NHS England

Annual Report and Accounts 2022-23

For the year ended 31 March 2023

HC468

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Annual Report and Accounts 2022/23

For the period 1 April 2022 to 31 March 2023

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Foreword: a view from Richard Meddings CBE, Chair

The 2022/23 financial year was my second in the NHS and marked the NHS' 75th.

In those 75 years the NHS has proven again and again that it can adapt and change to meet the needs of patients and the public, and I have once again been humbled by the hard work and innovation of staff during a challenging year. The NHS remains at its heart focused primarily on the patient, and whilst demand is rising in some areas very significantly, the NHS works hugely hard to serve society's health needs and continues to do that with true commitment but also innovation.

But there are huge challenges. December 2022 saw the start of an unprecedented run of industrial action which to date has seen over one million elective appointments postponed, which inevitably also had a knock-on financial impact on trusts.

Staff faced their busiest winter on record – with 8.3 million A&E attendances between December and March 2023 – 40,000 more than the previous high – while teams in GP practices delivered half a million more appointments every week than before the pandemic. Over 10% of the population have a GP appointment every single week.

This reflects an ageing population – with a 30% increase in the over 70s since 2010 – and an over 60% increase since 2010 in over 70s who have multiple conditions, making the care we need to offer more complex.

This rise in people coming for care is welcome after we saw a drop off in people accessing the NHS during the pandemic.

But it obviously also adds pressure on capacity. The NHS has around 133,000 staff vacancies and has one third of the number of hospital beds they have in Germany and less than half the average OECD diagnostic capacity.

This makes the progress of staff over these 12 months all the more impressive.

On mental health we have a world-leading talking therapies programme and have rolled out mental health support teams in schools ahead of schedule. We are experiencing huge growth in the numbers of people presenting with mental health conditions, often severe. The growth in demand is particularly evident amongst the young.

The 62-day cancer backlog fell, while the number of patients waiting more than 18 months for elective treatment fell to just 10,737 – down by more than 90% from 124,911 in September 2021. The NHS is now referring over 25% more patients for cancer tests than pre the pandemic and has rolled out greater testing and screening, for instance for lung cancer and bowel cancer. Our war on cancer remains a key priority.

Progress on the backlog has continued apace since, with the backlog falling overall during October and November. The waiting lists remain a huge challenge, but we have reduced

longer period waits and I am confident, absent industrial action, that we can make substantial further progress in reducing the lists further. Over 80% of the list does not require surgery but rather diagnostic tests or screening or other outpatient engagement.

These achievements have been a result of hard work but are also a result of NHS innovation. The NHS has to keep adapting, putting in place building blocks for the future.

Over 100 community diagnostic centres now exist across England, offering people easy and convenient access to tests, checks and scans.

We're also beginning to see the potential of AI cancer checks that will not only speed up care but save clinical time and money.

While just a few years ago patients would have had to go to a GP to pick up their prescription, now patients can access these at a touch of a button on the NHS app.

And extensive work, engagement and negotiation over 2022/23 meant that in July 2023, we were able to publish the first NHS Long Term Workforce Plan, with government backing, to plug the staffing gaps we have but also meet the needs of a growing and changing population.

These are just a small sample of the progress the NHS has made.

The NHS is dealing with exponential demand growth from population increases and ageing, and from our brilliant academic medical researchers identifying ever more ways the human condition can go wrong and the ways to treat them. This demand growth is met by a system with insufficient capacity whether workforce or beds or diagnostics. And yet the sheer scale of healthcare provision by the NHS is truly amazing and the range and depth of what is provided today would have been unthinkable ten or fifteen years ago, never mind in 1948. But what is frequently missed is the level of innovation in medicines and drugs, in medtech, in technology and data. The NHS today innovates continuously but has so much more to do in so many areas. The NHS remains one of the most efficient health services but also needs continuously to improve. The pressures are huge, and the system sometimes falls short of what both the public and our colleagues expect of it, but the commitment to serve remains clear across and throughout the NHS.

So, I would like to thank all NHS staff for their hard work and courage over the past year. Not only have they managed unprecedented levels of demand, but they have also made improvements in the way the NHS works.

Richard Meddings CBE Chair of NHS England

Performance report

Amanda Pritchard
21 January 2024

Chief Executive and Accounting Officer

Chief Executive's overview

Welcome to NHS England's Annual Report and Accounts for 2022/23.

This report covers the performance of the organisation between April 2022 and the end of March 2023, including from 1 July 2022 onwards the legally merged constituent organisations of NHS Improvement and from 1 February 2023 onward the legally merged organisation NHS Digital.

This ongoing merger had, by April 2023, successfully integrated NHS Improvement, Health Education England, and NHS Digital into one unified organisation. The new NHS England has a shared purpose, leading the NHS in England to deliver high-quality services for all, and putting workforce, data, digital and technology at the heart of our plans to transform the NHS.

In 2022/23, and since, the NHS has continued to face considerable challenges. In addition to the continued challenge of recovery from the first waves of Covid-19 and ongoing global economic volatility, last year saw the start of unprecedented operational and financial impact from industrial action.

Throughout the now several periods of action, we have done everything in our power to support front line staff and local leaders to ensure those needing life-saving care have continued to be able to receive it. However, each strike comes at a significant cost to the NHS - both in terms of resources and in momentum on our key recovery programmes - and this is ultimately borne by patients. We have therefore been steadfast in our calls on both Government and staff unions to engage in meaningful discussions which avoid further strikes.

Despite these strong headwinds, the NHS has delivered on many of our ambitions. We virtually eliminated two-year waits for routine hospital care by the end of July, and then achieved a vast reduction in those waiting 18 months or more by the end of March 2023.

GP practices delivered 337 million appointments, on top of COVID-19 vaccinations, supported by a growing workforce able to offer more services closer to patients' homes.

We have provided mental health support to ever more people, including fast-tracking the roll out of mental health teams in schools, and continued progress on expanding and improving support in the community for people with a learning disability and autistic people.

Record numbers of people have been checked for cancer symptoms, recovering the deficit caused by the pandemic and meaning that more people than ever before are getting diagnosed at an early stage, improving the chances of effective treatment.

We've achieved our NHS Long Term commitment to treat 1,000 children a year for severe complications related to their obesity.

And together, we have also shown the NHS remains at the forefront of innovation, with the introduction of several new cutting edge treatments, including the first new treatment for mesothelioma in over a decade and gene therapies for children born with ultra-rare conditions, the expansion of routine genomic testing for children seriously ill in hospital, and continued progress on frontline digitisation and the safe use of data to support better care planning and delivery.

These are just a few examples of the progress made over 2022/23 thanks to robust planning and the incredible commitment to patient care shown by NHS teams up and down the country – many more are set out in the pages that follow.

The start of 2023 marked the beginning of the health service's 75th year. And while we cannot, and do not, ignore the fact that in too many cases patients are not currently receiving the high quality and timely care we all aspire to, it is simultaneously true that the public retain belief in the NHS, its founding principles, and those who work within, and in support of, their local services.

We don't take that faith for granted, just as we don't take for granted the contribution made by each and every member of staff who works every day to live up to it.

I would therefore like to take this opportunity to thank staff for their ongoing hard work and continued commitment to patients and their colleagues, during what continues to be a period of significant challenge and change.

Amanda Pritchard NHS England Chief Executive and Accounting Officer

Performance overview

This performance overview provides a brief summary of NHS England and its objectives, along with progress made in health inequalities and prevention of ill-health, access and outcomes, recovery of services and using taxpayers' investment to maximum effect. Together, our work programmes (see analysis from page 17) encapsulate the objectives set out in the government's mandate to the NHS for 2022/23, on which more information is available from page 188.

About NHS England

NHS England was established by Parliament in 2012 as an independent statutory body. Its role is to lead the NHS in England to deliver high quality services for all.

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 and most recently the Health and Care Act 2022). We set the national direction, allocate resources, ensure accountability, define the national strategy for supporting and developing people, mobilise expert networks, give support to drive improvement, deliver essential services including national procurement and digital services, and lead the national agenda for transformation.

Supply Chain Coordination Limited (SCCL) transferred into NHS England on 1 October 2021. 2022/23 is the first full year SCCL is part of NHS England.

On 1 July 2022, NHS England merged with NHS Improvement when the Health and Care Act 2022 became law. NHS Improvement's constituent bodies, NHS Trust Development Authority (NHS TDA) and Monitor, were abolished and its staff, functions and resources transferred to NHS England.

On 1 February 2023, NHS England and NHS Digital legally merged. NHS England then became the custodian of national health and social care datasets and the single executive non-departmental public body with responsibility for digital technology, data and health service delivery in the NHS.

On 1 April 2023, NHS England incorporated Health Education England, the body responsible for the education and training of the health workforce.

Through ongoing delivery of the NHS Long Term Plan, we promote high quality health, care and support NHS organisations to work in partnership to deliver better outcomes for our patients and communities, at the best possible value for taxpayers.

How we operate

NHS England is governed by a Board which provides strategic leadership and accountability to the 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. Further details can be found from page 47.

NHS England works closely with other partners at national and regional level to ensure services are safe, effective, and clinically and financially sustainable.

Our work is also supported by third party organisations including NHS Business Services Authority (NHS BSA), NHS Shared Business Services, NHS Property Services Limited (NHS PS) and Primary Care Support England (PCSE) provided by Capita. Additionally, NHS England hosts NHS Interim Management and Support 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 NHS BSA but are formally a part of NHS England. CSU activities are included in our report and accounts except where otherwise indicated. Details on how we assure the activity of our organisation is presented in this annual report from page 67.

Services are commissioned by integrated care boards (ICBs), which replaced clinical commissioning croups (CCGs), and are overseen by NHS England on a regional and national basis. ICBs lead 42 local ICSs, which were fully established across England on a statutory basis on 1 July 2022. These are made up of NHS organisations, primary care professionals, local councils, social care providers and the community, voluntary and social enterprise sector. Our 7 regional teams support ICSs to improve the health of the population, improve the quality of care, tackle inequalities and deliver care more efficiently.

How we measure performance

The NHS Constitution sets out the rights of patients, the public and staff. We measure and monitor performance against a wide range of constitutional performance standards and publish statistics relating to these core constitutional standards on the NHS England website every month.[1]

Performance of integrated care boards

Under the terms of the NHS Act 2006 (as amended), NHS England has a duty to undertake a performance assessment of each ICB with respect to each financial year. NHS England has completed its first annual assessments for 2022/23 based on an approach developed with ICBs.

The assessments specifically considered how effectively each ICB had led its system and its contribution to each of the 4 fundamental purposes of an ICS, highlighting areas of good practice as well as opportunities for improvement. The outcome of each assessment was set out in a letter from the relevant NHS England Regional Director to the ICB Chair in response to the ICB's first annual report and accounts.

Overall, the assessments show that ICBs have made strong progress in their first year of operation to develop as new organisations and build on existing partnership arrangements, including the development of the 5-year joint forward plans.

Feedback from health and wellbeing boards considered as part of the assessment highlighted how ICBs have worked with partners to make progress on delivering the priorities set out in joint local health and wellbeing strategies. NHS England will continue to work alongside ICBs and the Care Quality Commission to evolve the approach to annual assessment for future years.

NHS England has the option of using its statutory powers, including the power to issue directions where an ICB is failing or is at risk of failing to discharge any of its duties, conferred by section 14Z61 of the National Health Service Act 2006 (as amended). There was no recorded use of these powers during 2022/23.

[1] https://www.england.nhs.uk/statistics/statistical-work-areas/combined-performance-summary/

Overview of 2022/23 operational performance

NHS England started out 2022/2023 with significant system pressures remaining from the tail end of the COVID-19 Omicron wave, with 15k hospital beds occupied by patients with the virus and a Level 4 National Incident in effect. Resources were therefore directed at wider NHS recovery.

The 2022/23 operational planning guidance[2] outlined 10 clear priorities to drive recovery and improvements across the year. These were:

1. Invest in our workforce.
2. Respond to COVID-19 ever more effectively.
3. Deliver significantly more elective care to tackle the elective backlog, reduce long waits and improve performance against cancer waiting times standards.
4. Improve the responsiveness of urgent and emergency care (UEC) and build community care capacity.
5. Improve timely access to primary care.
6. Improve mental health services and services for people with a learning disability and/or autistic people.
7. Continue to develop our approach to population health management, prevent ill-health and address health inequalities.
8. Exploit the potential of digital technologies to transform the delivery of care and patient outcomes.
9. Make the most effective use of our resources.
10. Establish ICBs and collaborative system working.

Over the course of 2022/23 we made significant progress against these areas, achieving some of the commitments made in the NHS Long Term Plan since its publication, while delivering a record number of patient contacts. We:

- delivered the target of all integrated care systems (ICSs) operating 2-hour community crisis response services in April 2022, ahead of the target date of March 2024
- delivered and exceeded the targets for patients receiving personalised care interventions, with almost 6 million recorded interventions by the end of 2022/23, against a target of 2.5 million by March 2024
- reached 1.72 million referrals to social prescribing schemes reached 1.72 million in 2022/23, against the a target of 900k by March 2024
- achieved the NHS Long Term Plan commitment of 1,000 children treated each year for severe complications related to their obesity in February 2023, a month earlier than the target date of March 2023

[2] https://www.england.nhs.uk/publication/2022-23-priorities-and-operational-planning-guidance/

- achieved and exceeded the commitment of 26,000 Additional Roles Reimbursement Scheme posts in March 2023, a year earlier than the target date of March 2024, boosting capacity in primary care.

In December 2022, there were 2.3 million A&E attendances, the highest on record. This was due to the combined impact of COVID-19, influenza and Group A Streptococcus, known as Strep A.

Ambulance services also saw unprecedented demand throughout 2022/23, with the number of the most serious ambulance callouts[3] (category 1) up by one third on pre-pandemic levels at some points in the year.

NHS acute hospitals admitted 275,977 people with COVID-19 over the course of the year, with an average of 5,811 beds per day occupied by patients with COVID-19.

In primary care, 347.4 million appointments were delivered by General Practice teams during 2022/23[4], exceeding pre-pandemic levels even when excluding the 10.5 million appointments relating to COVID-19 vaccinations.

A record 2,878,267 people were seen following an urgent suspected cancer referral – 21% above pre-pandemic levels.

From December 2022 onwards, local services were impacted by industrial disputes between the Government and unions representing multiple professions (including ambulance workers, nurses, radiographers, and junior doctors). The extensive planning and intensive management that the withdrawal of labour has necessitated – focused on maintaining the safest possible care for patients requiring urgent and emergency care as well as planned treatment for time-sensitive conditions – has inevitably impacted on the ability of systems and providers to recover and improve services.

To address some of the larger challenges, NHS England published further delivery plans in quarter 4 2022/23, including:

- The ‘Delivery plan for recovering urgent and emergency care’[5] in January 2023, a two-year plan focused on 2 key ambitions: to achieve A&E 4-hour performance of 76% by March 2024 and improve category 2 ambulance response times to an average of 30 minutes over the next year
- the 3-year delivery plan for maternity and neonatal services[6] in March 2023, which set out how we will make care safer, more personalised, and more equitable.

These plans sit alongside the ‘Delivery plan for tackling the COVID-19 backlog of elective care’, published in February 2022.

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[3] https://www.england.nhs.uk/urgent-emergency-care/improving-ambulance-services/arp/
[4] https://digital.nhs.uk/data-and-information/publications/statistical/appointments-in-general-practice/march-2023
[5] https://www.england.nhs.uk/publication/delivery-plan-for-recovering-urgent-and-emergency-care-services/
[6] https://www.england.nhs.uk/publication/three-year-delivery-plan-for-maternity-and-neonatal-services/

Performance analysis

Delegation of commissioning to ICBs

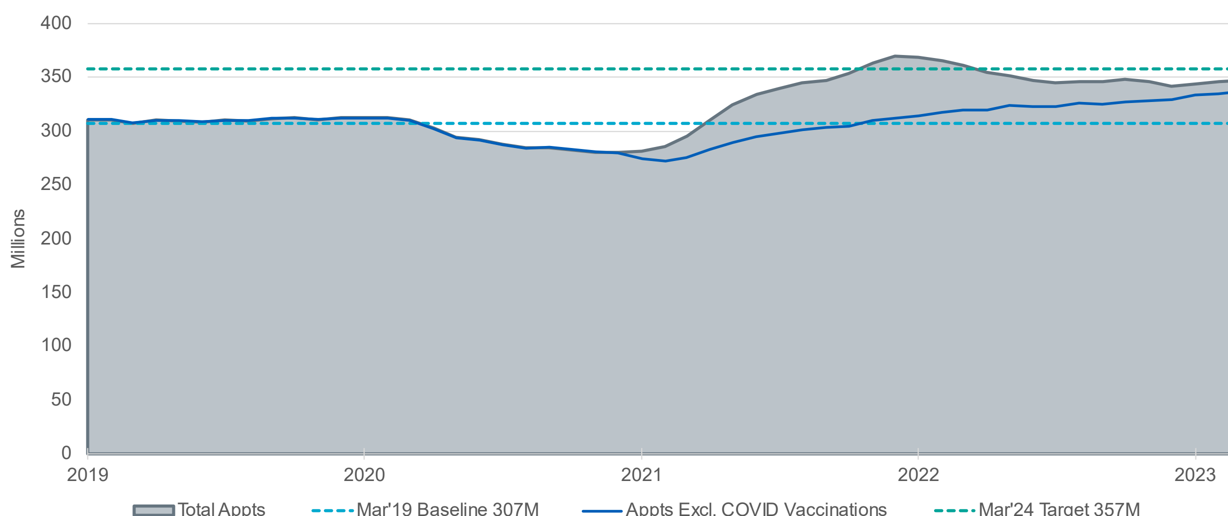
Since 1 July 2022[7], all 42 ICBs have had delegated responsibility for commissioning primary medical services, with 9 ICBs also taking on one or more of: dental (primary, secondary and community), general ophthalmic services and pharmaceutical services. All remaining ICBs were assigned delegated responsibility for all 4 primary care services from April 2023.[8]

Primary and community health services

General practice

General Practice continues to demonstrate increased activity with 347.4 million appointments in the 12 months to the end of March 2023, including 10.5 million COVID-19 vaccinations. This is 13% above the March 2019 baseline. The March 2024 target of an additional 50 million appointments was met in October 2023.

Appointments in general practice



In May 2022, the Fuller stocktake report[9] set out what is working well and how we can accelerate the implementation of integrated primary care. All ICB chief executive officers co-signed a letter committing to deliver this vision of streamlined access to urgent care, with continuity for those who would benefit the most, and a more proactive role in creating healthy communities.

In September 2022, we set out actions to boost capacity ahead of winter 2022/23. ICBs rapidly repurposed £37 million of the Investment and Impact Fund to expand clinical capacity. 351 acute respiratory infection hubs were established over winter, delivering more than 200,000 appointments.

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[7] https://www.england.nhs.uk/commissioning/publication/delegation-of-primary-medical-dental-ophthalmic-and-pharmaceutical-functions/
[8] https://www.england.nhs.uk/long-read/primary-care-commissioning-assurance-framework/
[9] https://www.england.nhs.uk/publication/next-steps-for-integrating-primary-care-fuller-stocktake-report/

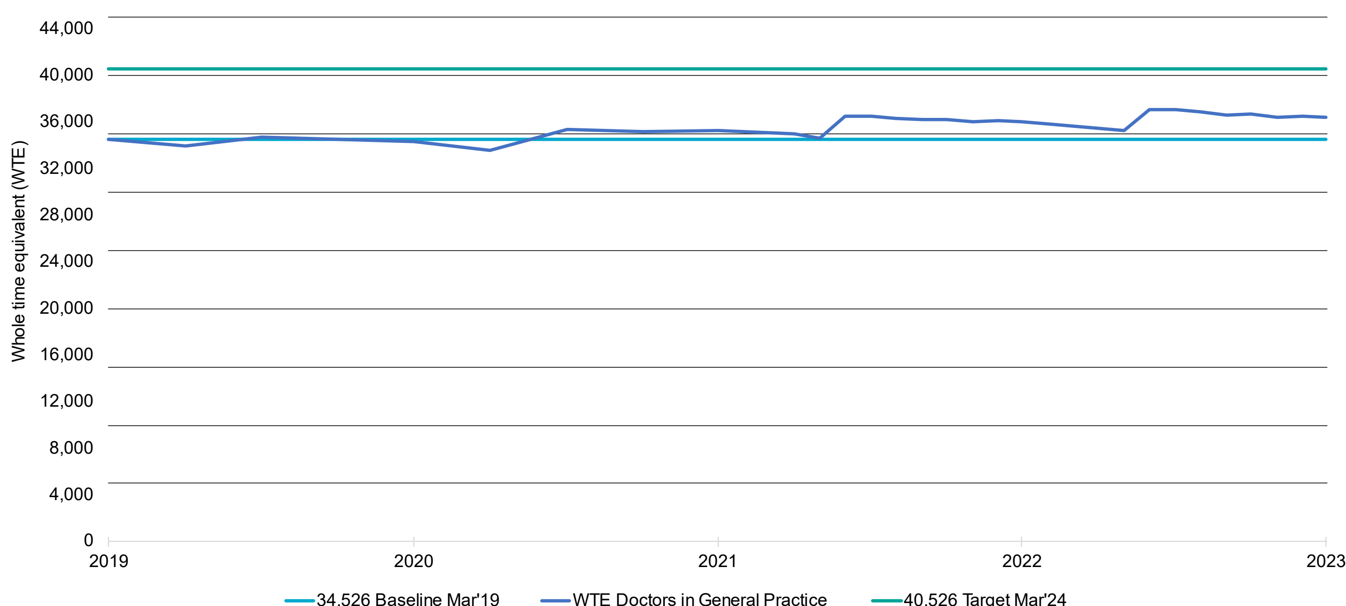
From 1 October 2022, primary care networks (PCNs) were required to provide a standardised service offer to patients, through the Network Contract Directed Enhanced Service, ensuring 6:30pm to 8pm evening appointments Monday to Friday and 9am to 5pm appointments on Saturday in all networks.

In 2022/23, the accelerated improvement programme supported 724 GP practices to address their immediate access pressures. As a result, 88% of practices reported a productivity gain and 99% of practice staff reported they felt better equipped to deal with their work challenges.

Primary care workforce

The wider workforce numbers continued to rise with more than 29,103 whole time equivalent (WTE) additional staff in place and an additional 1,903 WTE doctors in general practice at the end of March 2023 compared to the March 2019 baseline. This has achieved and exceeded the Additional Roles Reimbursement Scheme government commitment to deliver 26,000 additional roles in primary care by March 2024, however retention of the qualified GP workforce remains a significant issue.

Doctors in general practice



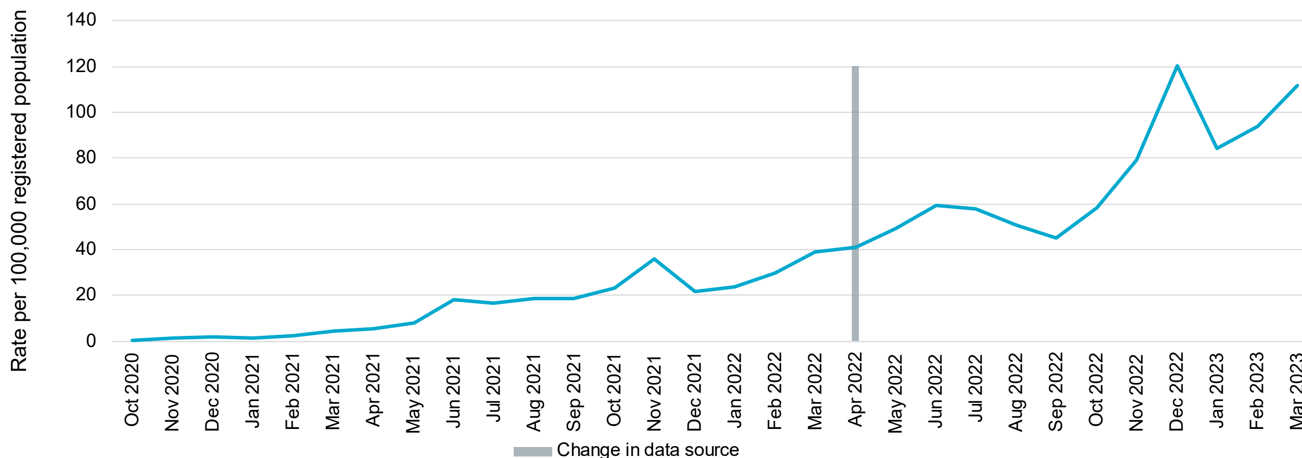
Targeted efforts are in place to retain GPs in the workforce, including working with systems to communicate and adopt the enhanced package of GP retention initiatives in 'Investment and evolution: updates to the GP Contract 2020/21 to 2023/24'.[10]

[10] https://www.england.nhs.uk/publication/investment-and-evolution-update-to-the-gp-contract-agreement-20-21-23-24/

Community pharmacy

The Community Pharmacist Consultation Service (CPCS) continued to grow. During 2022/23, 2.8 million consultations[11] were delivered in community pharmacies as part of the New Medicine Service.[12] This included significant increases in referrals from 111 and GPs.

Completed GP referrals to CPCS per 100,000 registered population



Other key achievements include the delivery across England of:

- a community pharmacy hypertension case-finding service[13] with a million clinical blood pressure checks and 55,000 ambulatory blood pressure checks delivered by community pharmacies in the reporting period
- a smoking cessation service for patients recently discharged from acute NHS trusts[14]. Implementation is planned to be completed across England by the end of March 2024 as hospital smoking cessation services mobilise. Almost 4,000 community pharmacies have signed up to deliver this service to the end of March 2023

Dentistry and optometry

Primary care dental services continue to recover from the pandemic following the lifting of infection prevention control constraints in July 2022, with 78% of contracted units of dental activity delivered in 2022/23. However, approximately 101% of contracted units of dental activity were delivered in March 2023, marking an improvement in performance.

In July 2022, we announced the first dental contract amendments since 2006 to improve care for higher-needs patients and improve overall access.[15]

Optometry services exceeded pre-COVID-19 activity levels in high street practices.

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[11] https://www.nhsbsa.nhs.uk/prescription-data/dispensing-data/complete-new-medicine-service-data
[12] https://www.nhs.uk/nhs-services/prescriptions-and-pharmacies/pharmacies/new-medicine-service-nms/
[13] https://www.england.nhs.uk/publication/advanced-service-specification-nhs-community-pharmacy-hypertension-case-finding-advanced-service
[14] https://www.england.nhs.uk/primary-care/pharmacy/nhs-smoking-cessation-transfer-of-care-pilot-from-hospital-to-community-pharmacy/
[15] https://www.england.nhs.uk/publication/first-stage-of-dental-reform/

The special schools eye care service[16] proof of concept began in May 2021 to provide sight tests to children with a learning disability and/or autism in a special educational setting. As of 28 February 2023, more than 11,000 sight tests had been undertaken and 4,700 spectacles had been dispensed.

Personalised care

We have already achieved more than double our commitment in the NHS Long Term Plan to 2.5 million people receiving personalised care, a year ahead of the target. More than 6 million people have benefitted from a personalised care intervention during the reporting period, giving patients more control of their care and alleviating pressure on GPs.

Urgent community response

Urgent community response (UCR) teams continued to provide urgent care to people in their homes, avoiding hospital admission. More than 80% of patients were seen within 2 hours of referral to UCR in January 2023, exceeding the national expectation of 70%. 88% of ICBs accepted falls referrals as part of their UCR provision from 8am to 8pm, 7 days a week, as a minimum, by February 2023.

Virtual wards

Significant progress was made in developing digitally enabled virtual wards (also known as 'Hospital at Home'), where the number of virtual ward beds increased from 4,845 (May 2022) to 8,241 (March 2023). More than 100,000 patients were treated in a virtual ward in the reporting period.

Urgent and emergency care

Average daily A&E attendances for 2022/23 were close to 69,500 (66,800 in 2021/22), an increase of 4% against the previous year. In March 2023, 71.5% of patients were admitted, transferred or discharged from A&E within 4 hours of arrival.

Admissions to hospital through the emergency department had however decreased over the same period, averaging 4% lower compared to 2021/22. Despite this, and increases in bed numbers, bed occupancy continued to rise averaging at 93.6% across the year.

To support reducing hospital occupancy rates, we increased bed capacity by the equivalent of more than 7,000 additional general and acute beds in 2022/23, as well as through the expansion of same day emergency care and urgent treatment centres.

As part of the plan to increase resilience over winter 2023/24, system control centres were set up across all 42 ICSs. These centres operate 24/7 and are staffed with senior clinical decision makers and operational teams with expertise in dealing with capacity and demand across both primary and secondary care.

[16] https://www.england.nhs.uk/learning-disabilities/improving-health/eye-care-dental-care-and-hearing-checks/eye-care/

NHS 111

NHS 111 received 22.3 million calls in 2022/23 with an exceptional level of calls during December 2022 due to winter pressures, including widespread public concern about Strep A infections. The number of NHS 111 call handlers increased by 12.4% by March 2023, compared to September 2021. In terms of 111 online services, digital uptake (the percentage of online completed sessions as a proportion of total activity, including calls and online pathways) during 2022/23 was typically just under 30%. This rose to approximately 40% in December 2023, equating to just over 1.1 million completed online sessions.

Ambulance services

By the end of March 2023, we had increased the number of 999 call handlers by 15% compared to September 2021. The total of 2,376 WTE is marginally short of the 2,500 target, however the average call answer times fell to their lowest in January 2023, before increasing slightly in February and March as demand increased.

The ambulance service[17] responded to 18% more category 1 incidents in December 2022 compared to the previous high in July 2022 and, by March 2023, performance was 8 minutes and 49 seconds. Category 2 incidents decreased by 10% in December 2022 against the same point in the previous year. However, ambulance services continued to be challenged by long handover delays that impacted the flow of patients through hospitals and response times increased to 39.3 minutes in March 2023.

In November 2022, 2 ambulance trusts trialled an intelligent digital call-routing system to reduce long waits for calls. Following a successful trial providing category 2 calls with additional clinical input in order to prioritise those calls most in need of an ambulance, this is now being rolled out to all ambulance trusts.

In January 2023, we published the UEC services recovery plan[18] which outlined the steps we will take to ensure patients are seen in emergency departments, and that ambulances get to patients quicker.

Elective care

In February 2022, the delivery plan for tackling the COVID-19 related backlog of elective care[19] set out clear ambitions for the next 3 years. This remains the blueprint for elective delivery.

The initial focus was on patients who were waiting 2 years or more by the end of July, with the exception of those who chose to wait longer, did not want to travel to be seen faster, or for very complex cases requiring specialist treatment. More than 22,500 people who had been waiting 2 years or more at the start of the year, and a further 51,000 who would have

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[17] https://www.england.nhs.uk/urgent-emergency-care/improving-ambulance-services/arp/
[18] https://www.england.nhs.uk/wp-content/uploads/2023/01/B2034-delivery-plan-for-recovering-urgent-and-emergency-care-services.pdf
[19] https://www.england.nhs.uk/coronavirus/publication/delivery-plan-for-tackling-the-covid-19-backlog-of-elective-care/

exceeded a 2-year wait by the end of July, were treated. The NHS met this first target by virtually eliminating waits longer than 2 years for elective care by July 2022, despite higher levels of COVID-19, with hospitals treating more than 220,000 patients with the virus since the plan was published.

The next milestone was to virtually eliminate waits of more than 18 months by the end of 2022/23 (with the exception of patients who chose to wait longer and a very small number of highly specialised areas). As of 31 March 2023, this figure was 10,718, down from a peak of 63,777 in April 2022.

While reducing the number of people waiting a very long time for treatment was the focus, the plan was clear that the total waiting list was likely to keep growing. In 31 March 2023, there were 7.3 million incomplete referral to treatment pathways (up from 6.4 million in March 2022).

Targeted Investment Fund (TIF)

This was the first year of the £1.5 billion TIF2 capital funding agreed at Spending Review 2021, ringfenced to increase elective activity. For 2022/23, £537.3 million had been drawn down against an allocation of £600 million, supporting a total of 85 schemes. We will be commencing an evaluation of the TIF schemes in 2023/24.

Mental health

The mental health programme is on track to invest an additional £2.3 billion a year in expanding services by the end of 2023/24, and there has been sustained growth in workforce and activity.

An additional 207,542 children and young people aged up to 17 received at least one contact from an NHS-funded mental health service in the 12 months up to March 2023. The programme is on course to achieve the overall access ambition to support an additional 345,000 people aged up to 25 by the end of 2023/24.

By the end of 2023, 35% of the school-age population were covered by 398 operational Mental Health Support Teams, meeting our Long Term Plan ambition a year earlier than planned.

The Early Intervention in Psychosis standard, requiring more than 60% of people who experience a first episode of psychosis begin treatment with an evidence-based care package within 2 weeks of referral, continued to be achieved in 2022/23.

Children and Young People (CYP) community eating disorder services are treating 55% more children and young people since the start of the pandemic, which is in turn affecting waiting-time standards. As of March 2023, 82.5% of routine CYP eating disorder referrals

were seen within 4 weeks and 78.7% of urgent referrals were seen within 1 week, compared to a standard of 95%.

NHS Talking Therapies[20] referral to treatment time target and the recovery standards continued to be met and, in quarter 4 of 2022/23, 320,254 people accessed services.

The new integrated model of primary and community mental health care supports adults and older adults with severe mental illnesses to access mental healthcare. In 2022/23, a record 313,022 people within this demographic received all 6 elements of the physical health checks, against an ambitious target of 346,000.

The urgent and emergency mental health pathway continues to be under significant pressure, experiencing exceptionally high bed occupancy of 95% to 97% since May 2022. According to quarter 4 2022/23 data, inappropriate out-of-area placements, which are driven by capacity limitations, totalled 58,515 days.

The estimated dementia diagnosis rate was 63% as of March 2023, against the national ambition of 66.7%. We are funding an evidence-based improvement project for 2 trusts in each region to pilot the ‘diagnosing advanced dementia mandate tool’ to improve the diagnosis of dementia in care homes.

People with a learning disability and autistic people

The number of people with a learning disability and autistic people in a mental health inpatient setting continued to reduce. During 2022/23, 1,229 adults were discharged from hospital, 444 (36%) of which had been in hospital for more than 1 year, and 147 (12%) had been in hospital for more than 5 years. The inpatient total at the end of July 2023 represented a 30% net reduction since March 2015 but there is further to go to reach the NHS Long Term Plan target.

We supported PCNs to deliver learning disability annual heath checks (AHCs). Between April 2022 and March 2023, 78.1% of people aged 14 and over on a GP learning disability register had received an AHC, meaning that we met our commitment to reaching 75% by March 2024 a year earlier than planned.

Our Learning from the Lives and Deaths of People with a Learning Disability and Autistic People programme[21] continued to review the care of people with a learning disability and autistic people who died. Drawing from the learnings from this programme and to support improvements in care and outcomes, we have published an acute care toolkit[22], British Thoracic Society clinical statements on aspiration pneumonia[23] community acquired

[20] https://www.england.nhs.uk/mental-health/adults/nhs-talking-therapies/
[21] https://leder.nhs.uk/
[22] https://www.rcp.ac.uk/projects/outputs/acute-care-toolkit-16-acute-medical-care-people-learning-disability
[23] https://thorax.bmj.com/content/78/Suppl_1/s3

pneumonia and a RightCare scenario on aspiration pneumonia[24], and Restore2 mini training via Skills for Care.[25]

Health inequalities and prevention of ill-health

The NHS Prevention Programme delivers targeted work to tackle risk factors and their underlying causes, subsequently helping to reduce health disparities and narrow inequalities.

Since its launch in June 2021 more than 200,000 people have been referred to the NHS Digital Weight Management Programme.[26]

By the end of 2022/23, more than a third of all inpatient trusts and around two-thirds of all maternity trusts had actively implemented new tobacco dependence treatment services. Additionally, 32 Alcohol Care Teams were optimally established in areas of the highest alcohol related harm and deprivation.

NHS Diabetes Prevention Programme

Referrals to the NHS Diabetes Prevention Programme[27] have recovered to pre-pandemic levels. More than 1.2 million referrals have now been made into the programme, with just under 600,000 people joining. An independent evaluation has shown a 37% relative reduction in incidence of those who complete the programme and a 7% reduction in population-level incidence of type 2 diabetes. The latest independent analysis published[28] in February 2023 showed the risk of developing type 2 diabetes is 20% lower for those referred, even if they do not complete the programme.

Non-cancer adult and young person screening

Following the pandemic, all 38 services providing the NHS abdominal aortic aneurysm screening programme[29] to men aged 65 years or older, were restored. At quarter 4, annual surveillance (92.3%) was above efficiency threshold of 85% and both below optimal standards of 85% and 95%, respectively. Coverage for men on quarterly surveillance is 93.1%, which is also above the efficiency standard of 85%, however coverage of initial screen (72.8%) was below efficiency threshold of 75%.

The NHS diabetic eye screening programme[30] was fully restored by September 2022, and its routine appointment uptake levels continued to perform above the required standard (75%) at 79.1% in quarter 4 2022/23.

[24] https://www.england.nhs.uk/publication/rightcare-learning-disability-and-aspiration-pneumonia-scenario/
[25] https://www.skillsforcare.org.uk/Developing-your-workforce/Care-topics/Spotting-the-signs-when-a-person-becomes-unwell/Spotting-the-signs-when-a-person-becomes-unwell.aspx
[26] https://www.england.nhs.uk/digital-weight-management/
[27] https://www.england.nhs.uk/diabetes/diabetes-prevention/
[28] https://www.england.nhs.uk/2023/02/nhs-scheme-reduces-chances-of-type-2-diabetes-for-at-risk-adults/
[29] https://www.nhs.uk/conditions/abdominal-aortic-aneurysm-screening/
[30] https://www.gov.uk/guidance/diabetic-eye-screening-programme-overview

NHS vaccinations and public seasonal flu programmes

The UK remains a world leader in uptake across many vaccination programmes and in 2022/23, the NHS achieved the second highest flu vaccination rates on record with 21.2 million people taking up the offer. A major national communications and marketing campaign ran, with a key focus on those at highest risk of serious illness and communities with the lowest uptake.

Please see page Appendix 3: Reducing health inequalities193 for more detail on our work to reduce healthcare inequalities in 2022/23.

Maternity and neonatal services

We published the 3-year delivery plan for maternity and neonatal services[31] in England on 30 March 2023. This includes learning from independent reports into maternity and neonatal services in Shrewsbury and Telford, and East Kent.

We aim to halve rates of stillbirth, neonatal death, maternal death and brain injury between 2010 and 2025. We made progress towards this ambition with the stillbirth and neonatal mortality rate in 2021 being 23% and 30% lower respectively compared with 2010.

Since March 2021, we have invested an additional £165 million recurrently in maternity and neonatal services. Our additional investment enabled a substantial increase in workforce establishment for midwives (over 2,000 WTE), obstetricians (over 400 WTE), maternity support workers (340 WTE) and neonatal nurses (550 WTE).

We have continued to expand and embed specialist community perinatal mental health services; 36 maternal mental health services were established for women who experience moderate to severe or complex mental health issues directly related to a trauma or loss. Work is ongoing to ensure one is established in each of the 6 remaining ICSs.

We continued working with trusts to implement all elements of the Saving Babies' Lives care bundle, version 2.[32] We have developed version 3 of the care bundle[33], which will roll out across all trusts in 2023/24, including the new Element 6 on managing diabetes in pregnancy.

NHS antenatal and newborn (ANNB) screening programmes

Coverage for the 3 antenatal screening programmes remained above 99% and above 98% for newborn screening programmes within the target timescales. The NHS ANNB programmes continue to deliver 2 important in-service evaluations for the UK National Screening Committee: non-invasive prenatal testing rollout within the NHS Fetal Anomaly

[31] https://www.england.nhs.uk/publication/three-year-delivery-plan-for-maternity-and-neonatal-services/
[32] https://www.england.nhs.uk/publication/saving-babies-lives-version-two-a-care-bundle-for-reducing-perinatal-mortality/
[33] https://www.england.nhs.uk/publication/saving-babies-lives-version-three/

Screening Programme[34] and severe combined immuno-deficiency within the NHS newborn blood spot screening programme.[35]

Cancer and NHS cancer screening

Our public awareness campaigns and case-finding initiatives are making a difference. GPs are referring more people for urgent cancer checks than ever before – more than 200,000 every month – meaning we have eradicated the shortfall in cancer referrals that began in the early part of the pandemic. We are diagnosing a higher proportion of cancers earlier than ever before and the number of people starting treatment is higher than ever before.

We are investing more in expanding diagnostic and treatment capacity to meet the rising demand and working with the most challenged trusts, which is showing positive results.

The number of people waiting longer than 62 days for treatment to begin from the date of referral for suspected cancer has reduced significantly. By the end of March 2023 there were 14,700 fewer people waiting more than 62 days than during the peak in September 2022, when there were over 33,900 patients.

The NHS is focusing particular attention on resolving the more challenged pathways, including interventions such as tele-dermatology for skin cancer pathways, a £2 million investment in dermatoscopes and increased use of faecal immunochemical tests for bowel cancer. More than 5,400 patients have benefited from a colon capsule endoscopy 'pill-cam' in 53 pilot sites, and approximately 70% have not needed a colonoscopy.

We have a comprehensive, 6-pillar strategy to diagnose more cancer types earlier, including rare and less common cancers, and others that are not assigned a staging group in the conventional way (such as some blood cancers and brain cancers). Highlights of this strategy include:

- in April 2022, we expanded the Targeted Lung Health Check programme[36] to invite people from 20 more areas, reaching 43 areas in total. By the end of March 2023, the programme had invited more than 890,000 current or former smokers from some of the most disadvantaged areas in the country. More than 2,100 people were diagnosed with lung cancer – 76% of those at stage 1 or 2 – compared with the previous overall lung cancer early diagnosis rate of 28%
- in 2022/23, we launched Community Liver Health Checks in 12 areas. Between June 2022 and March 2023, the pilots delivered more than 11,000 fibroscans and identified more than 1,200 people at increased risk of liver cancer. The programme is actively reducing health inequalities by offering mobile services to those most at risk, including homeless people, people using drug and alcohol services and people with type 2 diabetes

[34] https://www.gov.uk/guidance/fetal-anomaly-screening-programme-overview
[35] https://www.nhs.uk/conditions/baby/newborn-screening/blood-spot-test/
[36] https://www.nhs.uk/conditions/lung-health-checks/

- by Autumn 2022, the NHS-Galleri trial[37] successfully recruited 140,000 participants. The trial will assess the impact of offering a blood test to people without symptoms, with participants having 3 blood tests over 2 years

Cervical screening programme

2022/23 data[38] shows that for the higher age cohort, coverage is just marginally under the 75% efficiency standard at 74.9%. For the younger cohort aged 25 to 49 it remains lower at 66.4%.

Breast screening programme

The NHS breast screening programme continued to recover from the pandemic with a focus on removing the backlog in screening invitations and restoring the 3-year screening interval for the eligible population. Capacity was increased through additional evening and weekend appointments, building the workforce and investing in additional mobile breast screening units.

Bowel screening programme

The NHS bowel cancer screening programme exceeded the optimal coverage standard of 60%, with latest performance measured at 72.9% in March 2023. Eligibility was extended to include 56-year-olds in 2021/22 and 58-year-olds in 2022/23.

COVID-19 vaccination deployment

As of 31 March 2023, the NHS had administered more than 144 million COVID-19 vaccinations in England with around 4.5 million spring boosters. A major national campaign ran over autumn and winter alongside the annual flu campaign, offering protection to those at greater risk of severe illness and helping reduce hospital admissions.

Mpox vaccination deployment

In July 2022, the NHS began vaccinations against Mpox (previously known as monkeypox) to those at highest risk of exposure, following the World Health Organisation's declaration of a public health emergency of international concern. Working with sexual health services and other partners in health systems, the NHS vaccinated more than 70% of those eligible by 31 March 2023, nearly 100,000 doses in total.[39]

In March 2023, UK Health Security Agency (UKHSA) confirmed that, due to the success of this vaccination programme, a sustained reduction in case numbers meant that Mpox vaccination work could end in summer 2023.

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[37] https://www.nhs-galleri.org/
[38] https://digital.nhs.uk/data-and-information/publications/statistical/cervical-screening-programme/cervical-screening-programme-coverage-statistics-management-information
[39] https://www.england.nhs.uk/statistics/statistical-work-areas/vaccinations-for-Mpox/

Workforce

In 2022/23, our focus was on restoring services to full capacity following the pandemic, alongside continuing to support the delivery of innovative new ways of working, as described in the 2022/23 operational planning guidance.[40] The planning guidance set out actions to increase workforce capacity and resilience to deliver safe and high-quality services that meet health and care needs.

Over the course of the year we engaged extensively with staff groups and others over the development of the NHS Long Term Workforce Plan, published in June 2023. However, ongoing actions continued alongside this policy development to support workforce growth, redesign, improved retention and improved productivity. Achievements included:

More people:

- the NHS Hospital & Community Health Service (HCHS) workforce was 1,280,350 WTE strong in March 2023, 4.4% (53,672) more than in March 2022.
- within this, the number of professionally qualified clinical staff was 671,943 WTE by March 2023, an increase of 3.7% (24,098) against March 2022.
- we have continued to support Trusts with overseas recruitment to address domestic labour supply shortages and vacancy rates. As part of this, 15,146 additional international nurses were recruited over the year, an increase of 19.6% on the previous reporting period.

Compassionate and inclusive culture

The Staff Survey was redesigned to align with the 7 elements of the People Promise, to improve how staff experience is monitored. 2022 data shows the staff engagement score has remained stable since 2021 (6.8), though it remains lower than before the pandemic in 2018-2020 (7.0). The morale score has declined for a second consecutive year and is now 0.3 points below its peak (6.1) in 2020.

More than 5,300 managers have attended the national health and wellbeing conversation training programme, and 195 of those will become trainers.

23 People Promise exemplar sites were implemented, improving staff experience and retention. Initial insights show 14 out of the 23 sites improved their quarterly staff engagement scores from quarter 1 to quarter 2 2022/23, with the overall cohort improving by 1.1% compared to a deterioration nationally of 0.3%. The retention rate is improving faster in the exemplar cohort than for the rest of the NHS.

96% of secondary care organisations had a wellbeing guardian in post as of December 2022, and our regional teams are working with the remaining 4% of organisations to support them in appointing wellbeing guardians.

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[40] https://www.england.nhs.uk/publication/2022-23-priorities-and-operational-planning-guidance/

Health and justice

We achieved 100% coverage across England of mental health treatment requirements for individuals whose offence crosses the community order sentencing range.

RECONNECT services continue to be opened, supporting those leaving prison and immigration removal centres. Over the course of the reporting period, we achieved 51.4% coverage in England and are on track to deliver 100% coverage by March 2024.

3 pilot sites for Enhanced RECONNECT have been mobilised to support high risk and highly complex individuals leaving custody.

We have mobilised 7 vanguards, 1 in each of our 7 regional teams, to implement the Framework for Integrated Care (Community).

We have delivered the Private Finance Initiative programme, which transferred the healthcare commissioning of 5 private prisons to NHS England. All prisons in England now have their healthcare commissioned by NHS England.

All service specifications for healthcare services in health and justice settings have been updated. This includes further reinforcing our commitment to 'equivalence of care' in the much revised Service Specification 29 for NHS Section 7A (s7a) public health services for children and adults in secure and detained settings in England.

Armed forces

Work has progressed on the commitments in the document, 'Healthcare for the Armed Forces community: a forward view'[41], which include:

- re-procurement of Op COURAGE[42]: the Veterans Mental Health and Wellbeing Service, underpinned by an enhanced service model for a fully integrated mental healthcare pathway across each of our regions. These improved service arrangements began on 1 April 2023, to facilitate increased access to a broader range of mental health and wellbeing services for individuals due to leave the armed forces, reservists and those who have already left the military
- commissioning a new non-clinical service to improve the identification and support of veterans pre- and post-prison custody. Informed by local services across several of our regions and a robust programme of engagement, Op NOVA[43] services began on 1 April 2023, providing a single point of contact for veterans, who, following an assessment, will have a comprehensive support plan developed for them that is overseen by a care and support coordinator

[41] https://www.england.nhs.uk/publication/healthcare-for-the-armed-forces-community-a-forward-view/
[42] https://www.nhs.uk/nhs-services/armed-forces-community/mental-health/veterans-reservists/
[43] https://www.forcesemployment.org.uk/programmes/op-nova/

- implementation of the ICB-based single point of contact service for armed forces families and community. Over the last year, 7 pilots have been launched to test and inform a dedicated service that supports improved access to and continuity of care for this patient cohort that reflects the unique circumstances of military life and the impact on the wider family
- establishment of the national Serving and Ex-Serving Women's Health Improvement Group with members from across government departments and the armed forces charity sector
- expansion of services and support for the armed forces community through the ongoing development of:
  - fully functioning clinical pathways for the veterans' trauma network
  - military maternity care pathways
  - improving access to sexual assault referral centres (SARCs) for serving personnel, underpinned by a pathfinder at Catterick Garrison in North Yorkshire
  - the NHS England-commissioned Royal College of General Practitioners' veteran-friendly practice accreditation programme, with 2,000 practices accredited in-year
  - the NHS England-funded Veteran Covenant Healthcare Alliance, which has 140 accredited acute NHS trusts. Plans within the New Hospital Programme for a national rehabilitation centre have been approved and construction has commenced. Once opened the Centre will benefit veterans

Digitising, connecting and transforming health and care

Our strategy for technology in health and care is to digitise, connect and transform.[44] With the legal merger of NHS Digital and NHS England on 1 February 2023, the new NHS England became one of the largest digital and tech organisations in the country. The Transformation Directorate plays a critical role in supporting the development and spread of digital innovation by developing and deploying national products and platforms, while running many live services.

In June 2022, the data saves lives strategy[45] set out future plans for data and building on the lessons learned from COVID-19 about the power of data. The plan for digital health and social care[46] set out a vision and plan for digitally transformed health and social care services and, in March 2023, the cyber security strategy for health and social care[47] set out the approach for the sector and its suppliers to achieve cyber resilience no later than 2030.

[44] https://transform.england.nhs.uk/digitise-connect-transform/what-good-looks-like/what-good-looks-like-publication/
[45] https://www.gov.uk/government/publications/data-saves-lives-reshaping-health-and-social-care-with-data
[46] https://www.gov.uk/government/publications/a-plan-for-digital-health-and-social-care/a-plan-for-digital-health-and-social-care
[47] https://www.gov.uk/government/publications/cyber-security-strategy-for-health-and-social-care-2023-to-2030

Electronic records and digital foundations

We are committed to NHS organisations having a core level of digital maturity – specifically an electronic patient records (EPR) system – by March 2025, and 80% of Care Quality Commission (CQC) registered adult social care providers having digital records by March 2024. By March 2023, 86% of trusts had EPR, this is expected to rise to 91% by December 2023. In adult social care, 52% of providers had a digital social care record by March 2023 (up from 41% in December 2021).

Understanding, protecting and improving the health of the population

A data platform enables NHS organisations to bring together operational data stored on separate systems. In January 2023, we began procuring a federated data platform so that every trust and ICS will have its own platform that can connect and collaborate with other data platforms.

We are trialling tools locally with promising results. An elective care co-ordination pilot in East Sussex removed 16% of its waiting list by identifying errors and was made live in 36 trusts by the end of March 2023. A discharge pilot helped North Tees reduce patients staying 21 days or more to 12% over a 12-month period (the national average is 20%). This was live in 16 trusts at the end of March 2023.

Planning, evaluating and improving the delivery of services

During 2022/23, we began work to develop cross-ICS bed management systems to improve the flow of patients through hospitals and across the healthcare system.

Data for research and development

In 2022/23, we invested over £13.5 million[48], as part of a funding package of over £100 million, to catalyse the development of interoperable and multi-model sub-national secure data environments. Secure data environments will enable more rapid and efficient health research and innovation, and are designed to provide secure, transparent data access for approved researchers, without that data leaving NHS secured databases.

NHS App

The NHS App and NHS.UK was established as a digital 'front door' to the NHS, enabling more people to participate more in their health and care. The NHS website received more than 90 million visits per month in 2022/23, making it the UK's most popular health website, and more than 32 million people are registered for the NHS App, making it the UK's most popular non-commercial app.

By the end of 2022/23, each month the NHS App enabled people to undertake tasks relating to 2.1 million repeat prescription orders (saving practices 336,000 hours in administration time), 1.2 million referrals to secondary care, 300,000 primary care

[48] https://www.england.nhs.uk/blog/investing-in-the-future-of-health-research-secure-accessible-and-life-saving/

appointments (saving practices 12,500 hours of administration time), and 470,000 people view their secondary care appointments.

Artificial intelligence (AI)

The NHS AI Lab, set up in 2019, accelerates the development and deployment of safe, effective applications that support clinicians by informing their decisions and saving time. We have funded 7 technologies through the AI in Health and Care Award. These have been rolled out to 65 hospital sites and helped over 200,000 patients. In December 2022, one recipient of funding, 'Brainomix'[49], tripled the number of stroke patients recovering with no or only slight disability from 16% to 48%.

NHS DigiTrials service

The NHS DigiTrials service developed at pace and supported the NHS-Galleri early cancer detection study to recruit over 140,000 people to participate in ground-breaking research in less than a year. In November 2022, the service launched a 'beta' version of its feasibility self-service tool, creating more opportunities for life-saving innovations to be developed for the NHS.

Live services

Following the merger with NHS Digital, NHS England became responsible for the operation of several technology services and live services which directly support patients and staff across the NHS, ranging from core infrastructure through to data sharing and cybersecurity operations.

The NHSmail team continued to support the adoption of the centralised Microsoft tool set to build enhanced collaboration. Adoption of these technology solutions has been crucial to improving patient care and efficient service delivery. The NHSmail collaboration platform has supported more than 800,000 audio calls, 1.5 million Microsoft Teams meetings and 9 million Microsoft Teams chats per week throughout 2022/23.

The Future Connectivity programme[50] supported a series of wireless trials within NHS trusts that helped frontline staff improve services by using digital technology and provided valuable insights into how investing in advanced wireless infrastructure in the NHS can improve user experience, care and outcomes. We helped NHS organisations upgrade more than 1,000 networks to faster and more reliable fibre connectivity; supported 12 NHS organisations with upgrades to gigabit-capable connectivity; established bandwidth demand profiles for nearly half of NHS premises; and identified up to 2,000 sites eligible for funding under the Department for Digital, Culture, Media and Sport's 'Project Gigabit'.

[49] https://www.gov.uk/government/news/artificial-intelligence-revolutionising-nhs-stroke-care
[50] https://digital.nhs.uk/services/future-connectivity

Digital inclusion

Mitigating the risk that digital approaches exclude people unwilling or unable to use them is a continuing priority for action on health inequalities and, in September 2023, NHS England's framework for NHS action on digital inclusion[51] set out plans to support ongoing learning and action.

Emergency preparedness, resilience and response

During 2022/23, the NHS Resilience team continued to provide oversight to the COVID-19 response. Following the Omicron peak of just over 17,100 inpatients in early January 2022, there were several subsequent waves of COVID-19 infection alongside the return of the normal seasonal range of infections. In May 2022, we announced the move from COVID-19 response to recovery and moving from a Level 4 to Level 3 (regional leadership) incident response. At the end of March 2023, the NHS was caring for 7,500 patients with COVID-19 in inpatient beds; most had the infection as a complication of another condition that led to their admission.

The NHS Resilience team also manages the activation process for confirmed high consequence infectious disease (HCID) cases. These are usually single cases and include setting up HCID network calls to discuss patient placement, arranging safe patient transport where required and incident management. The team have supported the response to confirmed cases of Lassa fever, Crimean-Congo haemorrhagic fever and the Mpox outbreak during 2022. The team also worked with UKHSA on plans for managing any confirmed cases of returning travellers or healthcare workers linked to an Ebola outbreak in Uganda and monitored the global situation regarding Marburg virus, Lassa fever and avian flu.

In August 2022, the team worked closely with the NHS Cybersecurity Centre (then in NHS Digital) on the response to a cyber-attack on an NHS supplier.

The Resilience team led planning for significant national events and, following the death of Her Majesty the Queen, the plan for Operation London Bridge was activated.

Over the latter part of the reporting period, staff across a range of sectors, including the NHS, took industrial action. The NHS developed an operational plan in advance of strike action, informed by clinicians' views on risk and setting out arrangements to respond to multiple different clinical and non-clinical NHS staff groups taking industrial action across ambulance and nursing services. The NHS Resilience team, together with the nursing, UEC and people directorates, established effective relationships with trade unions to inform discussions on derogations, taking a risk-based approach.

We frequently set out key actions for trusts and ICBs to minimise disruption and support patient care. To ensure readiness, identify areas of concern and focus our support, NHS

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[51] https://www.england.nhs.uk/long-read/inclusive-digital-healthcare-a-framework-for-nhs-action-on-digital-inclusion/

Resilience worked with clinicians to develop and issue assurance ahead of each day of proposed strike action.

Other key responses over the reporting period include:

- supporting the UK response to the conflict in Ukraine
- a Level 4 heatwave alert
- supporting the NHS Blood and Transplant amber alert triggered by low bloodstock levels
- coordinating deployment of hazardous area response teams to assist with the suspected gas explosion in St Helier, Jersey

Access to medicines

The NHS is internationally competitive in adopting innovative medicines. Industry data shows 5 treatments are available in England for every 4 in Europe, and we have access to almost a third more cancer drugs.

Throughout 2022/23, the NHS Commercial Medicines Directorate (CMD) has secured new treatment options for thousands of patients while safeguarding the sustainability of the NHS medicines budget. Our approach is set out in the NHS Commercial Framework for New Medicines[52] and is aligned to the priorities and ambitions of both the NHS Long Term Plan and the UK's Life Sciences Vision.[53]

In June 2022, we launched the Innovative Medicines Fund (IMF), a £340 million initiative to support faster access to non-cancer drugs. Together with the existing £340 million Cancer Drugs Fund (CDF), a total of £680 million ringfenced NHS funding is now provided for innovative medicines that show clinical promise, but where there remains uncertainty around clinical and cost-effectiveness. This uncertainty is then resolved through real-world data collection in the IMF or CDF.

In July 2022, we reported a £1.2 billion saving on the NHS medicines bill over 3 years. This was in large part due to the CMD's Commercial Medicines Unit achieving better prices for hundreds of hospital medicines. This figure also included continued savings from the adoption of biosimilar versions of adalimumab (Humira®) which was previously the health service's most costly drug.

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[52] https://www.england.nhs.uk/medicines-2/commercial-medicines/nhs-commercial-framework-for-new-medicines/
[53] https://www.gov.uk/government/publications/life-sciences-vision

The CMD has continued to work closely with partners at the National Institute for Health and Care Excellence (NICE), the Medicines and Healthcare Products Regulatory Agency and in industry to reach commercial terms for innovative treatments, enabling patient access, including:

- Alpelisib (Piqray®) with fulvestrant is a life-extending drug for patients with advanced breast cancer, the 100th cancer drug fast-tracked to patients under the CDF
- Eladocagene Exuparvovec (Upstaza®) is a first and only gene therapy for children with the ultra-rare genetic condition, aromatic L-amino acid decarboxylase deficiency
- Nivolumab (Opdivo®) and Ipilimumab (Yervoy®) is a combination treatment benefiting around 1,000 people with aggressive respiratory cancer, the first new mesothelioma treatment to be approved in nearly 15 years
- Ataluren (Translarna®) – routine approval for the first licensed treatment for Duchenne muscular dystrophy that addresses the loss of dystrophin, following a period of managed access
- Darolutamide (Nubeqa®) is a life-extending treatment secured following a Project Orbis regulatory review for thousands of patients with one of the most advanced forms of prostate cancer
- Axicabtagene Ciloleucel (Yescarta®) is a pioneering CAR-T therapy which will benefit adults with an aggressive form of blood cancer

Following a 5-year medicines procurement deal for antiviral drugs and a concerted effort to identify people at risk, in December 2022 we announced that deaths from hepatitis C have fallen by 35%, keeping England on track to be the first country in the world to eliminate the virus ahead of the World Health Organisation's 2030 goal.

National deals to expand access to treatments have resulted in England being on track to have zero new HIV infections by 2030.

In June 2022, the NHS demonstrated global leadership on antimicrobial resistance, after the CMD reached agreements with 2 pharmaceutical companies for 2 antibiotics for treating severe drug-resistant Gram-negative bacterial infections.

Medicines account for between one-fifth and one-quarter of the NHS's carbon footprint. In January 2023, with support from professional anaesthesia bodies, we announced that Desflurane (a volatile anaesthetic used for surgery which has a global warming potential 2,500 times greater than carbon dioxide) will be decommissioned in 2024 and used only in exceptional circumstances. This will reduce harmful emissions by around 40 kilotons of carbon per year, the annual equivalent of powering 11,000 homes.

A new framework for local health and care providers aims to reduce inappropriate prescribing of high-strength painkillers and other addiction-causing medicines. We reported in March 2023 that opioid prescriptions have fallen by over 450,000 in under 4 years.

Research and innovation

We continue to support innovation, research and life sciences to improve patient outcomes and reduce health inequalities. The Accelerated Access Collaborative (AAC) provides patients with access to proven innovations by bringing together key partners from across government, charities, the NHS and industry.

Research and innovation are more important than ever in helping address operational pressures and mitigate increased demand. Work has continued to ensure that the NHS remains a partner for research and innovation, reflecting the aims in the government's Life Sciences Vision[54] and NHS priorities.

During the reporting period:

- more than 230,000 new patients registered their interest in participating in research via the NHS App
- we completed 24 demand-signaling projects, investing £7.7 million in mental health, learning disabilities and autism, and stroke priorities
- we exceeded the 5-year forecast for the number of patients accessing the NICE-approved sickle cell treatment (Spectra Optia) via the MedTech funding mandate policy
- we supported more than 1,000 NHS staff through the Clinical Entrepreneur Programme (CEP), a mentoring and development programme to develop innovative solutions. These NHS innovators have now raised more than £850 million for solutions they have developed for frontline challenges
- NHS trusts were supported to develop their in-house innovation implementation capability and capacity through the CEP InSites Programme. 23 innovations have already been procured or piloted in the sites, with a further 29 innovations in the initiation phase and plans to expand to more sites in 2023/24
- 1,125 innovators registered with the NHS Innovation Service, which is supporting innovators to get tailored support from AAC partners. More than 340 needs assessments have been completed with 15 innovations now available through NHS Supply Chain

[54] https://www.gov.uk/government/publications/life-sciences-vision

Support for providers

Provider collaboratives

Provider collaboratives play a key role in ICSs, bringing organisations together to share best practice and resources, and to transform services.

Most acute and mental health providers are now in a provider collaborative. In February 2023, we announced the 9 collaboratives – with at least one from each of the 7 NHS England regions – that we will work with under our provider collaborative innovator scheme to accelerate their development and the benefits they can deliver for patients.

We continued to work with NHS Providers on a support programme to accelerate the spread of good practice via peer learning and make resources available to develop provider collaboratives.

Supporting trust boards to collaborate as part of a system

We published an updated code of governance for NHS trusts and foundation trusts that takes account of system working and collaboration, along with an addendum to the guide on foundation trust governors' duties and new guidance, issued under the NHS provider licence, that sets clear expectations for collaboration and the governance arrangements.

Following consultation, we modified the NHS provider licence to bring it in line with statutory and policy requirements and enable us to develop our regulatory approach.

Mergers and acquisitions

In October 2022, we published 'Assuring and supporting complex change: statutory transactions, including mergers and acquisitions'[55], which supersedes NHS Improvement's guidance. It reflects the changing NHS landscape and focuses on the most important areas for successful transaction. All transaction proposals must have patient and population benefits at their core, underpinned by detailed plans for delivering them.

We offer bespoke support to trusts considering or proceeding with mergers or acquisitions and help ensure clarity about the intended benefits. Significant transactions completed during the reporting period included:

- Royal Devon and Exeter NHS Foundation Trust acquired Northern Devon Healthcare NHS Trust on 1 April 2022, with the newly enlarged trust renamed Royal Devon University Healthcare NHS Foundation Trust
- after year end, Yeovil District Hospital NHS Foundation Trust acquired Somerset NHS Foundation Trust on 1 April 2023, with the newly enlarged trust retaining the Somerset NHS Foundation Trust name

[55] https://www.england.nhs.uk/publication/statutory-transactions/

Regulating independent providers of NHS services

Since April 2014, all independent providers of NHS services have had to hold a provider licence, unless exempt, under Department of Health and Social Care (DHSC) regulations. The licence allows us to help commissioners protect essential local services if an independent provider fails. As of 31 March 2023, 135 independent providers held licences, of which 3 are NHS-controlled providers.

Commissioners are asked to consider which of their services must continue to be provided locally should the provider fail, and therefore should be designated as commissioner requested services (CRS). Out of the 135 licensed independent providers, 34 are providers of CRS as part of the national risk assessment and financial oversight regime. In the year to 31 March 2023, no formal enforcement action was taken with any independent providers, therefore on 31 March 2023, no enforcement undertakings were in place.

During the year, we consulted on updates to the Risk Assessment Framework and Reporting Manual for Independent Sector Providers. The proposed updates set out the oversight approach for standards of quality governance at some independent sector providers.

Recovery Support Programme

Where a trust is in breach or suspected breach of the conditions of its provider license, NHS England can use its statutory powers, including legal powers of direction, to intervene in line with the NHS Enforcement Guidance.[56] At the end of the 2022/23, NHS England was providing intensive support via the Recovery Support Programme to 15 trusts, with a further 2 trusts exiting the programme by March 2023.

[56] https://www.england.nhs.uk/long-read/nhs-enforcement-guidance/

Chief Financial Officer's report

Introduction

The financial statements for the year ending 31 March 2023 are presented later in this document on a going concern basis (as per note 1.5 of the accounts) 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, the CCGs from 1 April 2022 to the end of 30 June 2022, and 42 ICBs from their inception on 1 July 2022.

During 2021/22 the government announced the intention to effect the legal merger of NHS Digital, Health Education England and NHS England from April 2023. In preparation for this, the organisations undertook an extensive and consultative process to design the functions and form of the new, combined organisation, alongside the necessary work to ensure continuity of vital functions.

At the request of the Secretary of State for Health and Social Care at the time, in October 2022, we further announced an accelerated timeline for merger with NHS Digital, by 1 February 2023. The NHS England group therefore included NHS Digital from this mid-year point.

NHS England is required to manage spending within a fixed revenue limit. The total revenue limit for 2022/23 was £158,521 million.

Funding and allocations

In 2022/23, the NHS saw a real-terms reduction in total funding from the previous year of 0.6%, mainly driven by lower government funding for the impacts of COVID-19 and reductions in the scope – and therefore the costs of programmes such as vaccinations and testing. Additional funding has been agreed during the year for the pay award (including the 2022/23 backdated element), the voluntary scheme for branded medicines pricing and access to the COVID-19 vaccination and testing programmes, and funding for additional flu vaccine cohorts.

In 2022/23, the temporary COVID-19 financial framework came to an end, and we began the process of transitioning back to a more sustainable financial framework and allocation approach for the NHS. This included setting fixed allocations for ICBs for the year and ending the top-up funding arrangements that operated during the pandemic. The allocations for 2022/23 also included specific funding to reduce waiting lists, through the Elective Recovery Fund.

At the start of the year, we were forced to issue additional inflation funding of £1.5 billion to cover higher energy costs, a direct impact of inflation on index-linked contracts and other inflationary pressures. This required us to reprioritise transformation funding, in particular cutting funding for digital investment and for primary care.

We have also issued additional pay funding to the NHS totalling £4.4 billion to cover the costs of the recurrent in-year pay award and the back dated non-consolidated award, for which we received additional funding from the government.

Operational pressures

While government funding for pressures related to the pandemic was reduced in 2022/23, the NHS was still experiencing the ongoing impacts of COVID-19 on costs and services.

Industrial action has also created a significant pressure on the NHS in 2022/23, with a total of 17 days of strike action by nurses and other staff groups during the year.

Throughout the year, providers have struggled to discharge medically fit patients due to a lack of capacity in social care – in particular, care homes – which has led to longer lengths of stay and much higher bed occupancy.

In November 2022, we issued additional winter surge funding to the NHS which enabled us to put in place the equivalent of 7,000 beds, including community-based virtual wards. This enabled us to manage the highest ever number of A&E attendances in a single day, and to absorb the impact of the peak infection rates for COVID-19 and seasonal flu coinciding in the same week.

In spite of these pressures, the NHS has delivered around £5 billion of savings and has made significant improvements in productivity, allowing us to improve operational performance in a number of key areas including reducing elective waiting lists, though not by as much as we had planned.

The real terms cut in core funding, combined with the high rate of inflation and operational pressures set out above, has made this a very challenging year for the NHS.

Irregular spending

As noted above, the NHS was allocated additional funding under the Elective Recovery Fund to reduce waiting lists. This money was ringfenced, to be used for this purpose only. Because elective activity was lower than planned, some of this money should have been returned to the government. However, the lower levels of elective activity were due to ongoing COVID-19 pressures and longer lengths of stay, factors for which no additional funding had been provided. Therefore, we decided to allow providers to retain the elective funding to cover these costs, which the government has now deemed to be irregular.

Financial performance

This year, NHS England delivered an underspend of £1,153 million against the revenue resource budget. Of this, £120 million (2021/22: £604 million) related to budgets restricted for specific purposes. The remaining £1,033 million underspend was against core funding budgets, of which around £600 million was necessary to offset overspending by NHS providers and the balance to offset the pressure caused by provider technical issues. By the end of the year, 40 out of 42 systems either broke-even or achieved the stretch target that we set for them.

Revenue Department Expenditure Limit (RDEL) general (non-ringfenced)

Financial performance	2022/23				2021/22		2020/21		2019/20		2018/19		2017/18	
	Expenditure plan	Expenditure actual	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	
	£m	£m	£m	%	£m	%	£m	%	£m	%	£m	%	£m	%
ICBs/CCGs	119,151	119,087	64	0.1%	195	0.2%	154	0.2%	(507)	(0.6%)	(150)	(0.2%)	(213)	(0.3%)
Direct commissioning	29,970	29,418	552	1.8%	310	1.1%	1,087	3.9%	390	1.5%	310	1.3%	223	0.9%
NHS England admin/ central programmes/ other[57]	9,400	8,863	537	5.7%	192	2.9%	4,132	21.3%	1,113	14.2%	755	17.0%	960	23.2%
Total	**158,521**	**157,368**	**1,153[58]**	**0.7%**	**697[58]**	**0.5%**	**5,373**	**3.6%**	**996**	**0.8%**	**915**	**0.8%**	**970**	**0.9%**

In 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.

2022/23 performance against key financial performance duties

a) Revenue limits

Revenue limits	Target (2022/23)					2021/22
	Mandate limit £m	Actual £m	Underspend	Target met	Underspend as % of mandate	Underspend £m
RDEL – general	158,521	157,368	1,153	✓	0.7%	697
RDEL – ring-fenced for depreciation and operational impairment	288	259	29	✓	10.0%	0
Annually Managed Expenditure limit for provision movements and other impairments	250	12	238	✓	95.4%	28
Technical accounting limit (e.g., for capital grants)	200	(274)	474	✓	237.2%	199
Total revenue expenditure	**159,259**	**157,364**	**1,895[58]**		**1.2%**	**924**

b) Administration costs (within overall revenue limits above)

Total administration costs	**2,011**	**1,832**	**179**	✓	**8.9%**	**243**

c) Capital limit

Capital expenditure contained within our capital departmental expenditure limit	**330**	**276**	**54**	✓	**16.5%**	**46**

[57] Supply Chain Coordination Ltd included in ‘other’
[58] The underspend in 2022/23 includes £120 million (2021/22: £604 million) relating to specific ringfenced budgets included in DHSC’s financial directions to NHS England with these amounts not available to support general spending.

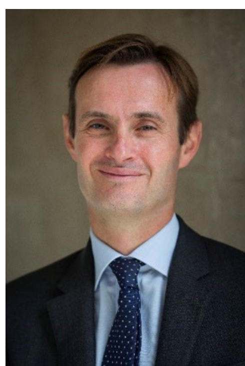
Financial priorities for 2023/24

Our priorities continue to focus on making sure that the frontline of the NHS has the resources it needs to deliver on our key priorities for patients, with a focus on recovering cancer performance, maintaining emergency care services and treating as many patients who are waiting for elective care as we can.

We must also recognise the continuing efforts of NHS staff and ensure that colleagues are supported in order that they can continue to deliver their best work for patients.

For 2023/24 we will be working with ICSs to:

- ensure we have the physical and workforce capacity to manage COVID-19 in the long term
- ensure the smooth delegation of pharmaceutical services, general ophthalmic services, and dental services to ICBs
- continue to support DHSC in delivering the multi-year New Hospital Programme and invest in our wider estate
- use the specific resources we have been provided with to reduce the number of people waiting for elective procedures, and continue to increase our investment in mental health and primary care services
- continue the journey towards greater system working and integrated care budgets
- maintain spending controls and deliver care as efficiently as we can in the context of ongoing operational constraints.



Julian Kelly

Chief Financial Officer

Accountability report

Amanda Pritchard

21 January 2024

Accounting Officer

The accountability report sets out how NHS England meets key accountability requirements to Parliament and is comprised of 3 key sections:

The corporate governance report sets out how the organisation was governed during 2022/23, including membership and organisation of our governance structures and how they support achievement of our objectives. The report includes:

- directors' report (from page 47)
- statement of Accounting Officer's responsibility (page 64)
- governance statement (from page 65)

The remuneration and staff report sets out our remuneration policies for executive and non-executive directors and how these policies have been implemented for the reporting period, including salary information and pension liabilities. The report provides further detail on remuneration and staff and starts from page 88.

The parliamentary accountability and audit report (from page 116) 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 Houses of Parliament.

Corporate governance report

Directors' report

The key responsibility of the Board is to support strategic leadership to the organisation, including:

- setting the overall direction of NHS England, within the context of the NHS Mandate from government
- approving the business plan, which is designed to support achievement of our strategic objectives and monitor our performance against it
- holding the NHS Executive to account for this performance and for the proper running of the organisation (including operating in accordance with legal and government requirements)
- determining which decisions, it will make and which it will delegate to the Executive or committee or sub-committee, via the Scheme of Delegation
- ensuring high standards of corporate governance and personal conduct
- monitoring the performance of the group against core financial and operational objectives
- providing effective financial stewardship
- promoting effective dialogue between NHS England, its partners, ICBs and providers of healthcare and communities served by the commissioning system.

The Board

The Board comprises the Chair, at least 5 non-executive directors and 5 executive directors including the Chief Executive. The number of executive members must be less than the number of non-executive members.

Appointments

The Chair and non-executive directors are appointed by the Secretary of State for Health and Social Care and executive directors are appointed by the chair and non-executive directors. The appointment of the Chief Executive is subject to the Secretary of State for Health and Social Care's consent.

On 1 July 2022, Sir Andrew Morris joined as Deputy Chair, having previously served as Chair of NHS Improvement. Sir David Behan joined the Board on 1 September 2022, having served as Associate Non-Executive Director on the NHS Improvement Board.

On 30 June 2022, Lord Ara Darzi's non-executive directorship tenure ended.

The Secretary of State for Health and Social Care approved the appointment of Baroness Mary Watkins, Professor Sir Simon Wessely and Professor Sir Mark Walport as non-executive directors as of 27 January 2023.

As noted beneath the table below, various members temporarily transferred between the boards of NHS England and NHS Improvement to ensure that the boards of the

organisations were appropriately constituted ahead of the legislative changes to the organisations in 2022.

Board members

Directors who served on the NHS England Board during the year are listed in the table below, along with their attendance.[59]

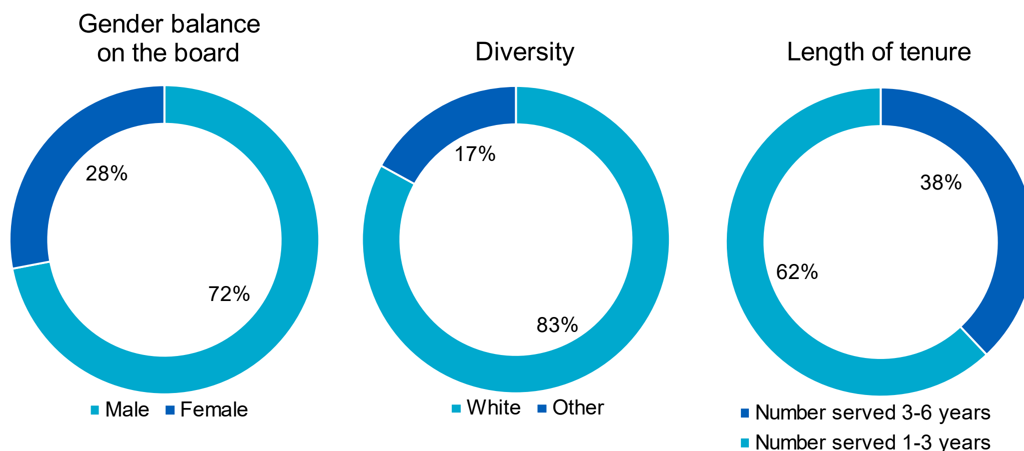
Members	Role	Term ends/notes	Number of eligible Board meetings attended
Richard Meddings CBE	Chair	24 March 2026	6/6
Wol Kolade	Deputy Chair	24 March 2025	6/6
Sir Andrew Morris[60]	Deputy Chair	24 March 2025	5/5
Sir David Behan[61]	Non-Executive Director	31 August 2024	5/5
Michael Coupe	Non-Executive Director	31 December 2026	5/6
Rakesh Kapoor[62]	Non-Executive Director	31 December 2023	4/6
Susan Kilsby	Non-Executive Director	31 December 2023	5/6
Jeremy Townsend[63]	Non-Executive Director	30 September 2026	5/6
Laura Wade-Gery	Non-Executive Director	30 June 2023	5/6
Baroness Mary Watkins[64]	Non-Executive Director	26 January 2026	2/2
Professor Sir Mark Walport[65]	Non-Executive Director	26 January 2026	2/2
Professor Sir Simon Wessely[66]	Non-Executive Director	26 January 2026	2/2
Amanda Pritchard	Chief Executive Officer		6/6
Julian Kelly[67]	Chief Financial Officer		6/6
Dame Ruth May	Chief Nursing Officer		5/6
Professor Sir Stephen Powis	National Medical Director		5/6
Sir David Sloman	Chief Operating Officer		6/6

Former members	Role	Term ends/notes	Number of eligible Board meetings attended
Professor Lord Ara Darzi	Non-Executive Director	Left on 30 June 2022	1/1

[59] Biographical details may be viewed on our website https://www.england.nhs.uk/about/board/nhs-england-board/members/
[60] Sir Andrew Morris was appointed to the NHS England Board from the NHS Improvement Board following the merger on 1 July 2022.
[61] Sir David Behan was appointed to the NHS England Board as a Non-Executive Director on 1 September 2022, having previously served as an Associate Non-Executive Director.
[62] Rakesh Kapoor's directorship was temporarily transferred to NHS Improvement from 1 May 2021 to 31 March 2022, returning on 1 April 2022 as a Non-Executive Director of NHS England.
[63] Jeremy Townsend's directorship was temporarily transferred to NHS Improvement on 24 March 2022, returning 1 July as a Non-Executive Director of NHS England.
[64] Baroness Mary Watkins was appointed as Non-Executive Director to the NHS England Board on 27 January 2023.
[65] Professor Sir Mark Walport was appointed as Non-Executive Director to the NHS England Board on 27 January 2023.
[66] Professor Sir Simon Wessely was appointed as Non-Executive Director to the NHS England Board on 27 January 2023.
[67] Julian Kelly was appointed as deputy chief executive by the nominations committee on 14 December 2022.

Board diversity

The charts below show the composition of the Board members by gender, diversity and tenure as of 31 March 2023.



The governance structure

Prior to the legal merger on 1 July 2022, NHS England and NHS Improvement could not legally have a joint board or joint board committees. Each organisation retained its given statutory functions and NHS England could not delegate its functions to NHS Improvement, or vice versa.

Nevertheless, the organisations operated as one, with the boards and their committees meeting in common during the year on shared business while having separate membership and the ability to take their own decisions. The governance framework included established procedures for dealing with 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 61.

Following the legal merger on 1 July 2022, a new Board committee structure was established:

- the People, Remuneration and Nominations Committee was superseded by the People and Remuneration Committee and Nominations Committee
- the Quality & Innovation Committee was superseded by the Quality Committee
- Digital Committee was superseded by the Data, Digital and Technology Advisory Group
- the New NHS England Committee was established
- the Audit and Risk Assurance Committee's membership was updated
- the System Oversight Committee transitioned to a subcommittee of the NHS Executive but with formal delegated duties from the Board

Further changes were implemented to the Board committee structure from 1 February 2023 when NHS England merged with NHS Digital. Namely, the Cyber Security and Risk Subcommittee was established as a subcommittee of the Audit and Risk Assurance Committee, and the Data, Digital and Technology Advisory Group was replaced with the

Data, Digital and Technology Committee. 3 former NHS Digital non-executive directors were appointed as non-executive committee members of the Data, Digital and Technology Committee, and 2 were appointed as non-executive committee members of the Cyber Security and Risk Sub-Committee.

An overview of the Board governance framework is shown on the next page and individual Board committee reports can be found from page 52 to 61. A report detailing the business considered by the Board committees is provided to each Board meeting.

NHS England Board governance framework and committees

NHS England Board

Audit and Risk Assurance Committee	People and Remuneration Committee	Nominations Committee	Data, Digital and Technology Committee	The New NHS England Committee	Quality Committee
Main responsibilities					
Provides assurance to the Board that NHS England's governance, internal controls and risk managing systems are effective and monitors the integrity of the financial statements.	Oversees the delivery of the overall workforce strategy for the NHS, ensures there is a single coherent remuneration policy for NHS England and approves remuneration for senior executives, as well as overseeing appointment and remuneration matters for Integrated Care Boards and trusts.	Oversees succession plans for the Board and senior management, Board composition and Board evaluation.	Considers and makes recommendations on digital and technology strategy (including cyber strategy) to the NHS England Board and oversees implementation. It advises on development of data and technology architecture and assures the Board on discharge of data functions.	Time-limited, to provide leadership and strategic oversight of the delivery of the New NHS England Programme, including the safe transfer of staff and functions from NHS Digital and Health Education England.	Provides assurance to the Board that NHS England ensures continued improvements in quality of services and outcomes in relation to the safety of services, patient care and experience.

Main responsibilities

Cyber Security and Risk Sub-Committee	Executive HR Group and Regional Appointments and Approvals Committees	Chief Financial Officer Advisory Group
Provides assurance to the Board, through Audit Risk and Assurance Committee, on cyber security and insider threats.	Executive HR Group – Internal recruitment and remuneration; establishment control; internal HR practices and policies. Regional Appointments and Approvals Committees – Appointment and remuneration matters for ICBs and NHS trusts.	An advisory group which oversees and provides advice to the Board on the financial position across the NHS, including financial performance and efficiencies, the financial framework and NHS capital schemes.

Board activity and administration

The Board held 1 scheduled Board meeting in common with NHS Improvement, and 6 NHS England Board meetings during the year. Each had a public and a private session.

Members of the public can observe the public sessions. The option for members of the public to attend in person was available from the September 2022 meeting.

The agenda, papers and minutes for the public sessions are also published on our website.[68]

Additionally, the Board held 1 strategy session and a number of topic-specific deep-dive sessions during the reporting period. There were also a number of Board calls where the non-executive directors were updated on operational pressures across the NHS.

Key items considered by the Board during the year were:

Strategy

- establishment of ICBs and delegation of commissioning functions
- development of the medium-term strategy for the NHS
- strategic opportunities and challenges facing the NHS
- accelerating digitally enabled transformation in the NHS, including the Federated Data Platform commercial strategy for the NHS
- NHS Capital Strategy
- NHS England productivity and efficiency
- approved the 2023/24 business plan for Supply Chain Co-ordination Limited
- NHS Long Term Workforce Plan

Performance

- updates on the continued management of COVID-19 and the associated recovery and restoration of NHS services
- operational, quality, and financial performance of NHS providers
- approved the planning guidance and priorities for 2023/24
- approved NHS England's 3-year delivery plan for maternity and neonatal services
- updates on mental health services
- considered the primary care access recovery plan
- updates on winter planning and development and implementation of the delivery plan for recovering urgent and emergency care services
- updates on elective recovery leadership and people
- considered progress and received reports on tackling inequalities in the NHS
- considered progress in NHS England's internal Freedom to Speak Up

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[68] https://www.england.nhs.uk/about/nhs-england-board/meetings/

Governance and risk

- approved changes to the Board governance framework
- received updates on the Health and Care Act 2022
- merger of NHS England and NHS Improvement, and the merger of Health Education England, NHS Digital and NHSX with NHS England

Review of Board effectiveness and performance evaluation

An internal review of the effectiveness of NHS England's Board, including Chair effectiveness and Board leadership, commenced in February 2023. The findings of the review and recommendations for improvement will be considered by the Board and implemented in 2023/24. We will therefore report on this in the 2023/24 annual report, by which time we will be better placed to describe the outcomes and reflect on delivery of the resulting actions.

Board committees

Audit and Risk Assurance Committee

Role of the committee

The committee's primary role is to provide assurance to the Board that NHS England's governance, internal controls and risk-managing systems are effective and monitor the integrity of the financial statements. The committee met in common with NHS Improvement's Audit and Risk Assurance Committee (ARAC) until NHS Improvement's abolition on 30 June 2022, from which time there was a single committee for NHS England.

Committee members

The committee met 6 times and the following table details membership, and the number of meetings attended by each member during the year:

Members	Number of eligible meetings attended	Comment
Jeremy Townsend[69]	6/6	Non-Executive Director, Chair from 1 July 2022
Wol Kolade[70]	6/6	Non-Executive Director, Chair until 30 June 2022
Mike Coupe	2/4	Non-Executive Director, Member from 1 July 2022
Rakesh Kapoor	3/4	Non-Executive Director, Member from 1 July 2022
Susan Kilsby	5/6	Non-Executive Director
Gerry Murphy	6/6	Non-executive Chair of DHSC's Audit Committee (non-voting member)

Wol Kolade was Chair of the NHS England Committee, until the 30 June 2022, when Jeremy Townsend took over as Chair. Jeremy Townsend is a qualified accountant and has

[69] Jeremy Townsend's directorship was temporarily transferred to NHS Improvement on 25 March 2022, and he took over the chair of NHS Improvement's Audit and Risk Assurance Committee.
[70] Wol Kolade's directorship was transferred from NHS Improvement to NHS England on 25 March 2022 and he took over the chair of the Audit and Risk Assurance Committee.

considerable experience in chairing audit committees in other organisations. Wol Kolade is the managing partner of a private equity firm with valuable and recent financial experience.

Good governance provides that an ARAC should consist of 3 independent non-executive directors. Until 30 June 2022, the committee considered mainly joint organisation business and met in common with NHS Improvement's committee. It was agreed and supported by the internal auditors, that the committee should comprise 2 non-executive directors because together there are 4 non-executive directors involved in deliberations. This was a time-limited arrangement and pre-legislative change until the merger of NHS England and NHS Improvement on 1 July. The committee has a good balance of skills and knowledge covering accounting and finance, audit committee best practice and clinical services.

Attendees

Additional attendees are invited to attend meetings to assist with committee business. For 2022/23 these included, among others, the Chief Executive Officer, the Chief Financial Officer, the Director of Governance, Legal and Inquiry, 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 committee can meet with the internal and external auditors without management when required, and the auditors have full access to the organisations.

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 and the annual Head of Internal Audit Opinion
- reviewed NHS England's Corporate Risk Register
- considered several risk deep dives, including data and analytics, maternity, workforce, and integrated care systems
- received updates on information security and cyber risks
- approved changes in accounting policies and reviewed areas of significant estimation or judgement
- assessed the integrity of NHS England's financial reporting
- approved NHS England's 2021/22 Annual Report and Accounts
- received updates on delivery of the objectives set out in the Economic crime strategy – tackling fraud, bribery, and corruption
- approved governance manual changes for 2022/23, including approval of the standing financial instructions
- considered NAO reports and management letters and received an update on the status of the NAO Value for Money Programme

External audit

During the year, ARAC has worked constructively with the NAO Director responsible for the NHS England audit and their 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.

Data, Digital and Technology Committee

The committee was established on 1 February 2023 to support the safe transfer and continued robust oversight of functions from NHS Digital. The committee's role is to consider and make recommendations on digital and technology strategy (including cyber strategy) to the NHS England Board and oversee implementation. It advises on development of data and technology architecture and assures the Board on discharge of data functions, including overseeing and scrutinising how the functions are exercised and the steps taken by NHS England to follow the statutory guidance and protect confidential information.

Committee members

The committee did not meet in 2022/23 and held its first meeting on 6 April 2023.

Members	Number of eligible meetings attended	Comment
Richard Meddings	0/0	Chair of NHS England
Laura Wade-Gery (Chair)	0/0	Non-Executive Director
Rakesh Kapoor	0/0	Non-Executive Director
Mark Walport	0/0	Non-Executive Director
Daniel Benton[71]	0/0	Non-Executive Committee Member
John Noble[72]	0/0	Non-Executive Committee Member
Steve Woodford[73]	0/0	Non-Executive Committee Member

Attendees

Additional attendees will be invited to attend meetings to assist with committee business, including the National Director of Transformation, Interim Chief Information Officer, Chief Operating Officer, Chief Strategy Officer, Head of the NHS England/DHSC Digital Policy Unit, Chief Delivery Officer, Director of Privacy, Transparency and Ethics, and the Chief Data and Analytics Officer.

[71] Daniel Benton was previously a Non-Executive Director of NHS Digital until 31 January 2023 and was appointed as a Non-Executive Committee Member of the Data, Digital and Technology Committee as of 1 February 2023.
[72] John Noble was previously a Non-Executive Director of NHS Digital until 31 January 2023 and was appointed as a Non-Executive Committee Member of the Data, Digital and Technology Committee as of 1 February 2023.
[73] Steve Woodford was previously a Non-Executive Director of NHS Digital until 31 January 2023 and was appointed as a Non-Executive Committee Member of the Data, Digital and Technology Committee as of 1 February 2023.

People, Remuneration and Nominations Committee

Role of the committee

The committee's role is to oversee the delivery of the overall workforce strategy for the NHS and provide the Board with assurance and oversight of all aspects of strategic people management and organisational development.

The committee is also responsible for people and organisational development policies and ways of working designed to ensure NHS England's workforce is appropriately engaged and motivated. This includes reviewing the organisation's gender pay gap and ensuring NHS England develops policies and actions to reduce it, reviewing progress in increasing black and minority ethnic representation at senior levels in the organisation and initiatives relating to diversity and inclusion.

The committee ensures that NHS England has a single formal, robust and transparent remuneration policy that is in line with DHSC Executive and Senior Manager Pay Framework for arm's length bodies (ALBs). The committee considers and approves remuneration, benefits, and terms of service for senior executives covered by this pay framework before submission to DHSC for approval. The committee's role also involves employee remuneration and engagement matters.

The committee has delegated certain functions to the Executive HR Group and to the Regional Appointments and Approvals Committee.The committee receives regular reports from the group and the committees on cases considered and approved.

Committee members

The committee met 5 times and the following table details membership and attendance:

Members	Number of eligible meetings attended	Comment
Sir David Behan (Chair)	5/5	Non-Executive Director
Susan Kilsby[74]	2/4	Non-Executive Director
Richard Meddings[75]	3/4	Chair of NHS England
Sir Andrew Morris	5/5	Non-Executive Director
Jeremy Townsend[76]	2/4	Non-Executive Director
Laura Wade-Gery	5/5	Non-Executive Director

Committee attendees

Additional attendees are invited to meetings to assist with committee business. For 2022/23 these included the Chief Workforce Officer, Chief Delivery Officer, National Director for People and the Director of Human Resources and Organisation Development.

[74] Susan Kilsby was appointed as a member of the People and Remuneration Committee on 1 July 2022.
[75] Richard Meddings was appointed as a member of the People and Remuneration Committee on 1 July 2022.
[76] Jeremy Townsend was appointed as a member of the People and Remuneration Committee on 1 July 2022.

Principal activities during the year

Matters considered by the committee included:

- development of the Long Term Workforce Plan
- the approach to improving equality, diversity, and inclusion within NHS England and across the NHS
- updates on the integration of NHS England, Health Education England, and NHS Digital
- the developing approach to management and leadership development in the NHS
- updates on the 'The future of NHS human resources and organisational development' report and delivery of the national priority actions
- updates on NHS England's workforce, including recruitment, staff absence and diversity
- internal NHS England Freedom to Speak Up arrangements, and themes from staff feedback
- NHS England staff survey results and actions to address areas for improvement
- recommended revision of the NHS Very Senior Managers Pay Framework, for agreement through DHSC and HM Treasury
- approved, in line with DHSC pay framework, the remuneration and appointment of several senior executives
- approved, in line with DHSC recommendation, annual salary increases for executive senior managers and medical colleagues on local pay arrangements

During the year, the committee stood down 1 of its subcommittees, the Appointments and Approvals Committee. The subcommittee's duties in relation to the appointment, remuneration, suspension and termination of trust and ICB chairs were reassumed by the People and Remuneration Committee, and its remaining duties delegated to the Executive Human Resources Group and the Regional Appointments and Approvals Committees.

Nominations Committee

The committee oversees the succession plans for the Board and senior management, Board composition and Board evaluation.

Committee members

The committee was established on 1 July 2022 and met 3 times. The following table details membership, and the number of meetings attended by each member during the year:

Members	Number of eligible meetings attended	Comment
Richard Meddings (Chair)	3/3	Chair of NHS England
Sir Andrew Morris	2/3	Deputy Chair, NHS England
Wol Kolade	3/3	Deputy Chair, NHS England
Michael Coupe	3/3	Non-Executive Director
Amanda Pritchard	2/3	Chief Executive Officer

Committee attendees

The Director of Human Resources and Organisational Development is invited to attend meetings to assist with committee business.

Principal activities during the year

Matters considered by the committee included:

- succession plans for national directors
- updates on non-executive director recruitment
- approving the appointment of the Chief Financial Officer as the Deputy Chief Executive on 14 December 2022

Quality and Innovation Committee and Quality Committee

The committee's primary role is to support the Board in ensuring that areas concerning patient safety, the quality of care provided to patients and patient experience are continuing to improve and develop to meet the needs of patients in England. In doing so, the committee will ensure strategies are continually improving quality, safety, and experience of care. The committee met in common with NHS Improvement's Quality and Innovation Committee and met once during the reporting period. The Quality and Innovation Committee was superseded by the Quality Committee, following the merger of NHS England and NHS Improvement and the Quality Committee met 3 times in the reporting period.

Quality Committee

The committee met 3 times and the following table details membership and attendance:

Members	Number of eligible meetings attended	Comment
Sir Munir Pirmohamed (Chair)	3/3	Non-Executive Director
Dr Aidan Fowler	3/3	National Director of Patient Safety
Sir David Sloman	2/3	Chief Operating Officer
Sir Andrew Morris	2/3	Non-Executive Director
Mike Coupe	2/3	Non-Executive Director
Simon Wessely	1/1	Non-Executive Director
Dame Ruth May	3/3	Chief Nursing officer
Professor Sir Stephen Powis	3/3	National Medical Director
Amanda Doyle	3/3	National Director for Primary Care and Community Services
Vinod Diwakar	1/2	Medical Director for Secondary Care and Transformation
Charlotte McArdle	2/2	Deputy Chief Nursing Officer
Patient and Public Voice members	1/1	

Committee attendees

Additional attendees are invited to attend meetings to assist with committee business. For 2022/23 these included the Director of Health Inequalities, Director for Experience, Participation and Equalities, and the Head of Quality Strategy.

Principal activities during the year

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. In doing this, matters considered by the committee included:

- proposals for strategic oversight of NHS quality issues and performance
- updates on the implementation of the NHS Patient Safety Strategy and related systems
- patient safety improvements
- updates on palliative and end of life care
- updates on children and young people's care
- the development of the Quality Framework
- the delivery plan for recovering access to primary care
- reviewing the quality risks and associated mitigations

Other items considered included:

- escalations from the Quality and Performance Committee data relating to quality of services and how this can best be presented to the Committee
- patient experience, from hearing personal accounts

The Quality Committee also held 3 informal roundtables to bring the clinical and service user voice into our board governance, and the outcomes of these roundtables were reported to the committee. The roundtables were held on:

- urgent and emergency care
- maternity and neonatal services
- the model of care for patients with long-term mental health conditions.

Quality and Innovation Committee

The committee met once and the following table details membership and attendance:

Members	Number of eligible meetings attended	Comment
Sir Munir Pirmohamed (Chair)	1/1	Non-Executive Director
Dr Aidan Fowler	1/1	National Director of Patient Safety
Dr Timothy Ferris	0/1	National Director of Transformation
Rakesh Kapoor	0/1	Non-Executive Director
Mike Coupe	1/1	Non-Executive Director
Dame Ruth May	1/1	Chief Nursing officer
Professor Sir Stephen Powis	1/1	National Medical Director/NHS Improvement Chief Executive
Patient and Public Voice members	1/1	

The New NHS England Committee

Role of the committee

The New NHS England Committee is a time-limited committee, to provide leadership and strategic oversight of the delivery of the Creating the New NHS England Programme.

Committee members

The committee met 12 times and the following table details membership, and the number of meetings attended by each member during the year:

Members	Number of eligible meetings attended	Comment
Wol Kolade (Chair)	12/12	Deputy Chair, NHS England
Richard Meddings	8/12	Chair of NHS England
Sir Andrew Morris	12/12	Deputy Chair, NHS England
Laura Wade-Gery	12/12	Non-Executive Director
Sir David Behan	9/12	Non-Executive Director
Amanda Pritchard	8/12	Chief Executive Officer
Julian Kelly	10/12	Chief Financial Officer
Mark Cubbon[77]	12/12	Chief Delivery Officer

Committee attendees

Additional attendees are invited to attend meetings to assist with committee business. For 2022/23 this included the Director of Human Resources and Organisational Development, the Programme Director, the Integration Director and the Clinical Integration Director for the Creating the New NHS England Programme, and the National Director of Vaccinations and Screening, who took up the post of Chief Delivery Officer from 30 March 2023.

Principal activities during the year

Matters considered by the committee included:

- agreeing the overall approach to and overseeing delivery of the Creating the New NHS England Programme
- advising on the culture of the new NHS England, including the organisational purpose
- overseeing the high-level organisational design and priorities for the new NHS England, including the associated consultation and implementation approach
- considering, approving, and receiving updates on the voluntary redundancy scheme
- overseeing and scrutinising Day 1 readiness ahead of the mergers between NHS England and NHS Digital, and NHS England and Health Education England.

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[77] Mark Cubbon left the organisation on 2 April 2023. Steve Russell was appointed as Chief Delivery Officer from 30 March 2023, undertaking this role jointly with his role as National Director of Vaccinations and Screening.

System Oversight Committee

The System Oversight Committee transitioned to a sub-committee of the NHS Executive but with formal delegated duties from the Board. Its duties from 1 September 2022 were assigned to the Quality and Performance Committee and the Strategy, Planning and Investment Committee. The System Oversight Committee met in common with NHS Improvement's System Oversight Committee. Together they ensured a consistent approach to oversight of ICSs and their constituent organisations, including determining appropriate support where required to organisations and systems for them to improve population health outcomes and address health inequalities. This assisted the Board with their formal intervention powers, including deciding on entry into and exit from the Recovery Support Programme and segment 4 of the System Oversight Framework. It also provided strategic oversight of transactions and investments involving clinical commissioning groups and their system partners.

Committee members

The committee met 4 times in the reporting period and the following table details membership and attendance:

Members	Number of eligible meetings attended	Comment
Professor Sir Stephen Powis (Chair)	4/4	National Medical Director/Chief Executive of NHS Improvement
Ronke Akerele	3/4	Director of Culture Transformation (deputising for Chief People Officer)
Mark Cubbon	3/4	Chief Delivery Officer (interim Chief Operating Officer from August 2021 to Dec 2021)
Miranda Carter	4/4	Director of Provider Development
Ian Dodge	0/2	National Director Strategy and Innovation
Iain Eaves	3/4	Director of Planning and Oversight
Dr Timothy Ferris	2/4	National Director of Transformation
Sue Holden	2/2	National Director of Improvement/Director of Intensive Support for Challenged Systems
Julian Kelly	0/4	Chief Financial Officer
Alex Kirkpatrick	1/4	Interim Director of Provider Development
Matthew Neligan	4/4	Director of System Transformation
Peter Ridley	2/4	Deputy Chief Financial Officer – Operational Finance
Simon Rogers	2/4	Deputy Director of Legal (non-voting)
Sir David Sloman	0/4	Chief Operating Officer
Seven Regional Directors of Strategy and Transformation		

Committee attendees

In addition, the Executive Director of Performance and Deputy Chief Financial Officer (Strategic Finance), were also invited to attend these meetings.

Principal activities during the period

Matters considered by the committee included:

- updates on the implementation of the NHS Oversight Framework for 2022/23, including segmentation
- approval for several organisations and systems to enter or exit the Recovery Support Programme on recommendations made by the regions
- updates on the implementation of the Maternity Safety Support Programme and its alignment with the Recovery Support Programme
- oversight of and support levers for independent providers of NHS services, including quality governance and finance, sustainability of services, and financial oversight of commissioner requested services
- development of the NHS Oversight Framework for 2023/24
- the approach to Use of Resources assessments for 2023/24 and for the future, linking to the Care Quality Commission's rating approach
- revised guidance on assuring and supporting complex change: statutory and other transactions, and complex provider governance arrangements.

Board disclosures

From 1 April to 30 June 2022, NHS England and NHS Improvement operated joint working arrangements involving the exercise of statutory functions of the organisations' constituent bodies in an aligned way under a single operating model. Directorates and teams within the structure performed both NHS England and NHS Improvement functions. During this period, however, NHS England, Monitor and NHS TDA remained separate bodies with distinct statutory roles and responsibilities. In some cases, the functions and decision-making of those bodies had to 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').

To manage this, the bodies had in place a separation of functions and conflicts of interest policy, separate from management of personal interests, which provided guidance for staff on managing functional and operational conflicts.

On 1 July 2022, Monitor and NHS TDA were abolished, and their functions transferred to NHS England, under changes made by the Health and Care Act 2022. NHS England continues to maintain a policy on conflicts between functions, to comply with its duty under new section 13SB of the National Health Service Act 2006 (inserted by section 34 of the Health and Care Act 2022) to make arrangements to minimise the risk of conflicts between the exercise of the former Monitor regulatory functions and NHS England's other functions, and to manage any conflicts that arise.

Register of Board members' interests

Personal interests held by Board and committee members are managed in accordance with the NHS England Standing Orders and the 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 beginning 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. A copy of the register of interest is available on our website.

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 19 on page 183.

Disclosure of personal data-related incidents

NHS England follows the NHS Digital Data Security and Protection incident reporting process guidance in the reporting of incidents. This is in line with data protection legislation, UK General Data Protection Regulation (UKGDPR).

The guidance[78] sets out the reporting requirements for NHS organisations where a potential or an actual incident may lead to a personal data breach defined under the Data Protection Act 2018 and UK General Data Protection Regulation. The 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 over recent years. As of 31 March 2023, no notifiable incidents had occurred relating to the loss of personal data.

Directors' third-party indemnity provisions

NHS England has appropriate directors' and officers' liability indemnification in place for legal action against, among others, its executive and non-executive directors. There is 1 ongoing legal claim brought against NHS England in respect of the conduct of 1 NHS England director in 2022/23.

Directors' responsibility statement

The Annual Report and Accounts have been reviewed in detail by NHS England's ARAC 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.

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[78] https://digital.nhs.uk/data-and-information/looking-after-information/data-security-and-information-governance/data-security-and-protection-toolkit

Human rights

NHS England supports the government's objectives to eradicate modern slavery and human trafficking. An NHS England Slavery and Human Trafficking Statement for the financial year ending 31 March 2023 will be published in October 2023. The statement for 2021/22, published in March 2022, is available on our website.[79] Our strategy on tackling fraud, bribery and corruption can be found on our website.[80]

Events after the reporting period

On 1 April 2023, NHS England and Health Education England merged. As part of this, the NHS England Board approved a revised Board governance framework, including the establishment of a Workforce, Training and Education Committee. The details of the new framework will be provided in the 2023/24 Annual Report and Accounts.

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[79] https://www.england.nhs.uk/wp-content/uploads/2021/03/agenda-item-13.2-slavery-and-human-trafficking-statement.pdf
[80] https://www.england.nhs.uk/publication/tackling-fraud-bribery-and-corruption-economic-crime-strategy-2018-2021/

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 2022)[81] and in particular to:

- observe the Accounts Direction issued by 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
- confirm that the Annual Report and Accounts are fair, balanced, and understandable, and take personal responsibility for the Annual Report and Accounts and the judgements required for determining that they are 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 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 May 2023).[82]

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

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[81] https://www.gov.uk/government/publications/government-financial-reporting-manual-2022-23
[82] 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, while 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 several organisations which are part of the wider commissioning system, including those organisations hosted by NHS England. My responsibilities in relation to the oversight of ICBs are set out from page 71.

Board arrangements

Information on our Board and its committees is set out from page 52.

Freedom to Speak Up

Our report on whistleblowing disclosures made by NHS workers is published on our website.[83]

Government functional standards

Functional standards[84] set out what needs to be done, and why, for different types of functional work. They were mandated for use in departments and their arm's length bodies from the end of March 2022. The extent to which these standards are adopted across NHS England varies, and certain elements of the standards are not applicable to the organisation.

[83] https://www.england.nhs.uk/ourwork/freedom-to-speak-up/whistleblowing-disclosures/
[84] https://www.gov.uk/government/publications/dao-0521-mandating-functional-standards-from-end-september-2021

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, Risk Management Framework and the 3 lines of defence model. Separate operating frameworks exist for each CSU.

Assessment against the Corporate Governance in Central Governance Departments: Code of Good Practice 2017 Compliance Checklist

As part of implementing best practice, an assessment is undertaken each year against this checklist from HM Treasury. NHS England is compliant[85] against the provisions of the code, with the following exceptions:

Ref	Code provision	Exception
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, the Chief Executive's private 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 the 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 ARAC meetings.
5.9	The Board and Accounting Officer should be supported by an ARAC, comprising at least 3 members.	ARAC comprises at least 2 non-executive board members. The committee met in common with NHS Improvement's ARAC, until NHS Improvement was abolished in June 2022, and consequently there were in total 4 non-executive directors involved in deliberations. Most business considered by the committees was joint NHS England and NHS Improvement business.

[85] It should be noted that the following provisions in the code do not apply 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.

Corporate assurance

The NHS 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.

Assurance activity	How does it add value?
Organisational change framework Guidelines for assessing and implementing major changes across the organisation.	The framework provides a consistent approach to thinking about the impact of organisational change, including on 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 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.
Third-party assurance framework Guidelines for the assurance required for managing third-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 2022/23, the corporate governance and compliance team worked with teams across the organisation to embed controls and underpin processes including by:

- ensuring that officers undertook staff declarations in line with the standards of business conduct policy[86]
- targeted interventions with teams to ensure the timely completion of actions arising from internal audit reviews.

Management assurance

Throughout 2022/23, the Board has been provided with regular performance updates on the implementation of the priorities and programmes committed to in the NHS Long Term Plan.
The report integrates performance against constitutional standards, NHS Long Term Plan commitments and workforce and quality metrics.

Individual programme boards and oversight groups meet frequently, with representatives from national and regional teams, each with responsibility for delivery of their programme.

Risk governance

The Board is responsible for defining NHS England's strategy within the context of the NHS Mandate. It ensures the effective running of the organisation, approving the internal business plan, which is designed to support achievement of NHS England's strategic objectives.

ARAC is responsible for reviewing the establishment and maintenance of an effective system of governance, risk management and internal control covering NHS England's activities.
The committee considers the key risks faced by the organisation on a quarterly basis and reports its conclusions directly to the Board.

The internal audit team provides regular reports to ARAC based on their work programme. The Board discusses the most significant risks and actions identified to mitigate their likelihood and impact. Each year, ARAC evaluates the effectiveness of the risk management framework and approves the annual internal audit plan for the following year.

The transfer of NHS Digital's functions to NHS England on 1 February 2023 brought a change to the overall organisational risk profile. To ensure robust oversight of transferred key risks,
a Cyber Committee has been established as a subcommittee of the Board. This committee provides assurance on the effectiveness of cyber threat protection and risk management.

[86] https://www.england.nhs.uk/publication/standards-of-business-conduct-policy/

The Chief Executive Officer, supported by senior management, provides leadership, and articulates their continued commitment to risk management through the organisational risk management framework.

The Chief Risk Officer is appointed by the Chief Executive Officer to lead NHS England's overall approach to risk management. In 2022/23, the position of Chief Risk Officer was delivered by the Chief Delivery Officer.

The executive team owns the corporate risk register (CRR) and nominates a responsible officer for each of the risks that are included within it. This approach is supported by the NHS England risk management framework, which underpins the monitoring and management of risk.

The Executive Risk Group is responsible for assuring ARAC about how risks across the organisation are being managed. This group reviews the risks escalated to it and considers which risks should be managed through the CRR and associated processes. ARAC oversees implementation of NHS England's risk management framework. The NHS Executive also periodically reviews the CRR and, when appropriate, undertakes in-depth review.

Our executives are responsible for managing risk at a directorate/regional level (that is, 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 risk management framework mirrors the three lines of defence of our overarching assurance framework.

Risk and control framework

In 2022/23, NHS England continued to embed its risk management framework to ensure that employees follow a single process for identifying and managing risks that may threaten delivery of services and achievement of objectives. This framework aligns with the main principles of HM Treasury's Orange Book[87] and is informed by ISO 31000 Risk management principles and guidelines, and the UK Corporate Governance Code.[88]

Our risk appetite by category of risk

Category of risk	Risk appetite
Patient safety and quality of care	Very low
Operational performance (across the system)	Medium
Innovation	High
Financial	Low
Compliance and regulatory	Medium
Reputation	Low
Operational delivery across NHS England	Medium

[87] https://www.gov.uk/government/publications/orange-book
[88] https://www.frc.org.uk/directors/corporate-governance/uk-corporate-governance-code

Principal risks

The CRR considers a full cross-section of risks to the organisation. NHS England's most significant principal risks in 2022/23, including strategic, reputational, financial and operational risks, and risks to the achievement of the organisations' objectives and external threats, were:

Risk	Key mitigations in place
Demand and capacity: Risk of failure to create additional capacity that meets demand, which would have an adverse impact on patients' outcomes.	Urgent and emergency care recovery plan was published in January 2023 and targeted improving performance over a 2-year period through a variety of interventions, including: additional capacity for general and acute beds, virtual wards, ambulance hours on the road and community care. As part of this £1 billion was allocated to systems for 2023/24, building on the £500m allocated last year. The elective recovery programme's focus is on reducing long-wait lists. There have been a number of high impact actions taken in Mental Health, including a discharge challenge that took place between December 2022 and March 2023. Learnings from this challenge have been embedded through the system to help drive flow improvements through the urgent and emergency care pathway
Workforce capacity: The NHS workforce will not be sufficient to meet the challenges of recovery in the NHS and the NHS Long Term Plan; this is particularly relevant in key staff groups.	Additional staff were recruited into the substantive and contingent workforce with a focus on shortage areas, including nurses, healthcare support workers, with key targets for 2022/23. GP numbers: an additional 1,903 within primary care. 16,964 more international nurses and new funding for maternity services, with an increase of more than 2,000 WTE midwives. The existing national retention programme, initially established to respond to the 50,000 nursing manifesto commitment, has now been extended to other staff groups. We are promoting an inclusive culture by developing an equality, diversity and inclusion plan to improve equality in the NHS, including high impact actions for all protected characteristics. Ongoing health and wellbeing interventions including health and wellbeing guardians, embedding health and wellbeing conversations and psychological support via growing occupational health.
Quality of care: The risk to care quality (safety, effectiveness and experience) for patients, carers and families if NHS England does not satisfactorily deliver its commissioning and regulatory duties, covering assurance, improvement and planning functions.	Publication of cross-system quality oversight and governance guidance through the National Quality Board (NQB). Continuous monitoring of quality of care at system and regional levels through the NQB quality framework. Enhanced quality oversight of maternity services and implementation improvement action. Communications campaign to encourage people to take up vaccination offers (COVID-19 booster and flu) as well as services. Maternity Support Programme and CQC maternity service inspection regime.
Data and digital security: There is a risk that malicious cyber actors deploy widespread, catastrophic cyber-attacks against the NHS leading to patient harm and/or data misuse causing knock-on reputational and financial consequences for NHS England.	The Data Security and Protection Toolkit (DSPT) is an online self-assessment tool that provides guidance for and measures compliance with cyber security best practice across the NHS. It is refreshed on an annual basis allowing us to increase the standard year-on-year. £12 million capital was allocated to address critical infrastructure weakness such as outdated equipment in trusts. The Cyber Security Operations Centre is responsible for providing protective monitoring services across the NHS, enabling real-time threat detection and response.

NHS Oversight Framework

The NHS Oversight Framework[89] describes how NHS England oversees ICBs, NHS trusts and foundation trusts. Under the framework, organisations' support needs are regularly assessed, and each organisation is allocated into 1 of 4 support segments; from segment 1, for those with no specific support needs, to segment 4 where intensive support is provided through the national Recovery Support Programme. Decisions on which support segment organisations are allocated to are routinely reviewed and updated throughout the year and published on our website.

NHS England has met regularly with each CCG/ICB to review performance and the support needs of each NHS organisation across their ICS footprint. At the end of 2022/23 NHS England was providing intensive support via the Recovery Support Programme to 4 ICBs, 1 ICB was successfully supported to exit the Recovery Support Programme.

NHS England is committed to ensuring that the model of oversight remains relevant and effective. During 2023/24, we will complete a full review of our approach to oversight and consult on an updated Oversight Framework that is fully aligned with the NHS England Operating Framework.

Quality oversight and assurance

NHS England has a statutory duty to act with a view to securing continuous improvements in care quality. NHS England, as co-chair of the NQB, uses the definition of quality as care that is safe, effective, provides a personalised experience, is well-led, sustainable and equitable. NHS England's approach to managing quality is based on the quadruple aim, recognising the interoperability of quality, cost, staff experience and outcomes, and a quality management system approach (combining quality planning, improvement and control activities).

All NHS organisations have responsibility for the quality of services, and both ICBs and NHS England have a statutory duty to act with a view to securing continuous improvement in quality. NHS England, as co-chair of the NQB, uses the definition of quality as care that is safe, effective, provides a personalised experience, is well-led, sustainable and equitable.

NHS England's approach to managing quality is based on the quadruple aim, recognising the interoperability of quality, cost, staff experience and outcomes, and a quality management system approach that combines quality planning, improvement and control activities.

[89] https://www.england.nhs.uk/wp-content/uploads/2022/06/B1378_NHS-System-Oversight-Framework-22-23_260722.pdf

Governance

From 1 July 2022, the NHS England Board has a Quality Committee to support the duties and powers of the Board in respect of quality. The committee's duties are to:

- ensure NHS England has clear priorities for improving quality and a strategy to deliver them
- gain assurance that NHS England is delivering its functions, initiatives and policies in a way that secures continuous improvement in the quality of services and outcomes
- gain assurance that NHS England is effectively identifying, mitigating, and managing quality concerns and risks as appropriate, including through intelligence-sharing with ICSs, regulators, and wider partners.

Reporting to the Quality Committee, the NHS England Executive has a Quality and Performance Committee (QPC) to scrutinise quality, performance, workforce and finance issues, and an Executive Quality Group (EQG) to provide oversight and scrutiny of care quality across regions and receives regional quality insight from ICBs and providers.

NHS England also hosts the NQB which champions the importance of quality and drives system alignment across key health and care ALBs (NHS England, CQC, UKHSA, NICE, the Office for Health Improvement and Disparities, DHSC, and Healthwatch England). NQB discussions are also shared at the EQG and QPC.

The EQG provides an executive-level forum through which quality early warning signs, concerns and risks are shared, discussed, managed and escalated. The EQG is co-chaired by the National Medical Director and Chief Nursing Officer and brings together regional medical directors, regional chief nurses, directors of clinical quality and senior national colleagues, including the directors for patient safety, clinical effectiveness, patient experience and quality.

Assurance of the commissioning system

Specialised services

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

The specialised commissioning allocation was £23 billion at the end of 2022/23. Most of this allocation is held across seven regional teams for commissioning specialised services, with the balance held centrally to fund national budgets such as the CDF and other national programmes.

During 2022/23, the 2 major governance groups were established to set the strategic direction for specialised commissioning. In line with the ambition to delegate those

specialised services which are suitable and ready for greater local leadership[90], the Delegated Commissioning Group for Specialised Services was established to provide strategic direction for such services. Correspondingly, the National Commissioning Group (NCG) for Specialised, Health and Justice Armed Forces Services was established to set strategic direction and oversee commissioning of services still to be commissioned by NHS England. The Clinical Priorities Advisory Group made formal recommendations on the commissioning position of treatments and interventions for adoption.

Health and justice and sexual assault services

NHS England commissions healthcare for 112 adult prisons, immigration removal centres and the children and young people's secure estate. NHS England is also responsible for co-commissioning 47 SARCs to support victims and survivors of sexual assault and abuse. While the strategic direction for these services is set at a national level via the NCG, commissioning responsibilities are discharged regionally. The Health and Justice Delivery and Oversight Group and Health and Justice Clinical Reference Group were set up to oversee and join up health and justice commissioning.

The NHS England domestic abuse and sexual violence programme was established to transform the way the NHS in England responds to domestic abuse and sexual violence for both patients and staff. The programme worked with systems, regions and national and local partners to help with the implementation of the 'Serious Violence Duty.'[91] The duty came into force on 31 January 2023, requiring specified organisations, including ICBs, to collaborate locally to prevent and reduce 'serious violence', which includes domestic abuse and sexual offences.

In November 2022, we published the 'Health and Justice Framework for Integration 2022-2025: Improving lives – reducing inequality'.[92] This sets a strategic vision for the delivery of health and justice services and provides a framework for NHS commissioners, service providers, those with lived experience and cross-departmental partners to work collaboratively to improve patients' health and wellbeing outcomes.

We published renewed national partnership agreements (NPA) to ensure a joined-up approach for all patients in health and justice. This includes the adult prisons NPA, health and justice children programme NPA and an NPA for immigration removal centres.

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[90] https://www.england.nhs.uk/wp-content/uploads/2022/05/PAR1440-specialised-commissioning-roadmap-addendum-may-2022.pdf?dm_i=21A8,7VVXR,QZXL6D,W7GK7,1
[91] https://www.gov.uk/government/publications/serious-violence-duty
[92] https://www.england.nhs.uk/publication/health-and-justice-framework-for-integration-2022-2025-improving-lives-reducing-inequality/#:~:text=our%20site%20work.-,Health%20and%20justice%20framework%20for%20integration,2025%3A%20Improving%20lives%20%E2%80%93%20reducing%20inequality&text=This%20framework%20sets%20out%20the,and%20justice%20services%20across%20England.

Armed forces health

NHS England directly commissions all secondary care health services for serving personnel and families registered with Defence Medical Services and specific specialised services for veterans that, by law, we must provide access to for those distinct populations across England.

The services directly commissioned by NHS England with providers of secondary and specialised services include:

- all secondary healthcare services
- specialised veterans' mental health service – Op COURAGE
- prosthetics

NHS England sets policy, national clinical and governance standards and service specifications, which providers are contracted to deliver against.

The 42 ICBs commission healthcare for armed forces veterans and the families of veterans who are either currently serving or registered with an NHS GP practice. ICBs are required to give due regard to the health and social care needs of the armed forces community in planning and commissioning services.

During 2022/23, assurance to the NHS England Commissioning Group was through the Armed Forces Oversight Group on quality, performance and value for money.

The Armed Forces Clinical Reference Group and the Patient and Public Voice Advisory Group made formal recommendations on commissioning services based on strong evidence and lived experience.

We published a renewed national partnership agreement with the Ministry of Defence, which sets out the strategic intent and commitment for us to work together to commission health services for the armed forces community.

Delegation of primary care services

Since 1 July 2022, all ICBs have had delegated responsibility for commissioning primary medical services, which represented a transfer of responsibilities previously delegated to CCGs. However, 9 ICBs also took on delegated responsibility for 1 or more of dental (primary, secondary and community), general ophthalmic and pharmaceutical services. Delegation to ICBs was enabled by the Health and Social Care Act 2022. All remaining ICBs took on delegated responsibility for all four primary care services from 1 April 2023.

Delegation has been at the forefront of our vision to support more integrated care by ensuring local health and care leaders take collective responsibility for system performance and the transformation of care to improve population health, including primary care.

Where NHS England delegates its functions to ICBs it obtains assurances that these functions are being discharged effectively through the Primary Care Assurance

Framework. The framework covers issues such as providing information to NHS England 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. The Primary Care Assurance Framework has been developed specifically to cover all delegated activity across primary care services and replaces the previous framework that covered only primary medical services that were delegated to CCGs.

Vaccinations and screening – governance and the Section 7A agreement

Our Vaccinations and Screening Directorate commissions 11 screening programmes, around 20 routine immunisation programmes including the public seasonal influenza programme, and the COVID-19 vaccination deployment programme. The annual NHS Section 7A public health functions agreement between NHS England and DHSC sets out the arrangements under which the Secretary of State delegates responsibility to the NHS England Board for commissioning certain NHS public health services, including in 2022/23:

- NHS national cancer and non-cancer screening services
- NHS national routine immunisation services in general practice and school-age delivery
- Child Health Information Service (CHIS) including the Red Book
- NHS SARCs (led by Health and Justice Commissioning)
- NHS public health services for people in secure and detained settings (led by Health and Justice Commissioning)
- provision of an effective screening quality assurance service
- promotion of healthcare public health
- seasonal flu vaccinations
- COVID-19 vaccinations

Internal assurance in 2022/23 was provided through the quarterly NHS England Public Health Oversight Group. These were informed by programme-specific boards for each screening, vaccinations, flu and the CHIS programmes.

Integrated care systems

ICS development

The Health and Care Act 2022 placed ICSs on a statutory footing by creating ICBs as new NHS bodies on 1 July 2022. CCGs were simultaneously closed down, with NHS England overseeing the safe transfer of functions and staff to ICBs, which now lead strategic planning with their system partners, manage NHS resources and oversee and support NHS providers locally.

CCG and ICB annual reports

ICBs produced 2022/23 reports and accounts for each legacy CCG from within the ICB footprint (covering April to June 2022), and separate reports were published for each new ICB (accounting for the period 1 July 2022 to 31 March 2023). These annual reports were

published on their individual websites. A list of ICBs, along with links to their websites, can be found on the NHS England website.[93]

A review of the ICB governance statements found that issues identified by internal auditors over the year (covering CCGs for months 1-3 and ICBs for months 4-12), primarily focused on ‘quality and performance’ and ‘finance, governance and control’. The majority of control issues raised related to service capacity, referral to treatment times, finance and procurement for CCGs and ICBs. Additionally, CCGs additionally raised issues relating to governing body arrangements. These closely align with the issues highlighted by ICBs in their exception reports.

The NHS England group account has been prepared using unaudited information for four CCGs (NHS Birmingham and Solihull CCG, NHS Herefordshire and Worcestershire CCG, NHS West Essex CCG and NHS North West London) and five ICBs (NHS Birmingham and Solihull ICB, NHS Hereford and Worcestershire ICB, NHS Hertfordshire and West Essex ICB, NHS North West London ICB and NHS Suffolk and North East Essex ICB), as their audit reports remain outstanding at the time of finalising this account due the auditors not completing the local audits. More information is provided in note 1.3 to the consolidated financial statements on page 143.

Timeliness of local accounts

In preparing the consolidated NHS England account we use financial information extracted centrally from the single integrated financial environment and other information from schedules submitted to us by group bodies. This is assured based on audited annual reports and accounts provided to us by each CCG and ICB, other than the nine entities listed above.

We and the Department of Health and Social Care issue directions to NHS commissioners (CCGs and ICBs for the year ended 31 March 2023) on the timing by which these should be submitted.

The vast majority of NHS commissioners and their auditors continued to meet the deadline set for submission of audited accounts in 2022/23 and we recognise the significant efforts by commissioners and audit firms made to achieve this. The compliance rate was similar in percentage terms to 2021/22 but the number significantly late in 2022/23 is worse than 2021/22. This small but significant number of CCG and ICB audited accounts that were significantly late has delayed the preparation of these consolidated accounts.

There are many reasons why a set of audited accounts may go beyond the deadline: for example, this may reflect illness in the preparer finance team or audit team, or a significant issue may be encountered that takes time to resolve, which may reflect weaknesses in a commissioner’s preparation of its accounts. It is important that auditors can complete their

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[93] https://www.england.nhs.uk/publication/integrated-care-boards-in-england/

work independently of outside influence and take the necessary time to ensure their audit opinion is the right one and supported by appropriate audit evidence. However, standing back from the level of individual engagements, it is clear that success in enabling commissioners to achieve the audited accounts deadline, to which all firms sign up collaboratively, varies significantly between audit firms. For example, of the sixteen NHS commissioners audited by one audit firm, only three had submitted audited accounts by 31 August, two months after the deadline.

NHS England continues to work to improve timeliness in financial reporting including:

- encouraging auditors to give clear reporting to audit committees where the preparer's quality of draft accounts or working papers needs to improve
- working closely with commissioners to ensure they appoint external auditors in good time, which helps increase the likelihood of deadlines being achieved
- regular engagement with partners including the Department of Levelling Up, Housing and Communities and the Financial Reporting Council on policy matters affecting the broader local audit system: we believe strongly that firms having sufficient capacity across their wider portfolio of work to enable effective interim audits at NHS bodies is important for success
- working with commissioners where financial reporting issues arise to ensure they can address findings effectively
- regular engagement with the audit firms and responding to their feedback to continue to strengthen the NHS financial reporting landscape, and working with partners to make sure training and guidance is available for preparers

We acknowledge that 2022/23 was a complex year for financial reporting and audit in the NHS, in particular the implementation of IFRS 16, the mid-year transition from CCGs to ICBs meaning there was an increased number of bodies in 2022/23 requiring audit, and the growing backlog of audits in local government putting pressure on audit teams. We will continue to take the steps including those outlined above to improve overall timeliness in NHS financial reporting. The Department of Health and Social Care has an ambition to return to laying the main national consolidated accounts (being the DHSC group, NHS England group and consolidated provider accounts) before Parliament in advance of the summer Parliamentary recess in July. Significant improvements in overall timeliness of NHS financial reporting and audit would be required if this is to be achievable in the years ahead.

Commissioning support units

4 NHS CSUs operate across the whole country, providing essential support to a number of organisations including ICSs, ICBs, trusts, national organisations, local authorities and non-NHS bodies. With a workforce of 7,000 people, CSUs deliver a range of support services that have been independently assessed to ensure the NHS receives the benefits derived from working at scale.

CSUs rely on income for services delivered, creating an incentive for them to offer services of quality and value to other parts of the NHS. This ensures CSU services remain value for money as well as being responsive to the needs of their local health system and national priorities. They develop innovative solutions to areas of support, including managing waiting times, ICT services, data analytics, cyber security and transformation of local health systems. CSUs work closely together to ensure integration of service offerings and benefit from expertise, regardless of geographical location.

As an integral part of the NHS, CSUs operate in accordance with good governance principles. Each CSU is led by a managing director accountable to NHS England for their CSU's performance and delivery. This includes regular monitoring of CSU activity and the delivery of a monthly assurance statement to NHS England confirming adherence to appropriate governance processes and policies.

In 2022/23, CSUs supported development of the new NHS England and again achieved their financial targets.

Supply Chain Coordination Limited (SCCL)

SCCL ownership and responsibility for oversight of SCCL was transferred to NHS England from DHSC on 1 October 2021, to strengthen NHS England's ability to deliver savings in procurement, as committed in the NHS Long Term Plan. SCCL is a UK incorporated company and their Articles of Association include a range of matters reserved for shareholder decision. NHS England has established a governance framework with regard to its shareholdings. In addition to controls set out in the company's Articles of Association, NHS England sits on the Board of SCCL and holds quarterly accountability meetings to review performance against key performance indicators (KPIs) and financial targets, both of which are agreed by the NHS England board annually.
Additionally, NHS England sits on SCCL's ARAC as shareholder director, and ensures the appropriate Senior Finance representation.

In addition to controls set out in the company's Articles of Association, NHS England is represented on the SCCL Board and ARAC by a shareholder director. NHS England holds quarterly accountability meetings to review performance against KPIs and financial targets, both of which are agreed by the NHS England Board annually.

Other assurance

Information governance

The corporate information governance (IG) department is led by the Head of Corporate Information Governance who is also NHS England's Data Protection Officer. 4 workstreams make up the IG service: data governance, IG delivery, IG assurance and records management, supported by a business support office responsible for communication and engagement, project support and a central IG support desk which handles thousands of enquiries a year.

The corporate IG team supports the Data Protection Officer to ensure compliance with data protection legislation, common law, IG standards, best practice and NHS England policies and procedures.

Data Security and Protection Toolkit (DSPT)

A key achievement during 2022/23 was compliance with the DSPT, which requires all organisations that handle NHS data to measure their performance against the National Data Guardian's 10 data security standards every year. Achieving this standard provides assurance to the Board that good data security is in place and personal information is being handled correctly.

The Corporate Records Management team

The Corporate Records Management team completed a detailed analysis of the inventories for our legacy primary care services records (more than 324,600 boxes), including application of disposition and action date. IG and records management mandatory and statutory training achieved over 95% and 86% compliance respectively, with the required number of nominated records and information management co-ordinators (RIMCs) increasing to 30% by March 2023, representing over a quarter of all internal teams having two trained RIMCs.

The Data Governance team

The Data Governance team provided vital advice, direction and support to ensure adequate technical and organisational measures were in place to meet legal obligations and provided critical IG support to high profile programmes including:

- Vaccination Programme
- Get It Right First Time
- Model Health System
- Federated Data Platform
- OpenSafely COVID-19 Research Platform
- Data Management Information Services
- Clinical and medical device registries.

The Data Governance team supported the Model Health programme team to amend the data collection for Theatres Productivity, enabling the collection of the NHS number to enable data linkage (once de-identified). The Data Governance team also reviewed

access controls for all major platforms, apps and dashboards and helped the organisation meet its obligations.

The IG Assurance team

The assurance service oversees IG assurance of internal directorates and functions, as well as externally hosted bodies, high-risk data processors, CSUs and PCSE to minimise information risk to NHS England. Ensuring information assets are identified and managed is another key indicator of good IG and records management. The percentage of information assets compliant with their annual review increased to over 84% in-year, demonstrating how internal asset management controls have strengthened.

The IG Delivery team

To ensure the organisation is meeting its data protection accountability obligations, the IG Delivery team oversaw and managed a privacy-by-design approach for many new projects. The team supported several hundred data protection impact assessments, maintained IG policies and procedures, and provided communication and awareness materials to the public to meet transparency obligations with the ongoing publication of privacy notices.

During the year, NHS England received 169 subject rights requests, and compliance against the statutory response times was 83.4% (141/169). Of those subject rights requests handled, there were 33 internal review requests and data protection complaints made to the ICO requiring a response. The data protection officer team and the assurance team handle data protection complaints and responded to 100% of data protection concerns within the required timeframe since August 2022 (21/21), with 88% performance over the year (29/33).

There were 327 data breach incidents/near-misses reported internally during the year requiring investigation. 1 data breach incident required reporting to the ICO via the data security and protection incident reporting portal. This consisted of a cyber security incident on 4 August, which affected the Advance and Adastra systems. An emergency response team, which included representatives from NHS Digital and NHS England, helped to manage the incident. However, NHS England was not a data controller for the data but voluntarily reported the incident to follow NHS IG policy team guidance for all other NHS and social care organisations relating to the lack of availability of systems such as Adastra.

The number of notices served on an organisation by the UK's supervisory authority, the ICO, demonstrates a level of assurance in its information governance controls. During 2022/23, NHS England did not have any notices issued to it by the ICO.

This provides significant assurance to the data protection officer, the senior information risk owner and the Board of the organisation's compliance with data protection legislation, common law, IG standards, best practice and policies and procedures.

Business critical models

We operate a register of business-critical models and audit of the quality assurance strategy associated with them, overseen by a committee of experienced analysts. In 2022/23, this register was developed to work on a rolling basis, supporting a continuous improvement approach to our system of quality assurance. To date all relevant NHS England models in the register have passed.

Service auditor reporting and third-party assurances

NHS England relies on a number of third-party providers (such as NHS SBS, NHS BSA 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 2022/23, service auditor reports were specifically commissioned to provide assurance over the operation of our control environment and we are working, where appropriate, with our suppliers to implement International Standard on Assurance Engagements (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 2022/23 have been reviewed and where necessary action plans are being agreed to address any control issues identified. There are 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.

Control issues

Managing third-party contracts

We have continued to roll out our approach to third-party contract management, based on government commercial function guidance and methodologies for clarity of responsibility and accountability. The central commercial team now has overall responsibility for 886 contracts worth £3 billion.[94] All members of the central Contract Management team have government commercial function contract management accreditation. In line with the government's transparency agenda, we publish quarterly KPI data for our gold/strategic contracts.

[94] The number and value of contracts does not include NHS Digital due to separate accounts being submitted for 2022/23

Primary Care Support England performance management

Primary care support services are administration and payment services for the effective running of primary care. They are delivered by partner organisations: Capita Business Services Ltd and three CSUs.

The services:

- support more than 40,000 GP practices, dentists, opticians, and pharmacists
- pay more than £10 billion each year to primary care providers for NHS services
- invite more than 4.5 million women each year for NHS cervical screening
- process registrations for more than six million patients joining or changing GP
- move 5.8 million patient medical records each year between GPs

The PCSE contract saves the NHS more than £30 million each year compared to the previous in-house arrangement. The services have been assured throughout 2022/23 by regularly monitoring performance and quality indicators and a year-end assessment against International Audit Standard ISAE3402.

A project to assure the quality of historical GP pensions data, held by PCSE and NHS Pensions, continued to make progress including the pilot of a complex queries service. Other system and service improvements included supporting NHS Digital to build replacement software systems for the NHS cervical screening programme and patient registration function; continuing to improve the transfer of electronic records between GP practices and development of infrastructure to enable future development of an electronic only service. The programme to determine the future delivery of primary care support services began in 2022/23 to ensure continued delivery of these services from 2025 onwards.

Capita cyber incident

NHS England reported a data breach to the ICO following a cyber incident involving Capita, at the end of March 2023. Capita are contracted to provide primary care support services on behalf of NHS England. Capita informed NHS England that a document containing limited optometry information for 2 patients was accessed. Capita wrote to the 2 individuals to notify them and offer support.

Capita also informed us that 2 files containing names and NHS numbers of deceased and de-registered patients were suspected of being accessed. The files identified archived records that related to individuals who had died more than 10 years ago, or who have not been registered with a GP in England for more than 10 years. Capita informed us that no health data or other patient data was included in the lists or accessed as a result of the

incident. NHS England published a statement on its website on the 5 June 2023 to publicly disclose the nature of the incident.[95]

An independent cyber security company, appointed by Capita, has not found any evidence that the information had been made available more widely. Capita continues to further investigate and undertake diagnostic analysis on data that may have been exfiltrated from its systems.

The cyber incident did cause some short-term limited interruption to the operation of PCSE services. NHS England worked with Capita to implement its business continuity plan to mitigate any impacts for primary care.

Overpayments to medical practitioners

If a medical practitioner is suspended, they may be entitled to receive payments under the statutory regulations if the qualifying criteria is met. During the reporting period, NHS England identified payments to 12 medical practitioners (2 of which have been recovered) that did not meet the qualifying criteria when subsequently reviewed. Some of these include where circumstances had changed, and the practitioner was no longer eligible but continued to receive payments and also incorrect amounts calculated due to incorrect application of the guidance. This resulted in overpayments equating to £1.3 million, as noted in the losses and special payment disclosures.

This was an issue that was first identified in 2021/22. To ensure the issue was contained, NHS England commissioned a review of all suspension payments by internal audit to ensure that NHS England understood the full scope of any problems.

To strengthen the controls on this NHS England is implementing changes to how these payments are administered and suspensions are monitored to ensure a standardised approach. This will avoid variability in judgements around applying the guidance with improved oversight from the Professional Standards national team.

NHS England is seeking to recover all overpayments subject to legal advice.

Review of economy, efficiency and effective use of resources

Allocations

NHS England has responsibility for allocating the NHS funding agreed with DHSC as part of our mandate. Please see the Chief Financial Officer’s Report on page 39, for information on allocations.

Financial performance monitoring

July 2022 saw the establishment of ICBs, so the financial position for 2022/23 includes 3 months of CCG reporting and 9 months of ICB reporting.

[95] https://www.england.nhs.uk/2023/06/nhs-england-statement-on-capita-cyber-incident/

The financial position across the commissioning system was reported monthly using the Integrated Single Financial Environment system and supporting information collections. From July these collections included key elements of provider reporting which facilitated the focus on overall system reporting. Alongside this, NHS providers continued to report their full data using the Provider Financial Monitoring System. This reporting has enabled a detail monthly review by regional and national finance leadership teams and the Chief Financial Officer.

Individual CCG, ICB, direct commissioning and provider financial performance is monitored against KPIs including balance sheet indicators, performance against efficiency plans and specific categories of COVID-19 expenditure, in addition to the reported forecast and year-to-date position.

The financial position of commissioners is consolidated and reported in the overall NHS England accounts. The provider positions, NHS trusts and foundation trusts, are not recorded in the accounts of NHS Improvement or NHS England: these are treated as separate consolidations.

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 (including professional services and consultancy), onward approval is also sought from DHSC and for some cases this also requires approval from the Minister, Cabinet Office and/or HM Treasury.

There were a number of cases during 2022/23 where, predominately because of the operational need to continue services or to deliver Ministerial priorities, some spend was incurred before business cases were fully approved and before the relevant expenditure controls were completed. In some cases, the DHSC declined to provide retrospective approval, and therefore this expenditure is deemed to be irregular. NHS England has continued to work within the organisation to ensure that everyone is aware of the need to pre-approve activity and have worked with the Department to ensure that any urgent cases are reviewed promptly. This has helped reduce the value and instances of irregular spend.

Counter fraud

NHS England has a dedicated counter-fraud team which ensures that appropriate counter-fraud arrangements are in place. This includes proactive activities to prevent and detect fraud, as well as the reactive investigation of allegations of fraud related to our functions.

The Director of Financial Control has day-to-day operational responsibility for the function, and the Chief Financial Officer provides executive support and direction.

We continued to work collaboratively with key partners in both proactive and reactive areas. These include DHSC, NHS Counter Fraud Agency, NHS Business Service Authority, NHS Digital (pre-merger) and others, including law enforcement agencies.

In preparation for the merger, to form the new NHS England a number of key tasks were completed in 2022/23. These included the creation of a new counter-fraud strategy 2023-26, counter-fraud policy and counter-fraud response plan.

Ministerial directions

On 1 February 2023, the statutory functions of NHS Digital transferred to NHS England under the Health and Social Care Information Centre (Transfer of Functions, Abolition and Transitional Provisions) Regulations 2023 (Transfer Regulations).

Under the Transfer Regulations, all previous directions to NHS Digital to establish and operate systems for the collection or analysis of health and social care information (information systems) or to exercise functions in relation to the development or operation of information or communication systems in connection with health or adult social care (system delivery functions), whether given by the Secretary of State or NHS England, and which were in effect on 1 February 2023 are now treated as directions made by the Secretary of State to NHS England. The one exception is for system delivery directions issued by NHS England to NHS Digital – as these relate to NHS England system delivery functions, the directions are no longer required.

There are also the Secretary of State's financial directions.[96] There were routine financial directions issued every year – but in addition this year (and for subsequent years), they set out NHS England's budgets, as these no longer appear in the mandate to NHS England (following changes made by the Health and Care Act 2022).

[96] https://www.gov.uk/government/publications/2023-to-2024-financial-directions-to-nhs-england

Head of Internal Audit opinion

Internal audit's opinion is based on a programme of work designed to address the specific assurance requirements of the NHS England Board and focused on areas of risk identified by management. Results of internal audit work, including remedial actions agreed with management, have been regularly reported to management and ARAC.

In the context of the overall environment for NHS England for 2022/23, the opinion of internal audit is that the design of the governance and risk management framework at the year-end is effective and provides the foundation of a framework to take the organisation forward during 2023/24.

The organisation has been under significant operational pressure and subject to large scale change as a result of several factors including recovery from the pandemic and re-establishing business as usual processes, establishment of ICBs and navigating the new landscape NHS England operates in, and the mergers with NHS Improvement, NHS Digital and Health Education England.

Partly as a result of these factors, internal audit has found that while control frameworks are largely defined, there are weaknesses in compliance with those frameworks in a number of areas. In some cases, this has been driven by processes to identify non-compliance being paused to support the pandemic response and not yet fully re-established.

Internal audit has concluded that limited assurance can be provided over the effectiveness and efficiency of the internal control framework.

The limited assurance opinion has in part been driven by the risk-based approach to identifying audit topics and management's desire to focus on areas where there were known or suspected issues. As a result, internal audit's findings in these areas are not necessarily an indicator of broader issues across the organisation.

Actions have been agreed to address the issues identified by internal audit. Implementing actions in a timely manner has been challenging in the context of the ongoing organisational change programme and operational pressures, and management continues to focus on this. Management is also implementing a more holistic response to the identified compliance issues through a programme of work to further embed the corporate assurance framework, and as part of developing NHS England's culture following the organisational mergers. This will include re-establishing processes paused to support the pandemic response where appropriate.

Some of the weaknesses in internal controls for core processes were assessed as being fundamental to the system of controls. Management actions have been agreed to address these observations, not all of which have been completed by year end given their nature. Where possible, interim solutions have been put in place.

There remains significant reliance on third party providers of core services, such as payroll processing, and there remains a requirement to further embed the contract management framework to obtain assurance over the delivery of services.

Remuneration and staff report

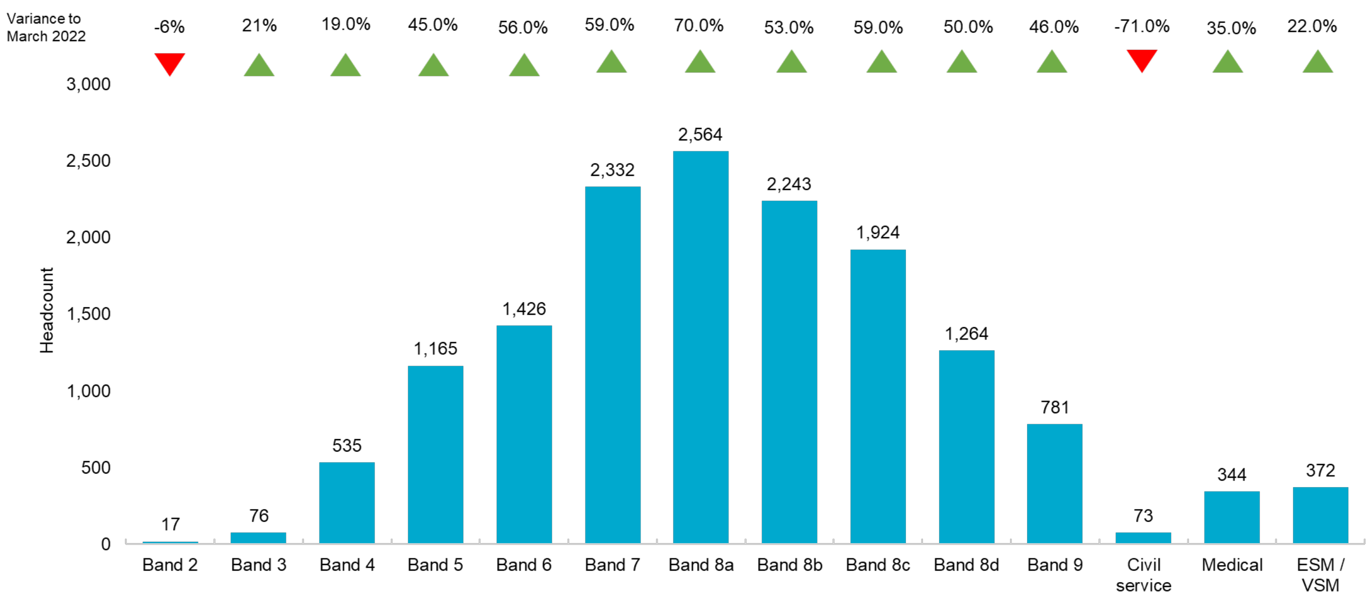
Our people

Our NHS People Plan[97] ambitions and values drive our workforce strategy, which aims for more staff working flexibly in a compassionate and inclusive culture. Alongside our People Plan, our NHS People Promise[98] sets out our pledge to one another of how we want to improve the experience of working in the NHS for everyone.

Staff numbers

On 31 March 2023, NHS England directly employed 15,172 staff (14,392 full time equivalents). Of these, 13,333 were permanently employed, and 1,839 were employed on payroll on fixed term contracts of employment. A further 914 individuals were engaged in an off-payroll capacity which includes agency staff and secondees.

All staff by grade



Detail on staff numbers and costs for NHS England and the consolidated group, including CSUs, are presented from page 97. The chart above shows the headcount by pay band on 31 March 2023.

The headcount of permanent and fixed term staff in NHS England increased by 50% since 31 March 2022. The growth in headcount can be largely attributed to NHS Improvement legally merging with NHS England on 1 July 2022 and NHS Digital transferring to NHS England on 1 February 2023. In preparing to safely receive staff and functions from NHS Digital into NHS England in January 2023, and to be ready to receive Health Education England staff and functions on 1 April 23, NHS England commenced the New NHS England Programme to integrate and restructure all three organisations, to create the new

[97] https://www.england.nhs.uk/ournhspeople/
[98] https://www.england.nhs.uk/ournhspeople/online-version/lfaop/our-nhs-people-promise/

NHS England. In January 2023, a voluntary redundancy scheme was made available for all eligible staff.

Staff turnover

Turnover increased in 2022/23 compared to 2021/22. Both the headcount and the number of people leaving the organisation also increased.

Staff turnover (%)

	April 2018 to March 2019	April 2019 to March 2020	April 2020 to March 2021	April 2021 to March 2022	April 2022 to March 2023
NHS England	14.0%	13.2%	4.88%	9.65%	11.01%
NHS TDA	14.9%	15.2%	4.65%	7.30%	8.10%
Monitor	19.4%	29.5%	4.13%	11.58%	2.21%
NHS Digital				11.79%	10.17%
Total	**14.7%**	**14.0%**	**4.85%**	**10.00%**	**10.90%**

NHS Digital and Health Education England merger with NHS England

On 22 November 2021, the Secretary of State announced[99] that NHS Digital and Health Education England would merge with NHS England. The NHS England Board committed to reducing the size of the combined organisations by 30% to 40%. On 15 July 2022, recruitment controls were introduced to make the most of our internal talent and maintain staffing levels. Our aim is to come together as an effective organisation with the right vision, values and culture to deliver the best for patients, communities and people.

Our commitment to equality, diversity and inclusion (EDI) will be integral to creating our new culture, drawing on the strengths of all our existing cultures. As a first step, we put EDI at the centre of our work by building on initial engagement activity in 2022, held workshops in February 2023 designed to hear colleagues' views and further shape our new culture and development of our new behaviour framework. To support the change programme, 135 design leads and team members were trained in the Equality Impact Assessment (EQIA) process, and over 140 EQIA panel members were trained in reviewing EQIA submissions from October to December 2022. EQIA panels are made up of volunteers from across the organisations who bring a wide range of lived experience and expertise, with individual review panels selected to be as balanced and representative as possible. Staff Networks are a key partner in advancing EDI and supporting our people through the organisational change.

[99] https://www.gov.uk/government/publications/health-education-england-mandate-2022-to-2023/the-department-of-health-and-social-care-mandate-to-health-education-england-april-2022-to-march-2023

Employment policies

Our priorities for 2022/23 included:

- in partnership with trade unions, the continued development and endorsement of new and harmonised human resources policies following the merger of NHS England, NHS TDA and Monitor on 1 July 2022, and the review of the temporary policy changes that were made in response to the pandemic
- identifying the employment policies that would apply to all staff transferring into NHS England from NHS Digital and Health Education England on 1 February and 1 April 2023 respectively
- committing to and beginning engagement with key stakeholders to agree an approach to harmonise of key employment policies which reflect the culture of the new NHS England

Partnership working

Trade unions make a vital contribution to representing the interests of colleagues and our organisations. Partnership work includes consulting on organisational change, a legal requirement, as well as developing and refining our policies and discussing and negotiating on a wide range of issues affecting people and the organisation. We have a National Partnership Forum, which meets regularly and provides strategic direction for other important subgroups which focus on specific issues, including policy, organisational change, equality and diversity and the Local Negotiating Committee. In addition, we have regional and corporate engagement forums to address any local issues, which can be escalated to the national partnership structure(s) if necessary.

To facilitate partnership working between NHS England, NHS Digital and Health Education England ahead of the merger, we set up a trilateral partnership forum, which consisted of management and trade union representatives from across all 3 organisations. This is the forum where we formally consult on all matters relating to the 'Creating the new NHS England' change programmes, including organisational change consultations arising from this.

In recognition of the increasing number of medical staff that we employ, especially following the transfer of staff from Public Health England into NHS England in 2021, we set up a Local Negotiating Committee, as a subgroup to the National Partnership Forum. This forum deals with all employment-related issues concerning medical staff's terms and conditions.

Equality, diversity, and inclusion

Workforce Disability Equality Standard

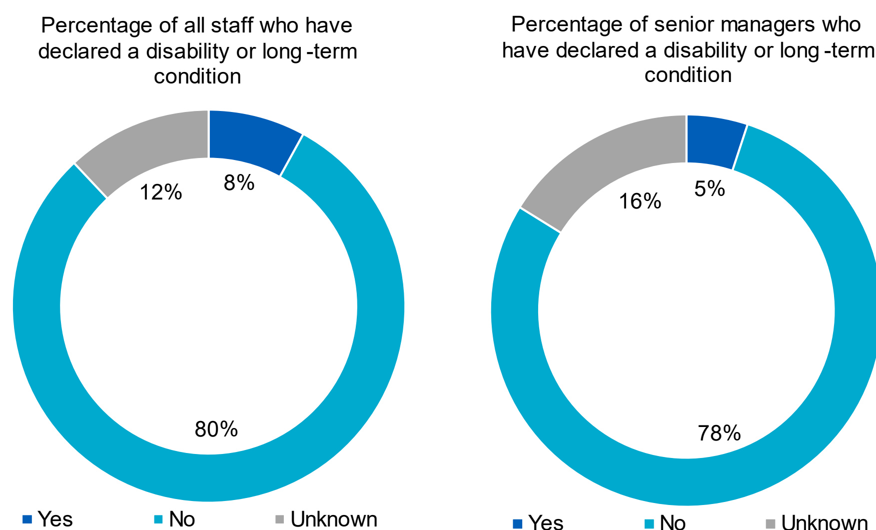
We have an action plan to improve working conditions for people with disabilities, drawing on the Workforce Disability Equality Standard.[100]

The first priority has been to increase the disability declaration level in the Electronic Staff Record (ESR), as there is a large disparity between those who declare their disability status in ESR, and the disability data collected as part of the annual NHS Staff Survey.

Since April 2020, the organisation has noticed a positive trend in colleagues declaring their disability from 5.6% to 8% in December 2022. However, the staff survey showed the disability declaration rate of 20%, which indicates that there is more to be done on creating trust in the ESR system to support colleagues in making their personal declarations.

The graphs below show the reporting of staff disability/long-term conditions in ESR, in addition to the percentage of senior managers, which is noted as 5%.

Declared disabilities or long term conditions



Stonewall Workplace Equality Index

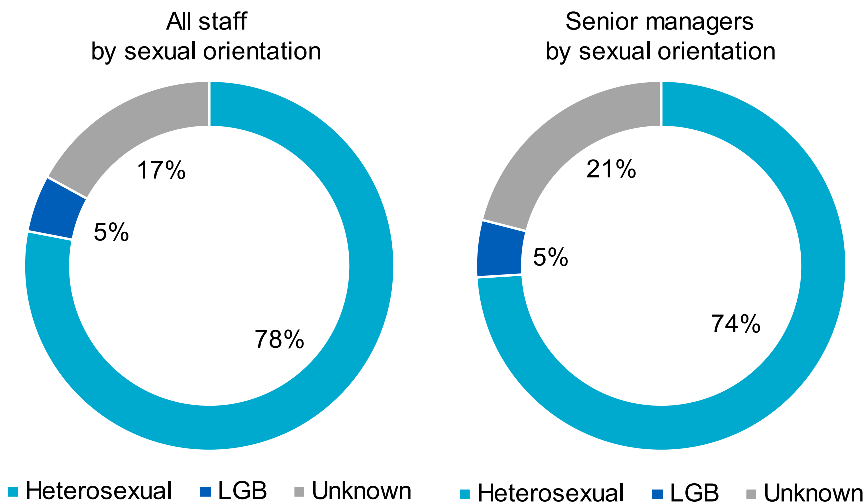
We are committed to building a diverse workforce and that includes creating a safe and inclusive place to work for all our LGB colleagues. NHS England submitted the Stonewall Workplace Equality Index[101], which was developed in partnership with our internal LGB Staff Network. We were informed in February 2023 we continued to maintain a position within the top 100 employers in the UK for the second year running; we are currently in the 68th position.

[100] https://www.england.nhs.uk/about/equality/equality-hub/workforce-equality-data-standards/wdes/
[101] https://www.stonewall.org.uk/full-list-top-100-employers-2022

Sexual orientation of staff and senior managers

The percentage of staff who disclose their identity as lesbian, gay and bisexual is 5% as of March 2023. The breakdown of sexual orientation declaration is detailed below, including an overview of senior managers who have declared as LGB in ESR (5%).

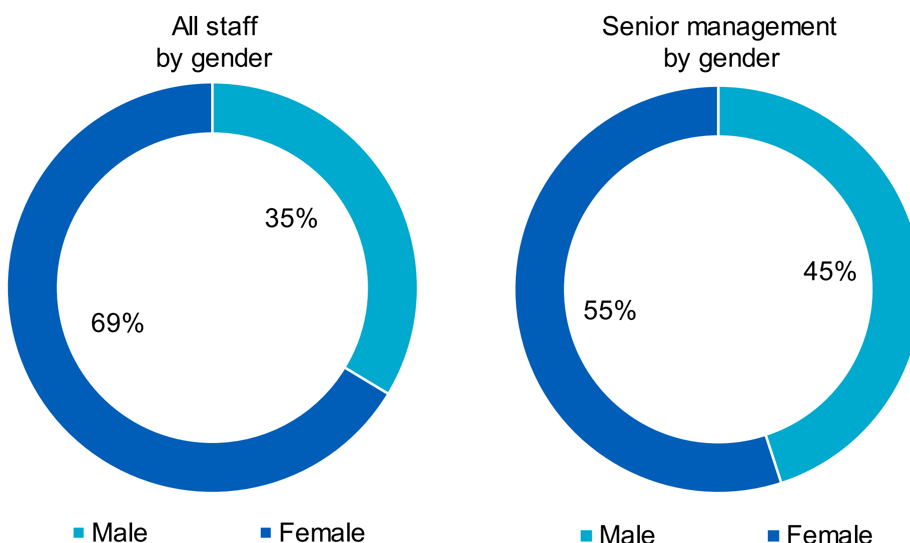
Staff and managers by sexual orientation



Gender of all staff and senior managers

The female gender profile of the total NHS England 'on payroll' workforce decreased by 5.3% between 31 March 2022 and 31 March 2023. There has been a 3.1% increase in the number of female senior managers to 54.7%. The gender diversity of Board members is set out on page 49. The graphs below highlight gender reporting in ESR:

All staff and senior managers by gender

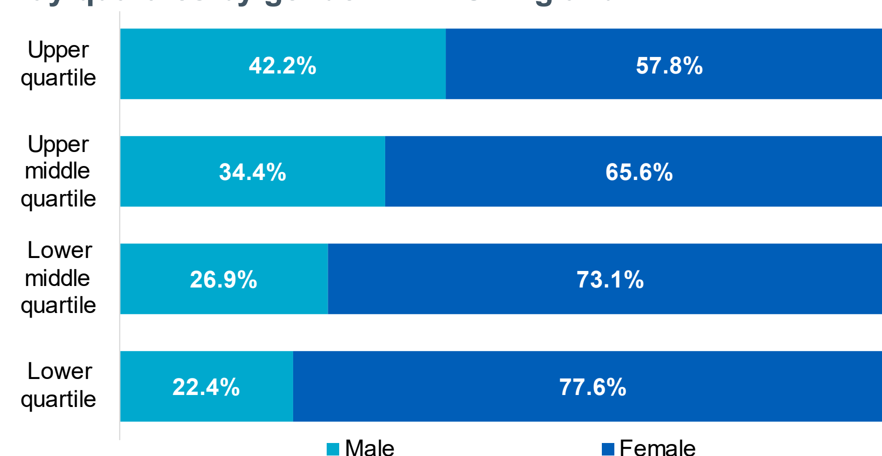


Gender pay gap

Based on the government's methodology, the mean gender pay gap across NHS England was 14.7%, showing a positive downward trend since 2018 and a 1.5% improvement from the previous year.

Year	Mean gender pay gap
2022	14.7%
2021	16.2%
2020	16.7%
2019	18.3%
2018	19.5%

Pay quartiles by gender in NHS England



The proportion of males and females in each pay quartile is detailed above, as of 31 March 2022. Women represent the majority of staff in the upper pay quartile of the organisation, which is an increase of 1.5% from the previous year.

Working in partnership with our recognised trade unions and our Women's Network, we continue to progress initiatives with the aim of addressing 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.

The Gender Pay Gap Report is available on our website.[102]

[102] https://www.england.nhs.uk/long-read/gender-pay-gap-report-2022/

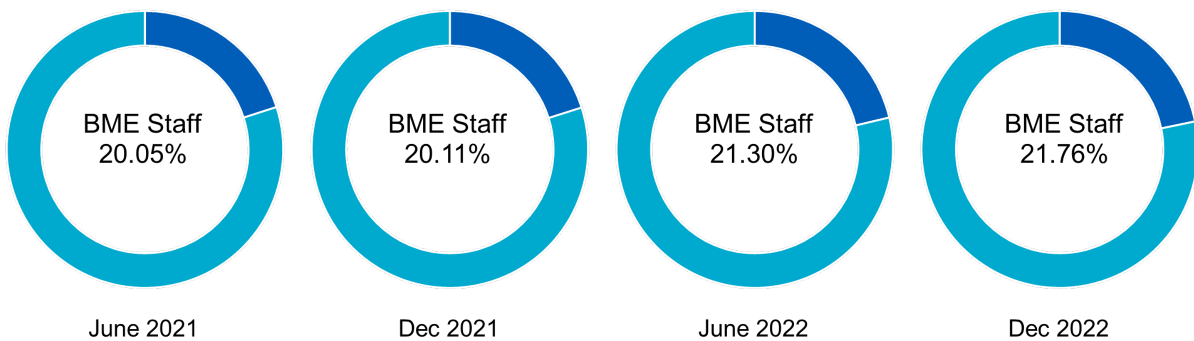
Ethnicity of all staff and senior managers

19% black and minority ethnic aspirational target across all pay bands

In March 2020, we set an aspirational target to achieve 19% black and minority ethnic representation across all pay bands in the organisation by 2025.

Since the target was set, there has been steady progress as highlighted below, recognising there is more work to be done to build representation across all grades.

Figures below show the overall percentage of black and minority ethnic staff and the change over the last 2 years:

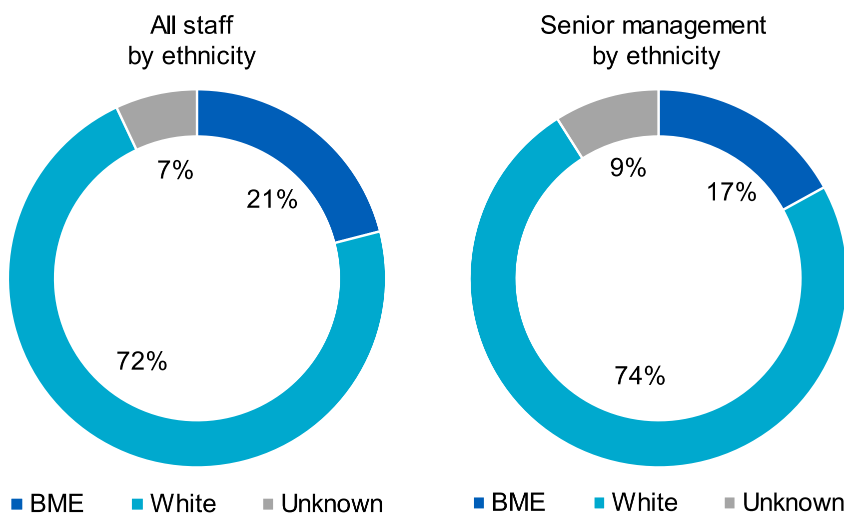


Our focus on black and minority ethnic talent is evidenced through proportionally more black and minority ethnic staff (14.94%) than white staff (11.29%) being promoted between April 2022 and March 2023.

The proportion of people employed by NHS England who consider themselves to be from a black or minority ethnic heritage has remained the same with 20.7% for both 2021/22 and 2022/23. The proportion of senior managers who identify as black or minority ethnic has decreased from 17.0% in 2021/22 to 16.4% in 2022/23.

See the below graphs reflecting the ethnicity reporting in ESR.

All staff and senior managers by ethnicity



Talent management and development

As we transition to the new NHS England, we have made it our priority to support talent development as we bring teams together across NHS England, NHS Digital and Health Education England. We implemented the recruitment assurance process across all three organisations, ensuring that existing internal talent is harnessed, and business-critical vacancies continue to be filled during the change programme. Our internal recruitment process continues to drive talent progression, creating opportunities for talent growth within our organisation.

We enhanced the organisational development offers available to all colleagues to support internal talent during the change programme. Our 'Me and My Brand' workshop series and 'Supporting You through Change' webinar series focused on helping colleagues identify their key strengths and development areas, improve application writing and interview skills and tackle imposter syndrome, ensuring internal talent can flourish in the new NHS England. Our Learning Development Hub brings together key learning and development interventions, including our coaching and mentoring offer and our leadership and management development programme which continues to support new and experienced managers to develop their skills, underpinned by health and wellbeing as a core principle.

Our approach to apprenticeships continues to make progress with more than 100 apprentices currently in training. We have partnered with NHS organisations in Leeds to create a cohort of data analyst apprentices who will be able to share experience and skills, creating a future talent pool of individuals with highly sought-after skillsets. We have 44 data analysts in training with the remaining apprentices focused on leadership and management disciplines.

Staff engagement and feedback

We carried out a full staff survey on 3 October 2022 for 8 weeks, closing on 25 November 2022, with a response rate of 63%, with 7,611 staff completing the survey.

Sickness absence

Sickness absence for the period 1 April 2022 to 31 March 2023 was as follows:

	Whole time equivalent days available	Whole time equivalent days lost to sickness absence	Sickness absence rate
NHS England	5,279,191	124,442	2.38%
CSU	2,332,095	65,004	2.79%
Total	**7,635,084**	**182,172**	**2.39%**

Trade union facility time disclosures

We will fulfil our obligations under the Trade Union (Facility Time Publication Requirements) Regulations 2017 for 2022/23 by reporting the information to form part of the government's public sector trade union facility time data, which has to be submitted by July 2023. Below is last year's submission, which is published on the gov.uk website in August each year.[103] Please note that this includes NHS Digital and NHS England data for 2022/23.

Trade union representatives – the total number of employees who were trade union representatives during the relevant period:

Number of employees who were relevant union officials during the relevant period	WTE employee number
45	44.4

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

Percentage of time	Number of employees
0%	24
1-50%	20
51-99%	0
100%	1

Percentage of pay bill spent on facility time – the figures requested in the first column of the table below will determine the percentage of the total pay bill spent on paying employees who were trade union representatives for facility time during the relevant period:

Description	Figures
Provide the total cost of facility time	£81,042.79
Provide the total pay bill	£1,032,277,344[104]
Provide the percentage of the total pay bill spent on facility time, calculated as: (total cost of facility time – total pay bill) x 100	0.02%[105]

[103] https://www.gov.uk/guidance/report-trade-union-facility-time-data
[104] NHS England and NHS Digital's 2022/23 wage bill combined.
[105] This figure is rounded up using Cabinet office's reporting criteria.

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 2022/23	Permanently employed number[106]	CSU employed number	Other number	CSU other number	Total number
Total	13,293	7,150	1,956	252	**22,651**
Of the above:					
Number of whole time equivalent people engaged on capital projects	245	-	24	-	**269**

Parent 2021/22	Permanently employed number	CSU employed number	Other number	CSU other number	Total number
Total	7,754	6,897	844	430	**15,925**
Of the above:					
Number of whole time equivalent people engaged on capital projects	-	-	-	-	-

Consolidated group 2022/23	Permanently employed number	CSU employed number	Other number	CSU other number	Total number
Total	35,383	7,150	4,122	252	**46,907**
Of the above:					
Number of whole time equivalent people engaged on capital projects	245	-	24	-	**269**

Consolidated group 2021/22	Permanently employed number	CSU employed number	Other number	CSU other number	Total number
Total	27,777	6,897	2,814	430	**37,918**
Of the above:					
Number of whole time equivalent people engaged on capital projects	-	-	-	-	-

[106] The most significant increase in staffing is including the transfer of staff from Monitor and Trust Development Authority at 1st July 2022 plus 2 months of NHS digital from 1 February 2023

Employee benefits

Parent group 2022/23	Permanently employed £000	Permanent CSU employees £000	Other £000	CSU other £000	Total £000
Employee benefits					
Salaries and wages	738,631	301,482	104,581	19,410	**1,164,104**
Social security costs	85,414	32,521	-	-	**117,935**
Employer contributions to NHS Pension Scheme	122,765	52,001	-	-	**174,766**
Other pension costs	11	-	-	-	**11**
Apprenticeship Levy	3,343	1,502	-	-	**4,845**
Other post-employment benefits	-	-	-	-	**-**
Termination benefits	78,945	(86)	-	-	**78,859**
Gross employee benefits expenditure	**1,029,807**	**387,420**	**104,581**	**19,410**	**1,540,520**
Less: Employee costs capitalised	(3,302)	-	(754)	-	**(4,056)**
Net employee benefits excluding capitalised costs	**1,025,807**	**387,420**	**103,827**	**19,410**	**1,536,464**
Less recoveries in respect of employee benefits	124	-	(75)	-	**49**
Total net employee benefits	**1,025,931**	**387,420**	**103,752**	**19,410**	**1,536,513**

Parent group 2021/22	Permanently employed £000	Permanent CSU employees £000	Other £000	CSU other £000	Total £000
Employee benefits					
Salaries and wages	491,283	301,959	61,913	22,514	877,669
Social security costs	56,417	32,803	-	5	89,225
Employer contributions to NHS Pension Scheme	90,413	55,335	-	-	145,748
Other pension costs	-	7	-	-	7
Apprenticeship Levy	2,447	2,858	-	-	5,305
Other post-employment benefits	-	154	-	-	154
Termination benefits	542	705	-	-	1,247
Gross employee benefits expenditure	**641,102**	**393,821**	**61,913**	**22,519**	**1,119,355**
Less: Employee costs capitalised	-	-	-	-	-
Net employee benefits excluding capitalised costs	**641,102**	**393,821**	**61,913**	**22,519**	**1,119,355**
Less recoveries in respect of employee benefits	(274)	-	(32)	-	(306)
Total net employee benefits	**640,828**	**393,821**	**61,881**	**22,519**	**1,119,049**

Consolidated group 2022/23	Permanently employed £000	Permanent CSU employees £000	Other £000	CSU other £000	Total £000
Employee benefits					
Salaries and wages	1,938,829	301,482	261,003	19,410	**2,520,724**
Social security costs	223,186	32,521	681	-	**256,388**
Employer contributions to NHS Pension Scheme	327,632	52,001	701	-	**380,334**
Other pension costs	2,941	-	-	-	**2,941**
Apprenticeship Levy	8,162	1,502	-	-	**9,664**
Other post-employment benefits	-	-	-	-	**-**
Termination benefits	91,304	(86)	-	-	**91,218**
Gross employee benefits expenditure	**2,592,054**	**387,420**	**262, 385**	**19,410**	**3,261,269**
Less: Employee costs capitalised	(3,302)	-	(754)	-	**(4,056)**
Net employee benefits excluding capitalised costs	**2,588,752**	**387,420**	**261,631**	**19,410**	**3,257,213**
Less recoveries in respect of employee benefits	(9,118)	-	(75)	-	**(9,193)**
Total net employee benefits	**2,579,634**	**387,420**	**261,556**	**19,410**	**3,248,020**

Consolidated group 2021/22	Permanently employed £000	Permanent CSU employees £000	Other £000	CSU other £000	Total £000
Employee benefits					
Salaries and wages	1,485,366	301,959	195,976	22,514	**2,005,815**
Social security costs	167,266	32,803	547	5	**200,621**
Employer contributions to NHS Pension Scheme	272,369	55,335	453	-	**328,157**
Other pension costs	1,147	7	-	-	**1,154**
Apprenticeship Levy	6,017	2,858	-	-	**8,875**
Other post-employment benefits	-	154	-	-	**154**
Termination benefits	3,814	705	-	-	**4,519**
Gross employee benefits expenditure	**1,935,979**	**393,821**	**196,976**	**22,519**	**2,549,295**
Less: Employee costs capitalised	-	-	-	-	**-**
Net employee benefits excluding capitalised costs	**1,935,979**	**393,821**	**196,976**	**22,519**	**2,549,295**
Less recoveries in respect of employee benefits	(11,810)	-	(32)	-	**(11,842)**
Total net employee benefits	**1,924,169**	**393,821**	**196,944**	**22,519**	**2,537,453**

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

The employment contracts or secondment agreements of almost all these staff are held for NHS England on a ‘hosted basis’ by the NHS BSA.

SCCL provided for 6 months of 2021/22.

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 £17.3 million during the financial year, a decrease of £16.6 million since previous year (2021/22: £33.9 million).

Across the group, there was a total spend of £51.1 million on consultancy services during the period, against £75.7 million the previous year.

Expenditure on contingent labour, including agency staff and secondees, is given in the employee benefits table on page 98, under the ‘other’ column.

Net expenditure for NHS England and CSUs in this area was £124 million in 2022/23, against £84.4 million in 2021/22. Across the group, there was a total spend of £281.8 million on contingent labour during the year, against £219.5 million the previous year. The increase in these 2 figures are due to legacy NHS Digital contingent labour costs, along with a full year of SCCL costs (2021/22 only accounted for 6 months of SCCL costs).

Further detail on efficiency controls, and steps we have taken to improve procurement practices and compliance within NHS England during the year, can be found in our governance statement from page 65.

Contingent labour	2022/23 £000	2021/22 £000	(Increase) / Decrease £000
Parent Inc CSU Other	123,991	84,432	(39,559)
CSU Other	19,410	22,519	3,109
Group Other	262,385	196,976	(65,409)
Total group contingent labour	**281,795**	**219,495**	

Consultancy	2022/23 £000	2021/22 £000	(Increase) / Decrease £000
Parent consultancy	17,290	33,899	16,609
Group consultancy	51,147	75,764	24,617

Off-payroll engagements

NHS England is committed to employing a capable, talented, and diverse on-payroll workforce to support the delivery of its business. It is recognised that in some specific circumstances the use of off-payroll workers, working alongside our on-payroll workforce, can be helpful. For some of our time-limited programmes, short-term contracts are appropriate. The following tables identify off-payroll workers engaged by NHS England at March 2023. Off-payroll workers engaged by ICBs are reported in ICB annual reports and published on their websites.[107]

[107] https://www.england.nhs.uk/publication/integrated-care-boards-in-england/

Off-payroll engagements longer than 6 months

Off-payroll engagements on 31 March 2023, covering those earning more than £245[108] per day and staying longer than 6 months are as follows:

Off-payroll engagements longer than 6 months	NHS England[109] (number)	CSUs (number)	SCCL (number)	Total (number)
Number of existing engagements as of 31 March 2023	420	107	0	527
Of which, the number that have existed:				
for less than 1 year at the time of reporting	80	96	0	176
for between 1 and 2 years at the time of reporting	164	10	0	174
for between 2 and 3 years at the time of reporting	87	1	0	88
for between 3 and 4 years at the time of reporting	45	0	0	45
for 4 or more years at the time of reporting	44	0	0	44

Most off-payroll workers who provide services to NHS England are clinical medical staff. All existing off-payroll engagements, outlined above, were subject to a risk-based assessment as to whether assurance was required that the individual was paying the right amount of tax and, where necessary, assurance has been sought.

New off-payroll engagements

New off-payroll engagements or those that reached 6 months in duration, between 1 April 2022 and 31 March 2023, for more than £245[110] per day and that last longer than 6 months are as follows:

New off-payroll engagements	NHS England[111] (number)	CSUs (number)	SCCL (number)	Total (number)
Number of off-payroll workers engaged during the year ended 31 March 2023	142	205	0	347
Of which:				
Number not subject to off-payroll legislation[112]	115	0	0	115
Number subject to off-payroll legislation and determined as in-scope of IR35[112]	24	205	0	229
Number subject to off-payroll legislation and determined as out of scope of IR35[112]	3	0	0	3
Number of engagements reassessed for compliance or assurance purposes during the year	0	0	0	0
Of which:				
Number of engagements that saw a change to IR35 status following review	0	0	0	0

[108] The £245 threshold is set to approximate the minimum point of the pay scale for a Senior Civil Servant.
[109] Includes NHS Digital from 1 February 2023.
[110] The £245 threshold is set to approximate the minimum point of the pay scale for a Senior Civil Servant.
[111] Includes NHS Digital from 1 February 2023.
[112] A worker that provides their services through their own limited company or another type of intermediary to the client will be subject to off-payroll legislation and the Department must undertake an assessment to determine whether that worker is in-scope of Intermediaries legislation (IR35) or out-of-scope for tax purposes.

Off-payroll board member/senior official engagement

Off-payroll engagements of Board members and/or senior officials with significant financial responsibility between 1 April 2022 and 31 March 2023 are shown in the table below:

Off-payroll board member/senior official engagement	NHS England[113] (number)	CSUs (number)	SCCL (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	0
Total number of individuals on-payroll and off-payroll who have been deemed ‘Board members and/or senior officials with significant financial responsibility’ during the financial year	365	31	0	396

Senior officials are defined as those at pay grade executive senior manager (ESM) 1 and ESM2, shown on the chart on page 88.

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.

[113] Includes NHS Digital from 1 February 2023.

Exit packages agreed during the year (subject to audit)

Parent	2022/23 Compulsory redundancies Number	2022/23 Other agreed departures Number	2022/23 Total Number	2021/22 Compulsory redundancies Number	2021/22 Other agreed departures Number	2021/22 Total Number
Less than £10,000	1	25	26	1	1	2
£10,001 to £25,000	2	124	126	1	-	1
£25,001 to £50,000	3	220	223	2	-	2
£50,001 to £100,000	1	261	262	3	-	3
£100,001 to £150,000	1	216	217	1	-	1
£150,001 to £200,000	3	106	109	1	-	1
Over £200,001	-	-	-	-	-	-
Total	**11**	**952**	**963**	**9**	**1**	**10**
Total cost (£000)	**837**	**74,704**	**75,541**	**601**	**5**	**606**

Parent	2022/23 Departures where special payments have been made Number	2022/23 Departures where special payments have been made £	2021/22 Departures where special payments have been made Number	2021/22 Departures where special payments have been made £
Less than £10,000	-	-	1	5,256
Total	**-**	**-**	**1**	**5,256**

Consolidated group	2022/23 Compulsory redundancies Number	2022/23 Other agreed departures Number	2022/23 Total Number	2021/22 Compulsory redundancies Number	2021/22 Other agreed departures Number	2021/22 Total Number
Less than £10,000	54	51	105	7	12	19
£10,001 to £25,000	30	156	186	7	10	17
£25,001 to £50,000	18	256	274	11	5	16
£50,001 to £100,000	17	289	306	4	4	8
£100,001 to £150,000	7	217	224	11	-	11
£150,001 to £200,000	37	108	145	7	4	11
Over £200,001	-	-	-	-	-	-
Total	**163**	**1,077**	**1,240**	**47**	**35**	**82**
Total cost (£000)	**9,352**	**78,996**	**88,348**	**3,319**	**1,424**	**4,743**

Consolidated group	2022/23 Departures where special payments have been made Number	2022/23 Departures where special payments have been made £	2021/22 Departures where special payments have been made Number	2021/22 Departures where special payments have been made £
Less than £10,000	-	-	3	19,902
£10,001 to £25,000	1	20,000	2	35,251
£25,001 to £50,000	1	30,000	2	61,128
£50,001 to £100,000	-	-	2	137,152
Total	**2**	**50,000**	**9**	**253,433**

Analysis of other agreed departures (subject to audit)

Parent	2022/23		2021/22	
	Other agreed departures Number	Other agreed departures £000	Other agreed departures Number	Other agreed departures £000
Voluntary redundancies including early retirement contractual costs	951	74,696	-	-
Mutually agreed resignations (MARS) contractual costs	-	-	-	-
Contractual payments in lieu of notice	1	8	-	-
Exit payments following Employment Tribunals or court orders	-	-	-	-
Non-contractual payments requiring HM Treasury approval	-	-	1	5
Total	**952**	**74,704**	**1**	**5**

Consolidated group	2022/23		2021/22	
	Other agreed departures Number	Other agreed departures £000	Other agreed departures Number	Other agreed departures £000
Voluntary redundancies including early retirement contractual costs	955	75,251	7	805
MARS contractual costs	91	3,115	1	90
Early retirements in the efficiency of the service contractual costs	1	8	-	-
Contractual payments in lieu of notice	29	572	19	276
Exit payments following Employment Tribunals or court orders	-	-	1	13
Non-contractual payments requiring HM Treasury approval	2	50	8	241
Total	**1,078**	**78,996**	**36**	**1,425**

The level of voluntary redundancies has increased significantly in the parent, compared to prior year. In this financial year NHS England underwent a significant restructure to reduce the size of the organisation by between 30% to 40%. This was to reflect the merger of NHS England with NHS Digital in January 2023 and Health Education England from April 2023 and the need to resize the organisation post the Covid 19 pandemic.

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

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

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

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

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

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

Remuneration report

People, Remuneration and Nominations Committee

Detail on the role and activity of the Strategic HR and Remuneration Committee is given in our Directors' Report on page 55.

Percentage change in remuneration of highest paid director (subject to audit)

Percentage change in remuneration of highest paid director	Salary and allowances	Performance pay and bonuses
The percentage change from the previous financial year in respect of the highest paid director	0%	0%
The average percentage change from the previous financial year in respect of employees of the entity, taken as a whole	3.00%	2,423.19%

The large average percentage increase in performance pay and bonuses across NHS England can be explained by the retrospectively agreed Governments' Agenda for Change (AfC 2022/23 Non-Consolidated Pay Award that consisted of 2 one off non-consolidated awards on top of the 2022/23 consolidated award agreed earlier in the year. Employees received a non-consolidated award worth 2%, in addition to a one-off NHS backlog bonus worth an additional 4% of the AfC pay bill to recognise the sustained pressure facing the NHS following the COVID-19 pandemic.

Pay ratio information (subject to audit)

Reporting bodies are required to disclose the relationship between the total remuneration of the highest-paid director/member in their organisation against the 25th percentile, median and 75th percentile of remuneration of the organisation's workforce. Total remuneration of the employee at the 25th percentile, median and 75th percentile is further broken down to disclose the salary component.

The banded remuneration of the highest paid director/member in NHS England in the financial year 2022/23 was £255,000 to £260,000 (2021/22: £255,000-£260,000). The relationship to the remuneration of the organisation's workforce is disclosed in the below table.

2022/23	25th percentile	Median	75th percentile
Total remuneration (£)	37,633	50,847	69,855
Salary component of total remuneration (£)	35,572	48,526	67,064
Pay ratio information	6.84:1	5.06:1	3.69:1

2021/22	25th percentile	Median	75th percentile
Total remuneration (£)	32,306	47,126	63,862
Salary component of total remuneration (£)	32,306	47,126	63,862
Pay ratio information	7.97:1	5.46:1	4.03:1

The pay ratio information for the 2022/23 financial year is consistent with the pay, reward and progression policies for the employees taken as a whole, due to applying all nationally

mandated Pay Awards where applicable and adhering to the relevant pay progression principles. The increased total remuneration at the 25th, median and 75th percentiles versus the salary component of total remuneration at the 25th, median and 75th percentiles were attributable to the AfC 2022/23 Non-Consolidated Pay Award, as referenced above.

In 2022/23, no employees received remuneration in excess of the highest-paid director/ member (2021/22: none). Remuneration ranged from £7,883 to £260,000 (2021/22: £7,883 to £260,000).

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

Policy on remuneration of senior managers

The framework for the remuneration of executive directors is set by DHSC through the ESM pay framework for ALBs.

It is NHS England's policy to pay salaries that are appropriate to recruit senior managers with the necessary skills, capability and experience for the effective running of a more than £158 billion organisation, while recognising the importance of demonstrating pay restraint at a time of considerable pressure on NHS finances. Recommending appropriate remuneration for executive directors is undertaken by the People, Remuneration and Nominations Committees. Final decisions are made by the DHSC ALB Remuneration Committee and HM Treasury, where appropriate.

Performance-related pay

The 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 does not currently allocate any funding for PRP non-consolidated bonus payments. In recognition of the current economic climate and the need to provide effective system leadership for the NHS, the decision was taken by the Strategic HR and Remuneration Committee and Nomination and Remuneration Committee not to allocate funds for PRP non-consolidated bonus payments for 2022/23. Secondees are subject to the terms and conditions of their employing organisation.

Policy on senior managers' contracts

Contracts of employment for senior managers are open-ended and recurrent, unless otherwise specified. Notice periods follow the provisions of the ESM contract of employment, as applied by NHS England, of 6 months' contractual notice. Termination payments can only be authorised where they are contractual and, subject to the value involved, may still require further approval from the DHSC Governance and Assurance Committee. Any proposed non-contractual special severance payment requires formal approval from DHSC and HM Treasury.

Payments for loss of office (subject to audit)

A payment was made to 1 senior manager to compensate for loss of office during 2022/23, and details of this payment are included in the senior manager salary and pension entitlement table on page 109.

Payments to past directors (subject to audit)

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

Senior managers' service contracts

Name and title	Date of appointment	Notice period	Provisions for compensation for early termination	Other details
Amanda Pritchard Chief Executive Officer	1 August 2021	6 months	Option to provide taxable pay in lieu of part or all of the notice period	
Sir David Sloman Chief Operating Officer – Joint	14 December 2021	6 months		
Mark Cubbon Chief Delivery Officer – Joint	14 December 2021	6 months		Left NHS England 2 April 2023
Ian Dodge National Director for Primary Care, Community Services and Strategy – Joint	7 July 2014	6 months		Left NHS England 30 June 2022
Jacqueline Rock Chief Commercial Officer – Joint	1 January 2022	6 months		
Professor Sir Stephen Powis National Medical Director – Joint	1 March 2018	6 months		
Julian Kelly CB Chief Financial Officer – Joint	1 April 2019	6 months		
Dame Ruth May Chief Nursing Officer – Joint	7 January 2019	6 months		
Prerana Issar Chief People Officer – Joint	1 April 2019	6 months		Left NHS England 4 October 2022
Dr Tim Ferris National Director of Transformation – Joint	10 May 2021	6 months		
Christopher Hopson Chief Strategy Officer – Joint	13 June 2022	6 months		
Dr Navina Evans Chief Workforce Officer	1 July 2022	6 months		

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) until 30 June 2022. Full salary disclosures are included within the Remuneration Reports of all 3 entities and the costs are split equally between NHS England and NHS Improvement, with NHS Improvement costs being split at a ratio of 2:1 NHS TDA-to-Monitor.

Remuneration (salary, benefits in kind and pensions) 2022/23 (subject to audit)

Name and title	(a) Salary (bands of £5,000) £000	(b) Benefits in kind (taxable) to nearest £100 £s	(c) Performance pay and bonuses (bands of £5,000) £000	(d) Long-term performance pay and bonuses (bands of £5,000) £000	(e) Pension-related benefits (bands of £2,500)[114] £000	(f) Total (a to e) (bands of £5,000) £000
Amanda Pritchard Chief Executive Officer	255-260	0	0	0	70-72.5	325-330
Sir David Sloman Chief Operating Officer[115]	235-240	3,900	0	0	0	245-250
Mark Cubbon Chief Delivery Officer[116]	220-225	1,900	0	0	50-52.5	270-275
Ian Dodge National Director for Primary Care, Community Services and Strategy[117]	200-205	0	0	0	0	200-205
Jacqueline Rock Chief Commercial Officer	230-235	0	0	0	50-52.5	280-285
Professor Stephen Powis National Medical Director	235-240	0	0	0	0	235-240
Julian Kelly CB Chief Financial Officer	210-215	0	0	0	50-52.5	260-265
Dame Ruth May Chief Nursing Officer[118]	175-180	0	0	0	0	175-180
Prerana Issar Chief People Officer[119]	150-155	0	0	0	92.5-95	245-250
Dr Tim Ferris National Director of Transformation[120]	190-195	0	0	0	0	190-195
Christopher Hopson Chief Strategy Officer[121]	165-170	0	0	0	37.5-40	205-210
Navina Evans Chief Workforce Officer[122]	75-80	0	0	0	0	75-80

[114] The value of pension benefits accrued during the year is calculated as the real increase in pension multiplied by 20, less the contributions made by the individual. The real increase excludes increases due to inflation or any increase or decrease due to a transfer of pension rights. This value derived does not represent an amount that will be received by the individual. It is a calculation that is intended to provide an estimation of the potential benefit of being a member of the pension scheme.
[115] Sir David Sloman's salary was recharged to NHS England from the Royal Free London NHS Foundation Trust where he was also formally employed and retained a post.
[116] Mark Cubbon's salary was recharged to NHS England from Portsmouth Hospitals NHS Trust where he was also formally employed and retained a post. Mark Cubbon left NHS England on 2 April 2023.
[117] Ian Dodge left NHS England and NHS Improvement on 30 June 2022 and was paid a redundancy payment in the salary range of £160,000-£165,000 in July 2022 as compensation for loss of office; this is included in the salary band disclosed within the table. The full-year equivalent salary is £175,000-£180,000.
[118] Dame Ruth May retired on 16 June 2022 to access NHS Pension benefits and returned to post 18 June 2022 following the required 24 hours' break in service. The full-year equivalent salary is £180,000-£185,000.
[119] Prerana Issar left NHS England on 04 October 2022. The full year equivalent salary is £230,000-£235,000.
[120] 80% of the salary costs for Dr Tim Ferris are recharged to NHS England and NHS Improvement from Mass General Brigham Inc. where is he is also formally employed and retains a post, with NHS England and NHS Improvement directly funding the remaining 20%. The full year equivalent salary is £190,000-£195,000. NHS England and NHS Improvement also paid Mass General Brigham Inc. a retirement contribution of $35,000-$40,000. Incorrect enrolment into the NHS Pension Scheme on commencement resulted in an underpayment of salary during 2021/22 due to pension contributions being deducted from his salary in error and these contributions were refunded during 2022/23.
[121] Christopher Hopson commenced in post on 13 June 2022. The full year equivalent salary is £205,000-£210,000.
[122] Navina Evans commenced in post on 01 July 2022 and 50% of the salary costs are recharged to NHS England from Health Education England where she was also formally employed and retained a post during 2022/23. As such, the above figures disclose 50% of salary, with Health Education England disclosing the remaining 50%. Dr Evans also received a payment for unused annual leave of £10-£15k, however Health Education England absorbed this full cost and 50% was not re-charged to NHS England. The full year equivalent salary is £205,000-£210,000.

Remuneration (salary, benefits in kind and pensions) 2021/22 (subject to audit)

Name and title	(a) Salary (bands of £5,000) £000	(b) Benefits in kind (taxable) to nearest £000	(c) Performance pay and bonuses (bands of £5,000) £000	(d) Long-term performance pay and bonuses (bands of £5,000) £000	(e) Pension-related benefits (to nearest £1,000) [123] £000	(f) Total (a to e) (bands of £5,000) £000
Sir Simon Stevens Chief Executive Officer [124]	65-70	0	0	0	0	65-70
Amanda Pritchard Chief Executive Officer [125]	255-260	0	0	0	74	330-335
Mark Cubbon Interim Chief Operating Officer [126]	80-85	300	0	0	16	95-100
Sir David Sloman Chief Operating Officer [127]	65-70	1300	0	0	0	65-70
Ian Dodge National Director for Primary Care, Community Services and Strategy	170-175	0	0	0	0	170-175
Dr Emily Lawson Chief Commercial Officer [128]	65-70	0	0	0	0	65-70
Blake Dark Interim Chief Commercial Officer [129]	75-80	0	0	0	19	95-100
Jacqueline Rock Chief Commercial Officer [130]	55-60	0	0	0	13	70-75
Professor Sir Stephen Powis National Medical Director	225-230	0	0	0	0	225-230
Julian Kelly CB Chief Financial Officer	205-210	0	0	0	50	255-260
Dame Ruth May Chief Nursing Officer	180-185	0	0	0	33	210-215
Prerana Issar Chief People Officer	230-235	0	0	0	54	280-285
Matthew Gould CMG MBE National Director for Digital Transformation [131]	100-105	0	0	0	21	120-125
Dr Tim Ferris National Director of Transformation [132]	170-175	0	0	0	0	170-175

[123] The value of pension benefits accrued during the year is calculated as the real increase in pension multiplied by 20, less the contributions made by the individual. The real increase excludes increases due to inflation or any increase or decrease due to a transfer of pension rights. This value derived does not represent an amount that will be received by the individual. It is a calculation that is intended to provide an estimation of the potential benefit of being a member of the pension scheme.
[124] 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. He continued with this voluntary reduction in pay during 2021/22 and until he left NHS England on 31 July 2021. The full-year equivalent salary is £195,000-£200,000.
[125] During the period 1 April 2021 to 31 July 2021 the salary for Amanda Pritchard was recharged to NHS England and NHS Improvement from Guy's and St Thomas' NHS Foundation Trust where she was also formally employed and retained a post. From 1 August 2021 Ms Pritchard replaced Sir Simon Stevens as Chief Executive Officer for NHS England.
[126] Mark Cubbon replaced Amanda Pritchard as Interim Chief Operating Officer for the period 1 August 2021 to 13 December 2021. His salary was recharged to NHS England and NHS Improvement from Portsmouth Hospitals NHS Trust, where he was also formally employed and retained a post. The full-year equivalent salary is £225,000-£230,000.
[127] Sir David Sloman replaced Mark Cubbon as Chief Operating Officer on 14 December 2021. His salary was recharged to NHS England and NHS Improvement from Royal Free London NHS Foundation Trust, where he was also formally employed and retained a post. The full-year equivalent salary is £230,000-£235,000.
[128] Dr Emily Lawson left the position of Chief Commercial Officer on 18 July 2021. The full-year equivalent salary is £230,000-£235,000.
[129] Blake Dark replaced Dr Emily Lawson as Interim Chief Commercial Officer for the period 1 August 2021 to 31 December 2021. The full-year equivalent salary is £190,000-£195,000.
[130] Jacqueline Rock replaced Blake Dark as Chief Commercial Officer on 1 January 2022. The full-year equivalent salary is £230,000-£235,000.
[131] 80% of the salary costs for Matthew Gould are recharged to NHS England and NHS Improvement from DHSC where he is also formally employed and retains a post. As such, the above figures disclose 80% of salary and pension benefits, with DHSC disclosing the remaining 20%. The full-year equivalent salary is £125,000-£130,000.
[132] Dr Tim Ferris started in the joint post on 10 May 2021. 80% of the salary costs are recharged to NHS England and NHS Improvement from Mass General Brigham Inc where is he is also formally employed and retains a post, with NHS England and Improvement directly funding the remaining 20%. The full-year equivalent salary is £190,000-£195,000. Incorrect enrolment into the NHS Pension Scheme on starting resulted in underpayment of salary during 2021/22 due to pension contributions being deducted from his salary in error.

Pension benefits (subject to audit)

Name and title	Real increase in pension at pension age (bands of £2,500) £000	Real increase in pension lump sum at pension age (bands of £2,500) £000	Total accrued pension at pension age on 31 March 2023 (bands of £5,000) £000	Lump sum at pension age related to accrued pension on 31 March 2023 (bands of £5,000) £000	Cash Equivalent Transfer Value on 31 March 2022[133] £000	Real Increase in Cash Equivalent Transfer Value £000	Cash Equivalent Transfer Value on 31 March 2023 £000	Employer's contribution to partnership pension £000
Amanda Pritchard Chief Executive Officer	5-7.5	(2.5)-0	90-95	135-140	1,229	56	1,340	0
Mark Cubbon Chief Delivery Officer	2.5-5	(2.5)-0	65-70	110-115	1,025	43	1,129	0
Sir David Sloman Chief Operating Officer[134]	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Ian Dodge National Director for Strategy and Innovation[135]	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Jacqueline Rock Chief Commercial Officer	2.5-5	N/A	5-10	N/A	14	26	72	0
Professor Sir Stephen Powis National Medical Director and Interim Chief Executive Officer[136]	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	15-20	N/A	152	26	211	0
Dame Ruth May Chief Nursing Officer[137]	(15)-(12.5)	65-67.5	65-70	310-315	1,763	0	43	0
Prerana Issar Chief People Officer	5-7.5	N/A	15-20	N/A	151	50	228	0
Dr Tim Ferris National Director of Transformation[138]	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Christopher Hopson Chief Strategy Officer[139]	2.5-5	N/A	0-5	N/A	0	23	46	0
Dr Navina Evans Chief Workforce Officer[140]	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

[133] As per previous submissions, the column Cash Equivalent Transfer Value on 31 March 2021 is the uninflated value whereas the real increase in CETV is the employer-funded increase.
[134] Sir David Sloman chose not to be covered by the NHS Pension arrangements during the reporting period.
[135] Ian Dodge chose not to be covered by the NHS Pension arrangements during the reporting period.
[136] Professor Sir Stephen Powis chose not to be covered by the NHS Pension arrangements during the reporting period.
[137] Dame Ruth May accessed NHS 1995 Pension Scheme benefits on 16 June 2022. This is the reason for the large decrease in CETV from 31 March 2022 to 31 March 2023.
[138] Dr Tim Ferris was not eligible to be covered by NHS Pension arrangements during the reporting period.
[139] Christopher Hopson commenced in post on 13 June 2022.
[140] Dr Navina Evans commenced in post on 1 July 2022 and chose not to be covered by the NHS Pension arrangements during the reporting period.

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

A CETV is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time.

The benefits valued are the member's accrued benefits and any contingent spouse's (or other allowable beneficiary's) pension payable from the scheme.

A CETV is a payment made by a pension scheme or arrangement to secure pension benefits in another pension scheme or arrangement when the member leaves a scheme and chooses to transfer the benefits accrued in their former scheme.

The pension figures shown relate to the benefits that the individual has accrued as a consequence of their total membership of the pension scheme, not just their service in a senior capacity to which disclosure applies.

The CETV figures and the other pension details include the value of any pension benefits in another scheme or arrangement which the individual has transferred into 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 on appointment and is non-pensionable. All non-executive directors are paid the same amount, except the Chair, Vice Chair and Chair of ARAC, to reflect the equal time commitment expected from each non-executive director. The Chair, Vice Chair and Chair of ARAC are entitled to higher amounts to reflect the increased time commitment associated with their respective roles.

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

Non-executive director service contracts

Name and title	Date of appointment	Unexpired term at 31 March 2023	Notice period	Provisions for compensation for early termination	Other details
Richard Meddings CBE Chair	25 March 2022	36 months	3 months	None	
Wol Kolade Vice Chair	25 March 2022	24 months	3 months	None	Waived entitlement to remuneration
Professor Lord Ara Darzi Non-Executive Director	1 April 2020	0 months	3 months	None	Left NHS England on 30 June 2022
Jeremy Townsend Non-Executive Director Chair of ARAC	1 October 2020	42 months	3 months	None	Returned from temporary transfer to NHS Improvement on 1 July 2022
Laura Wade-Gery Non-Executive Director	6 November 2020	4 months	3 months	None	Left on 30 June 2023
Rakesh Kapoor Non-Executive Director	1 January 2021	9 months	3 months	None	Returned from temporary transfer to NHS Improvement on 1 April 2022
Susan Kilsby Non-Executive Director	1 January 2021	9 months	3 months	None	
Michael Coupe Non-Executive Director	1 January 2021	45 months	3 months	None	
Professor Sir Munir Pirmohamed Non-Executive Director	1 July 2022	9 months	3 months	None	
Sir Andrew Morris Non-Executive Director	1 July 2022	24 months	3 months	None	
Sir David Behan Non-Executive Director	1 September 2022	17 months	3 months	None	Chair of Health Education England
Baroness Mary Watkins Non-Executive Director	27 January 2023	34 months	3 months	None	
Professor Sir Simon Wessely Non-Executive Director	27 January 2023	34 months	3 months	None	
Sir Mark Walport Non-Executive Director	27 January 2023	34 months	3 months	None	

Non-executive director remuneration (including salary entitlements)

Salaries and allowances 2022/23 (subject to audit)

Name of non-executive director	(a) Salary (bands of £5,000) £000	(b) Benefits in kind (taxable) rounded to nearest £100 £s	(c) Performance pay and bonuses (bands of £5,000) £000	(d) Long-term performance pay and bonuses (bands of £5,000) £000	(e) Pension-related benefits to the nearest £1,000[141] £000	(f) Total (a to e) (bands of £5,000) £000
Richard Meddings CBE[142]	60-65	0	0	0	N/A	**60-65**
Wol Kolade[143]	0	0	0	0	N/A	**0**
Professor Lord Ara Darzi[144]	0-5	0	0	0	N/A	**0-5**
Jeremy Townsend[145]	5-10	0	0	0	N/A	**5-10**
Laura Wade-Gery	5-10	0	0	0	N/A	**5-10**
Rakesh Kapoor	5-10	0	0	0	N/A	**5-10**
Susan Kilsby	5-10	0	0	0	N/A	**5-10**
Michael Coupe	5-10	0	0	0	N/A	**5-10**
Professor Sir Munir Pirmohamed[146]	5-10	0	0	0	N/A	**5-10**
Sir Andrew Morris[147]	5-10	0	0	0	N/A	**5-10**
Sir David Behan[148]	0-5	0	0	0	N/A	**0-5**
Baroness Mary Watkins[149]	0-5	0	0	0	N/A	**0-5**
Professor Sir Simon Wessely[150]	0-5	0	0	0	N/A	**0-5**
Sir Mark Walport[151]	0-5	0	0	0	N/A	**0-5**

[141] Non-executive directors do not receive pensionable remuneration and therefore have no pension-related benefits
[142] Richard Meddings donated his non-executive director remuneration to charity via NHS England's Give As You Earn scheme.
[143] Wol Kolade waived his entitlement to non-executive director remuneration.
[144] Professor Lord Ara Darzi left NHS England on 30 June 2022. The full-year equivalent salary is £5,000-£10,000.
[145] Jeremy Townsend returned from a temporary transfer to NHS Improvement in the same role and salary of Non-Executive Director and Chair of ARAC on 1 July 2022. The full-year equivalent salary is £10,000-£15,000.
[146] Professor Sir Munir Pirmohamed transferred from NHS Improvement to NHS England in the same role and salary of Non-Executive Director on 1 July 2022. The full-year equivalent salary is £5,000-£10,000.
[147] Sir Andrew Morris transferred from NHS Improvement where he held the role of Interim Chair at a salary of £60,000-65,000 to NHS England as a Non-Executive Director on 1 July 2022. The full-year equivalent salary is £5,000-£10,000.
[148] Sir David Behan joined NHS England on 1 September 2022 and waived entitlement to non-executive director remuneration due to also being the Chair of Health Education England. The full-year equivalent salary is £5,000-£10,000.
[149] Baroness Mary Watkins joined NHS England on 27 January 2023. The full-year equivalent salary is £5,000-£10,000.
[150] Professor Sir Simon Wessely joined NHS England on 27 January 2023. The full-year equivalent salary is £5,000-£10,000.
[151] Sir Mark Walport joined NHS England on 27 January 2023. The full-year equivalent salary is £5,000-£10,000.

Salaries and allowances 2021/22 (subject to audit)

Name of non-executive director	(a) Salary (bands of £5,000) £000	(b) Benefits in kind (taxable) rounded to nearest £100 £s	(c) Performance pay and bonuses (bands of £5,000) £000	(d) Long-term performance pay and bonuses (bands of £5,000) £000	(e) Pension-related benefits to the nearest £1,000 [152] £000	(f) Total (a to e) (bands of £5,000) £000
Lord David Prior [153]	60-65	0	0	0	N/A	**60-65**
Richard Meddings CBE [154]	0-5	0	0	0	N/A	**0-5**
David Roberts CBE [155]	0	0	0	0	N/A	**0**
Wol Kolade [156]	0	0	0	0	N/A	**0**
Professor Lord Ara Darzi	5-10	0	0	0	N/A	**5-10**
Jeremy Townsend	10-15	0	0	0	N/A	**10-15**
Laura Wade-Gery	5-10	0	0	0	N/A	**5-10**
Rakesh Kapoor	5-10	0	0	0	N/A	**5-10**
Susan Kilsby	5-10	0	0	0	N/A	**5-10**
Michael Coupe	5-10	0	0	0	N/A	**5-10**

[152] Non-executive directors do not receive pensionable remuneration and therefore have no pension-related benefits.
[153] Lord David Prior left NHS England on 24 March 2022. The full-year equivalent salary remains at £60,000-£65,000.
[154] Richard Meddings CBE joined NHS England on 25 March 2022 and waived his entitlement to non-executive director remuneration. The full-year equivalent salary is £60,000-£65,000.
[155] David Roberts CBE waived his entitlement to non-executive director remuneration and left NHS England on 30 June 2021.
[156] Wol Kolade joined NHS England on 25 March 2022 and waived his entitlement to non-executive director remuneration.

Parliamentary accountability and audit report

All elements of this report are subject to audit.

Remote contingent liabilities

There were no remote contingent liabilities.

Notation of gifts over £300,000

NHS England made no political or charitable donations of gifts during the 2022/23 financial year.

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 NHS 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 and ICBs can be found within individual CCGs and ICBs annual reports which are published on ICB websites. A list of CCGs and ICBs, along with links to their websites, can be found on the NHS England website.

Losses

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

	Parent				Consolidated group			
	Total number of cases 2022/23 Number	Total value of cases 2022/23 £000	Total number of cases 2021/22 Number	Total value of cases 2021/22 £000	Total number of cases 2022/23 Number	Total value of cases 2022/23 £000	Total number of cases 2021/22 Number	Total value of cases 2021/22 £000
Administrative write-offs	-	-	41	82	131	580	555	2,875
Fruitless payments	214	192	188	24,206	232	2,472	195	26,373
Stores losses	25,060	1,098	-	-	303,711	2,322	3	4
Bookkeeping losses	62	17	43	21	72	58	44	23
Constructive loss	7	5,902	1	383	7	5,902	2	384
Cash losses	11	1,647	22	22,033	17	1,685	28	22,065
Claims abandoned	361	3,000	2	395	364	3,011	96	4,746
Total	**25,715**	**11,856**	**297**	**47,120**	**304,534**	**16,030**	**923**	**56,470**

2022/23 Disclosure: Fruitless payments

£0.6 million. NHS Gloucestershire ICB have agreed and paid a legal settlement agreement granted by the court in financial year 2022/23. The ICB settled a court order agreement in breach of the Public Contracts Regulations 2015 in their award of the contract for advice and guidance services in 2022/23.

£0.9 million. NHS Bath and North East Somerset, Swindon and Wiltshire ICB have agreed and paid a legal settlement agreement granted by the court in financial year 2022/23. The

ICB settled a court order agreement in breach of the Public Contracts Regulations 2015 in their award of the contract for advice and guidance services in 2022/23.

2022/23 Disclosure: Store losses

£1.10 million. This case relates to various stock items that cannot be utilised in healthcare facilities as the stock has reached the manufacturers expiry date and therefore requires writing off.

2022/23 Disclosure: Constructive losses

£1.102 million. This case relates to six vaporisers which support the provision of oxygen to patients. The vaporisers were purchased in March 2020 by NHS England for the London Nightingale Hospital at the ExCeL. Following decommissioning of the facility, the vaporisers were placed into storage to be available if ever required. As many hospital facilities have since been upgraded, these vaporisers are too big to be used in any other existing facility and are therefore excess to requirements.

£4.80 million. This case relates to stock that was procured as part of the Vaccine Deployment Programme in response to the COVID-19 pandemic. The stock was procured in extreme urgency and considerable uncertainty in supply chains and demand. The stock is now deemed as surplus to requirement and retaining the stock in storage will not equate to value for money when compared to the running cost of storage.

2022/23 Disclosure: Cash losses

Total cash losses for 2022/2023 amount to £1.6 million. £1.3 million of this total relates to the overpayment of suspension payments made to 10 medical practitioners. As per the reporting requirement, the overpaid suspension payments that exceed £300k are disclosed below:

£421k. This loss relates to the overpayment of suspension payments to a medical practitioner between March 2020 and June 2022 equating to a sum of £420,588. The overpayment is due to the medical practitioners qualifying entitlement ceasing, meaning that they would not have been eligible for the suspension payment as per the Secretary of States Payment Determination Guidance.

£305k. This loss relates to the overpayment of suspension payments to a medical practitioner between May 2019 and March 2022 equating to a sum of £305,000. The overpayment is due to the medical practitioners qualifying entitlement ceasing, meaning that they would not have been eligible for the suspension payment as per the Secretary of States Payment Determination Guidance.

£378k. This loss relates to the overpayment of suspension payments to a medical practitioner between June 2018 and October 2023 equating to a sum of £377,590. The overpayment is as a result of the medical practitioner continuing to receive payment at a

rate higher than that which they were eligible as per the Secretary of States Payment Determination Guidance, following the cessation of one of their qualifying relationships.

£311k. The remaining cash loss relates to non-delivery of contractual dental units of activity as part of the General Dental Service. The registered performer failed to deliver the contractual agreed units of Dental and orthodontic activities for the financial years 2016 to 2022. In addition, as part of the new procedure requirements issued by NHS England during the pandemic, the registered performer did not comply with new contractual obligations to provide urgent face to face dental care. The sum being reported represents the totality of payments made where there has been no benefit to NHS England or patients.

2022/23 Disclosure: Claims abandoned

£2.83 million. This case relates to the request to write off a grant awarded to the sum of £1,749,500 and the subsequent capital gain on the property equating to £1,080,000. The funded asset was utilised for the provision of mental health care within Trust grounds by a charitable organisation. A decision was taken to dispose the funded asset to the Trust as part of a modernisation programme for mental health inpatient facilities. The capital grant agreement included a legal charge in favour of the Secretary of State for the receipts in the event that the applicant disposes the funded asset. NHS England is the successor of Health Authorities and PCTs for the purposes of this capital grant agreement.

2021/22 Disclosure: Fruitless payments

£2.1 million. This case relates to a procurement challenge as a result of a breach of Procurement Contract regulations 2015. The breach is in relation to NHS England's incorrect application of a framework agreement which has resulted in a claim for damages for loss of a chance to provide services and legal costs incurred. The case was settled in favour of the claimant and is therefore reported to reflect the court outcome.

£17.8 million. This cost relates to a contractual amount to be paid by NHS England to exit a long-term contract for a university medical school where no future value to the entity is expected. The total represents the sum to be paid from 2023 to 2029. The cost represents a stream of funding for medical schools funding which began in 1988 when it was provided by the Regional Health Authority as part of a national policy to fund clinical academic posts. The funding and governance have passed through numerous organisations and oversight committees across the period as the NHS evolved through regular structural changes. The accrual of £17.8 million is representative of an unpaid discounted future cost that is payable to the universities, however, any final settlement will need to be approved by Treasury.

£6.2 million. This sum represents a payment to be made by NHS England to HMRC for back taxes, national insurance and related interest for the historical treatment of a cohort of clinical workers who have been paid in an off-payroll capacity. The workers should have

been paid as “employed” for tax purposes. This sum is in the process of being settled by NHS England.

2021/2022 Disclosure: Constructive losses

£0.3 million included in the parent figure for NHS England relates to provision of enemas to support the Bowel Scope Screening programme. The manufacturer of the enema products decided to cease manufacturing the enema product as it was not one of their main areas of business. It was agreed to bulk order 2 years’ worth of the enema product to give time for either another product to be sourced or a decision to be made on the future of the Bowel Scope programme in light of the bowel screening age extension. Due to the bulk order in 2019, there was a large element of unused enema products that were out of date and not required due to the impact of COVID-19 on activity and decommissioning of the bowel scope service.

2021/22 Disclosure: Cash losses

£4.2 million. This relates to the review of the GP Contract Vaccinations and Immunisations (V&I) programmes within NHS England. The outcome of the review confirmed that some contractors could not meet the vaccination targets that were set in relation to routine childhood vaccination and immunisation, therefore, resulted in an overpayment. The V&I repayment mechanism is intended to limit financial gain by practices with lower levels of performance.

Having reviewed a large volume of commissioner and practice queries, it became apparent that practices were struggling to meet the performance threshold. The main reasons for this are issues outside of a practice’s control, such as increased vaccine hesitancy, people either not coming forward when invited or declining, less ability to opportunistically offer vaccination when children are present in practice for another reason, and the impacts of the COVID-19 pandemic on practice capacity.

£15.7 million relates to pharmacy cash advances paid by NHS England. At the start of the COVID-19 pandemic, community pharmacies faced significant and unexpected cash flow pressures. These were caused by several issues, including a sharp increase in prescription items in March and April 2020, higher drug prices, delayed payments for the Pharmacy Quality Scheme and extra COVID-19 related costs. It was agreed to provide an urgent uplift to the normal advance payments to support pharmacies with their cash flow pressures and to help them stay open to continue to provide vital NHS pharmaceutical services. The cash advances were made on the basis that payments would be recovered from pharmacies in 2020/21, however, a significant number of pharmacy contractors closed down between April 2020 and March 2022 making recovery of the advanced sum not feasible.

£964,000. This relates to 2 suspended GPs within NHS England that had salary overpayments, 1 due to be being ineligible for suspension payments and 1 due to being paid more than they were entitled to. Recovery of £473,000 of the £964,000 is being pursued as part of an ongoing criminal investigation, the remainder is not able to be recovered due to legal advice that estoppel would be applicable. New management processes with regard to suspension payments helped to identify these payments. These new processes have improved controls and are intended to prevent recurrence of such cases. Actions such as a new payment mechanism and authorisation procedures have been implemented along with training on application of the suspension payment rules.

£1 million relates to overpayment made on a contract with an independent sector service provider in response to the COVID-19 pandemic. NHS England has reached an agreement to recover the full amount in due course. Having made this agreement, the service provider made a repayment of £82.5k and went into administration by October 2022. Measures have been implemented within NHS England to prevent recurrence of such cases.

2021/22 Disclosure: Claims abandoned

£0.3 million relates to Dentaris (a dental provider) who went into liquidation on 21 April 2020. The provider owed money relating to 2017/18 and 2018/19 underperformance of activity on the contract. The company was dissolved at Companies House on 21 April 2021, and no creditor will receive any dividend in respect of monies owed from Dentaris. The practice closed without prior notification to NHS England. Until the closure, the practice and NHS England had agreed a repayment plan, for the moneys owing, which had been agreed to support the practice to remain open and therefore supportive of patients continuing to receive care.

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 2022/23 Number	Total value of cases 2022/23 £000	Total number of cases 2021/22 Number	Total value of cases 2021/22 £000	Total number of cases 2022/23 Number	Total value of cases 2022/23 £000	Total number of cases 2021/22 Number	Total value of cases 2021/22 £000
Compensation payments	7	159	1,008	311	15	199	1,013	353
Compensation payments Treasury approved	-	-	-	-	-	-	1	32
Extra contractual payments	1	80			2	190	1	1
Ex gratia payments	6	30	475	314	18	87	488	409
Ex gratia payments Treasury approved	-	-	-	-	19	55	1	18
Extra statutory extra regulatory payments	-	-	-	-	-	-	-	-
Special severance payments Treasury approved	-	-	-	-	-	-	1	57
Special severance payments	-	-	1	5	2	50	6	167
Total	**14**	**269**	**1,484**	**630**	**56**	**581**	**1,511**	**1,037**

All cases classified as special severance payments are subject to HM Treasury approval.

2022/23 Special severance payments

During 2022/23 SCCL paid two special severance payments for £30,000 and £20,000 respectively. The payment of £30,000 relates to a non-contractual amount to terminate employment and the payment of £20,000 relates to a non-contractual payment in relation to a dispute settlement. These payments were not approved by NHS England and are therefore irregular.

2021/22 Disclosure: Ex gratia payment

During the year 3 CSUs paid ex gratia payments to current and former employees in relation to monies received from NHS Fleet Solutions relating to refunds of VAT obtained as a result of the decision in the Northumbria Healthcare NHS Foundation Trust v HMRC on salary sacrifice lease cars of £314,000.

2021/22 Special severance payments

There was 1 Treasury approved special severance payments as follows:

NHS Surrey Heartlands CCG

During 2021/22, the CCG has paid 1 special severance payments recorded in their accounts for £56,416.75. The CCG sought approval from NHS England and HM Treasury prior to agreement and payment and approval was granted.

There were 6 special severance payments that do not have HMT approval, as follows:

NHS North of England CSU

During 2021/22, the CSU has paid 1 special severance payment in the parent account for £5,256. It relates to a non-contractual payment in lieu of notice (PILON) payment made to the individual. This payment was not approved by NHS England and is therefore irregular.

NHS Kernow CCG

During 2021/22, the CCG has paid 3 special severance payments recorded in their accounts for £22,751, £24,497 and £28,800 respectively. They relate to non-contractual PILON payments made to the individuals. This payment should have been submitted to NHS England and HMT for review and approval prior to being paid. This approval was not in place prior to making the payment. The CCG sought retrospective approval, but this was not granted and therefore the payments are considered irregular.

NHS North East Essex CCG, NHS Ipswich and East Suffolk CCG and NHS West Suffolk CCG

The 3 CCGs recorded a special severance payment in their accounts totalling £81,000 in June 2022, under a settlement agreement with a former senior employee. This payment should have been submitted to NHS England for review and approval prior to being paid. The CCG sought retrospective approval from NHS England which was granted. However, HM Treasury did not approve the payment and, as this was not granted, the payment is irregular.

NHS Bristol, North Somerset and South Gloucestershire CCG

During 2021/22, a non-contractual special severance payment of £5,389 was made by the CCG. This required approval from NHS England and the CCG has sought retrospective approval.

The payments noted above are also included in the Exit Packages disclosures from page 99.

Cost allocation and setting of charges

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

		Parent			Consolidated group		
2022/23	**Note**	**Income £000**	**Full cost £000**	**Surplus/ (deficit) £000**	**Income £000**	**Full cost £000**	**Surplus/ (deficit) £000**
Dental	2 & 4	631,415	(2,593,407)	(1,961,992)	746,642	(3,023,228)	(2,276,586)
Prescription	2 & 4	519,753	(1,728,499)	(1,208,746)	670,324	(11,904,187)	(11,233,863)
Total fees and charges		**1,151,168**	**(4,321,906)**	**(3,170,738)**	**1,416,966**	**(14,927,415)**	**(13,510,449)**

		Parent			Consolidated group		
2021/22	**Note**	**Income £000**	**Full cost £000**	**Surplus/ (deficit) £000**	**Income £000**	**Full cost £000**	**Surplus/ (deficit) £000**
Dental	2 & 4	633,809	(3,099,805)	(2,465,996)	633,847	(3,099,805)	(2,465,958)
Prescription	2 & 4	641,033	(2,351,608)	(1,710,575)	651,964	(11,430,430)	(10,778,466)
Total fees and charges		**1,274,842**	**(5,451,413)**	**(4,176,571)**	**1,285,811**	**(14,530,235)**	**(13,244,424)**

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 International Financial Reporting Standards (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[157] are a contribution to the cost of pharmaceutical services including the supply of drugs. In 2022/23, the NHS prescription charge for each medicine or appliance dispensed was £9.35. However, around 90% of prescription items[158] 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 £30.25 for 3 months or £108.10 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[159] which fall into 3 bands depending on the level and complexity of care provided. In 2022/23, the charge for Band 1 treatments was £23.80, for Band 2 was £65.20 and for Band 3 was £282.80. Dental patient charges have not changed since 14 December 2020.

[157] https://www.legislation.gov.uk/uksi/2021/178/made
[158] https://digital.nhs.uk/data-and-information/publications/statistical/prescriptions-dispensed-in-the-community/prescriptions-dispensed-in-the- community-england---2007---2017
[159] https://questions-statements.parliament.uk/written-statements/detail/2020-11-23/hcws593

Accountability to Parliament and the Public

During 2022/23, NHS England has continued to work closely with the National Audit Office in their work to test whether public bodies are delivering value for money. During this period, the Chief Executive and other senior leaders gave evidence to Public Accounts Committee hearings on 'Managing NHS backlogs and waiting times' and 'Introducing Integrated Care Systems' and the NAO published reports on Introducing Integrated Care Systems[160], Managing NHS backlogs and waiting times in England[161], Progress in improving mental health services in England[162] and Alcohol Treatment Services.[163]

In response to the Public Accounts Committee's recommendations, NHS England has:

- Continued to offer targeted support to the providers with the greatest performance challenges, including weekly or fortnightly oversight meetings, on-site diagnostic visits from the Intensive Support Team and national support to improve, which between July 2022 and July 2023 delivered a greater reduction in patients waiting over 78 weeks than in better performing providers; (Letter from Amanda to Public Accounts Committee Chair on Backlogs and Waiting times).[164]
- Investing in a Federated Data Platform, which by linking data will help Integrated Care Systems to better coordinate care across health and social care providers; and
- Supported Integrated Care Systems to accelerate and embed adoption of population health management across systems and places through the Population Health Management Academy, supporting the development of effective place-based partnerships. (both of the latter two from a letter from Sir Chris to PAC Chair on Implementing ICSs).[165]

[160] https://www.nao.org.uk/reports/introducing-integrated-care-systems-joining-up-local-services-to-improve-health-outcomes/
[161] https://www.nao.org.uk/reports/managing-nhs-backlogs-and-waiting-times-in-england/
[162] https://www.nao.org.uk/reports/progress-in-improving-mental-health-services-in-england/
[163] https://www.nao.org.uk/reports/alcohol-treatment-services/
[164] https://committees.parliament.uk/publications/41823/documents/207410/default/
[165] https://committees.parliament.uk/publications/41370/documents/203376/default/

The certificate of the Comptroller and Auditor General to the Houses of Parliament

Opinion on financial statements

I certify that I have audited the financial statements of NHS England and its group for the year ended 31 March 2023 under the National Health Service Act 2006 and the Health and Social Care Act 2012.

The financial statements comprise NHS England and its group's:

- Statement of Financial Position as at 31 March 2023;
- Statement of Comprehensive Net Expenditure, Statement of Cash Flows and Statement of Changes in Taxpayers' Equity for the year then ended; and
- the related notes including the significant accounting policies.

The financial reporting framework that has been applied in the preparation of the group financial statements is applicable law and UK adopted International Accounting Standards.

In my opinion, the financial statements:

- give a true and fair view of the state of NHS England and its group's affairs as at 31 March 2023 and their total net expenditure for the year then ended; and
- have been properly prepared in accordance with the National Health Service Act 2006 and the Health and Social Care Act 2012 and Secretary of State directions issued thereunder.

Qualified opinion on regularity

In my opinion, except for the effects of the matters described in the *Basis for qualified opinion on regularity* section below, 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 for qualified opinion on regularity

I have qualified my opinion on regularity because of ineligible payments made to suspended medical practitioners, where the transactions do not conform to the relevant statutory regulations specifying entitlement to such payments. The expenditure is therefore irregular.

12 suspended medical practitioners received suspension payments of £1,335,626 during the financial years 2017-18 to 2022-23 (of which £156,429 relating to eight suspended medical practitioners was paid in 2022-23) to which they were not entitled. Such payments were not made in accordance with statutory regulations governing entitlement to suspension payments to suspended medical practitioners and therefore, in my opinion, the payments are irregular. I also do not have assurance over the completeness of the population of irregular suspension payments disclosed.

In respect of these payments, I consider that insufficient regard has been paid to the framework of authorities and use of public funds. These payments are therefore material by virtue of their nature. Further detail can be found in my report on pages 131-133.

Basis for opinions

I conducted my audit in accordance with International Standards on Auditing (UK) (ISAs UK), applicable law and Practice Note 10 *Audit of Financial Statements and Regularity of Public Sector Bodies in the United Kingdom (2022)*. 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 2019*. I am independent of NHS England and its group in accordance with the ethical requirements that are relevant to my audit of 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

In auditing the financial statements, I have concluded that NHS England and its group's use of the going concern basis of accounting in the preparation of the financial statements is appropriate.

Based on the work I have performed, I have not identified any material uncertainties relating to events or conditions that, individually or collectively, may cast significant doubt on NHS England and its group's ability to continue as a going concern for a period of at least twelve months from when the financial statements are authorised for issue.

My responsibilities and the responsibilities of the Board and the Accounting Officer with respect to going concern are described in the relevant sections of this certificate.

The going concern basis of accounting for NHS England and its group is adopted in consideration of the requirements set out in HM Treasury's Government Financial Reporting Manual, which require entities to adopt the going concern basis of accounting in the preparation of the financial statements where it is anticipated that the services which they provide will continue into the future.

Other information

The other information comprises the information included in the Annual Report but does not include the financial statements nor my auditor's certificate and report. The Board and Accounting Officer is responsible for the other information.

My opinion on the financial statements does not cover the other information and, except to the extent otherwise explicitly stated in my certificate, I do not express any form of assurance conclusion thereon.

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 I identify such material inconsistencies or apparent material misstatements, I am required to determine whether this gives rise to a material misstatement in the financial statements themselves. 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 part of the Remuneration and Staff Report to be audited has been properly prepared in accordance with Secretary of State directions issued under the National Health Service Act 2006 and the Health and Social Care Act 2012.

In my opinion, based on the work undertaken in the course of the audit:

- the parts of the Accountability Report subject to audit have been properly prepared in accordance with Secretary of State directions made under the National Health Service Act 2006 and the Health and Social Care Act 2012; and
- the information given in the Performance and Accountability Reports for the financial year for which the financial statements are prepared is consistent with the financial statements and is in accordance with the applicable legal requirements.

Matters on which I report by exception

In the light of the knowledge and understanding of NHS England and its group, and its environment obtained in the course of the audit, I have not identified material misstatements in the Performance and Accountability Reports.

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 by NHS England and its group or returns adequate for my audit have not been received from branches not visited by my staff; or
- I have not received all of the information and explanations I require for my audit; or
- the financial statements and the parts of the Accountability Report subject to audit are not in agreement with the accounting records and returns; or
- certain disclosures of remuneration specified by HM Treasury's Government Financial Reporting Manual have not been made or parts of the Remuneration and Staff Report to be audited is not in agreement with the accounting records and returns; or
- the Governance Statement does not reflect compliance with HM Treasury's guidance.

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 Accounting Officer are responsible for:

- maintaining proper accounting records;
- providing the C&AG with access to all information of which management is aware that is relevant to the preparation of the financial statements such as records, documentation and other matters;
- providing the C&AG with additional information and explanations needed for his audit;
- providing the C&AG with unrestricted access to persons within NHS England and its group from whom the auditor determines it necessary to obtain audit evidence;
- ensuring such internal controls are in place as deemed necessary to enable the preparation of financial statement to be free from material misstatement, whether due to fraud or error;
- ensuring that the financial statements give a true and fair view and are prepared in accordance with Secretary of State directions made under the National Health Service Act 2006 and the Health and Social Care Act 2012;
- ensuring that the annual report, which includes the Remuneration and Staff Report, is prepared in accordance with Secretary of State directions made under the National Health Service Act 2006 and the Health and Social Care Act 2012; and
- assessing NHS England and its Group's ability to continue as a going concern, disclosing, as applicable, matters related to going concern and using the going concern basis of accounting unless the Accounting Officer anticipates that the services provided by NHS England and its group will not continue to be provided in the future.

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 National Health Service Act 2006 and the Health and Social Care Act 2012.

My objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue a certificate that includes my opinion. 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.

Extent to which the audit was considered capable of detecting non-compliance with laws and regulations including fraud

I design procedures in line with my responsibilities, outlined above, to detect material misstatements in respect of non-compliance with laws and regulations, including fraud. The extent to which my procedures are capable of detecting non-compliance with laws and regulations, including fraud is detailed below.

Identifying and assessing potential risks related to non-compliance with laws and regulations, including fraud

In identifying and assessing risks of material misstatement in respect of non-compliance with laws and regulations, including fraud, I:

- considered the nature of the sector, control environment and operational performance including the design of NHS England and its group's accounting policies, key performance indicators and performance incentives.
- inquired of management, NHS England's head of internal audit and those charged with governance, including obtaining and reviewing supporting documentation relating to NHS England and its group's policies and procedures on:
  - identifying, evaluating and complying with laws and regulations;
  - detecting and responding to the risks of fraud; and
  - the internal controls established to mitigate risks related to fraud or non-compliance with laws and regulations including NHS England and its group's controls relating to NHS England's compliance with the National Health Service Act 2006 and the Health and Social Care Act 2012 and Managing Public Money.
- inquired of management, NHS England's head of internal audit and those charged with governance whether:
  - they were aware of any instances of non-compliance with laws and regulations; and
  - they had knowledge of any actual, suspected, or alleged fraud;
- discussed with the engagement team regarding how and where fraud might occur in the financial statements and any potential indicators of fraud.

As a result of these procedures, I considered the opportunities and incentives that may exist within NHS England and its group for fraud and identified the greatest potential for fraud in the following areas: revenue recognition, posting of unusual journals, complex transactions, and bias in management estimates. In common with all audits under ISAs (UK), I am also required to perform specific procedures to respond to the risk of management override.

I obtained an understanding of NHS England and its group's framework of authority and other legal and regulatory frameworks in which NHS England and its group operate. I focused on those laws and regulations that had a direct effect on material amounts and disclosures in the financial statements or that had a fundamental effect on the operations of NHS England and its group. The key laws and regulations I considered in this context included the National Health Service Act 2006, Health and Social Care Act 2012, Health and Care Act 2022, Managing Public Money, employment law, or tax legislation, relevant legislation relating to fees charged by the NHS England, and regulations relating to suspension payments to suspended medical practitioners.

In addition, I considered regulations and regularity relating to exit packages and, in particular, special severance payments, as I identified the completeness and regularity of exits packages as a significant risk.

Audit response to identified risk

To respond to the identified risks resulting from the above procedures:

- I reviewed the financial statement disclosures and testing to supporting documentation to assess compliance with provisions of relevant laws and regulations described above as having direct effect on the financial statements;
- I enquired of management, the Audit and Risk Assurance Committee and in-house legal counsel concerning actual and potential litigation and claims;
- I reviewed minutes of meetings of those charged with governance and the board and internal audit reports;
- in addressing the risk of fraud through management override of controls, I tested the appropriateness of journal entries and other adjustments; assessed whether the judgements on estimates are indicative of a potential bias; and evaluated the business rationale of any significant transactions that are unusual or outside the normal course of business; and
- substantive testing of exit packages disclosed within the NHS England's Remuneration and Staff Report and review of all special severance payments included in the NHS England's group Remuneration and Staff Report.

I communicated relevant identified laws and regulations and potential risks of fraud to all engagement team members and remained alert to any indications of fraud or non-compliance with laws and regulations throughout the audit.

A further description of my responsibilities for the audit of the financial statements is located on the Financial Reporting Council's website at: www.frc.org.uk/auditorsresponsibilities.
This description forms part of my certificate.

Other auditor's responsibilities

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

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 I identify during my audit.

Gareth Davies **22 January 2024**

Comptroller and Auditor General

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

The report of the Comptroller and Auditor General to the Houses of Parliament

Introduction

1. The National Health Service Act 2006 and the Health and Social Care Act 2012 requires NHS England to prepare consolidated annual accounts for each financial year. The consolidated accounts must contain NHS England's annual accounts and a consolidation of NHS England's annual accounts, the annual accounts of each Clinical Commissioning Group (CCG), Integrated Care Board (ICB) and the accounts of the Supply Chain Coordination Limited (SCCL).[166] NHS England's consolidated accounts are in turn consolidated in the accounts of the Department of Health and Social Care (DHSC). I consider NHS England to be a significant component of DHSC and my audit of NHS England must be complete before I complete my audit of DHSC.

2. I am required to examine, certify, and report on NHS England's consolidated accounts. I provide an opinion on whether the consolidated accounts give a "true and fair" view of NHS England's finances for the year. I also provide an opinion on whether the transactions recorded in NHS England's consolidated accounts have been applied to the purposes intended by Parliament and whether they conform to the authorities which govern them ("regularity").

3. In this report, I explain why I have qualified my regularity opinion on NHS England's 2022-23 consolidated accounts, with regards to ineligible suspension payments made to suspended medical practitioners.[167] I also set out my observations on the performance of CCGs and ICBs ("Commissioners") in delivering accounts to support the timely production of NHS England's consolidated accounts.

4. This is the second consecutive year I have qualified my regularity opinion on NHS England's consolidated accounts for ineligible suspension payments to suspended medical practitioners. Details of the prior year qualification are provided on pages 137 to 146 of the NHS England annual report and accounts 2021-22.[168]

Qualification of regularity opinion due to irregular suspension payments to suspended medical practitioners

5. Under certain qualifying circumstances NHS England can make suspension payments to medical practitioners who have been suspended as set out in relevant statutory regulations. Under statutory regulations issued by the Secretary of State for Health and Social Care, NHS England may suspend a medical practitioner, when satisfied that it is necessary to do so for the protection of patients or members of the public or that it is otherwise

[166] There were 106 CCGs until 30 June 2022. CCGs were then replaced with 42 ICBs from 1 July 2022.
[167] A medical practitioner could be a doctor, dentist or optician.
[168] https://www.england.nhs.uk/wp-content/uploads/2023/01/nhs-england-nhs-commissioning-board-ara-21-22.pdf

in the public interest. A suspended medical practitioner may be entitled to receive suspension payments if the medical practitioner meets certain qualifying conditions. If the medical practitioner qualifies for suspension payments, such payments may continue until a relevant tribunal has considered the suspension and either ends the suspension or removes the medical practitioner from the medical register. For example, the General Medical Council (GMC) maintains a medical register of doctors licensed to practice medicine. The GMC considers suspensions concerning doctors. The General Dental Council and General Optical Council perform a similar role for dentists and opticians, respectively.

6. In 2022/23 it was identified, by NHS England and my staff, that 12 medical practitioners had received ineligible suspension payments over the 2017/18 to 2022/23 financial years. As NHS England has set out in its governance statement on page 83, during 2022-23, 12 medical practitioners were identified in 2022-23 as having received ineligible suspension payments over the 2017-18 to 2022-23 financial years. Total payments to these 12 medical practitioners over the 2017-18 to 2022-23 financial years was £1,335,626. Of this £156,429 was paid in 2022-23 to eight medical practitioners. These cases are in addition to the two medical practitioners, who received ineligible suspension payments over the 2017-18 to 2021-22 financial years, which led me to qualify my regularity opinion in 2021-22.

7. NHS England failed to establish a system of control to ensure suspension payments were only paid to medical practitioners who met the qualifying criteria and that these suspension payments were stopped promptly once the qualifying period ended. There were various reasons the 12 medical practitioners were paid ineligible suspension payments. In most cases NHS England continued making suspension payments to GPs after they had resigned their partnership in a GP practice. The regulations are clear that suspension payments should cease when the medical practitioner's employment is terminated, which includes a GP resigning from a GP partnership. In most of these cases the GPs had informed NHS England that they had resigned their partnership, but NHS England continued to make the suspension payments; in one case for over four years, after being notified. Other ineligible suspension payments happened because NHS England had erroneously interpretated the regulations and made payments when the medical practitioner did not qualify for suspension payments.

8. I have qualified my regularity opinion in relation to these ineligible suspension payments. As the suspension payments I refer to in paragraph 6 were made contrary to the statutory regulations governing such payments, I consider them to be irregular. The circumstances that led to these irregular payments being made are such that I consider that insufficient regard has been paid to the framework of authorities and use of public funds and that the payments are therefore material by virtue of their nature. Additionally, suspension of a medical practitioner often involves serious misconduct and I consider payment of ineligible suspension payments in those circumstances to be contentious. NHS England should have had checks in place to prevent or detect such payments. I have therefore qualified my regularity opinion on the consolidated accounts. My regularity opinion is on pages 125-126.

9. NHS England has not recovered most of the ineligible suspension payments it made. Ineligible suspension payments made to two of the 12 medical practitioners have been recovered in full by NHS England. These recoveries amount to £32,747. The remaining £1,302,879 has not been recovered. NHS England is taking legal advice regarding recovery.

Audit completion delays of NHS England group entities

10. NHS England group entities are audited by a number of different audit firms. Commissioners are free to appoint their external auditors ("local auditors"). Local auditors must comply with the Code of Audit Practice ("the Code").[169] Under the Local Audit and Accountability Act 2014, I am responsible for the preparation, publication, and maintenance of the Code. The Code sets out what local auditors are required to do to fulfil their statutory responsibilities under the Local Audit and Accountability Act 2014. For 2022-23 the commissioner audits were undertaken by six audit firms.

11. The Code stresses the need for local auditors to report on a timely basis. Section 1.19 of the Code requires local auditors to report on a timely basis. Timely reporting includes producing audit reports in time, insofar as the auditor can do so under auditing standards, to allow local bodies to comply with the requirements placed on them to publish their audited financial statements. It also means ensuring that when matters of concern arise during the audit, the auditor raises them promptly with the body and considers whether the matter needs to be brought to public attention at the appropriate time.

12. The timetable set by NHS England and DHSC for the 2022-23 group accounts required Commissioners to have their statutory audits complete by 30 June 2023.[170] The statutory deadline, under the Government Resources and Accounts Act 2000, requires government departments to lay their annual reports and accounts in Parliament by 31 January, ten months after the financial year end. Although NHS England does not have a statutory deadline for laying its annual report and accounts in Parliament, as NHS England is a significant component of the DHSC group, the accounts of NHS England must be completed to the same timetable as DHSC.

13. DHSC committed to laying its 2022-23 annual report and accounts before the end of 2023. At a Public Accounts Committee hearing[171] on 20 March 2023, regarding the timeliness of the DHSC annual report and accounts 2021-22, DHSC committed to aiming to lay its 2022-23 accounts before the 2023 Parliamentary Christmas recess and then to gradually improve the timeliness in future years. DHSC's stated aim was to bring forward the laying date by two months each year to eventually enable laying before the Parliamentary summer recess. Before the Covid-19 pandemic, DHSC and NHS England routinely laid their annual reports and accounts in Parliament before the Parliamentary summer recess. The last time this happened

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[169] https://www.nao.org.uk/wp-content/uploads/sites/29/2020/01/Code_of_audit_practice_2020.pdf
[170] https://www.england.nhs.uk/wp-content/uploads/2023/04/Timetable-letter-22-23-with-provider-annex-2023-06-12.pdf
[171] https://committees.parliament.uk/publications/40738/documents/198470/default/

was for the 2018-19 annual report and accounts. For the 2022-23 accounts, NHS England, DHSC and my staff agreed a target date of 30 November 2023 for audit certification, to enable laying before the 2023 Parliamentary Christmas recess.

14. Delays in the enactment of the Health and Care Act 2022 increased the complexity of the NHS England group for 2022-23. NHS England is a large group account which consolidates the local commissioning bodies in England. In 2022-23 the Health and Care Act 2022 abolished the 106 CCGs and replaced them with 42 ICBs. It was originally planned that CCGs would be abolished on 31 March 2022 and replaced by ICBs on 1 April 2022. However, delays in the enactment of the Health and Care Act 2022 meant the abolition of CCGs was delayed by three months. This delay complicated the NHS England group structure for 2022-23, resulting in 149 group entities (106 CCGs producing three month accounts, 42 ICBs producing nine month accounts, and SCCL. If ICBs had been established on 1 April 2022, only 43 group entities would have been required to produce audited accounts.

15. Of the 148 Commissioner 2022-23 annual report and accounts, 117 were audited by 30 June 2023. 117 Commissioner audits were completed by 30 June 2023, meaning just under four fifths of bodies achieved the target date set by NHS England. By 31 July 2023, 131 (88.5%) Commissioner audits were completed, with 134 (90.5%) Commissioner audits completed by 31 October 2023. This was the latest practical date to enable certification of the NHS England and DHSC annual report and accounts by 30 November 2023.

16. At the point NHS England finalised its accounts, nine Commissioner audits remained outstanding, and these entities account for material transactions and balances in the NHS England group accounts. By Christmas 2023, 139 Commissioner audits were completed, with the remaining nine audits outstanding as the accounts were finalised. NHS England has had to perform alternative procedures to obtain sufficient assurance that the material transactions streams in the outstanding Commissioners are not materially misstated, in the context of the NHS England group accounts. My staff have reviewed the procedures performed by NHS England and are content that in the context of the NHS England group accounts, the results provide sufficient and appropriate assurance to my audit. I have therefore issued a clean “true and fair” audit opinion in respect of the NHS England annual report and accounts 2022-23. Note 1.3 to the accounts provides details of the transactions and balances relating to these nine Commissioners.

17. NHS England clearly recognises the risks that late auditor reporting can represent and has been proactive in using its influence to support Commissioners and local auditors with timely delivery. As set out in its governance statement (on page 76 and 77), NHS England demonstrates a clear understanding of the risks around late auditor reporting including the delays this has caused to the laying of its own annual report and accounts. NHS England has set out the range of interventions it has used to support Commissioners and local auditors to try and accelerate the audit of Commissioners’ accounts and it is critical this work continues for 2023-24.

18. In 2023-24 the NHS England group has fewer entities and NHS England should continue its role in proactively monitoring audit progress of Commissioner accounts. In 2023-24 the NHS England group consists of the NHS England parent, 42 ICBs and SCCL. There are fewer Commissioners to consolidate but on average ICBs are significantly larger than CCGs. NHS England has been proactive in 2022-23 in monitoring the progress of late Commissioner accounts, including engaging with the local auditors, my staff, HM Treasury and the Financial Reporting Council (which regulates local audit firms). NHS England remains concerned about the capacity of local auditors to bring forward certification to enable NHS England, and hence DHSC, to lay their annual reports and accounts in Parliament significantly earlier than has happened over the last four financial years.

19. I also have concerns given the wider local audit challenges, as set out in my report, *Timeliness of local auditor reporting on local government in England.*[172] Whilst the number of Commissioner audits in 2023-24 has reduced to 42, there could still be some risk in the delivery of NHS local audits due to the wider local audit system issues and significant delays in local government audits as the auditors work to clear this backlog.

Gareth Davies **22 January 2024**

Comptroller and Auditor General

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

[172] https://www.nao.org.uk/wp-content/uploads/2023/01/progress-update-timeliness-of-local-auditor-reporting.pdf

Annual Accounts

Amanda Pritchard
21 January 2024

Accounting Officer

Statement of comprehensive net expenditure for the year ended 31 March 2023

	Note	Parent		Consolidated group	
		2022/23 £000	2021/22 £000	2022/23 £000	2021/22 £000
Income from sale of goods and services	2	(1,631,684)	(1,770,922)	(5,091,892)	(3,219,691)
Other operating income	2	(13,653)	(11,049)	(130,544)	(85,105)
Total operating income		**(1,645,337)**	**(1,781,971)**	**(5,222,436)**	**(3,304,796)**
Staff costs	3	1,536,464	1,119,355	3,257,213	2,549,295
Purchase of goods and services	4	157,252,961	149,813,284	156,430,732	148,881,815
Depreciation and impairment charges	4	206,029	180,166	259,270	197,142
Provision expense	4	30,693	78,008	33,195	150,813
Other operating expenditure	4	159,194	431,549	2,892,654	1,897,079
Total operating expenditure		**159,185,341**	**151,622,362**	**162,873,064**	**153,676,144**
Net operating expenditure		**157,540,004**	**149,840,391**	**157,650,628**	**150,371,348**
Finance expense	13	5,046	2,805	35,741	3,424
Net expenditure for the year		**157,545,050**	**149,843,196**	**157,686,369**	**150,374,772**
Other (gains)/losses		425	-	836	1,699
Net (gain)/loss on Transfer by Absorption	12	(324,602)	(154,540)	(324,602)	(139,840)
Total net expenditure for the year		**157,220,873**	**149,688,656**	**157,362,603**	**150,236,631**
Other comprehensive net expenditure					
Items which will not be reclassified to net operating costs					
Net (gain)/loss on revaluation of Financial Assets [173]		(270)	17,808	-	
Actuarial (gain)/loss in pension schemes		-		-	(4,172)
Movements in General Fund		-		(53)	
Total other comprehensive net expenditure		**(270)**	**17,808**	**(53)**	**(4,172)**
Comprehensive net expenditure for the year		**157,220,603**	**149,706,464**	**157,362,550**	**150,232,459**

On 1 February 2023, NHS Digital became part of the NHS England parent account. As a result, the assets, liabilities and ongoing operational income and expenditure relating to former NHS Digital functions form part of the NHS England parent account from this date.

In October 2021 NHS England, the Parent, acquired 100% of the shareholding of SCCL. As a result, the assets, liabilities and ongoing operational income and expenditure form part of the NHS England Consolidated Group Account from this date.

The notes on pages 143 to 185 form part of this statement.

[173] The change in revaluation of financial assets represents the change on equity instruments measured at fair value through OCI in respect of NHS England investment in SCCL.

Statement of financial position as at 31 March 2023

		Parent		Consolidated group	
Non-current assets:	**Note**	**31 March 2023 £000**	**31 March 2022 £000**	**31 March 2023 £000**	**31 March 2022 £000**
Property, plant and equipment	5	410,196	396,194	481,317	474,993
Right Of Use Assets	6	123,458	-	327,731	-
Intangible assets	7	369,427	56,119	373,851	58,223
Trade and other receivables	9	4,693	-	4,816	1,496
Other financial assets	9	141,462	141,192	1,106	2,106
Total non-current assets		**1,049,236**	**593,505**	**1,188,821**	**536,818**
Current assets:					
Inventories	8	8,980	29,911	174,371	193,056
Trade and other receivables	9	1,004,283	724,623	2,696,447	3,738,887
Cash and cash equivalents	10	374,885	229,575	625,049	385,172
Total current assets		**1,388,148**	**984,109**	**3,495,867**	**4,317,115**
Total assets		**2,437,384**	**1,577,614**	**4,684,688**	**4,853,933**
Current liabilities					
Trade and other payables	11	(5,004,887)	(3,021,567)	(13,348,391)	(11,022,960)
Right of use asset lease liabilities	6	(27,004)	-	(55,455)	-
Other financial liabilities	11	-	-	(65,355)	(10,538)
Provisions	14	(36,443)	(82,584)	(190,214)	(250,926)
Total current liabilities		**(5,068,334)**	**(3,104,151)**	**(13,659,415)**	**(11,284,424)**
Total assets less current liabilities		**(2,630,950)**	**(1,526,537)**	**(8,974,727)**	**(6,430,491)**
Non-current liabilities					
Trade and other payables	11	(3,360)	(31)	(4,026)	(876)
Right of use asset lease liabilities	6	(104,730)	-	(276,127)	-
Other financial liabilities	11	-	-	(781,673)	(2,234,536)
Provisions	14	(428,451)	(352,452)	(477,202)	(413,543)
Total non-current liabilities		**(536,541)**	**(352,483)**	**(1,539,028)**	**(2,648,955)**
Total assets less total liabilities		**(3,167,491)**	**(1,879,020)**	**(10,513,755)**	**(9,079,446)**
Financed by taxpayers' equity and other reserves					
General fund		(3,152,183)	(1,861,212)	(10,515,993)	(9,076,430)
Revaluation reserve		2,230	-	2,238	18
Other reserves		(17,538)	(17,808)	-	(3,034)
Total taxpayers' equity		**(3,168,491)**	**(1,879,020)**	**(10,513,755)**	**(9,079,446)**

The notes on pages 143 to 185 form part of this statement.

The financial statements on pages 138 to 142 were approved by the Board on 21 January 2024 and signed on its behalf by:

Amanda Pritchard, Accounting Officer

Statement of changes in taxpayers' equity for the year ended 31 March 2023

Parent 2022/23	General fund £000	Revaluation reserve £000	Other reserves £000	Total taxpayers' equity £000
Balance at 01 April 2022	**(1,861,212)**	**-**	**(17,808)**	**(1,879,020)**
Total net expenditure for the period	(157,220,873)	-	-	(157,220,873)
Net gain/(loss) on revaluation of property, plant and equipment	-	-	270	270
Transfers in reserves following Absorption	(2,230)	2,230	-	-
Transfers by absorption to (from) other bodies	3,891	-	-	3,891
Comprehensive net expenditure for the period	**(157,219,212)**	**2,230**	**270**	**(157,216,712)**
Grant in aid	155,928,241	-	-	155,928,241
Balance at 31 March 2023	**(3,152,183)**	**2,230**	**(17,538)**	**(3,167,491)**

Parent 2021/22	General fund £000	Revaluation reserve £000	Other reserves £000	Total taxpayers' equity £000
Balance at 01 April 2021	**(2,601,953)**	**-**	**-**	**(2,601,953)**
Total net expenditure for the year	(149,688,656)	-	-	**(149,688,656)**
Net gain/(loss) on revaluation of other investments and Financial Assets (excluding available for sale financial assets)	-	-	(17,808)	**(17,808)**
Transfers by absorption to (from) other bodies	-	-	-	**-**
Comprehensive net expenditure for the year	**(149,688,656)**	**-**	**(17,808)**	**(149,706,464)**
Grant in aid	150,429,397	**-**	-	**150,429,397**
Balance at 31 March 2022	**(1,861,212)**	**-**	**(17,808)**	**(1,879,020)**

Consolidated group 2022/23	General fund £000	Revaluation reserve £000	Other reserves £000	Total taxpayers' equity £000
Balance at 01 April 2022	**(9,076,430)**	**18**	**(3,034)**	**(9,079,446)**
Changes in total taxpayers' equity for 2022/23				
Total net expenditure for the year	**(157,362,603)**	**-**	**-**	**(157,362,603)**
Other movements in reserves	(2,981)	-	3,034	53
Transfers in reserves following absorption	(2,230)	2,230	-	-
Transfers between reserves	10	(10)	-	-
Transfers by absorption to (from) other bodies	-	-	-	-
Comprehensive net expenditure for the year	**(157,367,804)**	**2,220**	**3,034**	**(157,362,550)**
Grant in aid	155,928,241	-	-	155,928,241
Balance at 31 March 2023	**(10,515,993)**	**2,238**	**-**	**(10,513,755)**

Consolidated group 2021/22	General fund £000	Revaluation reserve £000	Other reserves £000	Total taxpayers' equity £000
Balance at 01 April 2021	**(9,269,196)**	**18**	**(7,206)**	**(9,276,384)**
Total net expenditure for the year	(150,236,633)	-	-	(150,236,633)
Movements in other reserves	2	-	4,172	4,174
Movements in general fund	-	-	-	-
Comprehensive net expenditure for the period	**(150,236,631)**	**-**	**4,172**	**(150,232,459)**
Grant in aid	150,429,397	-	-	150,429,397
Balance at 31 March 2022	**(9,076,430)**	**18**	**(3,034)**	**(9,079,446)**

The general fund is used in public sector accounting to reflect the total assets less liabilities of an entity, which are not assigned to another reserve.

Other reserves in the parent relate to fair value losses on equity investments designated as fair value through other comprehensive income under IFRS 9

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

The notes on pages 143 to 185 form part of this statement.

Statement of cash flows for the year ended 31 March 2023

Cash flows from operating activities	Note	Parent 2022/23 £000	Parent 2021/22 £000	Consolidated group 2022/23 £000	Consolidated group 2021/22 £000
Total net expenditure for the financial year		(157,220,873)	(149,688,656)	(157,362,603)	(150,236,778)
Depreciation and amortisation	4	206,029	180,166	259,282	196,400
Impairments and reversals	4	-	-	(12)	742
Other non-cash adjustments [174]		(188)	-	(305)	89
Donated assets received credited to revenue but non-cash		(11,598)	-	(13,525)	-
Movement due to transfers by absorption		(378,044)	(160,543)	(376,090)	(145,845)
Interest paid/(received)		639	-	(2,692)	150
Loss on disposal	12	425	-	836	1,699
Unwinding of discount	14	4,224	2,726	4,322	3,118
Change in discount rate	14	(245,623)	(23,209)	(246,120)	(23,040)
Decrease in inventories		20,931	28,918	18,684	32,963
(Increase)/decrease in trade & other receivables	9	(285,625)	283,963	1,039,265	366,041
Increase/(decrease) in trade & other payables	11	1,986,732	(947,384)	2,325,288	(791,650)
Provisions utilised		(10,398)	(8,326)	(48,668)	(37,483)
Increase in provisions	14	278,051	102,903	282,819	177,711
Net cash outflow from operating activities		**(155,655,318)**	**(150,229,442)**	**(154,119,519)**	**(150,455,883)**
Cash flows from investing activities					
Interest received/(paid)		(110)	-	46	-
Payments for property, plant and equipment		(119,180)	(100,634)	(140,263)	(111,838)
Payments for intangible assets		(35,122)	(20,488)	(35,264)	(21,714)
Payments for other financial assets		-	-	(652)	-
Proceeds from disposal of assets: property, plant and equipment		40	710	6,378	776
Proceeds from disposal of other financial assets		-	-	2,629	-
Net cash outflow from investing activities		(154,372)	(120,412)	(167,126)	(132,776)
Net cash outflow before financing activities		**(155,816,690)**	**(150,349,854)**	**(154,286,645)**	**(150,588,659)**
Cash flows from financing activities					
Grant in aid funding received		155,928,241	150,429,397	155,928,241	150,429,397
Other loans received		-	-	-	150,000
Other loans repaid			-	(1,427,638)	-
Repayment of Lease Liability		(20,383)	-	(51,535)	-
Capital element of payments in respect of finance leases		-	-	(17)	(98)
Cash Transferred under absorption		47,142	-	47,142	269,704
Net cash inflow from financing activities		**155,955,000**	**150,429,397**	**154,496,193**	**150,849,003**
Net increase (decrease) in cash & cash equivalents		**145,310**	**79,543**	**209,548**	**260,344**
Cash & cash equivalents at the beginning of the financial year	10	229,575	150,032	374,755	114,411
Cash & cash equivalents at the end of the financial year	10	**374,885**	**229,575**	**584,303**	**374,755**

The notes on pages 143 to 185 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.

[174] Other non-cash adjustments comprise of underlying adjustments in ICB books.

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 NHS Act 2006 (as amended by the Health and Care Act 2022) and in accordance with the Financial Reporting Manual (FReM) 2022/23 issued by HM Treasury and the DHSC Group Accounting Manual (GAM) issued by the Department of Health & Social Care. The accounting policies contained in the FReM and DHSC GAM apply International Financial Reporting Standards (IFRS) as adapted or interpreted for the public sector context. Where the FReM or 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. 2 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 22.

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 18) 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 18.

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, 106 related CCGs, 42 ICBs and Supply Chain Coordination Limited. Transactions between entities included in the consolidation are eliminated.

For 2022/23 4 CCG audits and 5 ICB audits are incomplete at the time of finalising the NHS England group account on 4 January 2024. Unaudited information has been used to prepare the NHS England group account.

Details of the entities outstanding are shown in the table below.

Entities outstanding	Reason for delay
- NHS Birmingham and Solihull CCG - NHS West Essex CCG - NHS Hertfordshire And West Essex Integrated Care Board - NHS North West London CCG - NHS North West London Integrated Care Board - NHS Suffolk And North East Essex Integrated Care Board - NHS Birmingham And Solihull Integrated Care Board	The auditor, BDO LLP, has not been able to complete its audit prior to this group account being prepared. No significant issues that would impact on the completion of the NHS England group account have been reported to us.
- NHS Herefordshire and Worcestershire CCG - NHS Herefordshire And Worcestershire Integrated Care Board	The auditor, Deloitte LLP, has not been able to complete its audit prior to this group account being prepared due to the late appointment of an auditor by the CCG and the ICB. This followed the CCG and the ICB having difficulty appointing an auditor due to the wider capacity constraints in the local audit market. No significant issues that would impact on the completion of the NHS England group account have been reported to us.

A summary of the financial statements of these commissioners is presented below:

NHS Commissioner	Operating Income £000	Operating expenditure £000	Total Assets £000	Total liabilities £000	Reserves £000
NHS Birmingham and Solihull CCG	(3,573)	588,567	33,205	(140,923)	(107,718)
NHS Birmingham And Solihull Integrated Care Board	(3,049)	2,264,631	4,845	(204,485)	(199,640)
NHS Herefordshire and Worcestershire CCG	(1,552)	365,555	17,653	(92,012)	(74,359)
NHS Herefordshire And Worcestershire Integrated Care Board	(6,046)	1,242,816	20,283	(107,774)	(87,491)
NHS West Essex CCG	(821)	175,850	1,957	(46,132)	(44,175)
NHS Hertfordshire And West Essex Integrated Care Board	(16,185)	2,221,768	23,059	(205,787)	(182,728)
NHS North West London CCG	(1,889)	1,085,030	62,141	(402,393)	(340,252)
NHS North West London Integrated Care Board	(11,383)	3,568,190	43,200	(453,957)	(410,757)
NHS Suffolk And North East Essex Integrated Care Board	(11,515)	1,577,760	14,514	(143,320)	(128,806)
Total	**(56,013)**	**13,090,167**	**220,857**	**(1,796,783)**	**(1,575,926)**

With reference to materiality for these consolidated accounts of £1.5 billion, operating expenditure for these entities is material so we have performed additional assurance procedures on these balances. Following these procedures, we are satisfied that the residual balances over which uncertainty remains are not material to these consolidated accounts.

The NHS England group account for 2021/22 was finalised using unaudited information for three NHS commissioners. These three commissioners have now published audited accounts for 2021/22 and there were no changes in their financial information as presented in the NHS England group account for 2021/22.

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

From 1 July 2022 NHS England took on the functions of NHS TDA and Monitor and on this date their functions, assets and liabilities were transferred into the NHS England statutory entity.

From 1 February 2023 the functions, assets and liabilities of NHS Digital were transferred into the NHS England statutory entity and are now included as part of the NHS England parent account.

1.4 Comparative information

The comparative information provided in these financial statements is for the year ended 31 March 2022.

1.5 Going concern

NHS England's financial statements are produced on a going concern basis. NHS England is financed by grant-in-aid 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 Care Act 2022. 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 application of IFRS 15 a number of practical expedients have been employed. These are as follows:

- NHS England is not required to disclose information regarding performance obligations that are part of a contract that has an original expected duration of one year or less
- NHS England is not required to disclose information where revenue is recognised in line with the practical expedient offered in the Standard, where the right to consideration corresponds directly with the value of the performance completed to date.

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, such as 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 1 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 or collectively 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

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 Leases

A lease is a contract or part of a contract that conveys the right to use an asset for a period of time in exchange for consideration.

IFRS 16 Leases is effective across the public sector from 1 April 2022. The transition to IFRS 16 has been completed in accordance with paragraph C5 (b) of the Standard, applying IFRS 16 requirements retrospectively recognising the cumulative effects at the date of initial application.

In the transition to IFRS 16 a number of elections and practical expedients offered in the Standard have been employed. These are as follows:

NHS England has applied the practical expedient offered in the Standard per paragraph C3 to apply IFRS 16 to contracts or arrangements previously identified as containing a lease under the previous leasing standards IAS 17 Leases and IFRIC 4 Determining whether an Arrangement contains a Lease and not to those that were identified as not containing a lease under previous leasing standards.

On initial application NHS England has measured the right of use assets for leases previously classified as operating leases per IFRS 16 C8 (b)(ii), at an amount equal to the lease liability adjusted for accrued or prepaid lease payments.

No adjustments have been made for operating leases in which the underlying asset is of low value per paragraph C9 (a) of the Standard.

The transitional provisions have not been applied to operating leases whose terms end within 12 months of the date of initial application has been employed per paragraph C10 (c) of IFRS 16.

Hindsight is used to determine the lease term when contracts or arrangements contain options to extend or terminate the lease in accordance with C10 (e) of IFRS 16.

Due to transitional provisions employed the requirements for identifying a lease within paragraphs 9 to 11 of IFRS 16 are not employed for leases in existence at the initial date of application. Leases entered into on or after 1 April 2022 will be assessed under the requirements of IFRS 16.

There are further expedients or election that have been employed by NHS England in applying IFRS 16. These include:

The measurement requirements under IFRS 16 are not applied to leases with a term of 12 months or less under paragraph 5 (a) of IFRS 16.

The measurement requirements under IFRS 16 are not applied to leases where the underlying asset is of a low value which are identified as those assets of a value of less than £5,000, excluding any irrecoverable VAT, under paragraph 5 (b) of IFRS 16.

NHS England will not apply IFRS 16 to any new leases of intangible assets applying the treatment described in section 1.12 instead.

HM Treasury have adapted the public sector approach to IFRS 16 which impacts on the identification and measurement of leasing arrangements that will be accounted for under IFRS 16.

NHS England is required to apply IFRS 16 to lease like arrangements entered into with other public sector entities that are in substance akin to an enforceable contract, that in their formal legal form may not be enforceable. Prior to accounting for such arrangements

under IFRS 16 NHS England has assessed that in all other respects these arrangements meet the definition of a lease under the Standard.

NHS England is required to apply IFRS 16 to lease like arrangements entered into in which consideration exchanged is nil or nominal, therefore significantly below market value. These arrangements are described as peppercorn leases. Such arrangements are again required to meet the definition of a lease in every other respect prior to inclusion in the scope of IFRS 16. The accounting for peppercorn arrangements aligns to that identified for donated assets. Peppercorn leases are different in substance to arrangements in which consideration is below market value but not significantly below market value.

The nature of the accounting policy change for the lessee is more significant than for the lessor under IFRS 16. IFRS 16 introduces a singular lessee approach to measurement and classification in which lessees recognise a right of use asset.

For the lessor leases remain classified as finance leases when substantially all the risks and rewards incidental to ownership of an underlying asset are transferred to the lessee. When this transfer does not occur, leases are classified as operating leases.

1.16.1 NHS England as a lessee

At the commencement date for the leasing arrangement a lessee shall recognise a right of use asset and corresponding lease liability. NHS England employs a revaluation model for the subsequent measurement of its right of use assets unless cost is considered to be an appropriate proxy for current value in existing use or fair value in line with the accounting policy for owned assets. Where consideration exchanged is identified as below market value, cost is not considered to be an appropriate proxy to value the right of use asset.

Lease payments are apportioned between finance charges and repayment of the principal. Finance charges are recognised in the Statement of Comprehensive Net Expenditure. Irrecoverable VAT is expensed in the period to which it relates and therefore not included in the measurement of the lease liability and consequently the value of the right of use asset.

The incremental borrowing rate of 0.95% has been applied to the lease liabilities recognised at the date of initial application of IFRS 16. Where changes in future lease payments result from a change in an index or rate or rent review, the lease liabilities are remeasured using an unchanged discount rate.

Where there is a change in a lease term or an option to purchase the underlying asset NHS England applies a revised rate to the remaining lease liability.

Where existing leases are modified NHS England must determine whether the arrangement constitutes a separate lease and apply the Standard accordingly.

Lease payments are recognised as an expense on a straight-line or another systematic basis over the lease term, where the lease term is in substance 12 months or less or is elected as a lease containing low value underlying asset by NHS England.

1.17 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.

1.18 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 3 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 3 separate discount rates according to the expected timing of cashflows:

- a nominal short-term rate of 3.27 percent (2021/22: 0.47 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 3.20 percent (2021/22: 0.70 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 3.51 percent (2021/22: 0.95 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, CCGs and ICBs 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, CCGs and ICBs 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 2022/23. These standards are still subject to HM Treasury FReM adoption.

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.

2. Operating income

Income from sale of goods and services (contracts)	Parent 2022/23 £000	Parent 2021/22 £000	Consolidated group 2022/23 £000	Consolidated group 2021/22 £000
Education, training and research	15,487	2,180	60,728	12,269
Non-patient care services to other bodies	350,769	403,229	3,280,382	1,665,898
Prescription fees and charges [175]	519,753	641,033	670,324	651,964
Dental fees and charges[141]	631,415	633,809	746,642	633,847
Other contract income	114,309	90,366	324,623	243,871
Recoveries in respect of employee benefits	(49)	305	9,193	11,842
Total income from sale of goods and services	**1,631,684**	**1,770,922**	**5,091,892**	**3,219,691**
Other operating income				
Rental revenue from finance leases	-	-	147	87
Rental revenue from operating leases	-	-	4,051	2,053
Charitable and other contributions to revenue expenditure: non-NHS	5	48	1,246	684
Receipt of donations (capital/cash) [176]	11,598	-	13,043	-
Non-cash apprenticeship training grants revenue	1,159	848	1,920	1,313
Other non-contract revenue	891	10,153	110,137	80,968
Total other operating income	**13,653**	**11,049**	**130,544**	**85,105**
Total operating income	**1,645,337**	**1,781,971**	**5,222,436**	**3,304,796**

Intercompany trading is eliminated between bodies within the NHS England group upon consolidation.

In October 2021 NHS England, the Parent, acquired 100% of the shareholding of SCCL. As a result, the assets, liabilities and ongoing operational income and expenditure form part of the NHS England consolidated group account for the full year. There has therefore been a significant growth in income and expenditure year on year.

[175] In line with the adaptation in the HM Treasury 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.
[176] The receipts of donation(capital/cash) is in relation to donated imaging assets from Department of Health and Social Care

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 18.

Income from sale of goods and services (contracts)

Parent 2022/23	CCG/ ICB £000	SCCL £000	Direct commissioning £000	NHS England £000	Other £000	i/co eliminations £000	Total £000
Education, training and research	-		3,897	10,432	1,338	(180)	15,487
Non-patient care services to other bodies	-		10,621	13,720	520,099	(193,671)	350,769
Prescription fees and charges	-		519,753	-	-	-	519,753
Dental fees and charges	-		631,415	-	-	-	631,415
Other contract income	-		16,890	43,359	19,618	34,442	114,309
Recoveries in respect of employee benefits	-		-	47	-	(96)	(49)
Total income from sale of goods and services	**-**		**1,182,576**	**67,558**	**541,055**	**(159,505)**	**1,631,684**

Parent 2021/22	CCG/ ICB £000	SCCL £000	Direct commissioning £000	NHS England £000	Other £000	i/co eliminations £000	Total £000
Education, training and research	-		844	688	649	(1)	2,180
Non-patient care services to other bodies	-		2,665	7,296	614,063	(220,795)	403,229
Prescription fees and charges	-		641,033	-	-	-	641,033
Dental fees and charges	-		633,809	-	-	-	633,809
Other contract income	-		12,100	31,474	19,938	26,854	90,366
Recoveries in respect of employee benefits	-		-	336	-	(31)	305
Total income from sale of goods and services	**-**		**1,290,451**	**39,794**	**634,650**	**(193,973)**	**1,770,922**

Consolidated group 2022/23	CCG/ ICB £000	SCCL £000	Direct commissioning £000	NHS England £000	Other £000	i/co eliminations £000	Total £000
Education, training and research	46,511	-	3,897	10,432	1,338	(1,450)	60,728
Non-patient care services to other bodies	312,306	3,234,617	10,621	13,720	520,099	(810,981)	3,280,382
Prescription fees and charges	150,571	-	519,753	-	-	-	670,324
Dental fees and charges	115,227	-	631,415	-		-	746,642
Other contract income	212,512	-	16,890	43,359	19,618	32,244	324,623
Recoveries in respect of employee benefits	9,006	1,170	-	47	-	(1,030)	9,193
Total income from sale of goods and services	**846,133**	**3,235,787**	**1,182,576**	**67,558**	**541,055**	**(781,217)**	**5,091,892**

Consolidated group 2021/22	CCG/ ICB £000	SCCL £000	Direct commissioning £000	NHS England £000	Other £000	i/co eliminations £000	Total £000
Education, training and research	10,364	-	844	688	649	(276)	12,269
Non-patient care services to other bodies	353,943	1,477,301	2,665	7,296	614,063	(789,370)	1,665,898
Prescription fees and charges	10,931	-	641,033	-	-	-	651,964
Dental fees and charges	38	-	633,809	-	-	-	633,847
Other contract income	185,570	-	12,100	31,474	19,938	(5,211)	243,871
Recoveries in respect of employee benefits	11,148	1,516	-	336	-	(1,158)	11,842
Total income from sale of goods and services	**571,994**	**1,478,817**	**1,290,451**	**39,794**	**634,650**	**(796,015)**	**3,219,691**

3. Employee benefits

3.1. Employee benefits table

Employee benefits	Parent 2022/23 £000	Parent 2021/22 £000	Consolidated group 2022/23 £000	Consolidated group 2021/22 £000
Salaries and wages	1,164,104	877,669	2,520,724	2,005,815
Social security costs	117,935	89,225	256,388	200,621
Employer contributions to NHS Pension scheme	174,766	145,748	380,334	328,157
Other pension costs	11	7	2,941	1,154
Apprenticeship levy	4,845	154	9,664	8,875
Other employment benefits	-	5,305	-	154
Termination benefits	78,859	1,247	91,218	4,519
Gross employee benefits expenditure	**1,540,520**	**1,119,355**	**3,261,269**	**2,549,295**
Less: Employee costs capitalised	(4,056)	-	(4,056)	-
Gross employee benefits excluding capitalised costs	**1,536,464**	**1,119,355**	**3,257,213**	**2,549,295**
Less recoveries in respect of employee benefits	49	(306)	(9,193)	(11,842)
Net employee benefits	**1,536,513**	**1,119,049**	**3,248,020**	**2,537,453**

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

3.2 Pension costs

Past and present employees are covered by the provisions of the 2 NHS Pension schemes. Details of 0.42the benefits payable and rules of the schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State for Health and Social Care in England and Wales. They are 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, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in each scheme is taken as equal to the contributions.

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 2023, is based on valuation data as 31 March 2022, updated to 31 March 2023 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.

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% of pensionable pay.

The actuarial valuation as at 31 March 2020 is currently underway and will set the new employer contribution rate due to be implemented from April 2024.

3.2 Pension costs

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 3 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 12 months ending 30 September in the previous calendar year. From 2011/12 the Consumer Price Index has been used and replaced the Retail Prices Index
- 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 5 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 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 ICBs 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 and the Civil Servant and Other Pension Scheme. 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

Purchase of goods and services – cash	Parent 2022/23 £000	Parent 2021/22 £000	Consolidated group 2022/23 £000	Consolidated group 2021/22 £000
Services from other CCGs, ICBs and NHS England	27,230	12,201	-	-
Services from foundation trusts	22,090,846	18,674,370	74,214,062	68,920,966
Services from other NHS trusts	8,869,410	7,558,049	34,579,223	32,958,715
Services from other Whole of Government Accounts (WGA) bodies [177]	6,552	8,776	67,763	66,774
Purchase of healthcare from non-NHS bodies	913,875	1,207,066	16,640,277	17,029,247
Purchase of social care	-	-	1,024,918	931,424
General dental services and personal dental services	2,593,407	3,099,805	3,023,228	3,099,805
Prescribing costs	21,236	21,122	9,780,935	9,089,310
Pharmaceutical services	1,707,263	2,330,486	2,123,252	2,341,120
General ophthalmic services	440,513	545,904	539,053	561,006
GP primary care services	796,452	1,278,041	11,506,437	11,365,278
Supplies and services – clinical	(508,706)	(417,252)	(433,679)	(351,453)
Supplies and services – general	670,147	526,520	1,833,574	1,335,720
Consultancy services	17,290	33,899	51,147	75,764
Establishment	333,827	317,982	615,275	608,015
Transport	6,249	1,503	121,483	111,117
Premises	44,400	68,545	299,040	372,604
Audit fees [178]	800	480	19,944	10,964
Other non-statutory audit expenditure [179]	-	-	3,525	2,418
Other professional fees	183,381	153,789	269,820	237,105
Legal fees	10,995	7,594	30,138	23,521
Education and training	70,614	58,482	119,397	91,082
Funding to group bodies [180]	118,956,021	114,325,074	-	-
Total purchase of goods and services - cash	**157,251,802**	**149,812,436**	**156,428,812**	**148,880,502**
Other operating expenditure - cash				
Chair and non-executive members	136	121	14,056	32,637
Grants to other bodies	78,443	244,560	120,164	300,071
Clinical negligence	-	-	202	335
Research and development (excluding staff costs)	414	454	16,080	17,122
Other expenditure	31,043	46,721	57,446	61,693
Other operating expenditure - cash	**110,036**	**291,856**	**207,948**	**411,858**
Total operating expenses - cash	**157,361,838**	**150,104,292**	**156,636,760**	**149,292,360**
Depreciation and impairment charges - non cash items				
Depreciation	167,284	166,390	219,012	181,604
Amortisation	38,745	13,776	40,270	14,796
Impairments and reversals of property, plant and equipment	-	-	-	742
Impairments and reversals of right-of-use-assets	-	-	(12)	-
Total depreciation and impairment charges	**206,029**	**180,166**	**259,270**	**197,142**

[177] 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.
[178] Audit fees for the parent are NAO fees of £550k for the NHS England financial statements and £250k for the Consolidated NHS Provider Account.
[179] In both financial years NHS England purchased no non-statutory audit services from NAO. Details of CCGs and ICBs non-statutory audit expenditure can be found in the underlying individual CCGs and ICBs accounts.
[180] Funding to group bodies is shown above and represents cash funding drawn down by the CCGs and ICBs. These balances are eliminated on consolidation.

Purchase of goods and services – cash	Parent 2022/23 £000	Parent 2021/22 £000	Consolidated group 2022/23 £000	Consolidated group 2021/22 £000
Provision expense – non-cash items				
Change in discount rate	(245,623)	(23,209)	(246,120)	(23,040)
Provisions	276,316	101,217	279,315	173,853
Total provision expense	**30,693**	**78,008**	**33,195**	**150,813**
Purchase of goods and services – non-cash				
Non-cash apprenticeship training grants	1,159	848	1,920	1,313
Total purchase of goods and services – non-cash	**1,159**	**848**	**1,920**	**1,313**
Other operating expenditure – non-cash items				
Expected credit loss on receivables	4,258	1,418	12,917	1,344
Inventories written down	1,097	-	2,321	1,529
Inventories consumed	43,803	138,275	2,669,468	1,482,348
Total other operating expenditure	**49,158**	**139,693**	**2,684,706**	**1,485,221**
Total other operating expenses – non-cash	**287,039**	**398,715**	**2,979,091**	**1,834,489**
Total operating expenditure	**157,648,877**	**150,503,007**	**159,615,851**	**151,126,849**

Intercompany trading is eliminated between bodies within the NHS England group upon consolidation.

In October 2021 NHS England, the Parent, acquired 100% of the shareholding of SCCL. As a result, the assets, liabilities and ongoing operational income and expenditure form part of the NHS England consolidated group account from this date. There has therefore been a significant growth in income and expenditure year on year.

5. Property, plant, and equipment

Parent 2022/23	Buildings excluding dwellings £000	Assets under construction and payments on account £000	Plant and machinery £000	Transport equipment £000	Information technology £000	Furniture and fittings £000	Total £000
Cost or valuation at 1 April 2022	**213**	**-**	**470**	**591**	**855,367**	**6,314**	**862,955**
Additions purchased	-	-	-	-	113,912	1,685	**115,597**
Additions donated	-	-	-	-	11,598	-	**11,598**
Reclassifications	-	-	-	-	4,372	-	**4,372**
Disposals	(100)	-	-	-	(124,163)	(73)	**(124,336)**
Transfer (to)/from other public sector body	-	-	-	-	14,826	21,466	**36,292**
Cost or valuation at 31 March 2023	**113**	**-**	**470**	**591**	**875,912**	**29,392**	**906,478**
Depreciation 1 April 2022	**205**	**-**	**368**	**463**	**462,515**	**3,210**	**466,761**
Reclassifications	-	-	-	-	(255)	-	**(255)**
Disposals	(100)	-	-	-	(124,163)	(48)	**(124,311)**
Charged during the year	8	-	94	118	146,072	1,563	**147,855**
Transfer (to)/from another public sector body	-	-	-	-	2,711	3,521	**6,232**
At 31 March 2023	**113**	**-**	**462**	**581**	**486,880**	**8,246**	**496,282**
Carrying value at 31 March 2023	**-**	**-**	**8**	**10**	**389,032**	**21,146**	**410,196**
Asset financing:							
Owned	-	-	8	10	389,032	21,146	**410,196**
Total at 31 March 2023	**-**	**-**	**8**	**10**	**389,032**	**21,146**	**410,196**

Parent 2021/22	Buildings excluding dwellings £000	Assets under construction and payments on account £000	Plant and machinery £000	Transport equipment £000	Information technology £000	Furniture and fittings £000	Total £000
Cost or valuation at 1 April 2021	**221**	**-**	**794**	**591**	**814,714**	**4,764**	**821,084**
Additions purchased	-	-	-	-	109,555	1,801	**111,356**
Reclassifications	-	(1,539)	-	-	(3,197)	-	**(4,736)**
Disposals	(8)	-	(324)	-	(65,705)	(251)	**(66,288)**
Transfer (to)/from other public sector body	-	1,539	-	-	-	-	**1,539**
Cost or valuation at 31 March 2022	**213**	**-**	**470**	**591**	**855,367**	**6,314**	**862,955**
Depreciation 1 April 2021	**170**	**-**	**595**	**345**	**363,855**	**2,704**	**367,669**
Reclassifications	-	-	-	-	(1,010)	-	**(1,010)**
Disposals	(8)	-	(324)	-	(65,705)	(251)	**(66,288)**
Charged during the year	43	-	97	118	165,375	757	**166,390**
Transfer (to)/from other public sector body	-	-	-	-	-	-	**-**
At 31 March 2022	**205**	**-**	**368**	**463**	**462,515**	**3,210**	**466,761**
Carrying value at 31 March 2022	**8**	**-**	**102**	**128**	**392,852**	**3,104**	**396,194**
Asset financing:							
Owned	8	-	102	128	392,852	3,104	**396,194**
Total at 31 March 2022	**8**	**-**	**102**	**128**	**392,852**	**3,104**	**396,194**

Consolidated group 2022/23	Buildings excluding dwellings £000	Assets under construction and payments on account £000	Plant and machinery £000	Transport equipment £000	Information technology £000	Furniture and fittings £000	Total £000
Cost or valuation at 1 April 2022	**9,064**	**26,019**	**30,893**	**694**	**931,368**	**21,042**	**1,019,080**
Addition of assets under construction and payments on account	-	14,949	-	-	-	-	**14,949**
Additions purchased	11	-	179	-	116,285	1,797	**118,272**
Additions donated	-	-	-	-	11,598	-	**11,598**
Reclassifications	-	(5,148)	-	-	5,788	45	**685**
Disposals	(1,191)	-	(20,734)	-	(141,976)	(3,320)	**(167,221)**
Transfer (to)/from other public sector body	-	-	-	-	32,737	22,606	**55,343**
Cost or valuation at 31 March 2023	**7,884**	**35,820**	**10,338**	**694**	**955,800**	**42,170**	**1,052,706**
Depreciation 1 April 2022	**3,199**	**-**	**18,522**	**566**	**509,975**	**11,825**	**544,087**
Reclassifications	-	-	-	-	(236)	-	**(236)**
Disposals	(1,191)	-	(14,185)	-	(141,719)	(3,294)	**(160,389)**
Charged during the year	863	-	3,884	118	156,396	2,528	**163,789**
Transfer (to)/from other public sector body	-	-	-	-	19,477	4,661	**24,138**
At 31 March 2023	**2,871**	**-**	**8,221**	**684**	**543,893**	**15,720**	**571,389**
Carrying value at 31 March 2023	**5,013**	**35,820**	**2,117**	**10**	**411,907**	**26,450**	**481,317**
Asset financing:							
Owned	5,013	35,820	2,117	10	411,907	26,450	**481,317**
Total at 31 March 2023	**5,013**	**35,820**	**2,117**	**10**	**411,907**	**26,450**	**481,317**

Consolidated group 2021/22	Buildings excluding dwellings £000	Assets under construction and payments on account £000	Plant and machinery £000	Transport equipment £000	Information technology £000	Furniture and fittings £000	Total £000
Cost or valuation at 1 April 2021	**2,643**	**115**	**10,337**	**694**	**878,009**	**16,007**	**907,805**
Addition of assets under construction and payments on account	-	15,154	-	-	-	-	**15,154**
Additions purchased	-	-	125	-	113,179	1,891	**115,195**
Reclassifications	(38)	(16,527)	11	-	11,362	(38)	**(5,230)**
Disposals	(216)	(115)	(3,267)	-	(84,358)	(3,183)	**(91,139)**
Impairments charged	-	-	-	-	-	-	**-**
Transfer (to)/from other public sector body	6,675	27,392	23,687	-	13,176	6,365	**77,295**
Cost or valuation at 31 March 2022	**9,064**	**26,019**	**30,893**	**694**	**931,368**	**21,042**	**1,019,080**
Depreciation 1 April 2021	**896**	**-**	**7,864**	**448**	**413,065**	**11,695**	**433,968**
Reclassifications	(38)	-	12	-	(1,441)	(35)	**(1,502)**
Disposals	(127)	-	(2,902)	-	(83,583)	(2,799)	**(89,411)**
Impairments charged	742	-	-	-	-	-	**742**
Charged during the year	572	-	2,667	118	176,060	2,187	**181,604**
Transfer (to)/from other public sector body	1,154	-	10,881	-	5,874	777	**18,686**
At 31 March 2022	**3,199**	**-**	**18,522**	**566**	**509,975**	**11,825**	**544,087**
Carrying value at 31 March 2022	**5,865**	**26,019**	**12,371**	**128**	**421,393**	**9,217**	**474,993**
Asset financing							
Owned	5,865	26,019	11,860	128	421,393	9,217	474,482
Held on finance lease	-	-	511	-	-	-	511
Total at 31 March 2022	**5,865**	**26,019**	**12,371**	**128**	**421,393**	**9,217**	**474,993**

6. Right-of-use assets

6.1 Right-of-use assets

Parent 2022/23	Land £000	Buildings excluding dwellings £000	Plant & machinery £000	Transport equipment £000	Information technology £000	Furniture & fittings £000	Total £000
Cost or valuation at 1 April 2022	-	-	-	-	-	-	-
IFRS 16 Transition Adjustment	-	44,342	-	114	7,946	-	**52,402**
Additions	-	26,875	-	238	1,271	-	**28,384**
Reclassifications	-	-	-	-	-	-	-
Modifications	-	1,312	-	-	-	-	**1,312**
Transfer (to) from other public sector body	-	63,771	-	-	3,327	-	**67,098**
Cost or valuation at 31 Mar 2023	**-**	**136,300**	**-**	**352**	**12,544**	**-**	**149,196**
Depreciation 1 April 2022	**-**	**-**	**-**	**-**	**-**	**-**	**-**
Charged during the year	-	16,408	-	178	2,843	-	**19,429**
Reclassifications	-	-	-	-	-	-	-
Transfer (to) from other public sector body	-	4,142	-	-	2,167	-	**6,309**
Depreciation at 31 March 2023	**-**	**20,550**	**-**	**178**	**5,010**	**-**	**25,738**
Net book value at 31 March 2023	**-**	**115,750**	**-**	**174**	**7,534**	**-**	**123,458**

Consolidated group 2022/23	Land £000	Buildings excluding dwellings £000	Plant & machinery £000	Transport equipment £000	Information technology £000	Furniture & fittings £000	Total £000
Cost or valuation at 01 April 2022	-	-	-	-	-	-	-
IFRS 16 Transition Adjustment	975	263,143	4	398	8,150	100	**272,770**
Additions	28	38,577	8	257	1,735	14	**40,619**
Reclassifications	-	24,372	-	581	-	-	**24,953**
Lease remeasurement	-	8,067	-	-	-	(2)	**8,065**
Modifications	-	1,204	-	-	-	-	**1,204**
Disposals on expiry of lease term	-	(672)	-	-	-	-	**(672)**
Derecognition for early terminations	-	(123)	-	-	-	-	**(123)**
Transfer (to) from other public sector body	-	63,771	-	-	3,327	-	**67,098**
Cost/Valuation at 31 March 2023	**1,003**	**398,339**	**12**	**1,236**	**13,212**	**112**	**413,914**
Depreciation 1 April 2022	-	-	-	-	-	-	-
Charged during the year	120	51,729	5	292	3,033	44	**55,223**
Reclassifications	-	24,372	-	581	-	-	**24,953**
Disposals on expiry of lease term	-	(292)	-	-	-	-	**(292)**
Derecognition for early terminations	-	(10)	-	-	-	-	**(10)**
Transfer (to) from other public sector body	-	4,142	-	-	2,167	-	**6,309**
Depreciation at 31 March 2023	**120**	**79,941**	**5**	**873**	**5,200**	**44**	**86,183**
Net book value at 31 March 2023	**883**	**318,398**	**7**	**363**	**8,012**	**68**	**327,731**

6.2 Right of use asset lease liabilities

2022/23	Parent £'000	Consolidated group £'000
Right of use asset lease liabilities at 01 April 2022		
IFRS 16 Transition Adjustment	(52,402)	(305,211)
Addition of Assets under Construction & Payments on Account	-	-
Additions purchased	(28,080)	(40,851)
Reclassifications	-	1,301
Interest expense relating to lease liabilities	-	(2,846)
Repayment of lease liabilities (including interest)	(795)	51,112
Lease remeasurement	20,383	(12,747)
Modifications	(71)	25
Disposals on expiry of lease term	-	366
Derecognition for early terminations	-	172
Transfer from/(to) other public sector body	-	(56,054)
Other	(70,769)	33,151
Right of use asset lease liabilities on 31 March 2023	**(131,734)**	**(331,582)**

6.3 Right of use asset lease liabilities - maturity analysis of undiscounted future lease payments

2022/23	Parent £'000	Consolidated group £'000
Within 1 year	(29,398)	(61,974)
Between 1 and 5 years	(58,783)	(146,360)
After 5 years	(50,603)	(139,362)
Balance on 31 December 2022	**(138,784)**	**(347,696)**
Effect of discounting	**7,050**	**16,114**
Included in:		
Current right of use asset lease liabilities	(27,004)	(55,455)
Non-current right of use asset lease liabilities	(104,730)	(276,127)
Balance at 31 December 2022	**(131,734)**	**(331,582)**

6.4 Impact of IFRS 16

The table below reconciles the amount disclosed as future operating lease commitments on 31 March 2022 as disclosed in the NHS England parent 2021/22 financial statements to the amount recognised on the Statement of Financial Position in respect of right of use lease liabilities on adoption of IFRS 16.

Consolidated group 2022/23	Parent £'000	Consolidated group £'000
Operating lease commitments under IAS 17 on 31 March 2022	(58,846)	(212,098)
Incremental borrowing rate	0.95%	0.95%
Operating lease commitments under IAS17 discounted using incremental	**(58,842)**	**(178,453)**
Add: Finance lease liabilities at 31 March 2022	-	(79,319)
Add: Residual value guarantees	-	(1,192)
Add: Rentals associated with extension options reasonably certain to be exercised	-	(20,494)
Add: Leases without full documentation previously excluded from operating lease disclosure	(9,799)	(10,069)
Add: Differences in the assessment of the lease term used for future minimum payments at 31 March 2023	(1,889)	(407)
Less: Short-term leases (including those with <12 months at application date)	2,458	2,816
Less: Low value leases	-	116
Less: Variable payments not included in the valuation of the lease liabilities	-	6,416
Less: Correction of immaterial prior period error in IAS 17 disclosure	7,014	5,177
Add/Less: Other	6,656	(29,802)
Lease liability on 1 April 2022 under IFRS 16	**(52,402)**	**(305,211)**

The comparative information for future minimum lease payments under IAS 17 is below

	Parent 2021/22			Consolidated group 2021/22		
Payments recognised as an expense under IAS17	**Buildings £000**	**Other £000**	**Total £000**	**Buildings £000**	**Other £000**	**Total £000**
Minimum lease payments	49,087	465	49,552	120,934	1,235	122,169
Contingent rents	-	-	-	-	1,531	1,531
Total	**49,087**	**465**	**49,552**	**120,934**	**2,766**	**123,700**

	Parent 2021/22			Consolidated group 2021/22		
Future minimum lease payments under IAS17 Payable:	**Buildings £000**	**Other £000**	**Total £000**	**Buildings £000**	**Other £000**	**Total £000**
No later than 1 year	26,069	199	26,268	52,001	684	52,685
Between 1 and 5 years	25,787	137	25,924	99,539	533	100,072
After 5 years	6,654	-	6,654	59,341	-	59,341
Total	**58,510**	**336**	**58,846**	**210,881**	**1,217**	**212,098**

6.5 Amounts recognised in statement comprehensive net expenditure

Parent 2022/23	£'000
Depreciation expense on right-of-use assets	19,430
Interest expense on lease liabilities	795
Expense relating to short-term leases	3,315
Consolidated group 2022/23	
Depreciation expense on right-of-use assets	55,222
Interest expense on lease liabilities	2,805
Expense relating to short-term leases	3,540
Expense relating to leases of low value assets	(34)
Expense relating to variable lease payments not included in the measurement of the lease liability	971

6.6 Amounts recognised in statement of cash flows

Parent 2022/23	£'000
Total cash outflow on leases under IFRS 16	20,383

Consolidated group 2022/23	£'000
Total cash outflow on leases under IFRS 16	51,535
Total cash outflow for lease payments not included within the measurement of lease liabilities	283

7. Intangible non-current assets

Parent 2022/23	Computer software: purchased £000	Development expenditure (internally generated) £000	Websites £000	Total £000
Cost or valuation on 1 April 2022	**57,742**	**17,141**	-	**74,883**
Additions purchased	5,459	29,663	-	35,122
Additions internally generated	-	3,686	-	3,686
Reclassifications	(4,372)	-	-	(4,372)
Disposals	(749)	(7,798)	-	(8,547)
Transfer (to)/from another public sector body	16,959	570,133	4,127	591,219
On 31 March 2023	**75,039**	**612,825**	**4,127**	**691,991**
Amortisation 1 April 2022	**15,902**	**2,862**	-	**18,764**
Reclassifications	(235)	490	-	255
Disposals	(749)	(7,359)	-	(8,108)
Charged during the year	14,384	24,231	130	38,745
Transfer (to)/from another public sector body	13,186	256,505	3,217	272,908
At 31 March 2023	**42,488**	**276,729**	**3,347**	**322,564**
Carrying value at 31 March 2023	**32,551**	**336,096**	**780**	**369,427**
Asset financing:				
Owned	32,551	336,096	780	**369,427**
Total at 31 March 2023	**32,551**	**336,096**	**780**	**369,427**

Parent 2021/22	Computer software: purchased £000	Development expenditure (internally generated) £000	Websites £000	Total £000
Cost or valuation at 1 April 2021	**46,886**	**4,216**	**-**	**51,102**
Additions purchased	9,103	11,386	**-**	**20,489**
Reclassifications	3,197	1,539	**-**	**4,736**
Disposals	(1,444)	-	**-**	**(1,444)**
At 31 March 2022	**57,742**	**17,141**	**-**	**74,883**
Amortisation 1 April 2021	4,218	1,204	**-**	**5,422**
Reclassifications	1,010	-	**-**	**1,010**
Disposals	(1,444)	-	**-**	**(1,444)**
Charged during the year	12,118	1,658	**-**	**13,776**
At 31 March 2022	**15,902**	**2,862**	**-**	**18,764**
Carrying value at 31 March 2022	**41,840**	**14,279**	**-**	**56,119**
Asset financing:			**-**	
Owned	41,840	14,279	**-**	**56,119**
Total at 31 March 2022	**41,840**	**14,279**	**-**	**56,119**

Consolidated group 2022/23	Computer software: purchased £000	Development expenditure (internally generated) £000	Websites £000	Total £000
Cost or valuation at 1 April 2022	**66,011**	**18,777**	**-**	**84,788**
Additions purchased	5,598	29,663	0	**35,261**
Additions internally generated	-	3,686	-	**3,686**
Reclassifications	(685)	-	0	**(685)**
Disposals	(4,523)	(7,885)	-	**(12,408)**
Transfer (to)/from other public sector body	16,959	570,133	4,127	**591,219**
At 31 March 2023	**83,360**	**614,374**	**4,127**	**701,861**
Amortisation 1 April 2022	**22,288**	**4,277**	**-**	**26,565**
Reclassifications	(254)	490	-	**236**
Disposals	(4,523)	(7,446)	-	**(11,969)**
Charged during the year	15,690	24,450	130	**40,270**
Transfer (to) from another public sector body	13,186	256,505	3,217	**272,908**
At 31 March 2023	**46,387**	**278,276**	**3,347**	**328,010**
Carrying value at 31 March 2023	**36,973**	**336,098**	**780**	**373,851**
Asset financing:				
Owned	36,973	336,098	780	**373,851**
Total at 31 March 2023	**36,973**	**336,098**	**780**	**373,851**

Consolidated group 2021/22	Computer software: purchased £000	Development expenditure (internally generated) £000	Websites £000	Total £000
Cost or valuation at 1 April 2021	**55,979**	**5,851**	**-**	**61,830**
Additions purchased	10,327	11,386	**-**	**21,713**
Reclassifications	3,690	1,540	**-**	**5,230**
Disposals	(5,127)	-	**-**	**(5,127)**
Transfer (to)/from other public sector body	1,142	-	**-**	**1,142**
At 31 March 2022	**66,011**	**18,777**	**-**	**84,788**
Amortisation 1 April 2021	**12,197**	**2,398**	**-**	**14,595**
Reclassifications	1,502	-	**-**	**1,502**
Disposals	(5,089)	-	**-**	**(5,089)**
Charged during the year	12,917	1,879	**-**	**14,796**
Transfer (to) from another public sector body	761	-	**-**	**761**
At 31 March 2022	**22,288**	**4,277**	**-**	**26,565**
Carrying value at 31 March 2022	**43,723**	**14,500**	**-**	**58,223**
Asset financing:				
Owned	43,723	14,500	**-**	**58,223**
Total at 31 March 2022	**43,723**	**14,500**	-	**58,223**

8. Inventories

Parent 2022/23	Consumables £'000	Loan equipment £'000	Other £'000	Total £'000
Balance at 1 April 2022	7,528	-	22,383	**29,911**
Additions	-	-	23,969	**23,969**
Inventories recognised as an expense in the period	(1,234)	-	(42,569)	**(43,803)**
Write-down of inventories (including losses)	(1,097)	-	-	**(1,097)**
Balance at 31 March 2023	**5,197**	**-**	**3,783**	**8,980**

Parent 2021/22	Consumables £'000	Loan equipment £'000	Other £'000	Total £'000
Balance at 1 April 2021	15,966	-	42,863	**58,829**
Additions	-	-	109,357	**109,357**
Inventories recognised as an expense in the period	(8,438)	-	(129,837)	**(138,275)**
Balance at 31 March 2022	**7,528**	**-**	**22,383**	**29,911**

Consolidated group 2022/23	Consumables £'000	Loan equipment £'000	Other £'000	Total £'000
Balance at 1 April 2022	**159,684**	**8,320**	**25,052**	**193,056**
Additions	2,620,255	1,907	30,942	**2,653,104**
Inventories recognised as an expense in the period	(2,624,088)	(1,967)	(43,413)	**(2,669,468)**
Write-down of inventories (including losses)	(2,321)	-	-	**(2,321)**
Transfer (to)/from other public sector body	-	-	-	**-**
Balance at 31 March 2023	**153,530**	**8,260**	**12,581**	**174,371**

Consolidated group 2021/22	Consumables £'000	Loan equipment £'000	Other £'000	Total £'000
Balance at 1 April 2021	17,640	9,814	43,814	**71,268**
Additions	1,336,502	3,280	111,133	**1,450,915**
Inventories recognised as an expense in the period	(1,345,363)	(4,774)	(132,211)	**(1,482,348)**
Write-down of inventories (including losses)	(1,529)	-	-	**(1,529)**
Transfer (to)/from other public sector body	152,434	-	2,316	**154,750**
Balance at 31 March 2022	**159,684**	**8,320**	**25,052**	**193,056**

9. Trade and other receivables

	Parent				Consolidated group			
	2022/23 Current £000	2022/23 Non-current £000	2021/22 Current £000	2021/22 Non-current £000	2022/23 Current £000	2022/23 Non-current £000	2021/22 Current £000	2021/22 Non-current £000
NHS receivables: revenue	102,293	-	67,029	-	403,955	-	324,737	-
NHS prepayments	93,800	-	72,474	-	188,691	-	155,247	-
NHS accrued income	11,503	-	11,668	-	31,160	-	76,913	-
NHS non-contract	379	-	1,658	-	455	-	491	-
Non-NHS and other WGA receivables: Revenue	394,690	-	263,340	-	723,202	-	431,777	-
Non-NHS and other WGA receivables: Capital	-	-	-	-	-	-	-	-
Non-NHS and other WGA prepayments	169,278	4,693	89,254	-	297,607	4,816	203,127	238
Non-NHS and other WGA accrued income	207,958	-	190,772	-	961,955	-	2,203,102	-
Non-NHS and other WGA non-contract	804	-	400	-	7,259	-	2,413	-
Non-NHS contract assets	-	-	-	-	27	-	-	-
Expected credit loss allowance-receivables	(15,064)	-	(10,868)	-	(39,065)	-	(27,725)	-
VAT	31,393	-	37,230	-	55,522	-	334,141	-
Finance lease receivables	-	-	-	-	-	-	363	1,258
Other receivables and accruals	7,249	-	1,666	-	65,679	-	34,301	-
Total	**1,004,283**	**4,693**	**724,623**	**-**	**2,696,447**	**4,816**	**3,738,887**	**1,496**
Other financial assets	-	141,462	-	141,192	-	1,106	-	2,106
Total current and non-current	**1,150,438**		**865,815**		**2,702,369**		**3,742,489**	

10. Cash and cash equivalents

	Note	Parent 2022/23 £000	Parent 2021/22 £000	Consolidated group 2022/23 £000	Consolidated group 2021/22 £000
Balance at 1 April		229,575	150,032	374,755	114,411
Transfer in from other org under absorption		47,142	-	47,142	269,704
Net change in year		98,168	79,543	162,406	(9,360)
Balance at statement of financial position date		**374,885**	**229,575**	**584,303**	**374,755**
Made up of:					
Cash with the Government Banking Service		345,398	214,719	596,028	370,517
Hosted cash/cash in hand		28,454	13,634	27,988	13,433
Current investments		1,033	1,222	1,033	1,222
Cash and cash equivalents as in statement of financial position		**374,885**	**229,575**	**625,049**	**385,172**
Bank overdraft: Government Banking Service	11	-	-	(40,746)	(10,417)
Total bank overdrafts		**-**	**-**	**(40,746)**	**(10,417)**
Balance at statement of financial position date		**374,885**	**229,575**	**584,303**	**374,755**

For details of bank overdraft see note 11.

Included within hosted cash/cash in hand above is £21.5 million (2021/22 £13.6 million) 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.

11. Trade and other payables

	Parent				Consolidated group			
	2022/23 Current £000	2022/23 Non-current £000	2021/22 Current £000	2021/22 Non-current £000	2022/23 Current £000	2022/23 Non-current £000	2021/22 Current £000	2021/22 Non-current £000
NHS payables: revenue	157,396	-	178,777	-	470,176	-	340,774	-
NHS payables: capital	23,703	-	22,622	-	-	-	103	-
NHS accruals [181]	3,045,525	-	633,882	-	3,424,687	-	904,319	-
NHS deferred income	2,950	142	1,081	-	5,317	122	40,268	-
NHS contract liabilities	-	-	-	-	94,498	-	96,519	-
Non-NHS and other WGA payables: revenue	135,788	-	204,405	-	1,811,418	-	1,772,912	-
Non-NHS and other WGA payables: capital	55,627	-	60,292	-	55,779	-	62,730	-
Non-NHS and other WGA accruals	924,333	-	1,418,112	-	5,805,449	-	6,309,794	-
Non-NHS and other WGA deferred income	3,166	22	1,866	-	105,765	708	41,154	612
Non-NHS contract liabilities	-	-	-	-	15,176		10,336	-
Social security costs	17,349	-	13,043	-	36,317	-	30,487	-
VAT	-	-	-	-	23,279	-	54,039	-
Tax	29,685	-	24,890	-	47,630	-	40,108	-
Payments received on account	56	-	-	-	351	-	160	-
Other payables and accruals	609,309	3,196	462,597	31	1,452,549	3,196	1,319,257	264
Total	**5,004,887**	**3,360**	**3,021,567**	**31**	**13,348,391**	**4,026**	**11,022,960**	**876**
Other financial liabilities								
Bank overdraft - Government Banking Service	-	-	-	-	40,746	-	10,417	-
Finance lease liabilities	-	-	-	-	-	-	121	544
Other financial liabilities - other	-	-	-	-	-	-	-	72
Loans from Department of Health and Social Care [182]	-	-	-	-	24,609	781,673	-	2,233,920
Total	**-**	**-**	**-**	**-**	**65,355**	**781,673**	**10,538**	**2,234,536**
Total trade & other payables (current)	**5,004,887**		**3,021,567**		**13,413,746**		**11,033,498**	
Total trade & other payables (non-current)[182]		**3,360**		**31**		**785,699**		**2,235,412**
Total trade & other payables (current and non-current)		**5,008,247**		**3,021,598**		**14,199,445**		**13,268,910**

[181] The increase in NHS accruals is in relation to the pay award.
[182] Loans from the Department of Health and Social Care represent amounts issued to Supply Chain Coordination Limited to provide a working capital facility

12. Net gain/(loss) on transfer by absorption

Business combinations within the public sector are accounted for using absorption accounting principles.

2022/23

On 1 July 2022, the functions of NHS TDA and Monitor transferred to NHS England. The impact of the transfer of the assets and liabilities is shown under NHSI. In addition, the CCGs were dissolved under the Health and Care Act 2022 and the liabilities of the CCGs were transferred in full to the ICBs. There is no impact on the group position as the transactions eliminate in full.

On 1 October 2022, NHS England transferred responsibility for the provisions and liabilities held by NHS England in relation to previously unassessed periods of care (PUPOC) transactions. These transfers eliminate on consolidation to leave nil impact in the group position.

On 1 February 2023, the functions of NHS Digital transferred to NHS England. The assets and liabilities related to the transfer are shown in the table below.

Parent 2022/23	NHSI £'000	NHS Digital £'000	NHS Provider £'000	ICBs £'000
Transfer of property plant and equipment	425	30,780	-	(1,145)
Transfer of right-of-use assets	1,946	58,843	-	-
Transfer of intangibles	11,030	307,281	-	-
Transfer of cash and cash equivalents	41,438	5,704	-	-
Transfer of receivables	6,738	56,404	(34)	(14,063)
Transfer of payables	(41,571)	(74,777)	330	8,808
Transfer of provisions	(3,146)	(6,020)	-	2,398
Transfer of right-of-use liabilities	(1,949)	(68,820)	-	-
Transfer of PUPOC provision to ICBs	-	-	-	3,165
Transfer of PUPOC liability to ICBs	-	-	-	4,728
Net gain on transfers by absorption	**14,911**	**309,395**	**296**	**3,891**

Group 2022/23	NHSI £'000	NHS Digital £'000	NHS Provider £'000
Transfer of property plant and equipment	425	30,780	-
Transfer of right-of-use assets	1,946	58,843	-
Transfer of intangibles	11,030	307,281	-
Transfer of cash and cash equivalents	41,438	5,704	-
Transfer of receivables	6,738	56,404	6,072
Transfer of payables	(41,571)	(74,777)	(4,350)
Transfer of provisions	(3,146)	(6,020)	(1,426)
Transfer of right-of-use liabilities	(1,949)	(68,820)	-
Transfer of PUPOC provision to ICBs	-	-	-
Transfer of PUPOC liability to ICBs	-	-	-
Net gain on transfers by absorption	**14,911**	**309,395**	**296**

2021/22

On 1 October 2021, the activities of Public Health England were divided between DHSC, the UK Health Security Agency, NHS Digital and NHS England. The assets and liabilities transferred to NHS England, the parent, are included in the table below.

On 1 October 2021, the entire shareholding of SCCL transferred from DHSC to NHS England, the parent entity. On consolidation into the NHS England group this equity investment is eliminated and replaced with the net assets and liabilities of SCCL. The value of the net assets transferred under the absorption method is included in the table below.

	Parent 2021/22		Consolidated group 2021/22	
	PHE £'000	DHSC £'000	PHE £'000	SCCL £'000
Transfer of property plant and equipment	-	-	-	57,270
Transfer of intangibles	1,543	-	1,543	380
Transfer of financial assets	-	159,000	-	-
Transfer of cash and cash equivalents	-	-	-	269,704
Transfer of inventories	-	-	-	154,751
Transfer of receivables	727	-	727	370,615
Transfer of other current assets	-	-	-	2,162,901
Transfer of payables	(6,730)	-	(6,730)	(189,221)
Transfer of other current liabilities	-	-	-	(595,377)
Transfer of provisions	-	-	-	(2,803)
Transfer of non-current borrowings	-	-	-	(2,083,920)
Net gain/(loss) on transfers by absorption	**(4,460)**	**159,000**	**(4,460)**	**144,300**

13. Finance costs

	Parent		Consolidated group	
Interest	2022/23 £000	2021/22 £000	2022/23 £000	2021/22 £000
Interest on loans and overdrafts	-	-	28,560	150
Interest on obligations under finance leases	795	-	2,805	27
Interest on late payment of commercial debt	-	-	3	-
Other interest expense	27	79	51	79
Total interest	**822**	**79**	**31,419**	**256**
Other finance costs	-	-	-	50
Provisions: unwinding of discount	4,224	2,726	4,322	3,118
Total finance costs	**5,046**	**2,805**	**35,741**	**3,424**

14. Provisions

Parent	2022/23 Current £000	2022/23 Non-current £000	2021/22 Current £000	2021/22 Non-current £000
Restructuring	647	-	3,651	-
Redundancy	1,449	-	1,686	-
Legal claims	135	148	133	158
Continuing care	1,444	-	5,228	-
Clinician tax charge	5,231	272,397	2,955	286,607
Other	27,537	155,906	68,931	65,687
Total	**36,443**	**428,451**	**82,584**	**352,452**
Total current and non-current	**464,894**		**435,036**	

Parent 2022/23	Restructuring £000	Redundancy £000	Legal claims £000	Continuing care £000	Clinician tax charge £000	Other £000	Total £000
Balance at 1 April 2022	**3,651**	**1,686**	**291**	**5,228**	**289,562**	**134,618**	**435,036**
Arising during the year	-	190	92	-	229,209	61,137	**290,628**
Utilised during the year	(3,004)	-	(25)	(619)	(1,278)	(5,472)	**(10,398)**
Reversed unused	-	(427)	(75)	-	(1,178)	(10,897)	**(12,577)**
Unwinding of discount	-	-	-	-	5,559	(1,334)	**4,225**
Change in discount rate	-	-	-	-	(244,246)	(1,377)	**(245,623)**
Transfer (to) from other public sector body under absorption	-	-	-	(3,165)	-	6,768	**3,603**
Balance at 31 March 2023	**647**	**1,449**	**283**	**1,444**	**277,628**	**183,443**	**464,894**
Expected timing of cash flows:							
Within 1 year	647	1,449	135	1,444	5,231	27,537	**36,443**
Between 1 and 5 years	-	-	148	-	13,340	150,630	**164,118**
After 5 years	-	-	-	-	259,057	5,276	**264,333**
Balance at 31 March 2023	**647**	**1,449**	**283**	**1,444**	**277,628**	**183,443**	**464,894**

Consolidated group	2022/23 Current £000	2022/23 Non-current £000	2021/22 Current £000	2021/22 Non-current £000
Restructuring	14,922	358	14,040	984
Redundancy	2,770	1,786	5,980	-
Legal claims	10,123	888	8,651	1,065
Continuing care	69,807	21,845	86,532	31,646
Clinician tax charge	5,231	272,397	2,955	286,607
Other	87,361	179,928	132,768	93,241
Total	**190,214**	**477,202**	**250,926**	**413,543**
Total current and non-current	**667,416**		**664,469**	

Consolidated group 2022/23	Restructuring £000	Redundancy £000	Legal claims £000	Continuing care £000	Clinician tax charge £000	Other £000	Total £000
Balance at 1 April 2022	**15,024**	**5,980**	**9,716**	**118,178**	**289,562**	**226,009**	**664,469**
Arising during the year	8,235	4,500	5,276	47,869	229,209	108,972	404,061
Utilised during the year	(4,381)	(2,406)	(1,843)	(22,018)	(1,278)	(16,742)	(48,668)
Reversed unused	(3,606)	(3,518)	(2,160)	(52,330)	(1,178)	(58,448)	(121,240)
Unwinding of discount	8	-	22	99	5,559	(1,366)	4,322
Change in discount rate	-	-	-	(146)	(244,246)	(1,728)	(246,120)
Transfer (to) from other public sector body under absorption	-	-	-	-	-	10,592	10,592
Balance at 31 March 2023	**15,280**	**4,556**	**11,011**	**91,652**	**277,628**	**267,289**	**667,416**
Expected timing of cash flows:							
Within 1 year	14,922	2,770	10,123	69,807	5,231	87,361	190,214
Between 1 and 5 years	358	1,786	888	21,845	13,340	160,097	198,314
After 5 years	-	-	-	-	259,057	19,831	278,888
Balance at March 2023	**15,280**	**4,556**	**11,011**	**91,652**	**277,628**	**267,289**	**667,416**

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 clinician tax charge is the pensions reimbursement provision in the parent of £278 million 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 are primarily provisions for pension disputes and dilapidations.

The NHS Resolution financial statements disclose a provision of £70,041,046 as of 31 March 2023 in respect of clinical negligence liabilities and employment liability scheme of NHS England (31 March 2022: £74,786,491).

15. Contingencies

	Parent		Consolidated group	
Contingent liabilities	**2022/23 £000**	**2021/22 £000**	**2022/23 £000**	**2021/22 £000**
Employment tribunal	975	338	975	438
NHS Resolution employee liability claim	18	9	100	10
Continuing healthcare	-	-	14,066	12,955
Legal claims	2,907	2,278	3,107	2,589
Legacy Pension issues	250	250	250	250
Her Majesty's Revenue and Customs	-	-	21,000	-
Liverpool Community Health Trust (re Maternity and neonatal care investigation)	500	-	500	-
Christies Foundation Trust (re Maternity and neonatal care investigation)	300	-	300	-
Sandwell Children's Trust Complex Placements	-	-	-	1,592
GP Non Reimbursable property costs	-	-	1,907	2,990
Other	-	1,673	35	1,673
Total contingent liabilities	**4,950**	**4,548**	**42,240**	**22,497**

	Parent		Consolidated group	
Contingent assets	**2022/23 £000**	**2021/22 £000**	**2022/23 £000**	**2021/22 £000**
Legal cases	1,707	2,522	1,707	2,522
Employee pension issues	162	-	162	-
Rates Rebates	-	-	-	251
Total contingent assets	**1,869**	**2,522**	**1,869**	**2,773**

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.

16. Commitments

16.1 Capital commitments

	Parent		Consolidated group	
	2022/23 £000	2021/22 £000	2022/23 £000	2021/22 £000
Property, plant and equipment	8,379	32,734	13,114	37,626
Total	**8,379**	**32,734**	**13,114**	**37,626**

16.2 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	
	2022/23 £000	2021/22 £000	2022/23 £000	2021/22 £000
In not more than 1 year	580,377	517,836	863,719	777,875
In more than 1 year but not more than 5 years	509,223	505,649	549,901	590,205
In more than 5 years	25,436	-	63,171	44,716
Total	**1,115,036**	**1,023,485**	**1,476,791**	**1,412,796**

In the parent account the most significant contracts relate to:

1. Delivery of administration services for Primary Care contract with Capita Business Services Ltd
2. PET Scanner contract with Alliance Medical
3. Health & Justice contract with Spectrum
4. Integrated Single Financial Environment contract with NHS SBS

Excluding the largest parent financial commitments already disclosed, the most significant other group commitments relate to:

1. a contract between NHS Banes, Swindon & Wiltshire CCG and Wiltshire Health & Care Ltd in relation to the Adult Community Services

17. Financial instruments

17.1 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.

17.1.1 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.

17.1.2 Interest rate risk

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

17.1.3 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.

17.1.4 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.

17.1.5 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.

18. Operating segments

Consolidated group 2022/23	CCGs/ICB £000	SCCL £000	Direct commissioning £000	NHS England £000	Other £000	Intra-group eliminations £000	NHS England group total £000
Income	(962,732)	(3,239,985)	(1,182,458)	(68,350)	(554,034	785,123	**(5,222,436)**
Gross expenditure	120,060,753	3,239,715	30,670,325	5,987,612	3,411,757	(785,123)	**162,585,039**
Total net expenditure	**119,098,021**	**(270)**	**29,487,867**	**5,919,262**	**2,857,723**	**-**	**157,362,603**
Reconciliation to financial performance (note 21)							
Total revenue net expenditure above and in SoCNE							157,362,603
Additional amount charged to Technical budget							1,795
Total amount charged to financial performance limits							**157,364,398**
Revenue resource expenditure							
Revenue departmental expenditure limit							157,627,035
Annually managed expenditure							11,630
Technical expenditure							(274,267)
Net expenditure for the financial year charged to financial performance limits							**157,364,398**

Consolidated group 2021/22	CCGs £000	SCCL £000	Direct commissioning £000	NHS England £000	Other £000	Intra-group eliminations £000	NHS England group total £000
Income	(658,908)	(1,480,957)	(1,290,789)	(49,033)	(636,122)	811,013	(3,304,796)
Gross expenditure	115,514,149	1,484,067	30,176,545	5,595,599	1,582,080	(811,013)	153,541,427
Total net expenditure	**114,855,241**	**3,110**	**28,885,756**	**5,546,566**	**945,958**	**-**	**150,236,631**
Revenue resource expenditure							
Revenue departmental expenditure limit							150,113,603
Annually managed expenditure							121,752
Technical expenditure							1,276
Net operating expenditure for the financial year							**150,236,631**

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:

- CCGs – clinically led groups that are responsible for commissioning healthcare services as defined in the Health and Social Care Act 2012
- ICBs – bodies that are responsible for planning most NHS services in their area including commissioning healthcare services, as defined in the Health and Care Act 2022
- SCCL – the management function for the NHS Supply Chain operating model
- Direct Commissioning – the services commissioned by NHS England 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.

19. 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 106 CCGs for 3 months (April 2022 to June 2022); plus 42 ICBs for 9 months (July 2022 to March 2023) and SCCL 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 and 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
- Health Education England
- NHS Shared Business Services (DH Equity Investment)

In addition, NHS England has had a number of significant transactions with other government departments and their agencies including HMRC, Ministry of Justice and His 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 109.

20. 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 2023 Health Education England demised. The operational activities, assets and liabilities of Health Education England were transferred in full to NHS England. This

transfer will be reflected as an absorption transfer in the NHS England parent account from that date.

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

21. Financial performance targets

The Mandate: A mandate from the government to NHS England: April 2022 to March 2023 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 and Social Care, set out NHS England's total revenue resource limit and total capital resource limit for 2022/23 and certain additional expenditure controls to which NHS England must adhere. These stem from budgetary controls that HM Treasury applies to the Department of Health and Social Care.

	2022/23 RDEL Non ringfenced £000	2022/23 RDEL Ringfenced £000	2022/23 Total RDEL £000	2022/23 Annually managed expenditure £000	2022/23 Technical £000	2022/23 Total £000	2021/22 Total £000
Mandate limit	158,521,000	288,000	158,809,000	250,000	200,000	159,259,000	151,161,000
Actual expenditure [183]	157,367,764	259,271	157,627,035	11,630	(274,267)	157,364,398	150,236,631
Surplus	**1,153,236**	**28,729**	**1,181,965**	**238,370**	**474,267**	**1,894,602**	**924,369**

Capital resource limit	2022/23 Capital departmental expenditure limit £000	2022/23 Capital annually managed expenditure £000	2022/23 Total £000	2021/22 Capital resource limit [184] £000
Limit	330,000	400	330,400	337,000
Actual expenditure [179]	275,683	-	275,683	291,417
Surplus	**54,317**	**400**	**54,717**	**45,583**

NHS England is required to spend no more than £2,011,000k of its Revenue Departmental Expenditure Limit mandate on matters relating to administration. The actual amount spent on RDEL administration matters to 31st March 2023 was £1,831,625k as set out below:

Administration limit:	2022/23 £000	2021/22 £000
Net administration costs before interest	1,841,028	1,597,217
Less:		
Administration expenditure covered by AME/Technical funding	(9,403)	(54,718)
Administration costs relating to RDEL	1,831,625	1,542,499
RDEL Administration expenditure limit	2,011,000	1,785,000
Underspend	**179,375**	**242,501**

[183] Amounts relating to dilapidation provisions on leases within the DHSC group (£1,795k) have been charged to the Technical budget rather than to capital annually managed expenditure as directed by DHSC. Total net expenditure excluding this amount is shown in note 18.
[184] The capital resource limit in 2021/22 is comparable to the 2022/23 capital departmental expenditure limit only. NHS England did not have a limit for capital annually managed expenditure in 2021/22.

The various limits of expenditure set out in the table above stem from the limits imposed by HM Treasury on the Department of Health and Social Care. 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 Department of Health and Social Care and NHS England may not therefore exceed its Departmental Expenditure Limit.

Annually Managed Expenditure is subject to budgets set by HM Treasury. Departments must manage AME closely and inform HM Treasury if they expect AME to rise above forecast. Any increase requires HM Treasury approval.

22. Entities within the consolidated group

NHS England acts as the Parent of the group comprising 106 CCGs for 3 months (April 2022 to June 2022) plus 42 ICBs for 9 months (July 2022 to March 2023), compared to 106 CCGs in 2021/22 whose accounts are consolidated within these Financial Statements.

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

NHS England acts as the Parent of SCCL whose accounts are consolidated within these financial statements. Copies of their accounts can be found on their website https://www.supplychain.nhs.uk/sccl/

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

The largest group of entities for which group accounts are drawn up and of which NHS England is a member is the DHSC.

Copies of the accounts can be obtained from the government website[185].

[185] www.gov.uk/government/publications

Appendices

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

The government's mandate to NHS England sets out the strategic direction of the organisation, describes the government's healthcare priorities and the contribution NHS England and NHS Improvement are expected to make within the allocated budget, and helps ensure the NHS is accountable to both Parliament and the public.

The 2022/23 mandate was set as NHS services and functions continued to recover from the COVID-19 pandemic. NHS England was asked to prioritise 3 key missions over the course of 2022/23 and extending beyond: the continued COVID-19 response, recovery of the health system and taking forward reform.

In addition, this was a transition year as the Health and Care Act 2022 allowed for NHS England to become legally responsible for the functions carried out by NHS Improvement, NHS Digital and Health Education England. There was also an acceleration to the move to greater partnership working through ICS and ICBs.

This assessment of delivery against the 2022/23 mandate captures our broad assurance of performance as we continue to address the impact of the pandemic and look towards recovery. This follows assessments by policy teams at NHS England and DHSC.

Objective 1: Continue to lead the NHS in managing the impact of COVID-19 on health and care

This objective focused on how NHS England should continue to lead in treating patients with COVID-19 or long COVID, delivering COVID-19 vaccinations to eligible patients and preparing for the forthcoming public inquiry into the pandemic.

In July 2022, NHS England published commissioning guidance for adult and children post-COVID-19 services (in accordance with NICE guidelines). Internal assurance returns in January 2023 demonstrated improved delivery against this guidance across all themes of care: access, assessments, rehabilitation and recovery, discharge and review, workforce and wider system support.

Since December 2021, community-based COVID-19 therapeutics have been made available for around 1.5-2.0 million highest risk patients through COVID Medicine Delivery Units (CMDUs). In addition, around 16,000 patients received a COVID-19 antiviral or nMAB treatment in hospital between October 2022 and end of March 2023

NHS England has maintained COVID-19 vaccination for millions of people in England through its booster programmes. Following the September 2022 to February 2023 launch for care homes, health and social care workers and severely immunosuppressed, 17.5 million booster vaccinations were recorded. As of March 2023, 11.5 million autumn booster COVID-19 vaccinations were recorded. A push towards co-administration has been successful, with flu and COVID co-administration significantly increased in the autumn 2023 programme.

The COVID-19 UK Public Inquiry is now 'live' and NHS England has been directly disclosing information to it. Preparatory work has largely concluded, with a year-end report provided to the Programme Board in February 2023.

Objective 2: Recover, and maintain delivery of, wider NHS services and functions

This objective focused on addressing the impact of COVID-19 on levels of demand and access to NHS services, including elective care, primary and community care, cancer care, screening and vaccination services, mental health services, community support for people with a learning disability and autistic people and dentistry services.

The key targets in the NHS's Delivery Plan for tackling the COVID-19 backlog of elective care have been met or are on track. The first milestone was met in July 2022 as we eliminated virtually all 104 week waits, while the number of people waiting over 18 months has reduced by more than 90%.

In October 2022, NHS England and DHSC published patient choice guidance to support those waiting for elective care. The My Planned Care platform was also broadened to include postcode search and waiting time information for independent sector provides to allow for easier comparison of local providers.

NHS England has addressed additional demand in primary and community care through recruiting for additional roles in general practice. As of March 2023, there were 29,103 more direct patient care roles in primary care which is 11% above target for March 2024. There are also now more GP appointments nationally than pre-pandemic.

Cancer services have continued to recover with significant progress in reducing the 62-day backlog, meeting the Faster Diagnosis Standard in February 2023 and improving the early diagnosis rate above 57%, our best proxy for clinical outcomes of improved survival.

Recovery is underway for NHS breast, bowel and screening services that were paused or had reduced uptake due to the pandemic. NHS Abdominal Aortic Aneurysm screening programmes and NHS Diabetic Eye Screening services have fully recovered from the pandemic and NHS antenatal and newborn services have remained unaffected.

In 2022/23 the NHS achieved the second highest flu vaccination rates on record, with 21.2 million people vaccinated, compared to a record 22.2 million in 2021/22.

Although there has been some recovery in mental health services, community support for people with a learning disability and autistic people and dentistry services, challenges remain with demand particularly high in these areas.

Objective 3: Renew focus on delivering against the NHS Long Term Plan and broader commitments for the NHS

This objective focused on a return to delivering the commitments outlined in the NHS Long Term Plan. It also aimed to embed partnership working through the establishment of ICSs and support timely and safe hospital discharges.

NHS England has supported ICS partners to develop place arrangements and have worked with them to develop meaningful leadership, governance, local shared plans and build sustainable improvement capability.

Discharge delays remain a key issue driven largely by capacity challenges in adult social care. The 100-Day Challenge was launched to drive improvement in discharge, using the 10 best practice initiatives identified by the Discharge Taskforce, to improve in-hospital discharge processes, and has been rolled out to community and mental health trusts.

Objective 4: Embed a population health management approach within local systems, stepping up action to prevent ill health and tackle health disparities

This objective focused on how NHS England should support NHS organisations working together with local government and others to identify and meet the needs of their communities through investment in evidence-based prevention programmes.

The NHS Digital Weight Management Programme has been successfully operational since 2021 and yielded 240,000 referrals by March 2023.

NHS England continues to ensure national and local plans are focused on health inequalities and wider determinants of health. Guidance on ICB Joint Forward Plans, published in December 2022, included a section on health inequalities, reinforcing related associated legal duties on health inequalities.

Objective 5: Ensure effective NHS leadership, culture, and use of organisational resource to realise the benefits from future structural changes within health and care

This objective focused on the leadership NHS England should give to ICBs and systems to ensure effective use of resources and a positive culture.

The first-ever NHS Long Term Workforce Plan was published in July 2023 with support from the government. Extensive stakeholder engagement was undertaken with very positive feedback overall, including from think tanks, ICSs, Royal Colleges and trade unions.

NHS England is implementing commitments in the Data Saves Lives strategy, which will increase transparency and ensure clearer public understanding of how data used across the health and care system.

The Children and Young People's Transformation Board is now well established and published the Core20PLUS5 for children and young people in December 2022, providing a framework for how ICBs can reduce health inequalities.

Finally, the ‘Creating the New NHS England Programme’ established and delivered the successful merger with NHS Digital in January 2023 and Health Education England in April 2023. To support the smooth transition of the merger, partnership arrangements with Health Education England and NHS Digital were established to enable joint planning across the 3 organisations.

Appendix 2: Meeting our Public Sector Equality Duty

The Public Sector Equality Duty (PSED)[186] is a duty of due regard. In meeting the PSED (the Equality Act 2010), NHS England hopes to drive strategic and demonstrable equality improvements by reference to the nine protected characteristics in the Equality Act 2010[187] for the people we serve, the people that we employ and in the exercise of our broader activities and functions. Detailed information on the purpose of the PSED and the Specific Equality Duties (SEDs) is provided in NHS England's Specific Equality Duties Review Report[188] (see chapter 1.2 and Appendix 1).

2022/23 was a year of major change for the NHS with the passage and implementation of the Health and Care Act 2022, the establishment of ICBs, the creation of the new NHS England and the end of a number of separate NHS statutory bodies. There was significant complexity during 2022/23 which impacted on how NHS England addressed its responsibilities under the PSED and the specific equality duties (SEDs) because of the changes to the functions of NHS England.

The review report

In May 2023, NHS England's Board considered a detailed report that assessed key progress made against the equality objectives and targets that we set for NHS England and NHS Improvement for 2022/23. The full review report 2022/23 is located on the NHS England's website.[189] This review report provides wider equality information, as of March 2023, as required by the Specific Equality Duties (SEDs). It also addresses the SED reporting requirements placed on NHS Improvement between April and June 2022 before its dissolution. This review informed the revision of our equality objectives and targets for 2023/24 and 2024/25.

Part 1 of this report explains the changing context within which the new NHS England is now functioning and what reporting is covered by this report. Part 2 provides a summary assessment of our performance against our 8 equality objectives and the associated targets set for 2022/23.

Part 3 provides broader equality information looking at NHS England's 2022/23 business plan priorities and key national equality programmes. Part 4 provides key employment statistics for 2022/23 for NHS England looking at the protected characteristics on which employment data is gathered on the NHS ESR and part 5 provides key employment statistics for April to June 2022 for NHS Improvement, prior to its merger with NHS England, again looking at the protected characteristics on which employment data is gathered on ESR.

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[186] https://www.equalityhumanrights.com/en/advice-and-guidance/public-sector-equality-duty
[187] https://www.gov.uk/discrimination-your-rights
[188] https://www.england.nhs.uk/long-read/the-review-report-equality-objectives-and-information-review-as-at-31-march-2023/#appendix-1-introduction-to-the-general-and-specific-public-sector-equality-duties
[189] https://www.england.nhs.uk/wp-content/uploads/2022/05/B1588-nhsei-equality-objectives-for-2022-2023-2023-2024.pdf

The report has 3 supporting appendices. Appendix 1 provides information of the PSED and SEDs. Appendix 2 provides information on the health inequalities duties and appendix 3 provides a list of key acronyms.

The engagement work undertaken in 2022/23

In May 2023, NHS England's Board also considered and approved the publication of an engagement report. The full engagement report 2022/23 is located on NHS England's website.[190]

This engagement report reflects on the consultation and engagement carried out by NHS England during 2022/23 to inform the development of the equality objectives and targets for 2023/24 and 2024/25. Part 1 of this report, the overview, explains the purpose of the report, how this report builds on the last report to the Board on engagement and explains with whom NHS England engaged. Part 2 identifies key themes from the engagement and how we are addressing these.

There are 3 annexes to this report. Annex A identifies overall feedback on the equality objectives and targets and some wider issues and questions beyond the scope of the PSED/SED. Annex B analyses the feedback received via a questionnaire sent to Equalities and Health Inequalities Network, a network hosted on the NHS Future website. This also provides information on the respondents. Annex C provides a condensed version of the rich feedback we received from the NHS England patient and engagement forums.

[190] https://www.england.nhs.uk/wp-content/uploads/2023/05/board-18-may-23-item-8iii-sed-report-2-engage.pdf

Appendix 3: Reducing health inequalities

Our work to reduce healthcare inequalities in 2022/23 sought to focus system efforts to narrow the gap and strengthen accountability and capability, building on learning from the pandemic.

Our strategic approach to reducing healthcare inequalities

The pandemic highlighted the urgent need to prevent and manage ill health, particularly in groups that experience the worst outcomes. To help achieve this, ICSs were asked to focus on 5 priority areas for tackling healthcare inequalities in the first half of 2021/22, continued into 2022/23:

- priority 1: Restore NHS services inclusively
- priority 2: Mitigate against digital exclusion
- priority 3: Ensure datasets are complete and timely
- priority 4: Accelerate preventative programmes that proactively engage those at greatest risk of poor health outcomes
- priority 5: Strengthen leadership and accountability

Framework for action – Core20PLUS5 approach

Core20PLUS5[191] is our approach to help reduce healthcare inequalities at both national and system level. It defines a target population comprising the most deprived 20% of the population (the Core20) and other population groups identified by local health data such as ethnic minority communities (PLUS groups). It sets out 5 clinical areas of focus:

- early cancer diagnosis (screening and early referral)
- hypertension case finding
- chronic respiratory disease (driving COVID-19 and flu vaccination uptake)
- annual health checks for people with serious mental illness
- continuity of maternity carer plans

We recruited 132 Core20PLUS ambassadors (people working in the NHS) to promote reduction of inequalities for all, particularly groups likely to experience health inequalities such as communities in deprived areas.

7 accelerator sites were launched by the Core20 PLUS Collaborative to progress the 5 clinical areas of focus with locally identified populations. The collaborative brings together strategic partners and experts to reduce and prevent health inequalities.

The Core20PLUS Connectors programme has 24 connector sites across the 7 NHS regions. We recruited 350 connectors with 50 Voluntary, Community and Social Enterprise (VCSE) or Healthwatch delivery partners to influence and engage local people on how to overcome barriers to accessing services.

[191] https://www.england.nhs.uk/about/equality/equality-hub/national-healthcare-inequalities-improvement-programme/core20plus5/

Work continues to agree Core20PLUS5 indicators and improvement goals with national clinical programmes.

Governance

The programme continues to host governance and accountability mechanisms for engaging with national, regional and local stakeholders on healthcare inequalities. Systems are in place to receive updates on the Health Inequalities Plan and its alignment with wider ICS plans in development, tackling health inequalities in urgent and emergency care, national digital channels and reviews of the whole sickle cell disease pathway. We continue to engage senior responsible owners for healthcare inequalities in ICSs and trusts to share learning and innovation.

Priority 1: Restore NHS services inclusively

We published case studies with practical actions that can be taken across the care pathway to help trusts deliver an inclusive recovery. We have published case studies[192] on board performance reporting, including waiting list data, to show how different trust types are presenting and using their data to address health inequalities. This was completed by April 2023 following a peer learning event with NHS providers and co-design with the provider public health network.

Priority 2: Mitigate against digital exclusion

The framework for NHS action on digital inclusion sets the vision for digital participation in healthcare and reflects on opportunities and risks as the system undergoes major digital transformation.

Priority 3: Ensure datasets are complete and timely

Robust data enables the NHS to understand more about the populations we serve, helping to ensure equitable access, excellent experience and optimal outcomes for all. The Health Inequalities Improvement Dashboard[193] provides insights for tackling health inequalities across our 5 priority areas in the 2023/24 planning guidance[194] and the 5 clinical areas of the Core20PLUS5 approach.

The dashboard is complemented by the priority neighbourhoods for unplanned hospitalisations dashboard, the actionable insights tool and the PCN dashboard. These are designed to drive improvement for populations with the poorest access, experiences and outcomes of healthcare.

During the year, our healthcare inequalities data tools and products were improved through quality assurance and user testing. This helped users interpret the dashboards and create strategies for improvement at ICS and PCN level for cancer and respiratory disease.

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[192] https://www.strategyunitwm.nhs.uk/publications/inclusive-elective-care-recovery
[193] https://www.england.nhs.uk/about/equality/equality-hub/national-healthcare-inequalities-improvement-programme/data-and-insight/hi-improvement-dashboard/
[194] https://www.england.nhs.uk/wp-content/uploads/2022/12/PRN00021-23-24-priorities-and-operational-planning-guidance-v1.1.pdf

Priority 4: Accelerate preventative programmes that proactively engage those at greatest risk of poor health outcomes

The Core20PLUS5 approach was adapted in November 2022 to apply to children and young people[195], defining a target population and identifying five clinical areas requiring accelerated improvement: asthma, diabetes, epilepsy, oral health and mental health.

Five new e-learning modules were launched to help implement Core20PLUS5, covering narrowing health inequalities in hypertension, early cancer diagnosis, chronic respiratory disease, maternity, and severe mental illness. The modules are available free on the Health Education England e-learning platform.[196]

A unique collaboration between the Accelerated Access Collaborative, our National Healthcare Inequalities Improvement team and academic health science networks working with their ICSs was developed to adopt and spread evidence-based innovations (medicines, medical devices, diagnostics and digital technologies) in the 5 clinical areas outlined in Core20PLUS5. 38 ICSs were selected and supported with funding to work on 39 innovation for health inequalities programme projects.

Priority 5: Strengthen leadership and accountability

In 2022, we commissioned the University College London Institute of Health Equity to review accountability mechanisms for health inequalities, undertaking an evidence synthesis and interviews with 17 system leaders and academics to better understand barriers, challenges and opportunities for holding systems to account for measurable improvements in health outcomes. The research will inform the development of practical tools, approaches and resources for accountability mechanisms for health inequalities, in line with our operating framework.

With the NHS Confederation, we co-designed webinar master classes and a board assurance tool for non-executive directors and chairs in systems and trusts, to equip them to better understand the impact of health inequalities in service delivery.

In response to the NAO report on managing NHS backlogs and waiting times[197], a draft health inequalities elective recovery data strategy was developed with the relevant data planned for publication by March 2023. The strategy includes a roadmap for engagement and routine reporting of health inequalities data across elective care workstreams.

The NHS Long Term Plan makes the case for stronger action on health inequalities to drive fairness and improved population health outcomes, and it outlined a more concerted and systematic approach to reducing health inequalities and addressing unwarranted variation in care. Our expectations for health inequalities set out in the planning guidance contribute towards a more systematic approach across the NHS. Our policy documents

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[195] https://www.england.nhs.uk/about/equality/equality-hub/national-healthcare-inequalities-improvement-programme/core20plus5/core20plus5-cyp/
[196] https://www.e-lfh.org.uk/programmes/health-inequalities/
[197] https://www.nao.org.uk/wp-content/uploads/2022/11/managing-NHS-backlogs-and-waiting-times-in-England-Report.pdf

published in 2022 and early 2023 build on this aim, including the NHS Standard Contract[198], urgent and emergency care recovery plan[199] and PCN Direct Enhanced Service for tackling neighbourhood inequalities.[200]

We continued to support and hold leaders to account through quarterly regional stocktake meetings, influencing and driving national funding for targeted health inequalities improvement and developing collaborative networks such as the emerging leaders' network. This network is aimed at clinical fellows, clinicians, allied health professionals and managers in training or developing their careers who have an interest in leadership and health inequalities.

As part of our commitment to provide strategic direction and influence action, we initiated a programme on the sickle cell disease clinical pathway to improve the quality of care and ultimately outcomes. A 'Can you tell it's sickle cell?'[201] campaign was part of a drive to improve sickle cell care across the NHS. A phase one review was completed with recommendations to improve the pathway grouped into 10 themes. A phase 2 review has begun.

We launched an e-learning course providing 'An introduction to inclusion health' with the Royal College of General Practitioners, to help people understand what inclusion health is, the factors driving social exclusion and the actions to improve access to services and care for people from inclusion health groups.

The Health Anchors Learning Network (HALN)[202], hosted with the Health Foundation and now in its second year, reached 1,600 members. We invested in 5 trusts through test and learn grants for HALN members.[203] HALN played a significant role in innovating and spreading practice, increasing the NHS's contribution and impact on social and economic development and benefiting communities, particularly those that experience inequalities.

We developed a communications and engagement toolkit[204] to improve reach into socio-economically deprived areas and worked with stakeholders to publish guidance for NHS estates and facilities staff[205] on reducing health inequalities.

To build capability for action on health inequalities, we hosted 5 Core20PLUS5 webinars, jointly delivered the Royal Society of Medicine's Tackling Inequalities Conference on 11

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198 https://www.england.nhs.uk/nhs-standard-contract/
199 https://www.england.nhs.uk/publication/delivery-plan-for-recovering-urgent-and-emergency-care-services/
200 https://www.england.nhs.uk/wp-content/uploads/2022/02/B1366-tackling-neighbourhood-health-inequalities-supplementary-guidance-v1.1.pdf
201 https://www.england.nhs.uk/blog/can-you-tell-its-sickle-cell/
202 https://haln.org.uk/
203 https://www.health.org.uk/sites/default/files/2021-09/haln_test_and_learn_grant_funding_guidance.pdf#:~:text=The%20Health%20Foundation%20and%20NHS%20England%20and%20NHS,participants%20and%20the%20wider%20health%20and%20care%20system.
204 https://future.nhs.uk/connect.ti/EHIME/view?objectId=160802853
205 https://www.england.nhs.uk/about/equality/equality-hub/national-healthcare-inequalities-improvement-programme/contacts-and-resources/building-for-health/#case-study-8

January 2023, made several educational films to raise the programme’s profile and supported 238 speaking engagements to embed action and share messages.

Appendix 4: Working in partnership with people and communities

In 2022/23, our work continued to focus on using the learning from the pandemic to support health and care services to take a more community-centred approach in how they work with people and communities.

In July 2022, we published new statutory guidance for ICBs, NHS trusts and foundation trusts on working with people and communities. This guidance aligns with the changes in the Health and Care Act 2022 and supports ICSs to develop effective approaches to working with people and communities. We set up a network of ICB engagement leads that met regularly in the year to help them embed the principles and approaches of the guidance in their systems, provide peer support and share effective practice. We worked with ICBs, Healthwatch England and other partners on the new assurance process for how ICBs apply the guidance, which forms part of the 2022/23 ICB annual assessment.

We finalised the review of the NHS England patient and public participation policy, undertaking extensive engagement with stakeholders throughout the year. The policy forms part of our established process for ensuring and assuring consideration of our duty to involve the public in commissioning (section 13Q of the NHS Act 2006 (as amended)). In March 2023, the Strategy Performance and Investment Committee considered the 'public participation dashboard', which offers an overview of practice including commentary on the section 13Q duty.

We supported and advised professionals working across health and care to ensure public participation is embedded into ways of working. This included delivery of 80 online training and learning sessions accessed by 2,900 individuals. Internally this included assuring NHS England's duty to involve the public in commissioning (section 13Q of the NHS Act 2006). Additionally, we ran our bi-annual Engagement Practitioners Network event, #StartWithPeople. More than 3,000 people signed up to attend our 3 1-day virtual events held in April 2022, November 2022 and March 2023, covering more than 80 sessions.

In March 2023, we launched our new Working with People and Communities to Improve Health Outcomes course on FutureLearn. So far more than 900 people have taken part, and the course is now available on demand, so we expect many hundreds more to do so over the next 12 months.

We have worked with ICBs throughout the year to build a strong network of those leading work with people and communities. The group supports leads in their roles to embed the statutory guidance at ICB level as well as ensuring a regular flow of communication and insight.

We continue to build our internal network of engagement and equality champions and provide them with support and resources to fulfil their role. The champions are senior leaders who promote the benefits of our approach and embed the practice of working with people and communities in their directorates and regions.

Maximising the impact of NHS volunteers and the VCSE sector

We continue to support NHS volunteers and the wider VCSE sector to undertake activities which benefit our patients and staff. This year we have seen, for example, thousands of NHS Volunteer Responders and other volunteers contribute to the smooth-running of COVID-19 vaccination sites.

The NHS Volunteer Responders programme was originally established as a COVID-19 response, delivering more than 2.5 million tasks, and attracting many new volunteers. We commissioned a development of this programme to enable volunteers to support emerging priorities across both health and social care, as well as to retain a bank of volunteers who can be activated rapidly if required in potential future emergency situations.

The VCSE sector's reach into diverse communities makes it a key partner in our drive to reduce health inequalities and we continue to work with our sector partners and with DHSC and UKHSA in the Health and Wellbeing Alliance. This enables health and care decision-makers to hear the views of communities which experience the greatest health inequalities, leading to inclusive policies and services. To strengthen the voice of VCSEs at system level we continue to support and develop the VCSE Alliances which are embedded within every ICS.

The sector's impact was particularly clear this winter when we used our existing networks with charities that work with children and families to raise awareness of the unexpected national outbreak of Group A Streptococcus and influenza among children. This included the distribution of essential health information in a range of accessible and translated formats.

The added value that the sector can bring in supporting the NHS during times of additional pressure was amplified during the pandemic. We commissioned a multi-year ambulance auxiliary contract with St John Ambulance to provide additional emergency ambulance support at times of high demand and a consortium led by British Red Cross to support people who are medically fit for discharge to receive support to return home from hospital, and provide other practical assistance, thus reducing avoidable readmissions and reducing length of hospital stay. The success of this in demonstrating the role that voluntary sector organisations can play in supporting hospital discharge led to many local areas commissioning their own home-from-hospital provision.

Looking to the future, we drew on the experience of a wide range of VCSE sector and health leaders to make it easier for people from all groups and communities to volunteer within the NHS. This NHS Volunteering Taskforce made four strategic recommendations which we will publish during 2023/24, along with our initiatives to achieve them.

Supporting PCNs to work with people and communities

The PCN people and communities workstream continued to build on the previous years' work to trial various involvement approaches through our test and learn sites. This included sharing the learning from those sites and building capacity and confidence

around using community-centred approaches. We worked with an organisation, 'Better Ways', to explore how we can build a 'connecting the connecters' network. We also worked with New Local, which is undertaking research to explore the impact of using community-centred approaches to support and develop communities at a PCN level.

We continue to learn from the work at Central Liverpool PCN.[206] With the support of CoCreate[207], it set out to develop sustainable engagement approaches to tackle racial health inequalities. The evaluation of the project[208] shares its approach and reflections from some of the clinicians involved. Morecambe Bay has also looked into how it can address local health inequalities through community engagement.[209]

Working in partnership with the National Association for Patient Participation, the Patients Association, Co-create, Healthwatch England and the NHS Confederation, we continue to use the widening participation animation[210] and a FutureNHS[211] site to support and widen the reach of the patient participation groups (PPGs). There is a particular focus on encouraging practices to understand and reach out to their whole populations, including those people they are not connected with. We created a PPG Champions Group to support and influence PPG members towards community-led approaches and created an FutureNHS space for sharing good practice.

Access to employment – supporting people with experience of homelessness into healthcare support worker (HCSW) roles

Working with Pathway[212], Groundswell[213] and the Royal Society for Public Health[214], we are addressing some of the systematic and individual barriers to employment. To achieve this, we worked with trusts to examine culture, employment practices and readiness to adopt 'trauma informed' employment practice – which can help recruit people with a lived experience of homelessness into employment as HCSWs.

By early 2022/23, across 4 trusts, 11 people were offered HCSW roles, and another trust is in the application process.

The project was a success from the trusts' perspective, with many changing their procedures. Pennine Care[215] developed a leaflet describing how it would support people and eliminated the need for complex application forms, helping people to apply with a short CV. These approaches have been shared across all the trusts involved.

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[206] https://clpcn.co.uk/tackling-racial-inequality-working-group/
[207] https://www.wearecocreate.com/
[208] https://www.wearecocreate.com/wp-content/uploads/Co-create-CLPCN-Tackling-Racial-Inequality-Engagement-Project-Evaluation-1.pdf
[209] https://www.wearecocreate.com/wp-content/uploads/Health-Inequalities-in-Morecambe-Bay-Final-Report.pdf
[210] https://www.youtube.com/watch?v=4_Y1FLMrdsw
[211] https://future.nhs.uk/PPGnetwork/grouphome
[212] https://www.pathway.org.uk/
[213] https://groundswell.org.uk/
[214] https://www.rsph.org.uk/
[215] https://www.penninecare.nhs.uk/

Based on this success, the 3 organisations involved are developing a model which could be commissioned by trusts in the future; with commitment from at least 2 trusts to have a regular cycle of recruitment for people who have experienced homelessness.

Work with young people

Through the ongoing development of the NHS Cadets[216] programme we enabled more than 3,000 14 to 18-year-olds to volunteer in health and care. NHS Cadets aims to recruit young people from deprived communities and under-represented groups. The Cadets have been developing their first aid, mental health, leadership and communication skills, and volunteering with the aim of considering a career in health and care. The programme is run in partnership with St John Ambulance.

We continued to work with the Pears #IWill Fund to embed youth volunteering in 32 NHS trusts. In May 2022 IVAR published 'The power of youth volunteering'[217] to share learning and best practice from this project with a wider audience.

We trialled a Young People's Health Challenge to inspire 7- to 14-year-olds from deprived communities and underrepresented groups to consider NHS volunteering and act as a forerunner to NHS Cadets. We worked with 195 young people across 19 pilot sites to co-develop an open access Health Challenge toolkit. This will connect local youth organisations to the NHS and help to reduce health inequalities by supporting children and their families to gain a better understanding of the NHS and of self-care. The programme is run with Barnardo's and the Royal College of Paediatrics and Child Health.

The long-established NHS Youth Forum[218] continued to meet regularly, both online and through attending two weekend residentials. Run in partnership with the British Youth Council[219], the Forum consists of 25 young people from across the country. In 2022/23, it worked on 4 youth-led projects, exploring the following themes:

- young people and health information: What do young people think of the NHS's Instagram and wider social media output? Where do young people go to find health information? And what can be done to make that information more accessible?
- barriers to accessing healthcare: How do health inequalities affect young people, and how easy is it for them to get information to help them access healthcare? What do young people think of waiting lists and their impact? And how could staff training help remove barriers to healthcare?
- NHS App and digital services: How do young people use the NHS App? What about the design of it and the user interface? How could the app be used as an appointment booking service?

[216] https://www.sja.org.uk/get-involved/young-people/nhs-cadets/
[217] https://www.ivar.org.uk/publication/the-power-of-youth-volunteering/
[218] https://www.byc.org.uk/uk/nhs-youth-forum
[219] https://www.byc.org.uk/uk/nhs-youth-forum

- improving mental health services: How do young people's experiences of mental health services differ across the country? Where are the examples of best practice? How can those services be used as models to improve mental health services across the country?

Through surveys, hundreds of other young people contributed their thoughts and ideas, culminating in further engagement at the NHS Youth Summit in February 2023. The findings and recommendations for each project will be produced as an end-report.

A Youth Advisory Network was established, advising on a wide range of topics with programme and policy leads, such as:

- managing conflict in healthcare settings
- stopping smoking and vaping
- connecting care for children, the 'Own it' project – looking at young people having ownership of their healthcare

The Young Carers Health Champion programme was established in 2015 to enable young carers to participate in planning and developing young carer friendly services aiming to support service change through young carer voices. In 2022/23 the eighth cohort of 16 young carers focused on using social media to promote the top tips for GPs and the new cluster of Systematized Nomenclature of Medicine Clinical Terms[220] codes for identifying unpaid carers of all ages.

Working in partnership with parents and carers of young people

The #Gettingthrough the First Few Days[221] (published in 2021/22) set out important information family members need when their child or young person has been admitted to a Child and Adolescent Mental Health Service (CAMHS) inpatient unit.

These guides have been highlighted in our Tier 4 CAMHS service specifications and the Royal College of Psychiatrists' quality network standards.

The guides were formally launched in June 2022 at the Royal College of Psychiatrists' Quality Network for Inpatient CAMHS and have been distributed to all inpatient units, with webinars delivered in October to address any questions relating to implementation.

Working in partnership with carers

The Commitment to Carers programme worked towards formalising and improving carer data collection and coding, essential to track progress against NHS Long Term Plan deliverables. This will feed into system learning and transformation processes. The programme continues to gain insight and strength from the biannual System Maturity Matrix assessment which for quarter 4 2022/23 included 90% of all ICSs. This gives us a

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[220] https://digital.nhs.uk/data-and-information/data-collections-and-data-sets/data-sets/mental-health-services-data-set/submission-guidance/an-introduction-to-snomed
[221] https://www.england.nhs.uk/publication/gettingthrough-the-first-few-days/

clear view of progress on the Commitment to Carers agenda across 8 component themes and is shared with our oversight group.

Engagement with the carer agenda on hospital discharge encouraged conversations and collaborative working between health, social care and voluntary sector organisations to improve outcomes for carers. Progress is being maintained around introduction of quality markers and carer champion approaches alongside resource pack and staff training initiatives. Building on our success in 2022/23 in gaining access and providing assurance for the Better Care Fund (BCF) carer narrative plans, the latest BCF policy framework and planning guidance for 2023-25 provides further opportunities to improve transparency of spend and collaborative working for the benefit of carers. The impact and reach of our Mind the Gap projects continue to gain plaudits and is building evidence of sharing best practice. Use of our FutureNHS platform (open to NHS and other organisations) is growing for all our programmes, supported by our social media work.

Working with leading national charity Carers UK in 2022/23 we gave all unpaid carers in England free access to Carers UK Digital Resource for Carers[222], an online platform hosting information and advice for carers to help them build resilience in their caring role, including a contingency planning tool. This means that staff have practical support to offer carers once they have been identified. We co-produced guidance for professionals to help them make this support offer available.

'This May Help' films

Gary Lineker, Myleene Klass and Tanni Grey-Thompson are among the 16 presenters helping raise awareness for This May Help.[223] This is a national initiative providing mental health advice to parents and carers, jointly launched by NHS England (Children and Young People's Mental Health Quality Taskforce[224] and Public Participation Team[225]) and Bradford District and Craven Health and Care Partnership.[226]

The website gives easy-to-follow advice to help families manage their child's mental health. This advice has been developed by NHS professionals and parents who have been through their own child's mental health journey. Parents and carers have shared advice that helped them and that may also help other families. Professionals who work with children are also encouraged to use the website.

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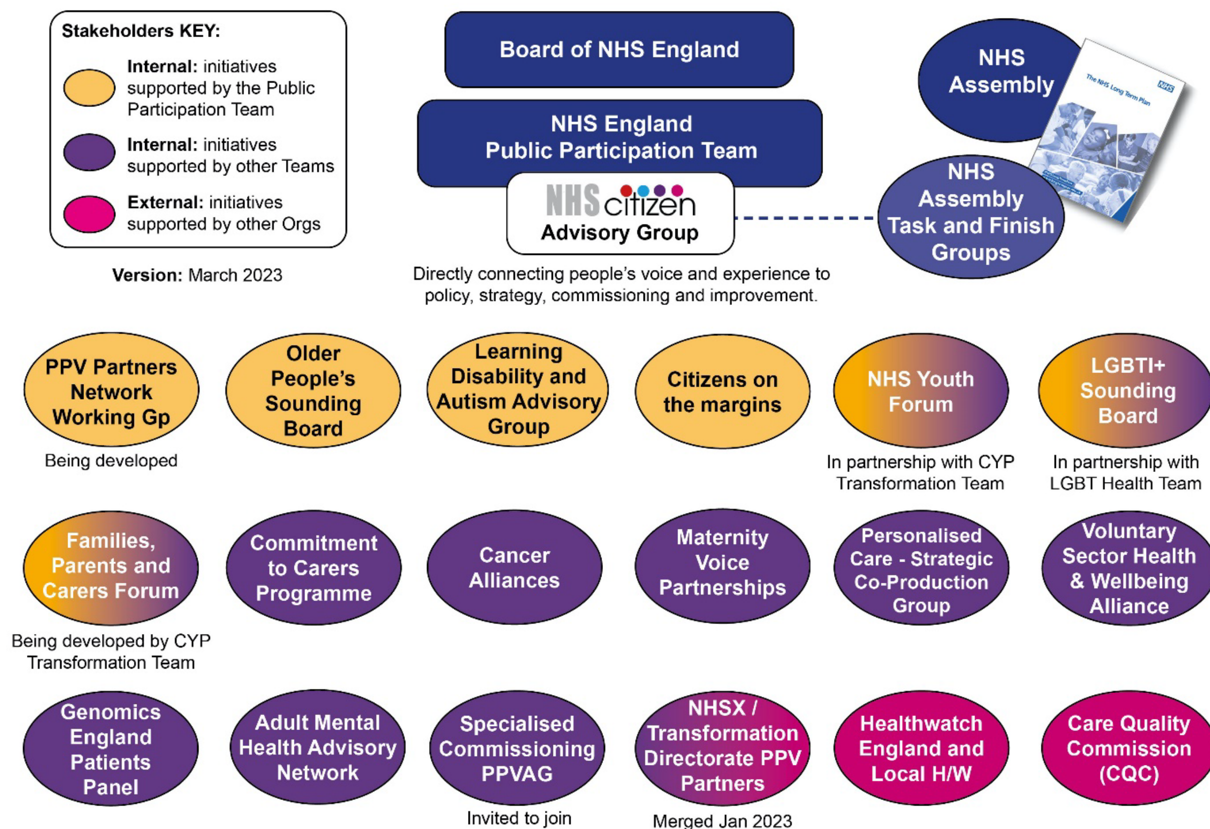
[222] https://www.carersuk.org/for-professionals/digital-products-and-services/digital-resource-for-carers/what-is-the-digital-resource-for-carers/
[223] www.thismayhelp.me/
[224] https://www.england.nhs.uk/mental-health/cyp/children-and-adolescent-mental-health-service-inpatient-services/improvement-taskforce-children-young-people/
[225] https://www.england.nhs.uk/get-involved/get-involved/
[226] https://bdcpartnership.co.uk/

Networks and forums

Across the organisation, we run a wide range of forums, advisory groups and sounding boards, involving people from different communities and health interests. These include the Learning Disability and Autism Advisory Group, the NHS Youth Forum, the Older People's Sounding Board, the LGB Sounding Board, the Adult Mental Health Advisory Network and more.

A key forum is the NHS Citizen Advisory Group (detailed in the diagram below), which brings together patient and public voice partners from across the forums. It champions appropriate, effective and meaningful participation, including identifying good practice and opportunities for improvement.



Meeting bi-monthly throughout the year, the NHS Citizen Advisory Group provided constructive challenge and feedback on areas such as NHS England's equality duties; the NHS Long Term Plan; the revised public participation policy; and engagement within mental health programmes.

Learning Disability and Autism Advisory Group and Forum

The Learning Disability and Autism Advisory Group continued to advise on changes which affect autistic people and people with a learning disability. In 2022/23 the group has advised on:

- ways that GPs can support people with a learning disability and autistic people get the healthcare they need through development of autism registers and learning disability annual health checks
- mental health services in the community and from GPs
- crisis support in the in the community

- NHS England’s equality objectives
- making conversations in primary care more compassionate (to support the reducing violence work)
- sharing GP records on the NHS App, after safeguarding issues had been raised
- shaping work to improve quality of inpatient mental healthcare

The work with the wider Learning Disability and Autism Forum was mainly through social media with examples of great practice shared during Learning Disability Week – promoting lifesaving practice and reasonable adjustments in healthcare. In Autism Awareness Week we raised awareness of work to improve health outcomes for autistic people. Several consultations were shared, accessibly, with the Forum – including the special educational needs paper, the Down Syndrome paper and the public participation guidance for ICSs. Great feedback was received about the work to promote reasonable adjustments in cancer screening during cervical screening week. Through the forum we encouraged people to talk to health staff if they had worries about cancer screening and encouraged staff to make reasonable adjustments. We also encouraged people with a learning disability to access primary care services, post-COVID-19, with an easy read newsletter.

Learning Disability Employment Programme

The Learning Disability Employment Programme was launched in 2015. In 2019, the NHS Long Term Plan committed to improving the number of supported internship opportunities in the NHS workforce for young people with a learning disability and autistic people as a key route to employment. In quarter 1 of 2022/23, we continued to encourage the development of local and national solutions to improve the equality prospects and outcomes of these young people through meaningful employment in the NHS.

One important step towards achieving this ambition was the launch of the Pan-London Supported Employment Board in June 2022. This board is co-chaired by Jane Clegg, Chief Nurse for London, and Mayor Rokhsana Fiaz, London Borough of Newham. Consisting of senior leaders from across the capital and national bodies, the board’s aim is to develop a shared, ambitious vision for London for making employment a realistic opportunity for all young people with disabilities, with a particular focus on those with learning disabilities and autistic people. During 2022/23 and beyond, the board was tasked with agreeing and setting out a 3-year strategic plan to drive this ambition.

In relation to developing supported internship programmes, critical engagement work with trusts continued in quarter 1 through our delivery partner DFN Project SEARCH to secure agreement to begin up to 38 new supported internship programmes between the autumn 2023 and 2024. This will support rebuilding opportunities for young people with a learning disability and autistic people, following the devastating impact of the pandemic.

Appendix 5: Sustainability

Scope

All reporting in this section covers NHS England, NHS Improvement and the CSUs. Each trust and ICS will have its own Green Plan and will report its sustainability performance separately. Sustainability across the wider NHS continues to be led by the Greener NHS.[227]

Summary

We continue to be committed to the Greening Government Commitments and to the Greener NHS commitment to be a net zero health service by 2040. In May, the Board approved our 2022-25 Green Plan for NHS England, which outlines the carbon reduction milestones we aim to reach as we progress to net zero. Measured from a 2017/18 baseline, we aim to achieve the following reductions in greenhouse gas emissions:

- 44% by 2025
- 80% by 2028
- net zero for the emissions we control by 2040
- net zero for the emissions we influence by 2045

Each CSU will have its own Green Plan and while their targets may vary, they will continue to be included in the figures reported in this sustainability report.

Consumption and emissions related to energy use across our corporate estate reduced this year compared with last. Levels of business travel and related emissions have increased after two years of limited travel, which has resulted in higher emissions overall. Our greenhouse gas emissions are currently below the levels we'd hoped to have by 2025 and are at a similar level to the target we aim to achieve by 2028.

We are also making good progress with moving our salary sacrifice car fleet to zero-emissions at the tailpipe and with reduced water consumption.

Areas for focus in the future include removing consumer single use plastics (CSUP) from our estate, improving the recycling rate and better provision of good quality data. We plan to include more categories in future reporting, and we are considering the inclusion of homeworking emissions and those related to commuting.

[227] https://www.england.nhs.uk/greenernhs/

Reporting for multi-occupancy buildings

We are reporting on the proportion of the NHS PS buildings occupied by NHS England and NHS Improvement and CSUs. Where we are a tenant of a government department, energy, waste and water information will be reported in its annual report and published on its respective websites.

Provision of data

NHS PS is the landlord for most NHS England and NHS Improvement and CSU offices, and we rely on it for the provision of utilities and waste data. The energy and water data provided for this financial year comes with the following guidance from NHS PS:

- all waste costs for quarter 1 2022/23 were estimated based on average tariffs
- all water usage and cost were estimated
- all electricity, gas, water, and waste were apportioned by floor area by occupant
- where utilities information was unavailable, it was estimated based on the averages for the rest of the estate

ICT waste data was unavailable for this report. Although we are unable to report on the amount of waste per category, we are confident that our processes align to the requirements of the Government's ICT and Digital Services Strategy[228]. The provision of this data for future reports remains a priority.

Mitigating climate change: working towards net zero by 2040

2021-25 GGCs headline target:

Reduce the overall greenhouse gas emissions from a 2017/18 baseline and reduce direct greenhouse gas emissions from the estate and operations from a 2017/18 baseline.

2021-25 GGC sub targets:

Reduce the emissions from domestic business flights by at least 30% from a 2017/18 baseline and report the distance travelled by international business flights.

Contextual information

	2019/20	2020/21	2021/22	2022/23
Net internal area reported in m^2	73,942	68,016	56,347	47,658
WTEs reported	15,408	15,801	16,318	18,575

[228] https://www.gov.uk/government/publications/greening-government-ict-and-digital-services-strategy-2020-2025

Greenhouse gas emissions[229]

Scope 1 emissions tCO_2e	2019/20	2020/21	2021/22	2022/23	Change from baseline
Emissions from organisation-owned fleet vehicles	243	57	14	53	
Gas	2,034	936	1,005	823	
Total Scope 1[230] (tCO_2e)	**2,277**	**993**	**1,018**	**876**	**-67%**

Scope 2 emissions tCO_2e	2019/20	2020/21	2021/22	2022/23	Change from baseline
Electricity	2,892	1,592	1,273	807	
Total Scope 2[231] (tCO_2e)	**2,892**	**1,592**	**1,273**	**807**	**-88%**

Scope 3 emissions tCO_2e	2019/20	2020/21	2021/22	2022/23	Change from baseline
Road travel	2,851	465	375	863	
Rail travel	1,418	50	162	626	
Domestic air travel	32	1	2	16	
International air travel	55	2	2	16	
Total Scope 3[232] (tCO_2e)	**4,356**	**519**	**541**	**1,522**	**-73%**
Total (tCO_2e)	**9,524**	**3,104**	**2,833**	**3,205**	**-79%**

Related use and cost

Scope 1 related use	2019/20	2020/21	2021/22	2022/23	Change from baseline
Scope 1 business travel (km)	1,346,591	364,503	83,520	301,497	-83%
Gas (kWh)	11,062,757	5,089,362	5,486,632	4,507,467	-59%
Scope 1 business travel (cost)	£367,840	£26,984	£24,044	£119,867	
Gas (cost)	£410,829	£161,714	£192,395	£202,532	

Air travel

Domestic air travel

	2019/20	2020/21	2021/22	2022/23
Number of domestic flights	913	20	40	255

International air travel

	2019/20 (km)	2020/21 (km)	2021/22 (km)	2022/23 (km)
Short Haul International Unknown	0	0	0	0
Short Haul International Economy	233,989	13,647	13,402	65,690
Short Haul International Business	444	0	0	0
Long Haul International Average	0	0	0	0
Long Haul International Economy	320,294	10,168	10,535	72,227
Long Haul International Premium Economy	0	0	0	0
Long Haul International Business	11,819	0	0	0

[229] Figures have been rounded to the nearest whole number.
[230] Scope 1 emissions arise from organisation owned and operated vehicles, plant and machinery.
[231] Scope 2 emissions arise from the consumption of purchased electricity, heat, steam and cooling.
[232] Scope 3 emissions arise from official business travel by vehicles not owned by the organisation.

	2019/20 (km)	2020/21 (km)	2021/22 (km)	2022/23 (km)
Long Haul International First	0	0	0	0
International (non-UK) Unknown	0	0	0	0
International (non-UK) Economy	0	0	0	0
International (non-UK) Premium Economy	0	0	0	0
International (non-UK) Business	0	0	0	0
International (non-UK) First	0	0	0	0

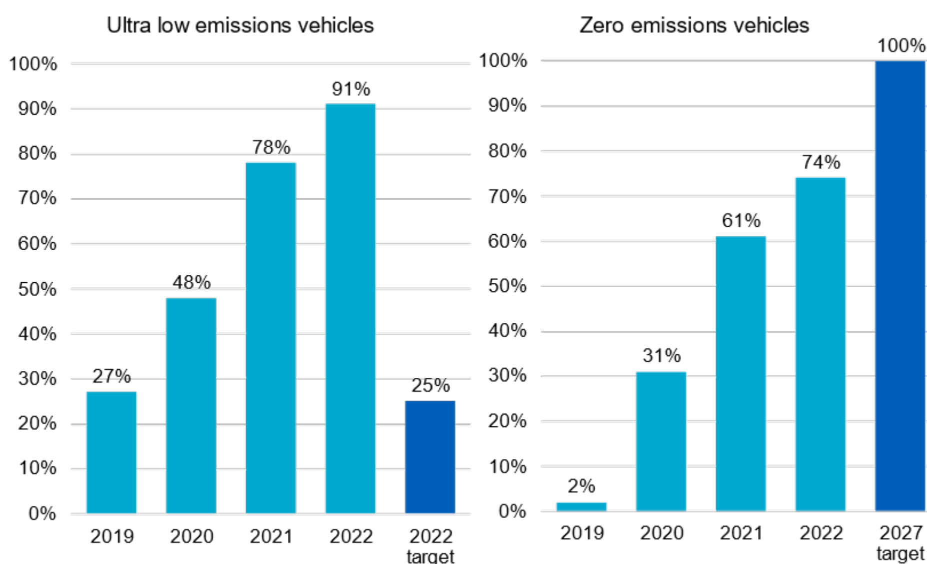
Car fleet

2021-25 GGC sub-target:

Meet the government fleet commitment for 25% of the government car fleet to be ultra-low emission vehicles[233] by 31 December 2022, and 100% of the government car and van fleet to be fully zero emission at the tailpipe by 31 December 2027. This commitment covers vehicles which are leased by employees through the employer's salary sacrifice scheme.

Vehicle emissions

We have exceeded the target for 25% of fleet vehicles to be ultra-low emissions, having met the target before 2019, and are on track for 100% of fleet vehicles to be zero emissions at the exhaust pipe by 2027.



[233] Emissions less than $50gCO_2/km$

Minimising waste and promoting resource efficiency

2021-25 GGC headline target:

Reduce the overall amount of waste generated by 15% from the 2017/18 baseline.

Sub targets:

- reduce the amount of waste going to landfill to less than 5% of overall waste
- increase the proportion of waste which is recycled to at least 70% of overall waste
- reduce government's paper use by at least 50% from a 2017/18 baseline
- remove CSUP from the central government office estate
- report on the introduction and implementation of reuse schemes

Minimising waste and promoting resource efficiency	2019/20	2020/21	2021/22	2022/23
Total (tonnes)	**1,440**	**291**	**173**	**263**
Recycled (tonnes)	1,241	177	63	153
Incinerated with heat recovery (tonnes)	190	109	110	110
Incinerated without heat recovery[234]	0	0	0	0
Landfill (tonnes)	10	6	0	0
Waste to landfill (%)	1%	2%	0%	0%
Recycling (%)	86%	61%	36%	58%
Cost of recycling[235]	Not available	Not available	£31,276	£73,552
Cost of incineration with heat recovery[236]	Not available	Not available	£73,794	£70,325
Cost of incineration without heat recovery	£0	£0	£0	£0
Cost of waste to landfill[237]	Not available	Not available	£0	£0
Total cost of waste disposal	**£199,127**	**£96,175**	**£105,070**	**£143,876**
Paper use (reams)	91,153	9,826	6,035	5,106[238]
Reduction in paper use from a 2017/18 baseline	-26%	-92%	-95%	-96%
Total (tonnes)	**1,440**	**291**	**173**	**263**
Recycled (tonnes)	1,241	177	63	153

Consumer single use plastics

We procured 106,562 items which are defined as consumer single use plastics, according to the Greening Government Commitment definition. This figure was used to estimate the number of items for CSUs; 50,882. This is the first time we have been able to report on CSUP and we will continue to report on this regularly, working with our suppliers to understand what items are being purchased and identify alternatives to reduce levels of CSUPs.

[234] This is the first year we have distinguished between waste being incinerated with and without heat recovery.
[235] Cost of waste disposal for recycling was not provided by our supplier until 2021/22
[236] Cost of waste disposal for incineration with heat recovery was not provided by our supplier until 2021/22
[237] Cost of waste disposal for waste to landfill was not provided by our supplier until 2021/22
[238] This figure has been estimated. Where figures were available, the average was used to estimate missing figures.

Reducing our water use

2021-25 GGC headline target: Reduce water consumption by at least 8% from the 2017/18 baseline, with the following sub targets:

- ensure all water consumption is measured
- provide a qualitative assessment to show what is being done to encourage the efficient use of water

Reducing our water use	2019/20	2020/21	2021/22	2022/23
Water used (m^3)	54,974	15,779	24,964	21,851
Cost of water used	£216,318	£33,518	£73,169	£63,054

Water use continues to be estimated by our head leaseholder, NHS Property Services. Over the last few years, it has worked hard to reduce the number of water suppliers from more than 25 to under 10 at the end of 2021. However, to further improve its ability to manage water supply and consumption across its estate, it is developing a procurement process to select a single national water supplier. This will provide enhanced cost and billing certainty, while improving the metering of water and developing mechanisms to reduce consumption. The selection criteria will also include key requirements around leak detection, usage reporting and net zero commitments strategy.

Based on the estimates we have been provided, water consumption has reduced by 87% from the 2017/18 baseline.

Sustainable procurement

Sustainable Procurement is championed by the Chief Sustainability Officer and the Chief Commercial Officer at a senior level. Oversight is provided by the NHS Sustainability Board.

We continue to follow the NHS Net Zero Supplier Roadmap[239] and related guidance[240], applying a mandatory minimum weighting of 10% on net zero and social value in all NHS England procurements, as well as require suppliers bidding for contracts with a value of £5 million per annum and more to have a Carbon Reduction Plan, aligned to Procurement Policy Note (PPN) 06/21[241]. Our procurement management system supports sustainability risk assessments and the implementation of the Social Value Model (PPN 06/20)[242]

We continue to encourage suppliers to use the Evergreen Sustainable Supplier Assessment[243], which is an online tool for suppliers to engage with the NHS on their

[239] https://www.england.nhs.uk/greenernhs/get-involved/suppliers/
[240] https://www.england.nhs.uk/greenernhs/publication/applying-net-zero-and-social-value-in-the-procurement-of-nhs-goods-and-services/
[241] https://www.gov.uk/government/publications/procurement-policy-note-0621-taking-account-of-carbon-reduction-plans-in-the-procurement-of-major-government-contracts
[242] https://www.gov.uk/government/publications/procurement-policy-note-0620-taking-account-of-social-value-in-the-award-of-central-government-contracts
[243] https://www.england.nhs.uk/nhs-commercial/central-commercial-function-ccf/evergreen/

sustainability journey and understand how to align with the NHS net zero and sustainability ambitions, including those set out in the NHS net zero supplier roadmap.

Reviewing policy compliance informs ongoing training needs and identifies new areas for development. Training is also provided when policy changes are introduced. A review of practice in line with the Commercial Continuous Improvement Assessment Framework also provides support to determine training need.

Adapting to climate change

Business continuity planning is used to approach the management of risks and threats to our organisation. Business continuity management identifies our priorities and prepares solutions to address disruptive threats, including those which may be the result of climate change and extreme weather events.

Reducing environmental impacts from ICT and digital.

We maintain the use of ICT equipment for as long as possible. When items become obsolete, we work with other organisations to process our ICT waste responsibly and sustainably. This may be through approved authorised treatment facilities, following waste electrical and electronic equipment regulations or using corporate recycling schemes. All partner organisations operate a zero-waste to landfill policy.

The Greener NHS national programme

The Greener NHS national programme was launched in 2020, alongside the world's first commitment for a national health service to reach net zero. This programme is important because:

- climate change threatens the public's health and impacts on the NHS's ability to deliver high quality care
- the NHS's response to climate change is set to deliver unprecedented health benefits through cleaner air, healthier diets, increased energy security and more liveable communities
- reaching net zero provides opportunities to reduce long-term running costs for the NHS
- there is staunch support from the system's 1.3 million staff, with over 9 out of 10 supporting the NHS's net zero ambitions.

The Greener NHS national programme is led by the NHS sustainability board. The programme is delivered in the way that is most appropriate and sensitive to each local context by working carefully through the NHS regions and systems.

NHS carbon footprint

The NHS has committed to reducing greenhouse gas emissions under our direct control (the NHS carbon footprint) from 6,100 $ktCO_2e$ in 2019/20 to 3,200 $ktCO_2e$ by 2028 to 2032 and to net zero by 2040. This trajectory implies a reduction to 5,000 $ktCO_2e$ in 2022/23.

Calculated emissions for 2022/23 are 4,550 $ktCO_2e$ as shown below. This data, combined with the evidence of action across the NHS as described below, suggests the NHS is on

track to meet the target trajectories for the NHS carbon footprint in the coming years, giving confidence in our ability to meet the commitments in 2028 to 32 and 2040.

These figures are based on both actual and forecasted data as at end April 2023, and may be subject to revision as final input data is published. There is therefore some uncertainty in these estimates.

Provisional estimate of the NHS carbon footprint by emissions source

($ktCO_2e$, rounded to nearest 50kt)	2022/23 emissions
NHS carbon footprint	4,550
Of which:	
Estates	2,850
Medicines	1,150
Fleet and business travel	550

This progress is supported by targeted action across the NHS, including the following areas:

Medicines

In recent years, desflurane use has fallen from 20% of all volatile anaesthetics by volume to 3%, and the January 2023 announcement to eliminate desflurane use across the NHS will bring the overall reduction in emissions from desflurane to 40 $ktCO_2e$ per year from 2024. Nitrous oxide emissions are estimated to have fallen by over 40 $ktCO_2e$ in 2022/23, driven by efforts to make more efficient use of nitrous oxide (improved supply and stock management, enhanced piping systems maintenance and audits and demand reductions where clinically appropriate).

Annual inhaler emissions have fallen by over 100 ktCO2e from 2019/20. The Impact and Investment Fund, the range of resources developed including by Asthma and Lung UK, and clinician engagement have successfully reduced the national average emissions per inhaler prescribed by more than 10% compared to last year.

Fleet and business travel

Progress is being made across the NHS towards decarbonising travel and transport. 8 ambulance trusts are trialling 21 zero-emission vehicles, 6 of which are dedicated to support mental health response, cutting emergency response times, and reducing demand on traditional double-crewed ambulances. In addition, 5 electric trucks (Heavy Goods Vehicles) are being trialled across the NHS, while London Ambulance service has procured 35 fully electric Fast Response vehicles. For the first time drones have been used to deliver vital chemotherapy to the Isle of Wight, reducing a 4-hour journey time by road and sea to a 30-minute flight, minimising wastage and treatment delays while also reducing carbon.

Estates

More than £800 million funding has been secured by NHS trusts through the Public Sector Decarbonisation Scheme which is being invested in heat pumps, solar panels, LED lighting and other energy efficiency measures, reducing NHS energy bills as well as carbon emissions. Progress will be further supported by the NHS Net Zero Buildings

Standard[244] which was published in February 2023 to become operational in October 2023, and will ensure the development of sustainable, resilient, and energy efficient buildings that meet the needs of patients now and in the future.

NHS Carbon Footprint Plus

The NHS has also committed to reducing emissions from its Carbon Footprint Plus (greenhouse gas emissions under our direct control as well as the emissions we can influence) from 25,000 ktCO_2e in 2019/20 to 6,800 ktCO_2e by 2036 to 2039 and to net zero by 2045. This trajectory implies a reduction to 22,000 ktCO_2e in 2022/23.

Estimated emissions in 2022/23 are 21,700 ktCO_2e. This modelling, combined with the evidence of action across the NHS as described below, suggests that the NHS is on track to meet the target trajectories for the NHS Carbon Footprint Plus in 2022/23.

This total is reported on a target-consistent basis to allow a like-for-like[245] comparison with the Net Zero NHS trajectory. This modelling is based on both actual and forecasted data as at end-April 2023, and may be subject to revision as final input data is processed. Emissions for much of the Carbon Footprint Plus are modelled based on spend data and hence this estimate carries some uncertainty and should be interpreted with caution. More detail of the modelling approach can be found in the 'Delivering a Net Zero NHS[246]' report.

Progress has been supported by targeted action including in the following areas.

Supply chain

Emission reductions in 2022/23 are realised principally through the adoption of a 10% weighting for net zero and social value into all tenders, work by NHS organisations to make more efficient use of supplies through local supply chains and the forthcoming requirement that suppliers of all new contracts over £5 million per annum provide a publicly available carbon reduction plan for their scope 1, 2 and a subset of scope 3 emissions, with a commitment to reach net zero by or before 2050. In 2024, this will go further, with the requirement of a carbon reduction plan being extended to all procurements, providing greater confidence in future emission savings at scale.

Clinical transformation

Meeting our net zero emission targets requires carbon reductions across all patient pathways, achieved by adopting a clinical and patient-centred approach to delivering high-quality low carbon care. This approach has ensured that new models of care such as virtual wards, the GIRFT High Volume Low Complexity and elective surgical hub programmes are considering their carbon impact and harnessing their carbon reduction potential. As the NHS continues to offer patients greater flexibility in how they receive their

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[244] https://www.england.nhs.uk/wp-content/uploads/2023/02/B1697-NHS-Net-Zero-Building-Standards-Feb-2023.pdf
[245] This approach compares emissions with the trajectories based on carbon factors and budget assumptions for the Carbon Footprint Plus consistent with the modelling underpinning the NZ report
[246] https://www.england.nhs.uk/greenernhs/wp-content/uploads/sites/51/2020/10/delivering-a-net-zero-national-health-service.pdf

care, increased access with fewer repeat trips will improve patient care while reducing travel emissions.

Supported by the NHS and respective Royal medical colleges specific net zero initiatives such as the Royal College of General Practitioners Net Zero learning hub and the Royal college of Emergency Medicine GreenED accreditation scheme are equipping the growing and engaged clinical communities to act on meeting our net zero targets.

Research

In 2022/23, the SBRI Healthcare programme, an Accelerated Access Collaborative, NHS England's programme, allocated £6 million funding to 18 ground-breaking innovation projects to advance greener innovations and support their net zero evidence generation for implementation in the NHS. Sustainability criteria were integrated in some of NHS England's wider research and innovation programmes to ensure net zero is strongly considered within all programmes and decision-making. Partnerships have now been forged with the Medical Research Council and National Institute for Health and care Research to advance environmentally sustainable research.

Workforce

In 2022/23, the NHS delivered a sharp rise in engagement in training at the intersection between climate change and health; from County Durham and Darlington NHS Trust training more than eight out of ten staff on the topic, to more 50,000 NHS staff engaging with the 'Building a Net Zero NHS' e-learning module.

Delivering a net zero NHS

The Health and Care Act 2022, introduced new legally binding duties on all NHS bodies, including NHS England, to have regard to contributing to the legally binding targets in the Climate Change Act and Environment Act.

The Greener NHS[247] national programme was launched in 2020, alongside the appointment of a Chief Sustainability Officer, to deliver the world-leading commitment of a net zero national health service. During 2022/23, the Greener NHS team – with support from across the NHS – helped to:

- publish statutory guidance on how the NHS and NHS bodies should seek to meet their net zero targets
- support all trusts and ICSs to develop their own sustainability strategies – Green Plans – to chart their course to net zero, with all trusts and ICBs appointing board-level leads to ensure they are achieved

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[247] https://www.england.nhs.uk/greenernhs/

- secure just under £1 billion in additional funding for NHS through the Public Sector Decarbonisation Scheme[248] and funding programmes focused on net zero clinical innovation and workforce training
- implement the new NHS net zero hospital standard to encourage sustainable, resilient, and energy-efficient buildings that meet the needs of patients now and in future
- launch new patient and clinical resources with Asthma and Lung UK, to help patients improve their lung health while supporting the environment by offering the choice to switch to less carbon-intensive inhalers; this along with other initiatives helped reduce national average emissions per inhaler prescribed by 16% compared to previous year
- decommission desflurane by early 2024, with support from the Association of Anaesthetists and the Royal College of Anaesthetists, which will lead to a total reduction of 40 ktCO2e per year from 2024
- implement new procurement guidance for suppliers bidding for NHS contracts above £5 million a year, requiring suppliers to produce and publish a Carbon Reduction Plan committing the supplier to achieving net zero by 2050 or sooner
- share best practice on how to set up and deliver a net zero health service, following commitments from the government, and working with the World Health Organization. At COP27 an agreement was made with the US government to align healthcare procurement to the NHS net zero supplier roadmap
- award £6 million through two phases of the Small Business Research Initiative to pioneer net zero MedTech and digital innovations for high quality, efficient and more accessible healthcare
- deliver a Healthier Futures Action Fund, to kick-start innovative initiatives to improve health and patient care, reduce inequalities, deliver value and efficiencies while supporting a more sustainable health service
- establish the Zero Emission Emergency Vehicle Pathfinder programme, resulting in a national specification for zero emission rapid response vehicles; eight ambulance trusts are trialing 21 zero-emission vehicles of several types including the new, rapid mental health community response vehicles
- trial the use of drone technology to deliver vital supplies, such as chemotherapy drugs and pathology samples, as sustainable as possible; Portsmouth Hospitals University NHS Trust and Northumbria NHS Trust participated in the project

These milestones helped the NHS reduce its carbon footprint to an estimated 4.55Mt in 2022/23, keeping us on track with the trajectories set out in the ‘Delivering a net zero NHS’ report.[249]

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[248] https://www.gov.uk/government/collections/public-sector-decarbonisation-scheme
[249] https://www.england.nhs.uk/greenernhs/publication/delivering-a-net-zero-national-health-service/

Appendix 6: Key acronyms

Acronym	Definition
ALBs	Arm's length bodies
ARAC	Audit and Risk Assurance Committee
CCG	Clinical commissioning group
CDF	Cancer Drugs Fund
CETV	Cash equivalent transfer values
CMD	Commercial Medicines Directorate
CRR	Corporate risk register
CSUP	Consumer single use plastics
CSU	Commissioning support unit
DHSC	Department of Health and Social Care
DSPT	Data Security and Protection Toolkit
EPR	Electronic Patient Record
ESM	Executive senior manager
ESR	Electronic Staff Record
FReM	Financial Reporting Manual
ICB	Integrated care board
ICO	Information Commissioner's Office
ICS	Integrated care system
IFRS	International Financial Reporting Standards
IG	Information governance
KPI	Key performance indicator
NAO	National Audit Office
NHS BSA	NHS Business Services Authority
NHS PS	NHS Property Services
NHS TDA	NHS Trust Development Authority
NICE	National Institute for Health and Care Excellence
NQB	National Quality Board
PCN	Primary care network
PCSE	Primary Care Support England
PRP	Performance-related pay
PSED	Public Sector Equality Duty
PUPOC	Previously unassessed periods of care
SARC	Sexual assault referral centre
SCCL	Supply Chain Coordination Limited
UEC	Urgent and emergency care
UKHSA	UK Health Security Agency
VCSE	Voluntary, Community and Social Enterprise
WGA	Whole of Government Accounts
WTE	Whole Time Equivalent

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