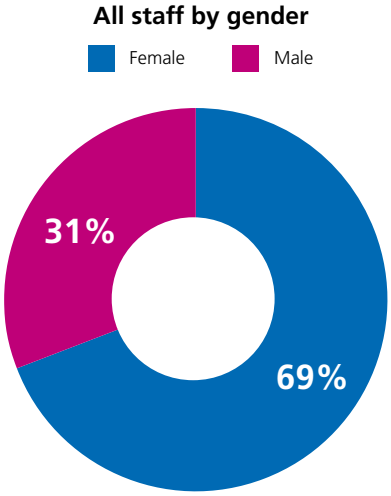
In line with our workforce equality objectives, we continue to seek external review, challenge and accreditation of NHS England's actions as an employer. NHS England participated in the annual Stonewall Workplace Equality Index, being placed 174 out of the 434 participating organisations. This represents a rise of 178 places over the last three years and reflects the work of the LGBT+ Staff Network along with the work we have put in to better recognise and support colleagues from a range of backgrounds. We have also continued to implement and report against the Workforce Race Equality Standard along with other arm's length bodies.

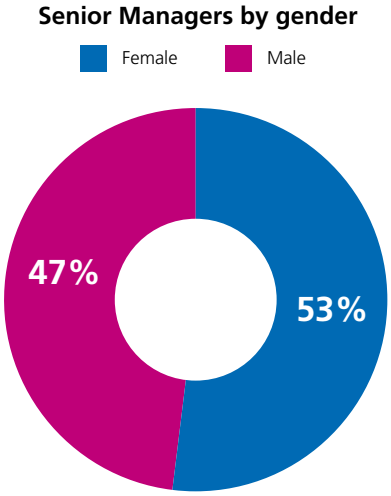
Recruitment and retention of disabled persons

We are proud to be a Disability Confident Employer as recognised by the Department for Work and Pensions; this reflects our desire and our responsibility to ensure that people with disabilities are supported in their employment. NHS England has a number of policies and activities in place to aid the recruitment and retention of disabled staff and those with long term conditions, ensuring that we give full and fair consideration to applications for employment made by people from all backgrounds and offering tailored support for people with disabilities and long term conditions. These include Equality, Diversity and Inclusion in the Workplace; Recruitment and Selection and Flexible Working policies.

A Reasonable Adjustment Task and Finish Group has also been established to undertake a strategic review of current systems and processes, to ensure staff members who have a disability or long term condition are treated fairly and are not discriminated against and to check that reasonable adjustments are effectively implemented across the organisation. The group is comprised of key stakeholders, including those with lived experience from our DAWN network. This group has been established to educate and raise awareness of reasonable adjustments and take positive action, to help create an inclusive environment for all. This includes ensuring reasonable adjustments are understood and delivered to support retention, career development and the promotion of those with disabilities and long term conditions.

All staff by gender and senior managers by gender



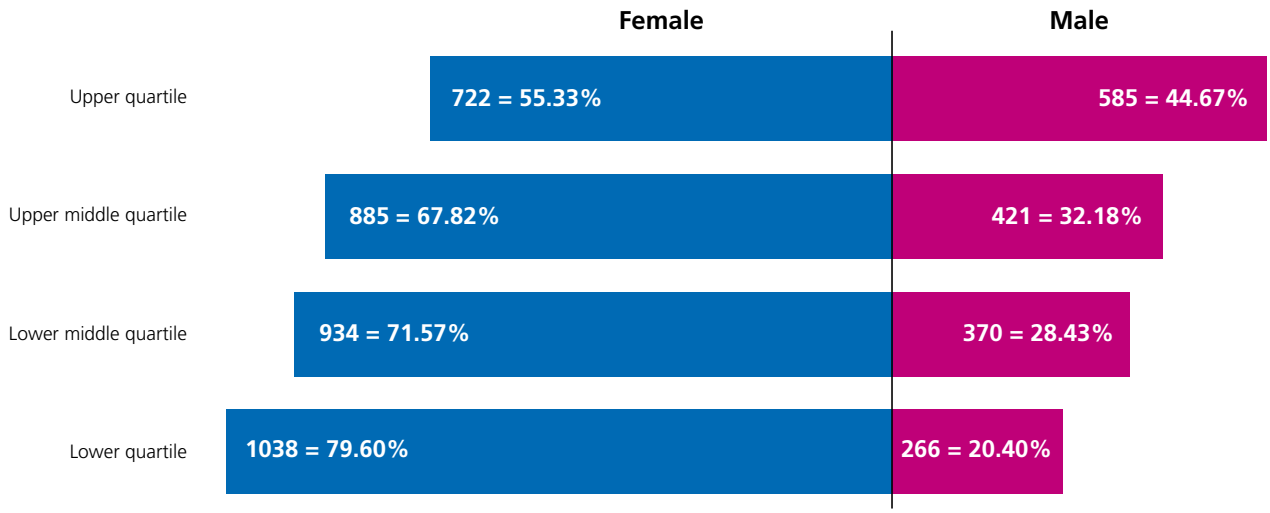


The gender proportions of the total on payroll workforce remain largely unchanged, although the proportion of females in senior manager roles has increased by 2% over the year (2016/17: 51% female, 49% male). The gender diversity of Board members is set out on page 41.

Gender pay gap

Based on the Government's methodology, using snap shot data as of 31 March 2017, NHS England had a mean gender pay gap of 21.2%, calculated as the percentage difference between the average hourly salary for men and the average annual salary for women. The median gender pay gap of 21.5% is calculated as the percentage difference between the mid-point hourly salaries for men and women.

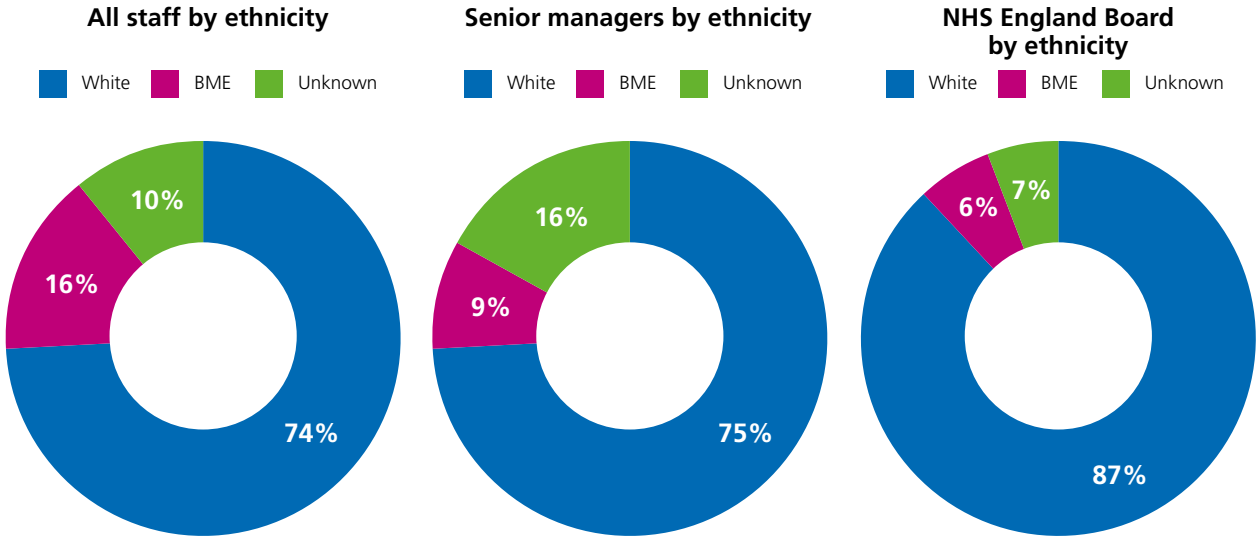
The proportion of males and females in each pay quartile are detailed below:



51% of the population of England are women, and 55% of NHS England's upper quartile senior staff are women. However, 79.6% of employees in the lower quartile are female.

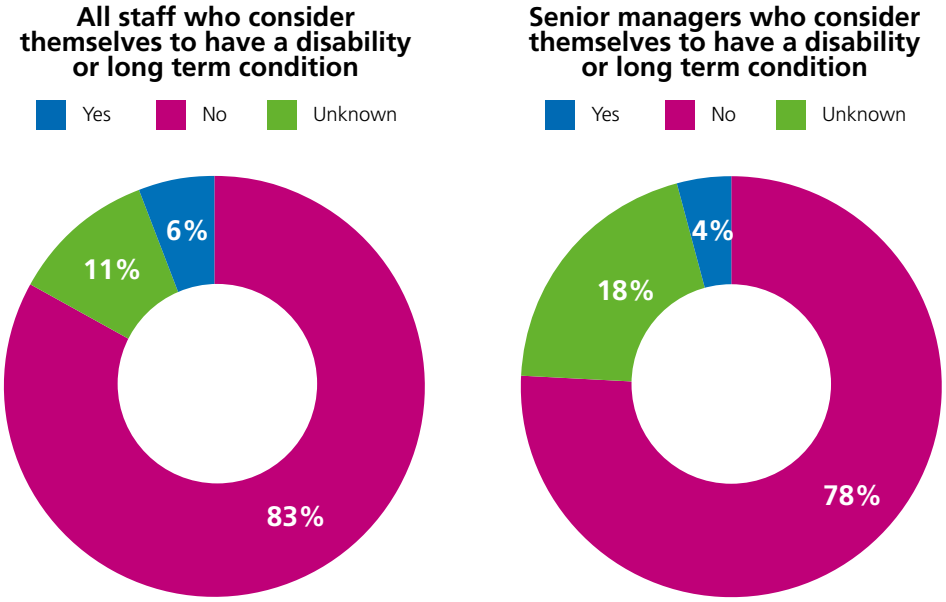
This and other analysis therefore shows that the major driver of our pay gap, as defined by Government, is having a lower proportion of men in lower pay bands relative to their share of the population.

All staff by ethnicity



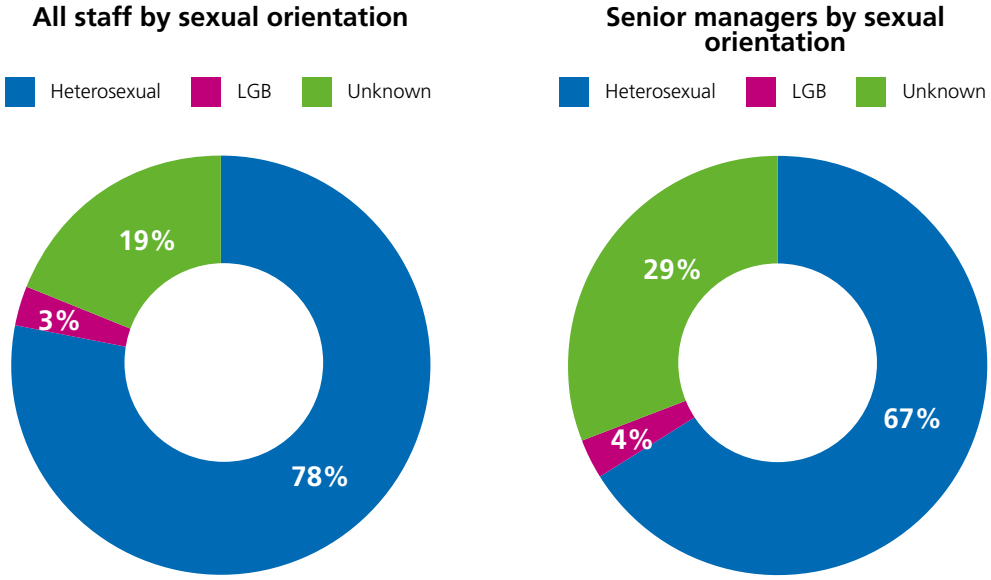
The proportion of people employed by NHS England that consider themselves to be from a BME heritage has increased by 2% over the year for all staff and 1% for senior managers (2016/17: 14% all staff, 8% senior managers and 6% NHS England Board). This is a consequence of sustained and focussed effort with the BME staff network to improve our workplace diversity and inclusion and provides evidence of progress towards the achievement of our workforce equality objective to address data gaps and increase disclosure rates.

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



We have worked closely with the DAWN staff to close the gaps in workforce diversity data and encourage people to self-classify. This year an additional 1% of all staff and 3% of senior managers have chosen to disclose whether they have a disability or long-term condition (2016/17: 12% all staff, 21% senior managers). Whilst the proportion of senior managers disclosing a disability or long-term condition has remained constant, there has been a marginal increase in the percentage of staff disclosing a disability or long-term condition (2016/17: 5% all staff, 4% senior managers).

All staff by sexual orientation and senior managers by sexual orientation



Disclosure rates relating to sexual orientation have increased by 2% during the year. The number of staff reporting that they are lesbian, gay or bisexual has remained constant at 3%[39], although there has been an increase of 1% in the number of senior managers reporting that they are lesbian, gay or bisexual (2016/17: 3% all staff, 3% senior managers).

Our people commitments

Our long-term success relies on us having talented, capable, dedicated and patient-focussed people at our core. Over the last year we have continued to shape and strengthen our processes and infrastructure to help to make NHS England a more inclusive employer by making more use of the diverse talents and capabilities of our staff to deliver our business plan. Progress made in each of our 'People Commitment' areas is detailed below.

Talent management and development

Our stretch assignment programme has continued to go from strength to strength, with 64 individuals placed successfully during the year, primarily at middle management grades. Opportunities for stretch assignments are promoted via our staff networks and engagement groups, with approximately one third of assignments being undertaken by individuals from a BME background.

Our coaching and mentoring service provides four key services to the organisation: leadership and governance, service management and network development, research and best practice and consultancy support. The internal service has continued to grow and there are currently 38 qualified coaches, 45 coaches-in-training, a further 12 beginning the qualification and 83 mentors. We have successfully increased the number of coaches and mentors from under represented groups. During the year approximately 330 people received coaching.

Line management development programme

The Line Management Development Programme (LMDP) has proved an important part of our strategy to ensure consistently strong people management practice around the organisation. Key elements of the strategy include:

- Clarifying expectations of our managers.
- Establishing robust policies and procedures to guide good practice, for example; Supporting Employee Performance, Personal Development Reviews and Respect at Work.
- Improving self-awareness using 360° feedback.

During the year 238 staff have graduated from the LMDP, with a further 184 people on current cohorts. When this is combined with managers who attended one of our one day line management workshops (847), this equates to approximately 28% of our total middle/senior manager population who have had this line management training. The positive impact of the programme is evident within the staff survey engagement scores, where 88% staff agreed with the statement 'my immediate line manager treats me with dignity and respect'.

39 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.

A pilot Senior Line Management Development Programme was also launched in 2017/18 for 16 of our most senior leaders to help build a skilled and cohesive senior management cadre across NHS England.

Apprenticeships

NHS England is embracing apprenticeships as an opportunity to build key capabilities and improve the diversity of our workforce. Our vision is to offer apprenticeships to people of all ages, backgrounds and pay bands and across all of our professions. Our Apprenticeship Scheme was launched in May 2017. We currently employ 20 apprentices across the organisation. In addition we have received around 70 expressions of interest from existing members of staff to undertake apprenticeships once contracting arrangements are in place with national suppliers. This will enable us to offer further apprenticeship opportunities across the organisation.

Workplace health, safety and wellbeing

In October 2017, we made a commitment to become a 'Mindful Employer'. Over the next two years we will ensure that we show a positive and enabling attitude to employees and job applicants with mental health issues. This year, to date, we have trained another 196 Mental Health First Aiders (MHFA) bringing us to a total of 791 members of staff trained as MHFAs since 2014. In addition to delivering training, we have focussed on engagement events with existing MHFAs and have encouraged the development of local MHFA networks.

NHS England discharges its statutory duties to consult with employees on matters that may affect their health, safety or welfare at work. In this regard, a health and safety committee is constituted under the relevant health and safety acts and regulations, with appointed representatives from both management and trade unions.

In recognition of our working carers, we have collaborated with our Carers Network, to produce a Carers Strategy for NHS England and a Carers Toolkit. The Toolkit has been devised specifically to stimulate conversations around individual, team and organisational support for working carers.

Staff engagement and experience

Staff survey

During 2017/18 we ran an interim pulse and full census survey across the whole organisation. Using an external provider, we were able to benchmark the experience of our colleagues with other organisations, in addition to reviewing results for variations based upon protected characteristics. Over the last three years there has been a 13% increase in the engagement of our staff which is now at 76%. This is a very positive reflection of the work of our local staff engagement teams and our line managers, comparing favourably to the ORC UK benchmark of 74% and is comparable with the wider NHS average.

Staff engagement groups

We have 32 local staff engagement groups operating across NHS England, enabling a locally bespoke approach to staff engagement. Local groups feed into a National Network to share best practice across the organisation, connect local leads, bring corporate engagement into

local groups and connect the groups to the Board via the National Director: Transformation and Corporate Operations. This group contributes to the development of our people policies and is more widely engaged in issues affecting staff and impacting on the organisation. The staff survey results are owned locally by these groups and respective action plans developed, with successes celebrated and best practice shared.

Staff recognition

During the last year we have continued to build on the success of our staff recognition scheme 'Everyone Counts Awards', recognising a further 33 colleagues and six teams who have gone the extra mile and been trues advocates of our values and behaviours.

Facility time

Facility time is paid time off for union representatives to carry out Trade Union activities. The information below relates to Trade Union facility time within NHS England.

Number of employees who were relevant union officials during the relevant period	Full-time equivalent employee number
15	6,158

NHS England is currently working in partnership with recognised Trade Unions to ensure that a full disclosure, stating information relating to the percentage of time spent on facility time and percentage of pay bill spent on facility time and paid trade union activities in line with the Trade Union Regulations 2017 (Facility Time Publication Requirements) is published on the NHS England website.

Our improvement and change activities

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 staff on our future plans.

Progress in 2017 has included realigning our national directorates so they are better able to deliver our priorities and aligning our support to the STPs through the Regional and DCO teams.

In the South region we have been testing closer working with NHS Improvement and in the North we have been using continuous improvement methodology to review some of our systems and processes to identify ways in which we can become more efficient and reduce duplication.

We have assessed our current informatics portfolio and analytical capabilities across NHS England and CSUs and have created implementation plans that will ensure we harness our existing analytical capabilities.

Looking forward to 2018/19

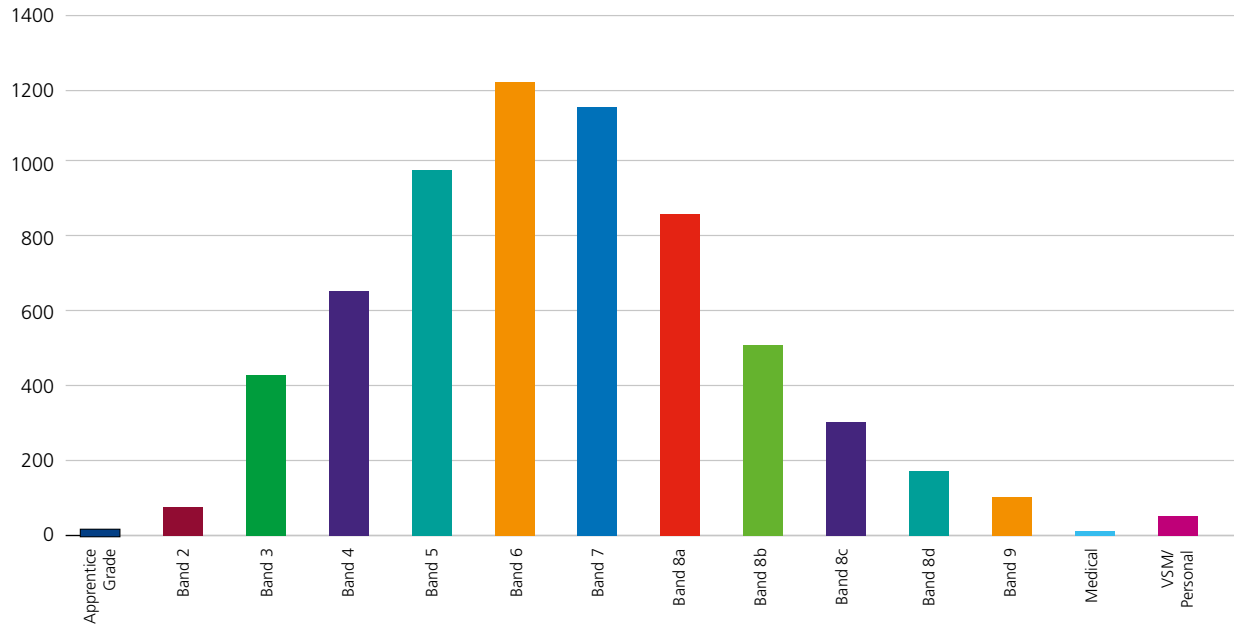
Our approach to People and Organisation Development for 2018/19 will focus upon talent management, leadership, engagement, capability and culture as NHS England continues to evolve.

We will design a future operating model, which will also enable our staff to provide direct support to STPs and the integration of health and care systems.

Staff report - CSUs

As at 31 March 2018, CSUs directly employ a total 6525 people. Of these, 6080 people were permanently employed on recurrent, open-ended contracts of employment, based around the country within the 5 separate organisations. In addition, a further 445 people were employed on payroll on fixed term contracts of employment. A further 931 individuals are engaged in an off-payroll capacity these include agency staff and secondees.

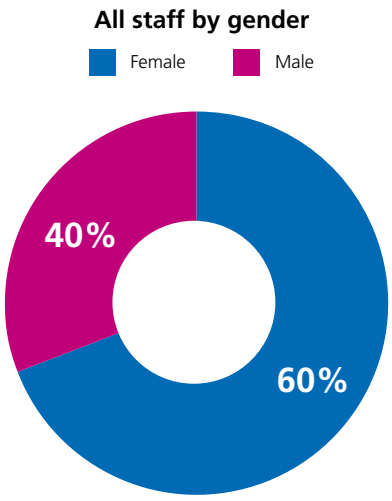
All CSU staff by pay band

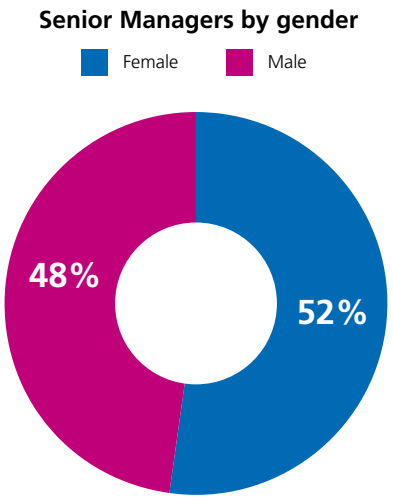


The term 'senior manager' denotes all staff remunerated at or above the pro-rata salary of £79,415 per annum (this includes the top tier of Band 8d; 74 of the 172 CSU Band 8d staff are remunerated in the top tier). This is consistent with the definition used within Cabinet Office and HM Treasury returns.

Paybands	Headcount	% of workforce
Apprentice Grade	3	0.0%
Band 2	86	1.3%
Band 3	428	6.6%
Band 4	652	10.0%
Band 5	989	15.2%
Band 6	1212	18.6%
Band 7	1154	17.7%
Band 8a	856	13.1%
Band 8b	510	7.8%
Band 8c	301	4.6%
Band 8d	172	2.6%
Band 9	102	1.6%
Medical	6	0.1%
VSM/ Personal	54	0.8%
Total	**6,525**	**100%**

All CSU staff by gender and senior managers by gender





Details of the individual gender pay gap for each CSU is obtainable on the Government's gender pay gap service website[40].

40 https://gender-pay-gap.service.gov.uk/

Employee benefits and staff numbers (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	2017/18				
	Permanently employed number	CSU employed number	Other number	CSU other number	Total number
Total	5,278	6,095	871	482	**12,726**
Of the above: Number of whole time equivalent people engaged on capital projects	-	-	-	-	-

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

Employee benefits

Parent	2017/18				
	Permanent employees £000	CSU employees £000	Other £000	CSU other £000	Total £000
Employee benefits					
Salaries and wages	270,694	235,163	50,833	43,572	**600,262**
Social security costs	31,139	25,140	17	1	**56,297**
Employer contributions to NHS Pension scheme	34,980	30,198	24	1	**65,203**
Other pension costs	-	-	-	-	**-**
Apprenticeship Levy	1,357	1,329	-	-	**2,686**
Termination benefits	257	4,943	-	-	**5,200**
Gross employee benefits expenditure	**338,427**	**296,773**	**50,874**	**43,574**	**729,648**
Less: Employee costs capitalised	-	-	-	-	**-**
Net employee benefits excluding capitalised costs	**338,427**	**296,773**	**50,874**	**43,574**	**729,648**
Less recoveries in respect of employee benefits	(162)	-	-	-	**(162)**
Total net employee benefits	**338,265**	**296,773**	**50,874**	**43,574**	**729,486**

Parent

	2016/17				
	Permanent employees £000	CSU employees £000	Other £000	CSU other £000	Total £000
Employee benefits					
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 Pension scheme	31,278	29,501	25	6	**60,810**
Other pension costs	-	-	-	-	**-**
Apprenticeship Levy	-	-	-	-	**-**
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**

Average number of people employed

Consolidated Group

	2017/18				
	Permanently employed number	CSU employed number	Other number	CSU other number	Total number
Total	22,408	6,095	2,725	482	**31,710**
Of the above: Number of whole time equivalent people engaged on capital projects	-	-	-	-	-

Consolidated Group

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

Employee benefits

Consolidated Group	2017/18				
	Permanent employees £000	CSU employees £000	Other £000	CSU other £000	Total £000
Employee benefits					
Salaries and wages	1,046,741	235,163	194,512	43,572	**1,519,988**
Social security costs	116,284	25,140	317	1	**141,742**
Employer contributions to NHS Pension scheme	134,388	30,198	242	1	**164,829**
Other pension costs	18	-	-	-	**18**
Apprenticeship Levy	2,824	1,329	-	-	**4,153**
Termination benefits	7,436	4,943	-	-	**12,379**
Gross employee benefits expenditure	**1,307,691**	**296,773**	**195,071**	**43,574**	**1,843,109**
Net employee benefits excluding capitalised costs	**1,307,691**	**296,773**	**195,071**	**43,574**	**1,843,109**
Less recoveries in respect of employee benefits	(6,793)	-	(82)	-	**(6,875)**
Total net employee benefits	**1,300,898**	**296,773**	**194,989**	**43,574**	**1,836,234**

Consolidated Group	2016/17				
	Permanent employees £000	CSU employees £000	Other £000	CSU other £000	Total £000
Employee benefits					
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 Pension scheme	121,997	29,501	172	6	**151,676**
Other pension costs	-	-	-	-	**-**
Apprenticeship Levy	-	-	-	-	**-**
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**

CSUs are part of NHS England and provide services to CCGs.

The employment contracts or secondment of almost all of these staff are held for NHS England on a "hosted basis" by the NHS Business Services Authority.

Sickness absence

From 1 January 2017 to 31 December 2017, the average number of sick days taken by whole time equivalent employees decreased by 0.4 days against the previous year.

Sickness absence for the period 1 January 2017 to 31 December 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	1,929,432	39,567	4.6
CSUs with 12 months of data	1,578,501	46,439	6.6
CSUs with fewer than 12 months of data	683,690	18,125	6.0

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 £27 million during the financial year. Across the group, there was a total spend of £85 million on consultancy services during the period, against £101 million the previous year.

Expenditure on contingent labour, including agency staff and secondees, is given on page 86: Employee Benefits and Staff Numbers under the 'other' column. Net expenditure for NHS England and CSUs in this area was £94 million in 2017/18, down from £131 million in 2016/17. Across the group, there was a total spend of £239 million on contingent labour during the year, down from £311 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 65.

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. Use of fixed term or non-permanent roles can help reduce our future redundancy liabilities and costs. Furthermore, for some of our time-limited programmes, it makes sense to use short term contracts.

The following tables identify off-payroll workers[41] engaged by NHS England as at March 2018.

41 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 2,800 appraisers.

Table 1: Off-payroll engagements longer than six months

Off-payroll engagements as at 31 March 2018, covering those earning more than £245 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 2018	514	66	580
Of which, the number that have existed:			
for less than one year at the time of reporting	348	49	397
for between one and two years at the time of reporting	95	14	109
for between 2 and 3 years at the time of reporting	34	2	36
for between 3 and 4 years at the time of reporting	15	0	15
for 4 or more years at the time of reporting	22	1	23

All existing off-payroll engagements, outlined above, have 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, assurance has been sought.

Table 2: New off-payroll engagements

New off-payroll engagements or those that reached six months in duration, between 1 April 2017 and 31 March 2018, for more than £245 per day and that last longer than six months are as follows:

	NHS England	CSUs	Total
Total number of new engagements, or those that reached six months in duration, between 1 April 2017 and 31 March 2018	408	77	485
Of which….			
Number assessed as caught by IR35	58	42	100
Number assessed as NOT caught by IR35	350[42]	35	385
Number engaged directly (via PSC contracted to department) and are on departmental payroll	0	0	0
Number of engagements reassessed for consistency / assurance purposes during the year	13	63	76
Number of engagements that saw a change to IR35 status following the consistency review	3	2	5

Table 3: Off-payroll board member/senior official engagement

Off-payroll engagements of Board members and/or senior officials with significant financial responsibility, between 1 April 2017 and 31 March 2018 are shown in the table below:

	NHS England	CSUs	Total
Number of off-payroll engagements of board members, and/or senior officers with significant financial responsibility, during the financial year	0	0	0
Total no. 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.	277	38	315

42 The majority are medical OPWs who will be reassessed during 2018/19 to determine IR35 status

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 DHSC and HMT.

All contractual severance payments were subject to full external oversight by DHSC.

Exit packages agreed during the year

Parent	2017/18			2016/17		
	Compulsory redundancies number	Other agreed departures number	Total number	Compulsory redundancies number	Other agreed departures number	Total number
Less than £10,000	13	10	23	12	9	21
£10,001 to £25,000	8	22	30	34	15	49
£25,001 to £50,000	12	26	38	46	16	62
£50,001 to £100,000	8	15	23	16	12	28
£100,001 to £150,000	1	4	5	7	8	15
£150,001 to £200,000	1	4	5	13	2	15
Over £200,001	-	-	-	-	-	-
Total	**43**	**81**	**124**	**128**	**62**	**190**
Total cost (£000)	**1,453**	**3,628**	**5,081**	**6,372**	**2,919**	**9,291**

Consolidated Group	2017/18			2016/17		
	Compulsory redundancies number	Other agreed departures number	Total number	Compulsory redundancies number	Other agreed departures number	Total number
Less than £10,000	56	78	134	31	28	59
£10,001 to £25,000	48	61	109	49	37	86
£25,001 to £50,000	28	46	74	63	31	94
£50,001 to £100,000	24	33	57	23	18	41
£100,001 to £150,000	5	5	10	12	9	21
£150,001 to £200,000	19	5	24	16	3	19
Over £200,001	2	-	2	1	1	2
Total	**182**	**228**	**410**	**195**	**127**	**322**
Total cost (£000)	**7,983**	**6,946**	**14,929**	**9,057**	**4,878**	**13,935**

Exit packages agreed during the year: Other agreed departures

	2017/18		2016/17	
	Other agreed departures		Other agreed departures	
Parent	**number**	**£000**	**number**	**£000**
Voluntary redundancies including early retirement contractual costs	72	3,539	56	2,854
Contractual payments in lieu of notice	9	89	6	64
Exit payments following Employment Tribunals or court orders	-	-	-	-
Total	**81**	**3,628**	**62**	**2,918**

	2017/18		2016/17	
	Other agreed departures		Other agreed departures	
Consolidated Group	**number**	**£000**	**number**	**£000**
Voluntary redundancies including early retirement contractual costs	82	3,875	69	3,696
Mutually agreed resignations (MARS) contractual costs	48	1,423	-	-
Early retirements in the efficiency of the service contractual costs	4	386	1	48
Contractual payments in lieu of notice	92	1,162	53	1,061
Exit payments following Employment Tribunals or court orders	2	100	4	70
Non-contractual payments requiring HMT approval	-	-	-	3
Total	**228**	**6,946**	**127**	**4,878**

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.

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 full in the year of departure.

Where NHS England and CCGs have agreed early retirements, the additional costs are met by NHS England or the CCG rather than 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. During the reporting period there were two ill-health retirements in NHS England. The total cost, which was met by NHS Pensions, was £161,236.

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 Directors' Report at page 49.

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 2017/18 was £215,000 to £220,000 (2016/17: £205,000-£210,000). This was 5.38 times the median remuneration of the workforce, which was £40,428 (2016/17: £38,812: 5.35). During 2017/18 the Chief Executive Officer (Simon Stevens) voluntarily took a £20,000 per annum pay cut for the fourth year in a row.

In 2017/18, two employees received remuneration in excess of the highest-paid member of the Board (2016/17: 2), one of whom is employed on a part time basis. Remuneration ranged from £6,844 (part time salary) - £220,430. (2016/17 figures: £1,452 (part time salary) to £220,430).

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

Policy on remuneration of senior managers

The framework for the remuneration of executive directors is set by DHSC 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 necessary for the effective running of a more than £110 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 DHSC 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; they follow guidance prescribed by DHSC 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 2017/18.

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 DHSC Governance and Assurance Committee. Any proposed non-contractual special severance payment requires formal approval from DHSC and HMT.

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

No payments have been made to past directors and no compensation has been paid on early retirement. This is subject to audit.

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 Officer	1 April 2014	6 months	Option to provide taxable pay in lieu of part or all of the notice period	
Paul Baumann CBE 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		Left NHS England on 28 January 2018
Ian Dodge National Director: Commissioning Strategy	7 July 2014	6 months		
Matthew Swindells National Director: Operations and Information	30 May 2016	6 months		
Emily Lawson National Director: Transformation and Corporate Operations	1 November 2017	6 months		
Professor Stephen Powis National Medical Director	1 March 2018	6 months		

Secondments

Name and Title	Date of appointment	Unexpired term at 31 March 2018	Notice period	Provisions for compensation for early termination	Other details
Karen Wheeler CBE National Director: Transformation and Corporate Operations	1 April 2014	0	N/A	N/A	3 year secondment from the DHSC, with the option to extend for 2 further years. Left NHS England on 30 June 2017

With NHS Improvement we jointly appointed Jennifer Howells, Regional Director – South West and Anne Eden, Regional Director – South East with effect from 1 October 2017. These positions are recognised by both organisations as senior leadership roles, with both Jennifer Howells and Anne Eden being members of the executive team at NHS Improvement and disclosed in the NHS Improvement Annual Report and Accounts.

Senior manager salary and pension entitlement 2017/18 (subjected to audit)

Name and Title	(a) Salary (bands of £5,000)	(b) Benefits in kind (taxable) rounded to nearest £100	(c) Performance pay and bonuses (bands of £5,000)	(d) Long term performance pay and bonuses (bands of £5,000)	(e) All pension-related benefits (bands of £2,500)	(f) TOTAL (a to e) (bands of £5,000)
	£000	£s	£000	£000	£000	£000
Simon Stevens Chief Executive Officer[43]	190-195	0	0	0	45.0-47.5	235-240
Paul Baumann CBE Chief Financial Officer	205-210	0	0	0	0	205-210
Professor Jane Cummings Chief Nursing Officer[44]	175-180 (pro-rata - allowance only)	0	0	0	0	175-180 (pro-rata allowance only)
Professor Sir Bruce Keogh National Medical Director[45]	155-160 (pro-rata)	0	0	0	0	155-160 (pro-rata)
Ian Dodge National Director Strategy and Innovation	165-170	0	0	0	37.5-40.0	205-210
Matthew Swindells National Director: Operations and Information[46]	205-210	0	0	0	0	205-210
Karen Wheeler CBE National Director: Transformation and Corporate Operations[47]	35-40 (pro-rata)	0	0	0	27.5-30.0 (pro-rata)	65-70 (pro-rata)
Emily Lawson National Director: Transformation and Corporate Operations[48]	90-95 (pro-rata)	0	0	0	0	90-95 (pro-rata)
Professor Stephen Powis National Medical Director[49]	15-20 (pro rata)	0	0	0	0	15-20 (pro rata)

43 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 be within the range £210,000–£215,000. Mr Stevens has continued with this voluntary reduction in pay throughout 2017/18.

44 Professor Jane Cummings commenced receipt of an additional responsibility allowance from 15 September 2017 for covering the London regional director role. The figures shown reflect this part year receipt of the allowance. The full year equivalent salary is £185,000-£190,000.

45 Professor Sir Bruce Keogh received an overpayment of £42,818 paid in error between 1 April 2015 and 31 January 2016, and this was fully recovered in the 2017/18 financial reporting period. The amount of the overpayment is not included in the total remuneration figures disclosed. Professor Sir Bruce Keogh retired on 28 January 2018. The full year equivalent salary is £190,000-£195,000.

46 Matthew Swindells was pro-rata previous year as he did not join the post until 30 May 2016. There has also been a pay award which has increased his salary into the next salary band.

47 Karen Wheeler was seconded from DHSC and her salary recharged to NHS England. As such, she was subject to the terms and conditions of her employing organisation. Karen Wheeler left NHS England on 30 June 2017. The full year equivalent salary is £155,000-£160,000.

48 Emily Lawson joined NHS England on 1 November 2017, replacing Karen Wheeler. The full time equivalent salary is £190,000-£195,000. This includes an 8% additional responsibility allowance that recognises extra duties in relation to the PCS service. However, an additional amount of £10,876.92, relating to days worked prior to commencement on 1 November 2017, is included in the pro rata salary disclosed but not in the full time equivalent salary.

49 Professor Stephen Powis joined NHS England on 1 March 2018, replacing Professor Sir Bruce Keogh. The full year equivalent salary is £215,000-£220,000.

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

Name and Title	(a) Salary (bands of £5,000)	(b) Benefits in kind (taxable) rounded to nearest £100	(c) Performance pay and bonuses (bands of £5,000)	(d) Long term performance pay and bonuses (bands of £5,000)	(e) All pension-related benefits (bands of £2,500)	(f) TOTAL (a to e) (bands of £5,000)
	£000	£s	£000	£000	£000	£000
Simon Stevens Chief Executive Officer[50]	190-195	0	0	0	42.5-45.0	235-240
Paul Baumann CBE 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[51]	190-195	0	0	0	0	190-195
Richard Barker National Director: Commissioning Operations[52]	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[53]	170-175 (pro-rata)	0	0	0	0	170-175 (pro-rata)
Karen Wheeler CBE National Director: Transformation and Corporate Operations[54]	155-160	0	10-15	0	50-52.5	215-220

50 On joining NHS England on 1 April 2014, Simon Stevens voluntarily reduced his pay by 10% from the substantive rate of pay for the post of Chief Executive Officer, which would normally be within the range £210,000-£215,000. Mr Stevens has continued with this voluntary reduction in pay throughout 2016/17.

51 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.

52 Richard Barker was in post from 1 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 £175,000-£180,000.

53 Matthew Swindells joined in the post of National Director from 30 May 2016, his full time earnings were within the range £200,000-£205,000.

54 Karen Wheeler is seconded from DHSC 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.

Pension benefits as at 31 March 2018 (subjected to audit)

Name and Title	Real increase in pension at pension age (bands of £2,500)	Real increase in pension lump sum at pension age (bands of £2,500)	Total accrued pension at pension age at 31 March 2018 (bands of £5,000)	Lump sum at pension age related to accrued pension at 31 March 2018 (bands of £5,000)	Cash Equivalent Transfer Value at 31 March 2017 [55]	Real Increase in Cash Equivalent Transfer Value	Cash Equivalent Transfer Value at 31 March 2018	Employers contribution to partnership pension
	£000	£000	£000	£000	£000	£000	£000	£000
Simon Stevens Chief Executive Officer	2.5-5.0	0	30-35	55-60	470	27	529	0
Paul Baumann CBE Chief Financial Officer[56]	N/A	N/A	N/A	N/A	508	N/A	N/A	N/A
Professor Jane Cummings Chief Nursing Officer[57]	0	0	75-80	235-240	1,616 (Restated)	1	1,669	0
Professor Sir Bruce Keogh National Medical Director[58]	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Ian Dodge National Director: Commissioning Strategy	2.5-5.0	N/A	10-15	N/A	78	10	113	0
Matthew Swindells National Director: Operations and Information[59]	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Karen Wheeler CBE National Director: Transformation and Corporate Operations[60]	0-2.5	0	60-65	0	1,151	29	1,191	0
Emily Lawson National Director: Transformation and Corporate Operations[61]	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Professor Stephen Powis National Medical Director[62]	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

55 As per previous submissions, the column Cash Equivalent Transfer Value at 31 March 2017 is the uninflated value whereas the real Increase in CETV is the employer funded increase.
56 Paul Baumann chose not to be covered by the NHS pension arrangements during the reporting year.
57 The CETV at 31 March 2017 has been restated for Professor Jane Cummings following receipt of revised information from NHS Pensions. Professor Jane Cummings ceased her contributions to the NHS Pension Scheme from 1 May 2017.
58 Professor Sir Bruce Keogh chose not to be covered by the NHS pension arrangements during the reporting year.
59 Matthew Swindells chose not to be covered by the NHS Pension arrangements during the reporting year.
60 Karen Wheeler left NHS England on 30 June 2017, therefore the Pension Benefits disclosed are pro-rata for the period 1 April 2017 to 30 June 2017.
61 Emily Lawson chose not to be covered by the NHS Pension arrangements during the reporting year.
62 Professor Stephen Powis chose not to be covered by the NHS Pension arrangements during the reporting year.

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 or 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 DHSC upon appointment. All non-executive directors are paid the same amount, except the Chair, Vice-Chair and Chair of ARAC, to reflect the equal time commitment expected from each non-executive director. The Chair, Vice-Chair and Chair of ARAC are entitled to higher amounts to reflect the increased time commitment associated with their respective roles.

Some non-executive directors, including the Vice-Chair, have opted to waive their contractual remuneration. Non-executive directors do not receive PRP or pensionable remuneration.

Non-executive director service contracts

Name and Title	Date of Appointment	Unexpired Term at 31 March 18	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	7 months	6 months	None	
David Roberts Vice-Chair	1 July 2014	3 months	None	None	Waived entitlement to remuneration
Lord Victor Adebowale CBE Non-executive director	1 July 2012, reappointed to a second term on 1 January 2015	9 months	None	None	
Professor Sir John Burn Non-executive director	1 July 2014	3 months	None	None	
Dame Moira Gibb Non-executive director	1 July 2012, reappointed to a second term on 1 January 2015	9 months	None	None	
Noel Gordon Non-executive director	1 July 2014	3 months	None	None	
Wendy Becker Non-executive director	1 March 2016	23 months	None	None	Waived entitlement to remuneration from Sept 16
Michelle Mitchell OBE Non-executive director	1 March 2016	23 months	None	None	
Joanne Shaw Non-executive director, ARAC Chair	1 October 2016	30 months	None	None	
Richard Douglas CB Associate non-executive director	1 March 2018	23 months	None	None	

Non-executive director remuneration (including salary entitlements)

Salaries and allowances 2017/18 (subjected to audit)

Name of non-executive director	2017/18					
	A: Salary (bands of £5,000	**B: Benefits in kind (taxable)** Rounded to nearest £100	**C: Performance pay and bonuses** (bands of £5,000)	**D: Long term performance pay and bonuses** (bands of £5,000)	**E: All pension-related benefits[63]** (bands of £2,500)	**F: TOTAL (A to E)** (bands of £5,000)
	£000	**£s**	**£000**	**£000**	**£000**	**£000**
Professor Sir Malcolm Grant Chair[64]	55-60 (pro-rata)	0	0	0	n/a	55-60 (pro-rata)
David Roberts Vice-Chair[65]	0	0	0	0	n/a	0
Lord Victor Adebowale CBE	5-10	0	0	0	n/a	5-10
Wendy Becker[66]	0	0	0	0	n/a	0
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[67]	5-10	0	0	0	n/a	5-10
Joanne Shaw[68]	25-30	0	0	0	n/a	25-30
Richard Douglas From 1 March 2018[69]	0-5 (pro-rata)	0	0	0	n/a	0-5 (pro-rata)

63 Non-executive directors do not receive pensionable remuneration, and therefore have no pension related benefits.

64 Professor Sir Malcolm Grant chose to take six weeks unpaid leave from 12 February 2018 to 23 March 2018. This period of unpaid leave is included in the pro rata salary disclosed. During the period of unpaid leave an overpayment of £3,188 was paid in error to Professor Sir Malcolm Grant which will be subject to recovery in 2018/19. The overpayment is not included in the total remuneration figures disclosed. The full year equivalent salary is £60,000-£65,000.

65 David Roberts has waived his entitlement to non-executive director remuneration. David Roberts also covered the role of Chair for the six week period of unpaid leave taken by Professor Sir Malcolm Grant, to which he waived his entitlement to remuneration. David Roberts is also an associate (non-voting) non-executive director at NHS Improvement.

66 Wendy Becker waived her enititlement to non-executive director remuneration from the 1 September 2016. In 2016/17 pension deductions were taken in error from Wendy Becker, initially these were planned to be refunded in 2017/18, the actual refund will now be made in 2018/19. The underpayment is not included in the total remuneration figures disclosed.

67 Pension contributions were taken in error from Michelle Mitchell during 2016/17. These were discovered and fully refunded in 2017/18. The underpayment is not included in the remuneration figures disclosed.

68 Joanne Shaw received a gross overpayment of £4,379 during the reporting periods 2016/17 and 2017/18, due to the incorrect payment of a High Cost Allowance. This has been fully recovered in the 2017/18 reporting period. The overpayment is not included in the remuneration figures disclosed.

69 Richard Douglas joined NHS England on 1 March 2018. The full year equivalent salary is £5,000-£10,000. Richard Douglas is also a non-executive director at NHS Improvement.

Salaries and allowances 2016/17

Name of non-executive director	2016/17					
	A: Salary (bands of £5,000)	**B: Benefits in kind (taxable)** Rounded to nearest £100	**C: Performance pay and bonuses** (bands of £5,000)	**D: Long term performance pay and bonuses** (bands of £5,000)	**E: All pension-related benefits[70]** (bands of £2,500)	**F: TOTAL (A to E)** (bands of £5,000)
	£000	**£s**	**£000**	**£000**	**£000**	**£000**
Professor Sir Malcolm Grant Chair	60-65	0	0	0	n/a	60-65
David Roberts Vice-Chair from October 2015[71]	0	0	0	0	n/a	0
Lord Victor Adebowale	5-10	0	0	0	n/a	5-10
Wendy Becker From 1 March 2016[72]	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 From 1 March 2016	5-10	0	0	0	n/a	5-10
Joanne Shaw from 1 October 2016[73]	10-15	0	0	0	n/a	10-15

70 Non-executive directors do not receive pensionable remuneration and therefore have no pension related benefits.
71 David Roberts has waived his entitlement to non-executive director remuneration.
72 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.
73 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 overpayments are included in the total remuneration figures disclosed.

Parliamentary accountability and audit report

All elements of this report are subject 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 of 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[74].

74 www.england.nhs.uk/ccg-details

Losses and special payments

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

Losses

	Parent				Consolidated Group			
	Total number of cases 2017/18 Number	Total value of cases 2017/18 £000	Total number of cases 2016/17 Number	Total value of cases 2016/17 £000	Total number of cases 2017/18 Number	Total value of cases 2017/18 £000	Total number of cases 2016/17 Number	Total value of cases 2016/17 £000
Administrative write-offs	31	358	126	245	314	20,749	341	9,464
Fruitless payments	44	6	38	233	86	15	90	849
Stores losses	-	-	-	-	7	4	-	-
Bookeeping losses	71	5	-	-	71	5	-	-
Constructive loss	-	-	-	-	-	-	-	-
Cash losses	-	-	-	-	8	468	3	1
Claims abandoned	1	34	1	338	2	43	2	339
Total	**147**	**403**	**165**	**816**	**488**	**21,284**	**436**	**10,653**

2017/18 Disclosure: Administrative write offs

Included within Admininstrative write offs in the group is a loss declared by NHS Horsham and Mid Sussex CCG (£7,305k), NHS Crawley CCG (£5,106k), NHS Brighton & Hove CCG (£1,393k) relating to contract payments to providers which have been deemed to be irrecoverable. The value also includes a receivables impairment in Nene CCG (2017/18 £2,658k, 2016/17/nil) for outstanding debt with a local authority.

2017/18 Disclosure: Cash losses

NHS Newham CCG have declared a cash loss of £383k which relates to payments made in financial years 2014/15 to 2016/17 by a third party on behalf of the CCG through a contracting arrangement which is currenlty under investigation. As at 31st March 2018, the investigation was still on-going, and no conclusion has yet been reached as to the recoverability of the amount. There were no such payments made within financial year 2017/18.

2016/17 Disclosure : 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 2016/17 financial year.

Special payments

	Parent				Consolidated Group			
	Total number of cases 2017/18 Number	Total value of cases 2017/18 £000	Total number of cases 2016/17 Number	Total value of cases 2016/17 £000	Total number of cases 2017/18 Number	Total value of cases 2017/18 £000	Total number of cases 2016/17 Number	Total value of cases 2016/17 £000
Compensation payments	5	30	-	-	10	95	10	410
Extra contractual Payments	6,950	3,839	7,330	2,451	6,961	5,373	7,341	2,974
Ex gratia payments	1	5	-	-	11	46	14	228
Special severance payments	-	-	-	-	-	-	1	3
Total	**6,956**	**3,874**	**7,330**	**2,451**	**6,982**	**5,514**	**7,366**	**3,615**

2017/18: Extra contractual payments

Included within extra contractual payments in the parent is a loss for £3 million to meet the expected cost of compensation payments in respect of operational issues with the delivery of Primary Care Support Services. Claims are reviewed on an individual basis and cover items such as claims for interest and charges, claims relating to lost earning as a result of issues with the National Performers List and other payment delays.

In 2016 Guildford and Waverley CCG ran a procurement process for the Surrey Children's Community Health Service on behalf of itself, five other CCGs, NHS England (together the "NHS Commissioners") and Surrey County Council.

The procurement process was challenged and, following legal advice and a mediation process, the parties involved agreed on an out of court settlement and a total payment of £1.560 million has been made in 2017/18 on behalf of all of NHS commissioners. As an organisation NHS England paid £220,000 of the settlement sum.

2016/17: Extra contractual payments

The parent case payments in the prior year 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 2016/17 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:

2017/18

		Parent			Consolidated Group		
	Note	Income £000	Full cost £000	Surplus (deficit) £000	Income £000	Full cost £000	Surplus (deficit) £000
Dental	2 & 4	807,333	(2,944,521)	(2,137,188)	807,333	(2,944,521)	(2,137,188)
Prescription	2 & 4	567,594	(1,942,072)	(1,374,478)	575,963	(10,467,886)	(9,891,923)
Total fees & charges		**1,374,927**	**(4,886,593)**	**(3,511,666)**	**1,383,296**	**(13,412,407)**	**(12,029,111)**

2016/17

		Parent			Consolidated Group		
	Note	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)**

The fees and charges information in this note is provided for fees and charges purposes as per the FReM and not for IFRS8 purposes. The financial objective of prescription and dental charges is to collect charges only from those patients that are eligible to pay.

Prescription charges[75] are a contribution to the cost of pharmaceutical services including the supply of drugs. In 2017/18, the NHS prescription charge for each medicine or appliance dispensed was £8.60. However, around 90% of prescriptions items[76] are dispensed free each year where patients are 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.

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 2017/18, the charge for Band 1 treatments was £20.60, for Band 2 was £56.30 and for Band 3 was £244.30.

75 https://www.gov.uk/government/speeches/nhs-prescription-charges-from-april-2017
76 https://files.digital.nhs.uk/publication/s/o/pres-disp-com-eng-2006-16-rep.pdf

Certificate and Report of the Comptroller and Auditor General to the House of Commons

Opinion on financial statements

I certify that I have audited the financial statements of the NHS Commissioning Board for the year ended 31 March 2018 under the Health and Social Care Act 2012. The financial statements comprise: the Group and Parent Statements of Comprehensive Net Expenditure, Financial Position, Cash Flows, Changes in Taxpayers' Equity and the related notes.

These financial statements have been prepared under the accounting policies set out within them. I have undertaken an audit of the information in the Remuneration and Staff Report and the Parliamentary Accountability and Audit Report, which is described in those reports as having been audited.
In my opinion:

- the financial statements give a true and fair view of the state of the group's and of NHS Commissioning Board's affairs as at 31 March 2018 and of the group's and the parent's net operating costs for the year then ended; and
- the financial statements have been properly prepared in accordance with the Health and Social Care Act 2012 and Secretary of State directions issued thereunder.

Opinion on regularity

In my opinion, in all material respects the income and expenditure 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.

Basis of opinions

I conducted my audit in accordance with International Standards on Auditing (ISAs) (UK) and Practice Note 10 'Audit of Financial Statements of Public Sector Entities in the United Kingdom'. My responsibilities under those standards are further described in the Auditor's responsibilities for the audit of the financial statements section of my certificate. Those standards require me and my staff to comply with the Financial Reporting Council's Revised Ethical Standard 2016. I am independent of the NHS Commissioning Board in accordance with the ethical requirements that are relevant to my audit and the financial statements in the UK. My staff and I have fulfilled our other ethical responsibilities in accordance with these requirements. I believe that the audit evidence I have obtained is sufficient and appropriate to provide a basis for my opinion.

Responsibilities of the Board and the Accounting Officer for the financial statements

As explained more fully in the Statement of Accounting Officer's Responsibilities, the Board and the Accounting Officer are responsible for the preparation of the financial statements and for being satisfied that they give a true and fair view.

Auditor's responsibilities for the audit of the financial statements

My responsibility is to audit, certify and report on the financial statements in accordance with the Health and Social Care Act 2012.

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. Reasonable assurance is a high level of assurance, but is not a guarantee that an audit conducted in accordance with ISAs will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in the aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of these financial statements.

As part of an audit in accordance with ISAs, I exercise professional judgment and maintain professional scepticism throughout the audit. I also:

- identify and assess the risks of material misstatement of the financial statements, whether due to fraud or error, design and perform audit procedures responsive to those risks, and obtain audit evidence that is sufficient and appropriate to provide a basis for my opinion. The risk of not detecting a material misstatement resulting from fraud is higher than for one resulting from error, as fraud may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal control
- obtain an understanding of internal control relevant to the audit in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the group's and the NHS Commissioning Board's internal control
- evaluate the appropriateness of accounting policies used and the reasonableness of accounting estimates and related disclosures made by management
- conclude on the appropriateness of management's use of the going concern basis of accounting and, based on the audit evidence obtained, whether a material uncertainty exists related to events or conditions that may cast significant doubt on the group's and the NHS Commissioning Board's ability to continue as a going concern. If I conclude that a material uncertainty exists, I am required to draw attention in my auditor's report to the related disclosures in the financial statements or, if such disclosures are inadequate, to modify my opinion. My conclusions are based on the audit evidence obtained up to the date of my auditor's report. However, future events or conditions may cause the entity to cease to continue as a going concern
- evaluate the overall presentation, structure and content of the financial statements, including the disclosures, and whether the consolidated financial statements represent the underlying transactions and events in a manner that achieves fair presentation

- obtain sufficient appropriate audit evidence regarding the financial information of the entities or business activities within the Group to express an opinion on the consolidated financial statements. I am responsible for the direction, supervision and performance of the group audit. I remain solely responsible for my audit opinion.

I communicate with those charged with governance regarding, among other matters, the planned scope and timing of the audit and significant audit findings, including any significant deficiencies in internal control that I identify during my audit.

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

Other information

The Board and the Accounting Officer are responsible for the other information. The other information comprises information included in the annual report, other than the parts of the Accountability Report described in that report as having been audited, the financial statements and my auditor's report thereon. My opinion on the financial statements does not cover the other information and I do not express any form of assurance conclusion thereon. In connection with my audit of the financial statements, my responsibility is to read the other information and, in doing so, consider whether the other information is materially inconsistent with the financial statements or my knowledge obtained in the audit or otherwise appears to be materially misstated. If, based on the work I have performed, I conclude that there is a material misstatement of this other information I am required to report that fact. I have nothing to report in this regard.

Opinion on other matters

In my opinion:

- the parts of the Remuneration and Staff Report and the Parliamentary Accountability and Audit Report to be audited have been properly prepared in accordance with Secretary of State directions made under the Health and Social Care Act 2012
- in the light of the knowledge and understanding of the group and the parent and its environment obtained in the course of the audit, I have not identified any material misstatements in the Performance Report or the Accountability Report
- the information given in 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; or
- the financial statements and the parts 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; or
- I have not received all of the information and explanations I require for my audit; or
- the Governance Statement does not reflect compliance with HM Treasury's guidance.

Report

I have no observations to make on these financial statements.

Sir Amyas C E Morse
Comptroller and Auditor General

12 July 2018

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

Annual Accounts

Simon Stevens
Accounting Officer
3 July 2018

Statement of comprehensive net expenditure for the year ended 31 March 2018

	Note	Parent		Consolidated Group	
		2017/18	2016/17	2017/18	2016/17
		£000	£000	£000	£000
Income from sale of goods and services	2	(574,629)	(650,390)	(503,965)	(565,444)
Other operating income	2	(1,464,115)	(1,534,046)	(1,679,310)	(1,677,010)
Total operating income		**(2,038,744)**	**(2,184,436)**	**(2,183,275)**	**(2,242,454)**
Staff costs	3	729,648	720,782	1,843,109	1,781,450
Purchase of goods and services	4	109,170,258	106,122,171	108,641,524	104,988,385
Depreciation and impairment charges	4	90,184	75,719	103,315	89,508
Provision expense	4	(3,240)	(205,479)	49,562	(171,937)
Other operating expenditure	4	200,419	112,964	309,271	222,556
Total operating expenditure		**110,187,269**	**106,826,157**	**110,946,781**	**106,909,962**
Net operating expenditure		**108,148,525**	**104,641,721**	**108,763,506**	**104,667,508**
Finance expense	11	(1,089)	(8,218)	(1,263)	(8,030)
Net expenditure for the year		**108,147,436**	**104,633,503**	**108,762,243**	**104,659,478**
Other (gains)/losses		-	-	143	(10)
Net (gain)/loss on Transfer by Absorption[1]		-	4,003	-	-
Total net expenditure for the year		**108,147,436**	**104,637,506**	**108,762,386**	**104,659,468**
Other comprehensive net expenditure					
Items which will not be reclassified to net operating costs					
Net (gain) on revaluation of Intangibles	7	-	-	-	(540)
Actuarial (gain)/loss in pension schemes		-	-	(850)	1,024
Sub total		-	-	(850)	484
Comprehensive net expenditure for the year		**108,147,436**	**104,637,506**	**108,761,536**	**104,659,952**

The notes on pages 119 to 158 form part of this statement.

1 The net gain on absorption is eliminated on consolidation as the transfer of functions was between NHS England, the parent, and a CCG on 1 April 2016.

Statement of financial position as at 31 March 2018

	Note	Parent		Consolidated Group	
		31 March 2018	31 March 2017	31 March 2018	31 March 2017
		£000	£000	£000	£000
Non-current assets					
Property, plant and equipment	6	350,557	275,434	390,371	319,338
Intangible assets	7	4,857	7,486	11,256	12,714
Trade and other receivables	8	-	-	443	291
Other financial assets	8	-	-	554	540
Total non-current assets		**355,414**	**282,920**	**402,624**	**332,883**
Current assets					
Inventories		28,102	10,594	36,911	17,348
Trade and other receivables	8	243,143	237,914	1,008,482	962,052
Cash and cash equivalents	9	144,765	263,885	165,745	284,835
Total current assets		**416,010**	**512,393**	**1,211,138**	**1,264,235**
Total assets		**771,424**	**795,313**	**1,613,762**	**1,597,118**
Current liabilities					
Trade and other payables	10	(3,850,294)	(3,239,950)	(9,381,168)	(8,142,409)
Provisions	12	(71,857)	(81,869)	(177,931)	(159,750)
Total current liabilities		**(3,922,151)**	**(3,321,819)**	**(9,559,099)**	**(8,302,159)**
Total assets less current liabilities		**(3,150,727)**	**(2,526,506)**	**(7,945,337)**	**(6,705,041)**
Non-current liabilities					
Trade and other payables	10	(26)	-	(3,285)	(4,927)
Provisions	12	(11,151)	(11,049)	(26,221)	(26,440)
Total current liabilities		**(11,177)**	**(11,049)**	**(29,506)**	**(31,367)**
Total assets less current liabilities		**(3,161,904)**	**(2,537,555)**	**(7,974,843)**	**(6,736,408)**
Financed by taxpayers' equity and other reserves					
General fund		(3,161,904)	(2,537,555)	(7,970,187)	(6,730,907)
Revaluation reserve		-	-	37	42
Other reserves		-	-	(4,693)	(5,543)
Total taxpayers' equity		**(3,161,904)**	**(2,537,555)**	**(7,974,843)**	**(6,736,408)**

The notes on pages 119 to 158 form part of this statement.

The financial statements on pages 114 to 118 were approved by the Board on 3 July 2018 and signed on its behalf by: Simon Stevens, Accounting Officer.

Statement of changes In taxpayers equity for the year ended 31 March 2018

Parent	General fund £000	Revaluation reserve £000	Other reserves £000	Taxpayers equity £000
Changes in taxpayers' equity for 2017/18				
Balance at 1 April 2017	**(2,537,555)**	**-**	**-**	**(2,537,555)**
Changes in taxpayers' equity for 2017/18				
Total Net Expenditure for the financial year	(108,147,436)	-	-	(108,147,436)
Transfers between reserves	-	-	-	-
Comprehensive net expenditure for the year	**(108,147,436)**	**-**	**-**	**(108,147,436)**
Grant in Aid	107,523,087	-	-	107,523,087
Balance at 31 March 2018	**(3,161,904)**	**-**	**-**	**(3,161,904)**

Parent	General fund £000	Revaluation reserve £000	Other reserves £000	Taxpayers equity £000
Changes in taxpayers' equity for 2016/17				
Balance at 1 April 2016	**(2,184,523)**	**24**	**-**	**(2,184,499)**
Changes in taxpayers' equity for 2016/17				
Total Net Expenditure for the financial year	(104,637,506)	-	-	(104,637,506)
Transfers between reserves	24	(24)	-	-
Comprehensive net expenditure for the year	**(104,637,482)**	**(24)**	**-**	**(104,637,506)**
Grant in Aid	104,284,450	-	-	104,284,450
Balance at 31 March 2017	**(2,537,555)**	**-**	**-**	**(2,537,555)**

Consolidated Group	General fund £000	Revaluation reserve £000	Other reserves £000	Taxpayers equity £000
Changes in taxpayers' equity for 2017/18				
Balance at 1 April 2017	**(6,730,907)**	**42**	**(5,543)**	**(6,736,408)**
Changes in taxpayers' equity for 2017/18				
Total Net Expenditure for the financial year	(108,762,386)	-	-	(108,762,386)
Net gain/(loss) on revaluation of intangible assets	-	-	-	-
Total revaluations against revaluation reserve	**-**	**-**	**-**	**-**
Movements in other reserves	-	-	850	850
Transfers between reserves	5	(5)	-	-
Release of reserves to the Statement of Comprehensive Net Expenditure	14	-	-	14
Comprehensive net expenditure for the year	**(108,762,367)**	**(5)**	**850**	**(108,761,522)**
Grant in Aid	107,523,087	-	-	107,523,087
Balance at 31 March 2018	**(7,970,187)**	**37**	**(4,693)**	**(7,974,843)**

Consolidated Group	General fund £000	Revaluation reserve £000	Other reserves £000	Taxpayers equity £000
Changes in taxpayers' equity for 2016/17				
Balance at 1 April 2016	**(6,356,524)**	**137**	**(4,519)**	**(6,360,906)**
Changes in taxpayers' equity for 2016/17				
Total Net Expenditure for the financial year	(104,659,468)	-	-	(104,659,468)
Net gain/(loss) on revaluation of intangible assets	-	540	-	540
Total revaluations against revaluation reserve	**-**	**540**	**-**	**540**
Movements in other reserves	-	-	(1,024)	(1,024)
Transfers between reserves	635	(635)	-	-
Release of reserves to the Statement of Comprehensive Net Expenditure	-	-	-	-
Comprehensive net expenditure for the year	**(104,658,833)**	**(95)**	**(1,024)**	**(104,659,952)**
Grant in Aid	104,284,450	-	-	104,284,450
Balance at 31 March 2017	**(6,730,907)**	**42**	**(5,543)**	**(6,736,408)**

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

The notes on pages 119 to 158 form part of this statement.

Statement of cash flows for the year ended 31 March 2018

	Note	Parent		Consolidated Group	
		2017/18	2016/17	2017/18	2016/17
		£000	£000	£000	£000
Cash flows from operating activities					
Net expenditure for the financial year		(108,147,436)	(104,633,503)	(108,762,243)	(104,659,478)
Depreciation and amortisation	4	90,184	75,719	103,293	87,948
Impairments and reversals	4	-	-	22	1,560
Other non cash adjustments[2]		-	-	(173)	81
Movement due to transfers by absorption		-	(320)	-	-
Unwinding of discount	11	(1,089)	(8,605)	(1,306)	(8,501)
Change in discount rate	12	(227)	342	(291)	255
(Increase)/decrease in inventories		(17,508)	(10,444)	(19,563)	(12,111)
(Increase)/decrease in trade & other receivables	8	(5,229)	32,097	(46,582)	(109,039)
Increase/(decrease) in trade & other payables	10	550,937	729,359	1,213,633	877,480
Provisions utilised	12	(5,581)	(104,761)	(30,294)	(127,475)
Increase/(decrease) in provisions	12	(3,013)	(205,821)	49,853	(172,192)
Net cash outflow from operating activities		**(107,538,962)**	**(104,125,937)**	**(107,493,651)**	**(104,121,472)**
Cash flows from investing activities					
Payments for property, plant and equipment		(101,031)	(144,322)	(131,634)	(160,865)
Payments for intangible assets		(2,214)	(1,523)	(4,242)	(2,030)
Proceeds from disposal of assets: property, plant and equipment		-	-	1,265	168
Proceeds from disposal of assets: intangible assets		-	-	-	540
Net cash outflow from investing activities		**(103,245)**	**(145,845)**	**(134,611)**	**(162,187)**
Net cash outflow before financing activities		**(107,642,207)**	**(104,271,782)**	**(107,628,262)**	**(104,283,659)**
Cash flows from financing activities					
Grant in aid funding received		107,523,087	104,284,450	107,523,087	104,284,450
Capital element of payments in respect of finance leases		-	(10,523)	(85)	(10,606)
Net cash inflow from financing activities		**107,523,087**	**104,273,927**	**107,523,002**	**104,273,844**
Net increase/(decrease) in cash & cash equivalents		**(119,120)**	**2,145**	**(105,260)**	**(9,815)**
Cash & Cash Equivalents at the Beginning of the Financial Period	9	263,885	261,740	268,356	278,171
Cash & cash equivalents at the end of the Financial Year	9	**144,765**	**263,885**	**163,096**	**268,356**

The notes on pages 119 to 158 form part of this statement.

2 Other non cash adjustments comprise a non cash charge to reflect a discount on future lease charges of £5k (2016/17 £25k) and a pension credit of £178k (2016/17 charge of £56k).

Notes to the financial statements

1. Statement of accounting policies

These financial statements have been prepared in a form directed by the Secretary of State under Schedule 1(A), paragraph 15(2) of the Health and Social Care Act 2012 and in accordance with the 2017/18 DHSC Group Accounting Manual (DHSC GAM) issued by the Department of Health & Social Care and comply with HM Treasury's Financial Reporting Manual 2017/18 (FReM). The accounting policies contained in the DHSC GAM apply International Financial Reporting Standards (IFRS) as adapted or interpreted for the public sector context. Where the DHSC GAM permits a choice of accounting policy, the accounting policy which is judged to be most appropriate to the particular circumstances of NHS England for the purpose of giving a true and fair view has been selected. The particular policies adopted by NHS England are described below. They have been applied consistently in dealing with items considered material to the accounts.

The functional and presentational currency is pounds sterling and figures are expressed in pounds thousands unless expressly stated. Two sets of figures are presented - the first relating to NHS England itself (the Parent) and a second set of consolidated figures (Consolidated Group). The entities making up the Consolidated Group are declared in Note 20.

1.1 Operating segments

Income and expenditure are analysed in the Operating Segments note (note 16) and reflect the management information used within NHS England. Information on assets less liabilities is not separately reported to the Chief Operating Decision Maker and therefore in accordance with IFRS 8 does not form part of the disclosure in note 16.

1.2 Accounting convention

These accounts have been prepared under the historical cost convention, modified to account for the revaluation to fair value of property, plant and equipment, intangible assets, and certain financial assets and financial liabilities.

1.3 Basis of consolidation

These accounts comprise the results of the NHS England statutory entity as well as the consolidated position of NHS England and its 207 related CCGs. Transactions between entities included in the consolidation are eliminated.

CSUs form part of NHS England and provide services to CCGs. The CSU results are included within the Parent accounts as they are not separate legal entities.

1.4 Comparative information

The comparative information provided in these financial statements is for the year ended 31 March 2017.

1.5 Going concern

NHS England's financial statements are produced on a going concern basis. NHS England is supply-financed and draws its funding from the Department of Health & Social Care. Parliament has demonstrated its commitment to fund the Department of Health & Social Care for the foreseeable future via the latest Spending Review and the passing of the Health and Social Care Act 2012. In the same way, the Department of Health & Social Care has demonstrated commitment to the funding of NHS England (with funding flows for the 2018/19 financial year having already commenced). It is therefore considered appropriate to adopt the going concern basis for the preparation of these financial statements.

1.6 Transfer of functions

As public sector bodies within a Departmental Boundary are deemed to operate under common control, business reconfigurations are outside the scope of IFRS 3 Business Combinations. When functions transfer between two public sector bodies (except for transfers between government departments) the FReM requires the application of "absorption accounting". Absorption accounting requires that entities account for their transactions in the period in which those transactions took place. Where assets and liabilities transfer, the gain or loss resulting is recognised in the Statement of Net Comprehensive Expenditure, and is disclosed separately from operating costs.

1.7 Revenue recognition

The main source of funding for NHS England is grant-in-aid from the Department of Health & Social Care. NHS England is required to maintain expenditure within this allocation. The Department of Health & Social Care also approves a cash limit for the period. NHS England is required to draw down cash in accordance with this limit. Grant-in-aid is drawn down and credited to the general fund. Grant-in-aid is recognised in the financial period in which it is received.

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

1.8 Employee benefits

Recognition of short-term benefits - retirement benefit costs:

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

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

The scheme is subject to a full actuarial valuation every four years and an accounting valuation every year.

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

1.9 Value Added Tax (VAT)

Most of the activities of the group are outside the scope of value added tax (VAT). Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of non-current assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

1.10 Property, plant and equipment recognition

Property, plant and equipment is capitalised if:

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

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

Valuation of property, plant and equipment

All property, plant and equipment is measured initially at cost, representing the cost directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management. All assets are measured subsequently at depreciated historical cost as a proxy for fair value, with no material differences.

IT equipment, transport equipment, furniture and fittings, and plant and machinery that are held for operational use are valued at depreciated historical cost as a proxy for fair value. This is in accordance with FReM requirements as these assets have short useful lives or low values or both.

Balances held in the Revaluation reserve relate to balances inherited as at 1st April 2013. In line with our accounting policy, no further revaluation gains have been recognised.

Subsequent expenditure

Where subsequent expenditure enhances an asset beyond its original specification, the directly attributable cost is capitalised. Where subsequent expenditure restores the asset to its original specification, the expenditure is capitalised and any existing carrying value of the item replaced is charged to operating expenses.

1.11 Intangible non-current assets

Intangible non-current assets are non-monetary assets without physical substance that are capable of sale separately from the rest of the group's business or arise from contractual or other legal rights. They are recognised only when it is probable that future economic benefits will flow to, or service potential be provided to, the group; where the cost of the asset can be measured reliably; and where the cost is at least £5,000.

Intangible non-current assets acquired separately are initially recognised at cost. Software that is integral to the operation of hardware is capitalised as part of the relevant item of property, plant and equipment. Software that is not integral to the operation of hardware is capitalised as an intangible asset.

Following initial recognition, intangible assets are carried at depreciated historic cost as a proxy for fair value.

1.12 Research and development

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

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

- the technical feasibility of completing the intangible asset so that it will be available for use;
- the intention to complete the intangible asset and use it;
- the ability to sell or use the intangible asset;
- how the intangible asset will generate probable future economic benefits or service potential;
- the availability of adequate technical, financial and other resources to complete the intangible asset and sell or use it;
- the ability to reliably measure the expenditure attributable to the intangible asset during its development.

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

1.13 Depreciation, amortisation and impairments

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

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

Depreciation/amortisation is charged as follows:

	Minimum life (years)	Maximum life (years)
Buildings excluding dwellings	5	20
Plant and machinery	5	10
Transport equipment	5	10
Information technology	2	10
Furniture and fittings	5	10
Computer software: purchased	2	5
Licences and trademarks	2	5
Development expenditure (internally generated)	2	5

A revaluation decrease that does not result from a loss of economic value or service potential is recognised as an impairment charged to the revaluation reserve to the extent that there is a balance on the reserve for the asset being impaired and, thereafter, to expenditure. Impairment losses that arise from a clear consumption of economic benefit are taken to expenditure. Where an impairment loss subsequently reverses, the carrying amount of the asset is increased to the revised estimate of the recoverable amount but capped at the amount that would have been determined had there been no initial impairment loss. The reversal of the impairment loss is credited to expenditure to the extent of the decrease previously charged there and thereafter to the revaluation reserve.

1.14 Leases

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

Property, plant and equipment held under finance leases are initially recognised at the inception of the lease at fair value or, if lower, at the present value of the minimum lease payments, with a matching liability for the lease obligation to the lessor. Lease payments are apportioned

between finance charges and reduction of the lease obligation to achieve a constant rate of interest on the remaining balance of the liability. Finance charges are recognised in the statement of comprehensive net expenditure.

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

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

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

1.15 Inventories

Inventories are valued at the lower of cost and net realisable value, and are utilised using the First in First Out method of inventory controls.

1.16 Cash and cash equivalents

Cash is cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours. Cash equivalents are investments that mature in three months or less from the date of acquisition and are readily convertible to known amounts of cash with insignificant risk of change in value.

In the statement of cash flows, cash and cash equivalents are shown net of bank overdrafts that are repayable on demand and that form an integral part of cash management. Cash, bank and overdraft balances are recorded at current values.

1.17 Provisions

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

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

- A short term rate of minus 2.42 percent (2016/17: minus 2.70 percent) is applied to expected cash flows in a time boundary of between 0 and up to and including five years from the statement of financial position date
- A medium term rate of minus 1.85 percent (2016/17: minus 1.95 percent) is applied to the time boundary of after five and up to and including 10 years
- A long-term rate of minus 1.56 percent (2016/17: minus 0.80 percent) is applied to expected cashflows exceeding 10 years

All percentages are in real terms.

1.18 Clinical negligence costs

The NHS Resolution operates a risk pooling scheme under which NHS England and CCGs pay an annual contribution to the NHS Resolution, which in turn settles all clinical negligence claims. The contribution is charged to expenditure. Although the NHS Resolution is administratively responsible for all clinical negligence cases, the legal liability rests with the group.

1.19 Non-clinical risk pooling

NHS England participates in the Property Expenses Scheme and the Liabilities to Third Parties scheme. Both are risk pooling schemes under which the CCG pays an annual contribution to the NHS Resolution and, in return, receives assistance with the cost of claims arising. The annual membership contributions, and any excesses payable in respect of particular claims, are charged to operating expenses when they become due.

1.20 Continuing healthcare risk pooling

In 2014/15 a risk pool scheme was introduced by NHS England for continuing healthcare claims, for claim periods prior to 31 March 2013. Under the scheme CCGs contributed annually to a pooled fund until 31 March 2017, which is used to settle the claims. The contribution of CCGs are charged to operating income in year in the NHS England parent account.

1.21 Contingent liabilities and contingent assets

A contingent liability is:

- A possible obligation that arises from past events and whose existence will be confirmed only by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the organisation.
- A present obligation that is not recognised because it is not probable that a payment will be required to settle the obligation or the amount of the obligation cannot be measured sufficiently reliably.

A contingent liability is disclosed unless the possibility of a payment is remote.

A contingent asset is a possible asset that arises from past events and whose existence will be confirmed by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the organisation. A contingent asset is disclosed where an inflow of economic benefits is probable.

Where the time value of money is material, contingent liabilities that are required to be disclosed under IAS37 are stated at discounted amounts.

1.22 Financial assets

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

As available for sale financial assets, the group's investments are measured at fair value. With the exception of impairment losses, changes in value are taken to the revaluation reserve. Accumulated gains or losses are recycled to the consolidated statement of net comprehensive expenditure on de-recognition.

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

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

1.23 Financial liabilities

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

Financial liabilities are initially recognised at fair value.

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

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

The FReM does not require the following Standards and Interpretations to be applied in 2017/18, these are applicable for accounting periods starting on or after 1st January 2018.

- IFRS 9 Financial Instruments (application from 1 January 2018).
- IFRS 14 Regulatory Deferral Accounts (not applicable to Department of Health & Social Care group bodies).
- IFRS 15 Revenue for Contract with Customers (application from 1 January 2018).
- IFRS 16 Leases (application from 1 January 2019).
- IFRS 17 Insurance contracts (application from 1 January 2021).

IFRS 9 - Financial Instruments

IFRS 9 is due to be implemented from 1 April 2018 and we have performed a preliminary assessment of the impact as follows:

Classification

An assessment of the material financial assets of the parent and the group has shown that the majority of items are simple debt instruments held in order to collect contractual cash flows. Under IAS39 these are classified at amortised costs and no material change is expected under IFRS 9.

An assessment of the material financial liabilities of the parent and the group has shown that the majority of items are trade payables and accruals, that are currently at amortised cost and no material change is expected under IFRS 9.

Impairment

IFRS 9 requires the recognition of impairments on a forward looking expected credit loss model. HMT has interpreted the provisions in the standard for calculating the expected credit loss to mandate the use of the simplified approach. This means that the loss allowance at initial recognition will be the equal to the lifetime expected credit loss. In addition DHSC provides a guarantee of last resort against debts of DHSC group bodies and therefore the NHS England parent and group bodies must not recognise lifetime expected credit losses against other DHSC group bodies, in line with the HMT adaptation.

An assessment of the non NHS financial assets has not indicated that there would be a material movement in the value of the impairment of receivables.

Transition

NHS England parent and CCGs must recognise any differences between the carrying amounts at the end of the 2017/18 financial year compared to the carrying amount at 1 April 2018 in the opening retained earnings under the HMT interpretation specified in the Government Financial Reporting Manual. The review of the carrying values has indicated there will be no material change due to the implementation of IFRS 9.

IFRS 15 - Revenue for contract with customers

IFRS 15 is due to be implemented from 1 April 2018 and we have performed a preliminary assessment of the impact as follows:

Income recognition

In the parent entity the material elements of revenue are Prescription fees & charges, and Dental fees & charges. HMT have expanded the definition of a contract to include legislation or regulations that allow an entity to impose a charge on the customer. These two sources of revenue are therefore subject to IFRS 15. Our expectation is that there will be no change in the timing of the recognition of this income.

CCGs do not have significant external income sources. The majority of their income relates to recognition of revenue from continuing healthcare contracts and our expectation is that revenue can continue to be recognised over time and therefore there is no material impact from the implementation of IFRS 15.

Transition

The impact of implementation has been assessed to be immaterial but any changes will be recognised through reserves as the option to restate under IAS 8 has been withdrawn.

IFRS 16 Leases

The impact of IFRS 16 cannot be reasonably estimated at this time because it will be dependent on the leases that the Group holds at the time of implementation. The new standard will require the Group to assess its accounting processes and internal controls relating to the reporting of leases and this will not be complete until application guidance is issued by HMT.

Other accounting standards issued but not yet adopted

Full assessments of the impact of the remaining standards issued but not yet adopted will be completed by NHS England in due course following any relevant guidance issued in the Government Financial Reporting Manual.

2. Operating revenue

	Parent		Consolidated Group	
	2017/18	2016/17	2017/18	2016/17
	Total £000	Total £000	Total £000	Total £000
Income from sale of goods and services				
Education, training and research	165,237	187,119	177,657	202,158
Non-patient care services to other bodies[3]	409,392	463,271	326,041	362,849
Rental revenue from operating leases	-	-	267	437
Total Income from sale of goods and services	**574,629**	**650,390**	**503,965**	**565,444**
Other operating income				
Recoveries in respect of employee benefits	162	8	6,875	5,084
Prescription fees and charges	567,594	547,961	575,963	554,935
Dental fees and charges	807,333	776,812	807,333	776,812
Charitable and other contributions to revenue expenditure: non-NHS	410	631	2,695	2,889
Continuing Healthcare risk pool contributions[4]	-	100,000	-	-
Non cash apprenticeship training grants revenue	24	-	98	-
Other revenue	88,592	108,634	286,346	337,290
Total other operating income	**1,464,115**	**1,534,046**	**1,679,310**	**1,677,010**
Total operating income	**2,038,744**	**2,184,436**	**2,183,275**	**2,242,454**

3 Parent non-patient care services to other bodies revenue figures are greater than those of the Consolidated Group due to the elimination of intra-group trading.

4 Continuing healthcare risk pool contributions comprise contributions from CCGs to a risk pool scheme for which the related continuing healthcare liabilities are settled by NHS England. This is eliminated on consolidation for the group account. There was no contribution during 2017/18.

3. Employee benefits and staff numbers

3.1 Employee benefits

	Parent		Consolidated Group	
	2017/18	2016/17	2017/18	2016/17
	Total £000	Total £000	Total £000	Total £000
Employee benefits				
Salaries and wages	600,262	601,132	1,519,988	1,490,620
Social security costs	56,297	52,230	141,742	130,152
Employer contributions to NHS Pension scheme	65,203	60,810	164,829	151,676
Other pension costs	-	-	18	-
Apprenticeship Levy	2,686	-	4,153	-
Termination benefits	5,200	6,806	12,379	9,444
Gross employee benefits expenditure	**729,648**	**720,978**	**1,843,109**	**1,781,892**
Less: Employee costs capitalised	-	(196)	-	(442)
Net employee benefits excluding capitalised costs	**729,648**	**720,782**	**1,843,109**	**1,781,450**
Less recoveries in respect of employee benefits	(162)	(8)	(6,875)	(5,083)
Net employee benefits	**729,486**	**720,774**	**1,836,234**	**1,776,367**

Staff numbers can be found in the Accountability report on page 88.

The Apprenticeship levy scheme was introduced from 6 April 2017. This is a tax payable on pay bills above £3 million. For 2017/18 NHS England, CSUs and 125 CCGs are required to contribute to the levy.

3.2 Pension costs

As described in Note 1.8 past and present employees are covered by the provisions of the NHS Pensions Scheme. The scheme is not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities.

Therefore, the scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS Body of participating in the scheme is taken as equal to the contributions payable to the scheme for the accounting period.

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

3.2.1 Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2018, is based on valuation data as 31 March 2017, updated to 31 March 2018 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

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

Full actuarial (funding) valuation

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the schemes (taking into account their recent demographic experience), and to recommend contribution rates payable by employees and employers.

The last published actuarial valuation undertaken for the NHS Pension Scheme was completed for the year ending 31 March 2016.

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

3.2.2 Scheme provisions

The NHS Pension Scheme provided defined benefits, which are summarised below. This list is an illustrative guide only, and is not intended to detail all the benefits provided by the Scheme or the specific conditions that must be met before these benefits can be obtained:

- The Scheme is a "final salary" scheme. Annual pensions are normally based on 1/80th for the 1995 section and of the best of the last three years pensionable pay for each year of service, and 1/60th for the 2008 section of reckonable pay per year of membership. Members who are practitioners as defined by the Scheme Regulations have their annual pensions based upon total pensionable earnings over the relevant pensionable service.
- With effect from 1 April 2008 members can choose to give up some of their annual pension for an additional tax free lump sum, up to a maximum amount permitted under HMRC rules. This new provision is known as "pension commutation".
- Annual increases are applied to pension payments at rates defined by the Pensions (Increase) Act 1971, and are based on changes in retail prices in the twelve months ending 30 September in the previous calendar year. From 2011/12 the Consumer Price Index (CPI) has been used and replaced the Retail Prices Index (RPI).
- Early payment of a pension, with enhancement, is available to members of the scheme who are permanently incapable of fulfilling their duties effectively through illness or infirmity. A death gratuity of twice final year's pensionable pay for death in service, and five times their annual pension for death after retirement is payable.
- For early retirements other than those due to ill health the additional pension liabilities are not funded by the scheme. The full amount of the liability for the additional costs is charged to the employer.
- Members can purchase additional service in the NHS Scheme and contribute to money purchase AVC's run by the Scheme's approved providers or by other Free Standing Additional Voluntary Contributions (FSAVC) providers.

3.2.3 Local Government Pension Scheme

Within the group there are CCGs who account for defined benefit pension scheme assets and liabilities primarily in respect of local government super annuation schemes. These schemes are immaterial to the group financial statements and therefore have not been disclosed separately. Full disclosures are available in the underlying CCGs published accounts.

3.2.4 Principal Civil Service Pension Scheme

Past and present employees are covered by the provisions of the Principal Civil Service Pension Scheme (PCSPS) and the Civil Servant and Other Pension Scheme (CSOPS). These schemes are unfunded, defined benefit schemes covering civil servants. The schemes are not designed in a way that would enable employers to identify their share of the underlying scheme assets and liabilities. Therefore, the schemes are accounted for as though they were defined contribution schemes: the cost to NHS England of participating in a scheme is taken as equal to the contributions payable to the scheme for the accounting period.

For defined contribution schemes, such as Civil Service partnership pensions, NHS England recognises the contributions payable for the year.

NHS England recognises the full cost of benefits paid under the Civil Service Compensation Scheme, including the early payment of pensions.

4. Operating expenses

	Parent		Consolidated Group	
	2017/18	2016/17	2017/18	2016/17
	Total £000	Total £000	Total £000	Total £000
Other costs				
Services from CCGs	19,475	21,970	-	-
Services from Foundation Trusts	11,859,158	11,170,819	44,044,652	42,196,636
Services from other NHS Trusts	5,651,306	5,132,890	24,684,323	23,785,519
Sustainability and Transformation Fund[5]	1,800,000	1,800,000	1,800,000	1,800,000
Services from Other WGA bodies[6]	6,718	9,231	55,477	44,872
Purchase of healthcare from non-NHS bodies	1,226,871	1,201,276	13,095,600	12,637,063
Purchase of social care	-	678	599,274	388,461
General dental services and personal dental services	2,944,521	2,909,509	2,944,521	2,909,509
Prescribing costs	46,541	14,794	8,560,895	8,534,616
Pharmaceutical services	1,895,531	1,982,372	1,906,991	1,992,230
General ophthalmic services	547,518	545,981	556,015	554,399
Primary care services[7]	1,654,779	3,771,509	8,274,354	7,971,342
Supplies and services – clinical	57,150	33,418	131,245	110,059
Supplies and services – general	356,249	503,973	820,880	959,624
Chair and lay membership body and governing body members	130	141	53,201	52,454
Consultancy services	26,611	18,353	85,476	101,264
Establishment	172,747	161,978	368,988	316,281
Transport	10,974	9,891	44,826	33,318
Premises	96,225	71,493	392,345	371,719
Audit fees	300	315	10,402	13,599
Other non-statutory audit expenditure[8]	-	-	1,927	1,865
Other professional fees excl. services provided by external audit	26,799	27,670	65,212	64,543
Legal fees	19,030	22,882	47,187	61,221
Grants to other public bodies	63,629	76,007	85,347	106,760
Clinical negligence	-	-	189	338
Research and development (excluding staff costs)	238	549	11,856	12,937
Education and training	120,308	112,153	150,834	140,245
Funding to group bodies[9]	80,631,423	76,599,016	-	-
Other expenditure	42,124	35,884	42,356	41,726
Total operating expenses - cash	**109,276,355**	**106,234,752**	**108,834,373**	**105,202,600**
Operating expenditure - non cash				
Impairments and reversals of receivables	-	2	19,774	6,514
Impairments of loan	-	278	-	278
Inventories consumed and written down	94,298	103	96,548	1,549
Depreciation	85,341	70,903	97,308	82,091
Amortisation	4,843	4,816	5,985	5,857
Impairments of property, plant and equipment	-	-	22	1,154
Impairments of intangible assets	-	-	-	406
Change in discount rate	(227)	342	(291)	255
Provisions	(3,013)	(205,821)	49,853	(172,192)
Non cash apprenticeship training grants	24	-	100	-
Total operating expenses - non cash	**181,266**	**(129,377)**	**269,299**	**(74,088)**
Total operating expenses	**109,457,621**	**106,105,375**	**109,103,672**	**105,128,512**

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

The comparatives for purchase of healthcare and other professional fees have been reclassified to reflect the two new categories of operating expenditure - purchase of social care and legal fees.

5 In 2016/17 and 2017/18 NHS England has allocated expenditure through the Sustainability and Transformation Fund for provider sustainability support, in line with 2016/17 and 2017/18 NHS England mandate.
6 Services from other WGA bodies comprises expenditure with DHSC, DHSC Arm's Length Bodies and NHS Blood and Transplant.
7 The reductions in primary care expenditure in 2017/18 in the NHS England parent account are due to the switch in budget from NHS England to those CCGs who have taken delegated commissioning responsibilities. This also results in an increase in Group Funding to those CCGs who have assumed delegated commissioning responsibilities.
8 In both financial years NHS England purchased no Non Audit services from NAO. Details of CCG non audit expenditure can be found in the underlying individual CCG accounts.
9 Funding to group bodies is shown above and represents cash funding drawn down by the CCGs. These balances are eliminated on consolidation.

5. Operating leases

5.1 As lessee

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

Although formal signed leases are not typically in place for these properties, the transactions involved do convey the right of the group to use property assets. The group has considered the substance of these arrangements under IFRIC 4 'Determining whether an arrangement contains a lease' and determined that the arrangements are (or contain) leases. Work is on-going with NHS PS to determine the future minimum lease payments.

Accordingly the payments made in 2017/18 and 2016/17 are disclosed as minimum lease payments in the buildings category in note 5.1.1. However in the absence of formal contracts it is not possible to confirm minimum lease payments for future years and hence no disclosure is made for these buildings in note 5.1.2. It is expected that the payments recognised in 2017/18 would continue to be minimum lease payments in 2018/19.

Within the group a small number CCGs act as a lessor. Details of these arrangements can be found in the underlying CCG accounts.

5.1.1 Payments recognised as an expense

Parent	2017/18			2016/17		
	Buildings £000	Other £000	Total £000	Buildings £000	Other £000	Total £000
Payments recognised as an expense						
Minimum lease payments	78,042	2,087	**80,129**	50,358	1,182	**51,540**
Contingent rents	-	-	**-**	-	-	**-**
Total	**78,042**	**2,087**	**80,129**	**50,358**	**1,182**	**51,540**

Consolidated Group	2017/18			2016/17		
	Buildings £000	Other £000	Total £000	Buildings £000	Other £000	Total £000
Payments recognised as an expense						
Minimum lease payments	322,075	3,969	**326,044**	288,065	3,305	**291,370**
Contingent rents	-	27	**27**	-	36	**36**
Total	**322,075**	**3,996**	**326,071**	**288,065**	**3,341**	**291,406**

5.1.2 Future minimum lease payments

Parent

	2017/18			2016/17		
	Buildings £000	Other £000	Total £000	Buildings £000	Other £000	Total £000
Payable:						
No later than one year	31,303	1,214	**32,517**	17,189	1,086	**18,275**
Between one and five years	59,956	274	**60,230**	32,078	2,206	**34,284**
After five years	4,257	-	**4,257**	327	-	**327**
Total	**95,516**	**1,488**	**97,004**	**49,594**	**3,292**	**52,886**

Consolidated Group

	2017/18			2016/17		
	Buildings £000	Other £000	Total £000	Buildings £000	Other £000	Total £000
Payable:						
No later than one year	66,190	2,154	**68,344**	35,707	2,144	**37,851**
Between one and five years	116,578	943	**117,521**	83,277	3,085	**86,362**
After five years	27,771	2	**27,773**	29,297	15	**29,312**
Total	**210,539**	**3,099**	**213,638**	**148,281**	**5,244**	**153,525**

6. Property, plant and equipment

Parent 2017/18	Buildings excluding dwellings £000	Assets under construction and payments on account £000	Plant & machinery £000	Transport equipment £000	Information technology £000	Furniture & fittings £000	Total £000
Cost or valuation at 1 April 2017	**2,292**	**676**	**1,940**	**32**	**414,408**	**6,902**	**426,250**
Addition of assets under construction and payments on account	-	-	-	-	-	-	**-**
Additions purchased	-	-	501	179	159,077	707	**160,464**
Reclassifications	-	(676)	(162)	-	937	(99)	**-**
Disposals	(1,888)	-	(1,217)	-	(22,556)	-	**(25,661)**
Impairments charged	-	-	-	-	-	-	**-**
Transfer (to)/from other public sector body	-	-	-	-	-	-	**-**
Cost or valuation at 31 March 2018	**404**	**-**	**1,062**	**211**	**551,866**	**7,510**	**561,053**
Depreciation 1 April 2017	**1,889**	**-**	**1,394**	**18**	**145,459**	**2,056**	**150,816**
Reclassifications	-	-	-	-	-	-	**-**
Disposals	(1,888)	-	(1,217)	-	(22,556)	-	**(25,661)**
Charged during the year	37	-	112	5	84,060	1,127	**85,341**
Transfer (to)/from other public sector body	-	-	-	-	-	-	**-**
At 31 March 2018	**38**	**-**	**289**	**23**	**206,963**	**3,183**	**210,496**
Net Book Value at 31 March 2018	**366**	**-**	**773**	**188**	**344,903**	**4,327**	**350,557**
Asset financing:							
Owned	366	-	773	188	344,903	4,327	**350,557**
Total at 31 March 2018	**366**	**-**	**773**	**188**	**344,903**	**4,327**	**350,557**

Parent 2016/17	Buildings excluding dwellings £000	Assets under construction and payments on account £000	Plant & machinery £000	Transport equipment £000	Information technology £000	Furniture & fittings £000	Total £000
Cost or valuation at 1 April 2016	**12,027**	**447**	**4,404**	**32**	**316,324**	**3,579**	**336,813**
Addition of assets under construction and payments on account	-	229	-	-	-	-	**229**
Additions purchased	396	-	190	-	138,485	3,524	**142,595**
Reclassifications	-	-	-	-	1,757	(113)	**1,644**
Disposals	(10,131)	-	(2,654)	-	(31,833)	(73)	**(44,691)**
Transfer (to)/from other public sector body	-	-	-	-	(10,325)	(15)	**(10,340)**
Cost or valuation at 31 March 2017	**2,292**	**676**	**1,940**	**32**	**414,408**	**6,902**	**426,250**
Depreciation 1 April 2016	**10,521**	**-**	**3,645**	**13**	**116,218**	**983**	**131,380**
Reclassifications	-	-	-	-	114	(113)	**1**
Disposals	(10,131)	-	(2,654)	-	(31,833)	(73)	**(44,691)**
Charged during the year	1,499	-	403	5	67,730	1,266	**70,903**
Transfer (to)/from other public sector body	-	-	-	-	(6,770)	(7)	**(6,777)**
At 31 March 2017	**1,889**	**-**	**1,394**	**18**	**145,459**	**2,056**	**150,816**
Net Book Value at 31 March 2017	**403**	**676**	**546**	**14**	**268,949**	**4,846**	**275,434**
Asset financing:							
Owned	403	676	546	14	268,949	4,846	**275,434**
Total at 31 March 2017	**403**	**676**	**546**	**14**	**268,949**	**4,846**	**275,434**

6. Property, plant and equipment

Consolidated Group 2017/18	Buildings excluding dwellings £000	Assets under construction and payments on account £000	Plant & machinery £000	Transport equipment £000	Information technology £000	Furniture & fittings £000	Total £000
Cost or valuation at 1 April 2017	**4,046**	**2,579**	**17,849**	**148**	**470,190**	**16,275**	**511,087**
Addition of assets under construction and payments on account	-	148	-	-	-	-	**148**
Additions purchased	353	-	517	179	167,642	1,217	**169,908**
Reclassifications	57	(1,117)	183	-	(236)	(171)	**(1,284)**
Disposals	(1,889)	(1,298)	(1,326)	-	(24,433)	(165)	**(29,111)**
Impairments charged	-	-	-	-	(22)	-	**(22)**
Cost or valuation at 31 March 2018	**2,567**	**312**	**17,223**	**327**	**613,141**	**17,156**	**650,726**
Depreciation 1 April 2017	**2,084**	**-**	**8,309**	**134**	**175,046**	**6,176**	**191,749**
Reclassifications	1	-	-	-	(951)	-	**(950)**
Disposals	(1,889)	-	(1,302)	-	(24,412)	(149)	**(27,752)**
Impairments charged	-	-	-	-	-	-	**-**
Charged during the year	198	-	1,944	5	92,742	2,419	**97,308**
At 31 March 2018	**394**	**-**	**8,951**	**139**	**242,425**	**8,446**	**260,355**
Net Book Value at 31 March 2018	**2,173**	**312**	**8,272**	**188**	**370,716**	**8,710**	**390,371**
Asset financing:							
Owned	1,783	312	7,421	188	370,716	8,710	**389,130**
Held on finance lease	390	-	851	-	-	-	**1,241**
Total at 31 March 2018	**2,173**	**312**	**8,272**	**188**	**370,716**	**8,710**	**390,371**

Consolidated Group 2016/17	Buildings excluding dwellings £000	Assets under construction and payments on account £000	Plant & machinery £000	Transport equipment £000	Information technology £000	Furniture & fittings £000	Total £000
Cost or valuation at 1 April 2016	**13,441**	**2,475**	**20,626**	**151**	**352,837**	**11,967**	**401,497**
Addition of assets under construction and payments on account	-	837	-	-	-	-	**837**
Additions purchased	736	-	334	-	148,535	4,456	**154,061**
Reclassifications	-	(733)	252	-	2,142	(17)	**1,644**
Disposals	(10,131)	-	(2,920)	(3)	(32,095)	(127)	**(45,276)**
Impairments charged	-	-	(443)	-	(1,229)	(4)	**(1,676)**
Reversal of impairments	-	-	-	-	-	-	**-**
Cost or valuation at 31 March 2017	**4,046**	**2,579**	**17,849**	**148**	**470,190**	**16,275**	**511,087**
Depreciation 1 April 2016	**10,613**	**-**	**9,146**	**104**	**131,560**	**3,874**	**155,297**
Reclassifications	-	-	-	-	114	(113)	**1**
Disposals	(10,131)	-	(2,787)	(3)	(32,095)	(102)	**(45,118)**
Impairments charged	-	-	(338)	-	(184)	-	**(522)**
Charged during the year	1,602	-	2,288	33	75,651	2,517	**82,091**
At 31 March 2017	**2,084**	**-**	**8,309**	**134**	**175,046**	**6,176**	**191,749**
Net Book Value at 31 March 2017	**1,962**	**2,579**	**9,540**	**14**	**295,144**	**10,099**	**319,338**
Asset financing:							
Owned	1,692	2,579	8,604	14	295,144	10,099	**318,132**
Held on finance lease	270	-	936	-	-	-	**1,206**
Total at 31 March 2017	**1,962**	**2,579**	**9,540**	**14**	**295,144**	**10,099**	**319,338**

7. Intangible non-current assets

Parent 2017/18	Computer software: purchased £000	Licences and trademarks £000	Development expenditure (internally generated) £000	Total £000
Cost or valuation at 1 April 2017	**20,672**	**8**	**349**	**21,029**
Additions purchased	590	-	1,624	**2,214**
Reclassifications	-	-	-	**-**
Disposals	(5,796)	-	-	**(5,796)**
Transfer (to)/from other public sector body	-	-	-	**-**
At 31 March 2018	**15,466**	**8**	**1,973**	**17,447**
Amortisation 1 April 2017	**13,186**	**8**	**349**	**13,543**
Reclassifications	-	-	-	**-**
Disposals	(5,796)	-	-	**(5,796)**
Charged during the year	4,818	-	25	**4,843**
Transfer (to) from other public sector body	-	-	-	**-**
At 31 March 2018	**12,208**	**8**	**374**	**12,590**
Net Book Value at 31 March 2018	**3,258**	**-**	**1,599**	**4,857**
Asset financing:				
Owned	3,258	-	1,599	**4,857**
Total at 31 March 2018	**3,258**	**-**	**1,599**	**4,857**

Parent 2016/17	Computer software: purchased £000	Licences and trademarks £000	Development expenditure (internally generated) £000	Total £000
Cost or valuation at 1 April 2016	**20,526**	**8**	**1,893**	**22,427**
Additions purchased	1,523	-	-	**1,523**
Reclassifications	(100)	-	(1,544)	**(1,644)**
Disposals	(520)	-	-	**(520)**
Transfer (to)/from other public sector body	(757)	-	-	**(757)**
At 31 March 2017	**20,672**	**8**	**349**	**21,029**
Amortisation 1 April 2016	**9,208**	**8**	**349**	**9,565**
Reclassifications	(1)	-	-	**(1)**
Disposals	(520)	-	-	**(520)**
Charged during the year	4,816	-	-	**4,816**
Transfer (to)/from other public sector body	(317)	-	-	**(317)**
At 31 March 2017	**13,186**	**8**	**349**	**13,543**
Net Book Value at 31 March 2017	**7,486**	**-**	**-**	**7,486**
Asset financing:				
Owned	7,486	-	-	**7,486**
Total at 31 March 2017	**7,486**	**-**	**-**	**7,486**

Consolidated Group 2017/18

	Computer software: purchased £000	Licences and trademarks £000	Development expenditure (internally generated) £000	Total £000
Cost or valuation at 1 April 2017	**27,143**	**8**	**2,573**	**29,724**
Additions purchased	2,617	-	1,625	**4,242**
Reclassifications	1,273	-	11	**1,284**
Disposals	(5,854)	-	(600)	**(6,454)**
Upward revaluation gains	-	-	-	**-**
Impairments charged	-	-	-	**-**
At 31 March 2018	**25,179**	**8**	**3,609**	**28,796**
Amortisation 1 April 2017	**15,597**	**8**	**1,405**	**17,010**
Reclassifications	950	-	-	**950**
Disposals	(5,805)	-	(600)	**(6,405)**
Charged during the year	5,905	-	80	**5,985**
At 31 March 2018	**16,647**	**8**	**885**	**17,540**
Net Book Value at 31 March 2018	**8,532**	**-**	**2,724**	**11,256**
Asset financing:				
Owned	8,532	-	2,724	**11,256**
Total at 31 March 2018	**8,532**	**-**	**2,724**	**11,256**

Consolidated Group 2016/17

	Computer software: purchased £000	Licences and trademarks £000	Development expenditure (internally generated) £000	Total £000
Cost or valuation at 1 April 2016	**26,168**	**8**	**4,117**	**30,293**
Additions purchased	2,030	-	-	**2,030**
Reclassifications	(100)	-	(1,544)	**(1,644)**
Disposals	(549)	-	(540)	**(1,089)**
Upward revaluation gains	-	-	540	**540**
Impairments charged	(406)	-	-	**(406)**
At 31 March 2017	**27,143**	**8**	**2,573**	**29,724**
Amortisation 1 April 2016	**10,427**	**8**	**1,268**	**11,703**
Reclassifications	(1)	-	-	**(1)**
Disposals	(549)	-	-	**(549)**
Charged during the year	5,720	-	137	**5,857**
At 31 March 2017	**15,597**	**8**	**1,405**	**17,010**
Net Book Value at 31 March 2017	**11,546**	**-**	**1,168**	**12,714**
Asset financing:				
Owned	11,546	-	1,168	**12,714**
Total at 31 March 2017	**11,546**	**-**	**1,168**	**12,714**

8. Trade and other receivables

	Parent				Consolidated Group			
	Current 2017/18 £000	Non-current 2017/18 £000	Current 2016/17 £000	Non-current 2016/17 £000	Current 2017/18 £000	Non-current 2017/18 £000	Current 2016/17 £000	Non-current 2016/17 £000
NHS receivables: revenue	49,853	-	46,492	-	123,989	-	127,601	-
NHS prepayments	10,359	-	6,273	-	219,877	-	213,712	-
NHS accrued income	29,417	-	6,885	-	125,090	-	78,193	-
Non-NHS and other WGA receivables: revenue	62,481	-	75,105	-	225,799	-	247,794	-
Non-NHS and other WGA prepayments	62,283	-	76,340	-	163,777	440	171,803	161
Non-NHS and other WGA accrued income	15,803	-	17,859	-	131,674	-	96,709	130
Provision for the impairment of receivables	(1,279)	-	(997)	-	(29,438)	-	(15,049)	-
VAT	8,564	-	8,990	-	23,350	-	24,670	-
Other receivables and accruals	5,662	-	967	-	24,364	3	16,619	-
Total	**243,143**	**-**	**237,914**	**-**	**1,008,482**	**443**	**962,052**	**291**
Other financial assets	-	-	-	-	-	554	-	540
Total current and non-current	**243,143**		**237,914**		**1,009,479**		**962,883**	

9. Cash and cash equivalents

	Parent		Consolidated Group	
	2017/18	**2016/17**	**2017/18**	**2016/17**
	£000	**£000**	**£000**	**£000**
Balance at 1 April 2017	263,885	261,740	268,356	278,171
Net change in year	(119,120)	2,145	(105,260)	(9,815)
Balance at 31 March 2018	**144,765**	**263,885**	**163,096**	**268,356**
Made up of:				
Cash with the Government Banking Service	58,465	193,173	78,845	213,635
Cash with commercial banks	-	-	26	-
Hosted cash/cash in hand	86,300	70,712	86,874	71,200
Cash and cash equivalents as in statement of financial position	**144,765**	**263,885**	**165,745**	**284,835**
Bank overdraft: Government Banking Service	-	-	(2,649)	(16,479)
Total bank overdrafts	**-**	**-**	**(2,649)**	**(16,479)**
Balance at 31 March 2018	**144,765**	**263,885**	**163,096**	**268,356**

For details of bank overdraft see note 10.

Included within hosted cash/cash in hand above is £86.3 million (2016/17 £70.7 million) held on behalf of NHS England by the NHS Business Services Authority.

10. Trade and other payables

	Parent				Consolidated Group			
	Current 2017/18 £000	Non-current 2017/18 £000	Current 2016/17 £000	Non-current 2016/17 £000	Current 2017/18 £000	Non-current 2017/18 £000	Current 2016/17 £000	Non-current 2016/17 £000
NHS payables: revenue	645,415	-	492,491	-	1,394,629	-	1,143,087	-
NHS payables: capital	24,013	-	3,323	-	114	-	1,088	-
NHS accruals	1,633,777	-	1,149,796	-	2,200,725	-	1,700,133	-
NHS deferred income	649	-	1,654	-	199	-	687	-
Non-NHS and other WGA payables: revenue	144,477	-	162,420	-	975,487	-	988,834	-
Non-NHS and other WGA payables: capital	39,356	-	613	-	41,763	-	2,401	-
Non-NHS and other WGA accruals	1,033,456	-	1,115,898	-	3,945,570	-	3,620,281	-
Non-NHS and other WGA deferred income	2,926	-	5,042	-	19,713	73	19,073	360
Social security costs	7,407	-	7,504	-	20,305	-	19,662	-
VAT	-	-	-	-	316	-	519	-
Tax	19,980	-	6,738	-	31,642	-	17,185	-
Payments received on account	7	-	65	-	88	-	170	-
Other payables and accruals	298,831	26	294,406	-	747,847	2,188	612,689	3,464
Total	**3,850,294**	**26**	**3,239,950**	**-**	**9,378,398**	**2,261**	**8,125,809**	**3,824**
Other financial liabilities								
Bank overdraft - Government Banking Service	-	-	-	-	2,649	-	16,479	-
Finance lease liabilities	-	-	-	-	121	917	121	1,002
Other financial liabilities - other	-	-	-	-	-	107	-	101
Total	**-**	**-**	**-**	**-**	**2,770**	**1,024**	**16,600**	**1,103**
Total trade & other payables (current)	**3,850,294**		**3,239,950**		**9,381,168**		**8,142,409**	
Total trade & other payables (non-current)		**26**		**-**		**3,285**		**4,927**
Total trade & other payables (current and non-current)		**3,850,320**		**3,239,950**		**9,384,453**		**8,147,336**

11. Finance costs

	Parent		Consolidated Group	
	2017/18	2016/17	2017/18	2016/17
	£000	£000	£000	£000
Interest				
Interest on obligations under finance leases	-	379	39	422
Interest on late payment of commercial debt	-	8	3	33
Other interest expense	-	-	1	16
Total interest	**-**	**387**	**43**	**471**
Other finance costs	-	-	-	-
Provisions: unwinding of discount	(1,089)	(8,605)	(1,306)	(8,501)
Total finance costs	**(1,089)**	**(8,218)**	**(1,263)**	**(8,030)**

12. Provisions

Parent	Current 2017/18 £000	Non-current 2017/18 £000	Current 2016/17 £000	Non-current 2016/17 £000
Restructuring	486	-	522	-
Redundancy	201	-	1,147	-
Legal claims	1,769	564	930	-
Continuing care	33,634	-	54,261	822
Other	35,767	10,587	25,009	10,227
Total	**71,857**	**11,151**	**81,869**	**11,049**
Total current and non-current	**83,008**		**92,918**	

	Restructuring £000	Redundancy £000	Legal claims £000	Continuing care £000	Other £000	Total £000
Balance at 1 April 2017	**522**	**1,147**	**930**	**55,083**	**35,236**	**92,918**
Arising during the year	460	34	1,860	18,301	30,908	51,563
Utilised during the year	(475)	(95)	-	(1,991)	(3,020)	(5,581)
Reversed unused	-	(881)	(456)	(36,873)	(16,366)	(54,576)
Unwinding of discount	(21)	(5)	3	(783)	(283)	(1,089)
Change in discount rate	-	-	(3)	(102)	(122)	(227)
Balance at 31 March 2018	**486**	**200**	**2,334**	**33,635**	**46,353**	**83,008**
Expected timing of cash flows:						
Within one year	486	200	1,770	33,635	35,766	71,857
Between one and five years	-	-	564	-	6,333	6,897
After five years	-	-	-	-	4,254	4,254
Balance at 31 March 2018	**486**	**200**	**2,334**	**33,635**	**46,353**	**83,008**

Consolidated Group	Current 2017/18 £000	Non-current 2017/18 £000	Current 2016/17 £000	Non-current 2016/17 £000
Restructuring	1,389	-	825	-
Redundancy	2,826	-	2,481	-
Legal claims	2,274	564	1,392	2
Continuing care	80,296	6,224	87,817	8,213
Other	91,146	19,433	67,235	18,225
Total	**177,931**	**26,221**	**159,750**	**26,440**
Total current and non-current	**204,152**		**186,190**	

	Restructuring £000	Redundancy £000	Legal claims £000	Continuing care £000	Other £000	Total £000
Balance at 1 April 2017	**825**	**2,481**	**1,394**	**96,030**	**85,460**	**186,190**
Arising during the year	1,217	2,665	2,124	60,380	67,825	134,211
Utilised during the year	(604)	(1,400)	(38)	(12,789)	(15,463)	(30,294)
Reversed unused	(28)	(915)	(642)	(56,000)	(26,773)	(84,358)
Unwinding of discount	(21)	(5)	3	(955)	(328)	(1,306)
Change in discount rate	-	-	(3)	(146)	(142)	(291)
Balance at 31 March 2018	**1,389**	**2,826**	**2,838**	**86,520**	**110,579**	**204,152**
Expected timing of cash flows:						
Within one year	1,389	2,826	2,274	80,296	91,146	177,931
Between one and five years	-	-	564	6,224	13,764	20,552
After five years	-	-	-	-	5,669	5,669
Balance at 31 March 2018	**1,389**	**2,826**	**2,838**	**86,520**	**110,579**	**204,152**

NHS Continuing Healthcare is a package of health and social care arranged and funded solely by the NHS for a person aged 18 or over to meet physical or mental health needs which have arisen as a result of disability, accident or illness. Where an individual has both health and social care needs, but they have been assessed as having a 'primary health need' under the National Framework for NHS Continuing Healthcare and NHS funded Nursing Care, the NHS has responsibility for providing for all of that individual's assessed needs, both the health and social care. The amount included in the table above as 'Continuing Care' represents the best estimate, at the year end date, of the liabilities of NHS England group relating to the obligation of the NHS to pay for cases of such care and hence its responsibility for reimbursing patients and their families for costs incurred.

NHS England, in its role as commissioner for current breast screening services, is leading the implementation of the service response to the national breast screening incident. Included within other provisions in the parent account in 2017/18 is £30 million to support the elements of the response, details of which can be found in the annual report on page 24. This provision does not relate to legal liability (if any), on which PHE are leading.

"Other" provisions include miscellaneous provisions inherited under the Health and Social Care Reforms (April 2012) including onerous contracts, property related provisions and dilapidations.

The NHS Resolution financial statements disclose a provision of £68,476,936 as at 31 March 2018 in respect of clinical negligence liabilities and employment liability scheme of NHS England (31 March 2017: £71,795,033).

13. Contingencies

	Parent		Consolidated Group	
	2017/18	2016/17	2017/18	2016/17
	£000	£000	£000	£000
Contingent liabilities				
Employment tribunal	163	863	163	863
NHSLA employee liability claim	3	12	20	31
Continuing healthcare	-	-	13,603	13,695
Local authority - package recharges	-	-	171	532
Legal claims	14,991	5,526	14,991	5,526
NHS Resolution legal claims	-	-	2	3
Pension claims	7,070	250	7,070	250
Other employee related litigation	-	103	-	103
Responsible commissioner dispute	-	-	-	615
Her Majesty's Revenue and Customs	-	-	1,113	832
West Wakefield Health & Wellbeing Ltd potential VAT liability	-	-	685	685
Other - service issues	1,500	15,000	1,500	15,000
Risk share	-	-	-	392
Contract disputes with NHS bodies	-	-	1,958	3,712
Other	34	-	1,090	1,259
Net value of contingent liabilities	**23,761**	**21,754**	**42,366**	**43,498**

	Parent		Consolidated Group	
	2017/18	2016/17	2017/18	2016/17
	£000	£000	£000	£000
Contingent assets				
Legal cases	1,138	3,913	1,138	3,913
Potential recoveries re disrupted services	103	10,000	103	10,000
Potential rate rebates	-	-	407	-
Net value of contingent assets	**1,241**	**13,913**	**1,648**	**13,913**

Seven Sussex CCGs are jointly taking steps to enforce the terms of a parent company guarantee submitted as part of the non-emergency patient services contract which was terminated with effect from 31 March 2017. The position remains that due to the inherent uncertainties regarding the claim, it is not possible to give an accurate quantification of the precise financial consequences of the legal steps initiated but it is considered that these will not have a material impact on the future reported position of the CCGs.

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

14. Commitments

14.1 Capital commitments

	Parent		Consolidated Group	
	2017/18	2016/17	2017/18	2016/17
	£000	£000	£000	£000
Property, plant and equipment	38,061	2,675	38,833	2,855
Intangible assets	-	-	-	-
Total	**38,061**	**2,675**	**38,833**	**2,855**

The capital commitments are higher than the comparative figures at 31 March 2017. This in part is due to the timing of capital spend and represents capital that will result in additions in the next financial year.

14.2 Other financial commitments

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

	Parent		Consolidated Group	
	2017/18	2016/17	2017/18	2016/17
	£000	£000	£000	£000
In not more than one year	133,292	125,920	229,469	224,440
In more than one year but not more than five years	406,477	421,921	616,635	657,291
In more than five years	40,252	80,304	69,614	146,228
Total	**580,021**	**628,145**	**915,718**	**1,027,959**

In the parent account the most significant contracts relate to:

a) Contract with Capita for the delivery of administration services for Primary Care.
b) PET Scanner contract with Alliance Medical.

In the group account the most significant contracts relate to:

a) Contract with Virgin Healthcare for the delivery of Community Services in Staffordshire.

15. Financial instruments

15.1 Financial risk management

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

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

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

15.1.1 Currency risk

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

15.1.2 Interest rate risk

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

15.1.3 Credit risk

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

15.1.4 Liquidity risk

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

15.1.5 Financial instruments

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

16. Operating segments

Consolidated Group 2017/18	CCGs £000	Direct commissioning £000	NHS England £000	Other £000	Intra-group eliminations £000	NHS England group total £000
Income	(986,284)	(1,563,636)	(27,875)	(504,964)	899,484	(2,183,275)
Gross expenditure	82,232,658	25,821,470	3,307,317	483,700	(899,484)	110,945,661
Total net expenditure	**81,246,374**	**24,257,834**	**3,279,442**	**(21,264)**	**-**	**108,762,386**
Revenue resource expenditure						
Revenue departmental expenditure limit						108,689,363
Annually managed expenditure						18,107
Technical expenditure						54,916
Total net expenditure						**108,762,386**
Reconciliation back to SoCNE						
Total net expenditure for the year						108,762,386
Net (gain)/loss on revaluation of intangibles						-
Actuarial (gain)/loss in pension schemes						(850)
Comprehensive net expenditure for the year						**108,761,536**

Consolidated Group 2016/17	CCGs £000	Direct commissioning £000	NHS England £000	Other £000	Intra-group eliminations £000	NHS England group total £000
Income	(1,089,513)	(1,547,506)	(56,051)	(646,165)	1,096,781	(2,242,454)
Gross expenditure	77,710,491	26,907,600	2,992,480	388,132	(1,096,781)	106,901,922
Total net expenditure	**76,620,978**	**25,360,094**	**2,936,429**	**(258,033)**	**-**	**104,659,468**
Revenue resource expenditure						
Revenue departmental expenditure limit						104,896,663
Annually managed expenditure						(307,842)
Technical expenditure						70,647
Total net expenditure						**104,659,468**
Reconciliation back to SoCNE						
Total net expenditure for the year						104,659,468
Net (gain)/loss on revaluation of intangibles						(540)
Actuarial (gain)/loss in pension schemes						1,024
Comprehensive net expenditure for the year						**104,659,952**

The reportable segments disclosed within this note reflect the current structure of NHS England with the activities of each reportable segment reflecting the remit of the organisation. These operating segments are regularly reported to the NHS England Board of Directors for financial management and decision making purposes.

The activities of each segment are defined as follows:-

Clinical Commissioning Groups - clinically led groups that are responsible for commissioning healthcare services as defined in the Health and Social Care Act 2012.

Direct Commissioning - the services commissioned by NHS England (via Local Offices and Specialised Commissioning Hubs) as defined in the Health and Social Care Act 2012.

NHS England - the central administration of the organisation and centrally managed programmes.

Other - includes CSUs, national reserves, technical accounting items and legacy balances.

Multiple transactions take place between reportable segments, all of which are eliminated upon consolidation as shown in the "Intra-group eliminations" column. Information on total assets and liabilities and net assets and liabilities is not separately reported to the Chief Operating Decision Maker and thus, in accordance with IFRS 8, does not form part of this disclosure.

17. Related party transactions

Related party transactions associated with the Parent are disclosed within this note. As disclosed in note 1.3 NHS England acts as the parent to 207 CCGs whose accounts are consolidated within these Financial Statements. These bodies are regarded as related parties with which the Parent has had various material transactions during the year; those transactions are disclosed in those entities' financial statements.

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

For example:

- NHS Foundation Trusts;
- NHS Trusts;
- NHS Litigation Authority;
- NHS Business Services Authority;
- NHS Property Services;
- NHS Health Education England;
- NHS Shared Business Services (DH Equity Investment).

In addition, NHS England has had a number of significant transactions with other government departments and their agencies including HMRC, Ministry of Justice and Her Majesty's Prison and Probation Service. No related party transactions were noted with key managment pesonnel other than the compensation paid to them which can be found in the remuneration report on pages 95 to 104.

Following a review of disclosure requirements under IAS 24, transactions with organisations with which NHS England Board members also hold key management roles are not separately disclosed.

18. Events after the end of the reporting period

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

In March 2018, NHS England announced jointly with Monitor and NHS Trust Development Authority (NHS Improvement) to plan to work in a more integrated way to deliver better outcomes for patients, whilst improving performance and efficiency. The organisations are working together on an effective model of joint working but the underlying legal entities of NHS England, Monitor and NHS TDA will remain in place. This has no impact on NHS England's accounts and no adjustments have been made as a result.

From 1 April 2018 a further 14 CCGs commenced delegated commissioning arrangements, taking the total number operating under this initiative to 178. These arrangements were first introduced in 2014/15 as part of the NHS Five Year Forward View, under which CCGs assume full responsibility for contractual GP performance management and the design and implementation of local incentive schemes. This will result in a switch in expenditure from NHS England to those CCGs and a corresponding increase in funding to those CCGs.

The accounts were authorised for issue by the Accounting Officer on the date of the Audit Certificate of the Comptroller and Auditor General.

19. Financial performance targets

The Mandate: A mandate from Government to NHS England: April 2017 to March 2018 published by the Secretary of State under section 13A of the NHS Act 2006, and the associated Financial Directions as issued by DHSC, set out NHS England's total revenue resource limit and total capital resource limit for 2017/18 and certain additional expenditure controls to which NHS England must adhere. These stem from budgetary controls that HM Treasury applies to DHSC. These limits were revised in March 2018 and NHS England's performance against those limits is set out in the table below:

	2017/18						2016/17
	Revenue departmental expenditure limit			Annually-managed expenditure	Technical	Total	Total
	Non-ringfenced £000	Ringfenced £000	Total RDEL £000	£000	£000	£000	£000
Mandate limit	109,535,997	166,000	109,701,997	100,000	200,000	110,001,997	106,528,000
Actual expenditure	108,566,273	123,090	108,689,363	18,107	54,916	108,762,386	104,659,468
Surplus	**969,724**	**42,910**	**1,012,634**	**81,893**	**145,084**	**1,239,611**	**1,868,532**

	2017/18 Capital resource limit £000	2016/17 Capital resource limit £000
Limit	247,000	260,000
Actual expenditure	227,806	226,875
Surplus	19,194	33,125

NHS England is required to spend no more than £1,805,000,000 of its Revenue Departmental Expenditure Limit mandate on matters relating to administration in the full year. The actual amount spent on RDEL administration matters to 31 March 2018 was £1,582,503,511 as set out below:

Administration limit:	**2017/18 £000**	**2016/17 £000**
Net administration costs before interest	1,592,980	1,609,025
Less:		
Administration expenditure covered by AME/Technical funding	(10,476)	(13,562)
Administration costs relating to RDEL	1,582,504	1,595,463
RDEL Administration expenditure limit	1,805,000	1,832,000
Underspend	**222,496**	**236,537**

The various limits of expenditure set out in the table above stem from the limits imposed by HM Treasury on the DHSC. Departmental Expenditure Limits are set in the Spending Review, and government departments may not exceed the limits they have been set. This control is passed down to NHS England by the DHSC and NHS England may not therefore exceed its Departmental Expenditure Limit.

Annually Managed Expenditure budgets are set by HM Treasury and may be reviewed with departments in the run-up to the Budget. Departments must manage AME closely and inform HM Treasury if they expect AME to rise above forecast. Any increase requires Treasury approval.

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

20. Entities within the Consolidated Group

NHS England acts as the Parent of the group comprising 207 CCGs (2016/17: 209 CCGs) whose accounts are consolidated within these Financial Statements.

From the 1 April 2018 this became 195 CCGs with the merger of 18 CCGs creating 6 new CCGs as per the below:

Merging CCGs	New CCGs
NHS Bristol CCG NHS North Somerset CCG NHS South Gloucestershire CCG	NHS Bristol, North Somerset and South Gloucestershire CCG
NHS Aylesbury Vale CCG NHS Chiltern CCG	NHS Buckinghamshire CCG
NHS Windsor Ascot & Maidenhead CCG NHS Bracknell & Ascot CCG NHS Slough CCG	NHS East Berkshire CCG
NHS South Reading CCG NHS North & West Reading CCG NHS Newbury & District CCG NHS Wokingham CCG	NHS Berkshire West CCG
NHS Solihull CCG NHS Birmingham Cross City CCG NHS Birmingham South and Central CCG	NHS Birmingham and Solihull CCG
NHS Leeds North CCG NHS Leeds South & East CCG NHS Leeds West CCG	NHS Leeds CCG

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

The parent entity of NHS England is the Department of Health & Social Care.

The largest group of entities for which group accounts are drawn up and of which NHS England is a member is the Department of Health & Social Care Group.

Copies of the accounts can be obtained from www.gov.uk/government/publications

Appendices

Appendix 1: How we have delivered against the Government's mandate to the NHS

The Government mandate to NHS England sets out the Government's priorities for the NHS and the contribution NHS England is expected to make within its allocated budget.

The NHS has continued to respond to rising levels of demand for its services during 2017/18. The recent winter period has been one of the most demanding on record for the NHS, and standards such as 'referral to treatment' and 'four hour A&E waits' continue to face significant pressure. However, through the skill and dedication of its staff and in the context of a very constrained funding growth the NHS has managed to deliver the overwhelming majority of what it was mandated by government to achieve in 2017/18. Of the 71 deliverables set out in our mandate, 68 (96%) are assessed as on track. This represents real progress, with tangible benefits to patients, including more than 50% of patients now benefitting from extended GP access and cancer survival at its highest, with over 2000 additional patients surviving cancer one year on.

The mandate sets out deliverables against seven overarching objectives, linked to the 2020 mandate goals. The following summarises progress against each of these objectives in 2017/18:

Objective 1: Through better commissioning, improve local and national health outcomes, particularly by addressing poor outcomes and inequalities

- By July 2017, NHS England published the results of the CCG improvement and assessment framework for 2016/17, including independent assessments for cancer, dementia, and mental health. Following the publication of CCG operational plans, the tracking of these plans has been picked up within key priority programmes.

Objective 2: To help create the safest, highest quality health and social care service

- Good progress is being made on the rollout of the four clinical priority standards for seven day services. Additionally, all Trusts have published a Learning from Deaths policy to support the reduction of genuinely avoidable deaths in hospitals.
- Work is underway to deliver the Maternity Transformation Programme. There are 44 Local Maternity Systems established that are aligned with STP footprints. All locations have plans through which they are implementing the Better Births recommendations locally.
- Workstreams to deliver personal health budgets and increase patient choice in relation to end of life care are also making good progress. In 2017/18, in England, 28,040 people had a personal health budget. The NHS is on track to deliver against the NHS mandate commitment that 50,000-100,000 people should be benefitting from personal health budgets by 2020/21.
- The NHS has continued to expand patient access to cancer services including early diagnosis, more treatments and more support to trusts and CCGs. Performance against the 62 day standard from urgent GP referral to first definitive treatment was 84.7% in March 2018 against a standard of 85%.

Objective 3: To balance the NHS budget and improve efficiency and productivity

- The financial position of the NHS continues to be very challenging. Despite this, NHS England has managed to deliver financial balance in the commissioning system in line with plans for this year. Additionally, NHS England contributed a £970 million managed underspend to support financial balance across the NHS, including delivery of the risk reserve. NHS England continues to work collaboratively with NHS Improvement in relation to efficiency savings, trust deficit reduction plans and reducing spend on agency staff.
- Good progress has been made on rolling out NHS RightCare to a regional operating model, with staff attached to regional teams directly supporting CCGs and STPs to implement the programme.
- Additionally, all STPs are working with Strategic Estates Advisers to develop estates strategies, with drafts shared on the 31 March 2018.

Objective 4: To lead a step change in the NHS in preventing ill health and supporting people to live better lives

- NHS England continues to work with the DHSC and other partners to implement the government's child obesity action plan.
- To support these aims, NHS England is undertaking pioneering work through the Healthy New Towns Programme to reshape the built environment and achieve a step change in prevention. NHS England is also creating a model environment in NHS institutions, including by taking action to reduce sales of sugar-sweetened drinks on NHS premises.
- The Diabetes Prevention Programme is the most ambitious programme of its type in the world. Current referrals into the programme stand at 167,789, with 125,011 referrals received from April 1st 2017. This exceeds the mandate target of 60,000.
- Dementia remains a big challenge for the NHS and society as a whole. The aim of maintaining a minimum diagnosis rate of two thirds for people with dementia is being met. To support the 'dying well' ambitions within the Well Pathway for Dementia, a resource for Dementia Advance Care Planning has been developed to assist practitioners, providers and health and social care commissioners create opportunities for people living with dementia to develop an Advance Care Plan.

Objective 5: To maintain and improve performance against core standards

- Waiting times have been under pressure for a number of years, and this has continued to intensify in the context of increasing demand and the tough financial position the NHS currently faces. At March 2018 87.2% of patient pathways were completed within 18 weeks, compared with the 92% standard, as delayed emergency patient discharges affected hospitals' ability to further expand their routine surgery during 2017/18. Until winter, in-year RTT performance had fallen only 0.7% to November 2017, with 52 week waiters slightly improving from 1,528 in March 2017 to 1,452 in November 2017. However, the impact of flu and norovirus resulted in 2,000 more patients occupying beds than the previous year. RTT performance worsened by 1% over the following four months. Factoring in estimates for current non-reporters for March 2018, the waiting list size is 4,093,767 and the number of 52+ week waiters is 3,005. Whilst the September 2017 A&E performance target of 90% was met, year-end performance was 88.4% compared with the 95% standard, as the NHS tackled a challenging winter period. However, the providers saw more patients within four hours compared to last year.
- Good progress is being made on the staged rollout of integrated urgent care, testing new ambulance service performance metrics and developing and implementing plans to moderate avoidable growth in demand for elective services.
- Delayed transfers of care continue to be a challenge for both the NHS and social care services, which are facing unprecedented financial constraints.
- A programme has been established to support activity to reduce delayed transfers of care with further targeted support for the most challenged areas. As a result, delayed transfers fell substantially over winter 2017/18.

Objective 6: To improve out-of-hospital care

- NHS England has met the target set out in the Five Year Forward View Next Steps for 50% of the registered population to have access to extended GP hours. This exceeds the mandate target for 40% of the population to benefit from extended access to GP appointments at evenings and weekends.
- The New Care Models programme has demonstrated positive impact. Per capita emergency admissions growth was lower in PACS and MCPs than for the rest of England: PACS 2.6% and MCP 0.9% compared to the rest of England 6.3%.
- Greater integration of health and social care is a key priority for NHS England. Implementation of Better Care Fund plans has taken place across the country, and NHS England has worked closely with a number of areas to progress health proposals as part of their devolution plans.
- Good progress is being made against all the mental health mandate deliverables. At March 2018, 74% of people starting treatment with an earlier intervention in psychosis service did so within two weeks of referral. In February 2018, 89.5% of people finished treatment having waited less than six weeks to enter treatment and 98.7% of people finished treatment having waited less than 18 weeks to enter treatment.
- In relation to learning disabilities there has been an increase in the number of people being cared for in the community rather than inpatient services, and the total number of people in inpatient units fell by 18% from March 2015 to March 2018.

Objective 7: To support research, innovation and growth

- NHS England and DHSC have agreed a proposal for managing excess treatment costs, a consultation was published, and a response has been published. Work is also underway to increase local commissioner and STP/ICS input into identification of research needs of the NHS.
- NHS England, with Genomics England and other partners, launched the procurement to establish a national genomic testing service of up to seven genomic laboratory hubs. NHS England has begun work to align efforts to support genomics to be embedded into routine care.
- Good progress is being made in relation to the rollout of new technologies in the NHS. There has also been a strong focus on improving areas of IT vulnerability, supported by capital investment.
- In February 2018, the number of general practices to have at least 10% of patients registered for one or more online services was 88.3%. Additionally, almost 14 million patients (24% of patients in England) are now registered for one or more online services, an increase of 42% from February 2017.
- NHS England continues to support the Government's ambition to reduce the impact of ill health and disability on people's ability to work. NHS England, with partners, has developed two health-led employment trials involving a total of 11,300 people that will go live in 2018/19.

Appendix 2: Our customer contact and complaints report

Overview

Throughout 2017/18 we have undertaken the following activities to improve complaint handling and learning from customer feedback:

Key Achievements 2017/18

- We have implemented an independent review of our own complaints handling, working with partners from local Healthwatch and complaints advocacy services, to help identify good practice and to continuously improve the quality of our responses.
- As well as driving up the quality of our responses we have also improved our performance against the existing Key Performance Indicators of acknowledging complaints within three working days and responding within 40 working days.
- We have strengthened our link to the Cross Government Complaints Forum in order to learn from other public sector bodies and share good practice.
- Working with providers we have piloted The Picker Institute's model survey to measure complainants' experiences across health and social care bodies, building on the Parliamentary and Health Service Ombudsman's (PHSO) 'My Expectations', and also the suite of tools to support the use of the survey. This will be published on our website, alongside case studies from pilot sites to enable providers to measure the complainant's experience.
- We have developed our learning programme to allow NHS England to better provide assurance of quality, learning and improvement. We have also produced a report based on themes and trends identified through complaints which have progressed to the PHSO. This has been shared with local and national commissioning leads, and has led to increased collaboration with the PHSO on insight.
- People with a learning disability, autism (or both) and their families often face additional difficulties in raising concerns or making complaints about health, education and social care services. NHS England is working with individuals, carers, families, providers and other key stakeholders to help remove some of the barriers to complaining.
- We have worked closely with NHS Improvement and the PHSO on determining our role in supporting local NHS providers and CCGs to conduct and learn from serious incident investigations, including those that are multi organisation and cross boundary, and to use that learning to inform change and foster a culture of improvement.

In 2018/19 we will:

- Continue to collaborate with stakeholders to share intelligence and insights we hold from customer contact and complaints to ensure that information from complaints and other forms of feedback help inform local and national policies and procedures.
- Use the survey of complainants in order to continuously improve our services.
- Continue to deliver our training for GPs, dentists, and practice managers in good complaints handling.
- We will be working to improve overall performance against complaints and concern handling targets.

Headlines by contact type

General enquiry cases

- We received 105,880 General Enquiries in 2017/18, up from 101,161 (+4.7%) in 2016/17.
- 98.4% of enquiries were resolved within 3 working days, up from 96.4% the previous year.

Freedom of Information (FOI) requests

- 2,372 Freedom of Information requests were received in 2017/18, down from 2,624 (-9.6%) the previous year.
- We responded to 85.9% of requests within the target of 20 working days, up from 83.7% in 2016/17.

Concerns

- 10,351 concerns were recorded in 2017/18, up from 8,257 (+25.4%) in 2016/17.
- We responded to 77.6% of concerns within the target of 10 working days, down from 84.9% last year and slightly below the 80% target.

Complaints

- We recorded 6,432 complaints in 2017/18, down from 6,480 the previous year (-0.7%).
- 94.6% of complaints were acknowledged within the target 3 working days, and 59.3% resolved within the target 40 days. This compared with 95.3% and 52.0% respectively in 2016/17. We will focus on further improvement towards the respective targets in 2018/19.

Parliamentary and Health Service Ombudsman

The table below shows activity relating to complaints managed by NHS England which were closed by the PHSO between 1 April 2017 and 31 March 2018. Some of these complaints will have been received by NHS England prior to 1 April 2016 (but will have progressed to the PHSO after 1 April 2016 hence inclusion within these figures).

All recommendations relating to Partially Upheld or Upheld complaints were accepted and implemented.

	Upheld	Partially Upheld	Not Upheld	Discontinued or Other	Total Cases
Region					
Midlands & East	0	1	12	8	21
South	1	0	0	6	7
London	3	1	2	9	15
North	5	7	7	10	29
Greater Manchester	1	0	1	4	6
National	0	1	1	4	6
	10	**10**	**23**	**41**	**84**

KPI performance

Case volume and associated KPI measures 2017/18

			2017/18				
	Target	2016/17	Q1	Q2	Q3	Q4	2017/18
General enquiries							
No. of cases received	-	101,161	24,064	28,316	25,550	27,951	105,880
Resolved within 3 working days	95%	96.4%	98.3%	99.2%	98.0%	98.0%	98.4%
FOI							
No. of cases received	-	2,624	580	544	587	661	2,372
Resolved within 20 working days	80%	83.5%	81.9%	89.5%	86.0%	86.3%	85.2%
Concerns							
No. of cases received	-	8,257	2,984	2,556	2,150	2,661	10,351
Resolved within 10 working days	80%	84.9%	80.3%	86.2%	84.2%	60.9%	77.6%
Complaints							
No. of cases received	-	6,480	1,384	1,622	1,690	1,736	6,432
Acknowledged within 3 working days	100%	95.3%	93.9%	98.0%	96.5%	90.2%	94.6%
Resolved within 40 working days	90%	52.0%	60.5%	58.6%	61.3%	57.2%	59.3%
Median response time (working days)	< 40	40	39	39	39	40	39
Admin Closures[1]							
No. of cases received		14,739	2,858	2,719	2,519	2,782	10,878

1 An admin closure is where a case does not reach a conclusion, such as where a complainant does not consent to an investigation or an investigation is not permitted under NHS policy

Who contacted us?

The table below shows the groups of people who made contact with us:

	2016/17	2017/18
Caller type		
Member of the public	96%	95%
NHS Staff	3%	4%
Other	1%	1%

'Other' includes MPs/Parliament, Her Majesty's Prisons personnel, journalists and people who did not wish to identify themselves.

Contact method

The table below shows the ways people contacted us:

	2016/17	2017/18
All Cases		
Phone	66%	74%
Email	31%	25%
Post	3%	1%
Complaints		
Phone	45%	43%
Email	44%	48%
Post	11%	9%

Complaints by service area

The table below shows the proportion of complaints concerning each service:

	2016/17	2017/18
Service area		
GP Surgery	72%	71%
Dental Surgery	16%	15%
Pharmacy	3%	4%
Other	9%	10%

Service areas attracting 1% or less of the total number of complaints have been grouped as 'other'. This includes ophthalmic services, services in the detained estate, specialised services and complaints about NHS England.

Appendix 3: Our prescribed person whistleblowing report for 2017/18

In April 2016, NHS England became a Prescribed Person under the Public Interest Disclosure Order 1999. This means that primary care service staff working in GP surgeries, opticians, pharmacies and dental practices, can raise concerns to us (often known as 'whistleblowing') about inappropriate activity.

Whistleblower protection

Under the statutory protection afforded to workers who raise such concerns, whistleblowing is the term used when a worker provides information to their employer or a prescribed person concerning wrongdoing. To gain the statutory protection under the legislation, the worker making the disclosure must reasonably believe:

- That the disclosure is in the public interest; and
- It falls into one of the following categories:
  - Criminal offence.
  - Breach of any legal obligation.
  - Miscarriage of justice.
  - Endangering of someone's health and safety.
  - Damage to the environment.
  - Covering up wrongdoing in the above categories.

Where the worker raises their concerns directly with a Prescribed Person, such as NHS England, the worker must also reasonably believe that the fault falls within the remit of the prescribed person in question.

Workers have the right not to be subjected to any detriment on the ground that they have made such a "protected disclosure" to their employer or a prescribed person.

NHS England's role as a Prescribed Person

NHS England's remit, in relation to its role as a Prescribed Person, relates to the arrangements for contracting and commissioning of GP, dental, ophthalmic and pharmaceutical services.

Where concerns are raised to us by primary care workers about these issues, we are required to produce annual reports of the disclosures of information made to us, but without identifying the workers concerned or their employers.

In addition, NHS England is committed to assigning any concerns raised for further investigation and providing support to individuals that have suffered fiscal or professional detriment as a result of whistleblowing. This includes signposting whistleblowers to the correct organisation responsible for dealing with their concerns.

Qualifying disclosures received by NHS England during 2017/18 and action taken

Between 1 April 2017 and 31 March 2018, 66 whistleblowing disclosures were made to us relating to primary care organisations.

The table below summarises how we dealt with the disclosures:

Signposted to an alternative body	Investigated – no remedial action required	Investigated and action taken during 2017/18	Under investigation	No investigation required
3	7	7	43	6

As a result of those investigations, we have agreed changes with primary care providers designed to improve services delivered to patients. These actions include:

- Staff required to undertake additional training to address issues which have become apparent as a result of the concerns raised to NHS England and the subsequent investigation.
- GP practice merged with a neighbouring surgery to ensure that there is sufficient access for patients.
- Additional performance monitoring regimes implemented.
- Improvements to the management of controlled drugs.
- Decision made to cancel the NHS contract for the practice.

In addition, following a period of consultation with staff working in primary care, we have issued Freedom to Speak Up guidance for primary care providers. Key measures in the guidance include:

- Each NHS primary care provider should name an individual, who is independent of the line management chain and is not the direct employer, as the Freedom to Speak Up Guardian. They are expected to raise awareness of how staff can share a concern and offer support to staff who do so.
- NHS primary care providers should be proactive in preventing any inappropriate behaviour, such as bullying or harassment, towards staff who raise a concern.
- All NHS primary care providers were required to review and update their local policies and procedures by September 2017, to align with the new guidance.

Appendix 4: How we have involved patients and the public in 2017/18

We made significant progress in 2017/18 to further embed public participation in the work of NHS England and remained committed to fulfilling our duty under section 13 of the NHS Act 2006 (as amended) to involve the public in commissioning.

During 2017/18, the Empowering People and Communities Task Force have developed an innovative 'Public Participation Dashboard' which provides a high-level overview or 'snapshot' of public participation in practice. This enables participation to be tracked and improvements to be made.

Included below are three examples of ways in which we have worked in partnership with people and communities during 2017/18. The dashboard is available as part of papers for NHS England's July 2018 Board meeting[2]. Further information about our public participation approaches, activities and opportunities can be found on our Information Hub[3].

Engaging families in Learning from Deaths

In December 2016, the CQC published 'Learning, candour and accountability - A review of the way NHS trusts review and investigate the deaths of patients in England'. The report concluded that many families and carers are treated poorly by the NHS following the death of a loved one in unexpected, accidental, or untoward circumstances. Often they experience a lack of openness and transparency; and as a result, the opportunities for the system to learn from deaths that potentially could have been prevented are missed.

In response, the National Quality Board (NQB) established a 'Learning from Deaths Programme Board', involving NHS England alongside other system partners. One of the workstreams - on bereavement support and communication with families - has been tasked to produce guidance, with NHS England leading on its development.

As an early step, NHS England established a Steering Group including AvMA (Action against Medical Accidents), NHS Improvement and family members with lived experience as Patient and Public Voice (PPV) Partners. The Steering Group have strongly advocated that the guidance cannot be produced in isolation, and that the 'real experts' are those who have suffered the untoward death of a loved one whilst in NHS care. NHS England is therefore now working with a large group of family members, carers, advocate groups and health professionals to co-produce guidance aimed at family members and NHS trusts.

2 https://www.england.nhs.uk/publication/nhs-england-board-meeting-papers-04-july-2018/
3 https://www.england.nhs.uk/participation/

Key participation activities led by NHS England as part of the programme to date include:

- A two-day event in November 2017, involving approximately 75 family members and a similar number of people from NHS Trusts. The event was also webcast with a live chat-function, enabling others across the country to take part.
- A smaller one-day event in December 2017, attended by the Secretary of State, involving Trust staff and approximately 25 family members. The event was preceded by two webinars in which family members discussed and agreed the key issues and questions to be raised. The Programme Board family members also gave a powerful presentation, based on a thematic summary of the November event comments.
- An online community to support coproduction of the guidance, with opportunities to develop content through commenting via an online space, via email, or in person. There is also ongoing social media engagement, especially through Twitter and the use of #learningfromdeaths.

Co-production with children and young people: self-care everywhere event

"It was an event organised by young people for young people – health professionals facilitated the process, and they respected us and worked with our ideas without giving us the answers." Young volunteer.

In 2017, NHS England worked with young people and partners in Bradford to showcase the power and potential of partnership working, co-design and co-production. Bradford was chosen as the host city due to the commitment of the three local CCG's, the close involvement of the local voluntary and community sector in the STPs and the city's relatively young population (Bradford is set to be the 'youngest' city in Europe by 2020).

Young people were involved from the event's inception, discussing ideas and themes with youth groups and friends, and planning and preparing workshops. The event was heavily reliant on volunteers of all ages and backgrounds, who were supported by Bradford People's Board.

The event focused on 'self-care' and encompassed a range of related health and care topics. It took place on Saturday 8 July 2017 across three main venues within Bradford city centre. On the day, people and organisations came together to make best use of their skills and networks to ensure the event was a success. Workshops were run by experienced health professionals and by young people who had been given the opportunity for the first time. Approximately 200 young people attended alongside senior CCG, local authority and STP leaders.

Key outcomes from the event included empowering, supporting and connecting young people into wider NHS and social care activities, including young people's direct involvement in:

- Research as part of the NHS England Widening Digital Participation programme - through which people who are using counselling and/or mental health services share their experiences of using the internet / online spaces to seek support.
- Developing a campaign for the University of Bradford to tackle street harassment and raise awareness of the impact this has on young people. Young people took part in the design workshops and informed the campaign #freeourstreet which the University launched in November 2017.
- Workshops on: digital wellbeing tools; sports and activity; and the link to mental wellbeing and confidence, led by young people in partnership with commissioners.

Following the event, the #selfcareeverywhere young volunteers were funded by Bradford Council to undertake a four day Catalyst Leadership programme course in October 2017. The young people were also supported and mentored by staff from the local CCGs and other NHS organisations. As a result of the leadership course, the social action project chosen by the young people is to promote Bradford as a City of Youth which invests in health and wellbeing on young people. The young people have 'pitched' to the Council and NHS to garner their support. The young people who took part in the leadership course have also initiated a campaign to raise awareness of bullying #bfdbeatsbullying and led workshops at the 2018 Learning and Innovation in Health and Social Care event on power and leadership.

A number of young people that were part of the event have also been invited to attend, participate and lead on key discussions, including at the Health and Care Innovation Expo, focusing on the benefit of co-design in developing services for the future, specifically focusing on the work of STPs.

Recovery and outcome conference 2017 – developing a recovery charter in secure mental health services

NHS England commissioned Rethink Mental Illness to support and develop a Recovery and Outcomes Network for Secure Mental Health Services. There are nine Recovery and Outcome Networks across the country, bringing together service users, providers and commissioners to further develop secure services, ensuring that service users are at the centre of developments. As part of this network there is an annual Recovery and Outcomes Conference. In 2017, the event, jointly led by NHS England and Rethink, included over 400 people, with at least 200 of the participants currently detained in secure mental health services.

The conference theme in previous years has included developing service user defined outcomes and working with the Secure Carer Programme to explore the support people require to stay out of secure services. The theme of the 2017 event was 'it's about me' and focussed on identifying important considerations for people in secure services to support their recovery and move on from secure services. This day was the start of a conversation and the development of a 'HOPE Charter' (the name people chose for the Recovery Charter on the day – 'Hope on Personal Expectations'). The idea of the charter was to clearly identify key factors for people in secure services and what providers need to do to support people around these identified areas.

Top of the 'most important list' was 'friends and family'. People identified that they need help to stay in touch with their friends and family while they are in secure accommodation and made suggestions about how this can be supported. Participants also shared ideas and made specific requests about the help they need to find accommodation, stay healthy, and participate in civic society through joining groups, volunteering or moving into employment. The day was co-facilitated by NHS England, Experts by Experience and Rethink staff and included creative workshops such as art and music, ensuring everyone could contribute. A senior officer from the Mental Health Act Review team also attended, so that participants could begin to help shape the independent review of mental health services which began that month.

The HOPE Charter will continue to be developed in the Regional Recovery and Outcome Groups.

Appendix 5: How we have reduced health inequalities in 2017/18

During 2017/18, NHS England has continued to focus on a range of work programmes with the aim of addressing health inequalities in line with the objectives set out in the Next Steps on the NHS Five Year Forward View and the criteria set by the Secretary of State. Progress has been made in a number of the priority areas and this appendix presents a summary of how we have met our legal duties with regard to health inequalities during 2017/18.

Recently the NHS Outcome Framework indicators showed a statistically significant narrowing of health inequalities (related to deprivation) for two indicators, and a statistically significant widening for one. Seven other changes were not statistically significant. Further information on the indicators for 2017/18 will be set out on the NHS England website in July.

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

Our strategic approach is to embed an understanding of the need to reduce health inequalities through our priority programmes and policies to build insight into the impact of inequalities upon health and healthcare and support a coordinated, evidence-based approach in access to, and experience of, NHS services and health outcomes.

Partnership working is achieved in a number of ways, including the development of RightCare Packs to support the work of CCGs and through the work of the Equality and Diversity Council (EDC). Further work to develop the evidence on interventions that successfully address health inequalities at a CCG level is planned during 2018. This will also focus on sharing good practice across the system, including engagement with STPs.

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

The NHS Outcomes Framework Indicators for Health Inequalities Assessment (DHSC, 2015) set out 11 indicators identified for health inequalities assessment which have been used to guide reporting in 2017/18 using data available on NHS Digital's website. Information and data on the indicators will be published on our website in July 2018.

NHS England leads wider work on data monitoring and information standards in partnership with the DHSC and other key stakeholder organisations. In October the Information Standard on sexual orientation monitoring was published, with 25 NHS Trusts agreeing to pilot the Standard to help inform implementation.

To support commissioners and providers in CCGs better understand inequalities in access, NHS England developed a practical resource "Improving Access for all: reducing inequalities in access to general practice services" in July 2017. This was recently refreshed in February 2018. In addition, the Equality and Health Inequalities Analysis (EHIA) for the improving access to general practice services policy was published on NHS England's website in April. Assurance is monitored through CCGs completing monthly GP Forward View (GPFV) monitoring surveys.

The 2017/18 indicator 106a (for chronic ambulatory care sensitive conditions) and 106b (for urgent care sensitive conditions) in the CCG Improvement and Assessment Framework were combined into a new indicator (106a) for chronic ambulatory care sensitive and urgent care sensitive conditions. This combined indicator on health inequalities is designed to help CCGs monitor and plan improvements in NHS equity performance.

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

Analysts at NHS England have been looking closely at the approaches some of the new care model vanguards have taken to identify patients at risk in their communities. The term used for this is 'risk stratification'. Tower Hamlets, Sunderland, North East Hants and Farnham, Erewash and Morecambe Bay vanguards have introduced the 'building blocks' of an effective risk stratification process.

In 2017/18, we have continued to increase the use of data and information to shape policy, drive improvement and assess progress in reducing health inequalities in cancer. In conjunction with DHSC, PHE, academics, charities and other stakeholders we have scoped unanswered and understudied questions on health inequalities. We took evidence of effectiveness of interventions into account as a step to devise policies aimed at reducing those health inequalities. We will be developing this work further in 2018/19.

Criterion 4: Improve prevention, access and effective use of services for Inclusion Health groups

To deliver improvements in prevention and access, we published information which aimed to make it easier for patients from Inclusion Health Groups to overcome barriers when accessing the healthcare. The information is available on the NHS Choices website.

In London, NHS England and CCGs established a pan-London programme to deliver 'Once for London' work to assist CCGs to plan for the needs of people who are homeless within their localities. During 2017/18 we continued to support commissioners and providers to implement good homeless health practice; develop and promote clinical engagement in relation to homeless health and promote good homeless health practice to stakeholders and professional groups in London.

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

Working with its leadership role NHS England included in the 2017/18 CCG IAF a composite to help CCGs set priorities for tackling inequalities. This informs the headline assessment of CCGs together with a number of other indicators. CCG year end annual assessments will be published on NHS England's website and on the MyNHS website.

Analysis of CCG IAF indicator 106a inequality in unplanned hospital admissions for chronic ambulatory care, sensitive, and urgent care sensitive conditions[4], showed a statistically significant narrowing of health inequalities for the 12 month period ending 2017/18 Q2, compared to the previous year.

4 https://www.england.nhs.uk/commissioning/regulation/ccg-assess/iaf/

The Quality Premium (QP) scheme is about rewarding CCGs for improvements in the quality of the services they commission, a key element of the scheme being to reduce relevant inequalities. There are five national measures and in total these are worth 85% of the QP. They include early cancer diagnosis; GP access and experience; continuing health care; mental health; and bloodstream infections. CCGs can select one local indicator which is worth 15% of the QP.

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

The Government's mandate to NHS England 2017/18 set a specific long term objective on tackling health inequalities by 2020 as set out in Appendix 1, underpinned by specific deliverables to be achieved in 2017/18. The Next Steps on the NHS Five Year Forward View published in March 2017 together with associated documentation, formally constituted NHS England's 2017/18 Business Plan.

Progress has also been made to embed health inequalities considerations across our corporate priority areas, some examples of which are set out below:

- In Cancer, NHS England worked on the recommendations set out in the Cancer Strategy (2015) to ensure that patient experience is on a par with clinical effectiveness and safety. One of the specific areas is to increase BME representation in the Cancer Patient Experience Survey. As BME people report a poorer experience of care for six out of the seven indicators in the cancer dashboard, a programme of projects was created – Equalities Cancer 2020 - to look at the actions that can be taken to address this.
- NHS England has engaged with 10 CCGs / CSUs and has been working with them to ensure that they have the best access to data to begin to address this issue.
- In mental health, addressing equalities and health inequalities is one of the cross-cutting themes of the Five Year Forward View for Mental Health and a number of initiatives are underway to improve equitable access to services for groups with protected characteristics and people vulnerable to poor mental health. This includes equality issues in perinatal mental health service development, design, delivery and evaluation in order to meet the needs of underserved women and communities and the needs of BME groups within wider mental health programmes. The Young Minds Children and Young People participation programme is designed to support young people have their voices heard throughout the system. The focus for 2017/18 was vulnerable groups. As part of this programme, 'Trailblazer' sites were selected from a range of Local Authorities, NHS Services and voluntary groups. Projects within the Trailblazers were focussed on gender and identity, looked after children, those living with neurodevelopmental issues, the needs of BAME Children and Young People and Children and Young People in the justice system. NHS England has also been working with NHS Digital to ensure that all relevant data reports are broken down by protected characteristics.

Appendix 6: Our sustainability report

NHS England continues to develop our approach to sustainable development, as evidenced by the delivery of our Sustainable Development Management Plan (SDMP)[5]. Our Plan for 2018-2020 demonstrates our commitment to go beyond our statutory obligations wherever possible to:

- operate as a socially responsible employer;
- create equal opportunity and create an inclusive and supportive environment for our staff;
- take action to positively impact the wider community; and
- promote sustainable business practices, for the benefit of the environment.

NHS England and PHE jointly fund the Sustainable Development Unit (SDU). The SDU leads the sustainable development strategy for the NHS, public health and social care system. Incorporating prevention into all service design and healthcare delivery helps create healthier places, economies and communities. Supporting a healthier population is essential to create a more efficient health and care system that needs to able to provide high quality care for all, for now and for future generations. The SDU's strategy sets a vision and goals to aim for by 2020 to support sustainable development, reduce emissions, save money and improve the health and resilience of people and communities and can be viewed on the SDU's website[6].

More health and care organisations have board approved SDMPs and are reporting annually on their progress. The new Sustainable Development Assessment Tool is ensuring that as these organisational plans are developed they are aligned with the UN Sustainable Development Goals and cover the breadth of positive influence on population health that we can have in local communities.

This Appendix covers NHS England and CSUs only. CCGs report on sustainability within their individual annual reports which are published on their websites. A list of CCGs, and links to their websites, can be found on the NHS England website[7].

Reporting for multi-occupancy buildings

Within this report, NHS England and CSUs will report on their proportion of occupied buildings and, where NHS England is a tenant of DHSC, energy usage, waste and water information will be reported within their annual report. This will be published on the DHSC's website[8].

Where NHS England is a tenant of the Department of Work and Pensions (DWP), energy, waste and water information will be reported within their annual report. This will be published on their website[9].

5 The Sustainable Development Management Plan: https://www.england.nhs.uk/publication/sustainable-development-management-plan-for-nhs-england-2016-18/
6 The SDU website: https://www.sduhealth.org.uk/policy-strategy
7 NHS England Website: www.england.nhs.uk/ccg-details
8 The DHSC's website: www.gov.uk/government/organisations/department-of-health
9 The Department for Work and Pensions: www.gov.uk/government/organisations/department-for-work-pensions

Provision of data

NHS Property Services is the landlord for the majority of NHS England and CSU offices and we are reliant on them for the provision of utilities and waste data. NHS PS have been able to provide data for electricity, gas and water consumption and cost for each site during 2017/18. Where accurate data has not been available they have made an estimation based on the building size and the performance of other properties occupied by NHS England and the CSUs. As with previous years, we have estimated waste data using the average values available from partial figures, which were provided to us by NHS PS in 2015/16. NHS PS has been unable to provide estimated waste data because it has not been provided to them by the national provider. They are looking to re-procure the provider in the next year, and a reporting requirement will be included in the tender.

Due to the use of estimated figures in previous years and partial estimates for this financial year, it is not possible to draw any definitive conclusions about our performance in this area. However, due to estates rationalisation over recent financial years, we would expect to see a reduction in actual scope 2 emissions. Our SDMP outlines our intention to set a baseline and targets for ongoing reductions, when full data becomes available from NHS PS.
Scope 3 emissions are explored further in the Business Travel section.

Greenhouse gas emissions[10]

Total (NHS England and CSUs)

			2015/16	2016/17	2017/18
Scope 1 emissions[11]	Non-financial indicators (tCO2e)	Emissions from organisation-owned fleet vehicles	203	173	177
	Total Scope 1 (tCO2e)		203	173	177
	Financial indicators	Expenditure on official business travel	£269,777	£244,063	£237,732
Scope 2 emissions[12]	Non-financial indicators[13 14] (tCO2e)	Electricity	6,886*	4,638*	3,957*
		Gas	2,095*	1,439*	1,753*
	Total Scope 2 (tCO2e)		8,981*	6,077*	5,710*
	Related use (kWh)	Electricity	15,018,639*	10,428,527*	10,081,220*
		Gas	11,381,312*	7,709,202*	9,732,430*
Scope 3 emissions[15]	Non-financial indicators (tCO2e)	Car travel	3,540	3,501	2,934
		Rail Travel	1,605	1,520	1,926
		Air Travel (domestic only)	30	34	34
	Total Scope 3 (tCO2e)		5,175	5,055	4,894
		Total (tCO2e)	14,359*	11,305*	10,781*

*estimated data fields. Please see the relevant footnotes for further details.

10 For the following Greenhouse Gas Emissions table, the following conditions apply:
11 Scope 1 emissions arise from organisation owned and operated vehicles, plant and machinery.
12 Scope 2 emissions arise from the consumption of purchased electricity, heat, steam and cooling. To estimate scope 2 emissions in the section, we have used a formula based on the typical usage figures from the Chartered Institute of Building Services Engineers (CIBSE) and the Net Internal Area (NIA) of space occupied.
13 The figures published in 2016/17 used the incorrect conversion factor for the years 2015/16 and 2016/17. They have been updated with the correct figures.
14 2016/17 figures have also been adjusted to acknowledge that NHS England vacated Southside in November 2016. The figures previously reported included Southside occupancy for 12 months.
15 Scope 3 emissions arise from official business travel by vehicles not owned by the organisation

Water consumption

To estimate the figures for water consumption in 2015/16 and 2016/17, we have used the Construction Industry Research and Information Association (CIRIA) figure for average water consumption per m2 of Net Internal Area (NIA) of office space occupied. NHS PS provided water data, as described above, for 2017/18. Because previous years have been estimated using the CIRIA figure for average water usage and the current year has been based on actual data provided by NHS PS, it is not possible to draw any comparisons or conclusions about our performance over the years.

Total (NHS England and CSUs)

		2015/16	2016/17	2017/18
Non-financial indicators (m3)	**Water used**	71,245*	49,469*	61,580*
Financial indicators (cost of purchase of water)	**Cost of water used**	£258,515*	£179,503*	£113,605*

* estimated data fields.

Waste

The waste figures have been estimated using the averages from partial data provided by NHS PS in 2015/16, multiplied by the NIA of space occupied.

Total (NHS England and CSUs)

		2015/16	2016/17	2017/18
Non-financial indicators (tonnes)	**Total waste**	710*	493*	515*
	Waste sent to landfill	415*	288*	301*
	Waste recycled/ reused	280*	194*	203*
	Waste incinerated	15*	11*	11*
Financial indicators (cost of waste disposal)	**Total waste**	£187,155*	£129,953*	£135,586*
	Waste sent to landfill	£75,447*	£52,387*	£54,658*
	Waste recycled/ reused	£103,126*	£71,607*	£74,710*
	Waste incinerated	£8,582*	£5,959*	£6,217*

*estimated data fields.

NHS England business travel

This year we have seen a small increase in the amount of carbon emissions from business travel. This is partly due to an increase in FTE staff working across NHS England, and the increased need for our staff to work more closely with local health and care systems. We continue to be committed to reducing carbon emissions from business travel and have seen a decrease of 5% in carbon emissions from business travel per FTE. We remain focussed on achieving further reductions through our current and future SDMP and supporting our smarter working practices.

This data is for NHS England business travel only. Requests for information relating to CSU business travel should be made directly to the CSUs. Contact details for CSUs can be found on our website[16].

		2015/16	2016/17	2017/18
Miles	**Rail**	20,274,544	20,343,565	21,716,790
	Car use (scope 1 and 2)	4,974,652	4,979,326	4,777,511
	Domestic air	103,051	100,068	125,126
	Non-domestic flights	235,446	144,930	194,841
	Total	**25,587,693**	**25,567,889**	**26,814,268**
	Total per FTE	**4,669**	**4,749**	**4,628**
tCO2e	**Rail**	1,470	1,475	1,707
	Car use (scope 1 and 2)	1,525	1,480	1,366
	Domestic air	26	25	30
	Non-domestic flights	31	21	27
	Total	**3,053**	**3,001**	**3,130**
	Total per FTE	**0.585**	**0.583**	**0.552**

NHS England has a Business Travel and Expenses policy, which prioritises the use of technology to hold virtual meetings, followed by the use of public transport instead of more environmentally harmful modes of transport. We continue to increase opportunities for colleagues to meet virtually (internally and externally) and we also encourage and support colleagues to cycle where possible, through our cycle to work scheme and cycle mileage rate.

16 https://www.england.nhs.uk/commissioning/supporting/commissioners/csu/

Sustainable procurement

Sustainable procurement training, which includes environmental, ethical and labour issues, continues to be a requirement for all new entrants to the NHS England commercial team. Sustainability also features in the recruitment of commercial team members.

We apply our Sustainability Risk Assessment methodology to all procurements over £150K. This helps us to identify and address the sustainability impacts and opportunities presented by our commercial decisions. We are also driving added Social Value out of procurements, as appropriate, making the health pound go further. For example, we recently awarded a professional services contract, which secured best value for the NHS and included an additional commitment from the supplier to offer a set amount of pro bono consultancy days to help two Voluntary, Community and Social Enterprise Sector (VCSE) organisations scale up their delivery models. This will help them reach more patients and improve more lives. The two candidate VCSEs identified serve economically disadvantaged communities, and their main objective is to deliver health and care to those who face the greatest health inequalities. We are looking to scale up this model of driving added Social Value through our suppliers, to maximise benefits for society. This is an area where we believe NHS England can set a high benchmark.

In addition, we are finalising our Code of Conduct which we plan to launch with strategic suppliers in summer 2018. Over the last year, NHS England supported collaborative SME engagement activity in the North of England. We will continue to look for similar capacity building opportunities to support.

Sustainability is embedded within our commercial reporting framework (the Commercial Balanced Scorecard). Our Sustainable Procurement Programme is aligned with the Flexible Framework.

Climate change adaptation

In partnership with PHE and others, we produce a national Heatwave Plan and Cold Weather Plan for England each year. The purpose of these plans is to reduce the number of deaths and illness by raising public awareness and triggering actions in health, social care and other organisations. This is in order to to support people who have health, housing or economic circumstances which increase their vulnerability to extreme weather. The plans, and associated alerts, can be viewed on our website[17].

We are also working alongside DHSC and PHE to develop actions for the next National Adaptation Programme, which sets out what the Government, businesses and society are doing to become more climate ready.

17 http://www.england.nhs.uk/ourwork/eprr/sw

Appendix 7: Disclosure of personal data-related incidents

As at 31 March 2018, a total of 37 Serious Incidents Requiring Investigation (SIRI) had occurred relating to the loss of personal sensitive data in NHS England and Commissioning Support Units (CSUs). All incidents are logged and a full investigation undertaken. Unless otherwise stated in the tables below, remedial actions were implemented for all incidents and the Information Commissioner's Office (ICO) kept informed as appropriate.

Summary of incident	Date of incident	Number of incidents	Status	Organisation	Breach type	Number of people affected	Format	Comments
Complaint information/ response sent to incorrect person/organisation with patient identifiable data	July 2017 -March 2018	8	4 Open 4 Closed	NHS England	Disclosed in error	8	Paper	Investigation underway. - 4 Incident Closed - 3 Confirmed no action from the ICO - 1
Information relating to 307 patients sent to Clinical Commissioning Group (CCG) in error by East Midlands Specialised Commissioning team.	March 2018	1	Open	NHS England	Disclosed in error	307	Digital	Incident open. Awaiting report from relevant service line.
Medical record sent to applicant. However, on receipt of the record it was identified that the record also consisted of clinical correspondence relating to other patients.	October 2017 – February 2018	3	Open	NHS England	Disclosed in error	8	Paper	Incident open. Investigation underway - 3
Email containing personal confidential data (PCD) was received in error from a Trust and was subsequently shared within NHSE.	November 2017	1	Closed	NHS England	Disclosed in error	21	Digital	Incident closed. The ICO has confirmed that formal enforcement action is not appropriate.
Copy of verbal complaint sent to the incorrect complainant via email.	November 2017	1	Closed	NHS England	Disclosed in error	2	Digital	Incident closed. The ICO has confirmed that formal enforcement action is not appropriate.
A spreadsheet containing personal confidential data (PCD) was disclosed in error via email to external organisations	July 2017 - November 2017	2	Closed	NHS England	Disclosed in error	363	Digital	Incident closed. The ICO has confirmed that formal enforcement action is not appropriate - 1 Incident closed. Remedial actions implemented - 1
Reports regarding two serious incidents were sent to the incorrect provider.	October 2017	1	Closed	NHS England	Disclosed in error	2	Digital	Incident closed. The ICO has confirmed that formal enforcement action is not appropriate.
Sensitive clinical correspondence delivered to incorrect location.	July 2017	1	Closed	NHS England	Digital	3	Paper	Incident closed. Remedial actions implemented, confirmed no action from the ICO.

Summary of incident	Date of incident	Number of incidents	Status	Organisation	Breach type	Number of people affected	Format	Comments
Email sent in error containing names of Black, Asian, and Minority Ethnic (BAME) staff and their talent assessment.	July 2017	1	Closed	NHS England	Disclosed in error	16	Digital	Incident closed. Remedial actions implemented, confirmed no action from the ICO.
A parcel of medical records individually sealed in tamper proof bags was incorrectly delivered to another medical practice. The practice opened the bags to verify the contents.	June 2017 - March 2018	14	Closed	PCSE	Disclosed in error	420	Paper	Incident closed. Remedial actions implemented and the ICO has been engaged - 5 Incident closed. Remedial actions implemented and the ICO has confirmed no further action required – 9
Notification of performer conditions were sent to an existing list of approved organisations, which pre-dated an updated list being issued.	June 2017	1	Closed	PCSE	Disclosed in error	50	Paper	Incident closed. The ICO suggested measures to be applied. Remedial actions implemented.
Information relating to staff disclosed by Arden and Greater East Midlands CSU in error to a CCG.	February 2018	1	Closed	CSU	Disclosed in error	47	Digital	Incident closed. Remedial actions implemented and the ICO has confirmed no further action required.
North of England CSU - Medicines Optimisation team advised that appropriate user access controls were not in place for sub-folders containing personal data.	January 2018	1	Closed	CSU	Unauthorised access/ disclosure unauthorised access/	1000	Digital	Incident closed. Remedial actions implemented.
Immunisation invitation letter issued to the wrong address with patient information.	November 2017	1	Closed	CSU	Disclosed in error	1	Paper	Incident closed. Remedial actions implemented and the ICO has been engaged.

NHS England

All IG incidents are assessed and managed according to NHS Digital's Checklist Guidance for Reporting, Managing and Investigating Information Governance and Cyber Security. NHS England continues to promote IG good practice through annual training and regular communications. Lessons learnt are disseminated to staff, and where appropriate key themes / messages are incorporated into NHS England's IG training module.

PCSE

The contract for providing primary care support services was awarded to Primary Care Support England (Capita) (PCSE) on behalf of NHS England in September 2015. As part of this contract, PCSE is responsible for moving paper medical records, when patients register with new GP practices – moving around 6 million records annually / 115,000 per week. During 2017, NHS England worked with PCSE and its stakeholders to roll out a new process for the delivery of patient records to GP Practices and archive. As part of the transformed service, records are sealed individually before they are moved, and we are now able to record and track the movement of records between practices. This service was introduced in phases and is now fully rolled out. NHS England and PCSE continue to work closely together to ensure that any learning from incidents is used to identify potential future enhancements to the service.

For records deliveries, every GP practice has been allocated a Stop ID – a unique code which the courier uses to identify practices. Delivery errors to date have in the most part been due to similarities with Stop IDs. As a further measure to address these learnings, additional information has been added to the containers the courier uses to deliver records to practices. This is aimed at significantly reducing delivery errors caused by similar Stop IDs, by providing greater clarity to both couriers and practice recipients.

PCSE has enhanced IG and Security practices during this financial year, including introducing a dedicated and experienced full time Information Governance and Security Team. Strategic enhancements have resulted in continued Information Governance and Security improvements being realised, which have been successfully validated by an independent auditor as part of the NHS IG Toolkit compliance obligations.

CSUs

As of 31 March 2018, there have been three SIRIs reported to NHS England by a CSU. NHS England continues to work with its CSUs to ensure lessons learned.

CCGs

Details of any incidents occurring in CCGs can be found within individual CCG annual reports which were published on CCG websites in June 2018. A list of CCGs and links to their websites can be found on the CCG pages of the NHS England website[18].

18 https://www.england.nhs.uk/ccg-details/

Appendix 8: Assessment against the Corporate Governance in Central Government Departments: Code of Good Practice 2017

Provisions against which there are the following exceptions:

Ref	Code provision	Exception
3.6	Non-executive Board members form a Nominations and Governance Committee	NHS England does not have a Nominations Committee, as appointments of the executive and non-executive members are managed as required by the NHS Act 2006 (as amended). Governance issues are delegated to the Audit and Risk Assurance Committee.
4.3 **4.4** **4.5**	Terms of reference for the Nominations Committee.	There is no Nominations Committee (see above). The specific code provisions are handled by the Strategic Human Resources and Remuneration Committee.
4.7	Through the Board Secretariat, the Department provides the necessary resources for developing the knowledge and capabilities of Board members, including access to its operations and staff.	This responsibility is shared between the Chair, Chief Executive's Office and Board Secretary.
4.11	The Board Secretary's responsibilities include: f. arranging induction and professional development of Board Members.	This responsibility is shared between the Chair, Chief Executive's Office and Board Secretary.
5.5	The Head of Internal Audit is periodically invited to attend Board meetings, where key issues are discussed relating to governance, risk management, or control issues across the department and its ALBs.	The Head of Internal Audit routinely attends meetings of the Audit and Risk Assurance Committee.

Provisions which are not applicable:

Sections 1, 2.3, 2.11, 3.3a, 3.3b, 3.3c, 3.6e, 3.7, 3.8, 3.9, 3.14, 3.19, 4.9, 4.12, 4.13, 4.14, 5.7, 5.8 and 6.

Appendix 9: List of acronyms used in our annual report

	Acronym used	Meaning
A	AAA	Abnormal Aortic Aneurysm
	AAC	Accelerated Access Collaborative
	A&E	Accident and Emergency
	AHSN	Academic Health Science Networks
	AME	Annually Managed Expenditure
	ARAC	Audit and Risk Assurance Committee
B	BCF	Better Care Fund
	BCS	British Computer Society
	BEIS	Business, Energy and Industrial Strategy
	BME	Black, Minority, Ethnic
C	CareCERT	Care Computer Emergency Response Team
	CCG	Clinical Commissioning Group
	CCIO	Chief Clinical Information Officer
	CETR	Care, Education and Treatment Review
	CETV	Cash Equivalent Transfer Value
	CHC	Continuing Healthcare
	CIO	Chief Information Officer
	COPD	Chronic Obstructive Pulmonary Disease
	CPAG	Clinical Priorities Advisory Group
	CQC	Care Quality Commission
	CSOPS	Civil Servant and Other Pension Scheme
	CSU	Commissioning Support Unit
	CTR	Care Treatment Reviews
D	DAWN	Disability and Wellbeing Network
	DCO	Director of Commissioning Operations
	DfE	Department for Education
	DHSC	Department for Health and Social Care
	DToC	Delayed Transfer of Care
	DWP	Department of Work and Pensions
E	e-RS	e-referral system
	ECDR	Elective Care Development Collaborative
	EDC	Equality and Diversity Council
	EHIA	Equality and Health Inequalities Analysis
	EPRR	Emergency Preparedness, Resilience and Response
	ERMG	Executive Risk Management Group
	ESM	Executive Senior Manager
	ESR	Electronic Staff Record

	Acronym used	Meaning
F	FOI	Freedom of Information
	FReM	Financial Reporting Manual
	FTE	Full Time Equivalent
	FTSU	Freedom to Speak Up
	FYFV	Five Year Forward View
	FYFV MH	Five Year Forward View for Mental Health
G	GAM	Group Accounting Manual
	GDPR	General Data Protection Regulation
	GPFV	General Practice Forward View
H	HMRC	HM Revenue and Customs
	HMT	HM Treasury
	HQIP	Health Quality Improvement Partnership
	HR	Human Resources
I	IAF	Improvement and Assessment Framework
	IAPT	Improving access to psychological therapies
	ICO	Information Commissioners Office
	ICT	Information and Communications Technology
	ICS	Integrated Care System
	IFR	Individual Funding Requests
	IG	Information Governance
	ISA	International Standards on Auditing
	ISFE	Integrated Single Financial Environment
	ITT	Innovation and Technology Tariff
L	LGBT+	Lesbian, Gay, Bisexual, Trans +
	LMDP	Line Management Development Programme
	LMS	Local Maternity Systems
M	MHFA	Mental Health First Aider
	MSK	Musculoskeletal
N	NAO	National Audit Office
	NHS	National Health Service
	NHSCFA	NHS Counter Fraud Authority
	NHS IMAS	NHS Interim Management and Support
	NHS BSA	NHS Business Services Authority
	NHS PS	NHS Property Services
	NHS SBS	NHS Shared Business Services
	NICE	National Institute for Health and Care Excellence
	NQB	National Quality Board
O	OGSCR	Oversight Group for Service Change and Recognition
	OPW	Off-Payroll Workers

	Acronym used	Meaning
P	PAC	Public Accounts Committee
	PCSE	Primary Care Support England
	PCSPS	Principal Civil Service Pension Scheme
	PHB	Personal Health Budget
	PHE	Public Health England
	PHSO	Parliamentary and Health Service Ombudsman
	PMCB	Personal Maternity Care Budget
	PPV	Patient and Public Voice
	PRP	Performance Related Pay
	PSED	Public Sector Equality Duty
Q	QAG	Quality Assurance Group
	QP	Quality Premium
	QSG	Quality Surveillance Group
R	RDEL	Revenue Department Expenditure Limit
	RTT	Referral to Treatment Time
S	SBLCB	Saving Babies Lives Care Bundle
	SCOG	Specialised Commissioning Oversight Group
	SCID –	Severe Combined Immunodeficiency
	SDMP	Sustainable Development Management Plan
	SDU	Sustainable Development Unit
	SFI	Standing Financial Instructions
	SIRI	Serious Incident Requiring Investigation
	SMEs	Small and Medium-sized Enterprises
	STP	Sustainability Transformation Programmes
U	UTC	Urgent Treatment Centres
V	VAT	Value Added Tax
	VSM	Very Senior Manager
W	WRES	Workforce Race Equality Standard

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