NHS Improvement

NHS Trust Development Authority Annual Report and Accounts 2015-16

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Quality. Delivery. Sustainability.

NHS Trust Development Authority Annual Report and Accounts

For the period 1 April 2015 – 31 March 2016

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About NHS Improvement

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

NHS Improvement is the operational name for the organisation that from 1 April 2016 brings together Monitor, NHS Trust Development Authority (NHS TDA), Patient Safety, including the National Reporting and Learning System, the Advancing Change team and the Intensive Support Teams.

About the NHS TDA

The NHS TDA is here to provide support, oversight and governance for all NHS trusts on their journey to delivering what patients want; high quality services today, secure for tomorrow.

The range of services provided by NHS trusts covers the entire spectrum of healthcare, from acute hospitals to ambulance services through to mental health and community providers; the size of organisation varies from very small providers through to some of the largest organisations in the NHS, and therefore each trust has a set of unique challenges.

Due to this variation, we recognise that there is not going to be a 'one size fits all' solution to the challenges trusts face. Our goal is first and foremost to help each and every NHS trust to improve the services they provide for their patients.

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Foreword from the Chairman

I am pleased to introduce NHS TDA's annual report and accounts for 2015-16, the first since I became Chair of Monitor and Chair designate of NHS TDA in July 2015 and Chair of NHS TDA on 1 December 2015.

During the year NHS TDA continued with its important existing activities and prepared for the creation on 1 April 2016 of NHS Improvement. NHS Improvement brings together Monitor, the NHS TDA, Patient Safety, including the National Reporting and Learning System, the Advancing Change team and the Intensive Support Teams.

Together we concentrate expertise on healthcare improvement, regulation and patient safety, with a mandate and the resources to work right across the NHS. While Monitor and NHS TDA will remain as entities, we will have a single operating model for our people, our resources and our responsibilities to Government and the NHS. I am grateful to the joint working group of senior leaders from all the bodies involved that helped design the new organisation and are overseeing implementation of the integration programme while remaining very focused on our external obligations.

Our principal focus is to support and enable urgent operational improvement in NHS provider organisations and the long-term sustainability of the healthcare system; in addition, we are the health sector regulator.

To do this we will build on the achievements of the previous successful organisations and functions and add new capability as well as a greater sense of collaboration with system leaders. While recognising and celebrating our diversity, everyone shares a single set of values centred on providing the healthcare system with support, development and constructive challenge.

Our NHS faces the formidable task of providing care at the quality patients deserve and within the resource provided principally by the Government. Our NHS clearly needs more support and access to improvement and innovation activities in striking that balance than at any point in recent history, which makes NHS Improvement's remit both exciting and challenging.

I hope this report offers an insight into the commitment and professionalism of our staff. I know they will play a vital part in NHS Improvement's work in the year ahead.

Regulation, inspection and improvement all have a role to play. The challenge is to establish the right balance between them and we have made a shift in emphasis: first and foremost, we offer real support to providers and local health systems. We do, of course, hold boards to account, and sometimes it is still necessary to intervene. In the short term, the scale of many trusts' financial and operational challenges means more involvement than we intend long term. But our ambition is to support first, building deep and lasting relationships with trusts and working alongside them to help them to improve – only intervening when we have to. Our purpose is better health, transformed care delivery and sustainable finances: a purpose that we know NHS patients, carers, staff and organisations all share with us.

I am delighted that we appointed Jim Mackey as Chief Executive of NHS TDA and Chief Executive Designate of NHS Improvement. Jim, who joined in November 2015, has 25 years' experience in our NHS and an exceptional record in achieving change, particularly during 10 years at Northumbria Healthcare NHS Foundation Trust. He has influenced national policy on new and innovative models of emergency care and is passionate about taking an integrated approach to improving services.

I am equally pleased to welcome our new non-executive directors to the board: Lord Carter, Lord Darzi, Professor Dame Glynis Breakwell, Laura Carstensen and Richard Douglas. They bring a wealth of expertise and knowledge to NHS Improvement, as do Sigurd Reinton, formerly a member of Monitor's board, and Caroline Thomson and Sarah Harkness, who join from NHS TDA's board.

In conclusion I would like to thank the members of the NHS TDA's board who have stepped down for their contribution. My predecessor, Sir Peter Carr, chaired the organisation since its inception and was fundamental to the supportive approach that the NHS TDA adopted. Sir Peter, along with Dame Christine Beasley and Crispin Simon, and the organisation's Chief Executives, David Flory and Bob Alexander, all played a role in achieving the common goal of working alongside NHS organisations to help them to overcome difficulties and challenge them to make improvements. I am also delighted that Bob Alexander, who led the NHS TDA from April 2015 until Jim's appointment to NHS Improvement in the autumn, will be remaining in the new organisation as its Deputy Chief Executive. I would also like to extend particular thanks to Sir Peter Carr who retires this year after 26 years of service to the NHS.

I hope this report offers an insight into the commitment and professionalism of our staff. I know they will play a vital part in NHS Improvement's work in the year ahead.

Ed Smith

Chairman of NHS TDA
and Chairman of NHS Improvement

4 July 2016

Introduction from the Chief Executive

This has been one of the most challenging years in the NHS's history. The rising pressures, which we have seen trusts and their staff working hard to cope with in recent times, continued to increase as record numbers of people sought treatment. Alongside this, the financial picture turned ever more difficult.

Yet NHS staff have done a remarkable job keeping the service running: for example, over 112,000 more people were treated in emergency departments within 4 hours in January than the year before. I would like to record my thanks to all in the service who do their utmost for patients every day. The NHS remains among the best healthcare systems in the world.

The NHS TDA's approach has been one of support to the 90 trusts with which it worked over the course of the year. It has worked closely with its partner organisation Monitor, before and after the announcement of NHS Improvement's creation, in developing plans to help the sector to tackle the twin challenges of demand and financial pressure. In particular, we have taken a joint approach to creating and developing measures to help control spiralling spending on agency staff.

I am pleased to say that partnership working has extended well beyond the boundaries of NHS TDA and Monitor, with both organisations working with NHS England (NHSE) and other partners to fulfil the long-term aims set out in the Five Year Forward View. We have seen a strong focus on future care models through our involvement with the Vanguard programme, intensive support for the areas that need it most through the Success Regime and a new joint approach to planning that will see organisations in local areas – providers, commissioners and local authorities – working together to design services and care for their patients. Local and regional commitment to true partnership working is crucial, not only to improving care and patients' experience, but to ensuring we have strong, sustainable organisations fit to tackle the current challenges and respond to change in the future.

Some of the leadership and frontline roles in the NHS are among the toughest jobs right now. We need to continue to focus on how we can develop NHS staff in these demanding roles and help them deal with the long-term challenges, including how every part of an organisation can help itself become more efficient, not least through implementing the Carter Review's recommendations.

The NHS TDA was built on a foundation of creating and maintaining strong relationships with non-foundation trusts and providing support to help organisations become strong and independent. As NHS Improvement we will continue to offer practical help to providers and local health systems, building on the best that Monitor and NHS TDA have achieved. A supportive approach – working with and for the service – will be fundamental to the new organisation as we seek to build long-term, sustainable improvement: support will come first and intervention will follow only when necessary.

I look forward to working with NHS Improvement's new executive team: every member brings a wealth of knowledge and experience to lead the new organisation. I would also like to thank NHS TDA staff for all their hard work in the past year, not least in helping to launch NHS Improvement successfully.

Jim Mackey

Chief Executive of NHS TDA
and Chief Executive of NHS Improvement

4 July 2016

Management commentary

The challenges that the NHS is facing have been building in recent years.

The work of the NHS TDA has focused on supporting trusts over 3 broad areas – quality, performance and finance. These 3 areas need to be in balance if trusts are to be sustainable.

However, we have seen the NHS facing significant challenges this year on meeting key performance standards, in particular in A&E, and on their finances. The NHS TDA, working alongside Monitor to provide consistent support to trusts and foundation trusts wherever possible, has been working with the NHS provider sector to understand the reasons for these difficulties so that the right support can be put in place.

One of the key issues identified was that of spending on agency staff. Trusts have been struggling to balance the requirements for safe staffing levels with difficulties in recruiting permanent staff, in particular in light of the fact that existing staff could earn more doing extra agency shifts than taking on trust overtime or bank shifts.

The NHS TDA and Monitor worked together to introduce a range of measures – including discouraging trusts to rely on agency staff by setting maximum amounts that they can spend and encouraging a greater focus on developing better internal systems, such as internal banks; providing the sector with mandatory approved frameworks for agency staff; and tackling the payment of very high rates with pricing caps which define what the workers themselves receive, ensuring that it is equivalent to standard NHS terms and conditions for individual shifts introduced in phases over 6 months. These measures saved the NHS £300 million by the end of 2015-16 and we will be working with trusts to embed them further and create additional savings over the coming year.

Measures (introduced by the NHS TDA and Monitor) saved the NHS £300 million by the end of 2015-16 and we will be working with trusts to embed them further and create additional savings over the coming year.

Ultimately, to truly address the pressure that agency costs places on the NHS, we need to see a long-term and sustainable shift, including by staff themselves, away from agency shifts and towards substantive and bank roles within their trust. This will help with ongoing recruitment issues and also increase the number of staff taking on extra shifts with a hospital or trust that they are familiar with.

Despite the fact that some trusts are dealing with a more difficult financial position than others, almost every organisation has faced challenges in this area over the last year. Those that have maintained their position or minimised the impact on their overall financial position while ensuring high quality and timely care for patients have done extremely well. However, we know that longer-term, transformation will be key to financial as well as performance, quality and sustainability.

The spending review, alongside the new place-based approach that NHS Improvement and NHSE have set out to long-term planning, gives us a unique opportunity to make the changes that are required. This investment and joint local working are together essential to the short-term and long-term sustainability of the NHS.

We know, from both statistics and from feedback from trusts, that there is a particular challenge around meeting operational standards in A&E. While we have been supporting the sector to improve on this as one of our key priorities, we also know that more patients with minor illnesses are visiting A&E, which is adding to the pressure – more work is needed from across the health system to understand why this is and what is needed locally to ensure patients are treated in the right setting.

Nevertheless, we also know that the system and the individuals that it consists of are working harder than ever before to deal with a significant increase in volume. There were over 22 million A&E attendances in 2015-16, an increase of 2.3% over the previous year. In March 2016 alone we saw over 2 million patients in A&E, the highest number ever seen and an increase of 7.5% more than in March 2015.

For those trusts requiring more targeted help, the NHS TDA this year took the successful role of the Improvement Director and implemented it outside the package of support for those trusts in special measures.

We are already working closely with some of the most challenged hospitals across the country to ensure that sustainable improvements are being put in place on the front line that will impact on A&E. Other key areas of performance, such as operational standards on referral to treatment and cancer, are also being closely monitored, particularly in challenged trusts, so that support can be provided if needed.

This builds on the approach taken over the winter period this year, working with NHSE to ensure local health systems were operationally prepared and with both NHSE and Public Health England on the very successful Stay Well This Winter campaign. Although NHS Improvement did not formally exist until 1 April 2016, the NHS TDA and Monitor worked together, alongside NHSE, to ensure comprehensive plans were established and then implemented across health systems to help them deal with a traditionally challenging time of year.

There are good signs that joined-up approach had significant benefits. For example, while over 200,000 more patients required treatment in A&E in February 2016 than in the same month last year, front line staff saw more people within 4 hours than ever before. It will be important to learn from this approach as the NHS prepares for future winters or for any other period where it expects to face peaks in demand.

For some trusts, the best option for a strong and sustainable future is to enter into some form of transaction – to join with or be acquired by another organisation, as we have seen in previous years with, for example, the Royal Free NHS Foundation Trust taking on Barnet and Chase Farm NHS Trust. This year, Chelsea and Westminster Hospital NHS Foundation Trust acquired West Middlesex University Hospital NHS Trust and we saw the creation of Torbay and South Devon NHS Foundation Trust, formed by the merging of South Devon Healthcare NHS Foundation Trust and Torbay and Southern Devon Health and Care NHS Trust, to become the first fully integrated NHS healthcare organisation.

Ahead of the announcement of NHS Improvement, the NHS TDA had already begun a programme of targeted development. The main element of this was setting up and managing a relationship between the Virginia Mason Institute in Seattle and 5 NHS trusts: University Hospitals Coventry and Warwickshire NHS Trust; The Shrewsbury and Telford Hospital NHS Trust; Barking, Havering and Redbridge University Hospitals NHS Trust; The Leeds Teaching Hospitals NHS Trust and Surrey and Sussex Healthcare NHS Trust. These 5 trusts were selected after a competitive process, which included considering their willingness to embrace opportunities for positive change. This ambitious improvement programme is based on a long-term partnership that will last for 5 years and look at the benefits that introducing a lean approach to healthcare can have, following the success seen in both safety and efficiency at Virginia Mason Hospital, the USA's 'Hospital of the Decade'.

For those trusts requiring more targeted help, the NHS TDA this year took the successful role of the Improvement Director and implemented it outside the package of support for those trusts in special measures. A number of organisations facing entrenched challenges are now benefitting from having a senior and experienced advisor working at a leadership level within their trust.

A key part of NHS leadership is the role played by chairs and non-executive directors. The NHS TDA has delegated responsibility to make these appointments to NHS trusts on behalf of the Secretary of State for Health. This year 235 appointments were made and for those non-executives new to the NHS we have run an induction programme, supported by NHS Providers, to ensure that boards are fully prepared to hold NHS trusts to account.

2016-17 will see NHS Improvement take on its formal role. NHSE's Patient Safety team, including the National Reporting and Learning System, the Advancing Change team and the Intensive Support teams transferred to the NHS TDA on 1 April 2016. The NHS TDA and Monitor have also already been working increasingly closely in recent years, developing a more consistent approach to supporting both trusts and foundation trusts. Formalising this relationship through the creation of NHS Improvement will mean greater traction in helping NHS organisations to make the improvements, as well as the innovation and transformation required at local and regional levels to ensure a strong and sustainable future for the NHS, its staff and its patients.

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Strategic report

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

In 2015 the NHS TDA Directions were amended to reflect some of these changes, but the role of the NHS TDA remains unchanged: to oversee and support NHS trusts to improve the quality and sustainability of the services it offers to patients and enabling them to achieve a sustainable organisational form.

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

In addition to this important day-to-day business, the NHS TDA has continued to discharge its formal powers and duties in order to achieve its objectives in 2015-16 through:

- the authorisation of 2 new NHS foundation trusts – Bradford District Care NHS Trust and Oxford University Hospitals NHS Trust;
- approval by the NHS TDA Board of the foundation trust applications of 3 further trusts – Lincolnshire Community Health Services NHS Trust, Sussex Community NHS Trust and Mersey Care NHS Trust - to proceed to assessment by Monitor;
- overseeing successful transactions involving the West Middlesex University Hospital NHS Trust acquisition by Chelsea and Westminster Hospital NHS Foundation Trust completed in September 2015 and Torbay and Southern Devon Health and Care NHS Trust merging with South Devon Foundation Trust to form Torbay and South Devon NHS Foundation Trust in October 2015;
- completing the dissolution of Mid Staffordshire NHS Foundation Trust and the transfer of the relevant assets and services to University Hospitals of North Midlands NHS Trust and Royal Wolverhampton Hospitals NHS Trust;
- providing challenge and support to NHS trusts in special measures;
- the appointment, extension or re-appointment of 152 chairs and non-executive directors to NHS trust boards;
- completion of 82 appraisals for NHS trust chairs;
- the provision of a development programme for aspirant foundation trusts, in conjunction with NHS Providers, and other initiatives to support leaders of NHS trusts;
- working with NHSE and Monitor to deliver the Success Regime, a whole systems intervention which provides challenge and support to some of the most challenged local health and care economies in England in order to improve the quality and sustainability of services that they offer to patients;
- the publication of joint planning guidance with NHSE, Monitor and other key national partners which sets out how providers and commissioners should work to implement the vision set out in the NHS Five Year Forward View;
- there are a number of key strategic risks facing the NHS TDA, full details of which are set out in the strategic risk register which is regularly approved by the Board. The most significant risks include:
  - the risk that the NHS trust sector is unable to deliver key NHS standards because of rising expectations, increased demand and the impact of the safer staffing initiative;
  - the risk that NHS trusts do not deliver on their financial plans and that financial performance deteriorates as a result of operational issues and quality considerations;
  - the risk that NHS trusts struggle to provide high quality care due to workforce supply issues in key professions; and
  - the risk to NHS TDA business continuity as a result of cyber attacks.

Our business model – matrix working

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

Performance summary

The following table summarises the NHS TDA's financial performance. Further details are shown in the performance analysis and financial statements.

	2015-16	2014-15
	£000	**£000**
Administration costs and programme expenditure		
Expenditure	59,904	65,962
Revenue	(1,412)	(953)
Net expenditure	**58,492**	**65,009**
Change £000	(6,517)	25,250
Change %	(10)	64
	As at 31 March 2016	As at 31 March 2015
	£000	**£000**
Non current assets	498	584
Change £000	(86)	167
Change %	(15)	40

Performance analysis

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.

The accounts for 2015-16 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 Department of Health (DH) against which we are expected to deliver. The statutory financial duties of the NHS TDA for the year 2015-16 were to:

- manage revenue expenditure within a resource limit of £60.8 million;
- manage capital expenditure within a resource limit of £0.5 million;
- manage cash spend within a cash limit of £61.9 million;
- meet the minimum performance requirements of the Better Payment Practice Code to pay at least 95% of invoices within 30 days.

The financial objectives of the NHS TDA in respect of these allocations in 2015-16 were:

- to manage the costs of administration within an allocation of £35 million – this funding covers staff, accommodation and other running costs;
- to manage an allocation of £25.8 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 2015-16 the NHS TDA met its statutory duties and maintained expenditure within these targets.

Better Payment Practice Code (BPPC)

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

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

Fraud

The NHS TDA has a whistleblowing policy giving contact details for NHS Counter Fraud and NHS Protect.

Principal risks and uncertainty

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

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

Better Payment Practice Code	2015-16		2014-15	
	Number	**£000**	**Number**	**£000**
Non-NHS payables				
Total non-NHS trade invoices paid in the year	2,102	8,507	2,304	15,393
Total non-NHS trade invoices paid within target	2,081	8,320	2,248	15,242
% of non-NHS trade invoices paid within target	**99%**	**98%**	**98%**	**99%**
NHS payables				
Total NHS trade invoices paid in the year	393	18,000	373	23,884
Total NHS trade invoices paid within target	384	17,700	362	23,425
% of NHS trade invoices paid within target	**98%**	**98%**	**97%**	**98%**

NHS trust financial performance

Revenue performance

As reported during the year, 2015-16 has been a challenging financial year for the NHS trust sector. The trust sector financial position has been impacted by a number of key generic cost drivers as detailed below:

- an unplanned growth in demand for care in a hospital setting, particularly in urgent and emergency care. This is often paid at a marginal rate and displaces elective activity paid for at full cost;
- the high level of delayed transfers of care experienced by hospitals is causing both a service and a financial pressure. Providers have estimated that such delays have cost £114 million in direct costs for the year. However, full costs could be much higher;
- a continued and significant increase in the use of agency and contract staff, especially during the first half of the financial year. The cost of agency staff amounted to £1,567 million for the financial year. The overspending was partly offset by savings from underspending on substantive staff. This is despite the introduction of additional controls during the year which have started to mitigate this impact towards the end of the year;
- failure to deliver the levels of cost improvement schemes planned at the start of the financial year and the reliance on non-recurrent CIPs;
- financial pressure was further exacerbated by £214 million of fines and readmission penalties and providers have spent £124 million this financial year on Waiting List Initiative (WLI) work to avoid breaches of waiting time targets;
- a reduction in non-recurrent income compared to 2014-15, including the loss of project diamond funding and one-off deficit support this year.

In aggregate, the NHS trust sector has delivered a net deficit of £1,350 million, compared to a planned net deficit of £1,059 million, a negative variance of £291 million. The planned net deficit at the start of the year was flexed by the amendments to trust plans in August and September which amounted to £129 million. The overall plan was adjusted by £7 million to reflect part year foundation trusts and dissolved trusts.

There were 59 NHS trusts that reported a deficit in the financial year 2015-16, the combined value of gross deficits was £1,448 million (including 2 trusts that have become FTs in year and 2 that have merged with existing FTs). The total number of NHS trusts in deficit was higher than the original plan of 56 trusts. There were a number of movements from original plans including 7 NHS trusts that have reported unplanned deficits and 43 NHS trusts that have improved their financial performance against plan.

Despite the unprecedented financial pressure faced by the NHS trust sector in 2015-16, there are 31 NHS trusts that have demonstrated good financial control and achieved breakeven or a surplus in 2015-16. The aggregate combined surplus for these NHS trusts is £97 million.

At an aggregate sector level the community and mental health NHS trusts continue to forecast a solid aggregate performance, despite increased pressure. Of the 30 NHS trusts in these sectors, 24 have delivered a surplus or breakeven in 2015-16 amounting to £54.5 million. There is, however, further pressure building in these sectors which has resulted in a reduction in margins and 6 NHS trusts are reporting a deficit for 2015-16 amounting to £24.4 million.

The ambulance sector is under increased financial pressure and in aggregate; the sector reported a net deficit for 2015-16 of £10.3 million with 2 of the 5 NHS ambulance trusts ending the year in deficit.

Acute NHS trusts experienced significant levels of financial pressure. The following table clearly identifies the extent of financial challenge that acute trusts faced during 2015-16 with 93% of acute NHS trusts in deficit at the year end. Many acute trusts continued to signal operational pressures in urgent and emergency care and the financial impact of the heightened focus on service quality and safety which manifest as increased permanent and non-permanent clinical staffing expenditure.

Financial performance of the NHS trust sector for the year ending 31 March 2016

NHS trust sector	2015-16			Number of trusts	Number of trusts in deficit	% of trust sector
	Plan £m	**Outturn £m**	**Variance £m**			
Acute	(1,080)	(1,370)	(290)	55	51	93%
Ambulance	(6)	(10)	(4)	5	2	40%
Community	15	18	3	16	3	19%
Mental Health	12	12	0	14	3	21%
Total	**(1,059)**	**(1,350)**	**(291)**	**90**	**59**	**66%**

(brackets) denote deficit

During this financial year, Bradford District NHS Care Trust and Oxford University Hospitals NHS Trust both became NHS foundation trusts. Additionally, West Middlesex University Hospital NHS Trust merged with Chelsea and Westminster Hospital Foundation Trust and Torbay and Southern Devon Health and Care NHS Trust merged with South Devon Foundation Trust to form Torbay and South Devon NHS Foundation Trust.

In total the NHS trust sector delivered £1,135 million of efficiency savings during 2015-16 whilst maintaining or improving service performance. This is an adverse variance against plan of £192 million.

The aggregate deficit for NHS trusts is 4.7% of operating revenue for the sector as a whole. The NHS TDA measured the financial performance of all NHS trusts against their individual plans for the 2015-16 financial year.

Capital

The hospital buildings used to treat patients, 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 2015-16 the NHS TDA worked with NHS trusts and approved 28 Full Business Cases (FBC) totalling just over £1,195 million and a further 32 Strategic Outline Cases (SOC) and Outline Business Cases (OBC) that were outside of the delegated authority of individual NHS trusts (2014-15: 42 FBCs totalling £746 million and 46 SOCs and OBCs).

In total NHS trusts spent £1,394 million on capital projects during 2015-16 (Month 12 draft accounts), (2014-15: £1,606 million) in a planned and managed way aimed at improving the quality of the infrastructure in the NHS trust sector.

Cash

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

In 2015-16 the NHS TDA worked with all NHS trusts that were forecasting revenue deficits and supported them through the process and, where necessary, supported in the completion of applications for revenue financing required to fund operating deficits and working capital requirements. The NHS TDA reviewed each NHS trust's application to consider the most appropriate financing solution before making recommendations to the DH. All NHS trusts that required revenue cash support in 2015-16 received sufficient cash to meet immediate operating requirements.

During the financial year 2015-16, 51 NHS trusts required access to cash financing of £1,325 million to support forecast revenue account deficit positions (2014-15: 32 NHS trusts accessed £593 million) which is in line with the deterioration of the income and expenditure (I&E) position in the NHS trust sector.

Operational performance of the NHS trust sector

Summary of NHS trust sector performance against key national standards for 2015-16.

Metric	Period	Standard %	Performance %
Referral to Treatment			
18 Weeks incomplete (%)	March 2016	92	90.79
52 Week Waits (numbers)		0	535
Diagnostics			
Number of diagnostic tests waiting longer than 6 weeks (%)	March 2016	1	1.61
Accident and Emergency			
All Types Performance (%)	Quarter 4	95	84.71
Type 1 Performance (%)		95	78.36
Cancer			
Two week wait referral to date first seen	Quarter 4		
2 week GP referral to 1st outpatient – cancer (%)		93	94.2
2 week GP referral to 1st outpatient – breast symptoms (%)		93	94.0
31 day wait for second or subsequent treatment			
31 day wait from diagnosis to first treatment (%)		96	97.1
31 day second or subsequent treatment – surgery (%)		94	93.8
31 day second or subsequent treatment – drug (%)		98	98.9
31 day second or subsequent treatment – radiotherapy (%)		94	96.7
62 day wait for first treatment			
62 day urgent GP referral to treatment for all cancers (%)		85	80.8
62 day urgent GP referral to treatment from screening (%)		90	89.8
Ambulance			
Category A call – emergency response within 8 minutes	YTD March 2016		
Red 1 calls (%)		75	71.48
Red 2 calls (%)		75	65.56
Category A call – ambulance vehicle arrives within 19 minutes (%)		95	91.91

Metric	Period	Standard %	Performance %
Infection Control			
MRSA	YTD March 2016	0	130
Clostridium Difficile		1,789	1,955
Eliminating Mixed Sex Accommodation			
Mixed Sex Accommodation	March 2016	0	320
Mental Health			
Proportion on CPA discharged from inpatient care were followed up within 7 days (%)	Quarter 4	95	97.88
Proportion admitted in inpatient service had access to Crisis Resolution/Home Treatment teams (%)	Quarter 4	95	98.82
Proportion with a delayed transfer of care (%)	March 2016	7.5	5.81
Proportion of Improving Access to Psychological Therapies (IAPT) patients completing treatment moved to recovery (%)	February 2016	50	48.33

Oversight and escalation scores by NHS trust sector as at 31 March 2016

Sector	5 Standard oversight	4 Standard oversight	3 Intervention	2 Intervention	1 Special measures	Total trusts
Acute	0	2	6	36	9	53
Ambulance	0	0	1	3	1	5
Community	3	8	2	2	0	15
Mental Health	1	5	5	2	0	13
Total	**4**	**15**	**14**	**43**	**10**	**86**

Sustainability report

The NHS TDA has been committed to long-term sustainable development and takes its responsibilities to the wider community very seriously. We acknowledge the potential impact that our activities may have on the environment so will ensure that effective environmental management and sustainable development becomes an integral part of our work. The core purpose of the NHS TDA is to help local providers of NHS services work towards a sustainable future that also delivers high quality care. As the organisation joins with Monitor, this work will continue to contribute to a strong, healthy and sustainable society for future generations.

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

The NHS TDA has office space in 9 sites throughout England. All are in multiple occupancy buildings and there are no more than 80 staff members on any single site. Seven of the 9 sites are managed by NHS Property Services, which is currently exempt from the Government reporting procedures and therefore do not hold the required reporting data. In their annual stewardship report 2014-15 NHS Property Services highlighted their work with NHSE, the Local Government Association and Public Health England to create a sustainability development strategy for the whole of the health and care system in England. The DH published sustainability data in its annual report but does not report on the smaller Arm's Length Bodies (ALBs) at an individual level.

The NHS TDA has adhered to Government targets to reduce the level of office space it uses per staff member and continues to work towards the targets set out in the Government Estates Strategy 2014. NHS Improvement will seek to ensure it meets new targets on efficient use of office space set by Cabinet Office for delivery by 2020.

The NHS TDA is committed to using its resources efficiently, economically and effectively, avoiding waste and reducing CO^2 emissions. However, following the substantial expansion in staffing numbers in 2014-15 and the introduction of the Virginia Mason programme in Seattle, it has not been possible to set a baseline from which to calculate reductions in emissions. The NHS TDA has continued to invest in both technologies and new ways of working to:

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

Transport

The NHS TDA does not own any commercial transport. However, staff travel throughout England in the course of their duties visiting NHS trusts from Cumbria to Cornwall, thus travel is the single largest generator of carbon emissions within the control of the NHS TDA. The NHS TDA has also introduced a new development programme to learn from the improvements in healthcare in Seattle which has increased air travel in 2015-16. The organisation contracts its rail, flight and hotel booking through Redfern Travel. Their reports show rail travel during 2015-16 equated to126,254.36 CO^2e and air travel at CO^2e 63411.59. Data collected through expense claims shows a total of 433,628 business miles undertaken during 2015-16 which equates to 178.55 tonnes CO^2e.

Procurement

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

Jim Mackey
Chief Executive Officer
NHS Trust Development Authority
4 July 2016

Accountability report

Directors' report

2015-16 was a transitional year which saw the NHS TDA preparing to work more closely with Monitor to oversee the trust provider sector under the banner of NHS Improvement.

There were no legislative changes associated with the creation of NHS Improvement on 1 April 2016 and the 2 organisations continue to exist as separate legal entities. Each organisation continues to have its own board, although they have identical membership and meet as one board.

In January 2016 the boards of the NHS TDA and Monitor began to hold monthly joint meetings. Prior to that the NHS TDA Board met in public on 4 occasions.

NHS TDA BOARD

Ed Smith CBE, FCA, CPFA, Hon DUniv, Hon LLDs **– Chair**

Ed Smith was appointed Chair of Monitor and Chair designate of the NHS TDA in July 2015. He took up the post as Chair of the NHS TDA on 1 December 2015. He is the Lead Non-Executive Director for the Department for Transport.

Ed is also the Pro-Chancellor and Chairman of Council at the University of Birmingham, a Member of the Competition and Markets Authority panel and is a Member of Council and Treasurer of Chatham House.

He was the former Global Assurance Chief Operating Officer and Strategy Chairman of PricewaterhouseCoopers (PwC). Before retiring he had a successful 30-year career with PwC, holding many leading board and top client roles in the UK and globally as a Senior Partner.

Sir Peter D Carr CBE – Chair

Sir Peter Carr chaired the NHS TDA from 2012 until 30 November 2015 when he took up the post of Deputy Chair. Sir Peter has signalled his intention to resign from the board on 31 May 2016.

Sir Peter chaired the North East Strategic Health Authority (SHA) until 3 October 2011 when it was re-shaped under the Government reforms. He has held Chairmanship of NHS organisations in the North East region since 1990 when he led the Regional Health Authority. He is a member of Court of Newcastle University and the Newcastle University Business School.

In the 1980's he held a senior position for 5 years in the diplomatic service based in Washington DC, where he engaged in a range of key negotiations on behalf of the British Government. He has held senior and national positions with the Department of Employment, was a founding Director of the Advisory Conciliation and Arbitration Service (ACAS) and a Director of the Commission on Industrial Relations. From 1993 to 1997, during a period of intense reform, he was Chairman of the Occupational Pensions Board.

He has a long standing interest in economic development and led the regional task force in the North East established by Central Government in the 1990's. He has maintained that interest by chairing an economic development board and has made a special international study of research parks.

For 10 years he chaired a commercially successful waste management and recycling company.

In his early career Sir Peter worked as a lecturer in management structures and labour market economics. He began his working life as a cabinet maker.

Dame Christine Beasley – Non Executive Director

Dame Christine Beasley was appointed Non-Executive Director and Deputy Chair of the NHS TDA in September 2012. She resigned from the latter role on 30 November 2015 and from the board as a whole on 31 March 2016.

Dame Christine served the NHS in a number of roles during a 50 year career. She started as a student nurse in the Royal London Hospital in 1962. Dame Christine held a number of regional nursing, operations and organisational development posts and in 2002 was appointed Head of Development and Nursing in the DH's Directorate of Health and Social Care. In 2003 she was appointed Partnership Development Director of the Modernisation Agency. A year later, she took up her final role as Chief Nursing Officer for England, a post she held until 2012.

In parallel with her executive career, Dame Christine has been a member of various national nursing and health related committees. She has also been appointed to a number of non-executive positions in the health, charity and higher education sectors. In 2008, she was appointed Dame Commander of the Order of the British Empire for her public and voluntary service.

Sarah Harkness – Non-Executive Director

Sarah Harkness was first appointed to the role of Non-Executive Director of the NHS TDA in September 2012. Sarah has remained in post to become joint NHS TDA and Monitor Non-Executive Director under the banner of NHS Improvement.

Sarah is an experienced finance professional who has worked at the highest level in a range of roles and organisations. She started her executive career in banking and in 1992 was appointed as Corporate Finance Director of NatWest Markets. Six years later she moved to Arthur Andersen, where she remained until 2002.

Sarah left this role to launch the corporate division of Directorbank Executive Search Ltd, which specialised in non-executive recruitment. While there, Sarah took on her own first non-executive roles in the private sector, as Director on the board of Homestyle Group PLC, a financially challenged retailer with an annual turnover of £400m and as Chair of McInnes Corporate Finance.

Sarah served as Non-Executive Director of Rotherham Priority Health NHS Trust and of NHS North of England. In 2011 she was appointed as Non-Executive Director of JRI Orthopaedics Ltd and now chairs its audit, risk and policy committee. She is also a board adviser to Neyber and pro-chancellor of the University of Sheffield.

Crispin Simon CBE – Non-Executive Director

Crispin Simon joined the NHS TDA in the role of Non-Executive Director in May 2013.

Crispin is Chief Executive of Rex Bionics having previously been a Managing Director at UK Trade and Industry.

He resigned from his post on 31 December 2015.

Caroline Thomson – Non-Executive Director

Caroline Thomson was first appointed to the role of Non-Executive Director of the NHS TDA in May 2013. Caroline has remained in post to become joint NHS TDA and Monitor Non-Executive Director under the banner of NHS Improvement.

Caroline is Chair of Digital UK, the body which is responsible for digital terrestrial television, a Non-Executive Director of VITEC plc (and Chair of the remuneration committee) and of CN media group. She is also a Non-Executive Director of UKGI (formerly the Shareholder Executive) and Chair of its remuneration committee. In the arts world she recently retired as Executive Director of English National Ballet, is Deputy Chair of the National Gallery and a trustee of Tullie House Gallery in Cumbria.

Caroline stepped down from her role as Chief Operating Officer (COO) at the BBC in September 2012 after serving 12 years as a member of the Executive Board.

As COO she was the Deputy Director General and was responsible for all the non-programme parts of the BBC except finance, including the property portfolio and the negotiation of the Royal Charter and 2 license fee settlements.

Caroline received an honorary doctorate from York University in 2013 and was made an honorary fellow of the University of Cumbria in 2015. She is a member of the council of the University of York and a trustee of The Conversation.

Jim Mackey – Chief Executive

Jim Mackey became Chief Executive of NHS Improvement on 1 November 2015.

Jim is a qualified accountant who joined the NHS in 1990. His previous roles have included:

- Chief Executive of Northumbria Healthcare NHS Foundation Trust
- Interim Chief Executive of Northumberland Care Trust
- Chief Operating Officer of Northumbria Healthcare NHS Trust
- Regional Director of Finance at the Regional Health Authority North East
- Deputy Chief Executive of Northumbria Healthcare NHS Trust
- Director of Finance at North Tyneside Healthcare NHS Trust

He has a keen interest in quality of care, especially patient and family experience, and has participated in a number of reviews and national projects, including the Dalton Review in 2014.

Jim is a voting member of the NHS TDA and Monitor Boards.

Robert Alexander

Robert Alexander was Chief Executive of the NHS TDA until 31 October 2015 when he became Deputy Chief Executive. Before this, he served as Director of Finance at NHS TDA. He was appointed Executive Director of Resources/Deputy Chief Executive of NHS Improvement on 1 April 2016.

Prior to joining NHS TDA in 2012, Robert was the Finance Director of NHS South of England and the Director of NHS Finance at the DH from 2007. There he led on NHS financial policy and performance as well as being responsible for the national tariff programme and finance issues underpinning the Health Reform Programme. Robert re-entered the NHS as a SHA Finance Director from 2002 to 2007, first with Kent and Medway SHA, then with South East Coast SHA.

Previous to this he held senior financial positions in both the public and private sectors. He is CIPFA qualified.

Robert is a voting member of the NHS TDA and Monitor Boards.

Elizabeth O'Mahony – Director of Finance

Before taking on the role of acting Finance Director, Elizabeth was the Director of Corporate and Strategic Finance for the NHS TDA.

Elizabeth has spent most of her career in NHS finance and worked across a number of provider and commissioning organisations and in the intermediate tier at a strategic and operational level. Elizabeth was formerly Director of Finance for the South West SHA where she developed financial frameworks which supported the financial success of the region. Elizabeth's portfolio of financial experience is wide-ranging and includes financial turnaround, provider development and mergers and acquisitions. She has been actively involved in the development of national financial policy for a number of years.

She is a fellow of the Association of Chartered Certified Accountants.

Elizabeth remained in post as Director of Finance until the launch of NHS Improvement on 1 April 2016.

Peter Blythin – Director of Nursing

Peter Blythin qualified as a general nurse in Liverpool, before completing mental health registration in North Wales. Scholarships in America and Australia contributed to a clinical career in accident and emergency. Peter holds a BSc in Nursing from Manchester Metropolitan University and an MBA from the University of Leeds.

Peter has a strong clinical background and has a wealth of experience of the NHS. He was previously the Director of Nursing and Workforce at West Midlands SHA. He has held a number of board positions and recently joined the DH National Quality Team as Director of Nursing. He works closely with the DH Chief Nurse and is familiar with the development of national policy.

Peter remained in post as Director of Nursing until the launch of NHS Improvement on 1 April 2016.

Dr Kathy McLean – Medical Director

Dr Kathy McLean was Medical Director of the NHS TDA before being appointed as Medical Director of NHS Improvement on 1 April 2016.

Prior to her appointment as Medical Director of the NHS TDA Kathy was the Clinical Transitions Director working with Sir Bruce Keogh building the NHS Commissioning Board, now NHSE. Her work has focused on improving quality by building in clinical leadership and expertise across the system, including development of clinical networks and senates, and she was also a leading member of the NHS Future Forum.

Kathy was Medical Director at East Midlands SHA and prior to that was Medical Director at Derby Hospitals NHS Foundation Trust where she was a physician from 1994 until 2009.

Kathy is a voting member of the NHS TDA and Monitor Boards.

Ralph Coulbeck – Director of Strategy

Ralph Coulbeck began his career on the NHS Management Training Scheme and has worked in the NHS, Parliament and Government. Before taking up his current post, Ralph was Chief Adviser to the NHS Chief Executive and worked on key strategic issues such as the Next Stage Review, the Quality, Innovation, Productivity and Prevention (QIPP) challenge, and the current health reforms.

Ralph resigned from the position of Director of Strategy on 31 March 2016.

Robert Checketts – Director of Communications

Prior to taking up his post as Director of Communications at the NHS TDA Robert had been the Director of Strategic Communications at Birmingham Children's Hospital. He has previously worked as the NHS South West's Associate Director for Strategic Development, the NHS Chief Executive's Chief Communications Adviser and the Director of Communications at Dudley PCT.

Prior to joining the health service, Robert was the Director of Communications and Marketing for the national children's charity, The Pre-school Learning Alliance, and a journalist in Scotland.

Robert resigned from the post of Director of Communications on 5 January 2016.

Lyn Simpson – Director of Delivery and Development (North)

Lyn Simpson was Director of Delivery and Development (North) at the NHS TDA until 31 March 2016 when she took up the post of Executive Regional Managing Director (North) for NHS Improvement.

Based on an important foundation of nurse, health visitor and midwife posts, Lyn has successfully pursued an extensive and progressive career within the NHS, occupying a series of director and trust board level positions within a range of healthcare settings.

Lyn was Director of Operational Performance and Service Improvement at a SHA for 5 years before moving to the DH to support the Deputy NHS Chief Executive as Director of NHS Operations. Lyn joined NHS TDA to oversee the transition from NHS trust to foundation trust status for organisations in the north.

Dale Bywater – Director of Delivery and Development (Midlands and East)

Dale Bywater was Director of Delivery and Development (North) at the NHS TDA until 31 March 2016 when he took up the post of Executive Regional Managing Director (Midlands and East) for NHS Improvement.

Dale joined the NHS TDA at its beginning in 2012. Prior to that, Dale was the National Director of Provider Delivery working within the DH. He was Director of Provider Development for the Midlands and East SHA Cluster, having undertaken a similar role previously within NHS East Midlands. Previous SHA roles include Director of Performance, Operations and Commissioning and Director of Planning & Delivery.

Prior to working in an SHA he was National Associate Director leading a number of national programmes including the development of NHS treatment centres and service improvement programmes to improve day surgery and operating theatre efficiency within the provider sector.

Dale spent the first 10 years of his career working in a variety of senior operational roles within NHS acute hospitals.

Anne Eden – Director of Delivery and Development (South)

Anne Eden joined the NHS TDA as Director of Delivery and Development (South) on 1 April 2015 on secondment from Buckingham Healthcare NHS Trust. On 1 April 2016 she took up the post of Acting Executive Regional Managing Director (South) for NHS Improvement.

With more than 30 years' experience in the NHS Anne started her career as an NHS management trainee and has experience in acute and teaching hospitals, mental health, community and specialist services.

She joined Buckinghamshire Healthcare NHS Trust as Chief Executive in December 2006. She led the integration of the county's acute and community services in 2010.

Previously Director of Clinical Services at Hammersmith Hospitals and Director of Services at St Mary's Hospital, Paddington, Anne also worked for the DH and in 2013 chaired the Better Training, Better Care group on behalf of Health Education England, which looked at how spending time in and out of hospital settings could help doctors determine their specialist futures.

Anne has an MBA and is a qualified performance coach and a graduate member of the Institute of Health Services Management and the Chartered Institute of Marketing. In 2012 she became a visiting professor at Buckinghamshire New University and adviser to the faculty of society and health, supporting the Institute of Applied Leadership's MA in Leadership and Management programme.

Alwen Williams – Director of Delivery and Development (London)

Alwen Williams was appointed to the role of Director of Delivery and Development (London) in 2012.

Alwen has been a manager in the NHS since 1980, working in primary care, community and acute services, commissioning and planning. She became Chief Executive of Tower Hamlets Primary Care Trust in June 2004, was seconded to the post of Chief Executive of East London and City Alliance of primary care trusts in 2009 and in January 2011 became Chief Executive of NHS East London and the City. In December 2011 Alwen also took on the role of Chief Executive of NHS outer north east London leading the 2 PCT clusters.

In June 2015 Alwen was seconded to Barts Health NHS Trust as Interim Chief Executive. On 3 January 2016 the appointment was made substantive.

NHS IMPROVEMENT

In addition to the directors listed above, the following appointments have been made to the leadership of NHS Improvement.

Professor the Lord Ara Darzi of Denham – Non-Executive Director

Professor Darzi is Director of the Institute of Global Health Innovation at Imperial College London. He also holds the Paul Hamlyn Chair of Surgery at Imperial College London and the Institute of Cancer Research and is Executive Chair of the World Innovation Summit for Health in Qatar. He is a Consultant Surgeon at Imperial College Hospital NHS Trust and the Royal Marsden NHS Trust.

Professor Darzi leads a large multidisciplinary team across a diverse and impactful portfolio of academic and policy research. His work drives the identification, development and adoption of innovation across international healthcare systems and champions high quality care. He has published over 950 peer-reviewed research papers to date and has developed his status as a leading voice in the field of global health policy and innovation. In recognition of his achievements, Professor Darzi was elected a Fellow of the Academy of Medical Sciences, an Honorary Fellow of the Royal Academy of Engineering, a Fellow of the Royal Society and, most recently, a foreign associate of the Institute of Medicine.

He was knighted for his services in medicine and surgery in 2002. In 2007, he was introduced to the United Kingdom's House of Lords as Professor the Lord Darzi of Denham and appointed Parliamentary Under-Secretary of State at the DH to lead a major review of the NHS, which culminated in the publication of his report, 'High Quality Care for All: NHS Next Stage Review', in 2008. Upon relinquishing this Ministerial role in 2009, Professor Darzi was appointed by the Prime Minister as the United Kingdom's Global Ambassador for Health and Life Sciences until March 2013. He currently sits as a Council Member for the UK's Engineering and Physical Sciences Research Council and a Non-Executive Director of Monitor, and has been a member of Her Majesty's Most Honourable Privy Council since June 2009. In January 2016, Professor Darzi was awarded the Order of Merit by Her Majesty the Queen for exceptionally meritorious service towards the advancement of medicine.

Lord Patrick Carter of Coles – Non-Executive Director

Lord Carter has pursued a successful career in business and in public service.

He was educated at Brentwood School and after receiving a degree in Economics from Durham University Patrick joined an investment bank. What followed is a career creating, developing and selling businesses. He founded Westminster Health Care in 1985 which he built into a leading provider of care to both the private and public sectors in the UK. Patrick has served on the boards of US and UK healthcare, insurance and technology companies and is currently Chair of Primary Insurance Group.

He was Chair of Sport England from 2002 to 2006, Board member of the London 2012 Olympic bid, a Member of HM Treasury's Productivity Panel and a Non-Executive member of the Home Office and Prisons Boards. He is also Chair of the DH Procurement and Efficiency Board.

Patrick has also chaired a number of challenging Government reviews including Criminal Records Bureau, Offender Management, the Procurement of Legal Aid, Commonwealth Games 2002, The English National Stadium (Wembley), National Athletics, Public Diplomacy and Pathology Services.

He was made a Life Peer in 2004.

Professor Dame Glynis Breakwell DBE DL **– Non-Executive Director**

Professor Dame Glynis Breakwell, Vice-Chancellor of the University of Bath, is one of Europe's leading social psychologists. She is an active public policy adviser and researcher specialising in leadership, identity processes and risk management.

In addition to her role as Vice-Chancellor, Dame Glynis holds a number of senior positions both nationally and internationally, acting as an adviser to the higher education sector, Government organisations, multi-national corporations and not-for-profit organisations.

Sigurd Reinton, CBE – Non-Executive Director

Sigurd Reinton was, until 2013, a Director of NATS Holdings, which provides the air traffic control services for UK and North Atlantic airspace and for the main UK airports. At NATS he served on the Audit and Nominations Committees and chaired the Stakeholder Council.

He was Chairman of the London Ambulance Service NHS Trust for 10 years until 2009 and before that of Mayday University Hospitals NHS Trust. He was a member of the Board of the Ambulance Services Network and of the advisory board of The Foundation. He was a member of the Council of the NHS Confederation from 1998 to 2007 and was the lead for London. He was previously a Director (senior partner) at McKinsey & Company.

Laura Carstensen – Non-Executive Director

Laura Carstensen is a Commissioner of the UK Equality and Human Rights Commission where she has led the recent statutory inquiry into Gender Diversity on FTSE 350 Boards and chairs the Commission's RIO (Regulators, Inspectorates and Ombudsmen) Forum which provides guidance and leadership on the role of equalities and human rights for RIOs.

She is a former partner in the leading international law firm Slaughter and May and, since leaving the firm in 2005, has held a number of public service roles including Deputy Chairman of the Competition Commission and a founder member of the Co-operation and Competition Panel for NHS-Funded Services. She has also served as a foundation trust board member.

She has broad and deep expertise in both sectoral and strategic regulatory policy, underpinned by a commitment to diversity, inclusion and social justice. She is based in the North.

Richard Douglas CB **– Non-Executive Director**

Richard Douglas is the former Director-General (DG) of Finance at the DH and has extensive experience of working across Whitehall.

He retired as DG of finance, commercial and the NHS directorate at the DH in April 2015. He was responsible for ensuring that the DH properly managed its finances and those of the health service and accounted to Parliament. He oversaw one of the biggest and most complex accounts consolidations in the world, covering about 700 separate organisations, accounting for almost 7% of UK GDP. He also had primary responsibility for NHS policy and the Government's relationship with the NHS. He was the DH's sponsor for a number of national ALBs, including NHSE, Monitor and the NHS TDA.

He is a member of the Chartered Institute of Public Finance and Accountancy.

Stephen Hay – Executive Director of Regulation/ Deputy Chief Executive

Stephen Hay was previously Managing Director of Provider Regulation at Monitor, the healthcare sector regulator whose responsibilities transferred to NHS Improvement on 1 April 2016, responsible for the monitoring, compliance and intervention regime for NHS foundation trusts. He joined Monitor in 2004.

A qualified chartered accountant, Stephen previously worked with KPMG, latterly as a Director within the Transaction Services Department where he advised boards of corporate and private equity houses. His portfolio of financial experience is wide ranging and includes mergers and acquisitions, due diligence, initial public offerings and risk assessment.

Stephen was a Non-Executive Director at the Department for Communities and Local Government from 2009 to 2015 where he also chaired the Audit and Risk Committee.

Stephen is a voting member of the NHS TDA and Monitor Boards.

Dr Ruth May – Executive Director of Nursing

Dr Ruth May was previously Nursing Director at Monitor, the healthcare sector regulator whose responsibilities transferred to NHS Improvement on 1 April 2016. She joined Monitor in July 2015. Prior to that she was Regional Chief Nurse and Nurse Director for the Midlands and East region of NHSE.

Ruth began her career with a variety of nursing roles before becoming a theatre sister at Frimley Park Hospital. She was Acting Director of Nursing at Barnet Hospital before being appointed the substantive Director of Nursing and Deputy Chief Executive with Havering Primary Care Trust.

In October 2005 she became Chief Executive of The Queen Elizabeth Hospital, King's Lynn, a post she held for 2 years. She has also been Chief Executive of Mid-Essex Hospital Services NHS Trust. Ruth led 'Stop the Pressure' which nearly halved the number of pressure ulcers in M&E, improving care for patients as well as delivering cost savings to the NHS.

Ruth is a voting member of the NHS TDA and Monitor Boards.

Adrian Masters – Executive Director of Strategy

Adrian Masters was previously Director of Sector Development at Monitor, the healthcare sector regulator whose responsibilities transferred to NHS Improvement on 1 April 2016. He joined Monitor in September 2005 and his prior roles include Director of the Health Team in the Prime Minister's Delivery Unit and roles at McKinsey, IBM and PwC.

Adrian is a qualified accountant and has an MBA from Stanford University. He has recently taken up a secondment as Director of Strategy at Public Health England.

Prior to his secondment Adrian was a voting member of the NHS TDA and Monitor Boards.

Helen Buckingham – Executive Director of Corporate Affairs

Helen Buckingham joined the NHS as a Regional Finance Management Trainee in 1992.

Much of her career has been spent in commissioning and system leadership roles. Immediately prior to joining Monitor she was Deputy Chief Executive of the Kent and Medway PCT Cluster and Director of Operations and Delivery for the Area Team.

Helen joined Monitor, the healthcare sector regulator whose responsibilities transferred to NHS Improvement on 1 April 2016, as Chief of Staff in April 2013.

Our people – The Board

The NHS TDA Board meets in public at least 6 times per year. Board members during the course of the year are shown below.

Chair Ed Smith CBE	Chief Executive[3] Jim Mackey	Director of Delivery and Development: Midlands and East Dale Bywater
Deputy Chair Sir Peter Carr CBE	Deputy Chief Executive[3] Robert Alexander	Director of Communications Robert Checketts
Non-executive director[1] Dame Christine Beasley	Director of Nursing[3] Peter Blythin	Director of Strategy Ralph Coulbeck
Non-executive director[2] Sarah Harkness	Medical Director[3] Dr Kathy McLean	Acting Director of Delivery and Development: South Anne Eden
Non-executive director Crispin Simon	Director of Finance[3] Elizabeth O'Mahony	Director of Delivery and Development: North Lyn Simpson
Non-executive director Caroline Thomson		Director of Delivery and Development: London Alwen Williams CBE

There were a number of changes to Board membership during the course of 2015-16. On 30 November 2015 Sir Peter Carr stood down from the role of Chair of the NHS TDA and became Deputy Chair. Ed Smith took up the position of joint Chair of the NHS TDA and Monitor on 1 December 2015. Dame Christine Beasley stood down from the role of Vice Chair on 30 November 2015. Following the departure of David Flory on 31 March 2015, the Director of Finance, Robert Alexander took up the role of Chief Executive and Elizabeth O'Mahony replaced Robert Alexander as Director of Finance. Following Jim Mackey's appointment as joint Chief Executive of the NHS TDA and Monitor on 1 November 2015, Robert Alexander was named Deputy Chief Executive of the NHS TDA.

Alwen Williams resigned from her post as Director of Delivery and Development (London) on 3 January 2016. Robert Checketts resigned from his post as Director of Communications on 5 January 2016.

[1] Interim Chair of the Appointments Committee

[2] Chair of Audit Committee

[3] Voting members

Directors' interests

A register of interests of Board members has been maintained and is available to download from the NHS TDA's website.

Emergency preparedness

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

The plan is closely linked with the evacuation plans for each of the 9 sites and can be triggered through the emergency alert service. This service also has a response element in the event of a major incident for all staff to confirm their safety. The business continuity policy will be reviewed in 2016-17 to reflect the new organisation and any changes in key information assets.

Disclosure of serious untoward incidents

As part of the NHS TDA's Information Governance (IG) policy a log of IG breaches and advice from the Caldicott Guardian is kept. There were no significant losses of personal data. The NHS TDA has introduced a series of physical and virtual spot-checks to ensure adherence to information governance policies, including security of data. Phishing email and misdirected email continue to be the dominant issues reported. Cyber issues are relayed to the Health and Social Care Information Centre who are responsible for the contract for NHS mail to ensure that any necessary patching is undertaken. Communications on the threat from phishing and other cyber threats have been highlighted to staff. The NHS TDA is represented at the fora on information governance and cyber security for the DH and its ALBs.

Articles for the staff newsletter on the importance of checking email addresses and copy lists have been developed and advice issued on when to consider additional protections such as password protection for sensitive documents. The continued need for vigilance is also highlighted in records management training for staff.

The NHS TDA has completed the Health and Social Care Information Centre Information Governance Toolkit for 2015-16 with a satisfactory score of 90%.

Principles for remedy

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

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

Statement of Accounting Officer's responsibilities

Under the National Health Service Act 2006, the Secretary of State, with the consent of HM Treasury, has directed the NHS TDA to prepare for each financial year a statement of accounts in the form and on the basis set out in the Accounts Direction. The accounts are prepared on an accruals basis and must give a true and fair view of the state of affairs of the NHS TDA 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;
- prepare the accounts on an going concern basis.

The Accounting Officer of the DH has designated the Chief Executive as Accounting Officer of the NHS TDA. 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 TDA's assets, are set out in Managing Public Money published by the HM Treasury.

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.

The Accounting Officer confirms that the NHS TDA's annual report and accounts as a whole is fair, balanced and understandable. He takes personal responsibility for the annual report and accounts and the judgements required for determining that it is fair, balanced and understandable.

Annual Governance Statement 2015-16

Introduction and context

This Governance Statement outlines how responsibility for the management and control of the NHS TDA resources were discharged during the year.

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

In June 2015, the Secretary of State announced that the NHS TDA and Monitor would be led by a single chair and chief executive. The 2 organisations were to work together closely to oversee the trust provider sector under the banner of NHS Improvement. There were no legislative changes associated with the creation of NHS Improvement and the 2 organisations continue to exist as separate legal entities. Each organisation continues to have its own board, although they have identical membership and meet as one board.

Scope of responsibility

As Accounting Officer, I have responsibility for maintaining effective governance and 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 in 'Managing Public Money and the Accounts Direction' from the DH.

NHS TDA's Governance Framework

Board composition

Following the decision to establish NHS Improvement, changes were made to the NHS TDA Regulations to enable a single chair to be appointed across both organisations. A further change to the Regulations was made to add more flexibility regarding the number of non-executives permitted on the NHS TDA Board. These changes have facilitated the creation of unified board arrangements whilst adhering to the principle that the NHS TDA and Monitor will remain as 2 separate bodies.

Chair and non-executive directors

In July 2015, Ed Smith was appointed as Chair of Monitor and Chair designate of the NHS TDA. Following the required change to the NHS TDA Regulations (outlined above) his appointment as Chair of the NHS TDA became effective on 1 December 2015. At the same time Sir Peter Carr resigned from the position of Chair of the NHS TDA to become Vice-Chair of the NHS TDA until 31 May 2016 when he stepped down from the NHS TDA Board. Dame Christine Beasley resigned from the position of Vice-Chair and Senior Independent Director of the NHS TDA but remained as a Non-Executive Director until 31 March 2016 when she too stepped down from the NHS TDA Board.

Crispin Simon resigned from the position of Non-Executive Director of the NHS TDA with effect from 31 December 2015.

Sarah Harkness and Caroline Thomson have remained on the NHS TDA Board and are joined by Sigurd Reinton, Lord Ara Darzi and Lord Patrick Carter (formerly Monitor only board members) and Richard Douglas, Professor Dame Glynis Breakwell and Laura Carstensen (new appointees). All are now appointed jointly to the NHS TDA and Monitor Boards.

Directors

In November 2015, I was appointed as Chief Executive of Monitor and the NHS TDA. Robert Alexander stood down from the position of Chief Executive of the NHS TDA (a post he had taken up following the departure of the former Chief Executive, David Flory, on 31 March 2015) to become Deputy Chief Executive of the NHS TDA until 31 March 2016. Elizabeth O'Mahony remained in her role as Director of Finance.

On 1 April 2015, Anne Eden joined the organisation on secondment from Buckingham Healthcare NHS Trust as Director of Delivery and Development (South).

In June 2015 Alwen Williams, Director of Delivery and Development (London), was seconded to Barts Health NHS Trust as Interim Chief Executive. On 3 January 2016 the appointment was made substantive.

Robert Checketts, Director of Communications, resigned from the organisation on 5 January 2016.

NHS Improvement

The NHS TDA and Monitor Boards held the first of their joint meetings on 28 January 2016 and met monthly until 26 May 2016 before moving to a bi-monthly pattern of meetings. Informal Board workshops are being held in the intervening months to enhance Board understanding of key areas of the organisation's business.

On 11 February 2016 NHS Improvement's new executive structure was announced and the new appointments took effect on 1 April 2016. As Chief Executive, I am a member of the NHS TDA/Monitor Boards and 4 other Executive Board Members have been appointed: Robert Alexander (Director of Resources/Joint Deputy Chief Executive), Stephen Hay (Director of Provider Regulation/Joint Deputy Chief Executive), Dr Kathy McLean (Medical Director) and Dr Ruth May (Chief Nurse).

NHS TDA board meetings

In addition to the joint NHS TDA/Monitor Board meetings (outlined above), the NHS TDA standalone Board held 4 meetings in public during 2015-16. Attendance at NHS TDA/joint Board meetings and NHS TDA committee meetings is shown in Table 1.

The NHS TDA 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 the lead up to the creation of NHS Improvement the NHS TDA's governance arrangements were kept under review to ensure that they remained fit for purpose and any proposed changes were reported to the Audit and Risk Committee and the Board.

In March 2016, the NHS TDA/Monitor Boards adopted a new governance framework which became effective on 1 April 2016.

NHS TDA committees

The NHS TDA stand-alone Board delegated responsibility for discharging certain duties to a series of committees and sub-committees; these were detailed in the Board's Scheme of Delegation. In line with its statutory responsibilities, the NHS TDA had 3 statutory committees: Audit and Risk, Remuneration and Appointments.

A further 2 non-statutory committees existed to provide an appropriate level of scrutiny to key areas of NHS TDA business - these were the Investment Committee and the Finance and Procurement Controls Committee. Further details of the role and remit of the committees are set out in the following paragraphs.

Audit and Risk Committee

Role

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

Composition and attendance

Committee membership consisted of 3 non-executive directors until the departure of Crispin Simon on 31 December 2015 when it reduced to 2. The Director of Finance, together with representatives from the internal and external auditors, also attended every meeting of the Committee. The Committee met 4 times during 2015-16.

The Committee's work

In July 2015, the Committee reviewed the accounts and annual report of the NHS TDA for 2014-15 on behalf of the Board and considered issues arising from the audit of the accounts.

The Committee received a report on the outcomes of an assurance exercise to validate Annual Governance Statements made by NHS trusts.

The Committee played a key role in the scrutiny of the NHS TDA's risk management arrangements and undertook detailed reviews of the contents of the strategic risk register on a quarterly basis. The Committee had a programme of 'in depth' reviews in which senior responsible officers attended committee meetings to provide a detailed explanation of the handling of individual risks. During 2015-16 in-depth risk topics included winter planning and deployment of linked additional resources, benefits appraisal exercise of the dissolution of NHS Direct and talent shortages in NHS trusts/value for money in redundancy/severance cases.

A programme of work for 2015-16 was agreed with Health Group Internal Audit based on business need and key areas of risk. During the course of 2015-16 the internal audit programme was adapted to reflect the move towards the creation of NHS Improvement. The Committee oversaw progress with delivery of the programme and received internal audit reports on key areas of NHS TDA business. The Committee monitored the actions taken to address the findings and recommendations set out in the reports.

Remuneration Committee

Role and membership

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

The terms of reference of the Committee made 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 were circulated to members via email and members delivered their views in writing. Teleconferences were arranged to discuss individual cases when necessary. A summary report of cases agreed via correspondence was presented at every Committee meeting.

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

The Remuneration Committee met 4 times during 2015-16. Three of the meetings were via teleconference.

Appointments Committee

The Appointments Committee was responsible for making recommendations to the NHS TDA on the appointment of chairs, non-executive directors and charity trustees to NHS trusts. The Committee met 3 times during 2015-16 and conducted the remainder of its business via correspondence.

Four sub-committees of the Appointments Committee were established to discharge the functions relating to appointment of non-executive directors in NHS trusts on behalf of the Appointments Committee. The sub-committees mirrored the 4 regions of the NHS TDA and each was chaired by the relevant Director of Delivery and Development.

Finance and Procurement Controls Committee (FPCC)

A Finance and Procurement Controls Committee supported the Board in the discharge of its responsibilities for financial and procurement efficiency control. The Committee met 5 times during 2015-16.

Investment Committee

The Investment Committee advised the Board on the discharge of its responsibilities concerning capital investments and approval of capital schemes in the NHS trust sector. The Committee also reviewed cases where a NHS trust was being merged with, or acquired by, another NHS trust or a foundation trust, or where a NHS Trust was acquiring services from a NHS trust or foundation trust and where a capital outlay was required to enable the transaction to be effected. The Committee maintained an overview of the NHS TDA's transaction programme. The Committee met 10 times during 2015-16.

Table 1: Members in attendance at Board and committee meetings

Name	Board (including joint meetings)	Audit and Risk Committee	Investment Committee	Finance and Procurement Controls Committee	Remuneration Committee
Board members					
Ed Smith	3/3	n/a	n/a	n/a	n/a
Sir Peter Carr	5/7	n/a	n/a	n/a	4/4
Dame Christine Beasley	7/7	n/a	n/a	n/a	2/4
Sarah Harkness	7/7	3/3	10/10	6/6	4/4
Crispin Simon	4/4	2/2	1/1	n/a	4/4
Caroline Thomson	7/7	3/3	n/a	n/a	4/4
Jim Mackey	4/4	n/a	n/a	n/a	n/a
Robert Alexander	7/7	1/3	3/3	4/6	n/a
Elizabeth O'Mahony	7/7	2/3	8/8	5/6	n/a
Kathy McLean	7/7	n/a	n/a	n/a	n/a
Peter Blythin	6/7	n/a	9/10	n/a	n/a
Board attendees					
Ralph Coulbeck	6/6	n/a	5/10	n/a	n/a
Robert Checketts	4/4	n/a	n/a	n/a	n/a
Dale Bywater	4/4	n/a	n/a	n/a	n/a
Anne Eden	4/4	n/a	n/a	n/a	n/a
Alwen Williams	1/1	n/a	n/a	n/a	n/a
Lyn Simpson	4/4	n/a	n/a	n/a	n/a

Wider governance arrangements

Senior Management Team

The NHS TDA Senior Management Team comprised the Chief Executive and Directors. It was charged with executive responsibility for ensuring delivery of the NHS TDA's strategic objectives. Until December 2015 the team 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. In January 2016 the team began meeting jointly with the Senior Management Team at Monitor on a fortnightly basis at 'ExCo' meetings. Following appointment of a new team of directors designate for NHS Improvement the ExCo was re-named the Executive Team and began to meet on a weekly basis.

Other decision making groups

The NHS TDA Senior Management Team was supported by a series of sub groups chaired by individual directors and with responsibility for specific areas of the business. Following the transition to NHS Improvement a new set of executive groups is being established to support delivery of the organisation's strategic priorities.

Risk assessment

The NHS TDA approach to risk is set out in its Risk Appetite Statement which was adopted by the Board and formed part of the Risk Management Strategy of the organisation. The statement set out the over-arching appetite for risk together with statements in relation to 4 key domains of its business: quality of care, financial management, service performance and NHS TDA reputation. The NHS TDA Board recognised that it was not possible to eliminate all the potential risks which are inherent in the oversight of healthcare providers and was willing to accept a certain degree of risk where it was considered to be in the best interest of patients. The Board had a low level of risk in relation to quality of services to patients and held NHS trusts to account where there was evidence of poor performance. The Board also had 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 was prepared to tolerate a moderate level of risk to maximise the potential of achieving high quality, sustainable services for patients. The Board had a low appetite for any actions or decisions taken which might have affected the reputation of the NHS TDA or its employees.

During 2015-16 the main risks for the NHS TDA were the deteriorating financial position and the decline in the delivery of certain performance standards of NHS trusts. The organisational risk profile took account of the additional work required to establish the new arrangements linked to the creation of NHS Improvement which could not be allowed to distract from business as usual. Work is underway to create an integrated risk management system for NHS Improvement which will enable the joint Board and Audit and Risk Committee to receive single risk reports.

The risk and control framework

The NHS TDA systems of management and financial control were designed to minimise risk in the organisation. The NHS TDA Audit and Risk Committee had lead responsibility for reviewing the risk profile of the organisation and the new joint Audit and Risk Committee will continue to exercise this function on behalf of NHS Improvement.

NHS TDA directorate level risk registers were maintained and were the responsibility of the relevant director. The NHS TDA risk management arrangements were supported by the Risk Assurance Group, chaired by the Director of Finance, which ensured an effective link between directorate level and strategic risks. After 1 April 2016, Robert Alexander assumed executive responsibility for risk in respect of NHS Improvement in his role as Executive Director of Resources.

An assurance map was created for the NHS TDA to ensure that the Board and its committees were provided with the appropriate levels of assurance in relation to key areas of the business.

The Audit Committee agreed a programme of work to be undertaken by the internal auditors during 2015-16. The Committee receives regular reports from the internal auditors on progress with the delivery of the plan and the outputs from individual audits. A system is in place to ensure that actions arising from internal audit reports are monitored and duly completed.

Head of Internal Audit Opinion 2015-16

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

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

For the 3 areas on which I must report, I have concluded the following:

- **In the case of risk management: moderate**

  We reviewed risk management as part of the reviews of cyber phase 2 – IT security, success regimes and turnaround plans. The review of the independent risk management arrangements was deferred at the request of management due to the coming together of NHS TDA and Monitor from 1 April 2016. It was considered that a review of this area would be more beneficial once the risk management arrangements for the new organisation had been determined.

- **In the case of governance: moderate**

  We reviewed governance as part of the reviews of revised arrangements for reporting performance of NHS Trusts, including oversight arrangements, success regimes and turnaround plans.

- **In the case of control: moderate**

  We reviewed controls in place throughout the audits contained within the audit plan. In total we have raised 2 high risk recommendations relating to cyber security. Our review in the area of financial controls was concluded as substantial. The remaining 4 areas reviewed were concluded as moderate.

In summary, therefore, my overall opinion is that I can give **moderate assurance** to the Accounting Officer that NHS TDA has had adequate and effective systems of control, governance and risk management in place for the reporting year 2015-16.

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 has been informed by the work of the internal auditors and senior managers within the organisation 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 provided 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 had an adequate system of internal control in place during 2015-16.

Data quality

The Board received reports detailing financial and service performance in NHS trusts. The NHS TDA's internal auditors have undertaken a review of the revised arrangements for reporting performance of NHS trusts including oversight arrangements and gave an overall rating of 'moderate'. An action plan has been developed to address the findings of the auditors' report and will be monitored quarterly by the Audit and Risk Committee.

Data security

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

Whistle-blowing

The NHS TDA became a prescribed body on 1 October 2014 for the purposes for workers at NHS trusts to make a protected disclosure in relation to any concern about public interest danger or illegality.

We greatly value the concerns raised with us by those working in the NHS. This year we received 17 whistleblowing cases. All of these were analysed and a determination made whether they were relevant to our role and, if so, what further work we needed to do to pursue the matter. In some cases this involved (in a manner agreed with the whistle-blower) contacting the relevant NHS trust to gather further information. In others, whistleblowing information directly contributed to a decision to open a formal investigation. Provided concerns were not raised with us anonymously, we explained the overall outcome to the whistle-blower.

The following table contains all the numbers of potential whistleblowing concerns received since 1 October 2014 and which still remain open:

Whistleblowing	2015-16	2014-15	Total
Cases received	17	26	43
Cases closed	9	22	31
Cases open	8	4	12

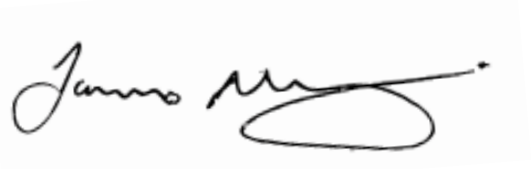
Following the Freedom to Speak Up Review in February 2015, the NHS TDA has undertaken a lot of work this year to improve the experience of whistle-blowing in the NHS. This has included delivering (with Monitor and NHSE) one of the key recommendations from the review, a national whistle-blowing policy for all NHS organisations. We have also helped the Care Quality Commission (CQC) set up the office of the National Freedom to Speak Up Guardian. Work on an employment support scheme to help whistle-blowers return to work is ongoing, and we hope to pilot the scheme in 2016-17.

Discharge of statutory functions

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

Conclusion

The NHS TDA governance arrangements are appropriate and proportionate to an organisation of its size. This was evidenced by reviews of the NHS TDA's internal systems of control, governance and risk management arrangements by the internal auditors which provided 'moderate' assurance. The Annual Report and Accounts for 2015-16 was produced within the given deadlines with an unqualified opinion without modification from the external auditors.



Jim Mackey

Chief Executive, NHS Trust Development Authority

4 July 2016

Remuneration report

Remuneration policy

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

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 Non-Executive Directors of the Authority. The Chief Executive and other senior staff members are invited to attend as and when required. No individual is in attendance when their remuneration is being discussed.

The Remuneration Committee has convened 4 times during the period 1 April 2015 and 31 March 2016.

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

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

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

A provision of £93,000 has been recognised in note 12 in relation to performance related pay, amounts awarded for 2015-16 may be determined and paid in 2016-17. Payments made to senior staff during 2015-16 in relation to the previous year are included within the performance related pay and bonuses column of the remuneration table.

Appointments

Non-Executive Directors are appointed by the Secretary of State for a term of 4 years.

The VSMs are appointed under standard NHS VSM contracts of employment in accordance with national NHS terms and conditions. As at 31 March 2016 all contracts are either fixed term or permanent with a notice period up to 6 months.

The Chief Executive is seconded from the Northumbria Healthcare NHS Foundation Trust and has a NHS contract of employment.

The Acting Director of Delivery and Development (South) is seconded from Buckinghamshire Healthcare NHS Trust and has a NHS 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 the DH terms and conditions.

Emoluments of board members

The remuneration relating to all directors that have undertaken duties and responsibilities supporting the NHS TDA during 2015-16 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:

2015-16					
Name and position	Salary (bands of £5,000)	Benefits in Kind (to nearest £100)	Total (bands of £5,000)	Date of appointment	Appointment ends
	£000	**£00**	**£000**		
Ed Smith CBE[1] Chair *On 1 December 2015 Ed Smith took up the position of joint Chair of NHS TDA and Monitor*	10-15	–	10-15	1 December 2015	31 July 2018
Sir Peter Carr CBE Deputy Chair *On 30 November 2015 Sir Peter Carr stood down from the role of Chair of the NHS TDA and became Deputy Chair*	50-55	–	50-55	1 June 2012	31 May 2016
Dame Christine Beasley Non-Executive Director *Resigned from the NHS TDA board on 31 March 2016*	10-15	–	10-15	26 September 2012	31 March 2016
Sarah Harkness Non-Executive Director	10-15	–	10-15	26 September 2012	25 September 2016
Crispin Simon[2] Non-Executive Director *Resigned from the NHS TDA board on 31 December 2015*	5-10	–	5-10	13 May 2013	31 December 2015
Caroline Thomson Non-Executive Director	5-10	–	5-10	13 May 2013	12 May 2017
The information above has been subject to audit.					

[1] Ed Smith CBE took up the position of Joint Chair of NHS TDA and Monitor from 1 December 2015. From this date 50% of his remuneration is disclosed in the NHS TDA's remuneration table and 50% is disclosed in Monitor's remuneration table. His annualised remuneration is within the band £100,000-£105,000 (50% of this, £50,000-£55,000, would be applicable to his NHS TDA duties).

[2] Crispin Simon left the NHS TDA on 31 December 2015 his annualised remuneration would have been in the band £5,000-£10,000.

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

The information above has been subject to audit.

Chief Executive and senior managers

The following table sets out details of payments made, contract commencement dates and notice periods for the Chief Executive and other directors, as appropriate:

2015-16							
Name and position	Salary (bands of £5,000)	Performance related pay and bonuses (bands of £5,000)	Benefits in kind (to nearest £100)	All pension-related benefits[6]	Single Total Remuneration (bands of £5,000)	Contract commencement date	Notice period (months)
	£000	£000	£00	£000	£000		
Jim Mackey[1] Chief Executive *Appointed as joint Chief Executive of the NHS TDA and Monitor commenced 1 November 2015, seconded from Northumbria Healthcare NHS Foundation Trust*	50-55	–	20	–	50-55	1 Nov 2015	2
Robert Alexander Deputy Chief Executive *For the period 1 April 2015–31 October 2015 Robert Alexander was Chief Executive of the NHS TDA. From 1 November 2015 he became Deputy Chief Executive of the NHS TDA*	170-175	5-10	–	58	235-240	1 Oct 2012	6
Elizabeth O'Mahony Director of Finance *Appointment commenced 1 April 2015*	135-140	5-10	–	60	200-205	1 Apr 2015	6
Dr Kathy McLean Medical Director	180-185	–	–	8	190-195	1 Oct 2012	6
Peter Blythin Director of Nursing	150-155	–	–	1	150-155	1 Oct 2012	6
Ralph Coulbeck[2] Director of Strategy *Left the NHS TDA on 31 March 2016*	95-100	–	–	(11)	85-90	1 Mar 2015	6
Robert Checketts[3] Director of Communications *Left the NHS TDA on 5 January 2016*	80-85	5-10	–	(17)	70-75	1 June 2012	6
Dale Bywater Director of Delivery and Development (Midlands and East)	155-160	5-10	–	(20)	140-145	1 Oct 2012	6
Anne Eden[4] Acting Director of Delivery and Development (South) *Seconded from Buckinghamshire Healthcare NHS Trust the appointment commenced 1 April 2015*	170-175	–	–	(2)	170-175	1 Apr 2015	1
Alwen Williams CBE[5] Director of Delivery and Development (London) *Seconded to Barts Health NHS Trust from 1 June 2015–3 January 2016 and left the NHS TDA on 3 January 2016*	25-30	–	–	216	240-245	1 Oct 2012	6
Lyn Simpson Director of Delivery and Development (North)	155-160	–	–	4	160-165	14 Oct 2013	6

The information above has been subject to audit. ***Notes 1-6 are explained on page 42.***

2014-15							
Name and position	Salary (bands of £5,000)	Performance related pay and bonuses (bands of £5,000)	Benefits in kind (to nearest £100)	All pension-related benefits[6]	Single Total Remuneration (bands of £5,000)	Contract commencement date	Notice period (months)
	£000	£000	£00	£000	£000		
David Flory CBE[1] Chief Executive *Left the NHS TDA on 31 March 2015*	205-210	20-25	–	3	230-235	1 Jun 2012	3
Robert Alexander Director of Finance	150-155	5-10	–	18	180-185	1 Oct 2012	6
Dr Kathy McLean Medical Director	180-185	–	–	(17)	165-170	1 Oct 2012	6
Peter Blythin Director of Nursing	150-155	–	—	(64)	85-90	1 Oct 2012	6
Ralph Coulbeck[2] Director of Strategy *On secondment from the DH from 13 August 2012 to 28 February 2015. Transferred to the NHS TDA payroll with effect from 1 March 2015*	85-90	–	—	29	115-120	1 Mar 2015	6
Robert Checketts Director of Communications	110-115	–	–	(62)	45-50	1 June 2012	6
Dale Bywater Director of Delivery and Development (Midlands and East)	155-160	5-10	–	16	180-185	1 Oct 2012	6
Dr Stephen Dunn[3] Director of Delivery and Development (South) *Left the NHS TDA on 3 November 2014*	90-95	–	–	12	100-105	1 Oct 2012	6
James Lusby[4] Acting Director of Delivery and Development (South) *Appointed from 2 November 2014 to 31 March 2015 inclusive*	55-60	–	–	–	55-60	2 Nov 2014	6
Alwen Williams CBE Director of Delivery and Development (London)	160-165	–	–	(19)	140-145	1 Oct 2012	6
Lyn Simpson Director of Delivery and Development (North)	155-160	–	–	21	175-180	14 Oct 2013	6
Yasmin Chaudhry[5] Interim Director of Special Measures *Left the NHS TDA 27 July 2014*	40-45	–	–	–	40-45	1 Jul 2013	6

The information above has been subject to audit. Notes 1-6 are explained on page 42.

Chief Executive and senior managers table references

2015-16 (see page 40)

1 Jim Mackey is on secondment from Northumbria Healthcare NHS Foundation Trust from 1 November 2015 as joint Chief Executive of the NHS TDA and Monitor. From this date onwards, 50% of his remuneration is disclosed in the NHS TDA's remuneration report and 50% is disclosed in Monitor's remuneration report.

Jim Mackey left the NHS Pension Scheme on 1 October 2010. Salary disclosed comprises two elements; his salary for 5 months within the band of £45,000–£50,000 and a payment in lieu of employers contributions to the NHS Pension Scheme within the band £5,000–£10,000. His full time annualised salary is within the band £215,000–£220,000 and his payment in lieu of employer's pension contributions is within in the band £25,000–£30,000, of which 50% is attributable to his NHS TDA duties.

His remuneration for 1 April 2015 to 31 October 2015 is disclosed in Northumbria Healthcare NHS Foundation Trust's annual report.

2 Ralph Coulbeck's NHS TDA contract is for 0.8 whole time equivalent. His annualised salary is within the band £115,000–£120,000. His 2015-16 pension related benefits are associated with the NHS Pension Scheme.

3 Robert Checketts left the NHS TDA on 5 January 2016 his annualised salary would have been in the band £110,000–115,000.

4 The notice period disclosed for Anne Eden is the period the NHS TDA is required to give Buckinghamshire Healthcare NHS Trust to terminate the secondment agreement.

5 Alwen Williams was seconded to Barts Health NHS Trust from 1 June 2015 to 3 January 2016 and left the NHS TDA on 3 January 2016 her annualised salary would have been in the band £160,000–£165,000.

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

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2014-15 (see page 41)

1 In addition to the remuneration shown in the table, David Flory received a termination payment within the band £410,000–£415,000 in accordance with a settlement agreement agreed on completion of a fixed term appointment set out in 2012. The notice period of 3 months was worked in full. This payment is included within note 7.4 Exit Packages of the NHS TDA's Annual Accounts. David Flory's performance related pay and bonuses has 2 elements, a one off payment relating to 2012-13 from the DH within the band £10,000–£15,000 and a NHS TDA payment relating to 2013-14 of £10,000–£15,000.

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

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

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

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

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

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 2015-16 was £180,000–£185,000 (£225,000–£230,000 in the period April 2014 to March 2015). This was 3.2 times the median remuneration of the directly employed workforce which was £57,069 (2014-15 figure was 4 times with a median remuneration of £56,504).

In 2015-16 no employees received remuneration in excess of the highest paid director (2014-15 nil). Remuneration ranged from £8,000 to £185,000 (2014-15 £8,000 to £230,000).

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

The highest paid director is the Medical Director as the Chief Executive of the NHS TDA is now a shared appointment with Monitor. The ratio between the highest paid director and the median remuneration of the workforce has decreased from the previous year. This is due to the decrease in the highest salary from £225,000–£230,000 in 2014-15 to £180,000–£185,000 in 2015-16. Consequently the pay multiple moved from 4.0 in 2014-15 to 3.2 in 2015-16.

The pay multiples information above has been subject to audit.

Pension benefits

Senior managers shown in the pension benefits table on page 44 are members of the NHS Pension Scheme.

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

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

Change in discount rate for pensions

On 16 March 2016, the Chancellor of the Exchequer announced a change in the Superannuation Contributions Adjusted for Past Experience (SCAPE) discount rate from 3.0% to 2.8%. This rate affects the calculation of the cash equivalent transfer value (CETV) in this report.

Due to the lead time required to perform calculations and prepare annual reports, the CETV figures quoted in this report for members of the NHS Pension Scheme are based on the previous discount rate and have not been recalculated.

Cash equivalent cash transfer

The method used to determine the value of a members retirement benefits is the CETV.

A CETV is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member's accrued benefits and any contingent spouse's (or other allowable beneficiaries) 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.

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 and pension benefits tables within the remuneration report.

Pension benefits

Name and title	Real increase in pension at pension age (bands of £2,500)	Real increase in pension lump sum at pension age (bands of £2,500)	Total accrued pension at pension age at 31 March 2016 (bands of £5,000)	Lump sum at age 60 related to accrued pension at 31 March 2016 (bands of £5,000)	Cash Equivalent Transfer Value at 31 March 2015	Cash Equivalent Transfer Value at 31 March 2016	Real increase in Cash Equivalent Transfer Value
	£000	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**
Jim Mackey[1] Chief Executive	–	–	–	–	–	–	–
Robert Alexander Deputy Chief Executive	2.5-5.0	10.0-12.5	35-40	115-120	744	834	82
Elizabeth O'Mahony Director of Finance	2.5-5.0	10.0-12.5	35-40	110-115	466	566	84
Dr Kathy McLean Medical Director	0-2.5	2.5-5.0	75-80	225-230	1,547	1,617	51
Peter Blythin[2] Director of Nursing	0-2.5	2.5-5.0	75-80	230-235	–	–	–
Ralph Coulbeck[3] Director of Strategy	0-2.5	–	10-15	–	75	88	12
Robert Checketts Director of Communication	0-(2.5)	0-(2.5)	15-20	45-50	235	248	8
Dale Bywater Director of Delivery and Development (Midlands and East)	0-2.5	0-2.5	35-40	110-115	559	597	31
Anne Eden Acting Director of Delivery and Development (South)	0-2.5	0-2.5	70-75	215-220	1,471	1,510	21
Alwen Williams CBE Director of Delivery and Development (London)	2.5-5.0	7.5-10.0	80-85	240-245	1,519	1,779	60
Lyn Simpson Director of Delivery and Development (North)	0-2.5	2.5-5.0	65-70	200-205	1,398	1,459	44

The information above has been subject to audit.

[1] Jim Mackey chose not to be covered by the NHS Pension Scheme during the reporting year.

[2] There is no CETV for the pension of Peter Blythin as he has now reached the pension scheme's normal retirement age.

[3] The figures for Ralph Coulbeck disclosed in the pension benefits table relate to his membership of the NHS Pension Scheme which he joined in March 2015. Prior to this he was a member of the Civil Service Pension Scheme.

Staff report

Number of senior managers by pay band

	2015-16		
Pay band	Total	Permanently employed	Other
Very senior manager	49	40	9
Band 9	39	37	2
Band 8d	49	42	7
Total	**137**	**119**	**18**

Average staff numbers

	2015-16			2014-15
Average staff numbers	Total	Permanently employed	Other[1]	Total
Staff Number	326	296	30	284

The analysis of staff costs are disclosed within the Financial Statements Note 5 and are subject to audit.

[1] Relates to fixed term staff on payroll, seconded staff and agency staff.

Exit Packages

During 2015-16 the NHS TDA had one exit package, a compulsory redundancy costing £305,000.

Exit packages are subject to audit.

Employee policies

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

The NHS TDA has a suite of employment policies agreed with the trades unions and recognised by the NHS TDA. Regular reviews are undertaken to ensure all policies are fully compliant with most recent legislative changes, Agenda for Change Handbook updates and good practice.

Equal opportunities and diversity

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

The NHS TDA Equality and Diversity Strategy sets out the NHS TDA's strategic approach to equality and diversity and its aims and objectives. The strategy document also sets out the governance arrangements that will ensure that the NHS TDA continues to have an appropriate focus on this important issue. The NHS TDA Equality and Diversity Forum remains in place, providing a forum "within which the whole organisation can engage in the equality and diversity agenda".

Social, community and human rights

The NHS TDA produces a regular staff newsletter as well as providing an intranet site which is regularly updated with information on matters of concern to employees. A new bulletin is also circulated on a weekly basis in order to inform and update staff on the proposed establishment of NHS Improvement.

The NHS TDA has a good relationship with regional Trades Union officers and regular Joint Consultative and Negotiation Committee meetings are held to consider issues likely to affect staff. Internal staff representatives are also invited to this meeting.

The Organisational Development strategy saw the introduction of learning representatives, health and wellbeing champions, an Organisational Development Support group, and an Organisational Development Implementation Group. The groups have proved to be excellent opportunities for staff to feed back to the organisation on issues which affect their employment, wellbeing and development.

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

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

Gender of NHS TDA staff as at 31 March 2016		
Staff category	**Female**	**Male**
Directors	4	5
Other VSMs	24	13
Other Staff	191	90
Total	**219**	**108**

Ethnicity of NHS TDA staff at 31 March 2016	
	Number of staff
White	265
Mixed race	4
Asian or Asian British	23
Black or Black British	14
Other	3
Did not state/undisclosed	18

Health and safety

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

The NHS TDA has invested in a training programme for staff and has access to fully qualified first aiders and fire wardens on each site. Health and safety and fire training is also included in the mandatory staff training package. There were 2 events registered in the 2015-16 incident log. A member of staff in Quarry House, Leeds was taken ill. NHS TDA first aiders attended and the staff member sent to accident and emergency for checks but subsequently discharged. The other incident involved a member of staff being stuck in lifts in Southside, London. This was taken up with NHS Property Services who provided assurance on the maintenance of the equipment. This is the same number of incidents as reported in 2014-15.

Staff sickness, absence and ill health retirements

The absence rate for the year 1 January 2015 to 31 December 2015 is an average working day loss per employee of 3.2 inclusive. This provides an overall sickness figure of 1.4%.

Staff sickness, absence and ill health retirements	2015 Calendar Year	2014 Calendar Year[1]
Total days lost	995	769
Total staff years worked	306	235
Total staff days available	68,850	52,779
Average working days lost	3.2	3.3
Number of persons retired on ill health grounds	1	0

[1] The staff sickness figures are produced in a format required by the DH.

Staff survey

The most recent staff survey results reinforced positive feedback from previous surveys undertaken by the NHS TDA. Staff were particularly positive about their understanding of the objectives, feeling trusted to do the job and generally feeling valued. Staff were also more positive than previous years about having the right equipment to do the job and about knowing how to report concerns.

Areas where some further development was identified included staff working additional hours.

Expenditure on consultancy

NHS TDA had consultancy expenditure of £136,195 for 2015-16.

Expenditure on contingent labour

NHS TDA had contingent labour expenditure of £597,743 for 2015-16.

Off-payroll engagements

All existing off-payroll engagements have been subject to a risk based assessment as to whether assurance is required, that the individual is paying the right amount of tax and, where necessary, that assurance has been sought.

Assurance has been sought for all new off-payroll engagements, or those that reached 6 months in duration between 1 April 2015 and 31 March 2016 that are more than £220 per day and last longer than 6 months.

The tables below report details of individuals engaged by the NHS TDA who are paid through their own companies and are responsible for their own tax and national insurance arrangements.

For all off-payroll engagements still engaged as at 31 March 2016 for more than £220 per day and that last longer than 6 months (not including agency contractors):

	Number
Number of existing engagements as at 31 March 2016	0
Of which, the number that have existed:	
for less than one year at time of reporting	0
for between 1 and 2 years at time of reporting	0
for between 2 and 3 years at time of reporting	0
for between 3 and 4 years at time of reporting	0
for more than 4 years at time of reporting	0

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

	Number
Number of new engagements, or those that reached 6 months in duration, between 1 April 2015 and 31 March 2016	8
Number of the above which include contractual clauses giving the DH the right to request assurance in relation to income tax and National Insurance obligations	8
Number for whom assurance has been requested	8
Of which:	
assurance has been received	8
assurance has not been received	0
engagements terminated due to assurance not being received	0

There were no off-payroll engagements of board members and/or senior officials with significant financial responsibility between 1 April 2015 and 31 March 2016.

There were 17 individuals on payroll that have been deemed 'Board Members, and/or senior officials with significant financial responsibility' during the financial year.

Auditor

The Comptroller and Auditor General is appointed by statute to audit the NHS TDA. The audit fee for the period ended 31 March 2016 of £45,000 is for the audit of these accounts. The external auditors have not undertaken any non-audit services on behalf of the NHS TDA.

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.

Parliamentary accountability and audit report

Parliamentary accountability

Regularity of expenditure

The income and expenditure recorded in the financial statements have been applied to the purposes intended by Parliament and the financial transactions recorded in the financial statements conform to the authorities given to the NHS TDA. This information is subject to audit opinion.

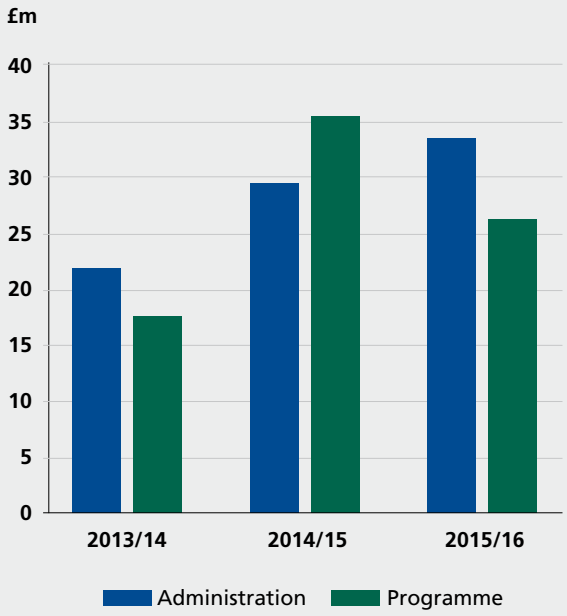
Cost allocation and charges for information

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

Long term expenditure trend

The NHS TDA took up its full statutory duties from 1 April 2013. During 2014-15 the NHS TDA implemented an expansion plan which saw a steady increase in the recruitment of staff.

NHS TDA expenditure



Jim Mackey
Chief Executive Officer
NHS Trust Development Authority

4 July 2016

Audit certificate and report

The certificate and report of the Comptroller and Auditor General to the House of Commons

I certify that I have audited the financial statements of NHS Trust Development Authority for the year ended 31 March 2016 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 and Staff Report and the Parliamentary Accountability Disclosures 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 2016 and of the net operating cost for the year then ended; and
- the financial statements have been properly prepared in accordance with the National Health Service Act 2006 and Secretary of State directions issued thereunder.

Opinion on other matters

In my opinion:

- the parts of the Remuneration and Staff Report and the Parliamentary Accountability Disclosures to be audited have been properly prepared in accordance with Secretary of State directions made under the National Health Service Act 2006; and
- the information given in the Performance Report and Accountability 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 parts of the Remuneration and Staff Report and the Parliamentary Accountability Disclosures 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

6 July 2016

Financial statements

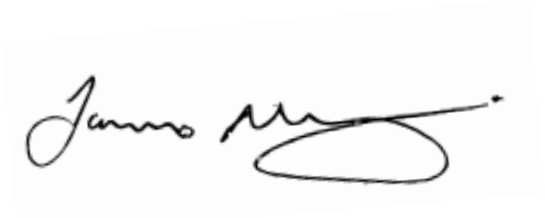
Statement of comprehensive net expenditure for the period ended 31 March 2016

	Note	2015-16 £000	2014-15 £000
Other operating revenue	4	1,412	953
Total operating revenue		**1,412**	**953**
Staff costs	5	27,091	24,150
Purchase of goods and services	6	10,799	8,894
Depreciation and impairment charges	6	232	150
Provision expense	6	73	30
Other operating expenditure	6	21,709	32,738
Total operating expenditure		**59,904**	**65,962**
Net operating costs for the financial year		**58,492**	**65,009**
Other comprehensive net expenditure		–	–
Total comprehensive net expenditure for the year		**58,492**	**65,009**

In line with the implementation of the Simplifying and Streamlining Accounts project, the comparative operating expenditure figures have been reclassified. The notes on pages 58 to 75 form part of these accounts.

Statement of Financial Position as at 31 March 2016	Note	31 March 2016 £000	31 March 2015 £000
Non current assets			
Property, plant and equipment	8.1	438	540
Intangible assets	8.2	60	44
Total non-current assets		**498**	**584**
Current assets			
Trade and other receivables	9	759	264
Cash and cash equivalents	10	4,805	108
Total current assets		**5,564**	**372**
Total assets		**6,062**	**956**
Current liabilities			
Trade and other payables	11	10,470	8,757
Provisions	12	93	90
Total current liabilities		**10,563**	**8,847**
Net current (liabilities)/assets		**(4,999)**	**(8,475)**
Total net (liabilities)/assets		**(4,501)**	**(7,891)**
Financed by taxpayers' equity			
General fund		(4,501)	(7,891)
Total taxpayers' equity		**(4,501)**	**(7,891)**

The financial statements and the notes on pages 58 to 75 were signed on behalf of the NHS TDA by:



Chief Executive Officer

NHS Trust Development Authority
4 July 2016

Statement of Changes in Taxpayers' Equity for the year ended 31 March 2016		
	Note	**General Fund £000**
Balance at 31 March 2015		**(7,891)**
Changes in taxpayers' equity for 2015-16		
Comprehensive net expenditure for the year	SoCNE	(58,492)
Net parliamentary funding	SOCF	61,882
Balance at 31 March 2016		**(4,501)**
Balance at 31 March 2014		**(11,553)**
Changes in taxpayers' equity for 2014-15		
Net operating cost for the year	SoCNE	(65,009)
Net parliamentary funding	SOCF	68,671
Balance at 31 March 2015		**(7,891)**

The notes on pages 58 to 75 form part of these accounts.

Statement of Cash Flows for the year ended 31 March 2016

	Note	2015-16 £000	2014-15 £000
Cash flows from operating activities			
Net operating cost		**(58,492)**	(65,009)
Adjustments for non-cash transactions			
Depreciation, amortisation and impairments	6	**232**	150
Provisions arising during the year	12	**93**	90
Provisions reversed unused	12	**(20)**	(60)
(Increase)/decrease in trade and other receivables	9	**(495)**	442
Increase/(decrease) in trade payables and other current liabilities		**1,858**	(5,248)
Provisions utilised	12	**(70)**	(70)
Net cash inflow/(outflow) from operating activities		**(56,894)**	**(69,705)**
Cash flows from investing activities			
(Payments) for property, plant and equipment		**(244)**	(496)
(Payments) for intangible assets		**(47)**	–
Net cash inflow/(outflow) from investing activities		**(291)**	**(496)**
Cash flows from financing activities			
Net parliamentary funding	SoCTE	61,882	68,671
Net financing		**61,882**	**68,671**
Net increase/(decrease) in cash and cash equivalents		4,697	(1,530)
Cash and cash equivalents at the beginning of the period		**108**	1,638
Cash and cash equivalents at the end of the period	10	**4,805**	**108**

The notes on pages 58 to 75 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.

1.2 Going concern

As part of the creation of NHS Improvement which took effect from 1 April 2016, both NHS TDA and Monitor were brought under joint leadership and working arrangements. Both organisations now operate under the umbrella of NHSI but remain separate legal entities.

NHS TDA's 2015-16 accounts have been prepared on a going concern basis. NHS TDA continues to be resourced by the DH with additional functions being transferred into the organisation from NHSE. For these reasons it is appropriate to continue to adopt the going concern basis in preparing the accounts.

1.3 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.

1.4 Movement of assets within the DH Group

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

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

1.5 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.

1.5.1 Critical judgements in applying accounting policies

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

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

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

Provisions recognised at 31 March 2016 were based on the NHS TDA's best professional judgement in line with IAS 37 and details of provisions can be seen in note 12.

1.5.2 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 1.5.1) estimation techniques are used to ensure that the correct levels of income and expenditure due and relating to current year, are included through the recording of accruals based on known commitments.

1.6 Revenue and funding

The main source of funding for the Special Health Authority is Parliamentary grant from the DH within an approved cash limit which is credited to the general fund. Parliamentary funding is recognised in the financial period in which it is received.

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

1.7 Employee benefits

1.7.1 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.

1.7.2 Retirement benefit costs

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

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

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

1.8 Property, plant and equipment

1.8.1 Capitalisation

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

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

An exception to capitalisation of expenditure for laptops, iPhones and iPads has been made within critical judgements – see note 1.5.1.

1.8.2 Valuation

Property, plant and equipment are capitalised initially at cost. Assets with a short useful life or low value are carried on the Statement of Financial Position at depreciated historic cost as a proxy for fair value. Assets not meeting these requirements are carried at fair value using the most appropriate valuation methodology available.

1.9 Intangible assets

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

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

1.10 Depreciation, amortisation and impairments

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

Depreciation is charged on each individual fixed asset as follows:

(i) Intangible assets are amortised, on a straight line basis, over the estimated useful lives of the assets varying between 3 and 5 years.

(ii) Each equipment asset is depreciated evenly over its useful life:

- plant and machinery – 5 years;
- information technology assets – between 3 and 5 years;
- furniture and fittings assets – between 5 and 10 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.

1.11 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.

1.12 Cash and cash equivalents

Cash is the balance held with the Government Banking Service.

1.13 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 – minus 1.55% (previously minus 1.5%);
- Medium term – minus 1.00% (previously minus 1.05%);
- Long term – plus 0.8% (previously plus 2.2%).

1.14 Financial Instruments

1.14.1 Financial assets

Financial assets are recognised on the Statement of Financial Position when the NHS TDA becomes party to the financial instrument contract or, in the case of trade receivables, when the goods or services have been delivered. Financial assets are derecognised when the contractual rights have expired or the asset has been transferred.

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

1.14.2 Financial liabilities

Financial liabilities are recognised on the Statement of Financial Position when the NHS TDA becomes party to the contractual provisions of the financial instrument or, in the case of trade payables, when the goods or services have been received. Financial liabilities are derecognised when the liability has been discharged, that is the liability has been paid or has expired.

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

1.15 Value Added Tax

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

1.16 Foreign currencies

The NHS TDA's functional and presentational currency is sterling. A transaction which is denominated in a foreign currency is translated into the functional currency at the spot exchange rate at the date of the transaction. At the end of the reporting period, monetary items denominated in foreign currencies are retranslated at the spot exchange rate on 31 March. Resulting exchange gains and losses are recognised in income or expense in the period in which they arise.

1.17 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.

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).

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

The HM Treasury FReM does not require the following Standards and Interpretations to be applied in 2015-16. The application of the Standards as revised would not have a material impact on the accounts for 2015-16 were they applied:

- IFRS 5 Non-current Assets Held for Sale and Discontinued Operations: Change in methods of disposal (amendment) – to be applied in 2016-17;
- IFRS 7 Financial Instruments: Disclosures: Servicing Contracts (amendment) – to be applied in 2016-17;
- IFRS 7 Financial Instruments: Disclosures: Applicability of the amendments to IFRS 7 Disclosure – Offsetting Financial Assets and Financial Liabilities to condensed interim financial statements (amendment) – to be applied in 2016-17;
- IAS 34 Interim Financial Reporting: Disclosure of information "elsewhere in the interim financial report" (amendment) – to be applied in 2016-17;

- IAS 1 Disclosure Initiative (amendment) – to be applied in 2016-17;
- IAS 27 Equity Method in Separate Financial Statements (amendment) – to be applied in 2016-17;
- IAS 16 and IAS 38 Clarification of acceptable methods of depreciation and amortisation (amendment) – to be applied in 2016-17;
- IFRS 11 Accounting for acquisitions of interests in joint operations (amendment) – to be applied in 2016-17;
- IAS 7 Disclosure Initiative (issued in January 2016) (amendment) – to be applied in 2017-18;
- IFRS 9 Financial Instruments – to be applied in 2018-19; and
- IFRS 15 Revenue from contracts with customers – to be applied in 2017-18.

2 Pension costs

Past and present employees are covered by the provisions of the 2 NHS Pension Schemes. Details of the benefits payable and rules of the Schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State in England and Wales. They are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Each scheme is therefore accounted for as if it were a defined contribution scheme. The cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to that scheme for the accounting period.

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

2.1 Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period and are accepted as providing suitably robust figures for financial reporting purposes. The valuation of scheme liability as at 31 March 2016 is based on valuation data as at 31 March 2015, updated to 31 March 2016, 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. These accounts can be viewed on the NHS Pensions website and are published annually. 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 schemes (taking into account their recent demographic experience) and to recommend contribution rates payable by employees and employers.

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

The Scheme Regulations allow for the level of contribution rates to be changed 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.

3 Operating segments

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

	Administration		Programme		Total	
	2015-16 £000	2014-15 £000	2015-16 £000	2014-15 £000	2015-16 £000	2014-15 £000
Revenue	(1,187)	(760)	(225)	(193)	(1,412)	(953)
Expenditure	35,136	30,230	24,768	35,732	59,904	65,962
Net Operating Costs	**33,949**	**29,470**	**24,543**	**35,539**	**58,492**	**65,009**
Assets	5,914	953	148	3	6,062	956
Liabilities	(3,172)	(3,001)	(7,391)	(5,846)	(10,563)	(8,847)
Net assets/(liabilities)	**2,742**	**(2,048)**	**(7,243)**	**(5,843)**	**(4,501)**	**(7,891)**

Administration

The financial objective of the NHS TDA is to manage the recurrent costs of management and administration within the allocation of £35,364,000. This funding covers staff, accommodation and other running costs.

Programme

The NHS TDA received an allocation of £25,814,000 programme funding for other expenditure made on behalf of the NHS. Programme funding cannot be used to supplement administration funding for the running costs for the NHS TDA.

4 Revenue

	2015-16 £000	2014-15 £000
Administration revenue		
Other fees and charges	–	350
Other miscellaneous revenue	59	10
Rental revenue recovery	81	92
Revenue in respect of seconded staff	1,047	308
Total administration revenue	**1,187**	**760**
Programme revenue		
Other miscellaneous revenue	161	–
Revenue in respect of seconded staff	64	193
Total programme revenue	**225**	**193**
Total revenue	**1,412**	**953**

5 Employee benefits and staff numbers

5.1 Employee benefits

	2015-16			2014-15
	Total	Permanently employed	Other	Total
	£000	£000	£000	£000
Gross expenditure				
Salaries and wages	22,393	19,285	3,108	19,573
Social security costs	2,047	2,036	11	1,958
Employer contributions to NHS BSA – Pensions Division	2,651	2,641	10	2,361
Termination benefits	–	–	–	258
Total gross expenditure	**27,091**	**23,962**	**3,129**	**24,150**
Administration expenditure				
Salaries and wages	22,342	19,234	3,108	19,336
Social security costs	2,041	2,030	11	1,936
Employer contributions to NHS BSA – Pensions Division	2,644	2,634	10	2,336
Termination benefits	–	–	–	467
Total administration expenditure	**27,027**	**23,898**	**3,129**	**24,075**
Programme expenditure				
Salaries and wages	51	51	–	237
Social security costs	6	6	–	22
Employer contributions to NHS BSA – Pensions Division	7	7	–	25
Termination benefits	–	–	–	(209)
Total programme	**64**	**64**	**–**	**75**

2014-15 termination benefits include the release of an unutilised redundancy accrual.

5.2 Staff numbers

	2015-16			2014-15
	Total	Permanently employed	Other	Total
Staff Number	**326**	**296**	**30**	284
Administration staff	325	295	30	283
Programme staff	1	1	–	1

5.3 Ill health retirements

	2015-16	2014-15
	Total	Total
Number of persons retired early on ill health grounds	1	–

There were no additional pensions liabilities accrued in the year (2014-15 NIL).

5.4 Exit packages agreed

	2015-16	2014-15
Number of other departures agreed	Total	Total
Exit package cost band		
£50,000 – £100,000	–	1
> £200,000	1	1
Total number of exit packages by type	1	2
Total resource cost (£000s)	**305**	**524**

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

5.5 Severance payments

There have been no severance payments in 2015-16 and 2014-15.

6 Operating expenditure

	Note	2015-16 £000	2014-15 £000
Purchase of goods and services			
Administration costs			
Auditors' remuneration		45	50
Business travel		1,236	1,146
Consultancy		17	36
Establishment expenses		1,186	950
External contract staffing		–	365
Information and communications		1,297	812
Premises		2,377	1,932
Professional fees		704	337
Sub-total		**6,862**	**5,628**
Programme costs			
Business travel		46	–
Consultancy		120	131
Establishment expenses		51	–
External contract staffing		19	26
Information and communications		–	146
Professional fees		3,701	2,963
Sub-total		**3,937**	**3,266**
Total purchase of goods and services	SoCNE	**10,799**	**8,894**

Within the Programme professional fees £2,420,000 relates to the Transformation programme (2014-15 Nil). In 2014-15 £1,890,000 related to the NHS TDA's cost of the tri-partite arrangement with NHSE and Monitor to support challenged local health authorities with their financial planning process.

Depreciation and impairment charges			
Administration costs			
Depreciation	8.1	195	119
Amortisation	8.2	34	31
Impairments and reversals of intangible assets	8.2	3	–
Total depreciation and impairment charges	SoCNE	**232**	**150**
Provision expense			
Administration costs			
Provision expense	12	73	30
Total provision expense	SoCNE	**73**	**30**

	Note	2015-16 £000	2014-15 £000
Other operating expenditure			
Administration costs			
Miscellaneous expenditure		**819**	242
Non-executive members' remuneration		**124**	105
Sub-total		**943**	**347**
Programme costs			
Miscellaneous expenditure		**635**	406
Funding provided to NHS trusts and partners:			
Dissolution Legacy of South London Healthcare Trust		**–**	13,145
Intervention and support to NHS trusts		**5,875**	6,731
Reimbursement of vendor costs in respect of trust transactions		**8,747**	9,039
Special measures		**5,509**	3,070
Sub total		**20,766**	**32,391**
Total other operating expenditure	SoCNE	**21,709**	**32,738**
Total operating expenditure	SoCNE	**32,813**	**41,812**

7 Operating leases

	2015-16 £000	2014-15 £000
Payments recognised as an expense		
Minimum lease payments	**41**	45
Total	**41**	**45**
Payable		
No later than one year	**11**	15
Between 1 and 5 years	**–**	–
After 5 years	**–**	–
Total	**11**	**15**

Included in the Administration Premises expenditure in note 6 is £1,954,000 of costs paid to NHS Property Services for the occupation of 7 sites, and £450,000 to the Department of Health for the occupation of 2 sites (2014-15 £1,335,000 and £316,000 for one site, respectively). They are operated under a memorandum of understanding.

8 Non-current assets

8.1 Property, plant and equipment

2015-16	Information technology £000	Furniture and fittings £000	Total £000
Cost or valuation			
At 1 April 2015	487	174	**661**
Additions purchased	93	–	**93**
Disposals	–	–	**–**
At 31 March 2016	**580**	**174**	**754**
Depreciation			
At 1 April 2015	116	5	**121**
Charged during the year	160	35	**195**
Disposals	–	–	**–**
At 31 March 2016	**276**	**40**	**316**
Net book value at 31 March 2015	371	169	**540**
Net book value at 31 March 2016	**304**	**134**	**438**

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

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

8.2 Intangible assets

2015-16	Software purchased £000	Licences and trademarks £000	Development expenditure £000	Websites £000	Total £000
Cost or valuation					
At 1 April 2015	10	16	77	–	**103**
Additions purchased	–	–	–	53	**53**
Impairments charged to SOCNE	–	(16)	(77)	–	**(93)**
Disposals	–	–	–	–	**–**
At 31 March 2016	**10**	**–**	**–**	**53**	**63**
Amortisation					
At 1 April 2015	–	8	51	–	**59**
Charged during the year	3	6	25	–	**34**
Impairments charged to SOCNE	–	(14)	(76)	–	**(90)**
Disposals	–	–	–	–	**–**
At 31 March 2016	**3**	**–**	**–**	**–**	**3**
Net book value at 31 March 2015	10	8	26	–	44
Net book value at 31 March 2016	**7**	**–**	**–**	**53**	**60**

The website purchased was not amortised in the year due to being purchased in March 2016.

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

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

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

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

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

8.3 Profit/ (loss) on disposal of fixed assets

The NHS TDA did not make any disposals of non-current assets during the period up to the 31 March 2016 (2014-15 NIL).

9 Trade receivables and amounts falling due within one year

	31 March 2016 £000	31 March 2015 £000
NHS receivables	395	94
NHS prepayments and accrued revenue	148	35
Non-NHS receivables	3	1
Non-NHS prepayments and accrued revenue	10	11
VAT	180	88
Other receivables	23	35
Trade and other receivables	**759**	264

10 Cash and cash equivalents

	31 March 2016 £000	31 March 2015 £000
Opening balance	108	1,638
Net change in year	4,697	(1,530)
Closing balance	**4,805**	108
Made up of		
Cash with Government Banking Service	4,805	108
Commercial banks and cash in hand	–	–
Current investments	–	–
Cash and cash equivalents as in Statement of Financial Position	**4,805**	108

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

	31 March 2016 £000	31 March 2015 £000
NHS payables	4,881	3,062
NHS accruals and deferred revenue	2,840	3,021
Non-NHS payables	877	332
Non-NHS accruals and deferred revenue	1,872	1,936
Pension payables	–	406
Trade and other payables	**10,470**	**8,757**

12 Provisions

	2015-16 £000	2014-15 £000
Balance at 1 April 2015	90	130
Arising during the year	93	90
Utilised during the year	(70)	(70)
Reversed unused	(20)	(60)
Balance at 31 March 2016	**93**	**90**
Expected timing of cash flows:		
No later than one year	93	90
Later than one year and not later than 5 years	–	–
Later than 5 years	–	–

A provision arose during 2015-16 in relation to performance related pay of very senior managers; the 2014-15 provision for very senior managers performance related pay was utilised.

13 Commitments

The NHS TDA has entered into a contract relating to the provision of accounting services commencing on 28 January 2013 for a period of 4 years. The annual cost of the contract is £30,000.

The NHS TDA entered into a contract relating to the provision of human resource services commencing on 1 April 2013 on a rolling basis with a termination notice period of 6 months. The total cost of the contract for the year was £61,485 (2014-15: £59,847).

14 Financial instruments

14.1 Financial risk management

Financial reporting standard IFRS 7 requires disclosure of the role that financial instruments have had during the period in creating or changing the risks a body faces in undertaking its activities. Because of the continuing relationship that the NHS TDA has with the DH and the way in which it is financed, the NHS TDA is not exposed to the degree of financial risk faced by business entities. Financial instruments also 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 NHS TDA is principally a domestic organisation with the great majority of transactions, assets and liabilities being in the UK and sterling based. The NHS TDA has no overseas operations. The NHS TDA therefore has low exposure to currency rate fluctuations.

Interest rate risk

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

Credit risk

Because the majority of the NHS TDA's revenue comes from funds voted by Parliament and from other NHS bodies, the NHS TDA has low exposure to credit risk. The maximum exposures as at 31 March 2016 are in receivables from customers as disclosed in the trade and other receivables.

Liquidity risk

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

14.2 Financial assets

	2015-16 Loans and receivables £000	2014-15 Loans and receivables £000
Trade and other receivables	398	95
Other receivables	203	123
Cash at bank and in hand	4,805	108
Total at 31 March 2016	**5,406**	**326**

14.3 Financial liabilities

	2015-16 Other £000	2014-15 Other £000
Trade and other payables	10,470	8,757
Total at 31 March 2016	**10,470**	**8,757**

15 Contingencies

At 31 March 2016 there were no known contingent assets or liabilities (31 March 2015: NIL).

16 Events after the reporting period

From 1 April 2016, the NHS TDA and Monitor operate as part of NHS Improvement, with a new shared governance structure. The underlying legal entities of Monitor and NHS TDA will remain in place.

As part of the creation of NHS Improvement, the Patient Safety and NHSIQ functions transferred to NHS TDA from NHSE on 1 April 2016.

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

17 Related parties

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

The DH is regarded as a related party. During the year the NHS TDA had a number of material transactions with the DH and other entities for which the DH is regarded as the parent department including NHSE, 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
2015-16				
HM Revenue & Customs	2,036	–	–	180
National Health Service Pension Scheme	2,641	–	–	–
Northumbria Healthcare NHS FT	458	–	80	20
2014-15				
HM Revenue & Customs	1,834	–	–	88
National Health Service Pension Scheme	2,213	–	406	–

During the year no DH Minister, board member, key manager or other related parties has undertaken any material transactions with the NHS TDA (2014-15 NIL).

18 Resource limits

18.1 Revenue resource limit

	2015-16 £000	2014-15 £000
Net operating costs for the financial period	58,492	65,009
Revenue resource limit	61,178	65,216
Under/(over) spend against revenue resource limit	**2,686**	207

18.2 Capital resource limit

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

	2015-16 £000	2014-15 £000
Charge against capital resource limit (gross capital expenditure)	146	317
Capital resource limit	500	500
Under/(over) spend against capital resource limit	**354**	183

18.3 Under/(over)spend against cash limit

	2015-16 £000	2014-15 £000
Total charge to cash limit	61,882	68,671
Cash limit	61,882	68,671
Under/(over) spend against cash limit	**–**	–

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

NHS
Improvement

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