NHS
Trust Development Authority

Annual Report and Accounts

For the period 1 April 2014 – 31 March 2015

tda Trust Development Authority
Quality. Delivery. Sustainability.

HC 321

NHS Trust Development Authority Annual Report and Accounts

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Any enquiries regarding this publication should be sent to us at:

NHS Trust Development Authority
Southside
105 Victoria Street
London SW1E 6QT
England

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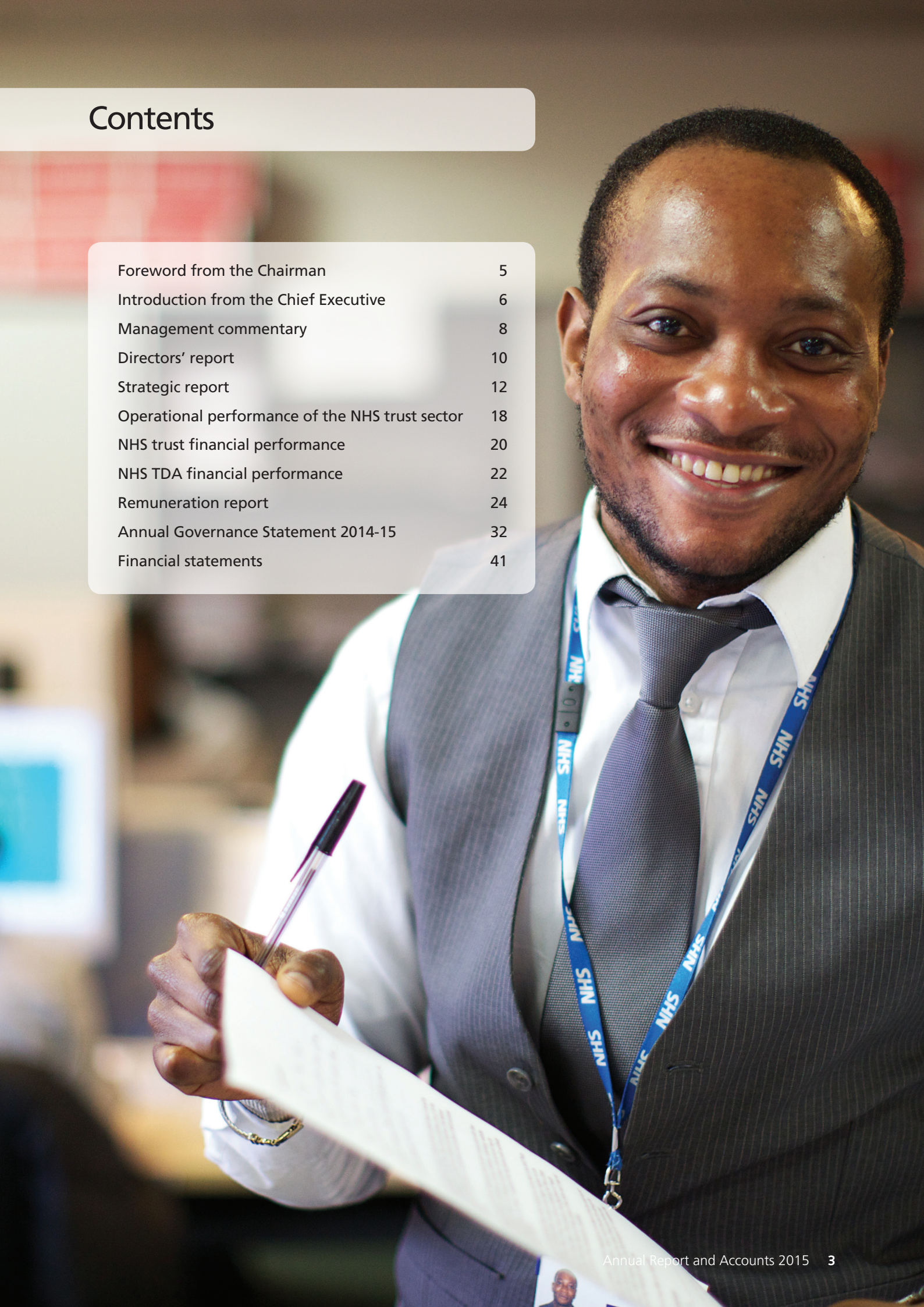


"We now have just over 300 staff supporting the NHS trust sector on quality of care, delivery of services, financial performance and future sustainability of services for patients."

Sir Peter Carr

Foreword from the Chairman

I am pleased to commend this publication, the NHS Trust Development Authority's Annual Report and Accounts for 2014-15, as an accurate reflection of the Authority's work and finances for the past year.

This year, funding for the NHS Trust Development Authority (NHS TDA) was increased in order to allow the organisation to expand to meet the growing demand that we have faced since the early days of the organisation. This is recognition of the importance of our work and the effectiveness of our approach. We now have just over 300 staff supporting the NHS trust sector on quality of care, delivery of services, financial performance and future sustainability of services for patients.

Despite a challenging year, with trusts balancing increased demand for services with additional costs, we have seen the results of our focused approach, with trusts being considered at Monitor's board meetings and completing their journey to foundation trust status.

While the number of trusts has started to decline and the number of foundation trusts rise, the NHS TDA has continued to focus on supporting its organisations to provide high quality care on a sustainable basis. Indeed, it will be increasing its offer to the NHS trust sector on development further in the coming year, building on success and focusing not only on supporting trusts to improve but also on helping them to develop cultures and practices that will ensure excellence in the care they provide.

Since the end of the financial year, we have seen a change in the leadership of the NHS TDA with Robert Alexander replacing David Flory as the Chief Executive. David worked tirelessly to establish the NHS TDA and to take it through the expansion programme. He leaves behind a strong organisation staffed with dedicated and capable individuals, all mirroring his commitment to excellent patient care provided by strong and sustainable organisations. I would like to thank him for his hard work and welcome Robert as he steps up from the role of Director of Finance to Chief Executive.

This year I will be working with the Chair of Monitor to appoint a Chief Executive to lead both organisations. This will be an opportunity for both the NHS TDA and Monitor to bring the best of what each organisation does and ensure a consistent offer to NHS providers.

Sir Peter Carr
Chairman

Introduction from the Chief Executive

2014-15 has been a very challenging year for NHS providers. While the emphasis on the quality of care that patients receive has rightly continued, NHS trusts have also faced financial challenges and significant scrutiny on operational performance, coupled with increasing demand for its services.

I would like to thank staff at the NHS TDA who have worked extremely hard to support trusts to be in the strongest possible position to face these challenges and welcome the additional staff that have joined the organisation throughout the year.

In 2014-15, 6 trusts, including for the first time community trusts, successfully met the conditions of both the Care Quality Commission (CQC) and Monitor, following changes brought into effect after Sir Robert Francis QC's public inquiry into Mid Staffordshire NHS Foundation Trust, and were approved as foundation trusts. I am pleased to report that the NHS TDA Board has already approved a further 5 organisations to move forward in this process during 2015-16 and I am confident that the coming year will see more trusts going through this process.

Although the introduction of more rigorous assessments has led to a pause in trusts moving through the foundation trust pipeline, this has also given us the opportunity to cement the relationships with the NHS trust sector that we have built since the NHS TDA was established. These relationships are truly valuable and I would like to thank the leadership of NHS trusts for openly engaging with the support we offer.

We have used this opportunity to continue to support trusts, including over the challenging winter period. With demand rising we have focused not only on helping organisations to

deal with a greater number of people needing urgent and emergency care, but also on providing broader strategic support. This helps trusts to identify issues and develop plans to improve their performance, for example, better management throughout hospitals in order to relieve pressure on the front door.

In particular, following the winter period, a focused effort on supporting trusts to tackle backlogs of patients on the referral to treatment pathways saw an improvement across the board putting trusts in a stronger position to start 2015-16 and demonstrating that improvements can be achieved despite challenging circumstances.

In line with our focus on supporting organisations to improve, during 2014-15, 4 NHS trusts successfully improved and left the special measures regime. We continue to work with those who still have improvements to make, providing dedicated support such as putting an Improvement Director in place and buddying the trust with a high performing organisation to share, implement and embed good practice. Importantly, our experience

"With demand rising we have focused not only on helping organisations to deal with a greater number of people needing urgent and emergency care, but also on providing broader strategic support."

Robert Alexander

with the first cohort of trusts to be placed in special measures has allowed us to refine how we work with these challenged organisations, ensuring that the special measures regime is focused on positive improvements.

Mental health services have never been more important and we have been supporting trusts as they prepare for the introduction of the new mental health waiting time standards to be implemented from 1 April 2016. Although a new challenge, this gives mental health trusts an opportunity to improve how they provide services and will continue to be an important part of our work in 2015-16.

The pressures that have occurred during 2014-15 will continue to challenge organisations but it is essential that NHS trusts strive to balance continuously improving the quality of care with good operational performance and good financial performance in order to be sustainable for the future. These are challenges that many providers are facing, whether they are NHS trusts or foundation trusts, so going forward the NHS TDA and Monitor will operate under a joint Chief Executive to ensure that all providers have access to the same level of support.

Robert Alexander
Chief Executive Officer

Management commentary

2014-15 has seen the NHS TDA expand in size which has meant that it has been able to increase the level of support provided to NHS trusts. At the same time, the NHS has finished the task of implementing the changes brought about following the recommendations of Sir Robert Francis QC and NHS trusts are able to increasingly focus on the future of the organisation.

While pressures over the winter period are seen annually, the NHS has started this year to shift from planning for high demand focused mainly on winter, to planning for year-round resilience in order to respond swiftly to rising demand by working together with local and regional partners. This represents a system-wide shift, supported by the national organisations, to improving how healthcare responds to the needs of patients at times of increased pressure.

At the same time, trusts are implementing national guidance on safe staffing levels as part of the approach to ensuring safe and high quality care and there will be further guidance to come in this area. The challenge for NHS trusts now is to meet this guidance with a lower reliance on agency staff as a contribution to greater efficiency.

Of the 9 trusts already in special measures at the beginning of the year, or placed into special measures during the year, 4 had demonstrated sufficient improvement to leave the regime by the end of 2014-15, although all had demonstrated improvement. As these first trusts successfully exited special measures, key learning points have begun to emerge. Focusing on special measures as a vehicle for improvement and not a kitemark for failure, coupled with strong leadership committed to a culture that allows staff to respond positively to the challenge that lies ahead to ensure improvements are made on the frontline, are both vital for any organisation starting out on this journey.

2014-15 saw private healthcare firm Circle take the decision to withdraw from the management franchise to run Hinchingbrooke Health Care NHS Trust. Joint working between the NHS TDA, Circle and staff at Hinchingbrooke enabled a smooth and expedient transition back to a NHS trust with standard governance arrangements to take place in time for the end of March, allowing the trust to start the new financial year under NHS management. Following an inspection by the CQC, the trust was also placed in special measures and is focused on making the necessary improvements with the support of staff from both the clinical and development teams at the NHS TDA.

The NHS TDA also assumed significant responsibility for ensuring the effective transfer of the majority of services from Mid Staffordshire NHS Foundation Trust to the newly created University Hospitals of North Midlands NHS Trust (formerly University Hospital of North Staffordshire Hospital NHS Trust) and to Royal Wolverhampton Hospitals NHS Trust. Close working between clinical, delivery and development, business support, governance and communications colleagues ensured that this sensitive transition was handled effectively and safely for local patients.

As part of our role in ensuring strong leadership for NHS trusts, at what is a challenging time, the NHS TDA has appointed (or re-appointed) 276 chairs and non-executive directors during 2014-15 and in line with the organisation's focus on support, training and networking, opportunities have been made available to new and experienced non-executives throughout the year.

Our ambition to support NHS trusts to deliver high quality, sustainable services in the communities they serve, with the ultimate aim of being referred by the NHS TDA Board to Monitor for approval as a foundation trust, has begun to be realised, with Monitor considering and approving 6 trusts during 2014-15 and more trusts expected to follow during 2015-16.

Not all trusts have a sustainable future as a standalone organisation. In such cases, the NHS TDA has worked, with the trust, through a transaction process so that it can merge with or be acquired by another organisation in order to provide greater sustainability going forward. The NHS TDA has now successfully completed several transactions where it acted as the vendor, with a focus on ensuring a smooth transition for patients and staff. Taking completed transactions together with those organisations that have already successfully progressed to foundation trust status brought the total number of trusts overseen by the NHS TDA to 90 by the end of the financial year, with further reductions expected during 2015-16.

"The NHS TDA has maintained its focus on supporting organisations, not just to progress to foundation trust status, but also to deliver for patients today and to focus on continuous improvement."

The NHS TDA has maintained its focus on supporting organisations, not just to progress to foundation trust status, but also to deliver for patients today and to focus on continuous improvement. As part of this, trusts had the opportunity to take part in specific programmes of support during 2014-15. As well as events for clinical leaders, there were workshops on demand and capacity management to feed into the planning process and a development programme for communications staff was launched to focus on supporting trust engagement with patients, staff, communities and stakeholders. The NHS TDA is now planning to expand the development offer to meet the needs of a range of trusts, focused not only on intensive change and improvement, but also themed improvement support and professional leadership support and development.

In 2015-16 the NHS TDA and Monitor will operate under a single Chief Executive. We will continue to provide the same level of support to NHS trusts and, in discussions about how the 2 organisations can work more closely together, we will ensure that support for providers remains a key priority.

Directors' report

Our people – The Board

The NHS TDA Board meets in public at least 6 times per year. Members appointed to the Board are as follows:

Chair
Sir Peter Carr CBE

Vice Chair/
Senior Independent Director[1]
Dame Christine Beasley

Non-executive director[2]
Sarah Harkness

Non-executive director
Crispin Simon

Non-executive director
Caroline Thomson

Chief Executive[3]
David Flory CBE

Director of Finance[3]
Robert Alexander

Director of Nursing[3]
Peter Blythin

Medical Director[3]
Dr Kathy McLean

Acting Director of Delivery
and Development: South
James Lusby

Director of Delivery and
Development: Midlands and East
Dale Bywater

Director of Special Measures
Yasmin Chaudhry

Director of Communications
Robert Checketts

Director of Strategy
Ralph Coulbeck

Director of Delivery
and Development: North
Lyn Simpson

Director of Delivery
and Development: London
Alwen Williams CBE

There were a number of changes to the executive team during the course of 2014-15. In July 2014, Yasmin Chaudhry, the former Director of Special Measures, left the organisation. In November 2014, Dr Stephen Dunn, Director of Development and Delivery (South), left and was replaced on an interim basis by James Lusby. James Lusby has since moved on to a new post and Anne Eden has been appointed as Dr Stephen Dunn's permanent replacement from 1 April 2015. On 31 March 2015, David Flory stepped down from the post of Chief Executive and was replaced on 1 April 2015 by the Director of Finance, Robert Alexander. Elizabeth O'Mahony has replaced Robert Alexander as Director of Finance.

[1] Interim Chair of the Appointments Committee
[2] Chair of Audit Committee
[3] Executive Directors of the Board

Directors' interests

A register of interests of Board members has been established and maintained and a cross-checking exercise has taken place to identify any potential conflicts of interest with NHS TDA suppliers. The register of directors' interests is available to download from the NHS TDA's website.

Pensions liability

Past and present employees are covered by the provisions of the NHS Pension Scheme. The scheme is an unfunded defined benefit scheme and is not designed to be run in a way that would enable NHS bodies to identify their share of the schemes' underlying assets. Further details of the pension liabilities can be found in note 2 of the Annual Accounts and details of the senior managers' pension liability is shown in the remuneration table within the remuneration report.

Auditor

The Comptroller and Auditor General are appointed by statute to audit the Authority. The audit fee for the period ended 31 March 2015 of £50,000 is for the audit of these accounts. The external auditors have not undertaken any non-audit services on behalf of the NHS TDA.

Accounting Officer's disclosure to the auditors

As far as the Accounting Officer is aware, there is no relevant audit information of which our auditors are unaware and the Accounting Officer has taken all steps he ought to have taken to make himself aware of any relevant audit information and to establish that our auditors are aware of that information.

Cost allocation and charges for information

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

Events and future developments

Details of events affecting the NHS TDA after the reporting date are included in the Notes to the Accounts. Our Strategic Report details likely future developments, and our plans to address them. Further information about our people, including sickness absence and personal data related incidents is contained in the Strategic Report.

Robert Alexander

Chief Executive Officer
NHS Trust Development Authority

8 July 2015

Strategic report

Since the establishment of the NHS TDA in April 2013 there have been significant changes in the NHS, such as the introduction of the Chief Inspector of Hospitals and a new regime of inspection and rating of NHS providers.

In 2014 the NHS TDA Directions were amended to reflect some of these changes, but the role of the NHS TDA remains unchanged: to oversee and support NHS trusts to improve the quality and sustainability of the services it offers to patients and enabling them to achieve a sustainable organisational form.

The foundation of the NHS TDA's work is the day-to-day support and challenge that is provided to all NHS trusts, on all aspects of their business: clinical colleagues working with trusts to improve the quality and safety of services; delivery and development colleagues supporting the delivery of NHS Constitution standards; business support colleagues ensuring effective use of public resources; corporate colleagues providing communications expertise, or ensuring that strong leaders are appointed to senior positions.

In addition to this important day-to-day business, the NHS TDA has continued to discharge its formal powers and duties in order to achieve its objectives in 2014-15 through:

- the authorisation of 6 new NHS foundation trusts – Royal United Hospitals Bath NHS Foundation Trust, Bridgewater Community Healthcare NHS Foundation Trust, Derbyshire Community Services NHS Foundation Trust, St George's Healthcare NHS Foundation Trust, Nottinghamshire Healthcare NHS Foundation Trust and Kent Community Health NHS Foundation Trust
- approval by the NHS TDA Board of the foundation trust applications of 5 further trusts – Bradford District Care NHS Trust, Oxford University Hospitals NHS Trust, South West London and St George's Mental Health NHS Trust, Surrey and Sussex Healthcare NHS Trust and Wirral Community NHS Trust – to proceed to assessment by Monitor
- overseeing successful transactions involving the acquisition of Barnet and Chase Farm NHS Trust and the creation of London North West Healthcare NHS Trust
- completing the dissolution of Mid Staffordshire NHS Foundation Trust and the transfer of the relevant assets and services to University Hospitals of North Midlands NHS Trust and Royal Wolverhampton Hospitals NHS Trust

- providing challenge and support to NHS trusts in special measures resulting in the successful exit of 4 NHS trusts from the regime – Buckinghamshire Healthcare NHS Trust, East Lancashire Hospitals NHS Trust, George Eliot Hospital NHS Trust and United Lincolnshire NHS Trust
- the appointment, extension or re-appointment, of 276 chairs and non-executive directors to NHS trust boards
- completion of 81 appraisals for NHS trust chairs
- the provision of a development programme for aspirant foundation trusts, in conjunction with NHS Providers, and other initiatives to support leaders of NHS trusts
- jointly commissioning support for 11 of the most challenged local health economies to develop strategic plans with Monitor and NHS England (NHSE)
- the publication of joint planning guidance, with NHSE, Monitor and other key national partners, which sets out how providers and commissioners should work to implement the vision set out in the NHS Five Year Forward View
- there are a number of key strategic risks facing the NHS TDA, full details of which are set out in the strategic risk register which is regularly approved by the Board. The most significant risks include:
  - the risk that the NHS trust sector is unable to deliver key NHS standards because of rising expectations, increased demand and the impact of the safer staffing initiative
  - the risk that NHS trusts do not deliver on their financial plans and that financial performance deteriorates as a result of operational issues and quality considerations
  - the risk that NHS trusts struggle to provide high quality care due to workforce supply issues in key professions
  - the risk to NHS TDA business continuity as a result of cyber attacks

Our business model – matrix working

In order to best provide oversight and support to NHS trusts, the NHS TDA has adopted matrix working. Trust-facing staff come together in regional delivery and development teams, with responsibility for a portfolio of trusts. Specialist support is provided by a range of professionals, including clinicians and financial experts, who work as part of the delivery and development teams whilst reporting to the NHS TDA clinical and finance directors.

Our people – staff

Employee policies

The NHS TDA is currently applying to renew its 'Two Ticks' status and continues to operate in the spirit of this. The NHS TDA currently employs staff with declared disabilities and, where an employee develops a disability during employment, is fully cognisant of its responsibilities in relation to reasonable adjustments. No individual is treated detrimentally due to any protected characteristic during their employment with the NHS TDA.

The NHS TDA has a suite of employment policies that were developed for new staff upon the organisation's set up. These were agreed with the trades unions and recognised by the NHS TDA. During the first year the organisation commenced an employment policy harmonisation programme in partnership with the trade unions (Managers in Partnership and Unison) and consulted with the staff on the harmonisation of 20 employment policies.

There are a small number of remaining policies to harmonise and the programme is due to conclude in June 2015. Within the second year the NHS TDA has also revised and improved a number of policies following employee/ line manager usage feedback, changes to the HR systems and also employment legislative changes.

Whilst the NHS TDA has successfully harmonised 20 employment policies, it is important to note that this harmonisation process is not applicable for staff that transferred into the NHS TDA under the Transfer of Undertakings (Protection of Employment) Regulations where previous employer policies still apply.

Equal opportunities and diversity

The NHS TDA is committed to providing equality of opportunity for both current and prospective employees in that everyone who works for the NHS TDA, or applies to work at the NHS TDA, should be treated fairly and valued equally. Providing equality of opportunity means that an individual's diversity is viewed positively and, in recognising that everyone is different, valuing equally the unique contribution that individual experience, knowledge and skills can make. The NHS TDA's equality and diversity policy aims to ensure that all staff are aware that any form of discrimination against people because of their gender, marital status, race, age, sexual orientation, religion, disability, part-time or fixed-term working, is prohibited within the organisation, and to ensure that the NHS TDA abides by the statutory regulations regarding human rights and discrimination.

The NHS TDA Board also agreed the Equality and Diversity Strategy for 2014-15. As well as setting out the NHS TDA's strategic approach to equality and diversity, and its aims and objectives, the strategy document sets out the governance arrangements that will ensure that the NHS TDA has an appropriate focus on this important issue. A key new initiative is the establishment of a NHS TDA Equality and Diversity Forum with the purpose of providing a forum "within which the whole organisation can engage in the equality and diversity agenda".

Social, community and human rights

The NHS TDA produces a regular staff newsletter as well as providing an intranet site which is regularly updated with information on matters of concern to employees. The NHS TDA has a good relationship with regional Trades Union officers and regular Joint Consultative and Negotiation Committee meetings are held to consider issues likely to affect staff.

In addition, through the implementation of its Organisational Development strategy, the NHS TDA has introduced learning representatives, health and wellbeing champions and an Organisational Development Support group, all of which provide significant opportunities for staff to feed back to the organisation on issues which affect their employment, wellbeing and development.

The all staff away day is an additional example of keeping staff abreast of national and organisational developments including the NHS TDA's performance. All staff are reminded of the organisational values which place patients at the centre of all that the NHS TDA does. The values are also embedded into the induction and appraisal processes and promoted on the staff intranet.

The following tables show gender and ethnicity breakdowns of NHS TDA staff:

Gender of NHS TDA staff as at 31 March 2015		
Staff category	Female	Male
Directors	3	7
Other VSMs	20	11
Other Staff	171	92
Total	**194**	**110**

Ethnicity of NHS TDA staff at 31 March 2015	Number of staff
White	251
Mixed race	3
Asian or Asian British	17
Black or Black British	12
Other	1
Did not state/undisclosed	20

Health and safety

The NHS TDA has a Health and Safety policy for the organisation and individual evacuation plans for each of its 9 sites. All of the sites are multi-occupancy and the NHS TDA works closely with the leaseholders, NHS Property Services and Government Property Services on issues that affect shared space such as stairwells and lifts and the buildings as a whole. All buildings have held evacuation drills and occupants of Skipton House have undertaken an additional safe refuge exercise.

The NHS TDA has invested in a training programme for staff and has access to fully qualified first aiders and fire wardens on each site. Health and safety and fire training is also included in the mandatory staff training package. There were 2 events registered in the 2014-15 incident log. Both took place outside the NHS TDA offices, one during a practice fire evacuation and the other at an external venue. In both cases a staff member slipped and fell. NHS TDA first aiders attended and staff members were sent to accident and emergency for checks. Both were discharged. This is a reduction on the number of incidents reported in 2013-14 when 6 events were logged.

Staff sickness, absence and ill health retirements

The absence rate for the year 1 January 2014 to 31 December 2014 is an average working day loss per employee of 3.3 inclusive. This provides an overall sickness figure of 1.5%.

	2014 Calendar Year[1]	2013-2014
Total days lost	769	875
Total staff years worked	235	185
Total staff days available	52,779	-
Average working days lost	3.3	5
Number of persons retired on ill health grounds	0	0

[1] The 2014 staff sickness figures are produced in a format required by the Department of Health.

Staff survey

The most recent staff survey results reinforced positive feedback from previous surveys undertaken by the NHS TDA. Staff were particularly positive about their understanding of the objectives of the NHS TDA and how these linked to their own objectives. Staff again reiterated that they felt positive about feeling supported by line managers. The most recent survey also returned particularly positive results around staff feeling enthusiastic about their job and returned improved results with regard to access to required facilities.

Off-payroll engagements

All existing off-payroll engagements have been subject to a risk based assessment as to whether assurance is required, that the individual is paying the right amount of tax and, where necessary, that assurance has been sought. Assurance has been sought for all new off-payroll engagements, or those that reached 6 months in duration between 1 April 2014 and 31 March 2015 that are more than £220 per day and last longer than 6 months. The tables below report details of individuals engaged by the NHS TDA who are paid through their own companies and are responsible for their own tax and national insurance arrangements.

For all off-payroll engagements still engaged as at 31 March 2015 for more than £220 per day and that last longer than 6 months (not including agency contractors):

	Number
Number of existing engagements as at 31 March 2015	5
Of which, the number that have existed:	
for less than one year at time of reporting	4
for between 1 and 2 years at time of reporting	1
for between 2 and 3 years at time of reporting	0
for between 3 and 4 years at time of reporting	0
for more than 4 years at time of reporting	0

The following table relates only to off-payroll workers paid through their own companies and who are responsible for their own tax and national insurance arrangements.

	Number
Number of new engagements, or those that reached 6 months in duration, between 1 April 2014 and 31 March 2015	8
Number of the above which include contractual clauses giving the department the right to request assurance in relation to income tax and National Insurance obligations	8
Number for whom assurance has been requested	8
Of which:	
assurance has been received	8
assurance has not been received	0
engagements terminated due to assurance not being received	0

There were no off-payroll engagements of board members, and/or senior officials with significant financial responsibility, between 1 April 2014 and 31 March 2015.

Emergency Preparedness

The NHS TDA has developed its business continuity function by undertaking a business impact analysis. This determines which functions are essential and how quickly the functions need to be up and running without major risk to the work or reputation of the NHS TDA.

The plan is closely linked to the evacuation plans for each of the 9 sites and can be triggered through the emergency alert service. This service also has a response element in the event of a major incident for all staff to confirm their safety.

Disclosure of serious untoward incidents

As part of the NHS TDA's Information Governance (IG) policy a log of IG breaches and advice from the Caldicott Guardian is kept. There were no significant losses of personal data. However, there has been a marked increase in phishing email and this has been reported to the Health and Social Care Information Centre who are responsible for the contract for NHS mail to ensure that any necessary patching is undertaken. Communications on the threat from phishing and other cyber threats have been highlighted to staff. The NHS TDA is represented at the fora on information governance and cyber security for the Department of Health (DH) and its arm's length bodies (ALBs).

Principles for remedy

The NHS TDA does not have any remit under the current NHS Complaints Regulations to deal directly with complaints about individual patient cases or care and treatment provided by NHS trusts (including FTs), NHSE, Clinical Commissioning Groups or any other provider of NHS services. However, through its oversight processes, the NHS TDA does ensure that NHS trusts have effective complaints processes in place to ensure the patient's concerns are addressed. Complaints against the NHS TDA itself are handled in accordance with its Complaints Policy and Procedure.

In addition, since 1 October 2014 the NHS TDA has been a prescribed person with regard to whistleblowing. This means that NHS trust workers who make a protected disclosure (blow the whistle) to the NHS TDA will be protected from detriment and dismissal as long as certain conditions are met. Information has been added to the website and necessary processes have been implemented by the NHS TDA for handling receipt of cases.

Sustainability report

The NHS TDA is committed to long-term sustainable development and takes its responsibilities to the wider community very seriously. The potential impact that these activities may have on the environment is acknowledged and it will therefore be ensured that effective environmental management and sustainable development becomes an integral part of the NHS TDA work. The core purpose of the NHS TDA is to help local providers of NHS services work towards a sustainable future that also delivers high quality care. This will contribute to a strong, healthy and sustainable society for future generations.

The NHS TDA is committed to managing its estate and activities in a way that is compatible with the principles and objectives of sustainability contained within the Greening Government Commitments (GGC) and through a close association with the DH. The main areas of environmental impact are through building use in terms of energy and the use of finite material resources such as water, transport and travel, waste and procurement.

The NHS TDA has office space in 9 sites throughout England. All are in multiple occupancy buildings and there are no more than 80 staff members on any single site. Seven of the 9 sites are managed by NHS Property Services, which is currently exempt from the Government reporting procedures and therefore do not hold the required reporting data. In their annual report 2013-14 NHS Property Services highlighted their work with NHSE, the Local Government Association and Public Health England to create a sustainability development strategy for the whole of the health and care system in England. The DH published sustainability data in its annual report but does not report on the smaller ALBs.

The NHS TDA has adhered to Government targets to reduce the level of office space it uses per staff member and continues to work towards the targets set out in the Government Estates Strategy 2014.

The NHS TDA is committed to using its resources efficiently, economically and effectively, avoiding waste and reducing CO_2 emissions. However, 2013-14 was the NHS TDA's first full year of operation and it has experienced substantial expansion in staffing numbers in 2014-15. It has not been possible to set a baseline from which to calculate reductions in emissions in its first 2 years. It has implemented several new policies and invested in technology in 2014-15 to:

- ensure the use of public transport is encouraged by the promotion of use of season ticket loans for staff and central systems for booking rail travel;
- reduce the use of paper and print by harnessing wireless and mobile technology, including tablets, to move towards a paper-lite environment;
- recycle waste material on all sites;
- reduce the need for physical meetings and travel by the installation of additional video conference units at each site and promoting the use of telephone conference technology.

Transport

The NHS TDA does not own any commercial transport. However, members of staff travel throughout England in the course of their duties visiting NHS trusts from Cumbria to Cornwall, thus travel is the single largest generator of carbon emissions within the control of the NHS TDA. Data collected through expense claims show a total of 353,513 business miles undertaken during 2014-15 which equates to 102.06 tonnes CO_2e. The organisation contracts its rail, flight and hotel bookings through Redfern Travel. Their reports shows rail travel during 2014-15 equated to 117.71 tonnes CO_2e and air travel to 11.20 tonnes CO_2e.

	Carbon emissions	
	2014-15 Tonnes	2013-14 Tonnes
Business Miles	102.06	n/a
Rail Travel	117.71	117.46
Air Travel	11.20	3.85

Procurement

IT and telephony services are outsourced through the DH contracts to Atos and Vodafone. Both companies report on their environmental commitments in their annual reports. Sustainability is a key element in the contracting process led by the DH's Procurement Centre of Excellence on behalf of the DH and its ALBs.

Operational performance of the NHS trust sector

Summary of NHS trust sector performance against key national standards for 2014-15

Metric	Period	Standard	Performance
Referral to Treatment			
18 Weeks Admitted Pathways (%)	March 2015	90	84.40
18 Weeks Non Admitted Pathways (%)		95	94.95
18 Weeks incomplete (%)		92	93.31
52 Week Waits (numbers)		0	273
Diagnostics			
Number of diagnostic tests waiting longer than 6 weeks (%)	March 2015	1	1.23
Accident and Emergency			
All Types Performance (%)	Quarter 4	95	89.79
Type 1 Performance (%)		95	85.36
Cancer			
Two week wait referral to date first seen	Quarter 4		
2 week GP referral to 1st outpatient – cancer (%)		93	94.6
2 week GP referral to 1st outpatient – breast symptoms (%)		93	94.2
31 day wait for second or subsequent treatment			
31 day wait from diagnosis to first treatment (%)		96	97.1
31 day second or subsequent treatment – surgery (%)		94	94.9
32 day second or subsequent treatment – drug (%)		98	99.4
32 day second or subsequent treatment – radiotherapy (%)		94	97.7
62 day wait for first treatment			
62 day urgent GP referral to treatment for all cancers (%)		85	81.1
62 day urgent GP referral to treatment from screening (%)		90	90.2

Metric	Period	Standard	Performance
Ambulance			
Category A call – emergency response within 8 minutes	March 2015		
Red 1 calls (%)		75	70.15
Red 2 calls (%)		75	66.09
Category A call – ambulance vehicle arrives within 19 minutes (%)		95	93.06
Infection Control			
MRSA	YTD to March 2015	0	150
Clostridium Difficile		2,049	2,089
Eliminating Mixed Sex Accommodation			
Mixed Sex Accommodation	March 2015	0	78
Mental Health			
Proportion on Care Programme Approach (CPA) for at least 12 months who had a CPA review in the last 12 months (%)	December 2014	95	89.93
Proportion on CPA who have had HoNOS assessment in last 12 months (%)	December 2014	90	89.30
Proportion on CPA discharged from inpatient care were followed up within 7 days (%)	Quarter 4	95	96.97
Proportion admitted in inpatient service had access to Crisis Resolution/Home Treatment teams (%)	Quarter 4	95	96.02
Proportion with a delayed transfer of care (%)	March 2015	7.5	4.19
Proportion on Improving Access to Psychological Therapies (IAPT) patients completing treatment moved to recovery (%)	Quarter 3	50	44.51
Number of admissions to adult facilities for patients under 16 years of age	December 2014	0	0

Oversight and escalation scores by NHS trust sector as at 31 March 2015

Sector	5 Standard oversight	4 Standard oversight	3 Intervention	2 Intervention	1 Special measures	Total trusts
Acute	0	3	14	33	5	55
Ambulance	0	0	1	4	0	5
Community	2	9	3	2	0	16
Mental Health	2	9	0	3	0	14
Total	4	21	18	42	5	90

NHS trust financial performance

Revenue performance

As reported during the year, 2014-15 has been a challenging financial year for the NHS trust sector. The trust sector financial position has been impacted by a number of key generic cost drivers as detailed below:

- an unplanned growth in demand for care in a hospital setting particularly in urgent and emergency care. This is often paid at a marginal rate and displaces elective activity paid for at full cost. The adverse financial position is further compounded by the various contract sanctions applied against providers for not managing activity;
- a significant increase in the use of agency and contract staff;
- failure to deliver the levels of cost improvement schemes planned at the start of the financial year.

In aggregate, the NHS trust sector has delivered a net deficit of £485 million, compared to a planned net deficit of £408 million, a negative variance of £77 million. At the start of the financial year the planned net deficit was £425 million, this has been adjusted by £17 million to reflect part year foundation trusts and dissolved trusts.

There were 43 NHS trusts that reported a deficit in the financial year 2014-15, the combined value of gross deficits was £625 million (including 3 ceased and 1 new trust). The total number of NHS trusts in deficit was higher than the original plan of 34 trusts. There were a number of movements from original plans within these figures, 17 NHS trusts have reported unplanned deficits and 8 NHS trusts improved their financial performance and delivered breakeven or surplus positions at the year end.

Despite the unprecedented financial pressure faced by the NHS trust sector in 2014-15, there are 56 NHS trusts that are demonstrating good financial control and achieved breakeven or a surplus in 2014-15. The aggregate combined surplus for these 56 NHS trusts is £140 million.

At an aggregate sector level the community, mental health and ambulance NHS trusts continue to deliver a solid financial performance. Of these 39 NHS trusts, 34 have delivered a surplus or breakeven in 2014-15. There is however further pressure building in the non-acute sector which has resulted in a reduction in margins and 5 non-acute NHS trusts are reporting a deficit for the first time. For the financial year to the 31 March 2015 the aggregate surplus for the non-acute NHS trust sector is £62 million compared to a planned surplus for the year of £65 million, an adverse variance of £3 million.

Acute NHS trusts, however, experienced significant levels of financial pressure. The following table clearly identifies the extent of financial challenge that acute trusts faced during 2014-15 with 63% of acute NHS trusts in deficit at the year end. With many acute trusts signalling operational pressures in urgent and emergency care and the financial impact of the heightened focus on service quality and safety which manifest as increased permanent and non-permanent clinical staffing expenditure.

Financial performance of the NHS trust sector for the year ending 31 March 2015

NHS Trust Sector	2014-15			Number of Trusts	Number of Trusts in Deficit	% of Trust Sector
	Plan £m	Outturn £m	Variance £m			
Acute	(473)	(547)	(74)	60	38	63%
Ambulance	7	11	4	5	0	0%
Community	30	14	(16)	19	3	16%
Mental Health	28	37	9	15	2	13%
Total	(408)	(485)	(77)	99	43	43%

*(brackets) denote deficit

During this financial year, Bridgewater Community Healthcare NHS Trust, Derbyshire Community Health Services NHS Trust, Kent Community Health NHS Trust, Nottingham Healthcare NHS Trust, Royal United Hospital Bath NHS Trust and St George's Healthcare NHS Trust became NHS Foundation Trusts.

Barnet and Chase Farm Hospitals NHS Trust, Ealing Hospital NHS Trust and North West London Hospitals NHS Trust have dissolved, and London North West Healthcare NHS Trust has been established. There was also one trust that formally changed its name to University Hospital North Midlands NHS Trust (previously University Hospital of North Staffordshire Hospital NHS Trust). This reflected the fact some of the services from Mid Staffordshire NHS Foundation Trust transferred during the year. This has left 90 NHS trusts as at the 31 March 2015.

NHS trust efficiency plans were quality impact assessed at the start of the financial year as it was not acceptable for trusts to respond to funding shortfalls by reducing service quality.

In total the NHS trust sector delivered £1.3 billion of efficiency savings during 2014-15 whilst maintaining or improving service performance, this is an adverse variance against plan of £205 million.

The aggregate deficit for NHS trusts is 1.59% of operating revenue for the sector as a whole. The NHS TDA measured the financial performance of all NHS trusts against their individual plans for the 2014-15 financial year.

Capital

The hospital buildings used to treat patients in, the equipment that is used to treat those patients and the information systems that are relied on must be in a suitable condition to facilitate the delivery of modern patient care and able to respond to future service strategy needs.

The NHS TDA is committed to ensuring that patients who rely on services provided by NHS trusts up and down the country can expect the high quality services that are now commonplace in the NHS. As such, during 2014-15 the NHS TDA worked with NHS trusts and approved 42 full business cases totalling just under £746 million and a further 46 strategic outline cases and outline business cases that were outside of the delegated authority of individual NHS trusts.

In total NHS trusts spent £1,606 million on capital projects during 2014-15 in a planned and managed way aimed at improving the quality of the infrastructure in the NHS trust sector.

Cash

Accessing financing is key to improving and operating services for NHS trusts, particularly for those trusts where access to finance has been limited in the past or the trust has a revenue deficit.

In 2014-15 the NHS TDA worked with all NHS trusts that were forecasting revenue deficits and supported them through the process and, where necessary, supported in the completion of applications for revenue funding to address working capital deficiencies. The NHS TDA reviewed each NHS trust's application to consider the most appropriate financing solution before making recommendations to the DH. All NHS trusts that required revenue cash support in 2014-15 received sufficient cash to pay staff and meet current liabilities.

During the financial year 2014-15 32 NHS trusts required access to cash financing of £593 million to support forecast revenue account deficit positions.

NHS TDA financial performance

Background

The financial statements contained within this report have been prepared in accordance with the direction given by the Secretary of State for Health under the NHS Act 2006.

Our accounts for 2014-15 have been prepared under International Financial Reporting Standards (IFRS) as adapted by the Financial Reporting Manual (FReM) and comprise of a Statement of Financial Position, Statement of Comprehensive Net Expenditure, a Statement of Cash Flows and a Statement of Changes in Taxpayers Equity, all with related notes.

Financial performance

We have been set objectives and targets by the DH against which we are expected to deliver.

The NHS TDA took up its full statutory duties from 1 April 2013. The statutory financial duties of the NHS TDA for the year 2014-15 were to:

- manage revenue expenditure within a resource limit of £65.2 million;
- manage capital expenditure within a resource limit of £0.5 million;
- manage cash spend within a cash limit of £68.7 million;
- meet the minimum performance requirements of the Better Payment Practice Code to pay at least 95% of invoices within 30 days.

The financial objectives of the NHS TDA in respect of these allocations in 2014-15 were:

- to manage the recurrent costs of management and administration within an allocation of £29.6 million – this funding covers staff, accommodation and other running costs;
- to manage an allocation of £35.6 million programme funding for other expenditure made on behalf of the NHS, such as due diligence exercises as part of FT readiness assessments and support of NHS trust organisational form transactions. Programme funding cannot be used to supplement administration funding for the running costs of the NHS TDA.

We are able to report that for 2014-15 the Board Authority met its statutory duties and maintained expenditure within these targets.

Better Payment Practice Code (BPPC)

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

	2014-15 Number	2014-15 £000	2013-14 Number	2013-14 £000
Non-NHS payables				
Total non-NHS trade invoices paid in the year	2,304	15,393	1,491	8,038
Total non-NHS trade invoices paid within target	2,248	15,242	1,446	7,958
% of non-NHS trade invoices paid within target	98%	99%	97%	99%
NHS payables				
Total NHS trade invoices paid in the year	373	23,884	162	5,932
Total NHS trade invoices paid within target	362	23,425	157	5,895
% of NHS trade invoices paid within target	97%	98%	97%	99%

The NHS TDA achieved the required 95% target to pay NHS and non-NHS payables within 30 days (unless other terms were agreed).

Fraud

The internal auditors provide counter fraud and corruption services to the NHS TDA in accordance with the NHS Counter Fraud and Corruption Manual as stated in the NHS TDA's Standing Financial Instructions. The NHS TDA has a whistleblowing policy giving contact details for NHS Counter Fraud and NHS Protect.

Principal risks and uncertainty

Effective risk management is a cornerstone of good governance and our framework of procedures and internal controls contribute to mitigating and controlling the risks we face.

Our Annual Governance Statement provides further details of our risk management strategy and procedures.

Robert Alexander

Chief Executive Officer
NHS Trust Development Authority

8 July 2015

Remuneration report

The remuneration of the directors of the NHS TDA is set by the Remuneration Committee, following job evaluations, on behalf of the Board in conjunction with the DH. The pay rates are in line with the Very Senior Manager (VSM) pay framework for ALBs and are subject to the DH approval.

The Remuneration Committee advises the Board about the appropriate remuneration and terms of service for the Chief Executive and other VSMs.

Membership of this committee consists of the Chairman and 4 non-executive directors of the Authority. The Chief Executive and other senior staff members are invited to attend as and when required. No individual is in attendance when their remuneration is being discussed.

The Remuneration Committee has convened 5 times during the period 1 April 2014 and 31 March 2015.

The Remuneration Committee operates within a framework laid down by the DH. Its remit is to determine, on behalf of the Board Authority, the terms of service, remuneration and other benefits of the Chief Executive, national directors and other posts as specifically designated by the Board whilst ensuring employees are fairly rewarded for their individual contributions to the organisation.

The remuneration of VSMs is reviewed by the Remuneration Committee, taking account of national awards, central guidance and other relevant factors. The remuneration of non-executive directors is determined by the Secretary of State for Health.

The Board Authority, with the approval of the DH Remuneration Committee, operates the NHS VSM Pay Framework. This framework also provides access to an approved scheme for performance related payments which are paid in line with the DH instructions.

A provision of £90,000 has been recognised in note 12 in relation to performance related pay, amounts awarded for 2014-15 are to be determined and paid in 2015-16. Payments made to senior staff during 2014-15 in relation to the prior year are included within the performance related pay and bonuses column of the remuneration table.

Appointments

Non-executive directors are appointed by the Secretary of State for a term of 4 years.

The Chief Executive and other VSMs are appointed under standard NHS VSM contracts of employment in accordance with national NHS terms and conditions. As at 31 March 2015 all contracts are either fixed term or permanent with a notice period up to 6 months.

There are no contractual clauses or other agreements for compensation in the event of early termination of office other than those provided by statutory requirements, NHS national terms and conditions or the DH terms and conditions.

Emoluments of board members

The remuneration relating to all directors that have undertaken duties and responsibilities supporting the NHS TDA during 2014-15 is detailed in the following tables. Tables disclose the salary, other payments and allowances and pension benefits applicable to both executives and non-executives. This information is subject to audit and has been audited by the Board Authority's external auditors, as referred to in the Audit Certificate.

Non-executive directors

The following table sets out details of payments made and appointment term details for the Chair and non-executive members.

Non-executive Directors 2014-15					
Name and position	Salary (bands of £5,000)	Benefits in Kind (to nearest £100)	Total (bands of £5,000)	Date of appointment	Appointment ends
	£000	£00	£000		
Sir Peter Carr CBE Chair	50–55	–	50–55	1 June 2012	31 May 2016
Dame Christine Beasley Non-executive Director	10–15	–	10–15	26 September 2012	25 September 2016
Sarah Harkness Non-executive Director	10–15	–	10–15	26 September 2012	25 September 2016
Crispin Simon Non-executive Director	5–10	–	5–10	13 May 2013	12 May 2017
Caroline Thomson Non-executive Director	5–10	–	5–10	13 May 2013	12 May 2017
The information above has been subject to audit					

Non-executive Directors 2013-14					
Name and position	Salary (bands of £5,000)	Benefits in Kind (to nearest £100)	Total (bands of £5,000)	Date of appointment	Appointment ends
	£000	£00	£000		
Sir Peter Carr CBE Chair	50–55	–	50–55	1 June 2012	31 May 2016
Dame Christine Beasley Non-executive Director	10–15	–	10–15	26 September 2012	25 September 2016
Sarah Harkness Non-executive Director	10–15	–	10–15	26 September 2012	25 September 2016
Crispin Simon Non-executive Director	5–10	–	5–10	13 May 2013	12 May 2017
Caroline Thomson Non-executive Director	5–10	–	5–10	13 May 2013	12 May 2017
The information above has been subject to audit					

Chief Executive and senior managers

The following table sets out details of payments made and commencement details for the Chief Executive and other directors, as appropriate.

Chief Executive and Senior Managers 2014-15

Name and position	Salary (bands of £5,000)	Performance related pay and bonuses (bands of £5,000)	Benefits in kind (to nearest £100)	All pension-related benefits[6]	Total (bands of £5,000)	Contract commencement date	Notice period (months)
	£000	£000	£00	£000	£000		
David Flory CBE[1] Chief Executive *Left the NHS TDA on 31 March 2015*	205-210	20-25	–	3	230-235	1 June 2012	3
Robert Alexander Director of Finance	150-155	5-10	–	18	180-185	1 October 2012	6
Dr Kathy McLean Medical Director	180-185	–	–	(17)	165-170	1 October 2012	6
Peter Blythin Director of Nursing	150-155	–	–	(64)	85-90	1 October 2012	6
Ralph Coulbeck[2] Director of Strategy *On secondment from the DH from 13 August 2012 to 28 February 2015. Transferred to the NHS TDA payroll with effect from 1 March 2015*	85-90	–	–	29	115-120	1 March 2015	6
Robert Checketts Director of Communications	110-115	–	–	(62)	45-50	1 June 2012	6
Dale Bywater Director of Delivery and Development (Midlands and East)	155-160	5–10	–	16	180-185	1 October 2012	6
Dr Stephen Dunn[3] Director of Delivery and Development (South) *Left the NHS TDA on 3 November 2014*	90-95	–	–	12	100-105	1 October 2012	6
James Lusby[4] Acting Director of Delivery and Development (South) *Appointed from 2 November 2014 to 31 March 2015 inclusive*	55-60	–	–	–	55-60	2 November 2014	6
Alwen Williams CBE Director of Delivery and Development (London)	160-165	–	–	(19)	140-145	1 October 2012	6
Lyn Simpson Director of Delivery and Development (North)	155-160	–	–	21	175-180	14 October 2013	6
Yasmin Chaudhry[5] Interim Director of Special Measures *Left the NHS TDA 27 July 2014*	40-45	–	–	–	40-45	1 July 2013	6

The information above has been subject to audit

Chief Executive and Senior Managers 2013-14

Name and position	Salary (bands of £5,000)	2012-13 Back pay entitlement (bands of £5,000)[7]	Benefits in kind (to nearest £100)	All pension-related benefits	Total (bands of £5,000)	Contract commencement date	Notice period (months)
	£000	**£000**	**£00**	**£000**	**£000**		
David Flory CBE Chief Executive	205-210	–	–	30	235-240	1 June 2012	3
Robert Alexander Director of Finance	160-165	0-5	–	23	185-190	1 October 2012	6
Dr Kathy McLean Medical Director	180-185	–	–	37	220-225	1 October 2012	6
Peter Blythin Director of Nursing	150-155	10-15	–	86	250-255	1 October 2012	6
Ralph Coulbeck[8] Director of Strategy *On secondment from Department of Health*	85-90	–	–	44	130-135	13 August 2012	3
Robert Checketts Director of Communications *On secondment from Birmingham Children's Hospital from 1 June 2012 to 30 September 2013. Transferred to NHS TDA payroll from 1 October 2013*	110-115	–	20	41	150-155	1 June 2012	6
Dale Bywater Director of Delivery and Development (Midlands and East)	155-160	0-5	–	45	205-210	1 October 2012	6
Dr Stephen Dunn Director of Delivery and Development (South)	155-160	5-10	–	94	255-260	1 October 2012	6
Alwen Williams CBE Director of Delivery and Development (London)	160-165	0-5	18	100	265-270	1 October 2012	6
Lyn Simpson[9] Director of Delivery and Development (North)	70-75	–	–	28	100-105	14 October 2013	6
Yasmin Chaudhry[10] Interim Director of Special Measures *Role commenced from 1 October 2012. No salary was recharged to the NHS TDA up to 30 June 2013 when transferred to the NHS TDA*	85-90	–	–	–	85-90	1 July 2013	6

The information above has been subject to audit

Pay multiples

Reporting bodies are required to disclose the relationship between the remuneration of the highest paid director in their organisation and the median remuneration of the organisation's workforce.

The banded remuneration of the highest paid director in the NHS TDA in the financial year 2014-15 was £225,000-£230,000 (£205,000-£210,000 in the period April 2013 to March 2014). This was 4.0 times the median remuneration of the directly employed workforce which was £56,504 (2013-14 figure was 3.7 times with a median remuneration of £55,376).

In 2014-15 no employees received remuneration in excess of the highest paid Director (2013-14 nil).

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.

The ratio between the highest paid director and the median remuneration of the workforce has increased from the previous year. The increase in the ratio is due to the effect of the highest paid director receiving non-consolidated performance related pay in the banding £20,000-£25,000 increasing the annual salary by 10.8% whilst the median salary increased by 1.4%. Consequently the pay multiple moved from 3.7 in 2013-14 to 4.0 in 2014-15.

The pay multiples information above is subject to audit.

Pension benefits

The Chief Executive and senior managers are members of the NHS Pension Scheme. For the period 1 April 2014 to 1 March 2015 Ralph Coulbeck was seconded from the DH and contributed to the Civil Service Pension Scheme.

The following table details the pension entitlements for each of the senior managers who receive pensionable remuneration.

As non-executive directors do not receive pensionable remuneration, there are no entries in respect of pensions for non-executive directors.

Notes from tables on pages 26 and 27

1 In addition to the remuneration shown in the table above, David Flory received a termination payment within the band £410,000-£415,000 in accordance with a settlement agreement agreed on completion of a fixed term appointment set out in 2012. The notice period of 3 months was worked in full. This payment is included within note 7.4 Exit Packages of the NHS TDA's Annual Accounts. David Flory's performance related pay and bonuses has two elements, a one off payment relating to 2012-13 from the Department of Health within the band £10,000-£15,000 and a NHS TDA payment relating to 2013-14 of £10,000-£15,000.

2 Figures disclosed in the above table for Ralph Coulbeck are from two sources. For the period 1 April 2014 to 28 February 2015 the figures represent the recharge to the NHS TDA from the Department of Health and for the period 1 March 2015 to 31 March 2015 the figure reports transactions processed through the NHS TDA's payroll system. Ralph Coulbeck's NHS TDA contract is for 0.8 whole time equivalent his annualised salary is within the band £115,000-£120,000. The figure reported for his all pension related benefits relate to the Civil Service Pension Scheme for the period ended 28 February 2015. From 1 March 2015 he contributes to the NHS Pension Scheme and these figures will be disclosed in 2015-16.

3 Dr Stephen Dunn left the NHS TDA on 3 November 2014 and his annualised salary was within the band £155,000-£160,000.

4 James Lusby's contract as Acting Director of Delivery and Development (South) commenced on 2 November 2014 and ended 31 March 2015. His annualised salary would be within the band £140,000-£145,000.

5 Yasmin Chaudhry left the NHS TDA on 27 July 2014 and her annualised salary would be within the band £155,000-£160,000.

6 The all pension related benefits calculation may result in negative figures as the final salary pension is calculated by reference to pay and length of service. The pension will increase from one year to the next by virtue of an individual having an extra year's service and any pay rise during the year. Where there is no pay rise, the increase in pension due to extra service may not be sufficient to offset the inflationary increase – that is, in real terms, the pension value can reduce, hence the negative figures.

7 During 2012-13 some Executive Directors performed a dual role supporting the NHS Transition and were entitled to back pay relating to their roles with the NHS TDA.

8 Figures disclosed in the above table for Ralph Coulbeck represent the recharge to the NHS TDA from the DH.

9 Lyn Simpson's contract commenced on 14 October 2013 and her annualised salary would be within the band £155,000-£160,000.

10 Yasmin Chaudhry's contract commenced on 1 July 2013 and her annualised salary would be within the band £125,000-£130,000.

All benefits in kind payments relate to the provision of a lease car.

Pension benefits

Name and title	Real increase in pension at age 60 (bands of £2,500)	Real increase in pension lump sum at age 60 (bands of £2,500)	Total accrued pension at age 60 at 31 March 2015 (bands of £5,000)	Lump sum at age 60 related to accrued pension at 31 March 2015 (bands of £5,000)	Cash Equivalent Transfer Value at 31 March 2014	Cash Equivalent Transfer Value at 31 March 2015	Real increase in Cash Equivalent Transfer Value	Normal retirement age
	£000	£000	£000	£000	£000	£000	£000	Years
David Flory CBE Chief Executive	0-2.5	0-2.5	30-35	95-100	624	671	30	60
Robert Alexander Director of Finance	0-2.5	5.0-7.5	35-40	105-110	668	744	57	60
Dr Kathy McLean Medical Director	0-2.5	0-2.5	70-75	215-220	1,456	1,547	51	60
Peter Blythin[1] Director of Nursing	0-(2.5)	(5.0)-(7.5)	75-80	225-230	1,712	–	(1,759)	60
Ralph Coulbeck[2] Director of Strategy	0-2.5	–	10-15	–	61	75	7	68
Robert Checketts Director of Communications	0-(2.5)	(5.0)-(7.5)	15-20	50-55	250	235	(22)	60
Dale Bywater Director of Delivery and Development (Midlands and East)	0-2.5	5.0-7.5	35-40	105-110	505	559	40	60
Dr Stephen Dunn[3] Director of Delivery and Development (South)	0-2.5	–	50-55	–	452	498	20	65
James Lusby[4] Acting Director of Delivery and Development (South)	0-2.5	0-2.5	25-30	75-80	381	416	10	60
Alwen Williams CBE Director of Delivery and Development (London)	0-2.5	0-2.5	65-70	205-210	1,431	1,519	49	60
Lyn Simpson Director of Delivery and Development (North)	0-2.5	5.0-7.5	65-70	195-200	1,286	1,398	78	60

The information above has been subject to audit

Notes from table on page 29

[1] As at 31 March 2015 there is no CETV for the pension of Peter Blythin as he has now reached the pension scheme's normal retirement age.

[2] For the period 1 April 2014 – 28 February 2015 Ralph Coulbeck was a member of the Civil Service Pension Scheme. From 1 March 2015 he contributes to the NHS Pension Scheme, his normal retirement age is 68 years. The figures disclosed relate to the Civil Service Pension Scheme for the period ended 28 February 2015. Pension benefits from 1 March 2015 will be disclosed in 2015-16. He has an option to transfer his Civil Service Pension benefits to the NHS Pension Scheme and has 12 months to register his interest from the date he started with the NHS TDA. The DH's pension provider has recalculated Ralph Coulbeck's 2013-14 CETV as £114,000 which has been revised to £61,000.

[3] Dr Stephen Dunn left the NHS TDA on the 3 November 2014. The values included in the Pension Benefits table for the 'Real increase in pension at age 60' and the 'Real increase in cash equivalent transfer value' relate to the period 1 April 2014 to 3 November 2015. The 'Total accrued pension at age 60 at March 2015' and the 'Cash equivalent transfer value at 31 March 2014' and 2015 are annual figures. As a member of the 2008 section of the NHS Pension Scheme Stephen Dunn does not receive a lump sum payment.

[4] James Lusby commenced his post as Acting Director of Delivery and Development (South) from 2 November 2014. The figures reported for the real increase in accrued pension, accrued lump sum and CETV in the pensions table related to the period 2 November 2014 – 31 March 2015. The total accrued pension, lump sum at age 60 and CETV 2014 and 2015 are annual figures.

During the period 1 April 2014 – 27 July 2014 Yasmin Chaudhry did not contribute to the NHS Pension Scheme.

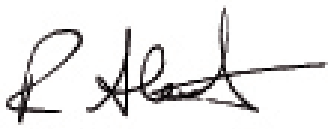
Cash equivalent cash transfer

The method used to determine the value of a members retirement benefits is the cash equivalent transfer value (CETV).

A CETV is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member's accrued benefits and any contingent spouse's (or other allowable beneficiary's) pension payable from the scheme. CETVs are calculated in accordance with the Occupational Pension Schemes (Transfer Values) Regulation 2008.

Real increase in CETV

This reflects the increase in CETV effectively funded by the employer. It takes account of the increase in accrued pension due to inflation, 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.



Robert Alexander

Chief Executive Officer
NHS Trust Development Authority

8 July 2015


Emergency Department
A&E
Main Entrance
Main Entrance
No access to the Emergency Centre
A&E
Please turn around & follow the red signs

Annual Governance Statement 2014-15

Introduction and context

This Governance Statement outlines how responsibility for the management and control of the NHS TDA's resources were discharged during the year. David Flory was the Chief Executive and Accounting Officer prior to his departure and was in post for the entire year in question. After a thorough handover process, which included the provision of a range of formal assurances, I took on the roles of Chief Executive and Accounting Officer on 1 April 2015. As such, I have assumed responsibility for signing off the Annual Governance Statement for the year.

The NHS TDA was legally established as a Special Health Authority in June 2012 and assumed its full range of statutory duties on 1 April 2013. It is responsible for making appointments of chairs and non-executive members of NHS trusts and trustees in certain NHS bodies; performance managing NHS trusts; reviewing and approving NHS trust capital schemes above delegated levels; assuring clinical quality, governance and risk in NHS trusts and supporting NHS trusts to deliver high quality, sustainable services, including preparation for foundation trust status, where appropriate.

As an ALB, the NHS TDA works closely with its sponsor branch at the DH and with its partner organisations NHSE, CQC and Monitor. Arrangements are in place for the NHS TDA to work with its tripartite partners, NHSE and Monitor, to develop a whole system approach to issues affecting local health economies.

Scope of responsibility

As Accounting Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of the NHS TDA's policies, aims and objectives, whilst safeguarding public funds and department assets for which I am personally responsible, in accordance with the responsibilities assigned to me.

Governance framework of the organisation

The NHS TDA's governance arrangements have been developed to ensure appropriate oversight and scrutiny of its business and to ensure that its strategic objectives are delivered.

Compliance with the UK Corporate Governance Code

In line with good practice, the NHS TDA has completed an annual review of its compliance with the Financial Reporting Council's UK Corporate Governance Code (September 2012 version). For the period ending 31 March 2015 the organisation was compliant with all but 2 of the Code's provisions. The first is that because of the Remuneration Committee's role in considering remuneration issues related to the wider NHS trust community, the Committee is chaired by the Chair of the NHS TDA. The second is that as the Chair's appraisal is undertaken by the DH, the non-executive directors do not meet to discuss the Chair's performance.

The Board

The following paragraphs detail the role and composition of the NHS TDA's Board and Committees and provide an outline of the NHS TDA's wider governance arrangements.

The NHS TDA Board consists of a non-executive Chair, 4 non-executive directors, a Chief Executive and 3 executive directors. A further 7 non-voting directors attend board meetings.

Non-executive director, Dame Christine Beasley has been nominated as Vice-Chair and Senior Independent Director of the Board.

The 4 non-executive directors are each assigned to one of the regional delivery and development teams and have assumed certain responsibilities within their respective regions. These include appraisal of chairs in NHS trusts and attendance at board to board meetings with the relevant NHS trusts.

In July 2014 Yasmin Chaudhry, the former Director of Special Measures, left the organisation. The special measures programme of work was incorporated into wider performance management processes and became part of the day to day responsibilities of the directors of delivery and development. In November 2014 the former Director of Delivery and Development (South), Dr Stephen Dunn left the organisation to take up a new post and was replaced on an interim basis by James Lusby, Portfolio Director for the South. Anne Eden was appointed to the substantive role of Director of Delivery and Development (South) from 1 April 2015.

The Board held 8 meetings in public during 2014-15. Attendance at board meetings is shown in the table below.

Attendance at Board meetings								
	Date of meeting							
Attendees	30 Apr '14	15 May '14	24 Jul '14	18 Sep '14	23 Oct '14	20 Nov '14	22 Jan '15	19 Mar '15
Sir Peter Carr CBE Chair	✓	✓	✓	✓	✓	✓	✓	✓
Dame Christine Beasley Non-executive Director	✗	✓	✓	✓	✓	✓	✓	✓
Sarah Harkness Non-executive Director	✓	✓	✓	✓	✓	✓	✓	✓
Crispin Simon Non-executive Director	✗	✗	✓	✓	✓	✓	✗	✓
Caroline Thomson Non-executive Director	✓	✓	✓	✓	✓	✓	✓	✓
David Flory CBE Chief Executive	✓	✓	✓	✓	✓	✓	✓	✓
Robert Alexander Director of Finance	✓	✓	✓	✓	✓	✓	✓	✓
Peter Blythin Director of Nursing	✓	✓	✓	✓	✓	✓	✓	✓
Dr Kathy McLean Medical Director	✓	✓	✓	✓	✓	✓	✓	✓
Dale Bywater Director of Delivery and Development	✓	✓	✓	✓	✓	✓	✓	✓
Robert Checketts Director of Communications	✓	✓	✗	✓	✓	✓	✓	✓
Ralph Coulbeck Director of Strategy	✓	✓	✓	✓	✓	✓	✓	✓
Yasmin Chaudhry Interim Director of Special Measures	✗	✓	N/A	N/A	N/A	N/A	N/A	N/A
Dr Stephen Dunn Director of Delivery and Development	✓	✗	✓	✓	✓	N/A	N/A	N/A
Lyn Simpson Director of Delivery and Development	✓	✓	✓	✓	✓	✓	✗	✓
Alwen Williams CBE Director of Delivery and Development	✓	✓	✓	✓	✓	✓	✓	✓
James Lusby Acting Director of Delivery and Development	N/A	N/A	N/A	N/A	N/A	✓	✓	✓

The Board is collectively responsible for ensuring a sound system of internal control and is responsible for putting in place arrangements for gaining assurance about the effectiveness of that system.

The NHS TDA's governance arrangements are subject to ongoing review to ensure that they remain fit for purpose. The key governance documents: Standing Orders, Standing Financial Instructions and the Scheme of Delegation are subject to a full and detailed review on an annual basis and are maintained on an interim basis to ensure they reflect the NHS TDA's governance arrangements. Amendments to the document are formally adopted by the Board as necessary.

The Board has delegated responsibility for discharging certain duties to a series of committees and sub-committees; these are detailed in the Board's Scheme of Delegation. In line with its statutory responsibilities, the NHS TDA has 3 statutory committees: Audit, Remuneration and Appointments. A further 2 non-statutory committees exist to provide an appropriate level of scrutiny to key areas of the NHS TDA: the Investment Committee (formerly the Capital Investment Group) and the Finance and Procurement Controls Committee. Further details of the role and remit of the committees are set out in the following paragraphs.

The Board has not undertaken a further review of its own effectiveness during 2014-15. Instead the DH group internal audit function will complete a review of the Board's overall effectiveness and level of maturity during the first quarter of 2015-16. The exercise will include a self-assessment of the Board's performance together with observation of board interactions and interview with board members.

Audit Committee

Role

The Audit Committee is responsible for providing the Board with independent and objective scrutiny and advice on the NHS TDA's financial systems and processes, its financial obligations, the risk management arrangements and compliance with relevant legislation.

Composition and attendance

Committee membership consists of 3 non-executive directors. The Director of Finance, together with representatives from the internal and external auditors, also attends every meeting of the Audit Committee.

The Committee has met 5 times during 2014-15. Attendance at individual meetings is shown below.

The Committee's work

In July 2014, the Committee reviewed the accounts and annual report of the NHS TDA for 2013-14 on behalf of the Board and considered issues arising from the audit of the accounts.

The Committee commented on the NHS TDA's draft Annual Governance Statements and received a report on the outcomes of an assurance exercise to validate Annual Governance Statements made by NHS trusts.

The Committee also noted the annual report and accounts from 2 NHS trusts that had been dissolved during the course of 2013-14: South London Healthcare NHS Trust and NHS Direct.

The Committee plays a key role in the scrutiny of the NHS TDA's risk management arrangements within the NHS TDA and undertakes a detailed review of the

Attendance at Audit Committee meetings

	Date of meeting				
Committee Members	3 Apr '14	3 Jul '14	6 Nov '14	30 Jan '15	24 Mar '15
Sarah Harkness Chair, Non-executive Director	✓	✓	✓	✓	✓
Crispin Simon Non-executive Director	✓	✓	✗	✓	✓
Caroline Thomson Non-executive Director	✗	✓	✓	✗	✓

contents of the strategic risk register on a quarterly basis. The Committee has a programme of 'in depth' reviews in which senior responsible officers attend committee meetings to provide a detailed explanation of the handling of individual risks. During 2014-15 in-depth risk topics have included triangulation of workforce plans, working relationships with the NHS TDA's tripartite partners and handling of NHS trust turnaround plans.

A programme of work for 2014-15 was agreed with Health Group Internal Audit based on business need and key areas of risk. The Committee oversees progress with delivery of the programme and has received internal audit reports on key areas of NHS TDA business. The Committee monitors the actions taken to address the findings and recommendations set out in the reports. A similar programme of work has been established for 2015-16 and will be subject to the same overview and scrutiny by the Committee.

Remuneration Committee

Role and membership

The Remuneration Committee is comprised of the non-executive directors of the NHS TDA. Its duties include approving the remunerations and terms of service for the Chief Executive, executive directors and other very senior managers in the NHS TDA and considering contractual and non-contractual payments to certain staff in NHS trusts.

The terms of reference of the Committee make provision for cases to be considered via correspondence to enable the NHS TDA to respond quickly to time critical business cases from NHS trusts. In these circumstances, cases are circulated to members via email and members deliver their views in writing. Teleconferences are arranged to discuss individual cases when necessary. A summary report of cases agreed via correspondence is presented at every committee meeting.

A remuneration sub-committee has been established to discharge certain internal and external functions on behalf of the Remuneration Committee within delegated limits. Membership of the sub-committee comprises the Chief Executive and the Directors of Finance and Strategy. The Remuneration Committee receives a report at every meeting summarising decisions taken by the sub-committee.

The Remuneration Committee met twice during 2014-15 and, in addition, has convened via teleconference on 3 occasions. Attendance at the meetings and teleconferences is shown below:

Attendance at Remuneration Committee meetings

	Date of meeting				
Committee Members	8 May '14	27 Jun '14 (telecom)	26 Aug '14 (telecom)	19 Sep '14	15 Dec '14 (telecom)
Sir Peter Carr CBE Chair	✓	✓	✓	✓	✓
Dame Christine Beasley Non-executive Director	✓	✓	✓	✓	✓
Sarah Harkness Non-executive Director	✗	✓	✓	✓	✗
Caroline Thomson Non-executive Director	✓	✗	✓	✓	✗
Crispin Simon Non-executive Director	✓	✓	✗	✓	✓

Appointments Committee

The Appointments Committee is responsible for making recommendations to the NHS TDA on the appointment of chairs, non-executive directors and charity trustees to NHS trusts. The Committee met 3 times during 2014-15 and conducted the remainder of its business via correspondence.

Four sub-committees of the Appointments Committee have been established to discharge the functions relating to appointment of non-executive directors in NHS trusts on behalf of the Appointments Committee. The sub-committees mirror the 4 regions of the NHS TDA and each is chaired by the relevant director of delivery and development.

Finance and Procurement Controls Committee

A Finance and Procurement Controls Committee was established to support the Board in the discharge of its responsibilities for financial and procurement efficiency control. The Committee met 4 times during 2014-15.

Investment Committee (formerly the Capital Investment Group)

The Capital Investment Group was established at the outset of the NHS TDA to advise the Board on the discharge of its responsibilities concerning capital investments and approval of capital schemes in the NHS trust sector. During the course of 2014-15 it was recognised that the scope of the Group needed to expand to reflect the increasing number of capital approvals linked to transactions. These relate to instances where a NHS trust is being merged with, or acquired by, another NHS trust or a foundation trust, or where a NHS trust is acquiring services from a NHS trust or foundation trust and where a capital outlay is required to enable the transaction to be effected.

In order to reflect the wider scope of its responsibilities, the terms of reference of the Capital Investment Group were updated and the Group was re-named the Investment Committee. The new arrangements came into force in September 2014.

Wider governance arrangements

Senior Management Team

The Senior Management Team comprises the Chief Executive and directors. The group is charged with executive responsibility for ensuring delivery of the NHS TDA's strategic objectives. The team meets on a weekly basis to discuss and agree actions relating to the development of the NHS TDA as a corporate body and to consider those issues relating to its responsibility for the NHS trust sector.

Other decision making groups

The Senior Management Team is supported by a series of sub groups, chaired by individual directors, and with responsibility for specific areas of the business. Each group has clearly defined terms of reference and most report to either the Senior Management Team or one of the NHS TDA's formal committees.

Risk assessment

The NHS TDA approach to risk is set out in its Risk Appetite Statement, which has been adopted by the Board and forms part of the Risk Management Strategy of the organisation. The statement sets out the over-arching appetite for risk together with statements in relation to 4 key domains of its business: quality of care, financial management, service performance and NHS TDA reputation. The Board has recognised that it is not possible to eliminate all the potential risks, which are inherent in the oversight of healthcare providers, and is willing to accept a certain degree of risk where it is considered to be in the best interest of patients. The Board has a low level of appetite for risk in relation to quality of services to patients and will hold NHS trusts to account where there is evidence of poor performance. The Board also has a low appetite for risk in relation to financial management in respect of both its own statutory duties and the statutory duty for NHS trusts to break even. In relation to development and delivery, the Board is prepared to tolerate a moderate level of risk to maximise the potential of achieving high quality, sustainable services for patients. The Board has a low appetite for any actions or decisions taken which may affect the reputation of the NHS TDA or its employees.

Attendance at Appointments Committee meetings

	Date of meeting		
Committee Members	2 Jul '14	8 Oct '14	14 Jan '15
Dame Christine Beasley Non-executive Director	✓	✓	✓
Ralph Coulbeck Director of Strategy	✓	✓	✓

Attendance at Finance and Procurement Controls Committee meetings

	Date of meeting			
Committee Members	2 Jul '14	3 Dec '14	15 Jan '15	19 Mar '15
David Flory CBE Chief Executive	✗	✗	✗	✓
Robert Alexander Director of Finance	✓	✓	✓	✓
Sarah Harkness Non-executive Director	✓	✓	✓	✓
Ralph Coulbeck Director of Strategy	✓	✓	✗	✓

Attendance at Investment Committee (IC)/Capital Investment Group (CIG) meetings

	Date of meeting										
Group members	(CIG) 7 May 2014	(CIG) 25 Jun 2014	(CIG) 3 Jul 2014	(IC) 3 Sep 2014	(IC) 16 Oct 2014	(IC) 18 Nov 2014	(IC) 15 Dec 2014	(IC) 15 Jan 2015	(IC) 26 Feb 2015	(IC) 11 Mar 2015	(IC) 19 Mar 2015
Robert Alexander Director of Finance	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Sarah Harkness Non-executive Director	✓	✓	✓	✓	✓	✓	✓	✓	✓	✗	✓
Ralph Coulbeck Director of Strategy	✓	✗	✓	✓	✓	✓	✓	✓	✓	✗	✗
Peter Blythin Director of Nursing	✗	✓	✓	✓	✓	✓	✓	✓	✓	✗	✓
Stan Silverman Deputy Medical Director	✗	✗	✗	✗	✗	✗	✓	✓	✓	✓	✗
Crispin Simon Non-executive Director	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	✓	N/A

During 2014-15 the main risk for the NHS TDA remained the capacity of the organisation to respond to the increased demands in relation to patient safety and experience which led to intensified service and financial performance management and more detailed scrutiny of clinical quality in individual trusts. Following the decision by the DH to award additional resources to the NHS TDA, a programme of work was undertaken to expand staff numbers around key areas of the business. The expansion of the business is now almost complete and the increased resource has served to reduce the severity of the risk.

The risk and control framework

Systems of management and financial control have been developed to minimise risk in the organisation. A summary of the mechanisms for handling risk in the NHS TDA is set out in Annex 1.

The NHS TDA's risk management strategy was refreshed during the course of 2014 and work has since been underway to further embed risk management arrangements throughout the organisation. The strategic risk register continues to be updated on a quarterly basis and is reviewed in detail by the Audit Committee before being presented for discussion by the Board.

Directorate level risk registers have been created and are the responsibility of the relevant director. The NHS TDA's risk management arrangements are supported by the Risk Assurance Group, chaired by the Director of Finance, who is the executive lead on risk. The Risk Assurance Group ensures an effective link between directorate level and strategic risks ensuring that appropriate risks are included on the strategic risk registers.

An assurance map has been created to ensure that the Board and its committees are provided with the appropriate levels of assurance in relation to key areas of the business.

The Audit Committee agreed a programme of work to be undertaken by the internal auditors during 2014-15. The Committee receives regular reports from the internal auditors on progress with delivery of the plan and the outputs from individual audits. A system is in place to ensure that actions arising from internal audit reports are monitored and duly completed.

The Head of Internal Audit Opinion for 2014-15 is as follows:

In accordance with the requirements of the UK Public Sector Internal Audit Standards, I am required to provide the Accounting Officer with my annual opinion of the overall adequacy and effectiveness of the organisation's risk management, control and governance processes.

My opinion is based on the outcomes of the work that Internal Audit has conducted throughout the course of the reporting year and on the follow up action from audits conducted in the previous reporting year. There have been no undue limitations on the scope of Internal Audit work and the appropriate level of resource has been in place to enable the function to satisfactorily complete the work planned.

- In the case of risk management, we have worked with management in the year to embed the overall arrangements. This has entailed providing ad hoc support in developing an assurance map across the NHS TDA and the inclusion of risk management within the 2014-15 internal audit plan. We note arrangements are in place to report to the Board and Audit Committee on the ongoing monitoring and management of strategic risks. There is a risk management framework and strategy in place to manage the key strategic risks to achieving its objectives. Our review of risk management was rated 'substantial'.
- In the case of governance we have conducted a number of reviews to inform our understanding of the NHS TDA. This has included a review of the framework agreement between the DH and the NHS TDA and the accountability framework, in particular, the special measures programme.
- In the case of control – 8 assurance based reviews have been completed; of which 3 were rated 'substantial' and 5 were rated 'moderate'. We also concluded that good progress had been made in implementing internal audit recommendations relating to the 2013-14 and the 2014-15 audit plans.

In summary, my overall opinion is that some improvements are required to enhance the adequacy and effectiveness of the framework of governance, risk management and control. Therefore, I can give moderate assurance to the Accounting Officer that the NHS TDA has had adequate and effective systems of control, governance and risk management in place for the reporting year 2014-15.

Review of the Effectiveness of Risk Management and Internal Control

As Accounting Officer, in addition to maintaining a sound system of internal control, I also have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control is informed by the work of the internal auditors and senior managers within the NHS TDA who have responsibility for the development and maintenance of the internal control framework. I have also drawn on regular reports from executive directors and other members of the senior management team covering all aspects of the NHS TDA's performance including clinical quality, service delivery and financial performance. My review is also informed by comments made by the external auditors in their management letter and other reports. The Head of Internal Audit provides me with an opinion on the overall arrangements for gaining assurance through the Risk Management System and on the controls reviewed as part of internal audit's work. The Strategic Risk Register itself provides me with evidence of the effectiveness of controls that manage the risks to the NHS TDA achieving its strategic objectives. I am satisfied that the NHS TDA has had an adequate system of internal control in place during 2014-15.

Data Quality

The Board receives a report detailing financial and service performance in NHS trusts. The NHS TDA's internal auditors have undertaken a review of the completeness and accuracy of the performance reporting data as it is reported by the NHS TDA. The overall rating for the review was satisfactory, meaning that the control environment assured delivery of objectives but was subject to minor control weaknesses. An action plan has been developed to address the findings of the auditors' report and is monitored quarterly by the Audit Committee.

Data Security

The NHS TDA has submitted a satisfactory level of compliance with the information governance toolkit. There have been no serious data related incidents.

Discharge of statutory functions

In line with the requirements of the Harris Review, the NHS TDA has arrangements in place that it deliver its statutory duties and powers.

Conclusion

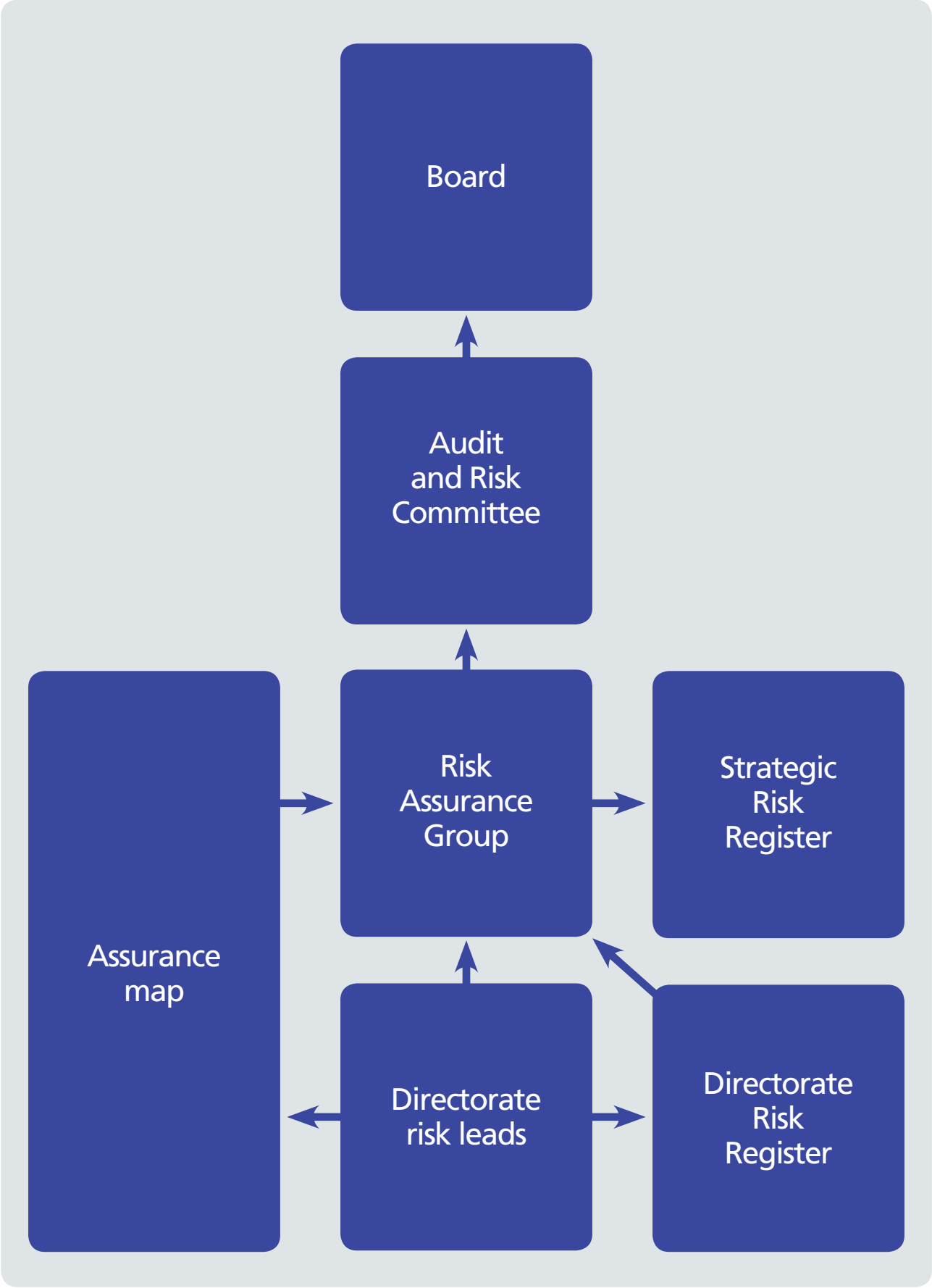
The NHS TDA governance arrangements are appropriate and proportionate to an organisation of its size. Risk management arrangements have been in place since the outset of the organisation and a recent internal audit report provided 'substantial' assurance. The Annual Report and Accounts for 2014-15 was produced within the given deadlines with an unqualified opinion without modification from the external auditors.

Robert Alexander

Chief Executive Officer
NHS Trust Development Authority

8 July 2015

Annex 1: NHS TDA risk management arrangements



Financial statements

Statement of Accounting Officer's responsibilities

Under the National Health Service Act 2006, the Secretary of State with the consent of the Treasury has directed the NHS Trust Development Authority to prepare for each financial year a statement of accounts in the form and on the basis set out in the Accounts Direction. The accounts are prepared on an accruals basis and must give a true and fair view of the state of affairs of the NHS Trust Development Authority and of its net resource outturn, application of resources, changes in taxpayers' equity 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 and in particular to:

- observe the Accounts Direction issued by the Secretary of State, 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 accounts; and
- prepare the accounts on a going concern basis.

The Accounting Officer of the Department of Health has designated the Chief Executive as Accounting Officer of the NHS Trust Development Authority. The responsibilities of an Accounting Officer, including responsibility for the propriety and regularity of the public finances for which the Accounting Officer is answerable, for keeping proper records and for safeguarding the NHS Trust Development Authority's assets, are set out in Managing Public Money, published by the HM Treasury.

The Certificate and Report of the Comptroller and Auditor General to the House of Commons

I certify that I have audited the financial statements of NHS Trust Development Authority for the year ended 31 March 2015 under the National Health Service Act 2006. The financial statements comprise: the Statements of Comprehensive Net Expenditure, Financial Position, Cash Flows, Changes in Taxpayers' Equity; and the related notes. These financial statements have been prepared under the accounting policies set out within them. I have also audited the information in the Remuneration Report that is described in that report as having been audited.

Respective responsibilities of the Accounting Officer and Auditor

As explained more fully in the Statement of Accounting Officer's Responsibilities, the Chief Executive as Accounting Officer is responsible for the preparation of the financial statements and for being satisfied that they give a true and fair view. My responsibility is to audit, certify and report on the financial statements in accordance with the National Health Service Act 2006. I conducted my audit in accordance with International Standards on Auditing (UK and Ireland). Those standards require me and my staff to comply with the Auditing Practices Board's Ethical Standards for Auditors.

Scope of the audit of the financial statements

An audit involves obtaining evidence about the amounts and disclosures in the financial statements sufficient to give reasonable assurance that the financial statements are free from material misstatement, whether caused by fraud or error. This includes an assessment of: whether the accounting policies are appropriate to the NHS Trust Development Authority's circumstances and have been consistently applied and adequately disclosed; the reasonableness of significant accounting estimates made by NHS Trust Development Authority; and the overall presentation of the financial statements. In addition I read all the financial and non-financial information in the Annual Report to identify material inconsistencies with the audited financial statements and to identify any information that is apparently materially incorrect based on, or materially inconsistent with, the knowledge acquired by me in the course of performing the audit. If I become aware of any apparent material misstatements or inconsistencies I consider the implications for my certificate.

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.

Opinion on regularity

In my opinion, in all material respects 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.

Opinion on financial statements

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 2015 and of the net operating cost for the year then ended; and
- the financial statements have been properly prepared in accordance with the National Health Service Act 2006 and Secretary of State directions issued thereunder.

Opinion on other matters

In my opinion:

- the part of the Remuneration Report to be audited has been properly prepared in accordance with Secretary of State directions made under the National Health Service Act 2006; and
- the information given in the Strategic Report, the Directors Report and the Governance Statement sections of the Annual Report, for the financial year for which the financial statements are prepared is consistent with the financial statements.

Matters on which I report by exception

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

- adequate accounting records have not been kept or returns adequate for my audit have not been received from branches not visited by my staff; or
- the financial statements and the part of the Remuneration Report to be audited are not in agreement with the accounting records and returns; or
- I have not received all of the information and explanations I require for my audit; or
- the Governance Statement does not reflect compliance with HM Treasury's guidance.

Report

I have no observations to make on these financial statements.

Sir Amyas C E Morse
Comptroller and Auditor General
National Audit Office
157-197 Buckingham Palace Road
Victoria
London SW1W 9SP

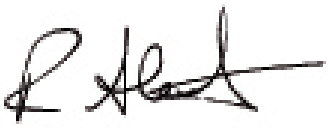
9 July 2015

STATEMENT OF COMPREHENSIVE NET EXPENDITURE FOR THE PERIOD ENDED 31 MARCH 2015			
	Note	**2014-15 £000**	2013-14 £000
Administration costs and programme expenditure			
Gross employee benefits		24,180	17,836
Other expenditure		41,782	23,667
Revenue		(953)	(1,744)
Net operating costs for the financial year		**65,009**	39,759
Of which:			
Administration costs:			
Gross employee benefits	7	24,105	17,007
Other expenditure	5	6,125	5,234
Revenue	4	(760)	(212)
Net administration costs for the financial year		**29,470**	22,029
Programme costs:			
Gross employee benefits	7	75	829
Other expenditure	5	35,657	18,433
Revenue	4	(193)	(1,532)
Net programme costs for the financial year		**35,539**	17,730
Other comprehensive net expenditure			
Impairments and reversals		–	–
Net gain/(loss) on revaluation of property, plant and equipment		–	–
Net gain/(loss) on revaluation of intangibles		–	–
Total comprehensive net expenditure for the year		**65,009**	39,759
The notes on pages 48 to 66 form part of these accounts			

STATEMENT OF FINANCIAL POSITION AS AT 31 MARCH 2015

	Note	31 March 2015 £000	31 March 2014 £000
Non current assets			
Property, plant and equipment	8.1	540	352
Intangible assets	8.2	44	65
Total non-current assets		**584**	417
Current assets			
Trade and other receivables	9	264	706
Cash and cash equivalents	10	108	1,638
Total current assets		**372**	2,344
Total assets		**956**	2,761
Current liabilities			
Trade and other payables	11	8,757	14,184
Provisions	12	90	130
Total current liabilities		**8,847**	14,314
Net current (liabilities)/assets		**(8,475)**	(11,970)
Non-current assets plus/less net current assets/liabilities		**(7,891)**	(11,553)
Total net (liabilities)/assets		**(7,891)**	(11,553)
Financed by taxpayers' equity			
General fund		(7,891)	(11,553)
Total taxpayers' equity		**(7,891)**	(11,553)

The financial statements and the notes on pages 48 to 66 were signed on behalf of the NHS TDA by:



Robert Alexander
Chief Executive Officer
8 July 2015

STATEMENT OF CHANGES IN TAXPAYERS' EQUITY FOR THE YEAR ENDED 31 MARCH 2015		
	Note	General Fund £000
Balance at 31 March 2014		**(11,553)**
Changes in taxpayers' equity for 2014-15		
Net operating cost for the year	SoCNE	(65,009)
Net parliamentary funding	SOCF	68,671
Balance at 31 March 2015		**(7,891)**
Balance at 31 March 2013		**14**
Changes in taxpayers'equity for 2013-14		
Net operating cost for the year		(39,759)
Transfers to/(from) other bodies within the group under modified absorption accounting	16	(1,997)
Net parliamentary funding – drawdown cash		27,900
Net parliamentary funding – legacy items paid by Department of Health	16.1	2,289
Balance at 31 March 2014		**(11,553)**
The notes on pages 48 to 66 form part of these accounts.		

STATEMENT OF CASH FLOWS FOR THE YEAR ENDED 31 MARCH 2015

	Note	2014-15 £000	2013-14 £000
Cash flows from operating activities			
Net operating cost		(65,009)	(39,759)
Adjustments for non-cash transactions			
Depreciation and amortisation	5	150	30
Legacy balance working capital movement	16.1	–	292
Provisions arising during the year	12	90	130
Provisions reversed unused	12	(60)	(28)
(Increase)/decrease in trade and other receivables	9	442	(502)
Increase/(decrease) in trade payables and other current liabilities		(5,248)	12,192
Provisions utilised	12	(70)	(107)
Net cash inflow/(outflow) from operating activities		**(69,705)**	(27,752)
Cash flows from investing activities			
(Payments) for property, plant and equipment		(496)	(14)
(Payments) for intangible assets		–	(25)
Net cash inflow/(outflow) from investing activities		**(496)**	(39)
Cash flows from financing activities			
Net parliamentary funding	SoCTE	68,671	27,900
Net financing		68,671	27,900
Net increase/(decrease) in cash and cash equivalents		(1,530)	109
Cash and cash equivalents at the beginning of the period		**1,638**	1,529
Cash and cash equivalents at the end of the period	10	**108**	1,638

The notes on pages 48 to 66 form part of these accounts.

Notes to the Accounts

1 Accounting Policies

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 International Financial Reporting Standards (IFRS) 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 the NHS Trust Development Authority (NHS TDA) has been selected for the purpose of giving a true and fair view. The particular policies adopted by the NHS TDA are described below. They have been applied consistently in dealing with items that are considered material to the accounts.

The financial statements contained within this report have been prepared in accordance with the direction given by the Secretary of State for Health under the NHS Act 2006.

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. Special Health Authorities are not required to provide a reconciliation between current cost and historical cost surplus and deficits.

1.2 Acquisitions and Discontinued Operations

Activities are considered to be 'acquired' only if they are taken on from outside the public sector. Activities are considered to be 'discontinued' only if they cease entirely. They are not considered to be 'discontinued' if they transfer from one public sector body to another.

1.3 Movement of assets within the DH Group

Transfers as part of reorganisation fall to be accounted for by use of absorption accounting in line with the HM Treasury FReM. Absorption accounting requires that entities account for their transactions in the period in which they took place, with no restatement of performance required when functions transfer within the Departmental family.

For transfers of assets and liabilities from those NHS bodies that closed on 1 April 2013, HM Treasury has agreed that a modified absorption approach should be applied. For these transactions only, gains and losses are recognised in reserves rather than the Statement of Comprehensive Net Expenditure.

Other transfers of assets and liabilities within the Group are accounted for in line with IAS 20 and similarly give rise to income and expenditure entries.

1.4 Critical accounting judgements and key sources of estimation uncertainty

In the application of the 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.

1.4.1 Critical judgements in applying accounting policies

The following are the critical judgements, apart from those involving estimations that management has made in the process of applying the NHS TDA's accounting policies and that have the most significant effect on the amounts recognised in the financial statements.

Management has assumed that expenditure for laptops, iPhones and iPads will be required on a replacement cycle and have a recurrent annual cost. Hence these costs will be fully accounted for within current year operating costs and therefore not capitalised and depreciated over their estimated useful life.

In making this judgement the NHS TDA has considered materiality and significance of the information. Should the expenditure for laptops, iPhones and iPads significantly increase and be material to the financial statements then this judgement will be reviewed and expenditure reclassified.

Provisions recognised at 31 March 2015 were based on the NHS TDA's best professional judgement in line with IAS 37 and details of provisions can be seen in note 12.

1.4.2 Key sources of estimation uncertainty

There are no key sources of estimation uncertainty at the Statement of Financial Position date, that have a significant risk of causing a material adjustment to the carrying amounts of assets and liabilities within the next financial year.

With the exception of provisions (see note 1.4.1) estimation techniques are used to ensure that the correct levels of income and expenditure due relating to current year are included through the inclusion of accruals based on known commitments.

1.5 Revenue and Funding

The main source of funding for the Special Health Authority is Parliamentary grant from the DH 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.

Operating income is income which relates directly to the operating activities of the NHS TDA. Revenue in respect of services provided is recognised when, and to the extent that, performance occurs, and is measured at the fair value of the consideration receivable. Where income is received for a specific activity which is to be delivered in the following financial year, that income is deferred.

1.6 Employee benefits

1.6.1 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.

1.6.2 Retirement benefit costs

Past and present employees are covered by the provisions of the NHS Pensions Scheme as outlined in note 2 Pension costs.

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

The NHS Pensions Scheme is the only scheme in which employees are enrolled in, no present employees have pension benefits provided through the Principle Civil Service Pension Scheme (PCSPS) and no other pension scheme operates.

1.7 Property, plant and equipment

1.7.1 Capitalisation

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

- individually have a cost equal to or greater than £5,000; or
- collectively have a cost of at least £5,000 and an individual cost of more than £250, where the assets are functionally interdependent, they have broadly simultaneous purchase dates, are anticipated to have simultaneous disposal dates and are under single managerial control; or
- form part of the initial setting-up cost of a new building, irrespective of their individual or collective cost.

An exception to capitalisation of expenditure for laptops, iPhones and iPads has been made within critical judgements in applying the accounting policy for capitalisation of property, plant and equipment.

1.7.2 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.

1.8 Intangible assets

Intangible assets with a useful economic 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.

1.9 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 the NHS TDA expects to obtain economic benefits or service potential from the asset. This is specific to the 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.

Assets held under finance leases are depreciated over their estimated useful lives.

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 their useful economic lives:

- plant and machinery – five years;
- information technology assets – between three and five years;
- furniture and fittings assets – between five and ten years.

At each reporting period end, the 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.

1.10 Leases

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

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

1.11 Cash and cash equivalents

Cash is the balance held with the Government Banking Service.

1.12 Provisions

The NHS TDA provides for legal or constructive obligations as a result of past events that are of uncertain timing or amount at the Statement of Financial Position date, on the basis of the best estimate of the expenditure required to settle the obligation. Where the effect of the time value of money is significant, the estimated risk-adjusted cash flows are discounted using the HM Treasury's discount rate of:

- Short term (1.5%)
- Medium term (1.05%)
- Long term 2.2%

Figures in brackets represent a negative value.

1.13 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.

The NHS TDA has financial assets that are classified into the category of 'loans and receivables.'

1.13.1 Loans and receivables

Loans and receivables are non-derivative financial assets with fixed or determinable payments which are not quoted in an active market and are carried in the Statement of Financial Position at cost less appropriate provisions for specific doubtful receivables. After initial recognition, they are measured at amortised cost using the effective interest method, less any impairment. The NHS TDA has no loans.

At the end of the reporting period, the NHS TDA assesses whether any financial assets are impaired. Financial assets are impaired and impairment losses recognised if there is objective evidence of impairment as a result of one or more events which occurred after the initial recognition of the asset and which has an impact on the estimated future cash flows of the asset.

1.14 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 or has expired. The NHS TDA has financial liabilities that comprise of trade and other payables and other financial liabilities. They are initially recognised at fair value and subsequently at amortised cost in accordance with IAS 39.

1.15 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.

1.16 Losses and special payments

Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way each individual case is handled.

Losses and special payments are charged to the relevant functional headings in the operating cost statement on an accruals basis, including losses which would have been made good through insurance cover had the NHS TDA not been bearing their own risks (with insurance premiums then being included as normal revenue expenditure).

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

The Treasury FReM does not require the following Standards and Interpretations to be applied in 2014-15. The application of the Standards as revised would not have a material impact on the accounts for 2014-15, were they applied in that year:

- IFRS 9 Financial Instruments – to be applied in 2018-19;
- IFRS 13 Fair Value Measurement – to be applied in 2015-16.

2 Pension costs

Past and present employees are covered by the provisions of the NHS Pensions Scheme. Details of the benefits payable under these provisions can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. The scheme is an unfunded, defined benefit scheme that covers NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State, in England and Wales. The scheme is not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, the scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS Body of participating in the scheme is taken as equal to the contributions payable to the scheme for the accounting period.

In order that the defined benefit obligations recognised in the financial statements do not differ materially from those that would be determined at the reporting date by a formal actuarial valuation, the FReM requires that "the period between formal valuations shall be 4 years, with approximate assessments in intervening years". An outline of these follows:

2.1 Accounting valuation

A valuation of the scheme liability is carried out annually by the scheme actuary as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and are accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2015, is based on valuation data as at 31 March 2014, updated to 31 March 2015 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 scheme actuary report, which forms part of the annual NHS Pension Scheme (England and Wales) Pension Accounts, published annually. These accounts can be viewed on the NHS Pensions website. Copies can also be obtained from The Stationery Office.

2.2 Full actuarial (funding) valuation

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the scheme (taking into account its recent demographic experience) and to recommend the contribution rates.

The last published actuarial valuation undertaken for the NHS Pension Scheme was completed for the year ending 31 March 2012.

The Scheme Regulations allow contribution rates to be set by the Secretary of State for Health, with the consent of HM Treasury, and consideration of the advice of the Scheme Actuary and appropriate employee and employer representatives as deemed appropriate.

2.3 Scheme provisions

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

The Scheme is a "final salary" scheme. Annual pensions are normally based on 1/80th for the 1995 section and of the best of the last 3 years pensionable pay for each year of service, and 1/60th for the 2008 section of reckonable pay per year of membership. Members who are practitioners as defined by the Scheme Regulations have their annual pensions based upon total pensionable earnings over the relevant pensionable service.

With effect from 1 April 2008 members can choose to give up some of their annual pension for an additional tax free lump sum, up to a maximum amount permitted under HMRC rules. This new provision is known as "pension commutation".

Annual increases are applied to pension payments at rates defined by the Pensions (Increase) Act 1971, and are based on changes in retail prices in the twelve months ending 30 September in the previous calendar year. From 2011-12 the Consumer Price Index (CPI) has been used and replaced the Retail Prices Index (RPI).

Early payment of a pension, with enhancement, is available to members of the scheme who are permanently incapable of fulfilling their duties effectively through illness or infirmity. A death gratuity of twice final year's pensionable pay for death in service, and 5 times their annual pension for death after retirement is payable.

For early retirements other than those due to ill health the additional pension liabilities are not funded by the scheme. The full amount of the liability for the additional costs is charged to the employer.

Members can purchase additional service in the NHS Scheme and contribute to money purchase Additional Voluntary Contributions (AVC) run by the Scheme's approved providers or by other Free Standing Additional Voluntary Contributions (FSAVC) providers.

3 Operating segments

The NHS TDA's activities are considered to fall within 2 operating segments: the management and administration of the Authority and the funding of programme activities.

	Administration		Programme		Total	
	2014-15 £000	2013-14 £000	**2014-15 £000**	2013-14 £000	**2014-15 £000**	2013-14 £000
Revenue	**(760)**	(212)	**(193)**	(1,532)	**(953)**	(1,744)
Expenditure	**30,230**	22,241	**35,732**	19,262	**65,962**	41,503
Net Operating Costs	**29,470**	22,029	**35,539**	17,730	**65,009**	39,759
Assets	**953**	2,761	**3**	–	**956**	2,761
Liabilities	**(3,001)**	(2,966)	**(5,846)**	(11,348)	**(8,847)**	(14,314)
Net assets/(liabilities)	**(2,048)**	(205)	**(5,843)**	(11,348)	**(7,891)**	(11,553)

Administration

The financial objectives of the NHS TDA is to manage the recurrent costs of management and administration within the allocation of £29,628,000 this funding covers staff, accommodation and other running costs.

Programme

The NHS TDA received an allocation of £35,588,000 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.

4 Revenue

	2014-15 £000	2013-14 £000
Administration revenue		
Other fees and charges	**350**	–
Other miscellaneous revenue	**10**	50
Rental revenue recovery	**92**	162
Revenue in respect of seconded staff	**308**	–
Total administration revenue	**760**	212
Programme revenue		
Other miscellaneous revenue	**–**	49
Revenue from NHS England to fund the Productivity Programme	**–**	1,483
Revenue in respect of seconded staff	**193**	–
Total programme revenue	**193**	1,532
Total revenue	**953**	1,744

5 Operating expenses

	Note	2014-15 £000	2013-14 £000
Administration costs			
Auditors' remuneration		50	50
Business travel		1,146	978
Consultancy		36	–
Establishment expenses		950	940
External contract staffing		365	520
Information and communications		812	841
Miscellaneous expenditure		242	139
Non-executive members' remuneration		105	104
Premises		1,932	1,523
Professional fees		337	109
Non-cash items			
Depreciation	8.1	119	2
Amortisation	8.2	31	28
Sub-total		**6,125**	5,234
Programme costs			
Business travel		–	38
Consultancy		131	1,562
Establishment expenses		–	2,406
External contract staffing		26	585
Information and communications		146	–
Miscellaneous expenditure		406	224
Professional fees		2,963	1,843
Funding provided to NHS trusts and partners:			
Dissolution legacy of South London Healthcare NHS Trust		13,145	–
Intervention and support to NHS trusts		6,731	–
Project support to NHS trusts		–	400
Reimbursement of vendor costs in respect of trust transactions		9,039	10,504
Special measures		3,070	871
Sub-total		**35,657**	18,433
Total		**41,782**	23,667

Within the 2014-15 Programme professional fees £1,890,000 relates to the NHS TDA's cost of the tri-partite arrangement with NHS England and Monitor to support challenged local health authorities with their financial planning process.

6 Operating leases

	2014-15 £000	2013-14 £000
Payments recognised as an expense		
Minimum lease payments	45	54
Total	**45**	54
Payable		
No later than one year	15	23
Between one and five years	–	2
After five years	–	–
Total	**15**	25

Included in the Administration Premises expenditure in note 5 is £1,335,000 of costs paid to NHS Property Services for the occupation of 7 sites, and £316,000 to the Department of Health for the occupation of 2 sites (2013-14 £1,423,000 and £73,000 for one site, respectively). They are operated under a memorandum of understanding.

7 Employee benefits and staff numbers

7.1 Employee benefits

	2014-15			2013-14
	Total	Permanently employed	Other	Total
	£000	£000	£000	£000
Gross expenditure				
Salaries and wages	19,597	16,740	2,857	14,673
Social security costs	1,961	1,834	127	1,398
Employer contributions to NHS BSA – Pensions Division	2,364	2,213	151	1,765
Termination benefits	258	258	–	–
Total gross expenditure	**24,180**	**21,045**	**3,135**	17,836
Administration expenditure				
Salaries and wages	19,360	16,562	2,798	13,993
Social security costs	1,939	1,812	127	1,325
Employer contributions to NHS BSA – Pensions Division	2,339	2,188	151	1,689
Termination benefits	467	467	–	–
Total administration expenditure	**24,105**	**21,029**	**3,076**	17,007
Programme expenditure				
Salaries and wages	237	178	59	680
Social security costs	22	22	–	73
Employer contributions to NHS BSA – Pensions Division	25	25	–	76
Termination benefits	(209)	(209)	–	–
Total programme	**75**	**16**	**59**	829

Termination benefits include the release of an unutilised redundancy accrual.

7.2 Staff numbers

	2014-15			2013-14
	Total	Permanently employed	Other	Total
Staff Number	**284**	**256**	**28**	203
Administration staff	283	255	28	197
Programme staff	1	1	–	6

7.3 Ill health retirements

There were no retirements in the year on the grounds of ill health (2013-14 NIL).
There were no additional pensions liabilities accrued in the year (2013-14 NIL).

7.4 Exit Packages agreed

	2014-15	2013-14
Exit package cost band		
£50,000 – £100,000	1	–
> £200,000	1	–
Total number of exit packages by type	2	–
Total resource cost (£000)	**524**	–

Exit costs in this note are accounted for in full in the year of departure.

7.5 Severance payments

There have been no severance payments in 2014-15 and 2013-14.

8 Non-current assets

8.1 Property, plant and equipment

2014-15	Information technology £000	Furniture and fittings £000	Total £000
Cost or valuation			
At 1 April 2014	340	14	**354**
Additions purchased	147	160	**307**
Disposals	–	–	**–**
At 31 March 2015	**487**	**174**	**661**
Depreciation			
At 1 April 2014	–	2	**2**
Charged during the year	116	3	**119**
Disposals	–	–	**–**
At 31 March 2015	**116**	**5**	**121**
Net book value at 31 March 2014	340	12	**352**
Net book value at 31 March 2015	**371**	**169**	**540**

2013-14	Information technology £000	Furniture and fittings £000	Total £000
Cost or valuation			
At 1 April 2013	–	–	**–**
Additions purchased	340	14	**354**
Disposals	–	–	**–**
At 31 March 2014	**340**	**14**	**354**
Depreciation			
At 1 April 2013	–	–	**–**
Charged during the year	–	2	**2**
Disposals	–	–	**–**
At 31 March 2014	**–**	**2**	**2**
Net book value at 31 March 2013	–	–	**–**
Net book value at 31 March 2014	**340**	**12**	**352**

The information technology assets were not depreciated in 2013-14 due to coming into use in March 2014.

8.2 Intangible assets

2014-15	Software purchased £000	Licences & trademarks £000	Development expenditure £000	Total £000
Cost or valuation				
At 1 April 2014	–	16	77	**93**
Additions purchased	10	–	–	**10**
Disposals	–	–	–	**–**
At 31 March 2015	**10**	**16**	**77**	**103**
Amortisation				
At 1 April 2014	–	3	25	**28**
Charged during the year	–	5	26	**31**
Disposals	–	–	–	**–**
At 31 March 2015	**–**	**8**	**51**	**59**
Net book value at 31 March 2014	**–**	13	**52**	**65**
Net book value at 31 March 2015	**10**	**8**	**26**	**44**

The software purchased was not amortised in the year due to coming into use in March 2015.

2013-14	Licences & trademarks £000	Development expenditure £000	Total £000
Cost or valuation			
At 1 April 2013	–	68	**68**
Additions purchased	16	9	**25**
Disposals	–	–	**–**
At 31 March 2014	**16**	**77**	**93**
Amortisation			
At 1 April 2014	–	–	**–**
Charged during the year	3	25	**28**
Disposals	–	–	**–**
At 31 March 2014	**3**	**25**	**28**
Net book value at 31 March 2013	**–**	**68**	**68**
Net book value at 31 March 2014	**13**	**52**	**65**

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

Licences & trademarks and development expenditure are bespoke assets. Software purchased relates to commercially available products.

There is no revaluation reserve balance for intangible non-current assets.

8.3 Profit (loss) on disposal of fixed assets

The NHS TDA did not make any disposals of non-current assets during the period up to 31 March 2015 (2013-14 NIL).

9 Trade receivables

9.1 Trade receivables and amounts falling due within one year

	31 March 2015 £000	31 March 2014 £000
NHS receivables	94	544
NHS prepayments and accrued revenue	35	30
Non-NHS receivables	1	-
Non-NHS prepayments and accrued revenue	11	13
VAT	88	85
Other receivables	35	34
Trade and other receivables	**264**	706

9.2 Trade receivables – intra government and other balances

	31 March 2015 £000	31 March 2014 £000
Balances with other central government bodies	88	85
Balances with NHS bodies	28	23
Balances with NHS Trusts and Foundation Trusts	101	521
Balances with bodies external to government	47	77
Trade and other receivables	**264**	706

10 Cash and cash equivalents

	31 March 2015 £000	31 March 2014 £000
Opening balance	1,638	1,529
Net change in year	(1,530)	109
Closing balance	**108**	1,638
Made up of		
Cash with Government Banking Service	108	1,638
Commercial banks and cash in hand	–	–
Current investments	–	–
Cash and cash equivalents as in Statement of Financial Position	**108**	1,638

11 Trade payables

11.1 Trade payables and other current liabilities falling due within one year

	31 March 2015 £000	31 March 2014 £000
NHS payables	3,062	11,141
NHS accruals and deferred revenue	3,021	670
Non-NHS payables	332	611
Non-NHS accruals and deferred revenue	1,936	1,762
Pension payables	406	–
Trade and other payables	**8,757**	**14,184**

11.2 Payables – intra-government balances

	31 March 2015 £000	31 March 2014 £000
Balances with other central government bodies	406	–
Balances with NHS bodies	790	653
Balances with NHS Trusts and Foundation Trusts	5,293	11,158
Balances with bodies external to government	2,268	2,373
Trade and other payables	**8,757**	**14,184**

12 Provisions

	2014-15 £000	2013-14 £000
Balance at 1 April 2014	130	135
Arising during the year	90	130
Utilised during the year	(70)	(107)
Reversed unused	(60)	(28)
Balance at 31 March 2015	**90**	**130**
Expected timing of cash flows:		
No later than one year	90	130
Later than one year and not later than five years	–	–
Later than five years	–	–

A provision arose during 2014-15 in relation to performance related pay of very senior managers. The 2013-14 provision for very senior managers performance related pay was utilised and the provision for very senior manager pay review was reversed unused.

13 Commitments

The authority has entered into a contract relating to the provision of accounting services commencing on 28 January 2013 for a period of 4 years with a break clause at 27 January 2016. The annual cost of the contract is £30,000.

The authority entered into a contract relating to the provision of human resource services commencing on 1 April 2013 on a rolling basis with a termination notice period of 6 months. The total cost of the contract for the year was £59,847 (2013-14 £53,363).

14 Financial instruments

14.1 Financial risk management

Financial reporting standard IFRS 7 requires disclosure of the role that financial instruments have had during the period in creating or changing the risks a body faces in undertaking its activities. Because of the continuing relationship that the NHS TDA has with the Department of Health and the way in which it is financed, the NHS TDA is not exposed to the degree of financial risk faced by business entities. Also financial instruments play a much more limited role in creating or changing risk than would be typical of listed companies, to which the financial reporting standards mainly apply. The NHS TDA has limited powers to borrow or invest surplus funds and financial assets and liabilities are generated by day-to-day operational activities rather than being held to change the risks facing the NHS TDA in undertaking its activities.

The NHS TDA treasury management operations are carried out by the finance department, within parameters defined formally within the NHS TDA's standing financial instructions and policies agreed by the board of directors. NHS TDA treasury activity is subject to review by the NHS TDA's internal auditors.

Currency risk

The Authority is principally a domestic organisation with the great majority of transactions, assets and liabilities being in the UK and sterling based. The Authority has no overseas operations. The Authority therefore has low exposure to currency rate fluctuations.

Interest rate risk

All of the Authority's financial assets and financial liabilities carry nil or fixed rates of interest. The Authority is not, therefore, exposed to significant interest-rate risk.

Credit risk

Because the majority of the Authority's revenue comes from funds voted by Parliament and from other NHS bodies the Authority has low exposure to credit risk. The maximum exposures as at 31 March 2015 are in receivables from customers, as disclosed in the trade and other receivables.

Liquidity risk

The Authority's net operating costs are financed from resources voted annually by Parliament. The Authority largely finances its capital expenditure from funds made available from Government under an agreed capital resource limit. The Authority is not, therefore, exposed to significant liquidity risks.

14.2 Financial assets

	2014-15 Loans and receivables £000	2013-14 Loans and receivables £000
Trade and other receivables	95	544
Other receivables	123	119
Cash at bank and in hand	108	1,638
Total at 31 March 2015	**326**	2,301

14.3 Financial liabilities

	2014-15 Other £000	2013-14 Other £000
Trade and other payables	8,757	14,184
Total at 31 March 2015	**8,757**	14,184

15 Contingencies

At 31 March 2015 there were no known contingent assets or liabilities (31 March 2014: NIL).

16 Legacy balance transfer in 2013-14

This note is only applicable to 2013-14; there was no legacy balance transfer in 2014-15.

In accordance with the Health and Social Care Act 2012, Strategic Health Authorities and Primary Care Trusts were dissolved on 1 April 2013 and their assets and liabilities transferred to successor bodies in the NHS or to other entities. Under the terms of the Property Transfer Scheme and supporting Schedules, a number of assets and liabilities were transferred to the NHS TDA from the following Strategic Health Authorities (SHA) on that date.

		Receivables 2013-14 £000	Payables 2013-14 £000
North East SHA		3	–
North West SHA		36	13
East Midlands SHA		–	1,618
West Midlands SHA		–	7
South West SHA		12	17
London SHA		275	668
		326	**2,323**
Net transfers from other bodies within the group under modified absorbtion accounting	**SOCTE**		**(1,997)**

These assets and liabilities are associated with the transfer of functions from the SHA to the NHS TDA. The scope of the NHS TDA's activities are discussed in the Strategic Report.

16.1 Legacy balance working capital movement

		2013-14 £000
Legacy receivables		
Opening balance		–
Transferred in during year		326
Sub total		326
Non-cash adjustment for non-recoverable balances transferred		(42)
Adjusted trade and other receivables		284
Closing receivables		–
Cash received by Department of Health on behalf of NHS TDA in respect of balances transferred		284
(Increase)/decrease in Trade and other receivables		–

		2013-14 £000
Legacy payables		
Opening balance		–
Transferred in during year		2,323
Sub total		2,323
Non-cash adjustment for unaccrued payables		250
Adjusted trade and other payables for working capital movement		2,573
Closing payables		–
Cash paid by Department of Health on behalf of NHS TDA in respect of legacy balances transferred		(2,573)
Increase / (decrease) in Trade and other payables		–
Net non-cash adjustments	**SOCF**	**292**
Net parliamentary funding – legacy items paid by Department of Health	**SOCTE**	**(2,289)**

17 Events after the reporting period

The Department of Health has announced that the NHS TDA and Monitor will move to a single leadership with one Chief Executive Officer to lead both organisations. It is the intention that this appointment will be made by the end of the summer 2015.

This change will mean that all NHS providers, whether they are Trusts or FTs, will be under the oversight of one Chief Executive, overseeing teams at both the NHS TDA and Monitor. However, there are currently no plans to merge the 2 organisations and the NHS TDA will continue to have the same functions and responsibilities.

Throughout this next period, the support and development that we provide will not change and our focus remains on maintaining and improving patient care.

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

18 Related parties

The NHS TDA is a body corporate established by order of the Secretary of State for Health.

The Department of Health (DH) is regarded as a related party. During the year the NHS TDA had a number of material transactions with the Department and other entities for which the Department is regarded as the parent department including NHS England, NHS Trusts and NHS Foundation Trusts.

In addition the NHS TDA has had a number of material transactions with other government departments and other central government bodies, these transactions are as follows:

	Payments to related party £000	Receipts from related party £000	Amount owed to related party £000	Amounts due from related party £000
2014-15				
HM Revenue & Customs	1,834	–	–	88
National Health Service Pension Scheme	2,213	–	406	–
2013-14				
HM Revenue & Customs	1,325	–	–	85
National Health Service Pension Scheme	1,765	–	–	–

During the year no Department of Health Minister, Board member, key manager or other related parties has undertaken any material transactions with the NHS TDA (2013-14 NIL).

19 Resource limits

19.1 Revenue resource limit

	2014-15 £000	2013-14 £000
Net operating costs for the financial period	65,009	39,759
Revenue resource limit	65,216	40,116
Under/(over) spend against revenue resource limit	**207**	**357**

19.2 Capital resource limit

The NHS TDA is required to keep within its capital resource limit

	2014-15 £000	2013-14 £000
Charge against capital resource limit (gross capital expenditure)	317	379
Capital resource limit	500	400
Under/(over) spend against capital resource limit	**183**	**21**

19.3 Under/(over)spend against cash limit

	2014-15 £000	2013-14 £000
Total charge to cash limit	68,671	27,900
Cash limit	68,671	40,516
Under/(over) spend against cash limit	**–**	**12,616**

The revenue and capital resource and cash limit are all annual figures.

NHS

Trust Development Authority

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