NHS Improvement

Trust Development Authority

2021/22

Annual Report

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

HC 1012

THE NHS CONSTITUTION
the NHS belongs to us all

NHS Trust Development Authority

Annual Report and Accounts 2021/22

For the period 1 April 2021 to 31 March 2022

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A view from Richard Meddings CBE, Chair

When I was appointed as Chair of NHS England in late March 2022, I was greatly humbled to be joining an NHS that was still battling one of the greatest health challenges of our time. The most affecting of the many insights shared by my predecessor, Lord David Prior, was the incredible effort and sacrifice made by NHS staff to keep the population safe in the face of the pandemic. In my first several months as Chair I have been hugely privileged to see this first hand through meeting many of our frontline staff across the country, and I thank them for their passion, dedication, and sheer hard work.

As we enter the 75th year since the founding of the NHS it is important that we reflect on our successes, while not losing sight of the very real challenges ahead. The ongoing effects of the COVID-19 pandemic continue to put pressure on services and, while many areas are delivering at higher than pre-pandemic levels, creative solutions will be required to meet increasing demand. It is also true to say the NHS entered the pandemic years already facing severe operational stresses and missing its targets in several delivery and service areas.

To give a couple of examples, an astonishing 320 million appointments were delivered by GPs and their teams in the financial year, providing a sense of the scale at which the NHS operates. However, we know that many of the public still struggle to access primary care in the way they would like. Similarly, mental health services have put a huge effort into recovery but are seeing record numbers of people, including a significant increase in young people presenting, requesting help, including more complex needs.

Add to this the demands of an ageing population and a difficult economic forecast: it is abundantly clear that the NHS must continue to be innovative, preventative, and embrace new technologies if it is to remain true to its founding principles. And it must do all of this while providing value for money to the taxpayer.

Much of how the NHS operates is challenged by its multiple and legacy technology systems and its data, with far too much paper based. Where we do have digital systems, too often they do not communicate with each other nor use common definitions. We have recently launched a procurement for a Federated Data Platform, essentially an intermediate connecting layer, which will be a significant step forward in connecting the systems and helping to drive more uniform definitional coding. The NHS is also investing significantly in increasing the functionality of the NHS App where already some 30 million of the population have activated the service.

However, the fundamental issue that the NHS faces is starkly insufficient capacity, be it workforce or beds or scanners and at the same time facing fast growing demand from a population which both grows but also ages. There also exists a significant dependency on resourcing in the social care system, where the lack of key resources in that sector directly impacts the operational ability of the NHS.

To meet these challenges locally, the NHS must adapt to the communities it serves and work more closely with local councils, the voluntary, community, and social enterprise sector, and other vital partners. In July the Health and Care Act 2022 came into effect, but much of the work was already well underway. Integrated Care Systems and their Boards have been busy establishing local relationships and gaining better insights into the particular health needs of their growing populations.

Collaborative whole-system partnerships provide an opportunity for a more efficient and joined-up approach. This in turn supports a greater focus on prevention, reducing health inequalities and improving outcomes for local populations. Integrated Care Systems must be supported towards greater devolution if we are to empower local systems to respond to local needs.

The new operating framework requires NHS England and other national bodies to change the way we interact with the system. NHS England and NHS Improvement have been working as a single organisation since 2019, fully merging in 2022. Following the instruction from the Secretary of State for Health and Social Care in November 2021, NHS England, Health Education England, and NHS Digital are now also in the final stages of coming together. A headcount reduction at the centre, and after merging these organisations, of at least 30 and up to 40 percent, will further help NHS England to reduce bureaucracy and create a leaner but still expert centre and with fewer priorities.

But, of course, we cannot achieve more for patients without the right workforce. If we are to become a more preventative, agile, and innovative system we need to make sure we have the necessary skills and cultures. If we have an insufficient workforce in size and in particular disciplines, combined with inadequate physical capacity, then the whole system is stressed and spends its time firefighting, which impacts workforce morale and the quality of care provided to patients.

The NHS must be a desirable place to work, where people feel that their expertise is valued and that they are able to do the job for which they are trained. Key to achieving this is having the right number of people in the right places: which is why NHS England has worked hand in glove with Health Education England to produce a long-term workforce plan. We look forward to its publication in the Spring. This plan considers not just how many people we will need in 5-, 10- and 15-years' time, but also what we need to do to support and retain this workforce of the future. The plan considers skill mix, changes in working practices, the impact of

technology, productivity, and a shift of provision much more towards primary care and the community and further recognises the need for a substantial increase in our workforce even to reach international averages.

The Board recognises the importance of having a long-term workforce plan in reducing the current burden on staff and we will continue to support the Government on this seminal piece of work.

In the meantime, I would again like to express on behalf of the Board our heartfelt thanks to all NHS staff as we enter our 75th year, a year in which we intend a better informed understanding of the excellent levels of service so often provided as well as the urgent focus on the areas where we are not performing well and which are under intense operational pressure. It will be a year where we continue the many reforms and innovations and changes already underway, which will improve what we do, along with improving the understanding of the basic foundational capacity we need if we are to provide a national health service for the population.

Richard Meddings CBE Chair of NHS England

About NHS Trust Development Authority

Until its abolition on 1 July 2022 and the transfer of its staff, functions and resources to NHS England, NHS Improvement was responsible for overseeing NHS foundation trusts, NHS trusts and some independent providers. We supported providers to give patients consistently safe, high quality, and responsive care within local integrated care systems (ICSs) that are financially sustainable. By holding providers to account and intervening where necessary, we helped the NHS to meet its operational goals and its longer-term strategy.

NHS Improvement was the operational name for the organisation that brought together Monitor and the NHS Trust Development Authority (NHS TDA). NHS TDA's role was to provide support, oversight and governance for NHS trusts (non-foundation) and to support other providers with a view to improving the quality and financial sustainability of NHS services

The NHS Mandate for 2021/22 brought together the annual mandate to NHS England and the annual remit for NHS Improvement. This prioritised continuing to lead the NHS response to COVID-19 and implementing the NHS Long Term Plan by focusing on transforming services.

As a custodian of the NHS Constitution, we committed to putting patients at the heart of everything we did, promoting transparency and equity while ensuring the most efficient use of public taxpayer resources.

How we operated

During 2021/22, NHS England and NHS Improvement worked together as a single organisation, which we have done since 1 April 2019. On 1 July 2022, the legal merger of NHS England and NHS Improvement took place when the Health and Care Act became law.

NHS Improvement was governed by a Board which provided strategic leadership and accountability to government, Parliament, and the public. The NHS Improvement Board was the statutory board of both Monitor and NHS TDA and was supported by committees which undertook detailed scrutiny in their respective areas of responsibility and provided it with regular reporting and formal assurance. NHS Improvement aligned and streamlined its board committee structures to work more closely with NHS England. Further details can be found from page 56.

We had a single leadership model under the overall leadership of the Chief Executive Officer (CEO) of NHS England and a single Chief Operating Officer (COO) who also served as the CEO of NHS Improvement. National directors, either reporting to the NHS England CEO or COO, operated across both organisations, and national teams provided expertise, support and intervention.

Our integrated regional teams, led by regional directors with a single reporting line to the COO, were responsible for the performance of all NHS organisations in their region in relation to

quality, finance and operational performance. They worked closely with ICSs to ensure the performance and sustainability of NHS trusts and foundation trusts were considered and supported in system-wide plans and decisions for improving health services and health outcomes for their local communities.

We supported and relied on local healthcare professionals making decisions about services in partnership with patients and local communities. NHS Improvement also worked closely with other partners, such as the Care Quality Commission and the National Institute for Health and Care Excellence (NICE) to ensure services were safe, effective and clinically and financially sustainable.

Detail on how we assured the activity of our organisation can be found from page 81.

Performance Report

Amanda Pritchard
19 January 2023

Accounting Officer

Chief Executive's overview

April 2021, the first month of the period covered by this report, was a time of real hope for many people. Thanks to the incredible success of the NHS in rolling out the first two doses of the new COVID-19 vaccines to the most at-risk groups, the acute impact of the once-in-a-century pandemic was waning, and the country was firmly on the road to opening back up after a year of restrictions.

But pandemic viruses have no respect for accounting periods. COVID-19 was, and is, still with us. We will continue to feel its effects – directly and indirectly – for years to come, with the most complex challenges only now emerging.

It is worth taking a moment to remember that over the course of financial year 2021/22, by the Government's official measure, more than 34,000 people died in England within 28 days of a positive COVID-19 test, with each of those individual lives lost touching many more.

The NHS therefore continued to operate in an extraordinary way – simultaneously working to recover from the disruption of 2020/21, while also remaining the front line of the national response to an ongoing pandemic.

An average of 5,811 people with COVID-19 were being treated by hospital teams every day during 2021/22, with two peaks of Omicron variant infections in January and March 2022 seeing significantly more inpatients requiring life-saving care. This would have been far higher were it not for the 89 million doses of COVID-19 vaccines we delivered over the year - in particular the rapid speed with which we delivered the Omicron booster campaign in December - or the new Covid Medicine Delivery Units stood up to provide effective new treatments to prevent tens of thousands of clinically vulnerable patients from deteriorating.

But just like in 2020/21 – and to a far greater degree thanks to the vaccine programme and other innovations and adaptations – the NHS was far from being a Covid-only service in 2021/22. Activity rebounded across all service areas, despite the ongoing restrictions on productivity caused by infection prevention and control measures, with a record number of people coming forward for cancer checks (a record likely to be beaten again in 2022/23), more than 15 million elective pathways completed, and 320 million GP appointments delivered.

Over the course of 2021/22 the NHS also successfully prepared for the transition to a new structure built on local partnership and collaboration through Integrated Care Systems and Boards, which was eventually gained legal status in July 2022 following a short delay in the passage of the Health and Care Act. Through the necessity of COVID-19 and the opportunity of these preparations, we have not just adjusted how we are legally organised; we have developed a new way of working together – locally, with local authorities, the voluntary sector and other partners, and nationally in the relationship between NHS England and the wider service, too.

This way of working is about recognising our respective strengths and the unique contributions we can make towards achieving our shared goal of better meeting the needs of patients and the wider communities we all serve. It is in service of this goal that, following an announcement from the Secretary of State for Health and Social Care in November 2021 and subsequent Parliamentary approval through the Health and Care Act, NHS England, NHS Digital and Health Education England began work to bring together our three organisations from April 2023 (with the legal merger of NHS England and NHS Digital since accelerated to February 2023, subject to further parliamentary approval).

Aside from the many other significant aspects of this process - including our plans to reduce the number of roles across the three organisations by a minimum of 30%, and up to 40% - it afforded an opportunity for extensive engagement with local and regional leaders over 2021/22 on how the new organisation best supports systems to deliver on their aims and objectives for improving services, which formed the basis for the first iteration of the new NHS Operating Framework published in October.

As I noted in my overview for last year's Annual Report, the historical capacity efficiency of the NHS has meant that significant levels of additional funding have been required to meet the additional demands of the pandemic. However, our ongoing commitment to living within the resources allocated by the Government and Parliament means I can again report that both NHS England as an organisation, and the wider NHS as a whole, returned a small underspend on non-ringfenced revenue funding during the financial year, as we have done for each of the past nine years, and we met all of our financial performance metrics.

The end of the 2021/22 accounting period did however see the first signs of the changing economic context which would develop further into 2022/23. Finances have been stretched as a result of rapidly increasing inflation, particularly in energy costs. The NHS has adjusted to protect frontline care, and in the Autumn Statement 2022 we now have the certainty of an improved settlement over the next two years.

As ever, none of these achievements would have been possible without the sustained herculean effort, and expertise, of the entire NHS workforce, and on behalf of everyone at NHS England I thank them once again for their individual and collective contributions. We know, however, that thanks are not going to be enough; it is part of our responsibility, alongside Government, to help tackle the issues which matter most to them. Chief among those issues is having enough people with the right skills and in the right places to be able to deliver safe, high-quality care sustainably for our growing and ageing population, now and in the years ahead.

Following a commission from the Secretary of State in January 2022, NHS England and Health Education England started work on a plan to achieve this, with expected publication in Spring 2023 following independent review of the modelling.

Of all the many imperatives that exist for the coming months and years, showing visible commitment and progress on a long term workforce plan is among the biggest – not just in practical terms, but symbolically too, as a sign to the current NHS workforce that we recognise the immense pressure they are under, and are working to ensure things will be better in the future.

NHS England is committed to doing exactly that, and to continuing our many other efforts to meet our new, shared purpose – as we come together with NHS Digital and Health Education England - to lead the NHS in England to deliver high-quality services for all by:

- Enabling local systems and providers to improve the health of their people and patients, and reduce health inequalities;
- Making the NHS a great place to work, where our people can make a difference and achieve their potential;
- Working collaboratively to ensure our healthcare workforce has the right knowledge, skills, values, and behaviours, to deliver accessible, compassionate care;
- Optimising the use of digital technology, research and innovation, and;
- Delivering value for money.

Each of these 'missions' on their own would be a significant ask for any organisation, particularly one of the size and complexity of the NHS, and we are realistic about that fact.

But the ingenuity, commitment and collaboration we continued to see over 2021/22 also allows us to approach them with optimism that, as the NHS has done for almost 75 years, we can, and we will deliver on them for our patients and the public.

Amanda Pritchard CEO of NHS England, and Accounting Officer

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].

Supported by the legislative provisions enabled by the *Health and Care Act 2022* we have developed the NHS Oversight Framework for 2022/23, which reinforces our vision for system-led delivery of integrated care. This updated framework sets out how we and the new Integrated Care Boards (ICBs) which were created on 1 July 2022, replacing Clinical Commissioning Groups (CCGs) that demised on 30 June 2022.

All ICBs, NHS trusts and foundation trusts were allocated into one of four support segments, determined by assessing the level of required support and ranged from no specific support needs (segment one) to a requirement for mandated national intensive support (segment four). These decisions have been routinely reviewed and updated throughout the year and are published on our website.

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

Performance overview

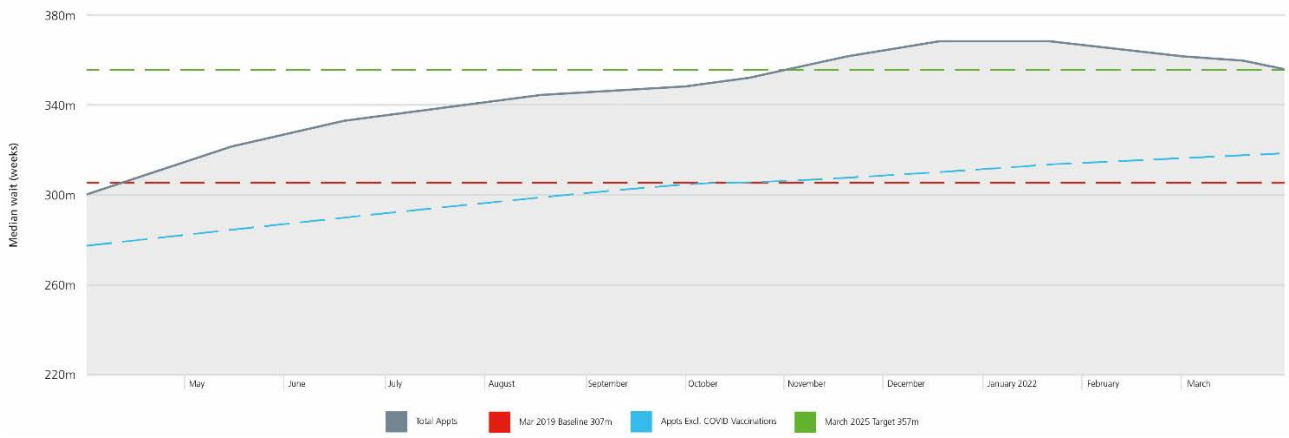
This year was the second in which the NHS managed additional demand from people seriously ill in hospital or cared for in virtual wards with COVID-19, while delivering a world class COVID-19 vaccination service, maintaining a wide range of essential services and continuing the recovery of those services hardest hit by the pandemic.

Over the course of the financial year, NHS acute hospitals admitted 275,977 people with COVID-19, with an average of 5,811 beds occupied by someone with COVID-19 per day. Thanks to the successful vaccine rollout, this is lower than the previous financial year (357,556 admissions, and an average 9,418 beds occupied by someone with COVID-19), but still high enough to put pressure on the system, with total occupancy in acute trusts above 90%.

COVID-19 booster vaccinations were offered to all eligible adults by 31 December 2021, a month ahead of the original planned milestone, and alongside the most successful flu vaccination programme in the history of the NHS.

There were 361 million appointments in primary care, of which 41 million were for COVID-19 vaccinations, exceeding pre pandemic levels even when excluding the additional activity for COVID-19 vaccinations.

12 month rolling total estimated GP appointments



Community pharmacy relieved pressure on other parts of the NHS with over 840,000 referrals from NHS 111 for urgent medicines supply and minor illness consultations.

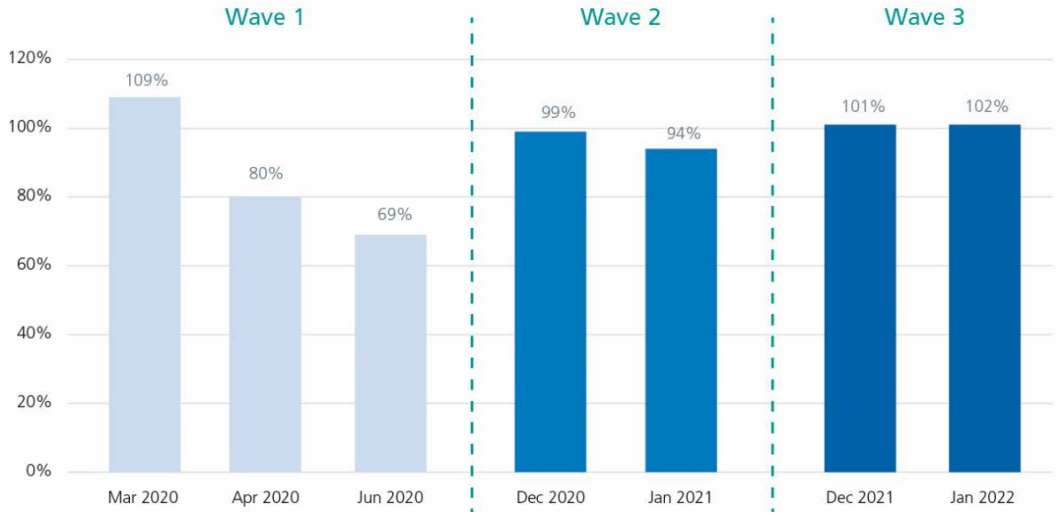
Over 600 urgent dental centres remained mobilised to ensure access to urgent care was maintained.

Unlike in 2020/21, increases in hospitalisations with COVID-19 were not accompanied with reductions in people coming forward for other emergency care to the same extent. Emergency admissions via Accident and Emergency (A&E) were 12% higher than 2020/21 and December saw a record number of the most serious ambulance call outs.

In order to address these pressures, there was a £98 million investment in NHS 111, supporting services to meet the record demand, with 7% more calls responded to than in 2020/21. There are now 185 designated Urgent Treatment Centres across England, and same-day emergency care (SDEC) services have been maximised where possible to restore them to pre-pandemic levels. Ten major capital schemes were completed, adding 382 waiting spaces, 175 major cubicles, 42 resus cubicles and 177 SDEC cubicles.

The NHS learned lessons from previous waves to ensure that periods of high COVID-19 infection rates had a lower impact on pre-planned care, meaning the reduction in elective activity in the January 2022 peak was smaller than for the April 2020 and January 2021 peaks, while the number of first cancer treatments exceeded pre-pandemic levels for the January 2022 peak.

Cancer first treatments during COVID-19 peaks relative to pre-pandemic levels



In February 2022, NHS England and NHS Improvement published the Delivery plan for tackling the COVID-19 backlog of elective care[2], the first milestone in which was to virtually eradicate waits of two years or more. At the end of March 2022, the number of patients waiting over 104 weeks in acute providers was below 15,000.

During 2021/22, a record 2,678,976 people were seen following an urgent suspected cancer referral – 12% above pre-pandemic levels. 315,549 people started cancer treatment, 93% of them within a month of a decision to treat.

The record number of people coming forward - including as a result of NHS symptom awareness campaigns - has meant some patients have waited longer for diagnostic tests than we would want. The NHS is putting in place the extra capacity needed to meet this demand, with cancer prioritised - £2.3 billion for Community Diagnostic Centres and extra endoscopy capacity - and £1.5 billion for additional treatment capacity.

[2] https://www.england.nhs.uk/coronavirus/wp-content/uploads/sites/52/2022/02/C1466-delivery-plan-for-tackling-the-covid-19-backlog-of-elective-care.pdf

In 2021/22 an additional £95 million was invested in maternity services across England, leading to an increase of nearly 1,700 full time equivalents (FTE) for midwifery and over 180 FTE obstetricians, exceeding the stated aim for the funding. Recent data confirms the achievement of the 2020 ambitions to reduce stillbirths (down from 5.1 to 3.8 per 1,000) and neonatal mortality (down from 2.0 to 1.3).[3] This means around 1,000 more babies survive each year compared to ten years ago.

An additional £500 million investment for mental health was made available to respond to pressures and continue service expansion. Many existing commitments were achieved ahead of plan, such as the roll-out of 24/7 all age mental health crisis helplines, two years ahead of schedule. 1.2 million people accessed IAPT services in 2021/22, with a recovery rate of 50.5%. The NHS continues to meet the Early Intervention in Psychosis (EIP) two-week waiting time standard, achieving 68% as of March 2022.

We have already met the commitment in the NHS Long Term Plan of 2.5 million people having received personalised care, two years ahead of the stated target, and have agreed a revised ambition that 4 million people benefit from personalised care by March 2024.

As of 31 March 2022, there were more people working in the NHS than ever before, with 30,332 more nurses towards the 50,000 manifesto commitment; 1,462 more GPs and 18,221 Additional Roles in primary care against the 6,000 and 26,000 manifesto commitments; and 5,767 more Healthcare Support Workers since January 2020.

[3] ONS Child and infant mortality in England and Wales 2020 - https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/bulletins/childhoodinfantandperinatalmortalityinenglandandwales/2020

Management and treatment of COVID-19

During 2021/22, NHS England and NHS Improvement continued to lead the UK-wide policy and access arrangements which enabled the timely rollout of new COVID-19 treatments to eligible patients. The Research to Access Pathway for Investigational Drugs for COVID-19 multi-agency collaboration has ensured that UK-wide adoption of decisions has continued to be based on the latest high quality UK and international research.

In December, alongside the already established hospital based COVID-19 treatment options, the NHS made available new cutting-edge antiviral and monoclonal antibody treatments to patients in the community through new COVID-19 Medicine Delivery Units (CMDUs). Up to March 2022, CMDUs had treated nearly 30,000 patients at highest potential risk of hospitalisation or death from COVID-19 across England. In addition to those receiving the repurposed medicine dexamethasone, a further 52,000 commissioned COVID-19 treatments were also provided to hospitalised patients with COVID-19 in England during 2021/22[4].

NHS hospital and primary care teams have continued to be at the forefront of recruitment into and delivery of clinical trials which have helped identify effective COVID-19 treatments, benefiting patients across the NHS and around the world. More than a million people have taken part in COVID-19 research in the UK. National Institute for Health and Care Research sponsored trials, including the innovate adaptive 'platform' trials such as RECOVERY, REMAP-CAP and PANORAMIC, have been pivotal in generating key evidence for mortality reduction and recovery benefits across a range of new treatments.

Better clinical understanding of the disease also enabled improvements in care for our most severely unwell patients. Treatment changed as clinicians learned more about COVID-19, so that more patients were cared for using non-invasive ventilation in general wards, rather than being sedated on a mechanical ventilator in intensive care.

The NHS rapidly implemented COVID-19 'Oximetry at home' and COVID-19 'virtual ward' models, offering supported self-management and monitoring at home for silent hypoxia (where blood oxygen levels fall without obvious symptoms) and supported discharge/alternative to admission respectively. By March 2022, over 150,000 patients were estimated to have benefited from both pathways.

Post COVID-19 assessment services were established to assess people with long-term effects of COVID-19 and direct them to effective treatment pathways, including a digital self-management platform.

[4] https://www.england.nhs.uk/statistics/statistical-work-areas/covid-therapeutics-antivirals-and-neutralising-monoclonal-antibodies/

COVID-19 vaccination deployment

As of 31 March 2022, the NHS had administered a total of 119 million doses in England with 44 million first doses, 41.5 million second doses and 32 million third doses. This extraordinary achievement, managed alongside winter pressures and the demands of treating patients with COVID-19, would not have been possible without the dedication of tens of thousands of NHS staff and volunteers, working with our local authority and community partners.

Over 250,000 staff and volunteers have been recruited throughout the lifetime of the vaccination programme and nearly 14,000 people have decided that their future lies in the NHS.

Our approach has flexed over time as local partners, working with their communities, have adapted our offer to meet the needs of communities, ensuring safe and easy access for local people. At the peak of the rollout, we had a fully-supplied network of 239 hospital hubs, 1,582 Community pharmacies, 1,080 Primary Care services and 133 vaccination centres, ensuring that over 99% of the population in England lived within 10 miles of an NHS vaccination site. We also put in place a school-based vaccination programme to offer all 12-15-year olds a COVID-19 vaccine, which was further supplemented by an out of school offer later in the year. By 18 July 2021, all adults aged 18 or over had been offered a first dose.

With the emergence of the B1.1529 Omicron variant, the NHS and partners mobilised an emergency response to ensure all eligible adults were offered a booster vaccination by 31 December 2021, bringing delivery of this planned milestone forward by a month. This incredible achievement resulted in nearly 13 million adults taking up the offer of a booster vaccination in December 2021.

The Spring Booster campaign was launched in March 2022 to top up immunity for adults aged 75 years and over, residents of older adult care homes and individuals aged 12 years and over who are immunosuppressed.

Building confidence, reducing complacency, and optimising convenience continues to sit at the heart of the programme, to maximise uptake across all communities. Local engagement and collaboration between the NHS, local authorities and voluntary, and faith sectors, as well as communities themselves, has helped us to respond to the needs of these local communities, for example, by offering mobile and pop up clinics in temples, gurdwaras, mosques, workplaces, shopping centres and sports venues, at times that work. As we prepare for an Autumn Booster programme and continue to work with community organisations to build confidence and continue to offer first, second and booster doses to those yet to come forward, we will continue to build on what we have learned, listening to communities and responding to what they tell us.

Performance analysis

Primary and community health services

General practice

General practice capacity remains a priority, supported by the £120 million General Practice COVID-19 Capacity Expansion Fund for April to September 2021. Further to this, in October NHS England published "Our plan for improving access for patients and supporting general practice"[5] alongside a new £250 million Winter Access Fund to March 2022. The aim was to improve variation in access and encourage good practice, including building referral pathways to divert appropriate patients to access the GP Community Pharmacist Consultation Service.

Rapid transformation meant that large numbers of patient contacts could be delivered virtually, including around 600,000 per week via online consultation systems, which is significantly above pre-pandemic levels and exceeds the Long Term Plan ambition.

PCNs firmly established themselves as an integral part of the primary care landscape, with 99% of practices now part of a PCN. They have played a critical part in the COVID-19 response, delivering c. 70% COVID-19 vaccinations alongside community pharmacies, while at the same time delivering the best ever flu vaccination performance (see NHS immunisations and public seasonal flu programmes on page 32). Through the Enhanced Health in Care Homes framework, PCNs – working with community services - provided enhanced clinical support to Care Homes with regular multi-disciplinary team discussions and care planning.

Social prescribing services have begun in most PCNs, with over 2,500 Social Prescribing Link Workers responding to 535,036 referrals in 2021/22.

Wider workforce numbers continue to rise, supported by the Additional Roles Reimbursement Scheme[6], with over 18,200 additional staff in place at year end compared to the March 2019 baseline. This is in line with the government commitment of delivering 26,000 additional roles in primary care by March 2024.

Continued progress has also been made towards the government's commitment for an additional 6,000 full-time equivalent doctors in general practice, with 1,462 more in March 2022 than March 2019. Targeted efforts to retain GPs in the workforce, with a specific focus on 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'[7].

[5] https://www.england.nhs.uk/coronavirus/wp-content/uploads/sites/52/2021/10/BW999-our-plan-for-improving-access-and-supporting-general-practice-oct-21.pdf
[6] https://www.england.nhs.uk/wp-content/uploads/2019/12/network-contract-des-additional-roles-reimbursement-scheme-guidance-december2019.pdf
[7] https://www.england.nhs.uk/publication/investment-and-evolution-update-to-the-gp-contract-agreement-20-21-23-24/

Building on the coaching initiatives introduced in 2020/21 - the 'Looking After You' and 'Looking After Your Team' services - a 'Looking After Your Career' coaching service was subsequently launched in 2021/22.

An evaluation conducted by the Institute of Employment Studies showed that participation in the award-winning 'Looking After You' coaching led to a significant increase in staff wellbeing and resilience. A specific 'Looking After You' pilot for Trust staff from black and minority ethnic backgrounds was successfully conducted between February and March 2021, and a coaching offer for primary care staff was successfully rolled out over the course of the year.

Community pharmacy

New services were set up at pace to support the pandemic response including the NHS Medicines Delivery Service[8] and Pharmacy Collect[9] (Lateral Flow Tests). Smaller community pharmacies continue to play an important role in ensuring COVID-19 vaccination is accessible to our more deprived and ethnic minority communities.

The Community Pharmacist Consultation Service[10] has relieved pressure on other parts of the NHS throughout the pandemic. Over 2021/22 there were 515,514 referrals from NHS 111 to community pharmacy for urgent medicines supply and 334,000 referrals for minor illness consultation as part of the NHS community pharmacist consultation service.

Community Pharmacy is also contributing to reducing health inequalities and improving access; for example, a Contraceptive Management Service pilot is ongoing aimed at expanding access for all to contraception and increasing capacity in general practice.

Key achievements supporting recovery and implementation of the NHS Long Term Plan include the launch across England of:

- a community pharmacy Hypertension Case Finding Service[11] – October 2021, with 75,052 clinical blood pressure cheeks and 2,428 Ambulatory BP Checks delivered up to end of February 2022
- a Smoking Cessation Service for patients recently discharged from acute NHS Trusts[12] – March 2022. Implementation across England planned to complete by end of March 2024 as hospital smoking cessation services mobilise.

Following the achievements of both general practice and community pharmacy in delivering the accelerated COVID-19 vaccination booster campaign, we asked that practices and PCNs

[8] https://www.england.nhs.uk/coronavirus/documents/home-delivery-of-medicines-and-appliances-during-the-covid-19-outbreak-service-specifications-and-guidance-march-2021/
[9] https://www.nhsbsa.nhs.uk/pharmacies-gp-practices-and-appliance-contractors/community-pharmacy-covid-19-lateral-flow-device-distribution-service
[10] https://www.england.nhs.uk/primary-care/pharmacy/pharmacy-integration-fund/community-pharmacist-consultation-service/
[11] https://www.england.nhs.uk/primary-care/pharmacy/pharmacy-integration-fund/nhs-community-pharmacy-bp-checks-and-hypertension-case-finding-advanced-service/
[12] https://www.england.nhs.uk/primary-care/pharmacy/pharmacy-integration-fund/nhs-smoking-cessation-transfer-of-care-pilot-from-hospital-to-community-pharmacy/

focus on three key priority areas from January to March 2022, while continuing to use their professional judgement to clinically prioritise care:

- continued delivery of general practice services, including ongoing access for urgent care with clinical prioritisation, the ongoing management of long-term conditions, suspected cancer, routine vaccination and screening, annual health checks for vulnerable patients, and tackling the backlog of deferred care events
- management of symptomatic COVID-19 patients in the community, as part of the local system approach, including supporting monitoring and access to therapeutics where clinically appropriate
- ongoing delivery of the COVID-19 vaccination programme with a focus on reaching the most vulnerable people and minimising inequalities in uptake. PCNs were asked to prioritise booster vaccination of care home residents and staff, those with underlying health conditions and carers.

Dentistry and optometry

Dentistry capacity remined constrained due to enhanced Infection Prevention Control (IPC) guidance issued by Public Health England (PHE) (now UK Health Security Agency (UKHSA)). A networked of 600 urgent dental centres remained to protect access to urgent care. The overall activity thresholds increased from 60% of contracted levels in the first half of the year to 85% by Q4, leading to observed activity rising from 67% of that contracted in April 2021 to 83% in March 2022. In January 2022 a further £50 million was available to regions to secure additional dental activity outside of contract hours focused upon those with urgent care needs and identified priority groups such as children.

Optical services were able to resume pre-COVID-19 activity levels within high street practices. However domiciliary eye care services remained challenged as access to care/nursing homes was restricted across the year. The Special School Eye Care Service Proof of Concept commenced in May 2021 to provide sight tests to children with a learning disability and/or autism in a special educational setting as detailed in the NHS Long Term Plan. As of 31 March 2022, 3,681 actual sight tests have been claimed by contractors. Of these, 3,298 (89.60%) are first time tests for the child. As a result of these tests, 1,592 (43.25%) children have been issued glasses.

Community Health Services

Community health services have provided care to people in their own homes throughout the pandemic and redeployed staff from their traditional roles to ensure care could be delivered to those most in need.

During the pandemic, community health services were asked to:

- take immediate full responsibility for discharge of all eligible patients identified by acute providers on a discharge list, as set out in the guidance for Hospital Discharge Service Requirements

- use digital technology, by default, to provide advice and support to patients remotely wherever possible
- manage local demand for services, as set out in the guidance for COVID-19 prioritisation within, and later restoration of, children's' and young peoples' community health services guidance prioritising support for high-risk individuals when advised to self-isolate for 12 weeks
- apply the principle of mutual aid with health and social care partners, as decided through their local resilience forum
- enhance levels of support for people living in care homes and in receipt of home care, working with primary care
- take a key role in leading COVID-19 vaccinations through large scale centres or with primary care network sites.

Capacity was created to support higher numbers of people admitted with COVID-19, the NHS and Local Authorities were asked to jointly focus on four specifics:

- improving support to enable more people to be cared for at home with effective, reablement and rehabilitation
- maximise the numbers given an alternative to being admitted to acute care, through remote monitoring of conditions using virtual wards and where possible the introduction/extension of hospital at home schemes
- increase the bed capacity in care centres, for those being discharged into bedded care for recovery, rehabilitation and reablement
- the actions NHS acute hospitals can take to discharge more people per day who no longer meet the reasons to reside in an acute bed and those with delays associated with internal hospital factors.

Urgent and emergency care (UEC)

The UEC Recovery 10 Point Action Plan – Implementation Guide[13] (September 2021) set out the immediate actions to be taken collectively across all parts of the health and care pathway in every ICS. It represents the first step towards full recovery from the impact of the pandemic and will be built on in 2022/23 with the development of the longer term UEC strategy.

Demand for UEC services has gradually returned throughout 2021/22, as public behaviours moved back towards normal. There were on average 66,800 A&E attendances per day in 2021/22, compared to 47,800 in 2020/21, and approximately 68,500 in 2019/20. Emergency admissions via A&E were 12% higher this past year when compared to 2020/21, and just 4% lower than in 2019/20.

The 2021/22 Winter period (defined as November through to February) was particularly pressured as services responded to the end of the Delta variant wave and the subsequent Omicron variant wave. These waves were particularly challenging for UEC services as we did

[13] https://www.england.nhs.uk/wp-content/uploads/2021/09/Urgent-and-emergency-care-recovery-10-point-action-plan.pdf

not experience the same reductions in non-COVID-19 urgent care activity that had been seen during previous waves. In February 2022, headline A&E performance reached a low point of 73.3% during this period against the 95% standard.

To support the timely admission and discharge of patients from hospital, the SAME DAY strategy was launched in early 2021. During 2021/22 a median of 39% patients were admitted as an emergency and were subsequently assessed, treated and discharged on the same day, up from 32% at the start of the pandemic. 2021/22 saw the second phase of £450 million for increasing capacity in emergency departments and SDEC units.

NHS 111 demand and activity remained high in 2021/22 seeing further year-on-year increases in demand, around 24% up on levels that would have been expected pre-pandemic. An additional £98 million of targeted funding was provided to increase capacity and resilience to respond to 7% more calls than in 2020/21.

The challenges across the UEC pathway, and particularly with patient flow and discharge, were felt most acutely by ambulance services. Despite extensive system wide and ambulance sector actions taken during 2021/22, Summer 2021 saw ambulance response times and 999 call handling times increase, with category 2[14] response times increasing significantly, linked to an unseasonal and significant rise in the time lost handing over patients to hospitals. This trend continued into Winter 2021 where ambulance services faced ongoing challenges including unprecedented demand, notably in December 2021, with a record number of ambulance call outs. Ambulances responded to 82,000 category 1 calls, an average of one every 33 seconds, and higher than any other month on record.

Conveyances to Emergency Department from ambulance services continued to remain proportionally low compared to pre-pandemic levels at 52% (compared to 57.1% in 2019/20). Support to ambulance services was provided through £55 million of funding for the second half of 2021/22. This was made available to stabilise and improve performance by delivering increased call handling and operational response capacity, additional clinical support, and to provide hospital ambulance liaison officer support for acute trusts with continued challenges in the handover of patients. By the end of March 2022, trajectories reported by ambulance services indicated that c.400 additional call handlers were in place nationally compared to Summer 2021.

[14] There are four categories of ambulance call. The details can be found on our website https://www.england.nhs.uk/urgent-emergency-care/improving-ambulance-services/arp/

Elective care

In February 2022, NHS England and NHS Improvement published the Delivery plan for tackling the COVID-19 backlog of elective care[15], which outlines a set of clear ambitions for the recovery of elective services over the next three years.

The plan details the key activities the NHS will undertake to increase the amount of elective activity through expanding capacity; ensuring care is prioritised based on clinical need; transforming services to improve productivity; embedding new models of care and technologies; and, empowering patients with the information and support they need whilst they wait. These are supported by progressive commitments to patients about the recovery of elective services.

NHS England continues to support local systems to maximise the use of and grow their workforce, minimise the impact of treating patients with COVID-19 on elective services, continue utilising the independent sector where appropriate, increase validation of referrals, and make the most effective use of the physical estate through separation of physical elective and non-elective capacity.

As at 31 March 2022, there were almost 6.4 million incomplete RTT pathways (up from 5 million in March 2021), with 62% waiting less than 18 weeks. Around 80% of the waiting list is for outpatient-based care only, with just 4% requiring overnight admission for surgery and the remainder being treated as admitted day cases. Elective activity in March 2022 (total completed pathways) was at 93% of equivalent levels in 2019/20.

Long waits

The first target in the delivery plan is that, by July 2022, no one will wait longer than two years for elective care, apart from those who choose to wait longer, and a very small number of specific highly specialised areas. At the end of March 2022, the number of patients waiting over 104 weeks in acute providers was below 15,000. Since April 2021, the NHS has treated over 400,000 patients who, if not treated, would have been waiting over two years by the end of March 2022.

Targeted Investment Fund (TIF)

The £700 million TIF was made available through the second half of the financial year planning process, with £500 million available as capital and half of this (£250 million) ringfenced for technology that enables elective recovery. As at the end of March 2022, £679.7 million had been drawn down against the fund, supporting a total of 1,020 schemes.

[15] https://www.england.nhs.uk/coronavirus/wp-content/uploads/sites/52/2022/02/C1466-delivery-plan-for-tackling-the-covid-19-backlog-of-elective-care.pdf

Good waiting list management

We have supported good waiting list management through the national clinical validation and prioritisation programme. By March 2022, 92% of the surgical waiting list and 86% of the diagnostic waiting list had a prioritisation code, supporting a clinically safe waiting list.

Work with the Independent Sector

We have worked closely with independent sector providers to maximise the capacity, by building on existing local relationships and enabling long-term contract arrangements at the local level to secure capacity.

Evidence based interventions

The Evidence Based Interventions programme provides guidance on when it is and is not appropriate to carry out specific interventions. In 2021/22 more than 800,000 interventions of limited clinical value were removed from waiting lists, so that resources are prioritised for the maximum public benefit.

Outpatient Transformation

Significant work was undertaken during 2021/22 to give patients greater control of their NHS secondary care pathway, making more efficient use of existing outpatient services and releasing clinical capacity. Interventions include telephone or video consultations, PIFU and use of specialist advice to prevent additional onward referrals. Several pilot sites have been set up to determine how existing interventions can be extended and accelerated.

Specific workstream achievements

PIFU is now being delivered across every secondary care trust across England, empowering patients to take control of their care. By February 2022, nearly 90,000 people each month were benefitting from PIFU, around 700,000 people in total throughout the year.

In line with the NHS Long Term Plan, NHS England and NHS Improvement has focussed its work in 2021/22 on supporting patient choice around the use of remote consultations. A significant part of this work has also been to start to address the recommendations of the 2021 published Equalities and Health Inequalities Impact Assessment for video consultations.

During 2021/22, the use of specialist advice[16] has continued to increase, with the projected number of requests over 3 million; a doubling compared to the previous year. Current data indicates in excess of 1.3 million fewer unnecessary outpatient attendances by the end of March 2022 as a direct result of advice and guidance, an increase of a third from the previous year.

[16] Specialist advice, encompassing A&G and referral assessment services/triage models, enables primary care clinicians to access specialist advice to help avoid unnecessary outpatient appointments in hospital settings.

Mental health

In the context of rising mental health demand and COVID-19 pressures, we worked with systems to ensure that mental health service provision, particularly face-to-face contact, was maintained where possible.

An additional £500 million investment for mental health was made available via the government's 2021/22 COVID-19 mental health and wellbeing recovery action plan[17], £330 million of which was allocated by the NHS England and NHS Improvement Mental Health programme. Systems used this funding to recover 2021/22 trajectories as far as possible.

COVID-19 became the catalyst for some existing commitments to be realised sooner than planned, including the roll-out of 24/7 all age mental health crisis lines two years ahead of schedule; and fast-tracking the expansion of Mental Health Support Teams in schools. Additionally, new services were established in response to the pandemic, including 40 mental health and wellbeing hubs for health and care staff across England.

COVID-19 continues to impact mental health through increased prevalence, acuity and complexity. While more people could access mental health support than ever before, service capacity was restricted due to staff absences, IPC requirements, and inevitable impacts on referrals.

Between April 2021 and March 2022, 674,485 children and young people (CYP) accessed support, over 160,500 above the target of 513,964. Mental Health Support Teams in schools now cover 26% of the pupil population, meaning the NHS is ahead of the original Long Term Plan commitment of 20-25% coverage by 2023/24.

Demand for CYP eating disorder services at year-end remained higher than pre-COVID-19 levels. 590 urgent cases were accepted for treatment in Q4 2021/22 compared to 353 during the same period of 2019/20, whilst 2,396 routine cases were accepted for treatment compared to 1,853 in Q4 2019/20. This increased demand had an impact on waiting times, with 64% of patients accessing treatment within four weeks (routine referrals) and 62% within one week (urgent referrals) against the 95% standard.

National coverage for 24/7 crisis provision services for CYP that cover the four minimum specified functions offered to people aged 0-18 years is 72%, ahead of the trajectory of 57% coverage target for 2021/22. Integrated adult primary and community care teams saw 182,915 people in 2021/22, exceeding the target of 126,000.

IAPT waiting time standards continued to be met, with 89.3% of people waiting less than six weeks (against a standard of 75%) for treatment and 98.4% of people waiting less than 18 weeks (against a standard of 95%). Nationally, the IAPT recovery rate was 50.5%. 1.2 million people accessed IAPT services in 2021/22, lower than the target of 1.6 million due to a

[17] https://www.gov.uk/government/publications/covid-19-mental-health-and-wellbeing-recovery-action-plan

combination of COVID-19 pressures, workforce shortfalls and interrupted referral pathways. The NHS continued its focus on advancing mental health equalities, in Quarter 1 of 2021/22 the overall IAPT recovery rate for ethnic minorities was on target for the first time.

Data for Quarter 4 shows that 227,000 people with serious mental illness received a physical health check against a target of 302,000 for 2021/22, and 19,000 people had accessed Individual Placement Support services against a target of 32,000. Specialist community perinatal mental health services saw a total of 43,550 women, which was below the target of 57,000. The NHS continues to meet the EIP two-week waiting time standard, achieving 68% as of March 2022.

Referrals to community crisis teams have risen 30% prior to pre-pandemic levels and the all age crisis lines brought-forward to respond to the pandemic are fielding around 200,000 calls per month. 100% of acute hospitals now have adult mental health liaison teams available, with 55% providing a 'core-24' offer.

Adult acute bed occupancy remains high, over the maximum safe levels of 85% as of end of year 2021/2022. Despite this the number of inappropriate out of area placements have remained broadly stable (53,575 bed days in the rolling quarter to April 2022), and the number of new people being admitted out of area has reduced to approximately 300 placements in the months to the end of 2021/22.

The 2023/24 deliverable for Rough Sleeping has already been met and our Long Term Plan target exceeded, with 22 sites receiving funding to roll-out specialist rough sleeping mental health support.

NHS England and NHS Improvement continued to work with Patient and Carers Race Equality Framework pilot trusts to improve Black, Asian and minority ethnic experiences of care. Each trust was supported to undertake community engagement with voluntary and community sector partners to explore how mental health services can provide more culturally appropriate care. The findings of this engagement will inform the Framework, which will be tested in 2022/23.

People with a learning disability and autistic people

We supported primary care to deliver learning disability Annual Health Checks to over two hundred thousand (214,622) people by the end of March 2022. This was more than seven in ten people (71.3%) compared to 73.5% in the 12 months to March 2021. We also established a pilot programme to encourage the take up of annual health checks.

We published a new Learning from lives and deaths (LeDeR) policy in March 2021, which now includes reviews of the deaths of autistic people as well as deaths of people with a learning disability. At the end of March 2022, 97% of eligible LeDeR reviews had been completed.

To support autistic people, in 2021/22 we invested one off funding that will support future improvements: £7 million for local areas to test ways to improve the quality of autism diagnostic pathways; £1.5 million supported autism training for staff working in adult mental health inpatient settings; £4 million for projects to improve the sensory environment of mental health hospitals

We asked the University of Reading to develop a sensory assessment tool for use in mental health hospitals. We commissioned the National Development Team for Inclusion to refresh the ten sensory principles and the Green Light Toolkit (resources to support good care in hospital). Work to develop a Reasonable Adjustment Digital Flag[18] in patient records is being tested in 12 pilot sites across the country to support the flag being made available across the NHS.

Throughout 2021/22, work to reduce reliance on mental health inpatient care for autistic children and young people and those with a learning disability included:

- £15 million for keyworkers for children and young people with complex needs supported 27 new keyworker services in local areas and over 1,000 children and young people
- £10 million for community support included roll out of Autism in Schools project in over 200 schools; project to identify and take action on children at particular risk of hospital admission and health-funded respite care
- to showcase innovative community services, we hosted a series of events which were accessed by over 250 health and social care professionals.

A Senior Children's Intervenor programme has enabled discharge planning for young people with complex needs and extended lengths of hospital stay.

This year, through the Children's Transformation Programme, additional funding has been allocated to source a national special educational needs and disability team to support regions and systems in meeting their responsibilities and duties for CYP with special educational needs and disability.

The number of people with a learning disability and autistic people in mental health inpatient settings continued to fall, but the pandemic impacted upon progress, particularly for adults. At the end of March 2022, there were 2,005 people with a learning disability, autism or both in a mental health inpatient setting: 200 fewer than in March 2021[19]. We invested £25 million in community health services (intensive support, forensic and crisis support) as alternatives to inpatient care.

[18] https://www.england.nhs.uk/learning-disabilities/improving-health/reasonable-adjustments/

[19] From Assuring Transformation dataset: https://digital.nhs.uk/data-and-information/data-collections-and-data-sets/data-collections/assuring-transformation/reports-from-assuring-transformation-collection

In 2021/22 we developed and delivered a Safe and Wellbeing programme to review the quality of care and plans for discharge for people with a learning disability and autistic people in mental health inpatient settings. At the end of April 2022, 99% of reviews had been completed.

We worked with partners to provide independent Care, Education and Treatment Reviews for people in long-term segregation in hospital; piloted a Senior Intervenors programme for adults; supported 250 people to have a Life Plan completed and commissioned the HOPES programme to help improve the quality of care in mental health hospitals.

More action on health inequalities and prevention of ill-health

The NHS Digital Weight Management Programme successfully launched in June 2021 and received 115,000 referrals from Primary Care and NHS Staff Self-referral in its first year. The programme, as part of the NHS Long Term Plan commitment, delivered a targeted support offer and access to weight management services in primary care for people living with obesity with a diagnosis of diabetes or hypertension. The proportion of people referred to the programme is higher in those from Black, Asian and minority ethnic communities, and the majority of referrals were from the most deprived socioeconomic groups.

Progress was made on implementing the alcohol and tobacco dependence interventions outlined in the NHS Long Term Plan, with 24 sites being established for tobacco and 10 for Alcohol Care Teams.

The Latent Tuberculosis Infection Testing and Treatment Programme continues to support CCGs and now ICBs with the greatest number of high-risk patients at increased risk of developing active tuberculosis. The Latent Tuberculosis Infection Testing and Treatment Programme has also supported the provision of screening in response to arrivals from Afghanistan and Ukraine.

Through the NHS Antimicrobial Resistance Programme, the NHS continues to work towards the UK 5 Year Antimicrobial Resistance Programme plan to reduce the rates of healthcare-associated Gram-negative Bloodstream Infections by 50% by 2024. Prescribing levels are still within the 2024 target levels, despite increased prescribing as normal activity returns following reduction due to the pandemic.

NHS Diabetes Prevention Programme

Referrals to the NHS Diabetes Prevention Programme have steadily recovered to pre-pandemic levels, and by adopting remote and digital delivery the programme has remained open and achieved 60% of the Long Term Plan target. There have now been 1 million referrals into the programme and approximately 490,000 people have joined the programme so far. Work is ongoing with systems to support recovery and further expansion of the programme to meet the Long Term Plan of 200,000 people supported on the programme each year from 2023/24.

New independent research from the University of Manchester shows that people completing the programme reduce their chances of developing Type 2 Diabetes by 37%, and that rollout of the programme across the country between 2016 and 2018 was associated with a 7% reduction in the rate of new-onset diabetes.

Non-cancer adult and young person screening

The majority of NHS Abdominal Aortic Aneurysm screening programme providers have now recovered services for people waiting to be offered screening during 2020/21, with 95% of providers fully recovered. For the NHS Diabetic Eye Screening programme, 77% of providers have fully restored to pre-pandemic provision levels for routine screening.

NHS immunisations and public seasonal flu programmes

The UK remains a world leader in uptake across many immunisation programmes, and public confidence in vaccinations remains high. In 2021/22 the NHS achieved the highest flu vaccination rates on record for the, with 22.2 million people taking up the offer of a vaccination, compared to 19.2 million in 2020/21. Improvements were seen in the over 65 years, clinical at-risk cohorts as well children, 3.8 million of whom were vaccinated by the end January 2022 compared to 3.3 million the previous year.

Coverage of the NHS school aged immunisation service (SAIS) has improved from levels reported for the 2019/20 academic year, with SAIS providers working to vaccinate those children who were missed in 2019/20 due to school closures and wider impacts of the COVID-19 pandemic alongside vaccinating the 2021/22 cohort. In the 2020/21 academic year:

- HPV vaccine coverage was: 76.7% for dose 1, in year 8 females, compared with 59.2% in 2019 to 2020
- meningococcal bacteria – A, C, W and Y (MenACWY) vaccine coverage in the local authorities where NHS England commissioned providers delivered the MenACWY vaccine to year 9 students (born between 1 September 2006 and 31 August 2007) was 76.5%, compared to 58.3% in 2019 to 2020
- Td/IPV vaccine coverage in the local authorities where NHS England commissioned providers delivered the Td/IPV vaccine to year 9 cohorts (born between 1 September 2006 and 31 August 2007) was 76.4%, compared to 57.6% in 2019 to 2020.

For routine child immunisations, measles, mumps and rubella (MMR) catch up remains a priority, a focused call/recall catch up will be delivered from July 2022. Coverage remains below the 95% target for two MMR doses evaluated at 5 years, but the decline in coverage has halted for first time since the start of pandemic.

The neonatal Bacillus Calmette-Guérin (BCG) vaccination programme was re-commissioned, and a new delivery model successfully implemented in September 2021, to avoid any baby with a suspected severe combined immunodeficiency being vaccinated with BCG.

During 2021/22, with the alignment of flu and COVID-19 vaccination programmes ensuring co-promotion and co-administration, this has led to work commencing on designing an integrated NHS vaccination service.

Maternity and neonatal services

The ambition of 20% reduction in the rate of stillbirths, neonatal deaths, maternal deaths, and serious intrapartum brain injuries from a 2010 baseline by 2020 was exceeded, down from 5.1 to 3.8 per 1,000, and neonatal mortality fell from 2.0 to 1.3 per 1,000.[20] This means around 1,000 more babies survive each year compared to ten years ago.

Throughout the pandemic, maternity services continued to provide a full range of antenatal, intrapartum and postnatal care, whilst adapting to new guidance and addressing workforce challenges as a result of COVID-19 related absence.

NHS Trusts have made progress implementing actions and learning from the interim report[21] on Shrewsbury and Telford NHS Trust in 2020. 30% of Trusts with maternity services reported that they are fully compliant with all twelve clinical priorities. 75% of Trusts were fully compliant with at least 10 of the 12 clinical priorities and working towards compliance in the remaining priority areas. For some Trusts, full compliance against these interim actions will take time as they have required additional workforce and service reconfiguration at the same time as managing the pandemic.

The final Ockenden report on Shrewsbury and Telford NHS Trust [22] published in March 2022 proposed 15 areas for national action. The NHS Chief Executive wrote[23] to Trusts asking their Boards to review the report and act, paying particular attention to the report's four pillars: safe staffing levels, a well-trained workforce, learning from incidents, and listening to families.

In 2021/22, we invested £40.8 million across 128 units and Trusts, which will help to address the varying levels of digital maturity within trusts across England and put in place the digital foundations services require.

We have commissioned 15 Maternal Medicine Networks, which will ensure specialist management and care for women with chronic and acute medical problems around pregnancy across England, tackling the biggest contributor to maternal mortality.

We have funded 14 Local Maternity Systems to implement Perinatal Pelvic Health Services to improve prevention, identification, and treatment of pelvic floor issues; at least nine further systems are due to begin as Fast Followers in 2022/23.

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[20] https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/bulletins/childhoodinfantandperinatalmortalityinenglandandwales/2020

[21] https://www.gov.uk/government/publications/ockenden-review-of-maternity-services-at-shrewsbury-and-telford-hospital-nhs-trust

[22] https://www.gov.uk/government/publications/final-report-of-the-ockenden-review

[23] https://www.england.nhs.uk/wp-content/uploads/2020/12/B1523-ockenden-final-report-letter-1-april-22.pdf

We have expanded specialist community perinatal mental health services; 33 maternal mental health services are being established for women who experience moderate to severe or complex mental health issues directly related to a trauma or loss. Our ambition is to have one in each ICS by 2024.

The Saving Babies' Lives Care Bundle Version 2[24] defines a package of good practice interventions being implemented by all Trusts including, for example, reducing smoking in pregnancy which has now fallen to the lowest rate on record[25]. Whilst COVID-19 pressures have delayed the full implementation of version 2 bundle in 2021/22, we are working with Trusts to implement all five elements and develop a further version 3 to be rolled out in 2023/24.

NHS Antenatal and newborn screening programmes

Coverage for the six ANNB programmes remained high during the year - more than 96% for all six programmes - with over 98% of new born babies and 99% of antenatal women receiving screening within the target timescales.

The NHS ANNB programme has also taken on responsibility for two in-service evaluations for the UK National Screening Committee, previously run by PHE - Non-Invasive Pre-natal Testing rollout within the Fetal Anomaly Screening Programme and the introduction of Severe Combined Immuno-Deficiency into the newborn blood spot screening programme.

Cancer

A record 2,678,976 people were seen following an urgent suspected cancer referral in 2021/22: 12% above pre-pandemic levels. 315,549 people started cancer treatment, 93% of them within a month of a decision to treat.

The NHS ran multiple phases of the 'Help Us Help You' public awareness campaigns to encourage people to come forward promptly if they have symptoms they're worried could be cancer. The NHS also partnered with Prostate Cancer UK to deliver a campaign urging men to use the charity's online risk checker. More than 550,000 men used the risk checker during the campaign and the NHS saw an all-time record number of urgent urological cancer referrals in March 2021.

The record number of people coming forward following these campaigns has meant some patients have waited longer for diagnostic tests. The NHS is putting in place the extra capacity needed to meet this demand with cancer prioritised in £2.3 billion for Community Diagnostic Centres and extra endoscopy capacity and £1.5 billion for additional treatment capacity.

[24] https://www.england.nhs.uk/wp-content/uploads/2019/03/Saving-Babies-Lives-Care-Bundle-Version-Two-Updated-Final-Version.pdf
[25] The proportion of women in England known to be smokers at the point of delivery fell from 10.4% in 19-20 to 9.6% in 2020/21

A new Faster Diagnosis framework is helping to ensure that cancer pathways run more efficiently:

- Non-symptom-specific pathways – 86 of which were live by the end of 2021/22 – are providing GPs with a route to refer people with general symptoms which could be an indication of various cancers like weight loss, fatigue or loss of appetite. Nearly 38,000 patients have been referred on these pathways so far and 1,800 cancers diagnosed.
- Seven new or refreshed best practice timed pathways have been published, providing step-by-step guides to ensuring pathways are as efficient and as speedy as possible.
- The NHS is also focusing particular attention on the more challenged pathways, with interventions such as tele-dermatology for skin cancer pathways and the increased use of faecal immunochemical test kits for triaging those with suspected bowel cancer, backed up by a £5.5 million incentive included in the GP Contract to increase use in primary care.

In March 2022 the NHS launched a public consultation on prosed new standards for cancer care as part of the clinical review of standards, which recommended simplifying the performance measures for cancer from nine to three: the Faster Diagnosis Standard (ensuring patients receive a diagnosis or ruling out of cancer within 28 days of being referred); a maximum of 62 days from referral to receiving a first definitive treatment; and, a maximum of 31 days from a decision to treat to receiving a first definitive treatment.
The outcome of the consultation is expected during 2022/23.

By March 2022, the Targeted Lung Health Checks programme was issuing 30,000 invitations a month to people who have ever smoked in disadvantaged areas with some of the highest mortality from lung cancer in the country. The programme has identified over 600 people with cancer, more than three quarters of which have been found at stage 1 or 2, compared with the overall lung cancer early diagnosis rate of 28%.

Innovation is at the core of the early diagnosis strategy. The NHS Galleri trial – the world's first and largest trial of its kind is assessing the effectiveness of a blood test devised by a company called Grail as a screening tool in asymptomatic patients and is now at the halfway stage. More than 2,000 'pill-cams' have been swallowed by patients – a camera in a pill-sized capsule swallowed that helps diagnose bowel cancer. 2,000 patients have also benefited from Cytosponge – a sponge on a string swallowed by patients looking for pre-cancerous cells in the oesophagus. The second round of an open call to fund new technology and artificial intelligence (AI) in clinical settings will see more innovations funded in 2022/23.

The first ever Under 16s Cancer Patient Experience Survey was published in 2021 and showed parents and carers gave a mean rating of 9.21 out of 10 for the overall experience of their child's care, while for the adult Cancer Patient Experience Survey results ranged between 8.2 and 9.1 out of 10. The first ever cancer patients' Quality of Life survey was also published providing vital insights into the experiences of patients living with and beyond cancer 18 months after diagnosis.

NHS cancer screening

Normal screening intervals for the cervical screening programme, designed to detect HPV, were restored by October 2020 and this standard has been maintained. The national 14-day turnaround time for screening results continues to be significantly better compared to pre-pandemic performance in 2019/20 and 2020/21.

To drive improvements in uptake, a national cervical screening campaign ran throughout February and March 2022 to encourage people to come forward for their screen as soon as possible and included headline messages on HPV screening. It was aimed at eligible women and people with a cervix, and included focused activity aimed at lesbian, gay, bisexual, transgender (LGBT+) and ethnic minority group communities to improve inequalities.

The NHS bowel cancer screening programme performed strongly throughout the year, with now only a small number of providers inviting people over the 6-week recommended target. Uptake has exceeded the expected standards while extending the programme to include 56-year olds in 2021/22 in line with Long Term Plan ambition.

The NHS breast screening programme was significantly impacted by the COVID-19 pandemic. The backlog in sending out screening invitations continues to fall and activity levels in mammography being delivered by NHS providers continues to increase.

The NHS People Plan

In July 2020, in partnership with HEE, we published the People Plan 2020/21: action for us all[26] in order to deliver the ambitions of the Long Term Plan. Alongside this, we published the NHS People Promise[27], setting out seven elements developed with thousands of colleagues across the NHS representing what matters most to them and which will make the greatest difference in improving their experience of work, aiding retention.

For 2021/22, we acted on feedback from systems and regions to prioritise a smaller number of People Plan actions, taking account of reduced capacity due to the pandemic. This made sure our collective efforts were focused on the things that would make the most difference to the workforce: supporting staff to be safe and well; ensuring their voices were heard; delivering safe staffing for the COVID-19 response and vaccination programme; and sustaining other services with greater use of innovation, technology, and new ways of working. A set of priority actions was set out in the national planning guidance, which had our strongest ever focus on people and workforce as a strategic priority.

[26] https://www.england.nhs.uk/wp-content/uploads/2020/07/We-Are-The-NHS-Action-For-All-Of-Us-FINAL-March-21.pdf
[27] https://www.england.nhs.uk/wp-content/uploads/2020/07/NHS-People-Promise.pdf

Pressure on our workforce is greater than ever, due to the cumulative impact of the pandemic and the determination to address the backlog of patients waiting to be treated. The 2021 Staff Survey (redesigned to align with the seven elements of the People Promise) showed a drop in engagement and morale.

Efforts to date have resulted in:

- 30,332 more nurses towards the 50,000 manifesto commitment (Sep 2019 - Feb 2022), including 12,062 more nurses in the past 12 months
- 1,462 more GPs and 18,221 Additional Roles in primary care against the 6,000 and 26,000 manifesto commitments (March 2022)
- 5,767 more Healthcare Support Workers since January 2020
- over 500,000 volunteers supported the national NHS pandemic response and the vaccination programme
- 4,098 people returned to work in the NHS, 1,306 of whom were employed on the vaccination programme, and at peak of the pandemic, more than 2,500 military colleagues were deployed
- Over 40,000 students, learners and trainees stepped forward to support the COVID-19 response, including nursing, midwifery and AHP students, and 3,800 final year medical students
- 23 People Promise Exemplar site trusts from all regions have been selected to implement a bundle of actions with support from national and regional teams to improve staff experience and retention
- Proportion of staff in senior leadership roles who are from a BME background is 9.2% (band 8c and above). Other senior bands also show an improvement
- 193,879 leaders enrolled for support through national leadership programmes and Graduate Management Training Scheme to date. All leadership development programmes refreshed and digital by default.

Digitally enabled care

Policy makers and commissioners continue to collaborate with clinical and technology experts on the digital transformation of health and social care across England.

During the 2021/22 period, the 'What Good Looks Like' framework was published to provide clear guidance for health and care leaders to digitise, connect and transform services safely and securely. In addition, the 'Who Pays for What' guidance was published to clarify how technology funding should be made available to the system.

Basic Shared Care Records are now available in every ICS nationwide, allowing health and care staff to view and edit the same version of a person's medical history across different settings so that they can collectively deliver safer, joined up care. Analytics teams across the NHS made improvements to enable the transfer of patient data safely across health systems and the COVID-19 data store. Developed to support the health and care system with near-

real-time data in its response to the pandemic, it delivered crucial insights to stem the spread of the disease and deliver an effective vaccine rollout.

Over 2021/22 ICSs were supported to implement population health analytics; in particular, Cheshire and Mersey ICS who built a data platform to harness health insights from 17 million citizens.

As part of a wider shift to care provision at home, progress was also made to the development of digitally enabled virtual wards. West Hertfordshire Hospitals NHS Trust was the first trust to set up their own virtual hospital, the first of its kind in the country (spurred by the pandemic). As of March 2022, a further 44 virtual wards were developed across the country, caring for over 2,500 patients. This programme was further bolstered through the recent NHS England planning guidance and accompanying funding, ensuring virtual wards continue to play a role in the NHS landscape. Working within regional ICSs, clinicians were able to remotely monitor the health and needs of approximately 200,000 people with long-term health conditions.

The NHS AI Lab has continued to work alongside other healthcare agencies to design the world's first comprehensive regulatory framework for AI in health. As a result of the pandemic, the lab established a national COVID-19 chest imaging database. As of March 2022, this database hosted over 40,000 images from more than 20 Trusts, to help researchers and developers train new AI tools to better detect and treat COVID.

The NHS App and NHS.uk continued to help people with advice support and access to services. The NHS App enabled millions of people to travel abroad and attend events more safely. Adding the NHS Covid Pass to the NHS App led it to become the most downloaded free iPhone app of 2021 and, by March 2022, the number of registered users grew to 24 million. The NHS also worked with industry partners to enable additional features within the App. By December 2021, the NHS App had been used to register 38,000 organ donation preferences, order 1.5m repeat prescriptions, and view over 11m GP records. The NHS App is just one platform of engagement with patients, the NHS website (NHS.UK) received over a billion visits in 2021.

Other key achievements include:

- to help NHS organisations digitise more quickly and cost effectively we are actively sharing best practice, with 188 blueprints (step by step guides to digital transformation)
- publication in October 2021 of the digital blueprint for the New Hospital Programme[28], setting out how digital technologies are to be designed into new hospital build initiatives
- we have supported clinical teams to transform patient care through the publication of more digital playbooks from cancer and musculoskeletal to dermatology and eyecare. These playbooks showcase proven technologies and have had over 130,000 views

[28] https://files.smartsurvey.io/2/0/KOLVQ6T1/0940__NHP_Digital_Blueprint_and_Financial_Model.pdf

- publication of a draft data strategy for health and care in 2021, setting out a clear vision and action plan to make better use of data to save lives
- we have increased access to the Electronic Prescription Service, with the first hospital now accessing the system to support remote outpatient consultations. Every provider of hospital outpatient prescribing systems can now work to add in this functionality
- we supported publication of a new standard to ensure medicines and prescriptions information is shared in a standard way across Health and Social Care to improve patient safety
- we supported the publication of the People at the Heart of Care White Paper for Adult Social Care, with a commitment to invest at least £150m in digitisation as a key enabler for reform and ensured that digital, data and technology provisions were embeded in the Government's white paper, Health and social care integration: joining up care for people, places and populations[29]
- launch of the assured supplier list for Digital Social Care Records, supporting a diverse marketplace of electronic systems that are interoperable with the NHS
- publication of simple, empowering guidance on sharing patient records safely, endorsed by the ICO and the NDG, providing clinicians with the confidence they could share data when they needed to do so
- the 'Control of Patient Information Regulations (2002)' were used to ensure information could be shared to support the COVID-19 response
- in collaboration with NHS Digital's Cyber Security Operations Centre, we have provided 24/7/365 cyber incident and response capability across 1.6m endpoints and thousands of servers across the health and care system, enabling the prevention of 5 'WannaCry-style' cyber-attacks
- for the first time ever, we provided system CEOs with key metrics so they can understand the cyber risk to their clinical services and take appropriate action to address them
- our 'Better Security, Better Care' programme has delivered direct support to care providers to comply with health and care cyber standards, resulting in care provider compliance with cyber standards going from under 10% (prior to the pandemic) to over 40% today.

Digital transformation of screening and vaccinations

We are learning from the successful delivery of all vaccination programmes in 2021/22 to ensure all section 7A programmes benefit from the data capture architecture and other digital innovations such as a national booking system.

The Transformation Directorate (which includes the former NHSX) continued to lead the digital child health strategy to secure resolution to the future of Child Health Information Services (CHIS) and to ensure integration of the planning (tripartite and with CYP team) into the immunisation data tech solutions and ANNB screening requirements.

[29] https://www.gov.uk/government/publications/health-and-social-care-integration-joining-up-care-for-people-places-and-populations

How NHS England and NHS Improvement supported the wider NHS

Emergency Preparedness, Resilience and Response (EPRR)

As in 2020/21, the response to the coronavirus pandemic was the priority through 2021/22, with national incident management arrangements stood up throughout the year. Although the COVID-19 response reduced to level 3 in March 2020 (with co-ordination moving to regional level), there was still a need to maintain a national incident infrastructure. In December 2021, a level 4 incident was again declared in response to the Omicron variant and other Winter pressures.

In January 2022, as part of preparations for a potential wave of Omicron admissions, eight Nightingale surge hubs were erected to improve NHS resilience should existing capacity be at risk from a surge in admissions. Trusts were also asked to identify areas that could be converted to accommodate patients to create up to an additional 4,000 super surge beds.

Other incidents

A significant number of other incidents occurred throughout the year, requiring incident management mechanisms to be established:

- operation Forth Bridge plans activated following the death of the Duke of Edinburgh in April 2021
- damage to the helipad at Addenbrookes hospital during the departure of a US Air Force aircraft in April 2021
- support to the G7 Leaders' summit in the South West in June 2021
- flooding at Whipps Cross Hospital (July 2021) and Queen Alexandra Hospital, Portsmouth (January 2022)
- Plymouth shootings in August 2021
- supporting the health input into the Afghan Relocations and Assistance Policy and Managed Quarantine Service setup for those travelling to England from red list countries
- impact on the NHS of increased demand for road fuel supplies in September 2021
- Coordination of potential health support following a tanker explosion in Freetown, Sierra leone in November 2021
- taxi explosion outside Liverpool Women's Hospital in November 2021, which was declared a terrorist incident
- IT disruption to the South East Coast Ambulance Service Computer Aided Dispatch system in November 2021
- impacts from a number of severe weather events including Storms Arwen, Eunice and Franklin in November 2021 and February 2022
- supporting NHS Digital and NHSX with a number of High Severity Alerts for cyber security, including the Log4J issue in December 2021
- monitoring of avian influenza cases, and response to a human case in the South West in December 2021
- declaration of critical incidents due to system pressures between January and March 2022.

An increased number of supply disruptions occurred throughout 2021/22. Field Safety Notices were issued for continuous positive airway pressure and Bilevel Positive Airway Pressure devices used by patients with Obstructive Sleep Apnoea and type 2 respiratory failure. A shortage in the supply of blood specimen collection tubes which are used for a wide range of diagnostic tests across Pathology networks. These incidents were supported by either Incident Management Teams or by the Clinical Cell providing advice on the management of the disruption and communications to those areas affected.

The UK terrorism threat level was increased to Severe following the explosion outside Liverpool Women's Hospital in November 2021. This was reduced to Substantial in February 2022.

Productivity and efficiency

Our Commercial Medicines Directorate (CMD) is aligned to the clinical priorities in the NHS Long Term Plan and supports the broader ambitions of the UK's Life Sciences Vision[30] to ensure frontline staff have access to healthcare innovation that can improve outcomes of the patients they care for. CMD's approach to delivery is set out in the NHS Commercial Framework for New Medicines.[31]

In July 2021, we announced a new Innovative Medicines Fund (IMF) to provide early access to potentially life-saving new medicines with a consultation on proposals now complete ahead of the IMF's launch in 2022/23.[32] Along with the existing £340 million Cancer Drugs Fund (CDF), which is guaranteed its current funding levels, this new £340 million initiative means from 2022/23 a total of £680 million of ringfenced NHS England funding will be available to deploy on fast-tracked drugs 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.

The CMD used the national buying power of the NHS to accelerate access to effective treatments at-scale. Most notably in November 2021, CMD concluded national agreements to enable more than 600,000 people to benefit from direct oral anticoagulants, capitalising on the opportunity to avert tens of thousands of potentially fatal cardiovascular events over the next three years.[33]

Building on activity in 2020/21, the Commercial Medicines Unit (CMU) continued to surpass savings expectations this year with over £300 million realised against reduced spend in NHS trusts. The CMU also progressed with implementation of a value-based generics strategy which includes a requirement for suppliers to hold buffer stock in the UK, improving supply

[30] https://www.gov.uk/government/publications/life-sciences-vision
[31] https://www.england.nhs.uk/publication/nhs-commercial-framework-for-new-medicines/
[32] https://www.england.nhs.uk/2021/07/nhs-england-announces-new-innovative-medicines-fund-to-fast-track-promising-new-drugs/
[33] https://www.england.nhs.uk/2021/11/thousands-spared-strokes-thanks-to-new-nhs-drug-agreements/

chain resilience and supporting clinical decision-making by enabling continued availability of first-choice treatments for patient.

The CMU also demonstrated its abilities to support the NHS respond to global supply pressures, notably with immunoglobulin (ImGo) following a worldwide fall in plasma donations due to the pandemic, whereby working with partners – including in industry – the ImGo volumes required for NHS patients were secured.

Ensuring supply of COVID-19 medicines is an ongoing priority for the CMD. Over the past year our CMU and Medicines Policy and Analysis teams, working in partnership with colleagues across the NHS, government, and industry have continued to support clinical services in their delivery of patient care and treatment.

The MPA teams have made good progress in leading the implementation of the recommendations of the independent review of overprescribing[34], with around 6.5% of all hospital admissions caused by the adverse effects of medicines, demonstrating the opportunities for improved patient care and greater utilisation of finite NHS resources.[35] Addressing overprescribing also has important implications for sustainability as medicines represent about 20% of the NHS's carbon footprint and more than half of NHS supply chain emissions.[36]

Building the structures required for a more systematic approach to medicines optimisation at all levels has also continued through the year, supporting ICSs ahead of the statutory establishment of ICBs in July 2022 to embed effective and efficient delivery for patients and taxpayers.

The CMD has expanded its commercial negotiation capabilities to conclude more pioneering agreements across pharmaceuticals and medical technologies. This investment in the team will enable CMD to build on a track-record of commercial deals that provided for patient access to new innovations, including:

- Atidarsagene autotemcel (Libmeldy®) – a life-saving gene therapy that offers the prospect of a normal life for children with metachromatic leukodystrophy[37]
- Risdiplam (Evrysdi®) – the first 'at home' oral treatment for spinal muscular atrophy (SMA) and the third new SMA treatment secured by the NHS for patients in England in less than three years[38]
- Crizanlizumab (Adakveo®) – a new first sickle cell drug in two decades, that could be used to treat thousands of people that have experienced sickle cell crises[39]

[34] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1019475/good-for-you-good-for-us-good-for-everybody.pdf
[35] https://www.gov.uk/government/news/government-pledges-to-reduce-overprescribing-of-medicines
[36] https://www.england.nhs.uk/greenernhs/a-net-zero-nhs/areas-of-focus/
[37] https://www.england.nhs.uk/2022/02/nhs-to-roll-out-life-saving-gene-therapy-for-rare-disease-affecting-babies/
[38] https://www.england.nhs.uk/2021/11/nhs-deal-on-spinal-muscular-atrophy-at-home-treatment/
[39] https://www.england.nhs.uk/2021/10/nhs-announces-deal-for-life-changing-sickle-cell-treatment/

- Pertuzumab with trastuzumab and hyaluronidase (PHESGO®) – a '5 minute' breast cancer treatment, enabling thousands of people to receive faster treatment that limits the time they need to spend in hospital[40]
- Inclisiran (Leqvio®) – a world-leading population health deal secured the 'cholesterol-busting jab' for NHS patients, creating an opportunity to save thousands of lives over the decade[41]
- Sotorasib (Lumykras®) – a first in Europe early access deal that enabled NHS patients with certain lung cancers to receive the first drug to target the so called 'death star' mutation.[42]

Research and innovation

NHS England continues 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 through its work. It is hosted by the Innovation, Research and Life Sciences (IRLS) team within NHS England and brings together key partners from across government, charities, NHS and industry.

The NHS has a strong track-record of supporting the adoption of proven innovation to increase capacity and improve patient outcomes and over 2 million patients have benefited from IRLS and AAC programmes to date.

Over the last year, we have:

- helped patients spend over 10,300 fewer days in hospital
- supported over 3,000 innovations, across 287 sites
- helped over 2,800 innovators, including over 171 NHS staff as part of the NHS Clinical Entrepreneurs Programme (over 700 people since the programme started)
- saved the NHS over £18 million.

During 2021/22 over 1.1 million people took part in research, with COVID-19 research continuing and research into other conditions building back. In 2020/21 100% of all NHS Trusts in England and 50% of GP practices were research active[43].

Our innovation programmes are focussed on priority clinical areas, including prevention and treatment of cardiovascular disease and diabetes; addressing health inequalities; and moving towards 'net zero'. Specific commitments around innovation were delivered, including:

- launching the MedTech Funding Mandate[44] to support the adoption of proven medical devices, diagnostics, and digital products
- the beta launch of the NHS Innovation Service, providing a single point of access for the support needed from AAC partner organisations to develop and launch innovations

[40] https://www.england.nhs.uk/2021/04/thousands-of-patients-set-to-benefit-from-five-minute-breast-cancer-treatment-2/
[41] https://www.england.nhs.uk/2021/09/nhs-cholesterol-busting-jab-to-save-thousands-of-lives/
[42] https://www.england.nhs.uk/2021/09/lung-cancer-patients-to-get-breakthrough-drug-on-nhs/
[43] NIHR Clinical Research Network High Level Objectives Outturn Report 2020/21
[44] https://www.england.nhs.uk/aac/what-we-do/how-can-the-aac-help-me/the-medtech-funding-mandate/

- delivering the AAC Rapid Uptake Product[45] programme, which supported the accelerated uptake of several areas of innovation, that, despite approval from the NICE, have had lower-than-expected uptake in the NHS. The programme identifies what the specific barriers are to their uptake and identifies the solutions to remove them to form bespoke packages of support for each innovative product.

Delivering a net zero National Health Service

In 2020, the NHS became the world's first national health service to commit to net zero and charted a course which will result in both direct and indirect improvements to people's health and patient care.

Alongside other direct actions, over the first year of delivering a Greener NHS:

- the NHS launched the world's first zero emission ambulance at the 26th United Nations Climate Change Conference (COP26)
- 15 key suppliers, with combined emissions larger than many developed national economies, collaborated with the NHS to match our 2045 net zero commitment
- over £310 million of capital from the NHS Energy Efficiency Fund and the Public Sector Decarbonisation Scheme was invested in renewable energy generation, energy efficiency measures, and lighting
- the Chief Sustainability Officer's clinical fellowship scheme was launched, to embed sustainability at the heart of clinical leadership
- a total of £1 million was awarded to 10 pioneering net zero MedTech and Digital Innovations to support high quality, efficient, and more accessible healthcare
- a 10% carbon weighting was embedded into the tendering criteria of all future procurement decisions
- 100% of Trusts developed their own strategies to chart their course to net zero, with almost all Trusts appointing board level leads to ensure the delivery of these plans
- the number of Trusts using 100% renewable certified energy increased to 124
- in response to a survey in August 2021, over nine out of 10 staff clearly stated their support for the' net zero commitments.

The NHS successfully delivered this ambitious and world leading programme of work to save over 1.2 million tonnes of carbon, significantly exceeding the requirement outlined in the Climate Change Act for a 51% reduction by 2025, and ensures that we remain on track against the trajectories set out within our October 2020 publication, *Delivering a Net Zero NHS*[46].

[45] https://www.england.nhs.uk/aac/what-we-do/what-innovations-do-we-support/rapid-uptake-products/
[46] Report: NHS England (2020) *Delivering a Net Zero National Health Service*. Available at https://www.england.nhs.uk/greenernhs/a-net-zero-nhs/

Reducing health inequalities

NHS England and NHS Improvement has undertaken a range of work to reduce health inequalities in 2021/22, particularly to bring focus to system efforts and strengthen accountability and capability, building on learning from the COVID-19 pandemic.

Our strategic approach to reducing healthcare inequalities

Priorities for tackling healthcare inequalities

The COVID-19 pandemic highlighted the urgent need to prevent and manage ill health, particularly in groups that experience the worst outcomes. To help achieve this, in August 2020, we issued guidance as part of our phase three response to the pandemic, setting out eight urgent actions for tackling healthcare inequalities.

Systems were subsequently asked to focus on five priority areas for tackling healthcare inequalities in the first half of 2021/22, distilled from the eight urgent actions:

- 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

In November 2021, we launched Core20PLUS5, an approach to support reductions in healthcare inequalities at both national and system level. The approach defines a target population comprising the most deprived 20% of the population of England (the Core20), and other population groups identified by local population health data such as ethnic minority communities (PLUS groups). It sets out five clinical area of focus:

1. early cancer diagnosis (screening and early referral)
2. hypertension case finding
3. chronic respiratory disease (driving COVID-19 and flu vaccination uptake)
4. annual health checks for people with serious mental illness
5. continuity of maternity carer plans.

We have mobilised the Core20PLUS5 approach across the NHS, running over 20 stakeholder focus groups and a range of introductory engagement sessions with audiences across the NHS and wider partners, including public health teams, local authorities, and voluntary sector organisations. We received around 600 responses to a survey[47] seeking feedback on the Core20PLUS5 approach. In response to feedback, to provide tailored support to systems on driving forward the Core20PLUS5 approach, we launched the Core20PLUS Connectors

[47] https://www.england.nhs.uk/blog/core20plus5-you-said-were-doing/

programme which is funding community-based support in 11 sites based across seven regions. We also commissioned the Institute for Health Improvement to establish a multi-sectoral network to drive a quality improvement approach to tackling health inequalities, the Core20PLUS Collaborative.

Governance and partnerships

We have several governance and accountability mechanisms for engaging with national, regional, and local stakeholders on the health inequalities agenda.

- the Health Inequalities Improvement Board coordinates and support efforts across NHS England and NHS Improvement programmes and policy areas to deliver the vision of exceptional quality healthcare for all. Board members include NHS England and NHS Improvement programme directors and regional Senior Responsible Officers (SRO) for health inequalities. The Board met monthly, considering a range of programme activity to tackle inequalities and monitoring progress on our priority areas
- the Health Inequalities Clinical Network provides clinical and professional advice and helps to shape deliverables that support our key priorities for tackling health inequalities. Fortnightly meetings were held throughout 2021/22, open to National Clinical Directors, National Specialty Advisors, and clinical and professional leads from across regions, ICS localities, PCNs and trusts
- the Health Inequalities Forum provides an opportunity for nominated health inequalities leads in systems, regions, trusts and PCNs to share updates, showcase learning and improvements, and outline any issues, challenges and risks to implementing and delivering on the health inequalities improvement agenda. This forum meets on a fortnightly basis.

We have established the Health Inequalities Futures Platform, sharing key information and system support on health inequalities with an online community with evidence of high levels of user engagement.

We have also continued our work with partners, including the NHS Race and Health Observatory, the Health Foundation, and the NHS Confederation. For example, with the Health Foundation, we have implemented The Health Anchors Learning Network. The UK wide network provides spaces and opportunities for participants to learn with peers and experts about how anchor organisations can consciously use their resources, influence, and work in partnership to improve the social determinants of health and help reduce inequalities.

Data to support action

We launched a Healthcare Inequalities Improvement Dashboard[48] for NHS users in October 2021. This brings together a range of indicators from national to local level, understand where health inequalities exist in their area; what is driving inequalities; and what local insights and actions they can take to drive improvement.

[48] https://www.england.nhs.uk/about/equality/equality-hub/core20plus5/hi-improvement-dashboard/

We have also taken steps to improve data collected through clinical audits and outcome reviews. We commissioned the National Confidential Enquiry into Patient Outcomes and Deaths to produce a thematic review of healthcare inequalities which will be updated annually.

Progress on key priorities

Priority 1: Restore NHS services inclusively

The Elective Recovery Fund, which was in place in the in the first half of 2021/22 included five requirements on health inequalities helping to bring focus to the agenda. We have reviewed all ICS plans to understand how they respond to the priority of inclusive elective recovery. The delivery plan for tackling the COVID-19 backlog of elective care,[49] put reducing inequalities at the core of recovery plans and performance monitoring, ensuring that this is part of how we hold systems to account for delivery.

Priority 2: Mitigate against digital exclusion

Following the independent review by Laura Wade-Gery the SRO role for Health Inequalities now incorporates oversight of digital inclusion, and a Digital Inclusion Steering Group has been established to co-ordinate and steer our approach to digital inclusion. The 'What Good Looks Like' framework[50] published in August 2021 set out success measures for digital transformation.

Priority 3: Ensure datasets are complete and timely

Our guidance on inclusive elective recovery asked systems to delineate waiting list and performance data by deprivation and ethnicity, monitor system performance for ethnic minority groups and the most deprived communities, and evaluate the impact of elective recovery plans on disparities in waiting lists. We have monitored health inequalities across a range of national programmes to inform actionable insights, including cancer, COVID-19 vaccination, and diabetes.

Priority 4: Accelerate preventative programmes that proactively engage those at greatest risk of poor health outcomes

The UK COVID-19 vaccine uptake plan was published in February 2021, with an emphasis on ensuring system partners work together to address inequalities in uptake and access.[51] We established the COVID-19 Vaccine Equalities Connect and Exchange Hub for systems to share experiences and best practice examples.[52] We developed the award-winning NHS COVID-19 Vaccine Equalities tool, which updates daily to provide detailed data on vaccine

[49] Coronavirus » Delivery plan for tackling the COVID-19 backlog of elective care (england.nhs.uk)
[50] What Good Looks Like framework - What Good Looks Like - NHS Transformation Directorate (nhsx.nhs.uk)
[51] https://www.gov.uk/government/publications/COVID-19-vaccination-uptake-plan/uk-COVID-19-vaccine-uptake-plan#our-approach
[52] https://future.nhs.uk/NationalCOVID19VaccineEquality/grouphome

uptake among underserved communities[53], and has been used to target uptake efforts at specific populations and communities at national, regional and local level.

Priority 5: Strengthen leadership and accountability

Our governance networks, forums and boards that focus on health inequalities, provide opportunities for engagement across the system and assurance that we are delivering at pace and scale to tackle inequalities. We continue to drive action on inequalities through our regional and system leadership. Alongside Senior Responsible Officers and Executive Leads for health inequalities across all our regions and ICSs, we have established regional health inequalities programme leads and support officer roles to ensure delivery capacity for regions and systems. We provided funding of £1.7 million for ICSs, via regions, to provide additional capacity to address health inequalities. The funding was provided on a fair shares basis, and allowed for some local level flexibility in delivery, with many systems recruiting for a specific health inequalities programme role.

We have undertaken activity to build capability to address healthcare inequalities, commissioning NHS Confederation to develop a leadership framework for tackling health inequalities. Phase one of the framework has been delivered through a series of webinars for ICS Chairs, Non-Executive Directors, and partners.

[53] https://www.gov.uk/government/news/analysis-in-government-award-winners-2021

Support for providers

Provider collaboratives

Provider collaboratives have a key role in delivering the core purpose of ICSs, alongside place-based partnerships, integrated care partnerships and ICBs.

We published guidance on provider collaboratives[54], outlining our expectations for how providers should work together at scale. We supplemented this with a toolkit and detailed case studies to help providers set up provider collaboratives. These resources were co-developed with system and provider leaders.

Also, in partnership with NHS Providers we established a support programme to accelerate the spread of good practice from peers in developing provider collaboratives and working through challenging issues. This support has been delivered through webinars and practical resources.

We undertook detailed analysis of nine provider collaboratives, focusing on how they can relate to and work with place-based partnerships and clinical networks, how they can address health inequalities and on their governance. The nine were a mix of those that accelerated their development during the early stages of the COVID-19 pandemic and longer established collaboratives. We have begun sharing these findings with the sector during 2022/23.

Supporting trust boards to collaborate as part of systems

Work to support trust boards to collaborate in the interest of systems continued in 2021/22. To deliver on commitments made in Integrating care: next steps to building strong and effective integrated care systems across England[55], we drafted an updated code of governance for NHS trusts that sets out a framework for corporate governance in the context of system working and collaboration, along with an addendum to the guide on foundation trust governors' duties and new guidance under the NHS provider licence that set clear expectations for collaboration in key areas and the governance arrangements required to support that.

Given the COVID-19 pressures on the system, we put plans to consult on these in 2021/22 on hold, and now intend to gather stakeholder views in 2022/23.

[54] https://www.england.nhs.uk/wp-content/uploads/2021/06/B0754-working-together-at-scale-guidance-on-provider-collaboratives.pdf
[55] https://www.england.nhs.uk/wp-content/uploads/2021/01/integrating-care-next-steps-to-building-strong-and-effective-integrated-care-systems.pdf

Provider projects

Provider projects involve focused detailed analysis to understand the challenges of implementing national policy at provider level on behalf of national and regional teams who ask for support. We completed the following projects in 2021/22:

- Collected insights from early adopter community diagnostic centres (CDCs) and developed recommendations to support the wider rollout of the CDC Programme
- Identified and analysed the drivers of lower levels of productivity in the NHS acute sector

Mergers and acquisitions

The NHS Long Term Plan committed NHS Improvement to "a more proactive role in supporting collaborative approaches between trusts [that wish to explore formal merger or acquisition]". We offer trusts considering or proceeding with mergers or acquisitions; this helps ensure the intended benefits are clear.

All plans for mergers or acquisitions that meet the threshold set out in the Transactions guidance[56] are assessed to ensure that trusts engage thoroughly with stakeholders, articulate clearly how they will deliver clinical improvements for patients, and have the capacity and capability to achieve the planned benefits. Assurance processes help identify risks early and support tailored work programmes proportionate to the risks in each case.

In late 2021 we consulted publicly on proposed changes to the *Transactions guidance* and expect to publish revised guidance during 2022.

Two acquisitions were assured during the year:

- Mersey Care NHS Foundation Trust acquired North West Boroughs Healthcare NHS Foundation Trust on 1 June 2021.
- 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.

[56] https://www.england.nhs.uk/wp-content/uploads/2021/04/transactions-guidance-2017.pdf

Operational performance of the NHS trust and foundation trust sectors against key national standards

We closely track NHS trusts' and foundation trusts' performance to help them address operational and financial performance issues and improve quality of patient care. Throughout the year we analyse performance at individual trusts and across the sector to better understand where operational and financial pressures or quality concerns exist and how to help the sector address them.

Metric	Period	Standard	Performance
Referral to treatment			
Proportion of patients beginning elective hospital treatment within 18 weeks of referral	March 2022	92%	62.4%
Number of patients waiting more than 52 weeks			306,286
Diagnostics			
Proportion of patients waiting longer than 6 weeks for diagnostic tests	March 2022	1%	24.8%
Accident and emergency			
Proportion of patients discharged, admitted or transferred within 4 hours of attending A&E (all types of A&E department)	March 2022	95%	71.6%
Major emergency departments (type 1)		95%	58.7%
Cancer			
Proportion of patients with suspected cancer receiving first outpatient consultation within 2 weeks of GP referral (all cancer symptoms)	March 2022	93%	80.6%
Breast cancer symptoms		93%	59.5%
Proportion of patients receiving first cancer treatment within 31 days of diagnosis		96%	93.4%
Proportion of patients receiving second or subsequent cancer treatment (surgery) within 31 days of decision to treat		94%	82.2%
Proportion of patients receiving second/subsequent treatment (drug therapy) within 31 days of decision to treat		98%	98.5%
Proportion of patients receiving second/subsequent treatment (radiotherapy) within 31 days of decision to treat		94%	82.2%
Proportion of patients receiving first cancer treatment within 62 days of urgent GP referral for suspected cancer		85%	67.4%
Proportion of patients receiving first cancer treatment within 62 days of urgent referral from NHS Cancer Screening Programme		90%	74.6%
Ambulance			
Average (mean) response time for people with life-threatening injuries and illness (Category 1)	March 2022	7:00	9:35
Response time for people with life-threatening injuries and illness (Category 1) – average for 90th centile		15:00	16:50
Average (mean) response time for other emergencies (Category 2)		18:00	1:01:05
Response time for other emergencies (Category 2) – average for 90th centile		40:00	2:17:10
Response time for urgent care (Category 3) – average for 90th centile		2:00:00	8:36:34
Response time for less urgent care (Category 4) – average for 90th centile		3:00:00	9:56:02

Metric	Period	Standard	Performance
Infection control			
Number of MRSA bloodstream infections	2021/22	0	674
Number of *Clostridium difficile* infections		-	14,260
Mixed sex accommodation Number of breaches of the mixed sex accommodation guidance	March 2022	0	3,398
Mental health			
Adult mental health inpatients receiving a follow up within 72hrs of discharge (%)	March 2022	80%	75%
Mental health adult acute inpatient length of stay over 60 days for people aged 18 - 64 (crude rate per 100K population, rolling quarterly figure)		8	8.5
Mental health adult acute inpatient length of stay over 90 days for people aged 65+ (crude rate per 100K population, rolling quarterly figure)		10.75	9.8
Adult Acute Out of Area Placements (bed days per rolling quarter - inappropriate only)			51,935

The collection and publication of statistics marked with * was paused to release capacity across the NHS to support the response to COVID-19.

Chief Financial Officer's Report

NHS TDA's accounts have been prepared on a going concern basis. More detail can be found in Note 1 to NHS TDA's annual accounts.

The revenue resource limit for NHS TDA is £228.4 million (2020/21: £225.7 million).

NHS TDA's net expenditure for the year was £222.5 million (2020/21: £220.8 million).

The under spend against the revenue resource limit is £5.9 million (2020/21: £4.9m).

Main categories of spend

The main categories of spend are shown in the table below:

	2021/22 £m	2020/21 £m	Reference to accounts
Operating revenue	(11.2)	(16.4)	Note 3
Staff	141.2	137.7	Note 4
Purchase of goods and services	90.8	98.6	Note 5
Depreciation and amortisation	1.7	0.9	Note 5
Total	**222.5**	**220.8**	

The decrease in operating revenue is mainly due to a reduction in income to support the intensive support team programmes which has been funded through grant in aid funding in 2021/22, and a decrease in joint working recharges with NHS England. This is partially offset by an increase in NHS Leadership Academy training due to activity increasing from the prior year.

The largest area of spend is staff costs, representing 63% of net expenditure (2020/21: 62%).

Purchase of goods and services spend relates to education and training costs largely relating to NHSLA (£36.1 million), programme support costs including intensive support to NHS provider organisations and the Getting It Right First Time programme (£19 million).

Parliamentary cash funding received was £226.5 million.

Net liabilities at 31 March 2022 were £43.7 million (31 March 2021: net liabilities £47.7 million). The position has remained reasonably consistent with the prior year.

Statement of payment practices

NHS TDA is required to pay its non-NHS and NHS trade payables in accordance with the Confederation of British Industry Better Payment Practice Code. The target is to pay non-NHS and NHS trade payables within 30 days of receipt of goods or a valid invoice (whichever is the later) unless other payment terms have been agreed with the supplier.

Payment practices

NHS TDA's performance against this target is shown in the table below.

	2021/22		2020/21	
	Number	£m	Number	£m
Non-NHS payables				
Non-NHS invoices paid in the year	5,541	56.1	7,340	49.1
Non-NHS invoices paid within target	5,217	52.6	6,997	46.7
% of non-NHS invoices paid within target	**94%**	**94%**	**95%**	**95%**
NHS payables				
NHS invoices paid in the year	879	59.5	1,334	54.4
NHS invoices paid within target	769	54.2	1,205	52.9
% of NHS invoices paid within target	**87%**	**91%**	**90%**	**97%**

More detail of how money has been spent in 2021/22 can be found in the main accounts.

Julian Kelly
Chief Financial Officer

Accountability Report

Amanda Pritchard
19 January 2023

Accounting Officer

Corporate Governance Report

Directors' Report

The Board is accountable to the Secretary of State for Health and Social Care for all aspects of NHS Improvement's activities and performance, including those activities carried out in the exercise of NHS TDA's and Monitor's statutory functions. It has reserved key decisions and matters for its own decision, including setting the strategic direction of NHS Improvement, overseeing the delivery of the agreed strategy, determining the approach to risk, agreeing the framework within which operational decisions are taken and establishing the culture and values of the organisation. These are functions and matters that the Board has agreed should be decisions that only it can take.

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

- ensuring high standards of corporate governance are observed and encouraging high standards of propriety
- the effective and efficient delivery of NHS Improvement's plans and functions
- promoting quality in NHS Improvement's activities and services
- monitoring performance against agreed objectives and targets
- ensuring effective dialogue with the Department of Health and Social Care (DHSC) and other stakeholders to best promote the continued success and growth of NHS trusts and NHS foundation trusts and other aspects of the healthcare sector.

The Board

The composition of the Board is essential to its success in providing strong and effective leadership. NHS Improvement's Board members bring a wide range of experience, skills and perspectives to the Board. With their diverse leadership experience, together they set the strategic direction of the organisation and ensure robust and open debate.

From 1 April 2016, the membership of NHS TDA and Monitor boards has been identical, and the two boards meet jointly to form the NHS Improvement Board. The Board is comprised of the Chair, five non-executive directors and four executive directors. The number of executive directors on the Board must not exceed the number of non-executive directors. The Board is further strengthened by the addition of a non-voting associate non-executive director.

Board members

Directors who served on the NHS Improvement Board during the year are listed in the table below, along with their attendance[57].

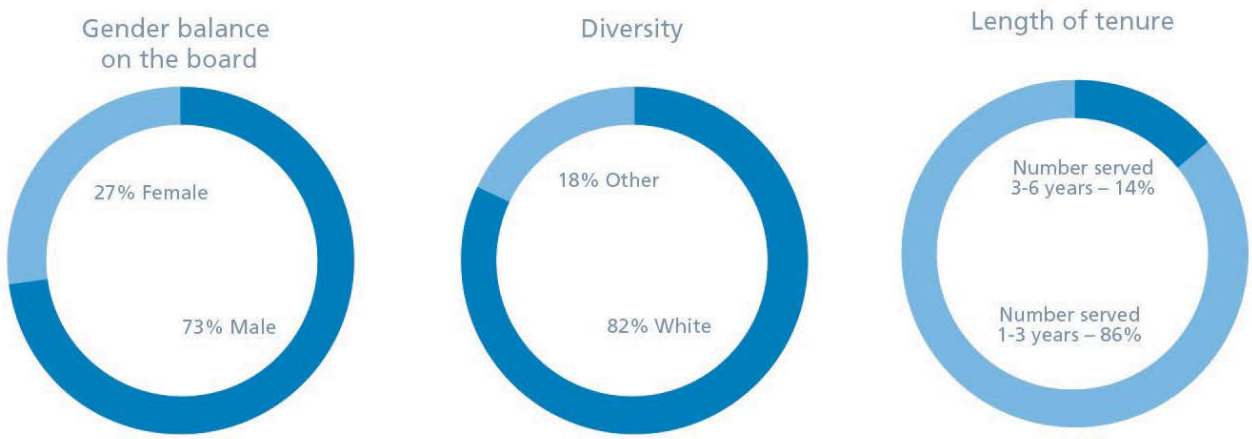
Members	Role	Term ends/notes	Number of eligible Board meetings attended
Sir Andrew Morris[58]	Interim Chair	31 July 2023	5/5
Lord Patrick Carter of Coles	Non-Executive Director & Senior Independent Director	30 June 2022[59]	5/5
Dame Julia Goodfellow[60]	Non-Executive Director	30 June 2022[61]	3/3
Rakesh Kapoor[62]	Non-Executive Director	31 December 2023	5/5
Prof. Sir Munir Pirmohamed	Non-Executive Director	31 December 2023	3/5
Jeremy Townsend[63]	Non-Executive Director	31 September 2023	0/0
Sir David Behan	Associate (non-voting) Non-Executive Director	1 July 2022[64]	5/5
Julian Kelly CB	Chief Financial Officer		4/5
Prof. Stephen Powis[65]	National Medical Director and Chief Executive		5/5
Ruth May	Chief Nursing Officer		5/5
Former members	**Role**		
Dr Timothy Ferris[66]	Non-Executive Director	Left on 9 May 2021	0/0
Baroness Dido Harding[67]	Chair	Left on 29 October 2021	1/2
Wol Kolade[68]	Non-Executive Director	Left on 24 March 2022	5/5
Amanda Pritchard[69]	Chief Operating Officer and Chief Executive	Left on 31 July 2021	1/1

[57] Biographical details may be viewed on our website https://www.england.nhs.uk/about/board/nhs-improvement-board/board-members/
[58] Sir Andrew Morris was appointed Interim Chair on 30 October 2021.
[59] Lord Patrick Carter remained a member of the Board until 30 June 2022, when the legislation came into effect and Monitor and NHS TDA were abolished and functions transferred to NHS England, at which point the new NHS England Board was created.
[60] Dame Julia Goodfellow joined the Board on 30 October 2021.
[61] Dame Julia Goodfellow remained a member of the Board until 30 June 2022, when the legislation came into effect and Monitor and NHS TDA were abolished and functions transferred to NHS England, at which point the new NHS England Board was created.
[62] Rakesh Kapoor's directorship was temporarily transferred from NHS England to NHS Improvement on 1 May 2021. His directorship was transferred back to NHS England when the legislation came into effect on 1 July 2022 and Monitor and NHS TDA were abolished and functions transferred to NHS England, at which point the new NHS England Board was created.
[63] Jeremy Townsend's directorship was temporarily transferred from NHS England to NHS Improvement on 25 March 2022. His directorship was transferred back to NHS England when the legislation came into effect and Monitor and NHS TDA were abolished and functions transferred to NHS England, at which point the new NHS England Board was created.
[64] Sir David Behan remained an Associate (non-voting) Non-Executive Director until 30 June 2022, until the legislation came into effect and Monitor and NHS TDA were abolished and functions transferred to NHS England.
[65] Prof. Stephen Powis was appointed Interim Chief Executive on 1 August 2021.
[66] Dr Timothy Ferris non-executive directorship ended on 9 May 2021 to take up the executive role as National Director of Transformation.
[67] Baroness Dido Harding took a leave of absence from 1 October 2020 to lead the NHS Test and Trace programme until leaving NHS Improvement on 31 October 2021.
[68] Wol Kolade's directorship was transferred to NHS England on 25 March 2022.
[69] Amanda Pritchard stepped down as Chief Operating Officer and Chief Executive of NHS Improvement on 31 July 2021 to take up the role as Chief Executive of NHS England as of 1 August 2021.

Board diversity

The charts below show the composition of the Board members by gender, diversity and tenure as of 31 March 2022.

Board diversity



Appointments

The Chair and non-executive directors are appointed by the Secretary of State for Health and Social Care. Non-executive directors are appointed to both Monitor and NHS TDA. As non-executive director for Monitor they hold statutory office under Schedule 8 to the Health and Social Care Act 2012 and as non-executive director for NHS TDA they hold statutory office under the National Health Service Trust Development Regulations 2012.

The Chief Executive of NHS TDA is appointed by the Secretary of State of Health and Social Care. The NHS TDA Chief Executive appoints the other executive directors. The Chief Executive and other executive directors of Monitor are appointed by the Chair and non-executive directors, subject to the consent of the Secretary of State for Health and Social Care.

Appointments made in the year are in the previous table.

The governance structure

Under the current statutory framework NHS England and NHS Improvement cannot legally have one joint board or joint board committees. Each organisation retains its given statutory functions and NHS England cannot delegate its functions to NHS Improvement, and vice versa.

Nevertheless, the organisations operate as one, with their Boards and their committees meeting in common during the year on shared business whilst having separate membership and the ability to take their own decisions. The governance framework includes established procedures in place for dealing with any situations in which a director may find they have a direct or indirect functional, operational or personal interest that conflicts with that of either

organisation. Further detail on the Separation of Functions and Conflicts of Interest policy can be found on page 74.

In June 2021, the Boards agreed to stand down the time-limited COVID-19 National Incident Response Board, and replaced it with an executive forum, that was responsible for the operational delivery of nationally agreed strategies and programmes, including NHS recovery and ongoing COVID-19 incident response. The Provider Oversight Committee was replaced by the System Oversight Committee and with its NHS England counterpart they reflect the transition to a 'system by default' approach to oversight, including formal intervention and mandated support where required.

An overview of the Board governance framework in place during the reporting period is shown on the next page and individual Board Committee reports can be found from page 64. A report detailing the business considered by the Board Committees is provided to each Board meeting and the terms of reference for each committee are on our website.

NHS Improvement Board governance framework and committees

NHS Improvement Board

Committees operating as a committee-in-common with NHS England						NHS Improvement only Committee
Audit and Risk Assurance Committee	**People, Remuneration and Nominations Committee**	**Digital Committee**	**Quality and Innovation Committee**	**System Oversight Committee (from 1 August 2021)**	**COVID-19 National Incident Response Board (to 31 July 2021)**	**Provider Oversight Committee (to 31 July 2021)**
Main responsibilities						
• Provide an independent and objective view of internal control, governance and risk management including overview of internal and external audit services, governance, risk management, counter fraud and financial reporting.	• Oversee the delivery of the overall people strategy for the NHS. • Oversee the implementation of key provisions in the NHS People Plan. • Approve the framework and policy for executives for submission to DHSC. • Approve individual executive remuneration packages. • Approves employee policies. • Review employee engagement initiatives.	• Ensure effective delivery of the digital commitment of the NHS Long Term Plan. • Ensures alignment of technology initiatives and spend across the system to ensure they are focused on commitments of the NHS Long Term Plan.	• Determine whether the NHS is maintaining and improving the quality of patient care and health outcomes within the context of delivering the NHS Long Term Plan. • Oversee implementation of innovation strategies	• Ensure consistent approach to oversight of ICSs and constituent organisations. • Oversee the development and delivery of oversight and regulatory policy. • Approve formal regulatory action and intervention, including entry and exit of trusts in special measures. • Approve transactions for trusts in segment 4 or rated as high risk.	• Oversee the organisation's response to the COVID-19 incident and EU Exit Programme. • Oversee NHS operational delivery and performance in relation to incident recovery in light of the commitments publicly set out in the NHS Long Term Plan and the NHS People Plan.	• Oversee the development and delivery of NHS Improvement's oversight and regulatory policy. • Approve formal regulatory action and intervention, including entry and exit of trusts in special measures. • Approve transactions for trusts in segment 4 or rated as high risk.

Executive HR Group	Appointments and Approvals Committee	Regional Trust Appointments and Approvals Committees	
Joint Finance Advisory Group (NHS Improvement and NHS England)			The group has no executive responsibility and oversees and provides advice to the Boards on the financial position across the NHS, including delivery of system-wide efficiency savings, and implementation of NHS England/NHS Improvement's national productivity programme.

NHS Executive Group

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

Key Board roles and responsibilities

Andrew Morris was the Interim Chair and Prof. Stephen Powis was the Interim Chief Executive. Lord Carter was the Senior Independent Director.

Their key areas of responsibility were:

Chair

Responsible for the leadership and effectiveness of the Board. This involved encouraging a culture of openness and debate to allow the Board to both challenge and support management. The Chair was also responsible for the Board governance, Board performance and stakeholder engagement. He ensured new board members received a tailored induction and worked with the chair of NHS Improvement and the Head of Board Governance to agree joint board training and development sessions.

Chief Executive

Responsible for the day-to-day leadership of the organisation and the delivery of the strategy. The Chief Executive was supported by their senior leadership team and together they were responsible for the implementation and execution of NHS Improvement's strategy. The Chief Executive was the Accounting Officer, responsible for ensuring that public funds were properly safeguarded and used in line with NHS Improvement's functions and responsibilities, as set out in HM Treasury guidance Managing Public Money.

Senior Independent Director

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

Non-executive Directors

Non-executive Directors supported executive management and provided constructive challenge and rigour, to bring sound judgement and objectivity to the Board's decision-making process. They would monitor the delivery of strategy within governance framework as set by the Board. All non-executive directors were considered to be independent; all made monthly declarations of interest and their independence was reviewed annually.

Executive Directors

Executive Directors supported the Chief Executive in leading the organisation to deliver its strategic objectives.

Board activity and administration

The Board held five scheduled Board meetings in common during the year. Each had a public and a private session. Members of the public can observe the public sessions, which are available to watch live, or after the event, on our website. The agenda, papers and minutes for the public sessions are also published on our website. In addition, the Boards held two strategy sessions and a number of topic specific deep dive learning sessions. There were also a number of Board calls where the non-executive directors were primarily updated on the organisations' response to the COVID-19 pandemic.

Board meetings are generally pre-scheduled on a rolling basis. There are also regular meetings between the Chair and the non-executive directors, and between the Chief Executive and the non-executive directors to allow discussions about the effectiveness of the Board and general matters and views to be shared.

Key items considered by the NHS England and NHS Improvement Boards during the year were:[70]

Strategy

- NHS Recovery Programme.
- COVID-19 vaccine deployment.
- Development of integrated care systems.
- Refresh of the NHS Long Term Plan.
- Strategic opportunities and challenges facing the NHS.
- Accelerating digital enabled transformation in the NHS.
- Endorsed work to support the NHS to embed and accelerate clinical innovations that had arisen in response to COVID-19 and the role of life sciences in the NHS.
- Progress in achieving a 'Net Zero' NHS.
- Endorsed the National Tariff proposals.

Performance

- Updates on the organisation's response to COVID-19 and the associated recovery and restoration of NHS services.
- Operational, quality and financial performance of NHS providers and the commissioning sector.
- Approved the approach to financial allocations and the financial framework for 2022/23.
- Approved the System Oversight Framework for 2021/22.

[70] Where applicable the individual boards have made the decisions.

- Approved NHS Improvement's and NHS England's response to the recommendations in the Ockenden Review.
- Updates on Mental Health Services

Leadership and people

- Approved NHS England's and NHS Improvement's response to the Kark recommendations,
- Considered progress in tackling inequalities in the NHS.
- Approved the 2022/23 Slavery and Human Trafficking statement.
- Considered progress in NHS England's and NHS Improvement's Internal Freedom to Speak Up.

Governance and risk

- Approved changes to the Board governance framework
- Approved changes to corporate risk register and an updated risk appetite.
- Received updates on the development of the Health and Social Care Act.
- Merger of HEE, NHS Digital and NHSX with NHS England and NHS Improvement.

Review of Board effectiveness and performance evaluation

An informal internal review of board governance was led by the Senior Independent Director for NHS England, Mike Coupe, in the summer of 2021 resulting in a number of improvements made to the governance framework, including the approach to Board meetings and the introduction of an annual strategy session. In light of the changes introduced by the Health and Care Act 2022 and the abolition of NHS Improvement in July 2022, it was agreed that no review of the Board effectiveness should be carried out.

It is recognised that the Chair's effectiveness is also vital to the operation and effectiveness of the Board. During the year Baroness Dido Harding tenure as Chair came to an end and Sir Andrew Morris was appointed Interim Chair of NHS Improvement. As the NHS Improvement Board meets in common with NHS England's Board it has informally been agreed that the chair of NHS England would take the lead on Board meetings and many of the board related matters. As a result, it was agreed that it would not be appropriate to carry out a performance review of Sir Andrew Morris.

Board committees

COVID-19 National Incident Response Board

Role of the committee

On 1 April 2020 NHS England's and NHS Improvement's Boards each established a time-limited[71] Board Committee, the COVID-19 National Incident Response Board (the COVID-19 Board). The COVID-19 Board was responsible for the strategic direction and providing oversight of NHS England's and NHS Improvement's response to the COVID-19 incident and was disbanded on 31 July 2021 and replaced with an executive forum that is responsible for the operational delivery of nationally agreed strategies and programmes, including NHS recovery and ongoing COVID-19 incident response.

Committee members

Until its disbandment, the COVID-19 Board met an average of twice per week, with members attending most of these meetings.

Members	Comment
Amanda Pritchard (Chair)	In her capacity as the former Chief Operating Officer
Julian Kelly	Chief Financial Officer
Prof. Stephen Powis	National Medical Director
Dr. Jonathan Berger	Interim Chief Medical Officer, NHS Digital
Ian Dodge	National Director: Strategy and Innovation
Simon Enright then James Lyons	Director of Communications
Matthew Gould	National Director Digital Transformation and former Chief Executive NHSX
Stephen Groves	Director of EPRR (National)
Prerana Issar	Chief People Officer
Dr. Nikita Kanani	Medical Director for Primary Care
Dr. Emily Lawson	Chief Commercial Officer
Ruth May	Chief Nursing Officer
Claire Murdoch	National Director Mental Health
Pauline Philip	National Director Emergency and Elective Care
Prof. Sir Keith Willett	Strategic Incident Director
Seven regional representatives	Rotational between Regional Directors and their senior teams

Attendees

In addition, the Director General, DHSC, and the Deputy Director, National Infection Service, Public Health England were invited to attend these meetings to support delivery of the Government's cross-departmental strategy and approach to COVID-19.

[71]The COVID-19 National Incident Response Board was established for an initial term of 1 April to 31 September 2020. On 1 October 2020, the Boards approved an extension to its operation from 1 October 2020 to 31 March 2021 to continue to oversee the NHS's operational response to COVID-19 and was formally disbanded on 31 July 2021.

Principal activities during the year

The COVID-19 Board oversaw NHS England's and NHS Improvement's response to the COVID-19 incident and NHS operational delivery and performance in relation to incident recovery. To support this the COVID-19 Board operated as the key oversight and assurance forum for the work carried out through NHS England's and NHS Improvement's COVID-19 incident response cells.

Audit and Risk Assurance Committee

Role of the committee

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

The Committee meets in common with NHS England's Audit and Risk Assurance Committee (ARAC).

Committee members

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

Members	Number of eligible meetings attended	Comment
Wol Kolade[72]	5/5	Non-Executive Director, chair to 25 March 2022
Jeremy Townsend (Chair)[73]	0/0	Non-Executive Director, chair from 25 March 2022
Andrew Morris	5/5	Non-Executive Director

Wol Kolade was the Chair of the Committee to 25 March 2022, when his directorship was transferred to NHS England. On the same day, Jeremy Townsend's directorship was temporarily transferred from NHS England to NHS Improvement. As the previous chair of the NHS England Committee, Jeremy Townsend has assumed the role of the chair of the NHS England Improvement Committee, and similarly Wol Kolade has assumed the role of the chair of the NHS England Committee. Wol Kolade is the managing partner of a private equity firm and has valuable and recent financial experience. Jeremy Townsend is a qualified accountant and has considerable experience in chairing audit committees in other organisations.

Good governance provides that an audit and risk committee should consist of three independent non-executive directors. As the Committee considers mainly joint organisation

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

business and meets in common with NHS Improvement's committee, it was agreed, and was supported by the internal auditors, that the Committee should comprise of two non-executive directors because together there are four non-executive directors involved in deliberations. This is a time-limited arrangement pre-legislative change.

As a Committee there is a good balance of skills and knowledge covering accounting, finance and clinical services.

Attendees

Additional attendees are invited to attend meetings to assist with committee business. For 2021/22 these included, among others, the Chief Executive Officer, the Chief Financial Officer, the Director of Governance and Legal, 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 is able to 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 and NHS Improvement's joint Corporate Risk Register.
- Considered a number of risk deep dives, including data and analytics, maternity, workforce and integrated care systems.
- Received updates on data security and cyber risks.
- Approved changes in accounting policies and reviewed areas of significant estimation or judgement.
- Assessed the integrity of Monitor's, NHS TDA's, consolidated provider and consolidated foundation trust financial reporting.
- Approved Monitor's, NHS TDA's, consolidated provider and consolidated NHS foundation trust 2020/21 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 2021/22, including approval of the joint NHS England and NHS Improvement Standing Financial Instructions.
- Oversaw the re-procurement of the internal audit service.
- Considered NAO reports and management letters, and received an update on the status of the NAO Value for Money Programme.

Internal audit

The joint internal auditor, Deloitte LLP, plays an important part in supporting the assurance role of both the NHS England and NHS Improvement Committees.

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

Digital Committee

Role of the committee

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

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

Committee members

The Committee met three times and the following table details membership and attendance:

Members	Number of eligible meetings attended	Comment
Rakesh Kapoor[74] (Chair)	2/3	Non-Executive Director
Dr. Timothy Ferris[75]	2/3	National Director of Transformation
Simon Eccles	3/3	Chief Clinical Information Officer
Matthew Gould	3/3	National Director of Transformation
Hugh McCaughey	3/3	National Director of Improvement

Attendees

Additional attendees are invited to attend meetings to assist with committee business. For 2021/22 these included, amongst others, the Chief Executive of NHS Digital and non-executive directors of NHS Digital and NHS Resolution.

[74] Rakesh Kapoor's directorship was temporarily transferred from NHS England to NHS Improvement on 1 May 2021 and his Committee membership was transferred on the 19 May 2021 to NHS Improvement's Digital Committee, at which point he took over the chair of the Committee.
[75] Dr. Timothy Ferris took up the role as the National Director of Transformation from 10 May 2021 and was appointed an executive member of the Committee from 19 May 2021.

Principal activities during the year

Considerable time was spent during the year to consider the digital transformation across the NHS and priorities for the Transformation directorate. Reports considered by the Committee included:

- Transformation directorate priorities.
- Putting data, digital and tech at the heart of transforming the NHS, including architecture, priorities and funding allocations.
- Digital innovation and transformation across ICSs.
- Deep Dives: digitally enabled transformation plans across UEC, mental health and elective recovery.
- Roll-out of a universal Electronic Patient Record system.

People, Remuneration and Nominations Committee

Role of the committee

The Committee's role is to set an overall people strategy and oversee the delivery of the NHS People Plan 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 the workforce of NHS Improvement is appropriately engaged and motivated, including workforce engagement. This includes reviewing the organisation's gender pay gap and ensuring that NHS England and NHS Improvement develop policies and actions to reduce this, and reviews progress in increasing BME representation at senior levels within the organisation and initiatives relating to diversity and inclusion.

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

The Committee meets in common with NHS England's People, Remuneration and Nominations Committee and has delegated certain functions to the Executive HR Group. The Committee also exercises NHS TDA's powers in relation to NHS trusts and other duties delegated to the organisation by the Secretary of State for Health and Social Care and has delegated certain functions to two sub-committees, the Appointments and Approvals Committee and the Regional Trust Appointments and Approval Committee. The Committee receives regular reports from the group and the sub-committees on cases considered and approved.

Committee members

The Committee met three times and the following table details membership and attendance:

Members	Number of eligible meetings attended	Comment
Sir Andrew Morris (Chair)	3/3	Non-Executive Director
Lord Patrick Carter of Coles	3/3	Non-Executive Director
Sir David Behan	3/3	Associate Non-Executive Director

Committee attendees

Additional attendees are invited to attend meetings to assist with committee business. For 2021/22 these included the Chief People Officer and the Director of Human Resources and Organisation Development.

Principal activities during the year

Matters considered by the Committee included:

- Updates on the implementation of the NHS People Plan, including in the context of Elective Recovery Programme.
- Considered initiatives to improve retention in the NHS.
- Considered proposals for workforce transformation and innovation.
- Considered NHS England's and NHS Improvement's response to the Kark review recommendations.
- Endorsed 'The Future of NHS Human Resources and Organisational Development' report.
- Reviewed the NHS England and NHS Improvement staff survey results.
- Considered the NHS and NHS England's and NHS Improvement's Diversity and Inclusion Strategies, including the approach to diversity and inclusion.
- Approved, in line with DHSC pay framework, the remuneration and appointment of a number of senior executives.
- Approved, in line with DHSC recommendation, annual salary increases for executive senior managers (ESMs) and medical colleagues on local pay arrangements.
- Approved an annual salary increase for employees not on Agenda for Change terms and conditions.
- Approved the publication of the NHS England and NHS Improvement gender and ethnicity pay gap reports.

During the year, the Committee established a sub-committee, the Approvals and Appointments to assist with the appointments, remuneration and tenure of chairs of ICSs and the appointment of the ICS chief executive by the ICS chair. The sub-committee consists of the Committee Chair, the COO and two Regional Directors (rotating annually).

Statutory function

The Board has delegated NHS TDA's powers, as delegated by the Secretary of State for Health and Social Care, to appoint chairs and non-executive directors of NHS trusts, and suspend and terminate those appointments to the Committee. The Committee is also responsible for specific matters relating to remuneration and termination of office in NHS trusts. To assist the Committee in carrying out these duties, it has established and delegated certain of these duties to two sub-committees, the Approvals and Appointments Committee (AACo) and the Regional Trust Approvals and Appointments Committees (TAAC). AACo consists of the Committee Chair, the COO and two Regional Directors (rotating annually). Its remit includes approval of NHS trust chair appointments and NHS trust termination cases. There is a Regional TAAC for each of the seven regions and the membership is made up of the Regional Director, senior members of the Regional Directors team and a member of the national Senior Appointments and Resourcing team. Each of these committees is, among other things, responsible for approving NHS trust non-executive director appointments and proposed salaries for very senior managers at NHS trusts whose proposed salary exceeds a certain amount.

Quality and Innovation Committee

Role of the committee

This 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 Committees will ensure strategies are continually improving quality, safety and experience of care. The Committee meets in common with NHS England's Quality and Innovation Committee.

Committee members

The Committee met four times and the following table details membership and attendance:

Members	Number of eligible meetings attended	Comment
Prof. Sir Munir Pirmohamed (Chair)	4/4	Non-Executive Director
Michael Coupe	4/4	Non-Executive Director
Dr. Timothy Ferris[76]	3/4	National Director of Transformation
Aidan Fowler	3/4	National Director of Patient Safety
Ruth May	4/4	Chief Nursing Officer
Prof. Stephen Powis	4/4	National Medical Director/NHS Improvement Chief Executive
Former member		
Rakesh Kapoor[77]	0/0	Non-Executive Director, left on 1 May 2021

[76] Dr. Timothy Ferris took up the role as the National Director of Transformation from 10 May 2021 and was appointed an executive member of the Committee on 19 May 2021.

[77] [77]Rakesh Kapoor's directorship was temporarily transferred from NHS England to NHS Improvement on 1 May 2021 and his Committee membership was transferred on the 19 May 2021 to NHS Improvement's Quality and Innovation Committee.

Committee attendees

Additional attendees are invited to attend meetings to assist with committee business. For 2021/22 these included the Director of Clinical Policy, Quality and Operations, Director for Experience, Participation and Equalities, and the Head of Quality Strategy.

Quality of patient care

A large part of the Committee's remit is to monitor and determine whether the NHS is maintaining and improving the quality of patient care and health outcomes within the context of delivering The NHS Long Term Plan. In doing these matters considered by the Committee included:

- Lessons and actions from independent reviews into maternity services, including recommendations in the Ockenden Review.
- Considered updates on the Maternity Transformation Programme and governance and oversight arrangements for maternity services.
- Considered the impact and lessons learned from the COVID-19 pandemic.
- Considered quality oversight and governance updates, both internally and cross-system.
- Considered proposals for strategic oversight of NHS quality issues and performance.
- Considered updates on the implementation of the NHS Patient Safety Strategy and related systems.
- Considered patient safety improvements, and training and education impacting on patient safety across systems.
- Reviewed the Quality of Care risk on the Corporate Risk Register and associated mitigations.
- Other items considered included:
- Regular updates from the Executive Quality Group and National Quality Board.
- The development of a NHS quality dashboard.
- Patient experience, from hearing personal accounts.

Provider Oversight Committee

Role of the Committee

The Committee was disbanded on 31 July 2021 and its responsibility for providing strategic oversight of transactions and investments, regulatory policies and decisions, including those relating to mandated recovery support was transferred to the System Oversight Committee.

Committee members

Until its disbandment, the Committee met four times and the following table details membership and the number of meetings attended by each member:

Members	Number of eligible meetings attended	Comment
Amanda Pritchard (Chair)	4/4	In her capacity as the Chief Operating Officer
Prof. Stephen Powis	4/4	National Medical Director
Miranda Carter	4/4	Director of Provider Development
Sandra Easton	3/4	Director of Operational Finance and Performance
Julian Kelly CB	3/4	Chief Financial Officer
Prerana Issar	0/4	Chief People Officer
Hugh McCaughey	4/4	National Director of Improvement
Simon Rogers	3/4	Deputy Director of Legal (non-voting)
Seven Regional Directors of Strategy and Transformation*		

*The Director of Strategy and Transformation or equivalent from each region is a member of the Committee

Committee attendees

In addition, the Director of Intensive Support, Director of Oversight and Planning and Regional Senior Oversight and Regulation Leads (or equivalent) were invited to attend these meetings.

Principal activities during the period

Until its disbandment on 31 July, items considered by the Committee included:

- An update on the implementation of the Immediate and Essential Actions in the Ockenden report.
- Independent providers of specialist mental health services, including inpatient mental health, learning disability and autism services.
- Updates on the implementation of the System Oversight Framework for 2021/22, including segmentation and implementation of the Recovery Support Programme
- Proposed approach to 'lessons learnt' from provider transactions.

System Oversight Committee

In August 2021, the Provider Oversight Committee was replaced by the System Oversight Committee, which meets in common with NHS England's System Oversight Committee. Together they ensure a consistent approach to oversight of integrated care systems and their constituent organisations, including determining appropriate support where required to organisations and systems in order for them to improve population health outcomes and address health inequalities. This assists 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 (SOF). It also provides strategic oversight of transactions and investments involving NHS foundations trusts and NHS trusts.

Committee members

Since its inauguration, the Committee met six times and the following table details membership and attendance:

Members	Number of eligible meetings attended	Comment
Prof. Stephen Powis (Chair)	6/6	National Medical Director/ Chief Executive of NHS Improvement
Ronke Akerele	3/6	Director of Culture Transformation (deputising for Chief People Officer)
Mark Cubbon	5/6	Chief Delivery Officer (interim Chief Operating Officer from August 2021 to Dec 2021)
Ian Dodge	2/6	National Director: Strategy and Innovation
Iain Eaves	6/6	Director of Planning and Oversight
Dr. Timothy Ferris	3/6	National Director of Transformation
Sue Holden	5/6	National Director of Improvement/Director of Intensive Support for Challenged Systems
Julian Kelly CB	1/6	Chief Financial Officer
Alex Kirkpatrick	6/6	Interim Director of Provider Development
Matthew Neligan	6/6	Director of System Transformation
Peter Ridley	5/5	Deputy Chief Financial Officer - Operational Finance (from October 2021)
Simon Rogers	6/6	Deputy Director of Legal (non-voting)
Sir David Sloman	2/3	Chief Operating Officer (from Dec 2021)
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 actives during the period

- Updates on the implementation of the SOF for 2021/22, including segmentation.
- At recommendations made by the regions, approval for a number of organisations and systems to enter into or exit the Recovery Support Programme.
- 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 2022/23.
- The approach to Use of Resources assessments for 2022/23 and for the future.
- Changes to the Foundation Trust Annual Reporting Manual requirements for 2021/22.
- Revised guidance on assuring and supporting complex change: Statutory and other transactions, and complex provider governance arrangements.
- Risk ratings for significant transactions in line with NHS Improvement Transaction Guidance.

Board disclosures

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

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

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

In addition to the issues raised by joint working, NHS Improvement is vigilant about the possibility of actual or perceived functional conflicts of interest arising from the exercise of its different statutory functions, whereby a directorate exercising one set of functions might prefer or adopt a particular course of action or decision that conflicts, actually or potentially, with the functions or decision-making of a different directorate. When exercising the statutory functions of Monitor (one of the constituent bodies of NHS Improvement), NHS Improvement has duties under section 67 of the 2012 Act to:

- exercise its competition and pricing functions and resolve conflicts between its general duties (set out in sections 62 and 66 of the Health and Social Care Act 2012);
- avoid conflicts between its specific functions in relation to NHS foundation trusts and its other functions; and
- ignore its functions in relation to imposing additional licence conditions on NHS foundation trusts when exercising its competition and pricing functions.

With a view to complying with those duties, NHS Improvement now applies the Separation of Functions and Conflicts of Interest policy referred to above to such conflicts.

NHS Improvement continues to recognise there is a difference between cases where there is an actual or reasonably perceived conflict arising from the exercise of different functions, and situations which are in reality not conflicts but operational manifestations of the overlap between different NHS Improvement functions: these will be Board disclosures addressed and resolved by NHS Improvement legitimately and reasonably balancing competing interests.

Where the organisation has resolved a conflict of interest in a case falling within section 67 of the 2012 Act, we must publish a statement setting out the nature of the conflict, the manner in which it was resolved and the reasons for deciding to resolve it in that manner. No such conflict was identified in 2021/22 and to the date of this report, so no statements were published.

Register of Board members interests

Personal interests held by Board and Committee members is managed by the NHS England Standing Orders, NHS Improvement Rules of Procedure 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 commencement of each Board and Committee meeting to declare any personal interest they might have in any business on the agenda and abstain from relevant Board or Committee discussion as required. Where potential conflicts arise, they are recorded in the Board and Committee minutes along with any appropriate action to address them. Any interests declared are then recorded on the register and signed off by the Board and executives on a regular basis. A copy of the register of interest is available on 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 13 on page 145.

Directors' third-party indemnity provisions

NHS Improvement has appropriate directors' and officers' liability insurance in place for legal action against, among others, its executive and non-executive directors. NHS Improvement did not indemnify any director during 2021/22.

Human rights

NHS England and NHS Improvement support the Government's objectives to eradicate modern slavery and human trafficking. A joint NHS England and NHS Improvement Slavery and Human Trafficking Statement for the financial year ending 31 March 2022 was published on our website[78] in March 2022. Our strategy on tackling fraud, bribery and corruption can be found on our website[79].

Disclosure of personal data-related incidents

NHS England and NHS Improvement follow 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 (GDPR)).

The guidance[80] 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 GDPR. 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 at 31 March 2022, no notifiable incidents had occurred relating to the loss of personal data.

[78] https://www.england.nhs.uk/wp-content/uploads/2021/03/agenda-item-13.2-slavery-and-human-trafficking-statement.pdf
[79] https://www.england.nhs.uk/publication/tackling-fraud-bribery-and-corruption-economic-crime-strategy-2018-2021/
[80] http://www.dsptoolkit.nhs.uk?Help/29

Directors' responsibility statement

The Annual Report and Accounts have been reviewed in detail by NHS Improvement'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 Improvement's stakeholders to assess the business model, performance and strategy.

Events after the reporting period

On 1 July 2022, the organisation was abolished and a number the non-executive directorships were transferred to NHS England. Professor Sir Munir Pirmohamed, Jeremy Townsend and Rakesh Kapoor's temporary non-executive directorships with the organisations came to an end and their directorships were transferred back to NHS England. On the same day, Sir Andrew Morris's directorship was also transferred to NHS England. Sir David Behan associate non-executive directorship was transferred to NHS England on 1 July. Lord Patrick Carter and Dame Julia Goodfellow directorships came to an end on 30 June 2022.

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 TDA 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 TDA 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 2021)[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 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 TDA's assets, are set out in Managing Public Money (HM Treasury, July 2013, as amended March 2022).[82]

The Accounting Officer of DHSC designated the CEO of NHS TDA as the Accounting Officer for NHS TDA. The Health and Care Act 2022 abolished NHS TDA and Monitor (operating as NHS Improvement) and transferred their functions to NHS England on 1 July 2022.

As the Accounting Officer for NHS England, I confirm that there was adequate and sufficient handover from NHS TDA's Accounting Officer, prior to the abolishment of NHS TDA in July 2022, to provide me with the assurances required to make these statements. I have taken the steps that I ought to have taken to make myself aware of any relevant audit information and to establish that auditors are aware of that information. So far as I am aware, there is no relevant audit information of which the auditors are unaware.

[81] https://www.gov.uk/government/publications/government-financial-reporting-manual-2021-22
[82] https://www.gov.uk/government/publications/managing-public-money

Governance statement

The NHS Improvement Board is committed to achieving high standards of integrity, ethics and professionalism across all our areas of activity. As a fundamental part of this commitment, we support and adopt best practice standards of corporate governance in the statutory framework. This annual governance statement sets out how we have managed and controlled our resources in 2020/21 to enable this.

As Accounting Officer, I have responsibility for the system of internal controls supporting and enabling the achievement of NHS Improvement'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.

Board arrangements

Information on our Board and its Committees is set out from page 64.

NHS England's and NHS Improvement's joint operating model

NHS England and NHS Improvement established a joint operating model in 2019 to work together to deliver both nationally agreed and locally owned priorities to improve health and patient care.

The Health and Care Act 2022 has introduced several structural changes for the NHS, most notably creating ICSs as NHS statutory bodies and formally abolishing Monitor and NHS TDA, transferring their functions into NHS England. As ICSs mature, the balance of activities that take place nationally, in regions and in ICSs will shift in line with the principle of subsidiarity and accountability for delivery will increasingly sit with systems, supported by the new NHS England. The future NHS England operating model has been designed to reflect this direction of travel and will continue to adapt as ICSs mature. By working in a more integrated way at all levels we will deliver better outcomes for patients, better value for taxpayers and better job satisfaction for our staff.

Freedom to speak up

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

Governance arrangements and effectiveness

Governance framework

The Governance Manual brings together all key strands of governance and assurance, including the Rules of Procedure, Standing Financial Instructions (SFI), Scheme of Delegation, Standards of Business Conduct Policy, Joint Risk Management Framework and three lines of defense model.

[83] https://www.england.nhs.uk/ourwork/freedom-to-speak-up/whistleblowing-disclosures/

Assessment against the Corporate governance in central government departments: Code of Good Practice 2017 compliance checklist

As part of implementing best practice, an assessment is undertaken each year against the Corporate Governance in Central Government Departments: Code of Good Practice 2017 (HM Treasury). NHS Improvement is compliant against the provisions of the code, with the following exceptions: [84]

Ref	NHS foundation trust code of governance - code provision	Ref	Cabinet Office code of good practice – code provision	Exception
B.2.11	It is a requirement of the Health and Social Care Act (the 2012 Act) that the chairperson, the other non-executive directors and – except in the case of the appointment of a chief executive – the chief executive, are responsible for deciding the appointment of executive directors.		N/A	NHS Improvement's executive directors are appointed by the Board and the appointments are approved by the Secretary of State for Health and Social Care.
C.3.6	The NHS foundation trust should appoint an external auditor for a period of time which allows the auditor to develop a strong understanding of the finances, operations and forward plans of the organisation		N/A	Given the statutory composition of Monitor and NHS TDA, the Comptroller and Auditor General, supported by the National Audit Office, acts as external auditor.
	N/A	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.
	N/A	4.11	The Board Secretary's responsibilities include: Arranging induction and professional development of Board Members.	This responsibility is shared between the Chair, Chief Executive's office and Board Secretary.
	N/A	5.5	The Head of Internal Audit is periodically invited to attend Board meetings, where key issues are discussed relating to governance, risk management, or control issues across the department and its ALBs.	The Head of Internal Audit routinely attends meetings of the ARAC.
	N/A	5.9	The board and accounting officer should be supported by an audit and risk assurance committee, comprising at least three members.	ARAC is comprised of at two non-executive board members. The Committee meets in common with NHS England's ARAC and consequently there are in total four non-executive directors involved in deliberations. The majority of business considered by the Committee is joint NHS England and NHS Improvement business.

[84] It should be noted that the following provisions in the code are not applicable to NHS Improvement: 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.

NHS England and NHS Improvement has continued to use the Three Lines of Defence model. This provides the mechanism for employees to manage risk and control as well as provide assurance over the delivery of services.

Assurance activity	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 2021/22, the corporate governance and compliance team have worked with teams across the organisation to embed controls and underpin processes including by:

- in line with the Standards of Business Conduct Policy ensuring that officers undertook Staff Declarations and Assurance Certifications despite the pressures on teams through responding to the COVID-19 pandemic
- targeted interventions with teams to ensure the timely completion of priority 1 actions arising from internal audit reviews.

Management assurance

Throughout 2021/22, 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.

In addition, the ARAC considers the outcomes of internal audit reviews of programmes and the Strategic Risk Group reviews our corporate risks, which can include causes, consequences, controls, and actions relating to individual programmes.

Underpinning the above corporate governance arrangements, individual programme boards and oversight groups meet frequently, with the attendance of representatives from national and regional teams, each with responsibility for delivery of their programme, for example UEC and primary care.

Assuring the quality of data and reporting

The Board has agreed the information it requires in order to carry out its duties. The Board is confident that performance reports have been through appropriate management review and scrutiny and that reporting continues to evolve to meet changing organisational needs.

Risk governance

The NHS England and NHS Improvement Boards are responsible for ensuring delivery of the strategies and goals outlined in their business plan.

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

NHS England's and NHS Improvement's ARACs are 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 risks faced by the joint organisation on a quarterly basis and reports conclusions directly to the Boards. The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives.

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

In 2021/22, the position of Chief Risk Officer/ SRO for risk for NHS England and NHS Improvement was delivered by the Chief Financial Officer, to further ensure senior sponsorship for risk at executive level. In March 2022 this position moved to the Chief Delivery Officer.

The executive team owns the corporate risks and nominates a responsible officer for each one. The approach is supported by the joint NHS England and NHS Improvement risk management framework which underpins the monitoring and management of risk.

The Strategic Risk Group is responsible for assuring the ARAC about how risks across the joint organisation are being managed. This group reviews the risks escalated to it and considers which risks should be managed through the Corporate Risk Register (CRR) and associated processes. The ARAC oversees implementation of NHS England's and NHS Improvement's joint risk management framework. The NHS Executive also periodically reviews the CRR and when appropriate undertakes in-depth review. The National Incident Response Board also considers the strategic risks in responding to the COVID-19 incident and these are fed into the CRR where relevant and reported to the NHS Executive.

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

Risk and control framework

In 2021/22 NHS England and NHS Improvement continued to embed their joint 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 overarching principles of HM Treasury's Orange Book and is informed by DHSC's risk management policy, ISO 31000 Risk management principles and guidelines, and the UK Corporate Governance Code.

In implementing the framework, our corporate risk function and directorate risk leads continued to share good practice, provide information on new and existing risks, and co-ordinate and support the embedding of an appropriate risk management culture. The quality of directorate risk registers continued to improve through 2021/22. We aim to continually improve our risk management maturity and risk culture year-on-year.

Principal risks

The CRR considers a full cross-section of risks to the organisations, including strategic, reputational, financial and operational risks, and risks to the achievement of the organisations' shared objectives and external threats.

NHS England and NHS Improvement's principal risks in 2021/22 were:

Risk	Key mitigations in place
Future progression of COVID-19: If wider government action is unsuccessful, available NHS capacity could be exceeded during potential further waves. Care quality could be compromised.	• Workforce capacity plans to activate when pre-agreed trigger points reached. • Surge capacity plans in place across all regions. • Nightingale hospitals. • Independent Sector support. • Tailored COVID-19 comms and deployment in communities with high prevalence.
Pandemic increases non-COVID-19 healthcare needs: Population outcomes impacted, some patients face longer waits and some NHS Long Term Plan deliverables may need rephasing.	• Regular data-gathering and analysis to monitor and report service restoration and performance. • Clinically-led review of key themes to manage the 'demand capacity gap'. • UEC Recovery Action Plan published in September 2021 to support actions on NHS 111, ambulance services, discharge and other domains, supporting a whole system recovery approach, incorporating a bespoke ambulance plan. • Elective recovery plan, including independent sector provision. • Continued push to deliver NHS Long Term Plan mental health commitments and investment of additional £0.5 billion in 2021/22 for mental health services.
Workforce capacity: The NHS workforce will not be sufficient to meet the challenges of the current pandemic, recovery in the NHS and the NHS Long Term Plan; particularly relevant in key staff groups.	• New supply: Existing commitments to 50,000 nursing manifesto, 6,000 GP and 26,000 additional roles in general practice. Focus on 111 recruitment. • Investment in international recruitment. • Workforce planning: to align activity, finance and workforce capacity. • Health and wellbeing interventions and psychological support via 40 mental health hubs. • Volunteers, reservists and the national retention programme.
Social care resilience and capacity: Social care provision may become more fragile due to local authority social care funding pressures and workforce shortages, resulting in unplanned pressures on frontline healthcare provision and timeliness of hospital discharge.	• 'Discharge to Assess' model and robust controls and oversight at ICS and regional level, with the option to escalate to national team for action. • Better Care Fund guidance includes system discharge approach. The planning requirements for this were published in September 2021. • National Discharge Taskforce established to provide executive cross-agency oversight of hospital discharge processes, activities and improvement support.
Quality of care: Is part of multi-agency systems of regulation and improvement, NHS bodies and staff may not sufficiently prevent and respond to quality concerns.	• Capacity and operational planning: elective recovery programme, 2021/22 priorities and operational planning guidance; clinical pathway transformation; co-ordinated national work on children and adolescent mental health services (CAMHS); additional investment in 111 and 999 call handling. • Quality surveillance: Revision of National Quality Board quality guidance for ICB structures; enhanced quality oversight of maternity services. • Patient Safety Strategy.
Data and digital security: Patient data could be misused and/or security compliance compromised, including through cyber-attacks. Appropriate data sharing ceases.	• New data strategy focuses on clarity, simplification, transparency and data/cyber security. • NHS England and NHS Improvement meet the Data Security and Protection Toolkit (DSPT) standard. • Internal audit and corporate controls around the use of technology. • NHSX hosting regular system-wide cyber drills to rehearse responses.
Supply mechanism: The fragility of suppliers and increased global demand affects price and availability across all NHS settings.	• Align with DHSC, MHRA and other Government departments on regulatory easements to mitigate supply issues. • Established shortages management process in place to manage and mitigate against shortages. • NHS England and NHS Improvement owned Supply Chain Coordination Ltd. responsible for managing the sourcing, delivery and supply of some healthcare products and services.

Risk appetite

In 2021/22 NHS England and NHS Improvement continued a joint approach to risk appetite, which we define as "the amount of risk that we are willing to seek or accept in the pursuit of long-term objectives".

Our risk appetite is grounded in the NHS Constitution, which sets out the rights to which patients, the public and staff are entitled, and the pledges the NHS seeks to honour, together with the responsibilities the public, patients and staff have to one another to ensure the NHS operates fairly and effectively. We believe no risk exists in isolation from others and that risk management is about finding the right balance between risks and opportunities to act in the best interests of patients and taxpayers. Our approach to risk appetite inevitably involves risk trade-offs and a consideration of the counterfactual; this gives us the flexibility to try new things, make agile decisions and find a balance between boldness and caution, risk and reward, cost and benefit. It also provides a balance between an excessively bureaucratic and burdensome approach and one that lacks rigor.

We tolerate some risks more than others. For example, we seek to minimise avoidable risks to care quality and have a very low appetite for risk in this area, whereas for innovation or proof of concept we are prepared to take managed 'moderate to high risk' on the proviso that the following have been undertaken:

- an assessment of what and where the current risks are
- that the potential future impact has been understood and agreed
- rapid cycle monitoring is in place to enable swift corrective action should things go wrong
- consideration of the system's ability to respond (that is, different regions face different circumstances and some areas are very challenged)
- trade-off between risks and cost–benefit is understood/impacts on other risks have been assessed (that is, whether these will increase or decrease)
- cost–benefit analysis and preference stated
- consideration of the reliability and validity of data used to make the assessment
- consideration of the counterfactual risks to ensure any learning is applied before taking the risk
- significant and measurable potential benefits (that is, enhanced efficiency and/or value-for-money delivery).

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 and NHS Improvement	Medium

Quality oversight and assurance

Quality care is defined by the National Quality Board as care that is safe, effective, provides a personalised experience, and is well-led and sustainable.

All NHS organisations, including NHS England and NHS Improvement, have a statutory responsibility to continually improve the quality of services. Quality is therefore considered within all policy programmes and functions such as patient safety, improvement, specialised commissioning and the NHS Long Term Plan programmes (eg cancer and mental health) – where defined quality governance and management is in place to ensure the delivery of high quality care.

Assuring the quality of services

The NHS England and of NHS Improvement Boards have both established Quality and Innovation Committees to meet in common to support the discharge of each Board's respective duties and powers, and their combined responsibilities for quality; by securing continuous improvement in the quality of services and outcomes.

Assurance of quality functions and duties

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

Quality improvement

A manageable number of quality indicators are selected to show national trends over time and provide a balance across the domains of quality (effective, safe and positive experience) and across care settings. The Quality and Innovation Committee uses high-level indicators aligned to the NHS Long Term Plan. When any of these selected indicators show significant deterioration or moderation in the rate of improvement, the committee discusses potential causes and directs a bespoke analysis. The Committee also conducts thematic reviews based on the above inputs and intelligence from members and in-depth analysis. This analysis is used to determine strategic actions to initiate/accelerate improvement.

The Boards also look at national improvement programmes, their models for improvement and how they are ensuring those improvements result in better outcomes for patients.

During the COVID-19 pandemic, NHS England and NHS Improvement adapted their quality and safety functions in a proportionate manner that maintained oversight of quality but gave

focus to the response to COVID-19. Regional medical directors and regional chief nurses are responsible for escalating issues to the Executive Quality Group (EQG), while also observing regional EPRR escalation processes. The EQG met virtually and continued to take regional reports.

Escalation of quality issues and sharing of learning

The committee facilitates the sharing of data and intelligence about quality risks and issues and of learning and best practice at national level. It is supported in this by regional routine reporting, which is filtered up through the EQG. This group 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. This builds on the arrangements that have been in place for several years in NHS England and NHS Improvement prior to the joint working arrangements.

The EQG receives routine quarterly reports from the regional teams and provides a forum to share intelligence and escalate quality risks. It takes collective action to address risks and issues raised by co-ordinating national and regional action and will escalate to the Quality and Innovation Committee if required.

Together the EQG and the Quality and Innovation Committee:

- oversee the identification and deployment of appropriate resources to tackle escalated quality risks and issues, and support quality improvement activities at national level.
- provide a coherent governance structure in which quality risks can be escalated if required.
- refer national cross-system quality risks and issues to the National Quality Board where appropriate
- share relevant and transferable learning gathered by national or regional teams.

Sustainability and Transformation Partnership (STPs) and ICSs

In line with the NHS Long Term Plan commitment, 42 systems across England were designated as ICSs by 1 April 2021. Following a major engagement exercise, and learning from local partnership working during the pandemic, NHS England and NHS Improvement had recommended to government that these arrangements be placed on a statutory footing. Legislation, including measures to promote collaboration and integration across health and care, was introduced in July 2021 and received Royal Assent as the Health and Care Act in April 2022.

During 2021/22, we worked with system leaders and our national partners to prepare for the introduction of statutory ICSs, including the creation of ICBs, by 1 July 2022, and the associated closure of CCGs. This included co-producing the policy framework for ICSs with system leaders and stakeholders, initiating recruitment to designate ICB leadership roles, and supporting local leaders plan for transition to the proposed arrangements.

We updated existing guidance to support the safe transition of CCG functions to ICBs and produced new statutory guidance where required; and developed and implemented a 'readiness to operate' process in partnership with systems to support their preparations for new statutory arrangements and to provide assurance over the safety of CCG closure.

Place-based partnerships between the NHS, local authorities and other partners continued to develop during 2021/22. We co-produced aspirations for these local collaborative arrangements with systems and set these out in guidance published jointly with the Local Government Association in summer 2021. Early in 2022 we started to roll out a practical support around their vision, governance and operating model across 39 systems.

All ICSs continued to develop their approaches to proactive population health management, supported by our national development programme to harness data and analytics to redesign personalised care for underserved and at-risk population groups.

Systems also made progress in formalising their provider collaborative arrangements to identify and maximise the benefits of working at scale across health and care organisations, supported by guidance and toolkits.

Other assurance

Cyber and data security

The Joint Cyber Security Unit provides the strategic direction for cyber security and works to strengthen cyber resilience across health and care, ensuring organisations comply with relevant standards, protect patient data and are able to respond effectively in the event of a data breach.

Working in partnership with NHS Digital and the National Cyber Security Centre, the strategy has been to increase central monitoring, assurance and regulation to hold organisations to account, whilst simultaneously centrally procuring services to assist local organisations to improve their cyber security posture and reduce overall risk. Over the past year, the programme has continued to increase the cyber resilience of the NHS.

During 2021/22 a total of 13 high severity cyber security alerts were issued by NHS Digital, with the most complex being the Log4Shell vulnerability in December 2021, which was one of the most serious IT vulnerabilities to have been discovered in recent history. Working with NHS Digital, significant improvements and enhancements have been made to the Respond to an NHS Cyber Alert Portal, improving the overall user experience.

In 2021/22 as part of the COVID-19 recovery phase the team worked with Regional Directors to reset an understanding of the cyber security risk across senior leaders. Chief Executive Officers from NHS organisations and system leaders were briefed on the current cyber security threat and key oversight actions for Boards to take.

Operational advice and instructions on improving cyber security resilience were issued to NHS organisations in March 2022, outlining priority actions to take to ensure that the NHS is prepared and ready to deal with any new or emerging threats.

Through the Unified Technology Fund, £26.9 million in capital funding was allocated to NHS organisations, which helped to address infrastructure weaknesses and increase their overall cyber resilience. In addition, a total of £5.7 million revenue funding was allocated to assist local NHS organisations with technical remediation. NHS England and NHS Improvement regional digital transformation teams worked with local organisations to identify priorities for available capital investment, ensuring the priorities were consistent with local plans for digital transformation.

NHS Digital's Cyber Security Operations Centre has benefitted from recent enhancements, giving it greater oversight and threat detection, through the integration of additional data and threat feeds to detect and protect against ransomware and COVID-19 phishing efforts. Protective monitoring services continue to be delivered to critical national services.

The Better Security, Better Care Programme, provides a range of tailored local and national support to help adult social care providers complete the DSPT, improving their overall data and cyber security. The DSPT helps organisations understand their data and cyber security risks and measures their compliance with mandatory cyber standards relevant to their sector. Between March 2021 and March 2022, the number of adult social care providers completing the DSPT to at least Approaching Standards status almost tripled from 15% of providers to 43% of providers.

The Network and Information Systems Regulations have continued to be used to increase compliance in the NHS, specifically in relation to managing unsupported systems, and to improve responses to high severity cyber alerts.

The Cyber Associates Network (CAN), established in partnership with NHS Digital, continues to be the leading network for cyber security professionals working in the health and care sector. The CAN virtual conference events held in October 2021 were attended by more than 1200 members of the network, providing key opportunities for collaboration and knowledge sharing. The conference has been further supported by a series of technical briefing webinars throughout the year.

Information governance

Our IG operating model provides the framework for NHS England and NHS Improvement to remain compliant in relation to data protection, records management and information security activities.

The Corporate IG and the Transformation Directorate IG teams together supported NHS England and NHS Improvement's implementation of appropriate governance controls around the acquisition and use of data to manage the pandemic and to ensure all records are

appropriately declared and retained. We provided advice and guidance to support the completion of data protection impact assessments, data processing agreements, data sharing agreements and provision of data notices associated, including for several high-profile initiatives:

- the COVID-19 Datastore and Foundry platform
- the OpenSafely Platform, which supports us to evaluate linked, de-identified GP data and support research associated with the pandemic
- the National Immunisation Management Service, which manages the vaccination service
- provision and acquisition of data under the COPI Regulations 2002 notices, and transition away from the use of such notices
- the COVID-19 Vaccination Programme, including but not limited to COVID-19 Passport, Vaccine Data Resolution Service, Overseas Vaccine Data Service, Vaccine Contact Preference Service and cross-Border vaccination data flows.

The teams continued to support all other areas of NHS England and NHS Improvement work to ensure that business as usual processes and new programmes obtained and used data appropriately to support their work. They helped ensure that during the transition of Public Health England into NHS England and NHS Improvement flows of data were maintained and migrated to comply with data protection legislation. The GIRFT programme ensures that NHS Improvement meets its statutory duties, while work on the NHS Improvement Model Hospital maintains improvement in practice. The NHS England and NHS Improvement Specialised Commissioning team is currently reviewing clinical registries, which requires intensive IG support as many pre-date UK data protection legislation.

The Corporate Records and Information Management team leads on the records management programme for the COVID-19 Programme Management Office, supplying advice and guidance to ensure records are available for this and other legal inquiries.

Business critical models

NHS England and NHS Improvement recognise the importance of quality assurance across the full range of their analytical work and have an approach that is consistent with the recommendations in Sir Nicholas Macpherson's review of quality assurance of government analytical models (2013). NHS England and NHS Improvement analysts are expected to ensure consistent performance and quality assurance across their analytical work. For business-critical models, where an error would have a significant patient care or other impact, NHS England and NHS Improvement operate a register of business critical models and audit of the quality assurance strategy associated with them, overseen by a committee of experienced analysts. To date all relevant NHS England and NHS Improvement models in the register have passed.

Internal audit

The internal audit service plays a significant role in independently reviewing management controls, risk management, compliance and governance:

- reviewing key systems and processes
- advising managers on internal control implications of proposed and emerging changes
- guiding managers and staff on improvements in internal controls
- focusing audit activity on key business risks.

Our internal audit service, provided by Deloitte LLP, operates in accordance with public sector audit standards and to an annual internal audit plan approved by the ARAC. It reports regularly on the effectiveness of our systems of internal control and management of key business risks, together with recommendations for improvement by management (including an agreed timetable for action). The status of audit recommendations is reported to each meeting of ARAC. The Head of Internal Audit Opinion for 2021/22 is set out from page 94.

External audit

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

Review of economy, efficiency and effective use of resources

Financial performance monitoring

In 2021/22 the financial position across the commissioning system was reported monthly using the Integrated Single Financial Environment system and supporting information collections. The financial position across NHS Providers was reported monthly using the Provider Financial Monitoring System and supporting information collections. This reporting has enabled a detailed monthly review by regional and national finance leadership teams, and the Chief Financial Officer (CFO).

Individual CCG, 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.

We have aligned financial performance monitoring across commissioner and provider sectors. At all levels we assess the combined financial and operational position locally and nationally, resulting in joint reporting and review. Commissioner and provider positions are combined to review the performance of local systems in readiness for the statutory basis for ICBs in 2022/23.

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 Monitor or the TDA: these are reported 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 Cabinet Office and/or HM Treasury.

During the COVID-19 pandemic, additional commercial guidance was issued internally in alignment with Cabinet Office guidance to ensure control and best value for money could be secured in a timely way. However, this process is now aligning with standard procedures as we transition out of the pandemic.

Counter fraud

NHS England and NHS Improvement directly employs a counter fraud team which investigates allegations of fraud related to our functions and ensures that appropriate anti-fraud arrangements are in place.

The Director of Financial Control has day-to-day operational responsibility for the NHS England and NHS Improvement counter fraud function, and the CFO provides executive support and direction.

The NHS Counter Fraud Authority undertakes an annual high-level estimate of the amount vulnerable to fraud, bribery and corruption, affecting the whole of the NHS, which the NHSCFA and its partners, including NHS England and NHS Improvement, hold the responsibility for tackling.

The ARAC receives updates regarding the counter fraud function. Counter fraud was the focus of a Deep Dive by the committee. This included reviewing the 2021 NHSCFA estimate of fraud vulnerability, the 2020/21 Counter Fraud Annual Report, proactive counter fraud work and fraud investigations.

During 2021/22, NHS England and NHS Improvement have continued to work collaboratively with key partners such as the DHSC, NHSCFA, NHSBSA, NHS Digital and others, including law enforcement. A major focus of this work continued to be addressing fraud risks associated with the COVID-19 response.

Successful prosecutions arising from investigations undertaken by the counter fraud team were featured in two episodes of the BBC series *Fraud Squad*. This publicised the effective reactive work of the team to protect NHS resources.

Head of Internal Audit opinion

In the context of the overall environment for NHS England and Improvement for 2021/22, in my opinion the framework for governance in 2021/22 is effective.

The design of the risk management framework at the year-end provides the foundation of a framework to take the organisation forward during 2022/23.

With respect to the internal control environment, progress has been made in addressing open internal audit actions. On this basis, the framework for internal control has been appropriately implemented in the organisation through 2021/22, except for the need to address significant weaknesses in the control framework for clinical off-payroll workers, which NHS England and Improvement is aware of.

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

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

The COVID-19 pandemic has continued to result in a rapidly evolving risk environment during 2021/22. To enable internal audit to adapt to these changing circumstances, as in 2020/21, an initial six-month internal audit plan for 2021/22 was reviewed and agreed by the ARAC. The plan for the second half of the year was then updated considering the emerging risks and agreed by the ARAC in September 2021.

Some weaknesses in internal controls in core processes were identified and reported during the internal audit work completed during the year, which were assessed as being fundamental to the system of controls.

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

Summary

Over the year we have continued to build on our approach to governance, risk and internal controls and it is positive that internal audit actions are being closed in a timely manner. We remain committed to delivering improvements in the areas highlighted in the audit opinion and work is well underway to prepare for the legislative changes which will be enacted in 2022.

Remuneration and Staff Report

Our people

Our NHS People Plan[85] ambitions and values drive our workforce strategy, which aims for more staff working differently in a compassionate and inclusive culture. Alongside our People Plan, our NHS People Promise[86] sets out our pledge to one another of how we want to work together to improve the experience of working in the NHS for everyone.

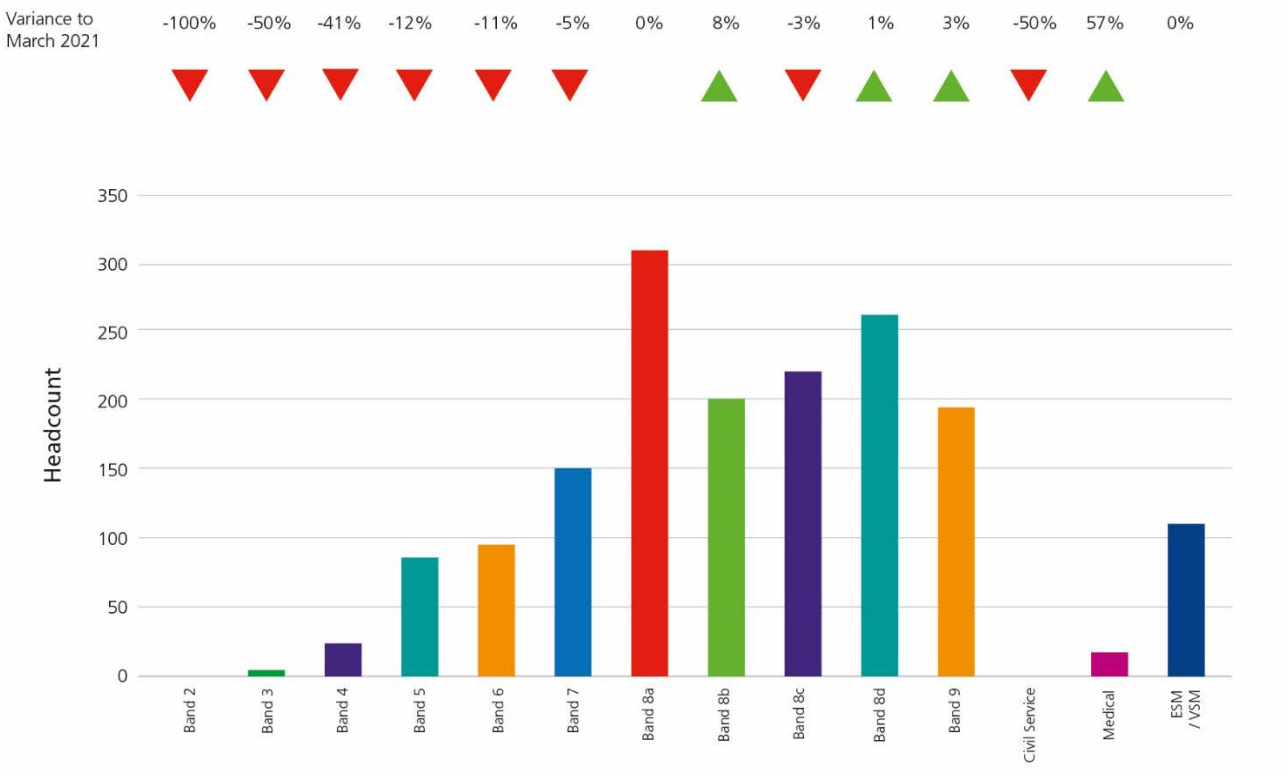
Staff numbers

On 31 March 2022, NHS Improvement directly employed 1,675 staff of whom 1,573 were permanently employed and 102 were employed on fixed-term contracts. 18% of directly employed staff worked locally in our seven regions.

Detail on staff numbers and costs for NHS Improvement are presented on page 101.

The chart below shows headcount by pay band at 31 March 2022. The headcount of permanent and fixed-term staff in NHS Improvement decreased by 1% since 2020/21. Staff joining the organisation from 1 April 2020 onwards were placed on NHS England employment contracts, rather than the NHS Trust Development Authority or Monitor employment contracts, attributing to the decrease in headcount.

All staff by grade



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

Staff turnover

Turnover has increased in 2021/22 compared to 2020/21. Headcount has increased, and we saw an increase in the number of people leaving the organisation.

Staff turnover

	April 2018 to March 2019	April 2019 to March 2020	April 2020 to March 2021	April 2021 to March 2022
NHS England	14.0%	13.2%	4.88%	9.65%
NHS TDA	14.9%	15.2%	4.65%	7.30%
Monitor	19.4%	29.5%	4.13%	11.58%
Total	**14.7%**	**14.0%**	**4.85%**	**9.32%**

NHS Digital, NHSX and Health Education England merger with NHS England and NHS Improvement)

Following the announcement[87] from the Secretary of State on 22 November 2021 on bringing together NHS Digital, NHSX and HEE with NHS England, we're working closely with colleagues across all of the organisations. We want to ensure we bring together the vital enablers of workforce and digital with the functions of NHS England to support the transformation across the NHS to continually improve patient care and achieve the best possible outcomes for our population. The 'merger' is a complex programme of work and significant planning has taken place to date, with the first step of the merger of NHS England and NHS Improvement now complete. At the very heart of our discussions is how we come together as an effective organisation, with the right vision, values and culture to deliver the very best for our patients, communities and people.

Employment policies

We have a range of employment policies to support our staff in line with our ambition to be an employer of choice. A priority for us in the last year has been to ensure that our policies align to government guidelines. During the pandemic we implemented 21 temporary policy changes to support our staff working from home and keep them safe when coming into the office. These have been kept under regular review through our formal partnership working arrangements; with 14 temporary policy changes currently still live.

We continued to harmonise key employment policies across our three organisations, NHS England, TDA and Monitor, ahead of full merger helping us to ensure consistency in the way staff are managed and rewarded.

[87] 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

Partnership working

Partnership working with our trade unions is instrumental to help us shape and develop a range of support products for line managers and staff.

The National Partnership Forum, meets quarterly and provides strategic direction for other important subgroups which focus on specific issues, including Policy, Organisational Change, Equality and Diversity and the Health and Safety Committee. In addition, we have regional and corporate partnership forums to address any local issues, which can be escalated to the national partnership structure(s) if necessary.

Following the transfer of 600 staff from PHE in October 2021 we are also in the process of setting up a local negotiating committee, with the British Medical Association and British Dental Association to focus on areas relating to clinical staff, such as clinical excellence awards.

Equality, diversity, and inclusion

Workforce Disability Equality Standard

NHS England has an action plan to improve working conditions for people with disabilities, drawing on the Workforce Disability Equality Standard (WDES).

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.

From April 2020 ESR showed 5.6% of our workforce declared a disability, whereas the staff survey (which is completed anonymously) showed that 19.9% of our workforce reported to have a disability. We have seen a small improvement to 6.1% of our people now declaring their disability status in ESR.

Stonewall Workplace Equality Index

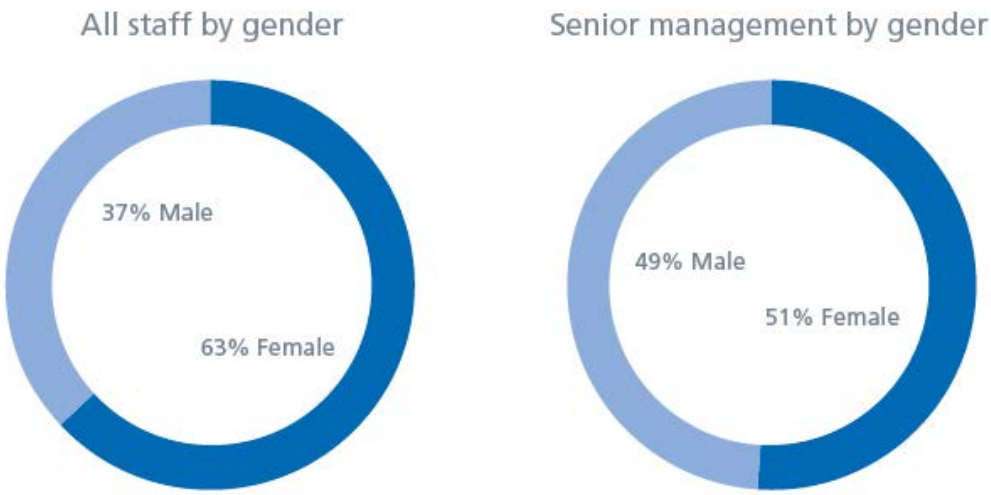
NHS England and NHS Improvement submitted the Stonewall Workplace Equality Index[88] in September 2021, which was developed in partnership with our internal LGBT+ Staff Network. We placed 58 out of 403 employers (internationally) and 53 in England.

[88] https://www.stonewall.org.uk/full-list-top-100-employers-2022

Gender of all staff and senior managers

The gender profile of the total 'on payroll' workforce and senior managers is unchanged from 2020/21. The gender diversity of board members is set out on page 58.

All staff and senior managers by gender



Gender pay gap

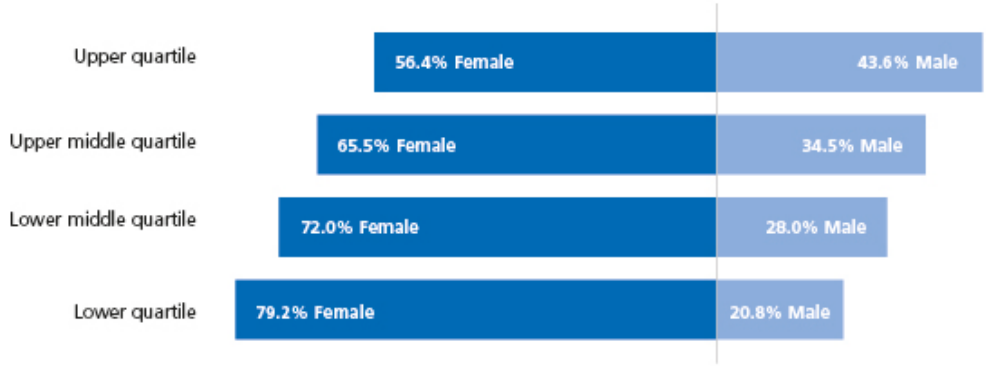
Based on the Government's methodology, the mean gender pay gap across NHS England and NHS Improvement is 16.2%, an improvement from 16.7% in the prior year.

Gender pay gap

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

Pay quartiles by gender in NHS England and NHS Improvement on 31 March 2021

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



Working in partnership with trade unions and our Women's Network we continued to progress initiatives to address gender equality in our workforce.

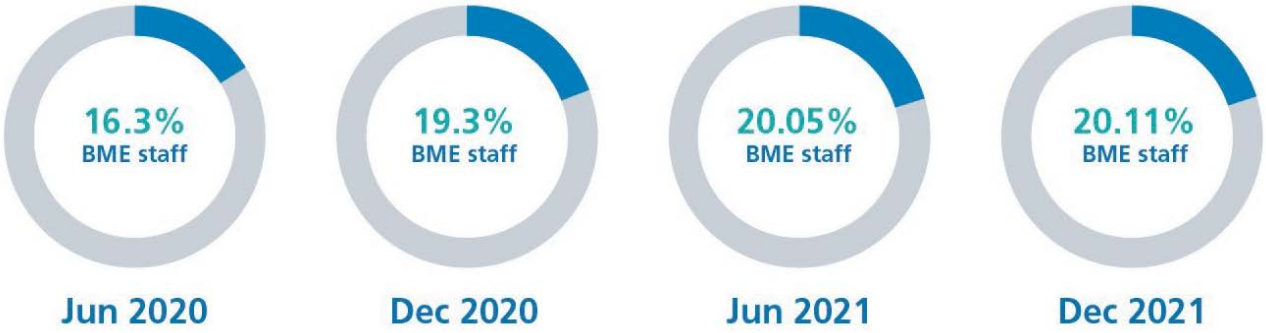
Our Gender Pay Action Plan includes specific priorities around recruitment practice, reward and recognition, flexible working, developing talent pipelines and intersectionality. The Gender Pay Gap Report is available on our website.[89]

Ethnicity of all staff and senior managers

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

In March 2020, we set a BME aspirational target to achieve 19% BME representation across all pay bands in the organisation by 2025. Since the target was set, there has been good progress highlighted below.

Figures below show the overall percentage of BME staff and the change over the last two years:

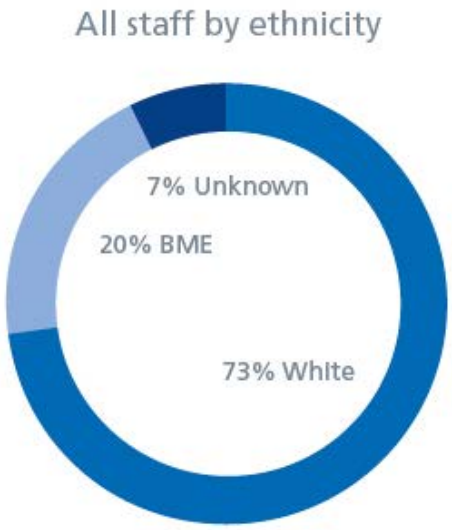


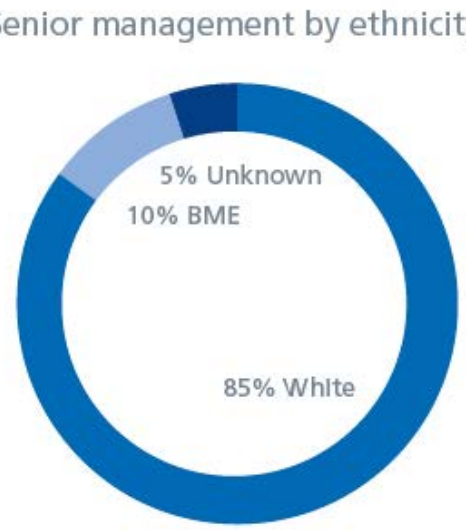
Our focus on BME talent is evidenced through proportionally more BME staff (20.43%) than white staff (15.81%) who have been promoted between January 2021 and December 2021.

The proportion of people employed by NHS Improvement who consider themselves to be from a BME heritage has increased from 19% (in 2020/21) to 20%. The proportion of senior managers who identify as BME is 10%.

[89] NHS England » Gender pay gap report 2021

All staff and senior managers by ethnicity



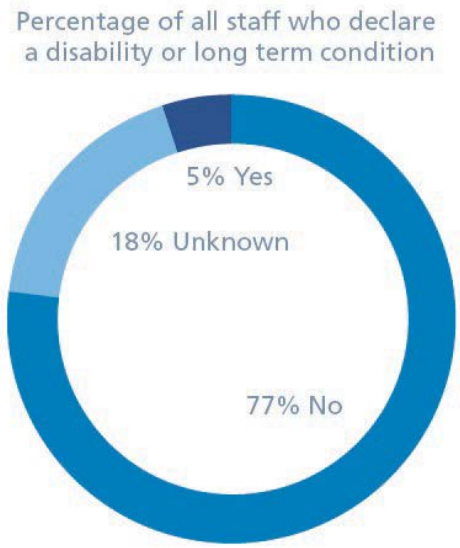


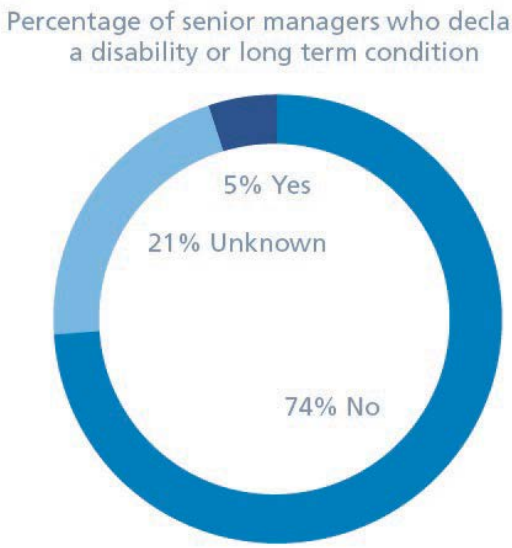
For information on board diversity please see page 58.

Declarations of disability or long-term conditions

We have continued to work with our Disability and Wellbeing Network (DAWN) to support employees. The percentage of staff who have declared a disability or long-term condition are given in the charts below.

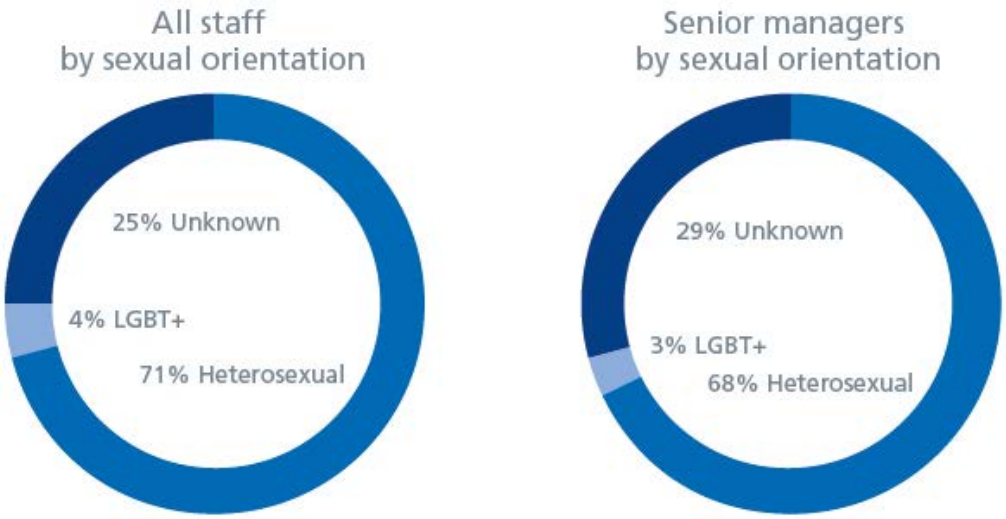
Proportion of staff and senior managers declaring a disability or long-term condition





Sexual orientation of staff and senior managers

The percentage of staff who disclose their identity as LGBT+ is given below.



Staff engagement and feedback

In addition to regular staff check ins throughout the year we carried out a full staff survey during October 2021, with a response rate of 70%.

Talent management and development

Our approach to apprenticeships continues to make progress with over 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, so creating a future talent pool of a much-needed skill. We have 44 data analysts in training with the remaining apprentices focused on leadership and management disciplines.

Trade union facility time disclosures

We have fulfilled our obligation under the Trade Union (Facility Time Publication Requirements) Regulations 2017 for the year 2021/22 by reporting facility time data.[90]

a) 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	FTE employee number
46	41.4

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

Percentage of time	Number of employees
0%	25
1-50%	20
51-99%	1
100%	N/A

c) Percentage of pay bill spent on facility time – the figures requested in the first column of the table below will determine the percentage of the total pay bill spent on paying employees who were trade union representatives for facility time during the relevant period: [92]

Description	Figures
Provide the total cost of facility time	£49,917
Provide the total pay bill	£751,640,622
Provide the percentage of the total pay bill spent on facility time, calculated as (total cost of facility time – total pay bill) x 100	0.01%

d) Paid trade union activities – as a percentage of total paid facility time hours, how many hours were spent by employees who were trade union representatives during the relevant period on paid trade union activities:

Description	Figures
Time spent on paid trade union activities as a percentage of total paid facility time hours calculated as: (total hours spent on paid trade union activities by representatives during the relevant period ÷ total paid facility time hours) x 100	15.02%

[90] These activities cross NHS England and NHS Improvement because the data cannot be split, we have provided a figure for both organisations.

Employee benefits and staff numbers

Average number of people employed (subject to audit)

2021/22	Permanently employed number	Other number	Total number
NHS TDA	1,481	96	1,577
Monitor	92	2	94
Total NHS Improvement	**1,573**	**98**	**1,671**
2020/21	**Permanently employed number**	**Other number**	**Total number**
NHS TDA	1,478	156	1,634
Monitor	110	6	116
Total NHS Improvement	**1,588**	**162**	**1,750**

Employee benefits (subject to audit)

	2021/22			2020/21
	Permanent employees £000	Other £000	Total £000	Total £000
Salaries and wages	103,252	7,571	110,823	107,600
Social security costs	12,611	-	12,611	12,469
Employer pension costs	18,209	-	18,209	17,604
Gross employee benefits expenditure	**134,072**	**7,571**	**141,643**	**137,673**
Administration costs	60,413	644	61,057	64,342
Programme costs	73,659	6,927	80,586	73,331
Total net employee benefits	**134,072**	**7,571**	**141,643**	**137,673**

Sickness absence

Whole time equivalent days available	Whole time equivalent days lost to sickness absence	Average sick days per whole time equivalent
508,146	10,049	1.98%

Exit packages, severance payments and off-payroll engagements

Expenditure on consultancy and contingent labour

NHS TDA spent £0.5 million on consultancy expenditure; an increase of £4.3 million since previous year (2020/21: £4.8 million).

Expenditure on contingent labour, including agency staff and secondees, was £0.8 million; a decrease of £1.3 million since previous year (2020/21 £2.1 million).

Off-payroll engagements

NHS England and NHS Improvement are committed to employing a capable, talented and diverse on-payroll workforce to support the delivery of its business. 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 TDA as at March 2022.

Off-payroll engagements longer than six months

Off-payroll engagements as at 31 March 2022, covering those earning more than £245 per day and staying longer than six months are as follows:

	NHS TDA (number)
Number of existing engagements as of 31 March 2022	82
Of which, the number that have existed:	
for less than 1 year at the time of reporting	47
for between 1 and 2 years at the time of reporting	15
for between 2 and 3 years at the time of reporting	11
for between 3 and 4 years at the time of reporting	5
for 4 or more years at the time of reporting	4

New off-payroll engagements

New off-payroll engagements or those that reached six months in duration, between 1 April 2021 and 31 March 2022, for more than £245 per day and that last longer than six months are as follows:

	NHSTDA (number)
Total number of new engagements, or those that reached six months in duration, between 1 April 2021 and 31 March 2022	108
Of which:	
Number assessed as caught by IR35	108
Number assessed as NOT caught by IR35	-
Number engaged directly via Personal Service Company contracted to department and are on departmental payroll	-
Number of engagements reassessed for consistency/assurance purposes during the year	-
Number of engagements that saw a change to IR35 status following the consistency review	**-**

Off-payroll board member/senior official engagement

Off-payroll engagements of Board members and/or senior officials with significant financial responsibility between 1 April 2021 and 31 March 2022 are shown in the following table.

	NHSTDA (number)
Number of off-payroll engagements of Board members and/or senior officers with significant financial responsibility during the financial year	-
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	**27**

Further detail on commercial approvals, and steps we have taken to improve procurement practices and compliance in this area within NHS Improvement during the year, can be found in our governance statement from page 79.

Exit packages including severance payments (subject to audit)

NHS TDA operates robust internal controls in respect of such matters, and any proposed non-contractual severance payments would first have to be scrutinised and approved by the Executive HR Sub-Committee before being considered by DHSC and HM Treasury. Details of exit packages agreed over the year are detailed in the following tables. All contractual severance payments were subject to full external oversight by DHSC.

Exit packages agreed during the year (subject to audit)

	Compulsory redundancies	Other agreed departures	Total	Compulsory redundancies	Other agreed departures	Total
	2021/22			2020/21		
	Number	Number	Number	Number	Number	Number
Less than £10,000	-	-	-	-	-	-
£10,001 to £25,000	-	-	-	3	-	**3**
£25,001 to £50,000	-	-	-	1	-	**1**
£50,001 to £100,000	-	-	-	1	-	**1**
£100,001 to £150,000	-	-	-	1	-	1
£150,001 to £200,000	-	-	-	-	-	-
Over £200,001	-	-	-	-	-	-
Total	**-**	**-**	**-**	**6**	**-**	**6**
Total cost (£000)	**-**	**-**	**-**	**302**	**-**	**302**

This table reports the number and value of exit packages agreed in the financial year. Exit costs are accounted for in accordance with relevant accounting standards and are paid in accordance with NHS TDA's redundancy policy. The Remuneration Report includes the disclosure of exit payments payable to individuals named in that 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 68.

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

	Salary and allowances	Performance pay and bonuses
The percentage change from the previous financial year in respect of the highest paid director	-9.71%	0%
The average percentage change from the previous financial year in respect of employees of the entity, taken as a whole	6.70%	0%

The reason for the increase in average annualised salary cost can be attributed to a reduction in FTE of lower banded roles and an increase in FTE of higher banded senior management and exec roles related to the organisation's response to COVID-19 during 2021/22.

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 Trust Development Authority in 2021/22 was £230,000 to £235,000 (2020/21: £255,000-£260,000). The relationship to the remuneration of the organisation's workforce is disclosed in the below table.

2021/22	25th percentile	Median	75th percentile
Total remuneration (£)	47,126	63,862	86,189
Salary component of total remuneration (£)	47,126	63,862	85,289
Pay ratio information	4.93:1	3.64:1	2.70:1
2020/21			
Total remuneration (£)	45,753	60,058	82,804
Salary component of total remuneration (£)	45,753	60,058	82,804
Pay ratio information	5.63:1	4.29:1	3.11:1

The pay ratio information for 2021/22 has reduced from 2020/21 and this is attributable to a change in the highest paid director / member, which reduced the highest paid director / member salary range from £255,000-£260,000 to £230,000-£235,000. The median pay ratio for the 2021/22 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. In 2021/22, no employees received remuneration in excess of the highest-paid director / member (2020/21: none). Remuneration ranged from £7,883 to £235,000 (2020/21: £7,883-£260,000).

Total remuneration includes salary, non-consolidated performance-related pay, 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 and NHS Improvement 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 £150 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 and NHS Improvement do not currently allocate any funding for performance related pay (PRP) non-consolidated bonus payments. In recognition of the current economic climate and the need to provide effective system leadership for the NHS, the decision was taken by the Strategic HR and Remuneration Committee and Nomination and Remuneration Committee not to allocate funds for PRP non-consolidated bonus payments for 2021/22. Secondees are subject to the terms and conditions of their employing organisation.

Policy on senior managers' contracts

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

Payments for loss of office (subject to audit)

No payments were made to any senior manager to compensate for loss of office in 2021/22.

Payments to past directors (subject to audit)

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

Senior managers' service contracts

Name and title	Date of appointment	Notice period	Provisions for compensation for early termination	Other details
Amanda Pritchard Chief Operating Officer (COO) Joint and Chief Executive Officer	1 August 2019	6 months		Left NHS Improvement 31 July 2021
Mark Cubbon Interim Chief Operating Officer – Joint	1 August 2021	6 months		Left this position 13 December 2021
Sir David Sloman Chief Operating Officer – Joint	14 December 2021	6 months		
Ian Dodge National Director for Primary Care, Community Services and Strategy – Joint	7 July 2014	6 months		
Dr Emily Lawson Chief Commercial Officer – Joint	1 April 2020	6 months		Left this position 18 July 2021
Blake Dark Interim Chief Commercial Officer – Joint	1 August 2021	6 months	Option to provide taxable pay in lieu of part or all of the notice period	Left this position 31 December 2021
Jacqueline Rock Chief Commercial Officer – Joint	1 January 2022	6 months		
Professor Stephen Powis National Medical Director – Joint Interim Chief Executive Officer	1 March 2018 1 August 2021	6 months		
Julian Kelly CB Chief Financial Officer – Joint	1 April 2019	6 months		
Ruth May Chief Nursing Officer – Joint	7 January 2019	6 months		
Prerana Issar Chief People Officer – Joint	1 April 2019	6 months		
Matthew Gould CMG MBE National Director for Digital Transformation – Joint	1 July 2019	6 months		
Dr Tim Ferris National Director of Transformation – Joint	10 May 2021	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). Full salary disclosures are included within the Remuneration Reports of all three 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 TDA-to-Monitor.

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

Name and title	(a) Salary (bands of £5,000)	(b) Benefits in kind (taxable) to nearest £100	(c) Performance pay and bonuses (bands of £5,000)	(d) Long-term Performance pay and bonuses (bands of £5,000)	(e) Pension-related benefits (to the nearest £1,000)	(f) TOTAL (a to e) (bands of £5,000)
	£000	£s	£000	£000	£000	£000
Amanda Pritchard Chief Executive Officer and Chief Operating Officer [91]	80-85	0	0	0	25	105-110
Mark Cubbon Interim Chief Operating Officer[92]	80-85	300	0	0	16	95-100
Sir David Sloman Chief Operating Officer[93]	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[94]	65-70	0	0	0	0	65-70
Blake Dark Interim Chief Commercial Officer[95]	75-80	0	0	0	19	95-100
Jacqueline Rock Chief Commercial Officer[96]	55-60	0	0	0	13	70-75
Professor Stephen Powis National Medical Director and Interim Chief Executive Officer[97]	225-230	0	0	0	0	225-230
Julian Kelly CB Chief Financial Officer	205-210	0	0	0	50	255-260
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[98]	100-105	0	0	0	21	120-125
Dr Tim Ferris National Director of Transformation[99]	170-175	0	0	0	0	170-175

[91] 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. Ms Pritchard left NHS Improvement on 31 July 2021. The full year equivalent salary is £255,000-£260,000

[92] Mark Cubbon replaced Amanda Pritchard as Interim Chief Operating Officer for the period 01 August 2021 to 13 December 2021. His salary was re-charged 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.

[93] Sir David Sloman replaced Mark Cubbon as Chief Operating Officer on 14 December 2021. His salary was re-charged 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.

[94] Dr Emily Lawson left the position of Chief Commercial Officer on 18 July 2021. The full year equivalent salary is £230,000-£235,000.

[95] Blake Dark replaced Dr Emily Lawson as Interim Chief Commercial Officer for the period 01 August 2021 to 31 December 2021. The full year equivalent salary is £190,000-£195,000.

[96] Jacqueline Rock replaced Blake Dark as Chief Commercial Officer on 01 January 2022. The full year equivalent salary is £230,000-£235,000.

[97] Professor Stephen Powis replaced Amanda Pritchard as Interim Chief Executive Officer on 1 August 2021.

[98] 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.

[99] Dr Tim Ferris commenced 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 commencement resulted in under-payment of salary during 2021/22 due to pension contributions being deducted from his salary in error.

Remuneration (salary, benefits in kind and pensions) 2020/21 (subject to audit)

Name and title	(a) Salary (bands of £5,000)	(b) Benefits in kind (taxable) to nearest £100	(c) Performance pay and bonuses (bands of £5,000)	(d) Long-term Performance pay and bonuses (bands of £5,000)	(e) Pension-related benefits (to the nearest £1,000)[100]	(f) TOTAL (a to e) (bands of £5,000)
	£000	£s	£000	£000	£000	£000
Amanda Pritchard Chief Executive and Chief Operating Officer[101]	255-260	0	0	0	60	315-320
Ian Dodge National Director for Primary Care, Community Services and Strategy[102]	170-175	0	0	0	0	170-175
Dr Emily Lawson Chief Commercial Officer[103]	230-235	0	0	0	0	230-235
Professor 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
Ruth May Chief Nursing Officer[104]	180-185	0	0	0	91	270-275
Prerana Issar Chief People Officer	230-235	0	0	0	53	280-285
Matthew Gould CMG MBE National Director for Digital Transformation[105]	100-105	0	0	0	42	140-145

[100] 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.
[101] The salary for Amanda Pritchard is recharged to NHS England and NHS Improvement from Guy's and St Thomas' NHS Foundation Trust where she is also formally employed and retains a post.
[102] The position title for Ian Dodge was updated to National Director for Primary Care, Community Services and Strategy from 01 April 2020.
[103] Dr Emily Lawson commenced in the role of Chief Commercial Officer on 1 April 2020; immediately prior to that she held the role of National Director of Transformation and Corporate Development.
[104] Ruth May's Pension-related benefits in column (e) and Total in column (f) have been re-stated since the publication of the 2020/21 Annual Report and Accounts, following receipt of corrected 2020/21 pension disclosure values from NHS Pensions.
[105] 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.

Pension benefits (subject to audit)

Name and title	Real increase in pension at pension age (bands of £2,500)	Real increase in pension lump sum at pension age (bands of £2,500)	Total accrued pension at pension age at 31 March 2022 (bands of £5,000)	Lump sum at pension age related to accrued pension at 31 March 2022 (bands of £5,000)	Cash Equivalent Transfer Value at 31 March 2021[106]	Real Increase in Cash Equivalent Transfer Value	Cash Equivalent Transfer Value at 31 March 2022	Employers contribution to partnership pension
	£000	£000	£000	£000	£000	£000	£000	£000
Amanda Pritchard Chief Executive Officer and Chief Operating Officer[107]	0-2.5	0-2.5	80-85	130-135	1,142	15	1,229	0
Mark Cubbon Interim Chief Operating Officer[108]	0-2.5	(2.5)-0	60-65	110-115	957	12	1,025	0
Sir David Sloman Chief Operating Officer[109]	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Ian Dodge National Director for Strategy and Innovation[110]	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Dr Emily Lawson Chief Commercial Officer[111]	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Blake Dark Interim Chief Commercial Officer[112]	0-2.5	N/A	10-15	N/A	113	9	163	0
Jacqueline Rock Chief Commercial Officer[113]	0-2.5	N/A	0-5	N/A	0	6	14	0
Professor Stephen Powis National Medical Director[114]	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Julian Kelly CB Chief Financial Officer	2.5-5	N/A	10-15	N/A	99	22	152	0
Ruth May Chief Nursing Officer	2.5-5	2.5-5	80-85	235-240	1,670	59	1,763	0
Prerana Issar Chief People Officer	2.5-5	N/A	10-15	N/A	98	20	151	0
Matthew Gould CMG MBE National Director Digital Transformation[115]	0-2.5	N/A	50-55	N/A	732	5	780	0
Dr Tim Ferris National Director of Transformation[116]	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

[106] As per previous submissions, the column Cash Equivalent Transfer Value at 31 March 2021 is the uninflated value whereas the real Increase in CETV is the employer funded increase.
[107] Amanda Pritchard left these posts on 31 July 2021, therefore the Pension Benefits disclosed are pro-rata for the period 01 April 2021 to 31 July 2021.
[108] Mark Cubbon covered this post on an interim basis for the period 01 August 2021 to 13 December 2021, therefore the Pension Benefits disclosed are pro-rata for this period.
[109] Sir David Sloman chose not to be covered by the NHS Pension arrangements during the reporting year.
[110] Ian Dodge chose not to be covered by the NHS Pension arrangements during the reporting year.
[111] Dr Emily Lawson chose not to be covered by the NHS Pension arrangements during the reporting year.
[112] Blake Dark covered this post on an interim basis for the period 01 August 2021 to 31 December 2021, therefore the Pension Benefits disclosed are pro-rata for this period.
[113] Jacqueline Rock commenced in post on 01 January 2022.
[114] Professor Stephen Powis chose not to be covered by the NHS Pension arrangements during the reporting year.
[115] 80% of the pension 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 pension benefits, with DHSC disclosing the remaining 20%.
[116] Dr Tim Ferris was not eligible to be covered by NHS Pension arrangements during the reporting year.

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.

Pensions liability

NHS pensions

Past and present employees are covered by the provisions of the two NHS Pension Schemes. Details of the benefits payable and rules of the Schemes can be found at NHS Pensions[117]. 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 payable to that scheme for the accounting period.

[117] www.nhsbsa.nhs.uk/pensions

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:

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 2022, is based on valuation data as 31 March 2021, updated to 31 March 2022 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

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

Full actuarial (funding) valuation

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

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

The 2016 funding valuation also tested the cost of the Scheme relative to the employer cost cap that was set following the 2012 valuation. There was initially a pause to the cost control element of the 2016 valuations, due to the uncertainty around member benefits caused by the discrimination ruling relating to the McCloud case.

HMT published valuation directions dated 7 October 2021 (see Amending Directions 2021[118]) that set out the technical detail of how the costs of remedy are included in the 2016 valuation process. Following these directions, the scheme actuary has completed the cost control element of the 2016 valuation for the NHS PS, which concludes no changes to benefits or member contributions are required. The 2016 valuation reports can be found on the NHS Pensions website.[119]

Policy on remuneration of non-executive directors

Non-executive directors are appointed by the Secretary of State for a term of four years. All remuneration paid to the Chair and non-executive directors is non-pensionable. Benefits in kind given to the Chair and non-executive directors are disclosed in Table 19. The monetary value of benefits in kind covers any payments (for business expenses or otherwise) or other benefits provided by NHS TDA or Monitor that are treated by HM Revenue and Customs as a taxable emolument. These figures are subject to audit.

Since 1 April 2016 NHS TDA has shared a joint Board with Monitor under the name of NHS Improvement. The below table shows the total remuneration; two-thirds of the 2020/21 costs are charged to the NHS TDA and one-third to Monitor.

[118] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1023845/The_Public_Service_Pensions_Valuations_and_Employer_Cost_Cap___Amendment__Directions_2021.pdf)
[119] https://www.nhsbsa.nhs.uk/nhs-pension-scheme-accounts-and-valuation-reports

Non-executive director service contracts

Name and Title	Date of Appointment	Unexpired Term at 31 March 2022	Notice Period	Provisions for compensation for early termination	Other Details
Baroness Dido Harding Chair	30 October 2017	0 months	3 months	None	Left NHS Improvement on 31 October 2021
Sir Andrew Morris Chair	30 October 2021	3 months	3 months	None	
Sir David Behan Associate (non-voting) Non-Executive Director	1 February 2019, tenure renewed on 1 February 2021	3 months	3 months	None	Chair of Health Education England
Lord Patrick Carter of Coles Non-Executive Director and Senior Independent Director	1 April 2016	3 months	3 months	None	
Dr Timothy G Ferris MD, MPH Non-Executive Director	1 August 2018	0 month	3 months	None	Waived entitlement to remuneration Left this role on 09 May 2021
Wol Kolade Non-Executive Director	1 August 2018	0 months	3 months	None	Waived entitlement to remuneration Transferred to NHS England on 25 March 2022
Professor Sir Munir Pirmohamed Non-Executive Director	6 November 2020	21 months	3 months	None	
Rakesh Kapoor Non-Executive Director	1 May 2021	0 months	3 months	None	Transferred back to NHS England on 01 April 2022
Jeremy Townsend Non-Executive Director	25 March 2022	3 months	3 months	None	
Professor Dame Julia Goodfellow Non-Executive Director	30 October 2021	3 months	3 months	None	

Non-executive director remuneration (including salary entitlements)

Salaries and allowances 2021/22 (subject to audit)

Name	Position	Salary (bands of £5,000)	Benefits in kind to nearest £100	Total (bands of £5,000)
		£000	£00	£000
Baroness Dido Harding[120]	Chair	35-40	-	35-40
Sir Andrew Morris[121]	Chair	60-65	-	60-65
Sir David Behan[122]	Associate (non-voting) Non-Executive Director	0-5	-	0-5
Lord Patrick Carter of Coles	Non-executive Director and Senior Independent Director	5-10	-	5-10
Dr Timothy G Ferris MD, MPH[123]	Non-executive Director	0-5	-	0-5
Wol Kolade[124]	Non-executive Director	0-5	-	0-5
Professor Sir Munir Pirmohamed	Non-executive Director	5-10	-	5-10
Rakesh Kapoor[125]	Non-executive Director	5-10	-	5-10
Jeremy Townsend[126]	Non-executive Director	0-5	-	0-5
Professor Dame Julia Goodfellow[127]	Non-executive Director	0-5	-	0-5

[120] Baroness Dido Harding took a leave of absence from 1 October 2020 to lead the NHS Test and Trace programme until 31 July 2021, before leaving NHS Improvement on 31 October 2021. The full year equivalent salary is £60,000-£65,000.
[121] Sir Andrew Morris was appointed as Vice Chair from 12 November 2020 and became acting Chair from this date also to cover Baroness Dido Harding's leave of absence before being appointed as Chair on 30 October 2021.
[122] Sir David Behan is also Chair of Health Education England and waived entitlement to Non-Executive Director remuneration in the band of £5,000-£10,000.
[123] Dr Timothy Ferris waived entitlement to Non-Executive Director remuneration in the band of £5,000-£10,000 and left this role on 09 May 2021.
[124] Wol Kolade waived entitlement to Non-Executive Director remuneration in the band of £5,000-£10,000 and transferred to NHS England on 25 March 2022.
[125] Rakesh Kapoor temporarily transferred to NHS Improvement from NHS England on 01 May 2021 until 31 March 2022. The full year equivalent salary remains at £5,000-£10,000.
[126] Jeremy Townsend temporarily transferred to NHS Improvement from NHS England on 25 March 2022 until 30 June 2022. The full year equivalent salary is £10,000-£15,000.
[127] Professor Dame Julia Goodfellow joined NHS Improvement on 30 October 2021 and waived entitlement to Non-Executive Director remuneration in the band of £5,000-£10,000.

Salaries and allowances 2020/21 (subject to audit)

Name	Position	Salary (bands of £5,000)	Benefits in kind to nearest £100	Total (bands of £5,000)
		£000	£00	£000
Baroness Dido Harding[128]	Chair	30-35	-	30-35
Sir David Behan[129]	Associate (non-voting) Non-Executive Director	0-5	-	0-5
Lord Patrick Carter of Coles	Non-executive Director	5-10	-	5-10
Dr Timothy G Ferris MD, MPH[130]	Non-executive Director	0-5	-	0-5
Wol Kolade[131]	Non-executive Director	0-5	-	0-5
Sir Andrew Morris[132]	Non-executive Director	25-30	-	25-30
Laura Wade-Gery[133]	Non-executive Director	0-5	-	0-5
Professor Sir Munir Pirmohamed[134]	Non-executive Director	0-5	-	0-5

[128] Baroness Dido Harding took a leave of absence from 1 October 2020 to lead the NHS Test and Trace programme. The full year equivalent salary is £60,000-£65,000.

[129] Sir David Behan, Chair of Health Education England, became an Associate (non-voting) Non-Executive Board member of NHS Improvement from 1 February 2019 and has waived his entitlement to Non-Executive Director remuneration in the band of £0 - £5000.

[130] Dr Timothy Ferris waived their entitlement to Non-Executive Director remuneration in the band of £5,000-£10,000.

[131] Wol Kolade waived entitlement to Non-Executive Director remuneration in the band of £5,000-£10,000.

[132] Sir Andrew Morris was appointed as Vice Chair from 12 November 2020 and became acting Chair from this date also to cover Baroness Dido Harding's leave of absence.

[133] Laura Wade-Gery transferred to NHS England on 6 November 2020. The full year equivalent salary is £5,000-£10,000.

[134] Professor Sir Munir Pirmohamed transferred to NHS Improvement from NHS England on 6 November 2020. The full year equivalent salary is £5,000-£10,000.

Parliamentary accountability and audit report

Cost allocation and charges for information

In the event of NHS TDA charging for services provided, the organisation will pass on the full cost for providing the services in line with HM Treasury guidance.

There is one main source of income in 2021/22 relating to NHS Leadership Academy training income which is recognised based on the timing of the underlying training. Further details are contained in the financial statements.

Regularity of expenditure: Losses and special payments

Losses and special payments are items that Parliament would not have contemplated when it agreed funds for NHS TDA 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.

Losses (subject to audit)

	Total Number of Cases (number)	Total Value of Cases (£000)	Total Number of Cases (number)	Total Value of Cases (£000)
	2021/22	2021/22	2020/21	2020/21
Administrative write-offs	-	-	-	-
Fruitless payments	107	25	167	151
Stores losses	-	-	-	-
Book Keeping Losses	-	-	-	-
Constructive loss	-	-	-	-
Cash losses	-	-	-	-
Claims abandoned	-	-	-	-
Total	**107**	**25**	**167**	**151**

Special payments (subject to audit)

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

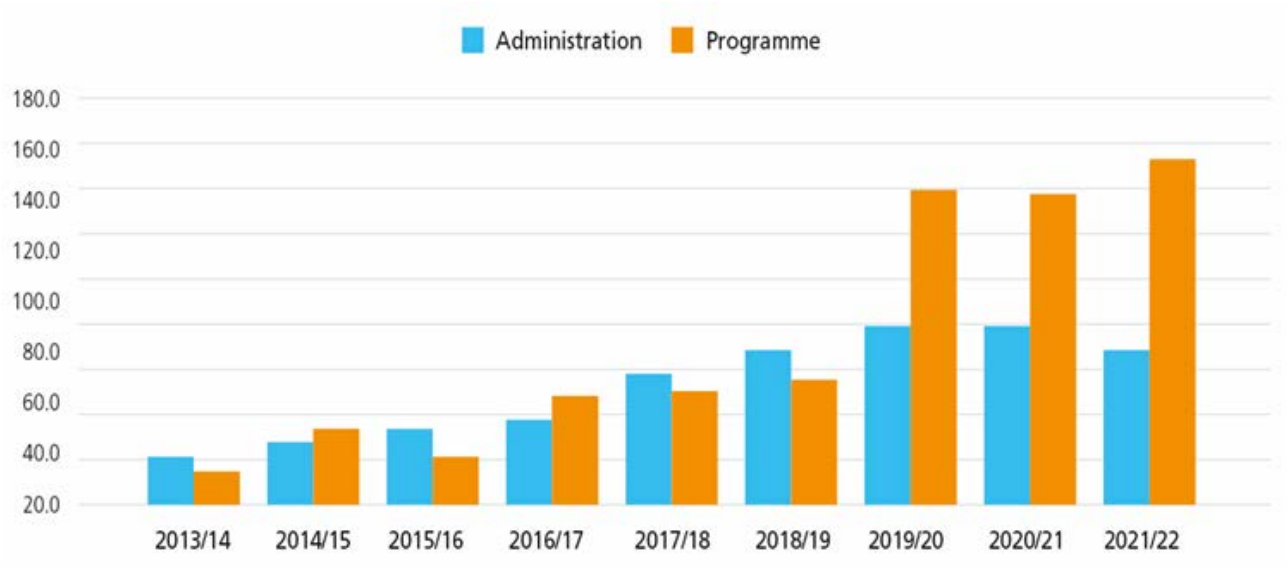
	Total Number of Cases (number)	Total Value of Cases (£000)	Total Number of Cases (number)	Total Value of Cases (£000)
	2021/22	2021/22	2020/21	2020/21
Compensation payments	-	-	1	98
Compensation payments Treasury Approved	-	-	-	-
Extra Contractual Payments	-	-	-	-
Ex Gratia Payments	-	-	-	-
Extra Statutory Extra Regulatory Payments	-	-	-	-
Special Severance Payments Treasury Approved	-	-	-	-
Total	**-**	**-**	**1**	**98**

Long-term expenditure trend

Below shows the trend in net expenditure since financial year 2013/14. NHS TDA's expenditure during this period reflects the statutory duties in the Health and Social Care Act 2012.

2021/22 expenditure details are disclosed in the annual accounts.

Trend in net expenditure since 2013/14 (£m)



Certificate and Report 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 the NHS Trust Development Authority for the year ended 31 March 2022 under the National Health Service Act 2006.

The financial statements comprise the NHS Trust Development Authority's:

- Statement of Financial Position as at 31 March 2022;
- 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 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 the NHS Trust Development Authority's affairs as at 31 March 2022 and its net expenditure for the year then ended; and
- have been properly prepared in accordance with the National Health Service Act 2006 and Secretary of State directions issued thereunder.

Opinion on regularity

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

Basis 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 of Public Sector Entities in the United Kingdom*. My responsibilities under those standards are further described in the *Auditor's responsibilities for the audit of the financial statements* section of my certificate.

Those standards require me and my staff to comply with the Financial Reporting Council's *Revised Ethical Standard 2019*. I have also elected to apply the ethical standards relevant to listed entities. I am independent of the NHS Trust Development Authority 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 the NHS Trust Development Authority'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 the NHS Trust Development Authority'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 Accounting Officer with respect to going concern are described in the relevant sections of this certificate.

The going concern basis of accounting for the NHS Trust Development Authority 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 anticipated that the services which they provide will continue into the future.

Other Information

The other information comprises information included in the Annual Report, but does not include the financial statements nor my auditor's certificate and report. The 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.

In connection with my audit of the financial statements, my responsibility is to read the other information and, in doing so, consider whether the other information is materially inconsistent with the financial statements or my knowledge obtained in the audit or otherwise appears to be materially misstated.

If 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.

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 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 the NHS Trust Development Authority and its environment obtained in the course of the audit, I have not identified material misstatements in the Performance and Accountability Report.

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

- I have not received all of the information and explanations I require for my audit; or
- adequate accounting records have not been kept by the NHS Trust Development Authority or returns adequate for my audit have not been received from branches not visited by my staff; or
- the financial statements and the parts of the Accountability Report 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 Accounting Officer for the financial statements

As explained more fully in the Statement of Accounting Officer's Responsibilities, the Accounting Officer is responsible for:

- maintaining proper accounting records;
- the preparation of the financial statements and Annual Report in accordance with the applicable financial reporting framework and for being satisfied that they give a true and fair view;
- ensuring that the Annual Report and accounts as a whole is fair, balanced and understandable;

- internal controls as the Accounting Officer determines is necessary to enable the preparation of financial statement to be free from material misstatement, whether due to fraud or error; and
- assessing the NHS Trust Development Authority'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 the NHS Trust Development Authority 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.

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, we considered the following:

- the nature of the sector, control environment and operational performance including the design of the NHS Trust Development Authority's accounting policies.
- Inquiring of management, NHS England and NHS Improvement's head of internal audit and those charged with governance, including obtaining and reviewing supporting documentation relating to the NHS Trust Development Authority's policies and procedures relating to:
  - identifying, evaluating and complying with laws and regulations and whether they were aware of any instances of non-compliance;
  - detecting and responding to the risks of fraud and whether they have knowledge of any actual, suspected or alleged fraud; and

- the internal controls established to mitigate risks related to fraud or non-compliance with laws and regulations including the NHS Trust Development Authority's controls relating to the NHS Trust Development Authority's compliance with National Health Service Act 2006 and Managing Public Money.

- discussing among 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 the NHS Trust Development Authority 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 of controls.

I also obtained an understanding of the NHS Trust Development Authority's framework of authority as well as other legal and regulatory frameworks in which the NHS Trust Development Authority operates, focusing 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 the NHS Trust Development Authority. The key laws and regulations I considered in this context included National Health Service Act 2006, Managing Public Money, Employment Law and Tax Legislation.

Audit response to identified risk

As a result of performing the above, the procedures I implemented to respond to identified risks included the following:

- reviewing 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;
- enquiring of management and the Audit and Risk Assurance Committee concerning actual and potential litigation and claims;
- reading and reviewing 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, testing the appropriateness of journal entries and other adjustments; assessing whether the judgements made in making accounting estimates are indicative of a potential bias; and evaluating the business rationale of any significant transactions that are unusual or outside the normal course of business; and
- in addressing the risk of fraud in revenue recognition, through; substantive sample testing of income transactions recorded in the last month of the financial year and of cash receipts received in the first month of the subsequent financial year, to confirm whether revenue has

been recognised in the correct financial year; and reviewing the volume and value of credit notes processed during the year and after the year-end for any unusual trends.

I also communicated relevant identified laws and regulations and potential fraud risks 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 income and expenditure reported in the financial statements have been applied to the purposes intended by Parliament and the financial transactions conform to the authorities which govern them

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

Report

I have no observations to make on these financial statements.

Gareth Davies **24 January 2023**

Comptroller and Auditor General

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

Annual Accounts

Amanda Pritchard
19 January 2023

Accounting Officer

Statement of comprehensive net expenditure for the year ended 31 March 2022

	Note	2021/22	2020/21
Other operating revenue	3	11,216	16,398
Total operating revenue		**11,216**	**16,398**
Staff costs	4	141,259	137,673
Purchase of goods and services	5	90,769	98,602
Depreciation and amortisation	5	1,732	929
Total expenditure		**233,760**	**237,204**
Net expenditure for the financial year		**222,544**	**220,806**

All operations are continuing.

The notes on pages 132 to 145 form part of these accounts.

Statement of financial position as at 31 March 2022

	Note	31 March 2022 £000	31 March 2021 £000
Non-current assets:			
Property, plant & equipment	7.1	160	239
Intangible assets	7.2	7,795	5,778
Total non-current assets		**7,955**	**6,017**
Current assets:			
Trade and other receivables	8	8,957	15,101
Cash and cash equivalents	9	8,263	3,574
Total current assets		**17,220**	**18,675**
Total assets		**25,175**	**24,692**
Current liabilities			
Trade and other payables	10.1	68,323	72,156
Provisions	5	-	88
Total current liabilities		**68,323**	**72,244**
Net current liabilities		**(51,103)**	**(53,569)**
Non-current liabilities			
Trade and other payables	10.2	549	101
Total non-current liabilities		**549**	**101**
Total net liabilities		**(43,697)**	**(47,653)**
Financed by taxpayers' equity			
General fund		(43,697)	(47,653)
Total taxpayers' equity		**(43,697)**	**(47,653)**

The financial statements and the notes on pages 132 to 145 were signed on behalf of the NHS Trust Development Authority by:

Amanda Pritchard
Chief Executive

19 January 2023

Statement of changes in taxpayers' equity for the period ended 31 March 2022

	Note	2021/22	2020/21
Changes in taxpayers' equity		**£000**	**£000**
Opening taxpayer's equity		**(47,653)**	**(24,497)**
Comprehensive net expenditure for the year	SoCNE	(222,544)	(220,806)
Net parliamentary funding	SoCF	226,500	197,650
Closing taxpayer's equity		**(43,697)**	**(47,653)**

The notes on pages 132 to 145 form part of these accounts.

Statement of cash flows for the year ended 31 March 2022

	Note	2021/22 £000	2020/21 £000
Cash flows from operating activities			
Net operating cost	SoCNE	(222,544)	(220.806)
Adjustments for non-cash transactions			
Depreciation and amortisation	5	1,732	929
Provisions arising/(written back) during the year	5	(88)	88
Loss on disposal	7.1	-	6
(Increase)/decrease in trade and other receivables	8	6,144	8,591
Increase/(decrease) in trade payables and other liabilities	10	(3,385)	11,717
Net cash inflow/(outflow) from operating activities		**(218,141)**	**(199,475)**
Cash flows from investing activities			
(Payments) for property, plant and equipment	7.1	(55)	(57)
(Payments) for intangible assets	7.2	(3,615)	(3,435)
Net cash inflow/(outflow) from investing activities		**(3,670)**	**(3,492)**
Cash flows from financing activities			
Net parliamentary funding	SoCTE	226,500	197,650
Net cash generated from financing activities		**226,500**	**197,650**
Net increase/(decrease) in cash and cash equivalents		**4,689**	**(5,317)**
Cash and cash equivalents at the beginning of the period		**3,574**	**8,891**
Cash and cash equivalents at the end of the period	9	**8,263**	**3,574**

The notes on pages 132 to 145 form part of these accounts.

Notes to the accounts

1. Statement of accounting policies

About NHS Improvement

NHS Improvement was responsible for overseeing NHS foundation trusts, NHS trusts and independent providers. We offered the support these providers need to give patients consistently safe, high quality, compassionate care within local health systems that are financially sustainable. By holding providers to account and, where necessary, intervening, we helped the NHS to meet its short-term challenges and secure its future.

NHS Improvement was the operational name for the organisation that brought together Monitor, NHS TDA, Patient Safety including the National Reporting and Learning System, the Advancing Change team and the Intensive Support Teams.

About the NHS Trust Development Authority

NHS TDA's role was to provide support, oversight and governance for all NHS trusts in their aim of delivering what patients want; high quality services today, secure for tomorrow. The range of services provided by NHS trusts covers the entire spectrum of healthcare, from acute hospitals to ambulance services through to mental health and community providers; the size of organisation varies from very small providers through to some of the largest organisations in the NHS, and therefore each trust has a set of unique challenges. Due to this variation, we recognised that there is not going to be a 'one size fits all' solution to the challenges trusts face. Our goal was first and foremost to help each and every NHS trust to improve the services they provide for their patients.

NHS TDA was a special health authority within DHSC and domiciled in the UK with its registered office at Wellington House, 133-155 Waterloo Road, London SE1 8UG.

The financial statements have been prepared in accordance with the accounts direction issued by the Secretary of State for Health and Social Care and the Government FReM issued by HM Treasury. The accounting policies contained in the FReM apply UK adopted International Accounting Standards as adapted or interpreted for the public sector context. Where the FReM permits a choice of accounting policy, the accounting policy which is judged to be most appropriate to the particular circumstances of NHS TDA for the purpose of giving a true and fair view has been selected. The particular policies adopted by NHS TDA are described below. They have been applied consistently in dealing with items that are considered material to the accounts.

1.1 Accounting conventions

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

1.2 Going concern

The Health and Care Act 2022 received Royal Assent on 28 April 2022. The Act abolished NHS TDA and Monitor (operating as NHS Improvement) and transferred their functions to NHS England on 1 July 2022.

The FReM has interpreted the going concern concept for non-trading entities. For such entities, the anticipated continuation of the provision of a service in the future is sufficient evidence of going concern.

The going concern basis of preparation for these accounts therefore remains appropriate, as the functions of the NHS Trust Development Authority are continuing as part of NHS England and financial provision for these services is included in the main estimates.

1.3 Critical accounting judgements and key sources of estimation uncertainty

In the application of NHS TDA's accounting policies, management is required to make judgements, estimates and assumptions about the carrying amounts of assets and liabilities that are not readily apparent from other sources. The estimates and associated assumptions are based on historical experience and other factors that are considered to be relevant. Actual results may differ from those estimates. The estimates and underlying assumptions are continually reviewed. Revisions to accounting estimates are recognised in the period in which the estimate is revised if the revision affects only that period; or in the period of the revision and future periods if the revision affects both current and future periods.

1.3.1 Apportionment of costs

From 1 April 2016 the NHS TDA and Monitor have worked together under the operational name of NHS Improvement and from 1 April 2019, NHS Improvement and NHS England have worked together under a similar joint arrangement. The majority of costs are retained within the organisation that holds the relevant employment or service contract. Shared non-pay costs such as accommodation are apportioned to ensure the financial statements of both entities reflect each organisation's cost.

1.3.2 Non-current asset valuations

In accordance with HM Treasury's Financial Reporting Manual (10.1.14), NHS TDA has opted to adopt depreciated historical cost as a proxy for value for assets that have short useful economic lives or low values.

1.4 Revenue and funding

The main source of funding for the special health authority is the parliamentary grant from DHSC within an approved cash limit, which is credited to the general fund. Parliamentary funding is recognised in the financial period in which it is received.

The NHS TDA has interpreted the application International Financial Reporting Standards 15 on the material revenue streams as follows:

- Leadership Academy training income

Training income is received from a number of organisations and individuals which is recognised in line with the timing of delivery of training.

1.5 Employee benefits

1.5.1 Short-term employee benefits

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

1.5.2 Retirement benefit costs

Past and present employees are covered by the provisions of the NHS Pensions Scheme which is an unfunded defined benefit scheme. The NHS Pension Scheme is an unfunded, multi-employer defined benefit scheme in which NHS TDA is unable to identify its share of the underlying assets and liabilities. NHS TDA contributes annual premiums and retains no further liability except in the case of employees who take early retirement. The scheme is accounted for as a defined contribution scheme.

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 NHS TDA commits itself to the retirement, regardless of the method of payment.

A small number of employees contribute to the National Employment Savings Trust pension.

1.6 Property, plant and equipment

1.6.1 Capitalisation

Property, plant and equipment which is capable of being used for more than one year and they:

- individually have a cost equal to or greater than £5,000 or
- collectively have a cost of at least £5,000 and an individual 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 or
- form part of the initial setting-up cost of a new building, irrespective of their individual or collective cost.

1.6.2 Valuation

Property, plant and equipment are capitalised initially at cost. Assets with a short useful life or low value are carried on the Statement of Financial Position at depreciated historic cost as a proxy for fair value.

1.7 Intangible assets

Intangible assets with a useful life of more than a year and a cost of at least £5,000 are capitalised initially at cost.

They are carried on the Statement of Financial Position at cost, net of amortisation and impairment.

Assets under construction comprises assets currently being developed and not yet in use. Assets under construction are not amortised.

1.8 Depreciation, amortisation and impairments

Depreciation and amortisation are charged to write off the costs or valuation of property, plant and equipment and intangible non-current assets, less any residual value, over their estimated useful lives, in a manner that reflects the consumption of economic benefits or service potential of the assets. The estimated useful life of an asset is the period over which NHS TDA expects to obtain economic benefits or service potential from the asset. This is specific to NHS TDA and may be shorter than the physical life of the asset itself. Estimated useful lives and residual values are reviewed each year end, with the effect of any changes recognised on a prospective basis.

Depreciation is charged on each individual fixed asset as follows:

i. Intangible assets are amortised, on a straight line basis, over the estimated useful lives of the assets varying between 3 and 5 years.
ii. Each equipment asset is depreciated evenly over its useful life:
    - plant and machinery – five years
    - information technology assets – between three and five years
    - furniture and fittings assets – between five and 10 years.

At each reporting period end, NHS TDA assesses the carrying amounts of tangible and intangible non-current assets to establish whether there are any indications of impairment. If there is indication of an impairment loss, the recoverable amount of the asset is estimated to determine whether there has been a loss and, if so, its amount. If the carrying amount exceeds the recoverable amount, an impairment loss is immediately recognised.

1.9 Leases

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

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

1.10 Cash and cash equivalents

Cash is the balance held with the Government Banking Service.

1.11 Financial Instruments

1.11.1 Financial assets

Financial assets are recognised on the Statement of Financial Position when the NHS TDA 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 derecognised when the contractual rights have expired, or the asset has been transferred.

As set out in IFRS 9 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 the profit and loss.

NHS TDA has financial assets that are classified into the category of financial asset held at amortised cost.

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

At the end of the reporting period, NHS TDA assesses whether any financial assets are impaired. The majority of receivables are with other DHSC group bodies which are guaranteed by the Department and, therefore, that no expected credit losses are recognised.

1.11.2 Financial liabilities

Financial liabilities are recognised on the Statement of Financial Position when the NHS TDA 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 derecognised when the liability has been discharged, that is, the liability has been paid, cancelled or has expired.

NHS TDA has financial liabilities that are classified into the category of financial liabilities measured at amortised costs comprising of trade and other payables. They are recognised in accordance with IFRS 9.

1.12 Value Added Tax

Most of the activities of the NHS TDA are outside the scope of VAT and, in general, output tax does not apply and input tax on purchases is not recoverable. Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of fixed assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

1.13 IFRSs, amendments and interpretations in issue but not yet effective, or adopted

'International Accounting Standard 8: Accounting policies, changes in accounting estimates and errors' requires disclosure in respect of new IFRSs, amendments and interpretations that are, or will be, applicable after the accounting period. There are a number of IFRSs, amendments and interpretations issued by the International Accounting Standards Board that are effective for financial statements after this accounting period.

Estimated impact of future standards

1.13.1 IFRS 16 Leases

Adoption of IFRS 16 is effective from 1 April 2022. Accommodation of office space is through a shared arrangement with NHS England and does not constitute a lease under IFRS 16 because no assets are specified under these arrangements.

Definition of a lease

IFRS 16 brings some changes to the definition of a lease compared to IFRIC 4 and IAS 17 currently. HM Treasury has decided that, as a practical expedient, entities will grandfather in their current assessment of whether a contract contains a lease. Given the practical expedient it is not expected that this part of IFRS 16 will have a material impact. The key impact will be in changing the accounting for arrangements currently identified as leases.

Lessee accounting: single model of accounting

For lessees, the current (IAS 17) distinction between operating leases and finance leases is removed. Under IFRS 16, a right-of-use asset and lease liability are included in the statement of financial position for all leased assets. Leased assets for NHS TDA mainly comprise property leases. Based on the current expiry of these leases and the estimated valuation this is not expected to be material to these accounts.

2. Operating segments

The NHS TDA's activities are considered to fall within three operating segments: the management and administration of the Authority; the funding of the Authority's programme activities and the activities of the Healthcare Safety Investigation Branch (a subset of programme activities). Assets and liabilities are not split in this way so not reported here.

2021/22	Administration	Programme	HSIB	Total
	£000	£000	£000	£000
Revenue	(1,990)	(9,226)	-	(11,216)
Expenditure	70,658	144,905	18,197	233,760
Net operating costs	**68,668**	**135,679**	**18,197**	**222,544**
2020/21	**Administration**	**Programme**	**HSIB**	**Total**
Revenue	(1,730)	(14,667)	(1)	(16,398)
Expenditure	81,901	137,120	18,183	237,204
Net operating costs	**80,171**	**122,453**	**18,182**	**220,806**

Administration

The financial objective of the NHS TDA is to manage the recurrent costs of management and administration within the allocation of £72.7m this funding covers staff, accommodation and other running costs.

Programme

The NHS TDA received an allocation of £155.6m programme funding for other expenditure made on behalf of the NHS. Programme funding cannot be used to supplement administration funding for the running costs for the NHS TDA.

The Health and Safety Investigation Branch (HSIB)

The HSIB was established in 2016/17. The purpose of the organisation is to improve patient safety through effective and independent investigations that do not apportion blame or liability. HSIB received an allocation of £19,800,000.

3. Revenue

Administration revenue	2021/22	2020/21
	£000	£000
Recharge to NHS England for joint working costs	988	1,014
Revenue in respect of seconded staff	442	399
Other miscellaneous revenue	560	317
Total administration revenue	**1,990**	**1,730**
Programme revenue		
Provision of emergency care improvement programme and elective care intensive support	-	5,364
Provision of NHS Leadership Academy training	7,467	2,974
Recharge to NHS England for joint working costs	-	4,900
Revenue in respect of seconded staff	1,373	385
Other miscellaneous revenue	386	1,045
Total programme revenue	**9,226**	**14,668**
Total revenue	**11,216**	**16,398**

4. Employee benefits

	2021/22	2020/21
	£000	£000
Gross expenditure		
Salaries and wages	110,439	107,319
Social security costs	12,611	12,469
Employer contributions to the NHS Pensions Scheme	18,209	17,604
Termination benefits	-	281
Total gross expenditure	**141,259**	**137,673**

More detailed disclosures on staff costs are contained in the Remuneration Report.

5. Operating expenditure

	Note	Admin	Programme	Total	Admin	Programme	Total
		2021/22			2020/21		
		£000	£000	£000	£000	£000	£000
Purchase of goods and services							
Auditors' remuneration for NHS TDA		55	-	55	53	-	53
Auditors' remuneration for consolidated accounts of NHS providers		130	-	130	110	-	110
Chair and non-executive members		126	-	126	116	-	116
Education and training		211	36,002	36,213	377	31,868	32,245
Programme support costs		411	18,600	19,011	5,309	20,885	26,194
Legal fees		12	312	324	155	829	984
Consultancy and other professional fees		240	11,031	11,271	4,172	14,344	18,516
Establishment expenses		1,190	7,081	8,271	1,168	4,490	5,658
Supplies and services - general		2,546	7,711	10,257	609	6,574	7,183
Premises		3,179	1,572	4,751	4,325	2,420	6,745
Transport		75	217	292	22	86	108
Provisions expense		-	(88)	(88)	-	88	88
Miscellaneous expenditure		54	102	156	285	317	602
Total purchase of goods and services		**8,229**	**82,540**	**90,769**	**16,701**	**81,901**	**98,602**
Depreciation and amortisation charges							
Depreciation	7.1	105	32	137	105	61	166
Amortisation	7.2	1,409	186	1,595	753	10	763
Total depreciation and amortisation		**1,514**	**218**	**1,732**	**858**	**71**	**929**
Total operating expenditure	SoCNE	**9,743**	**82,758**	**92,501**	**17,559**	**81,972**	**99,531**

6. Operating leases

	31 March 2022	31 March 2021
	£000	£000
Payments recognised as an expense in year		
Lease payments	2,157	2,358
Total	**2,157**	**2,358**
Minimum lease payments payable:		
No later than one year	947	1,158
Between one and five years	1,110	1,274
After five years	138	27
Total	**2,195**	**2,459**

Rent is payable in accordance with the occupancy documentation associated with each of the properties.

7. Non-current assets

7.1 Property, plant and equipment

2021/22	Information technology	Furniture & fittings	Total
	£000	£000	£000
Cost			
At 1 April 2021	969	651	**1,620**
Additions purchased	55	-	**55**
Disposals	(92)	-	**(92)**
At 31 March 2022	**932**	**651**	**1,583**
Accumulated depreciation			
At 1 April 2021	838	543	**1,381**
Charged during the year	96	38	**134**
Disposals	(92)	-	**(92)**
At 31 March 2022	**842**	**581**	**1,423**
Net book value at 31 March 2021	131	108	**239**
Net book value at 31 March 2022	**90**	**70**	**160**

2020/21	Information technology	Furniture & fittings	Total
	£000	£000	£000
Cost			
At 1 April 2020	950	674	**1,624**
Additions purchased	57	-	**57**
Disposals	(38)	(23)	**(61)**
At 31 March 2021	**969**	**651**	**1,620**
Accumulated depreciation			
At 1 April 2020	759	511	**1,270**
Charged during the year	117	49	**166**
Disposals	(38)	(17)	**(55)**
At 31 March 2021	**838**	**543**	**1,381**
Net book value at 31 March 2020	191	163	**354**
Net book value at 31 March 2021	**131**	**108**	**239**

All assets are purchased assets and are owned by NHS TDA.

7.2 Intangible assets

2021/22	Software purchased	Assets under construction	Software internally generated	Total
	£000	£000	£000	£000
Cost				
At 1 April 2021	118	3,211	4,009	7,338
Additions purchased	38	51	3,526	3,615
Reclassification	-	(3,195)	3,195	-
Disposals	(109)	-	-	(109)
At 31 March 2022	**47**	**67**	**10,730**	**10,844**
Accumulated amortisation				
At 1 April 2021	118	-	1,442	**1,560**
Charged during the year	4	-	1,594	**1,598**
Disposals	(109)	-	-	**(109)**
At 31 March 2022	**13**	**-**	**3,036**	**3,049**
Net book value at 31 March 2021	-	3,211	2,567	**5,778**
Net book value at 31 March 2022	**34**	**67**	**7,694**	**7,795**

2020/21	Software purchased	Assets under construction	Software internally generated	Total
	£000	£000	£000	£000
Cost				
At 1 April 2020	130	2,193	1,592	**3,915**
Additions purchased	-	1,018	2,417	**3,435**
Reclassification	-	-	-	**-**
Disposals	(12)	-	-	**(12)**
At 31 March 2021	**118**	**3,211**	**4,009**	**7,338**
Accumulated amortisation				
At 1 April 2020	120	-	689	**809**
Charged during the year	10	-	753	**763**
Disposals	(12)	-	-	**(12)**
At 31 March 2021	**118**	**-**	**1,442**	**1,560**
Net book value at 31 March 2020	10	2,193	903	**3,106**
Net book value at 31 March 2021	**-**	**3,211**	**2,567**	**5,778**

All intangible assets are purchased assets and are owned by NHS TDA.

8. Trade receivables and amounts falling due within one year

	31 March 2022	31 March 2021
	£000	£000
Contract Receivables	3,551	10,254
Prepayments	4,417	4,328
VAT	989	519
Trade and other receivables	**8,957**	**15,101**

The decrease in contract receivables reflects the timing of invoicing for operating income and the overall reduction in operating income from the prior year.

9. Cash and cash equivalents

	31 March 2022	31 March 2021
	£000	£000
Opening balance	3,574	8,891
Net change in cash and cash equivalent balances	4,689	(5,317)
Closing balance	**8,263**	**3,574**
Made up of		
Cash with Government Banking Service	8,263	3,574
Cash and cash equivalents as in Statement of Financial Position	**8,263**	**3,574**

10. Trade payables and other liabilities

10.1. Trade payables and other current liabilities falling due within one year

	31 March 2022	31 March 2021
	£000	£000
Other taxation and social security	3,377	3,244
Trade payables	13,289	23,059
Accruals	48,839	42,812
Contract liabilities	2,818	3,041
Trade and other payables	**68,323**	**72,156**

10.2. Trade payables and other non current liabilities falling due after one year

	31 March 2022	31 March 2021
	£000	£000
Contract liabilities	549	101
Trade and other payables	**549**	**101**

11. Financial instruments

11.1 Financial risk management

IFRS 7, Financial Instruments Disclosure, requires the disclosure of the role that financial instruments have had during the period in creating or changing the risk an entity faces in undertaking its activities. Financial instruments play a much more limited role in creating or changing risk for NHS TDA than would be typical of the listed companies to which IFRS 7 mainly applies.

As NHS TDA holds no financial instruments that are either complex or play a significant role in NHS TDA's financial risk profile, NHS TDA's exposure to credit, liquidity or market risk is limited.

11.2 Financial assets

	2021/22	2020/21
	£000	£000
Financial assets held at amortised cost	12,803	14,347
Total at 31 March 2022	**12,803**	**14,347**

11.3 Financial liabilities

	2021/22	2020/21
	£000	£000
Financial liabilities held at amortised cost	65,505	69,115
Total at 31 March 2022	**65,505**	**69,115**

12. Events after the reporting period

The Health and Care Act 2022 received Royal Assent on 28 April 2022. The Act abolished NHS TDA and Monitor and transferred their functions to NHS England on 1 July 2022.

The annual report and accounts have been authorised by the Accounting Officer for issue on the date the accounts were certified by the Comptroller and Auditor General.

13. Related Parties

The NHS TDA was a body corporate established by order of the Secretary of State for Health & Social Care.

The DHSC wass regarded as a related party. During the year the NHS TDA had a number of material transactions with the Department and other entities for which the Department is regarded as the parent department including NHS England, NHS Trusts, NHS Foundation Trusts and the National Health Service Pension Scheme.

Since the setup of NHS Improvement and during joint working with NHS England, NHS England and Monitor were considered related parties of NHS TDA.

During the reporting period, no DHSC Minister, Board member, key manager or other related parties had undertaken any material transactions with the NHS TDA (2020/21 NIL).

The remuneration of senior management and non-executives is disclosed in the Remuneration and Staff Report.

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 2021/22 mandate was set as we began to emerge from the COVID-19 pandemic, continuing to respond to it through treatment and vaccination while also recovering other services to pre-pandemic levels. Core performance objectives were set and, to assess against these objectives, 17 deliverables were agreed with the DHSC for assurance alongside a further requirement to ensure robust financial performance in 2021/22.

The assessment of performance against 2021/22 mandate captures our broad assessment of our performance against the backdrop of pandemic response and recovery, which follows assessments by policy teams at NHS England and NHS Improvement and DHSC.

In summary, as of January 2023 NHS England have delivered the majority of the commitments in the mandate at either Green or Amber/Green RAG ratings.

Objective 1: Continue to lead the NHS response to COVID-19

This objective focused on how NHS England and NHS Improvement would continue to lead the NHS in providing effective care to patients with COVID-19 both inside and outside hospital, support research and innovation in COVID-19 treatments to improve patient outcomes, and support the health and wellbeing of NHS staff. To this end, NHS England and NHS Improvement's success was measured on best practice for all COVID-19 patients and those with "long COVID-19", the rollout of the vaccine, and meeting Accessible Information Standards.

To ensure all COVID-19 patients were treated in accordance with emerging best practice, NHS England and NHS Improvement established 90 post- COVID-19 services and 14 paediatric specialist hubs, as well as the monthly publication of post- COVID-19 service performance data from September 2021. In addition to this, guidance was published to support NHS staff experiencing long- COVID-19 symptoms and vocational rehabilitation training provided through national webinars.

Vaccines have continued to be deployed at pace. Between April 2021 and March 2022, the COVID-19 vaccination programme delivered 89 million doses and a total of 123 million have been delivered since the programme was launched. Of these, 32 million have been third doses and boosters.

Ensuring that the NHS is meeting Accessible Information Standards continued through the commencement of a review of the standards by the Patient Equalities Team at NHS England

and NHS Improvement and the North of England Commissioning Support Unit. The consultation and engagement phase of this review was completed on time and recommendations are now being piloted, with supporting documentation due to be published in Q4 of 2022/23.

Objective 2: Continue to implement the NHS Long Term Plan, focusing on transformation of services, to support NHS resilience, and continue to inspire public confidence

Objective 2 captures the 52 metrics identified to measure progress against implementation of key Long Term Plan programmes. As agreed with the government, NHS England and NHS Improvement reports on performance against these metrics quarterly to DHSC.

The pandemic has had a significant, and variable impact on these metrics. For some we have seen an acceleration of delivery plans to assist with our response to COVID-19. However, delivery against many of the metrics has been severely negatively impacted by our need to focus on the pandemic response, the additional disease burden or the reduced productivity we have had to manage in the NHS in order to keep our patients and staff safe.

Objective 3: With support from Government, deliver the manifesto priorities that will enhance delivery of the NHS Long Term Plan

The Government's 2019 manifesto set out a number of commitments which NHS England and NHS Improvement will continue to take forward alongside their response to the pandemic. Objective 3 was measured on NHS England and NHS Improvement's adherence to conditions for the Better Care Fund (BCF) including the NHS contribution to the BCF, and NHS England's willingness to consult the government before approving BCF plans.

To this end, the Better Care Fund plans for 2021/22 were assured by the NHS and local government regional teams, and recommendations were agreed with the BCF Programme Board (Chaired by DHSC and Department for Levelling Up, Housing and Communities), prior to approval by NHS England regional directors on behalf of the NHS England Executive Group.

Objective 4: Improving prevention of ill health and delivery of NHS public health services

This objective focused on the urgency that the pandemic brought in highlighting the need for the government and NHS England to take broader action on preventable ill health. This included investment in evidence-based programmes on smoking, alcohol and secondary prevention of heart attacks, stroke, diabetes and dementia.

NHS England and NHS Improvement's success was measured on; timely influenza vaccine rollout, efforts to recover NHS public health services, including school aged vaccinations and cancer and non-cancer screening programmes that had paused or reduced due to the pandemic, meaningful action on measles and rubella, the age extension of the NHS bowel

cancer screening programme, weight management services including increasing access and coverage, and tackling health inequalities.

Vaccinations and immunisations (additional to COVID-19 vaccinations) continued to be delivered at pace, with 22.2 million flu vaccines being administered in 2021/22, the highest ever since the programme began in the late 1960s. In addition to this, the update of school age immunisations was 20% higher in 2021/22 than in 2020/21.

On cancer screening, the invitation backlog continued to decrease as mammogram screening activity by NHS providers remained at higher levels than pre-pandemic. In addition to this, budgetary approval was given to commence the build of interface to allow AI reads of images directly into breast screening systems.

On weight management services, new NHS-commissioned weight management services were mobilised from April 2021, with a digital referral hub for GPs operational from late April. An acceleration of referrals was observed in Q4 21/22 with 113,990 referrals recorded by the Digital Weight Management Programme (DWMP) to end March 2023. GP incentives for referrals to weight management services continues throughout 2022/23.

Progress on tackling health inequalities continued, with the Health Inequalities Improvement Dashboard being launched with local authorities, ICSs and PCNs having access – allowing them to build on learning from the COVID-19 pandemic around the importance of good quality data to provide insights to drive improvements in tackling health inequalities.

Objective 5: Maintain and improve information sharing

Sharing information with government has been an essential part of our pandemic response and supporting the Secretary of State to fulfil his functions. In meeting this objective, NHS England continued to embed a culture of transparency and openness through the NHS, reducing barriers to information sharing (including between providers of services) to ensure that patients receive high quality, safe and integrated care, whatever service they are using, while at the same time, continuing to work with Government and wider NHS partners to improve data collection processes, reducing unnecessary administrative burdens on frontline organisations.

Recognising the importance of transparency and openness, NHS England's IG Portal brings together national guidance on information governance to ensure frontline staff and IG professionals understand how to use information appropriately to support health and care purposes. NHS England and NHS Improvement have also been working in partnership with NHSX (now the NHS Transformation Directorate) and other national organisations to use their health and care data to minimise the burden of collecting more data from frontline service providers.

Financial objectives

The final budget for the year included an additional £16.3 billion of revenue resource to support NHS England and NHS Improvement with ongoing COVID-19 costs. With this funding, NHS England and NHS Improvement were able to deliver financial balance in 2021/22.

Robust financial performance was achieved through delivering timely updates on both capital and revenue spending plans including data on capital deployment.

Appendix 2: Meeting our Public Sector Equality Duty

Advancing equality for patients, the COVID-19 pandemic and addressing health inequalities

Key areas of patient equality focused work undertaken in 2021/22, by reference to protected characteristics, are described in Annex A under equality objectives (EO) 1, 3, 4, 5 and 7 of our full review report.[135]

In addition to extending and publishing, extended equality objectives for NHS England and NHS Improvement for 2021/22[136], key work focused on improving the capability of staff (EO1); improving the experience of LGBT staff (EO3); reducing language barriers (EO4); identifying how to improve equality information (EO5); and ensuring that the COVID-19 response effectively considered the Public Sector Equality Duty (PSED), equality considerations and associated health inequalities. We also worked on the publication of the 2020/21 Specific Equality Duties (SED) report, which was published in February 2022.[137] We also undertook a rapid review, engagement activities and key work to produce our future equality objectives report for 2022/23 and 2023/24 and develop targets for 2022/23.

At the end of March 2021, we published Priorities and Operational Planning Implementation Guidance for 2021/22[138]. This set out five key priority actions for the NHS to tackle health inequalities, and address equality considerations by reference to protected characteristics, which were:

- 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; and
- Priority 5: Strengthen leadership and accountability.

This is an area of joint interest that engaged both the PSED and the health inequalities duties. The priorities were set by the national Healthcare Inequalities Improvement Programme and the programme is overseeing their implementation. Key work undertaken is described in Annex 1, Equality Objective 7 of our full review report.[139]

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[135] NHS England and NHS Improvement: Equality objectives and information as at 31 March 2022
[136] NHS England's and NHS Improvement's equality objectives for 2020/21 and 2021/22, https://www.england.nhs.uk/about/equality/equality-objectives-for-20-21-and-21-22/
[137] NHS England's and NHS Improvement's equality objectives for 2020/21 and 2021/22, https://www.england.nhs.uk/about/equality/equality-objectives-for-20-21-and-21-22/
[138] https://www.england.nhs.uk/wp-content/uploads/2021/03/B0468-implementation-guidance-21-22-priorities-and-operational-planning-guidance.pdf

[139] NHS England and NHS Improvement: Equality objectives and information as at 31 March 2022

Our current equality objectives

The equality objectives for NHS England during 2020/21 and 2021/22 addressed our role as an NHS system leader, commissioner and our own role as an employer. The first six equality objectives have been in place since 2016/17 although they, and their associated targets, were reviewed in 2018. For 2019/20, 2020/21 and 2021/22, our seventh equality objective was approved by the Boards of NHS England and NHS Improvement. The seven equality objectives in place as at March 2022 were:

1. To improve the capability of NHS England's commissioners, policy staff and others to understand and address the legal obligations under the PSED and duties to reduce health inequalities set out in the Health and Social Care Act 2012.
2. To improve disabled staff representation, treatment and experience in the NHS and their employment opportunities within the NHS.
3. To improve the experience of LGBT+ patients and improve LGBT+ staff representation.
4. To reduce language barriers experienced by individuals and specific groups of people who engage with the NHS, with specific reference to identifying how to address issues in relation to health inequalities and patient safety.
5. To improve the mapping, quality and extent of equality information in order to better facilitate compliance with the PSED in relation to patients, service-users and service delivery.
6. To improve the recruitment, retention, progression, development and experience of the people employed by NHS England to enable the organisation to become an inclusive employer of choice.
7. To ensure that the equality and health inequality impacts of COVID-19 are fully considered and that clear strategies are developed and implemented for the NHS workforce and patients. To ensure that the proposed NHS People Plan and patient focused strategies reflect this and make an effective contribution to advancing equality for all protected characteristics and to reducing associated health inequalities.

National Advisor for LGBT+ Health

During 2021/22, the National Advisor for LGBT Health and his team continued to work on a number of priorities to reduce health inequalities, to improve the experience of healthcare for LGBT+ people and to address the inequalities of experience of the LGBT+ NHS workforce.

This work focused on three key areas: improving data collection and monitoring, education, training and workforce development and supporting the NHS to deliver LGBT+ inclusive services. In 2021/22, we worked with NHS England's Insight and Feedback team to include, for the first time, an inclusive question on gender identity and trans status in the Cancer Patient Experience Survey. This work has enabled us to better understand the experiences of trans and non-binary people of cancer care and will support improving data collection and

monitoring in other settings. We also worked with the Mental Health Team to include a similar question in the Mental Health Services Dataset.

In 2021/22, we expanded the commissioning of 'Phase 2' of the Rainbow Badge project to build on the successful Rainbow Badge initiative by developing a quality assurance framework to support a further 40 NHS trusts in their work to address LGBT+ health inequalities and to ensure an inclusive workplace for their LGBT+ staff. We also worked closely with the Maternity Team to deliver the 'Improving Trans and non-binary people's Experience of Maternity Services' project which produced a number of recommendations to improve antenatal and postnatal care for trans people and have supported work on developing more inclusive language in maternity services which will be relevant for other clinical and policy areas across NHS England and NHS Improvement.

Equality and Inclusion Team focused on workforce

With the launch of the People Directorate in April 2020, the Equality and Inclusion team was established, with a mandate to develop a national strategy to make the NHS future-proofed in EDI where everyone counts, and experiences a sense of belonging – part of our NHS constitutional values. The NHS workforce is not immune to the inequalities that pervade society at large and the COVID-19 pandemic illustrated groups with some protected characteristics (e.g. race, disability) within the workforce who were disproportionately affected by a combination of the virus, long term structural inequality, process deficits and the collateral impacts of the emergency and pandemic response.

Workforce Race Equality Standard

Since 2015, NHS England has set the standards and guidance on the data, analysis and strategic direction for workforce race equality in the NHS. The WRES supports all organisations involved in NHS service delivery to identify and evidence progress and close gaps in experience between BME and White staff. WRES reports since 2015 show year-on-year improvements across some WRES indicators. The next stage is developing means and measures on leadership accountability, provider responsibility and strategies to deliver sustainable, evidence-based and future-focused advancement of race equality across all professional groups and hierarchies.

Two published frameworks underpinning this work are: (i) Model Employer to increase BME representation across the NHS workforce pipeline and at leadership levels using evidence-based action plans; and (ii) A Fair Experience for All framework to support NHS organisations in closing the ethnicity gap in the application of disciplinary action between staff groups. Current and future WRES reports and wider work are aligned with the NHS People Plan, the NHS Long Term Plan and the wider priority of reducing avoidable health inequalities using an intersectional lens where data permits.

The forthcoming race equality strategy has been developed to support senior decision-makers to use targeted, measurable actions to improve their WRES indicators, especially in the areas of workforce development, retention, progression and experience. National WRES work will also include further development to compare effective actions and share learning across operations, while engaging and collaborating with wider stakeholders.

Workforce Disability Equality Standard

Similar to the strategic direction provided by the WRES on race equality, the WDES provides a strategic direction for disability equality.

The WDES was launched in 2019 following extensive engagement with Disabled staff, key stakeholders, leaders and national bodies.[140] The WDES is a collection of ten metrics that compare the experiences of Disabled and non-disabled staff. A WDES national data collection takes place annually, with trusts collecting, reporting and publishing their WDES metrics data. A national WDES report was produced with analysis of trends and key findings. The WDES is mandated to NHS trusts and NHS foundation trusts and was extended, on a voluntary basis, to ALBs in 2020. Like the WRES, the WDES supports trusts and ALBs to identify and close the gaps in experience between disabled and non-disabled staff.

The three years of metrics data that have been collected have informed a national programme of work, including the development of new innovative practice initiatives and resources, along with the establishment of national networks, such as the Disabled NHS Directors Network and the National Ambulance Disability Network. Trusts and ALBs have started to produce annual action plans setting out the key priorities that they will work towards in response to their local metrics data. Building on the work to date, a national plan is being developed to inform the direction of the WDES for the next three years.

Read our full report on SED compliance for 2021/22.[141].

[140] https://www.england.nhs.uk/about/equality/equality-hub/wdes/
[141] https://www.england.nhs.uk/publication/nhs-england-and-nhs-improvement-equality-objectives-and-information-as-at-31-march-22/

Appendix 3: Working in partnership with people and communities

In 2021/22 our work has focussed on using the learning from the COVID-19 pandemic to shift how health and care services work with people and communities to a more community-centred approach. The pandemic saw communities mobilise themselves to support each other and encourage vaccine take-up, developing approaches that fitted local circumstances and needs. Communities worked alongside health and care partners to find innovative solutions to new challenges. The learning from this needs to be transferred to help meet other challenges, developing the assets and skills that communities have, and building in to the new 'business as usual' model of practice.

We have undertaken a significant amount of engagement throughout the year with a diverse range of stakeholders to develop new statutory guidance for Integrated Care Boards, NHS Trusts and Foundation Trusts on working with people and communities, to align with the structural changes taking place with the proposed Health and Care Bill. These changes align with our new focus, and we look forward to this being published in 2022/23 and then supporting ICBs to develop meaningful and impactful approaches to working with people and communities in 2022/23.

To complement the new statutory guidance, we have refocused our work in a variety of ways, including updating and developing our learning and support offers; rebranding our network and events for those who work in engagement to #StartWithPeople; and building the range of partners that we work with and seek to influence. These include new and existing networks and partnerships with communities, the VCSE sector, ALBs and Government departments.

Alongside our existing forums, including the NHS Citizen Advisory Group, Learning Disability and Autism Advisory Group and the NHS Youth Forum, we have relaunched the Older People's Sounding Board and started preparation to launch a new LGBT+ Sounding Board in 2022/23.

We made improvements in the way we support Patient and Public Voice (PPV) Partners, and in April 2021 we changed our processes for issuing involvement payments to ensure compliance with His Majesty's Revenue and Customs (HMRC) requirements.

We have supported and advised professionals working across health and care, to ensure public participation is embedded into ways of working. This includes supporting staff to engage during the pandemic and in the recovery of services, through the delivery of 72 online training and learning sessions accessed by 1,778 individuals. Internally this has included assuring NHS England's duty to involve the public in commissioning (section 13Q of the NHS Act 2006). Our Engagement Practitioners Network events, #StartWithPeople, in April and November 2021 attracted over 700 people, with sessions from strategic engagement through to practical examples of good engagement.

We continue to build our internal network of engagement, equality and equity champions and provide them with support and resources to fulfil their role. The champions are senior managers who promote the benefits and embed the practice of working with people and communities in their directorates and regions.

Working with the Voluntary, Community and Social Enterprise (VCSE) Sector

We have continued to work closely with our partners in the sector both on a local and national level to understand the ongoing impact of both the pandemic and health inequalities on vulnerable communities.

Nationally, working in partnership with DHSC, the VCSE Health and Wellbeing Alliance amplified the voices of communities experiencing the greatest health inequalities to inform national policy and delivery. This included 36 research and co-production projects. We have also funded several partners to reach out to their communities to improve uptake of the COVID-19 vaccination.

As we approached the potential confirmation of ICBs as legal entities through legislation, we have worked closely with VCSE and system stakeholders. Our aim was to equip them to meet the requirement that the VCSE is embedded in ICB governance and decision-making arrangements. This has included the delivery of a national development programme across all 42 ICBs and the provision of advice and practical tools to overcome key challenges identified through earlier research.

NHS England also funded 13 projects on a local and national level to respond to the rise in respiratory illnesses in children. This work supported groups which experience health inequalities to keep their babies and young children safe and well.

Following the significant success of the NHS Volunteer Responders programme as a pandemic emergency response we started redeveloping it as a long-term resource. This involved engagement with VCSE and health and care system stakeholders and volunteers to capture learning from the programme.

To harness the enormous benefits of volunteering and the VCSE sector within health and care we established an NHS Volunteering Taskforce. This will harness the experience of a wide range of VCSE sector and health leaders to identify key opportunities for strategic improvement. The Taskforce will report its findings in summer 2022.

Supporting PCNs to work with people and communities

In 2021/22 the PCN people and communities workstream built on the previous years' work to continue to test out various approaches through our test and learn sites, share the learning from those sites and build capacity and confidence around using community centred approaches. We have also started to develop a network of people utilising community centred

approaches to support and develop communities at a PCN level to understand the impact of this way of working in primary care.

One of our Test and learn sites is Central Liverpool PCN[142] who have, with the support CoCreate[143], set out to learn and develop sustainable engagement approaches as a way to tackle racial health inequalities. You can read an evaluation of the project[144] which shares their approach and gives some powerful reflections from some of the clinicians involved. They are undertaking a filming project to further share this work nationally and inspire other PCNs.

Working in partnership with National Association for Patient Participation, The Patients Association, Healthwatch and National Voices we have developed an animation[145] and an NHS Futures[146] site to support PCNs develop their Patient Participation Groups (PPGs) and wider community engagement. Building a network of practitioners is working to challenge the present static model of PPGs often used and share other, dynamic approaches and models to engagement in General Practice. 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.

Access to employment – supporting people with experience of homelessness into Health care Support Worker (HCSW) Roles

Working with our programme partners; Pathway[147], Groundswell[148] and The Royal Society for Public Health (RSPH)[149], we are identifying and addressing some of the systematic and individual barriers to employment. To achieve this, we have been working with Trusts to examine culture, employment practices and the readiness to adopt 'trauma informed' employment practice – something that can support the recruitment of people with a lived experience of homelessness into employment as HCSWs.

Pathway has led on the engagement with Trusts and is developing an evidence base of evaluated approaches to the sustainable employment of people who have experienced homelessness in NHS careers, specifically HCSW roles. Pathway is also developing a 'toolkit of policy and practice' to support the wider application and adoption of approaches that improve the inclusiveness and accessibility of NHS careers, specifically into nursing roles through the HCSW entry point, for people who have experienced homelessness and other marginalised groups.

Groundswell is working with local VCSE organisations to identify potential candidates interested in HCSW roles, to take part in the Access to Employment course developed and

[142] https://clpcn.co.uk/tackling-racial-inequality-working-group/
[143] https://www.wearecocreate.com/wp-content/uploads/Co-create-CLPCN-Tackling-Racial-Inequality-Engagement-Project-Evaluation-1.pdf
[144] https://www.wearecocreate.com/wp-content/uploads/Co-create-CLPCN-Tackling-Racial-Inequality-Engagement-Project-Evaluation-1.pdf
[145] https://www.youtube.com/watch?v=4_Y1FLMrdsw
[146] https://future.nhs.uk/PPGnetwork/grouphome
[147] https://www.pathway.org.uk/
[148] https://groundswell.org.uk/
[149] https://www.rsph.org.uk/

delivered by RSPH as part of this project. The course is delivered alongside trust's individual recruitment practices and will equip candidates with the necessary skills and core values to support them in applying for vacant HCSW roles at their local trust.

RSPH is supporting those taking the course to understand the core skills and values required in the role of a HCSW and is helping participants to recognise their ownership of those same skills and values, as well as supporting them in to be able to evidence situations in which they have had to demonstrate them. RSPH is also supporting participants to build their skills and knowledge around health and wellbeing, through access to the RSPH Level 1 Award in Health Improvement and is assisting participants to identify and apply for HCSW roles in their local area and to access any support they need in order to do this.

The project is in its latter stages and due to finalise delivery in June 2022. There have been some excellent examples of Trusts adapting their approaches to support people into these roles. Pennine Care[150] developed a leaflet which set out how the Trust would support people and eliminated the need for complex application forms supporting people to apply via a short CV. These approaches have been shared across all the Trusts involved.

Work with young people

We have fulfilled our NHS Long Term Plan objective to increase youth volunteering within the NHS in two ways:

1. Through the ongoing development of the NHS Cadets[151] scheme which enables 14 to 18-year olds from deprived communities and under-represented groups to volunteer in health and care. NHS Cadets has involved 2,729 young people across 98 groups, many of which met virtually during the pandemic and are now beginning to meet in person. 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.
2. Through our support for the Pears #IWill Fund[152] to embed youth volunteering within 32 NHS trusts. This focused on the development of best practice youth volunteering models, collaboration with clinicians and local partners and increasing diversity within volunteering. The learning will be shared in a research report due to be published in early 2022/23.

The long-established NHS Youth Forum has continued to meet, run in partnership with the Council. Consisting of 25 young people, appointed for 1-3 years, from across the country, they have advised on a wide range of topics via regular 'consultation cafes'. They have additionally planned and delivered three, youth-led projects, engaging over 1,000 young people, focusing on:

[150] https://www.penninecar/e.nhs.uk/
[151] https://www.sja.org.uk/get-involved/young-people/nhs-cadets/
[152] https://pearsfoundation.org.uk/partners/nhs-trusts-young-volunteer-programmes/

- Young people's mental health and digital services, including delivery of a high-level presentation to NHS England's Children and Young People's Mental Health team on their preliminary findings, influencing the team's business planning.
- Young people's health inequalities, including presented their project and preliminary findings at an #IWill Health and Social Care Alliance network event on young people's health inequalities.
- Widening access to NHS careers, including an initial discussion with the NHS Workforce Improvement team about their project findings.

Working in partnership with parents and carers of young people

In 2021/22 we published the #Gettingthrough guides for parents and carers of young people in secure mental health units. The published booklets were sent to over 80 young peoples' inpatient mental health units.

#Gettingthrough the First Few Days[153] sets out important information family members need when their child or young person has been admitted to a CAMHS inpatient unit. This is part of a wider collection of guides created by and for families in collaboration between the NHS and parents and young people. Taking the time to talk through this information will help build trust from the outset and provide the reassurance families need. Staff and parents complete the booklet together, giving an invaluable opportunity to build an early relationship between parents and unit, as well as enabling the sharing of valuable information which will help support the care of the children and young people.

These guides will support our CAMHS units and will be highlighted in our Tier 4 CAMHS service specifications. The Royal College of Psychiatrists will also include the #Gettingthrough guides in their quality network standards.

Networks and forums

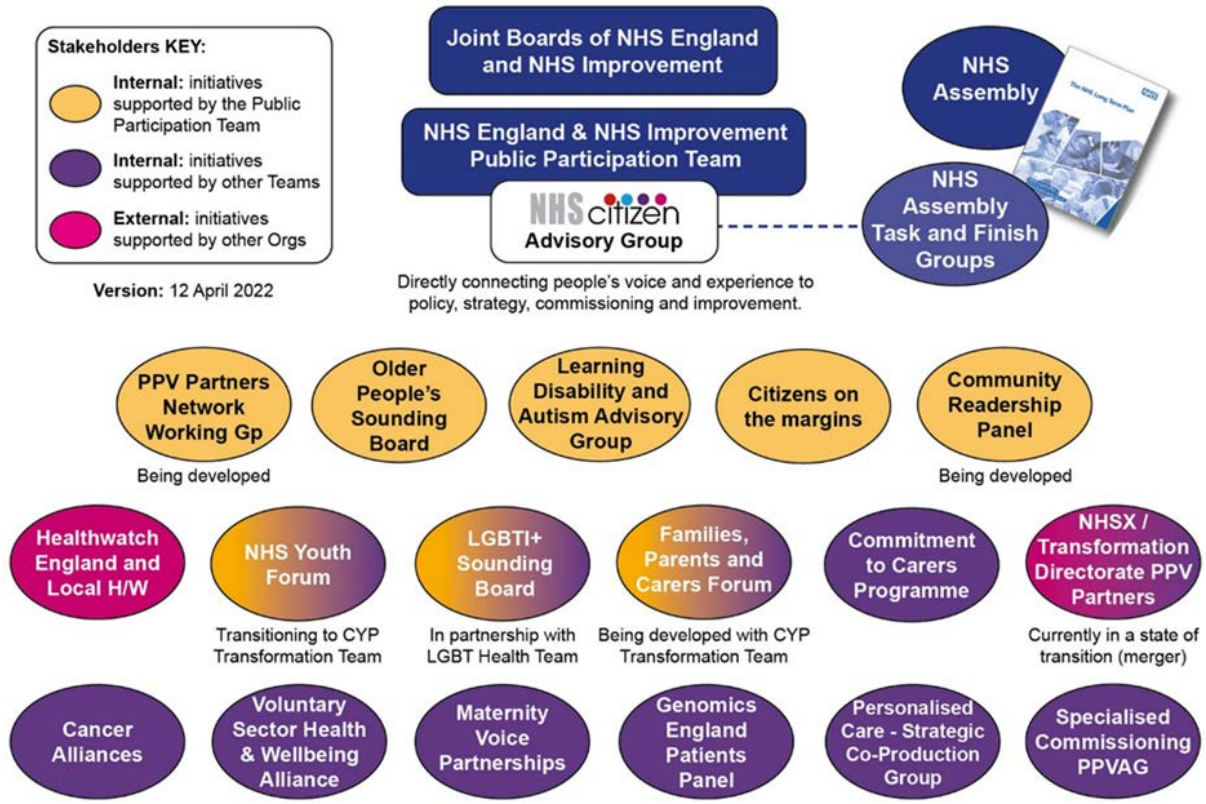
Across the organisation, we run a wide range of forums, advisory groups and sounding boards, involving people from different communities and health interests.

One of these is the NHS Citizen Advisory Group, which brings together a wide range of people who are committed to working with people and communities as partners. Members are mostly PPV partners, or 'experts by experience', who are involved in NHS England forums and networks. Together, they are supported by staff members, who often attend meetings to listen and learn. The Advisory Group acts as a critical friend within a safe space - providing constructive challenge and feedback on our work programmes, policy areas, and the engagement approaches used to inform them.

[153] https://www.england.nhs.uk/publication/gettingthrough-the-first-few-days/

The group meets on a bi-monthly basis, as well as hosting ad-hoc 'hot-topic' sessions for quickly evolving programmes, such as the Elective Recovery strategy, for rapid and timely feedback which helped with the ongoing development.

NHS Citizen advisory group



Learning Disability and Autism Advisory Group

The Learning Disability and Autism Advisory Group has continued to advise on changes which affect autistic people and people with a learning disability. They have worked on a review of GP services since -19, making sure changes work well for everyone. They have advised on the roll out of the Integrated Care Systems, in particular to ensure that the new commissioning structures work with and listen to autistic people and people with a learning disability.

The group has supported the review of the care, education and treatment review policy, to help people get the right mental health support and avoid inappropriate mental health hospital admission. The group has also influenced the development of learning from the lives and deaths of people with a LeDeR. The group had previously advocated for the LeDeR programme to be extended to work towards preventing autistic people's premature deaths. This has now happened and the group advised on their role in making this successful.

The group has provided advise to influence the development of safe and wellbeing reviews to make sure people with a learning disability and autistic people who are in mental health hospitals are safe and well. We coproduced (with clinicians, autistic people and people with a learning disability) simple questions that the commissioners could ask, that could really get to the point around people's care and quality of life in mental health hospitals.

Appendix 4: Sustainability

This sustainability report outlines our progress against the Greening Government Commitments (GGCs)[154] and the Greener NHS commitment to be a net-zero health service by 2040. Our progress is measured against 2017/18 as the baseline year, in line with the GGCs.

More in-person working over the past 12 months has resulted in increased utilities use and higher levels of business travel than last year. Levels are still lower than pre-pandemic however, and the related emissions are significantly lower than 2017-18.

Building on our Interim Green Plan last year, we have spent this year developing our Green Plan which will be published in summer 2022. As part of this, we've re-worked the data for all years from 2017-18; firstly, to include data which wasn't available previously and secondly to ensure a consistent method was used when estimating any missing data. The figures for all years included in this report have been updated to reflect the most accurate position possible with the information we have and to make it easier to draw comparisons over time.

Scope

All reporting in this sustainability report covers NHS England, NHS Improvement and the CSUs. For ease of comparison, the joint figures for previous years have been included where they previously may have been reported separately.

CCGs report on sustainability within their individual annual reports which are published on their respective websites. A list of CCGs, and links to their websites, can be found on the NHS England website.[155]

Reporting for multi-occupancy buildings

Within this annual report we are reporting on the proportion of the NHS Property Services (NHS PSe) buildings occupied by NHS England and NHS Improvement and CSUs. Where we are a tenant of a government department of other ALB, energy, waste and water information will be reported within its annual report and published on its respective websites.

Provision of data

NHS PSe is the landlord for most of NHS England and NHS Improvement and CSU offices and we rely on them for utilities and waste data. The energy and water data provided for this financial year comes with the following guidance from NHS PSe:

- All consumption and costs are apportioned by the percentage occupancy at each property.
- Data has been estimated where it is not readily available; all water data is estimated.
- Estimations have been based on actual data, considering floor area and site type.

[154] Greening Government Commitments 2021 to 2025 - GOV.UK (www.gov.uk)
[155] www.england.nhs.uk/ccg-details

- February to March 2022 data has been estimated due to the invoices not being available at the time of writing this report.

NHS PSe has also been able to provide partial data for waste collected from our sites. It has not provided estimates where data is unavailable, so we have made our own estimates based on the averages per m^2 of the data that has been provided. NHS PSe continues to work on improving its data collection ability.

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

	2018/19	2019/20	2020/21	2021/22[156]	Change from 2017/18 baseline
Net Internal Area reported in m^2	75,644	73,942	68,016	56,347	-52%
FTEs reported	14,119	15,408	15,801	16,318	+24%

[156] North East London CSU NIA and FTE has been included although it ceased to exist on 1 November 2021.

Greenhouse gas emissions[157]

		2018/19	2019/20	2020/21	2021/22	Change from 2017/18 baseline
Scope 1 emissions tCO_2e	Emissions from organisation-owned fleet vehicles	151	243	57	14	
	Gas	1,513	2,034	936	1,005	
	Total Scope 1[158] (tCO_2e)	**1,664**	**2,277**	**993**	**1,018**	**-61%**
Scope 2 emissions tCO_2e	Electricity	3,288	2,892	1,592	1,273	
	Total Scope 2[159] (tCO_2e)	**3,288**	**2,892**	**1,592**	**1,273**	**-85%**
Scope 3 emissions tCO_2e	Road travel	3,735	2,851	465	330	
	Rail Travel	1,651	1,418	50	161	
	Domestic air travel	45	32	1	2	
	International air travel	44	55	2	2	
	Total Scope 3[160] (tCO_2e)	**5,431**	**4,356**	**519**	**494**	**-99%**
	Total (tCO_2e)	**10,383**	**9,524**	**3,104**	**2,786**	**-94%**

Related use and cost

			2018/19	2019/20	2020/21	2021/22
Scope 1 Related use	Miles	Scope 1 business travel	605,576	836,735	226,492	51,897
	kWh	Gas	8,226,032	11,062,757	5,089,362	5,486,632
	Cost	Scope 1 business travel	£263,417	£367,840	£26,984	£24,044
		Gas	£315,331	£410,829	£161,714	£192,395
Scope 2 Related use	kWh	Electricity	10,702,260	10,428,921	6,288,476	5,997,467
	Cost	Electricity	£1,650,135	£1,785,300	£1,071,000	£778,529
Scope 3 Related use	Miles	Road travel	6,671,729	10,166,014	1,678,725	1,236,664
		Rail Travel	27,684,993	21,404,609	843,910	2,816,243
		Domestic air travel	199,514	155,961	6,381	9,686
		International air travel	390,579	253,062	14,798	12,102
	Total miles (scope 1 and 3)		**35,552,391**	**32,816,381**	**2,770,306**	**4,126,802**
	Cost	Road travel	£5,381,636	£4,951,830	£593,452	£639,481
		Rail Travel	£13,608,738	£10,355,117	£832,278	£1,310,779
		Domestic air travel	£81,195	£67,119	£6,381	£3,735
		International air travel	£56,234	£29,082	£14,798	£2,314
	Total cost of business travel (scope 1& 3)		**£19,391,220**	**£15,770,987**	**£1,473,893**	**£1,980,353**
	Total cost of related use (all scopes)		**£21,356,685**	**£17,967,116**	**£2,706,607**	**£2,951,277**

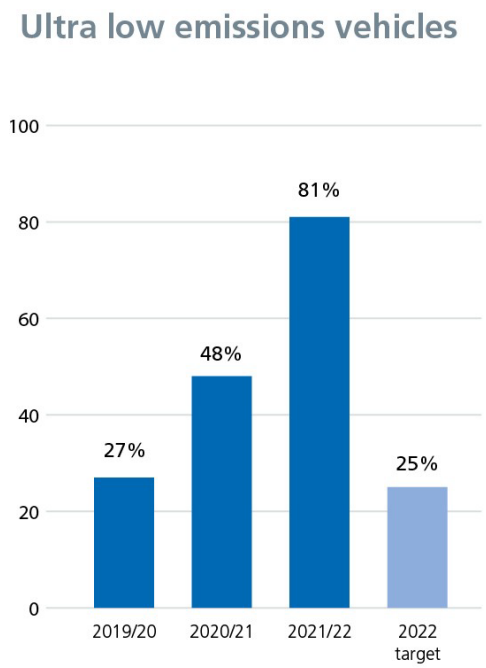
[157] Figures have been rounded to the nearest whole number
[158] Scope 1 emissions arise from organisation owned and operated vehicles, plant and machinery
[159] Scope 2 emissions arise from the consumption of purchased electricity, heat, steam and cooling.
[160] Scope 3 emissions arise from official business travel by vehicles not owned by the organisation

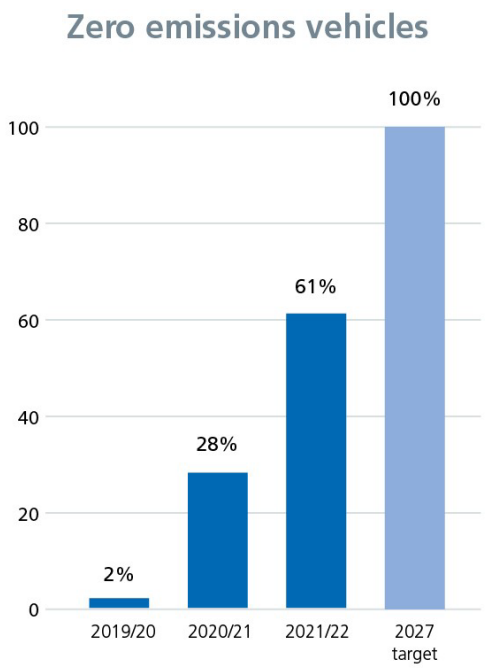
Car fleet

2021-25 GGC sub-target:

Meet the government fleet commitment for 25% of the government car fleet to be ultra-low emission vehicle 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.

Vehicle emissions





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.

	2018/19	2019/20	2020/21	2021/22	Change from 2017/18 baseline
Total (tonnes)	1,012	1,440	291	225	-23%
Recycled (tonnes)	451	1,241	177	103	
Incinerated with heat recovery (tonnes)	537	190	109	100	
Incinerated without heat recovery [161]	-	-	-	14	
Landfill (tonnes)	24	10	6	7	
Waste to landfill (%)	2%	1%	2%	3%	+1%
Recycling (%)	45%	86%	61%	46%	+1%
Cost of waste disposal	£364,615	£199,127	£96,175	[162]	
Paper use (sheets)	54,447,709	45,576,477	4,913,241	3,017,582	-95%

Although the overall amount of waste has decreased over the last three years, the proportion of recycling has also decreased to below the 70% target. The proportion of waste going to landfill has also increased over time, although it remains below the 5% target. This is likely to be the result of COVID-19 protective measures, including disposable face coverings and increased cleaning, coupled with a significantly smaller amount of waste overall.

The waste we have reported above covers our general office waste. Large waste removals, like office furniture, for example, have not been included although we are working with suppliers to provide this information in future. We also work in partnership with NHS PSe which helps co-ordinate the removal of office furniture from its sites where necessary and possible. Through its contract with a resource redistribution network, it can arrange collection and redistribution of surplus furniture on our behalf.

ICT waste

We maintain the use of information and communications technology (ICT) equipment for as long as possible. When items become obsolete, we work in partnership 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.

[161] This is the first year we have made a distinction between waste being incinerated with and without heat recovery.
[162] The cost of waste disposal during 2021/22 was not provided by NHS Property Services in time for the publication of this report.

Reducing our water use

2021-25 GGC headline target:

Reduce water consumption by at least 8% from the 2017/18 baseline.

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

	2018/19	2019/20	2020/21	2021/22	Change from 2017/18 baseline
Water used (m^3)	59,919	54,974	15,779	24,964	-85%
Cost of water used	£360,368	£216,318	£33,518	£73,169	

The water reported above is entirely water which has been purchased through the mains water supply. We do not own or control any water sources such as lakes or reservoirs for example.

Water use has significantly reduced from the baseline year. This is a combination of a reduction in the size of our corporate estate and less in-person working since the start of the pandemic.

Procuring sustainable products and services

2021-25 GGC headline commitment:

Continue to buy more sustainable and efficient products and services with the aim of achieving the best long-term, overall value for money for society.

With the publication of the Delivering a 'net zero' National Health Service[163], the NHS affirmed the need to take action on climate change and set ambitious reduction targets, including a commitment that before the end of the decade, the NHS will no longer purchase from suppliers that do not meet or exceed our commitment to net zero. In September 2021, the NHS England and NHS Improvement Board approved the Net Zero Supplier Roadmap,[164] which sets out the key milestones for suppliers through 2030.

Our commitments to deliver a net zero health service go beyond carbon reduction. It is imperative that alongside our environmental efforts, we make every effort to stamp out modern slavery throughout our supply chain. We also have a duty to use the money spent through the NHS to generate more social value for the communities that we serve, reducing health inequalities and improving the wider determinants of health.

[163] https://www.england.nhs.uk/greenernhs/wp-content/uploads/sites/51/2020/10/delivering-a-net-zero-national-health-service.pdf
[164] https://www.england.nhs.uk/greenernhs/get-involved/suppliers/

Within NHS England and NHS Improvement, we have integrated metrics that measure these benefits and include them as part of our procurement evaluations. We are aligned with the government's procurement policy note on social value, mandating that a minimum weighting of 10% of the total score for net zero and social value should be applied in all procurements,[165] and we have adopted this into the NHS England and NHS Improvement procurement strategy. Since April 2021, all our procurements must include a minimum weighting of 10% on net zero and social value, and this was expanded to cover the wider NHS from April 2022 as part of the net zero supplier roadmap.

Our sustainable procurement programme continues to grow, and we are committed to leading by example across the wider health system

Climate change adaptation

Our business continuity plans take account of the impacts of climate change. These plans ensure we will continue to operate during unplanned disruptions, including extreme weather events.

With PHE and others, we continue to produce a national Heatwave Plan[166] each year. This is intended to protect the population from heat-related harm to health. We also contribute to the Cold Weather Plan,[167] which gives advice to help prevent the major avoidable effects on health during periods of cold weather in England.

The Greener NHS national programme

The Greener NHS national programme was launched in 2020, alongside the appointment of the NHS's first Chief Sustainability Officer, to deliver the world-leading commitment of a net zero national health service. 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
- there is strong support from the system's 1.3 million staff, with over nine out of 10 supporting the NHS's net zero ambitions.

The Greener NHS national programme is led by the NHS sustainability board and reports to the NHS England and NHS Improvement board twice annually. The programme is delivered in

[165] B1030-applying-net-zero-and-social-value-in-the-procurement-of-NHS-goods-and-services-march-2022.pdf (england.nhs.uk)
[166] https://www.gov.uk/government/publications/heatwave-plan-for-england
[167] https://www.gov.uk/government/publications/cold-weather-plan-cwp-for-england

the way that is most appropriate and sensitive to each local context by working carefully through the NHS regions and systems.

Supporting sustainability across the NHS

This year, to achieve the carbon savings required to realise a net zero NHS, an ambitious change programme was delivered to improve patient care and health outcomes and secure long-term savings. Action was taken across several key thematic areas.

NHS estate

Reductions to the carbon footprint were achieved by 94 trusts as a result of £310 million of capital investment from the Public Sector Decarbonisation Scheme, and the NHS Energy Efficiency Fund. Examples range from Milton Keynes University Hospital fitting over 2,500 solar panels, producing 853 megawatt hours per year, through to the installation of heat pumps and other low-carbon heating measures to reduce reliance on fossil fuel.

NHS fleet

As well as unveiling the world's first zero emission ambulances, the NHS partnered with the Department for Transport to deploy 11 electric 19-tonne trucks, together with the required charging infrastructure. Progress towards a wider zero emissions fleet is also gaining momentum, with the NHS Non-Emergency Patient Transport review[168] published in July 2021 setting out plans for a zero emission non-emergency patient transport fleet by 2035, and several trusts already adopting electric vehicles for rapid response, patient transport and logistics.

NHS Supply Chain

With more than 60% of the NHS carbon footprint based within the NHS supply chain, we need the support of every supplier if we are to reach net zero by 2045. This year, the NHS launched a roadmap[169] to help suppliers align with our net zero ambition between now and 2030, and in April 2022 the NHS adopted a minimum 10% weighting for net zero and social value in the award of NHS contracts.

Medicines

A small number of medicines account for a large portion of NHS emissions, with anaesthetic gases and inhalers making up 5% of the total NHS carbon footprint. This year, the Primary Care Network Investment and Impact Fund included an incentive for primary care networks to prescribe lower-carbon inhalers where clinically appropriate and as part of a shared decision-making conversation with patients. In addition,149,000 tonnes of carbon were saved on nitrous oxide emissions through improved stock management, repairs to manifold leaks and demand

[168]Report: NHS England (2021) *Improving non-emergency patient transport services: Report of the non-emergency patient transport review.* Available at: https://www.england.nhs.uk/urgent-emergency-care/improving-ambulance-services/nepts-review/
[169] Webpage: NHS England (2021). Available at: https://www.england.nhs.uk/greenernhs/get-involved/suppliers/

reduction. Desflurane usage also decreased significantly, now comprising less than 10% of all volatile usage, with 40 trusts eliminating it altogether.

Staff engagement

In 2021/22 the NHS led a wide variety of activities, coalescing at the 26th United Nations Climate Change Conference (COP26). A new staff campaign, 'Healthier Planet, Healthier People', focused on what individual health professionals can do, or are already doing, to support our net zero ambitions. A regional roadshow from Cornwall to COP26 was held across each of the seven regions, with over 220 NHS trusts and integrated care systems, and nine national leaders participating.

Adaptation and resilience

In 2021, NHS England and NHS Improvement and the UKHSA published the third *Health and care adaptation report.*[170] It provides an overview of the next steps required at a local, regional and national level to address any identified risks and build resilience, while delivering on net zero commitments. Adapting the World Health Organization's *Operational framework for building climate-resilient health systems*,[171] the report covers three broad areas: health information systems, service delivery and leadership, workforce development and resourcing. As climate change could widen existing health inequalities, the report also outlines how to support those most vulnerable to the systemic shocks associated with climate change.

[170] Report: NHS England (2021) *Health and care adaptation report 2021.* Available at: https://www.england.nhs.uk/publication/health-and-care-adaptation-reports/

[171] Report: World Health Organization (2015) *Operational framework for building climate resilient health systems.* Available at: https://www.who.int/publications/i/item/9789241565073

Appendix 5: Acronyms

A

A&E Accident and Emergency

AAC Accelerated Access Collaborative

AACo Approvals and Appointments Committee

AI Artificial Intelligence

ALB Arm's Length Body

ANNB Antenatal and Newborn screening programmes

ARAC Audit and Risk Assurance Committee

B

BCF Better Care Fund

BCG Bacillus Calmette-Guérin

BME Black, Asian and Minority Ethnic

C

CAMHS Children and Adolescents Mental Health Services

CAN Cyber Associates Network

CCG clinical commissioning group

CDF Cancer Drugs Fund

CEO Chief Executive Officer

CETV Cash Equivalent Transfer Value

CFO Chief Financial Officer

CHIS Child health information services

CMD Commercial Medicines Directorate

CMDU COVID-19 Medicine Delivery Units

CMU Commercial Medicines Unit

COO Chief Operating Officer

CRR Corporate Risk Register

CSU Commissioning Support Unit

CYP Children and Young People

D

DAWN Disability and Wellbeing Network

DHSC Department of Health and Social Care

DSPT Data Security and Protection Toolkit

E

EIP Early Intervention in Psychosis

EO Equality Objectives

EPRR Emergency Preparedness, Resilience and Response

EQG Executive Quality Group

ESM Executive Senior Manager

ESR Electronic Staff Record

F

FReM Financial Reporting Manual

FTE Full-time Equivalent

G

GDPR General Data Protection Regulation

GGC Greening Government Commitments

H

HCSW Health care Support Worker

HEE Health Education England

HMRC His Majesty's Revenue and Customs

HPV Human Papillomavirus

I

IAPT Improving Access to Psychological Therapies

ICB Integrated Care Boards

ICO Information Commissioner's Office

ICS Integrated Care System

ICT Information and Communications Technology

IFRS International Financial Reporting Standard

IG Information Governance

IMF Innovative Medicines Fund

ImGo Immunoglobulin

IPC Infection Prevention Control

IRLS Innovation, Research and Life Sciences

ISA International Standards on Auditing

K

KPI Key Performance Indicator

L

LeDeR Learning Disability Mortality Review

LGBT+ Lesbian, gay, bisexual, transgender +

M

MenACWY Meningococcal bacteria – A, C, W and Y

MMR Measles, Mumps and Rubella

N

NAO National Audit Office

NICE National Institute for Health and Care Excellence

NHSPSe NHS Property Service

NHS TDA NHS Trust Development Authority

P

PCN Primary Care Network

PCSE Primary Care Support England

PHE Public Health England

PHESGO Pertuzumab with trastuzumab and hyaluronidase

PIFU Patient Initiated Follow-up

PPG Patient Participation Groups

PPTS Percentage Points

PPV Patient and Public Voice

PRP Performance Related Pay

PSED Public Sector Equality Duty

R

RSPH The Royal Society for Public Health

S

SAIS School Aged Immunisation Service

SDEC Same Day Emergency Care

SED Specific Equality Duties

SFI Standing Financial Instructions

SMA Spinal Muscular Atrophy

SOF System Oversight Framework

SRO Senior Responsible Officer

STP Sustainability and Transformation Partnership

T

TAAC Trust Approvals and Appointments Committees

TIF Targeted Investment Fund

U

UEC Urgent and Emergency Care

UKHSA UK Health Security Agency

V

VCSE voluntary, community and social enterprise

W

WDES Workforce Disability Equality Standard

WRES Workforce Race Equality Standard

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