Accountability Report

Simon Stevens
Accounting Officer
3 July 2019

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 2018/19, 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 61.

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 107.

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 135.

Corporate Governance Report

Directors' Report

The Board

The NHS England Board is composed of the Chair, six non-executive directors and five voting executive directors. These arrangements comply with the requirements of the National Health Service 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 voting executive directors is less than the number of non-executive directors (including the Chair). A number of non-voting executive directors also regularly attend Board meetings. In May 2018, the Boards of NHS England and NHS Improvement committed to deliver a new model of joint working, involving shared national director roles and alignment of national functions and integrated regional teams with new regional geographies. To support this closer alignment, the two Boards approved a new joint Board governance framework in November 2018. This new framework has been designed to enable the Boards to have full oversight of both organisations and together be able to support and challenge the delivery of ICSs and the NHS Long Term Plan. The new governance framework operated in an advisory capacity alongside the existing governance framework between 1 January to 31 March 2019, before being formally adopted in 2019/20.

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 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, NHS Improvement, Government departments, other ALBs, 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; executive directors are appointed by the Board. Board members bring a range of complementary skills and experience in areas such as the PPV, finance, governance and health policy. Any new appointments take account of the skills already represented on the Board and recognise where there are gaps that could be filled.

There were several changes in Board membership during the year. Professor Sir Malcolm Grant's appointment as Chair came to an end on 30 October 2018. Lord David Prior was appointed Chair on 31 October 2018. Three non-executive Directors left NHS England during the year, Professor Sir John Burn on 30 June 2018, Lord Victor Adebowale and Dame Moira Gibb on 31 December 2018. One new non-executive director, Professor Sir Munir Pirmohamed, was appointed to NHS England on 1 January 2019. Following the departure of Paul Baumann CBE on 18 November 2018, Matthew Style was appointed as acting Chief Financial Officer, with Julian Kelly taking on the role permanently from 1 April 2019. Following the retirement of Jane Cummings CBE, Ruth May was appointed joint Chief Nursing Officer with NHS Improvement, joining NHS England on 7 January 2019.

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 members, is maintained. This is open to public scrutiny and is published on NHS England's website. The register is reviewed at each Board meeting and may be viewed on our website[46].

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 the executive are required at the commencement of each Board meeting, and whenever relevant matters are raised, to declare any personal interest they may have in any business on the agenda and abstain from related Board discussion as required.

Details of related party transactions, where NHS England has transacted during 2018/19 with other organisations to which an individual holding a director position within NHS England is connected, are set out in Note 17 on page 187 of the Annual Accounts.

NHS England Board Members

The names of NHS England Board members, both non-executive and executive (voting and non-voting), are noted below. Full details, including biographies and photographs, may be viewed on our website[47].

Board meeting attendance

The agenda, papers and the minutes of NHS England Board meetings held in public, are published on the NHS England website[48]. 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.

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46 www.england.nhs.uk/about/whos-who/reg-interests/
47 https://www.england.nhs.uk/about/board/members/
48 www.england.nhs.uk/about/whos-who/board-meetings/.

During 2018/19, the Board met in common with the board of NHS Improvement on four occasions in public/private to discuss, amongst other matters, closer working.

Member	Job Title	Number of eligible meetings attended during the year[49]	Comments
Professor Sir Malcolm Grant	Chair	5/5	Until 31 October 2018
Lord David Prior	Chair	4/4	Appointed 31 October 2018
David Roberts CBE	Vice-Chair	9/9	
Lord Victor Adebowale	Non-Executive Director	5/6	Until 31 December 2018
Wendy Becker	Non-Executive Director	6/9	
Professor Sir John Burn	Non-Executive Director	2/2	Until 30 June 2018
Professor Sir Munir Pirmohamed	Non-Executive Director	1/3	Appointed 01 January 2019
Dame Moira Gibb	Non-Executive Director	6/6	Until 31 December 2018
Noel Gordon	Non-Executive Director	9/9	
Michelle Mitchell	Non-Executive Director	8/9	
Joanne Shaw	Non-Executive Director	8/9	
Richard Douglas (non-voting)	Associate Non-Executive Director	9/9	
Simon Stevens	Chief Executive	9/9	
Matthew Swindells	Deputy Chief Executive	9/9	Previously National Director: Operations & Information (non-voting) until 01 September 2018
Paul Baumann CBE	Chief Financial Officer	5/5	Until 18 November 2018
Matthew Style	Acting Chief Financial Officer	4/4	Interim 19 November 2018 to 31 March 2019
Professor Jane Cummings CBE	Chief Nursing Officer	6/6	Until 31 December 2018
Ruth May	Chief Nursing Officer	3/3	Appointed 07 January 2019
Professor Stephen Powis	National Medical Director	8/9	
Ian Dodge (non-voting)	National Director: Strategy & Innovation	9/9	
Emily Lawson (non-voting)	National Director: Transformation & Corporate Operations	9/9	

49 Includes meetings in common with NHS Improvement

Board diversity

NHS England had eight non-executive directors including one associate non-executive member (non-voting) as at 31 March 2019, three of whom were female and five were male. Of the seven members of NHS England's Executive Group as at 31 March 2019, five were male and two were female. More detail on the diversity of the NHS England Board is included in the Remuneration Report, at page 111.

Board performance

The NHS England Board regularly reviews its performance and works together to improve its effectiveness, although an independent review has not been conducted during 2018 given the advent of closer working with NHS Improvement. Work will now continue to further develop the Board's forward agenda as well as the Board's role in nurturing the culture of NHS England through its continuing transformation.

Board Committees

The Board has been supported in its assurance and oversight of the organisation by five committees up to the end of the year. 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 and based on the correct information.

As noted above, a new joint Board governance framework has been agreed by the Boards of NHS England and NHS Improvement. As a result of this, during Quarter 4 of 2018/19, the Board implemented a new committee structure in shadow format to extend working in common with NHS Improvement below board level. This resulted in support to the Board from five committees, two to be held independently and three to be held in common with NHS Improvement's corresponding committees. In addition, three sub-committees of one of these committees meeting in common have been created, again to meet in common with NHS Improvement's corresponding sub-committees. Meeting in common in this way allows the two organisations to meet at the same time, with shared agendas and papers whilst retaining separate committees that can take decisions on behalf of each individual organisation. NHS England and NHS Improvement have made a commitment to transform the way we work to provide a single system view, single messaging and shared leadership to support and enable integrated care across England, whilst ensuring that both organisations continue to respect the statutory commissioner or provider responsibilities that can be discharged only by NHS England or NHS Improvement.

All the above committees and sub-committees form part of NHS England's formal governance structure, with each providing a report to the Board (or, in the case of the sub-committees, to the relevant committee) following every meeting, ensuring that the Board is kept informed of how it has discharged its delegated responsibilities. Additionally, each committee provides the Board with an annual report covering a review of the activities in the previous year, a summary of the priorities for the coming year, a self-assessment of its effectiveness, and a review of the terms of reference. The Accounting Officer (Chief Executive), as well as being a member of the Board, is similarly informed of each committee's activities through discussions with the relevant Chair.

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

NHS England Board governance framework and committees effective between 1 April 2018 and 31 March 2019

NHS England Board				
Strategic HR & Remuneration Committee Chair: Professor Sir Malcolm Grant (1 Apr-30 Oct) Chair: Lord David Prior (31 Oct-31 Mar)	**Audit and Risk Assurance Committee** Chair: Joanne Shaw	**Investment Committee** Chair: Moira Gibb	**Commissioning Committee** Chair: Wendy Becker	**Specialised Services Commissioning Committee** Chair: Noel Gordon
Main responsibilities				
Advise the Board on Board and organisational development. Approve remuneration and terms of service for the Chief Executive and National Directors.	Provide an independent and objective view of internal control, governance and risk management - including overview of internal and external audit services, governance, risk management and financial reporting.	Receive assurance and agree recommendations on business cases for activities related to NHS England's functions, on behalf of the Board. Make decisions on reconfiguration proposals requiring Board sign-off (in accordance with delegated powers). Oversee the assurance of reconfigurations.	Advise on development & implementation of strategy for the commissioning sector. Agrees commissioning priorities & resource allocation. Monitor and challenge the delivery of service performance, quality and financial outcomes. Oversee development of the commissioning system.	Advise the Board on development & implementation of strategy for specialised commissioning. Agree specialised commissioning priorities & work programmes. Monitor and challenge the delivery of priorities and work programmes.

New NHS England Board governance framework and committees

The new Board and Committees framework held advisory meetings only between 1 Jan to 31 March 2019 to prepare for formal commencement from 1 April 2019.

NHS England Board

NHS England only Board Committee	NHS England Board Committee with some business being run as a committee-in-common with NHS Improvement	Committees operating as a committee-in-common with NHS Improvement		
Statutory Commissioning Committee Chair: Wendy Becker	**Audit and Risk Assurance Committee** Chair: Joanne Shaw	**Delivery, Quality and Performance Committee** Chair: David Prior	**Strategic HR and Remuneration Committee** Chair: David Prior	**Strategy Committee** Chair: David Prior
Main responsibilities				
Make decisions on the exercise of statutory powers in respect of CCGs under section 14 of the NHS Act 2006. Agree and approve individual CCG and commissioner allocations.	Provide an independent and objective view of internal control, governance and risk management - including overview of internal and external audit services, governance, risk management and financial reporting.	Review financial and operational performance of the NHS. Review the delivery and impact of the NHS Long Term Plan. Oversee the implementation and delivery of the new NHS financial framework.	Work with NHS Improvement to ensure that the organisations have: • a single formal and transparent remuneration policy • policies and practices to ensure that their people are properly recruited, engaged and motivated, diverse, performing and developed NHS England only: • approves the appointment, remuneration and terms of service for the Chief Executive and members of the Executive group, in line with the DHSC and ALB Pay Framework and Government decisions on public sector pay arising from the recommendations of the Senior Salaries Review Body	Provide overall strategic oversight, advice and leadership to the NHS. Provide strategic oversight for delivery of the Long-Term Plan.

Committees operating as a committee-in-common with NHS England

Digital Committee	People Committee	Quality Committee
Chair: Noel Gordon	Chair: Michelle Mitchell	Chair: Joanne Shaw

Details of these committees are provided overleaf

In addition, two advisory groups supported the Boards:

Advisory Group	Chair	Responsibilities
Joint Finance Advisory Group (NHS Improvement and NHS England)	Chair: Non-Executive Director of either NHS Improvement or NHS England	The group has no executive responsibility and has been formed to ensure that both organisations are working from a common understanding of the financial targets and financial performance of the entire health system.
Joint Transition Advisory Group (NHS Improvement and NHS England)[50]	Chair: Joanne Shaw, Non-Executive Director, NHS England	The group had no executive responsibility and was formed to oversee the integration of NHS England and NHS Improvement.

Delivery, Quality and Performance Committee's sub-committees

Sub- committees of the Delivery, Quality and Performance Committee		
Operating as a committee-in-common with NHS Improvement		
Digital Committee Chair: Noel Gordon	**People Committee** Chair: Michelle Mitchell	**Quality Committee** Chair: Joanne Shaw
Main responsibilities		
Advise on the delivery of digital commitments of the NHS Long Term Plan, alignment of technology initiatives and spend to ensure they are focused on NHS Long Term Plan commitments. Provide assurance on the alignment of ALBs accountabilities and responsibilities for cross cutting digital initiatives, managing NHS organisations and ALBs implementation and operation of digital initiatives.	Oversee the implementation of the key recommendations from the People Plan. Support and advise on new talent management arrangements. Support challenge and advise on initiatives for workforce improvement. Oversee the delivery of best practice support for all workforce issues. **NHSE only responsibilities:** Support, challenge and advise on the delivery of the primary care commitments set out in the NHS Long Term Plan, the primary care networks contract and continuing commitments in the GPFV to strengthen the workforce across primary and community care, including training, recruitment, support and retention of medical, clinical and non-clinical staff. Support, challenge and advise on the development of integrated multi-disciplinary teams working across primary and community settings, including dentistry, community pharmacy and optometry.	Consider issues in relation to three areas of quality – safety, clinical effectiveness and patient experience – in relation to all NHS services. **NHSE only responsibility:** Review reports on the quality of care delivered by the NHS from the integrated regional teams based on data and information from local and regional surveillance and activities. Review reports bringing together data and information on national and/or strategic importance relating to NHS England's statutory duties and services directly commissioned. Review reports on specific NHS England-led national programmes and initiatives relevant to quality, including quality improvement programmes and transformation programmes.

50 This group was disbanded in March 2019 and the oversight provided by this group has been assumed into other committees.

Audit and Risk Assurance Committee (ARAC)

Role of the Committee

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

Committee members

The Committee 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	
Wendy Becker	4/4	
Gerry Murphy	5/5	Non-executive Chair of DHSC's Audit Committee
Professor Sir John Burn	0/2	Left NHS England 30 June 2018
Michelle Mitchell	1/1	Appointed to Committee 01 January 2019
Professor Sir Munir Pirmohamed	0/1	Appointed to Committee 01 January 2019

Committee attendees

Additional attendees are invited to attend meetings to assist with committee business. For 2018/2019, these have included National Directors, Director of Governance and Legal, representatives from the National Audit Office (NAO), Deloitte LLP (internal auditors) and DHSC.

Principal activities during the year

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

- Reviewing the organisation's risk profile and the management and mitigation of current and emerging risks, and ensuring that all corporate risks have an accountable national director and delegated risk owner.
- Agreeing the internal audit plan for 2018/19 and reviewing progress.
- Reviewing issues with the delivery of Primary Care Services (Capita).
- Assessing the integrity of NHS England's financial reporting.
- Considering and approving the NHS England Final Annual Report and Accounts for 2017/18.
- Considering reports provided by the NAO that relate to NHS England's accounts and the achievement of value for money.
- Commissioning and receiving internal audit reports on the adequacy of internal control systems, risk management and corporate governance.

- Considering progress with implementing internal audit recommendations.
- Overseeing the organisation's arrangements for counter fraud.
- Reviewing Cyber security issues and the implementation of the General Data Protection Regulations (GDPR).
- Reviewing the status of planning for EU Exit.

Planned activities during the coming year

In the coming year, the Committee will:

- Consider areas for review by internal audit and approve the 2019/20 plan of work and then review the audit work during the year.
- Consider the 2018/2019 Annual Internal Audit Report and Head of Internal Audit opinion.
- Consider and approve the NHS England Final Annual Report and Accounts for 2018/19.
- Review the NHS England Economic Crime Strategy.
- Review updates from the NAO on progress with their audit work.
- Consider corporate risks and the status of internal audit recommendations.
- Oversee other risk areas such as cyber security, primary care assurance and third party assurance.
- Review the developing governance arrangements between NHS England and NHS Improvement.

The Committee met in joint session with the NHS Improvement ARAC for the first time on 27 February 2019, and discussed which aspects of Committee business they might consider in future joint session.

Commissioning Committee

Role of the Committee

The Committee provided advice to the Board on the development and implementation of strategy for the commissioning sector, agreed commissioning priorities and allocated resources, and received assurance that performance, quality and financial outcomes are delivered, including financial performance monitoring. It also oversaw assurance and development of the commissioning system, including CCGs.

Committee members

The Committee met seven times during the financial year 2018/19. 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
Wendy Becker (Chair)	7/7	
Lord Victor Adebowale	4/7	Until 31 December 2018
Noel Gordon	6/7	
Michelle Mitchell	6/7	
Paul Baumann CBE	5/5	Left NHS England 18 November 2018
Professor Jane Cummings CBE	5/7	Left NHS England 31 December 2018
Ian Dodge	7/7	
Professor Stephen Powis	6/7	
Simon Stevens	5/7	
Matthew Style	2/2	Member from 19 November 2018
Matthew Swindells	7/7	
Richard Barker	4/7	
CCG representative	5/7	

Committee attendees

Additional attendees were invited to attend meetings to assist with committee business.

For 2018/19, these included the Director of Primary Care, the Director of Strategic Finance, the Director of Commissioning Policy Group and the Director of Financial Planning and Delivery.

Principal activities during the year

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

- Delivery of the main system transformation programmes:
  - Next Steps on the NHS Five Year Forward View[51] priorities including cancer; mental health and dementia; urgent and emergency care; primary care; and the NHS' 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

As part of the new Board governance framework, the Commissioning Committee has been disbanded, with its remit being transitioned to the new Delivery, Quality and Performance Committee (and its sub-committees: Quality, People and Digital), which will meet in common with NHS Improvement's Delivery, Quality and Performance Committee (and sub-committees).

51 https://www.england.nhs.uk/wp-content/uploads/2017/03/NEXT-STEPS-ON-THE-NHS-FIVE-YEAR-FORWARD-VIEW.pdf

Specialised Services Commissioning Committee

Role of the Committee

The Committee provided advice to the Board on the development and implementation of NHS England's strategy for commissioning of prescribed specialised services, providing assurance of quality, performance and value for money. The Committee also covered health and justice, armed forces and sexual assault services commissioning.

Committee members

The Committee met five times during the financial year. The following table details core membership and the number of meetings attended by each member (although some members were not able to attend the whole of each meeting):

Member	Number of eligible meetings attended during the year	Comment
Noel Gordon (Chair)	5/5	
Michelle Mitchell	5/5	
Paul Baumann CBE	4/4	Left NHS England 18 November 2018
Ian Dodge	4/5	
Matthew Style	0/1	Member from 19 November 2018
Matthew Swindells	3/3	Member from 1 September 2018
John Stewart	5/5	
Simon Stevens	1/5	
Professor Stephen Powis	2/5	
Dame Moira Gibb	3/5	

Committee attendees

Additional attendees were invited to meetings to assist with committee business. For 2018/19, these have included: Director of Strategy and Policy, Specialised Commissioning; Medical Director, Specialised Commissioning; Finance Director, Specialised Commissioning; Clinical Programmes Director, Specialised Commissioning; and Director of Health & Justice, Armed Forces and Sexual Assault Referral Centres.

Principal activities during the year

Over the year, the Committee:

- Oversaw the development and, in some areas, implementation of:
  - revised strategic priorities for Specialised Commissioning, including alignment to the NHS Long Term Plan;
  - health and justice commissioning in England;
  - a new model of care for gender identity services;
  - the Genomic Medicine Service;
  - a focus on improving value by reducing variation;
  - healthcare commissioning for armed forces and their families;
  - proposals for decommissioning of specialised services, including obsolete services;
  - Chimeric Antigen Receptor T-cell Therapy (CAR-T) into the NHS in England;
  - an approach to horizon scanning for new technologies, including with closer links to National Institute for Health and Care Excellence (NICE);
  - opportunities provided by off-label medication usage; and
  - re-evaluation of health technologies for specialised services.
- Oversaw 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 2018/19;
  - operational decisions taken by NHS England's Specialised Commissioning Oversight Group (SCOG);
  - operational decisions made by the Specialised Commissioning Patient and Public Voice Assurance Group;
  - operational decisions taken by the Health & Justice Oversight Group and the Armed Forces Oversight Group.

Planned activities during the coming year

As part of the new Board governance framework, the Specialised Services Commissioning Committee has been disbanded, with the majority of its remit being transitioned to the new Delivery, Quality and Performance Committee and sub-committees, which will meet in common with NHS Improvement's Delivery, Quality and Performance Committee and sub-committees. Some decisions of the committee will now reside with the Board and/or Statutory Committee.

Investment Committee

Role of the Committee

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

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

Committee members

The Committee met twice during the year. In addition, it carried out its function by correspondence in July and November 2018. 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)	2/2	
Wendy Becker	2/2	
Paul Baumann CBE	2/2	Left NHS England on 18 November 2018
Matthew Style	0/0	Member from 19 November 2018
Ian Dodge	1/2	
Matthew Swindells	1/2	

Committee attendees

Additional attendees were invited to attend meetings to assist with committee business.

For 2018/19, these have included Director of Operations and Delivery, Head of Project Appraisals Unit and Chair of the OGSCR.

Principal activities during the year

During 2018/19, the Committee has:

- Approved investment cases relating to the Diabetes Prevention Programme, the National Ambulance Resilience Unit (NARU) and the General Practice Payment Calculation Futures (GPPCF) programme.
- Received an update on the Transformation Fund allocation.
- Reviewed the pipeline of service change and reconfiguration proposals presented by the OGSCR.

Planned activities during the coming year

As part of the new Board governance framework, the Investment Committee has been disbanded, with most of its decision making moving to the Executive Resource and Investment Group and some being transitioned to the new Delivery, Quality and Performance Committee, which will meet in common with NHS Improvement's Delivery, Quality and Performance Committee.

Strategic Human Resources (HR) and Remuneration Committee

Role of the Committee

The Committee provides the Board with assurance and oversight of all aspects of strategic people management and organisational development. It also approves the appointment, remuneration and terms of service for the Chief Executive and members of the Executive group, in line with the DHSC and ALB Pay Framework and Government decisions on public sector pay arising from the recommendations of the Senior Salaries Review Body.

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

Committee members

The Committee met twice during the year. In addition, it carried out its function by correspondence in July, October, November and March. The following table details core membership and the number of meetings attended by each member:

Member	Number of eligible meetings attended during the year
Professor Sir Malcolm Grant (Chair)	2/2
Dame Moira Gibb	2/2
David Roberts CBE	1/2
Wendy Becker	2/2

Committee attendees

Additional attendees are invited to attend meetings to assist with committee business.

For 2018/19, these have included:

- Chief Executive.
- 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 ALB 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 closer working arrangements with NHS Improvement, in particular considering the appointments of members of the new NHS Executive Group.

Planned activities during the coming year

During the coming year, the Committee will be renamed the Strategic HR, Nominations and Remuneration committee and hold its meetings in common with the NHS Improvement Nominations and Remuneration Committee. It will continue to focus primarily on reviewing organisational development plans, particularly in light of the closer working with NHS Improvement. The Committee will review the approach to appraisal and talent management. The Committee will continue to review progress with workforce diversity and inclusion and overall staff experience and engagement throughout the year ahead.

Board disclosures

Disclosure of personal data-related incidents

As at 31 March 2019, a total of 13 Notifiable incidents had occurred relating to the loss of personal sensitive data in NHS England and CSUs. All incidents are logged, and a full investigation undertaken.

NHS Digital updated the Data Security and Protection (DSP) incident reporting process guidance following the introduction of the GDPR in May 2018.

The 'Guide to the Notification of Data Security and Protection Incidents' was released in September 2018. This sets out the reporting requirements for NHS organisations where a potential or actual incident may lead to a personal data breach defined under the Data Protection Act 2018 and GDPR. The new scoring criteria references the circumstances where notification to the Information Commissioner's Office (ICO) may not be necessary, and has resulted in a reduction in the number of incidents classified as notifiable.

Unless otherwise stated in the tables on the following pages, remedial actions were implemented for all incidents and the ICO kept informed as appropriate.

Summary of incident	Organisation	Date of incident	Nature of incident	Number of individuals affected	How patients were informed	Lessons Learned
Subject Access Request (SAR) response lost - sent recorded delivery via Royal Mail but was not received by the applicant. (ref: IGI/19491)	NHSE	03/05/2018	Lost in transit	1	In writing	Correct procedure was followed, incident caused by Royal Mail - outside of NHS England's control.
In responding to an individual's request for access to their medical records, limited clinical documents relating to 2 other patients were incorrectly disclosed in (ref: IGI/19478)	NHSE	08/05/2018	Disclosed in error	2	Duty of candour process is ongoing, based on the finding of the review of the service, communication will be sent to those impacted.	Training needs were identified and a review of the team process was actioned. The team were to be more vigilant when redacting cases and the redactor was to make an additional check to the documents.
Email containing details of 281 patients sent to and accessed by former GP practice employee. (ref: IGI/19500)	NHSE	10/05/2018	Disclosed in error	281	N/A – incident occurred under previous data protection legislation prior to the introduction of GDPR.	Reviewing internal procedures for bulk emails and starter and leaver processes.
In responding to an individual's request for access to their medical records, limited clinical documents relating to 4 other patients were incorrectly disclosed in (ref: DSP/1686)	NHSE	04/07/2018	Disclosed in error	4	Duty of candour process is ongoing, based on the finding of the review of the service, communication will be sent to those impacted.	Following a previous similar incident, the previous actions taken were deemed insufficient to prevent a repeat incident. As such, NHS England reviewed its redaction process upon review of health record requests and made alterations that now include a three-step process that aims to eliminate the incidences of misfiles occurring.
West Midlands Performer Team forwarded investigation e-mail to a GP who was an alleged perpetrator of the allegation. (ref: DSP/3494)	NHSE	04/09/2018	Disclosed in error	2	In writing	The team developed a Standard Operating Procedure (SOP) to mitigate against the risk of future repeated incidents.
North complaints team sent SAR response to incorrect recipient. (ref: DSP/4702)	NHSE	06/09/2018	Disclosed in error	1	In writing	Reviewed SAR process and procedure to ensure consistent approach across regions.
13 medical records delivered to incorrect GP practice and opened by practice staff. (ref: IGI/19302)	PCSE	12/04/2018	Mis-delivered medical records	13	N/A - incident occurred under previous data protection legislation prior to the introduction of GDPR.	This was caused by individual courier error. The courier has received full re-training in the delivery process including the use of the tracking device and an emphasis on tag checking as a final measure.
21 medical records delivered to incorrect GP practice and opened by practice staff. (ref: IGI/19419)	PCSE	01/05/2018	Mis-delivered medical records	21	N/A - incident occurred under previous data protection legislation prior to the introduction of GDPR.	Warehouse error. Sacks are now sorted, separated and correctly labelled before being delivered.
27 medical records delivered to incorrect GP practice and opened by practice staff. (ref: IGI/19442)	PCSE	02/05/2018	Mis-delivered medical records	27	N/A - incident occurred under previous data protection legislation prior to the introduction of GDPR.	This was the first incident of its type for the Reading service centre. Warehouse staff have had a retraining session with the centre manager detailing and highlighting the Capita process and the courier has been reminded of the need for diligence when delivering records.

Summary of incident	Organisation	Date of incident	Nature of incident	Number of individuals affected	How patients were informed	Lessons Learned
76 medical records delivered to incorrect GP practice and opened by practice staff. (ref: IGI/19565)	PCSE	10/05/2018	Mis-delivered medical records	76	N/A - incident occurred under previous data protection legislation prior to the introduction of GDPR.	Warehouse staff to ensure labels are securely attached to tags. Individual courier in this specific case has received refresher training and been reminded to contact the control centre if there is any uncertainty about a delivery.
19 medical records delivered to incorrect GP practice and opened by practice staff. (ref: IGI/19563)	PCSE	17/05/2018	Mis-delivered medical records	19	N/A - incident occurred under previous data protection legislation prior to the introduction of GDPR.	Courier error. Due to limited space the courier picked up the wrong sack and compounded the delivery error due to similarity with the stop ID. Practice names are now being printed on tags.
Cervical screening letters sent to an old NHS office for over three years. The letters were shredded by the new tenants and therefore never reached the patients. (ref: IGI/19335)	PCSE	19/04/2018	Disclosed in error	Circa 2000	N/A - data subjects unknown	PCSE are reviewing policies and procedures to ensure clear guidance is provided to staff regarding the decommissioning of sites and redirection of mail and reviewing methods of communication to ensure all stakeholders are informed of the decommissioning of sites in a timely manner.
Patient identifiable information shared with CCG Clinical Lead without redaction.	CSU	05/04/2018	Disclosed in error	1	In writing by CSU Caldicott Guardian.	Staff to ensure appropriate processes are followed to mitigate against the risk of future repeated incidents.

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 2019 was published on our website[52] in May 2019.

Statement of disclosure to auditors

Each member of the Board at the time the Directors' Report is approved on 31 March 2019 confirms:

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

Board statement

The Board confirms that the Annual Report and Accounts for 2018/19, taken as a whole, is fair, balanced and understandable and provides the information necessary for stakeholders.

52 www.england.nhs.uk/safeguarding/slavery-human-trafficking-statement

Statement of Accounting Officer's responsibilities

Under the National Health Service Act 2006 (as amended), the Secretary of State for Health and Social Care (with the consent of HM Treasury) 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 income and expenditure, Statement of Financial Position 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 (HM Treasury, December 2018)[53] 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; and
- confirm that the Annual Report and Accounts as a whole is fair, balanced and understandable and take personal responsibility for the Annual Report and Accounts and the judgements required for determining that it is fair, balanced and understandable.

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 and for safeguarding NHS England's assets, are set out in Managing Public Money (HM Treasury, July 2013, as amended March 2018)[54].

As the Accounting Officer, I have taken all the steps that I ought to have taken to make myself aware of any relevant audit information and to establish that NHS England's auditors are aware of that information. So far as I am aware, there is no relevant audit information of which the auditors are unaware.

53 https://www.gov.uk/government/publications/government-financial-reporting-manual-2018-to-2019
54 https://www.gov.uk/government/publications/managing-public-money

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 94 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 Government via an assessment given to Parliament. A report on how we have delivered against the mandate objectives during 2018/19 can be found on page 192.

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 Standing Orders, Standing Financial Instructions (SFI), Scheme of Delegation, Standards of Business Conduct policy, Risk Management Framework and 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 2017 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). NHS England is compliant against the provisions of the code, with the following exceptions[55]:

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 National Health Service Act 2006 (as amended). Governance issues are delegated to the ARAC.
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 HR 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: 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 ARAC.

Board arrangements

Information on our Board and its Committees is set out from page 61.

55 It should be noted that the following provisions in the code are not applicable to NHS England: 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.

Closer working with NHS Improvement

We will continue to embed our new operating model, with NHS Improvement, within the two organisations. We created a single NHS Executive Group chaired by NHS England's CEO, including membership of all national directors across both organisations.

In 2019/20 NHS England and NHS Improvement are moving to a single leadership model under the CEO of NHS England and single COO who will also be the CEO and Accounting Officer of NHS Improvement. The single COO post covering both NHS England and NHS Improvement and reporting directly to the CEO of NHS England.

The CEO of NHS England will hold responsibility for overall leadership of the NHS in England. The COO will be responsible for the operational delivery of the NHS Long Term Plan. The seven Regional Directors, the National Director for Emergency and Elective Care and the National Director of Improvement will report directly to the COO.

As set out on page 10, new national director roles, reporting to the CEO of NHS England, have been created and we will continue to appoint to these positions over the coming year.

Seven regional teams now carry out the functions of both NHS England and NHS Improvement in each of their local areas, supporting local systems to provide more joined up and sustainable care for patients. With responsibility for the quality, financial and operational performance of all NHS organisations in their region, they draw on the expertise and support of the national teams to improve services for patients, as well as supporting local transformation by developing the identity of STPs and ICSs.

Working in a more integrated way, at all levels of our health and care services, will deliver better outcomes for patients, better value for taxpayers and better job satisfaction for our staff.

Harris Review

Having regard to the wider implications of the Harris Review[56], which recommended an explicit assurance that all statutory duties and powers are understood and complied with, NHS England maintains a register of all of the statutory duties and powers conferred on it by the National Health Service Act 2006 (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 Legal. Throughout 2018/19, NHS England has been using and updating this register to inform and capture the new operating model, to ensure that statutory duties and powers remain a priority for the new directorates.

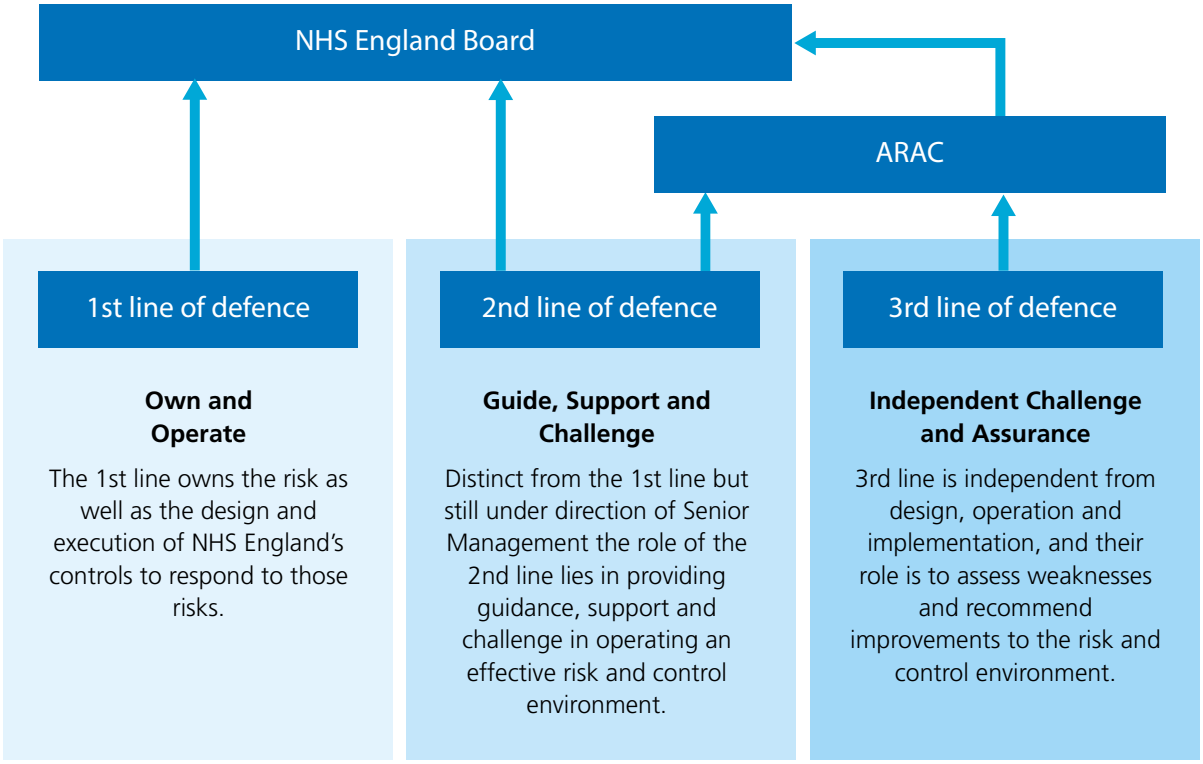
56 www.gov.uk/government/publications/independent-review-into-delegation-of-approval-functions-under-the-mental-health-act-1983

Corporate assurance

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.

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.

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.



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 2018/19, 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.
- As set out in NHS England's Standards of Business Conduct, an annual attestation was implemented requiring all decision making 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 staff declarations and assurance certifications.
- Further training on the electronic platforms for administering risk and internal audit actions.

Management Assurance

Management assurance processes form a critical part of our control processes. All staff above Band 9 (including off-payroll workers (OPW) covering a substantive position), ESMs 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 year-end. During 2018/19 we have seen a further increase in response rates, with a mid-year overall response rate of 91% and year-end rate of 84% compared to 86% and 85% in 2017/18).

We have seen an increased number of responses confirming non-compliance to a broader range of questions during this cycle. However, having reviewed the management information available, we consider that we have more considered and higher quality responses, rather than a decrease in compliance.

During 2018/19 we undertook a pilot of a new Management Assurance Framework, which is designed to reduce reliance on our third line of defence and strengthen our second through enabling management to perform an evidence-based evaluation of the effectiveness of NHS England's key controls for an agreed set of priority areas.

Oversight of NHS England's priorities and related programmes

Throughout 2018/19, the NHS England Board has been provided with regular updates on the implementation of the priorities and programmes that were committed to in Next Steps on the NHS Five Year Forward View. Matters relating to individual programmes were also considered within the formal committees of the Board, including the Specialised Commissioning Committee and the Commissioning Committee.

In addition, ARAC considers the outcomes of internal audit reviews of programmes and the Executive Risk Management Group (ERMG) reviews NHS England's corporate risks which can include causes, consequences, controls and actions relating to individual programmes.

Underpinning the above corporate governance arrangements, individual programme boards and oversight groups meet frequently, with the attendance of representatives from national and regional teams, each with responsibility for delivery of their particular programme, for example Urgent & Emergency Care, Primary Care etc.

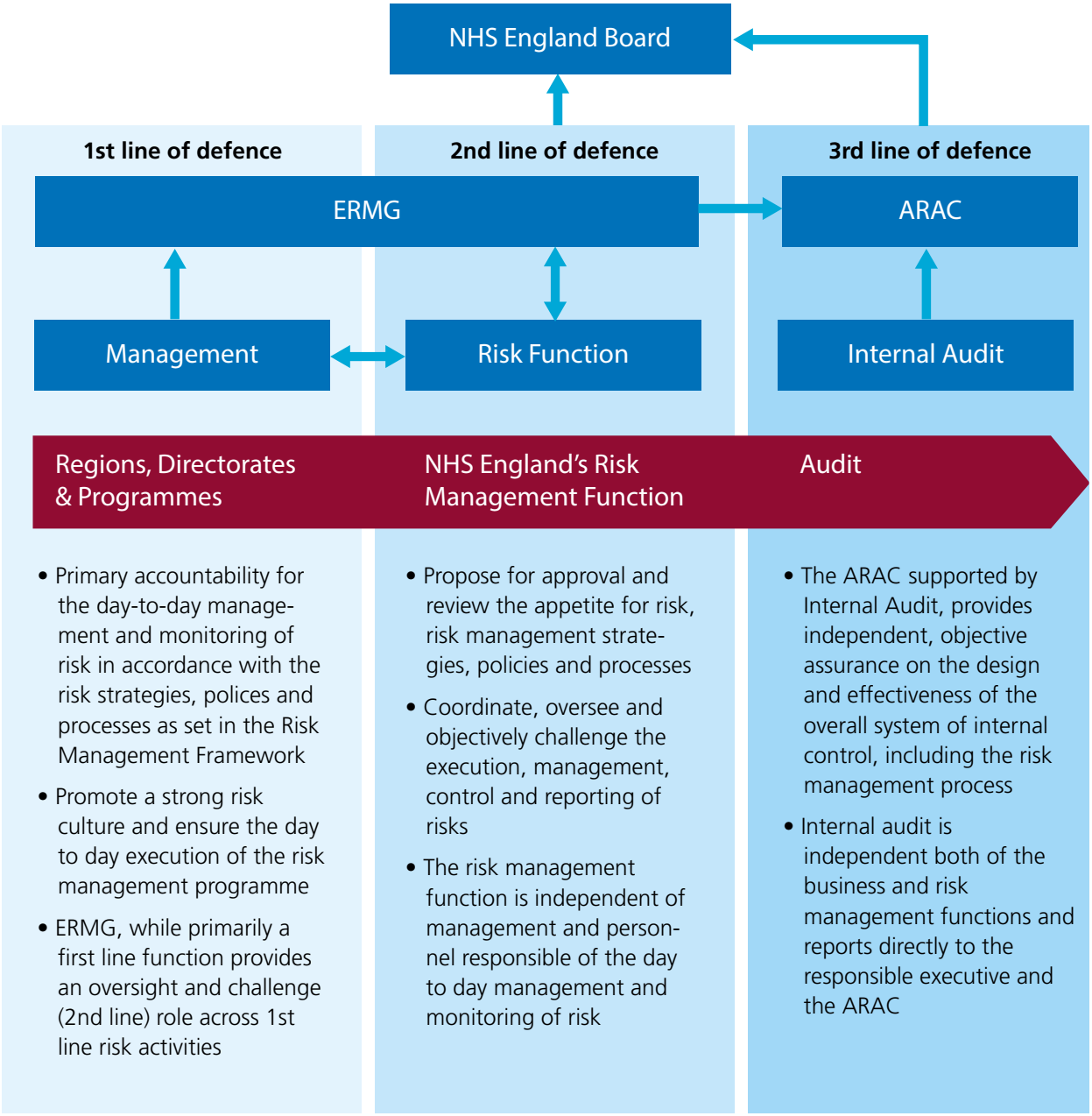
The Deputy Chief Executive Officer (DCEO) held quarterly assurance meetings with each of the regional teams, in addition to conducting regular detailed appraisals of the various national priority programmes. In future the COO will do the same.

Assuring the quality of data and reporting

At each meeting, the Board received 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 (continued by the Delivery, Quality and Performance Committee in Common, from 1 April 2019). 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

NHS England employees follow a single process for identifying and managing risks that may threaten delivery of services and achievement of objectives. The framework mirrors the three lines of defence of our overarching assurance framework. 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.



Our 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, reviews all risks escalated to it, and considers which risks should be managed through the Corporate Risk Register (CRR) and associated processes.

NHS England has strengthened CRR management processes through the development of robust risk analysis, improving the reporting format, and by ensuring consistent quality of reporting led by the accountable risk owners. This is overseen by ARAC and regularly reported to the Board.

NHS England is now in the process of preparing a joint risk register with NHS Improvement to allow the two organisations to manage those risks which they consider are best managed together, and during 2019/20 will introduce a common risk management framework.

During 2018/19, the CRR included:

Risk description	Potential impact	Key mitigation(s) in place included
EU Exit: Services commissioned or needing to be commissioned by NHS England are continued to be delivered with minimal impact on NHS services and patients.	In a no deal Brexit scenario, the NHS is dependent on the UK Government having secured appropriate supply continuity and transport logistics.	- Regular meetings with DHSC (responsible for leading EU Exit planning) policy workstreams, DHSC EU Exit team and with other ALBs (chaired by DHSC). - Establishment of a single EU exit function across NHS England and NHS Improvement with Directors leading work-streams. - Workstream leads are brought together in the 'EU Exit Oversight Group'.
Transforming Primary Care: We continue to work to secure additional general practice services and invest in new ways of improving primary care for patients.	Service availability for patients and demand impacts on other services could be affected.	- GPFV, monitored through the Primary Care Oversight Group. - Work with NHS Digital on replacement IT systems for general practice. - Delivery of a multi-year pipeline of investment in estates and technology infrastructure.
Joint Working: Joint working with NHS Improvement delivers the planned benefits to patients, services and staff.	Possible disruption to critical 'business as usual' activities.	- Shared set of system priorities covering key functions and capabilities. - Joint Working Programme. - Joint Staff Engagement Programme (Project 70).
Primary care **"back office" support services.**	Underperforming primary care support services have a potential impact on the efficiency and effectiveness of our frontline services.	- Standard operating procedures. Contract monitoring. Incident and complaint management arrangements. - Independent expert supporting and monitoring of the service line. - Governance arrangements amended to ensure greater stakeholder involvement.

Risk description	Potential impact	Key mitigation(s) in place included
Inequalities: NHS England continues to demonstrate through its systems, processes and programmes actions to deliver its statutory duties.	Missed opportunities for patients and population health improvement.	- Review process to support Equality and Health Inequalities completion with directorates. - Working directly with the National Director for Operations and Information to ensure Equality and Health Inequalities considerations are being applied to regions and local Directors in a systematic way and potential risks identified locally and managed and supported nationally. - Reporting to the Board and also as part of the Annual Reporting process on actions to reduce health inequalities.
Learning Disabilities: Scale and Delivery of Building the Right Support ambitions - NHS England commitments of 35%-50% reduction in inpatients for people with often complex needs.	Reliance on inpatients support with often complex needs.	- Programme undertakes regular assurance meetings with regions to understand progress and identify where recovery actions are required against performance below expected. - Programme regularly monitors progress via the performance and delivery board. - 'Virtual team working' across system to manage dependencies on social care, housing and workforce.

Risk Appetite

The risk appetite of NHS England is grounded in the NHS Constitution. The NHS Constitution sets out rights, to which patients, public and staff are entitled, and pledges which the NHS is committed to achieve, together with responsibilities, which the public, patients and staff owe to one another to ensure the NHS operates fairly and effectively.

NHS England will minimise avoidable risks to patient safety in the delivery of quality care.

NHS England has a low "risk appetite" with regards to meeting its obligations under the National Health Service Act 2006 (as amended) and in relation to operational performance and financial duties.

Innovation - in the form of technology, integration of services, new models of care and new ways of working - NHS England is prepared to accept moderate to high risk in these areas, where this does not entail risks in any of the above areas, and where rapid cycle monitoring is in place to enable swift corrective action.

In striving to improve the health and wellbeing of the public, NHS England will tolerate low to moderate reputational risk where necessary.

Categories of risk, along with NHS England's previously stated tolerances, are summarised in the table below:

Category of Risk	Tolerance
Patient Safety	No tolerance
Regulatory	Low
Operational Performance	Low
Finance	Low
Reputational	Low to Moderate
Innovation	Moderate to High

Whistleblowing

Arrangements are in place to support whistleblowing for NHS England staff and for those employed by external organisations. Our internal whistleblowing policy 'Voicing your Concerns for Staff' is accessible via our staff intranet and on our website[57]. Emily Lawson, National Director of Transformation and Corporate Operations, is the 'Freedom to Speak Up' (FTSU) guardian for staff in NHS England, and Lord David Prior, Chair of NHS England, is the Board lead. The FTSU network currently consists of 40 FTSU Guardians, of whom seven (18%) have reported a BAME background.

NHS England received three internal whistleblowing concerns during 2018/19, all of which were investigated in accordance with our policy. CSUs reported an additional concern which is being investigated under the CSU's Raising a Concern Policy.

Whistleblowing in primary care

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 pharmaceutical 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[58]. This activity is overseen by designated regional whistleblowing leads reporting into the Corporate Governance team.

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.

57 https://www.england.nhs.uk/wp-content/uploads/2016/09/voicing-concerns-staff-policy.pdf
58 https://www.england.nhs.uk/publication/external-whistleblowing-policy/

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 someone's health and safety.
  - Damage to the environment.
  - Covering up wrongdoing in the above categories.

NHS England's role as a Prescribed Person

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.

NHS England is committed to assigning any concerns raised for further investigation, and supporting 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 2018/19 and action taken

Between 1 April 2018 and 31 March 2019, 70 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 2018/19	Under investigation	No investigation required
3	5	3	53	6

As the result of these investigations we have agreed changes with primary care providers designed to improve services delivered to patients. These include:

- Improved record keeping and management processes.
- Implementation of multi-agency contract management meeting to address quality issues.

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, NHS England's 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, and in future to the Quality Committee, 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 2018/19 the group has:

- Shared learning and intelligence between regional and national teams relating to quality risks/ issues. For example, sharing learning and insight into: specific system and operational issues; from the review of the system's response into events at North Middlesex University Hospitals; from CAMHS Tier 4 Suicide quality summit and suicide investigation reports; and from the Learning Disability Mortality Review Programme.
- Continued to develop learning and improvement in three specific areas covering: prevention of future death reports; independent investigations into mental health homicides; and wider patient safety issues, under coroner's regulation 28[59]. On the latter we undertook detailed retrospective analysis of a wider range of regulation 28 reports to identify trends and are developing actions to address these. On all areas we have established closer working with NHS Improvement to ensure system oversight of learning and actions.
- 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).
- Contributed to the development of national policy and ensured operational alignment with this. For example: contributed to the National Quality Board review into aligning NHS England and NHS Improvement quality assurance and governance functions; worked through NHS England's role and fit with regards to the health and social care regulators' Emerging Concerns Protocol[60] and on the national policy for sharing person identifiable information.
- 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'.
- Used clinical leadership to draw attention across the system to specific quality issues such as: Improving prescribing behaviours for Sodium Valporate in at-risk groups, ensuring system readiness to an alternative supply of Intravenous Immuno-Globulin and circulated the Medicines and Healthcare products Regulatory Agency (MHRA) safety alert on biopsy equipment.

59 The Coroners (Investigations) Regulations 2013 http://www.legislation.gov.uk/uksi/2013/1629/pdfs/uksi_20131629_en.pdf

60 Those who have signed the protocol include: Local Government and Social Care Ombudsman, Care Quality Commission, General Medical Council, General Pharmaceutical Council, Health and Care Professions Council, Health Education England, Nursing and Midwifery Council and Parliamentary and the Health Service Ombudsman. For the full list of those signed up to the Emerging Concerns Protocol please visit: https://www.cqc.org.uk/sites/default/files/20181112_emerging-concerns-protocol.pdf

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 conditions or surgical needs. They deliver cutting-edge care and are a catalyst for innovation, supporting pioneering clinical practice in the NHS.

During 2018/19, the NHS England Board, through the Specialised Services Commissioning Committee (SSCC), set the strategic direction for specialised commissioning and provided assurance over quality, performance and value for money. The SSCC also assured decisions made by the SCOG, which had operational oversight of the £17.7 billion specialised commissioning budget. The Clinical Priorities Advisory Group (CPAG) made formal recommendations on the commissioning position of treatments and interventions for adoption, or otherwise. SCOG endorsed CPAG recommendations for prioritisation and the SSCC made the final decision. For in-year agreed service developments, SCOG made decisions and SSCC was informed.

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; and
- 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 reported to the Commissioning Committee and in future will report to the Delivery, Quality and Performance 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 on 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 2018/19, direct commissioning for non-specialised services accounted for £7.34 billion of total commissioning expenditure (this excludes delegated expenditure by CCGs on primary medical care which totalled £5.64 billion).

Co-commissioning of primary medical services

As of 1 April 2019, 184 CCGs have delegated arrangements for primary medical services (96%). Of the remaining seven CCGs, two (1%) have a joint commissioning arrangement with NHS England and five CCGs (3%) are operating under the 'greater involvement' model.

NHS England's Board has committed to support CCGs to take on the delegated model in future, and additional delegation arrangements have now been agreed with seven CCGs to be taken forward during 2019/20. Additionally, delegation agreements have been made with several newly-merged CCGs, replacing their previous agreements.

STPs

STPs were established in 2016 and are a mechanism for driving partnership working across localities to deliver health and social care integration.

Over the last year, STPs have strengthened their leadership and governance arrangements, enabling collective decision making to best meet the population need for their geographies. In many instances, commissioning functions have been streamlined to drive efficiencies and reduce variations across geographical footprints.

Over the last year, two systems have received a 'deep dive diagnostic' to support the alignment of all system partners on the actions required to deliver services to meet local populations' health needs. In addition, all STPs and ICSs have received a high-level diagnostic to arm them with system-wide insight into the quality, operational performance and financial opportunities for their populations.

Commissioning capability programme

NHS England established a programme to use a place-based approach to support commissioning leadership teams across health systems to deliver on the Next Steps on the NHS Five Year Forward View. This year saw the launch of the NHS Long Term Plan and the programme supports an overarching expectation to break down traditional barriers between organisations to ensure a more coordinated, sustainable and integrated approach.

Through a tailored approach, the programme has specifically supported strong leadership development and sustainable system planning across CCG, STP and ICS leadership teams as key drivers to effective system transformation with a core focus across three modules:

- Delivering Today's Challenges (focussed on developing CCG leadership and sustainability performance). To date, 46 local health and care systems have progressed through the programme including 84 individual CCGs.
- Preparing for the future: supporting aspiring ICSs (targeted at STP leadership teams). 10 STPs have participated in the programme resulting in the development of clear roadmaps to support their future journey to ICS status.
- Population Health Management (equipping ICSs with the capabilities to implement proactive anticipatory care models). Four ICS sites are completing this module of work which will allow them to have much greater insight into their patient level data allowing for effective care design decisions to be made.

In addition, NHS Clinical Commissioners have developed a buddying and action learning offer to complement the programme and support the sharing of best practice and built a peer to peer network for leadership development.

Commissioning Support Units (CSUs)

There are five CSUs, with a combined workforce of 6,700 people providing essential support to a range of organisations, primarily to CCGs, but increasingly also to local authorities, NHS Trusts as well as ICSs and STPs. Being reliant on income for services delivered, CSUs have to be responsive to the needs of their local health system as well as delivering against national priorities. They continued to secure new work in competition with the commercial sector, demonstrating both resilience and quality of delivery. Their ability to perform to a high standard was confirmed again in year as they successfully secured places on national procurement frameworks following independent scrutiny of both the quality and efficiency of services they deliver.

During the year CSUs have delivered on local health system priorities, supported the emerging STPs and the ICSs. As an integral part of the NHS, CSUs have delivered national priorities such as a population health management dashboard, CHC cost reduction, waiting list initiatives and leading on transformation of local health systems. They have also been at the forefront of the NHS response to the challenges of cyber security threats, providing protection to primary care services and helping to avert potential disruption. CSUs have achieved independent cyber security accreditation and they are continuing to develop systems to combat new threats.

The Managing Director within each CSU is accountable for ensuring their CSU adheres to appropriate governance processes and NHS England receives a monthly signed statement of assurance from each CSU. In 2018/19, CSUs once again met all financial targets, meaning they will have achieved a balanced budget position every year since they were established in 2013.

During 2018/19 CSUs have worked closely with NHS England to evaluate their offering and develop a future strategy in the context of the evolving STP / ICS landscape. During 2019/20 CSUs will focus greater resources on supporting STPs and ICSs in the work they are doing across their systems. CSUs will work with National and Regional Directors to support local system development and productivity improvement for ICSs, STPs and Primary Care Networks.

Clinical Commissioning Groups (CCGs)

In 2018/19, there were 195 CCGs each of which is an independent statutory membership organisation with an appointed accountable officer. CCGs are clinically led and responsible for commissioning high quality healthcare services for their local communities. NHS England is accountable for assuring the commissioning system and has a statutory duty to assess the performance of each CCG every year to determine how well it has discharged its functions.

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 required to demonstrate probity and good governance in managing their finances and performance. Together, CCGs are responsible for about 60% of the NHS budget.

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. Increasingly, account has been taken of CCGs' performance within their system and of system-level performance. Parliament has provided for specified but limited rights of intervention by NHS England into CCG functions, such as the power to issue directions to CCGs under certain circumstances.

CCG Improvement and Assessment Framework (IAF)

NHS England's CCG IAF was introduced in 2016/17 to align key national objectives and priorities and inform the way we manage our relationships with CCGs. It was recognised in 2016 that the NHS could only deliver on the NHS Five Year Forward View commitments through place-based partnerships spanning across CCGs, local government, providers, patients, communities, and the voluntary and independent sectors. Therefore, the IAF includes indicators that are beyond the scope of CCGs' direct control, reflecting the importance of tasks-in-common for the benefit of patients and communities.

The 2018/19 framework continued the principles of focusing on a manageable number of the highest priorities facing the NHS and reaching beyond CCGs. A small number of indicators were retired, and new indicators ensured alignment with NHS Improvement's Single Oversight Framework for NHS providers, supporting the development of integrated system working, and with the joint planning guidance published in February 2018.

NHS England and NHS Improvement have worked together to develop a new approach to oversight, starting with a transitional year in 2019/20, that will provide a consistent means of reviewing and supporting system-level performance. Legislation still requires an annual performance assessment to be carried out at individual CCG level.

NHS England has the option of using its statutory powers, conferred by section 14Z21 of the National Health Service 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[61].

NHS England also supports improvement through its special measures regime, which is an internal management approach to CCGs facing the most significant challenge in the areas of financial and operational performance. There are two routes by which a CCG enters 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 a CCG's leadership, quality and/or financial performance.

61 https://www.england.nhs.uk/commissioning/regulation/ccg-assess/directions/

18 CCGs assessed as inadequate at the 2017/18 yearend were placed in special measures and two CCGs entered the regime during 2018/19. Eight CCGs exited the regime during 2018/19, including those from the finalised 2017/18 year-end process.

When a CCG enters 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.

36 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.

CCG annual reports

CCGs published their individual annual reports via their websites in June 2019. A list of CCGs and links to their websites can be found on the NHS England website.

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 'quality and performance' and 'finance, governance and control', with the majority of control issues raised relating to delivery of performance targets in secondary care and achievement of financial balance. This matches issues highlighted by those CCGs in their earlier "exception" reports.

Other assurance

Cyber and data security

NHS England continues to work with Government agencies including NHS Digital, the National Cyber 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 aware of the latest threats and that our information is handled and stored safely and securely.

To mitigate the risks associated with cyber attacks, NHS England has instructed its IT suppliers to implement security patches in a timely and controlled manner, and we are working closely with our IT partners to address issues as they arise that could prevent the timely application of security patches and updates.

NHS England Corporate ICT provides support to the EPRR team, making communication flows and IT advice available in the event of a substantial attack. In addition to corporate activity, NHS England is working with other system partners to ensure that a robust approach is taken on cyber security across the service.

System-wide approach to cyber security

NHS England has worked to develop a target operating model for the cyber security programme that encompasses NHS Improvement, NHS Digital, and DHSC, whilst also taking account of planned changes to the operations of NHS England and NHS Improvement.

The cyber security programme operates through six workstreams, which are:

1. Establishing a Clear Contractual & Regulatory Framework.
   NHS England has continued to help to drive a clear contractual framework across the system, through the NHS Standard Contract for providers and the publication of an addendum to the GP IT Operating Model for primary care. The Standard Contract,

addendum, and new legislation, such as the GDPR and the Network Information Systems (NIS) regulations, have enabled the NHS to address issues such as the use of unsupported systems, and business continuity planning in NHS organisations. NHS England will continue to work with partners to promote awareness of and enforce the regulations. The 10 National Data Guardian (NDG) recommendations are integral to the new Data Security Protection Toolkit (DSPT) that NHS England has been promoting since the introduction of the DSPT In April 2018. NHS England has been active in escalating issues highlighted by the interim DSPT submissions made by providers in October 2018, and will continue to address issues raised in the full annual DSPT submissions made at the end of March 2019.

2. Addressing Infrastructure Weakness
   Work to evaluate the £61 million capital funding allocated in 2017/18 has been undertaken and a range of "local interventions" have been promoted across the system. Further cyber security funding of £150 million was announced by the Government for the next three years and NHS England has worked to develop a system to evaluate and identify key areas for priority investment. A cross-system group has been established to identify threats and risks and to ensure appropriate allocation and use of cyber security funding, to address the key threats and vulnerabilities across the system. The ongoing schedule of onsite assessments has been used to inform the decision-making process, with 50 additional assessments completed this year, and a programme of re-assessments planned to evaluate progress toward the certification standard of Cyber Essentials Plus. A pilot Cyber Essentials Plus accelerator scheme was undertaken to assess costs and requirement to achieve certification; the pilot will inform the Government's investment decisions for the coming year.

3. Communications & Engagement
   NHS England has continued to promote Board level engagement in cyber security through support of the NHS Digital board awareness training programme, and the continued use of the NHS England board framework. The framework has been promoted to trust and STP boards, at CCG events, to audit groups, and to incident response and business continuity partners.

   A Cyber Security Steering Group has been established. NHS Digital runs a 'Data Security Centre (DSC) Associates' scheme, and the programme has identified existing networks that can be coordinated to extend the 'cyber champions' network.

4. Building Local Performance and Boosting Capability
   The NHS continued to promote the development of the performance and capability of local organisations through a range of activities, including onsite assessments, Cyber Essentials Plus accelerator pilot, CSU deep dives and audit, and an internal audit of the 22 Chief Information Officer (CIO) recommendations. A range of metrics has been used to develop a "2 x 2" matrix of cyber security risk impact and the ability of organisations to address those risks. The 2 x 2 matrix has been used to focus intervention activities undertaken by NHS Digital DSC and the outcome of the interventions have then been used to develop a plan to target capital investment.

5. Improve Threat Surveillance and Incident Response
   Following feedback from the system-wide cyber incident exercise that was held in December 2017, the ALB Cyber Security Handbook has been merged with the DHSC incident handbook to provide a consolidated single approach which has been promoted at

regional events, exercises and workshops. A set of standard scenarios has been developed by NHS Digital and PHE that can be used by various organisations to run local cyber incident exercises. A communications protocol has been developed and agreed between ALBs, to ensure clear ownership and approval for messaging in pre-incident situations. A series of drills has been completed to rehearse and refine elements of the Cyber Incident Handbook; feedback from the drills has been collated to improve current processes and to update the handbook ahead of the next system-wide exercise.

NHS Digital has defined and implemented changes to the Care Computer Emergency Response Team's (CareCERT) "Collect" portal, to ensure it better meets the needs and requirements of the whole system, including primary care and GP IT suppliers, and continues to be a valuable source of communication and assurance during any future incidents.

NHS England has worked with the DHSC, NHS Digital and the CQC to use available threat intelligence to identify key areas of risk and to address those risks using the NIS Regulations.

6. Local Health and Care Records – Cyber security workstream
   As part of the move to ICSs, the Local Health and Care Records (LHCR) initiative looks to provide the longitudinal care record to support up joined up care but also the use of data for actionable insight. NHS England established a working group with DHSC, NCSC and NHS Digital on defining the cyber security standards needed for these local health and care records.

   We have developed a draft cyber framework for LHCR localities and will be undertaking "risk-tree" sessions with them to ensure that potential threat vectors have been considered.

Information Governance (IG)

Work continues to provide and assure an effective IG framework that ensures NHS England remains legally compliant in relation to data protection, records management and information security activities. Work is underway to develop an integrated IG operating model across NHS England and NHS Improvement, with a single Data Protection Officer now providing and assuring a corporate service across both organisations.

NHS England has achieved operational compliance with new data protection legislation, following the implementation of its GDPR readiness programme. We have delivered standardised processes and systems, a new corporate privacy notice and expanded IG policies, supported by an intensive communications campaign. Work continues to enhance compliance through ongoing engagement and a new IG assurance function. As the new laws became effective, the ICO carried out a voluntary audit to assess the compliance of NHS England's IG framework and governance arrangements. The outcome and any recommendations from the audit will form the basis for the NHS England IG action plan for 2019/20.

NHS England is working with NHS Digital to assign responsibilities pertaining to the governance of data for commissioning purposes. This aims to streamline national data access processes so that CCGs can make informed commissioning decisions based on high-quality and timely intelligence. This will support them to undertake population health management and, ultimately, improve outcomes for citizens in line with the NHS Long Term Plan.

Business critical models

NHS England recognises the importance of quality assurance across the full range of its analytical work and has an approach that is consistent with the recommendations in Sir Nicholas Macpherson's review of quality assurance of Government analytical models (2013).

NHS England analysts are expected to ensure consistent performance and quality assurance across their analytical work. For business critical models, where an error would have a significant patient care or other impact, NHS England operates a register of business critical models and audit of the quality assurance strategy associated with them, overseen by a committee of experienced analysts. To date all relevant NHS England models in the register have passed.

Business critical models operated by NHS England include:

Name of model	Type
Commissioner Finance Model (previously High level allocations model)	Allocation
CCG, primary medical care and specialised allocation model	Allocation
CVD treatment of high risk conditions	Forecasting
Referral-to-treatment ready reckoner, and associated Point of Delivery conversion file	Forecasting

During 2019/20 NHS England will work with NHS Improvement, to build on our joint experience and business critical models.

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 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.

We have continued to work with Capita on improvements to the control environment. The interim Type II report issued to cover the first half of 2018/19 showed improvement compared to 2017/18. The year end Type II report confirmed this improvement although it still includes exceptions.

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; and
- 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 the 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 the ARAC.

The Head of Internal Audit opinion for 2018/19 is set out from page 105.

External Audit

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

The Certificate and Report of the Comptroller and Auditor General is set out from page 139.

Control issues

During 2018/19 we have worked to build controls into management processes previously identified as requiring improvement:

Improving control processes for off-payroll workers

During 2018/19 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 HM Revenue and Customs (HMRC) requirements and are expanding the work to include clinical off-payroll workers in advisory roles.

Strengthening establishment controls

Refinements were made to the electronic system used at NHS England giving each department access to their establishment. Reconciliation work has taken place between budget holders, management accountants and the Workforce Systems team to ensure data is accurate and cross-checked. As a result, there is now greater assurance around processes for maintaining the establishment, enhanced with the changes enabled via the ESR when personnel join or depart.

Managing third party contracts

Historic issues with some third-party contracts have led to strengthened contract management. These ensure maximum value and confirm that all delivery requirements are consistently being delivered with issues identified proactively and resolved as soon as they arise.

Extensive work, utilising Government Commercial Operating Standard methodologies has been undertaken over the last two years to identify contracts that require specific assurance, assign specific responsibility for contract ownership and management and develop supporting guidance and training. This work has been informed and supported by targeted internal audit reviews of third party assurance.

The Commercial team used a risk based approach to ensure that the highest value and highest impact contracts were reviewed first by a dedicated central team of experienced contract managers who engage with the relevant third party. The management of other, non-strategic, third party contracts is assigned to contract owners and managers across NHS England.

Over 100 contract managers and owners, covering 80% of non-strategic contracts, have been assigned to embed the redesigned processes and achieve Government Commercial Function contract management qualifications.

Primary Care Support England (PCSE) cervical screening incident

As part of the PCSE contract, Capita provides administrative support for the National Cervical Screening Programme by producing and sending around 9 million invitation, reminder and result letters to women each year.

On 17 October 2018, PCSE informed NHS England and PHE that a number of cervical screening invitation and reminder letters had not been sent to women inviting them to make a routine cervical screening appointment.

Following investigation of this incident, it was confirmed that 51,319 items of screening correspondence (screening invitation, letters and reminder letters) in total were not sent in 2017 and 2018. Investigations have concluded that this was due to the correct process for uploading, organising and checking letter files not being properly followed within PCSE.

NHS England declared this as a serious incident and set up a clinically-led multiagency incident panel to assess any risk or harm to the women affected.

Following the investigation, NHS England concluded that the potential harm from this incident has been minimised because a 'failsafe in the system operated as expected'. However, the impact on individuals will not be known for some time as women go through the whole screening process. The clinical recommendation from PHE is to undertake a full audit of screening outcomes for the women affected in nine months.

As part of a regular audit, Capita's Primary Care Support unit identified that emails had been sent to three of their email addresses that they thought were no longer being used. Some of these emails related to administrative aspects of screening. They also identified letters scanned into their IT systems which they may not have actioned due to incorrect technical configurations between their systems.

NHS England, Public Health England and Capita have since then been working together through a clinically-led incident panel to ensure every individual's case is reviewed, so that appropriate action can be taken. There is no current evidence that this incident has led to harm.

Other PCSE service issues

The PCSE contract with Capita came into effect on the 1 September 2015. As was confirmed by the NAO report[62] and again at the Public Accounts Committee, NHS England's management of the primary care support services contract with Capita has already saved the taxpayer £60 million. 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

62 https://www.nao.org.uk/report/nhs-englands-management-of-the-primary-care-support-services-contract-with-capita/

four major sites processing all activity across England. This is a complex task that continues to require careful management.

Recognised issues including updates to the performers list; administration of GP pensions; movement of records; and, timely payments 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, there is more to achieve in the coming year.

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

Allocations

NHS England is responsible for allocating funding for the NHS provided by the Government. 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.

The Government has confirmed, alongside the NHS Long Term Plan, that annual funding for NHS England will grow by £33.9 billion in cash terms by 2023/24. In 2019/20 NHS England's funding will increase by 3.6% in real terms (adjusted for 2018/19 pay funding).

In January 2019 the NHS England Board approved allocations for the commissioning sector for the next five years, 2019/20 to 2023/24, with firm allocations for the first three years and indicative allocations for the final two.

Our approach to allocations is based upon:

- funding a realistic and sustainable level of activity for each commissioning stream;
- appropriately funding commissioning streams for price pressures, including the impact of 2018/19 pay awards and the impact of putting £1 billion of the Provider Sustainability Fund (PSF) into urgent and emergency care prices;
- protecting funding for the implementation of existing NHS Five Year Forward View commitments, particularly in respect of mental health, primary care and cancer services. We also allocate sufficient funds to meet the NHS Long Term Plan commitments to increase spending on mental health and primary medical and community health services.
- reducing running costs, whilst also prioritising funding for transformation and service development; and
- maintaining a prudent central provision given additional risks the Government is now requiring NHS England to manage.

Allocations to local areas are developed using statistical formulae, so that funding reflects local healthcare need and helps to reduce health inequalities. Based on advice from the independent Advisory Committee on Resource Allocations, we have made a number of improvements to the formulae including new or refreshed formulae for community services and mental health need, and changes to the health inequalities adjustment to make it more responsive to extreme health inequalities and unmet need.

We have continued to deliver on our previously established principle that no CCG should be more than 5% below the target "fair share" level of funding calculated using the updated formula. Over the five-year period we will continue to redistribute resources to bring those CCGs furthest from their target allocation closer to that level.

Financial Framework

The NHS Long Term Plan set out a number of reforms to the financial framework to deliver the five financial tests set by the Government as part of the long term financial settlement. These reforms will help to ensure that all organisations are able to deliver financial balance by the end of the five-year settlement and will drive the continued productivity and integration necessary to ensure sustainability in the medium and long term.

The key changes are:

- Reforms to the payment system, in particular the introduction of a blended payment model for urgent and emergency care activity in 2019/20, which will move funding away from activity-based payments over time ensure a majority of funding is population-based. This will make it easier to redesign care across providers, support the move to more preventive and anticipatory care models, and reduce transaction costs.
- Measures to re-set the financial framework for NHS providers including transferring £1 billion from the PSF into national prices and creating a new £1.05 billion Financial Recovery Fund (FRF) to support systems' and organisations' efforts to make all NHS services sustainable. As a result of this funding, we expect by 2023/24 no trust to be reporting a deficit.

Financial performance monitoring

In 2018/19 the financial position across the commissioning system has been reported monthly using the Integrated Single Financial Environment (ISFE) reporting system.

This has enabled a detailed monthly review by NHS England local offices, regional and national finance leadership teams, and the Chief Financial Officer. Regular updates on the overall financial position have been presented to the Executive Group, the Commissioning Committee and the NHS England public Board.

Individual CCG and direct commissioning financial performance is monitored against key performance indicators, with a focus on the underlying financial position of organisations and the presentation of any risks and mitigations, in addition to the reported forecast and year-to-date position. At critical points in the year the national team undertakes 'deep dives' with regional finance teams where organisational financial performance is analysed in greater detail.

Quarterly financial performance information for the commissioning sector at an organisational level is published on NHS England's website.

NHS England and NHS Improvement have continued to work more closely together in aligning financial performance monitoring across both the commissioner and provider sectors. At all levels the two organisations have been coming together to jointly assess the combined financial and operational position across local systems and the NHS as a whole, resulting in joint reporting and discussion at Board level.

NHS England central programme costs

In 2017/18 we agreed two-year allocations for our central programme resources and transformation funding. These baselines allocations were updated for 2018/19.

Most of this resource has been made available for direct investment to deliver on the priorities and objectives outlined in Next Steps on the NHS Five Year Forward View, in collaboration with STP areas, and focusing on priorities such as Urgent and Emergency Care, Primary Care, Cancer and Mental Health. The remaining available funding covers a variety of other operational commitments and charges for depreciation.

Cabinet Office efficiency controls

As part of the Government's control of expenditure, NHS England is subject to specified expenditure controls. These controls cover a range of expenditure categories and require proposed expenditure to be approved to secure best value for money and ensure efficiency is being maximised. For expenditure above certain thresholds in specified categories (e.g., professional services and consultancy), approval is also sought from DHSC and for some cases this also requires approval from Ministers, the Cabinet Office and/or HM Treasury.

Counter fraud

NHS England investigates allegations of fraud related to our functions, where these are not undertaken by the NHS Counter Fraud Authority (NHSCFA), in addition to ensuring that appropriate anti-fraud arrangements are in place.

NHS England established its own in-house team of Counter Fraud Specialists to investigate allegations of fraud and conduct fraud awareness activities. 2018/19 was the NHS England Counter Fraud team's first full year of operation and the change in delivery model has already enhanced the effectiveness of the response.

ARAC receives regular updates regarding the counter fraud function, proactive counter fraud work and the outcome of reactive investigations. ARAC also receives a report at least annually against the Standards for Commissioners: Fraud, Bribery and Corruption. 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.

The NHSCFA undertakes an annual high-level estimate of the potential scale of fraud affecting the whole of the NHS. Its Strategic Intelligence Assessment for 2017/18[63a] was recently published and reduced the estimated value of fraud from £1.29 billion to £1.27 billion which NHSCFA together with its partners have responsibility for tackling. Whilst this reduction is relatively small, the assessment records a £90 million reduction in estimated prescription, optical and dental exemption fraud.

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 other contractor focussed services 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 £28 million in 2018/19.

63a Report is published on the Counter Fraud Authority website: https://cfa.nhs.uk/about-nhscfa/corporate-publications

The continued cooperation with key partners and development of the counter fraud service in the coming years will further safeguard NHS England's resources.

On 14 May 2019, the NAO published their "Investigation into penalty charge notices in healthcare"[63b]. The report highlights the loss to the NHS as a result of people incorrectly claiming exemption from paying prescription and dental charges was around £212m in 2017/18, concluding it is important that the NHS can reclaim these funds and deter fraud. Whilst recognising NHSBSA's efforts in reducing fraud (with an estimated reduction of £50m in prescription fraud between 2012/13 and 2016/17), the NAO found eligibility rules set by Government and Parliament are complicated and difficult to understand, with a need for a simpler system or better real time checking to not disadvantage vulnerable people.
NHS England are continuing to work with NHSBSA and DHSC to improve public awareness and understanding. A communications campaign to raise public awareness of eligibility and penalty charges 'check before you tick' took place in 2018, with further campaigns planned for 2019. NHSBSA are already piloting real-time exemption checking in pharmacies with the intention to roll this out further in the future.

Head of Internal Audit opinion

In the context of the overall environment for NHS England for 2018/19, in my opinion, the framework for governance and risk management has substantially been adequate and effective in 2018/19.

The overall opinion is supported by my view in each of the areas of governance, risk management and internal control. Each of these areas is covered in more detail within my full report. It is however important that the overall opinion is considered within the context of the environment that NHS England has operated in during the year to 31 March 2019.

With respect to the internal control environment, significant effort and progress has been made in addressing weaknesses identified in previous years, for example, non-clinical off payroll workers and recruitment, and the second line of defence has been strengthened with the introduction of the management assurance framework. On this basis, the framework for internal control has been appropriately implemented in the organisation through the 2018/19 year, except for the need to address the areas highlighted below; all of which NHS England are aware of:

1. The management of clinical off-payroll workers
2. Primary Care Support England Services
3. Third Party; Business Critical Models; and Project and Programme Management Frameworks
4. Primary Care Services Oversight
5. Continuing Healthcare

63b https://www.nao.org.uk/report/investigation-into-healthcare-penalty-charge-notices/

In my view, taking into account the internal audit work under taken during the year and the changes which the organisation continues to undergo, the design of the internal control framework provides a substantially adequate and effective foundation for the year to take the organisation forward, except for these areas.

This opinion is based on the underlying internal audit programme of work, designed to address the specific assurance requirements of the NHS England Board and focussed on areas of risk identified by management. The planned internal audit programme, including revisions to the programme during the course of the year, has been reviewed and approved by the Audit and Risk Assurance Committee (ARAC). Results of internal audit work, including action taken by management to address issues included in internal audit reports, have been regularly reported to management and ARAC.

This opinion takes into account other relevant information brought to the attention of internal audit. It has not been limited by any shortfall in resources, absence of skills, or any significant limitation of scope of internal audit activity which would adversely affect the ability to form an opinion. It can only be reasonable in the sense that no opinion can ever be absolute and is a reflection of the evidence available.

This opinion is a key element of the assurance framework which the Accounting Officer needs to inform his annual Governance Statement, however it in no respect detracts from the Accounting Officer's personal responsibility for risk management, governance and control processes.

Overall summary

Over the year we have continued to build on our approach to governance, risk and internal controls. We welcome the acknowledgement of the improvements made in the management of non-clinical off-payroll workers and our strengthened management assurance processes. We are committed to delivering improvements in the areas highlighted in the audit opinion.

During 2019/20 we will continue to develop our approach to governance frameworks internal controls and oversight of specific services particularly in the context of our joint working arrangements with NHS Improvement.

Remuneration and Staff Report

Staff report - NHS England

Our People

As at 31 March 2019, NHS England directly employed 6,520 people[64]. Of these, 4,752 people were permanently employed on recurrent, open-ended contracts of employment, based around the country within seven directorates. A further 1,768 people were employed on payroll on fixed term contracts of employment and 853 individuals were engaged in an off-payroll capacity which includes agency staff and secondees. (Subject to Audit)

Breakdown of number of people employed by directorate

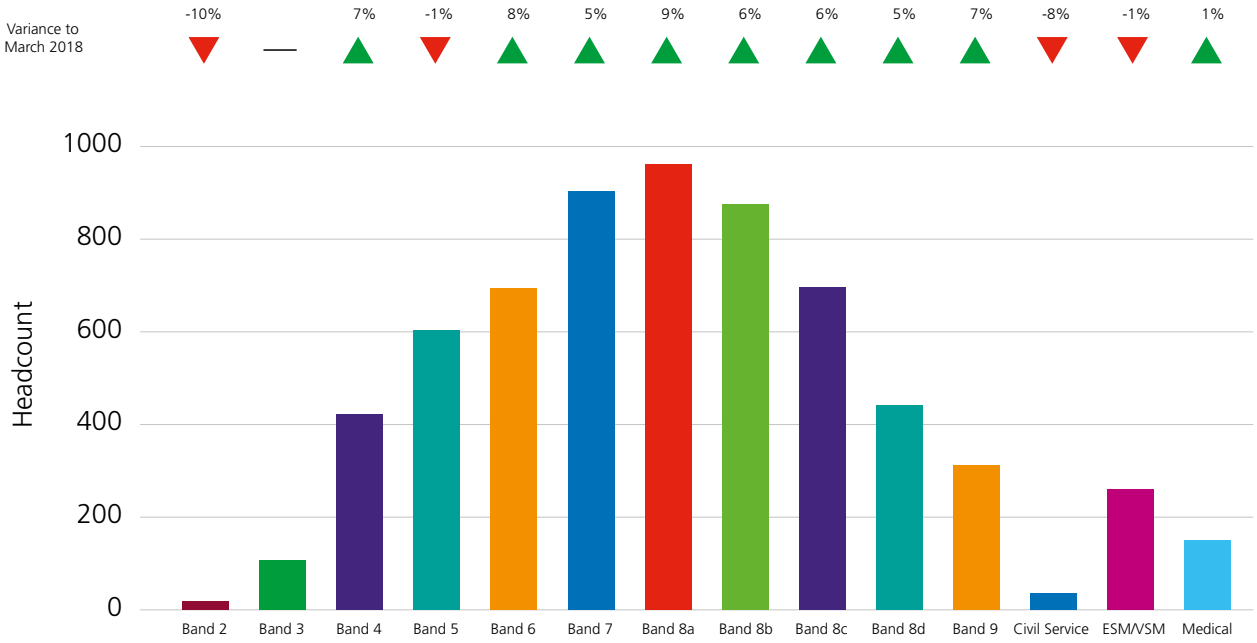
Member		No of people employed
Operations and Information - Central		1041
Operations and Information - London		579
Operations and Information - Midlands & East		1,131
Operations and Information - North		1,179
Operations and Information - South		918
Finance, Commercial and Specialised Commissioning:		495
of which..	*Finance*	181
	Specialised Commissioning	314
Medical		110
Nursing		176
Strategy and Innovation		312
Transformation & Corporate Operations		561
Chair and Chief Executive's Office		18
Total		**6,520**

Detail on staff numbers and costs for NHS England and the Consolidated Group, including CSUs, are presented from page 118.

64 CSU staff are employed via the NHS BSA and therefore not included in this analysis. The analysis of CSU staff is presented from page 117

All staff by pay band

NHS England has seen an increase in permanent and fixed term headcount of 5.9% since 2017/18 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 band 8a (salary range £42,414 - £49,969 per annum), band 8b (salary range £49,242 - £59,964 per annum and band 8d (salary range £70,206 - £85,333 per annum)[65].



The following organisational activities have been undertaken to ensure the ongoing advancement of our people to enable the continued delivery of the Next Steps on the NHS Five Year Forward View. Our Joint Working Programme with NHS Improvement has been designed to strengthen our joint working relationship and deliver a new operating model to ensure that collectively we can add greater value to the NHS.

Improving our workforce diversity and inclusion

We continue to work towards embedding the six ambitions of the Diversity and Inclusion Strategy across the organisation:

Individual	Organisation
I can make full use of my skills, experience and abilities	We have accurate data to support leadership accountability
I have equal opportunities for career progression	We tap into the lived experience of our staff
I am respected, valued and feel safe to be myself at work	Valuing diversity and supporting inclusion is part of the way we work

Giving permission:	**Impact:**	**Ownership:**
Pilot on small scale, evaluate, improve.	#real people camapign – sustainable change	Co-design with staff networks, regions and directorates

65 The term 'senior manager' (within this report) denotes all staff remunerated at or above the pro-rata salary of £84,507 per annum. This includes the top tier of Band 8d, where 163 of our 442 Band 8d staff are remunerated in the top tier. This is consistent with the definition used within Cabinet Office and HM Treasury returns.

Using the six ambitions as a focal point, we have enabled teams to retain ownership of the diversity and inclusion agenda, giving them permission to test out new ways of working and keeping them focused on developing practical actions that will help to improve the working lives of real people. Several teams are testing and piloting interventions on a small scale, evaluating them closely and then rolling the successful ideas out more widely.

A number of regional and central teams are participating in Reverse Mentoring programmes with the aim of supporting an improved understanding of the lived experience of staff from under-represented groups. The Strategy and Innovation directorate have completed a BAME positive action pilot and are now rolling out the programme to a wider cohort of staff.
A Diversity and Inclusion Leadership (DIL) programme has been developed, supporting 16 staff to complete stretch assignments, combined with in depth workshops on the subject of disability, race, LGBT+, Carers and Gender equality. It is envisaged that graduates from the DIL programme will use the knowledge they gain to become Diversity Innovators and share the learning they have gained with their teams.

Our staff network chairs and executive committee members continue to provide support to staff, influence policy development and hold the organisation to account. Staff networks across NHS England and NHS Improvement are enabling employees across both organisations to join as members, resulting in a total of eight networks. The offer to staff includes support from the BAME staff network; LGBT+ network, Disability and Wellbeing Network (DAWN), Carers, Muslim, Christian and Mental Health First Aid staff networks.

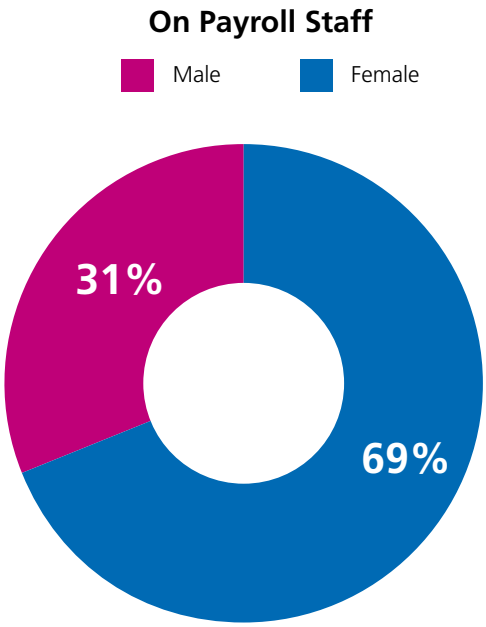
Recruitment and retention of disabled persons

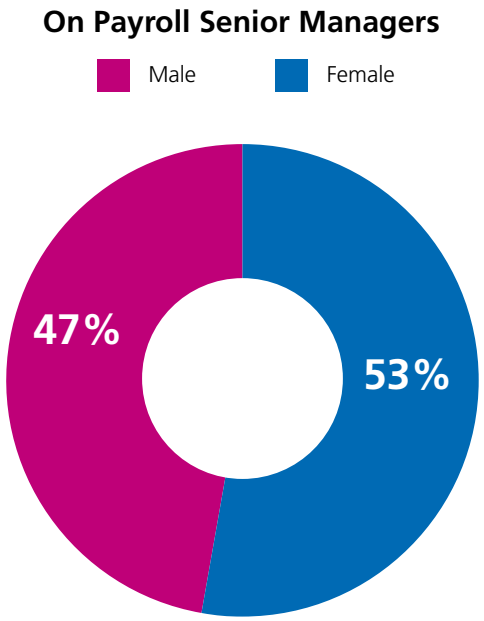
As a Disability Confident Employer, recognised by the Department for Work and Pensions, NHS England continues to work towards fulfilling our commitments to employ more disabled staff, and support disabled staff to work, develop and progress. Disabled staff voices have been sought out to improve conditions at work via three Disability and Wellbeing Network Staff Survey Focus Groups in 2018. Our major disability focus in 2018/19 has been on improving the provision of reasonable adjustments. This was in close collaboration with our active DAWN network which continues to grow year-on-year, and now includes three sub groups focused on Autism; Deaf and Hard of Hearing; and Mental Health.

We have continued to work with our DAWN network to support employees within the workplace and strive to ensure that all decisions relating to employment practices are objective, free from bias and based solely upon work criteria and individual merit. These principles are reinforced within our Equality, Diversity and Inclusion in the Workplace; and Recruitment and Selection and Flexible Working policies.

All staff by gender and senior managers by gender

The gender proportions of the total on payroll workforce and on payroll senior managers has remained constant over the year (all staff 2017/18: 31% male, 69% female; senior managers





2017/18: 47% male, 53% female). The gender diversity of Board members is set out on page 64.

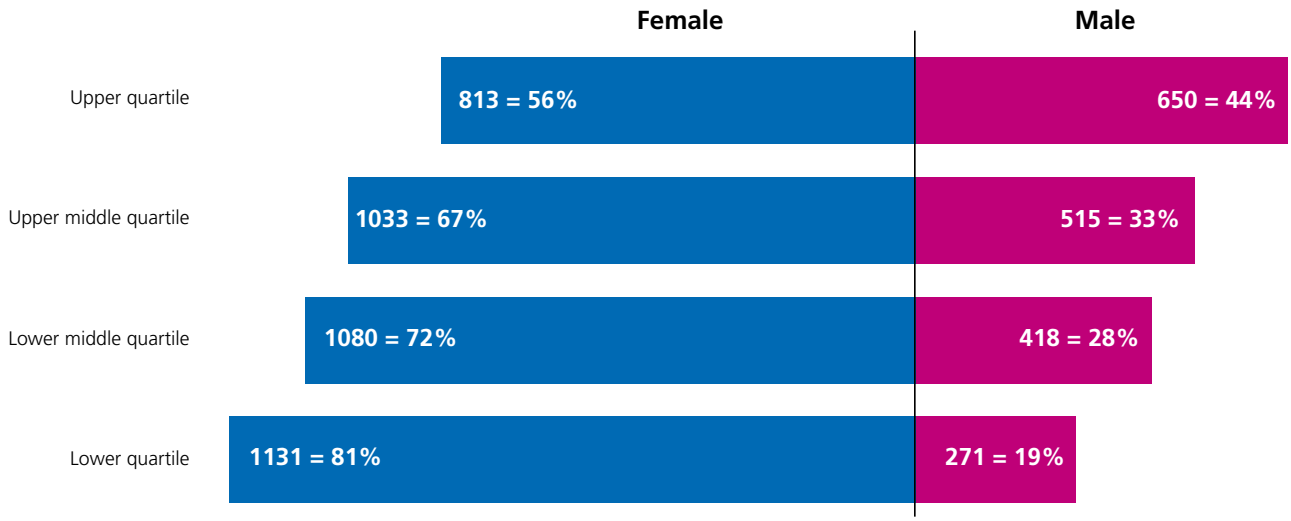
Gender pay gap

51% of the population of England are women, and 55% of NHS England's upper quartile senior staff are women. However, 81% of employees in the lower quartile are female. A significant driver of the pay gap therefore is a consequence of having a lower proportion of men in lower pay bands relative to their share of the population.

Based on the Government's methodology, using snap shot data as of 31 March 2018, NHS England had a mean gender pay gap of 19% 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 22% is calculated as the percentage difference between the mid-point hourly salaries for men and women.

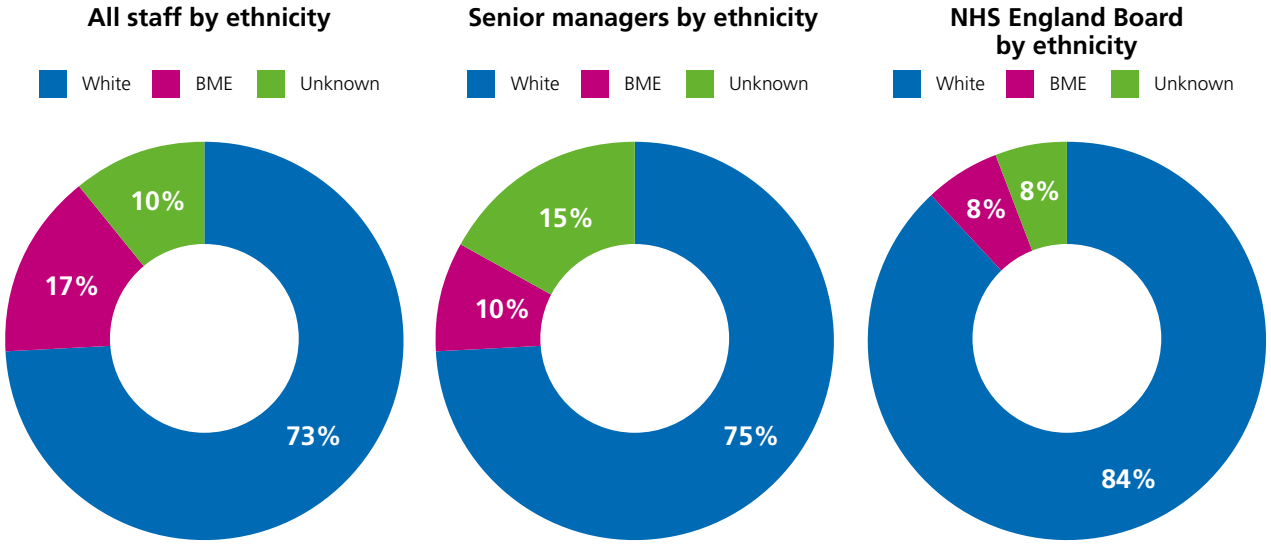
The mean gender pay gap compares favourably to March 2017, when we had a mean gender pay gap of 21%, however we have seen an increase of 1% in the median gender pay gap in comparison to March 2017.

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



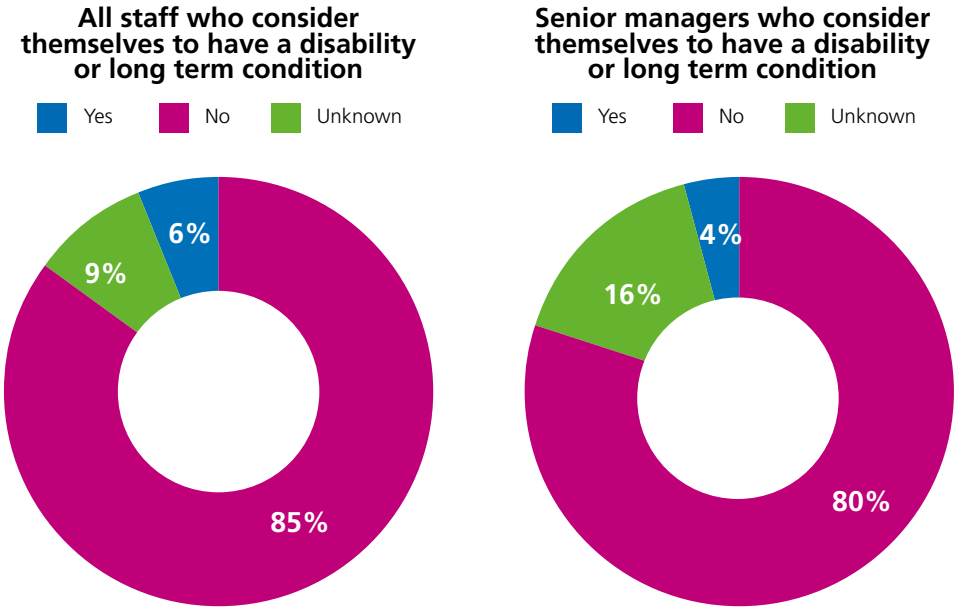
Working in partnership with our recognised trade unions and our Women's Network we continue to drive diversity and inclusion. Activities over the last 12 months include a refreshed flexible working policy which has resulted in a steady increase in the uptake of flexible working since the policy was launched; a demonstrable commitment to ensure that the NHS England and NHS Improvement Joint Working programme provides an opportunity to address gender equality in our workforce; and the formation of a Gender Pay group that has taken the lead role in identifying and supporting further initiatives to improve NHS England's and NHS Improvement's position with regard to gender pay. The group comprises representatives from the HR and Organisational Development (OD) group, trade unions and the Women's Network.

All staff by ethnicity and senior managers by ethnicity



The proportion of people employed by NHS England that consider themselves to be from a BAME heritage has increased by 1% over the year for all staff and for senior managers, with an increase of 2% at Board level (2017/18: 16% all staff, 9% senior managers and 6% NHS England board). We use the annual publication of the Workforce Race Equality Standard (WRES) data return as a driver for improvements in the working lives of BAME staff.

Following completion of interviews with Senior BAME Managers, NHS England produced the 'What Helps and What Hinders' report which provides a BAME-led perspective on the actions we need to take to improve race equality in the organisation. Following a national BAME Staff Network conference which was supported by our CEO, Chairs and over 160 staff, our Senior BAME Co-design group will continue to work with senior leaders to develop a 10-year action plan. This plan will mirror the national Model Employer guidance developed by the WRES team, to ensure that we work towards equal representation of BAME staff at the most senior pay bands.



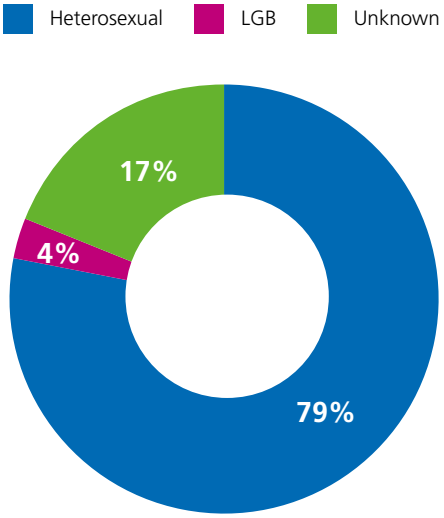
All staff who consider themselves to have a disability or long term condition and senior managers

We have continued to work closely with the DAWN staff to close the gaps in this workforce diversity data and encourage people to self-classify. This year an additional 2% of all staff and 1% of senior managers have chosen to disclose whether they have a disability or long-term condition (2017/18: 11% all staff, 18% senior managers). The proportion of our people disclosing a disability or long-term condition has remained constant.

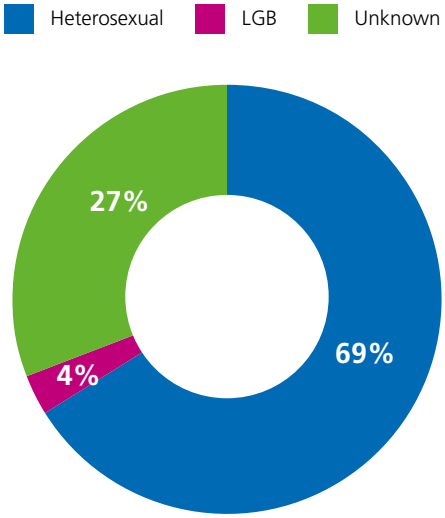
All staff by sexual orientation and senior managers by sexual orientation

Disclosure rates relating to sexual orientation have increased by 2% during the year for all staff, in line with the increase in the number of staff reporting that they are LGBT+ (2017/18: 3% all staff, 4% senior managers). This rise in disclosure rates reflects the positive work that has been done in conjunction with our LGBT+ network to build trust and confidence with our LGBT+ workforce.

All staff by sexual orientation



Senior managers by sexual orientation



As a Stonewall Workplace Equality Champion, we continue to embed LGBT+ inclusion. NHS England's Stonewall Workplace Equality Index 2019 result is 113th out of 445 organisations, a rise of 61 places since 2018. This strong progress reflects increased organisational ownership of an LGBT+ action plan, which in 2019/20 will be jointly owned with NHS Improvement. Progress is particularly strong around our active LGBT+ Network who have raised the visibility of LGBT+ staff and developed Trans and Bi Ally/Awareness training for staff. We have also secured a national rainbow NHS70 logo to celebrate the history of LGBT+ equality in the NHS. Organisationally we strive to embed LGBT+ inclusion across workforce data collection and making the facilities in our office environments more gender-inclusive.

Talent management and development

During the year we extended our talent management process from 8c and above to encompass staff at pay bands 8a and 8b, increasing the employee population involved in recorded talent development conversations by 97% in comparison to previous year.

Our stretch assignment service has continued to expand throughout the year, providing increased opportunities for staff to build their capabilities. 218 stretch assignments were placed by the service and of these 95 were successfully completed, representing a 64% increase in comparison to the previous year.

Our coaching and mentoring service continues to provide support to various national workstreams including: work with public and patient voice representatives; the line management and senior Line Management Development Programmes (LMDP); mentors to

support senior BAME talent; and, our work on gender equality. The service has continued to grow and there are currently 136 coaches on the register (2017/18:86) and 132 mentors (2017/18:79). We have increased the number of BAME coaches to 17% and BAME mentors to 12%. 11% of our mentors have disclosed a disability or long-term health condition compared to 7% in 2017/18. The proportion of coaches with a disability has remained at 7%. The coaching and mentoring service continues to engage with all staff networks to understand how coaching and mentoring can support their members and to inform them about the service offer. Recognising the need to increase in-house capability, we continue to develop our coaches at the Institute of Leadership Management (ILM) level 5 and level 7.

Line management development programme

The LMDP continues to play an important role in our strategy to ensure consistently high standards of people management practice that fully align with NHS values and behaviours. The LMDP has entered its third year of operation with over 1,967 employees having participated in the programme since August 2016 and a further 84 ESM colleagues having completed the programme.

Evaluation of the LMDP remains positive with feedback from delegates, teams and delegate's line managers continuing to evidence shifts in line management knowledge, skills and positive behaviours. The programme has delivered coherent and consistent standards of good management capability and skills; improved staff engagement and has contributed towards making NHS England a better place to work.

Apprenticeships

NHS England has embraced apprenticeships as an opportunity to build capabilities and improve the diversity of our workforce. Apprenticeships are offered to people of all ages, backgrounds, pay bands and across roles where the eligibility criteria are met. Our Apprenticeship Scheme was launched in May 2017 and we currently have 56 apprentices taking qualifications ranging from Level 2 Business Administration to Level 7 Senior Leader Master's Degree. Over £71,000 of the apprenticeship levy has been used to support these posts.

Workplace health, safety and wellbeing

In May 2018 we published our 'Mental Health in the Workplace Strategy' which details our proactive approach to tackling mental ill health within NHS England; it serves as our response to the 'Thriving at Work' Stevenson / Farmer Review and enables us to meet our 'Mindful Employer' commitments by October 2019.

We have trained 916 people in Mental Health First Aid since 2014, of whom 631 are employed by NHS England. In October 2018 we introduced Mental Health Aware, a half day course specifically promoted to those employed within leadership positions, and to date 69 senior managers have attended the course.

Staff engagement and experience

Staff survey

We have continued to address key themes emerging from our annual staff survey throughout the course of the year. As well as working with regions and directorates to develop and embed local action plans, we have invested in the development of organisation-wide initiatives to improve staff experience. We have introduced a Respect at Work contacts scheme, a new mediation service, trained more mental health first aiders (MHFA), increased opportunities to attend our LMDP and one-day workshops, and further developed our internal coaching and mentoring programmes. In the light of closer working with NHS Improvement work has taken place to make such offers accessible to staff across both organisations, as well as in-year "temperature checks" on the HR processes being used.

A key focus of our work this year has also been on the development of the staff survey itself. In preparation for our new operating model, we have engaged with stakeholders from across NHS England and NHS Improvement to agree a set of principles to underpin a new staff survey approach.

Staff engagement groups

We have more than 25 local staff engagement groups operating across NHS England. They feed into the national network to share best practice across the organisation. Our staff engagement groups contribute to the development of our people policies and are more widely engaged in staff affecting issues impacting the organisation. Over the last year we have also continued to build on the success of our staff recognition scheme.

Facility time

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

a) TU representative – the total number of employees who were TU representatives during the relevant period.

Number of employees who were relevant union officials during the relevant period	FTE employee number
27	25.93

b) Percentage of time spent on facility time (duties and activities) - How many employees who were TU representatives officials employed during the relevant period spent a) 0%, b) 1%-50%, c) 51%-99% or d) 100% of their working hours on facility time.

Percentage of time	Number of employees
0%	5
1-50%	22
51%-99%	0
100%	0

c) Percentage of pay bill spent on facility time - The figures requested in the first column of the table below will determine the percentage of the total pay bill spent on paying employees who were TU representatives for facility time during the relevant period.

Figures	Figures
Provide the total cost of facility time	£74,231.98
Provide the total pay bill	£385,617,880.95
Provide the percentage of the total pay bill spent on facility time, calculated as: (total cost of facility time ÷ total pay bill) x 100	0.02%

d) Paid TU activities - As a percentage of total paid facility time hours, how many hours were spent by employees who were TU representatives during the relevant period on paid TU activities.

Figures	Figures
Time spent on paid TU activities as a percentage of total paid facility time hours calculated as: (total hours spent on paid TU activites by TU representatives during the relevan period ÷ total paid facility time hours) x 100	22.7%

Our improvement and change activities

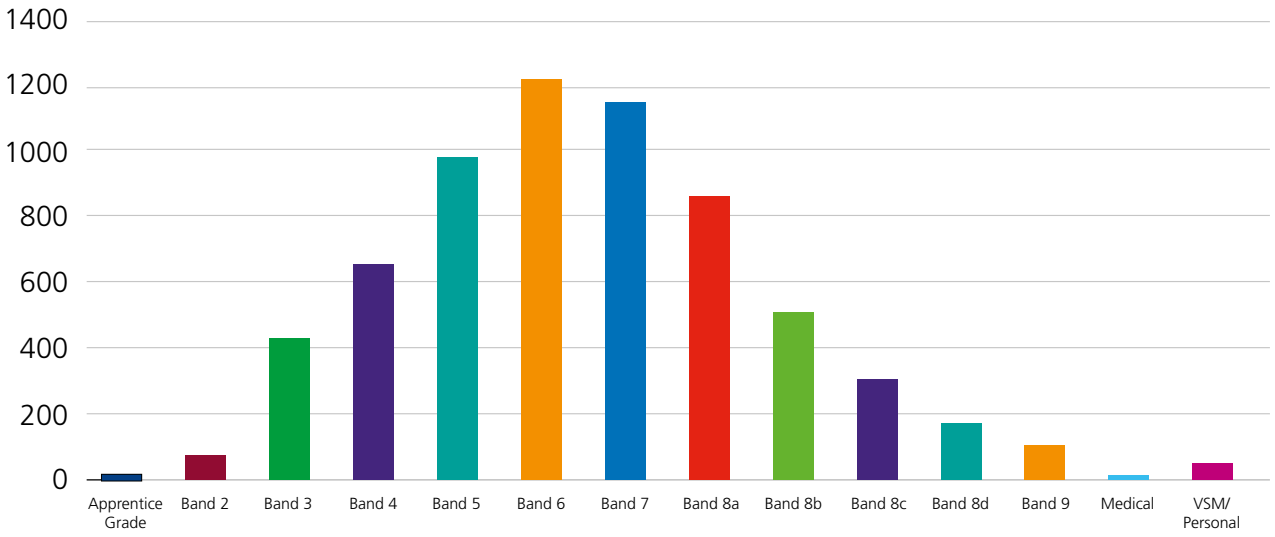
Organisational change programmes

Within the context of the NHS Long Term Plan, NHS England and NHS Improvement are coming together with a new shared operating model. At the same time we are implementing a 20% cut in our running costs. Substantial organisational design work has been undertaken to enable both organisations to achieve this. In December 2018 we announced a number of the appointments to our new senior team, and appointments to ESM roles were announced in March 2019. The organisation-wide redesign process will be completed by December 2019.

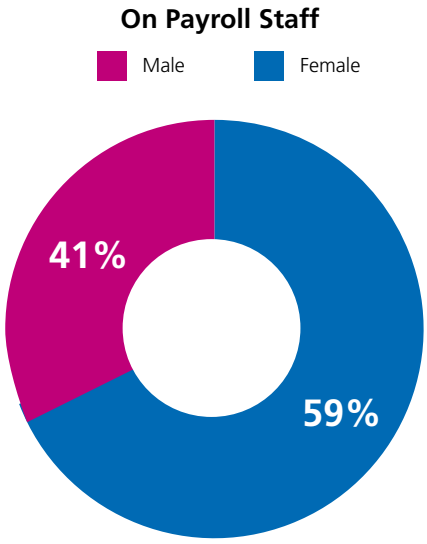
Staff report - CSUs

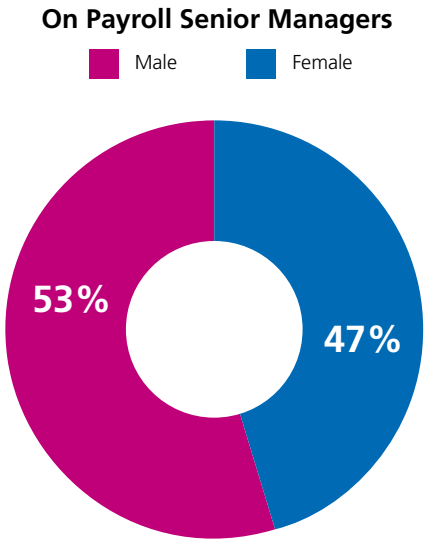
As at 31 March 2019, CSUs directly employ a total 6614 people. Of these 6138 people were permanently employed on recurrent, open-ended contracts of employment, based around the country within the five separate organisations. In addition, a further 476 people were employed on payroll on fixed term contracts of employment.

All CSU staff by pay band



All CSU staff by gender and CSU senior managers by gender





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	2018/19				
	Permanently employed number	CSU employed number	Other number	CSU other number	Total number
Total	5,866	6,056	794	344	**13,060**
Of the above: Number of whole time equivalent people engaged on capital projects	-	-	-	-	-

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	-	-	-	-	-

Employee benefits

Parent	2018/19				
	Permanent employees £000	CSU employees £000	Other £000	CSU other £000	Total £000
Employee benefits					
Salaries and wages	308,102	242,344	49,765	31,343	**631,554**
Social security costs	34,967	25,739	114	-	**60,820**
Employer contributions to NHS Pension scheme	39,358	30,828	14	1	**70,201**
Other pension costs	-	-	-	-	-
Apprenticeship Levy	1,537	948	-	-	**2,485**
Termination benefits	4,012	2,721	-	-	**6,733**
Gross employee benefits expenditure	**387,976**	**302,580**	**49,893**	**31,344**	**771,793**
Less: Employee costs capitalised	-	-	-	-	-
Net employee benefits excluding capitalised costs	**387,976**	**302,580**	**49,893**	**31,344**	**771,793**
Less recoveries in respect of employee benefits	(592)	-	-	-	**(592)**
Total net employee benefits	**387,384**	**302,580**	**49,893**	**31,344**	**771,201**

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**

Average number of people employed

Consolidated Group	2018/19				
	Permanently employed number	CSU employed number	Other number	CSU other number	Total number
Total	24,011	6,056	2,680	344	**33,091**
Of the above: Number of whole time equivalent people engaged on capital projects	-	-	1	-	1

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	-	-	-	-	-

Employee benefits

Consolidated Group	2018/19				
	Permanent employees £000	CSU employees £000	Other £000	CSU other £000	Total £000
Employee benefits					
Salaries and wages	1,142,091	242,344	188,425	31,343	**1,604,203**
Social security costs	125,319	25,739	686	-	**151,744**
Employer contributions to NHS Pension scheme	144,486	30,828	553	1	**175,868**
Other pension costs	60	-	-	-	**60**
Apprenticeship Levy	3,439	948	-	-	**4,387**
Termination benefits	10,481	2,721	-	-	**13,202**
Gross employee benefits expenditure	**1,425,876**	**302,580**	**189,664**	**31,344**	1,949,464
Less: Employee costs capitalised	-	-	(51)	-	**(51)**
Net employee benefits excluding capitalised costs	**1,425,876**	**302,580**	**189,613**	**31,344**	1,949,413
Less recoveries in respect of employee benefits	(7,151)	-	(430)	-	**(7,581)**
Total net employee benefits	**1,418,725**	**302,580**	**189,183**	**31,344**	1,941,832

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
Less: Employee costs capitalised	-	-	-	-	**-**
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

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 BSA.

Sickness absence

From 1 January 2018 to 31 December 2018, the average number of sick days taken by whole time equivalent employees increased by 0.3 days against the previous year.

Sickness absence for the period 1 January to 31 December 2018 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	2,169,943	47,333	4.9
CSUs	2,230,730	68,879	6.9

Exit packages, severance payments and off-payroll engagements

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 £9 million during the financial year, a decrease of £18 million since 2017/18 (2017/18: £27 million).
Across the group, there was a total spend of £64 million on consultancy services during the period, against £85 million the previous year.

Expenditure on contingent labour, including agency staff and secondees, is given in the Annual Accounts on page 118: Employee Benefits and Staff Numbers under the 'other' column.
Net expenditure for NHS England and CSUs in this area was £81 million in 2018/19, against £94 million in 2017/18. Across the group, there was a total spend of £221 million on contingent labour during the year, against £239 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 102.

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

The following tables identify off-payroll workers[66] engaged by NHS England as at March 2019.

66 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 2019, 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 2019	560	58	618
Of which, the number that have existed:			
for less than one year at the time of reporting	185	51	236
for between one and two years at the time of reporting	276	7	283
for between 2 and 3 years at the time of reporting	49	0	49
for between 3 and 4 years at the time of reporting	19	0	19
for 4 or more years at the time of reporting	31	0	31

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 2018 and 31 March 2019, 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 2018 and 31 March 2019	252	101	353
Of which:			
Number assessed as caught by IR35	114	70	184
Number assessed as NOT caught by IR35	138	31	169
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	30	34	64
Number of engagements that saw a change to IR35 status following the consistency review	30	0	30

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 2018 and 31 March 2019 are shown in the table below:

	NHS England (number)	CSUs (number)	Total (number)
Number of off-payroll engagements of Board members, and/or senior officers with significant financial responsibility, during the financial year	0	0	0
Total number of individuals on payroll and off-payroll that have been deemed "Board members, and/or, senior officials with significant financial responsibility", during the financial year.	267	40	307

Further detail on commercial approvals, and steps we have taken to improve procurement practices and compliance within NHS England during the year, can be found in our Governance Statement from page 61.

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 payments would first have to be scrutinised and approved by the Executive HR Sub-Committee before being considered by the DHSC and HM Treasury. Details of exit packages agreed over the year are detailed in the following tables. All contractual severance payments were subject to full external oversight by DHSC.

Exit packages agreed during the year: Compulsory redundancies

Parent	2018/19			2017/18		
	Compulsory redundancies number	Other agreed departures number	Total number	Compulsory redundancies number	Other agreed departures number	Total number
Less than £10,000	23	8	31	13	10	23
£10,001 to £25,000	20	-	20	8	22	30
£25,001 to £50,000	20	-	20	12	26	38
£50,001 to £100,000	26	-	26	8	15	23
£100,001 to £150,000	15	-	15	1	4	5
£150,001 to £200,000	17	-	17	1	4	5
Over £200,001	-	-	-	-	-	-
Total	**121**	**8**	**129**	**43**	**81**	**124**
Total cost (£000)	**7,640**	**37**	**7,677**	**1,453**	**3,628**	**5,081**

Consolidated Group	2018/19			2017/18		
	Compulsory redundancies number	Other agreed departures number	Total number	Compulsory redundancies number	Other agreed departures number	Total number
Less than £10,000	82	47	129	56	78	134
£10,001 to £25,000	67	33	100	48	61	109
£25,001 to £50,000	43	11	54	28	46	74
£50,001 to £100,000	52	13	65	24	33	57
£100,001 to £150,000	31	1	32	5	5	10
£150,001 to £200,000	29	1	30	19	5	24
Over £200,001	4	-	4	2	-	2
Total	**308**	**106**	**414**	**182**	**228**	**410**
Total cost (£000)	**16,246**	**2,327**	**18,573**	**7,983**	**6,946**	**14,929**

Exit packages agreed during the year: Other agreed departures

	2018/19		2017/18	
	Other agreed departures		Other agreed departures	
Parent	**number**	**£000**	**number**	**£000**
Voluntary redundancies including early retirement contractual costs	-	-	72	3,539
Contractual payments in lieu of notice	8	37	9	89
Exit payments following Employment Tribunals or court orders	-	-	-	-
Total	**8**	**37**	**81**	**3,628**

	2018/19		2017/18	
	Other agreed departures		Other agreed departures	
Consolidated Group	**number**	**£000**	**number**	**£000**
Voluntary redundancies including early retirement contractual costs	12	661	82	3,875
Mutually agreed resignations (MARS) contractual costs	19	584	48	1,423
Early retirements in the efficiency of the service contractual costs	1	10	4	386
Contractual payments in lieu of notice	72	1,055	92	1,162
Exit payments following Employment Tribunals or court orders	1	14	2	100
Non-contractual payments requiring HM Treasury approval	1	3	-	-
Total	**106**	**2,327**	**228**	**6,946**

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 the NHS England.

Exit costs are accounted for in accordance with relevant accounting standards and at the latest 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 and not by the NHS Pension Scheme, and are included in the tables. Ill-health retirement costs are met by the NHS Pension Scheme and are not included in the tables.

The Remuneration Report includes the disclosure of 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 75.

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 2018/19 was £220,000- £225,000 (2017/18: £215,000-£220,000). This was 5.42 times the median remuneration of the workforce, which was £41,034 (2017/18: £40,428: 5.38). During 2018/19 the Chief Executive Officer (Simon Stevens) voluntarily took a £20,000 per annum pay cut for the fifth year in a row.

In 2018/19, one employee received pro-rata remuneration in excess of the highest-paid member of the Board (2017/18: 2). This employee is employed on a part time basis. Remuneration ranged from £6,453 - £225,000 (2017/2018: £6,844 (part time salary) to £220,430).

Total remuneration includes salary, non-consolidated performance-related pay (PRP) 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 ESM pay framework for ALBs.

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 £113 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, with final decisions being made by the DHSC ALB Remuneration Committee and HM Treasury, where appropriate.

Performance related pay

The performance related pay arrangements for national (executive) directors are set out in the ESM pay framework for ALBs, they follow guidance prescribed by DHSC and are in line with HM Treasury requirements. As a local policy decision, since its inception, NHS England does not currently allocate any funding for 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 2018/19.

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 HM Treasury. 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	
Matthew Swindells Deputy Chief Executive	30 May 2016	6 months		
Paul Baumann CBE Chief Financial Officer	14 May 2012	6 months		Left NHS England on 18 November 2018
Professor Jane Cummings CBE Chief Nursing Officer	1 April 2013	6 months		Left NHS England on 31 December 2018
Ian Dodge National Director: Strategy	7 July 2014	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		
Matthew Style Acting Chief Financial Officer	19 November 2018	6 months		
Ruth May Chief Nursing Officer	7 January 2019	6 months		

With NHS Improvement we jointly appointed Ruth May as Chief Nursing Officer with effect from 7 January 2019 and continue to jointly appoint Jennifer Howells, Regional Director – South West and Anne Eden, Regional Director – South East. These positions are recognised by both organisations as senior leadership roles, with Ruth May, 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 2018/19 (subjected to audit)

Name and Title	(a) Salary[67] (bands of £5,000)	(b) Benefits in kind (taxable) 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[68] (bands of £2,500)	(f) TOTAL (a to e) (bands of £5,000)
	£000	£s	£000	£000	£000	£000
Simon Stevens Chief Executive Officer[69]	190-195	0	0	0	42.5-45.0	235-240
Matthew Swindells Deputy Chief Executive[70]	205-210	0	0	0	0	205-210
Paul Baumann CBE Chief Financial Officer[71]	130-135 (pro-rata)	0	0	0	0	130-135 (pro-rata)
Professor Jane Cummings CBE Chief Nursing Officer[72]	140-145 (pro-rata)	0	0	0	0	140-145 (pro-rata)
Ian Dodge National Director: Strategy[73]	165-170	0	0	0	37.5-40.0	205-210
Emily Lawson National Director: Transformation and Corporate Operations[74]	190-195	0	0	0	0	190-195
Professor Stephen Powis National Medical Director	220-225	0	0	0	0	220-225
Matthew Style Acting Chief Financial Officer[75]	55-60 (pro rata)	0	0	0	10-12.50 (pro rata)	70-75 (pro rata)
Ruth May Chief Nursing Officer[76]	40-45 (pro rata)	0	0	0	2.5-5.0 (pro rata)	40-45 (pro rata)

Note: Taxable expenses and benefits in kind are expressed to the nearest £100.

67 The salaries disclosed are inclusive of the 2018 ESM Pay Award. Although this was not implemented within the 2018/19 reporting period, approval was received before the date the accounts were authorised for issue under IAS 10 Events after the Reporting Period and have therefore been included for disclosure. This is excluding Professor Stephen Powis as he attracts Medical & Dental Terms and Conditions.

68 The 2018 ESM Pay Award has not been included in the calculation of all pension-related benefits. This is due to approval for payment of the Pay Award being received outside of the 2018/19 reporting period.

69 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 2018/19.

70 Matthew Swindells' took on the position title of Deputy Chief Executive from 01 September 2018.

71 Paul Baumann CBE left on 18 November 2018. The full year equivalent salary is £210,000-£215,000.

72 Professor Jane Cummings CBE continued to receive an additional responsibility allowance during 2018/19 for covering the London regional director role up until her retirement on 31 December 2018. The full year equivalent salary is £185,000-£190,000.

73 Ian Dodge took on the position title of National Director: Strategy and Innovation from 1 July 2017. This was not disclosed in the 2017/18 audited accounts, therefore is retrospectively being reported.

74 Emily Lawson continued to receive an additional responsibility allowance during 2018/19 that recognised extra duties in relation to the PCS service.

75 Matthew Style commenced in post on 19 November 2018. The full year equivalent salary is £160,000-£165,000. Mr Style chose to have Childcare Voucher deductions made from his salary via salary sacrifice. The full year equivalent salary remains at £160,000-£165,000 when taking into account the salary being sacrificed.

76 Ruth May was jointly appointed with NHS Improvement on 7 January 2019. The cost for the remuneration figures disclosed is wholly met by NHS Improvement. The full year equivalent salary is £175,000 to £180,000.

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[77]	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 CBE Chief Nursing Officer[78]	175-180 (pro-rata - allowance only)	0	0	0	0	175-180 (pro-rata allowance only)
Professor Sir Bruce Keogh National Medical Director[79]	155-160 (pro-rata)	0	0	0	0	155-160 (pro-rata)
Ian Dodge National Director: Strategy	165-170	0	0	0	37.5-40.0	205-210
Matthew Swindells National Director: Operations and Information[80]	205-210	0	0	0	0	205-210
Karen Wheeler CBE National Director: Transformation and Corporate Operations[81]	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[82]	90-95 (pro-rata)	0	0	0	0	90-95 (pro-rata)
Professor Stephen Powis National Medical Director[83]	15-20 (pro rata)	0	0	0	0	15-20 (pro rata)

77 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.

78 Professor Jane Cummings CBE 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.

79 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.

80 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.

81 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.

82 Emily Lawson joined NHS England on 1 November 2017, replacing Karen Wheeler. The FTE 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 FTE salary.

83 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.

Pension benefits as at 31 March 2019 (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 2019 (bands of £5,000)	Lump sum at pension age related to accrued pension at 31 March 2019 (bands of £5,000)	Cash Equivalent Transfer Value at 31 March 2018 [84]	Real Increase in Cash Equivalent Transfer Value	Cash Equivalent Transfer Value at 31 March 2019	Employers contribution to partnership pension
	£000	£000	£000	£000	£000	£000	£000	£000
Simon Stevens Chief Executive Officer	2.5-5.0	(2.5)-0	35-40	55-60	529	85	658	0
Matthew Swindells National Director: Operations and Information[85]	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Paul Baumann CBE Chief Financial Officer[86]	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Professor Jane Cummings CBE Chief Nursing Officer[87]	(10)-(12.5)	97.50-100	65-70	370-375	1,669	0	0	0
Ian Dodge National Director: Strategy	2.5-5.0	N/A	10-15	N/A	113	35	176	0
Emily Lawson National Director: Transformation and Corporate Operations[88]	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Professor Stephen Powis National Medical Director[89]	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Matthew Style Acting Chief Financial Officer[90]	0-2.5	N/A	5-10	N/A	23	1	50	0
Ruth May Chief Nursing Officer	0-2.5	0-2.5	60-65	190-195	1,112	34	1,317	0

84 As per previous submissions, the column Cash Equivalent Transfer Value at 01 April 2018 is the uninflated value whereas the real Increase in CETV is the employer funded increase.
85 Matthew Swindells chose not to be covered by the NHS Pension arrangements during the reporting year.
86 Paul Baumann chose not to be covered by the NHS pension arrangements during the reporting year.
87 Professor Jane Cummings CBE re-joined the NHS Pension Scheme from 1 November 2018 to 31 December 2018, when she retired.
88 Emily Lawson chose not to be covered by the NHS Pension arrangements during the reporting year.
89 Professor Stephen Powis chose not to be covered by the NHS Pension arrangements during the reporting year.
90 Matthew Style commenced in post on 19 November 2018, therefore the Pension Benefits disclosed are pro-rata for the period 19 November 2018 to 31 March 2019.

Cash equivalent transfer values (CETV) (subjected to audit)

A 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 in 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	0 months	6 months	None	Left NHS England on 31 October 2018
Lord David Prior Chair	31 October 2018	43 months	6 months	None	
David Roberts CBE Vice-Chair	1 July 2014, reappointed to a second term on 1 July 2018	27 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	0 months	None	None	Left NHS England 31 December 2018
Professor Sir John Burn Non-executive director	1 July 2014	0 months	None	None	Left NHS England 30 June 2018
Dame Moira Gibb Non-executive director	1 July 2012, reappointed to a second term on 1 January 2015	0 months	None	None	Left NHS England 31 December 2018
Noel Gordon Non-executive director	1 July 2014, reappointed to a second term on 1 July 2018	27 months	None	None	
Wendy Becker Non-executive director	1 March 2016	11 months	None	None	Waived entitlement to remuneration from September 2016.
Michelle Mitchell OBE Non-executive director	1 March 2016	11 months	None	None	
Joanne Shaw Non-executive director	1 October 2016	18 months	None	None	
Richard Douglas CB Associate Non-executive director	1 March 2018	11 months	None	None	
Professor Sir Munir Pirmohamed Non-executive director	1 January 2019	33 months	None	None	

Non-executive director remuneration (including salary entitlements)

Salaries and allowances 2018/19 (subjected to audit)

Name of non-executive director	2018/19					
	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[91]** (bands of £2,500)	**F: TOTAL (A to E)** (bands of £5,000)
	£000	**£s**	**£000**	**£000**	**£000**	**£000**
Professor Sir Malcolm Grant Chair[92]	35-40 (pro-rata)	0	0	0	N/A	35-40 (pro-rata)
Lord David Prior Chair[93]	25-30 (pro-rata)	0	0	0	N/A	25-30 (pro-rata)
David Roberts CBE Vice-Chair[94]	0	0	0	0	N/A	0
Lord Victor Adebowale CBE[95]	5-10	0	0	0	N/A	5-10
Wendy Becker[96]	0	0	0	0	N/A	0
Professor Sir John Burn[97]	0-5 (pro-rata)	0	0	0	N/A	0-5 (pro-rata)
Dame Moira Gibb[98]	5-10 (pro-rata)	0	0	0	N/A	5-10 (pro-rata)
Noel Gordon	5-10	0	0	0	N/A	5-10
Michelle Mitchell OBE	5-10	0	0	0	N/A	5-10
Joanne Shaw	25-30	0	0	0	N/A	25-30
Richard Douglas CB[99] Associate non-voting	5-10	0	0	0	N/A	5-10
Professor Sir Munir Pirmohamed[100]	0-5 (pro-rata)	0	0	0	N/A	0-5 (pro-rata)

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

92 Professor Sir Malcolm Grant's unpaid leave overpayment of £3,188 reported in 2017/18 was recovered in 2018/19. The overpayment recovery is not included in the total remuneration figures disclosed. Professor Sir Malcolm Grant left on 31 October 2018. The full year equivalent salary is £60,000-65,000.

93 Lord David Prior joined NHS England on 31 October 2018 as Chair, to replace Professor Sir Malcolm Grant, however was paid from the incorrect start date of 1 November 2018 leading to an underpayment of £169.35, which will be paid in 2019/20. In 2018/19 pension deductions of £3,281.25 were taken in error from Lord David Prior; these pension deductions will be refunded in full during the 2019/20 financial year. The underpayments are not included in the total remuneration figures disclosed. The full year equivalent salary is £60,000-£65,000.

94 David Roberts CBE has waived his entitlement to non-executive director remuneration. David Roberts CBE is also an associate (non-voting) non-executive director at NHS Improvement.

95 Lord Victor Adebowale CBE left on 31 December 2018. The full year equivalent salary is £5,000-£10,000.

96 Wendy Becker waived her entitlement 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 was processed in 2018/19. Wendy Becker also received an incorrect tax refund in 2018/19, this refund was recovered in year.

97 Professor Sir John Burn left on 30 June 2018. The full year equivalent salary is £5,000-£10,000.

98 Dame Moira Gibb left 31 December 2018. The full year equivalent salary is £5,000-£10,000.

99 Richard Douglas CB is a non-executive director at NHS Improvement.

100 Professor Sir Munir Pirmohamed joined on 1 January 2019. Due to an error with onboarding, Sir Munir Pirmohamed did not receive remuneration for the period 1 January 2019 to 31 May 2019 leading to an underpayment of £3,284.60, which will be paid in 2019/20. The underpayments are not included in the total remuneration figures disclosed. The full year equivalent salary is £5,000-£10,000.

Salaries and allowances 2017/18

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[101]** (bands of £2,500)	**F: TOTAL (A to E)** (bands of £5,000)
	£000	**£s**	**£000**	**£000**	**£000**	**£000**
Professor Sir Malcolm Grant Chair[102]	55-60 (pro-rata)	0	0	0	N/A	55-60 (pro-rata)
David Roberts CBE Vice-Chair[103]	0	0	0	0	N/A	0
Lord Victor Adebowale CBE	5-10	0	0	0	N/A	5-10
Wendy Becker[104]	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[105]	5-10	0	0	0	N/A	5-10
Joanne Shaw[106]	25-30	0	0	0	N/A	25-30
Richard Douglas CB From 1 March 2018 Associate non-voting[107]	0-5 (pro-rata)	0	0	0	N/A	0-5 (pro-rata)

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

102 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.

103 David Roberts CBE has waived his entitlement to non-executive director remuneration. David Roberts CBE 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 CBE is also an associate (non-voting) non-executive director at NHS Improvement.

104 Wendy Becker waived her entitlement 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.

105 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.

106 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.

107 Richard Douglas joined NHS England as an Associate non-voting NED on 1 March 2018. The full year equivalent salary is £5,000-£10,000. Richard Douglas is a non-executive director at NHS Improvement.

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 and are therefore subject to special control procedures compared to the generality of payments. They are divided into different categories, which govern the way that individual cases are handled.

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, along with links to their websites, can be found on the NHS England website.[108]

Losses and special payments

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

Losses

	Parent				Consolidated Group			
	Total number of cases 2018/19	Total value of cases 2018/19	Total number of cases 2017/18	Total value of cases 2017/18	Total number of cases 2018/19	Total value of cases 2018/19	Total number of cases 2017/18	Total value of cases 2017/18
	Number	£000	Number	£000	Number	£000	Number	£000
Administrative write-offs	-	-	31	358	50	885	314	20,749
Fruitless payments	54	161	44	6	79	325	86	15
Stores losses	-	-	-	-	2	1	7	4
Bookeeping losses	66	5	71	5	69	19	71	5
Cash losses	-	-	-	-	12	19	8	468
Claims abandoned	70,770	4,565	1	34	70,776	4,600	2	43
Total	**70,890**	**4,731**	**147**	**403**	**70,988**	**5,849**	**488**	**21,284**

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

2018/19 Disclosure: Administrative write offs

Included within Administrative write-off in the group is a loss declared by NHS Devon CCG (280k) of write off of receivables and by NHS Swindon CCG (170k), a write off a risk stratification tool due to obsolescence.

2018/19 Disclosure: Fruitless payments

NHS Swindon CCG recognised a receivable of £150k as part of the solvent closure of SEQOL. Initial indications from the administration process were that the CCG would receive a refund once all liabilities had been settled and tax positions had been declared. SEQOL ceased to operate in September 2016 and as we are now at the end of 2018/19 the likelihood of the CCG receiving a distribution is low and so NHS Swindon CCG are impairing the debt.

2018/19 Disclosure: Claims Abandoned

For the first time included within total losses are penalty charge notices issued by NHS BSA on behalf of NHS England to individuals who obtained exemptions for prescription or dental charges for which it was subsequently confirmed that they were not eligible. The National Health Service Act 2006 (as amended) entitles the NHS to issue such notices. In some exceptional circumstances "easements" are offered to specific patients (e.g. for vulnerable individuals) such that the penalty charge notices are not pursued for payment. The number and value of easements issued in 2018/19 are considered to be "claims abandoned". However, given no individual easement exceeds £300,000 they are included solely within the total number and value of losses in the table. The 2017/18 comparatives have not been restated on materiality grounds which explains the significant increase in the number of losses year-on-year.

Easements were also issued in prior years to 2018/19 following the introduction of penalty charge notices. In previous years they were not classified as "claims abandoned" in the Parliamentary accountability and audit report and were not therefore recorded as losses in the report. The presentational change has arisen as a result of review of disclosure requirements in this area.

2017/18 Disclosure: Admin Write Offs

Included within Administrative write offs in the group is a loss declared by NHS Horsham and Mid Sussex CCG (£7,305k), NHS Crawley CCG (£5,106k) and 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) for outstanding debt with a local authority.

2017/18 Disclosure: Cash Losses

NHS Newham CCG 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. There have been no further such payments.

Special payments

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

	Parent				Consolidated Group			
	Total number of cases 2018/19	Total value of cases 2018/19	Total number of cases 2017/18	Total value of cases 2017/18	Total number of cases 2018/19	Total value of cases 2018/19	Total number of cases 2017/18	Total value of cases 2017/18
	Number	£000	Number	£000	Number	£000	Number	£000
Compensation payments	1	1	5	30	7	192	10	95
Extra Contractual Payments	1,083	300	6,950	3,839	1,088	432	6,961	5,373
Ex Gratia Payments	1	1	1	5	23	99	11	46
Extra Statutory Extra Regulatory Payments	-	-	-	-	2	22	-	-
Special Severance Payments Treasury Approved	-	-	-	-	1	3	-	-
Total	**1,085**	**302**	**6,956**	**3,874**	**1,121**	**748**	**6,982**	**5,514**

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.

Cost allocation and setting of charges

NHS England certifies that it has complied with HM Treasury guidance on cost allocation and the setting of charges. The following provides details of income generation activities whose full cost exceeded £1 million or was otherwise material:

2018/19

	Note	Parent			Consolidated Group		
		Income £000	Full cost £000	Surplus (deficit) £000	Income £000	Full cost £000	Surplus (deficit) £000
Dental	2 & 4	856,384	(2,919,876)	(2,063,492)	856,384	(2,919,876)	(2,063,492)
Prescription	2 & 4	583,809	(1,943,531)	(1,359,722)	591,960	(10,171,990)	(9,580,030)
Total fees & charges		**1,440,193**	**(4,863,407)**	**(3,423,214)**	**1,448,344**	**(13,091,866)**	**(11,643,522)**

2017/18

	Note	Parent			Consolidated Group		
		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)**

The fees and charges information in this note is provided in accordance with section 3.2.12 of the Government Financial Reporting Manual. It is provided for fees and charges purposes and not for IFRS 8 purposes. The financial objective of prescription and dental charges is to collect charges only from those patients that are eligible to pay.

Prescription charges[109] 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, and in 2018/19 it was £8.80. However, around 90% of prescription items[110] 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[111] 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. In 2018/19, the charge for Band 1 treatment was £21.60, for Band 2 was £59.10 and for Band 3 was £256.50.

109 https://www.gov.uk/government/speeches/nhs-prescription-charges-from-april-2017 https://www.gov.uk/government/speeches/nhs-prescription-charges-from-1-april-2018

110 https://digital.nhs.uk/data-and-information/publications/statistical/prescriptions-dispensed-in-the-community/prescriptions-dispensed-in-the-community-england---2007---2017

111 https://www.parliament.uk/business/publications/written-questions-answers-statements/written-statement/commons/2018-03-12/HCWS537/

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 2019 under the Health and Social Care Act 2012. The financial statements comprise: the Group and Parent Statements of Comprehensive Net Expenditure, Financial Position, Cash Flows, Changes in Taxpayers' Equity; and the related notes. These financial statements have been prepared under the accounting policies set out within them. I have also audited the information in the Remuneration and Staff Report and the Parliamentary Accountability and Audit Report that is described in that report 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 2019 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.

Conclusions relating to going concern

I am required to 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 for a period of at least twelve months from the date of approval of the financial statements. 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. I have nothing to report in these respects.

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.

- 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; and
- 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.

Gareth Davies 10 July 2019

Comptroller and Auditor General

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