NHS England

Our 2019/20 Annual Report

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

THE NHS CONSTITUTION
the NHS belongs to us all

HC 1057

NHS England

Annual Report and Accounts 2019/20

NHS England is legally constituted as the National Health Service Commissioning Board.

Presented to Parliament pursuant to the National Health Service Act 2006 (as amended by the Health and Social Care Act 2012).

Ordered by the House of Commons to be printed 28 January 2021.

HC 1057

This publication is available at www.gov.uk/official-documents

Any enquiries regarding this publication should be sent to us at: NHS England and NHS Improvement, Quarry House, Quarry Hill, Leeds, LS2 7UE.

ISBN 978-1-5286-1952-3

CCS0320331828 01/21

Printed on paper containing 75% recycled fibre content minimum

Printed in the UK by the APS Group on behalf of the Controller of Her Majesty's Stationery Office

Contents

A view from Lord David Prior, Chair

I never had any doubt that the NHS would rise to the extraordinary challenge of coronavirus. In a crisis, the people who work for the NHS and within the NHS are magnificent. It is not overly hyperbolic to plagiarise the words of Winston Churchill after the Battle of Britain: "so much owed by so many to so few".

Who would have thought that the Nightingale hospitals could have been built in a matter of days? Who would have thought that hospitals could double critical care capacity? Who would have thought that a deliberately fragmented institutionalised structure could transform itself into an integrated system, the holy grail of healthcare so quickly? Who would have thought that we could cope with 32,000 hospitalised COVID-19 patients at one time? Who would have thought that 90% of GP practices would go virtual delivering more than 500,000 online consultations every week? And that in June alone the NHS could deliver over 1.6 million outpatient appointments remotely?

It is truly remarkable that one of the world's largest organisations showed itself so agile, so innovative and so 'can do'. It was also humbling that many NHS staff left their families at home and came into work at a time that was scary for all.

But that does not mean that everything in the garden is rosy.

COVID-19 exposed many weaknesses, not just in the national and international response to the pandemic but more broadly. The health and care system is too fragmented. We have to move quickly to integrated care systems and this must include social care and care homes. Procurement and distribution processes were strained. The digital and data infrastructure responded well but we are a long way from embedding digital into our normal way of working. Laboratory capacity had to be scaled. Finally, the disproportionate impact of COVID-19 on People from Black, Asian and minority ethnic backgrounds reveals again the unacceptable growing health inequality that shamefully disfigures nearly all western societies.

Whilst COVID-19 has exposed weaknesses it also obscures a more profound issue. Healthcare systems across the developed world be they publicly funded, private or a mix of the two are under great stress. To put it simply, demand for treatment across the globe is growing faster than the funding to pay for it. So, the pressure to increase the value received from every pound spent will be relentless. Approaching this in a Gradgrindish kind of a way will not be the right solution. It is not penny pinching or traditional cost reduction that is needed but a much more profound transformation, this will require a far greater emphasis on keeping people healthy rather than treating people who are sick.

It will mean giving citizens greater power over their own lives through giving them access to more insightful data about their health. It will mean new clinical pathways that, where appropriate, support people out of conventional healthcare settings in particular, it will mean treating more people outside hospitals. It will mean much earlier diagnosis for illnesses such as cancer. It will mean truly personalised medicine as we incorporate genomics into mainstream diagnosis and treatment.

It will mean far more insightful personalised health predictions based on new methods such as polygenic risk scores, which combined with health data will enable effective population health management, as well as more informed – and therefore empowered - patients. It will mean better access to healthcare through digital means and better care as we incorporate continuous remote monitoring of many diseases.

All this adds up to a paradigm shift in how healthcare is delivered: prediction, prevention, personalisation. And the only way to achieve this is through stepping up what we are already doing, bringing down the barriers between different parts of the NHS so we work together, and in the patient's eye that means as one NHS. Only then can we truly start transforming the whole NHS to work better for patients after COVID-19.

The NHS has long been seen as a good healthcare system and emblematic of British fairness and social justice, that will remain, but it has also been viewed as a cost rather than an investment.

Increasingly, we should see the NHS as part of the UK's economic recovery. The NHS is an anchor institution and that means as local employers, as the organisation which keeps the workforce healthy, and as often is the case the biggest physical estate in the many towns and cities across England, the NHS is at the centre of each local economy.

That's why it's so important that we ramp up our capital spend to get our buildings in modern order – benefiting patients, staff and the local construction economy. It's why we should be more open to innovation and support British businesses in export markets. We should work in partnership with pharmaceutical, biotech and medtech companies so we can get the latest drug devices and medicines to patients fast, keeping local communities healthier for longer, and so more productive.

We should be a pioneer of digital health and digital therapeutics, partnering with local tech companies, experts and researchers. We must accelerate access to the NHS, encourage uptake of new products and encourage innovation.

We should work hand in hand with our great research institutes and universities, one of the brightest feathers in the UK's cap. With their research excellence, a unique data set and our ability to trial and test new methods of healthcare we can be the health research centre of the world. The RECOVERY trials have set a new standard in trial design and shown how researchers, commissioners and regulators can work hand in hand for the benefit of patients. And we absolutely shouldn't be limiting our horizons to the higher education sector. Britain is bursting with talent in our colleges and further education institutes. Colleges are absolutely essential for training a wide variety of roles such as healthcare assistants, catering staff and lab technicians as well as many, many more. Turbo charging the skills agenda couldn't be more important.

Just like the economic recovery and the COVID-19 recovery, the NHS can't shy away from the other big threat to our future – climate change. At times in the past the melting polar ice caps have seemed far removed from the NHS. But now we are seeing poor air quality in our major cities and air pollution is linked to killer conditions like heart disease, stroke and lung cancer. And the English health and care system is responsible for an estimated 4-5% of the country's carbon footprint.

The NHS has to stand up to this global challenge. It is not just a necessity, it is our duty. So, I am proud we've committed to reaching Net Zero. But setting a target is the easy part. We have to deliver on radical change if we are going to achieve it. Some of that means boosting the changes we've already begun such as the digital revolution, but it absolutely means tackling the big problems such as polluting hospitals energy systems and uninsulated buildings.

COVID-19 has been a horrendous experience for everybody. But it is showing what the NHS can achieve when we pull out all the stops – and it's shown us the possibilities of what can be achieved when we work together with the other important institutions, from councils to businesses and universities.

When the NHS dives headfirst into local communities and recognises its potential and the potential of those around it, the possibilities are endless. That is one of the most important lessons of this awful virus, and the way the NHS, and England, come back stronger.

Lord David Prior,
Chair of NHS England

About NHS England

NHS England leads the NHS, sets strategic direction for the NHS through the NHS Long Term Plan, and funds key priorities for improvement. NHS England was established by Parliament in 2012 as an independent statutory body.

In 2019/20 Parliament and Government entrusted NHS England with £124 billion to commission health care services for the people of England. NHS England allocated £90 billion of funding to 191[1] local clinically-led CCGs. Alongside care providers, CCGs are increasingly working as part of local Integrated Care Systems. NHS England also directly commissions a range of services including specialised care. Further detail is presented from page 70.

NHS England shares with the Secretary of State for Health and Social Care the legal duty to promote a comprehensive health service in England, in accordance with the National Health Service Act 2006 (as amended by the Health and Social Care Act 2012).

The Government's 2019/20 accountability framework[2] brought together the annual mandate to NHS England and the annual remit for NHS Improvement. This framework prioritised delivery of the first year of the NHS Long Term Plan and addressed issues associated with the United Kingdom's exit from the European Union.

The NHS Constitution establishes the principles and values of the NHS in England and unites patients, the public and staff in a shared ambition for health and high quality care for all, now and for future generations. As a custodian of the values of the NHS Constitution, we are committed to putting patients at the heart of everything we do, promoting transparency and equity while ensuring the most efficient use of public taxpayer resources.

How we operate

Since 1 April 2019 NHS England and NHS Improvement have come together as a single organisation, as is permitted under the legislation governing our activities.

NHS England is governed by a Board which provides strategic leadership and accountability for the organisation to Government, Parliament and the public. The Board is supported by committees which undertake detailed scrutiny in their respective areas of responsibility and provide it with regular reporting and formal assurance. NHS England has aligned and streamlined its board committee structures to work more closely with NHS Improvement. Further details about our Board, its committees and membership are presented from page 38.

We have moved to a single leadership model under the overall leadership of the Chief Executive Officer (CEO) of NHS England, and a single Chief Operating Officer (COO) who also serves as the CEO of NHS Improvement. New national director roles, either reporting to the NHS England CEO or COO, operate across both organisations.

1 The number of CCGs reduced from 195 to 191 on 01 April 2019 as a result of mergers.
2 https://www.gov.uk/government/publications/nhs-accountability-framework-2019-to-2020

We have created integrated regional teams, led by regional directors with a single reporting line to the COO. They are responsible for the performance of all NHS organisations in their region in relation to quality, finance and operational performance. National teams provide expertise, support and intervention.

Our teams continue to work closely with CCGs, GP practices, local authorities, health and wellbeing boards and the voluntary sector. During the year, our regional teams strengthened their collaboration with Sustainability and Transformation Partnerships (STPs) and Integrated Care Systems (ICSs) across the country, with staff aligning their roles to STP and ICS geographical footprints and working closely with their leadership.

To support continuous improvement in the quality of treatment and care, we support and rely on local healthcare professionals making decisions about services in partnership with patients and local communities.

Our proposals to Parliament for new primary legislation to support implementation of the NHS Long Term Plan include legally merging NHS England and NHS Improvement.

Because a system-wide approach is taken to ensuring clinically and financially sustainable services, NHS England is committed to working closely with other partners, such as Health Education England (HEE), Public Health England (PHE) and NHS Digital, at national and regional level.

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

NHS England also oversees Commissioning Support Units (CSUs). The CSU staff group are employed by the NHS BSA, but they are formally a part of NHS England. CSU activities are included in our report and accounts except where otherwise indicated.

Detail on how we assure the activity of our organisation is presented in this annual report from page 61. For further information about how we operate please visit our website[3].

3 www.england.nhs.uk/about/

Performance Report

Sir Simon Stevens
Accounting Officer
15 January 2021

Chief Executive's overview - Simon Stevens

The twelve months covered by this annual report include the start of the greatest health emergency in the NHS's history. Following the outbreak of the SARS-COV-2 virus in China, NHS England declared a Level Four incident on 30 January 2020. This marked the beginning of an extraordinary and sustained response from the NHS.

The pandemic has come at enormous human cost - in lives lost, care disrupted, and extreme pressure on our staff. The 1.5 million people who work for the NHS are the NHS, and at no time in our 72 year history has their skill, dedication and sacrifice been more evident. Services have been adapted and expanded at great speed so that over 230,000 severely ill Covid-19 inpatients have been looked after to date, while other essential and urgent services have continued. Even at the height of the first wave in the Spring, two thirds of hospitalised patients were receiving treatment for other, non-Covid, conditions.

Staff have driven rapid innovations such as Covid-secure treatment hubs, new precision radiotherapy and a £160 million investment in 'Covid-friendly' cancer drugs. Over 30 million phone, online and video consultations helped patients safely access advice and treatment. The NHS also mobilised to support multiple Covid clinical trials, which yielded the world's first proven treatment to significantly improve survival.

Nevertheless, the impact of Covid will be felt well after the immediate pressures have abated. We are already seeing extra demands on health services, whether from disrupted routine operations, higher mental health needs, or new conditions such as 'Long Covid'. Looking forward, these will need to be factored into our operational planning as we continue to implement the NHS Long Term Plan next year and beyond.

However, looking back across the full year covered by this annual report, there was broad progress in delivering the NHS Long Term Plan, despite continuing and intense operational pressure. At year end, the Department of Health and Social Care judged that 90% of the 'deliverables' in its 2019/20 Mandate to the NHS were either on track or already completed, with just 4% assessed as off track despite the Covid pandemic.

In 2019/20 NHS England managed £124 billion of NHS funding on behalf of our patients and the public. We allocated nearly three quarters of that for local health services that are planned and arranged by GP-led Clinical Commissioning Groups. Continuing the commitment first made in the NHS Five Year Forward View in 2014, we ensured that for the fifth year in a row, real terms mental health funding grew faster than that of the NHS budget overall. And in line with the new commitment in the NHS Long Term Plan we are similarly now ensuring that primary and community health services funding also grows as a share of the NHS budget.

In terms of care quality, more acute hospital services were independently assessed as good or outstanding by the Care Quality Commission compared with the year before - including further improvements in NHS urgent and emergency care. Over four fifths of NHS mental health and community services, and nineteen out of twenty GP practices, were rated good or outstanding.

The NHS saw more people for an urgent cancer check and delivered more treatments than ever before, and continued progress on the Long Term Plan goal of catching more cancers early – including through the rollout of FIT tests, Rapid Diagnostic Centres, and agreement to pilot blood tests with the potential to detect over 50 different types of hard-to-diagnose cancers at a point where treatment is more effective.

NHS England has worked with the life sciences sector to bring promising new treatments to patients, while ensuring good value for UK taxpayers. As a result, people living with cystic fibrosis, multiple sclerosis, spinal muscular atrophy, Batten disease, severe haemophilia and heart defects are amongst those to have benefited over the past year from important new treatments. Innovative new cancer treatments include CAR-T gene therapy and 'tumour agnostic' drugs. New therapies are also enabling us to work with voluntary groups and local government towards the realistic twin goals of eliminating transmission of both Hepatitis C and HIV.

Mental health services continued to expand, delivering - amongst other improvements - a national network of specialist perinatal mental health teams, new clinics to support people with gambling addictions, and strong performance against the range of targets covering children and young people's services, adult care including IAPT, and dementia diagnoses. Since March 2015, ongoing action to improve community support for people with a learning disability and/or autism has seen 70% of people who were in hospital at that time discharged, and a 27% reduction in the overall number of inpatients.

We have continued to work with our partners including local employers and Health Education England to sustain and expand the NHS workforce. The amazing example set by dedicated NHS staff during the Covid pandemic is inspiring a new generation, now wanting to join them in the health professions. As a result, undergraduate nursing entrants and medical school applications have this year both risen by more than a fifth. The number of doctors choosing to train as GPs is also now at a record high. To help retain experienced health professionals, we implemented a specific direction from the Secretary of State to help reduce a wave of early retirements being driven by changes to pensions. Retention of our current workforce has improved, and vacancies have now fallen, so that there are now over 60,000 more whole time equivalent staff working in the NHS than a year ago.

In 2019/20 NHS England balanced its books and met all the financial targets set by Government, as we have done for each of the past seven years since being established by Parliament as a freestanding statutory body (see charts on pages 30 and 31). Over that period we have also generated operating surpluses of £5 billion which have been used to tackle other financial pressures across the NHS. In 2019/20 these funds helped NHS Improvement halve the number of provider trusts running deficits, so that three quarters of individual trusts broke even or made a surplus.

The performance of individual NHS organisations was helped by the move towards more partnership working between different parts of the health service, and with social care. Progress towards more joined-up primary and community care came through the creation of 1,250 Primary Care Networks. They are key delivery partners in the new NHS Covid mass vaccination campaign, and are recruiting thousands of additional staff including pharmacists and therapists to strengthen community health services, including for people living in care homes.

Our 29 Integrated Care Systems - covering 35 million people - also bring greater focus on prevention, inequalities reduction and population health. Our aim is that substantially the whole of England will be covered by ICSs from April 2021, which will mark an important milestone on the journey first set out in the NHS Five Year Forward View. In similar vein, over the past year we successfully brought together NHS England and NHS Improvement under unified leadership.

After widespread engagement and support, the NHS has now proposed to Government and Parliament that the time is right for legislation to place these ICSs on a statutory footing. This evolutionary approach of the past few years - in preference to a 'top down reorganisation' - builds on Aneurin Bevan's dictum that "legislation in this country starts off by voluntary effort, by empirical experiment, by improvisation; it then establishes itself by merit; and ultimately at some stage the state steps in and makes what was started by voluntary action and experiment a universal service".

As we look out to the year ahead - and the more hopeful possibility of a 'post pandemic world' - we also recognise our wider responsibilities. The NHS is the first national health system to set out a detailed and practical route map to becoming carbon net neutral. Covid has also exposed and exacerbated deeper and longstanding concerns about inequality, racism and exclusion. As one of the most trusted institutions in Britain, as an economic 'anchor' within the communities we serve, and as Europe's largest and most diverse employer, the NHS can and will play our part in building a better future. Doing so is not a discretionary activity or a diversion from our core mission. It is fundamental to fulfilling the moral basis of the NHS: health and high quality care for all, now and for future generations.

But in the meantime the NHS and our staff continue to respond to the worst pressure we have ever faced, with a winter wave of over 30,000 severely ill hospitalised coronavirus patients, at the same time as we deliver the largest and fastest vaccination programme in our history. These truly are the most challenging of circumstances for our country and for my fellow staff across the health service. We all owe them an enormous debt of gratitude which must not be forgotten in the years ahead.

Sir Simon Stevens

CEO of NHS England, and Accounting Officer

Performance of Clinical Commissioning Groups

The NHS Constitution sets out the rights of patients, public and staff. We measure and monitor performance against a wide range of standards. We publish statistics relating to these core standards on the NHS England website[4] every month.

NHS England monitors performance and delivery of the key commitments detailed in the NHS Long Term Plan. We have a statutory obligation to assess the performance of CCGs using a range of measures to create a balanced judgement of their effectiveness.

The table below shows the number of CCGs receiving each rating in 2019/20 compared to 2018/19[5].

	2019/20	2018/19
Outstanding	22	24
Good	104	102
Requires Improvement	56	58
Inadequate	9	11
TOTAL[6]	**191**	**195**

4 www.england.nhs.uk/statistics/statistical-work-areas/combined-performance-summary
5 The full data set is available at www.england.nhs.uk/comissioning/regulation/ccg-assess/iaf/
6 In April 2019, there were two CCG mergers involving six CCGs; hence the net reduction of 4 in the total number of CCGs.

Performance Overview

The NHS Long Term Plan, published in January 2019, set out a 10-year programme of practical phased improvements to NHS services and outcomes, including a number of specific commitments to invest the agreed NHS five-year revenue settlement.

This performance overview provides a brief summary of progress made on: prevention and health inequalities; care quality, access and outcomes; ensuring NHS staff get the backing they need; and using taxpayers' investment to maximum effect. Together, our work programmes encapsulate the objectives set out in the Government's accountability framework to the NHS for 2019/20. Further information is available on page 168.

The COVID-19 pandemic had a major impact on the NHS in the last quarter of the year, intensifying in March 2020 and into the new financial year. This needed an unprecedented and coordinated emergency response. From January 2020 NHS England and NHS Improvement, in partnership with the Department of Health and Social Care (DHSC), scaled up its response ensuring that every coronavirus patient who needed specialised inpatient care was able to receive it. A new remote COVID-19 Response Service (CRS), accessible via 111, was swiftly established with over 1,500 retired clinicians recruited to provide clinical assessment. Resources supporting clinical and operational teams on the front line were redeployed, which in some cases meant accelerating parts of the Long Term Plan. So while the long term priorities remain the same, the phasing of them has and will change. See page 26 for more detail on the NHS response to COVID-19.

A new service model for primary and community health services

During 2019/20 NHS England and NHS Improvement continued to invest more in primary care services, expand the number of people working in primary care, and make practical improvements to services and premises. We are on track to see real terms expenditure on primary medical and community service grow to almost £28.8 billion by 2023/24, having exceeded the 2019/20 £23.2 billion target by November 2019.

By 1 July 2019 1,250 Primary Care Networks (PCNs) were established with a PCN clinical director appointed to each. PCNs are groups of GP practices (typically with a population of between 30,000 and 50,000 people) working together with colleagues in wider primary care, social care and the voluntary sector, to develop expanded community multidisciplinary teams that are focused on delivering services for their specific patient populations. They are crucial pillars in the national Covid vaccination campaign.

Contributing to the goal of providing an additional 50 million extra appointments within general practice by 2024/25, this year saw increased financial and practical support for the roll out of online consultation (to support triage) and video consultation capabilities in general practice. This work was accelerated rapidly from February 2020 as part of the NHS response to the COVID-19 outbreak, with 90% of practices now having access to online consultation capability and 99% to video consultation capability by the end of 2020. This is a significant increase from the previous levels of 30% and 3% in December 2019. A major programme to

help meet the Government's new target of 6,000 additional GPs across the NHS (compared with the March 2019 baseline) was announced in February 2020. In conjunction with HEE we have continued to increase the numbers of GP trainees working in general practice during 2019/20, as well as the number of doctors returning to practice. The number of new doctors choosing general practice as a career is now at an all time high. In addition, in the 12 months leading up to December 2019, there was a growth of 1,473 headcount (199 FTE) doctors working in general practice. This is in addition to the GPs who have returned to registered practice since the COVID-19 pandemic.

We have continued to expand the personalised care programme, to provide people with choice and control over their own care, improve outcomes and deliver efficiency savings. The 2019/20 goal of 70,000 people with a personal health budget (PHB) was achieved by the second quarter of the year, exceeding our mandate commitment for PHBs two years early. A new legal right to a PHB was launched in December 2019 for people who access certain kinds of mental health support and for people who need to use a wheelchair. We estimate this could benefit a further 100,000 people by 2023/24.

By the end of 2023/24, 900,000 people will have benefited from social prescribing. Starting in 2019/20 we provided funding via the Additional Roles Reimbursement Scheme within the PCN contract, for over 1,000 additional trained link workers by March 2021, with the intention that numbers recruited will rise further by March 2024.

The Ageing Well programme is supporting the roll out of Enhanced Health in Care Homes (EHCH) to strengthen support for the people who live and work in care homes. Requirements for delivery were included in the Primary Care Network Directed Enhanced Service (DES) in 2020/21 and in the 'Update to the GP Contract Agreement 2020/21 – 2023/24[7]. Complementary EHCH requirements for relevant providers of community physical and mental health services have been included in the NHS Standard Contract[8]. Key elements of the EHCH model due for delivery in October 2020 have been fast-tracked across the country in response to the COVID-19 pandemic.

Mental health

In 2019/20 the NHS once again met the Mental Health Investment Standard which guarantees that real terms funding for mental health grows faster than that for the NHS overall. Mental health, access, recovery and referral to treatment time targets made good progress in 2019/20 and (prior to the COVID-19 pandemic) were on track to be achieved as expected by 2020/21. Among key achievements, there are now specialist perinatal mental health community services in place in every locality. Data from March 2020 indicates that the national access rate for children and young people's mental health for 2019/20 was exceeded (36.8% vs 34% target), and the access rate is already ahead of the 2020/21 ambition. A further 123 mental health support teams were confirmed in July 2019 and were introduced in 57 sites around the country during 2019/20, bringing the total number of sites to 73.

7 https://www.england.nhs.uk/wp-content/uploads/2020/02/update-to-the-gp-contract-agreement-2021-2324-v2.pdf (P40-46)
8 https://www.england.nhs.uk/nhs-standard-contract/20-21/

Quarter 4 2020/21 data for children and young people's eating disorder waiting times shows 84.4% of patients accessing treatment within four weeks (routine referrals) and 80.5% within one week (urgent referrals).

Progress continued on increasing access to individual placement support services and to Improving Access to Psychological Therapies (IAPT) for adults and older adults needing psychological therapies. IAPT waiting time standards continued to be met, with 87.1% of people entering treatment in March 2020 having waited less than six weeks (against a standard of 75%), and 97.7% of people entering treatment having waited less than 18 weeks (against a standard of 95%). The IAPT recovery rate was 47.7%, which was below the 50% target, and likely attributable to COVID-19. More recent data (May 2020) demonstrates delivery of the 50% recovery target is back to 50.6%.

The national standard for 56% of people to start treatment for Early Intervention in Psychosis (EIP) within two weeks was exceeded in March 2020, with performance of 71.9%.

In 2019/20, we awarded £70 million transformation funding to 12 early implementer sites to test new models of integrated primary and secondary mental health care for people with severe mental illnesses. All hospitals with 24/7 consultant-led A&E departments now have a liaison mental health service, and all areas of the country are implementing plans to expand their crisis services coverage.

Further progress has been made towards eliminating reliance on inappropriate adult acute out of area placements. During 2019/20, additional assurance was implemented for the ten most challenged providers, which successfully reduced their use of inappropriate out of area placements by approximately 11,500 out of area bed days (or just under 30%) between Q4 2018/19 and Q4 2019/20. We are continuing to work closely with providers to deliver the ambition to end inappropriate adult acute out of area placements, while also factoring in the impact of the pandemic on increasing acuity of patients and local demand for beds.

Three newly-funded problem gambling mental health support clinics started to see patients during the year, and the NHS opened its first specialist clinic for children and young people with severe or complex behavioural issues associated with gaming, gambling and social media. Funding was allocated to seven sites to develop specialist mental health services for rough sleepers.

A new Advancing Mental Health Equalities Taskforce was launched in 2019/20. The immediate priorities of the Taskforce relate to data quality improvement, metrics development and establishing the Patient and Carers Race Equality Framework.

The dementia diagnosis rate continued to be exceeded during 2019/20, with a 67.4% achievement by March 2020 against the 66.7% standard.

Learning disability

Improving the health of people with a learning disability and/or autism remains a key priority for the NHS. The NHS Long Term Plan commits to reducing reliance on specialist inpatient care for children and adults with a learning disability, autism or both. The number of people in an inpatient setting reduced by 27% from 2,895 in March 2015 to 2,105 at the end of March 2020. The number of children and young people in an inpatient setting at the end of March 2020 was 215, a reduction of 26% from the end of March 2019. A priority going forward is the number of children and young people who have autism and no learning disability, accounting for 79% of under 18 inpatients.

The NHS Long Term Plan commits to improving the uptake of annual health checks for people with a learning disability, so at least 75% are receiving a health check each year by 2023/24. New additional payments for GPs and PCNs to identify patients with a learning disability and to undertake annual health checks are being introduced and a national campaign to improve uptake will be launched.

More Learning Disabilities Mortality Reviews (LeDeR) than ever were completed in 2019, following investment of a further £5 million. At the end of March 2020, CCGs had completed 63% of eligible reviews (those not otherwise subject to statutory investigations or reviews or on hold to enable families to take part) within six months of notification. LeDeR is now the largest such body of evidence in the world, reviewed at an individual level, and it has led to the introduction of the Oliver McGowan mandatory training on learning disability and autism.

More NHS action on inequalities and preventing ill health

During 2019/20, we took action on health inequalities, in line with the commitments set out in the NHS Long Term Plan (2019)[9], and the criteria set by the Secretary of State. A fuller update can be found in appendix 4 on page 178.

During 2019/20, we worked with national and regional stakeholders to develop tobacco and alcohol interventions, being rolled out in 2020/21 at Early Implementer Sites (EIS). We also incorporated smoking cessation activities into the community pharmacy contract.

Diabetes is a leading cause of premature mortality, resulting in over 22,000 additional deaths each year and doubling an individual's risk of cardiovascular disease including heart attacks, heart failure, angina and stroke. The NHS Diabetes Prevention Programme (NHS DPP) is the world's first nationwide Type 2 diabetes prevention programme. Emerging outcomes data shows a mean weight loss in those who completed the programme of 3.3kg. Reductions in weight and HbA1c[10] compare favourably to those reported in recent studies and indicate likely future reductions in participant type 2 diabetes incidence. We have supported 120,000 people to access the NHS DPP in 2019/20 and are on the way to support 200,000 people per year. Following procurement of a new NHS DPP Provider Framework we have now rolled out digital services to complement face to face services across 45% of England.

9 NHS Long Term Plan – Chapter 2: Prevention and Health Inequalities - https://www.longtermplan.nhs.uk/

10 HbA1c is measured by clinicians to ascertain an overall picture of diabetic patients' blood glucose levels over a period of weeks/months

This year we have licenced, developed and begun roll out of Healthy Living, a digital self-management programme for those living with Type 2 diabetes, which will ultimately be available universally. The number of structured education places has expanded to support people newly diagnosed with diabetes, to understand how to look after themselves well and reduce the risks of diabetes related complications.

Maternity and neonatal services

Safe childbirth outcomes in England are at record levels. The stillbirth rate decreased by 21% between 2010 and 2018. The extra lives saved means the NHS met its own ambitious 20% target two years ahead of the 2020 deadline. The national maternity safety ambition is to reduce stillbirths, neonatal deaths, maternal deaths and brain injuries at birth by 20% by 2020 and 50% by 2025.

The latest neonatal mortality rate, for February 2020, was 2.8 per 1,000 live births. 5.1% lower than 2010, with further reduction now required. The latest data for 2015-17 shows a reduction in the rate of maternal deaths from 9.2 deaths per 100,000 maternities, down from 10.6 in 2010, with the target to reduce this further to 5.3 in 2025. Maternal mortality rates are influenced by multiple factors such as cardiac conditions, obesity, smoking, complex social factors and inequalities. Rates among women from Black, Asian and Minority Ethnic (BAME) backgrounds are up to five times those of white women, which is why we aim to provide continuity of carer to 75% of BAME women and those from the 10% most deprived neighbourhoods by 2024.

There are however continuing serious concerns about maternity services in a small number of providers, including Shrewsbury and Telford Hospital NHS Trust and East Kent Hosptals University NHS Foundation Trust, where NHS Improvement has commissioned independent reviews. Teams from NHS Improvement and NHS England will be working intensively with those providers to ensure they follow best practices in relation to safety, with independent scrutiny from both CQC or the new Healthcare Safety Investigation Branch (HSIB).

Serious brain injuries fell from 5.4 per 1,000 births in 2014 to 5.1 in 2017. Trends in brain injury rate are however currently difficult to interpret due to the measure's immaturity and likely improvements in data quality.

The NHS has rolled out a general practice campaign to encourage parents to have their children vaccinated against measles mumps and rubella. The seasonal flu vaccine was made available to all 600,000 primary school aged children in year 6 for the first time in 2019/20. Infants born on or after 1 January 2020 now only need two injections for the pneumococcal conjugate vaccine as opposed to three. The human papillomavirus HPV test achieved full geographic coverage in December 2019. All 12 and 13-year-olds are offered the HPV vaccine, and a catch-up programme is available for eligible people up to age 25.

Cancer

Cancer survival and patient experience of NHS care are both the highest they have ever been. In 2019/20 more people than ever before were referred urgently with suspected cancer: 2.4 million compared to 2.2 million in 2018/19, and 1 million in 2010/11. 167,000 patients went on to start treatment, a 2% increase on the previous year. This growth is welcome as it allows earlier diagnosis and treatment, but it also places increased pressure on services.

The NHS modernised key aspects of its national cancer screening programmes. 2.9 million breast cancer screenings were carried out during the 12 months to the end of December 2019. People eligible for bowel cancer screening are now being sent a testing kit that is more sensitive to risk signs and easier to use than the previous version. By December 2019, more than 45,000 extra kits were being returned every month – a 7.8% increase. The introduction of rapid diagnostic centres (RDC) aims to speed up diagnosis and offer a clear referral route for patients with non-specific symptoms that could indicate cancer, and 23 RDCs were 'live' by January 2020. In addition, the GP contract includes a new specification for PCNs to support the earlier diagnosis of cancer.

Outpatient transformation and planned care

The NHS Long Term Plan committed to re-design outpatient care to avoid the need for a third (30 million) of face-to-face hospital outpatient visits by 2023/24, saving patients' time, freeing up clinical capacity, and averting the need for up to £1.1 billion in new expenditure. National scale up of video conferencing for outpatient care was planned across the period of the Long Term Plan. As part of the NHS response to COVID-19, accelerated progress has been made on the use of video consultation in secondary care, achieving universal coverage in England in four weeks. As a result, nearly a quarter of all outpatient appointments in the last week of March were completed virtually without patients having to leave home, up from 4% in the first full week of January.

An early priority for outpatient transformation is the re-design of ophthalmology services, which is the largest outpatient specialty by volume. Early work began in 2019/20 to design and scope this activity with leading ophthalmologists, hospital chief executives and patient representatives feeding into the design of new pathways. Re-design of musculoskeletal, dermatology and cardiology outpatient services will follow in 2021.

Development of the NHS People Plan

The Interim NHS People Plan[11] was co-developed with national leaders and partners and published in June 2019. With a strong focus on the challenges specific to the NHS workforce, and setting out clear ambitions on how NHS staff will be bolstered and supported to deliver 21st century care, the plan was well received across the healthcare sector.

Underpinned by a commitment of almost £900 million by 2024, the NHS People Plan includes a major programme to help meet the Government's new target of 6,000 additional GPs across the NHS workforce, and a further 6,000 non-GP direct patient care staff, in addition to the 20,000 previously committed to. It was supplemented by a further publication setting out core priorities and actions on workforce, published in July 2020.

For information on our progress in these areas, see Appendix 3 on equality, and Appendix 4 on reducing health inequalities, from page 175.

Metrics will be developed to track progress on the NHS People Plan nationally, regionally, by STP, ICS and, where applicable, by individual trust and/or PCN.

11 https://www.longtermplan.nhs.uk/wp-content/uploads/2019/05/Interim-NHS-People-Plan_June2019.pdf

As part of the NHS response to COVID-19, the Bringing Back Staff (BBS) programme's aim is to recall as many staff as possible to the NHS. Over 5,635 recently retired clinicians have been deployed in acute frontline services and 2,557 have been passed to NHS 111 for deployment. As at 1 June 2020, 1,600 GPs had also returned to registered practice to support the NHS response to COVID-19.

Equipping the NHS to offer digitally-enabled care

NHSX is an organisation formed from the teams of DHSC, NHS England and NHS Improvement to drive the digital transformation of care. It reports into DHSC and NHS England and NHS Improvement. It is delivering several key products and services and guiding the overall digital ecosystem in partnership with NHS Digital and others. Its work during 2019/20 includes:

NHS.uk

The NHS website (www.nhs.uk) continues to be the UK's largest health website, with more than 50 million visits a month. It provides thousands of clinically validated articles, videos and tools to help people make the best choices about their health, care and wellbeing and reduce pressure on frontline services.

In 2019/20 significant improvements were made to the overall site including:

- New content throughout; expansion of the highly used medicines information.
- Redesign of the 'Mental health and wellbeing' information.
- A new Find a Service tool.
- A new system for submitting ratings and reviews.

The website provides key content for reuse to increase reach and quality of health information for people in England, with over 2000 organisations signed up to use our content.

NHS Login

NHS Login is a single, secure login enabling swift access to the NHS App, and other health and social care apps and websites wherever there is the NHS login button. Launched alongside the NHS App, NHS Login provides citizens with safe access to digital health services online.

Supporting the NHS response to COVID-19

As part of the NHS response to COVID-19 in the last quarter of 2019/20, work was accelerated on implementing digital alternatives to traditional face-to-face appointments. In addition to the progress that has been made on the use of video consultation in secondary care described on page 23, we have seen a rapid uptake in usage of video consultations in urgent and emergency care, community, mental health and ambulance services, and on behalf of DHSC, NHSX is now supporting its use in the care sector.

Comprehensive coverage of Integrated Care Systems

ICSs are the practical way that NHS organisations, local authorities, the voluntary sector and others will work together in every part of England to deliver the commitments set out in the NHS Long Term Plan. In June 2019, the coverage of these systems grew to include South East London, Oxfordshire (part of a single system with Buckinghamshire and Berkshire West) and the whole of the North East. There are now 29 ICSs in total, serving more than 60% of England's population and more ICSs will cover the whole of England by April 2021.

In 2019/20, NHS England and NHS Improvement set out the operational, leadership and governance arrangements needed in every system by 2021 in order to co-ordinate system-wide transformation and collectively manage system performance. Working in collaboration with a wide range of stakeholders, we have set out a new way of working referred to as 'system by default'. This is intended to support the transition to the agreed NHS England and NHS Improvement operating model and 100% ICS coverage by 2021. We are providing direct support to all health and care systems as they mature against the criteria in the ICS matrix framework, and through our new 'Accelerator' programme.

How we supported the wider NHS

Emergency Preparedness, Resilience and Response (EPRR)

The NHS response to COVID-19

During 2019/20 we have responded to a range of threats to patient and public safety, drawing on the experience and expertise in our EPRR teams. Of these incidents, dominant has been the NHS's response to the COVID-19 pandemic. This emergency, unprecedented in scale and complexity, was declared a Level 4 national incident on 30 January 2020. NHS England and NHS Improvement provides strategic direction, co-ordination and oversight of the NHS operational response, in line with the EPRR national framework.

Established EPRR response coordination processes were enhanced including national Strategic and Incident Directors, Incident Management Teams and Incident Co-ordination Centres (ICCs) at national and regional levels, and in individual organisations. An NHS England and NHS Improvement COVID-19 National Incident Response Board (chaired by the Chief Operating Officer and consisting of a committee of the NHS Executive and NHS England and NHS Improvement Boards) was established to oversee the NHS response to COVID-19 and set direction and policies. DHSC is represented on the incident response board, to help ensure coordination with the work of other agencies, such as PHE's responsibility for COVID-19 testing and infection control guidance, and DHSC's leadership on Personal Protective Equipment (PPE) procurement and supplies.

Our arrangements continue to evolve and anticipate developments, whilst ensuring an effective flow of information.

Britain's exit from the EU

Significant work went into preparation for the UK's departure from the European Union (EU). Incident Management Teams have also used trained volunteers from other parts of the organisation recruited under the NHS England and NHS Improvement reservist scheme. Work to help the NHS prepare for EU Exit during 2019 in conjunction with DHSC and wider Government helped improve transparency regarding medicines supply chains.

November London Bridge terrorist attack

On 29 November 2019 the NHS was once again required to respond to a terrorist attack. Two people tragically lost their lives on London Bridge, and the London Ambulance Service treated a number of people at the scene and conveyed people to hospitals. The NHS continues to work with cross Government and local partners to ensure that those affected by the incident receive care and psychosocial support.

Other incidents

Throughout 2019/20, before the pandemic, the NHS responded to the threat of high consequence infectious diseases (HCIDs) both in England and overseas, including the threat to the UK from the Ebola outbreak in the Democratic Republic of Congo, repatriation of workers suspected of being exposed to Lassa Fever, and one case of Monkeypox.

In 2019 the NHS also responded to several other incidents including listeria contamination and the home parenteral nutrition shortage.

NHS England and NHS Improvement continue to build resilience in key sectors of health, for example through the tendering of the National Ambulance Resilience Unit contract awarded to the West Midlands Ambulance Service University NHS Foundation Trust.

Productivity and efficiency

As part of our commitment to improving productivity throughout the health and care system, we are developing and implementing e-rostering and e-job planning to deploy the NHS clinical workforce to best effect, improving workforce productivity by an estimated £1.45 billion.

The NHS England and NHS Improvement Commercial Medicines Directorate (CMD) has been established to support patients to access the latest innovative and most clinically effective new medicines, while securing maximum value for the NHS and taxpayers. The work of the CMD is aligned with two key policy documents: the NHS Long Term Plan and the Voluntary Scheme for Branded Medicines Pricing and Access. Working alongside DHSC, NHS England and NHS Improvement are delivering a range of measures for England as set out in the Voluntary Scheme agreed with the pharmaceutical industry that started on 1 January 2019. The five-year scheme is designed to manage the branded medicines bill whilst supporting innovation and better patient outcomes through improved access to the most transformative and cost-effective new medicines. A key success during 2019/20 was the successful roll out of the Adalimumab smart procurement, where we are on track to deliver a total of over £280m of savings, despite around 16% growth in use.

The CMD has also successfully negotiated several innovative commercial agreements at fair and responsible prices, supported by NICE, and which have made new and promising treatments available for NHS patients. These include:

- Ocrelizumab in multiple sclerosis.
- Nusinersen in spinal muscular atrophy.
- Cerliponase in Batten disease.
- A deal with Vertex Pharmaceuticals to make available all three of their UK-licensed cystic fibrosis medicines.

Research and innovation

Research and innovation are a core part of the NHS. Organisations active in research often provide higher quality care for all patients, while innovation improves outcomes, patient experience and efficiency. We hosted the Accelerated Access Collaborative (AAC) in 2019/20 and more than 440,000 patients benefited from new tests and treatments made available through its work. For example, Heartflow – which creates a digital 3D model of the heart and avoids the need for invasive procedures – was offered in hospitals and reduced the need for invasive tests. We took measures to support AAC's mandate to speed up access of proven innovation to patients, including the launch of a £140 million award to encourage the safe deployment and testing of the most promising artificial intelligence technologies in the NHS.

Sustainability

For information on environmental matters, including NHS England and NHS Improvement's impact on the environment, please see appendix 6 on page 186. In January 2020 we launched a programme to set a feasible and measurable path to becoming a net zero health service. This blueprint was formally adopted by NHS England and NHS Improvement in October 2020[12].

12 https://www.england.nhs.uk/greenernhs/publication/delivering-a-net-zero-national-health-service/

Chief Financial Officer's Report

The financial statements for the year ending 31 March 2020 are presented later in this document on a going concern basis (as per note 1.5) and show the performance of both the consolidated group – covering the whole of the commissioning system – and NHS England as the parent of the group. The group comprises NHS England and 191 CCGs.

We are required to manage spending within a fixed revenue limit which in 2019/20 was £124,068 million. I am pleased to report that NHS England has again fulfilled all its financial duties as set out in the mandate from Government.

Our approach to Financial Management

In 2019/20 we began resetting the NHS financial framework to support service improvements and progress towards the sustainable financial path contained in the NHS Long Term Plan. The changes we introduced encouraged system working while giving more freedom to organisations and reducing the number in deficit. They included:

- Supporting systems to move away from activity-based payments through the creation of a new default 'blended payment' model covering non-elective admissions, A&E and ambulatory/same day emergency care. This hybrid approach increases the incentives for system working and collaboration.
- Creating a Financial Recovery Fund (worth £1.05 billion initially) to support the sustainability of essential NHS services, allowing trusts to cover day-to-day running costs whilst cutting their deficits. As the sustainability of services improves, we expect the number of CCGs and Trusts in deficit to continue to reduce (this was successfully achieved in 2019/20).
- Transferring £1 billion into urgent and emergency care prices and halving the value of CQUIN to 1.25%, helping to reduce the difference between average costs and national tariff prices.
- Recognising the hard work made in delivering savings in previous years, moving to stretching but achievable efficiency requirements for organisations. The national tariff efficiency factor was set at 1.1%.

At the same time, we also sought to give local systems certainty about the future resources available to them. We published five years of core CCG and primary care allocations, gave local systems greater certainty over future funding for NHS Long Term Plan commitments, and greater control over how those funds are deployed. Indicative specialised commissioning allocations were also supplied at provider level.

Financial Performance

Over the course of 2019/20 NHS England and NHS Improvement have come together as a single organisation to better support the NHS and help improve care for patients. As part of this we have been increasingly, alongside our partners in ICSs and STPs, taking a whole system approach to financial management. This has led to a rebalancing across the NHS with CCGs working with providers to deliver system level savings. In some areas, CCG overspends have increased which have been more than offset by reduced provider deficits.

Against our plan for the year the NHS England group has delivered a managed underspend of £996 million (0.8% of allocation). Thus for the seventh year in a row, NHS England has successfully balanced its books.

Revenue Department Expenditure Limit – (RDEL) general (non-ring-fenced)

Financial Performance	2019/20				2018/19		2017/18		2016/17		2015/16		2014/15		2013/14	
	Expenditure		Under/ (over) spend against plan		Under/ (over) spend against plan		Under/ (over) spend against plan		Under/ (over) spend against plan		Under/ (over) spend against plan		Under/ (over) spend against plan		Under/ (over) spend against plan	
	Plan	Actual	£m	%	£m	%	£m	%	£m	%	£m	%	£m	%	£m	%
CCGs	89,712	90,219	(507)	(0.6%)	(150)	(0.2%)	(213)	(0.3%)	154	0.2%	(15)	(0.0%)	70	0.1%	89	0.1%
Direct commissioning	25,836	25,446	390	1.5%	310	1.3%	223	0.9%	296	1.2%	82	0.3%	(12)	(0.0%)	(365)	(1.4%)
NHS England Admin/Central Progs/Other	7,829	6,716	1,113	14.2%	755	17.0%	960	23.2%	452	13.0%	532	28.5%	226	13.5%	602	30.5%[13]
Total	**123,377**	**122,381**	**996**	**0.8%**	**915**	**0.8%**	**970**	**0.9%**	**902**	**0.9%**	**599**	**0.6%**	**285**	**0.3%**	**326**	**0.3%[14]**

Within the systems of which they are part, CCGs continue to manage their finances well and collectively take appropriate action to deliver efficiency savings. CCGs delivered £2.2 billion (2.4% of total allocations) of efficiency savings over the course of the year. The number of CCGs reporting an overspend increased in 2019/20 (46 compared to 33 in 2018/19), in a context where the support provided through the Commissioner Support Fund (CSF) was reduced by £100 million and there were pressures outside of CCGs' control, for example on drugs prices.

NHS England actively managed the NHS Group financial position throughout the year. Investment was held back to support the group position. Strong financial management across Direct Commissioning and Specialised Commissioning also enabled these areas to deliver managed underspends.

Delivering this level of underspend across the NHS England Group has enabled us to offset the overspends across a number of NHS providers, thus making sure that the NHS as a whole lived within its budget for the year.

13 Historic Continuing Healthcare claims administered on behalf of CCGs included in "Other"
14 2019/20 actual expenditure is £360 million lower than in the financial statements to reflect the impact of additional direct COVID-19 spend that does not score against RDEL in line with the Ministerial direction issued by DHSC.

Performance against wider financial metrics

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

2019/20 Performance against key financial performance duties

Revenue Limits	Target				
	Mandate Limit £m	Actual £m	Underspend £m	Underspend as % of Mandate	Target met?
RDEL - general[15]	123,377	122,381	996	0.8%	✓
RDEL - ring-fenced for depreciation and operational impairment	166	149	17	10.2%	✓
Annually Managed Expenditure limit for provision movements and other impairments	325	295	30	9.2%	✓
Technical accounting limit (e.g. for capital grants)	200	62	138	69.0%	✓
Total Revenue Expenditure	**124,068**	**122,887**	**1,181**	**1.0%**	✓
Administration costs (within overall revenue limits above)					
Total administration costs	**1,874**	**1,623**	**251**	**13.4%**	✓
Capital limit					
Capital expenditure contained within our Capital Resource Limit (CRL) [16]	**260**	**255**	**5**	**2.0%**	✓

Allocations

NHS England has responsibility for allocating the NHS funding agreed with the DHSC as part of our Mandate. We are required to operate a transparent and equitable allocation process. The NHS Act 2006 (as amended) also requires NHS England to have regard to reducing inequalities in access to and outcomes from healthcare.

In January 2019, the NHS England Board approved allocations for the five years from 2019/20 to 2023/24, deploying the long-term revenue funding settlement made available by the Government to support the implementation of the NHS Long Term Plan. Significant improvements were also made to the formulae through which resources are distributed to CCGs and were implemented in 2019/20, on the basis of recommendations from the independent Advisory Committee on Resource Allocation.

15 2019/20 RDEL - General expenditure actual is £360 million lower than in the financial statements to reflect the impact of additional direct COVID-19 spend that does not score against RDEL in line with the Ministerial direction issued by DHSC.

16 2019/20 Capital Resource Limit (CRL) expenditure actual is £10 million lower than in the financial statements to reflect the impact of additional direct COVID-19 spend that does not score against CRL in line with the Ministerial direction issued by DHSC.

There were two major formula changes - the introduction of a new community services allocation formula, and an updated and improved mental health formula using new linked data. In addition, the health inequalities adjustment was updated and the methodology adjusted to better reflect the full range of variation in the mortality ratio used for the adjustment. The way in which populations are calculated and demographic projections are used was also enhanced.

These allocations remain the basis of our plans for 2020/21, updated for changes to tariff inflation and tariff adjustments.

Impact of COVID-19

COVID-19 is the biggest public health challenge facing the NHS and society in our lifetimes. As the whole health and care system mobilised to respond, this gave rise to a financial impact in the final months of 2019/20.

Financial sustainability

The NHS Long Term Plan sets out five tests for the NHS to meet as we move onto a sustainable financial path whilst delivering core service improvements. Responding to COVID-19 has meant that the timeline for delivering on these tests and delivering all of the NHS Long Term Plan service improvements will be evaluated over the coming months. The NHS has started to put down the foundations of financial sustainability, with the number of NHS providers reporting a deficit falling by half – 53 in 2019/20 against 107 in 2018/19.

Financial priorities for 2020/21

We will focus on continuing to support the NHS with the resources needed to respond to COVID-19, ensuring that finance is not a barrier to fighting the virus and making sure the NHS comes through this with a pathway to financial sustainability and delivery of the NHS Long Term Plan goals.

Julian Kelly

Chief Financial Officer

Our priorities for 2020/21

The NHS Long Term Plan, published in January 2019, will continue to be our focus over the coming years.

Our focus during 2020/21 will be on the continued response to COVID-19, while supporting systems in the restoration of other services that were affected by the COVID-19 pandemic.

We will work with the Government and local systems on the journey to delivering the commitments in the NHS Long Term Plan.

Accountability Report

Sir Simon Stevens
Accounting Officer
15 January 2021

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 2019/20, 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 37.

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 84.

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 108.

Corporate Governance Report

Directors' Report

The role of the Board

The Board is the senior decision making structure for NHS England. It has reserved key decisions and matters for its own decision, including strategic direction, overseeing delivery of the agreed strategy, the approach to risk, and establishing the culture and values of the organisation. They are set out in the Scheme of Delegation.

Key responsibilities to support its strategic leadership to the organisation include:

- Approving the business plan and monitoring performance against it.
- Holding the organisation to account for performance and the proper running of the organisation (including operating in accordance with legal and governance requirements).
- Determining which decisions it will make and which it will delegate to the Executive via the Scheme of Delegation.
- Ensuring high standards of corporate governance and personal conduct.
- Providing effective financial stewardship.
- Promoting effective dialogue between NHS England, NHS Improvement, government departments, other ALBs, partners, CCGs, providers of healthcare and communities served by the commissioning system.

The Board

NHS England's Board members bring a wide range of experience, skills and perspectives to the Board. They have strong leadership experience and together set the strategic direction of the organisation and ensure there is robust and open debate during Board deliberations.

The Board is comprised of the Chair, at least five non-executive directors and five executive directors. The number of executive directors on the Board must not exceed the number of non-executive directors. During the year one non-voting associate non-executive director has also attended the Board and two non-voting executive directors regularly attend Board meetings.

To support the model of joint working with NHS Improvement, involving shared national directors and functions and integrated regional teams, a new Board governance framework has been introduced. This new framework enables the two Boards to have full oversight of both organisations, whilst also fulfilling their separate duties, and together they support and challenge the delivery of ICSs and the NHS Long Term Plan. This framework was temporarily changed in April 2020 to manage the COVID-19 incident, with the introduction of the time limited Board committee, the National Incident Response Board, further information on which can be found on page 26.

Board members

Directors who served on NHS England's Board during the year and their attendance at Board meetings are listed in the table on page 39 and biographical details may be viewed on the website[17].

Wendy Becker stepped down from the Board at the end of June 2019 and Michelle Mitchell's term ended in February 2020. During the year, the Secretary of State for Health and Social Care approved the transfer of Lord Darzi's non-executive directorship from NHS Improvement to NHS England.

Julian Kelly took on the role as the joint Chief Financial Officer of NHS England and NHS Improvement from 1 April 2019. Matthew Swindells stepped down as Deputy Chief Executive Officer on 31 July 2019 and Amanda Pritchard joined the organisations on the same day as the joint Chief Operating Officer, as well as the Chief Executive of NHS Improvement.

The cross-associate directorship arrangements with NHS Improvement came to an end in early March 2020. As Richard Douglas CB was stepping down from NHS Improvement's Board and given that NHS England's and NHS Improvement's boards meet in common it was agreed that this role was no longer required.

17 https://www.england.nhs.uk/about/board/members/

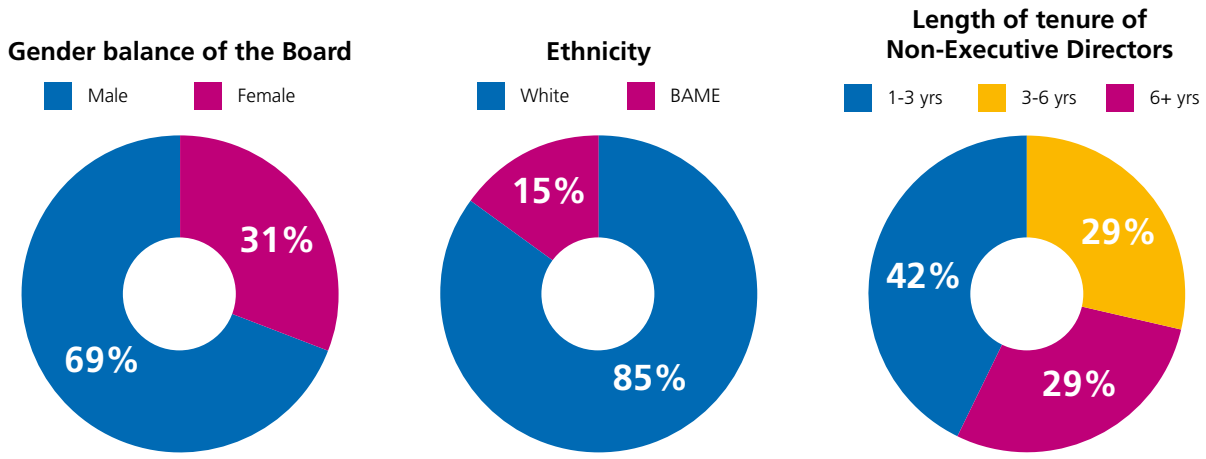
Board members (continued)

Member	Role	Term ends/notes	Number of eligible Board meetings attended
Lord David Prior	Chair	31 October 2022	4(5)
David Roberts CBE	Vice-Chair & Senior Independent Director	20 June 2021	5(5)
Prof. the Lord Ara Darzi of Denham[18]	Non-Executive Director	31 July 2021	n/a
Noel Gordon	Non-Executive Director	30 June 2021	4(4)
Prof. Sir Munir Pirmohamed	Non-Executive Director	31 December 2021	4(5)
Joanne Shaw	Non-Executive Director	30 September 2020	5(5)
Sir Simon Stevens	Chief Executive		5(5)
Amanda Pritchard[19]	Chief Operating Officer	Joined on 31 July 2019	4(5)[26]
Julian Kelly[20]	Chief Financial Officer	Joined on 1 April 2019	4(5)[26]
Ruth May	Chief Nursing Officer		4(5)
Prof. Stephen Powis	National Medical Director		5(5)
Ian Dodge	National Director: Strategy & Innovation (non-voting)		4(5)[26]
Dr. Emily Lawson[21]	National Director: Transformation & Corporate Operations (non-voting)		3(5)
Former members			
Wendy Becker[22]	Non-Executive Director	Left on 30 June 2019	1(1)
Richard Douglas CB[23]	Associate (non-voting) Non-Executive Director	Left on 4 March 2020	4(4)
Matthew Swindells[24]	Deputy Chief Executive	Left on 31 July 2019	1(1)
Michelle Mitchell[25]	Non-Executive Director	Left on 28 February 2020	4(5)

18 Professor the Lord Ara Darzi of Denham's directorship was transferred to NHS England from NHS Improvement on 1 April 2020.
19 Amanda Pritchard joined the Board on 31 July 2019.
20 Julian Kelly joined the Board on 1 April 2019.
21 Dr. Emily Lawson took up her new role as the Chief Commercial Officer on 1 April 2020.
22 Wendy Becker stepped down from the Board on 30 June 2019.
23 Michelle Mitchell's Non-Executive Directorship term came to an end on 28 February 2020.
24 Richard Douglas CB' Associate (non-voting) Non-Executive Directorship came to an end on 4 March 2020.
25 Matthew Swindells stepped down from the Board on 31 July 2019.
26 Due to ongoing work on the organisation's response to COVID-19 a number of Executive Directors sent their apologies for the March 2020 Board meetings as their sole focus was COVID-19 response work.

Board diversity

The charts below show composition of the Board members by gender, diversity and tenure as of the date of this report.



Appointments

The Chair and non-executive directors are appointed by the Secretary for State for Health and Social Care and executive directors are appointed by the Board, subject to the Secretary of State for Health and Social Care's consent.

On 1 April 2020, Professor Lord Ara Darzi of Denham's non-executive directorship was transferred to NHS England from NHS Improvement and the appointment will continue until 31 July 2021 when his second term with NHS Improvement would have ended. The rationale behind the transfer is to ensure better balance of the number of non-executive directors on the two boards and provide continuity.

Julian Kelly took on the role as the joint Chief Financial Officer from 1 April 2019 and Amanda Pritchard joined the organisations on 31 July 2019 as the joint Chief Operating Officer. She is also the Chief Executive of NHS Improvement.

The governance structure

Although the organisations operate as one, under the current statutory framework NHS England and NHS Improvement cannot legally have one joint board or joint board committees. Each organisation retains its given statutory functions and NHS England cannot delegate its functions to NHS Improvement, and vice versa. The joint NHS England and NHS Improvement board governance framework in place throughout the year reflects this. It has been designed to enable the Boards together to have full oversight of the organisations whilst retaining their own board and board committees. The Boards and the board committees therefore operate and meet in common. This allows the organisations to meet together, have joint discussions whilst having separate membership and take their own decisions. There are established procedures in place for dealing with any situations in which a director may find they have a direct or indirect functional, operational or personal interest that conflicts with that of either organisation. Further detail on the Separation of Functions and Conflicts of Interest policy can be found on page 55.

Each Board has been supported in its assurance and oversight of the organisation by eight Board committees, of which all but one have been operating as a committee-in-common. The Board committee structure seeks to align the organisation's long-term strategic approach and is underpinned by a clear division of responsibilities and accountabilities. The committees are all board committees but for reporting purposes three committees, Digital, People and Quality and Innovation, had a dotted reporting line into the Delivery, Quality and Performance Committee, the committee which in 2019/20 was responsible for the oversight of the delivery of the NHS Long Term Plan.

An overview of the Board and Executive Committee framework is shown on the next page and individual Board Committee reports can be found on pages 46 to 55. A report detailing the business considered by the Board Committees is provided to each Board meeting and the terms of references for each Committee are on the website.

New NHS England Board governance framework and committees in 2019/20

The new Board and Committees framework formally commenced from 1 April 2019.

NHS England Board

NHS England only Board Committee	Committees operating as a committee-in-common with NHS Improvement			
Statutory Committee	**Audit and Risk Assurance Committee**	**Delivery, Quality and Performance Committee**	**Strategic HR and Remuneration Committee**	**Strategy Committee**
		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 delivery and impact of the NHS Long Term Plan. Oversee the implementation and delivery of the new NHS financial framework.	Approve the framework and policy for executives. Approve individual executive remuneration packages. Approve employee policies. Review employee engagement initiatives.	Advise and make recommendations on the strategy for the commissioning sector and other services commissioned by NHS England.

Digital Committee	People Committee	Quality Committee

These committees are Board committees but as they have been delegated oversight of specific areas of the NHS Long Term Plan they reported into the Delivery, Quality and Performance Committee as this committee had overall responsibility for the delivery of the NHS Long Term Plan.

Main responsibilities		
Ensure effective delivery of the digital commitment of the NHS Long Term Plan. Ensures alignment of technology initiatives and spend across the system to ensure they are focused on commitments of the NHS Long Term Plan.	Oversee the delivery of the overall people strategy for the NHS. Oversee the implementation of key provisions in the NHS People Plan. Delivery of primary care commitments in the NHS Long Term Plan, PCN contract and commitments in GP Forward View.	Determine whether the NHS is maintaining and improving the quality of patient care and health outcomes within the context of delivering the NHS Long Term Plan. Oversee implementation of innovation strategies.

Joint Finance Advisory Group (NHS Improvement and NHS England)	The group is advisory only and was formed to ensure that both organisations are working from a common understanding of the financial targets and financial performance of the entire health system.

NHS Executive Group

The NHS Executive Group includes corporate and regional directors of each of the directorates of the joint organisation. The Group is chaired by the NHS England CEO and advises on the development and implementation of national policies and programmes, NHS performance and performance of the joint organisation and any other matters that require executive level oversight. The NHS Executive Group is supported by a number of other management groups and processes.

Key Board roles and responsibilities

Lord David Prior, as the Chair, is responsible for the leadership and effectiveness of the Board. He ensures that new board members receive a tailored induction suited to each director's existing knowledge and experience and works with the chair of NHS Improvement and the Head of Governance (which is a joint role) to agree joint board training and development sessions.

Sir Simon Stevens, as the Chief Executive of NHS England, is responsible for providing strategic leadership and for the implementation of the agreed strategy and objectives. As the Chief Executive Simon is also the Accounting Officer responsible for ensuring that public funds are properly safeguarded and are used in line with NHS England's functions and responsibilities as set out in HM Treasury guidance Managing Public Money. David Roberts is the Vice-chair and the Senior Independent Director.

Their key areas of responsibility are:

Chair

Responsible for the leadership and effectiveness of the Board. This involves encouraging a culture of openness and debate to allow the Board to both challenge and support management. The Chair is also responsible for the Board governance, Board performance and stakeholder engagement.

Chief Executive

Responsible for the day-to-day leadership of the organisation and the delivery of the strategy. He is supported by his senior leadership team and together they are responsible for the implementation and execution of NHS England's and NHS Improvement's strategy.

Senior Independent Director

In addition to the role of non-executive board member, the senior independent director acts as confidante to the Chair and an intermediary for other Board members. The senior independent director also performs the annual evaluation of the Chair's performance.

Non-executive Directors
Support executive management, whilst providing constructive challenge and rigour and bring sound judgement and objectivity to the Board's decision-making process. Monitor the delivery of strategy within governance framework as set by the Board. Their independence is reviewed annually, and all make monthly declarations of interest. All non-executive directors are considered to be independent.

Executive Directors
Executive Directors support the Chief Executive in leading the organisations to deliver its strategic objectives.

Board activity and administration

The Board meets in common with NHS Improvement's Board and there were five scheduled Board meetings in common during the year. Each Board meeting is divided into a public and a private session. Members of the public can attend and observe the public sessions, which are also available to watch live, or after the event, on our website. The agenda, papers and minutes for the public sessions are published on the website. In addition, there were a number of Board calls where the non-executives were updated on the organisations' response to the COVID-19 pandemic.

All Board meetings are pre-scheduled on a rolling basis. The Board culture is one of openness and collaboration and the Chair ensures that all directors have an opportunity to contribute to debates. There are also regular meetings between the Chair and the non-executive directors and between the Chief Executive and the non-executive directors to allow discussions about the effectiveness of the Board and general matters and views to be shared.

Key items considered by NHS England and NHS Improvement boards during the year[27]

Strategy

- Approved the publication of the NHS Long Term Plan implementation framework.
- Approved the publication and implementation of the NHS's patient safety strategy.
- Endorsed a number of items in relation to primary care.
- Approval of the NHS recommendations to Government and Parliament for an NHS Integrated Care Bill.
- Approval of digital-first primary care consultation outcome.
- Endorsed the National Tariff proposals.
- Considered a five year framework for GP contract reform.
- Approved items no longer to be routinely prescribed in primary care.
- Approved the transfer of the Supply Chain Company Limited.

27 where applicable the individual boards have made the decisions.

Performance

- Reviewed regular financial and operational performance updates.
- Received regular updates on providers currently in special measures or at risk of entering special measures.
- Considered the NHS operational planning and contracting guidance for 2020/21.
- Updates on the organisations' response to COVID-19.

Leadership and people

- Considered key aspects of the People Plan.
- Received regular progress updates on the integration with NHS Improvement.
- Approval of measures to address pension issues.

Governance and risk

- Approved a new joint corporate risk register and risk appetite.
- Received regular EU exit updates.
- Approved terms of reference for the Board Committees.

Review of Board effectiveness and performance evaluation

Good governance provides that an evaluation of the performance of the board and its committees, together with the effectiveness of the chair and non-executive directors, should be carried out annually. During the year an informal review of the effectiveness of the Board and the Committees was carried out. This was then supported by a formal internal governance review carried out by the internal auditors, Deloitte in May 2020. The findings from both reviews and changes made to the governance structure was considered and agreed by the Boards in June 2020 and a summary will be provided in the next annual report.

Board Committees

Audit and Risk Assurance Committee

Role of the Committee

The Committee's primary role is to assist the Board in fulfilling its oversight responsibilities in relation to financial reporting, systems of internal control and risk management processes. This includes an overview of the quality and integrity of NHS England's and NHS Improvement's financial reporting and the management of the internal and external audit services.

The Committee meets in common with NHS Improvement's Audit and Risk Assurance Committee.

Committee members

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

Member	Number of eligible meetings attended during the year	Comment
Joanne Shaw (Chair)	5/5	
Gerry Murphy	5/5	Non-executive Chair of DHSC's Audit Committee
Prof. Sir Munir Pirmohamed	5/5	
Previous members		
Wendy Becker	0/2	To 28 June 2019
Michelle Mitchell	5/5	To 28 February 2020

Joanne Shaw is the Chair of the Committee and is a qualified accountant and has considerable experience in chairing audit committees in other organisations. As a committee there is a good balance of skills and knowledge covering accountancy and finance (both public and private), audit committee best practice and clinical services. The Board is therefore satisfied that the members possess the financial knowledge and commercial experience to carry out the Committee's duties.

Attendees

Additional attendees are invited to attend meetings to assist with committee business. For 2019/20 these included, among others, the Chief Executive, Chief Financial Officer, the Chief Operating Officer, the Deputy Chief Executive (until July 2019), the National Director: Transformation and Corporate Development, the Director of Governance and Legal Services, the Director of Financial Control as well as representatives from the external auditors the National Audit Office (NAO), the internal auditors Deloitte LLP and DHSC. The internal auditors meet regularly with the Committee without management present. The external auditors have also met with the Committee on one occasion during the year.

Principal activities during the year

As part of ensuring the integrity of the organisation's financial statements, systems of internal control and risk management processes, the Committee:

- Approved the internal audit plan and considered regular progress reports from the internal auditors.
- Approved the new joint Risk Management Framework, considered the Joint Corporate Risk Register and risk appetite for submission to the Boards and agreed a programme of risk deep-dives.
- Considered accounting matters, disclosures and judgements in relation to the financial statements, including the impact of IFRS16 - leases.
- Considered reports from the external auditors, the NAO, on their audit planning report, the achievement of value for money and findings of the audit of the financial statements of NHS England.
- Assessed the integrity of NHS England's financial reporting.
- Approved NHS England's 2018/19 annual report and accounts.
- Reviewed arrangements for counter fraud, including the approval of joint NHS England and NHS Improvement Tackling Fraud, Bribery and Corruption: Policy and Corporate Procedures.
- Reviewed the Economic Crime Strategy.
- Reviewed the framework for Third Party Assurance.
- Reviewed issues with the delivery of Primary Care Services (Capita).
- Considered adoption of standards for Portfolio and Project Management and assurance reports against them.

Internal audit

The internal auditor, Deloitte LLP, plays an important part in supporting the assurance role of the Committees.

At the start of each financial year the Committee approves an annual plan of internal audit activity, which is structured to align with key strategic priorities and key risks and is developed with input from management. At each meeting the Committee receives an independent assurance from the internal auditor and reviews the result of that work together with management's progress in strengthening and enhancing internal controls where areas for improvement have been identified. The Committee works closely with the Head of Internal Audit and their teams who have full access to the organisation.

Financial reporting

As part of ensuring the integrity of the organisation's financial statements the Committee received regular updates on accounting matters, disclosures and judgements and reviewed management's approach to managing any issues and risks. They also received regular progress updates from the external auditors, the NAO, on the audit of the financial statements.

Digital Committee

Role of the Committee

The Committee's role is to provide advice and, where appropriate, make recommendations on strategic implications of technology within the context of the NHS Long Term Plan, and to ensure effective delivery of digital commitments and alignment of technology initiatives and spend across the system to focus on those commitments in the NHS Long Term Plan. The Committee is also responsible for providing assurance on the operating model and governance of digital implementation within the remit of NHS England, NHS Improvement, NHS Digital and other Arms Length Bodies (ALBs).

The Committee meets in common with NHS Improvement's Digital Committee.

Committee members

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

Member	Number of eligible meetings attended during the year	Comment
Noel Gordon (Chair)	4/4	
Simon Eccles	3/4	Chief Clinical Information Officer
Matthew Gould CMG MBE	3/4	National Director Digital Transformation and Chief Executive NHSX
Hugh McCaughey	3/4	National Director of Improvement
Previous members		
Will Smart	1/1	Chief Information Officer. Left the organisations in September 2019

Attendees

Additional attendees are invited to attend meetings to assist with committee business. For 2019/20 these included, among others, the Chief Executive of NHS Digital and non-executive directors of NHS Digital.

Principal activities during the year

Considerable time was spent during the year to consider the model for digital transformation, the digital transformation programme portfolio and an update on a number of associated transformation programmes. Other reports to the Committee included:

- Digital advice to STPs/ICSs for NHS Long Term Plan development.
- Accelerating Implementation of the Local Health and Care Records Programme.
- Theory of change regarding adoption of new technologies.
- Proposals for patient empowerment.
- Strategic screening platform and short term solutions.
- Screening Programme in NHSX.
- Digital Aspirant Programme.

NHSX

NHSX is responsible for providing digital and technology input into the NHS Long Term Plan implementation plan, the People Plan, and 2020/21 financial prioritisation. The Committee received regular updates from the National Director Digital Transformation (also the Chief Executive of NHSX) including updates on NHSX's portfolio prioritisation process.

Delivery, Quality and Performance Committee

Role of the Committee

The Committee's role was to oversee operational, quality and financial planning and performance of the commissioning sector, including specialised and other services directly commissioned by NHS England, oversee the delivery of The NHS Long Term Plan, the General Practice Forward View and the new financial frameworks and policies within the commissioning system. It scrutinises the performance of NHS England and considers high value investments and revenue expenditure.

The Committee meets in common with NHS Improvement's Delivery, Quality and Performance Committee.

Committee members

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

Member	Number of eligible meetings attended during the year	Comment
Lord David Prior (Chair)	4/5	
David Robert	5/5	
Joanne Shaw	5/5	
Sir Simon Stevens	4/5	
Amanda Pritchard	3/3	Member from 1 August 2019
Julian Kelly	5/5	
Ruth May	5/5	
Prof. Stephen Powis	5/5	
Dr Emily Lawson	5/5	
Ian Dodge	5/5	
Pauline Philip	5/5	National Director of Emergency and Elective Care
Previous members		
Matthew Swindells	2/2	

Principal activities during the year

In supporting the financial position across the wider NHS, the Committee has together with NHS Improvement's Delivery, Quality and Performance Committee considered the following core reports during the year:

- Operational, quality and financial performance of NHS providers and the commissioning sector.
- Operational planning reports for the winter period.
- NHS trusts receiving intensive support.
- The implementation of the NHS Long Term Plan.
- The 2018/19 annual performance assessment of each Clinical Commissioning Group.
- National operational plan for specialised services in 2019/20 and 2020/21.
- The approach to establishing ICSs.
- Deep dive into EU Exit readiness.
- The joint NHS England and NHS Improvement 2019/20 business plan.
- Updates on NHS England's and NHS Improvement's joint working programme including the new operating model.

Strategic Human Resources and Remuneration Committee

Role of the Committee

The remuneration of executive and senior managers (ESMs) is governed by the DHSC's Executive and Senior Manager Pay Framework for ALBs (DHSC's pay framework). Working together with NHS Improvement's Strategic HR, Nominations and Remuneration Committee, the Committee's role is to ensure the two organisations have a single formal, robust and transparent remuneration policy that is in line with DSHC's pay framework. The Committee considers and approves remuneration, benefits and terms of service for senior executives covered by DHSC's pay framework before submission to DHSC for approval. The Committee's role also involves employee remuneration and engagement matters.

The Committee is also responsible for people and organisational development policies, ways of working designed to ensure the workforce of NHS England is appropriately engaged and motivated, including staff engagement. The Committee also reviews the organisation's gender pay gap and ensures that NHS England develops policies and actions to reduce the gender pay gap, reviewing progress to increase BAME representation at senior levels within the organisation and initiatives relating to diversity and inclusion.

The Committee delegates certain functions to the Executive HR Group and receives regular reports from this group on cases considered and approved.

Committee members

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

Member	Number of eligible meetings attended during the year
David Roberts (Chair)	2/4
Noel Gordon	2/3
Lord David Prior	4/4
Previous member	
Wendy Becker	2/2

Committee attendees

Additional attendees are invited to attend meetings to assist with committee business. For 2019/20 these included the CEO, National Director: Transformation and Corporate Development and Director of Human Resources and Organisation Development.

Principal activities during the year

Reports considered by the Committee included:

- Proposals for a joint NHS England and NHS Improvement ESM pay framework.
- Approved the total individual remuneration for senior executives and other senior employees whose proposed salary was in excess of £150,000.
- The proposed ESM structure for NHSX and the People Directorate.
- Approved, in line with DHSC recommendation, annual salary increases for ESMs.
- Received regular progress updates on the Joint Working Programme.
- Approved, as part of the Joint Working Programme, redundancy payments.
- Approved the joint NHS England and NHS Improvement Strategic inclusion and diversity policy.
- Approved the publication of the gender pay gap report.
- Reviewed progress made against the Workforce Race Equality Standards.

Other

The Committee also had an informal session with the NHS England and NHS Improvement People Committees and NHS Improvement's Strategic Human Resources, Nominations and Remuneration on the new joint NHS England and NHS Improvement operating model and culture.

Statutory Committee

Role of the Committee

The role of the Committee is to exercise certain statutory powers in respect of CCGs under various sections of the 2006 NHS Act. As part of these duties the Committee approves individual CCG and commissioner allocations and the establishment and mergers of CCGs.

Committee members

The Committee met once and considered a number of items by correspondence. The following table details membership and attendance by each member during the year:

Member	Number of eligible meetings attended during the year
Michelle Mitchell (Chair)	1/1
Lord David Prior	1/1
Noel Gordon	1/1
Prof. Sir Munir Pirmohamed	1/1
SIr Simon Stevens	1/1
Julian Kelly	1/1
Prof. Stephen Powis	1/1
Ruth May	1/1
Ian Dodge	1/1
Dr. Emily Lawson	1/1
Previous members	
Matthew Swindells	1/1

Principal activities during the year

During the year the Committee considered a number of recommendations made by the regions, including:

- Approval of the statutory annual performance assessment of each CCG for 2019/20, including changes that will be made to CCGs following the assessment.
- Applications for a number of CCGs to merge.
- Recommendations to apply directions to a number of existing CCGs.
- Approved new clinical priorities for inclusion in routine commissioning.

People Committee

Role of the Committee

Meeting together with NHS Improvement's People Committee, the Committee's role was to work collaboratively with national partners to oversee and challenge the delivery of the overall people strategy for NHS England commissioned services to NHS staff.

Committee members

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

Member	Number of eligible meetings attended during the year	Comment
Michell Mitchell (Chair)	4/4	
Prerana Issar	4/4	Chief People Officer
Dr. Emily Lawson	4/4	
Ruth May	4/4	
Prof. Stephen Powis	3/4	

Committee attendees

Additional attendees are invited to attend meetings to assist with committee business. For 2019/20 these included the Chair of NHS Improvement and representatives from the Senior Appointments and Resourcing Function and the Leadership Academy.

Principal activities during the year

In its work to oversee and challenge the delivery of the overall people strategy for NHS England commissioned services and NHS staff, the Committee's key considerations included:

- Progress in delivering the 2019/20 actions from the Interim People Plan.
- Updates on the development of the full People Plan.
- Updates from the Leadership Academy.
- The main findings and recommendations arising from the Lord Holmes review[28] into opening up public appointments to disabled people and regular progress updates on actions being taken by NHS England and NHS Improvement in response to the findings.

28 https://www.gov.uk/government/publications/the-lord-holmes-review

Quality and Innovation Committee

Role of the Committee

This Committee's primary role is to provide strategic oversight of NHS quality issues and performance, including assurance of reporting and escalation mechanisms between regional and corporate directors, and establishing a quality improvement culture across NHS England and NHS Improvement.

Committee members

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

Member	Number of eligible meetings attended during the year
Prof. Sir Munir Pirmohamed (Chair)	4/4
Michelle Mitchell	1/3
Prof. Stephen Powis	4/4
Ruth May	4/4
Previous member	3/4
Joanne Shaw	1/1

Committee attendees

Additional attendees are invited to attend meetings to assist with committee business. For 2019/20 these included National Director of Patient Safety, Head of Quality Strategy and the Director of Clinical Policy, Quality and Operations.

Quality of patient care

A large part of the Committee's remit is to monitor and determine whether the NHS is maintaining and improving the quality of patient care and health outcomes with the context of delivering the NHS Long Term Plan. In doing this the Committee has considered:

- Proposals for strategic oversight of NHS quality issues and performance, including assurance of reporting and escalation mechanisms between regional and corporate directorates.
- Quality metrics and reporting.
- Governance arrangements for the implementation of the NHS Patient Safety Strategy.
- The role of learning disabilities nurses in delivering the NHS Long Term Plan.

Other items considered included:

- Regular updates from the Executive Quality Group.
- Updates on the Learning Disability Mortality Review Programme.
- Updates on Freedom to Speak Up issues and cases.
- Patient stories.

More information on the Quality and Innovation Committee can be found in our governance statement on page 68.

Strategy Committee

It was decided that rather than having a formal committee, seminar style sessions were held with external presenters and attendees to consider key future development areas and/or topics that would assist in moving the strategic agenda for the NHS forward. Two such sessions were held. The first considered health and care data and the second session covered integrated care policy.

Board disclosures

Functions in the joint working arrangements – separation and conflict of interest

NHS England and NHS Improvement's joint working arrangements involve the exercise of statutory functions of the organisation's constituent bodies in an aligned way under a single operating model. Directorates and teams within the new structure may be performing both NHS England and NHS Improvement functions. NHS England, Monitor and NHS TDA however remain separate bodies with distinct statutory roles and responsibilities. In some cases, the functions and decision-making of those bodies must remain independent and separate, to ensure compliance with the bodies' respective statutory functions and/or to avoid inherent conflicts of interest that would arise if the functions were exercised by the same part of the organisation ('functional conflicts'). In addition, even where a standing separation of functions is not required, the exercise of different functions by the same directorate or team may give rise to an actual or potential conflict in an individual case ('operational conflicts').

NHS England and NHS Improvement must ensure the effective discharge of their respective statutory functions in accordance with public law principles and be able to identify and manage the risk of conflict (real or perceived) appropriately and transparently. To manage this the organisations have a Separation of Functions and Conflicts of Interest policy which provides guidance for staff on managing functional and operational conflicts. This policy is not concerned with the declaration and management of personal interests held by individuals. Such conflicts continue to be dealt with in accordance with the Standards of Business Conduct policy which applies to the NHS as a whole.

Register of Board members interests

Personal interests held by Board and Committee members are managed according to NHS England's Standing Orders, NHS Improvement's Rules of Procedure and the joint standards of Business Conduct policy. The organisation also maintains a register of members' interests to ensure that potential conflicts of interests can be identified and addressed before Board and Committee discussions. Board members and executives are also required at the start of each Board and Committee meeting to declare any personal interest they might have in any business on the agenda and abstain from relevant Board or Committee discussion as required. Where potential conflicts arise, they are recorded in the Board and Committee minutes along with any appropriate action to address them. Any interests declared are then recorded on the register and signed off by the Board and executives on a regular basis. A copy of the register of interest is available on the website[29].

Details of related party transactions, where NHS England has transacted with other organisations during the year to which a Board or an executive is connected, are set out in Note 17 on page 162.

Directors' third-party indemnity provisions

NHS England has appropriate directors' and officers' liability insurance in place for legal action against, among others, its executive and non-executive directors. NHS England did not indemnify any director during 2019/20.

Human Rights

NHS England and NHS Improvement support the Government's objectives to eradicate modern slavery and human trafficking. A joint NHS England and NHS Improvement Slavery and Human Trafficking Statement[30] for the financial year ending 31 March 2020 was published in May 2020. Our strategy on tackling fraud, bribery and corruption can be found on the website[31].

Disclosure of personal data-related incidents

NHS England and NHS Improvement follow the NHS Digital Data Security and Protection (DSP) incident reporting process guidance in the reporting of incidents. This is in line with data protection legislation following the introduction of the General Data Protection Regulation (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.

29 https://www.england.nhs.uk/publication/board-of-directors-register-of-interests/
30 https://www.england.nhs.uk/safeguarding/slavery-human-trafficking-statement/
31 https://www.england.nhs.uk/publication/tackling-fraud-bribery-and-corruption-economic-crime-strategy-2018-2021/

As at 31 March 2020, a total of one notifiable incident had occurred relating to the loss of personal data. Incidents are logged and a full investigation is undertaken.

Unless otherwise stated in the tables below, 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
Two letters were sent to an incorrect recipient. The letters contained information regarding a GP investigation (IG Ref – IGI/13669)	NHSE	05.06.2019	Disclosed in error	2	In writing	IG training reviewed and reinforced for awareness and ongoing protection of data. The incident has been discussed internally within the Medical Directorate and is now a standing item for discussion at the weekly team meeting. The team has been reminded that email and postal addresses need checking carefully before correspondence is sent.

Disclosure of information to auditors

Each director of the Board at the date of approval of this report confirms that:

- so far as the Director is aware, there is no relevant audit information of which NHS England's external auditor is unaware; and
- the Director has taken all steps that he or she ought to have taken as a Director to make the Director aware of any relevant audit information and to establish that NHS England's auditor is aware of that information.

Directors' responsibility statement

The annual report and accounts have been reviewed in detail by NHS England's Audit and Risk Assurance Committee and Board. At each point it has been confirmed that the annual report and accounts, taken as a whole, are considered to be fair, balanced and understandable. They provide the information necessary for NHS England's stakeholders to assess the business model, performance and strategy.

Events after year-end

On 1 April 2020, the NHS England and NHS Improvement Boards established a time limited board committee, the COVID-19 National Incident Response Board, to provide oversight of the NHS England and NHS Improvement response to COVID-19 pandemic.

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 2019)[32] 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)[33].

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 the Comptroller and Auditor General is aware of that information. So far as I am aware, there is no relevant audit information of which the Comptroller and Auditor General is unaware.

32 https://www.gov.uk/government/publications/government-financial-reporting-manual-2019-to-2020
33 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 hosted by NHS England. My responsibilities in relation to the assurance of CCGs are set out from page 70 of this report.

The Government's Accountability Framework 2019/20

The Government's 2019/20 Accountability Framework with NHS England and NHS Improvement incorporates the statutory annual mandate to NHS England and annual remit for NHS Improvement. The framework sets out the expectations for NHS England and NHS Improvement to deliver the first year of the NHS Long Term Plan and address the immediate needs associated with EU exit.

The 2019/20 Accountability Framework is aligned with the long-term vision and direction for the health service and sets out a single set of objectives for NHS England and NHS Improvement. This reflects our shared responsibility for leading the NHS in implementing the NHS Long Term Plan.

Board arrangements

Information on our Board and its Committees is set out from page 33.

Governance arrangements and effectiveness

Governance framework

The governance manual brings together all key strands of governance and assurance; including Standing Orders, Standing Financial Instructions (SFI), Scheme of Delegation, Standards of Business Conduct Policy, Joint Risk Management Framework and three lines of defence model. During 2019/20 work has been undertaken to harmonise the governance processes across NHS England and NHS Improvement wherever possible. 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[34]:

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.

NHS England and NHS Improvement's joint operating model

In 2019/20 NHS England and NHS Improvement moved to a single leadership model under the Chief Executive Officer of NHS England and a single Chief Operating Officer (COO), who is also the Chief Executive Officer and Accounting Officer of NHS Improvement.

The NHS England CEO holds responsibility for the overall leadership of the NHS in England. The COO's responsibilities include the operational delivery of the NHS in England and the NHS Long Term Plan.

As set out on page 37 new national director roles have been established, either reporting to the NHS England CEO or COO. Seven regional teams have been established to carry out the functions of both NHS England and NHS Improvement in each of their localities; this supports the 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 support teams to improve services for patients, as well as supporting local transformation by developing further the identity of STPs and ICSs.

By working in a more integrated way at all levels of our health and care services ('system by default'), we will deliver better outcomes for patients, better value for taxpayers and better job satisfaction for our staff.

34 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.

Harris Review

The Harris review recommended greater assurance at board and departmental level that all statutory functions in the health and social care landscape are being exercised appropriately. As part of the new operating model, a detailed register of these core statutory duties and powers has been updated. This provides clarity about the legislative requirements associated with each function, including any restrictions of delegation of those functions. Responsibility for each duty and power has been clearly allocated to a national director (or equivalent) and the register is regularly reviewed by the Director of Governance and Legal.

Corporate assurance

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

NHS England has continued to use the three lines of defence model. This provides the mechanism for 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.	The framework provides a consistent approach to thinking about the impact of organisational change, including people, infrastructure, financial and legal issues.
Risk Management framework	Our approach to managing risk, including tools and methodologies for identifying, assessing, documenting and reporting risk	The framework enables a consistent approach to be taken across the organisation, allowing identification of cross-directorate risks and challenges. It provides a mechanism for managers to identify risks with a route of escalation to those accountable.
SFIs, Scheme of Delegation and Standing Orders	These documents protect both the organisation's interests and protect officers from possible accusation that they have acted less than properly	Together, these documents ensure that our financial transactions, accountabilities and responsibilities 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 organisational 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 both our internal and external auditors to strengthen and embed our assurance framework. Each directorate and region have 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 link with the governance, audit and risk teams to provide increased focus, accountability and improved communication at operating level across the organisation.

During 2019/20, the corporate compliance team has worked with teams across the organisation to embed controls and underpin processes including:

- Introducing a harmonised Standards of Business Conduct Policy across NHS England and NHS Improvement to ensure that staff were working to consistent requirements.
- Targeted interventions with teams to ensure the timely completion of priority 1 actions arising from internal audit reviews.

Management Assurance

Throughout 2019/20, the Board has been provided with regular updates on the implementation of the priorities and programmes that were committed to in the NHS Long Term Plan. Matters relating to individual programmes were also considered within the formal committees of the Board, including the Delivery, Quality and Performance Committee.

In addition, the Audit and Risk Assurance Committee considers the outcomes of internal audit reviews of programmes and the Executive Risk Management Group (ERMG) reviews our 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 programme, for example Urgent & Emergency Care, Primary Care etc. The Audit and Risk Assurance Committee receives reports on their adherence to good programme governance standards.

During 2019/20 we considered the data arising from the pilot of the Management Assurance Framework; a system designed to reduce reliance on our third line of defence and strengthen our second line through enabling management to perform evidence-based evaluation of the effectiveness of our key controls in a number of priority areas. We have used that data along with feedback from users to plan a relaunch of the framework in 2020/21.

Assuring the quality of data and reporting

The Board has agreed the information it requires in order to carry out its duties. This performance information is subject to scrutiny by both management and the Delivery, Quality and Performance Committee. The Board is confident that the data presented in the performance reports has been through appropriate review and scrutiny, and that it continues to evolve to meet changing organisational needs.

Risk governance

NHS England's and NHS Improvement's Boards are responsible for ensuring delivery of the strategies and goals outlined in the joint 2019/20 business plan.

Detailed plans are drawn up for each area with input from staff and risks against their achievement are reported to the Boards. The internal audit team consider the risks to NHS England and NHS Improvement and this directs the internal audit priorities reflected in the annual internal audit plan.

NHS England's Audit and Risk Assurance Committee 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. The Committee considers risks faced by the joint organisation on a bi-annual basis and reports conclusions directly to the Boards. The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives.

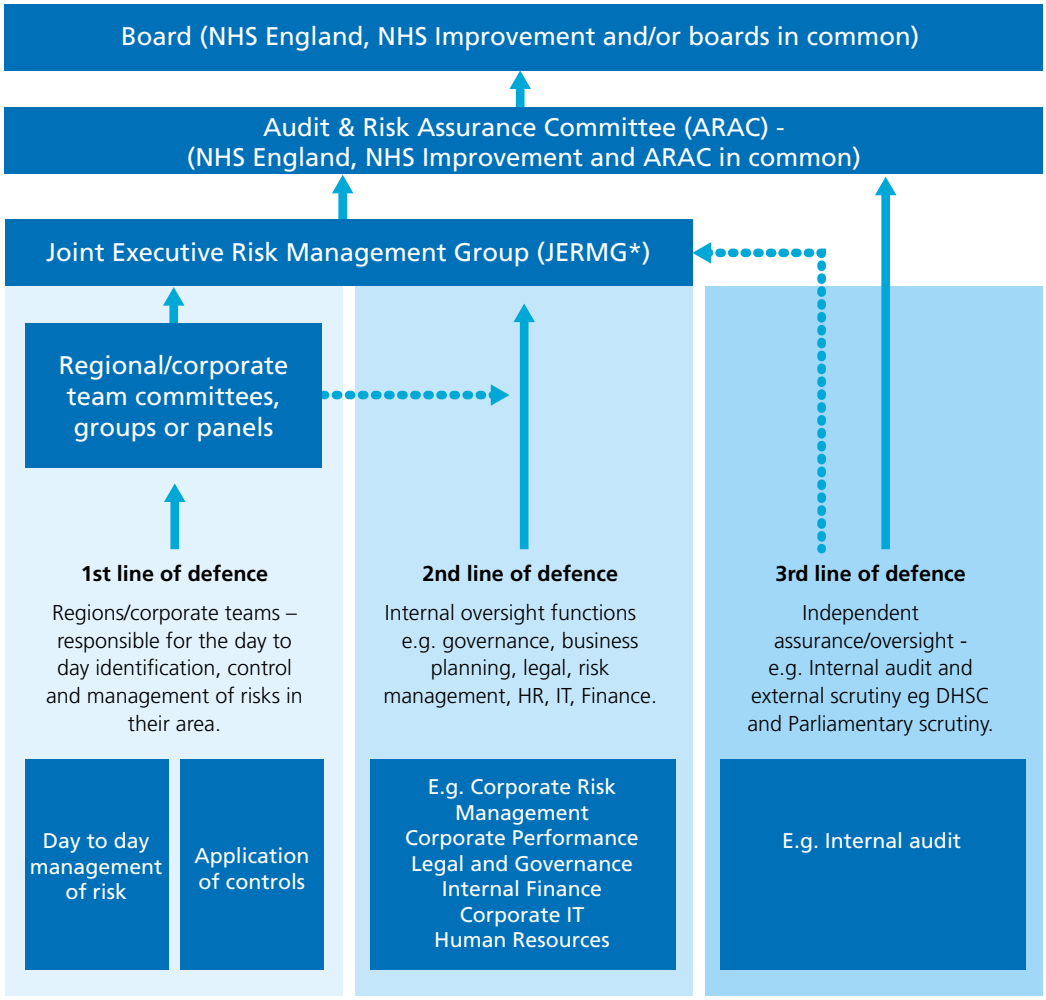
The internal audit team provides regular reports to the Audit and Risk Assurance Committee based on its work programme. The Boards discuss the most significant risks and actions identified to mitigate their likelihood and impact. Each year, the Audit and Risk Assurance Committee evaluates the effectiveness of the risk management framework and approves the annual internal audit plan for the following year.

The position of Chief Risk Officer/Senior Responsible Officer (SRO) for risk for NHS England and NHS Improvement has been delivered by the National Director of Transformation and Corporate Development for 2019/20 to further ensure senior sponsorship for risk at executive level. From April 2020 this role has passed to the Chief Financial Officer.

The executive team owns the corporate risks and nominates a responsible officer for each one. The approach is supported by the joint NHS England and NHS Improvement risk management framework which underpins the monitoring and management of risk. The joint executive risk management group (JERMG) has met quarterly over the year and is responsible for providing assurance to the Committee about how risks across the joint organisation are being managed. The JERMG reviews all risks escalated to it and considers which risks should be managed through the Joint Corporate Risk Register (JCRR) and associated processes. JERMG also oversees implementation of NHS England's and NHS Improvement's new joint risk management framework. The NHS Executive also periodically reviews the JCRR and when appropriate undertakes deeper dives. From April 2020, the JERMG is subsumed into the NHS Executive, where there is a regular standing item to discuss the JCRR. The National Incident Response Board also considers the strategic risks in responding to the COVID-19 incident and these are fed into the JCRR where relevant and reported to the NHS Executive.

Our executives are responsible for managing risk at a directorate/regional level (i.e. at the project delivery and day-to-day operational level). Each directorate therefore also holds its own risk register and reviews its risks on a regular basis.

The joint risk management framework mirrors the three lines of defence of our overarching assurance framework:



* From April 2020, the JERMG is subsumed into the NHS Executive

Risk and Control Framework

In 2019/20 NHS England and NHS Improvement developed a joint risk management framework to ensure that all employees follow a single process for identifying and managing risks that may threaten delivery of services and achievement of objectives. This new framework is aligned with the overarching principles of HM Treasury's Orange Book and is informed by DHSC's risk management policy, ISO 31000 Risk Management Principles and Guidelines and the UK Corporate Governance Code.

In implementing the framework, our corporate risk function and directorate risk leads have continued to share good practice, provide information on new and existing risks, and co-ordinate and support the embedding of an appropriate risk management culture. Improvements in the quality of directorate risk registers and the JCRR, migrated onto an electronic platform throughout 2019/20, have continued. We aim to continually improve our risk management maturity and risk culture year-on-year.

Principal Risks

In 2019/20 the NHS Executive undertook a full review of the three organisations' existing risk exposure and potential future risks, developing a JCRR. The JCRR considers a full cross section of risks to the organisations in their combined aims including strategic risks, reputational risks, financial risks, operational risks and risks to the achievement of the organisations' shared objectives, as well as external threats.

Outside of the COVID-19 incident and for the most part of 2019/20, the principal risks facing NHS England and NHS Improvement included:

Risk description	Key mitigation(s) in place included
EU Exit: There is a risk that EU Exit may result in disruption of day to day operations of the health and care system because the UK's future relationship with the EU is not adequately resolved before the end of the Implementation Period	• Single NHS England and NHS Improvement EU Exit function • National guidance for the NHS • National and local EPRR and business continuity plans
NHS Workforce Capacity: Workforce interventions do not address the full gap between workforce demand and supply	• NHS People Plan • National People Board • Primary Care Oversight Group • General Practice Forward View
Urgent and Emergency Care: Demand for urgent and emergency care exceeds the capacity available to meet it, undermining providers' ability to meet performance targets	• National oversight process • Capacity planning reviews • Same Day Emergency Care (SDEC) Accelerator programme • Frequent monitoring of demand and drivers • Winter planning
Demand for Elective Care: Demand exceeds the capacity available to meet it, undermining providers' ability to meet performance and access targets	• National and regional monitoring • RightCare programme comprehensively implemented to reduce unwarranted variation
Primary Care and System Transformation: Failure to achieve the ambitions for all integrated care systems in the NHS Long Term Plan and the five key service changes; boost hospital care, redesign and reduce pressure on emergency hospital services, more personalised care, digitally enabled primary and outpatient care, and a focus on population health	• NHS England and NHS Improvement System Transformation Board • Primary Care Long Term Plan, GP contract, and General Practice Forward View commitments monitored through the Primary Care Strategic Oversight Group • Establishment and development of PCNs

Risk Appetite

In 2019/20 NHS England and NHS Improvement developed a joint approach to risk appetite, which we have defined as 'the amount of risk that we are willing to seek or accept in the pursuit of long-term objectives.'

The risk appetite 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 and NHS Improvement believe no risk exists in isolation from others and that risk management is about finding the right balance between risks and opportunities to act in the best interests of patients and tax payers. Our approach to risk appetite involves risk trade-off conversations and a consideration of the counterfactual - giving us a flexible framework within which we can try new things, make agile decisions and find a balance between boldness and caution, risk and reward, cost and benefit. It also aims to provide a balance between an approach which is excessively bureaucratic and burdensome and one which lacks rigour.

When balancing risks, we will tolerate some more than others. For example, we will seek to minimise avoidable risks to patient safety in the delivery of quality care. In the case of innovation or proof of concept we are prepared to take managed 'moderate to high risk' on the proviso that the following has been undertaken:

- An assessment of what and where the current risks are.
- That the potential future impact has been understood and agreed.
- Rapid cycle monitoring is in place to enable swift corrective action should things go wrong.
- Consideration of the system's ability to respond i.e., different regions face different circumstances and some areas are very challenged.
- Trade-off between risks is understood / assessment of unintended impacts on other risks undertaken (i.e., whether it will lead to an increase or reduction in other categories of risk).
- Cost–benefit analysis and stated preference is undertaken.
- Reliability and validity of data used to make the assessment has been considered.
- Counterfactual risks have been considered to ensure management apply any learning before taking the risk.
- We can demonstrate significant and measurable potential benefits (i.e., enhanced efficiency and/or value-for-money delivery).

Categories of risk, alongside stated tolerances, are summarised in the table below:

Category of Risk	Tolerance
Patient Safety and Quality of Care	Very Low
Performance (operational and financial)	Moderate
Innovation	Moderate to High
Finance	Low
Compliance and Regulatory risk	Moderate
Reputation	Low to Moderate
Operational risk	Moderate

COVID-19

NHS England's and NHS Improvement's risk management approach has adapted to support management of the NHS response to the level 4 incident, COVID-19.

The Corporate Risk Team supported development and management of the COVID-19 Strategic Risk Register overseen by the National Incident Response Board. These risks are now recorded within the JCRR.

Freedom to Speak Up

Listening to NHS staff who speak up helps improve staff experience and patient care. NHS staff raised concerns with us, at a similar level to previous years: 74 compared to 70 in 2018/19.

The primary reasons for contacting us were discontent with their local employer's response and/or concern they may suffer detriment by raising their issues directly with their local employer.

Whistleblowing in primary care

In November 2019 NHS England and NHS Improvement launched our whistleblower support scheme to help whistleblowers return to work in primary and secondary care. This follows Sir Robert Francis's recommendation in 'Freedom to speak up – a review of whistleblowing in the NHS' to help whistleblowers find alternative employment in the NHS and set out what this should include. We have received 12 applications under this new scheme, who will benefit from coaching and have access to training and work placements or shadowing where appropriate. This scheme provides a useful opportunity to further understand the difficulties that whistleblowers face and how, through the People Plan, we can use the learning from the scheme to better support workers who speak up.

NHS England's role as a Prescribed Person

We are required to produce an annual report of the 'protected disclosures' of information made to us by workers, that meet the criteria (or 'qualify') as protected disclosures. More information about the criteria and our duties as a prescribed body are published online[35].

NHS England is committed to assigning any concerns raised for further investigation and supporting individuals that have suffered financial 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 2019/20 and action taken

Between 1 April 2019 and 31 March 2020 74 whistleblowing disclosures were made to us relating to primary care organisations. We take the cases we receive very seriously and took enforcement action in 57 (77%) of them.

The table below[36] summarises how we dealt with the disclosures:

Investigation	Communicated with an individual	Referred to alternative body	Incorporated into regular oversight	Ongoing
21	18	19	11	6

As the result of investigations, we have agreed changes with primary care providers that are designed to improve services delivered to patients. We took no action in 17 (23%) cases because the individual speaking up to us did not provide enough information, the matter was outside our remit, the issues raised were not current, or we did not have consent to act.

35 https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/604935/whistle-blowingprescribed-persons-guidance.pdf

36 Multiple actions may have been taken in some cases. For example, we may have engaged with an individual and referred to an alternative body

Clinical assurance

Assuring the quality of services

The Boards of NHS England and of NHS Improvement have both established Quality and Innovation Committees to meet in common to support the discharge of each Board's respective duties and powers and their combined responsibilities for quality. The Quality and Innovation Committee's duties can be described across four broad functions:

The escalation of quality issues and sharing of learning

The Committee facilitates the sharing of data and intelligence about quality risks and issues and the sharing of learning and best practice at national level. The Quality and Innovation Committee has been supported in doing this by regional routine reporting which is filtered up through a new group – the Executive Quality Group co-chaired by the National Medical Director and Chief Nursing Officer bringing together the Regional Medical Directors, Regional Chief Nurses and senior national colleagues. This builds on the arrangements that have been in place for several years in NHS England and NHS Improvement prior to the joint working arrangements.

The Executive Quality Group (EQG) receives routine quarterly reports from the Regional Teams. It takes actions to address any risks and issues raised in these reports by coordinating national and regional action and will escalate to the Quality and Innovation Committee if required.

Working in conjunction with the Executive Quality Group the Quality and Innovation Committee:

- Oversees the identification and deployment of appropriate resources to tackle escalated quality risks and issues, and supports quality improvement activities at national level.
- Escalates quality risks and issues to the Delivery, Quality and Performance Committee if required.
- Refers national cross-system quality risks and issues to the National Quality Board[37].

Assurance of quality functions and duties

The Quality and Innovation Committee seeks assurance from executives that robust mechanisms are in place to manage quality functions, including that quality risks and issues are managed at regional to national levels. It also receives reports and updates on relevant NHS England and NHS Improvement quality functions, programmes and initiatives. This includes statutory functions such as arrangements for safeguarding and controlled drugs; clinical effectiveness functions such as the commissioning of national clinical audits; patient safety functions and implementation of the patient safety strategy; and patient experience functions including complaints and surveys.

37 The National Quality Board brings together the clinical leadership for quality for NHS England, NHS Improvement, CQC, PHE, NICE, HEE, NHSD, DHSC and Healthwatch

National measures for quality

A manageable number of quality indicators are selected to show national trends over time and provide a balance across the domains of quality (effective, safe and positive experience) and across care settings.

The Quality and Innovation Committee indicator set uses high-level indicators aligned to the NHS Long Term Plan. When any of these selected indicators shows significant deterioration or moderation in the rate of improvement, the Quality and Innovation Committee discusses potential causes and directs a bespoke analysis.

Thematic reviews

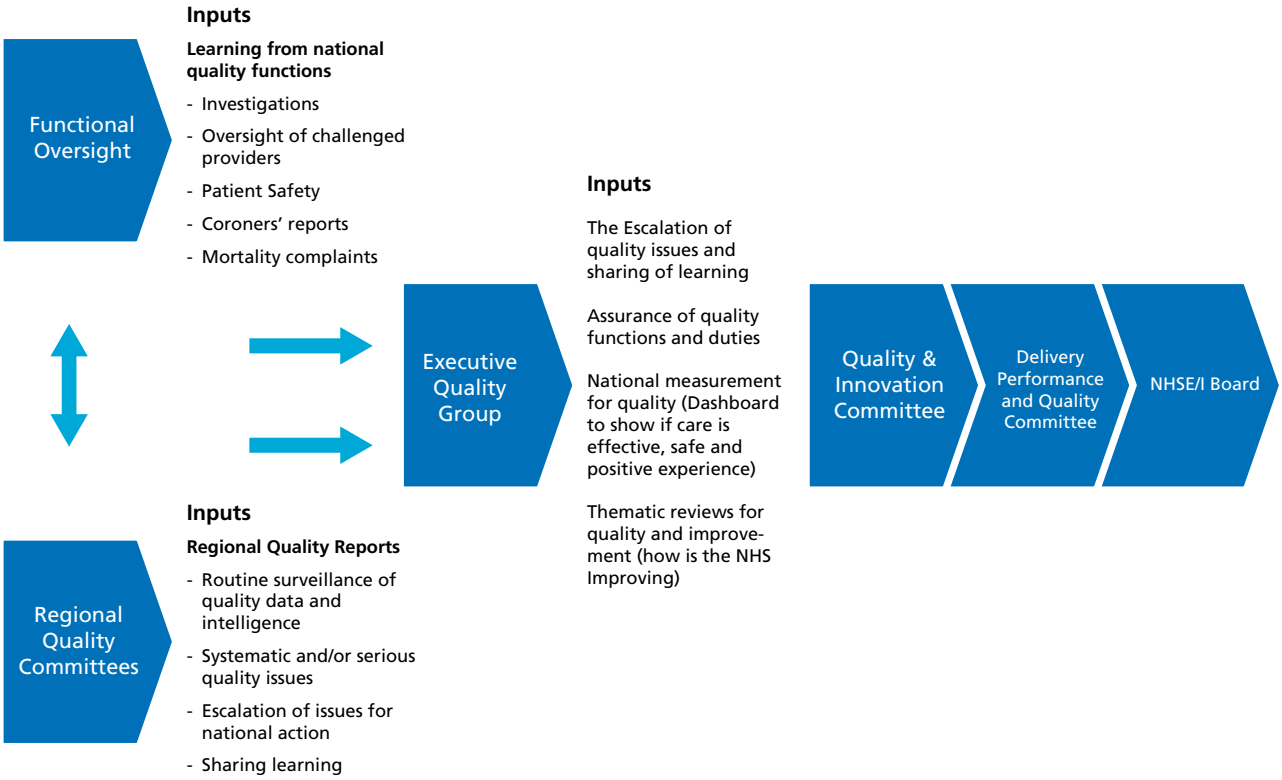
Based on the above inputs and intelligence from members, the Committee also conducts thematic reviews and deep dives. This analysis is used to determine what strategic actions are needed to initiate/accelerate improvement. The Board also looks at national improvement programmes, their models for improvement and how they are ensuring those improvements result in better outcomes for patients.

Since its establishment the Quality and Innovation Committee has also focussed on the following areas:

- Lessons and actions from the Gosport Independent Review Panel report.
- Quality of inpatient mental health services for children and young people.
- Implementation of the Patient Safety Strategy for the Learning Disability nursing profession and its importance in providing high quality care to people with learning disabilities and autistic people.
- Revised Quality and Innovation Committee data dashboard.

During the COVID-19 pandemic, NHS England and NHS Improvement have adapted their quality and safety functions in a proportionate manner that supports the focus on the response to COVID-19 while at the same time ensures the oversight of quality is maintained. It is the responsibility of Regional Medical Directors and Chief Nurses to escalate issues to the EQG, whilst also observing regional EPRR escalation processes. The EQG is meeting virtually and continues to take regional reports.

NHS England and NHS Improvement Quality Governance and Oversight



Assurance of the commissioning system

Specialised commissioning and health and justice

Specialised services support people with a range of rare and complex conditions. They often involve innovative treatments provided to patients with rare cancers, genetic disorders or complex medical conditions or surgical needs.

NHS England also commissions healthcare for 110 adult prisons, plus immigration removal centres, secure training colleges, youth offending institutions and secure children's homes in England (the 'residential estate'). This includes primary care, dentistry, public health, optometry, podiatry and a range of other services, and over a third of the total budget is spent on mental health and substance misuse services.

During 2019/20, the Specialised Commissioning and Health and Justice Strategy and Policy Group (SCHJSPG) set the strategic direction for specialised commissioning. Assurance was provided via reporting from the Specialised Commissioning and Health and Justice Delivery Group (SCHJDG) over quality, performance and value for money. The SSHJSPG also assured decisions made by the SCHJDG, which had operational oversight of the £18.1 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 endorsed CPAG recommendations for prioritisation and in year service developments.

Co-commissioning of primary medical services

Primary care co-commissioning has continued to progress with the majority (96%) of CCGs in 2019/20 having delegated commissioning arrangements for primary medical services. Delegated commissioning provides CCGs with full responsibility for the commissioning of general practice services and is therefore critical to our vision of integrated care by ensuring local health and care leaders take collective responsibility for system performance and the transformation of care, including general practice services.

NHS England retains responsibility for commissioning dental, optometry and community pharmacy services. A key aspect of NHS England and NHS Improvement's joint working programme in 2019/20 was to ensure that NHS England's regional teams who deliver this work are organised in alignment with local systems, to better support the planning and delivery of these services in a joined-up way.

Where NHS England delegates its functions to CCGs, it obtains assurances that these functions are being discharged effectively. A four-year framework is in place for the internal audit of CCGs' delegated primary medical care commissioning arrangements, providing information to CCGs on the running of this function and where it can be improved, which in turn provides aggregate information to support assurance and facilitate support for improvement where needed. With ratings reported to 31 October 2019, just two CCGs have reported "limited" assurances as part of this work and have been supported in their improvement recommendations.

STPs and ICSs

In 2019/20, NHS England and NHS Improvement set out the operational, leadership and governance arrangements that should be in place in every system by 2021.

Over the last year STPs and ICSs have continued to strengthen and develop their governance arrangements. To support this, the minimum requirements for the establishment of ICSs have been agreed and published as part of the 2020/21 planning guidance and NHS Long Term Plan Implementation Framework.

We have engaged with health and care systems and membership bodies to discuss the principles that underpin ICSs. The aim of this work is to provide further clarification and guidance to the health system on the operating arrangements of ICSs in future, to support all STPs to become ICSs by April 2021.

A new ICS accountability and performance framework is being developed to consolidate current accountability arrangements and provide a consistent and comparable set of performance measures. It will include an 'integration index' which will measure the progress being made on integration. ICSs will agree system-wide objectives and be accountable for their performance against these objectives.

Commissioning Support Units (CSUs)

The five NHS CSUs operate across the whole country, providing essential support to a number of organisations ranging from CCGs to local authorities and non-NHS bodies.

In year, the CSUs have developed their support arrangements to provide additional capacity to ICSs and STPs. With a workforce of 7,000 people, CSUs deliver a range of support services that have been independently assessed to ensure that the NHS receives the benefits of scale. CSUs have helped support the national and local response to the COVID-19 pandemic.

Being reliant on income for services delivered, CSUs must be responsive to the needs of their local health system as well as delivering against national priorities. These include managing waiting times, ICT services, data analytics, cyber security and service redesign. In line with the NHS Long Term Plan, CSUs are increasingly working together in a collaborative manner.

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 2019/20, CSUs once again met all financial targets, meaning they will have achieved a balanced budget position every year since they were established in 2013. They have worked closely with NHS England to evaluate their services and develop a future strategy in the context of the evolving STP/ICS landscape.

Clinical Commissioning Groups (CCGs)

On 1 April 2019, six CCGs merged reducing the number to 191 (from 195 in 2018/19), 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 approximately 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. On 1 April 2020 the number of CCGs further reduced to 135.

NHS Oversight Framework for 2019/20

In 2019/20 NHS England and NHS Improvement merged their regional teams and together developed the NHS Oversight Framework for 2019/20[38]. This replaced the separate provider Single Oversight Framework and the CCG Improvement and Assessment Framework.

No material changes were made to the mechanics of CCG (or provider) oversight. The information used, triggers of concern and the approach to assessing their support needs remained the same.

The published framework sets out a new way of working, including:

- NHS England and NHS Improvement teams speaking with a single voice, setting consistent expectations of systems and their constituent organisations.
- Greater emphasis on system performance, alongside the contribution of individual healthcare providers and commissioners to system goals.
- Oversight teams working with and through system leaders, wherever possible, to tackle problems.
- Matching accountability for results with improvement support, as appropriate.
- Greater autonomy for systems with evidenced capability for collective working and track record of successful delivery of NHS priorities.

Legislation requires an annual assessment of performance to be carried out at an individual CCG level. NHS England has the option of using its statutory powers, conferred by section 14Z21 of the National Health Service Act (as amended), to support CCG improvement where a CCG is failing or at risk of failing to discharge its functions. Details of CCG directions can be found on the NHS England website[39].

52 CCGs were 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. Additionally, 1 CCG has been reported by their auditors to the Secretary of State under section 24 of the Local Audit and Accountability Act 2014 due to their year-end financial position.

CCG annual reports

CCGs published their individual annual reports via their websites. 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 majority of control issues raised by CCG internal auditors related to delivery of performance targets in secondary care, referral to treatment times and achievement of financial balance. This matches issues highlighted by those CCGs in their earlier "exception" reports.

By year end, a number of CCGs raised issues relating to capacity and workforce due to CCG mergers, as well as issues (actual and potential) relating to the EU Exit & COVID-19 pressures. These included workforce numbers, obtaining medicines and planning uncertainty.

38 https://www.england.nhs.uk/publication/nhs-oversight-framework-for-2019-20/
39 https://www.england.nhs.uk/commissioning/regulation/ccg-assess/directions

Other assurance

Cyber and data security

The NHSX cyber security team provides the strategic direction for cyber security in the health and social care sectors. In November 2019, the Securing Cyber Resilience Update[40] was published, highlighting significant progress made in key areas. This included supporting NHS organisations to migrate to the Windows 10 Operating System, which is more secure and more efficient to use. The deployment of Microsoft Defender Advanced Threat Protection (ATP) now covers most Windows devices in the NHS, with the ability to detect and prevent cyber threats.

NHSX and NHS Digital have worked with the National Cyber Security Centre (NCSC) to incorporate the requirements of recognised external cyber security standards including Cyber Essentials into the Data Security and Protection Toolkit (DSPT) to form a single data and cyber security standard for the NHS. The DSPT helps organisations understand their data and cyber security risks and measures their compliance with mandatory cyber standards for their type of NHS or social care organisation.

The Network and Information Systems (NIS) Regulations have been used to increase compliance in the NHS with mandated standards such as responses to high severity cyber alerts.

NHSX allocated £23.62 million capital funding to address critical infrastructure weaknesses in NHS organisations. Using evidence gathered through NHS Digital's on-site assessments and other data available to help assess organisations' security risks, our regional teams worked with local organisations to identify priorities for available capital investment, ensuring they were consistent with local plans for digital transformation.

Working in partnership with NHS Digital, the Cyber Associates Network has been established and developed into the leading network for health and care cyber security professionals. Engagement events held in November 2019 were attended by more than 300 members of the network, providing key opportunities for networking, collaborating and knowledge sharing.

NHSX has worked with NCSC and NHS Digital to define the cyber security standards needed for the Local Health and Care Record (LHCR) localities. Security assessments and attack tree workshops have been carried out across a number of LHCR regions. A bespoke LHCR cyber security framework has also been published which provides further support and guidance to local cyber security leads.

In response to COVID-19, NHSX put in place additional measures to prevent a cyber attack or major IT outage and to make sure that, if such an event did happen, NHSX and its delivery partners could help local organisations get back up and running as quickly as possible.

40 https://www.gov.uk/government/publications/securing-cyber-resilience-in-health-and-care-progress-update-2019

Information Governance (IG)

Work continues to develop a joint IG operating model across NHS England and NHS Improvement to ensure both organisations remain compliant in relation to data protection, records management and information security activities. The IG teams now operate as a single service and workstreams have been realigned to support specific areas: Data Governance, Corporate Records and Information Management, IG Delivery and IG Assurance and Planning, supporting national and regional teams.

We have developed a Joint Controller and Information Sharing Framework Agreement to govern the processing of personal data by the NHS England and NHS Improvement joint enterprise. We have also developed a similar agreement between the NHSX partners (NHS England, NHS Improvement and DHSC). These set out the agreed responsibilities of the organisations, establishing effective procedures to ensure that the partners in these joint working initiatives comply with data protection legislation.

A new Information Governance Assurance team has been established to undertake pro-active compliance reviews with our teams and suppliers regarding processing of personal data lawfully under GDPR and the Data Protection Act 2018.

The Corporate Records and Information Management team have been working with local records and information management coordinators to ensure we work in a compliant manner. The team continues to support all relevant statutory and public inquiries including the Infected Blood Inquiry, the Gosport Inquiry and the Independent Inquiry into Child Sexual Abuse.

NHS England and NHS Improvement have aligned key datasets and are continuing to review data sharing agreements with NHS Digital with a view to reducing duplication of data flows to increase efficiency and reduce cost.

Business critical models

NHS England and NHS Improvement recognise the importance of quality assurance across the full range of its analytical work and have developed a joint approach that is consistent with the recommendations in Sir Nicholas Macpherson's review of quality assurance of Government analytical models (2013).

NHS England and NHS Improvement 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 and NHS Improvement have been developing a common framework to operating a register of business critical models and auditing of the quality assurance strategy associated with them.

The diversion of analytical resources to the COVID-19 response has meant that the development of this framework, the associated register and the review of the quality assurance included in the register is in process. Provisionally, business critical models operated by NHS England and NHS improvement include:

- CCG revenue allocations models.
- CCG revenue allocations – exceptional registration change adjustment.
- Cardiovascular disease (CVD) respiratory NHS Long Term Plan commitments modelling.
- Financial trajectories model.
- GP referral analysis.
- Long Term Financial model.
- Low Priority Prescribing (LPP) indicator.
- National diabetes prevention programme budget model.
- People analysis.
- Pharmacy services fee setting to pharmacy integration fund pilot services.
- Pricing calculation model.
- Pricing impact assessment model.
- PCNs – investment and impact fund.
- Referral to treatment time ready reckoner.
- Unavoidable costs (incurred by small acute providers).

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.

The service auditor reports commissioned for 2019/20 have been reviewed and where necessary action plans are being agreed to address any control issues identified. In some cases the service auditor was unable to gain audit evidence to some service provider records due to lockdown restrictions towards the end of 2019/20. In these circumstances the service auditor has issued a qualified opinion for the period for which they have been unable to test. There are also a limited number of other issues which service auditors have referred to in their opinion and these

are being addressed by services providers as a matter of priority. The issues identified are not considered to have a significant impact on the overall NHS England control environment.

We have moved to a 12 month service auditor report for Capita, based on the improving control environment.

Internal audit

The internal audit service plays a significant role in the independent review of the effectiveness of management controls, risk management, compliance 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 Audit Standards and to an annual internal audit plan approved by the Audit and Risk Assurance Committee.

The internal audit service submits regular reports on the effectiveness of our systems of internal control and 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 Audit and Risk Assurance Committee. Due to the focus on COVID-19, the Committee agreed that nine audits would not occur, with remaining audit days used to support the COVID-19 incident response.

In 2020/21 NHS England and NHS Improvement will move to an internal audit service provided by a single supplier.

The Head of Internal Audit Opinion for 2019/20 is set out from page 81.

External Audit

During the year, the Audit and Risk Assurance Committee has worked constructively with the NAO Director responsible for health and his team. The work of external audit sits outside our governance arrangements but independently informs our consideration of control, compliance, governance and risk. The work of external audit is monitored by the Audit and Risk Assurance Committee through regular progress reports. These include summaries of the value for money work that is either directly relevant to our work or may provide useful insights to the Committee.

Control issues

During 2019/20 we have worked to build controls into management processes previously identified as requiring improvement:

Improving control processes for off-payroll workers

It is important that we have strong processes for the onboarding and recording of off-payroll workers to ensure we meet key requirements such as IR35 compliance and manage workforce resource efficiently and effectively.

During 2019/20 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. For clinical off payroll worker groups a dedicated project has been established to review engagement models in this area and reconfirm employment status. This work continues into 2020/21.

Managing third party contracts

We have continued to roll out our refreshed and enhanced approach to contract management which is based on Government Commercial Operating Standard methodologies. As at March 2020 we managed £1bn of spend covering 228 contracts through this approach.

Our risk-based approach, built on Government Commercial Operating Standards, assigns a named contract owner and manager to all our contracts to ensure clear responsibility and accountability. We categorise our contracts to ensure that the appropriate resource and expertise is assigned. This allows us to proactively manage risk and use commercial expertise where necessary.

Our approach is supported by training and development of staff with 86 staff across the organisation, including 38 business contract managers, receiving Government Commercial Function Contract Manager accreditation during 2019/20. Our revised processes, the ongoing rollout of this across the organisation and the provision of innovative commercial training, means that there is now greater assurance of our processes for managing third party contracts. Further work is planned for 2020/21 to further enhance these processes.

Primary Care Support England (PCSE) cervical screening

The national Cervical Screening Programme produces and sends around nine million invitation, reminder and result letters to women each year. Until 31 July 2019, these letters were sent as part of the PCSE contract with Capita Business Services Ltd.

On 23 July 2019, Capita informed NHS England that, as part of an IT audit, they had identified emails and scanned post that may not have been actioned or may have been delayed in being actioned. Investigation of this incident confirmed that 6,215 items related to the cervical screening service had not been processed between 2017 and 2019 due to IT system errors. NHS England declared this a serious incident and set up a clinically-led multi-agency panel to assess any risk of harm to the women affected. In line with the recommendation of PHE, all women potentially affected had their screening history audited to establish if they had experienced any delay in the management of their care. The conclusion of the panel was that there was no evidence that this incident had led to any patient harm because the 'fail-safes in the cervical screening system

operated as expected'. In line with good practice, a further audit will take place to ensure that any women who experienced a delay in attending a screening have not been adversely impacted.

From the 1 August 2019 the cervical screening administration service was transferred out of PCSE and has since been provided by the NHS North of England Commissioning Support Unit (NECS). 87 staff were transferred under TUPE from Capita to NECS. NECS has started a programme to review the services and identify priority areas for improvement, such as the incident management process. This improvement work will continue through 2020/21 and is being overseen by new governance arrangements.

PCSE performance management

The PCSE contract with Capita came into effect on the 1 September 2015 and initially runs until 2022. As was confirmed by the NAO and the Public Accounts Committee in 2018, NHS England's contracting out of the primary care support services contract has saved taxpayers tens of millions of pounds per annum. In the first four years of the contract, administrative savings of £116 million have been realised.

In the early years of the contract there were service issues, as disparate local services were consolidated into a national standard service. However, over the last year there has been a significant improvement in the performance of the services and the risk profile of this contract has reduced.

A key area of focus has been to address the historical issues with the pension records of GPs. The project to assure the quality of data held by Capita is on track to be complete in 2020/21, and this will be supported by the launch of the new GP Pensions system offering GPs greater access to up-to-date information on their pension contributions.

The programme to replace legacy IT systems used by the service has made progress over the last 12 months and is on track to be complete in 2020/21. In 2019/20 new and improved systems were introduced for paying opticians, managing pharmacy changes and administering the National Performers List. These new systems have addressed some long-standing weaknesses in process, such as having a single place to track applications and changes to our National Performers List.

Assurance framework for business critical models

Although the formal assessment of the quality assurance of analytical models has not been completed for this year's report, this should not be taken to indicate that quality assurance has not happened.

For instance, prior to the decision to adopt fixed provider payments during the COVID-19 response, work to set national tariffs was well advanced. This work included correcting a previously incorrect inclusion of a currency, relating to mental health services for Alzheimer's patients, that should have been subject to local price setting. For 2020/21 this currency has correctly been excluded from the proposed tariff, but a balancing adjustment to the total tariff quantum was omitted, meaning all national prices in the consultation tariff are 0.2% too high.

This would have meant a small but significant impact on the distribution of net resources between providers and commissioners. Checks to reconcile price setting with other budgetary analysis identified the issue and so identified an appropriate correction before the tariff was finalised for the then expected implementation.

NHS England and NHS Improvement will complete this work during 2020/21 and further embed a shared culture of quality assurance across all our analytical work.

NHSX governance arrangements

As part of the 'Being Excellent' programme initiated in October 2019 several workstreams were established following the completion of the formative stage in December. One of the workstreams was the 'Governance and Assurance workstream'. The Programme is set to deliver in three phases, the first of which was January-March 2020. The purpose of phase one was primarily to identify gaps and opportunities, develop systems and processes to support NHSX responsibilities, recommending and implementing delegations and enablers, as well as the professional capability required to deliver its plans. Due to the focus on responding to the COVID-19 pandemic, phase two is ongoing.

Review of economy, efficiency and effective use of resources

Allocations

NHS England has responsibility for allocating the NHS funding agreed with the DHSC as part of our Mandate. We are required to operate a transparent allocation process to ensure equal access for equal need. The NHS Act 2006 (as amended) also requires NHS England to have regard to reducing inequalities in access to and outcomes from healthcare.

In January 2019, the NHS England Board approved allocations for the five years from 2019/20 to 2023/24, deploying the long-term revenue funding settlement made available by the Government to support the implementation of the NHS Long Term Plan. Significant improvements were also made to the formulae through which resources are distributed to CCGs in 2019/20, on the basis of recommendations from the independent Advisory Committee on Resource Allocation.

These allocations remain the basis of our plans for 2020/21, updated for changes to tariff inflation and tariff adjustments.

Financial performance monitoring

In 2019/20 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 regional and national finance leadership teams, and the Chief Financial Officer. Regular updates on the overall financial position have been presented to the Delivery, Quality and Performance 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.

In 2019/20 NHS England and NHS Improvement have aligned financial performance monitoring across commissioner and provider sectors. At all levels the two organisations have been jointly assessing the combined financial and operational position across local systems and the NHS as a whole, resulting in joint reporting and review at Board level.

Central programme costs

One-year allocations were agreed for 2019/20 for our central programme resources and service development funding. Most of this resource has been made available for direct investment to deliver on the priorities and objectives outlined in the NHS Long Term Plan, in collaboration with STPs and ICSs, 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, we are 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 the Cabinet Office and/or HM Treasury.

In anticipation of the impact of COVID-19, additional commercial guidance was issued internally in alignment with Cabinet Office guidance to ensure control and best value for money could be secured in a timely way.

Counter fraud

NHS England and NHS Improvement investigate 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.

The directly employed NHS England Counter Fraud Team was established in 2018. The team assumed responsibility for NHS Improvement on 1 April 2019. To reflect these arrangements the Tackling Fraud, Bribery and Corruption Policy and Economic Crime Strategy was reviewed, updated and approved by the Audit and Risk Assurance Committee.

The Committee receives regular updates regarding the counter fraud function, proactive counter fraud work and the outcome of reactive investigations, as well as an Annual Counter Fraud Report. The Director of Financial Control has day-to-day operational responsibility for the NHS England and NHS Improvement counter fraud function, and the Chief Financial Officer provides executive support and direction.

The NHS Counter Fraud Authority (NHSCFA) undertakes an annual high-level estimate of the potential scale of fraud affecting the whole of the NHS. Its Strategic Intelligence Assessment for 2018/19 was recently published and reduced the estimated value of fraud relevant to the NHS as a whole from £1.27 billion to £1.21 billion which NHSCFA itself together with its partners have responsibility for tackling.

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, resulting in net recoveries and behavioural change benefits of £36 million in 2019/20.

Ministerial Directions

NHS England received two ministerial directions in the course of 2019/20, in relation to clinicians pensions and the Mandate for 2019/20.

Pensions

In Autumn 2019 NHS England was asked by the Secretary of State to consider ways to alleviate the workforce capacity issues arising from some clinicians not wanting to maintain or increase their sessions and pensionable earnings due to the impact of the Annual Allowance Tax Charge. NHS England proposed an arrangement to incentivise clinicians to provide additional sessions by compensating them for utilising the 'Scheme Pays' facility in their NHS Pensions. In these circumstances, clinicians would elect that their 'pension pot' would pay their additional tax charges and NHS England would stand behind their employers' promise to compensate them for any shortfall arising from that upon retirement.

Accounting Officers are required to perform their duties in line with particular requirements set out in Managing Public Money (MPM). Given the risk that the proposed approach could be considered tax planning or tax avoidance, DHSC and HMT advised that a written ministerial direction was obtained before proceeding with the announcement. This was sought on 18 November 2019, and confirmed by way of a direction from the Secretary of State to the Chief Executives of NHS England and NHS Improvement in their capacity as additional Accounting Officers on 22 November. Advice was also obtained from HMRC and the Comptroller and Auditor General was informed.

Mandate 2019/20

NHS England and NHS Improvement undertook a variety of emergency actions to respond to the unfolding pandemic during the last quarter of 2019/20, ramping up in particular during March 2020. Acknowledging this, the Secretary of State wrote to NHS England on 29 March to recognise the extraordinary circumstances and to confirm that availability of funding would not be a barrier or cause delay to the actions that needed to be taken. NHS England was directed to continue with its response to the pandemic even where this meant spending would be in excess of formal delegated limits.

Head of Internal Audit opinion

My Head of Internal Audit has informed me that based on the internal audit work undertaken during 2019/20 and in the context of the overall environment for NHS England for 2019/20, the framework for governance and risk management has been substantially adequate and effective in 2019/20, whilst recognising the maturing nature of the governance framework and that future enhancements will be required due to the evolving nature of the joint organisation. I am also informed that the framework for internal control has been appropriately implemented in the organisation through 2019/20, except for two areas highlighted as needing strengthening, which NHS England is aware of:

- Clinical off-payroll workers.
- Business critical models.

In my internal auditors' view, taking into account the outstanding internal audit actions that have been addressed during the year, the status of the harmonised risk management processes and the response adopted for COVID-19 risk management, the design of the joint risk management framework at the year-end provides the foundation of a framework to take the organisation forward.

Their 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 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.

The opinion notes that NHS England took rapid steps in early 2020 to support the health care system. This resulted in changes to the internal control framework to enable the response. The changes took place after the internal audit work for 2019/20 had been completed and were not therefore subject to internal audit. Therefore, there is a need to confirm in 2020/21 that the changes that have been made to the internal control framework continue to support the organisation in an efficient and effective manner.

Overall summary

Over the year we have continued to build on our approach to governance, risk and internal controls and it is pleasing to see we have fewer areas of internal control weakness to address this year than in preceding years. We remain committed to delivering improvements in the areas highlighted in the audit opinion and work is already underway with our internal auditors to consider changes we made to our internal controls during our COVID-19 response.

Remuneration and Staff Report

Staff report

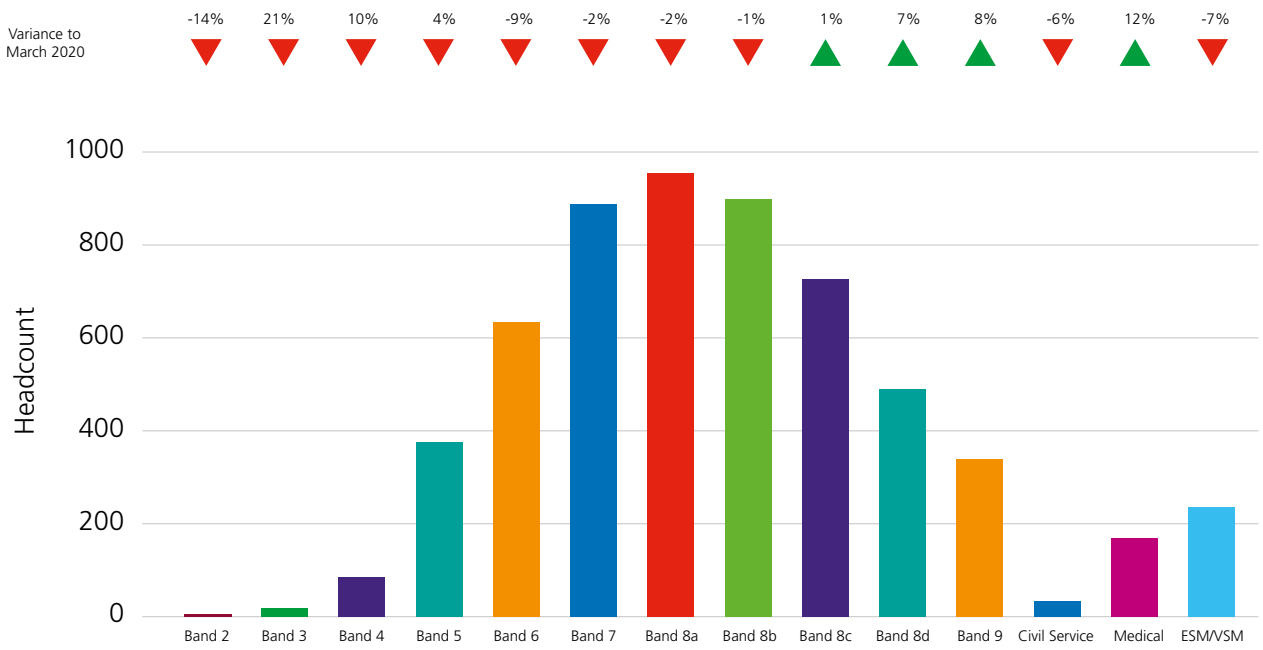
Our people

On 31 March 2020, NHS England directly employed 6,398[41] staff. Of these, 5,800 people were permanently employed on recurrent, open-ended contracts of employment, based around the country within our directorates and regions, and 598 people were employed on payroll on fixed term contracts of employment. A further 853 individuals were engaged in an off-payroll capacity which includes agency staff and secondees. Over half of directly employed staff (3,375) worked locally in our seven regions.

Detail on staff numbers and costs for NHS England and the Consolidated Group, including CSUs, are presented from page 91.

All staff by grade

The table below shows that, as at 31 March 2020, the headcount of permanent and fixed term staff in NHS England has reduced by 2% since 2018/19.



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

Employment policies

We have a range of employment policies to support all staff which have been consulted on with trade unions and have been regularly reviewed to ensure they are in line with legislative changes. To support the alignment of NHS England and NHS TDA and Monitor, joint policies have and are being drafted to apply across the three employers. This is with the intention of ensuring consistency in the way in which individuals are managed and rewarded. Most staff are employed on NHS terms and conditions, whilst some Monitor staff are employed under their legally contractual terms.

Partnership working

We work in partnership with our recognised trade unions on a range of employment related and other issues, including organisational change. A National Joint Working Partnership Forum was established in 2018 with staff-side representation from all of our recognised trade unions and management representation from our three employers.

Trade Union (TU) facility time

Facility time is paid time off for representatives to carry out TU-related activities. The information below relates to TU 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
40	39.33

b) Percentage of time spent on facility time (duties and activities):

Percentage of time	Number of employees
0%	20
1-50%	20
51%-99%	n/a
100%	n/a

c) Percentage of pay bill spent on facility time:

Figures	Figures
Cost of facility time	£74,743
Total pay bill	£410.7 million
Percentage of the total pay bill spent on facility time	0.02%

d) Paid TU activities:

Figures	Figures
Time spent on paid TU activities as a percentage of total paid facility time hours	9.6%

Equal opportunities, diversity and inclusion

A joint NHS England and NHS Improvement Diversity and Inclusion strategy, From Ambition to Action, has been developed which sets out how the organisation will work towards improving the working lives of our diverse workforce. This mirrors the NHS People Plan's ambition for the NHS to become the best employer and complies with the Workforce Race Equality Standard Model Employer guidance.

The four areas of the strategy include leadership and culture change, accountability and assurance, positive action and specialist support. Several interventions to support delivery of the strategy have been piloted and evaluated and are now being rolled out across the joint organisation.

For example, we are breaking down hierarchies through reverse mentoring programmes where people in less senior pay bands are matched with more senior managers. We have also focused on improving our recruitment practice through inclusive recruitment guidance, supported by bespoke training which has been delivered to over 1,400 staff. We carry out equality impact assessments on our policies and processes and have implemented a new reasonable adjustment process that includes a workplace adjustment passport.

Joint working

We ensured that diversity and inclusion were embedded into decision making throughout all phases of joint working. This included carrying out equality impact assessments during the change programme, involving senior equality and diversity representatives in senior recruitment activity and bringing together and ensuring more collaboration on all staff networks and our diversity steering group.

Our Equality Standards

To support our Public Sector Equality Duty as a joint organisation, we participate in external monitoring standards which hold us accountable for improving workforce diversity and equality. These are the Workforce Race Equality Standard (WRES), the Stonewall Workplace Equality Index, and we will be participating in the newly-launched Workforce Disability Equality Standard.

Our organisational accreditations include Disability Confident Employer, which commits us to a wide range of actions to attract, recruit, retain and support staff who are disabled and differently-abled. We are also a Mindful Employer which reflects our pledge to end stigma around mental health.

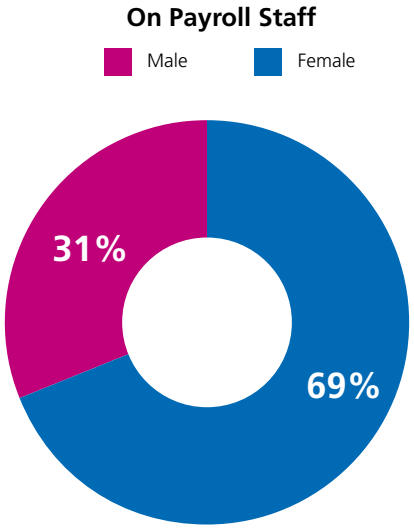
As a Stonewall Diversity Champion we draw on best practice to make our workplace safe and hospitable for colleagues of all gender identities and sexual orientations.

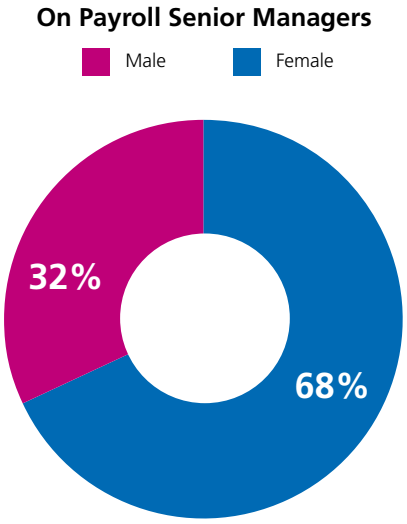
Staff networks

We support eight diversity staff networks across the joint organisation which provide peer support, influence policy development and create space where staff can speak up about areas that need to improve. Combined membership of staff networks amounts to over 2,800 staff across both organisations. We have also supported the development of new networks including a men's mental health group, and a menopause support group.

Gender of all staff and senior managers

The gender profile of the total 'on payroll' workforce is unchanged from 2018/19, and senior managers are now broadly in line with the overall profile, with 68% of our senior managers being female. The gender diversity of board members is set out on page 40.





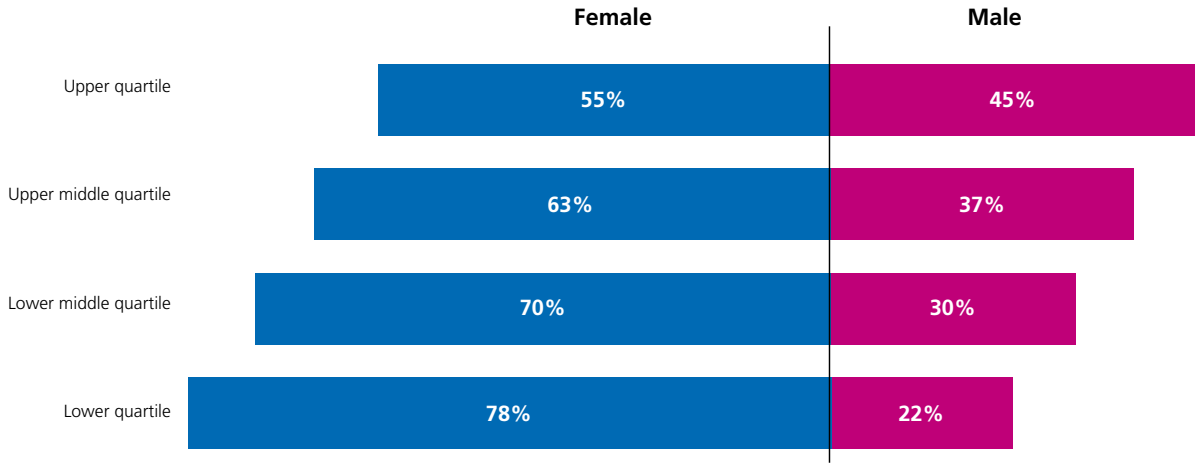
NHS England gender pay gap

Based on the Government's methodology, the median gender pay gap across NHS England is 14.7%, down from 22% the prior year.

Year	Median gender pay gap	Mean gender pay gap
2019	14.7%	18.3%
2018	22%	19.5%
2017	21.5%	21.2%

Pay quartiles by gender in NHS England and NHS Improvement on 31 March 2019

The proportion of males and females in each pay quartile in NHS England and NHS Improvement is detailed below. Women represent the majority of staff in the upper pay quartile.

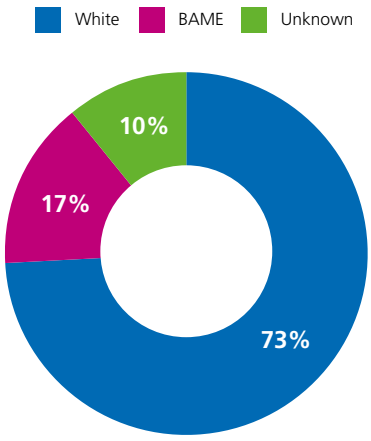


Working in partnership with our recognised trade unions and our Women's Network we continue to progress initiatives which aim to address gender equality in our workforce. Our Gender Pay Action Plan includes specific priorities around recruitment practice, reward and recognition, flexible working, developing talent pipelines and intersectionality.

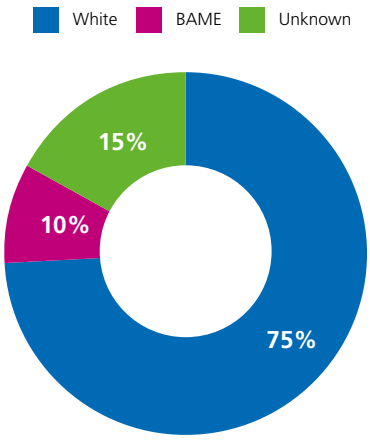
Ethnicity of all staff and senior managers

The proportion of people employed by NHS England that consider themselves to be from a black and minority ethnic (BAME) heritage has remained the same as 2018/19. 73% of all staff and 75% of senior managers report themselves to be white. For information on board diversity please see page 38. We continue to 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. NHS England and NHS Improvement are working to ensure that within five years at least 19% of all senior staff are from Black, Asian or minority ethnic backgrounds.

All staff by ethnicity



Senior managers by ethnicity

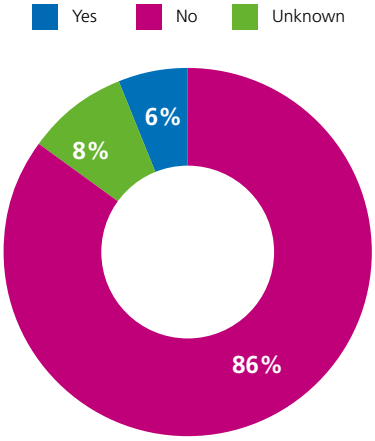


Declarations of disability or long term conditions

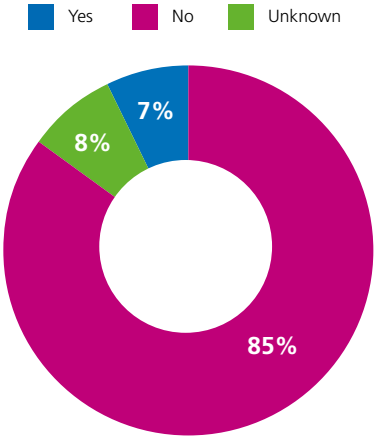
We have continued to work with our DAWN Network to support employees within the workplace, and strive to ensure that all decisions relating to employment practices are objective, free from bias and based solely upon work criteria and individual merit. These principles are reinforced within our joint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

The percentage of staff that have declared a disability or long-term condition are given in the tables below.

Percentage of staff that declare a disability or long term condition in NHS England



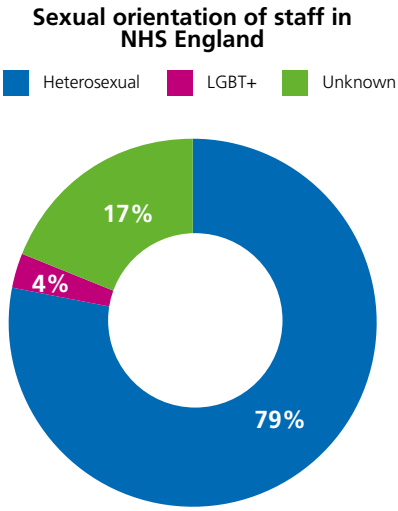
Percentage of senior managers that declare a disability or long term condition in NHS England

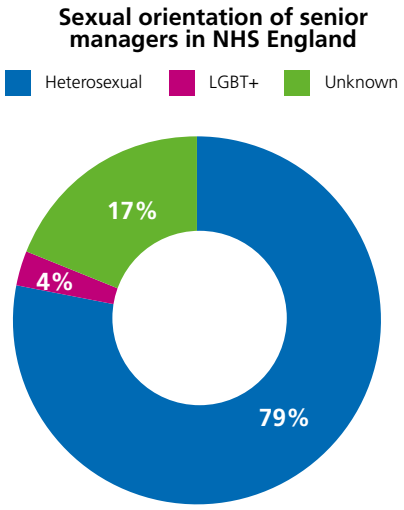


As a Disability Confident Employer, recognised by the Department for Work and Pensions (DWP), we continue to work towards fulfilling our commitments to employ more disabled staff, and support disabled staff to work, develop and progress.

Sexual orientation of staff and senior managers

The percentage of staff that disclose their identity as LGBT+ is given in the tables below.





In 2019/20 we submitted jointly to the Stonewall Workplace Equality Index for the first time, achieving a ranking of 113th out of 500 employers in LGBT equality. This position shows the positive impact of initiatives like our joint LGBT+ staff network's Trans and Bi Ally training.

Our culture and values

We have held culture sessions with our senior teams and introduced a series of Big Conversations to share work on culture change with colleagues.

Talent management and development

The joint organisation integrated its talent management and development and performance management processes into a single joint process from 1 April 2019 by introducing Quarterly Objectives Reviews and Career Development Conversations. These involve line managers and staff having a rolling cycle of conversations that include monthly, quarterly and annual check-ins that help informal relationship building, facilitate more formal objective reviews and a career development conversation. This process will be reviewed in 2020/21.

We have a range of initiatives that support our staff in their development and create opportunities for talented staff to progress their careers. These include our leadership and line management development programmes, stretch assignments, job shadowing, coaching and mentoring and 360° feedback.

We have a joint approach to apprenticeships and have continued to make progress towards meeting our public sector target with 16 completions and 46 apprentices currently in training, including 2 who are substantively employed by NHS Improvement. The apprenticeships are mainly focussed on higher level degree apprenticeships. NHS Improvement continues to support 13 trainees who are part of the NHS Graduate Trainee Scheme and explore options with other ALBs supporting the scheme in the future.

Workplace health, safety and wellbeing

We have continued to progress our Mental Health in the Workplace Strategy and have a range of services and resources in place to help support staff with their mental health. This includes a network of over 120 trained Mental Health First Aiders, access to the Work Mental Health Support Service, free access to various self-care apps and guidance and resources to help our managers.

We already had a good range of wellbeing support in place for our staff and this has been particularly important given the unprecedented impact of COVID-19 on our staff and their work. A range of resources are available for our staff including our free employee assistance programme, the support available from our occupational health provider, training and workshops on personal resilience, the NHS bereavement support service and various online resources. We have a well-established approach to identifying and managing interventions by carrying out stress and health risk assessments.

Staff engagement and feedback

In recognition of the importance of having dynamic and timely feedback throughout our change programme, we introduced a regular 'temperature check' to give staff an opportunity to shape how we implemented joint working.

As part of our move towards joint working we also conducted our first combined NHS England and NHS Improvement all-staff annual survey in January 2020.

Response to the COVID-19 Incident

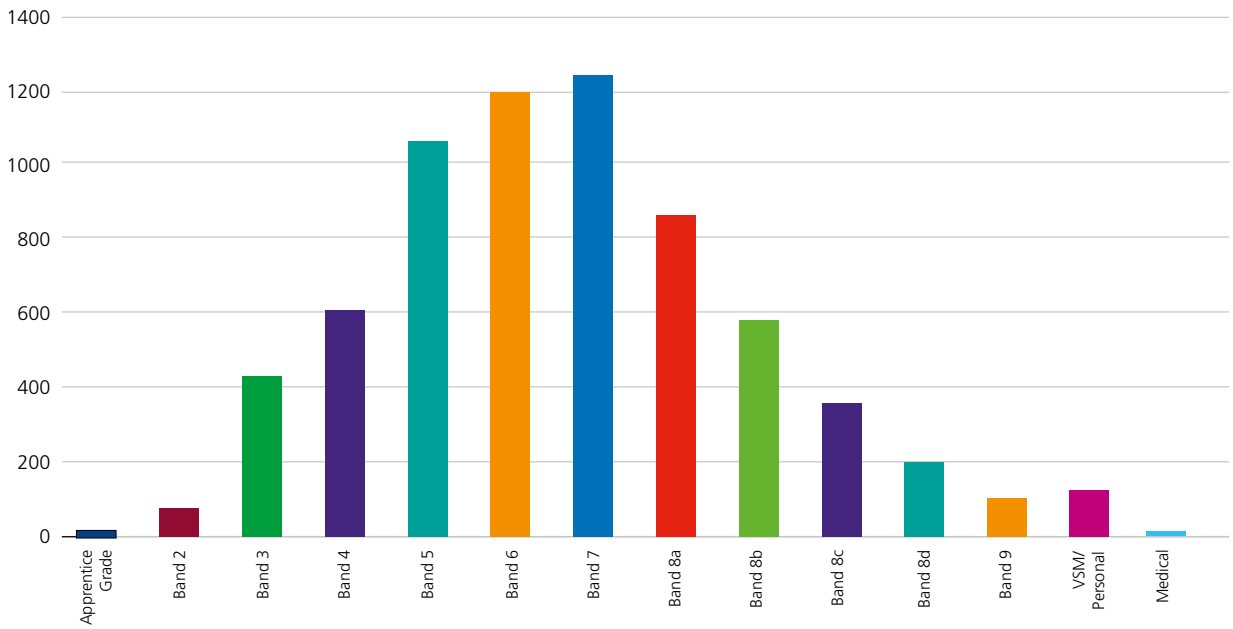
The COVID-19 incident at the end of 2019/20 had, and continues to have, a significant impact on our ways of working. However, we adapted in an agile way. The implementation of Microsoft Teams as our main audio and video conferencing tool was instrumental in enabling a quick move to offsite working. We quickly developed extensive online guidance to support our staff and provided weekly updates to wide ranging frequently asked questions relating to COVID-19 and new ways of working. We were also able to build on our existing wellbeing offer to support our colleagues during this challenging time and created an online absence tracker to help understand the impact of absence and self-isolation relating to COVID-19.

Although we still implemented our new structures as planned, we moved into a new operating mode and re-prioritised all activity around the COVID-19 incident, whilst maintaining other business critical services. A key focus of this was resourcing and included enabling a number of our staff to return to front line and operational roles, redeploying as many people as possible into COVID-19 related activity such as our EPRR unit and regional response teams and developing a fast-track approach to recruiting and contracting new staff into the organisation for COVID-19 related activity. A number of our staff that were due to leave at the end of 2019/20 deferred their leaving date to bolster our response to COVID-19.

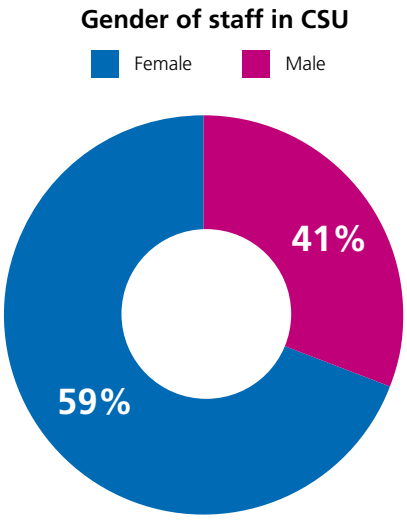
CSUs

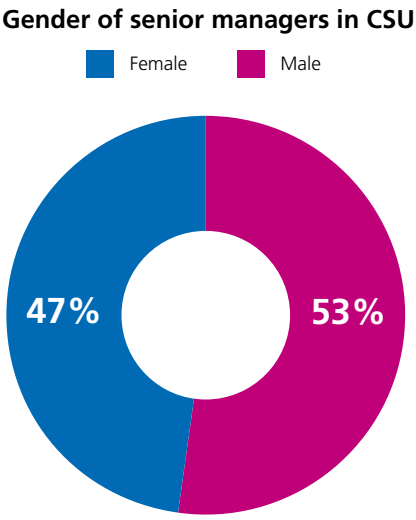
As at 31 March 2020, CSUs directly employ 6,542 people. Of these 6,273 people were permanently employed on recurrent, open-ended contracts of employment, based around the country within the five separate organisations. In addition, a further 269 people were employed on payroll on fixed term contracts of employment.

All CSU staff by pay band



All CSU staff by gender and CSU senior managers by gender





Employee benefits and staff numbers (subject 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	2019/20				
	Permanently employed number	CSU employed number	Other number	CSU other number	Total number
Total	5,746	6,273	731	269	**13,019**
Of the above: Number of whole time equivalent people engaged on capital projects	-	-	4	-	4

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	-	-	-	-	-

Consolidated Group	2019/20				
	Permanently employed number	CSU employed number	Other number	CSU other number	Total number
Total	24,575	6,273	2,437	269	**33,554**
Of the above: Number of whole time equivalent people engaged on capital projects	3	-	4	-	7

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

Employee benefits

Parent

	2019/20				
	Permanent employees £000	**CSU employees £000**	**Other £000**	**CSU other £000**	**Total £000**
Employee benefits					
Salaries and wages	316,661	258,709	46,653	21,315	**643,338**
Social security costs	36,307	28,459	3	1	**64,770**
Employer contributions to NHS Pension scheme	57,759	47,212	6	2	**104,979**
Other pension costs	-	-	-	-	**-**
Apprenticeship Levy	1,582	1,204	-	-	**2,786**
Termination benefits	10,573	8,180	-	-	**18,753**
Gross employee benefits expenditure	422,882	343,764	46,662	21,318	**834,626**
Less: Employee costs capitalised	-	-	(341)	-	**(341)**
Net employee benefits excluding capitalised costs	**422,882**	**343,764**	**46,321**	**21,318**	**834,285**
Less recoveries in respect of employee benefits	(410)	-	-	-	**(410)**
Total net employee benefits	**422,472**	**343,764**	**46,321**	**21,318**	**833,875**

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**

Employee benefits

Consolidated Group	2019/20				
	Permanent employees £000	CSU employees £000	Other £000	CSU other £000	Total £000
Employee benefits					
Salaries and wages	1,217,294	258,709	165,685	21,315	**1,663,003**
Social security costs	133,459	28,459	706	1	**162,625**
Employer contributions to NHS Pension scheme	220,789	47,212	668	2	**268,671**
Other pension costs	195	-	-	-	**195**
Apprenticeship Levy	3,970	1,204	-	-	**5,174**
Termination benefits	20,517	8,180	-	-	**28,697**
Gross employee benefits expenditure	**1,596,224**	**343,764**	**167,059**	**21,318**	**2,128,365**
Less: Employee costs capitalised	(223)	-	(341)	-	**(564)**
Net employee benefits excluding capitalised costs	**1,596,001**	**343,764**	**166,718**	**21,318**	**2,127,801**
Less recoveries in respect of employee benefits	(8,905)	-	(468)	-	**(9,373)**
Total net employee benefits	**1,587,096**	**343,764**	**166,250**	**21,318**	**2,118,428**

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**

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

Sickness absence rates for 2019/20 are published on the NHS Digital website[42].

Exit packages, severance payments and off-payroll engagements

Expenditure on consultancy and contingent labour

Expenditure on consultancy is detailed in the Annual Accounts under Note 4: Operating Expenses. NHS England and CSUs procured consultancy services worth £2.5 million during the financial year, a decrease of £6.2 million since 2018/19 (2018/19: £8.7 million).

Across the group, there was a total spend of £46 million on consultancy services during the period, against £64 million the previous year.

Expenditure on contingent labour, including agency staff and secondees, is given in the Annual Accounts on page 92: Employee Benefits and Staff Numbers under the 'other' column.

Net expenditure for NHS England and CSUs in this area was £68 million in 2019/20, against £81 million in 2018/19. Across the group, there was a total spend of £188 million on contingent labour during the year, against £221 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 59.

Off-payroll engagements

NHS England and NHS Improvement are 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 our 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 engaged by NHS England as at March 2020.

Table 1: Off-payroll engagements longer than six months

Off-payroll engagements as at 31 March 2020, 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 2020	573	26	599
Of which, the number that have existed:			
for less than one year at the time of reporting	266	17	283
for between one and two years at the time of reporting	70	9	79
for between 2 and 3 years at the time of reporting	140	0	140
for between 3 and 4 years at the time of reporting	63	0	63
for 4 or more years at the time of reporting	34	0	34

42 https://digital.nhs.uk/data-and-information/publications/statistical/nhs-sickness-absence-rates

The majority of off-payroll workers that provide services to NHS England are clinical medical staff. 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 2019 and 31 March 2020, 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 2019 and 31 March 2020	312	77	389
Of which:			
Number assessed as caught by IR35	30	71	101
Number assessed as NOT caught by IR35	282	6	288
Number engaged directly via Personal Service Company (PSC) contracted to department and are on departmental payroll	0	0	0
Number of engagements reassessed for consistency / assurance purposes during the year	0	0	0
Number of engagements that saw a change to IR35 status following the consistency review	2	0	2

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 2019 and 31 March 2020 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.	257	38	295

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 59.

Exit packages including severance payments (subject 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 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	2019/20			2018/19		
	Compulsory redundancies number	Other agreed departures number	Total number	Compulsory redundancies number	Other agreed departures number	Total number
Less than £10,000	28	5	33	23	8	31
£10,001 to £25,000	67	1	68	20	-	20
£25,001 to £50,000	57	1	58	20	-	20
£50,001 to £100,000	75	1	76	26	-	26
£100,001 to £150,000	35	-	35	15	-	15
£150,001 to £200,000	26	-	26	17	-	17
Over £200,001	-	-	-	-	-	-
Total	**288**	**8**	**296**	**121**	**8**	**129**
Total cost (£000)	**17,397**	**114**	**17,511**	**7,640**	**37**	**7,677**

Consolidated Group	2019/20			2018/19		
	Compulsory redundancies number	Other agreed departures number	Total number	Compulsory redundancies number	Other agreed departures number	Total number
Less than £10,000	85	92	177	82	47	129
£10,001 to £25,000	112	41	153	67	33	100
£25,001 to £50,000	88	23	111	43	11	54
£50,001 to £100,000	97	20	117	52	13	65
£100,001 to £150,000	46	3	49	31	1	32
£150,001 to £200,000	44	4	48	29	1	30
Over £200,001	-	-	-	4	-	4
Total	**472**	**183**	**655**	**308**	**106**	**414**
Total cost (£000)	**25,242**	**4,205**	**29,447**	**16,246**	**2,327**	**18,573**

	2019/20	2018/19
	Departures where special payments have been made	Other agreed departures
	number	number
£10,001 to £25,000	1	-
Total	**1**	**-**
Total cost (£000)	**20**	**-**

Exit packages agreed during the year: Other agreed departures

	2019/20		2018/19	
	Other agreed departures		Other agreed departures	
Parent	**number**	**£000**	**number**	**£000**
Contractual payments in lieu of notice	8	114	8	37
Total	**8**	**114**	**8**	**37**

	2019/20		2018/19	
	Other agreed departures		Other agreed departures	
Consolidated Group	**number**	**£000**	**number**	**£000**
Voluntary redundancies including early retirement contractual costs	25	1,447	12	661
Mutually agreed resignations (MARS) contractual costs	41	1,022	19	584
Early retirements in the efficiency of the service contractual costs	1	21	1	10
Contractual payments in lieu of notice	116	1,715	72	1,055
Exit payments following Employment Tribunals or court orders	-	-	1	14
Non-contractual payments requiring HM Treasury approval	-	-	1	3
Total	**183**	**4,205**	**106**	**2,327**

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.

Exit costs are accounted for in accordance with relevant accounting standards and are paid in accordance with NHS England's redundancy policy.

Where NHS England and CCGs have agreed early retirements the additional costs are met by NHS England or the CCG, 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 on page 50.

Pay multiples (subject 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 2019/20 was £255,000 to £260,000 (2018/19: £220,000-£225,000). This was 5.88 times the median remuneration of the workforce, which was £43,772 (2018/19: £41,034: 5.42).

During 2019/20 the Chief Executive Officer, Sir Simon Stevens, voluntarily took a £20,000 per annum pay cut for the sixth year in a row.

In 2019/20, no employees received pro-rata remuneration in excess of the highest-paid member of the Board (2018/19: 1). Remuneration ranged from £7,883 to £260,000 (2018/19: £6,453 to £225,000).

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 the DHSC through the Executive Senior Manager (ESM) pay framework for ALBs.

It is the policy of NHS England and NHS Improvement 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 £124 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 NHS England's Strategic HR and Remuneration Committee and NHS Improvement's Nomination and Remuneration Committee, with board committee meetings held in common. Final decisions are made by the DHSC ALB Remuneration Committee and Ministers and HM Treasury, where appropriate.

Performance related pay

The performance related pay (PRP) 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, NHS England and NHS Improvement do 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 and Nomination and Remuneration Committee not to allocate funds for PRP non-consolidated bonus payments for 2019/20. 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 and NHS Improvement, 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 payments requires formal approval from the DHSC Governance and Assurance Committee and HM Treasury.

Payments were made to six senior managers to compensate for loss of office during 2019/20 and details of these payments are included in the senior manager salary and pension entitlement table on page 101.

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

Senior managers' service contracts (not subject to audit)

Name and title	Date of appointment	Notice period	Provisions for compensation for early termination	Other details
Sir Simon Stevens Chief Executive Officer – NHS England	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 – NHS England	30 May 2016	6 months		Left NHS England on 31 July 2019
Amanda Pritchard Chief Operating Officer – Joint	31 July 2019	6 months		
Ian Dodge National Director for Strategy and Innovation – Joint	7 July 2014	6 months		
Dr. Emily Lawson National Director of Transformation and Corporate Development – Joint	1 November 2017	6 months		
Professor Stephen Powis National Medical Director – Joint	1 March 2018	6 months		
Julian Kelly Chief Financial Officer – Joint	1 April 2019	6 months		
Ruth May Chief Nursing Officer – Joint	7 January 2019	6 months		
Prerana Issar Chief People Officer – Joint	1 April 2019	6 months		
Matthew Gould CMG MBE National Director for Digital Transformation – Joint	3 June 2019	6 months		

From 1 April 2019, the senior managers indicated as 'Joint' in the above table were jointly appointed across NHS England and NHS Improvement (consisting of NHS TDA and Monitor). Full salary disclosures are included in all the entity Remuneration Reports, within the underlying accounts, and the costs are split equally between NHS England and NHS Improvement. Within NHS Improvement costs are split 2:1 NHS TDA:Monitor.

Remuneration (salary, benefits in kind and pensions) 2019/20 (subject to audit)

Name and Title	(a) Salary (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 (to the nearest £1,000)	(f) TOTAL (a to e) (bands of £5,000)
	£000	£s	£000	£000	£000	£000
Sir Simon Stevens Chief Executive Officer[43]	195-200	0	0	0	26	220-225
Matthew Swindells Deputy Chief Executive[44]	85-90	0	0	0	0	85-90
Amanda Pritchard Chief Operating Officer[45]	170-175	0	0	0	39	210-215
Ian Dodge National Director for Strategy and Innovation	170-175	0	0	0	30	200-205
Dr. Emily Lawson National Director of Transformation and Corporate Development	205-210	0	0	0	0	205-210
Professor Stephen Powis National Medical Director	220-225	0	0	0	0	220-225
Julian Kelly Chief Financial Officer[46]	205-210	0	0	0	46	250-255
Ruth May Chief Nursing Officer	175-180	0	0	0	127	305-310
Prerana Issar Chief People Officer[47]	230-235	0	0	0	52	280-285
Matthew Gould CMG MBE National Director for Digital Transformation[48]	0	0	0	0	0	0

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

43 On joining NHS England on 1 April 2014, Sir 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 £215,000–£220,000. Mr Stevens has continued with this voluntary reduction in pay throughout 2019/20.

44 Matthew Swindells left NHS England on 31 July 2019. The full year equivalent salary is £205,000-£210,000. Mr Swindells was paid a redundancy payment in the salary range of £15,000 - £20,000 in July 2019 as compensation for loss of office. This is included in the salary band disclosed within the table.

45 Amanda Pritchard commenced in both posts on 31 July 2019 with her salary recharged to NHS England and NHS Improvement from Guy's and St Thomas' NHS Foundation Trust where she is also formally employed and retains a post. The full year equivalent salary is £255,000-£260,000

46 Julian Kelly formally commenced in the joint post on 1 April 2019.

47 Prerana Issar commenced in the joint post on 1 April 2019.

48 Matthew Gould CMG MBE commenced in post on 1 July 2019 with his salary costs met wholly by the DHSC, where he is also formally employed and retains a post. The full year equivalent salary is £120,000-£125,000.

Remuneration (salary, benefits in kind and pensions) 2018/19 (subject to audit)

Name and Title	(a) Salary[49] (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[50] (to the nearest £1,000)	(f) TOTAL (a to e) (bands of £5,000)
	£000	£s	£000	£000	£000	£000
Sir Simon Stevens Chief Executive Officer[51]	190-195	0	0	0	45	235-240
Matthew Swindells Deputy Chief Executive[52]	205-210	0	0	0	0	205-210
Paul Baumann CBE Chief Financial Officer[53]	130-135 (pro-rata)	0	0	0	0	130-135 (pro-rata)
Professor Jane Cummings CBE Chief Nursing Officer[54]	140-145 (pro-rata)	0	0	0	0	140-145 (pro-rata)
Ian Dodge National Director: Strategy[55]	165-170	0	0	0	39	205-210
Dr. Emily Lawson National Director: Transformation and Corporate Operations[56]	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[57]	55-60 (pro rata)	0	0	0	12 (pro rata)	70-75 (pro rata)
Ruth May Chief Nursing Officer[58]	40-45 (pro rata)	0	0	0	3 (pro rata)	40-45 (pro rata)

49 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.

50 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.

51 On joining NHS England on 1 April 2014, Sir 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. Sir Simon Stevens continued with this voluntary reduction in pay throughout 2018/19.

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

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

54 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.

55 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.

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

57 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.

58 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.

Pension benefits (subject 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 2020 (bands of £5,000)	Lump sum at pension age related to accrued pension at 31 March 2020 (bands of £5,000)	Cash Equivalent Transfer Value at 31 March 2019[59]	Real Increase in Cash Equivalent Transfer Value	Cash Equivalent Transfer Value at 31 March 2020	Employers contribution to partnership pension
	£000	£000	£000	£000	£000	£000	£000	£000
Sir Simon Stevens Chief Executive Officer[60]	0-2.5	0-2.5	40-45	60-65	658	28	716	0
Matthew Swindells Deputy Chief Executive[61]	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Amanda Pritchard Chief Operating Officer[62]	2.5-5	(2.5)-0	70-75	130-135	945	24	1,040	0
Ian Dodge National Director for Strategy and Innovation[63]	0-2.5	N/A	15-20	N/A	176	14	211	0
Dr. Emily Lawson National Director of Transformation and Corporate Development[64]	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Professor Stephen Powis National Medical Director[65]	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Julian Kelly Chief Financial Officer	2.5-5	N/A	0-5	N/A	1	15	48	0
Ruth May Chief Nursing Officer[66]	5-7.5	17.5-20	70-75	215-220	1,317	146	1,508	0
Prerana Issar Chief People Officer	2.5-5	N/A	0-5	N/A	0	13	47	0
Matthew Gould CMG MBE National Director for Digital Transformation[67]	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

59 As per previous submissions, the column Cash Equivalent Transfer Value at 31 March 2019 is the uninflated value whereas the real Increase in CETV is the employer funded increase.
60 Sir Simon Stevens chose to opt out of the NHS Pension Scheme on 1 October 2019.
61 Matthew Swindells chose not to be covered by the NHS Pension arrangements during the reporting year up until the end of his employment with NHS England.
62 Amanda Pritchard commenced in post on 31 July 2019, therefore the Pension Benefits disclosed are pro-rata for the period 31 July 2019 to 31 March 2020.
63 Ian Dodge chose to opt out of the NHS Pension Scheme on 1 December 2019.
64 Dr. Emily Lawson chose not to be covered by the NHS Pension arrangements during the reporting year.
65 Professor Stephen Powis chose not to be covered by the NHS Pension arrangements during the reporting year.
66 Ruth May chose to opt out of the NHS Pension Scheme on 1 May 2019 and opt back into the NHS Pension Scheme on 1 December 2019.
67 Matthew Gould CMG MBE commenced in post on 1 July 2019, with costs met wholly by the DHSC where he is also formally employed and retains a post.

Cash equivalent transfer values (CETV)

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 the Audit and Risk Assurance Committee, 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 2020	Notice period	Provisions for compensation for early termination	Other details
Lord David Prior Chair	31 October 2018	31 months	6 months	None	
David Roberts CBE Vice-Chair	1 July 2014, reappointed to a second term on 1 July 2018	15 months	None	None	Waived entitlement to remuneration
Noel Gordon Non-executive director	1 July 2014, reappointed to a second term on 1 July 2018	15 months	None	None	
Wendy Becker Non-executive director	1 March 2016	0 months	None	None	Waived entitlement to remuneration from September 2016. Left NHS England 27 June 2019
Michelle Mitchell OBE Non-executive director	1 March 2016	0 months	None	None	Left NHS England 29 February 2020
Joanne Shaw Non-executive director	1 October 2016	6 months	None	None	
Richard Douglas CB Associate Non-executive director	1 March 2018	0 months	None	None	Left NHS England 29 February 2020
Professor Sir Munir Pirmohamed Non-executive director	1 January 2019	21 months	None	None	

Non-executive director remuneration (including salary entitlements)

Salaries and allowances 2019/20 (subjected to audit)

Name of non-executive director	2019/20					
	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[68] (bands of £2,500)	F: TOTAL (A to E) (bands of £5,000)
	£000	£s	£000	£000	£000	£000
Lord David Prior Chair[69]	60-65	0	0	0	N/A	60-65
David Roberts CBE Vice-Chair[70]	0	0	0	0	N/A	0
Wendy Becker[71]	0	0	0	0	N/A	0
Noel Gordon	5-10	0	0	0	N/A	5-10
Michelle Mitchell OBE[72]	5-10	0	0	0	N/A	5-10
Joanne Shaw	25-30	0	0	0	N/A	25-30
Richard Douglas CB[73] Associate non-voting	5-10	0	0	0	N/A	5-10
Professor Sir Munir Pirmohamed[74]	5-10	0	0	0	N/A	5-10

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

69 Lord David Prior incurred an underpayment of salary amounting to £169.35 during the 2018/19 financial year and this was paid in 2019/20. In 2018/19 pension deductions of £3,281.25 were taken in error from Lord David Prior; these pension deductions were refunded in full during 2019/20. These payments are not included in the total remuneration figures disclosed.

70 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 up until 31 March 2020.

71 Wendy Becker waived her entitlement to non-executive director remuneration from the 1 September 2016. Wendy Becker left NHS England on 27 June 2019. The full year equivalent salary is £5,000 - £10,000.

72 Michelle Mitchell left NHS England on 29 February 2020. The full year equivalent salary is £5,000-£10,000.

73 Richard Douglas CB left NHS England on 29 February 2020. The full year equivalent salary is £5,000-£10,000. Richard Douglas CB is also non-executive director at NHS Improvement and this tenure continued until 31 March 2020.

74 Professor Sir Munir Pirmohamed incurred an underpayment of salary amounting to £3,284.60 during the 2018/19 financial year and this was paid in 2019/20.This payment is not included in the total remuneration figures disclosed.

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[75] (bands of £2,500)	F: TOTAL (A to E) (bands of £5,000)
	£000	£s	£000	£000	£000	£000
Professor Sir Malcolm Grant Chair[76]	35-40	0	0	0	N/A	35-40
Lord David Prior Chair[77]	25-30	0	0	0	N/A	25-30
David Roberts CBE Vice-Chair[78]	0	0	0	0	N/A	0
Lord Victor Adebowale CBE[79]	5-10	0	0	0	N/A	5-10
Wendy Becker[80]	0	0	0	0	N/A	0
Professor Sir John Burn[81]	0-5	0	0	0	N/A	0-5
Dame Moira Gibb[82]	5-10	0	0	0	N/A	5-10
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[83] Associate non-voting	5-10	0	0	0	N/A	5-10
Professor Sir Munir Pirmohamed[84]	0-5	0	0	0	N/A	0-5

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

76 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.

77 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.

78 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.

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

80 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.

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

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

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

84 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.

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[85].

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	Total value of cases	Total number of cases	Total value of cases	Total number of cases	Total value of cases	Total number of cases	Total value of cases
	2019/20	2019/20	2018/19	2018/19	2019/20	2019/20	2018/19	2018/19
	Number	£000	Number	£000	Number	£000	Number	£000
Administrative write-offs	-	-	-	-	101	869	50	885
Fruitless payments	729	438	54	161	754	450	79	325
Stores losses	1	-	-	-	14	8	2	1
Bookeeping losses	53	10	66	5	56	19	69	19
Cash losses	2	276	-	-	11	281	12	19
Claims abandoned	7,315	1,119	70,770	4,565	7,317	1,138	70,776	4,600
Total	**8,100**	**1,843**	**70,890**	**4,731**	**8,253**	**2,765**	**70,988**	**5,849**

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

2019/20 Disclosure: Administrative write offs

Included within Administrative write offs in the group is a loss declared by NHS North East Essex CCG (671k). The CCG took a private provider to court and won. Invoices were raised to recover the £671k owed to the CCG by the provider but the provider went into administration and the debt was deemed irrecoverable and written off.

2019/20 Disclosure: Fruitless payments

Included within the parent costs are fruitless costs incurred by NHS England. A significant proportion of the reported costs, £245k, are a direct result of decisions made in response to COVID-19 to ensure the safety of employees and service users. An additional £153k was incurred as fruitless as part of the administration costs for cancelled events.

2019/20 Disclosure: Cash Losses

An investigation was commissioned by NHS England to review General Ophthalmic Service (GOS) claims submitted for payment. Following an initial review of payment profiles and claim patterns of all ophthalmic contractors across Cumbria, an optician was identified as being an outlier to the payments and claims patterns. An indicative audit was carried out and it was established that the optician was overpaid due to the administrative errors in submitted claim forms. The cost of £242k represents the sum overpaid.

2019/20 Disclosure: Claims Abandoned

In the Parent there are losses relating to easements offered in respect of penalty charge notices issued by NHS Business Services Authority on behalf of NHS England. The penalty charge notices are issued to individuals who obtained exemptions for prescription or dental charges which they were not eligible to claim. The number and value of easements issued in 2019/20 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.

In June 2018 NHS England's Dental Primary Care team (NHS England) identified inappropriate claims for the provision of Orthodontic services by a specific dental practice which resulted in an overpayment of £465k. An internal investigation was carried out and the outcome was that the claims submitted by the practice were inappropriate units of orthodontic activity and did not adhere to the General Dental Services (GDS) contract.

2018/19 Disclosure: Administrative Write Offs

Included within Administrative write offs 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 obsolesence.

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 18/19 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 Business Services Authority 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 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.

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. The presentational change has arisen as a result of review of disclosure requirements in this area.

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 2019/20	Total value of cases 2019/20	Total number of cases 2018/19	Total value of cases 2018/19	Total number of cases 2019/20	Total value of cases 2019/20	Total number of cases 2018/19	Total value of cases 2018/19
	Number	£000	Number	£000	Number	£000	Number	£000
Compensation payments	2	12	1	1	19	151	7	192
Extra Contractual Payments	1	2	1,083	300	2	21	1,088	432
Ex Gratia Payments	2	4	1	1	15	54	23	99
Extra Statutory Extra Regulatory Payments	-	-	-	-	1	10	2	22
Special Severance Payments Treasury Approved	-	-	-	-	-	-	1	3
Total	**5**	**18**	**1,085**	**302**	**37**	**236**	**1,121**	**748**

Fees and charges

NHS England certifies that it has complied with the 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:

2019/20

	Note	Parent			Consolidated Group		
		Income £000	Full cost £000	Surplus (deficit) £000	Income £000	Full cost £000	Surplus (deficit) £000
Dental	2 & 4	848,251	(3,089,173)	(2,240,922)	848,292	(3,089,173)	(2,240,881)
Prescription	2 & 4	607,397	(1,970,835)	(1,363,438)	614,126	(10,501,902)	(9,887,776)
Total fees & charges		**1,455,648**	**(5,060,008)**	**(3,604,360)**	**1,462,418**	**(13,591,075)**	**(12,128,657)**

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)**

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[86] are a contribution to the cost of pharmaceutical services including the supply of drugs. In 2018/19, the NHS prescription charge for each medicine or appliance dispensed was £8.80, and in 2019/20 it was £9.00. However, around 90% of prescription items[87] 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[88] which fall into three bands depending on the level and complexity of care provided. In 2018/19, the charge for Band 1 treatments was £21.60, for Band 2 was £59.10 and for Band 3 was £256.50. In 2019/20, the charge for Band 1 treatment was £22.70, for Band 2 was £62.10 and for Band 3 was £269.30.

86 https://www.gov.uk/government/speeches/nhs-prescription-charges-from-1-april-2018 and https://www.gov.uk/government/speeches/nhs-prescriptioncharges-from-april-2019
87 https://digital.nhs.uk/data-and-information/publications/statistical/prescriptions-dispensed-in-the-community/prescriptions-dispensed-in-the-communityengland---2007---2017
88 https://www.parliament.uk/business/publications/written-questions-answers-statements/written-statement/Commons/2019-03-11/HCWS1395

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 2020 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, including the significant accounting policies. These financial statements have been prepared under the accounting policies set out within them. I have also audited the information in the Accountability 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 2020 and of the group's and the parent's net expenditure 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 have nothing to report in respect of the following matters in relation to which the ISAs (UK) require me to report to you where:

- the NHS Commissioning Board's use of the going concern basis of accounting in the preparation of the financial statements is not appropriate; or
- the NHS Commissioning Board have not disclosed in the financial statements any identified material uncertainties that may cast significant doubt about the NHS Commissioning Board's ability to continue to adopt the going concern basis of accounting for a period of at least twelve months from the date when the financial statements are authorised for issue.

Responsibilities of the Board and 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 (UK) 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 (UK), 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.

- Conclude on the appropriateness of the NHS Commissioning Board'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 NHS Commissioning Board's ability to continue as a going concern. If I conclude that a material uncertainty exists, I am required to draw attention in my 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 report. However, future events or conditions may cause NHS Commissioning Board's to cease to continue as a going concern.

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 Performance Report and Accountability Report, but does not include 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 Accountability 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 the Performance Report and Accountability Report for the financial year for which the financial statements are prepared is consistent with the financial statements.

Matters on which I report by exception

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

- adequate accounting records have not been kept or returns adequate for my audit have not been received from branches not visited by my staff; or
- the financial statements and the parts of the Accountability Report 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 refer to the explanatory report that I have included alongside my audit certificate on the 2019/20 financial statements of the Department of Health and Social Care. This report is relevant to the NHS England financial statements because it reports on the regularity considerations arising from the ministerial direction given by the Secretary of State for Health and Social Care on 22 November 2019.

Gareth Davies 26 January 2021

Comptroller and Auditor General

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

Annual Accounts

Sir Simon Stevens
Accounting Officer
15 January 2021

Statement of comprehensive net expenditure for the year ended 31 March 2020

	Note	Parent		Consolidated Group	
		2019/20	2018/19	2019/20	2018/19
		£000	£000	£000	£000
Income from sale of goods and services	2	(1,945,492)	(1,916,960)	(2,058,318)	(1,993,191)
Other operating income	2	(3,813)	(3,636)	(93,478)	(111,019)
Total operating income		**(1,949,305)**	**(1,920,596)**	**(2,151,796)**	**(2,104,210)**
Staff costs	3	834,285	771,793	2,127,801	1,949,413
Purchase of goods and services	4	123,167,307	113,094,005	122,251,284	112,496,829
Depreciation and impairment charges	4	134,743	117,401	149,325	132,065
Provision expense	4	312,291	(28,953)	329,056	(3,024)
Other operating expenditure	4	431,800	277,547	541,817	394,160
Total operating expenditure		**124,880,426**	**114,231,793**	**125,399,283**	**114,969,443**
Net operating expenditure		**122,931,121**	**112,311,197**	**123,247,487**	**112,865,233**
Finance expense	11	(404)	533	(500)	644
Net expenditure for the year		**122,930,717**	**112,311,730**	**123,246,987**	**112,865,877**
Other (gains)/losses		-	-	331	33
Total net expenditure for the year		**122,930,717**	**112,311,730**	**123,247,318**	**112,865,910**
Other comprehensive net expenditure					
Items which will not be reclassified to net operating costs					
Actuarial (gain)/loss in pension schemes		-	-	(1,866)	871
Sub total		-	-	(1,866)	871
Comprehensive net expenditure for the year		**122,930,717**	**112,311,730**	**123,245,452**	**112,866,781**

The notes on pages 123 to 166 form part of this statement

Statement of financial position as at 31 March 2020

	Note	Parent		Consolidated Group	
		31 March 2020	31 March 2019	31 March 2020	31 March 2019
		£000	£000	£000	£000
Non-current assets					
Property, plant and equipment	6	454,625	393,207	486,460	433,679
Intangible assets	7	4,150	3,516	8,841	8,615
Trade and other receivables	8	-	-	747	538
Other financial assets	8	-	-	1,554	554
Total non-current assets		**458,775**	**396,723**	**497,602**	**443,386**
Current assets					
Inventories		46,168	37,027	64,710	48,932
Trade and other receivables	8	260,347	206,923	990,143	966,282
Cash and cash equivalents	9	151,683	188,941	171,238	205,488
Total current assets		**458,198**	**432,891**	**1,226,091**	**1,220,702**
Total assets		**916,973**	**829,614**	**1,723,693**	**1,664,088**
Current liabilities					
Trade and other payables	10	(4,435,806)	(4,527,004)	(10,808,461)	(10,598,850)
Provisions	12	(18,440)	(30,693)	(105,803)	(135,082)
Total current liabilities		**(4,454,246)**	**(4,557,697)**	**(10,914,264)**	**(10,733,932)**
Total assets less current liabilities		**(3,537,273)**	**(3,728,083)**	**(9,190,571)**	**(9,069,844)**
Non-current liabilities					
Trade and other payables	10	(26)	(26)	(2,185)	(4,535)
Provisions	12	(340,887)	(22,204)	(366,117)	(41,886)
Total non-current liabilities		**(340,913)**	**(22,230)**	**(368,302)**	**(46,421)**
Total assets less total liabilities		**(3,878,186)**	**(3,750,313)**	**(9,558,873)**	**(9,116,265)**
Financed by taxpayers' equity and other reserves					
General fund		(3,878,186)	(3,750,313)	(9,555,193)	(9,110,735)
Revaluation reserve		-	-	18	34
Other reserves		-	-	(3,698)	(5,564)
Total taxpayers' equity		**(3,878,186)**	**(3,750,313)**	**(9,558,873)**	**(9,116,265)**

The notes on pages 123 to 166 form part of this statement

The financial statements on pages 117 to 122 were approved by the Board on 15 January 2021 and signed on its behalf by:

Sir Simon Stevens
Accounting Officer

Statement of changes in taxpayers equity for the year ended 31 March 2020

Parent

	General fund £000	Revaluation reserve £000	Other reserves £000	Total Taxpayers' equity £000
Changes in taxpayers' equity for 2019/20				
Balance at 01 April 2019	(3,750,313)	-	-	(3,750,313)
Restated balance at 01 April 2019	**(3,750,313)**	**-**	**-**	**(3,750,313)**
Changes in taxpayers' equity for 2019/20				
Total Net Expenditure for the year	(122,930,717)	-	-	(122,930,717)
Comprehensive net expenditure for the year	**(122,930,717)**	**-**	**-**	**(122,930,717)**
Grant in Aid	122,802,844	-	-	122,802,844
Balance at 31 March 2020	**(3,878,186)**	**-**	**-**	**(3,878,186)**

Parent

	General fund £000	Revaluation reserve £000	Other reserves £000	Total Taxpayers' equity £000
Changes in taxpayers' equity for 2018/19				
Balance at 1 April 2018	(3,161,904)	-	-	(3,161,904)
Impact of applying IFRS 9 to Opening Balances	(1,983)	-	-	(1,983)
Impact of applying IFRS 15 to Opening Balances	-	-	-	-
Restated balance at 01 April 2018	**(3,163,887)**	**-**	**-**	**(3,163,887)**
Changes in taxpayers' equity for 2018/19				
Total Net Expenditure for the year	(112,311,730)	-	-	(112,311,730)
Comprehensive net expenditure for the year	**(112,311,730)**	**-**	**-**	**(112,311,730)**
Grant in Aid	111,725,304	-	-	111,725,304
Balance at 31 March 2019	**(3,750,313)**	**-**	**-**	**(3,750,313)**

Consolidated Group

	General fund £000	Revaluation reserve £000	Other reserves £000	Total Taxpayers' equity £000
Changes in taxpayers' equity for 2019/20				
Balance at 01 April 2019	(9,110,735)	34	(5,564)	(9,116,265)
Restated balance at 01 April 2019	**(9,110,735)**	**34**	**(5,564)**	**(9,116,265)**
Changes in taxpayers' equity for 2019/20				
Total Net Expenditure for the year	(123,247,318)	-	-	(123,247,318)
Movements in other reserves	-	-	1,866	1,866
Transfers between reserves	16	(16)	-	-
Comprehensive net expenditure for the year	**(123,247,302)**	**(16)**	**1,866**	**(123,245,452)**
Grant in Aid	122,802,844	-	-	122,802,844
Balance at 31 March 2020	**(9,555,193)**	**18**	**(3,698)**	**(9,558,873)**

Consolidated Group

	General fund £000	Revaluation reserve £000	Other reserves £000	Total Taxpayers' equity £000
Changes in taxpayers' equity for 2018/19				
Balance at 1 April 2018	(7,970,187)	37	(4,693)	(7,974,843)
Impact of applying IFRS 9 to Opening Balances	55	-	-	55
Impact of applying IFRS 15 to Opening Balances	-	-	-	-
Restated balance at 1 April 2018	**(7,970,132)**	**37**	**(4,693)**	**(7,974,788)**
Changes in taxpayers' equity for 2018/19				
Total Net Expenditure for the financial year	(112,865,910)	-	-	(112,865,910)
Movements in other reserves	-	-	(871)	(871)
Transfers between reserves	3	(3)	-	-
Comprehensive net expenditure for the year	**(112,865,907)**	**(3)**	**(871)**	**(112,866,781)**
Grant in Aid	111,725,304	-	-	111,725,304
Balance at 31 March 2019	**(9,110,735)**	**34**	**(5,564)**	**(9,116,265)**

Other reserves reflect pension assets/liabilities in respect of staff in non NHS defined benefit schemes in CCGs. Full details can be found in the CCG statutory accounts published on their websites.

The notes on pages 123 to 166 form part of this statement

Statement of cash flows for the year ended 31 March 2020

	Note	Parent		Consolidated Group	
		2019/20 £000	2018/19 £000	2019/20 £000	2018/19 £000
Cash flows from operating activities					
Net expenditure for the financial year		(122,930,717)	(112,311,730)	(123,247,318)	(112,865,910)
Depreciation and amortisation	4	134,743	117,401	149,325	131,524
Impairments and reversals	4	-	-	-	541
Non-cash movements arising on application of new accounting standards		-	(1,983)	-	55
Other non cash adjustments[1]		-	-	(169)	(223)
(Gain)/Loss on disposal		-	-	331	32
Unwinding of discount	12	(404)	533	(538)	588
Change in discount rate	12	(165)	(461)	(279)	(275)
(Increase)/decrease in inventories		(9,141)	(8,925)	(15,778)	(12,021)
(Increase)/decrease in trade & other receivables	8	(53,424)	36,220	(24,070)	42,105
Increase/(decrease) in trade & other payables	10	(113,069)	680,851	187,735	1,205,728
Provisions utilised	12	(5,457)	(1,692)	(34,908)	(24,902)
Increase/(decrease) in provisions	12	312,456	(28,491)	330,677	(2,595)
Net cash outflow from operating activities		**(122,665,178)**	**(111,518,277)**	**(122,654,992)**	**(111,525,353)**
Cash flows from investing activities					
Payments for property, plant and equipment		(172,690)	(161,824)	(187,257)	(164,579)
Payments for intangible assets		(2,235)	(1,027)	(3,817)	(1,826)
Payments for other financial assets		-	-	(1,000)	-
Proceeds from disposal of assets: property, plant and equipment		1	-	1,904	140
Proceeds from disposal of assets: intangible assets		-	-	-	-
Net cash outflow from investing activities		**(174,924)**	**(162,851)**	**(190,170)**	**(166,265)**
Net cash outflow before financing activities		**(122,840,102)**	**(111,681,128)**	**(122,845,162)**	**(111,691,618)**
Cash flows from financing activities					
Grant in aid funding received		122,802,844	111,725,304	122,802,844	111,725,304
Capital element of payments in respect of finance leases		-	-	(91)	(88)
Net cash inflow from financing activities		**122,802,844**	**111,725,304**	**122,802,753**	**111,725,216**
Net increase/(decrease) in cash & cash equivalents		**(37,258)**	**44,176**	**(42,409)**	**33,598**
Cash & cash equivalents at the beginning of the financial year	9	188,941	144,765	196,694	163,096
Cash & cash equivalents at the end of the financial year	9	**151,683**	**188,941**	**154,285**	**196,694**

The notes on pages 123 to 166 form part of this statement
There is no separate disclosure under IAS 7 for cash and non cash movements for financing activities because the values are immaterial.

1 Other non cash adjustments comprise a non cash credit on pension of £169k (2018/19 £211k credit) and on lease charges of £0k (2018/19 £12k charge)

Notes to the financial statements

1. Statement of accounting policies

These financial statements have been prepared in a form directed by the Secretary of State under Schedule 1(A), paragraph 15(2) of the Health and Social Care Act 2012 and in accordance with the 2019/20 DHSC Group Accounting Manual (DHSC GAM) issued by the Department of Health & Social Care and comply with HM Treasury's Financial Reporting Manual 2019/20 (FReM). The accounting policies contained in the DHSC GAM apply International Financial Reporting Standards (IFRS) as adapted or interpreted for the public sector context. Where the DHSC GAM permits a choice of accounting policy, the accounting policy which is judged to be most appropriate to the particular circumstances of NHS England for the purpose of giving a true and fair view has been selected. The particular policies adopted by NHS England are described below. They have been applied consistently in dealing with items considered material to the accounts.

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

Exchange gains and losses on monetary items (arising on settlement of the transaction or on retranslation at the Statement of Financial Position date) are recognised in the Statement of Comprehensive Net Expenditure in the period in which they arise.

1.1 Operating segments

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

1.2 Accounting convention

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

1.3 Basis of Consolidation

These accounts comprise the results of the NHS England statutory entity as well as the consolidated position of NHS England and its 191 related CCGs. Transactions between entities included in the consolidation are eliminated.

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

1.4 Comparative information

The comparative information provided in these financial statements is for the year ended 31 March 2019.

1.5 Going Concern

On 1 April 2019, a new joint leadership structure came into effect across NHS England, NHS TDA and Monitor. The underlying legal entities of NHS England, NHS TDA and Monitor remained in place. Should legislation be passed to formally merge the entities, the underlying activities of NHS England would continue.

NHS England's financial statements are produced on a going concern basis. NHS England is supply-financed and draws its funding from the DHSC. Parliament has demonstrated its commitment to fund the DHSC for the foreseeable future via the latest Spending Review and the passing of the Health and Social Care Act 2012. In the same way, the DHSC has demonstrated commitment to the funding of NHS England. It is therefore considered appropriate to adopt the going concern basis for the preparation of these financial statements.

1.6 Transfer of Functions

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

1.7 Revenue Recognition

In the adoption of IFRS 15 a number of practical expedients offered in the Standard have been employed. These are as follows:

- As per paragraph 121 of the Standard NHS England will not disclose information regarding the performance obligations part of a contract that has an original expected duration of one year or less,
- NHS England is to similarly not disclose information where revenue is recognised in line with the practical expedient offered in paragraph B16 of the Standard where the right to consideration corresponds directly with value of the performance completed to date.
- The FReM has mandated the exercise of the practical expedient offered in C7(a) of the Standard that requires NHS England to reflect the aggregate effect of all contracts modified before the date of initial application.

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

Revenue in respect of services provided is recognised when (or as) performance obligations are satisfied by transferring promised services to the customer, and is measured at the amount of the transaction price allocated to that performance obligation.

IFRS 15 is applicable to revenue in respect of dental and prescription charges in line with the adaptation in IFRS 15 which states that the definition of a contract includes revenue received under legislation and regulations. Revenue for these charges is recognised when the performance event occurs e.g. the issue of a prescription or payment for dental treatment.

Income received in respect of penalty charge notices issued in relation to non-payment of prescribing and dental charges is recognised on a cash receipts basis.

Where income is received for a specific performance obligation that is to be satisfied in the following year, that income is deferred.

Other operating revenue is recognised when the service is rendered and the stage completion of the transaction at the end of the reporting period can be measured reliably, and it is probable that the economic benefit associated with the transaction will flow to the group. Income is measured at fair value of the consideration receivable.

The value of the benefit received when NHS England accesses funds from the Government's apprenticeship service are recognised as income in accordance with IAS 20, Accounting for Government Grants. Where these funds are paid directly to an accredited training provider, non-cash income and a corresponding non-cash training expense are recognised, both equal to the cost of the training funded.

1.8 Employee Benefits

Recognition of short-term benefits - retirement benefit costs:

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

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

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

1.9 Other expenses

Other operating expenses are recognised when, and to the extent that, the goods or services have been received. They are measured at the fair value of the consideration payable.

1.10 Value Added Tax

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

1.11 Property, Plant and Equipment

Recognition

Property, plant and equipment is capitalised if:

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

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

Measurement of property, plant and equipment

All property, plant and equipment is measured initially at cost, representing the cost directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management. Assets that are held for their service potential and are in use are measured subsequently at their current value in existing use.

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

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

Subsequent expenditure

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

1.12 Intangible non-current assets

Intangible non-current assets are non-monetary assets without physical substance that are capable of sale separately from the rest of the group's business or arise from contractual or other legal rights. They are recognised only when it is probable that future economic benefits will flow to, or service potential be provided to, the group; where the cost of the asset can be measured reliably; and where the cost is at least £5,000 with each individual item costing more than £250.

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

Following initial recognition, intangible assets are carried at depreciated historic cost as a proxy for current value in existing use.

1.13 Research and development

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

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

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

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

1.14 Depreciation, amortisation and impairments

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

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

Depreciation/amortisation is charged as follows:

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

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

1.15 Government grants

Government grant funded assets are capitalised at their fair value on receipt, with a matching credit to income. Deferred income is recognised only where conditions attached to the grant preclude immediate recognition of the gain.

1.16 Non-current assets held for sale

Non-current assets are classified as held for sale if their carrying amount will be recovered principally through a sale transaction rather than through continuing use. This condition is satisfied once both of the following criteria are met:

- the asset is available for immediate sale in its present condition subject only to terms which are usual and customary for such sales; and
- the sale is highly probable.

Non-current assets held for sale are measured at the lower of their previous carrying amount and fair value less costs to sell. Fair value is open market value including alternative uses.

The profit or loss arising on disposal of an asset is the difference between the sale proceeds and the carrying amount and is recognised in the statement of comprehensive net expenditure. On disposal, the balance for the asset in the revaluation reserve is transferred to retained earnings.

Property, plant and equipment that is to be scrapped or demolished does not qualify for recognition as held for sale. Instead, it is retained as an operational asset and its economic life is adjusted. The asset is de-recognised when it is scrapped or demolished.

1.17 Leases

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

Property, plant and equipment held under finance leases are initially recognised at the inception of the lease at fair value or, if lower, at the present value of the minimum lease payments, with a matching liability for the lease obligation to the lessor. Lease payments are apportioned between finance charges and reduction of the lease obligation to achieve a constant rate of interest on the remaining balance of the liability. Finance charges are recognised in the statement of comprehensive net expenditure.

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

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

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

1.18 Inventories

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

1.19 Cash and cash equivalents

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

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

1.20 Provisions

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

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

- A nominal short term rate of 0.51 percent (2018/19: 0.76 percent in real terms) is applied to inflation adjusted expected cash flows up to and including 5 years from Statement of Financial Position date.
- A nominal medium-term rate of 0.55 percent (2018/19: 1.14 percent in real terms) is applied to inflation adjusted expected cash flows over 5 years up to and including 10 years from the Statement of Financial Position date.
- A nominal long-term rate of 1.99 percent (2018/19: 1.99 percent in real terms) is applied to inflation adjusted expected cash flows over 10 years and up to and including 40 years from the Statement of Financial Position date.

1.21 Clinical negligence costs

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

1.22 Non-clinical risk pooling

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

1.23 Contingent liabilities and contingent assets

A contingent liability is:

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

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

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

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

1.24 Financial assets

Financial assets are recognised on the statement of financial position when the group becomes party to the financial instrument contract or, in the case of trade receivables, when the goods or services have been delivered. Financial assets are de-recognised when the contractual rights have expired or the asset has been transferred and the group has transferred substantially all of the risks and rewards of ownership or has not retained control of the asset.

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

Financial assets are classified into the following categories: financial assets at amortised cost, financial assets at fair value through other comprehensive income, and financial assets at fair value through profit and loss. The classification is determined by the cash flow and business model characteristics of the financial assets, as set out in IFRS 9, and is determined at the time of initial recognition.

1.24.1 Financial assets at amortised cost

Financial assets measured at amortised cost are those held within a business model whose objective is to hold financial assets in order to collect contractual cash flows and where the cash flows are solely payments of principal and interest. This includes most trade receivables, loans receivable, and other simple debt instruments.

After initial recognition, these financial assets are measured at amortised cost using the effective interest method, less any impairment. The effective interest rate is the rate that exactly discounts estimated future cash receipts through the life of the financial asset to the gross carrying amount of the financial asset.

1.24.2 Financial assets at fair value through other comprehensive income

Financial assets measured at fair value through other comprehensive income are those held within a business model whose objective is achieved by both collecting contractual cash flows, and selling financial assets and where the cash flows are solely payments of principal and interest.

1.24.3 Financial assets at fair value through profit and loss

Financial assets measured at fair value through profit or loss are those that are not otherwise measured at amortised cost or fair value through other comprehensive income. This includes derivatives and financial assets acquired principally for the purpose of selling in the short term.

1.24.4 Impairment

For all financial assets measured at amortised cost or at fair value through other comprehensive income (except equity instruments designated at fair value through other comprehensive income), lease receivables and contract assets, NHS England recognises a loss allowance representing expected credit losses on the financial instrument.

NHS England adopts the simplified approach to impairment, in accordance with IFRS 9, and measures the loss allowance for trade receivables, contract assets and lease receivables at an amount equal to lifetime expected credit losses. For other financial assets, the loss allowance is measured at an amount equal to lifetime expected credit losses if the credit risk on the financial instrument has increased significantly since initial recognition (stage 2), and otherwise at an amount equal to 12-month expected credit losses (stage 1).

HM Treasury has ruled that central government bodies may not recognise stage 1 or stage 2 impairments against other government departments, their executive agencies, the Bank of England, Exchequer Funds, and Exchequer Funds' assets where repayment is ensured by primary legislation. NHS England therefore does not recognise loss allowances for stage 1 or stage 2 impairments against these bodies. Additionally, the Department of Health and Social Care provides a guarantee of last resort against the debts of its arm's length bodies and NHS bodies (excluding NHS charities), and NHS England does not recognise loss allowances for stage 1 or stage 2 impairments against these bodies.

For financial assets that have become credit impaired since initial recognition (stage 3), expected credit losses at the reporting date are measured as the difference between the asset's gross carrying amount and the present value of the estimated future cash flows discounted at the financial asset's original effective interest rate. Any adjustment is recognised in profit or loss as an impairment gain or loss.

1.25 Financial liabilities

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

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

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

The FReM does not require the following Standards and Interpretations to be applied in 2019/20. These Standards are still subject to HM Treasury FReM adoption, with IFRS 16 being for implementation in 2020/21, and the government implementation date for IFRS 17 still subject to HM Treasury consideration.

IFRS 16 Leases – The standard is effective from 1 April 2022 as adapted and interpreted by the FReM.

IFRS 17 Insurance Contracts – Application required for accounting periods beginning on or after 1 January 2021, but not yet adopted by the FReM: early adoption is not therefore permitted.

IFRS 16 Leases

IFRS 16 – Leases replaces IAS 17 - Leases, IFRIC 4 Determining whether an arrangement contains a lease and, SIC 27 - Evaluating the substance of transactions involving the legal form of a lease and introduces a single, on-statement of financial position lease accounting model for lessees.

Currently, the NHS England parent and the CCGs (the group) recognises operating lease expenses on a straight-line basis over the term of the lease, and recognises assets and liabilities only to the extent that there is a timing difference between actual lease payments and the expense recognised. Under IFRS 16 it will recognise a right-of-use asset representing its right to use the underlying asset and a lease liability representing its obligation to make lease payments for any operating leases it assesses fall under IFRS 16. There are recognition exemptions for short-term leases and leases of low-value items.

In addition, the group will no longer charge provisions for operating leases that it assesses to be onerous to the Statement of Comprehensive Net Expenditure. Instead, the group will include the payments due under the lease with any appropriate assessment for impairments in the right of use asset.

The group has assessed that there is no significant impact on its current finance leases due to the immaterial value on the statement of financial position and no significant impact on the limited transactions it undertakes as a lessor because IFRS 16 has not substantially changed the accounting arrangements for lessors.

IFRS 16 is effective for periods beginning on or after 1 January 2019 but under the requirements of the FReM NHS England group will not adopt it until 1 April 2022. NHS England has estimated the impact of initial application as described below. The actual impact may change however because:

a) The value and nature of the leases that the group holds at the time of implementation may change,

b) Processes and controls to identify and account for right of use assets under IFRS 16 are continuing to be developed.

Impact

Note 5 contains details of operating lease expenditure at 31 March 2020. An assessment of the nature of leases within other indicates that these comprise mainly low value office items that would fall under the short term lease or low value lease exemptions in IFRS 16 and therefore, this expense will continue to be treated as straight line operating expenditure.

The most significant impact will be that the group will need to recognise right of use assets and lease liabilities for any buildings currently treated as operating leases that meet the recognition criteria in IFRS 16. At 31 March 2020 the future minimum lease payments amounted to £226 million and this means that the nature of this expense will be assessed and change from being an operating lease expense to depreciation and interest expense.

Transition

The NHS England parent and the CCGs will recognise the cumulative effect of adopting the standard at the date of initial application as an adjustment to the opening retained earnings with no restatement of comparative balances.

IFRS 16 does not require entities to reassess whether a contract is, or contains, a lease at the date of initial application. HMT have interpreted this to mandate this practical expedient and therefore the group will apply IFRS 16 to contracts identified as a lease under IAS 17 or IFRIC 4 at 1 April 2021. However during the 2019/20 financial year the NHS England core department, CSUs and CCGs have reviewed material contracts to ensure they have been correctly treated under IAS 17. This has resulted in a fall in the number of transactions treated as an operating lease under IAS 17, but there has been no prior year adjustment under IAS 8 on the grounds that the change is not material.

The group will utilise three further practical expedients under the transition approach adopted:

a) The election to not make an adjustment for leases for which the underlying asset is of low value,

b) The election to not make an adjustment to leases where the lease terms ends within 12 months of the date of application,

c) The election to use hindsight in determining the lease term if the contract contains options to extend or terminate the lease.

Other accounting standards issued but not yet adopted

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

2. Operating income

	Parent		Consolidated Group	
	2019/20	2018/19	2019/20	2018/19
	Total £000	Total £000	Total £000	Total £000
Income from sale of goods and services (contracts)				
Education, training and research	1,367	483	13,753	13,624
Non-patient care services to other bodies[2]	400,313	384,599	291,944	274,915
Prescription fees and charges[3]	607,397	583,809	614,126	591,960
Dental fees and charges[3]	848,251	856,384	848,292	856,384
Other Contract income	87,754	91,093	280,829	248,727
Recoveries in respect of employee benefits	410	592	9,374	7,581
Total Income from sale of goods and services	**1,945,492**	**1,916,960**	**2,058,318**	**1,993,191**
Other operating income				
Rental revenue from operating leases	-	-	176	232
Charitable and other contributions to revenue expenditure: non-NHS	344	237	1,711	2,839
Non cash apprenticeship training grants revenue	173	90	544	349
Other non contract revenue	3,296	3,309	91,047	107,599
Total other operating income	**3,813**	**3,636**	**93,478**	**111,019**
Total operating income	**1,949,305**	**1,920,596**	**2,151,796**	**2,104,210**

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

3. In line with the adaptation in the HMT Financial Reporting Manual prescription fees and charges and dental fees and charges are treated as revenue arising from a contract and accounted for under IFRS15.

2.1 Disaggregation of revenue

We disaggregate our revenue from contracts with customers by the nature of the revenue. This is shown in note 2. Note 2.1 provides the disaggregation in line with our operating segments reported in note 16.

Parent 2019/20	CCG Total £000	Direct commissioning Total £000	NHS England Total £000	Other Total £000	I/co eliminations Total £000	Total £000
Income from sale of goods and services (contracts)						
Education, training and research	-	600	535	232	-	**1,367**
Non-patient care services to other bodies	-	6,154	3,108	478,714	(87,663)	**400,313**
Prescription fees and charges	-	607,397	-	-	-	**607,397**
Dental fees and charges	-	848,251	-	-	-	**848,251**
Other contract income	-	14,812	31,181	25,943	15,818	**87,754**
Recoveries in respect of employee benefits	-	-	410	-	-	**410**
Total Income from sale of goods and services	**-**	**1,477,214**	**35,234**	**504,889**	**(71,845)**	**1,945,492**

Parent 2018/19	CCG Total £000	Direct commissioning Total £000	NHS England Total £000	Other Total £000	I/co eliminations Total £000	Total £000
Income from sale of goods and services (contracts)						
Education, training and research	-	-	163	321	-	**484**
Non-patient care services to other bodies	-	4,087	3,628	458,148	(81,263)	**384,600**
Prescription fees and charges	-	583,809	-	-	-	**583,809**
Dental fees and charges	-	856,384	-	-	-	**856,384**
Other contract income	**-**	18,527	49,600	23,716	(752)	**91,091**
Recoveries in respect of employee benefits	**-**	**-**	592	-	**-**	**592**
Total Income from sale of goods and services	**-**	**1,462,807**	**53,983**	**482,185**	**(82,015)**	**1,916,960**

Consolidated Group 2019/20	CCG Total £000	Direct commissioning Total £000	NHS England Total £000	Other Total £000	I/co eliminations Total £000	Total £000
Income from sale of goods and services (contracts)						
Education, training and research	12,293	600	535	231	94	**13,753**
Non-patient care services to other bodies	469,958	6,154	3,108	478,714	(665,990)	**291,944**
Prescription fees and charges	6,728	607,398	-	-	-	**614,126**
Dental fees and charges	41	848,251	-	-	-	**848,292**
Other contract income	195,921	14,811	31,181	25,943	12,973	**280,829**
Recoveries in respect of employee benefits	14,540	-	410	-	(5,576)	**9,374**
Total Income from sale of goods and services	**699,481**	**1,477,214**	**35,234**	**504,888**	**(658,499)**	**2,058,318**

Consolidated Group 2018/19	CCG Total £000	Direct commissioning Total £000	NHS England Total £000	Other Total £000	I/co eliminations Total £000	Total £000
Income from sale of goods and services (contracts)						
Education, training and research	13,558	-	163	321	(418)	**13,624**
Non-patient care services to other bodies	466,341	4,087	3,628	458,148	(657,288)	**274,916**
Prescription fees and charges	8,151	583,809	-	-	-	**591,960**
Dental fees and charges	-	856,384	-	-	-	**856,384**
Other contract income	176,721	18,527	49,600	23,716	(19,839)	**248,725**
Recoveries in respect of employee benefits	11,679	-	592	-	(4,689)	**7,582**
Total Income from sale of goods and services	**676,450**	**1,462,807**	**53,983**	**482,185**	**(682,234)**	**1,993,191**

3. Employee benefits

	Parent		Consolidated Group	
	2019/20	2018/19	2019/20	2018/19
	Total £000	Total £000	Total £000	Total £000
Employee benefits				
Salaries and wages	643,338	631,554	1,663,003	1,604,203
Social security costs	64,770	60,820	162,625	151,744
Employer contributions to NHS Pension scheme	104,979	70,201	268,671	175,868
Other pension costs	-	-	195	60
Apprenticeship Levy	2,786	2,485	5,174	4,387
Termination benefits	18,753	6,733	28,697	13,202
Gross employee benefits expenditure	**834,626**	**771,793**	**2,128,365**	**1,949,464**
Less: Employee costs capitalised	(341)	-	(564)	(51)
Gross employee benefits excluding capitalised costs	**834,285**	**771,793**	**2,127,801**	**1,949,413**
Less recoveries in respect of employee benefits	(410)	(592)	(9,373)	(7,581)
Net employee benefits	**833,875**	**771,201**	**2,118,428**	**1,941,832**

Staff numbers can be found in the Accountability report on page 92.

3.2 Pension costs

As described in Note 1.8 past and present employees are covered by the provisions of the NHS Pensions Scheme. The scheme is not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, the scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS Body of participating in the scheme is taken as equal to the contributions payable to the scheme for the accounting period.

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

3.2.1 Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2020, is based on a valuation data as 31 March 2019, updated to 31 March 2020 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

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

Full actuarial (funding) valuation

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

The latest actuarial valuation undertaken for the NHS Pension Scheme was completed as at 31 March 2016. The results of this valuation set the employer contribution rate payable from April 2019 to 20.6%, and the Scheme Regulations were amended accordingly.

The 2016 funding valuation was also expected to test the cost of the Scheme relative to the employer cost cap set following the 2012 valuation. Following a judgment from the Court of Appeal in December 2018 Government announced a pause to that part of the valuation process pending conclusion of the continuing legal process.

3.2.2 Scheme provisions

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

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

3.2.3 Local Government Pension Scheme

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

3.2.4 Principal Civil Service Pension Scheme

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

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

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

4. Operating expenses

	Parent		Consolidated Group	
	2019/20 Total £000	2018/19 Total £000	2019/20 Total £000	2018/19 Total £000
Purchase of goods and services – cash				
Services from other CCGs and NHS England	12,773	26,171	-	-
Services from foundation trusts	15,150,671	12,197,211	51,643,165	46,028,030
Services from other NHS trusts	6,819,703	5,694,154	27,375,924	25,128,222
Provider Sustainability Fund[4]	2,595,848	2,450,000	2,595,848	2,450,000
Services from Other WGA bodies[5]	16,361	9,949	70,734	57,612
Purchase of healthcare from non-NHS bodies	1,431,572	1,319,697	14,413,662	13,734,227
Purchase of social care	50	(30)	705,362	647,354
General dental services and personal dental services	3,089,173	2,919,876	3,089,173	2,919,876
Prescribing costs	20,339	19,449	8,540,631	8,236,936
Pharmaceutical services	1,950,496	1,924,082	1,961,271	1,935,054
General ophthalmic services	534,875	543,097	547,797	553,598
GP primary care services[6]	891,670	1,075,268	9,153,611	8,526,114
Supplies and services – clinical	9,694	143,937	71,976	210,021
Supplies and services – general	358,220	379,961	931,637	897,109
Consultancy services	2,464	8,699	45,790	64,143
Establishment	172,907	176,861	409,991	388,180
Transport	11,960	12,112	68,461	63,144
Premises	72,879	81,903	389,468	430,893
Audit fees[7]	300	300	10,312	10,301
Other non statutory audit expenditure	-	-	2,848	3,034
Other professional fees	46,864	35,225	108,313	98,945
Legal fees	7,155	7,844	19,406	21,429
Education and training	58,183	57,974	95,360	92,258
Funding to group bodies[8]	89,912,977	84,010,175	-	-
Total purchase of goods and services - cash	**123,167,134**	**113,093,915**	**122,250,740**	**112,496,480**
Other operating expenditure – cash				
Chair and Non Executive Members	128	139	48,104	50,768
Grants to other bodies	78,155	60,466	100,949	82,108
Clinical negligence	-	-	240	219
Research and development (excluding staff costs)	910	1,297	15,107	15,235
Other expenditure	18,848	13,156	37,526	35,506
Other operating expenditure - cash	**98,041**	**75,058**	**201,926**	**183,836**
Total operating expenses - cash	**123,265,175**	**113,168,973**	**122,452,666**	**112,680,316**
Depreciation and impairment charges – non cash items				
Depreciation	133,335	115,098	145,988	127,106
Amortisation	1,408	2,303	3,337	4,418
Impairments and reversals of property, plant and equipment	-	-	-	541
Total depreciation and impairment charges	**134,743**	**117,401**	**149,325**	**132,065**
Provision expense – non cash items				
Change in discount rate	(165)	(461)	(279)	(275)
Provisions	312,456	(28,492)	329,335	(2,749)
Total provision expense	**312,291**	**(28,953)**	**329,056**	**(3,024)**
Purchase of goods and services - non cash				
Non cash apprenticeship training grants	173	90	544	349
Total purchase of goods and services - non cash	**173**	**90**	**544**	**349**
Other operating expenditure – non cash items				
Expected credit loss on receivables	192	2,650	913	7,660
Inventories consumed	333,567	199,839	338,978	202,664
Total other operating expenditure	**333,759**	**202,489**	**339,891**	**210,324**
Total operating expenses - non cash	**780,966**	**291,027**	**818,816**	**339,714**
Total operating expenses	**124,046,141**	**113,460,000**	**123,271,482**	**113,020,030**

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

4 In 2019/20 and 2018/19 NHS England has allocated expenditure through the Provider Sustainability Fund (formally Sustainability and Transformation Fund) for provider support, in line with the NHS England mandate.

5 Services from other WGA bodies comprises expenditure with the Department of Health and Social Care(DHSC), DHSC Arm's Length Bodies and NHS Blood and Transplant.

6 The reductions in GP primary care expenditure in 2019/20 in the NHS England parent account, compared to 2018/19 are due to the ongoing switch in budget from NHS England to those CCGs who have taken delegated commissioning responsibilities. This also results in an increase in Group Funding to those CCGs who have assumed delegated commissioning responsibilities.

7 In both financial years NHS England purchased no Non Audit services from NAO. Details of CCG non audit expenditure can be found in the underlying individual CCG accounts.

8 Funding to group bodies is shown opposite and represents cash funding drawn down by the CCGs. These balances are eliminated on consolidation.

5. Operating leases as lessee

5.1 Payments recognised as an expense

Parent

	2019/20			2018/19		
	Buildings £000	Other £000	Total £000	Buildings £000	Other £000	Total £000
Payments recognised as an expense						
Minimum lease payments	43,390	1,352	**44,742**	68,076	1,261	**69,337**
Total	**43,390**	**1,352**	**44,742**	**68,076**	**1,261**	**69,337**

Consolidated Group

	2019/20			2018/19		
	Buildings £000	Other £000	Total £000	Buildings £000	Other £000	Total £000
Payments recognised as an expense						
Minimum lease payments	173,003	2,570	**175,573**	345,259	2,841	**348,100**
Contingent rents	-	2,356	**2,356**	-	1,533	**1,533**
Total	**173,003**	**4,926**	**177,929**	**345,259**	**4,374**	**349,633**

5.2 Future minimum lease payments

Parent

	2019/20			2018/19		
	Buildings £000	Other £000	Total £000	Buildings £000	Other £000	Total £000
Payable:						
No later than one year	37,792	523	**38,315**	37,340	930	**38,270**
Between one and five years	61,285	211	**61,496**	56,394	234	**56,628**
After five years	7,161	-	**7,161**	3,414	-	**3,414**
Total	**106,238**	**734**	**106,972**	**97,148**	**1,164**	**98,312**

Consolidated Group

	2019/20			2018/19		
	Buildings £000	Other £000	Total £000	Buildings £000	Other £000	Total £000
Payable:						
No later than one year	60,296	1,075	**61,371**	79,819	1,613	**81,432**
Between one and five years	119,605	1,117	**120,722**	138,658	856	**139,514**
After five years	43,604	12	**43,616**	35,838	-	**35,838**
Total	**223,505**	**2,204**	**225,709**	**254,315**	**2,469**	**256,784**

6. Property, plant and equipment

Parent 2019/20	Buildings excluding dwellings £000	Assets under construction and payments on account £000	Plant & machinery £000	Transport equipment £000	Information technology £000	Furniture & fittings £000	Total £000
Cost or valuation at 1 April 2019	**221**	**-**	**1,030**	**629**	**679,831**	**8,853**	**690,564**
Additions purchased	-	-	-	13	194,439	109	**194,561**
Reclassifications	-	-	-	(19)	212	-	**193**
Disposals	-		(105)	(32)	(69,994)	(1,142)	**(71,273)**
Cost or valuation at 31 March 2020	**221**	**-**	**925**	**591**	**804,488**	**7,820**	**814,045**
Depreciation 1 April 2019	**82**	**-**	**487**	**63**	**292,560**	**4,165**	**297,357**
Disposals	-	-	(105)	(32)	(69,993)	(1,142)	**(71,272)**
Charged during the year	44	-	185	196	131,228	1,682	**133,335**
At 31 March 2020	**126**	**-**	**567**	**227**	**353,795**	**4,705**	**359,420**
Carrying Value at 31 March 2020	**95**	**-**	**358**	**364**	**450,693**	**3,115**	**454,625**
Asset financing:							
Owned	95	-	358	364	450,693	3,115	**454,625**
Total at 31 March 2020	**95**	**-**	**358**	**364**	**450,693**	**3,115**	**454,625**

Parent 2018/19	Buildings excluding dwellings £000	Assets under construction and payments on account £000	Plant & machinery £000	Transport equipment £000	Information technology £000	Furniture & fittings £000	Total £000
Cost or valuation at 1 April 2018	**404**	**-**	**1,062**	**211**	**551,866**	**7,510**	**561,053**
Additions purchased	-	-	-	418	155,610	1,655	**157,683**
Reclassifications	(183)	-	(32)	-	280	-	**65**
Disposals	-	-	-	-	(27,925)	(312)	**(28,237)**
Cost or valuation at 31 March 2019	**221**	**-**	**1,030**	**629**	**679,831**	**8,853**	**690,564**
Depreciation 1 April 2018	**38**	**-**	**289**	**23**	**206,963**	**3,183**	**210,496**
Reclassifications	-	-	-	-	-	-	**-**
Disposals	-	-	-	-	(27,925)	(312)	**(28,237)**
Charged during the year	44	-	198	40	113,522	1,294	**115,098**
At 31 March 2019	**82**	**-**	**487**	**63**	**292,560**	**4,165**	**297,357**
Carrying Value at 31 March 2019	**139**	**-**	**543**	**566**	**387,271**	**4,688**	**393,207**
Asset financing:							
Owned	139	-	543	566	387,271	4,688	**393,207**
Total at 31 March 2019	**139**	**-**	**543**	**566**	**387,271**	**4,688**	**393,207**

6. Property, plant and equipment

Consolidated Group 2019/20	Buildings excluding dwellings £000	Assets under construction and payments on account £000	Plant & machinery £000	Transport equipment £000	Information technology £000	Furniture & fittings £000	Total £000
Cost or valuation at 1 April 2019	**2,219**	**530**	**17,127**	**742**	**751,611**	**19,965**	**792,194**
Addition of assets under construction and payments on account	-	(78)	-	-	-	-	**(78)**
Additions purchased	693	-	5	13	199,324	793	**200,828**
Reclassifications	(250)	-	-	(19)	212	250	**193**
Disposals	-	(25)	(6,363)	(42)	(72,092)	(1,634)	**(80,156)**
Cost or valuation at 31 March 2020	**2,662**	**427**	**10,769**	**694**	**879,055**	**19,374**	**912,981**
Depreciation 1 April 2019	**592**	**-**	**10,741**	**176**	**336,052**	**10,954**	**358,515**
Reclassifications	(100)	-	6	-	(135)	169	**(60)**
Disposals	-	-	(4,526)	(42)	(71,720)	(1,634)	**(77,922)**
Charged during the year	152	-	1,349	196	141,332	2,959	**145,988**
At 31 March 2020	**644**	**-**	**7,570**	**330**	**405,529**	**12,448**	**426,521**
Carrying Value at 31 March 2020	**2,018**	**427**	**3,199**	**364**	**473,526**	**6,926**	**486,460**
Asset financing:							
Owned	2,018	427	2,518	364	473,526	6,926	**485,779**
Held on finance lease	-	-	681	**-**	**-**	**-**	**681**
Total at 31 March 2020	**2,018**	**427**	**3,199**	**364**	**473,526**	**6,926**	**486,460**

Consolidated Group 2018/19	Buildings excluding dwellings £000	Assets under construction and payments on account £000	Plant & machinery £000	Transport equipment £000	Information technology £000	Furniture & fittings £000	Total £000
Cost or valuation at 1 April 2018	**2,567**	**312**	**17,223**	**327**	**613,141**	**17,156**	**650,726**
Addition of assets under construction and payments on account	-	65	-	-	-	-	**65**
Additions purchased	14	-	35	418	167,581	2,964	**171,012**
Reclassifications	(362)	293	(32)	-	(9)	157	**47**
Disposals	-	(140)	(99)	(3)	(28,854)	(312)	**(29,408)**
Impairments charged	-	-	-	-	(248)	-	**(248)**
Cost or valuation at 31 March 2019	**2,219**	**530**	**17,127**	**742**	**751,611**	**19,965**	**792,194**
Depreciation 1 April 2018	**394**	**-**	**8,951**	**139**	**242,425**	**8,446**	**260,355**
Reclassifications	(11)	-	-	-	(26)	35	**(2)**
Disposals	-	-	(67)	(3)	(28,854)	(313)	**(29,237)**
Impairments charged	-	-	-	-	(44)	337	**293**
Charged during the year	209	-	1,857	40	122,551	2,449	**127,106**
At 31 March 2019	**592**	**-**	**10,741**	**176**	**336,052**	**10,954**	**358,515**
Carrying Value at 31 March 2019	**1,627**	**530**	**6,386**	**566**	**415,559**	**9,011**	**433,679**
Asset financing:							
Owned	1,627	530	5,620	566	415,559	9,011	**432,913**
Held on finance lease	-	-	766	-	**-**	**-**	**766**
Total at 31 March 2019	**1,627**	**530**	**6,386**	**566**	**415,559**	**9,011**	**433,679**

7. Intangible non-current assets

Parent 2019/20

	Computer software: purchased £000	Licences and trademarks £000	Development expenditure (internally generated) £000	Total £000
Cost or valuation at 1 April 2019	**7,483**	**8**	**1,908**	**9,399**
Additions purchased	1,672	-	563	**2,235**
Reclassifications	(193)	-	-	**(193)**
Disposals	(760)	(8)	(349)	**(1,117)**
At 31 March 2020	**8,202**	**-**	**2,122**	**10,324**
Amortisation 1 April 2019	**5,197**	**8**	**678**	**5,883**
Reclassifications	-	-	-	**-**
Disposals	(760)	(8)	(349)	**(1,117)**
Charged during the year	1,037	-	371	**1,408**
At 31 March 2020	**5,474**	**-**	**700**	**6,174**
Carrying Value at 31 March 2020	**2,728**	**-**	**1,422**	**4,150**
Asset financing:				
Owned	2,728	-	1,422	**4,150**
Total at 31 March 2020	**2,728**	**-**	**1,422**	**4,150**

Parent 2018/19

	Computer software: purchased £000	Licences and trademarks £000	Development expenditure (internally generated) £000	Total £000
Cost or valuation at 1 April 2018	**15,466**	**8**	**1,973**	**17,447**
Additions purchased	1,027	-	-	**1,027**
Reclassifications	-	-	(65)	**(65)**
Disposals	(9,010)	-	-	**(9,010)**
At 31 March 2019	**7,483**	**8**	**1,908**	**9,399**
Amortisation 1 April 2018	**12,208**	**8**	**374**	**12,590**
Reclassifications	-	-	-	**-**
Disposals	(9,010)	-	-	**(9,010)**
Charged during the year	1,999	-	304	**2,303**
At 31 March 2019	**5,197**	**8**	**678**	**5,883**
Carrying Value at 31 March 2019	**2,286**	**-**	**1,230**	**3,516**
Asset financing:				
Owned	2,286	-	1,230	**3,516**
Total at 31 March 2019	**2,286**	**-**	**1,230**	**3,516**

Consolidated Group 2019/20

	Computer software: purchased £000	Licences and trademarks £000	Development expenditure (internally generated) £000	Total £000
Cost or valuation at 1 April 2019	**17,799**	**8**	**3,544**	**21,351**
Additions purchased	3,255	-	562	**3,817**
Reclassifications	(193)	-	-	**(193)**
Disposals	(1,199)	(8)	(349)	**(1,556)**
At 31 March 2020	**19,662**	**-**	**3,757**	**23,419**
Amortisation 1 April 2019	**11,305**	**8**	**1,423**	**12,736**
Reclassifications	60	-	-	**60**
Disposals	(1,198)	(8)	(349)	**(1,555)**
Charged during the year	2,737	-	600	**3,337**
At 31 March 2020	**12,904**	**-**	**1,674**	**14,578**
Carrying Value at 31 March 2020	**6,758**	**-**	**2,083**	**8,841**
Asset financing:				
Owned	6,758	-	2,083	**8,841**
Total at 31 March 2020	**6,758**	**-**	**2,083**	**8,841**

Consolidated Group 2018/19

	Computer software: purchased £000	Licences and trademarks £000	Development expenditure (internally generated) £000	Total £000
Cost or valuation at 1 April 2018	**25,179**	**8**	**3,609**	**28,796**
Additions purchased	1,826	-	-	**1,826**
Reclassifications	18	-	(65)	**(47)**
Disposals	(9,224)	-	-	**(9,224)**
Upward revaluation gains	-	-	-	-
Impairments charged	-	-	-	**-**
At 31 March 2019	**17,799**	**8**	**3,544**	**21,351**
Amortisation 1 April 2018	**16,647**	**8**	**885**	**17,540**
Reclassifications	2	-	-	**2**
Disposals	(9,224)	-	-	**(9,224)**
Charged during the year	3,880	-	538	**4,418**
At 31 March 2019	**11,305**	**8**	**1,423**	**12,736**
Carrying Value at 31 March 2019	**6,494**	**-**	**2,121**	**8,615**
Asset financing:				
Owned	6,494	-	2,121	**8,615**
Total at 31 March 2019	**6,494**	**-**	**2,121**	**8,615**

8. Trade and other receivables

	Parent				Consolidated Group			
	Current 2019/20 £000	Non-current 2019/20 £000	Current 2018/19 £000	Non-current 2018/19 £000	Current 2019/20 £000	Non-current 2019/20 £000	Current 2018/19 £000	Non-current 2018/19 £000
NHS receivables: Revenue	51,410	-	48,684	-	90,593	-	100,583	-
NHS prepayments	2,614	-	10,805	-	215,704	-	217,589	-
NHS accrued income	24,446	-	17,477	-	94,844	-	120,132	-
NHS Non Contract	-	-	-	-	7,175	-	3,415	-
NHS Contract Assets	-	-	-	-	500	-	485	-
Non-NHS and Other WGA receivables: Revenue	36,956	-	34,813	-	218,646	326	251,116	326
Non-NHS and Other WGA prepayments	95,581	-	64,311	-	200,217	419	144,897	209
Non-NHS and Other WGA accrued income	39,623	-	23,638	-	127,198	-	98,634	-
Non-NHS and Other WGA Non Contract	-	-	-	-	8,590	-	8,085	-
Non-NHS Contract Assets	-	-	-	-	264	-	201	-
Expected credit loss allowance-receivables	(3,546)	-	(3,391)	-	(18,333)	-	(20,289)	-
VAT	11,663	-	8,962	-	24,584	-	24,113	-
Other receivables and accruals	1,600	-	1,624	-	20,161	2	17,321	3
Total	**260,347**	**-**	**206,923**	**-**	**990,143**	**747**	**966,282**	**538**
Other financial assets	-	-	-	-	-	1,554	-	554
Total current and non current	**260,347**		**206,923**		**992,444**		**967,374**	

9. Cash and cash equivalents

	Parent		Consolidated Group	
	2019/20	2018/19	2019/20	2018/19
	£000	£000	£000	£000
Balance at 1 April 2019	188,941	144,765	196,694	163,096
Net change in year	(37,258)	44,176	(42,409)	33,598
Balance at 31 March 2020	**151,683**	**188,941**	**154,285**	**196,694**
Made up of:				
Cash with the Government Banking Service	129,609	96,978	148,903	113,253
Cash with Commercial banks	-	-	-	-
Hosted cash/cash in hand	21,354	89,810	21,615	90,082
Current investments	720	2,153	720	2,153
Cash and cash equivalents as in statement of financial position	**151,683**	**188,941**	**171,238**	**205,488**
Bank overdraft: Government Banking Service	-	-	(16,953)	(8,794)
Total bank overdrafts	**-**	**-**	**(16,953)**	**(8,794)**
Balance at 31 March 2020	**151,683**	**188,941**	**154,285**	**196,694**

For details of bank overdraft see note 10.

Included within hosted cash/cash in hand above is £21.3m (2018/19 £89.8m) held on behalf of NHS England by the NHS Business Services Authority.

Current investments within cash and cash equivalents include cash held in solicitor commercial escrow accounts that is not available for use by the group.

10. Trade and other payables

	Parent				Consolidated Group			
	Current 2019/20 £000	Non-current 2019/20 £000	Current 2018/19 £000	Non-current 2018/19 £000	Current 2019/20 £000	Non-current 2019/20 £000	Current 2018/19 £000	Non-current 2018/19 £000
NHS payables: revenue	517,950	-	528,945	-	1,131,879	-	1,227,807	-
NHS payables: capital	24,488	-	15,368	-	43	-	767	-
NHS accruals	2,043,581	-	2,288,229	-	2,675,373	-	2,957,898	-
NHS deferred income	906	-	375	-	367	-	205	-
NHS contract liabilities	-	-	124	-	842	-	6,574	-
Non-NHS and other WGA payables: revenue	178,956	-	150,252	-	996,204	-	1,071,135	-
Non-NHS and other WGA payables: capital	56,611	-	43,860	-	61,151	-	47,608	-
Non-NHS and other WGA accruals	1,170,778	-	1,144,291	-	4,763,940	-	4,382,565	-
Non-NHS and other WGA deferred income	3,247	-	983	-	25,247	546	15,666	762
Non-NHS contract liabilities	-	-	2,125	-	-	-	2,125	-
Social security costs	9,936	-	7,693	-	24,891	-	21,912	-
VAT	-	-	-	-	51	-	375	-
Tax	21,236	-	20,190	-	34,523	-	33,796	-
Payments received on account	15	-	108	-	359	-	722	-
Other payables and accruals	408,102	26	324,461	26	1,076,517	813	820,780	2,850
Total	**4,435,806**	**26**	**4,527,004**	**26**	**10,791,387**	**1,359**	**10,589,935**	**3,612**
Other financial liabilities								
Bank overdraft - Government Banking Service	-	-	-	-	16,953	-	8,794	-
Finance lease liabilities	-	-	-	-	121	737	121	828
Other financial liabilities - other	-	-	-	-	-	89	-	95
Total	**-**	**-**	**-**	**-**	**17,074**	**826**	**8,915**	**923**
Total trade & other payables (current)	**4,435,806**		**4,527,004**		**10,808,461**		**10,598,850**	
Total trade & other payables (non-current)		**26**		**26**		**2,185**		**4,535**
Total trade & other payables (current and non-current)		**4,435,832**		**4,527,030**		**10,810,646**		**10,603,385**

11 Finance costs

	Parent		Consolidated Group	
	2019/20	2018/19	2019/20	2018/19
	£000	£000	£000	£000
Interest				
Interest on obligations under finance leases	-	-	34	36
Interest on late payment of commercial debt	-	-	-	12
Other interest expense	-	-	3	4
Total interest	**-**	**-**	**37**	**52**
Other finance costs	-	-	1	4
Provisions: unwinding of discount	(404)	533	(538)	588
Total finance costs	**(404)**	**533**	**(500)**	**644**

12 Provisions

Parent	Current 2019/20 £000	Non-current 2019/20 £000	Current 2018/19 £000	Non-current 2018/19 £000
Restructuring	576	-	576	-
Redundancy	-	-	-	-
Legal claims	65	149	978	945
Continuing care	13,480	63,000	21,853	-
Pensions Reimbursement	-	258000	-	-
Other	4,319	19,738	7,286	21,259
Total	**18,440**	**340,887**	**30,693**	**22,204**
Total current and non-current	**359,327**		**52,897**	

	Restructuring £000	Redundancy £000	Legal claims £000	Continuing care £000	Pensions Reimbursement £000	Other £000	Total £000
Balance at 1 April 2019	**576**	**-**	**1,923**	**21,853**	**-**	**28,545**	**52,897**
Arising during the year	-	-	149	70,775	258,000	3,077	**332,001**
Utilised during the year	-	-	(1,400)	(3,478)	-	(579)	**(5,457)**
Reversed unused	-	-	(416)	(12,589)	-	(6,540)	**(19,545)**
Unwinding of discount	-	-	(42)	(101)	-	(261)	**(404)**
Change in discount rate	-	-	-	20	-	(185)	**(165)**
Balance at 31 March 2020	**576**	**-**	**214**	**76,480**	**258,000**	**24,057**	**359,327**
Expected timing of cash flows:							
Within one year	576	-	65	13,480	-	4,319	**18,440**
Between one and five years	-	-	149	63,000	-	16,675	**79,824**
After five years	-	-	-	-	258,000	3,063	**261,063**
Balance at 31 March 2020	**576**	**-**	**214**	**76,480**	**258,000**	**24,057**	**359,327**

Consolidated Group	2019/20 £000	2019/20 £000	2018/19 £000	2018/19 £000
Restructuring	1,200	-	1,395	-
Redundancy	4,421	30	1,696	-
Legal claims	1,513	149	3,525	945
Continuing care	48,227	71,857	64,730	8,603
Pensions Reimbursement	-	258,000	-	-
Other	50,442	36,081	63,736	32,338
Total	**105,803**	**366,117**	**135,082**	**41,886**
Total current and non-current	**471,920**		**176,968**	

	Restructuring £000	Redundancy £000	Legal claims £000	Continuing care £000	Pensions Reimbursement £000	Other £000	Total £000
Balance at 1 April 2019	**1,395**	**1,696**	**4,470**	**73,333**	**-**	**96,074**	**176,968**
Arising during the year	478	4,099	952	96,341	258,000	39,543	**399,413**
Utilised during the year	(538)	(1,083)	(2,280)	(15,170)	-	(15,837)	**(34,908)**
Reversed unused	(135)	(261)	(1,438)	(34,303)	-	(32,599)	**(68,736)**
Unwinding of discount	-	-	(42)	(26)	-	(470)	**(538)**
Change in discount rate	-	-	-	(91)	-	(188)	**(279)**
Balance at 31 March 2020	**1,200**	**4,451**	**1,662**	**120,084**	**258,000**	**88,523**	**471,920**
Expected timing of cash flows:							
Within one year	1,200	4,421	1,513	48,227	-	50,442	**105,803**
Between one and five years	-	30	149	71,857	-	31,943	**103,979**
After five years	-	-	-	-	258,000	4,138	**262,138**
Balance at 31 March 2020	**1,200**	**4,451**	**1,662**	**120,084**	**258,000**	**86,523**	**471,920**

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

The pensions reimbursement provision in 19/20 in the parent is £258m for the commitment to pay clinicians in the NHS Pension Scheme for the effect of the 2019/20 Scheme Pays deduction on their income from the NHS Pension Scheme in retirement, in line with the ministerial direction to DHSC and NHS England.

Other provisions in both the parent and the group is primarily provisions for pension disputes and dilapidations.

The NHS Resolution financial statements disclose a provision of £44,484,845 as at 31 March 2020 in respect of clinical negligence liabilities and employment liability scheme of NHS England (31 March 2019: £47,605,694).

13. Contingencies

	Parent		Consolidated Group	
	2019/20	2018/19	2019/20	2018/19
	£000	£000	£000	£000
Contingent liabilities				
Employment tribunal	39	276	39	411
NHS Resolution employee liability claim	10	14	28	18
Continuing healthcare	-	-	12,302	14,581
Legal claims	7,994	8,966	7,994	8,966
Legacy Pension issues	10,000	-	10,000	-
Her Majesty's Revenue and Customs	-	-	8,543	1,794
West Wakefield Health and Wellbeing Ltd potential VAT liability	-	-	-	685
Other	-	-	4,115	1,150
Total value of contingent liabilities	**18,043**	**9,256**	**43,021**	**27,605**

	Parent		Consolidated Group	
	2019/20	2018/19	2019/20	2018/19
	£000	£000	£000	£000
Contingent assets				
Legal cases	1,079	4,424	1,079	4,424
Employee pension issues	135	-	135	-
Potential rate rebates	-	-	-	532
Total value of contingent assets	**1,214**	**4,424**	**1,214**	**4,956**

Contingent liabilities are those for which provisions have not been recorded as there is a possible obligation depending on uncertain future events, or a present obligation where payment is not probable or the amount cannot be measured reliably. Contingent assets are those where a possible asset arises from a past event and whose existence will be confirmed only by the occurrence or non occurrence of an uncertain future event not wholly within the control of the entity. These are disclosed only when the inflow of economic benefit is probable.

14. Commitments

14.1 Capital commitments

	Parent		Consolidated Group	
	2019/20	2018/19	2019/20	2018/19
	£000	£000	£000	£000
Property, plant and equipment	32,366	16,351	32,366	16,455
Total	**32,366**	**16,351**	**32,366**	**16,455**

14.2 Other financial commitments

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

	Parent		Consolidated Group	
	2019/20	2018/19	2019/20	2018/19
	£000	£000	£000	£000
In not more than one year	251,889	190,150	370,689	266,785
In more than one year but not more than five years	339,917	528,346	477,432	616,174
In more than five years	-	-	72,393	74,819
Total	**591,806**	**718,496**	**920,514**	**957,778**

In the parent account the most significant contracts relate to:
a) contract with Capita for the delivery of administration services for Primary Care
b) PET Scanner contract with Alliance Medical
c) Care UK contract for Prison Healthcare

Excluding the largest parent financial commitments already disclosed, the most significant other group commitments relate to:
a) An indemnity given by NHS Trafford CCG to NHS Property Services in relation to the Altrincham Hub

15. Financial instruments

15.1 Financial risk management

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

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

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

15.1.1 Currency risk

NHS England is principally a domestic organisation with the great majority of transactions, assets and liabilities being in the UK and sterling based.

NHS England has no overseas operations. NHS England therefore has low exposure to currency rate fluctuations.

15.1.2 Interest rate risk

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

15.1.3 Credit risk

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

15.1.4 Liquidity risk

NHS England is required to operate within revenue and capital resource limits, which are financed from resources voted annually by Parliament.

NHS England draws down cash to cover expenditure, as the need arises. NHS England is not, therefore, exposed to significant liquidity risks.

15.1.5 Financial instruments

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

16. Operating segments

Consolidated Group 2019/20	CCGs £000	Direct commissioning £000	NHS England £000	Other £000	Intra-group eliminations £000	NHS England group total £000
Income	(843,991)	(1,477,466)	(35,571)	(508,112)	713,344	**(2,151,796)**
Gross expenditure	91,073,569	26,970,886	6,919,943	1,148,060	(713,344)	**125,399,114**
Total net expenditure	**90,229,578**	**25,493,420**	**6,884,372**	**639,948**	**-**	**123,247,318**
Revenue resource expenditure						
Revenue departmental expenditure						122,890,421
Annually managed expenditure						294,699
Technical expenditure						62,198
Net operating expenditure for the financial year						**123,247,318**
Reconciliation back to SoCNE						
Total net expenditure for the year						123,247,318
Net (gain)/loss on revaluation of intangibles						-
Movements in other reserves						-
Retained Net Operating Costs for the Financial Year						**123,247,318**

Consolidated Group 2018/19	CCGs £000	Direct commissioning £000	NHS England £000	Other £000	Intra-group eliminations £000	NHS England group total £000
Income	(851,031)	(1,462,807)	(54,286)	(485,519)	749,434	**(2,104,209)**
Gross expenditure	85,415,387	25,984,756	3,826,387	493,023	(749,434)	**114,970,119**
Total net expenditure	**84,564,356**	**24,521,949**	**3,772,101**	**7,504**	**-**	**112,865,910**
Revenue resource expenditure						
Revenue departmental expenditure						112,836,816
Annually managed expenditure						(19,405)
Technical expenditure						48,499
Total net expenditure						**112,865,910**
Reconciliation back to SoCNE						
Total net expenditure for the year						112,865,910
Net (gain)/loss on revaluation of intangibles						-
Actuarial (gain)/loss in pension schemes						871
Comprehensive net expenditure for the year						**112,866,781**

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

The activities of each segment are defined as follows:-
Clinical Commissioning Groups - clinically led groups that are responsible for commissioning healthcare services as defined in the Health and Social Care Act 2012.
Direct Commissioning - the services commissioned by NHS England (via Local Offices and Specialised Commissioning Hubs) as defined in the Health and Social Care Act 2012.
NHS England - the central administration of the organisation and centrally managed programmes.
Other - includes commissioning support units, national reserves, technical accounting items and legacy balances.

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

17. Related party transactions

Related party transactions associated with the Parent are disclosed within this note. As disclosed in note 1.3 NHS England acts as the parent to 191 CCGs whose accounts are consolidated within these Financial Statements. These bodies are regarded as related parties with which the Parent has had various material transactions during the year; those transactions are disclosed in those entities' financial statements.

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

For example:

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

In addition, NHS England has had a number of significant transactions with other government departments and their agencies including HMRC, Ministry of Justice and Her Majesty's Prison and Probation Service. No related party transactions were noted with key management personnel other than the compensation paid to them which can be found in the remuneration report from page 97.

18. Events after the end of the reporting period

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

From 1 April 2019 a further 10 CCGs will commence delegated comissioning arrangements, taking the total number operating under the initiative to 184.

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

19. Financial performance targets

The Mandate: A mandate from the Government to NHS England: April 2019 to March 2020 published by the Secretary of State under section 13A of the National Health Service Act 2006, and the associated Financial Directions as issued by the Department of Health & Social Care, set out NHS England's total revenue resource limit and total capital resource limit for 2019/20 and certain additional expenditure controls to which NHS England must adhere. These stem from budgetary controls that HM Treasury applies to DHSC. These limits were revised in March 2020 and NHS England's performance against those limits is set out in the table below:

	2019/20						2018/19
	Revenue departmental expenditure limit			Annually-managed expenditure	Technical	Total	Total
	Non-ringfenced £000	Ringfenced £000	Total RDEL £000	£000	£000	£000	£000
Mandate limit	123,376,909	166,000	123,542,909	325,000	200,000	124,067,909	114,086,948
Actual expenditure	122,741,096	149,325	122,890,421	294,699	62,198	123,247,318	112,865,910
Surplus	**635,813**	**16,675**	**652,488**	**30,301**	**137,802**	**820,591**	**1,221,038**
Remove COVID-19 expenditure	360,143	-	360,143	-	-	360,143	
Revised Surplus / (Deficit)	**995,956**	**16,675**	**1,012,631**	**30,301**	**137,802**	**1,180,734**	

	2019/20 Capital resource limit £000	2018/19 Capital resource limit £000
Limit	260,000	254,000
Actual expenditure	264,528	221,232
Surplus	(4,528)	32,768
Remove COVID-19 expenditure	9,790	
Revised Surplus / (Deficit)	**5,262**	

NHS England is required to spend no more than £1,874,000,000 of its Revenue Departmental Expenditure Limit mandate on matters relating to administration in the full year. The actual amount spent on RDEL administration matters to 31st March 2020 was £1,623,112,830 as set out below:

Administration limit:	**2019/20 £000**	**2018/19 £000**
Net administration costs before interest	1,625,677	1,589,925
Less:		
Administration expenditure covered by AME/Technical funding	(2,564)	(2,077)
Administration costs relating to RDEL	1,623,113	1,587,848
RDEL Administration expenditure limit	1,874,000	1,820,561
Underspend	**250,887**	**232,713**

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

Annually Managed Expenditure budgets are set by HM Treasury and may be reviewed with departments in the run-up to the Budget. Departments must manage AME closely and inform HM Treasury if they expect AME to rise above forecast. Any increase requires Treasury approval. There are clear rules governing the classification of certain types of expenditure as Annually Managed Expenditure or Departmental Expenditure Limit.

20. Entities within the Consolidated Group

NHS England acts as the Parent of the group comprising 191 CCGs (2018/19: 195 CCGs) whose accounts are consolidated within these Financial Statements.

From the 1st of April 2020 this became 135 clinical commissioning groups with the merger of 74 CCGs creating 18 new CCGs as per the below:

Merging CCGs	New CCGs
NHS Bath and North East Somerset CCG NHS Swindon CCG NHS Wiltshire CCG	NHS Bath and North East Somerset, Swindon and Wiltshire CCG
NHS Airedale, Wharfedale and Craven CCG NHS Bradford City CCG NHS Bradford Districts CCG	NHS Bradford District and Craven CCG
NHS Eastern Cheshire CCG NHS South Cheshire CCG NHS Vale Royal CCG NHS West Cheshire CCG	NHS CHESHIRE CCG
NHS Durham Dales, Easington and Sedgfield CCG NHS North Durham CCG	NHS COUNTY DURHAM CCG
NHS Hastings and Rother CCG NHS High Weald Lewes Havens CCG NHS Eastbourne Hailsham and Seaford CCG	NHS EAST SUSSEX CCG
NHS Herefordshire CCG NHS Redditch and Bromsgrove CCG NHS South Worcestershire CCG NHS Wyre Forest CCG	NHS HEREFORDSHIRE AND WORCESTERSHIRE CCG
NHS Ashford CCG NHS Canterbury and Coastal CCG NHS Dartford, Gravesham and Swanley CCG NHS Medway CCG NHS South Kent Coast CCG NHS Swale CCG NHS Thanet CCG NHS West Kent CCG	NHS KENT AND MEDWAY CCG
NHS Lincolnshire East CCG NHS Lincolnshire West CCG NHS South Lincolnshire CCG NHS South West Lincolnshire CCG	NHS LINCOLNSHIRE CCG
NHS Great Yarmouth and Waveney CCG NHS North Norfolk CCG NHS West Norfolk NHS South Norfolk CCG NHS Norwich CCG	NHS NORFOLK & WAVENEY CCG
NHS Barnet CCG NHS Camden CCG NHS Enfield CCG NHS Haringey CCG NHS Islington CCG	NHS NORTH CENTRAL LONDON CCG

Merging CCGs	New CCGs
NHS Hambleton, Richmondshire and Whitby CCG NHS Scarborough and Ryedale CCG NHS Harrogate and Rural District CCG	NHS NORTH YORKSHIRE CCG
NHS Corby CCG NHS Nene CCG	NHS NORTHAMPTONSHIRE CCG
NHS Mansfield and Ashfield CCG NHS Newark and Sherwood CCG NHS Nottingham City CCG NHS Nottingham North and East CCG NHS Nottingham West CCG NHS Rushcliffe CCG	NHS NOTTINGHAM AND NOTTINGHAMSHIRE CCG
NHS Bexley CCG NHS Bromley CCG NHS Greenwich CCG NHS Lambeth CCG NHS Lewisham CCG NHS Southwark CCG	NHS SOUTH EAST LONDON CCG
NHS Croydon CCG NHS Kingston CCG NHS Richmond CCG NHS Merton CCG NHS Sutton CCG NHS Wandsworth CCG	NHS SOUTH WEST LONDON CCG
NHS Guildford and Waverley CCG NHS North West Surrey CCG NHS Surrey Downs CCG NHS East Surrey CCG	NHS SURREY HEARTLANDS CCG
NHS Darlington CCG NHS Hartlepool and Stockton-on-Tees CCG NHS South Tees CCG	NHS TEES VALLEY CCG
NHS Coastal West Sussex CCG NHS Crawley CCG NHS Horsham and Mid Sussex CCG	NHS WEST SUSSEX CCG

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

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

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

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

Appendices

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

The Government's mandate to NHS England sets the strategic direction for NHS England, describes the Government's healthcare priorities and the contribution NHS England and NHS Improvement are expected to make within the allocated budget. It also helps to ensure the NHS is held accountable to Parliament and the public.

For 2019/20, in line with the NHS Long Term Plan and ever closer joint working between our organisations, the NHS England mandate and NHS Improvement remit letter have been combined into a single Accountability Framework. The 2019/20 Accountability Framework set out deliverables against two overarching objectives – ensuring the effective delivery of the NHS Long Term Plan and supporting Government in managing the efforts of EU exit on health and care. 68 specific deliverables were set out alongside these overarching objectives in an annex to the mandate.

Towards the end of the reporting year, the Level 4 National Incident, declared as a result of COVID-19, fundamentally transformed the way in which the NHS operated. As such, a number of deliverables from the Accountability Framework were reprioritised and, in some cases, updated or redefined as part of the COVID-19 response. Despite this, the NHS response to the emergency has continued to demonstrate the dedication and resilience of the NHS and its staff to continue to deliver in many priority areas. Across the country, thousands of staff offered to return to the NHS to support with the COVID-19 frontline response. Actions taken by the NHS to increase capacity meant there have been enough beds and respiratory support to respond to demand.

This assessment of performance against the Accountability Framework therefore captures our broad assessment of performance before the incident was declared, using assessments made during the year, and agreed between NHS England and NHS Improvement policy teams and their counterparts in DHSC.

In summary, NHS England and NHS Improvement were on track to deliver 90% of its commitments in the 2019/20 Accountability Framework with 4% considered to be off track. The remaining deliverables were either superseded by other commitments in-year or it has not been possible to assess performance because of the response to COVID-19.

Objective 1: Ensure the effective delivery of the NHS Long Term Plan

1a) Laying the foundations for successful implementation of the NHS Long Term Plan

- In June 2019, NHS England and NHS Improvement published both the Interim People Plan and the NHS Long Term Plan Implementation Framework, which marked the first phase in the development of an NHS workforce implementation strategy. Following publication, NHS England and NHS Improvement oversaw strategic planning within each STP and ICS across England. Each system produced a locally-owned, clinically-led NHS Long Term

Plan implementation plan which specified their approach to meet all NHS Long Term Plan commitments and meet the Government's five financial tests. The overarching National Implementation Plan was halted as a result of COVID-19, but locally-owned, clinically led plans will be crucial when planning the recovery from the pandemic.

- NHS England and NHS Improvement worked closely with the Government to develop the National Implementation Plan and the NHS People Plan. The significant amount of work undertaken by NHS England and NHS Improvement, Health Education England and the DHSC prior to the COVID-19 incident allowed a number of the anticipated People Plan commitments to be accelerated to grow and transform the workforce and potentially capture long lasting cultural change. Specific elements that have been accelerated include:
  - An enhanced staff health and wellbeing offer, including targeted support for our BAME and most vulnerable staff, and opportunities for flexible and remote working (as outlined in the 'Making the NHS the best place to work' chapter);
  - Enhanced and expanded roles to allow staff to work beyond traditional boundaries e.g. to support critical care units (as outlined in the 'Accelerating workforce redesign' chapter); and
  - Digital transformation of outpatient appointments (as set out in the 'Releasing time for care' chapter).

  These principles will underpin effective COVID-19 recovery planning while helping deliver longer term service goals.

1b) Achieving financial balance

- The NHS has started to put down the foundations of financial sustainability, with the number of NHS providers reporting a deficit falling by half. We welcome the Government's announcement of a clean slate for trusts, writing off £13.4 billion in debts.
- NHS England and NHS Improvement were on course to deliver against their responsibilities to achieve financial balance across the system at mid-year including delivery of cash-releasing productivity gains of 1.1%. However, the impact of COVID-19 meant that reporting on cash-releasing productivity was suspended.
- The impact of COVID-19 has significantly impacted our ability to accurately assess delivery of cash releasing productivity gains and we are working with the department to assess how this should be captured.
- As the whole health and care system mobilised to respond to the challenge of COVID-19, this gave rise to a financial impact in the final months of 2019/20.
- Assessment for the reporting period pre-COVID-19, provides assurance that NHS England and NHS Improvement met their responsibility to achieve broad financial balance in the NHS over the reporting period and was within funding limits.
- NHS England and NHS Improvement have maintained their commitment to the Better Care Fund. Planning requirements were published in July 2019 along with allocations of the £3.84 billion NHS contribution. Plans from local areas were submitted at the end of September followed by an assurance process.

1c) Maintaining and improving performance, and improving the quality and safety of services

- 2019/20 was the start of the transition towards outcomes set out in the interim report on the clinically-led review of NHS access standards (published in March 2019). However, in light of continued increase in demand, meeting all core standards has been challenging. By January 2020, demand for A&E increased by 4% to reach 21,515,736 compared to 2019. More people were seen for urgent investigation of possible cancer (2,161,761 compared to 2,025,491 in 2019). Despite this the NHS managed to reduce the proportion of people waiting more than 52 weeks for treatment by 24% reaching 1,643 in January 2020 (compared to 2,169 in January 2019).
- COVID-19 had an unprecedented impact towards the end of the reporting year. The pandemic reversed progress on people waiting 52+ weeks for treatment, with 3,097 people waiting for treatment by the end of March 2020, mainly due to the postponement of non-urgent elective activity. By March 2020, the total number of people treated in A&E reached 1,531,800, a 29% reduction compared to the previous year. 181,873 people were referred for urgent investigation of possible cancer which represented a 7% reduction compared to March 2019.
- NHS England and NHS Improvement are working with DHSC to address these issues and will review performance measures through the Clinical Review of Standards to reflect the impact COVID-19 has had.
- The Clinical Review of Standards was commissioned to review NHS England's performance standards and recommend any updates and improvements to these standards. Following the publication of its interim report, NHS England and NHS Improvement began testing across all standards and progress was made in understanding the impact of the proposals to help determine possible approaches for national implementation. However, the COVID-19 response has meant plans for the publication of the findings so far and further consultation are currently postponed. This will consequently lead to an extraordinary increase in demand and the Clinical Review of Standards will need revisiting to ensure they reflect the transformation of the system.
- The COVID-19 response has disrupted our delivery but has also fast-tracked the re-design of outpatient care. Our hospitals have transformed, and we have accelerated the use of technology in GP surgeries, mental health services and hospital clinics. General practice has made changes on a remarkable scale in response to COVID-19, from a system which carried out most of its work face-to-face to providing most services remotely. Video consultations are now available in 99% of practices (from only 5% pre-COVID-19), covering 99% of the population – this is based on data from suppliers combined with intelligence gathered from practices and clinicians. The availability of online consultations in general practice grew very rapidly in 2020 in response to the COVID-19 pandemic. Online consultations are now available in more than 90% of practices, a rise from approximately 40% in March 2020. As part of the second phase of COVID-19 recovery, we are working with systems to resume non-COVID-19 urgent services. Our focus will remain on improving patient flow so that patients are seen, treated and discharged safely and quickly.

1d) Establishing a joint NHS England and NHS Improvement operating model to deliver integrated system leadership of the NHS

- NHS England and NHS Improvement have successfully been brought more closely together to deliver a new model of joint working strengthening their ability to support the NHS and improving its focus on the delivery of the NHS Long Term Plan.
- The implementation of the new operating model, with seven integrated regional teams, has started to deliver improvements. These seven integrated regions now have a "single conversation" with commissioners and providers – hitherto organisations sometimes received different messages. This has enabled regions to take a more holistic view of the use of NHS resources and of the support required to improve quality of care and health outcomes.
- In turn, this has helped local health and care organisations to work together and to develop integrated care systems, which now cover half of the country by population and provide more joined up care for service users – working across the NHS, local government and the voluntary sector – with a stronger focus on improving the health of populations. This partnership approach to delivering care, preventing illness and improving health has accelerated during the COVID-19 pandemic, with staff working across institutional and professional boundaries to provide services to their communities.

Objective 2: Support Government in managing the effects of EU Exit on health and care

- NHS England and NHS Improvement effectively prepared for EU Exit, with a particular focus on readying the system for a 'no deal' EU Exit. The NHS was in a good position of readiness, despite many factors being out of our control and the reliance on contingency plans being put in place by other government departments.
- NHS England and NHS Improvement have regularly input into the DHSC preparations for EU Exit, focussing on the following key areas:
  - Testing and contributing to DHSC contingency plans to consider NHS-specific impacts
  - Making ready the health and care system by increasing alignment of the National Coordination Centre (NCC) and the National Supply Disruption Response (NSDR), and extensively engaging with the NHS.
  - Assurance of high level of system preparation by revising "baseline" assurance exercise to re-assess levels of organisational preparedness.
  - Transition to incident response with hours of operation extended, daily data reporting and a new tiered escalation model of clinical advice with seven 'shortage response groups' of subject matter experts and clinicians in place.

Appendix 2: Public and patient contact and complaints

It is important that the NHS listens to our patients, carers and customers in order to make improvements to services. It is important that we make the experience of complaining and providing feedback as easy as possible and that the experience is a positive one.

Throughout 2019/20 we have undertaken the following activities to improve our own and the wider NHS' complaint handling and learning from customer feedback:

- We provided complaints handling training to around 450 dentists, GPs and practice managers across primary care in locations throughout England to universally positive feedback.
- Following the publication of a toolkit for surveying complainants in the previous year, the survey was rolled out across NHS England. Regular thematic reports identifying learning from the surveys have been shared with our regional teams to help them understand where our service could be improved.
- The peer review process for all regions was completed and an external review of the process was undertaken. The feedback was very positive, and we are using that information to undertake another round of reviews throughout 2020/21.
- We continue to learn from complaints. We have completed a national and local review of complaints to help identify themes and trends from the complaints NHS England has handled. This information has then been shared internally and with CCGs. The aim of this work is to use the information from complaints to influence our policy and commissioning decisions and help drive improvements.
- We have worked with the professional regulators on a number of initiatives to improve the quality of complaints handling.

Action for the year ahead includes:

- Providing more complaints training to GPs, dentists and practice staff.
- Expanding and developing our learning from complaints work, through working with appropriate stakeholders.
- Work with the Parliamentary and Health Service Ombudsman as they develop their Complaints Standard Framework, supporting primary care and our own regional complaints teams to assess the impact of the Framework on complaints handling.
- Following successful testing of a live web chat service, in 2020/21 our Customer Contact Centre will roll this out further, providing improved accessibility through this convenient way to make contact.

Parliamentary and Health Service Ombudsman

The table below shows activity relating to complaints managed by NHS England which were closed by the Parliamentary and Health Service Ombudsman between 1 April 2019 and 31 March 2020. Some of these complaints will have been received by NHS England prior to 1 April 2019, but have since progressed to the Parliamentary and Health Service Ombudsman (after 1 April 2019), hence are included in these figures

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

	Upheld	Partially Upheld	Not Upheld	Discontinued or other	Total cases
Number of cases	**3**	**4**	**18**	**25**	**50**

KPI performance

	Target	2018/19	Q1	Q2	Q3	Q4	2019/20
General Enquiries							
No. of cases received		122,021	29,808	33,272	33,839	43,184	140,103
Resolved within 3 working days	95%	91.2%	94.9%	93.2%	98.6%	96.6%	96.0%
FOI							
No. of cases received		2,326	553	525	661	719	2,458
Resolved within 20 working days	80%	81.2%	82.1%	79.4%	82.0%	75.1%	79.5%
Concerns							
No. of cases received		7,967	1,467	1,303	1,446	893	5,109
Resolved within 10 working days	80%	86.2%	91.9%	92.3%	92.4%	92.6%	92.2%
Complaints							
No. of cases received		6,511	2,005	2,092	1,936	1,809	7,842
Acknowledged within 3 working days	100%	88.3%	88.0%	89.8%	84.2%	86.8%	87.3%
Resolved within 40 working days	90%	55.0%	52.0%	45.4%	49.2%	35.4%	45.7%
Median response time (working days)	<= 40	40	40	44	42	60	45
Admin Closures[1]							
No. of cases received		9,122	2,563	2,528	2,778	2,409	10,278

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

Who contacted us?

The table below shows the types of people who contacted us.

Caller Type	2018/19	2019/20
Member of the public	94%	95%
NHS Staff	5%	3%
Other	1%	2%

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

Contact method

The table below shows the ways people contacted us

	2018/19	2019/20
All Cases		
Phone	67%	65%
Email	31%	32%
Post	2%	2%
Other (Facebook, Webchat, etc)	0%	1%
Complaints		
Phone	39%	38%
Email	51%	53%
Post	10%	5%
Other (Facebook, Webchat, etc)	0%	4%

Complaints by service area

The table below shows proportion of complaints concerning each service

	2018/19	2019/20
Service Area		
GP Surgery	73%	71%
Dental Surgery	16%	17%
Pharmacy	4%	4%
Commissioning	2%	2%
Prison or Detention	1%	3%
Other	4%	3%

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

Appendix 3: Meeting our Public Sector Equality Duty

Advancing equality and the NHS Long Term Plan and developing the NHS People Plan

By addressing our health inequalities duties, in conjunction with our Public Sector Equality Duty (PSED), NHS England and NHS Improvement have taken a strategic approach to addressing both sets of legal duties. A central focus during the COVID-19 pandemic and the recovery phase is on reducing health inequalities and advancing equality within the context of COVID-19.

In January 2019, NHS England published the NHS Long Term Plan and an Equalities and Health Inequalities Impact Assessment[2] (EHIA). NHS England and NHS Improvement have worked in partnership to ensure that the commitments set out in the NHS Long Term Plan in relation to advancing equality of opportunity are effectively delivered. In June 2019, NHS England and NHS Improvement published the NHS Long Term Plan Implementation Framework together with a range of resources that support equalities and the PSED[3].

During 2019/20, NHS England and NHS Improvement worked together, with a wide range of partners, to develop the Interim People Plan. The Interim People Plan, published in June 2019[4], made a commitment to the development of a full EHIA.

In view of the COVID-19 pandemic, the Equality and Human Rights Commission (EHRC) and the Government Equalities Office (GEO) decided to suspend the requirement for annual publication of various information. This means the next statutory publication timetable will not be until after March 2021.

Equality objectives for 2016/17 – 2020/21

NHS England's equality objectives for 2016 – 2020 addressed our role as an NHS system leader, commissioner and our own role as an employer. Each equality objective was supported by a number of targets[5]. The six overall objectives were:

1. To improve the capability of NHS England's commissioners, policy staff and others to understand and address the legal obligations under the PSED and duties to reduce health inequalities set out in the NHS Act 2006 (as amended).
2. To improve disabled staff representation, treatment and experience in the NHS and their employment opportunities within the NHS.
3. To improve the experience of Lesbian, Gay, Bisexual and Transgender People (LGBT+) patients and improve LGBT+ staff representation.
4. To reduce language barriers experienced by individuals and specific groups of people who engage with the NHS, with specific reference to identifying how to address issues in relation to health inequalities and patient safety.

2 https://www.england.nhs.uk/wp-content/uploads/2019/01/ehia-long-term-plan.pdf
3 https://www.longtermplan.nhs.uk/implementation-framework/
4 https://improvement.nhs.uk/resources/interim-nhs-people-plan/
5 https://www.england.nhs.uk/about/equality/objectives-16-20/

5. To improve the mapping, quality and extent of equality information in order to better facilitate compliance with the PSED in relation to patients, service-users and service delivery.
6. To improve the recruitment, retention, progression, development and experience of the people employed by NHS England to enable the organisation to become an inclusive employer of choice.

NHS England and NHS Improvement recognise the far reaching and adverse nature of the COVID-19 pandemic's impact on equalities and health inequalities. In light of the COVID-19 pandemic NHS England and NHS Improvement will add an additional objective to the equality objectives agreed for 2016-20, which will also be extended by a further year to cover 2020/21.

This additional equality objective is set out below.

7. To ensure that the equality and health inequality impacts of the COVID-19 are fully considered and that clear strategies are developed and implemented for the NHS workforce and patients. To ensure that the NHS People Plan and patient focused strategies reflect this and make an effective contribution to advancing equality for all protected characteristics and to reducing associated health inequalities.

Workforce Race Equality Standard

Since 2015, NHS England has been leading the strategic approach to workforce race equality across the NHS. The Workforce Race Equality Standard (WRES)[6] supports NHS organisations to identify and close the gaps in workplace experience between BAME and white staff. Annual WRES data reports show year-on-year improvements across several WRES indicators. In 2019/20, the national WRES team published two key strategies: (i) the Model Employer[7] strategy to increase BAME representation across the NHS workforce pipeline and at leadership levels, and (ii) A Fair Experience for All[8] framework to support NHS organisations in closing the ethnicity gap in the application of disciplinary action between staff groups. The 2019 WRES report[9] was published in February 2020. The report is the fifth publication, since the WRES was mandated and covers all nine indicators. It also compares data against previous years. Following publication, NHS England and NHS Improvement pledged actions to achieve a target of 19% BAME representation within the joint organisation by 2025.

Workforce Disability Equality Standard

In June 2019, NHS England published the final set of metrics[10] for the Workforce Disability Equality Standard (WDES) and NHS trusts have been reporting on progress against these metrics. The first Annual WDES report was published in March 2020[11]. The report provides the first national review of the NHS workforce that relates to the workplace representation and career experiences of Disabled staff.

6 https://www.england.nhs.uk/about/equality/equality-hub/equality-standard/
7 https://www.england.nhs.uk/wp-content/uploads/2019/01/wres-leadership-strategy.pdf
8 https://www.england.nhs.uk/wp-content/uploads/2019/07/closing-the-ethnicity-gap.pdf
9 https://www.england.nhs.uk/publication/workforce-race-equality-standard-data-reporting-2019/
10 https://www.england.nhs.uk/publication/nhs-workforce-disability-equality-standard-technical-guidance/
11 https://www.england.nhs.uk/publication/wdes-annual-report-2019/

National Advisor for LGBT+ Health

In 2019, NHS England appointed a National Advisor for LGBT+ Health, as part of the Government Equalities Office LGBT+ Action Plan. The National Advisor is working on a number of priorities to reduce health inequalities for LGBT+ people and improve their experience of health and social care services.

This includes working to improve monitoring of sexual orientation, gender identity and trans status in healthcare services and ensuring professionals understand the benefits of collecting this information to improve patient care. The National Advisor has also been working across the system to improve education and training on understanding and addressing LGBT+ health inequalities; supporting the delivery of services which are more inclusive of LGBT+ individuals and addressing the inequalities of experience of the LGBT+ NHS workforce.

Appendix 4: Reducing health inequalities

During 2019/20, NHS England and NHS Improvement have focused on a range of work programmes with the aim of addressing and reducing health inequalities in line with the commitments set out in the NHS Long Term Plan (2019)[12], NHS Long Term Plan Implementation Framework[13] and the criteria set by the Secretary of State.

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

The implementation of the NHS Long Term Plan has demonstrated a strong focus on areas where healthcare intervention can make the biggest difference:

- Prevention: Smoking, alcohol and obesity (top five risk factors for premature deaths);
- Clinically: On cancer, stroke and heart disease (50% of health inequality gap);
- Multiple morbidities: Through investment in personalisation and across all programmes. Health inequalities is now central to everything we do and a range of goals are being designed to incorporate a stronger measurable focus on narrowing and reducing health inequalities.

Over the last year, in partnership with PHE, Local Government Association (LGA), Healthcare systems (ICS/STP/CCGs and NHS Providers), health and well-being, and voluntary and community sector partners, we have worked to accelerate action nationally, regionally and locally so that the NHS and healthcare systems have the tools and resources they need to address health inequalities, segment and target disadvantaged communities according to deprivation, protected group and inclusion health group.

The following have been published:

- The Health Inequalities Menu of Evidence Based Interventions and Approaches[14]
- Equality and Health Inequalities NHS RightCare packs[15]
- PHE, LGA and the Association of Directors of Public Health published their Place Based Approaches for Reducing Health Inequalities[16]
- Population Health Management (PHM) and Reducing health Inequalities sections on the National Population Health Management Academy[17]

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

The NHS Outcomes Framework Indicators for Health Inequalities Assessment (DHSC, 2015) set out 11 indicators identified for health inequalities assessment which have been used to guide reporting in 2019/20 using data available on the NHS Digital's website. Information and data on the indicators will be published on the NHS England website in July 2020.

12 NHS Long Term Plan – Chapter 2: Prevention and Health Inequalities - https://www.longtermplan.nhs.uk/
13 https://www.longtermplan.nhs.uk/implementation-framework/
14 https://www.england.nhs.uk/ltphimenu/
15 https://www.england.nhs.uk/rightcare/products/ccg-data-packs/equality-and-health-inequality-nhs-rightcare-packs/
16 https://www.england.nhs.uk/ltphimenu/placed-based-approaches-to-reducing-health-inequalities/
17 https://future.nhs.uk/connect.ti/populationhealth/groupHome

Where data is sufficiently powered, key NHS Long Term Plan programmes are developing Health Inequalities Indicators (HIIs) at England and CCG level by deprivation and protected characteristics. Once finalised HIIs will be placed on the National Performance and Population Health Dashboard (NPPHD), allowing each CCG and healthcare system to review its health inequalities data collected locally. This information will be used to inform local commissioning decisions, segment to areas of deprivation, protected groups and inclusion health groups with poorest health outcomes, isolate key clinical areas of target, and set local metrics and measure reductions in health inequalities.

The health inequalities indicator 106 for chronic ambulatory care sensitive conditions and urgent care sensitive conditions in the CCG Improvement and Assessment Framework continues to help CCGs monitor and plan improvements in NHS equity performance and forms the basis of the Equality and Health Inequalities (EHI) Right Care Packs.

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

The Health Inequalities Menu of Evidence Based Interventions and Approaches provides a catalogue of interventions and approaches that local healthcare systems and commissioners, working with partners across the system, can draw upon to take effective action at neighbourhood, place and system-level to reduce health inequalities, through their local improvement plans. The Menu complements the content of the Place Based Approaches for Reducing Health Inequalities (PBA), published by PHE. The Menu is being developed through a phased approach, which will run through the life of the NHS Long Term Plan. The Menu will also enable us to identify where there are gaps in evidence and to develop further or commission work to fill these gaps.

Interventions in the Menu:

- Relate specifically to priorities and commitments already signalled in the NHS Long Term Plan;
- Specifically address the gap in health access and outcomes experienced between the least and most deprived populations, and other population groups such as inclusion health and protected characteristic groups most likely to experience health inequalities, and as a key enabler, this will include levelling-up access to high quality primary and community care;
- Enable local areas to identify the specific factors which are driving health inequalities in their area, including not just clinical risk, but behaviours and the underlying causes of health inequalities, also known as the wider determinants of health.

Some of these evidence-based solutions are already being implemented by local systems. For instance, Greater Manchester and other systems are implementing the targeted and enhanced midwifery led Continuity of Carer model which significantly improves outcomes for women from ethnic minority groups and women living in deprived areas.

We have continued to review available data and information to help shape policy, drive improvement and assess progress in reducing health inequalities in all major national clinical programmes such as cancer, mental health, cardiovascular disease and stroke, respiratory care, diabetes, maternity, child health and primary care.

Criterion 4: Improve prevention, access and effective use of services for Inclusion Health groups

During 2019/20 we have continued to support programmes focusing on prevention and access to primary care medical services, and we published information and resources that aims to make it easier for patients from inclusion health groups to overcome barriers when accessing the healthcare. We have developed a new Primary Care Access Card that will replace the current provision of a leaflet supporting and empowering inclusion health groups to register with GP services without facing discrimination of access to timely healthcare services.

We have published a range of 'how to guides' to accompany the Menu of Interventions. The guides will help local health systems to work with, and design targeted solutions for, specific vulnerable groups including Gypsy, Roma and Traveller communities, LGBT+ groups, vulnerable migrants, BAME communities, rough sleepers and offenders, and religious, spiritual and faith-based groups. In partnership with PHE and the Ministry of Housing, Communities and Local Government, we have continued the implementation of the Rough Sleepers Strategy, to ensure system compliance with the Homeless Reduction Act and the implementation of the Duty to Refer on NHS providers.

We continue to review and implement the recommendations outlined in the Ministerial - Women and Equalities Select Committee Report[18] on tackling inequalities faced by Gypsy, Roma and Traveller communities. We continue with the ongoing scoping exercise identifying the equality monitoring data gathered across major NHS data sets and propose what equality data should be gathered and how.

We have worked with the Gypsy, Roma and Traveller partners to develop health inequalities learning resources which support the PCNs, STP/ICSs to address health inequalities for all inclusion health groups and in particular Gypsy, Roma and Traveller groups. The Voluntary Community and Social Enterprise (VCSE) Inclusion Health Audit Tool aims to help STPs, ICSs and local healthcare systems to identify and engage with local inclusion health groups[19].

We have recommended that CCGs report on their use of the existing inequalities adjustment and also commissioned the Advisory Committee of Resource Allocations (ACRA) to review the existing adjustment; they will need to consider a range of issues such as how the adjustment to financial allocations is used to meet objectives in this area, including the issues raised in relation to Gypsy, Roma and Traveller communities. ACRA will report in 2021.

All of our local healthcare systems are working to implement an enhanced and targeted continuity of carer model to help improve outcomes for the most vulnerable mothers and babies living in our most deprived areas.

18 https://publications.parliament.uk/pa/cm201719/cmselect/cmwomeq/360/full-report.html
19 https://www.inclusion-health.org/

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

Working with its leadership role NHS England included in the 2019/2020 CCG Improvement and Assessment Framework (IAF) a composite to help CCGs set priorities for tackling inequalities. This informs the headline assessment of CCGs together with a number of other indicators.

Local healthcare systems are prioritising action on health inequalities and have been tasked to set measurable goals with specific interventions to narrow health inequalities.

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

Following the launch of the NHS Long Term Plan we are making good progress with our national programmes and local systems through the development of HIIs and interventions to reduce health inequalities, which are also segmented to key groups – such as those people living in deprived areas, people from protected groups and inclusion health groups.

Further information regarding meeting our PSED is given from page 172.

Appendix 5: Working in partnership with people and communities

During 2019/20, we have enhanced and evolved our own approaches to working in partnership with people and communities (also known as 'patient and public involvement'), whilst also providing support and leadership for the wider health and care system.

Our NHS Citizen programme, which seeks to ensure that we hear directly from the public, has developed, with a reconstituted Advisory Group bringing together representatives from all of our public voice forums, including the NHS Youth Forum, Older People's Sounding Board and National Cancer Programme Patient and Public Voices Forum.

We have ensured that patients, carers and members of the public are able to influence our work through a range of consultations, events and surveys, informing a wide range of programmes and initiatives, including implementation of NHS Long Term Plan commitments. Many of these activities have been supported by VCSE partners, and we continue to strive to include groups who may be termed 'seldom heard', in particular 'inclusion health' groups and marginalised communities.

We have undertaken a refresh of our Patient and Public Participation Policy this year, and will be completing further work on this, related policies, and the associated frameworks for each of our direct commissioning responsibilities during 2020/21. The Policy and frameworks form part of our established process for ensuring and assuring consideration of NHS England's duty to involve the public in commissioning (section 13Q of the NHS Act 2006) as well as the duties of CCGs. In September, the Board again considered the 'Public Participation Dashboard' which offers an overview of practice including commentary on the section 13Q duty. A copy of the dashboard is available as part of meeting papers.

This year we have had a particular focus on supporting the development of PCNs, seeking to ensure that they work alongside their local communities from the outset (see below).

Information about our public participation approaches, opportunities and support is available on our Involvement Hub.

NHS Citizen including 'citizens on the margins'

During 2019/20, we have co-hosted four events with 'WE Communities', a community group formed of people from marginalised communities. These bespoke events ensure that we hear from people who experience significant barriers to accessing health services, and poorer health outcomes, including Gypsies, Roma and Traveller people, and people with experience of sex work, drug use, homelessness, and domestic violence. This year, the events have focused primarily on primary care and the development of PCNs, exploring how they can improve services with and for marginalised communities, how to ensure digital inclusion for those who may experience barriers, and how to improve access in all forms. These have been an opportunity for professionals to hear directly from people with real, often traumatic, experiences, and to work towards practical and innovative solutions together. A report of each event has been produced and shared, ensuring that the insight is available to professionals working locally and nationally on developing PCNs.

Children and young people's participation

2019/20 has been an extraordinary year for increasing the voice and impact of young people in our decision making. Our NHS Youth Forum has gone from strength-to-strength, and we have introduced a 'Youth Expert Advisor' role to explore how we can benefit from the experience and connections of alumni members.

Significant achievements include the NHS Youth Voice Summit held in April 2019, which was co-designed and co-produced with young people. The event brought together over 200 children and young people, youth support workers and senior leaders, including members of our Joint Boards, to discuss how the NHS Long Term Plan goals can be achieved in the context of youth volunteering and social action. Outcomes from the summit include young people joining the National Children and Young People's Board, direct connections between young people and our Chairs, and a pilot reverse mentoring programme between a Youth Forum Member and our Chief People Officer, with plans to expand this over the coming year.

Going forwards, we will continue to ensure young people can shape our work. The Youth Social Action and volunteering programmes[20] were launched. This includes partnership working with St John Ambulance and NHS trusts on the NHS Cadets Programme that aims to enable 10,000 young people to develop their skills in First Aid, Mental Health and other core skills.

Young people's inpatient mental health services

Over the last year we have been working in partnership with parents, carers, Young Minds, Rollercoaster Family Support and the Royal College of Psychiatrists' Quality Network for Inpatient Child and Adolescent Mental Health Services (QNIC) to develop a resource for parents of young people in inpatient mental health units (including secure units). This is often a distressing time for parents, being separated from a child who is often at crisis point.

We have held co-design events with parents to understand their information and support needs, especially during the critical first 24-hour period. Parents explained that they often had practical questions which went unanswered and it was agreed that a '24-hour card' setting out key questions would be a useful aid, prompting staff to sit down with parents to complete the card together. This would help to build trust between parents and staff and promote parents' involvement at all stages of inpatient care. The '24-hour card' is in the final stages of development and will be launched, alongside an online information resource for parents at different points in their journey, early in 2020/21.

The implementation of the resource will be supported through relevant service specifications and through the inclusion of the resource in QNIC's standards, which will then form part of peer reviews. It is hoped that this resource will not only support parents to have the right information at the right time but also support a cultural shift towards parents being central to their child's mental health treatment. We will continue to work with parents, families and young people with experience of inpatient mental health services during the coming year.

20 See https://www.england.nhs.uk/participation/get-involved/how/forums/nhs-youth-forum/ for more information.

Primary Care Networks

First announced in the NHS Long Term Plan, by July, nearly all GP practices across England had signed up to a PCN. PCNs are local networks of primary and community health and care services with collective responsibility for the health and wellbeing of a defined population, usually 30-50,000 people.

In our system leadership role, we have been rolling out a support offer to PCNs to support them to work in partnership with people and communities from their inception and to establish routes for ongoing dialogue. Resources to support PCNs in assessing their own development and accessing support have made clear that to progress PCNs need to work increasingly with and empower the people they serve.

We have delivered over 15 webinars, reaching more than 1000 people directly, on topics including co-production, asset-based approaches, Patient Participation Groups, and digital inclusion. Meetings of 'inclusion health' practices and practices serving deprived communities have also been convened, as well as leading sessions at a range of events. We have supported innovative practice locally, including around access for marginalised communities and embedding coproduction, ensuring the learning can be shared nationally.

Over the coming year, we will continue to support PCNs to work in partnership with people and communities, including through training and development, professional networks and spreading good practice.

Co-production of maternity services with service users

Co-producing safe and personal maternity care is fundamental to how we work – with service user representatives at national, regional and local level

Fifteen national Public and Patient Voice (PPV) Partners were appointed in 2019/20, meaning that each of our maternity care transformation workstreams includes service user voice. Seven PPV Partners also support co-production in every region, ensuring effective arrangements are in place to hear parents' voices and acting as members of regional Maternity Transformation Programme boards.

At a local level, 123 user-led Maternity Voices Partnerships (MVPs) have been established across England. MVPs include those using services, those providing services (maternity and neonatal staff) and those who commission services. MVPs review maternity care and co-produce improvements, so women and families are at the heart of all that we do. Examples include MVPs using the 15 Steps for Maternity Toolkit and co-producing information for people about local maternity services. MVPs are supported by National Maternity Voices who, as well as providing resources, host a series of webinars, for example on how to ensure MVPs represent the ethnic diversity of their local areas.

Engagement with the VCSE sectors

The VCSE sectors are critical partners in health and care, and we continue to take proactive steps to ensure they are meaningfully engaged. We have worked to embed and promote our 'principles for VCSE engagement' and have extended our programme of investment and support to STPs and ICSs to enhance the integration of the sector as a strategic voice and delivery partner.

In partnership with the DHSC and PHE, we have provided grant funding to 23 organisations to support the spread and scale of programmes supporting children and young people's mental health. We have also continued to support the VCSE Health and Wellbeing Alliance, which aims to provide a voice and improve health and wellbeing for all communities. This year, the Alliance has been involved in co-designing and delivering a range of national policies and programmes including the 'menu of evidence-based interventions to reduce health inequalities', the development of PCNs, and Population Health Management approaches.

Appendix 6: Sustainability

This year we launched the Greener NHS programme and began work to develop a Net Zero Plan for the NHS, demonstrating the commitment we have to tackling climate change as a health emergency. Tangible actions continue to take place across the NHS to cut carbon, air pollutants and avoidable single-use plastics. Delivery over this year has already seen more than 100 NHS trusts pledge to cut single-use plastic used in canteens.

Within NHS England and NHS Improvement, we are committed to long-term sustainable development and acknowledge the potential impact that our activities may have on the environment. We will ensure that sustainable development continues to be an integral part of our work and our net-zero carbon ambitions as part of our Green Plan.

A complete set of sustainability reporting data for this year will be published in our next annual report.

Some key activities from this year include:

- Participating in the Government consumer single-use plastic (CSUP) elimination scheme, working to remove CSUP from our offices over the course of this year.
- Continuing to see the benefits of ICT investment and digital ways of working with a reduction in tCO^2e from business travel of 19% across NHS England, NHS Improvement and CSUs.
- Reducing paper use by a further 25%.
- Continuing to work in collaboration with NHS Property Services to progress the sustainability agenda in the non-Departmental buildings we occupy. This includes conducting energy audits across the estate, moving to renewable energy tariffs and diverting 99% of waste from landfill.

The Sustainable Development Unit (SDU)

The SDU plays a pivotal role in embedding the principles of sustainable development into the way in which the NHS, and wider health system in England works. It supports the NHS to lead by example, in reducing its own impacts on the environment including air pollutants, plastics and carbon emissions from medicines and clinical services. The unit is jointly funded by NHS England and NHS Improvement, and PHE.

In 2019/20 the NHS launched the 'For a Greener NHS' campaign and the 'Net Zero Call for evidence' to build on the work the SDU has driven for the last twelve years. The Greener NHS campaign is engaging NHS staff in reducing the NHS' contribution to climate change. The 'Net Zero Call for evidence' has generated over 600 responses with case studies and proposals, to help shape the route to a Net Zero NHS.

An expert panel has been set up, chaired by Dr Nick Watts from the Lancet Countdown, to look at how and when the NHS could get to Net Zero. The panel will explore changes the NHS can make in its own activities, in its supply chain, and through wider partnerships, to contributing to the government's overall target for the UK.

Actions that will help cut carbon have been included in the NHS Standard Contract with trusts and the GP contract, including measures to encourage GPs to offer to lower carbon inhalers where it is clinically safe to do so; the reduction of desflurane use in general surgery; ensuring all NHS organisations have a 'Green Plan'; and ensuring all leased and purchased vehicles are low or zero emission.

The SDU has also been developing reports on the NHS contribution to delivery of the UN Sustainable Development Goals, and the level of preparedness and resilience across the health and care system for the impacts of climate change.

Appendix 7: Glossary

	Acronym used	Meaning
	A&E	Accident and Emergency
	ACRA	Advisory Committee of Resource Allocations
	ALB	Arm's Length Body
A	AME	Annually Managed Expenditure
	ARAC	Audit and Risk Assurance Committee
	ARP	Ambulance Response Programme
	ATP	Advanced Threat Protection
B	BAME	Black, Asian and Minority Ethnicities
	CEO	Chief Executive Officer
	CCG	Clinical Commissioning Group
	CETV	Cash Equivalent Transfer Value
	CHC	Continuing Healthcare
	CIO	Chief Information Officer
	CMD	Commercial Medicines Directorate
	COO	Chief Operating Officer
	CPAG	Clinical Priorities Advisory Group
G	CPI	Consumer Price Index
	CQC	Care Quality Commission
	CQRS	Calculating Quality Report Service
	CQUIN	Commissioning for Quality and Innovation
	CSOPS	Civil Servant and Other Pension Scheme
	CSUP	Consumer Single Use Plastic
	CRR	Corporate Risk Register
	CSU	Commissioning Support Unit
	CVD	Cardiovascular Disease
	DAWN	Disability and Wellbeing Network
	DCO	Director of Commissioning Operations
	DCEO	Deputy Chief Executive Officer
	DEFRA	Department for Environment, Food and Rural Affairs
	DES	Directed Enhanced Service
D	DHSC	Department of Health and Social Care
	DIL	Diversity and Inclusion Leadership
	DSC	Data Security Centre
	DSP	Data Security and Protection
	DSPT	Data Security Protection Toolkit
	DWP	Department of Work and Pensions

	Acronym used	Meaning
E	EDC	Equality and Diversity Council
	EHCH	Enhancing Health in Care Homes
	EHIA	Equality and Health Inequalities Analysis
	EHRC	Equality and Human Rights Commission
	EIP	Early Intervention in Psychosis
	EPRR	Emergency Preparedness, Resilience and Response
	EQG	Executive Quality Group
	ERMG	Executive Risk Management Group
	ESM	Executive Senior Manager
	ESR	Electronic Staff Record
	EU	European Union
F	FOI	Freedom of Information
	FReM	Financial Reporting Manual
	FRF	Financial Recovery Fund
	FSAVC	Free Standing Additional Voluntary Contributions
	FTE	Full Time Equivalent
	FTSU	Freedom to Speak Up
G	GAM	Group Accounting Manual
	GDPR	General Data Protection Regulation
	GEO	Government Equalities Office
	GIRFT	Getting It Right First Time
H	HCID	High Consequence Infectious Disease
	HII	High Impact Intervention
	HIIs	Health Inequalities Indicators
	HMRC	HM Revenue and Customs
	HPV	Human Papillomavirus
	HR	Human Resources
	HSIB	Healthcare Safety Investigation Branch
I	IAF	Improvement and Assessment Framework
	IAPT	Improving Access to Psychological Therapies
	ICO	Information Commissioners Office
	ICP	Integrated Care Provider
	ICS	Integrated Care System
	IFRS	International Financial Reporting Standards
	IG	Information Governance
	ISA	International Standards on Auditing
	ISFE	Integrated Single Financial Environment
	ISN	Information Standards Notice
J	JCRR	Joint Corporate Risk Register
	JERMG	Joint Executive Risk Management Group
L	LeDeR	Learning Disabilities Mortality Review
	LGA	Local Government Associations
	LGBT+	Lesbian, Gay, Bisexual, Trans +
	LHCR	Local Health Care Record
	LMDP	Line Management Development Programme
	LMS	Local Maternity Systems
	LPP	Low Priority Prescribing

	Acronym used	Meaning
M	MHFA	Mental Health First Aider
	MHRA	Medicines and Healthcare Products Regulator Agency
	MoD	Ministry of Defence
	MSK	Musculoskeletal
N	NAO	National Audit Office
	NARU	National Ambulance Resilience Unit
	NCC	National Co-Ordination Centre
	NCSC	National Cyber Security Centre
	NGD	National Data Guardian
	NHS	National Health Service
	NHSCFA	NHS Counter Fraud Authority
	NHS DPP	The NHS Diabetes Prevention Programme
	NHS IMAS	NHS Interim Management and Support
	NHS BSA	NHS Business Services Authority
	NHS PS	NHS Property Services
	NHS SBS	NHS Shared Business Services
	NICE	National Institute for Health and Care Excellence
	NIHR	National Institute for Health Research
	NIS	Network and Information Systems
	NPPHD	National Performance and Population Health Dashboard
	NSDR	National Supply Disruption Response
O	OD	Organisational Development
	ONS	The Office of National Statistics
	OPW	Off-Payroll Workers
P	PCN	Primary Care Network
	PCSE	Primary Care Support England
	PCSPS	Principal Civil Service Pension Scheme
	PHB	Personal Health Budget
	PHE	Public Health England
	PHM	Population Health Management
	PHSO	Parliamentary and Health Service Ombudsman
	PPE	Personal Protect Equipment
	PPV	Patient and Public Voice
	PRP	Performance Related Pay
	PSED	Public Sector Equality Duty
	PSF	Provider Sustainability Fund
Q	QAG	Quality Assurance Group
	QNIC	Quality Network for Inpatient Child and Adolescent Mental Health Services
R	RDC	Rapid Diagnostic Centres
	RDEL	Revenue Department Expenditure Limit
	RPI	Retail Prices Index

	Acronym used	Meaning
S	SCHJDG	Specialised Commissioning and Health and Justice Delivery Group
	SCHJSPG	Specialised Commissioning and Health and Justice Strategy and Policy Group
	SDEC	Same Day Emergency Care Services
	SDU	Sustainable Development Unit
	SFI	Standing Financial Instructions
	SRO	Senior Responsible Officer
	STP	Sustainability Transformation Partnership
T	TU	Trade Union
V	VAT	Value Added Tax
	VCSE	Voluntary, Community and Social Enterprise
W	WDES	Workforce Disability Equality Standard
	WRES	Workforce Race Equality Standard
	WTE	Whole Time Equivalent

CSS0320331828
978-1-5286-1952-3