NHS
Trust Development Authority

Annual Report and Accounts

For the period 1 April 2013 – 31 March 2014

tda Trust Development Authority
Quality. Delivery. Sustainability.

HC 447

NHS Trust Development Authority Annual Report and Accounts

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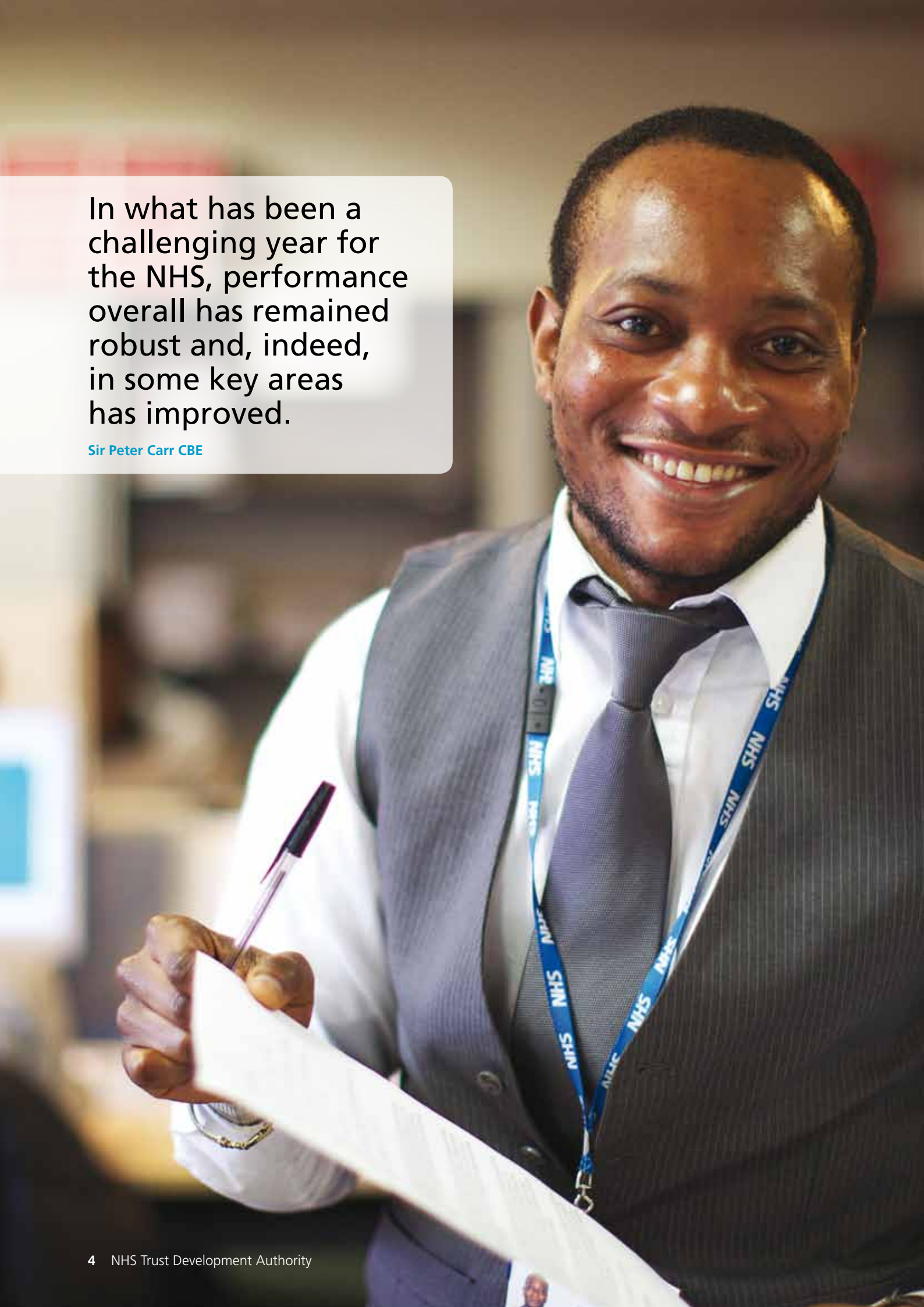


In what has been a challenging year for the NHS, performance overall has remained robust and, indeed, in some key areas has improved.

Sir Peter Carr CBE

Foreword from the Chairman

It gives me great pleasure to commend this publication; the NHS Trust Development Authority's Annual Report and Accounts for 2013/14 as an accurate reflection of the Authority's work and finances for the past year.

2013/14 was the NHS Trust Development Authority's (NHS TDA) first full year as a statutory body and I am hugely proud of what has been achieved. In a period of significant change across the NHS the principal role of the NHS TDA remains a simple one; we are here to support NHS trusts to deliver high quality, sustainable services for the communities they serve.

Over the past year our small cohort of around 200 staff have overseen the performance of all NHS trusts and have held them to account across all aspects of their business. Critical to our approach is the support we aim to offer the organisations for which we are accountable. We continue to focus on providing NHS trusts with the right support to improve services, develop their capability to cope with the challenges they face and ultimately achieve a sustainable organisational form.

Our role in supporting the NHS trust sector to be the best it can be has been recognised and 2014/15 will see us able to recruit extra staff to continue this good work. This is testament to the important work our staff have undertaken in 2013/14.

In what has been a challenging year for the NHS, performance overall has remained robust and, indeed, in some key areas has improved. This is down to the hard work of NHS staff across the country. It has been a privilege to work closely with so many skilled and dedicated professionals as we have developed closer relationships with all NHS trusts in 2013/14.

In the coming year the NHS TDA will broaden the framework of support it offers to NHS trusts, in light of the outcomes of the planning process which concludes in September 2014.

I look forward to continuing this work in 2014/15 as we continue to improve the NHS services available for patients.

Sir Peter Carr CBE
Chairman

Introduction from the Chief Executive

2013/14 was a very significant year for the NHS, with the most wide-ranging set of reforms the NHS has seen for more than a generation coming into place, and new healthcare bodies, both nationally and locally, being established.

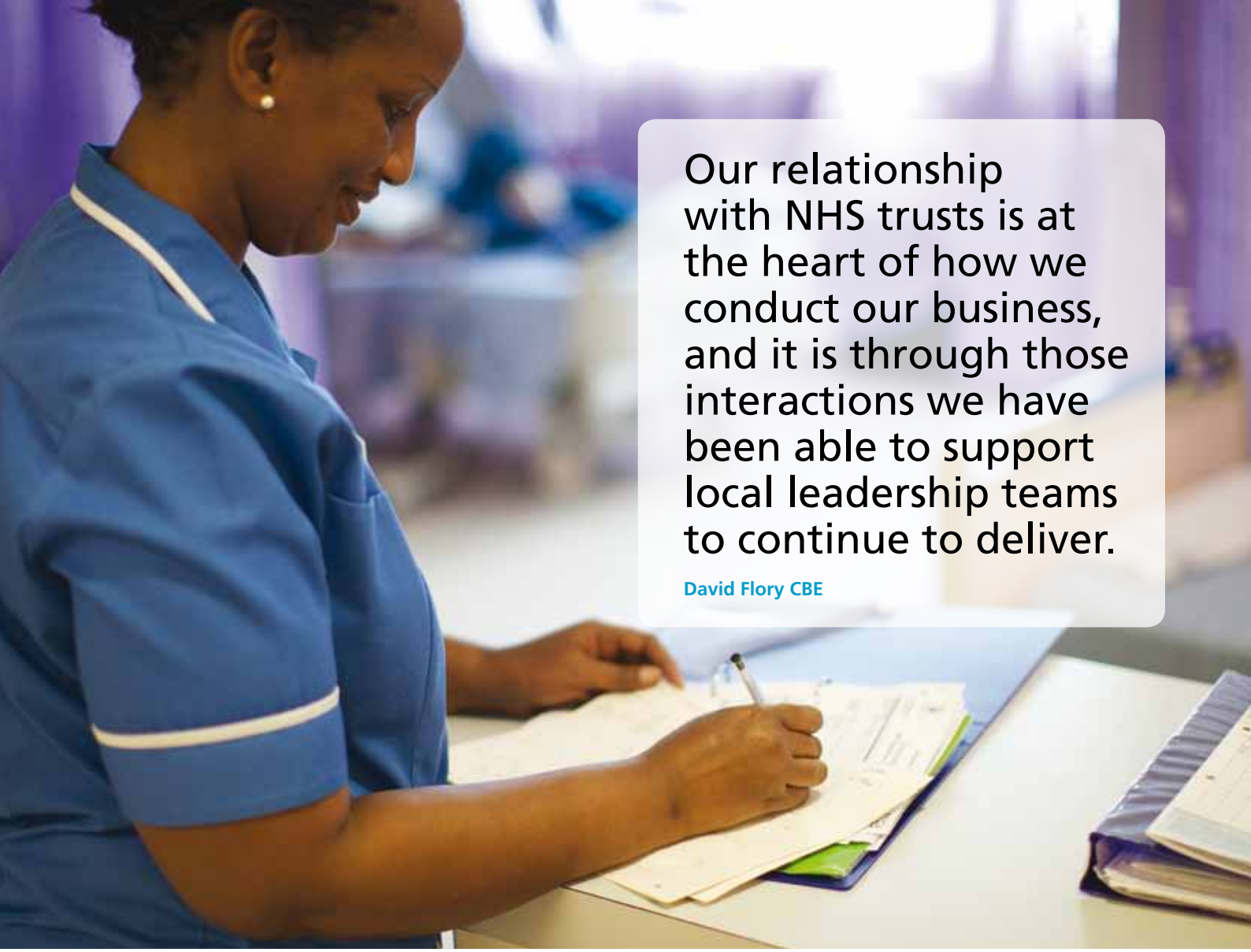
The structural changes to how the NHS is run have naturally provided challenges for local healthcare providers, as has the need to innovate around how healthcare is provided to ensure high quality care remains deliverable and sustainable in the future. Amidst this period of unprecedented change a great deal has been achieved.

The focus of the NHS TDA has, in its first year, been to establish close relationships with all NHS trusts and work with them to better understand the challenges they face and to help them work toward developing plans which will see them able to achieve the delivery of high quality and sustainable care.

There are rarely quick fixes to the challenges many NHS trusts face, and we recognise that leadership teams in NHS organisations, who need to give equal focus to delivering on the core standards set out in the NHS Constitution while at the same time developing plans with local partners for future sustainability, need support on both development and delivery: something the NHS TDA has strived to achieve in its first full year of operations.

Our relationship with NHS trusts is at the heart of how we conduct our business, and it is through those interactions we have been able to support local leadership teams to continue to deliver. Whether that has been working intensely with organisations such as those in transactions, i.e. pursuing with partners either a merger or acquisition; or in special measures, sharing best practice on key areas such as urgent and emergency care or patient experience.

We have also worked closely with our national partners, Monitor and the Care Quality Commission, to streamline the process for NHS trusts to achieve foundation trust (FT) status, creating a clearer definition of what success looks like and streamlining processes to support NHS trusts to achieve that aim. I am confident that after a pause largely linked to the impact of both the reforms and Sir Robert Francis's inquiry into Mid-Staffordshire NHS Foundation Trust, we will now start to see more NHS trusts passed onto Monitor for approval of FT status in the coming year.



> Our relationship with NHS trusts is at the heart of how we conduct our business, and it is through those interactions we have been able to support local leadership teams to continue to deliver.
>
> **David Flory CBE**

While the overall picture of service delivery across the trust sector remains resilient, many acute organisations experienced significant financial challenges that we explain in greater depth later in this report. Against the backdrop of a net aggregate deficit in the NHS trust sector of £241 million we must not be complacent as we recognise that the combination of planning towards delivering the Better Care Fund, the move towards seven day working and the focus on safer staffing will add new and substantial pressures on providers in the immediate future. We must all work to create the environment where these challenges can be addressed and patients can continue to access the services that are so vital for them and their families.

It is clear that, to meet those challenges, we are going to need to increase the amount of support provided to NHS trusts, and it is in that light that the Department of Health (DH) has agreed to significantly increase the funding available to the NHS TDA for the coming year.

With the systems and processes we have developed over 2013/14, and the talented, committed staff we have been able to attract to the NHS TDA, I am confident we can rise to the challenge in 2014/15 and beyond.

David Flory CBE
Chief Executive

Management commentary

The NHS TDA took on its full statutory duties from 1 April 2013.

The NHS TDA has a single 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.

With the introduction of the new Care Quality Commission (CQC) Chief Inspector of Hospitals process, the number of organisations moving through the FT assessment process slowed significantly during 2013 as the new inspection regime was implemented. This pause was necessary to ensure that the quality of care was truly embedded in the FT assessment process.

The NHS TDA worked closely with Monitor and CQC to streamline the process, building on the important lessons from the Mid-Staffordshire Public Inquiry about the need for close cooperation between regulators and the need for a consistent focus on the quality of care provided.

It is expected that in 2014/15 more organisations will begin to move through the process.

The new inspections regime is not the only change that has impacted on the work of the NHS TDA. The Keogh Mortality Review, initiated in February 2013, resulted in 11 NHS organisations being placed in special measures.

Rapidly improving care through the support packages introduced as part of special measures has been a key focus of the NHS TDA in 2013/14.

Five of these were NHS trusts and these were placed into special measures by the NHS TDA in July 2013. Since then the NHS TDA has placed a sixth NHS trust into special measures following concerns raised by the Chief Inspector of Hospitals. Rapidly improving care through the support packages introduced as part of special measures has been a key focus of the NHS TDA in 2013/14. Patients are already starting to see the benefits this is bringing about.

Excellent leadership is vital to ensuring NHS trusts continue to deliver high quality care and services to the communities they serve. The NHS TDA is responsible for the appointment of Chairs and Non-executive Directors to NHS trust boards. In 2013/14 the NHS TDA contributed to strengthening the leadership of NHS trusts by appointing 36 Chairs and 201 Non-executive Directors and reinforcing their appraisal processes. The diversity of those holding these posts also improved; 37% are now women, 8% from the Black, Asian and Minority Ethnic communities and 5% disabled, up from 34%, 6% and 4% respectively at the same time last year.

The NHS TDA has also played an important role in putting various parts of the NHS on a more sustainable financial footing through acting as the vendor in a number of transactions. The first use of the Unsustainable Providers Regime saw the dissolution of South London Healthcare NHS Trust completed on 1 October 2013, on time and in line with the Secretary of State's recommendations. NHS Direct was dissolved on 1 April 2014 and the vast majority of its services transferred to new providers. Other important transactions have progressed significantly over the year and it is hoped a number will conclude in 2014/15.

The completed transactions mean that there are now 98 NHS trusts overseen by the NHS TDA. 2014/15 will be a significant year in determining the future of many of these organisations. In December 2013 the NHS TDA published *Securing Sustainability: Planning Guidance for NHS Trust Boards 2014/15*. This guidance sets out a framework to enable NHS trusts to look in more depth at how they plan to continue to deliver high quality services in a sustainable way, not just over the coming year but over the next five years.

There are now 98 NHS trusts overseen by the NHS TDA. 2014/15 will be a significant year in determining the future of many of these organisations.

For many NHS trusts it will be possible to produce a balanced five year plan and therefore proceed with an FT application. A minority have already concluded that they are not sustainable in their current form and are therefore involved in a transaction process to ensure sustainability. For a third category of organisations, the five year planning process set out in December 2013 needs to be used as a platform to engage with commissioners on the nature of changes that are needed to secure sustainability for these organisations. It is through these conversations that they will determine a sustainable plan for the future.

In the meantime the NHS TDA has continued to focus on the day-to-day role of supporting NHS trusts to deliver consistently high quality care for patients. As well as being engaged in continuous dialogue with local NHS TDA teams, trusts have been invited to national summits on specific areas such as accident and emergency, elective waiting lists and patient experience. These summits bring together some of the best performing organisations with those who experience some of the biggest challenges with the aim of sharing what works well. This is one example of the in depth support offered by the NHS TDA.

On 31 March 2014 a refreshed NHS TDA Accountability Framework was published, setting out the detail of this support as well as the model for approving FT applications and transactions. This framework outlines how the NHS TDA will work alongside trusts to support the delivery of high quality, sustainable services for patients in the year ahead. The *2014/15 Accountability Framework for NHS Trust Boards* can be found at **www.ntda.nhs.uk**

Directors' report

Our people – The Board

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

Chair
Sir Peter Carr CBE

Chief Executive[3]
David Flory CBE

Interim Director of Special Measures
Yasmin Chaudhry

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

Director of Finance[3]
Robert Alexander

Director of Communications
Robert Checketts

Non-executive Director[2]
Sarah Harkness

Director of Nursing[3]
Peter Blythin

Director of Strategy
Ralph Coulbeck

Non-executive Director
Crispin Simon

Medical Director[3]
Dr Kathy McLean

Director of Delivery and Development: South
Dr Stephen Dunn

Non-executive Director
Caroline Thomson

Director of Delivery and Development: Midlands and East
Dale Bywater

Director of Delivery and Development: North
Lyn Simpson

Director of Delivery and Development: London
Alwen Williams CBE

In May, 2013, two new non-executive directors, Crispin Simon and Caroline Thomson, were appointed to the NHS TDA's Board. Following the publication of the Keogh report, and the introduction of the Chief Inspector of Hospital's inspection regime, Yasmin Chaudhry was appointed to the newly created post of 'Interim Director of Special Measures'. Lyn Simpson was appointed to fill the role vacated by Yasmin as Director of Delivery and Development for the North.

[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. In addition, staff members have completed declarations of interest and a cross-checking exercise has taken place to identify any potential conflicts of interest with NHS TDA suppliers. The register of interests is available upon request to the Board Secretariat.

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 2014 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

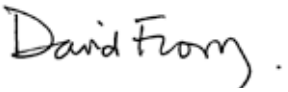
In the event of the NHS TDA charging for services provided the NHS TDA will pass on the full cost for providing the service, in line with HM Treasury guidance.

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.



David Flory CBE

Chief Executive
NHS Trust Development Authority

9 July 2014

Strategic report

The NHS TDA was established as a Special Health Authority on 1 June 2012. It took up specific responsibilities from the Appointments Commission in October 2012 ahead of taking up its full statutory duties on 1 April 2013.

Following publication of the findings of the Harris Review, which included governance arrangements and assurance for bodies having sufficient capacity and capability to undertake new functions, the NHS TDA was able to assure the Department of Health that it was ready to receive the statutory functions conferred on it by the Health and Social Care Act 2012 from 1 April 2013.

Our role remains simple: to oversee NHS trusts and hold them to account across all aspects of their business, while providing them with support to improve services and ultimately achieve a sustainable organisational form.

The powers and functions conferred on the NHS TDA by the Secretary of State for Health are set out in the *National Health Service TDA Directions 2013*. This section provides a brief summary as to how the NHS TDA has worked in exercising its powers and fulfilling its role in the health and care system.

- Providing a range of support for NHS trusts on quality improvement, including on reducing mortality rates, reducing infection rates, improving patient experience, ensuring safe staffing levels and preparing for inspection by the Chief Inspector of Hospitals.
- Supporting improvements in patient access by supporting and holding to account NHS trusts for meeting standards on elective access, emergency access, access to cancer services and ambulance response times.
- Supporting NHS trusts on managing financial performance, improving productivity and effective capital investment.
- Providing assurance and challenge to NHS trusts regarding the writing and delivery of their business plans throughout 2013/14.
- The publication of *Securing Sustainability: Planning Guidance for NHS Trust Boards 2014/15 to 2018/19*, which sets out priorities for trust boards in their long-term planning, and *Delivering for Patients: the 2014/15 Accountability Framework for NHS Trust Boards* which explains the way in which the NHS TDA will work with NHS trusts to support the delivery of high quality, sustainable services. These documents, and the NHS TDA approach, have been aligned with the standards set for NHS providers by the Care Quality Commission and Monitor as sector regulators.
- The appointment, or re-appointment, of 237 Chairs and Non-executive Directors to NHS trust boards.
- Completion of 79 appraisals for NHS trust Chairs.
- The approval of foundation trust applications by the NHS TDA Board from five NHS trusts, which have entered Monitor's assessment phase.
- The authorisation by Monitor of two new foundation trusts – Kingston Hospital NHS Foundation Trust and Western Sussex Hospitals NHS Foundation Trust.
- Managing the Trust Special Administration process for South London Healthcare NHS Trust, the subsequent dissolution of the Trust and the associated transactions.
- Managing the dissolution of NHS Direct.
- Working with a number of NHS trusts to take forward organisational transactions in order to support their long-term sustainability.

Our people – staff

Employee policies

The NHS TDA has a suite of employment policies that were developed for new staff upon NHS TDA set up. These were agreed with the Trade Union and recognised by the NHS TDA.

During the first year the NHS TDA 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 22 employment policies. This programme concluded in May 2014.

Whilst we have successfully harmonised 22 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 equal opportunities for all staff. Our aim, communicated through our equal opportunities policy, is 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.

Social, community and human rights

The NHS TDA kept all members of staff informed about organisational, management and policy issues through regular staff briefings and other internal communications.

The following table shows a gender breakdown of NHS TDA staff:

Staff Category	Female	Male
Directors	3	7
Other VSMs	17	10
Other Staff	116	64
Total	**136**	**81**

Health and safety

The NHS TDA has a Health and Safety policy for the organisation and individual evacuation plans for each of its eight 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. The NHS TDA has invested in a training programme for staff and has fully qualified first aiders and fire wardens on each site. Health and safety and fire training was also included in the mandatory staff training package. There were six reports in the 2013/14 incident log, two in London, one in Taunton, one in Leeds and two outside NHS TDA premises. In two cases first responders were called and the staff member taken to hospital, three were resolved by staff first aiders on site and one reported to NHS Property Services to take mitigating action on the physical estate.

Sickness and absence

The absence rate for the year 1 April 2013 to 31 March 2014 is 4.72%. It should be noted however that a small number of long-term sickness issues account for more than half of the absence and if these were excluded the absence rate would be below 2%. This compares with a figure of 2.7% for the period between 31 October 2012 and 31 March 2013.

Staff survey

In the staff survey, staff were particularly positive about their understanding of the objectives of the organisation and their team and how their own objectives related to these. There were also demonstrably good relationships between line managers and their staff with staff feeling supported by their line managers.

Off-payroll engagements

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 as of 31 March 2014, for more than £220 per day and that last longer than six months:

	Number
Number of existing engagements as of 31 March 2014	9
Of which, the number that have existed:	
for less than one year at the time of reporting	8
for between 1 and 2 years at the time of reporting	1
for between 2 and 3 years at the time of reporting	–
for between 3 and 4 years at the time of reporting	–
for 4 or more years at the time of reporting	–

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 six months in duration between 1 April 2013 and 31 March 2014, that are more than £220 per day and last longer than six months:

	Number
Number of new engagements between 1 April 2013 and 31 March 2014	14
Number of new engagements which include contractual clauses giving the TDA the right to request assurance in relation to income tax and National Insurance obligations (three are through an agency and not engaging direct)	11
Number for whom assurance has been requested	11
Of which:	
assurance has been received	8
assurance has not been received	3
engagements terminated as a result of assurance not being received, or ended before assurance received	–

There are no off payroll engagements of board members or senior officials with significant financial responsibility between 1 April 2013 and 31 March 2014.

Our business model – matrix working

The NHS TDA is structured in such a way as to provide comprehensive, coherent and consistent support and challenge to NHS trusts. Relationships with NHS trusts are led by Directors of Delivery and Development and their teams, who draw on the skills and expertise of professional staff from across the organisation. Delivery and Development teams are co-located and work closely with colleagues from the Clinical Quality and Finance directorates.

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.

Disclosure of serious untoward incidents

As part of the NHS TDA 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. In response to the theft of several mobile devices, the NHS TDA has purchased additional security from its suppliers to remotely wipe and track individual devices.

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), NHS England, 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 patients concerns are addressed.

Complaints against the NHS TDA itself are handled in accordance with its Complaints Policy and Procedure.

Environment

The NHS TDA is committed to using its resources efficiently, economically and effectively, avoiding waste and reducing CO^2 emissions. It has implemented several new policies and invested in technology in 2013-14 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;
- reduce the use of paper and print by harnessing wireless and mobile technology, including tablets, to move towards a paperlite environment recycling of waste material on all sites; and
- encourage new forms of collaboration, including webinars, videoconferencing and social media that reduce the need for physical meetings and travel.

The NHS TDA has adhered to Government targets to reduce the level of office space it uses per staff member, it is part of the arm's length bodies (ALB) contract on decommissioning equipment so that it can be wiped and re-used and it uses the Department of Health Procurement Centre of Excellence which ensures environmental issues are considered as part of major contracts.

Operational performance of the NHS trust sector

As outlined on page 12 the NHS TDA role is to oversee NHS trusts and hold them to account across all aspects of their business, while providing them with support to improve services and ultimately achieve a sustainable organisational form.

The dramatic changes that have taken place in the NHS when combined with the tighter fiscal environment means that the challenge of maintaining national standards is harder than at any other point in recent history.

The sector as a whole has however performed well against the national standards set out in the NHS Constitution, which describe how long patients should expect to wait for their care.

The following table provides a summary of performance against key national standards for 2013/14.

Summary of NHS trust sector performance against key national standards for 2013/14

Metric	Period	Standard	Performance
Referral to Treatment			
18 Weeks Admitted Pathways (%)	March 2014	90	87.47
18 Weeks Non Admitted Pathways (%)		95	95.83
18 Weeks Incomplete (%)		92	92.94
52 Week Waits (Number)		0	161
Diagnostics			
Number of diagnostic tests waiting longer than 6 weeks (%)	March 2014	1	1.80
Accident and Emergency			
All Types Performance (%)	2013/2014	95	95.05
Type 1 Performance (%)		95	92.72
Cancer			
Two week wait referral to date first seen	Quarter 4		
2 week GP referral to 1st outpatient – cancer (%)		93	94.40
2 week GP referral to 1st outpatient – breast symptoms (%)		93	93.20
31 day wait for second or subsequent treatment			
31 day wait from diagnosis to first treatment (%)		96	97.80
31 day second or subsequent treatment – surgery (%)		94	96.50
32 day second or subsequent treatment – drug (%)		98	99.60
33 day second or subsequent treatment – radiotherapy (%)		94	95.80
62 day wait for first treatment			
62 day urgent GP referral to treatment for all cancers (%)		85	83.60
63 day urgent GP referral to treatment from screening (%)		90	94.10

Metric	Period	Standard	Performance
Ambulance			
Category A call – emergency response within 8 minutes	2013/2014		
Red 1 calls (%)		75	75.10
Red 2 calls (%)		75	74.30
Category A call – ambulance vehicle arrives within 19 minutes (%)		95	95.80
Infection Control			
MRSA (b)	2013/2014	0	184.0
Clostridium difficile		1,970	2076.0
Eliminating Mixed Sex Accommodation			
Mixed Sex Accommodation	March 2014	0	1504.0
Mental Health			
Having formal review within 12 months / Proportion of users on new Care Programme Approach who have had HoNOS assessment in last 12 months	Quarter 4	90	90.20
Care Programme Approach patients for at least 12 months who had a CPA review in the last 12 months		90	88.67
Under 16 bed days on Adult wards		0	0.0
Proportion of patients on Care Programme Approach discharged from inpatient care followed up within 7 days		95	98.08
Proportion of admissions to inpatient services who had access to Crisis Resolution / Home Treatment Teams		95	98.82

The NHS TDA Accountability Framework describes how NHS trust performance is assessed and categorised as part of oversight. The following table provides a summary of the oversight and escalation scores awarded to NHS trusts at March 2014.

Oversight and escalation scores by NHS trust type at March 2014

Sector	1 No identified concerns	2 Emerging concerns	3 Concerns requiring investigation	4 Material issue	5 Formal action required	Total trusts
Acute	3	10	16	24	6	59
Ambulance	1	2	–	2	–	5
Community	7	10	2	–	–	19
Mental Health	4	6	2	3	–	15
NHS Direct	–	1	–	–	–	1
Total	**15**	**29**	**20**	**29**	**6**	**99**

The oversight and escalation scores are an assessment of organisational performance, financial performance and organisational governance. These are further defined within the Accountability Framework of the NHS TDA which can be found on the NHS TDA website.

NHS trust financial performance

Revenue performance

As predicted, 2013/14 has been a challenging financial year for the NHS trust sector. The impact of the newly-reformed commissioner landscape, the shift in focus brought about by the recommendations of the Francis, Keogh and Berwick reports and the results of a stricter interpretation of national contracting and business rules, have each had a significant impact on the financial position of the NHS trust sector.

In aggregate, the NHS trust sector delivered a net deficit of £241 million in 2013/14 (final accounts), compared to a planned net deficit of £76 million at the start of the financial year. This adverse variance of £165 million was largely attributable to five NHS trusts that had un-planned deficits during 2013/14.

There were 25 NHS trusts that recorded a deficit in 2013/14 and the combined value of gross deficits was £461 million. Whilst the total number of NHS trusts in deficit was in line with the original plan, the value of gross deficit increased. There were five NHS trusts that reported unplanned deficits in the year and five NHS trusts that improved their financial performance and delivered breakeven or surplus positions at the year end.

However, despite the unprecedented financial pressure faced by the NHS trust sector in 2013/14, there were 77 NHS trusts (75%) that demonstrated good financial control and delivered a breakeven or surplus result. The aggregate gross surplus of these 77 NHS trusts was £220 million reported per audited accounts.

At sub-sector level the Community, Mental Health and Ambulance NHS trusts delivered a solid financial performance. All 39 NHS trusts that planned a surplus or breakeven in 2013/14 achieved this with the gross level of surplus recorded being £3 million more than plan.

However, acute NHS trusts experienced significant levels of financial pressure. The table on page 19 clearly identifies the extent of financial challenge that these trusts faced during 2013/14 with 39% of acute NHS trusts in deficit at the year end. Some of this deterioration was attributable to the unplanned reduction in total operating income 2012/13 to 2013/14 plan, which was due to a combination of a net price deflator (annual inflationary uplift less a percentage reduction for efficiency), a reduction in education and training funding and a strict rules-based approach to commissioner contracting that resulted in a decrease in non-recurring income compared with previous years.

Many acute NHS trusts also experienced significant operational challenges during the year, predominantly caused by pressure in urgent and emergency care activity.

Financial performance of NHS trust sector for the year ending 31 March 2014 by type

	Final Accounts 2013/14			Number of trusts	Number of trusts forecasting a deficit	% of trust type
	Plan £m	**Actual** £m	**Variance** £m			
	*(brackets) denote deficit					
Acute	(142)	(310)	(168)	62	24	39%
Ambulance	10	6	(4)	5	–	–
Community	38	39	1	19	–	–
Mental Health	43	49	6	15	–	–
NHS Direct	(26)	(25)	1	1	1	100%
Total	**(76)**	**(241)**	**(164)**	**102**	**25**	**25%**

During the financial year Kingston Hospital NHS Trust and Western Sussex Hospitals NHS Trust became NHS Foundation Trusts. South London Healthcare NHS Trust was dissolved on 30 September 2013 which left 99 NHS trusts at 31 March 2014.

Whilst the aggregate forecast deficit for NHS trusts was less than 1% of operating revenue for the sector as a whole, the NHS TDA measures the financial performance of all NHS trusts against their individual plans for the 2013/14 financial year.

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 £1.377 billion of efficiency savings during 2013/14 whilst maintaining or improving service performance. This builds on the £2.794 billion of efficiency delivered by the NHS trust sector in the previous two years.

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 2013/14 the NHS TDA worked with NHS trusts and approved 15 full business cases totalling over £900 million and a further 22 strategic outline cases and outline business cases that were outside of the delegated authority of individual NHS trusts for onward review by the Department of Health and the Treasury where necessary.

In total NHS trusts spent £1.84 billion on capital projects in 2013/14 in a planned and managed way aimed at improving the quality of the infrastructure in the NHS trust sector.

Cash

Accessing appropriate and affordable 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 2013/14 the NHS TDA worked with all NHS trusts that were forecasting revenue deficits and supported them through the new process and, where necessary, 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 DH. All NHS trusts that required revenue cash support in 2013/14 received sufficient cash to pay staff and meet current liabilities.

During the financial year 2013/14, 20 NHS trusts accessed cash financing of £369 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 2013/14 have been prepared under International Financial Reporting Standards (IFRS) as adapted by the Financial Reporting Manual (FReM) and comprise 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 were to:

- manage revenue expenditure within a resource limit of £40.1 million
- manage capital expenditure within a resource limit of £0.4 million
- manage cash spend within a cash limit of £40.5 million
- meet the minimum performance requirements of the Better Payments 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 2013/14 were:

- to manage the recurrent costs of management and administration within an allocation of £22.2 million – this funding covers staff, accommodation and other running costs
- to manage an allocation of £17.9 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 2013/14 the Board Authority met its statutory duties and maintained expenditure within these targets.

As with all new arm's length bodies, the NHS TDA will be subject to a review of the continued need for it to remain in existence – this is likely to take place in 2016.

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 Payments 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 published on page 21.

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

2013/14 shows an improvement on 2012/13 when, due to the infrequent nature of transactions during the establishment of the NHS TDA, there was prioritisation to the controls over authorisation to spend which impacted on the performance against the BPPC.

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.

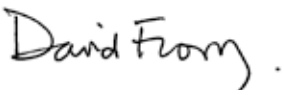
Principal risks and uncertainty

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.

Performance against Better Payment Practice Code targets

	2013-14 Number	2013-14 £000	2012-13 Number	2012-13 £000
Non-NHS payables				
Total non-NHS trade invoices paid in the year	1,491	8,038	123	377
Total non-NHS trade invoices paid within target	1,446	7,958	65	225
% of non-NHS trade invoices paid within target	**97%**	**99%**	53%	60%
NHS payables				
Total NHS trade invoices paid in the year	162	5,932	4	54
Total NHS trade invoices paid within target	157	5,895	3	36
% of NHS trade invoices paid within target	**97%**	**99%**	75%	67%



David Flory CBE

Chief Executive
NHS Trust Development Authority

9 July 2014

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 Department of Health (DH). The pay rates are in line with the Very Senior Manager (VSM) pay framework for ALBs and are subject to 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 four 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 met three times during the period 1 April 2013 and 31 March 2014.

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 DH instructions.

The 2013/14 individual's performance related payments are to be awarded during 2014/15. An assessment of £130,000 based on a percentage of 'base pay' has been included in the overall pay provisions reported in note 14 of the 2013/14 accounts.

Appointments

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

The Chief Executive and other VSMs are appointed under standard NHS VSM contracts of employment in accordance with national NHS terms and conditions. All contracts are either fixed term or permanent with a notice period up to six months.

The Director of Strategy is seconded from DH and has a DH contract of employment.

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 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 2013/14 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 2013/14					
Name and position	Salary (bands of £5,000)	Benefits in Kind (to nearest £100)	Total (bands of £5000)	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 Sept 2012	25 Sept 2016
Sarah Harkness Non-executive Director	10–15	–	10–15	26 Sept 2012	25 Sept 2016
Crispin Simon Non-executive Director	5–10	–	5–10	13 Sept 2013	12 May 2017
Caroline Thomson Non-executive Director	5–10	–	5–10	13 Sept 2013	12 May 2017
The information above has been subject to audit					

For the period 1 June 2012 – 31 March 2013					
Name and position	Salary (bands of £5,000)	Benefits in Kind (to nearest £100)	Total (bands of £5000)	Date of appointment	Appointment ends
	£000	£00	£000		
Sir Peter Carr CBE[1] Chair	45–50	–	45–50	1 June 2012	31 May 2016
Dame Christine Beasley[2] Non-executive Director	5–10	–	5–10	26 Sept 2012	25 Sept 2016
Sarah Harkness[3] Non-executive Director	5–10	–	5–10	26 Sept 2012	25 Sept 2016
The information above has been subject to audit					

[1] The salary for Sir Peter Carr CBE is for the period 1 June 2012 to 31 March 2013. His annualised salary for a full year is £50,000–55,000.

[2] The salary for Dame Christine Beasley is for the period 26 October 2012 to 31 March 2013. Her annualised salary for a full year is £10,000–15,000.

[3] The salary for Sarah Harkness is for the period 26 October 2012 to 31 March 2013. Her annualised salary for a full year is £10,000–15,000.

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 2013/14							
Name and position	Salary (bands of £5,000)	2012/13 Back pay entitlement (bands of £5000)[1]	Benefits in kind (to nearest £100)	All Pension-related Benefits	Total (bands of £5000)	Contract Commencement Date	Notice Period (months)
	£000	£000	£00	£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[2] Director of Strategy *(on secondment from the Department of Health)*	85–90	–	–	44	130–135	13 August 2012	3
Robert Checketts Director of Communications *(On secondment from Birmingham Children's Hospital NHS Foundation Trust 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[3] Director of Delivery and Development (North) *(Appointment commenced 14 October 2013)*	70–75	–	–	28	100–105	14 October 2013	6
Yasmin Chaudhry[4] 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 she transferred to the NHS TDA)*	85–90	–	–	–	85–90	1 July 2013	6
The information above has been subject to audit							

[1] 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.

[2] Figures disclosed in the above table for Ralph Coulbeck represent the recharge to the NHS TDA from the Department of Health.

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

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

For the period 1 June 2012 – 31 March 2013							
Name and position	Salary (bands of £5,000)	Other Remuneration (bands of £5000)	Benefits in Kind (to nearest £100)	All Pension-related Benefits	Total (bands of £5000)	Contract Commencement Date	Notice Period (months)
	£000	£000	£00	£000	£000		
David Flory CBE Chief Executive *(Role commenced from 1 June 2012. On secondment with proportionate 75% annual salary recharged to the NHS TDA)*	150–155	–	12	20	170–175	1 June 2012	3
Robert Alexander Director of Finance *(Role commenced from 1 October 2012. No salary was recharged to the NHS TDA)*	South East Coast Strategic Health Authority					1 October 2012	6
Dr Kathy McLean Medical Director *(Role commenced from 1 October 2012. No salary was recharged to the NHS TDA)*	East Midlands Strategic Health Authority					1 October 2012	6
Peter Blythin Director of Nursing *(Role commenced from 1 October 2012. No salary was recharged to the NHS TDA)*	West Midlands Strategic Health Authority					1 October 2012	6
Ralph Coulbeck Director of Strategy (DH Secondment) *(Role commenced from 13 August 2012. On secondment from the DH and salary has been recharged from 13 August 2012)*	65–70	–	–	–	65–70	13 August 2012	3
Robert Checketts Director of Communications *(Role commenced from 1 June 2012. On secondment from the Birmingham Childrens Hospital NHS Foundation Trust)*	65–70	–	–	–	65–70	1 June 2012	6
Dale Bywater Director of Delivery and Development (Midlands and East) *(Role commenced from 1 October 2012. No salary was recharged to the NHS TDA)*	East Midlands Strategic Health Authority					1 October 2012	6
Dr Stephen Dunn Director of Delivery and Development (South) *(Role commenced from 1 October 2012. No salary was recharged to the NHS TDA)*	East of England Strategic Health Authority					1 October 2012	6
Alwen Williams CBE Director of Delivery and Development (London) *(Role commenced from 1 October 2012. No salary was recharged to the NHS TDA)*	Tower Hamlets PCT					1 October 2012	6
Yasmin Chaudhry Interim Director of Special Measures *(Role commenced from 1 October 2012. No salary was recharged to the NHS TDA)*	County Durham PCT and Darlington					1 October 2012	6
The information above has been subject to audit							

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

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 2013/14 was £205,000–£210,000 (in the period June 2012 to March 2013 was £205,000–£210,000 (annualised for partial year remuneration of the director)). This was 3.7 times the median remuneration of the directly employed workforce which was £55,376. (2012/13 figure was 6 times with a median remuneration of £34,003).

In 2013/14 no employees received remuneration in excess of the highest paid Director. (2012-13 nil)

Total remuneration includes salary, non-consolidated performance-related pay, benefits-in-kind and 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 decreased from the previous year due to NHS TDA being fully operational in 2013-14 and recruiting staff into the establishment. This has resulted in a wider spread of salaries across the NHS TDA's workforce that increased the median remuneration. Consequently the pay multiple reduced from 6.0 in 2012-13 to 3.7 in 2013-14.

The pay multiples information above is subject to audit.

Pension benefits

The Chief Executive and senior managers are members of the NHS pension scheme. Ralph Coulbeck is seconded from the DH and is a member of the Civil Service pension scheme.

The table on page 27 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.

Cash equivalent cash transfer

The method used to determine the value of a member's 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 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.

Exit packages and severance payments

The NHS TDA did not agree any compulsory or voluntary termination of employment during 2013-2014.

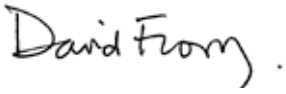
Pension benefits

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 2014 (bands of £5,000)	Lump sum at age 60 related to accrued pension at 31 March 2014 (bands of £5,000)	Cash Equivalent Transfer Value at 31 March 2013	Cash Equivalent Transfer Value at 31 March 2014	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	5.0–7.5	30–35	90–95	547	624	65	60
Robert Alexander Director of Finance	0–2.5	5.0–7.5	30–35	95–100	575	668	81	60
Dr Kathy McLean Medical Director	2.5–5.0	7.5–10.0	70–75	210–215	1,329	1,456	98	60
Peter Blythin Director of Nursing	2.5–5.0	12.5–15.0	75–80	225–230	1,570	1,712	108	60
Ralph Coulbeck Director of Strategy	0–2.5	–	15–20	–	93	114	22	None
Robert Checketts Director of Communications	0–2.5	5.0–7.5	15–20	50–55	207	250	39	60
Dale Bywater Director of Delivery and Development (Midlands and East)	2.5–5.0	7.5–10.0	30–35	100–105	440	505	55	60
Dr Stephen Dunn[1] Director of Delivery and Development (South)	5.0–7.5	–	45–50	–	379	452	65	65
Alwen Williams CBE Director of Delivery and Development (London)	5.0–7.5	15.0–17.5	65–70	200–205	1,254	1,431	149	60
Lyn Simpson Director of Delivery and Development (North)	0–2.5	0–2.5	60–65	185–190	1,189	1,286	32	60

The information above has been subject to audit

[1] As a member of the 2008 section of the NHS Pension Scheme, Stephen Dunn does not receive a lump sum payment.

* Yasmin Chaudhry does not contribute to the NHS Pension Scheme.



David Flory CBE

Chief Executive
NHS Trust Development Authority

9 July 2014

Annual Governance Statement 2013/14

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.

Context

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. Its main responsibilities are: 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 arm's length body, the NHS TDA works closely with its sponsor branch at the Department of Health as well as with its partner organisations, NHS England, the Care Quality Commission and Monitor.

Governance Framework of the organisation

Following the appointment of two further non-executive directors in May 2013, the NHS TDA Board now consists of a non-executive Chair, four non-executive directors, a Chief Executive and three executive directors. A further seven 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 four non-executive directors are each assigned to one of the regional Delivery and Development teams and have assumed certain responsibilities within their respective 'patches'. These include appraisal of chairs in NHS trusts and attendance at Board to Board meetings with NHS trusts.

The Board held eight meetings in public during 2013/14. Attendance at Board meetings is shown in the table on page 29.

The two non-executive directors appointed during 2013/14 undertook tailored induction programmes. These were supported by three development sessions for the whole Board which allowed members to discuss in detail key issues affecting the organisation.

The Board undertook a self-assessment exercise to review its performance during 2013/14. The results of the self-assessment were very positive. The Board was clear about its remit and confident that it was receiving appropriate assurance across all major aspects of the business. Consideration is being given as to how a small number of development needs identified in the exercise can be used to inform a Board development programme in 2014/15.

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.

In April 2013, the Board approved a suite of documents setting out the governance arrangements for the organisation. This included standing orders, standing financial instructions and a scheme of matters reserved to the Board and of those delegated to Committees. In September 2013, the standing orders were revised to incorporate changes to the terms of reference of the Board committees. In January 2014, a full review of the governance documents was undertaken and further minor changes made to the standing orders and standing financial instructions.

The NHS TDA has three statutory committees (audit, remuneration and appointments) and a further two non-statutory committees (financial and procurement controls and capital investment).

Public meetings: Board members attendance record								
Attendees	**Date of meeting**							
	4 Apr '13	**23 May '13**	**18 Jul '13**	**5 Sep '13**	**26 Sep '13**	**28 Nov '13**	**23 Jan '14**	**20 Mar '14**
Sir Peter Carr CBE Chair	✓	✓	✓	✓	✓	✓	✓	✓
Dame Christine Beasley Non-executive Director	✓	✓	✓	✓	✗	✓	✓	✓
Sarah Harkness Non-executive Director	✓	✓	✓	✓	✓	✓	✓	✓
Crispin Simon Non-executive Director	N/A	✓	✓	✓	✓	✓	✓	✓
Caroline Thomson Non-executive Director	N/A	✓	✓	✓	✓	✓	✓	✓
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	✗	✓	✗	✗	✗	✓	✓	✓
Dr Stephen Dunn Director of Delivery and Development	✗	✓	✓	✓	✓	✓	✓	✓
Lyn Simpson Director of Delivery and Development	N/A	N/A	N/A	N/A	N/A	✓	✓	✓
Alwen Williams CBE Director of Delivery and Development	✓	✓	✓	✓	✓	✓	✓	✓

Audit Committee

The Audit Committee provides the Board with independent and objective scrutiny and advice pertaining to the NHS TDA's financial systems and processes, financial obligations, risk management and compliance with relevant legislation. A key function of the audit committee has been to scrutinise the annual report and accounts prior to approval by the Board and sign-off by the Chief Executive.

The committee met four times during 2013/14; attendance at individual meetings is shown below.

Attendance at Audit Committee meetings

Committee Members	Date of meeting			
	18 Apr '13	9 Jul '13	24 Oct '13	14 Jan '14
Sarah Harkness Chair, Non-executive Director	✓	✓	✓	✓
Dame Christine Beasley Non-executive Director	✓	✓	N/A	N/A
Crispin Simon Non-executive Director	N/A	N/A	✗	✓
Caroline Thomson Non-executive Director	N/A	N/A	✓	✓

Committee membership consists of three non-executive directors. The Director of Finance and representatives from the internal and external auditors also attend every meeting of the Audit Committee. To support its function of scrutinising risk management arrangements, the committee has established a rolling programme of attendance by responsible directors to conduct in-depth discussion of individual risks.

The Audit Committee undertook a self-assessment exercise to ensure that it was meeting its duties and responsibilities. The results were very positive and no significant issues were identified. A small number of areas for development were identified and will be incorporated into the Audit Committee programme for 2014/15.

Remuneration Committee

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 Remuneration Committee met three times during 2013/14. 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 appropriate. 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 is comprised of the Chief Executive, the Director of Finance and the Director of Strategy. The Remuneration Committee receives a report at every meeting summarising decisions taken by the sub-committee.

Attendance at Remuneration Committee meetings			
Committee Members	**Date of meeting**		
	22 May '13	**5 Sep '13**	**22 Jan '14**
Sir Peter Carr CBE Chair	✓	✓	✗
Dame Christine Beasley Non-executive Director	✓	✓	✓
Sarah Harkness Non-executive Director	✓	✓	✓
Caroline Thomson Non-executive Director	N/A	✓	✓
Crispin Simon Non-executive Director	N/A	✗	✓

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 twice during 2013/14 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 four regions of the NHS TDA and each is chaired by the relevant Director of Delivery and Development.

Attendance at Appointments Committee meetings		
Committee Members	**Date of meeting**	
	21 Jun '13	**7 Jan '14**
Dame Christine Beasley Non-executive Director	✓	✓
Ralph Coulbeck Director of Strategy	✓	✓
Janice Scanlan Head of Appointments	✓	✓

Finance and Procurement Controls Committee

A Finance and Procurement Controls Committee (FPCC) was established to support the Board in the discharge of its responsibilities for financial and procurement efficiency control. The committee met six times during 2013/14.

Attendance at Finance and Procurement Controls Committee meetings						
Committee Members	**Date of meeting**					
	9 May '13	**28 Jun '13**	**18 Sep '13**	**13 Nov '13**	**11 Dec '13**	**26 Feb '14**
David Flory CBE Chief Executive	✗	✓	✓	✓	✓	✓
Robert Alexander Director of Finance	✓	✓	✓	✓	✓	✓
Sarah Harkness Non-executive Director	✓	✓	✓	✓	✓	✗
Ralph Coulbeck Director of Strategy	✗	✓	✓	✓	✗	✓

Capital Investment Group

The Capital Investment Group (CIG) is responsible for advising the Board on the discharge of its responsibilities concerning capital investments and approval of capital schemes in the NHS trust sector. The group met seven times during 2013/14.

Attendance at Capital Investment Group meetings

Group members	Date of meeting						
	28 Jun '13	18 Sep '13	16 Oct '13	13 Nov '13	11 Dec '13	15 Jan '14	12 Mar '14
David Flory CBE Chief Executive	✓	N/A	N/A	N/A	N/A	N/A	N/A
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	✓	✗	✗	✓	✓	✗	✓

The senior management team, comprising the Chief Executive and directors, has met 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, including the development of its approach to oversight, transaction approval and trust development.

Corporate Governance

An assessment of the NHS TDA compliance with the UK Corporate Governance Code was undertaken and found that the organisation was compliant with all but two of the Code's provisions. The first is that the Code recommends that the remuneration committee is chaired by a non-executive director. Given the NHS TDA's wider responsibility for remuneration across the NHS trust community, it is more appropriate for the Chair of the NHS TDA to Chair the remuneration committee. The second is that, as the Chair's appraisal is undertaken by DH, the non-executive directors do not meet to discuss the Chair's performance. DH's internal auditors also conducted a review of the NHS TDA's governance arrangements and gave 'strong' assurance on its fitness for purpose.

Legacy Responsibilities

During the course of the year South London Healthcare NHS Trust was placed into the unsustainable providers' regime and the responsibility for discharging the Trust's duties was assumed by the Trust Special Administrator. The Trust was dissolved on 30 September 2013 by order of the Secretary of State and formal responsibility for the NHS Trust legacy then passed to the NHS TDA. Its accounts and statutory reports for the period 1 April 2013 to 30 September 2013 were prepared by the NHS Trust's legacy finance team and noted by the NHS TDA Audit Committee on 3 July 2014.

NHS Direct became financially unsustainable following the launch of the NHS 111 service, which replaced its core business, and was dissolved by order of the Secretary of State on 1 April 2014. Formal responsibility for Trust legacy, including the final report and accounts passed to the NHS TDA and the annual report and accounts for the period 1 April 2013 to 31 March 2014 were noted by the NHS TDA Audit Committee on 3 July 2014.

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 four 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 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.

2013/14 saw the publication of several important reports on the quality of care delivered to NHS patients. Their wide-ranging recommendations have had a major impact on all sectors of the NHS and have raised the bar for acceptable standards of care in NHS trusts. The main risk for the NHS TDA during this period has been the capacity of the organisation to respond to the increased demands in patient safety and experience which has led to a more focussed performance management function and more detailed scrutiny of clinical quality in individual trusts.

In light of these developments, the NHS TDA has secured additional resources from DH to address an expanded remit and steps are now underway to expand the organisation in key areas.

The risk posed by the combination of a tighter financial environment and rising patient expectations has meant that NHS trust boards need to have a sharper focus on the long-term if they are going to be able to ensure they can deliver sustainable, high quality services going forward. In December 2013, the NHS TDA published *Securing Sustainability – Planning Guidance for NHS Trust Boards 2014/15-2018/19* setting out what NHS boards should focus on to be able to continue to deliver high quality care today whilst taking the necessary action to ensure they can continue to do so in the future. The planning guidance included a requirement for trusts to meet the rights and pledges set out in the NHS Constitution. The NHS TDA will be seeking assurance that each trust has a robust plan in place to meet the core standards contained in the NHS Constitution, including timely access to services for all patients.

There is an increasing risk that the production of five year plans will reveal greater sustainability challenges for the NHS trust sector than previously identified that will require intensive action from the NHS TDA. A joint planning process has been established with key partners to stratify risk across all parts of the health system and consider what support can be offered to those communities deemed to be at high risk.

The *NHS TDA Accountability Framework for NHS Trusts* was first published in 2012 and has since been refreshed to take account of significant changes in the NHS environment. The Framework explains the NHS TDA oversight and escalation model, setting out how trusts are held to account and what kind of support they can expect from the NHS TDA. The model uses a risk-based approach to ensure that NHS TDA activities are targeted towards those NHS trusts that are most challenged.

The risk and control framework

Systems of management and financial control have been developed to minimise risk in the organisation. These have been reviewed by DH's internal audit function and have been rated 'strong' for the year 2013/14.

In March 2014 the internal auditors conducted a review of post-transition governance arrangements. The auditors reviewed the NHS TDA governance arrangements against best practice guides and particularly the HM Treasury and Cabinet Office joint publication *Corporate Governance in Central Government Departments: Code of Good Practice* ('the Guide'). The review involved a detailed desktop examination of governance documentation and interviews with key staff together with the outcomes of other audits conducted during 2013/14. The auditors found that the governance arrangements of the NHS TDA were fit for purpose and proportionate and had matured significantly since their last review in March 2013. The auditors' overall rating for the control environment was 'strong'. An internal audit was undertaken of the adequacy and effectiveness of key controls within the NHS TDA finance function,

including payroll and handling of accounts. The audit involved interviews with key stakeholders in the finance department, a walkthrough of the key processes to assess the design of the control environment and a review of key policies and procedures. The control environment and the operating effectiveness of these controls were found to be effective and efficient and the overall rating was 'strong'.

A risk management strategy has been developed which explains how risks are identified, managed and mitigated. A revised version of the document will be published during the course of 2014/15 to reflect current circumstances.

The strategic risk register is updated on a quarterly basis. The Audit Committee is responsible for oversight of the NHS TDA's risk management arrangements and detailed scrutiny of the strategic risk register. Risk management is a standing item at every Audit Committee meeting. The Board receives quarterly updates of the strategic risk register at formal Board meetings.

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.

Risks relating to individual NHS trusts, including risks to the quality of clinical care, are addressed through the NHS TDA's oversight and escalation processes, as set out in the Accountability Framework.

The Audit Committee agreed a programme of work to be undertaken by the internal auditors during 2013/14. The programme focussed on key areas of the business where, as a newly created organisation, systems and processes were still being developed. An area of weakness was identified in relation to business continuity. This has subsequently been addressed and a Business Continuity Plan was approved by the Executive team in June 2014. Other internal audits have concluded that work in relation to specific areas of the business is 'satisfactory' but that further development is needed to enable strong assurance to be given that strategic objectives will be met. We have agreed a set of recommendations with the internal auditors in relation to each of these areas and progress against delivery of those recommendations is monitored by the Audit Committee.

The Head of Internal Audit Opinion for 2013/14 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 audit work and the appropriate level of resource has been in place to enable the function to satisfactorily complete the work planned.

For the three areas on which I must report, I have concluded the following:

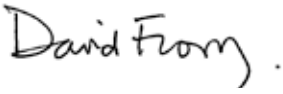
- In the case of risk management, we have worked with management in the year to embed the overall arrangements. This has entailed facilitating a risk management workshop in September 2013. The NHS TDA has identified the strategic risks to achieving its objectives, identified controls in operation to mitigate against these risks and the degree to which the organisation has received assurances that these issues are being controlled. We note arrangements are in place to report to the Board and Audit Committee on the arrangements in place for the ongoing monitoring and management of strategic risks. Whilst risk management is still being embedded throughout the NHS TDA there is a risk management framework and strategy in place to manage the key strategic risks to achieving its objectives.
- In the case of governance we conducted a review of governance arrangements within the NHS TDA during March 2013. On the basis of our work, we gave reasonable assurance overall that there is generally a sound system of internal control, risk management and governance. We have completed the second phase of our review into governance post- transition and gave an overall report rating of strong and concluded that the governance arrangements of NHS TDA is fit-for-purpose and proportionate. Furthermore, they have matured significantly in year since our initial review.

- In the case of control – 10 assurance based reviews have been completed to date; of which two were rated as 'strong'; seven were rated as 'satisfactory' and one was rated as 'weak'. We also concluded that good progress had been made in implementing internal audit recommendations relating to the 2013/2014 audit plan.

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 2013/14".

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 2013/14.



David Flory CBE

Chief Executive
NHS Trust Development Authority

9 July 2014

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 Houses of Parliament

I certify that I have audited the financial statements of NHS Trust Development Authority for the year ended 31 March 2014 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 2014 and of the net operating costs for the year then ended; and
- the financial statements have been properly prepared in accordance with the National Health Service Act 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 Management Commentary, Directors' Report and Strategic 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

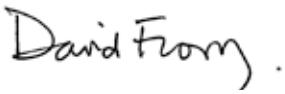
July 2014

STATEMENT OF COMPREHENSIVE NET EXPENDITURE FOR THE PERIOD ENDED 31 MARCH 2014			
	Note	**2013-14 £000**	2012-13* £000
Administration costs and programme expenditure			
Gross employee benefits		17,836	1,130
Other expenditure		23,667	1,382
Revenue		(1,744)	(126)
Net operating costs for the financial year		**39,759**	2,386
Of which:			
Administration costs:			
Gross employee benefits	7	17,007	1,130
Other expenditure	5	5,234	1,382
Revenue	4	(212)	(126)
Net administration costs for the financial year		**22,029**	2,386
Programme costs:			
Gross employee benefits	7	829	–
Other expenditure	5	18,433	–
Revenue	4	(1,532)	–
Net programme costs for the financial year		**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		**39,759**	2,386

* The NHS TDA was established on 1st June 2012. Financial Year 2012-13 comparative figures are for a ten month period and reflect the setup costs supporting the establishment of the NHS TDA prior to it being fully operational on 1 April 2013.

The notes on pages 42 to 61 form part of these accounts

STATEMENT OF FINANCIAL POSITION AS AT 31 MARCH 2014			
	Note	**31 March 2014 £000**	31 March 2013 £000
Non current assets			
Property, plant and equipment	8.1	352	–
Intangible assets	8.2	65	68
Total non-current assets		**417**	68
Current assets			
Trade and other receivables	11	706	204
Cash and cash equivalents	12	1,638	1,529
Total current assets		**2,344**	1,733
Total assets		**2,761**	1,801
Current liabilities			
Trade and other payables	13	14,184	1,652
Provisions	14	130	135
Total current liabilities		**14,314**	1,787
Non-currrent assets plus/less net current assets/liabilities		**(11,553)**	14
Total net (liabilities)/assets		**(11,553)**	14
Financed by taxpayers' equity			
General fund		(11,553)	14
Total taxpayers' equity		**(11,553)**	14
The financial statements and the notes on pages 42 to 61 were signed on behalf of the NHS TDA by:			



David Flory CBE
Chief Executive

Date: 9 July 2014

STATEMENT OF CHANGES IN TAXPAYERS' EQUITY FOR THE YEAR ENDED 31 MARCH 2014		
	Note	General Fund £000
Balance at 31 March 2013		**14**
Changes in taxpayers' equity for 2013/14		
Net operating cost for the year	SoCNE	(39,759)
Transfers to/(from) other bodies within the group under modified absorbtion accounting	16	(1,997)
Net parliamentary funding – drawdown cash		27,900
Net parliamentary funding – legacy items paid by Department of Health	16	2,289
Balance at 31 March 2014		**(11,553)**
Balance at 1 June 2012		**–**
Changes in taxpayers'equity for 2012/13		
Parliamentary funding		2,400
Net operating cost for the year		(2,386)
Balance at 31 March 2013		**14**
The notes on pages 42 to 61 form part of these accounts.		

STATEMENT OF CASH FLOWS FOR THE YEAR ENDED 31 MARCH 2014			
	Note	**2013-14 £000**	2012-13 £000
Cash flows from operating activities			
Net operating cost		(39,759)	(2,386)
Adjustments for non-cash transactions			
Depreciation and amortisation	5	30	–
Legacy balance working capital movement	16.1	292	–
Provisions arising during the year	14	130	135
Provisions reversed unused	14	(28)	–
(Increase)/decrease in trade and other receivables	11	(502)	(204)
Increase/(decrease) in trade payables and other current liabilities	13	12,192	1,652
Provisions utilised	14	(107)	–
Net cash inflow/(outflow) from operating activities		**(27,752)**	(803)
Cash flows from investing activities			
(Payments) for property, plant and equipment	8.1	(14)	–
(Payments) for intangible assets	8.2	(25)	(68)
Net cash inflow/(outflow) from investing activities		**(39)**	(68)
Cash flows from financing activities			
Net parliamentary funding – *drawdown cash*		27,900	2,400
Net financing		27,900	2,400
Net increase/(decrease) in cash and cash equivalents		109	1,529
Cash and cash equivalents at the beginning of the period		**1,529**	–
Cash and cash equivalents at the end of the period	12	**1,638**	1,529
The notes on pages 42 to 61 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 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.

The prior year comparatives are for the period from 1st June 2012 until 31st March 2013 and reflect part year activities when the organisation was being established and not fully operational.

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 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, 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 IAS20 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 (see below) 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 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 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 2014 were based on the TDA's best professional judgement in line with IAS 37 and details of provisions can be seen in note 14.

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 Authority. 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 Authority 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

(a) 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 and iPads has been made within critical judgements in applying the accounting policy for capitalisation of property, plant and equipment.

(b) 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, or amortised historic cost as a proxy for fair value where materially different.

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 Trust Development Authority expects to obtain economic benefits or service potential from the asset. This is specific to the NHS Trust Development Authority 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 three and five 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 (1.9%)
- Medium term (0.65%)
- Long term 2.2%

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'.

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 IAS39.

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 2013-14. The application of the Standards as revised would not have a material impact on the accounts for 2013-14, were they applied in that year:

- IFRS 9 Financial Instruments – subject to consultation
- IFRS 10 Consolidated Financial Statements – to be applied in 2014-15
- IFRS 11 Joint Arrangements – to be applied in 2014-15
- IFRS 12 Disclosure of Interests in Other Entities – to be applied in 2014-15
- IFRS 13 Fair Value Measurement – to be applied in 2015-16
- IAS 27 Separate Financial Statements – to be applied in 2014-15
- IAS 28 Investments in Associates and Joint Ventures – to be applied in 2014-15
- IPSAS 32 – Service Concession Arrangement – subject to consultation

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 four 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 2014, is based on valuation data as 31 March 2013, updated to 31 March 2014 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 2004. Consequently, a formal actuarial valuation would have been due for the year ending 31 March 2008. However, formal actuarial valuations for unfunded public service schemes were suspended by HM Treasury on value for money grounds while consideration is given to recent changes to public service pensions, and while future scheme terms are developed as part of the reforms to public service pension provision due in 2015.

The Scheme Regulations were changed to 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.

The next formal valuation to be used for funding purposes will be carried out at as at March 2012 and will be used to inform the contribution rates to be used from 1 April 2015.

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 three years pensionable pay for each year of service, and 1/60th for the 2008 section of reckonable pay per year of membership. Members who are practitioners as defined by the Scheme Regulations have their annual pensions based upon total pensionable earnings over the relevant pensionable service.

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

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

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

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

Members can purchase additional service in the NHS Scheme and contribute to money purchase AVCs 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 two operating segments: the management and administration of the Authority and the funding of programme activities.

	Administration		Programme		Total	
	2013-14 £000	2012-13 £000	**2013-14 £000**	2012-13 £000	**2013-14 £000**	2012-13 £000
Revenue	**(212)**	(126)	**(1,532)**	–	**(1,744)**	(126)
Expenditure	**22,241**	2,512	**19,262**	–	**41,503**	2,512
Net Operating Costs	**22,029**	2,386	**17,730**	–	**39,759**	2,386
Assets	**2,761**	1,801	**–**	–	**2,761**	1,801
Liabilities	**(2,966)**	(1,787)	**(11,348)**	–	**(14,314)**	(1,787)
Net assets/(liabilities)	**(205)**	14	**(11,348)**	–	**(11,553)**	14

Administration

The financial objectives of the NHS TDA is to manage the recurrent costs of management and administration within the allocation of £22,186,000 this funding covers staff, accommodation and other running costs.

Programme

The NHS TDA received an allocation of £17,930,000 programme funding for other expenditure made on behalf of the NHS, such as due diligence exercises as part of FT readiness assessments and the support of the NHS Trusts organisational form transactional costs.

Programme funding cannot be used to supplement administration funding for the running costs for the NHS TDA.

4 Revenue

	2013-14 £000	2012-13 £000
Administration revenue		
Rental revenue recovery	**162**	–
Other miscellaneous revenue	**50**	126
Total administration revenue	**212**	126
Programme revenue		
Revenue from NHS England to fund the Productivity Programme	**1,483**	–
Other miscellaneous revenue	**49**	–
Total programme revenue	**1,532**	–
Total revenue	**1,744**	126

5 Operating expenses

	Note	2013-14 £000	2012-13 £000
Administration costs			
Consultancy		–	164
Auditors' Remuneration		50	23
Non-executive members' remuneration		104	65
Professional Fees		109	223
Miscellaneous Expenditure		139	–
External Contract Staffing		520	–
Establishment expenses		940	277
Information and Communications		841	297
Business travel		978	77
Premises		1,523	256
Non-cash items			
Depreciation	8.1	2	–
Amortisation	8.2	28	–
Sub total		**5,234**	1,382
Programme costs			
Business travel		38	–
Miscellaneous Expenditure		224	–
External Contract Staffing		585	–
Professional Fees		1,843	–
Consultancy		1,562	–
Establishment expenses		2,406	–
Funding provided to NHS trusts and partners:			
Reimbursement of vendor costs in respect of London Trust transactions		10,504	–
Project support to NHS trusts		400	–
Special Measures		871	–
Sub-total		**18,433**	–
Total		**23,667**	1,382

Within the Programme establishment expenses £2,404,000 is the cost of the shortfall in contribution to NHS Litigation Authority as a result of the dissolution of the South London Healthcare Trust.

6 Operating leases

NHS Trust Development Authority as lessee	2013-14 £000	2012-13 £000
Payments recognised as an expense		
Minimum lease payments	54	–
Total	**54**	–
Payable		
No later than one year	23	–
Between one and five years	2	–
After five years	–	–
Total	**25**	–

Included in the Premises expenditure in note 5 is £1,423k of costs paid to NHS Property Services for the occupation of seven sites, and £73k to the Department of Health for the occupation of one site. Formal lease arrangements are in the process of being agreed.

7 Employee benefits and staff numbers

7.1 Employee benefits

2013-14	Total	Permanently employed	Other
	£000	£000	£000
Gross expenditure			
Salaries and wages	14,673	13,071	1,602
Social security costs	1,398	1,398	–
Employer contributions to NHS BSA – Pensions Division	1,765	1,765	–
Total gross expenditure	**17,836**	**16,234**	**1,602**
Administration expenditure			
Salaries and wages	13,993	12,453	1,540
Social security costs	1,325	1,325	–
Employer contributions to NHS BSA – Pensions Division	1,689	1,689	–
Total administration expenditure	**17,007**	**15,467**	**1,540**
Programme expenditure			
Salaries and wages	680	618	62
Social security costs	73	73	–
Employer contributions to NHS BSA – Pensions Division	76	76	–
Total programme	**829**	**767**	**62**

2012-13	Total	Permanently employed	Other
	£000	£000	£000
Gross expenditure			
Salaries and wages	1,070	443	627
Social security costs	26	26	–
Employer contributions to NHS BSA – Pensions Division	34	34	–
Total employee benefits	**1,130**	**503**	**627**

No programme expenditure was incurred during 2012-13.

7.2 Staff numbers

	Total	Permanently employed	Other
	Number	Number	Number
Staff Number 2013-14	**203**	**190**	**13**
Administration staff	197	185	12
Programme staff	6	5	1
Staff Number 2012-13	**25**	**25**	**–**

7.3 Staff sickness and ill health retirements

	2013-14 Number
Total days lost	875
Total staff years	185
Average working Days Lost	**5**

	2013-14 Number	2012-13 Number
Number of persons retired early on ill health grounds	–	–

	2013-14 £000	2012-13 £000
Total additional pensions liabilities accrued in the year	–	–

7.4 Exit Packages agreed in 2013-14

There have been no exit packages in 2013-14 and 2012-13.

7.5 Severance payments

There have been no severance payments in 2013-14 and 2012-13.

8 Non-current assets

8.1 Property, plant and equipment

	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 the year due to coming into use in March 2014.
The NHS TDA did not own any property, plant and equipment assets as at the 31 March 2013.
All assets are purchased assets and are owned by NHS TDA.

8.2 Intangible assets

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 2013	–	–	**–**
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**

2012-13	Licences & trademarks £000	Development expenditure £000	Total £000
Cost or valuation			
At 1 June 2012	–	–	**–**
Additions purchased	–	68	**68**
Disposals	–	–	**–**
At 31 March 2013	**–**	**68**	**68**
Amortisation			
At 1 June 2012	–	–	**–**
Charged during the year	–	–	**–**
Disposals	–	–	**–**
At 31 March 2013	**–**	**–**	**–**
Net book value at 1 June 2012	**–**	**–**	**–**
Net book value at 31 March 2013	**–**	**68**	**68**

The intangible assets were not amortised in the year due to coming into use in March 2013.
All intangible assets are purchased assets and are owned by NHS TDA.
The intangible assets are all bespoke assets.
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 the 31 March 2014.

9 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 total cost of the contract for the initial 3 years is based upon transaction volumes and is estimated at £48,000.

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 six months. The total cost of the contract for the first year was £53,363 .

10 Intra-Government and other balances

2013-14	Current receivables £000	Current payables £000
Balances with other central government bodies	85	–
Balances with local authorities	–	–
Balances with NHS bodies	23	653
Balances with NHS Trusts and Foundation Trusts	521	11,158
Balances with public corporations and trading funds	–	–
Balances with bodies external to government	77	2,373
At 31 March 2014	**706**	**14,184**

2012-13	Current receivables £000	Current payables £000
Balances with other central government bodies	29	842
Balances with local authorities	–	–
Balances with NHS bodies	175	225
Balances with NHS Trusts and Foundation Trusts	–	–
Balances with public corporations and trading funds	–	–
Balances with bodies external to government	–	585
At 31 March 2013	**204**	**1,652**

There were no non-current receivables or payables.

11 Trade receivables and amounts falling due within one year

	31 March 2014 £000	31 March 2013 £000
NHS receivables	544	175
NHS prepayments and accrued revenue	30	–
Non-NHS receivables	–	–
Non-NHS prepayments and accrued revenue	13	–
VAT	85	29
Other receivables	34	–
Trade and other receivables	**706**	204

12 Cash and cash equivalents

	31 March 2014 £000	31 March 2013 £000
Opening balance	1,529	–
Net change in year	109	1,529
Closing balance	**1,638**	1,529
Made up of		
Cash with Government Banking Service	1,638	1,529
Commercial banks and cash in hand	–	–
Current investments	–	–
Cash and cash equivalents as in Statement of Financial Position	**1,638**	1,529

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

	31 March 2014 £000	31 March 2013 £000
NHS payables	11,141	1,018
NHS accruals and deferred revenue	670	49
Non-NHS payables	611	–
Non-NHS accruals and deferred revenue	1,762	585
Social security costs	–	–
Trade and other payables	**14,184**	1,652

14 Provisions

	2013-14 £000	2012-13 £000
Balance at 1 April 2013	135	–
Arising during the year	130	135
Utilised during the year	(107)	–
Reversed unused	(28)	–
Balance at 31 March 2014	**130**	135
Expected timing of cash flows:		
No later than one year	130	
Later than one year and not later than five years	–	
Later than five years	–	

Provisions consist of a provision which has arisen during the year in relation to performance related pay and for pay review of very senior managers.

The provision in 2012/13 was for employee benefits relating to back pay arrears due to staff having undertaken dual roles in 2012/13.

15 Financial instruments

15.1 Financial risk management

Financial reporting standard IFRS 7 requires disclosure of the role that financial instruments have had during the period in creating or changing the risks a body faces in undertaking its activities. Because 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 2014 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.

15.2 Financial assets

	2013-14 Loans and receivables £000	2012-13 Loans and receivables £000
Trade and other receivables	**544**	175
Other receivables	**119**	29
Cash at bank and in hand	**1,638**	1,529
Total at 31 March 2014	**2,301**	1,733

15.3 Financial liabilities

	2013-14 Other £000	2012-13 Other £000
Trade and other payables	**14,184**	1,603
Total at 31 March 2014	**14,184**	1,603

16 Legacy balance transfer

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 TDA from the following Strategic Health Authorities (SHA) on that date.

		Receivables £000	Payables £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 TDA. The scope of the 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

There are no events after the reporting period to report. 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
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.

19 Resource limits

19.1 Revenue resource limit

	2013-14 £000	2012-13 £000
Net operating costs for the financial period	**39,759**	2,386
Revenue resource limit	**40,116**	2,390
Under/(over)spend against revenue resource limit	**357**	4

19.2 Capital resource limit

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

	2013-14 £000	2012-13 £000
Charge against capital resource limit (gross capital expenditure)	**379**	68
Capital resource limit	**400**	70
Under/(over)spend against capital resource limit	**21**	2

19.3 Under/(over)spend against cash limit

	2013-14 £000	2012-13 £000
Total charge to cash limit	**27,900**	2,400
Cash limit	**40,516**	2,460
Under/(over)spend against cash limit	**12,616**	60

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

NHS
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