NHS Improvement

Trust Development Authority

Annual Report and Accounts 2022-23

For the year ended
31 March 2023

HC1531

NHS Trust Development Authority

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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 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.

NHS Improvement was responsible for overseeing NHS foundation trusts, NHS trusts and some independent providers. We supported them to give patients consistently safe, high quality and responsive care within local, financially sustainable, integrated care systems (ICSs).

By holding providers to account and intervening where necessary, we helped the NHS to meet its operational goals and its longer-term strategy.

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.

We had an annual Mandate from government which, for 2022/23, prioritised three key issues: the continued COVID-19 response, the recovery of the health system, and taking forward reform.

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 April to June 2022, NHS England and NHS Improvement worked together as a single organisation, which we had done since 1 April 2019 as was permitted under the legislation governing our activities. On 1 July 2022, the legal merger of NHS England and NHS Improvement took place when the Health and Care Act 2022 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 NHS TDA and Monitor. It 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 29.

NHS Improvement 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). National directors, either reporting to the NHS England CEO or COO, operated across both organisations, and national teams provided expertise, support and intervention.

NHS England and NHS Improvement's 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 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 42.

Performance Report

Amanda Pritchard

Chief Executive of NHS England

17 July 2023

Chief Executive's and Chair's overview

This is the final Annual Report and Accounts report for NHS TDA, covering the performance of the organisation between April and June 2022, before NHS TDA and Monitor, NHS Improvement's constituent organisations, legally merged with NHS England on 1 July 2022.

This merger was part of a wider ongoing programme to bring together NHS England, NHS Improvement, Health Education England and NHS Digital by 1 April 2023, creating one single organisation with a shared purpose: to lead the NHS in England to deliver high-quality services for all, and put workforce, data, digital and technology at the heart of our plans to transform the NHS.

During this period, the NHS once again faced significant pressures from another wave of COVID-19 which resulted in increased hospitalisations and infections, as well as record levels of referrals for cancer, and continuing high demand for diagnostic tests and elective care. Simultaneously, urgent and emergency care (UEC) performance and hospital handover delays also remained a focus for extensive work across systems.

Frontline teams and those who support them have continued to demonstrate exceptional resilience and ingenuity in addressing these challenges. Further analysis on the results of this collective response will be provided in the NHS England Annual Report and Accounts to be published later in the year.

Alongside supporting colleagues to manage operational challenges and deliver on recovery priorities, a key focus for the NHS and our partners during this period was to help both commissioners and providers prepare for the wider legislative changes which, as well as transferring Monitor's functions to NHS England, established Integrated Care Boards and Partnerships within Integrated Care Systems. We have also been keen to promote provider collaboration as a means of building resilience and improving quality in key service areas across a larger footprint, as well as in finding further efficiencies to reinvest in patient care.

To conclude, we would like to take this opportunity to thank NHS staff – including those who have come to the new NHS England from previous roles in NHS TDA - for their ongoing hard work and continued commitment to support the NHS and its patients during a significant period of challenge and change.

Amanda Pritchard Chief Executive of NHS England

Richard Meddings Chair of NHS England

How NHS Improvement measured 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.

Supported by the legislative provisions enabled by the Health and Care Act 2022 NHS England and NHS Improvement developed the NHS Oversight Framework for 2022/23, published on 27th June 2022. This framework reinforced our vision for system-led delivery of integrated care and set out how the new NHS England and the new Integrated Care Boards (ICBs) (legally established on 1st July 2022) work together.

All ICBs, NHS trusts and foundation trusts were allocated to one of four oversight support framework segments, determined by assessing the level of required support and ranging from no specific support needs (Segment 1) to a requirement for mandated national intensive support (Segment 4). These decisions have been routinely reviewed and updated throughout the year and published on our website.

Performance overview

This performance report covers quarter 1 of 2022/23, the final quarter where NHS TDA existed as a separate legal entity. This period, 1 April to 30 June 2022, is referred to as the “reporting period” in the Performance and Accountability report.

NHS England and NHS Improvement had been operating as one organisation since April 2019. As a result, a substantial amount of work had already been completed ahead of the legal merger: for example, the operating model had been established, several IT systems had been merged and many staff had their terms and conditions aligned.

In the lead-up to the merger date of 1 July 2022, the primary focus was therefore on the legal requirements to enact the merger. All activities that had a legal imperative were completed in advance of the merger date:

- consequential amendments regulations were made by ministers on 9 June 2022 and laid before Parliament on 10 June 2022
- staff consultation was completed on 17 June 2022
- a revised Scheme of Delegation was approved by the Board on 30 June 2022
- the relevant Commencement Regulations were made on 6 May 2022 and commenced certain provisions on 9 May 2022
- all staff, assets, liabilities and reserves were transferred to NHS England on 1 July 2022.

On 28 April 2022, the Health and Care Act 2022 became law and included provision for the National Health Service Commissioning Board to be formally renamed as NHS England, the abolition of Monitor and NHS TDA and the transfer of their functions and staff to NHS England. The

commencement of these provisions and the creation of the related transfer schemes effected the statutory merger of NHS England and NHS Improvement on 1 July 2022.

Performance analysis

In quarter 1 2022/23 the NHS experienced another wave of COVID-19 which resulted in increased hospitalisations and infections. While it had learned lessons from previous waves to ensure that periods of high COVID-19 infection rates had a lower impact on pre-planned care, the result was significant pressures, including record levels of referrals. This position was improved during the remainder of the year – the detail will be provided in the NHS England Annual Report and Accounts later in the year.

Waiting list and performance figures at the end of June 2022 across high-profile areas were:

- the number of 104-week waits fell by 52% to 3,861 in June 2022, while the total elective waiting list stood at over 6.7 million.
- the Faster Diagnostic Standard for June 2022 stood at 70.4% of patients learning of a cancer diagnosis outcome within 28 days from an urgent referral, remaining below the 75% standard in quarter 1 2022/23
- performance against the diagnostic 6-week wait standard stood at 27.5% in June 2022, against a target of 5%, while the total waiting list was 1.57 million
- for mental health, out of area placements for the quarter stood at 51,390 - an improvement on 53,575 as of 31 March 2022.

UEC performance and hospital handover delays remained a challenge across the system, with ongoing support for ICSs, regions and acute sites in England that were facing the biggest challenges. NHS England and NHS Improvement supported implementation of development plans, focusing on the most impactful interventions.

From April to June 2022, the UEC performance returns showed:

- NHS 111 services saw 5.5 million calls received in quarter 1 2022/23, with an abandonment rate of 15.9% as of June 2022 and 47.1% of calls answered in 60 seconds
- there were 2.6 million 999 calls answered between April and June 2022, with the average time to answer 36 seconds in June. In this period there were 1.1 million Category 2 incidents and the average response time in June was 51 minutes and 26 seconds
- April to June 2022 saw total Accident & Emergency (A&E) attendances reach 6.4 million, with 1.5 million emergency admissions and 385,000 patients waiting over 4 hours from decision to admit, to admission
- the high pressure on services had led to worsened 4-hour performance, with the overall average across all trusts at the end of June 2022 standing at 72.1%, with Type 1 trusts at 58.8% in June 2022.

To respond to the challenges, the immediate focus for the NHS and partner organisations was to deliver timely urgent and emergency care and discharge; increase the provision of routine elective and cancer tests and treatments; improve patient experience by implementing the updated UK Health Security Agency's infection prevention and control guidance and return to pre-pandemic inpatient visiting policies.

A full strategic performance analysis will be provided in the 2022/23 NHS England annual report and accounts, due to be published later in the year. That report will provide an analysis of the performance on specific national programmes over the whole year and will include the work of NHS Improvement during April to June 2022. As such, this report does not seek to duplicate that content.

For information on environmental matters, including NHS TDA's impact on the environment during this reporting period, please see appendix 4 on page 121.

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

We closely tracked 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 analysed performance at individual trusts and across the sector to better understand where operational and financial pressures or quality concerns existed and how to help the sector address them. The performance table below reflects performance from 1 April to 30 June 2022.

Referral to treatment	Standard	Performance
Proportion of patients beginning elective hospital treatment within 18 weeks of referral	92%	62.2%
Number of patients waiting more than 52 weeks	0	355,774

Diagnostics	Standard	Performance
Proportion of patients waiting longer than 6 weeks for diagnostic tests	1%	27.5%

Accident and emergency	Standard	Performance
Proportion of patients discharged, admitted or transferred within 4 hours of attending A&E (all types of A&E department)	95%	72.1%
Major emergency departments (type 1)	95%	58.8%

Cancer	Standard	Performance
Proportion of patients with suspected cancer receiving first outpatient consultation within 2 weeks of GP referral (all cancer symptoms)	93%	77.7%
Breast cancer symptoms	93%	66.1%
Proportion of patients receiving first cancer treatment within 31 days of diagnosis	96%	91.8%
Proportion of patients receiving second or subsequent cancer treatment (surgery) within 31 days of decision to treat	94%	80.5%
Proportion of patients receiving second/subsequent treatment (drug therapy) within 31 days of decision to treat	98%	97.9%
Proportion of patients receiving second/subsequent treatment (radiotherapy) within 31 days of decision to treat	94%	91.2%
Proportion of patients receiving first cancer treatment within 62 days of urgent GP referral for suspected cancer	85%	59.9%
Proportion of patients receiving first cancer treatment within 62 days of urgent referral from NHS Cancer Screening Programme	90%	67.1%
Proportion of patients told if they have cancer, or if cancer was definitively excluded was not met within 28 days from urgent referral	75%	70.4%

Ambulance	Standard	Performance
Average (mean) response time for people with life-threatening injuries and illness (Category 1)	7:00	9:06
Response time for people with life-threatening injuries and illness (Category 1) – average for 90th centile	15:00	16:03
Average (mean) response time for other emergencies (Category 2)	18:00	51:38
Response time for other emergencies (Category 2) – average for 90th centile	40:00	1:54:17
Response time for urgent care (Category 3) – average for 90th centile	2:00:00	7:21:14
Response time for less urgent care (Category 4) – average for 90th centile	3:00:00	8:53:11

Infection control	Standard	Performance
Number of MRSA bloodstream infections	0	175
Number of *Clostridium difficile* infections	0	3,726

Mixed sex accommodation	Standard	Performance
Number of breaches of the mixed sex accommodation guidance	0	2,308
Proportion of patients discharged, admitted or transferred within 4 hours of attending A&E (all types of A&E department)	95%	72.1%

Mental health	Standard	Performance
Adult mental health inpatients receiving a follow up within 72 hours of discharge (%)	80%	75%
Mental health adult acute inpatient length of stay over 60 days for people aged 18-64 (crude rate per 100,000 population, rolling quarterly figure)	8	8.7
Mental health adult acute inpatient length of stay over 90 days for people aged 65+ (crude rate per 100,000 population, rolling quarterly figure)	8	10.9
Adult acute out of area placements (bed days per rolling quarter – inappropriate only)	0	51,390

How NHS Improvement supported providers

During April to June 2022, NHS TDA continued support for shadow ICSs to develop effective provider collaboratives, with national and regional teams providing advice and facilitating local peer information sharing.

We delivered a series of webinars in partnership with NHS Providers, which showcased how providers are collaborating across England. We also worked with nine provider collaboratives to gather insights about progress and challenges in delivering benefits of scale, and we engaged with stakeholders across the sector to understand what further support may be useful to accelerate the pace of provider collaborative implementation more broadly.

We consulted on an updated code of governance for NHS trusts that takes account 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 will set clear expectations for collaboration in key areas.

The NHS Long Term Plan committed NHS Improvement to 'a more proactive role in supporting collaborative approaches between trusts' that wished to explore formal merger or acquisition. Bespoke support was offered to trusts considering or proceeding with mergers or acquisitions and helped ensure clarity about the intended benefits.

All plans for mergers or acquisitions that met the threshold set out in NHS Improvement's transaction guidance were assessed to ensure that trusts engaged thoroughly with stakeholders, articulated clearly how they would deliver benefits for patients, and had the capacity and capability to achieve the planned benefits.

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 the accounts.

The revenue resource limit for NHS TDA for the three months to June 2022 was £41.6 million (2021/22: £228.4 million). NHS TDA's net expenditure for quarter one 2022/23 was £41.6 million (2021/22 restated: £220.7 million). The underspend against the revenue resource limit was £nil (2021/22 restated: £7.7 million).

Prior year comparatives have been restated following a review of accruals balances at 30 June 2022 which have also impacted balances in prior periods. Further detail on the restatement is in note 1.14 of the accounts.

The adjustment mainly relates to aged accruals, for which a more systematic process for review was not put in place until after the accounts period.

Main categories of spend

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

Main categories of spend	April to June 2022 £ million	2021/22 restated £ million	Reference to accounts
Operating revenue	(2.9)	(11.2)	Note 3
Staff	34.1	141.2	Note 4
Purchase of goods and services	9.6	89.0	Note 5
Depreciation and amortisation	0.8	1.7	Note 5
Total	**41.6**	**220.7**	**Not applicable**

Operating revenue was broadly in line with 2021/22 on a run-rate basis.

The largest area of spend was staff costs, representing 82% of net expenditure (2021/22 restated: 64%); the increase in proportion was largely due to the reduction in non-pay spend in the three months to June 2022.

Purchase of goods and services spend reduced significantly mainly due to the profile of spend within the underlying programmes. Further detail of operating expenditure can be found in Note 5 of the accounts.

Parliamentary cash funding received was £90 million.

Net assets as of 30 June 2022 were £9.5 million (31 March 2022 restated: net liabilities £38.9 million). The change in the net assets position was largely due to a reduction in payables and accruals and holding a higher cash balance to cover residual liabilities. Net assets were transferred to NHS England on 1 July 2022 via absorption accounting, which is reflected in the notes to the accounts and results in nil net assets at 31 March 2023.

Statement of payment practices

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

Payment practices

NHS TDA's performance against this target is shown in the table below. More detail of how money was spent in the three months to June 2022 can be found in the main accounts section from page 92.

Non-NHS payables	April to June 2022 Number	April to June 2022 £m	2021/22 Number	2021/22 £m
Non-NHS invoices paid in the year	1,183	20.9	5,541	56.0
Non-NHS invoices paid within target	1,097	20.5	5,217	52.8
% of non-NHS invoices paid within target	**93%**	**98%**	**94%**	**94%**

NHS payables	April to June 2022 Number	April to June 2022 £m	2021/22 Number	2021/22 £m
NHS invoices paid in the year	370	17.3	879	56.6
NHS invoices paid within target	304	16.2	769	52.3
% of NHS invoices paid within target	**82%**	**93%**	**87%**	**92%**

Accountability Report

Amanda Pritchard

Chief Executive of NHS England

17 July 2023

Corporate Governance Report

Directors' Report

The Board was 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 had reserved key decisions and matters for its own decision, including setting NHS Improvement's strategic direction, overseeing the delivery of the agreed strategy, determining the approach to risk, agreeing the framework within which operational decisions were taken and establishing the organisation's culture and values. These were functions and matters that the Board agreed should be decisions that can only the Board could take.

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

- ensuring high standards of corporate governance were 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 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
- ensuring and overseeing the closure and transfer of NHS Improvement's duties and functions to NHS England.

The Board

The composition of the Board was essential to its success in providing strong and effective leadership. Members brought a wide range of experience, skills and perspectives to the Board. With their diverse leadership experience, together they developed the strategic direction of the organisation and ensured robust and open debate.

From 1 April 2016 to the abolition of the organisations on 30 June 2022, the membership of NHS TDA and Monitor boards was identical, and the two boards met jointly to form the NHS Improvement Board. The Board comprised the chair, five non-executive directors and four executive directors. The number of executive directors on the Board did not exceed the number of non-executive directors. The Board was further strengthened by the addition of a non-voting associate non-executive director.

Board members

Directors who served on the NHS Improvement Board between 1 April to 30 June 2022 are listed in the table below, along with their Board and committee membership and attendance for those committees which met during the reporting period. Biographical details of those Board members whose directorship was transferred to NHS England on 1 July 2022 may be viewed on our website.

Members	Role	Board	Audit and Risk Assurance Committee	People, Remuneration and Nominations Committee	Digital Committee[1]	Quality and Innovation Committee	System Oversight Committee
Number of meetings in the reporting period	Not applicable	2	2	0	1	3	3
Sir Andrew Morris[2]	Interim Chair	1/2	2/2	0	0	0	0
Lord Patrick Carter of Coles	Non-Executive Director & Senior Independent Director	0	2/2	0	0	0	0
Dame Julia Goodfellow[3]	Non-Executive Director	0	0	0	0	0	0
Rakesh Kapoor[4]	Non-Executive Director	0	0	0	0/1	0	0
Professor Sir Munir Pirmohamed[5]	Non-Executive Director	0	0	0	1/1	0	0
Jeremy Townsend[6]	Non-Executive Director	2/2	0	0	0	0	0

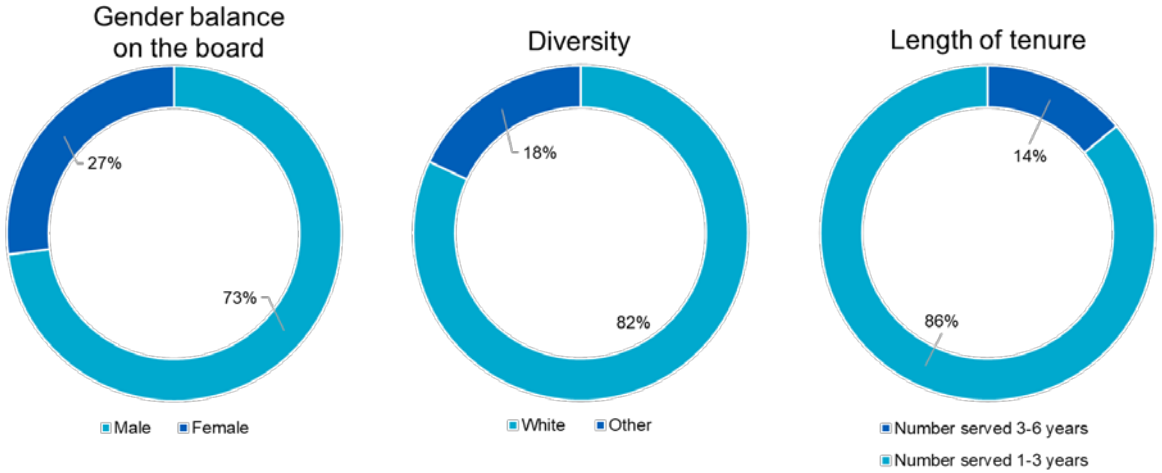
[1] The Digital Committee did not meet during the first quarter of 2022/23.
[2] Sir Andrew Morris was appointed Interim Chair on 30 October 2021 and his non-executive directorship was transferred to NHS England on 1 July 2022. The Board meeting in Sir Andrew Morris's absence was presided by Richard Meddings, with Rakesh Kapoor acting as the NHS Improvement Chair.
[3] Dame Julia Goodfellow remained a member of the Board until 30 June 2022.
[4] Rakesh Kapoor's directorship was temporarily transferred from NHS England to NHS Improvement on 1 May 2021 and his directorship was transferred back to NHS England on 1 July 2022.
[5] Professor Sir Munir Pirmohamed's directorship was transferred to NHS England on 1 July 2022.
[6] Jeremy Townsend's directorship was temporarily transferred from NHS England to NHS Improvement on 25 March 2022 and his directorship was transferred back to NHS England on 1 July 2022.

Sir David Behan[7]	Associate (non-voting) Non-Executive Director	0	2/2	0	0	0	0
Julian Kelly	Chief Financial Officer	0	0	0	0	0/3	0/3
David Sloman	Chief Operating Officer	0	0	0	0	0/3	0/3
Professor Stephen Powis	National Medical Director and Chief Executive	0	0	0	1/1	3/3	3/3
Dame Ruth May	Chief Nursing Officer	0	0	0	1/1	0	0

Board diversity

The charts below show the composition of the Board members by gender, diversity and tenure as of 30 June 2022.

Board diversity



Appointments

The Chair and non-executive directors were appointed by the Secretary of State for Health and Social Care. Non-executive directors were appointed to both Monitor and NHS TDA. As a non-executive director for Monitor they held statutory office under Schedule 8 to the Health and

[7] Sir David Behan's associate (non-voting) non-executive directorship was transferred to NHS England on 1 July 2022.

Social Care Act 2012, and as a non-executive director for NHS TDA they held statutory office under the National Health Service Trust Development Regulations 2012.

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

As noted beneath the table on page 23, a number of members' directorships were transferred to NHS England on 1 July 2022.

The governance structure

Although the NHS England and NHS Improvement operated as one, under the statutory framework in place before 1 July 2022, the two organisations could not legally have one joint board or joint board committees. Each organisation retained its given statutory functions; NHS England could not delegate its functions to NHS Improvement, or vice versa.

Nevertheless, the organisations operated as one, with their Boards and their committees meeting in common during the period on shared business while having separate membership and the ability to take their own decisions. The governance framework included 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 35.

In May 2022, the Boards agreed to implement a revised Board governance framework for NHS England after 1 July 2022, and details of this framework will be provided in the NHS England 2022/23 annual report and accounts.

An overview of the Board governance framework in place to 30 June 2022 is shown on the next page, including a high-level overview of the remit of the Board committees. A report on business considered by those committees that met during the reporting period can be found from page 29. A report detailing the business considered by the Board committees was provided to each Board meeting.

NHS Improvement Board governance framework

<table>
<tr><th colspan="5">NHS Improvement Board</th></tr>
<tr><td>  </td><td>  </td><td>  </td><td>  </td><td>  </td></tr>
<tr><td>Audit and Risk Assurance Committee</td><td>People, Remuneration and Nominations Committee</td><td>Digital Committee[8]</td><td>Quality and Innovation Committee</td><td>System Oversight Committee</td></tr>
<tr><td>• Provided 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.</td><td>• Oversaw the delivery of the overall people strategy for the NHS.
• Oversaw the implementation of key provisions in the NHS People Plan.
• Approved the framework and policy for executives for submission to DHSC.
• Approved individual executive remuneration packages.
• Approved employee policies.
• Reviewed employee engagement initiatives.
• Exercised NHS TDA’s powers in relation to chairs and non-executive directors of NHS trusts.
  </td><td>• Ensured effective delivery of the digital commitment of the NHS Long Term Plan.
• Ensured alignment of technology initiatives and spend across the system to ensure they are focused on commitments of the NHS Long Term Plan.</td><td>• Determined 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.
• Oversaw the implementation of innovation strategies
  </td><td>• Ensured consistent approach to oversight of ICSs and constituent organisations.
• Oversaw the development and delivery of oversight and regulatory policy.
• Approved formal regulatory action and intervention, including entry and exit of trusts in special measures.
• Approved transactions for trusts in Segment 4 or rated as high risk.</td></tr>
<tr><td>Executive
HR Group</td><td colspan="2">Appointments and
Approvals Committee

Regional Trust Appointments and
Approvals Committees</td><td colspan="2">Joint Finance Advisory Group
(NHS Improvement and NHS England)</td></tr>
</table>

[8] The Digital Committee did not meet during the first quarter of 2022/23.

NHS Executive

The NHS Executive included the national and regional directors of each of the directorates. The NHS Executive was chaired by the Chief Executive of NHS England and advised on the development and implementation of national policies and programmes, NHS performance and performance of the joint organisation, and any other matters that required executive-level oversight. The NHS Executive was supported by several other management groups and processes.

Key Board roles and responsibilities

Andrew Morris was the Interim Chair and Professor Stephen Powis was the Interim Chief Executive. Lord Carter carried out the role of the Senior Independent Director.

Their key areas of responsibility were:

Interim Chair

The Interim Chair was 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 Interim 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 England and the Head of Board Governance to agree joint board training and development sessions.

Interim Chief Executive

The Interim Chief Executive was responsible for the day-to-day leadership of the organisation and the delivery of the strategy. The Interim 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 also 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.

Non-executive directors

The non-executive directors supported executive management, while providing constructive challenge and rigour and bringing sound judgement and objectivity to the Board's decision-making process. They monitored the delivery of strategy within the governance framework as set by the

Board. Their independence was reviewed annually, and they all made monthly declarations of interest. All non-executive directors were considered to be independent.

Executive directors

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

Board activity and administration

The Board met once in common with NHS England between 1 April and 30 June 2022 and held two Board deep-dive sessions. The Board meeting had a public and a private session, and members of the public were able to observe the public session, which was available to watch live, or after the event, on our website. The agenda, papers and minutes for the public session were published on our website.

Board meetings were pre-scheduled. There were 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 reporting period were:[9]

Strategy

- The urgent and emergence care strategy
- NHS capacity
- Establishment of integrated care boards and delegation of NHS England direct commissioning functions
- Updates to the refresh of the NHS Long Term Plan
- Endorsement of the NHS England and NHS Improvement Green Plan

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
- Update on maternity and neonatal services, including NHS England's response to the recommendations in the Ockenden Review
- Update on mental health services
- Update on Claire Fuller's review into primary care

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

Leadership and people

- The NHS workforce strategy
- Endorsement of the Public Sector Equality Duty review report and future equality objectives and targets for NHS England and NHS Improvement.
- Consideration of the National Guardian's Office update and priorities for 2022/23
- The integration of NHS England and NHS Improvement

Governance and risk

- Approved changes to the Board governance framework
- Update on the implementation of the Health and Care Act 2022, including a summary of main changes to NHS England's functions arising from the implementation of provisions of the Health and Care Act 2022 from 1 July 2022
- Merger of Health Education England, NHS Digital and NHSX with the combined NHS England and NHS Improvement.

Review of Board effectiveness and performance evaluation

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 Board effectiveness should be carried out during the reporting period. As the NHS Improvement Board meets in common with NHS England's Board it had 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

Audit and Risk Assurance Committee

Role of the committee

The committee's primary role was to assist the Board in fulfilling its oversight responsibilities in relation to financial reporting, systems of internal control and risk management processes.
This included 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 met in common with NHS England's Audit and Risk Assurance Committee (ARAC).

Committee members

The committee met twice during the reporting period and was chaired by Jeremy Townsend, who is a qualified accountant and has considerable experience in chairing audit committees in other organisations.

Good governance provides that an audit and risk assurance committee should consist of three independent non-executive directors. As the NHS Improvement committee considered mainly joint organisation business and met in common with NHS England's committee, it comprised two non-executive directors because together with the NHS England committee, there were four non-executive directors involved in deliberations. The committee had a good balance of skills and knowledge covering accounting, finance and clinical services.

The membership of the NHS Improvement committee and attendance is reflected in the table on page 23.

Committee attendees

Additional attendees were invited to attend meetings to assist with committee business. For the reporting period these included, among others, the Chief Executive Officer, the Chief Financial Officer, the Chief Operating Officer, the Director of Governance and Legal and the Director of Financial Control, as well as representatives from external auditors (National Audit Office (NAO)), internal auditors (Deloitte LLP), and DHSC.

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:

- considered updates on the completion of the 2021/22 internal audit plan
- approved the 2022/23 internal audit plan
- reviewed NHS England's and NHS Improvement's joint corporate risk register
- considered in deep dives workforce and Urgent and Emergency Care
- received updates on data security and cyber risks
- approved review changes in accounting policies and reviewed areas of significant estimation or judgement
- assessed the integrity of Monitor's and NHS TDA's consolidated provider trust financial reporting
- considered an update on counter fraud, including the annual counter fraud report and the Tackling Fraud, Bribery and Corruption policy
- considered changes to the Governance Manual.

Digital Committee

Role of the committee

The committee's role was to provide advice and, where appropriate, make recommendations on strategic implications of technology in 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 was 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 did not meet during the reporting period.

People, Remuneration and Nominations Committee

Role of the committee

The committee's role was 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 was also responsible for people and organisational development policies and ways of working designed to ensure the NHS Improvement workforce was appropriately engaged and motivated.

The committee ensured that NHS England and NHS Improvement had a single formal, robust and transparent remuneration policy that was in line with DHSC's executive and senior manager pay framework for ALBs (DHSC's pay framework). The committee considered and approved 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 involved employee remuneration and engagement matters.

The committee met in common with NHS England's People, Remuneration and Nominations Committee and delegated certain functions to the Executive HR Group. It also exercised 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 it delegated certain functions to two subcommittees, the Appointments and Approvals Committee and the Regional Trust Appointments and Approval Committee. The committee received regular reports from the group and the subcommittees on cases considered and approved in relation to NHS trust chair appointments, NHS trust termination cases, NHS trust non-executive director appointments and proposed salaries for very senior managers at NHS trusts whose proposed salary exceeded a certain amount.

The committee met twice during the reporting period and in addition to the members was attended by the Chief People Officer, the Chief Delivery Officer and the Director of Human Resources and Organisation Development.

Committee members

The committee met twice during the reporting period and was chaired by Sir Andrew Morris.

The committee is comprised of non-executive director members as reflected in the table on page 23, alongside their attendance.

Committee attendees

Additional attendees were invited to attend meetings to assist with committee business. For the reporting period these included, among others, the Chief Delivery Officer, the Chief Workforce Officer, the Director of Human Resources and Organisational Development and the National Director for People.

Principal activities during the year

Matters considered by the committee included:

- the People Directorate priorities for 2022/23
- NHS workforce priorities for 2022/23
- an update on people, organisational change and culture
- the revised very senior managers pay framework
- the internal Freedom to Speak Up strategy
- NHS England and NHS Improvement staff survey results
- progress on the NHS's, and NHS England's and NHS Improvement's diversity and inclusion strategies.

Quality and Innovation Committee

Role of the committee

The committee's primary role was to support the Board in ensuring that patient safety, the quality of care provided to patients and patient experience continued to improve and develop. In doing so the committee ensured strategies were continually improving quality, safety and experience of care. It met in common with NHS England's Quality and Innovation Committee. The committee met once during the reporting period.

Committee members

The committee met once during the reporting period and was chaired by Professor Sir Munir Pirmohamed.

The membership is comprised of both non-executive director and executive director colleagues and patient and public voice members. This table details membership and attendance:

Members	Number of eligible meetings attended	Comment
Professor Sir Munir Pirmohamed (Chair)	1/1	Non-Executive Director
Aidan Fowler	1/1	National Director of Patient Safety
Dr Timothy Ferris	0/1	National Director of Transformation
Rakesh Kapoor	0/1	Non-Executive Director
Dame Ruth May	1/1	Chief Nursing officer
Professor Stephen Powis	1/1	National Medical Director Interim NHS Improvement Chief Executive
Patient and Public Voice members	1/1	Not applicable

Committee attendees

Additional attendees were 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.

Principal activities during the year

A large part of the committee's remit was to monitor and determine whether the NHS was maintaining and improving the quality of patient care and health outcomes in the context of delivering the NHS Long Term Plan. In doing this, matters considered by the committee included:

- lessons and actions from independent reviews into maternity services, including recommendations in the Ockenden Review.
- updates on the Maternity Transformation Programme, and governance and oversight arrangements for maternity services
- an update on the Children and Young People's Transformation Programme and the national response to a surge in paediatric respiratory viral infections
- the impact and lessons learned from the COVID-19 pandemic
- quality oversight and governance updates, both internally and cross-system
- proposals for strategic oversight of NHS quality issues and performance

- an update on the implementation of the NHS Patient Safety Strategy, quality data, public sector equality objectives and items considered by the Executive Quality Group and National Quality Board.

System Oversight Committee

Role of the committee

This committee, which met in common with NHS England's System Oversight Committee, ensured a consistent approach to oversight of ICSs and their constituent organisations, including determining appropriate support to organisations and systems for them to improve population health outcomes and address health inequalities. This assisted the Board with their formal intervention powers, including deciding on entry into and exit from the Recovery Support Programme and Segment 4 of the System Oversight Framework. It also provided strategic oversight of transactions and investments involving NHS foundations trusts and NHS trusts.

Committee members

The committee met three times during the reporting period and was chaired by the National Medical Director / Chief Executive of NHS Improvement.

The membership is comprised of executive directors and senior managers from across the NHS England and NHS Improvement directorates. This table details membership and attendance:

Members	Number of eligible meetings attended	Comment
Prof. Steve Powis (Chair)	3/3	National Medical Director/ Chief Executive of NHS Improvement
Ronke Akerele	2/3	Director of Culture Transformation (deputising for Chief People Officer)
Mark Cubbon	2/3	Chief Delivery Officer
Ian Dodge	0/3	National Director: Strategy and Innovation
Iain Eaves	3/3	Director of Planning and Oversight
Dr Timothy Ferris	1/3	National Director of Transformation
Sue Holden	2/3	National Director of Improvement/Director of Intensive Support for Challenged Systems
Julian Kelly	0/3	Chief Financial Officer
Alex Kirkpatrick	1/3	Interim Director of Provider Development
Matthew Neligan	3/3	Director of System Transformation
Peter Ridley	2/3	Deputy Chief Financial Officer - Operational Finance

Members	Number of eligible meetings attended	Comment
Simon Rogers	2/3	Deputy Director of Legal (non-voting)
Sir David Sloman	0/3	Chief Operating Officer
Seven Regional Directors of Strategy and Transformation[10]	Not applicable	Not applicable

Principal activities during the year

- Development and implementation of the System Oversight Framework for 2022/23
- alignment of the Maternity Safety Support Programme with the Recovery Support Programme
- on recommendations made by the regions, approval for a number of organisations and systems to enter into or exit the Recovery Support Programme
- a proposal for the review of the ambulance culture
- considered proposed amendments to the NHS provider licence
- approved the approach to assuring and supporting collaborative arrangements between providers, where complex governance is proposed
- approved updates to NHS Improvement's guidance for the review of trust subsidiary transactions and income generation transactions.

NHS Executive

The NHS Executive included the national and regional directors of each of the NHS England and NHS Improvement directorates. The NHS Executive was chaired by the Chief Executive of NHS England and advised on the development and implementation of national policies and programmes, NHS performance and performance of the joint organisation, and any other matters that required executive-level oversight. The NHS Executive was supported by several other management groups and processes.

Board disclosures

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

NHS England and NHS Improvement's joint working arrangements involved the exercise of statutory functions of the organisations' constituent bodies in an aligned way under a single operating model. Directorates and teams within the structure might be performing both NHS England and NHS Improvement functions. NHS England, Monitor and NHS TDA, however, remained separate bodies with distinct statutory roles and responsibilities. In some cases, the functions and decision-making of those bodies had to remain independent and separate, to ensure

[10] Each region was represented at all of the meetings.

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 was not required, the exercise of different functions by the same directorate or team might give rise to an actual or potential conflict in an individual case ('operational conflicts').

NHS England and NHS Improvement had to 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 had a Separation of Functions and Conflicts of Interest policy which provided guidance for staff on managing functional and operational conflicts. This policy was not concerned with the declaration and management of personal interests held by individuals. Such conflicts continued to be dealt with in accordance with the Standards of Business Conduct policy.

In addition to the issues raised by joint working, NHS Improvement was 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 conflicted, actually or potentially, with the functions or decision-making of a different directorate.

When exercising the statutory functions of Monitor, NHS Improvement had 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
- 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 applied the Separation of Functions and Conflicts of Interest policy referred to above to such conflicts.

NHS Improvement recognised there was a difference between cases where there was an actual or reasonably perceived conflict arising from the exercise of different functions, and situations which were in reality not conflicts but operational manifestations of the overlap between different NHS Improvement functions: these would have been Board disclosures addressed and resolved by NHS Improvement legitimately and reasonably balancing competing interests.

Where the organisation resolved a conflict of interest in a case falling within section 67 of the 2012 Act, it had to 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 the reporting period or previous financial year, so no statements were published.

Register of Board members interests

Personal interests held by Board and committee members were managed by the NHS England Standing Orders, NHS Improvement Rules of Procedure and the Standards of Business Conduct policy. The organisation also maintained a register of members interests to ensure that potential conflicts of interests could be identified and addressed before Board and committee discussions. Board members and executives were also required at the start of each Board and committee meeting to declare any personal interest they might have had in any business on the agenda and abstain from relevant Board or committee discussion as required. Where potential conflicts arose, they were recorded in the Board and committee minutes along with any appropriate action to address them. Any interests declared were recorded on the register and signed off by the Board and executives regularly. A copy of the register of interest is available on our website. Details of related party transactions, where NHS England transacted with other organisations during the year, to which a Board or an executive was connected, are set out in Note 14 on page 115.

Directors' third-party indemnity provisions

NHS Improvement had 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 the reporting period.

Human rights

NHS Improvement supported 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 in March 2022 and applied to the reported period. An NHS England Slavery and Human Trafficking Statement for the financial year ending 31 March 2023 will be published in October 2023. Our strategy on tackling fraud, bribery and corruption can be found on our website.

Disclosure of personal data-related incidents

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

The guidance set out in the DSP tool kit 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. Updated scoring criteria made reference to the circumstances where notification to the Information Commissioner's Office may not be necessary, which reduced the number of incidents classified as notifiable over recent years.

As at 30 June 2022, no notifiable incidents had occurred relating to the loss of personal data.

Statement of the 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) directed NHS TDA to prepare, for each financial year, a statement of accounts in the form and on the basis set out in the Government Financial Reporting Manual. 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) and in particular to:

- observe the Government Financial Reporting Manual, 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 assets, are set out in Managing public money (HM Treasury, July 2013, as amended March 2022).

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 Monitor and NHS TDA (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, before the abolition 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.

Governance statement

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

As Accounting Officer for NHS England during the reporting period, I had responsibility for the system of internal controls supporting and enabling the achievement of NHS Improvement's aims and objectives. Whilst safeguarding the public funds and assets for which I am personally responsible in accordance with Managing public money and as set out in my Accounting Officer appointment letter.

Board arrangements

Information on our Board and its committees is set out from page 29.

NHS England 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 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; accountability for delivery will increasingly sit with systems, supported by the new NHS England. The future NHS England operating model was designed to reflect this 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.

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 (SFIs), Scheme of Delegation, Standards of Business Conduct Policy, Joint Risk Management Framework and three lines of defence model.

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 *Corporate governance in central government departments: code of good practice 2017* (HM Treasury). NHS Improvement was compliant with the provisions of the code, with the following exceptions.[11]

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.	Not applicable	Not applicable	NHS Improvement's executive directors were appointed by the Board and the appointments were 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	Not applicable	Not applicable	Given the statutory composition of Monitor and NHS TDA, the Comptroller and Auditor General, supported by the National Audit Office, acted as external auditor.
Not applicable	Not applicable	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 was shared between the Chair, the Chief Executive's private office and Board Secretary.
Not applicable	Not applicable	4.11	The Board Secretary's responsibilities include arranging induction and professional development of Board members.	This responsibility was shared between the Chair, Chief Executive's private office and Board Secretary.
Not applicable	Not applicable	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 attended meetings of ARAC.
Not applicable	Not applicable	5.9	The board and accounting officer should be supported by an audit and risk assurance committee, comprising at least three members.	ARAC comprised two non-executive board members. The committee met in common with NHS England's ARAC and consequently there were in total four non-executive directors involved in deliberations. Most business considered by the committee was joint NHS England and NHS Improvement business.

[11] It should be noted that the following provisions in the code were 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 Improvement continued using 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, 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 worked with the support of both our internal and external auditors to strengthen and embed our assurance framework. Each directorate and region had designated leads with responsibility for ensuring that risk management, implementation of internal audit actions and other key assurance activities were carried out and approved by the relevant senior director, including appropriate regular reporting and exception escalation processes. The leads linked with the governance, audit and risk teams to provide increased focus, accountability and improved communication at operating level across the organisation.

During the reporting period, the corporate governance and compliance team 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 the reporting period, the Board was provided with 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, ARAC considered the outcomes of internal audit reviews of programmes and the Strategic Risk Group reviewed our corporate risks, which could include causes, consequences, controls, and actions relating to individual programmes.

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

Assuring the quality of data and reporting

The Board agreed the information it required to carry out its duties. The Board was confident that performance reports went through appropriate management review and scrutiny and that reporting continued to evolve to meet changing organisational needs.

Risk governance

The NHS Improvement Board was responsible for ensuring delivery of the strategies and goals outlined in its business plan.

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

ARAC was responsible for reviewing the establishment and maintenance of an effective system of governance, risk management and internal control covering NHS Improvement's activities. The committee considered risks faced by the joint organisation on a quarterly basis and reported conclusions directly to the Boards. The system of internal control was 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 provided regular reports to ARAC based on its work programme. The Board discussed the most significant risks and actions identified to mitigate their likelihood and impact. Each year, ARAC evaluated the effectiveness of the risk management framework and approved the annual internal audit plan for the following year.

Throughout the reporting period, the position of Chief Risk Officer/Senior Responsible Owner for risk for NHS England and NHS Improvement was delivered by the Chief Delivery Officer, to further ensure senior sponsorship for risk at executive level.

The executive team owned the corporate risks and nominated a responsible officer for each one. The approach was supported by the joint NHS England and NHS Improvement risk management framework which underpinned the monitoring and management of risk.

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

Our executives were 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 held its own risk register and reviewed its risks regularly.

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

Risk and control framework

Throughout the reporting period, NHS England and NHS Improvement continued to embed their joint risk management framework to ensure that employees followed a single process for identifying and managing risks that might threaten delivery of services and achievement of objectives. This framework aligned with the overarching principles of HM Treasury's Orange Book and was informed by 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. We aimed to continually improve our risk management maturity and risk culture year on year.

Principal risks

The CRR considered 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 the period between April and June 2022 were:

Risk	Key mitigations in place
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'. Capital investments of £450 million for increasing capacity and improving infection control in emergency departments and same-day emergency care. Elective recovery plan, including independent sector provision.
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. 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 and operational planning guidance; clinical pathway transformation co-ordinated national work on children and adolescent mental health services; additional investment in 111 and 999 call handling. Quality surveillance: Revision of National Quality Board (NQB) quality guidance for ICB structures; enhanced quality oversight of maternity services. Patient Safety Strategy.

Risk	Key mitigations in place
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 standard and are compliant with mandated immediate actions set out in operational instructions. Internal audit and corporate controls around the use of technology. 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, Medicines and Healthcare Products Regulatory Agency 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 Co-ordination Ltd responsible for managing the sourcing, delivery and supply of some healthcare products and services.

Risk appetite

Throughout the reporting period, NHS England and NHS Improvement continued a joint approach to risk appetite, which we defined as 'the amount of risk that we are willing to seek or accept in the pursuit of long-term objectives'.

Our risk appetite was 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 involved risk trade-offs. This gave 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 provided a balance between an excessively bureaucratic and burdensome approach and one that lacked rigour.

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

- an assessment of what and where the current risks were
- that the potential future impact had been understood and agreed
- rapid cycle monitoring was in place to enable swift corrective action should things go wrong

- consideration of the system's ability to respond (that is, different regions faced different circumstances and some areas were more challenged than others)
- trade-off between risks and cost-benefit was understood/impact on other risks had been assessed (that is, whether these would 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 was applied before taking the risk
- significant and measurable potential benefits (for example enhanced efficiency and/or value-for-money delivery).

Our risk appetite by category of risk as at 30 June 2022

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

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

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

Cross-system working

NQB brings together organisations to champion the importance of care quality and drive system alignment of quality across health and care on behalf of NHS England, NHS Digital, the Care Quality Commission, the Office of Health Promotion and Disparities, the National Institute for Health and Care Excellence, Health Education England, DHSC and Healthwatch England.

In quarter one of 2022/23 among other things, the NQB led the development of useful resources to support the establishment of ICBs including the Shared Commitment to Quality and guidance on quality governance and risk management. These products were co-designed with colleagues from ICSs to ensure they have strong practical value.

Assuring the quality of services

The Boards of NHS England and NHS Improvement both established quality and innovation committees (QIC) 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 QIC sought assurance from executives that robust mechanisms were in place to manage quality functions, including that quality risks and issues were managed at regional to national levels. It also received reports and updates on relevant NHS England and NHS Improvement quality functions, programmes and initiatives. This included statutory functions such as arrangements for safeguarding, responding to coroners' prevention of future deaths reports and controlled drugs; clinical effectiveness functions such as commissioning national clinical audits; patient safety functions and implementation of the patient safety strategy; and patient experience functions including complaints and surveys.

Improving care quality

During quarter 1, NHS England and NHS Improvement's quality governance framework was based on good practice principles, including:

- clinical leadership for quality embedded across key programmes, strategies and governance forums
- a defined governance, risk and response process for quality, linked to regional NHS England and NHS Improvement governance and wider forums (eg professional regulators)
- a defined way to engage and share intelligence and improvement for quality, through system quality groups, regional quality groups and the Executive Quality Group (EQG) (as defined in the NQB guidance). Further information on the EQG is provided below.

To meet its responsibilities for quality, NHS England and NHS Improvement considered a broad range of learning, insight and intelligence, including feedback from staff and people drawing on services (e.g., compliments, complaints, concerns), safeguarding, incident recording, safety culture measures, audits and risk management. This intelligence was triangulated, shared, embedded and its impact reviewed to gain comprehensive insight and allow for improvements in care quality.

The Board also looked at national improvement programmes, their models for improvement and how they ensure 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 supported the focus on the response to COVID-19 while ensuring that oversight of quality was maintained. It was the responsibility of regional medical directors and regional chief nurses to escalate issues to the EQG, while observing regional emergency preparedness, resilience and response escalation processes.

Escalation of quality issues and sharing of learning

NHS England and NHS Improvement took a proactive approach to risk management, as aligned with NQB's guidance on quality risk response and escalation. Regional clinical quality teams worked closely with local commissioners, regulators, and other stakeholders to identify and manage quality concerns, supporting risk profiling, improvement planning and oversight as required. Concerns and risks that required national attention were escalated through the EQG.

The EQG, co-chaired by the National Medical Director and Chief Nursing Officer, provides a defined forum to identify, manage, escalate and de-escalate quality concerns and risks, most notably issues that require a cross-regional response. The EQG brings together regional medical directors, regional chief nurses, directors of clinical quality and senior national colleagues including the directors for patient safety, clinical effectiveness and experience of care. It 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 QIC if required.

In 2023/23, together the EQG and the QIC:

- oversaw the identification and deployment of appropriate resources to tackle escalated quality risks and issues, and support quality improvement activities at national level
- provided a coherent governance structure in which quality risks can be escalated if required
- referred national cross-system quality risks and issues to NQB where appropriate
- shared relevant and transferable learning gathered by national or regional teams.

ICS development

In the months running up to formal establishment of ICSs on 1 July 2022, NHS England and NHS Improvement continued to work closely with colleagues from DHSC to respond to and influence the final form of the Health and Care Act 2022, which received royal assent on 28 April 2022.

Meanwhile, work had been ongoing to support the development of ICBs in areas such as the establishment of new governance arrangements and the financial framework for transition, producing preparatory and statutory guidance where appropriate and providing practical support. Extensive

work with third party partners was also planned and delivered including working with NHS Business Services Authority, NHS Shared Business Services and NHS Digital to ensure a smooth transition of functions and people from CCGs to ICBs on 1 July 2022.

Approval was secured from the NHS England Board for ICBs to take on direct commissioning functions for primary medical services in preparation for a step-change in commissioning arrangements. ICBs receiving additional primary care commissioning functions from July 2022 were also confirmed and a single standard delegation agreement produced ahead of further delegation in April 2023, with the Chief Delivery Officer writing to each system to clarify the commissioning roadmap.

Supporting the successful appointment of ICB chairs and chief executives, as well as non-executive directors and executive board roles, across all systems was a key undertaking in readiness for establishment and sat alongside contributions to the development and agreement of people transfer schemes to enable a smooth transition of staff from 106 CCGs and other NHS employers.

Direct support was provided to system leaders on a range of technical areas and will continue, including leadership support and development for systems facilitated through regional teams, and a series of practical webinars and masterclasses was delivered to support implementation and inspire system development.

Systems have continued to develop approaches to proactive population health management, supported by our national development programme, and are developing roadmaps to ensure this becomes a sustainable way of working across place-based partnerships, harnessing multidisciplinary intelligence to transform services.

In preparation for establishment on 1 July 2022, each ICS submitted a final assessment of its position in the form of a ‘readiness to operate’ statement, indicating a good state of readiness and reflecting the significant collaborative efforts of teams at system, regional and national levels. The due diligence checklist and ICB establishment timeline continued to be reviewed to support systems and regions, with due diligence completed for people and property elements. Assurance on digital and data third party configuration and readiness was also provided to enable the NHS England Chief Executive to sign the establishment order and transfer schemes.

Other assurance

Cyber and data security

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

Working in partnership with NHS Digital and the National Cyber Security Centre, we maintained focus on increasing central monitoring, assurance and regulation to hold organisations to account, while centrally procuring services to assist local organisations to improve their cyber security posture and reduce overall risk.

Between April and June 2022, NHS Digital issued three high-severity cyber security alerts. Operational advice and instructions on improving cyber security resilience were issued to NHS organisations, outlining priority actions to take to ensure the NHS was prepared and ready to deal with any new or emerging threats.

The Network and Information Systems Regulations continue to be used to increase compliance in the NHS. During this period information notices have been used within NHS Trusts to target unsupported systems and to ensure recommendations made in the response to the invasion of Ukraine are actioned. Work was undertaken in preparation for 1 July 2022, when ICBs were recognised as operators of essential services and aligned to NIS regulations.

The invasion of Ukraine by Russia in February 2022 led the National Cyber Security Centre to urge all UK organisations to bolster their cyber security resilience. While UK health and care infrastructure wasn't expected to be specifically targeted, it was at heightened risk of 'collateral damage' – being caught up in a wider attack, rather than being the primary target, as happened during Wannacry in 2017 – in cyberattacks that could be targeted at Ukraine or parts of the UK economy.

Information governance

A single information governance (IG) operating model is in place across NHS England and NHS Improvement. This provided the framework for the organisations to remain compliant in relation to data protection, records management and information security activities.

The Corporate IG and the Transformation Directorate IG teams worked in alignment to support NHS England and NHS Improvement with implementation of appropriate governance controls around the acquisition and use of data required to manage the COVID-19 pandemic and to ensure all records were appropriately declared and retained.

There was ongoing provision of advice and guidance to support the completion of data protection impact assessments, data processing agreements, data sharing agreements and provision of data notices associated with several high-profile initiatives:

- the COVID-19 Datastore and Foundry platform
- the OpenSafely Platform which supported NHS England and NHS Improvement 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 Control of Patient Information Regulations 2002 notices, and transition away from the use of such notices
- ongoing support to the COVID-19 Vaccination Programme, including but not limited to COVID-19 Pass/Vaccine Data Resolution Service/Overseas Vaccine Data Service/Vaccine Contact Preference Service and cross-border vaccination data flows.

The teams provided support in all other areas of NHS England and NHS Improvement work to ensure that business as usual processes continued, and new programmes were able to obtain and use data appropriately to support their work and provide better outcomes for patients. The Getting it Right First Time programme ensured NHS Improvement continued to meet its statutory duties, and work on the Model Hospital ensured that improvement in practice was maintained.

Business critical models

Quality assurance of analytical work is important. NHS England and NHS Improvement have developed an approach that consistent with the recommendations in Sir Nicholas Macpherson's review of quality assurance of government analytical models (2013).

For business-critical models, where an error would have a significant patient care or other impact, NHS England and NHS Improvement operated a register of business-critical models and audit of the quality assurance strategy associated with them, overseen by a committee of experienced analysts. This operated as an integrated process with NHS England and NHS Improvement and to date all relevant models in the register have passed.

Internal audit

The internal audit service played 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, operated in accordance with public sector audit standards and to an annual internal audit plan approved by ARAC. It reported 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

was reported to each meeting of ARAC. The Head of Internal Audit Opinion covering this reporting period is set out from page 55.

External audit

During the reporting period, ARAC worked constructively with the NAO director responsible for the NHS England and NHS Improvement audit and their team. The work of external audit sat outside our governance arrangements but independently informed our consideration of control, compliance, governance, and risk.

The work of external audit was monitored by ARAC through regular progress reports. These included summaries of the value for money work that was either directly relevant to our work or could provide useful insights to the committee.

Control issues

Prior period restatement

Prior year comparatives have been restated following a review of accruals balances at 30 June 2022 which have also impacted balances at 31 March 2022. This has reduced prior year liabilities by £3.5m which, though not material to the 2021/22 accounts, is material to 2022/23.

The adjustment mainly relates to aged accruals, for which a more systematic process for review was not put in place until after the accounts period.

Review of economy, efficiency and effective use of resources

Cabinet Office efficiency controls

As part of the government's control of expenditure, we were subject to specified expenditure controls. These controls covered a range of expenditure categories and required proposed expenditure to be approved to secure best value for money and ensure maximum efficiency. For expenditure above certain thresholds in specified categories (including professional services and consultancy), onward approval was also sought from DHSC and for some cases this required approval from the Cabinet Office and/or HM Treasury.

Counter fraud

NHS England and NHS Improvement directly employed a counter-fraud team which investigated allegations of fraud related to our functions and ensured that appropriate anti-fraud arrangements were in place.

The Director of Financial Control had day-to-day operational responsibility for the NHS England and NHS Improvement counter-fraud function, and the Chief Financial Officer provided executive support and direction.

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

ARAC received an update regarding the counter-fraud function. This included reviewing the Tackling Fraud, Bribery and Corruption: Policy and Corporate Procedures, the 2021/22 Counter Fraud Annual Report, proactive counter-fraud work and fraud investigations.

The following Head of Internal Audit Opinion relates to NHS England and NHS Improvement as a whole merged entity and as such cannot be disaggregated.

Head of Internal Audit opinion

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

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

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

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

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

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

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

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

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

Staff and Remuneration Report

Our people

Our NHS People Plan ambitions and values drive our workforce strategy, which aims for more staff working more flexibly in a compassionate and inclusive culture. Our NHS People Promisesets out our pledge of how we will work together to improve the experience of working in the NHS for everyone.

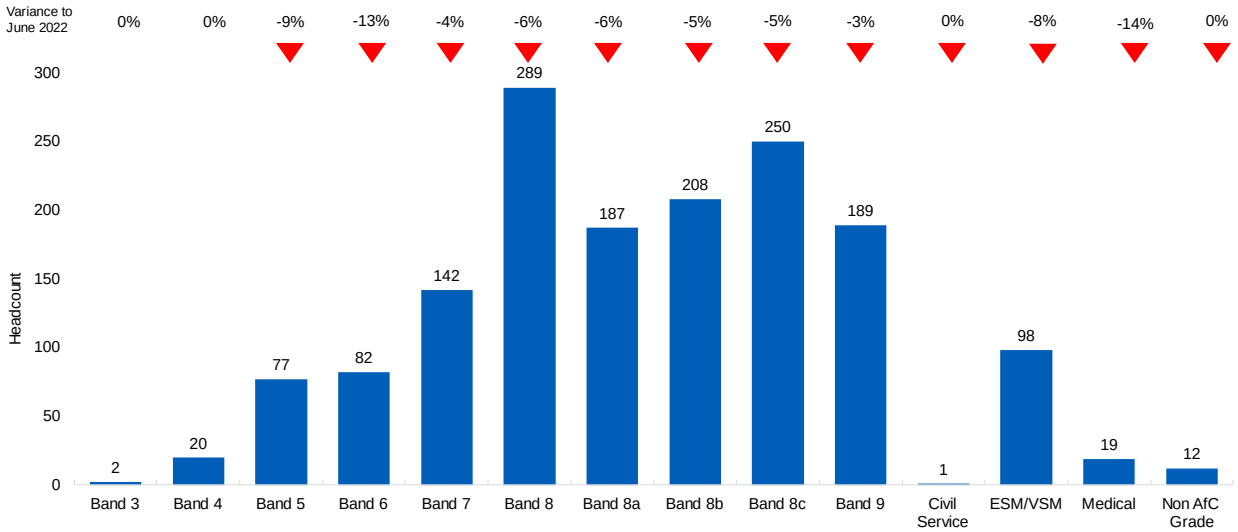
Staff numbers

On 30 June 2022, NHS Improvement directly employed 1,576 staff of whom 1,488 were permanently employed and 88 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 65

The chart below shows headcount by pay band at 30 June 2022. The headcount of permanent and fixed-term staff in NHS Improvement decreased by 6% since March 2022. Staff joining the organisation from 1 April 2020 onwards were placed on NHS England employment contracts, rather than the NHS TDA or Monitor employment contracts, attributing to the decrease in headcount.

All staff by grade



Staff turnover

As shown in the table opposite, turnover has increased during the reporting period compared to 2021/22. Headcount also decreased as we saw an increase in the number of people leaving the organisation. This level of in staff turnover is due to the volume of staff leaving NHS TDA to find employment elsewhere or being re-appointed on NHS England contracts.

Staff turnover

Staff turnover	April 2018 to March 2019	April 2019 to March 2020	April 2020 to March 2021	April 2021 to March 2022	April 2022 to June 2022
NHS TDA	14.9%	15.2%	4.65%	7.30%	2.53%
Monitor	19.4%	29.5%	4.13%	11.58%	2.21%
Total	**14.7%**	**14.0%**	**4.85%**	**9.32%**	**3.19%**

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 working from home and to keep our staff safe when coming into the office. These have been kept under regular review through our formal partnership working arrangements and 14 temporary policy changes remain live.

We have continued to harmonise key employment policies across our three organisations; NHS England, NHS TDA and Monitor, which helped us to ensure consistency in the way staff were managed and rewarded and prepare for the formal merger which took place on 1 July 2022.

Partnership working

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

The National Partnership Forum, met quarterly and provided strategic direction for other important sub-groups which focus on specific issues, including Policy, Organisational Change, Equality and Diversity and the Health and Safety Committee. In addition, we had a Regional and Corporate Partnership Forums to address any local issues, which were escalated to the National Partnership structure(s) if deemed necessary.

Workforce Disability Equality Standard

Work continued to reduce the disparity between the those who declare their disability status in the electronic staff record and the disability data collected as part of the annual staff survey.

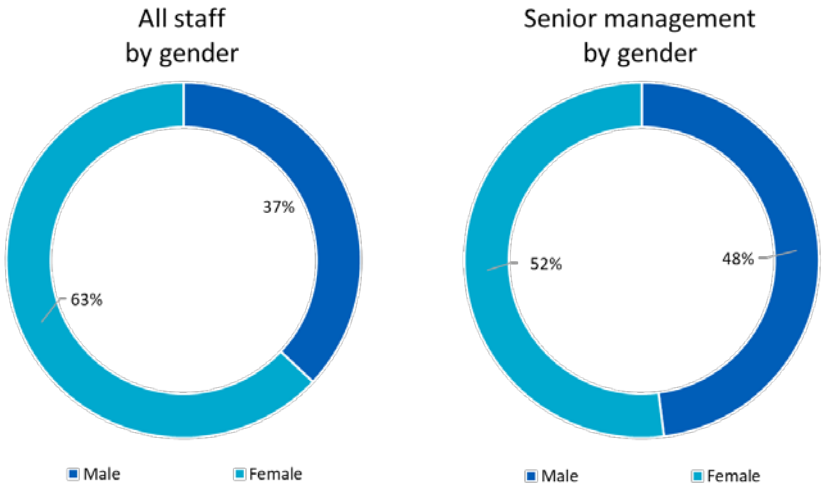
A full update, including NHS Improvement's performance during this reporting period, will be provided in the 2022/23 NHS England Annual Report and Accounts.

Gender of all staff and senior managers

As of 30 June 2022, the gender profile of the total 'on payroll' workforce was on average unchanged from March 2022, however the proportion of female senior managers increased by 1%.

The gender diversity of board members is set out on page 24.

All staff and senior managers by gender

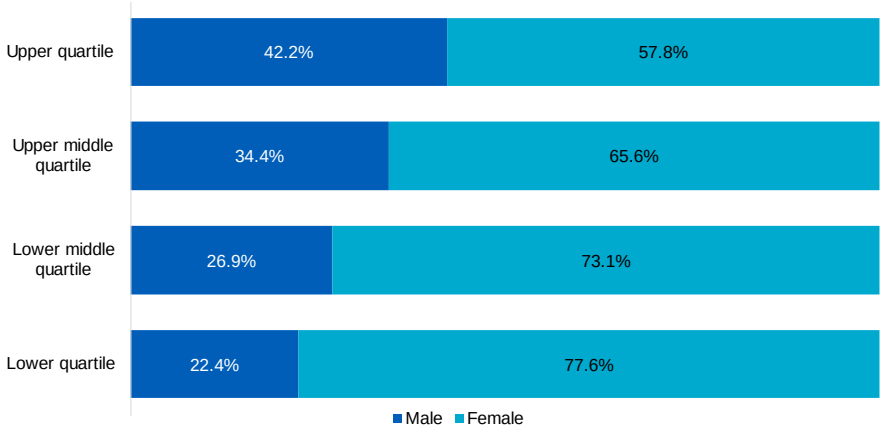


Gender pay gap

Based on the Government's methodology, the mean gender pay gap across NHS England and NHS Improvement is 14.7%, an improvement from 16.2% in the prior year.

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

Pay quartiles by gender in NHS England and NHS Improvement



The proportion of males and females in each pay quartile is detailed below and shows the position as at 31 March 2022 (the most recent data available at time of publication). 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.[12]

Ethnicity of all staff and senior managers

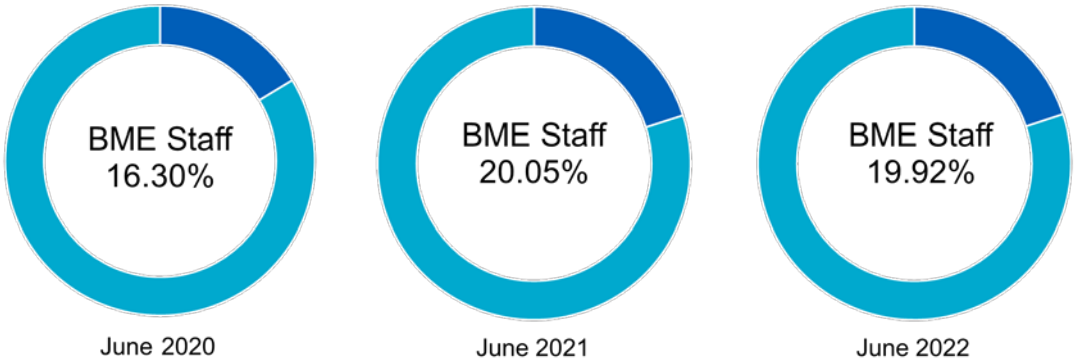
19% black and minority ethnic aspirational target across all pay bands

In March 2020, we set a BME aspirational target to achieve 19% BME representation across all pay bands in the organisation by 2025.

Much of this change is attributed to the drive in improving representation of our workforce through recruitment and promotions, our ongoing aspirational talent conversations, structural change and shifts in data collation.

Figures below show the overall percentage of BME staff, and the progress made over the previous two years:

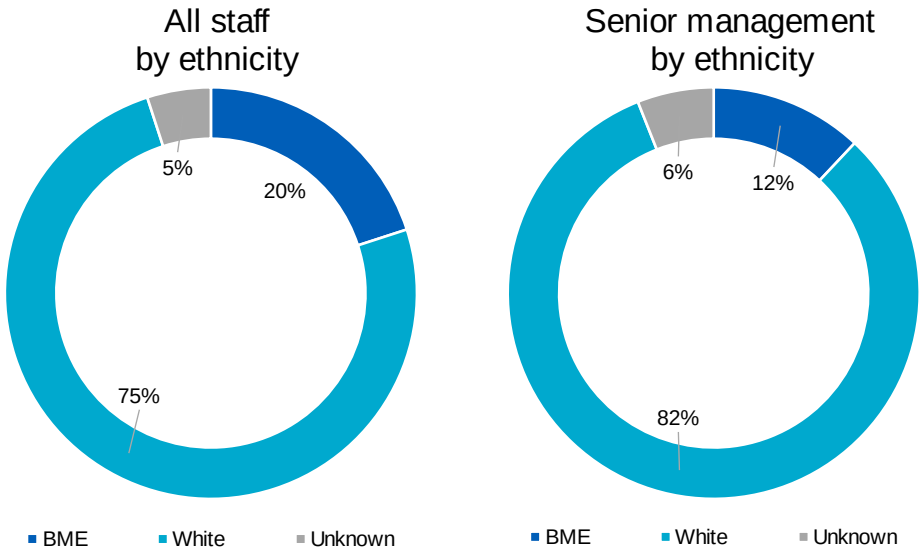
[12] https://www.england.nhs.uk/publication/gender-pay-gap-report/



Our focus on BME talent was evidenced through proportionally more BME staff (1.88%) than white staff (1.57%) who were promoted between April 2022 and June 2022.

As of 30 June 2022, the proportion of people employed by NHS Improvement who considered themselves to be from a BME heritage is unchanged since March 2022. The proportion of senior managers who identify as BME has seen an increase of 2% over the same period.

All staff and senior managers by ethnicity

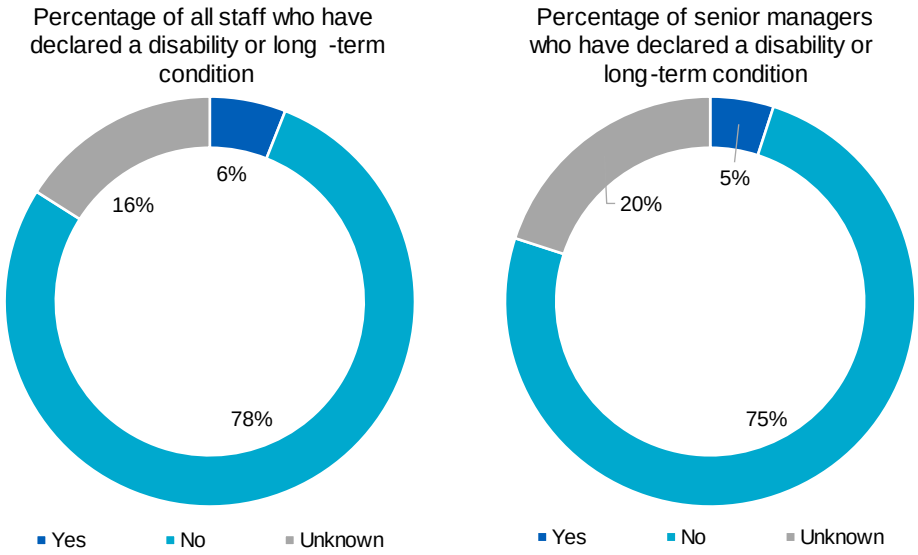


For information on board diversity please see page 24.

Declarations of disability or long-term conditions

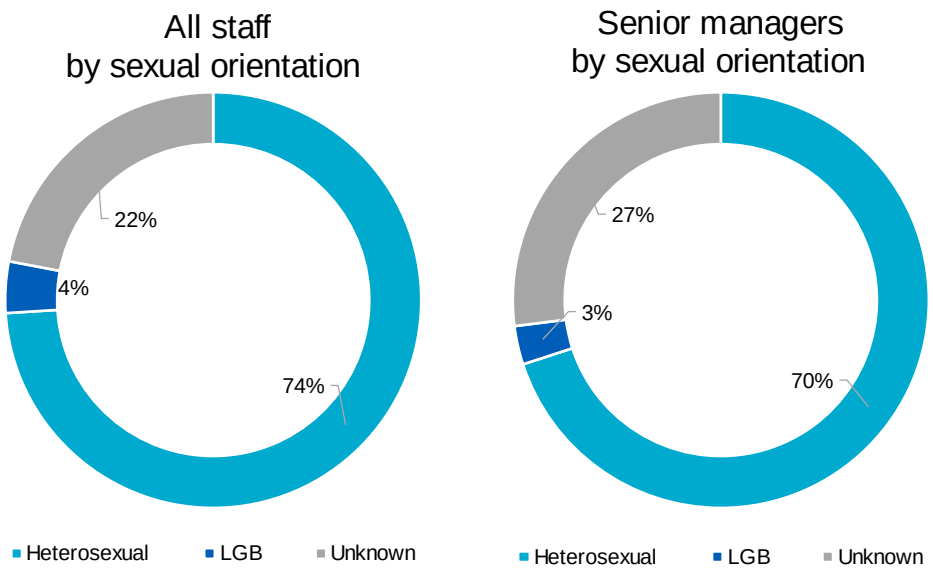
We have continued to work with our DAWN Network to support employees. The percentage of staff who declared a disability or long-term condition as at 30 June 2022 are given in the charts below.

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 LGB is given below.



A full update on the Stonewall Workplace Equality Index, incorporating NHS Improvement's performance during this reporting period, will be provided in the 2022/23 NHS England Annual Report and Accounts.

Staff engagement and feedback

An update will be provided that includes NHS Improvements data during this reporting period in the 2022/23 NHS England Annual Report and Accounts.

Talent management and development

Our approach to apprenticeships continued to make progress, with over 100 apprentices in training on the final day of reporting. We partnered with NHS organisations in Leeds to create a cohort of data analyst apprentices who will be able to share experience and skills, creating a future talent pool of a much-needed skill. We had 44 data analysts in training with the remaining apprentices focused on leadership and management disciplines.

Trade union facility time disclosures

A full update will be provided that includes NHS Improvement's data during this reporting period, in the 2022/23 NHS England Annual Report and Accounts.

Employee benefits and staff numbers

Staff numbers at 30 June 2022 (subject to audit)

April to June 2022	Permanently employed number	Other number	Total number
NHS TDA	1,402	85	1,487
Monitor	86	3	89
Total NHS Improvement	**1,488**	**88**	**1,576**

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**

Employee benefits (subject to audit)

Employee benefits	April to June 2022 Permanent employees £000	April to June 2022 Other £000	April to June 2022 Total £000	2021/22 Total Restated £000
Salaries and wages	26,049	82	26,131	**110,326**
Social security costs	3,348	0	3,348	**12,623**
Employer pension costs	4,554	25	4,579	**18,209**
Termination benefits	28	0	28	**0**
Gross employee benefits expenditure	**33,979**	**107**	**34,086**	**141,158**
Administration costs	15,249	(177)	15,072	**60,988**
Programme costs	18,730	284	19,014	**80,170**
Total net employee benefits	**33,979**	**107**	**34,086**	**141,158**

Sickness absence

Whole time equivalent days available	Whole time equivalent days lost to sickness absence	Average sick days per whole time equivalent
141,845	3,626	2.56%

Expenditure on consultancy and off-payroll engagements

Expenditure on consultancy and contingent labour

NHS TDA spent £nil on consultancy expenditure during April to June 2022 (2021/22: £0.5 million).

Expenditure on contingent labour, including agency staff and secondees, was £0.2 million during April to June 2022 (2021/22 £0.8 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 June 2022.

Off-payroll engagements longer than six months

Off-payroll engagements as of 30 June 2022, covering those earning more than £245 per day and staying longer than six months are as follows:

Off-payroll engagements longer than six months	NHS TDA (number)
Number of existing engagements as of 30 June 2022	34
Of which, the number that have existed:	Not applicable
for less than 1 year at the time of reporting	15
for between 1 and 2 years at the time of reporting	9
for between 2 and 3 years at the time of reporting	4
for between 3 and 4 years at the time of reporting	3
for 4 or more years at the time of reporting	3

New off-payroll engagements

New off-payroll engagements or those that reached six months in duration, between 1 April 2022 and 30 June 2022, for more than £245 per day and that last longer than six months are as follows:

New off-payroll engagements	**NHS TDA (number)**
Total number of new engagements, or those that reached six months in duration, between 1 April 2022 and 30 June 2022	10
Of which:	Not applicable
Number assessed as caught by IR35	10
Number assessed as NOT caught by IR35	0
Number engaged directly via personal service company contracted to department and on departmental payroll	0
Number of engagements reassessed for consistency/assurance purposes during the year	0
Number of engagements that saw a change to IR35 status following the consistency review	**0**

Off-payroll board member/senior official engagement

Off-payroll engagements of Board members and/or senior officials with significant financial responsibility between 1 April 2022 and 30 June 2022 are shown in the table below:

Off-payroll board member/senior official engagement	**NHS TDA (number)**
Number of off-payroll engagements of Board members and/or senior officers with significant financial responsibility during the financial year	0
Total number of individuals on payroll and off-payroll who have been deemed 'Board members and/ or senior officials with significant financial responsibility' during the financial year	27

Further detail on commercial approvals, and steps we took to improve procurement practices and compliance in this area within NHS Improvement during the year, can be found in our governance statement from page 40.

Exit packages including severance payments (subject to audit)

NHS TDA operated 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 subcommittee 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)

Exit packages agreed during the year	April to June 2022 Compulsory redundancies Number	April to June 2022 Other agreed departures Number	April to June 2022 Total Number	2021/22 Compulsory redundancies Number	2021/22 Other agreed departures Number	2021/22 Total Number
Less than £10,000	0	0	0	0	0	0
£10,001 to £25,000	0	0	0	0	0	0
£25,001 to £50,000	1	0	1	0	0	–
£50,001 to £100,000	0	0	0	0	0	0
£100,001 to £150,000	0	0	0	0	0	0
£150,001 to £200,000	0	0	0	0	0	0
Over £200,001	0	0	0	0	0	0
Total	**1**	0	**1**	0	0	0
Total cost (£000)	**28**	0	**28**	0	0	0

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.

Remuneration Report

People, Remuneration and Nominations Committee

Detail on the role and activity of the Strategic Human Resources and Remuneration Committee is given in our Directors' Report on page 31.

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

Percentage change in remuneration of highest paid director	Salary and allowances	Performance pay and bonuses
The percentage change from the previous financial year in respect of the highest paid director	0%	0%
The average percentage change from the previous financial year in respect of employees of the entity, taken as a whole	2.65%	0%

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 per annum of the highest paid director/member in NHS TDA during the period 1 April 2022 to 30 June 2022 was £230,000 to £235,000 (2021/22: £230,000-£235,000). The relationship to the remuneration of the organisation's workforce is disclosed in the table below.

Pay ratio information April to June 2022	25th percentile	Median	75th percentile
Total remuneration (£)	48,756	65,589	91,571
Salary component of total remuneration (£)	48,756	65,262	90,910
Pay ratio information	4.77:1	3.56:1	2.54:1

Pay ratio information 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

The pay ratio information for the 2022/23 financial year is consistent with the pay, reward and progression policies for the employees taken as a whole, due to applying all nationally mandated Pay Awards where applicable and adhering to the relevant pay progression principles. The AfC 2022/23 Non-Consolidated Pay Award retrospectively agreed in May 2023 is disclosed within the NHS England Annual Report and Accounts 2022/23 due to the eligibility criteria for receipt of these payments being outside the period 1 April to 30 June 2022.

During this period, no employees received remuneration in excess of the highest-paid director/ member (2021/22: none). Full-year equivalent remuneration ranged from £7,883 to £235,000 (2021/22: £7,883-£235,000). 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 Executive Senior Managers (ESM) pay framework for ALBs.

It was 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 £158 billion organisation, while recognising the importance of demonstrating pay restraint at a time of considerable pressure on NHS finances. Recommending appropriate remuneration for executive directors was 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 (PRP)

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 did not allocate any funding for PRP non-consolidated bonus payments. In recognition of the current economic climate and the need to provide effective system leadership for the NHS, the decision was taken by the Strategic HR and Remuneration Committee and Nomination and Remuneration Committee to not allocate funds for PRP non-consolidated bonus payments for 2022/23.

Secondees were subject to the terms and conditions of their employing organisation.

Policy on senior managers' contracts

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

Payments for loss of office (subject to audit)

A payment was made to one senior manager to compensate for loss of office during the period 1 April 2022 to 30 June 2022 and details of this payment are included in the senior manager salary and pension entitlement table on page 73.

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
Sir David Sloman Chief Operating Officer – Joint	14 December 2021	6 months	Option to provide taxable pay in lieu of part or all of the notice period	Not applicable
Ian Dodge National Director for Primary Care, Community Services and Strategy – Joint	7 July 2014	6 months	Option to provide taxable pay in lieu of part or all of the notice period	Left NHS Improvement 30 June 2022
Jacqueline Rock Chief Commercial Officer – Joint	1 January 2022	6 months	Option to provide taxable pay in lieu of part or all of the notice period	Not applicable
Professor Stephen Powis National Medical Director – Joint Interim Chief Executive Officer – NHS Improvement	1 March 2018 1 August 2021	6 months	Option to provide taxable pay in lieu of part or all of the notice period	Not applicable

Name and title	Date of appointment	Notice period	Provisions for compensation for early termination	Other details
Julian Kelly Chief Financial Officer – Joint	1 April 2019	6 months	Option to provide taxable pay in lieu of part or all of the notice period	Not applicable
Dame Ruth May Chief Nursing Officer – Joint	7 January 2019	6 months	Option to provide taxable pay in lieu of part or all of the notice period	Not applicable
Prerana Issar Chief People Officer – Joint	1 April 2019	6 months	Option to provide taxable pay in lieu of part or all of the notice period	Not applicable
Dr Tim Ferris National Director of Transformation – Joint	10 May 2021	6 months	Option to provide taxable pay in lieu of part or all of the notice period	Not applicable
Chris Hopson Chief Strategy Officer – Joint	13 June 2022	6 months	Option to provide taxable pay in lieu of part or all of the notice period	Not applicable

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 NHS TDA-to-Monitor.

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

Name and title	(a) Salary (bands of £5,000) £000	(b) Benefits in kind (taxable) to nearest £100 £s	(c) Performance pay and bonuses (bands of £5,000) £000	(d) Long-term performance pay and bonuses (bands of £5,000) £000	(e) Pension-Related benefits (bands of £2,500)[13] £000	(f) TOTAL (a to e) (bands of £5,000) £000
Sir David Sloman Chief Operating Officer[14]	55-60	1000	0	0	0	55-60
Ian Dodge National Director for Primary Care, Community Services and Strategy[15]	200-205	0	0	0	0	200-205
Jacqueline Rock Chief Commercial Officer[16]	55-60	0	0	0	12.5-15	70-75
Professor Stephen Powis National Medical Director and Interim Chief Executive Officer[17]	55-60	0	0	0	0	55-60
Julian Kelly Chief Financial Officer[18]	50-55	0	0	0	12.5-15	60-65
Dame Ruth May Chief Nursing Officer[19]	55-60	0	0	0	0	55-60

[13] 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.

[14] Sir David Sloman's salary was recharged to NHS England and NHS Improvement from the 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.

[15] Ian Dodge left NHS England and NHS Improvement on 30 June 2022 and he was paid a redundancy payment in the salary range of £160,000-£165,000 in July 2022 as compensation for loss of office; this is included in the salary band disclosed within the table. The full year equivalent salary is £175,000-£180,000.

[16] Jacqueline Rock's full year equivalent salary is £230,000-£235,000.

[17] Professor Stephen Powis' full year equivalent salary is £225,000-£230,000.

[18] Julian Kelly's full year equivalent salary is £205,000-£210,000.

[19] Dame Ruth May retired on 16 June 2022 to access 1995 NHS Pension benefits and returned to post 18 June 2022 following the required 24 hours break in service. The full year equivalent salary is £180,000-£185,000.

Name and title	(a) Salary (bands of £5,000) £000	(b) Benefits in kind (taxable) to nearest £100 £s	(c) Performance pay and bonuses (bands of £5,000) £000	(d) Long-term performance pay and bonuses (bands of £5,000) £000	(e) Pension-Related benefits (bands of £2,500)[13] £000	(f) TOTAL (a to e) (bands of £5,000) £000
Prerana Issar Chief People Officer[20]	55-60	0	0	0	22.5-25	80-85
Dr Tim Ferris National Director of Transformation[21]	45-50	0	0	0	0	45-50
Chris Hopson Chief Strategy Officer[22]	5-10	0	0	0	0-2.5	10-15

Earnings shown relate to April 2022 to June 2022.

[20] Prerana Issar's full year salary equivalent is £230,000-£235,000.

[21] 80% of the salary costs for Dr Tim Ferris are recharged to NHS England and NHS Improvement from Mass General Brigham Inc. where is he is also formally employed and retains a post, with NHS England and NHS Improvement directly funding the remaining 20%. The full year equivalent salary is £190,000-£195,000. Incorrect enrolment into the NHS Pension Scheme on commencement resulted in an underpayment of salary during 2021/22 due to pension contributions being deducted from his salary in error and these contributions were refunded during 2022/23.

[22] Chris Hopson commenced in post on 13 June 2022. The full year equivalent salary is £190,000-£195,000.

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

Name and title	(a) Salary (bands of £5,000) £000	(b) Benefits in kind (taxable) to nearest £100 £s	(c) Performance pay and bonuses (bands of £5,000) £000	(d) Long-term Performance pay and bonuses (bands of £5,000) £000	(e) Pension-related benefits (to the nearest £1,000)[23] £000	(f) TOTAL (a to e) (bands of £5,000) £000
Amanda Pritchard Chief Executive Officer and Chief Operating Officer[24]	80-85	0	0	0	25	105-110
Mark Cubbon Interim Chief Operating Officer[25]	80-85	300	0	0	16	95-100
Sir David Sloman Chief Operating Officer[26]	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[27]	65-70	0	0	0	0	65-70
Blake Dark Interim Chief Commercial Officer[28]	75-80	0	0	0	19	95-100
Jacqueline Rock Chief Commercial Officer[29]	55-60	0	0	0	13	70-75

[23] 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.

[24] 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

[25] 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.

[26] 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.

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

[28] 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.

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

Name and title	(a) Salary (bands of £5,000) £000	(b) Benefits in kind (taxable) to nearest £100 £s	(c) Performance pay and bonuses (bands of £5,000) £000	(d) Long-term Performance pay and bonuses (bands of £5,000) £000	(e) Pension-related benefits (to the nearest £1,000)[23] £000	(f) TOTAL (a to e) (bands of £5,000) £000
Professor Stephen Powis National Medical Director and Interim Chief Executive Officer [30]	225-230	0	0	0	0	225-230
Julian Kelly Chief Financial Officer	205-210	0	0	0	50	255-260
Dame Ruth May Chief Nursing Officer	180-185	0	0	0	33	210-215
Prerana Issar Chief People Officer	230-235	0	0	0	54	280-285
Matthew Gould CMG MBE National Director for Digital Transformation[31]	100-105	0	0	0	21	120-125
Dr Tim Ferris National Director of Transformation[32]	170-175	0	0	0	0	170-175

[30] Professor Stephen Powis replaced Amanda Pritchard as Interim Chief Executive Officer on 1 August 2021.
[31] 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.
[32] 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.

Pension benefits (subject to audit)

Name and title	Total accrued Pension at pension age at 30 June 2022 (bands of £5,000) £000	Lump sum at pension age related to accrued pension at 30 June 2022 (bands of £5,000) £000	Real increase in pension at pension age (bands of £2,500) £000	Real increase in pension lump sum at pension age (bands of £2,500) £000	Cash Equivalent Transfer Value at 30 June 2022 £000	Cash Equivalent Transfer Value at 31 March 2022[33] £000	Real Increase in Cash Equivalent Transfer Value £000	Employers Contribution to Partnership pension £000
Sir David Sloman Chief Operating Officer[34]	0	0	0	0	0	0	0	0
Ian Dodge National Director for Strategy and Innovation[35]	0	0	0	0	0	0	0	0
Jacqueline Rock Chief Commercial Officer[36]	5-10	0	0-2.5	0	72	14	6	0
Professor Stephen Powis National Medical Director and Interim Chief Executive Officer [37]	0	0	0	0	0	0	0	0
Julian Kelly Chief Financial Officer[38]	15-20	0	0-2.5	0	211	152	6	0
Dame Ruth May Chief Nursing Officer[39]	65-70	310-315	(15)-(12.5)	65-67.5	43	1,763	0	0

[33] As per previous submissions, the column Cash Equivalent Transfer Value at 31 March 2022 is the uninflated value whereas the real Increase in CETV is the employer funded increase.
[34] Sir David Sloman chose not to be covered by the NHS Pension arrangements.
[35] Ian Dodge chose not to be covered by the NHS Pension arrangements.
[36] Jacqueline Rock's Pension Benefits disclosed are pro-rata for the period 1 April 2022 to 30 June 2022.
[37] Professor Stephen Powis chose not to be covered by the NHS Pension arrangements.
[38] Julian Kelly's Pension Benefits disclosed are pro-rata for the period 1 April 2022 to 30 June 2022.
[39] Dame Ruth May accessed NHS 1995 Pension Scheme benefits on 16 June 2022.

Name and title	Total accrued Pension at pension age at 30 June 2022 (bands of £5,000) £000	Lump sum at pension age related to accrued pension at 30 June 2022 (bands of £5,000) £000	Real increase in pension at pension age (bands of £2,500) £000	Real increase in pension lump sum at pension age (bands of £2,500) £000	Cash Equivalent Transfer Value at 30 June 2022 £000	Cash Equivalent Transfer Value at 31 March 2022[33] £000	Real Increase in Cash Equivalent Transfer Value £000	Employers Contribution to Partnership pension £000
Prerana Issar Chief People Officer[40]	15-20	0	0-2.5	0	228	151	10	0
Dr Tim Ferris National Director of Transformation[41]	0	0	0	0	0	0	0	0
Chris Hopson Chief Strategy Officer[42]	0-5	0	0-2.5	0	46	0	1	0

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 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

[40] Prerana Issar's Pension Benefits disclosed are pro-rata for the period 1 April 2022 to 30 June 2022.
[41] Dr Tim Ferris was not eligible to be covered by NHS Pension arrangements.
[42] Chris Hopson commenced in post on 13 June 2022, therefore the Pension Benefits disclosed are pro-rata for the period 13 June 2022 to 30 June 2022.

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. CETV figures are calculated using the guidance on discount rates for calculating unfunded public service pension contribution rates that was extant at 31 March 2023.

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. 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. 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 Financial Reporting Manual (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). 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.

HM Treasury published valuation directions dated 7 October 2021 (see Amending Directions 2021) 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 Pension Scheme, which concludes no changes to benefits or member contributions are required. The 2016 valuation reports can be found on the NHS Pensions website.

The National Employment Savings Trust (NEST) pension

A small number of employees have chosen to contribute to the NEST pension instead of the NHS pension. This is a defined contribution workplace pension scheme into which both employee and employer make contributions.

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 the table below. 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 2022/23 costs are charged to the NHS TDA and one-third to Monitor.

Non-executive director service contracts

Name and Title	Date of Appointment	Unexpired Term at 30 June 2022	Notice Period	Provisions for compensation for early termination	Other Details
Sir Andrew Morris Chair	30 October 2021	0 months	3 months	None	Not applicable
Sir David Behan Associate (non-voting) Non-Executive Director	1 February 2019 tenure renewed 1 February 2021	0 months	3 months	None	Chair of Health Education England
Lord Patrick Carter of Coles Non-Executive Director and Senior Independent Director	1 April 2016	0 months	3 months	None	Not applicable
Professor Sir Munir Pirmohamed Non-Executive Director	6 November 2020	0 months	3 months	None	Not applicable
Jeremy Townsend Non-Executive Director	25 March 2022	0 months	3 months	None	Not applicable
Dame Julia Goodfellow Non-Executive Director	30 October 2021	0 months	3 months	None	Waived entitlement to remuneration

Non-executive director remuneration (including salary entitlements)

Salaries and allowances 2022/23[43] (subject to audit)

Name	Position	Salary (bands of £5,000) £000	Benefits in kind (to nearest £100) £00	Total (bands of £5,000) £000
Sir Andrew Morris[44]	Chair	15-20	0	15-20
Sir David Behan[45]	Associate (non-voting) Non-Executive Director	0-5	0	0-5
Lord Patrick Carter of Coles[46]	Non-executive Director	0-5	0	0-5
Professor Sir Munir Pirmohamed[47]	Non-executive Director	0-5	0	0-5
Jeremy Townsend[48]	Non-executive Director	0-5	0	0-5
Dame Julia Goodfellow[49]	Non-executive Director	0-5	0	0-5

Salaries and allowances 2021/22 (subject to audit)

Name	Position	Salary (bands of £5,000) £000	Benefits in kind (to nearest £100) £00	Total (bands of £5,000) £000
Baroness Dido Harding[50]	Chair	35-40	0	35-40
Sir Andrew Morris[51]	Chair	60-65	0	60-65
Sir David Behan[52]	Associate (non-voting) Non-Executive Director	0-5	0	0-5

[43] Earnings shown relate to April 2022 to June 2022.
[44] Sir Andrew Morris's full-year equivalent salary is £60,000-£65,000.
[45] 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.
[46] Lord Patrick Carter of Coles' full-year equivalent salary is £5,000-£10,000.
[47] Professor Sir Munir Pirmohamed's full-year equivalent salary is £5,000-£10,000.
[48] 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.
[49] Dame Julia Goodfellow waived entitlement to non-executive director remuneration in the band of £5,000-£10,000.
[50] 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.
[51] 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.
[52] 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.

Name	Position	Salary (bands of £5,000) £000	Benefits in kind (to nearest £100) £00	Total (bands of £5,000) £000
Lord Patrick Carter of Coles	Non-executive Director and Senior Independent Director	5-10	0	5-10
Dr Timothy G Ferris MD, MPH[53]	Non-executive Director	0-5	0	0-5
Wol Kolade[54]	Non-executive Director	0-5	0	0-5
Professor Sir Munir Pirmohamed[55]	Non-executive Director	5-10	0	5-10
Rakesh Kapoor[56]	Non-executive Director	5-10	0	5-10
Jeremy Townsend[57]	Non-executive Director	0-5	0	0-5
Professor Dame Julia Goodfellow[58]	Non-executive Director	0-5	0	0-5

Parliamentary accountability and audit report

Unless otherwise noted, all elements of this report are subject to audit.

Cost allocation and charges for information

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

There was one main source of income in the three months to June 2022 relating to NHS Leadership Academy training income which was recognised based on the timing of the underlying training. Further details are contained in the financial statements.

Government functional standards (not subject to audit)

A full update on the government functional standards will be provided in the 2022/23 NHS England Annual Report and Accounts.

[53] Dr Timothy Ferris waived entitlement to non-executive director remuneration in the band of £5,000-£10,000 and left this role on 9 May 2021.
[54] 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.
[55] 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.
[56] Rakesh Kapoor temporarily transferred to NHS Improvement from NHS England on 1 May 2021 until 31 March 2022. The full-year equivalent salary remains at £5,000-£10,000.
[57] 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.
[58] 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.

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)

During the period 1 April 2022 to 30 June 2022, the total number of NHS TDA losses cases, and their total value, was as follows:

Losses	Total Number of Cases (number) 2022/23	Total Value of Cases (£000) 2022/23	Total Number of Cases (number) 2021/22	Total Value of Cases (£000) 2021/22
Administrative write-offs	0	0	0	0
Fruitless payments	0	0	107	25
Stores losses	0	0	0	0
Book-keeping losses	0	0	0	0
Constructive loss	0	0	0	0
Cash losses	0	0	0	0
Claims abandoned	0	0	0	0
Total	0	0	**107**	**25**

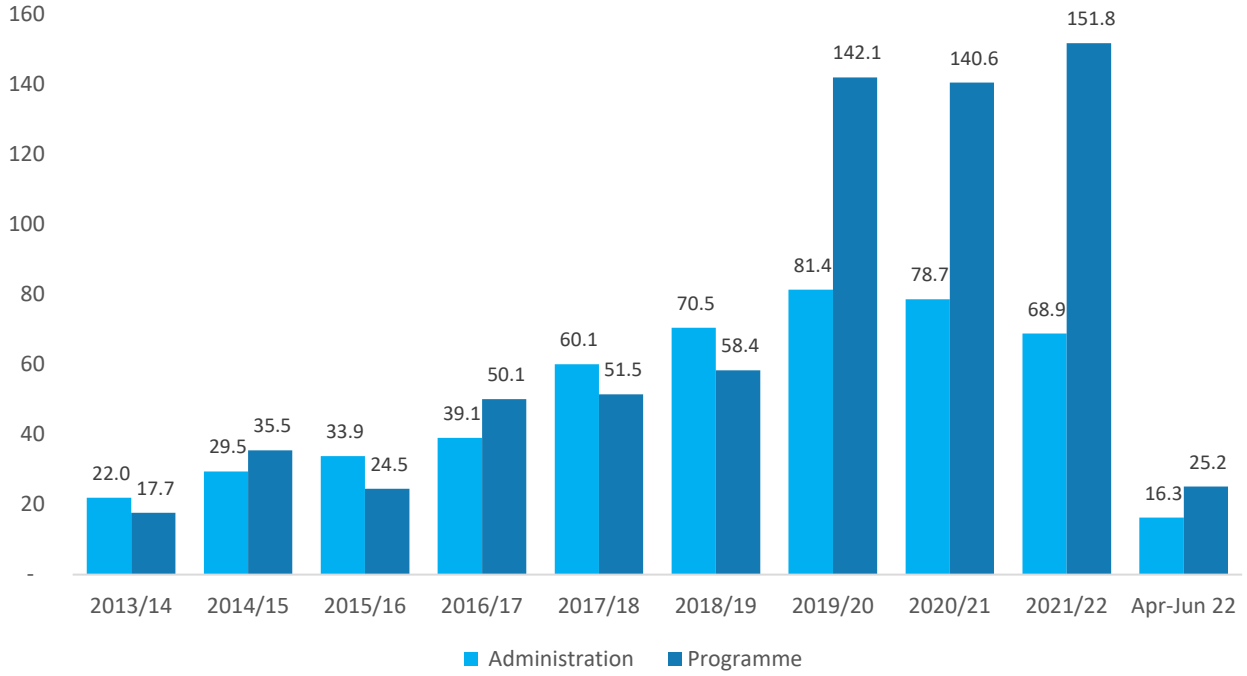
Special payments (subject to audit)

During the period 1 April 2022 to 30 June 2022, the total number of NHS TDA special payments cases was £nil (2021/22: £nil), and their total value was £nil (2021/22: £nil).

Long-term expenditure trend (not subject to audit)

The chart below sets out the trend in net expenditure since financial year 2013/14.

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



NHS TDA's expenditure during this period reflects the statutory duties set out in the Health and Social Care Act 2012.

The large increase from 2019/20 reflected the transfer in of the NHS Leadership Academy from Heath Education England.

Details of the expenditure are disclosed in the annual accounts.

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 NHS Trust Development Authority for the year ended 31 March 2023 under the National Health Service Act 2006.

The financial statements comprise NHS Trust Development Authority's

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

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

In my opinion, the financial statements:

- give a true and fair view of the state of NHS Trust Development Authority's affairs as at 31 March 2023 and its net expenditure for the year then ended; and
- have been properly prepared in accordance with the National Health Service Act 2006.

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 and Regularity of Public Sector Bodies in the United Kingdom (2022)*. My responsibilities under those standards are further described in the *Auditor's responsibilities for the audit of the financial statements* section of my certificate.

Those standards require me and my staff to comply with the Financial Reporting Council's *Revised Ethical Standard 2019*. I am independent of NHS 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 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 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 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 is anticipated that the services which they provide will continue into the future. As stated on page 11, NHS Trust Development Authority's functions transferred to NHS England on 1 July 2022 and will continue to be provided in the future.

Other Information

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

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

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

If I identify such material inconsistencies or apparent material misstatements, I am required to determine whether this gives rise to a material misstatement in the financial statements themselves. If, based on the work I have performed, I conclude that there is a material misstatement of this other information, I am required to report that fact.

I have nothing to report in this regard.

Matters on which I report by exception

In the light of the knowledge and understanding of 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 Reports.

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

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

Responsibilities of the Accounting Officer for the financial statements

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

- maintaining proper accounting records;
- providing the C&AG with access to all information of which management is aware that is relevant to the preparation of the financial statements such as records, documentation and other matters;
- providing the C&AG with additional information and explanations needed for his audit;
- providing the C&AG with unrestricted access to persons within NHS Trust Development Authority from whom the auditor determines it necessary to obtain audit evidence;
- ensuring such internal controls are in place as deemed necessary to enable the preparation of financial statement to be free from material misstatement, whether due to fraud or error;
- ensuring that the financial statements give a true and fair view and are prepared in accordance with the National Health Service Act 2006.
- ensuring that the annual report, which includes the Remuneration and Staff Report, is prepared in accordance with the National Health Service Act 2006; and

- assessing 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 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 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, I:

- considered the nature of the sector, control environment and operational performance including the design of NHS Trust Development Authority's accounting policies.
- inquired of management, NHS England's head of internal audit and those charged with governance, including obtaining and reviewing supporting documentation relating to NHS Trust Development Authority's policies and procedures on:
    - identifying, evaluating and complying with laws and regulations;
    - detecting and responding to the risks of fraud; and
    - the internal controls established to mitigate risks related to fraud or non-compliance with laws and regulations including NHS Trust Development Authority's controls relating to NHS Trust Development Authority's compliance with the National Health Service Act 2006 and Managing Public Money;
- inquired of management, NHS Trust Development Authority and those charged with governance whether:

    - they were aware of any instances of non-compliance with laws and regulations;
    - they had knowledge of any actual, suspected, or alleged fraud;
- discussed with the engagement team regarding how and where fraud might occur in the financial statements and any potential indicators of fraud.

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

I obtained an understanding of NHS Trust Development Authority's framework of authority and other legal and regulatory frameworks in which NHS Trust Development Authority operates. I focused on those laws and regulations that had a direct effect on material amounts and disclosures in the financial statements or that had a fundamental effect on the operations of NHS Trust Development Authority. The key laws and regulations I considered in this context included the National Health Service Act 2006, Managing Public Money, Employment Law, Tax Legislation and the regulations governing the Civil Service Injury Benefit Scheme.

Audit response to identified risk

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

- I reviewed the financial statement disclosures and testing to supporting documentation to assess compliance with provisions of relevant laws and regulations described above as having direct effect on the financial statements;
- I enquired of management and the Audit and Risk Committee concerning actual and potential litigation and claims;
- I reviewed minutes of meetings of those charged with governance and the Board and internal audit reports; and
- in addressing the risk of fraud through management override of controls, I tested the appropriateness of journal entries and other adjustments; assessed whether the judgements on estimates are indicative of a potential bias; and evaluated the business rationale of any significant transactions that are unusual or outside the normal course of business.

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

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

Other auditor's responsibilities

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

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

Report

I have no observations to make on these financial statements.

Gareth Davies **Date 18 July 2023**

Comptroller and Auditor General

National Audit Office

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

Annual Accounts

Amanda Pritchard

Chief Executive of NHS England

17 July 2023

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

Statement of comprehensive net expenditure for the year ended 31 March 2023	Note	2022/23 £000	2021/22 restated £000
Other operating revenue	3	**2,896**	11,216
Total operating revenue	Not applicable	**2,896**	**11,216**
Staff costs	4	34,086	141,158
Purchase of goods and services	5	9,567	89,064
Depreciation and amortisation	5	795	1,732
Total operating expenditure	Not applicable	**44,448**	**231,954**
Net expenditure for the financial year	Not applicable	**41,552**	**220,738**
Net loss on transfer by absorption	12	9,537	0
Total comprehensive net expenditure for the year	Not applicable	**51,089**	**220,738**

All operations are continuing.

The 2022/23 column of this Statement, and the related notes, show activity for the period 1 April 2022 to 30 June 2022. On 1 July 2022 NHS TDA was abolished and all operations were transferred to NHS England where they continued to operate.

For details of the restatement see note 1.14.

The notes on pages 99 to 115 form part of these accounts.

Statement of financial position as at 31 March 2023

Non-current assets	Note	31 March 2023 £000	31 March 2022 restated £000	1 April 2021 restated £000
Property, plant & equipment	6.1	0	160	239
Intangible assets	6.2	0	7,795	5,778
Total non-current assets	Not applicable	0	**7,955**	**6,017**

Current assets	Note	31 March 2023 £000	31 March 2022 restated £000	1 April 2021 restated £000
Trade and other receivables	7	0	8,957	15,101
Cash and cash equivalents	8	0	8,263	3,574
Total current assets	Not applicable	0	**17,220**	**18,675**
Total assets	Not applicable	0	**25,175**	**24,692**

Current liabilities	Note	31 March 2023 £000	31 March 2022 restated £000	1 April 2021 restated £000
Trade and other payables	9.1	0	63,537	69,176
Provisions	Not applicable	0	0	88
Total current liabilities	Not applicable	0	**63,537**	**69,264**
Net current liabilities	Not applicable	0	(46,317)	(50,589)

Non-current liabilities	Note	31 March 2023 £000	31 March 2022 restated £000	1 April 2021 restated £000
Trade and other payables	9.2	0	549	101
Total non-current liabilities	Not applicable	0	**549**	**101**
Total net liabilities	Not applicable	0	**(38,911)**	**(44,673)**

Financed by taxpayers' equity	Note	31 March 2023 £000	31 March 2022 restated £000	1 April 2021 restated £000
General fund	Not applicable	0	(38,911)	(44,673)
Total taxpayers' equity	Not applicable	0	**(38,911)**	**(44,673)**

For details of the restatement see note 1.14.

The financial statements and the notes on pages 99 to 115 were signed on behalf of the NHS Trust Development Authority by:

Amanda Pritchard

Chief Executive of NHS England 17 July 2023

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

Changes in taxpayers' equity	Note	2022/23 £000	2021/22 £000
Opening taxpayer's equity	Not applicable	**(38,911)**	**(47,653)**
Restatement	Not applicable	0	2,980
Opening taxpayer's equity restated	Not applicable	**(38,911)**	**(44,673)**
Comprehensive net expenditure for the year	SoCNE	(51,089)	(220,738)
Net parliamentary funding	SoCF	90,000	226,500
Closing taxpayer's equity	Not applicable	**0**	**(38,911)**

For details of the restatement see note 1.14.

The notes on pages 99 to 115 form part of these accounts.

Statement of cash flows for the year ended 31 March 2023

Cash flows from operating activities	Note	2022/23 £000	2021/22 (restated) £000
Net operating cost excluding lease-related transactions	Not applicable	(51,027)	(220,738)
Adjustments for non-cash transactions	Not applicable	Not applicable	Not applicable
Depreciation and amortisation	5	795	1,732
Provisions arising/(written back) during the year	5	0	(88)
Decrease in trade and other receivables	7	8,957	6,144
Decrease in trade payables and other liabilities excluding lease liabilities	9	(66,035)	(5,191)
Transfer by absorption of non-current assets	12	9,558	0
Payments for short term leases	Not applicable	(57)	0
Net cash (outflow) from operating activities	Not applicable	**(97,809)**	**(218,141)**

Cash flows from investing activities	Note	2022/23 £000	2021/22 £000
Payments for property, plant and equipment	6.1	(15)	(55)
Payments for intangible assets	6.2	(231)	(3,615)
Net cash (outflow) from investing activities	Not applicable	**(246)**	**(3,670)**

Cash flows from financing activities	Note	2022/23 £000	2021/22 £000
Net parliamentary funding	SoCTE	90,000	226,500
Payments for the principal of the right of use lease liability	Not applicable	(206)	0
Interest on right of use leases	5	(2)	0
Net cash generated from financing activities	Not applicable	**89,792**	**226,500**
Net increase/(decrease) in cash and cash equivalents	Not applicable	**(8,263)**	**4,689**
Cash and cash equivalents at the beginning of the period	Not applicable	**8,263**	**3,574**
Cash and cash equivalents at the end of the period	Not applicable	**0**	**8,263**

For details of the restatement see note 1.14.

The notes on pages 99 to 115 form part of these accounts.

Notes to the accounts

1. Statement of accounting policies

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 was not going to be a 'one size fits all' solution to the challenges trusts face. NHS TDA's 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 Government Financial Reporting Manual (FReM) issued by HM Treasury. The accounting policies contained in the FReM apply UK adopted International Financial Reporting 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.

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.

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 TDA are continuing as part of NHS England and financial provision for these services is included in the main estimates.

Assets and liabilities of NHS TDA transferred to NHS England on 1 July 2022 are summarised in the transfer by absorption note 11.

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 were 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 each entity reflects each organisation's cost.

1.3.2 Non-current asset valuations

In accordance with HM Treasury's FReM (10.1.14), NHS TDA has opted to adopt depreciated historical cost as a proxy for the value of 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.

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, multi-employer defined benefit scheme in which NHS TDA is unable to identify its share of the underlying assets and liabilities. NHS TDA contributed annual premiums and retained no further liability except in the case of employees who took 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 is capitalised where it 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. Assets not meeting these requirements are carried at fair value using the most appropriate valuation methodology available.

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 the activities of 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

A lease is a contract or part of a contract that conveys the right to use an asset for a period of time in exchange for consideration. IFRS 16 Leases is effective across public sector from 1 April 2022. The transition to IFRS 16 has been completed in accordance with paragraph C5 (b) of the Standard, applying IFRS 16 requirements retrospectively recognising the cumulative effects at the date of initial application.

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

Operating leases in which the underlying asset is of low value or whose terms end within 12 months of the date of initial application are not recognised as assets.

HM Treasury have adapted the public sector approach to IFRS 16 which impacts on the identification and measurement of leasing arrangements that will be accounted for under
IFRS 16. NHS TDA is required to apply IFRS 16 to lease-like arrangements entered into with other public sector entities that are in substance akin to an enforceable contract, that in their formal legal form may not be enforceable. Prior to accounting for such arrangements under IFRS 16 NHS TDA has assessed that in all other respects these arrangements meet the definition of a lease under the Standard.

NHS TDA leases relate to property occupancies, recognised as right of use assets and corresponding lease liability. Accommodation of office space through the shared arrangement with NHS England does not constitute a lease under IFRS 16 as the cost recharges do not contain an identifiable lease asset in accordance with IFRS 16.

Lease payments are apportioned between finance charges and repayment of the principal. Finance charges are recognised in the Statement of Comprehensive Net Expenditure. Irrecoverable VAT is expensed in the period to which it relates and therefore not included in the measurement of the lease liability and consequently the value of the right of use asset. The incremental borrowing rate of 0.95% has been applied to the lease liabilities recognised at the date of initial application of IFRS 16.

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.

1.13.1 IFRIC 23 Uncertainty over Income Tax Treatments

Application required for accounting periods beginning on or after 1 January 2019. The impact on NHS TDA accounts is not material.

1.14 Prior period restatement

Prior year comparatives have been restated following a review of accruals at 30 June 2022 impacting prior periods. The restatement has impacted the financial statements as follows:

Statement of Financial position (extract)	1 April 2021	Increase/ (decrease)	1 April 2021 restated
Trade and other payables	72,156	(2,980)	69,176
Total net assets/(liabilities)	(47,653)	2,980	(44,673)

Statement of changes in taxpayers' equity (extract)	1 April 2021	Increase/ (decrease)	1 April 2021 restated
Opening taxpayer's equity	(47,653)	2,980	(44,673)

Statement of comprehensive net expenditure (extract)	31 March 2022	Increase/ (decrease)	31 March 2022 restated
Total operating expenditure*	233,760	(1,806)	231,954
Comprehensive net expenditure for the year	222,544	(1,806)	220,738

Statement of Financial position (extract)	31 March 2022	Increase/ (decrease)	31 March 2022 restated
Trade and other payables	68,323	(4,786)	63,537
Total net assets/(liabilities)	(43,697)	4,786	(38,911)

Cash flow statement (extract)	31 March 2022	Increase/ (decrease)	31 March 2022 restated
Net operating cost excluding lease-related transactions	222,544	(1,806)	220,738
Decrease in trade payables and other liabilities excluding leases	(3,385)	(1,806)	(5,191)

Statement of changes in taxpayers' equity (extract)	31 March 2022	Increase/ (decrease)	31 March 2022 restated
Comprehensive net expenditure for the year	222,544	(1,806)	220,738
Closing taxpayer's equity	(43,697)	4,786	(38,911)

*The £1,806k adjustment to decrease total operating costs reflects a £101k reduction in staff costs and a £1,705k reduction in the purchase of goods and services.

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 (HSIB) (a subset of programme activities). Assets and liabilities are not split in this way so not reported here or reported to those charged with governance.

2022/23	Administration £000	Programme £000	HSIB £000	Total £000
Revenue	(481)	(2,415)	0	(2,896)
Expenditure	16,797	23,161	4,490	44,448
Net operating costs	**16,316**	**20,746**	**4,490**	**41,552**

2021/22 (restated)	Administration £000	Programme £000	HSIB £000	Total £000
Revenue	(1,990)	(9,226)	0	(11,216)
Expenditure	70,915	142,842	18,197	231,954
Net operating costs	**68,925**	**133,616**	**18,197**	**220,738**

Administration

The financial objective of the NHS TDA is to manage the recurrent costs of management and administration within the allocation of £16.4 million this funding covers staff, accommodation and other running costs.

Programme

The NHS TDA received an allocation of £21.5 million 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

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 £4.5 million.

3. Revenue

Administration revenue	**2022/23 £000**	**2021/22 £000**
Recharge to NHS England for joint working costs	242	988
Revenue in respect of seconded staff	191	442
Other miscellaneous revenue	48	560
Total administration revenue	**481**	**1,990**

Programme revenue	**2022/23 £000**	**2021/22 £000**
Provision of NHS Leadership Academy training	2,264	7,467
Revenue in respect of seconded staff	44	1,373
Other miscellaneous revenue	107	386
Total programme revenue	**2,415**	**9,226**
Total revenue	**2,896**	**11,216**

4. Employee benefits

Employee benefits Gross expenditure	2022/23 £000	2021/22 restated £000
Salaries and wages	26,131	110,326
Social security costs	3,348	12,623
Employer contributions to the NHS Pensions Scheme	4,579	18,209
Termination benefits	28	0
Total gross expenditure	**34,086**	**141,158**

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

5. Operating expenditure

Purchase of goods and services	2022/23 Admin £000	2022/23 Programme £000	2022/23 Total £000	2021/22 Admin £000	2021/22 Programme £000	2021/22 Total £000
Auditors' remuneration for NHS TDA	73	0	73	55	0	55
Auditors' remuneration for consolidated accounts of NHS providers	0	0	0	130	0	130
Chair and non-executive members	24	0	24	126	0	126
Education and training	40	2,233	2,273	210	34,250	34,460
Programme support costs	2	371	373	411	18,625	19,036
Legal fees	0	(47)	(47)	12	291	303
Consultancy and other professional fees	(30)	844	814	314	10,910	11,224
Establishment expenses	(314)	1,320	1,006	1,302	7,217	8,519
Supplies and services - general	(46)	3,834	3,788	2,525	7,471	9,996
Premises	1,373	(305)	1,068	3,194	1,655	4,849
Transport	38	160	198	75	218	293
Provisions expense	0	0	0	0	(88)	(88)
Interest on right of use leases	3	2	5	0	0	0
Miscellaneous expenditure	(21)	13	(8)	59	102	161
Total purchase of goods and services	**1,142**	**8,425**	**9,567**	**8,413**	**80,651**	**89,064**

Depreciation and amortisation charges	2022/23 Admin £000	2022/23 Programme £000	2022/23 Total £000	2021/22 Admin £000	2021/22 Programme £000	2021/22 Total £000
Depreciation	82	150	232	105	32	137
Amortisation	501	62	563	1,409	186	1,595
Total depreciation and amortisation	**583**	**212**	**795**	**1,514**	**218**	**1,732**
Total operating expenditure	**1,725**	**8,637**	**10,362**	**9,927**	**80,869**	**90,796**

Auditors' remuneration for consolidated accounts of NHS providers is nil in 2022/23 as the responsibility for production of these accounts switched to NHS England.

6. Non-current assets

6.1 Property, plant and equipment

2022/23 Cost	Information technology £000	Furniture & fittings £000	Right of use leases £000	Total £000
At 1 April 2022	932	651	0	**1,583**
Additions purchased	15	0	0	**15**
Leases recognised under IFRS16	0	0	2,152	**2,152**
Disposals	(802)	(151)	0	**(953)**
Transfer by absorption	(145)	(500)	(2,152)	**(2,797)**
At 31 March 2023	**0**	**0**	**0**	**0**

2022/23 Accumulated depreciation	Information technology £000	Furniture & fittings £000	Right of use leases £000	Total £000
At 1 April 2022	842	581	0	**1,423**
Charged during the year	16	10	206	**232**
Disposals	(802)	(151)	0	**(953)**
Transfer by absorption	(56)	(440)	(206)	**(702)**
Net book value at 31 March 2022	90	70	0	**160**
Net book value at 31 March 2023	**0**	**0**	**0**	**0**

2021/22 Cost	Information technology £000	Furniture & fittings £000	Right of use leases £000	Total £000
At 1 April 2021	969	651	0	**1,620**
Additions purchased	55	0	0	**55**
Disposals	(92)	0	0	**(92)**
At 31 March 2022	**932**	**651**	**0**	**1,583**

2021/22 Accumulated depreciation	Information technology £000	Furniture & fittings £000	Right of use leases £000	Total £000
At 1 April 2021	838	543	0	**1,381**
Charged during the year	96	38	0	**134**
Disposals	(92)	0	0	**(92)**
At 31 March 2022	**842**	**581**	**0**	**1,423**
Net book value at 31 March 2021	131	108	0	**239**
Net book value at 31 March 2022	**90**	**70**	**0**	**160**

All Information Technology and Furniture & fittings assets are purchased assets and are owned by NHS TDA.

6.2 Intangible assets

2022/23 Cost	Software purchased £000	Assets under construction £000	Software internally generated £000	Total £000
At 1 April 2022	47	67	10,730	**10,844**
Additions purchased	0	0	231	**231**
Reclassification	0	0	0	**0**
Disposals	(10)	0	(1,249)	**(1,259)**
Transfer by absorption	(37)	(67)	(9,712)	**(9,816)**
At 31 March 2023	**0**	**0**	**0**	**0**

2022/23 Accumulated amortisation	Software purchased £000	Assets under construction £000	Software internally generated £000	Total £000
At 1 April 2022	13	0	3,036	**3,049**
Charged during the year	2	0	561	**563**
Disposals	(10)	0	(1,249)	**(1,259)**
Transfer by absorption	(5)	0	(2,348)	**(2,353)**
At 31 March 2023	**0**	**0**	**0**	**0**
Net book value at 31 March 2022	34	67	7,694	**7,795**
Net book value at 31 March 2023	**0**	**0**	**0**	**0**

2021/22 Cost	Software purchased £000	Assets under construction £000	Software internally generated £000	Total £000
At 1 April 2021	118	3,211	4,009	**7,338**
Additions purchased	38	51	3,526	**3,615**
Reclassification	0	(3,195)	3,195	**0**
Disposals	(109)	0	0	**(109)**
At 31 March 2022	**47**	**67**	**10,730**	**10,844**

2021/22 Accumulated amortisation	Software purchased £000	Assets under construction £000	Software internally generated £000	Total £000
At 1 April 2021	118	0	1,442	**1,560**
Charged during the year	4	0	1,594	**1,598**
Disposals	(109)	0	0	**(109)**
At 31 March 2022	**13**	**0**	**3,036**	**3,049**
Net book value at 31 March 2021	**0**	3,211	2,567	**5,778**
Net book value at 31 March 2022	**34**	**67**	**7,694**	**7,795**

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

7. Trade receivables and amounts falling due within one year

Trade receivables and amounts falling due within one year	31 March 2023 £000	31 March 2022 £000
Contract Receivables	2,851	3,551
Prepayments	2,719	4,417
VAT	596	989
Transfer by absorption	(6,166)	0
Trade and other receivables	**0**	**8,957**

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

8. Cash and cash equivalents

Cash and cash equivalents	31 March 2023 £000	31 March 2022 £000
Opening balance	8,263	3,574
Change in cash and cash equivalent balances to 30 June 2022	23,832	4,689
Transfer by absorption	(32,095)	0
Closing balance	**0**	**8,263**
Made up of	Not applicable	Not applicable
Cash with Government Banking Service	0	8,263
Cash and cash equivalents as in Statement of Financial Position	**0**	**8,263**

9. Trade payables and other liabilities

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

Trade payables and other current liabilities falling due within one year	31 March 2023 £000	31 March 2022 (restated) £000
Other taxation and social security	3,350	3,377
Trade payables	5,093	13,289
Accruals	23,676	44,053
Contract liabilities	3,803	2,818
Right of use lease liabilities	833	0
Transfer by absorption	(36,755)	0
Current trade and other payables	**0**	**63,537**

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

Trade payables and other non current liabilities falling due after one year	31 March 2023 £000	31 March 2022 £000
Contract liabilities	411	549
Right of use lease liabilities	1,116	0
Transfer by absorption	(1,527)	0
Non current trade and other payables	**0**	**549**

10. Financial instruments

10.1 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.

10.2 Financial assets

Financial assets	2022/23 £000	2021/22 £000
Financial assets held at amortised cost	0	12,803
Total at 31 March 2023	**0**	**12,803**

10.3 Financial liabilities

Financial liabilities	2022/23 £000	2021/22 restated £000
Financial liabilities held at amortised cost	**0**	60,719
Total at 31 March 2023	**0**	**60,719**

11. IFRS 16 transition

IFRS 16 transition	2022/23 £000
Operating lease future payments at 31 March 2022	2,195
Less: short term leases recognised as an expense	(43)
Right of use lease liability at 1 April 2022	**2,152**
Right of use lease asset at 1 April 2022 (see note 6.1)	**2,152**

12. Transfer by absorption

On 1 July 2022 all assets, liabilities and reserves were transferred to NHS England. The transfer amount is broken down as follows:

Transfer by absorption	2022/23 £000
Non-current assets	(9,558)
Current assets excluding cash	(6,166)
Cash	(32,095)
Current liabilities	36.755
Non-current liabilities	1,527
Total transfer by absorption	**(9,537)**

13. 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.

14. Related Parties

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

The DHSC was regarded as a related party. During the year 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 NHS TDA (2021/22 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 the strategic direction for the organisation, describing the government's healthcare priorities and the contribution NHS England is expected to make within the allocated budget. The mandate also helps ensure the NHS is held accountable to Parliament and the public.

The 2022/23 mandate was issued to NHS England, in anticipation of the transfer of several functions from Monitor and the NHS Trust Development Authority (known as NHS Improvement) to NHS England. Following passage of the Health and Care Act 2022, the transfer of functions to NHS England took effect from 1 July 2022.

The 2022/23 mandate included five key objectives for NHS England:

- continue to lead the NHS in managing the impact of COVID-19 on health and care
- recover, and maintain delivery of, wider NHS services and functions
- renew focus on delivering against the NHS Long Term Plan and broader commitments for the NHS
- embed a population health management approach within local systems, stepping up action to prevent ill health and tackle health disparities
- ensure effective NHS leadership, culture, and use of organisational resource to realise the benefits from future structural changes within health and care.

To assess performance against objectives in the mandate, 45 deliverables were agreed with the DHSC for assurance. Alongside these core objectives was a requirement to ensure robust financial performance for 2022/23.

A full assessment of performance against the 2022/23 mandate will be undertaken at the end of the financial year and will be based on assessments by policy teams at NHS England and DHSC. A summary of performance will be included in NHS England's full 2022/23 Annual Report, which will also account for the performance of NHS Improvement during the three-month reporting period to the end of 30 June 2022.

The Mandate Assurance Report 2022/23 will be published in NHS England's annual report and accounts.

Appendix 2: Meeting our Public Sector Equality Duty (PSED)

About this report

As a result of the implementation of the Health and Care Act 2022, the NHS TDA and Monitor were abolished with effect from 1 July 2022 and relevant functions were transferred to NHS England. In practice, however NHS England, NHS TDA and Monitor had been working together to meet the requirements of the PSED and associated Specific Equality Duties (SEDs) since 2019. This final annual report for NHS TDA focuses on the review of work undertaken between April 2022 and June 2022 by NHS TDA and Monitor working in partnership with NHS England to meet the requirements of the PSED.

The Specific Equality Duties Review report for 2022/23

On 18 May 2023, NHS England's Board approved the NHS England report on compliance with the SEDs for 2022/23. This report, 'The Review Report: Equality objectives and information review, as at 31 March 2023', includes an assessment of the performance of NHS TDA between April and June 2022. During this time NHS England and NHS TDA continued to work largely as a single organisation in furtherance of the PSED and SEDs. This means that employment is the only area where some of the performance of NHS Improvement is separately identified.

Progress made during 2022/23 against the equality objectives for 2022/23 can be found in part three of the Review Report. Part 5 of the Review Report sets out the employment position of NHS Improvement (Monitor and NHS TDA) as at the end of June 2022 prior to dissolution. Please read the full Review Report to understand key work and performance during 2022/23.

Appendix 3: Working in partnership with people and communities

In the first quarter of 2022/23 our work continued to focus on using the learning from the COVID-19 pandemic, to support health and care services to take a more community-centred approach in how they work with people and communities.

One way we have done this is to develop new statutory guidance for ICBs, NHS trusts and foundation trusts on working with people and communities. This guidance aligns with the changes introduced by the Health and Care Act 2022. NHS England and NHS Improvement have undertaken a significant amount of engagement throughout the first quarter of this year with a diverse range of stakeholders to develop the guidance. These changes align with our new focus and support ICSs to develop meaningful and impactful approaches to working with people and communities in 2022/23. We have also set up a network of ICB engagement leads to help them embed the principles and approaches of the guidance in their systems.

To complement the new statutory guidance, we refocused our work in a variety of ways. This has involved 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 voluntary, community and social enterprise (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 also relaunched the Older People's Sounding Board and started a new LGBTI+ Sounding Board.

We have supported and advised professionals working across health and care, to ensure public participation is embedded into ways of working. This includes the delivery of 27 online training and learning sessions accessed by 1,020 individuals. Internally this has included assuring NHS England's duty to involve the public in commissioning (section 13Q of the NHS Act 2006). Additionally, in April 2022 we ran our bi-annual 'Engagement Practitioners Network' event, #StartWithPeople. Over 1,200 people signed up to attend the popular, one-day event, which had over 28 sessions.

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

A full summary of how we worked with people and communities over the past year will be provided in NHS England's 2022/23 annual report and accounts.

Appendix 4: Sustainability

All reporting in this section covers NHS England, NHS Improvement and the Commissioning Support Units (CSUs). Each trust and ICS will have its own Green Plan[59] and will report its sustainability performance separately.

Summary

We back the Greening Government Commitments and the Greener NHS commitment to be a net zero health service by 2040. In May 2022, the Board approved our 2022-25 Green Plan for NHS England which outlines the carbon reduction milestones we aim to reach as we progress to net zero. Measured from a 2017/18 baseline, we aim to achieve the following reductions in greenhouse gas emissions:

- 44% by 2025
- 80% by 2028
- net zero for the emissions we control by 2040
- net zero for the emissions we influence by 2045.

While each CSU's targets may vary, they will continue to be included in the figures reported in this sustainability report.

Reporting for multi-occupancy buildings

We are reporting on the proportion of the NHS Property Services (NHS PS) buildings occupied by NHS England and NHS Improvement and CSUs. Where we are a tenant of a government department, energy, waste and water information will be reported within their annual report and published on their respective websites.

Provision of data

NHS PS is the landlord for most of NHS England and NHS Improvement and CSU offices and we rely on it for the provision of utilities and waste data. The energy and water data provided for this financial year comes with the following guidance from NHS PS:

- all waste costs for quarter 1 2022/23 have been estimated based on average tariffs
- all water usage and cost has been estimated
- all electricity, gas, water and waste have been apportioned by floor area by occupant
- where utilities information is unavailable, it has been estimated based on the averages for the rest of the estate.

[59] https://www.england.nhs.uk/greenernhs/

Mitigating climate change: working towards net zero by 2040

2021-25 Greening Government Commitments 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 Greening Government Commitments 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.

2021-25 Greening Government Commitments sub-targets:	**2019/20**	**2020/21**	**2021/22**	**Apr-June 2022**
Net internal area reported in m^2	73,942	68,016	56,347	50,901
Full Time Equivalents reported	15,408	15,801	16,318	17,495

Greenhouse gas emissions[60]

Scope 1 emissions tCO_2e	**2019/20**	**2020/21**	**2021/22**	**Apr-June 2022**
Emissions from organisation-owned fleet vehicles	243	57	14	8
Gas	2,034	936	1,005	278
Total scope 1[61] (tCO_2e)	**2,277**	**993**	**1,018**	**286**

Scope 2 emissions tCO_2e	**2019/20**	**2020/21**	**2021/22**	**Apr-June 2022**
Electricity	2,892	1,592	1,273	174
Total scope 2[62] (tCO_2e)	**2,892**	**1,592**	**1,273**	**174**
Road travel	2,851	465	330	160

[60] Figures have been rounded to the nearest whole number.
[61] Scope 1 emissions arise from organisation owned and operated vehicles, plant and machinery.
[62] Scope 2 emissions arise from the consumption of purchased electricity, heat, steam and cooling.

Scope 3 emissions tCO_2e	2019/20	2020/21	2021/22	Apr-June 2022
Rail travel	1,418	50	161	137
Domestic air travel	32	1	2	4
International air travel	55	2	2	2
Total scope 3[63] (tCO_2e)	**4,356**	**519**	**494**	**303**
Total (tCO_2e)	**9,524**	**3,104**	**2,786**	**763**

The figures for quarter 1 2022/23 suggest that emissions are increasing following a period of decline throughout the COVID-19 pandemic, although they are still below pre-pandemic levels. Due to seasonal changes in energy use and requirements for business travel, a full year of figures is needed to draw any meaningful conclusions about performance in 2022/23.

Related use and cost

Scope 1	2019/20	2020/21	2021/22	Apr-June 2022
Business travel (miles)	836,735	226,492	51,897	35,552
Gas (kWh)	11,062,757	5,089,362	5,486,632	947,933
Business travel cost	£367,840	£26,984	£24,044	£19,144
Gas cost	£410,829	£161,714	£192,395	£40,205

Scope 2	2019/20	2020/21	2021/22	Apr-June 2022
Electricity (kWh)	10,428,921	6,288,476	5,997,467	1,201,500
Electricity cost	£1,785,300	£1,071,000	£778,529	£180,570
Road travel (miles)	10,166,014	1,678,725	1,236,664	523,129
Rail travel (miles)	21,404,609	843,910	2,816,243	2,406,240
Domestic air travel (miles)	155,961	6,381	9,686	15,862
International air travel (miles)	253,062	14,798	12,102	12,356

Scope 3	2019/20	2020/21	2021/22	Apr-June 2022
Road travel (cost)	£4,951,830	£593,452	£639,481	£269,852
Rail travel (cost)	£10,355,117	£832,278	£1,310,779	£1,240,794
Domestic air travel (cost)	£67,119	£6,381	£3,735	£6,411
International air travel (cost)	£29,082	£14,798	£2,314	£4,540

[63] Scope 3 emissions arise from official business travel by vehicles not owned by the organisation.

Total scope costs	2019/20	2020/21	2021/22	Apr-June 2022
Total miles (scope 1 and 3)	32,816,381	2,770,306	4,126,802	2,957,587
Total cost of business travel (scope 1& 3)	£15,770,987	£1,473,893	£1,980,353	£1,540,741
Total cost of related use (all scopes)	£17,967,116	£2,706,607	£2,951,277	£1,761,516

Car fleet

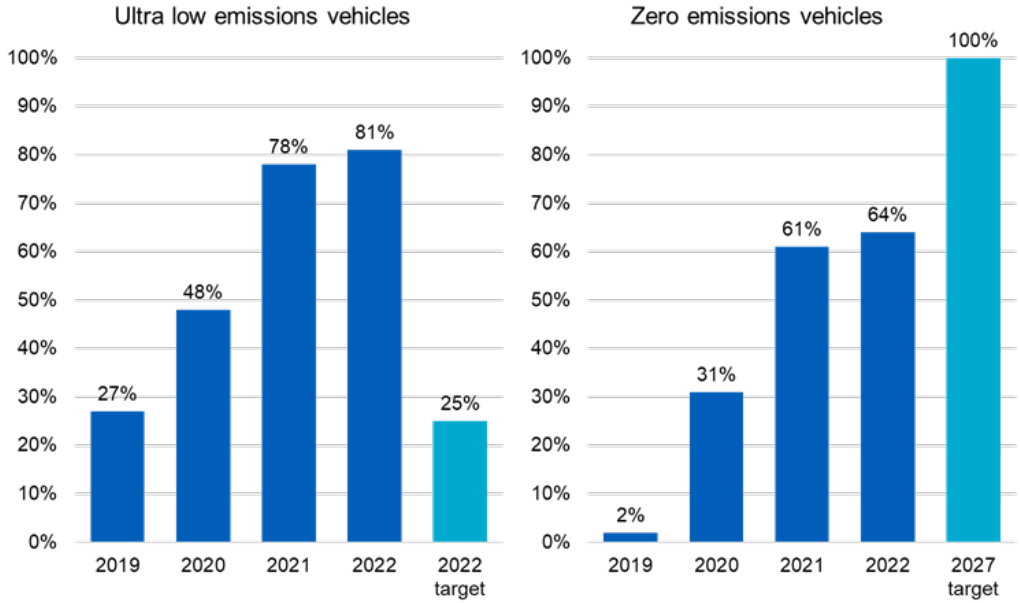
2021 to 2025 Greening Government Commitments sub-target:

Meet the Government Fleet Commitment for 25% of the government car fleet to be ultra-low emission vehicles[64] by 31 December 2022, and 100% of the government car and van fleet to be fully zero emission at the tailpipe by 31 December 2027. This commitment covers vehicles which are leased by employees through the employer's salary sacrifice scheme.

Vehicle emissions

Vehicle emissions	2019	2020	2021	2022	Target
Ultra-low emissions vehicles	27%	48%	78%	81%	25% by 2022
Zero emissions vehicles	2%	31%	61%	64%	100% by 2027

We have exceeded the target for 25% of fleet vehicles to have ultra-low emissions, having met the target before 2019, and are on track for 100% of fleet vehicles to have zero emissions at the tailpipe by 2027.



[64] Emissions less than 50gCO_2/km.

Minimising waste and promoting resource efficiency

2021-25 Greening Government Commitments 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 to 2018 baseline.
- Remove consumer single use plastic from the central government office estate.

Report on the introduction and implementation of reuse schemes	2019/20	2020/21	2021/22	Apr-June 2022
Total (tonnes)	1,440	291	225	105
Recycled (tonnes)	1,241	177	103	69
Incinerated with heat recovery (tonnes)	190	109	100	66%
Incinerated without heat recovery[65]	0	0	14	36
Landfill (tonnes)	10	6	7	0
Waste to landfill (%)	1%	2%	3%	0%
Recycling (%)	86%	61%	46%	46%
Cost of recycling[66]	0	0	0	£26,627
Cost of heat recovery[67]	0	0	0	£12,307
Cost of waste disposal	£199,127	£96,175	£104,325[68]	£38,935
Paper use (sheets)	45,576,477	4,913,241	3,017,582	434,100[69]

Similar to greenhouse gas emissions, waste arising in quarter 1 2022/23 suggests there will be an increase compared to the previous two years when a significant proportion of staff were working from home some or all of the time. Indicative levels are still below pre-pandemic levels. However, whole-year figures will be needed to draw any conclusions as staff continue to increase levels of in-person working.

[65] This is the first year we have made a distinction between waste being incinerated with and without heat recovery.
[66] We were not provided with the costs associated with each waste stream in 2020/21 or 20221/22.
[67] Same as note 7 above.
[68] The cost of waste disposal during 2021/22 was not provided by NHS Property Services in time for the publication of this report.
[69] This figure has been estimated. Where figures were available, the average was used to estimate missing figures.

Consumer single use plastics (CSUPs)

NHS England procured 524 items which are defined as consumer single use plastics, according to the Greening Government Commitment definition. This figure was used to estimate the number of items for CSUs, and we estimate that a total of 824 CSUP items were procured between April and June 2022. This is the first time we have been able to report on CSUP and we will continue to report on this regularly, working with our suppliers to understand what items are being purchased and identify alternatives to reduce levels of CSUPs.

Reducing our water use

2021-25 Greening Government Commitments 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.

Water usage	2019/20	2020/21	2021/22	Apr-Jun 2022
Water used (m^3)	54,974	15,779	24,964	5,496
Cost of water used	£216,318	£33,518	£73,169	£16,035

Water use continues to be estimated by our head leaseholder, NHS Property Services. Over the last few years, it has worked hard to reduce the number of water suppliers from more than 25 to under 10 at the end of 2021. However, to further improve its ability to manage water supply and consumption across its estate, it is developing a procurement process to select a single national water supplier. This will provide enhanced cost and billing certainty, while improving the metering of water and developing mechanisms to reduce consumption. The selection criteria will also include key requirements around leak detection, usage reporting and net zero commitments strategy.

Sustainable procurement

With the publication of the NHS net zero report, the NHS affirmed the need to act 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. The NHS Net Zero Supplier Roadmap sets out the key milestones for suppliers until 2030. From April 2022, mandatory minimum weighting of 10% on net zero and social value in all procurements was extended from NHS England to the wider NHS.

NHS England continues to collaborate with trade associations and suppliers through the NHS England Sustainable Supplier Forum to prepare suppliers to deliver on future requirements, including mandatory carbon reduction plans for contracts with a value of £5 million per year and above from April 2023.

NHS England has published net zero and social value guidance to complement the UK Government Social Value Model and support decision-makers and suppliers to reduce carbon emissions, generate more social value for the communities that we serve, reduce health inequalities and improve the wider determinants of health.

NHS England has committed to buying 100% fully recycled office paper and published a how-to guide for NHS colleagues to do the same, as well as reduce paper usage. We have also published two other how-to guides to encourage the return and reuse of walking aids (walking sticks, frames, rollators and crutches) and increase the uptake of remanufactured medical devices.

NHS England fully supports the government's objectives to eradicate modern slavery and human trafficking and recognises the significant role the NHS has to play in both combatting it and supporting victims. Our vision is for our supply chains and business activities to be free from ethical and labour standards abuses, working with stakeholders to improve conditions on the ground. In April, NHS England published its modern slavery statement to this effect.

Our sustainable procurement programme continues to grow, and NHS England is committed to leading by example across the wider health system.

Adapting to climate change

Business continuity planning is used to approach the management of risks and threats to our organisation. Business continuity management identifies NHS England's priorities and prepares solutions to address disruptive threats, including those which may be the result of climate change and extreme weather events.

Reducing environmental impacts from Information Communication Technology (ICT) and digital.

We maintain the use of 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.

Appendix 5: Acronyms

Acronym	Definition
A&E	Accident & Emergency
ALBs	Arm's Length Bodies
ARAC	Audit and Risk Assurance Committee
BME	Black Minority Ethnics
CCGs	Clinical Commissioning Groups
CEO	Chief Executive Officer
CETV	Cash Equivalent Transfer Values
COO	Chief Operating Officer
CRR	Corporate Risk Register
CRS	Commissioner Requested Services
CSUPs	Consumer Single Use Plastics
CSUs	Commissioning Support Units
DHSC	Department of Health and Social Care
EQG	Executive Quality Group
ESM	Executive Senior Managers
FReM	Financial Reporting Manual
GDPR	General Data Protection Regulation
ICB	Integrated Care Board
ICS	Integrated Care System
ICT	Information Communication Technology
IG	Information Governance
NAO	National Audit Office
NHS CFA	NHS Counter Fraud Authority
NHS PS	NHS Property Services
NHS TDA	NHS Trust Development Authority
NQB	National Quality Board
PCSPS	Principal Civil Service Pension Scheme
PRP	Performance-Related Pay

PSED	Public Sector Equality Duty
QIC	Quality and Innovation Committees
SED	Specific Equality Duties
SFI	Standing Financial Instructions
UEC	Urgent and Emergency Care

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