NHS Improvement

NHS Trust Development Authority: annual report and accounts 2016/17

HC 233

support collaborate challenge improve inspire

NHS Trust Development Authority

Annual report and accounts
1 April 2016 to 31 March 2017

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About NHS Improvement

NHS Improvement is responsible for overseeing NHS 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 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 Trust Development Authority

NHS TDA's role is to provide support, oversight and governance for all NHS trusts in their aim of delivering what patients want; high quality services today, secure for tomorrow. The range of services provided by NHS trusts covers the entire spectrum of healthcare, from acute hospitals to ambulance services through to mental health and community providers; the size of organisation varies from very small providers through to some of the largest organisations in the NHS, and therefore each trust has a set of unique challenges. Due to this variation, we 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.

This report covers the period from 1 April 2016 to 31 March 2017. Monitor and NHS TDA continue to exist as legal entities, but this report refers mainly to NHS Improvement.

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Performance report

Overview 2016/17

This section highlights achievements from NHS Improvement's first year and outlines our purpose and activities.

Reduced agency spending by over

£700 MILLION

Patient safety collaboratives:

- ✓ engaged with **1,575 organisations,** including
- ✓ **333** care homes
- ✓ **635 primary care** organisations
- ✓ **219** trusts

Collaborative involving **19 trusts** launched to reduce falls in hospital wards

10 Patient Safety Alerts and action on **162** patient safety issues

Intensive urgent and emergency care support **to 40 systems**

Leadership programmes **supported 21 senior cross-system teams**

9.2% more trusts rated good and **4.7%** more rated outstanding

✓ National safe staffing improvement resources

2-Year Tariff

Patient-level costing standards

9 trusts exited special measures on grounds of quality

GIRFT GETTING IT RIGHT FIRST TIME

in 31 specialties: aims to deliver more than **£1.3 billion efficiencies** over next three years

2,000 active Model Hospital users

Chairman's introduction

I am pleased to introduce our annual report and accounts for 2016/17, the first year of NHS Improvement. Monitor and the NHS Trust Development Authority (NHS TDA) remain as separate legal entities, but our people, our resources and our responsibilities to the government, the health service and patients are united in NHS Improvement. Our remit is helping trusts to improve quality of care, finances and use of resources, operational performance, leadership and contribution to strategic change across local health systems.

We came together at a fast pace to offer the NHS the support it needs to deal with some of the biggest challenges it has faced in a generation. In addition to Monitor and NHS TDA, we welcomed colleagues from Patient Safety including the National Reporting and Learning System, the Advancing Change team and the Intensive Support Teams. We didn't get everything right first time and we are learning how to improve ourselves. But with our staff's hard work and dedication, and with our chief executive Jim Mackey's outstanding leadership, we have built an organisation of which we can be justly proud – and we have achieved a huge amount.

The NHS remains challenged across our services, and those challenges will intensify. But 18 trusts previously rated as 'inadequate' or 'requires improvement' became 'good' or 'outstanding'. Much remains to be done, but it is encouraging that our stakeholders support the activities we are prioritising. An Ipsos MORI survey of senior staff in trusts, clinical commissioning groups and national healthcare organisations found many who spoke positively about their engagement with NHS Improvement, remarking that working relationships were strong and discussions constructive, robust, open and honest. They must remain so for us all to meet the challenges ahead.

Our stakeholders were particularly enthusiastic about our role in sharing learning across the NHS, and want to see more of it. This bears out my own experience when visiting trusts. I have found that however tough the conditions in which frontline staff work, they maintain upbeat attitudes and an appetite for innovation and improvement. Many are working with patients on redesigning processes and enhancing services. They are hungry for ideas on improving patient flow, securing better staff continuity and job satisfaction, and reducing unwarranted variation in care. We should all now be spreading good practice across our trusts, often beginning with the little things shown to work in one small area. Trusts are eager to learn from others and keenly aware there are many ideas they could import and adapt if only they knew about them: solutions may not always be identical, but the themes are the same and the crossover enormous.

Clearly, NHS Improvement can make a major difference here – in fact we are already doing so. Our online Improvement Hub brings together improvement tools and resources, and showcases ideas from across the health sector, while our Faculty of Improvement includes internationally recognised clinicians who promote work to improve the NHS from within, harnessing talent from across the country. The quality, productivity and efficiency metrics in our Model Hospital information system show what good looks like – and more than 2,000 people are already using it. Packaging innovations from individual trusts and sharing them across the sector will remain a core objective for us in the coming year.

Learning from each other, within and across organisations, is integral to the *Developing people – improving care* framework we devised with our national partners. It seeks to change people's perspectives on how we create improvement skills, develop talent and do training. Its ultimate aim is to make the climate in which NHS staff operate more inclusive and compassionate. That climate shapes the way we develop, work and collaborate day in, day out. Getting it right is more important than ever in an era of intense pressure.

Having been appointed as chairman in July 2015 to oversee NHS Improvement's creation, I am stepping down from my role before it is due to end in June 2018. As Jim Mackey's two-year secondment will end in October, I felt strongly that it would be better for NHS Improvement – and for the wider NHS – if the appointment of a successor was led by the chair who will work with the new chief executive in the longer term.

With the high calibre of passionate, professional and committed staff across the country that I have met throughout our new organisation, I am confident NHS Improvement will continue to play a crucial role in helping the NHS deliver great health and care safely and efficiently. I hope this report will give you a sense of what they have achieved in the past year, and I thank all those who work for us and our wider stakeholders.

Ed Smith CBE
Chairman of NHS Improvement
4 July 2017

Chief Executive's perspective on performance

NHS Improvement's first year coincided with a momentous period for the trusts we exist to support. They coped with record numbers of ambulance call-outs and patients attending accident and emergency departments, as well as difficulties getting people who didn't need to be in hospital into an increasingly pressured social care system. Staff worked relentlessly throughout, maintaining their dedication to patients and the public with great care and compassion. Their humbling and heroic efforts enabled the NHS to achieve things we all thought impossible. The NHS continues to outperform health systems in other major nations while often subject to scrutiny that focuses on the challenges and misses the great successes evident throughout the service.

Inevitably, this operational pressure caused additional and unplanned financial pressure. Many trusts found ways to address this, often with help from their commissioners. Others needed our support. Our clinically led Emergency Care Improvement Programme provided on-the-spot help to more than 40 local health and social care communities under the greatest strain. In trusts facing the biggest financial problems, our teams around the country worked with partners to bring about rapid recovery by restoring the kind of discipline, governance and processes that the best trusts display. The first wave of our Financial Improvement Programme identified £100 million of savings in the 16 trusts taking part. And we supported the NHS in reducing agency costs by more than £700 million in the financial year – a remarkable achievement.

Of course, the NHS still has a long way to go before we can regard it as being on a sustainable footing again. I know some trusts continue to face difficulties, and many risks persist. We hope that by producing with our partners NHS England a national tariff which for the first time covers two years, we have given trusts more certainty and stability as well as time to restore their finances. Already the number of trusts in deficit – and the total amount of the deficit – has fallen significantly in the last year, and we commend trusts for their efforts. We will work with providers and partners over the summer to develop a longer-term approach to financial sustainability.

Our approach is to use regulation only as a last resort, working hand in hand with the Care Quality Commission. During the year we took close control over the direction of the sector to restore confidence that it could manage itself. Having made great strides forward, in the next 12 months we will start to move towards earned autonomy for trusts that demonstrate they are on the right track. I'm a great believer that the NHS is populated by clinicians and managers who want to do the right thing without us having to tell them to. That is why we have based our Single Oversight Framework primarily on identifying how we can best help trusts improve services for patients, rather than on performance management.

Finally, I would like to thank our departing chairman, Ed Smith, for his personal support and for his contribution to the NHS. His oversight and hard work during NHS Improvement's first year have put us on a sound footing for the future and helped us build a strong organisation. Few leaders have had so much positive impact in such a short period of time and he will be greatly missed.

Jim Mackey
Chief Executive of NHS Improvement
4 July 2017

NHS Improvement's purpose and activities

NHS Improvement is responsible for overseeing NHS 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.

Our strategic objectives for 2020 have five themes:

1. **Quality of care:** Providers need to continuously improve care quality, helping to create the safest, highest quality health and care service. People deserve consistently high quality healthcare that is personal, effective and safe, that respects their dignity and that is delivered with compassion.

2. **Finance and use of resources:** Providers need to achieve financial balance and deliver efficiency and productivity improvements to support financial sustainability.

3. **Operational performance:** Providers need to maintain and improve performance against NHS Constitution standards. People deserve access to services wherever and whenever they need them.

4. **Strategic change:** Every area will need to have a clinically, operationally and financially sustainable pattern of care. This will require providers to transform services in line with the Five Year Forward View and will include making use of new care models and innovative organisational forms.

5. **Leadership and improvement capability:** Providers need strong leadership and the ability to continuously improve, foresee and tackle issues, and make well-informed decisions.

Performance analysis

We measure our performance against the five themes of our strategic objectives for 2020:

- quality of care
- finance and use of resources
- operational performance
- strategic change
- leadership and improvement capability.

Each theme is equally important, and all are interconnected. Quality of care, finance and use of resources, and operational performance relate directly to trusts' outcomes; strategic change – and leadership and improvement capability – are important for ensuring these outcomes are sustainable. Our role is both to support trusts in achieving their sector-wide objectives and to achieve specific objectives ourselves.

In addition, we also describe our early progress in establishing a major new operational productivity programme to support trusts in implementing the findings from Lord Carter's review. By reducing variations in how resources are used, and by reducing the prices paid for non-staff resources, this programme is designed to help trusts achieve substantial improvements across the interlinked objectives of quality of care, finance and use of resources, and operational performance.

The **Single Oversight Framework**, which we introduced in October 2016, signals a change in how we work with trusts. It shifts the emphasis away from regulation and performance management and towards identifying how we can best help trusts improve patient services. Developed with the Care Quality Commission (CQC) and NHS England, the framework applies to NHS trusts and foundation trusts – though not to independent providers – building on (and replacing) Monitor's Risk Assessment Framework and the NHS Trust Development Authority's Accountability Framework. It is intended to help us identify support needs of both NHS trusts and foundation trusts in a consistent fashion, recognising they face common challenges and have similar support needs.

We use information from our data monitoring and insights from our work with trusts to identify where they may need support under one or more of the five themes above.

The framework is designed to help increase the number of trusts achieving 'good' or 'outstanding' CQC ratings, and is closely aligned with CQC's approach. We assign trusts to one of four 'segments' depending on the level of support they need. Those in Segment 1 have maximum autonomy; trusts in Segment 2 receive targeted support for less serious issues. Where we have serious concerns we mandate support: trusts in Segment 3 are in breach or suspected breach of their licence or equivalent for NHS trusts; those in Segment 4 are in 'special measures'. Our regional teams tailor support packages for each trust. The framework will evolve in the light of experience.

With NHS England, we published **NHS planning guidance** in September, three months earlier than usual. This was to enable commissioners and providers to complete operational planning and contracting by the end of December, enabling them to move into 2017 with a stronger focus on working collaboratively to implement these plans. For the first time, the guidance covered two financial years, to provide greater stability, and was underpinned by a two-year tariff (see page 24) and a two-year NHS standard contract. The process was also designed to strengthen the increasingly collaborative approach being taken within sustainability and transformation partnerships, with an increased focus on managing resources and sharing financial risk across local health and care systems.

In addition, we have in our first year focused on building NHS Improvement as an organisation to ensure we effectively and efficiently offer strategic leadership, oversight and practical support.

Quality of care

We define quality in the NHS in terms of patient safety, clinical effectiveness and patient experience. Quality improvement and particularly the improvement of patient safety become ever more important when pressure in the system increases as the NHS responds to growing demand. We provide clinical and managerial leadership and improvement expertise to support trusts' care quality including patient safety. Much of what we achieve can only be done in partnership with others.

The most direct way we help trusts improve care quality is through our regional teams – for the North, Midlands and East, London and the South of England. They form lasting and productive relationships with trusts and support them and the wider system in implementing policy. The teams provide vital intelligence about the challenges and issues the system faces, which is used to inform national initiatives. They work closely with NHS England's regional teams, which in turn have a direct relationship with commissioners so together we identify shared priorities.

One of our overall quality objectives is to reduce the number of trusts in **special measures for quality**. Nine trusts exited special measures for quality during 2016/17, against a target of five in our 2016/17 business plan. At 31 March 2017, 11 trusts were in special measures for quality, compared to 16 at 1 April 2016 (although a further four entered special measures in April 2017). We have set a target for 2017/18 of a third of trusts in special measures at the end of 2016/17 exiting by the end of 2017/18, developing a plan to help the remainder to exit by 2020. We will achieve this by prioritising rapid quality improvement by all trusts in special measures, with dedicated support to address their specific challenges, including embedded improvement directors, funding for improvement programmes, monitoring improvement plans, building leadership capacity and facilitating change.

Another objective is to ensure that two-thirds of trusts will achieve the Care Quality Commission's (CQC) **'good' or 'outstanding' levels of quality** in the next few years. Between 1 April 2016 and 31 March 2017, the percentage of trusts rated 'good' by CQC rose from 29.9% to 39.1% and the percentage rated 'outstanding' rose from 1.3% to 6%. A total of 24 trusts improved from 'inadequate' or 'requires improvement' to 'good' or 'outstanding', against a target of 12. For 2017/18 we have set a target of at least 17 providers rated 'inadequate' or 'requires improvement' at

the end of 2016/17 achieving a ‘good’ or ‘outstanding’ rating when CQC re-inspects them. Our regional teams will work intensively with these providers to achieve this.

Our remit for patient safety extends across all areas of NHS-funded healthcare, including primary care, community health, mental health, ambulance and acute services. Our patient safety team is legally responsible for delivering some statutory patient safety duties across the NHS. The first of these duties is to collect information about patient safety in the NHS. We do this primarily by collecting patient safety incident reports via the **National Reporting and Learning System** (NRLS) and routinely reviewing the most significant incidents. We use that information to alert the NHS to emerging patient safety risks and advise how to reduce and avoid risk. We also use the insight and knowledge gained through performing these statutory duties to support other safety improvement work across the system.

When things go wrong in care, it is vital incidents are recorded to ensure organisations learn what went wrong and why, and act to reduce the risk of similar incidents reoccurring. At a national level we are responsible for collecting this information via the NRLS, the world’s largest and most comprehensive patient safety incident reporting system. It has recorded more than 15 million incidents since it began in 2003. Between January and December 2016 almost 2 million incidents were reported to it, a 7% increase on the previous year. This is a welcome sign of an improving safety culture in the NHS that is getting better at recognising risks and ensuring learning takes place when things go wrong.

Our clinical reviewers concentrate on incidents that result in severe harm or death – about 300 a week (including duplicate records). Most incident reports relate to relatively well-known risks, but about five a week describe risks that may be under-recognised or new, or represent unusual trends. A multidisciplinary clinical group assesses these for action that may be needed. Depending on what it sees, it reviews an average of one or two issues a week to better understand the problem and inform further action.

We published 10 **patient safety alerts** in 2016/17 to warn the NHS of emerging patient safety risks, highlight newly available resources to tackle a known risk, or ask that a specific definitive action is taken to prevent a risk arising. Our patient safety alerts are drafted in consultation with clinicians, patients and experts from professional bodies and regulators. Healthcare providers must share information in alerts with relevant teams and take any action required.

Raising awareness of acute kidney injury

Our patient safety alert on acute kidney injury (AKI) sought to highlight new resources available to help healthcare professionals diagnose, treat and raise awareness of AKI. AKI is a sudden reduction in kidney function and is a condition that affects more than 500,000 people a year in England. Around 40,000 excess deaths per annum are associated with the condition, up to a third of which are thought to be preventable. AKI usually occurs without symptoms, making it difficult to identify. Late diagnosis can miss opportunities for early treatment, leading to prolonged and complex treatment and reducing the chances of recovery.

During the autumn we consulted on our **Never Events policy** and the list of incidents we define as such. We received 574 responses, which we are taking into account as we consider how to update the policy and revise the list.

Working in partnership with the academic health science networks (AHSNs), the 15 **patient safety collaboratives** aim to create a culture of continuous learning and improvement, spreading safer care initiatives from within the NHS and beyond. Funded by NHS Improvement and led by the AHSNs, the collaboratives are made up of NHS, academic and healthcare experts who work with teams in local health systems and set their own priorities. They are active in all care settings including maternity care, mental health, GP practices, acute hospitals, community health services and nursing homes. They also work with people who manage their own conditions at home, as well as frail older people and those admitted to hospital.

The collaboratives work together nationally to share information about successful initiatives so that patient safety improvement can be quickly spread across the country. They create the environment to make the best use of both human and financial resources.

During 2016/17, the patient safety collaboratives:

- engaged with 1,575 organisations, including 333 care homes, 635 primary care organisations and 219 NHS trusts and foundation trusts
- trained 10,150 people as part of quality improvement capability building
- started 451 quality improvement projects, of which 170 have been completed
- recruited 1,972 patient safety champions, Q initiative participants and quality improvement experts.

Patient safety collaboratives

Locally led initiatives in patient safety collaboratives have:

- reduced deaths after emergency laparotomies by 42% (Kent, Surrey and Sussex AHSN with West of England and Wessex patient safety collaboratives)
- achieved a 50% increase in patients returning to mental health wards on time after a period of approved leave (Oxford AHSN patient safety collaborative)
- reduced inpatient medication errors (Imperial College Health Partners AHSN patient safety collaborative).

We have also begun to develop a **central measurement unit** to generate the evidence and learning needed to understand how to make the NHS safer and to support wider improvement. It will work through the patient safety collaboratives and also support other improvement programmes to help healthcare staff prevent and learn from errors, reduce avoidable harm and create safer systems of care.

The **Q initiative**, led by the Health Foundation and supported and co-funded by NHS Improvement, connects people with improvement expertise across the UK. Q creates opportunities for people to come together as an improvement community – sharing ideas, enhancing skills and collaborating to make health and care better. Participants represent a diverse range, including those at the front line of health and social care, patient leaders, commissioners, managers, researchers, policymakers and others. The initiative recruited 568 new participants in 2016/17 bringing the total to 799. By the end of 2017/18, Q will be a community of thousands of improvers.

Falls in hospital are the most commonly reported safety incident in acute trusts, as well as the most common source of injury and cause of death from injury among people over 65. Total costs to the NHS from falls among older people alone are estimated at £2 billion. Evidence suggests falls could be reduced by up to 30%, particularly when focused on wards with older patients. Our **falls collaborative**, launched in January 2017, aims to improve reporting of falls, increase quality improvement skills and ultimately reduce falls on wards in the 19 trusts taking part.

Our **national maternal and neonatal health safety collaborative** is a three-year programme to reduce the rates of maternal deaths, stillbirths, neonatal deaths and brain injuries that occur during or soon after birth by 20% by 2020 and 50% by 2030. It provides trusts with quality improvement training and expertise, and enables them to work together on improving clinical practices and reducing unwarranted clinical variation. Launched in February 2017, all maternity units in England will take part, and frontline staff will be involved in designing each unit's local improvement plans. NHS National Director for Patient Safety, Dr Mike Durkin, said the initiative could become "the largest collaborative learning network for maternal and neonatal health in the world".

We are leading the programme to reduce healthcare-associated **Gram-negative bloodstream infections** (GNBSIs) by 50% by March 2021. Our Executive Director of Nursing, Ruth May, was appointed as the national Director of Infection Prevention and Control in November 2016. GNBSIs numbered 58,000 in 2015/16. Of these, two-thirds were *E. coli* infections, from which about 5,000 patients died within 30 days. Our initial focus is to reduce *E. coli* bloodstream infections by 10% in 2017/18. With NHS England and Public Health England, we launched a Quality Premium incentive scheme for clinical commissioning groups to encourage a reduction of GNBSIs across the whole health economy, reduce inappropriate antibiotic prescribing for urinary tract infections in primary care, and continue to reduce inappropriate antibiotic prescribing generally in primary care.

We are helping NHS maternity services reduce the number of **full-term babies unexpectedly admitted to neonatal units**. Such admissions suggest that babies may have suffered preventable harm. Although the number of births of full-term babies declined by 3.6% between 2011 and 2015, the number of care days generated by admissions of full-term babies increased by 31%. We found the main causes of newborn admissions were low blood sugar levels, jaundice and breathing problems. The need to better identify babies at risk of deterioration was a common theme, and we found up to 30% could have been treated in hospital or in the

community without being separated from their mother. Enabling mother and baby to stay together promotes bonding and breastfeeding, and optimises both physical and mental health outcomes. Our work, led by clinical experts, shares insights, recommendations and examples of good practice to help develop services and staffing models that keep mother and baby together.

Avoidable pressure ulcers are a key indicator of the quality of patient care. They can profoundly affect a patient's overall wellbeing and be both painful and debilitating. Despite progress in the last five years, pressure ulcers affect 700,000 people a year and cost the NHS more than £3.8 million every day. We are co-ordinating a new **Stop the Pressure** improvement programme, building on the tools, knowledge and skills of the original, which led to a 50% reduction in pressure damage. The programme includes acute and community services in collaboration with key partners in social services and care homes.

Children and young people are known to suffer harm if deterioration in their condition during a hospital stay is not picked up and treated quickly enough. In some cases this has happened despite parents expressing concerns about their child's condition; in other cases, parents felt unable to raise their concerns with healthcare staff. The **safe system framework for children at risk of deterioration** is designed to rally all parts of the healthcare system to tackle deterioration in children's health while in hospital. We devised it with the Royal College of Paediatrics and Child Health, bereaved parents, doctors, nurses and healthcare experts.

The framework is designed around the child and their family. It emphasises the importance of recognising and responding to deterioration, developing a patient safety culture with open and consistent learning, focused education and training, and acting in partnership with patients and their families. The framework provides a map to drive action and local services for infants, children and young people.

Joanne Hughes from the campaign group Mother's Instinct said: "The NHS has much to gain from including families and their lived experiences in their education and training packages and when they are learning from incidents. The users of any service will always be far better at seeing faults or providing fresh ideas for improvement than the providers themselves, and I am sure NHS bodies who embrace this ethos will deliver the safest care".

Improving patient experience has a positive impact on safety and clinical outcomes. Our online **patient experience headlines tool** brings together key sources of

information for NHS staff to compare how their organisation is performing on patient experience. Developed by trusts and our quality improvement teams, it includes data from surveys on ambulance, A&E, community, mental health and maternity services, as well as the Friends and Family Test and CQC inspection ratings. Easy to use, it can present data in various ways and create charts to show progress.

The **NHS Seven Day Hospital Services Programme** is designed to ensure patients who require emergency treatment receive high quality, consistent care every day of the week. By 2020, all acute trusts must ensure that at least 90% of these patients have access to the same level of consultant assessment and review, diagnostic tests and consultant-led interventions every day of the week. These requirements are set out in four priority clinical standards chosen because of their potential to improve patient outcomes. Phased implementation means that trusts serving 25% of the population in England need to have implemented the four standards by April 2017 and 50% by April 2018. NHS Improvement is working closely with NHS England, providing improvement support to trusts to help them implement the clinical standards. We are particularly keen that trusts learn from other organisations that are further advanced in their work to improve services. As well as organising a learning event in 2016/17 and planning regional events for 2017/18, we published on our website video case studies of staff from various disciplines talking about the benefits and challenges of meeting the four priority standards seven days a week, and an animated film reinforcing the benefits, and clarifying the definition of seven day services for trust staff.

We are leading the national programme – working with the Chief Nursing Officer for England and the National Quality Board (NQB) – to support trusts to make safe and sustainable decisions about **staffing**. We are developing resources based on the NQB's expectations that trusts will have "the right staff, with the right skills, in the right place at the right time". The resources are produced by working groups of professional experts, system stakeholders and academics with representatives from the Royal College of Nursing, Royal College of Midwives, Queen's Nursing Institute, allied health professionals' organisations and trade unions. Each is based on the best available evidence and takes a multidisciplinary approach. They cover:

- acute adult inpatient services
- learning disability services
- mental health services
- maternity services

- children's services
- urgent and emergency care
- district nursing service
- neonatal care.

These resources are being released for an initial engagement period to allow the sector and public to comment and help shape the final resource. Final publication will be during summer/autumn 2017.

The National Quality Board (NQB) is a forum where the key NHS oversight organisations come together to share intelligence, agree action and monitor overall assurance on quality. Its members are:

- NHS Improvement
- NHS England
- CQC
- Public Health England
- National Institute for Health and Clinical Excellence
- Health Education England.

NQB (of which we are a member) introduced guidance for trusts in March 2017 on learning from the deaths of people in their care. This will help trusts learn from investigations following deaths and improve care quality. We are responsible for supporting trust boards to implement the **Learning from Deaths Framework**. Almost 500 people attended our conference in March for medical directors, non-executive directors and family representatives, at which we launched the guidance, told them about the framework and began to consider how trusts can introduce it. We are offering training, guidance and advice to trusts in coming months, as well as helping them learn from each other, to ensure the framework is instrumental in leading to improved care quality and support for families and carers.

We focused on two performance targets for **mental health**: Increasing Access to Psychological Therapies (IAPT) and Early Intervention Psychosis Access. Our mental health Intensive Support Team has supported many providers to achieve this standard.

We have continued work to improve the experience of **whistleblowers** in the NHS. In April 2016 with NHS England we published the first national policy for staff raising concerns in the NHS, to be adopted by all trusts as a minimum standard. We also supported CQC in setting up the Office of the National Guardian, whose role is to lead and advise trusts' Freedom to Speak Up guardians on best practice to enable staff to speak up safely. Since Henrietta Hughes was appointed National Guardian,

we have supported her in ensuring all trusts appoint their own Freedom to Speak Up guardian.

We continue to develop an employment support scheme to help whistleblowers return to work, which we plan to pilot in 2017/18.

We greatly value those working in the NHS raising concerns with us. This year we received 74 whistleblowing cases, all handled by our centralised, specialist team. We determined whether they were relevant to our role and, if so, how we needed to act. In some cases this involved – in a manner agreed with the whistleblower – contacting the relevant trust for further information. In others, whistleblowing information was factored into action we were already taking, or planning to take, to support trusts (including, for example, governance reviews). Provided concerns were not raised with us anonymously, we explained the overall outcome to the whistleblower.

In relation to one case, about a patient death, we exercised discretion to commission an independent investigation of the death, which involved two trusts. While that did not uphold the whistleblower's concerns, it did identify learning for both trusts, which we are helping them implement.

61% of providers thought NHS Improvement was doing well in supporting trusts on quality of care.

Source: Ipsos MORI stakeholder perception survey, December 2016

Finance and use of resources

We are committed to restoring trusts to financial balance so they can improve patient care and productivity as well as secure long-term sustainability. We therefore designed our financial approach to support recovery and financial discipline, rewarding ambition and success.

We devised with NHS England a **'financial reset'** in summer 2016 to help stabilise trusts' finances and start some of the wider changes needed to improve productivity. This included agreeing financial control totals with individual trusts, and replacing national fines with trust-specific incentives to improve performance. We capped the cost of interim managers, and asked trusts to identify opportunities to implement Lord Carter's recommendations on consolidating pathology and 'back office' services such as finance, human resources and IT. We also asked trusts to review unsustainable care services that relied on locums or agency staff and resulted in financial, operational and continuity problems.

Against an initial objective of reducing the aggregate provider sector deficit to £580 million, down from £2,447 million in 2015/16, the sector closed the year with a deficit of £791 million. Combined with the 2% efficiency improvements needed simply to stand still in financial terms (as reflected in national tariff prices), and the additional improvements needed to replace non-recurrent savings achieved in the previous year, this required overall **cost improvements** of £3.1 billion (equivalent to 3.7% of total operating costs). Given higher than planned levels of emergency hospital admissions, including exceptional pressures during the winter, this was a substantial achievement for the trust sector.

As part of the financial reset, we worked with NHS England to design how to use £1.8 billion of the **Sustainability and Transformation Fund** and reward good financial and operational performance and improve sustainability. Access to the fund partly depended on trusts accepting and achieving an agreed **financial control total**. In all, 228 out of 238 trusts accepted their financial control totals, and almost 74% delivered a full-year financial position that either met or exceeded their agreed financial control totals.

At the same time, we introduced **financial special measures** to provide rapid recovery plans for trusts that had not agreed control totals and were planning significant deficits, or those that had deviated significantly from agreed control totals.

Key fact

The financial special measures programme identified £100 million of savings for the NHS in its first eight months.

As part of this programme, we appoint a financial improvement director who makes sure the trust's financial systems and controls operate effectively so money is not spent without proper checks. They improve efficiency and productivity, adapting lessons from higher performing trusts, and improve the way the trust manages its workforce and plans rotas. To leave financial special measures, a trust's board must agree with us a recovery plan and details of how it will be achieved. Five trusts entered the programme in July 2016. Four trusts entered the programme in July 2016. By the end of March 2017, two of the first five trusts had successfully exited special measures, and a further seven trusts had entered special measures.

We asked trusts to volunteer for our **Financial Improvement Programme**, which we designed to help trusts identify quick ways of making savings as well as longer-term changes to ways of working. From more than 80 that applied, we initially chose 16 trusts where intensive support would have most impact; another six joined during the year. Each brought in teams of experts – jointly selected by the trust and us – with skills and experience to build on existing financial improvement measures, and focused on transferring skills and expertise to trust staff. They examined areas such as better working in theatres and outpatient departments, using staff better and buying products and services. We shared lessons learned and emerging good practice in *Where to look: making savings in the NHS*,[1] events and regional meetings. The programme's first wave saved over £100 million, equivalent to more than £120 million in a full year. The second wave is now underway.

Before we introduced controls in October 2015, trusts' **spending on agency staff** was growing at 25% a year and totalled £3.6 billion in 2015/16. Our controls helped reduce that to about £2.9 billion in 2016/17, with 85% of trusts reducing their agency spending; 92 trusts managed to reduce it by more than a quarter. There was an 18% reduction in nursing agency prices and a 13% reduction in medical agency prices between October 2015 and March 2017.

[1] https://improvement.nhs.uk/resources/10-ways-nhs-providers-find-savings-and-make-cost-improvements/

A year after introducing agency controls, we brought in new measures, such as publishing league tables of the trusts with the best and worst performance on agency costs. We reviewed data collection to avoid placing an undue burden on trusts, and worked with NHS Employers to streamline reporting. We asked trusts to improve how they manage their existing workforce to help encourage staff back to the NHS by allowing them to work more flexibly, and we asked them to stand up to excessive rates.

Much work remains to be done, particularly to tackle the excessive cost of medical locums. We estimate the NHS could save £300 million a year if all medical locums charged rates within the set price cap, but staff shortages – especially in A&E – make it difficult to achieve savings. We are working with the Royal College of Emergency Medicine to address these longer-term issues. After feedback from nurses, we suspended our instruction that trusts should ensure agency staff are not employed substantively elsewhere in the NHS.

Key fact

Controls on agency spending reduced costs for the NHS by more than £700 million.

We recognise that accessing **capital** is crucial to improving services and infrastructure for some trusts. However, the NHS had access to much less capital in 2016/17 than in the recent past. We are committed to working with the Department of Health (DH) to explore solutions to meet trusts' demand for increased capital funding. In November 2016, we published the capital regime, investment and property business case approval guidance for all trusts, setting out the rules and requirements regarding the review and approval of capital investment and property transactions. We also helped trusts improve the accuracy of their capital expenditure forecast and ensure capital expenditure funding sources were identified and approved. In total, trusts spent £2.9 billion on capital projects, which was more than the budget DH set for them. The reduced availability of capital resource means that managing capital expenditure will remain a challenge in the coming years.

Accessing appropriate financing is key to improving and operating services. In 2016/17, trusts accessed cash financing of £790 million for capital projects and £2.74 billion to support forecast revenue account deficit positions and operational working capital requirements.

Reducing agency costs: Northampton General Hospital NHS Trust

Northampton General Hospital NHS Trust reduced the amount it spends on agency nurses by more than £2 million by motivating them to join the in-house staff bank. It recruited 117 registered nurses as a result. The trust's communications team used the trust's Facebook page and localised targeted advertising to promote the campaign. The trust specifically targeted its own staff because it was keen to improve the consistency of care provided to inpatients, as well as achieving financial savings.

As part of our response to the challenges facing the NHS, we published with NHS England a national tariff that for the first time covers two years. This **two-year tariff** for 2017/18 and 2018/19 gives trusts greater certainty about the amount they will be paid for the care they provide over a longer period, making it easier to plan and make the investment decisions necessary to change their services. We recognise that trusts and commissioners together may be able to develop payment models locally that better meet their patients' needs than those in the tariff. So we simplified the rules and guidance on local pricing to make it easier to adopt these new approaches. We also changed the local pricing rules covering mental health services: commissioners and trusts must link a proportion of payment to locally agreed quality and outcome measures. This will help them better understand service users' needs and how best to meet them.

We published the **Healthcare Costing Standards for England** in early 2017, an important step towards the NHS being able to calculate precisely the cost of care for every single patient – not only drugs, tests and appliances but the time doctors and nurses devote to their treatment. Accurate, consistent patient-level costing information will encourage clinicians to review their practice, allow trusts to compare ways of working and enable the NHS to be sure it is making best use of its resources. The standards, which we developed and tested with trusts, explain how costs are calculated, and take account of international best practice. They include in draft form the first-ever costing standards for mental health and ambulance providers.

We continue to align with CQC our approach to overseeing trusts and understanding the support they need. Together we consulted on how to assess **use of resources** for acute trusts and are testing our proposals. Our approach looks both at how far acute trusts are meeting their financial controls and at how efficiently they are using their resources. CQC will in future use this information to give a rating for use of resources. It will initially present the 'use of resources' rating alongside its existing trust quality rating, but will next consider how to combine this with CQC's overall trust-level ratings. We want our approach to be simple, robust and transparent. It must also be meaningful for patients and the public, act as an incentive to improvement and minimise the regulatory burden on trusts.

74% of providers thought NHS Improvement was doing well in supporting trusts on finance and use of resources.

Source: Ipsos MORI stakeholder perception survey, December 2016

Operational performance

Our aim is that NHS providers maintain and improve performance against the standards in the NHS Constitution. We support them to do so, to cope with increased demand during winter months, for example, and to have sustainable strategies to maintain their performance.

Improving **accident and emergency** departments was a key priority in 2016/17. Performance had deteriorated for three years against the NHS Constitution standard that at least 95% of patients attending an A&E department should be seen, treated, admitted or discharged in under four hours. By summer 2016 performance had yet to recover from the winter's seasonal dip. With demand rising faster than planned for and constrained resources, it was clear that local systems should not be left to deal with the challenge on their own. We drew up with NHS England a plan to improve A&E performance well ahead of winter. Meeting the standard still proved difficult for many trusts, but in the 12 months to December 2016 the NHS treated over 230,000 more patients within four hours than in the previous year.

Our approach was to set national initiatives and use our regional teams to adapt them to local circumstances. We worked to get trusts to return to acceptable performance while helping them develop longer-term solutions through the sustainability and transformation planning process. Our national plan focused on:

- A&E department 'front door' initiatives to improve clinical assessment of patients and ensure they are directed to the most appropriate setting for their care or treatment
- initiatives to improve patient flow within hospitals
- making sure that patients who are ready to leave hospital, whether to their own homes, to social care settings or to elsewhere in the NHS, do not experience delayed transfers of care, helping both to provide care in the most appropriate setting and to free up hospital beds for emergency admissions and elective surgery.

We expanded our **Emergency Care Improvement Programme** (ECIP), which had supported 28 of the health and social care systems under the greatest strain, to cover 40 such systems. ECIP offers intensive on-the-ground support from a clinically led team of experts who use evidence-based methods to improve quality and patient

flow. ECIP also developed advice to tackle growing delays in transferring patient care from ambulance services to hospitals. The Royal College of Emergency Medicine and the Association of Ambulance Chief Executives supported the advice, while ECIP and our regional teams worked with trust managers and local A&E delivery boards to implement it.

Our regional teams help find long-term solutions to A&E performance problems by developing trusts' capacity and capability to use improvement tools and techniques. They also promote opportunities for organisations to work together, creating improvement chains and linking the challenged with the best. Our North team helped lead our national A&E programme and had notable success with its own programme, which brought together all acute trusts across the region to share examples of innovation, improvement and good practice.

Good practice in the North region

North East Urgent and Emergency Care Network piloted a phone system to refer patients calling 111 to an A&E consultant for advice on whether to attend A&E: 76% of patients referred do not attend and admissions fell by 2.5%.

University Hospital of South Manchester NHS Foundation Trust introduced a dedicated frailty service in A&E to identify and treat frail older patients who would benefit from specialist care from a geriatrician. Average length of stay fell from 5.8 to 3.8 days, and discharges of patients aged over 90 rose by 21%.

Mid Cheshire Hospitals NHS Foundation Trust created an ambulatory care unit so that no patient stays in hospital if they can be treated at home. The unit treats 33% of acute medical patients, and discharges 53% of its patients back home.

At the end of 2016/17 we asked local health and care systems to start taking further measures to improve A&E performance ahead of next winter and deliver the transformation needed in urgent and emergency care. This is set out in *Next steps on the NHS five year forward view*. It includes:

- using part of the extra £1 billion that the Budget made available for social care to help reduce delays in discharging patients and contribute to freeing up 2,000 to 3,000 acute hospital beds
- ensuring that patients with minor conditions are directed to the most appropriate care setting for their needs
- ensuring that best practice on patient flow – such as improving the use of ambulatory emergency care and establishing frailty pathways – is in place in all trusts.

With NHS England we appointed a single national leader, Pauline Philip, to a joint urgent and emergency care programme to ensure implementation of these measures and support the improvement needed in local health and care systems.

Sector performance against key standards

NHS trusts and foundation trusts had to cope with extensive operational pressures as they experienced exceptional levels of demand for urgent and emergency care. This had an adverse impact on elective care as work was displaced or cancelled due to the lack of available beds, which decreased income for most acute providers. Coupled with constrained community and social care, this placed further operational and financial strain on the system. Collectively, providers failed to meet several key national healthcare standards.

Accident and emergency

In Quarter 4 performance against the target of treating at least 95% of patients attending A&E within four hours dropped to 86.52% compared to 86.58% in the same quarter last year; 177,317 patients waited more than four hours for a bed, 14.2% more than a year ago. In total, A&E departments saw attendances increase by 3.0% and admitted 3.0% more patients than last year.

Diagnostic waiting times

Less than 1% of patients should wait six weeks or more for a test. At the end of the year, 890,404 patients were waiting for a diagnostic test (1.06%). Despite a 6.6% increase in the waiting list, fewer patients were waiting longer than six weeks than at the end of 2015/16. The sector failed to achieve the waiting-time standard for nine of the 15 key diagnostic tests, two less than in the fourth quarter of last year.

Red2Green campaign

The Midlands and East regional team launched a campaign to help trusts in the region embed Red2Green. Developed by Dr Ian Sturgess, the premise of Red2Green is that patients' time is the most important currency in healthcare. 'Red days' are those that fail to contribute to a patient's discharge from hospital; on 'green days' a patient receives an intervention that supports their pathway out of hospital and into the best setting for their needs. Ten days in hospital can contribute to up to 10 years of equivalent muscle ageing in patients over 80.

Ward staff start the day by asking whether it will be a red day or green day for each patient. If it is a red day, they try to resolve the problem early to convert it to a green day. If they cannot, they may involve other levels of the organisation or social care. A critical part of Red2Green is working together to find local solutions. Staff focus on what they can do to improve patient flow through hospitals, rather than spending time on factors that are difficult to influence. Red2Green also encourages patients to ask more questions about their care, discharge plans and readiness to go home.

We provided targeted service improvement support and ran a successful social media campaign to encourage adoption. We emphasised 'end pyjama paralysis', which encourages staff to help patients spend more time out of bed in their normal daytime clothing, reducing the risk of deconditioning.

Ipswich Hospital NHS Trust achieved its lowest ever length of stay by using Red2Green, and every acute trust in the region is now involved. We are developing the next phase, and working with mental health and community trusts. We produced the Midlands and East campaign in partnership with ECIP, NHS Elect and NHS England.

Shorter waiting times for endoscopy tests – which contribute over 10% of the diagnostics waiting list – drove this overall improvement. A national programme team worked with providers to address endoscopy performance and capacity issues. To increase capacity further, we are working with Health Education England to train 200 additional non-medical endoscopists by 2018.

Elective waiting times

Providers continue to miss the referral-to-treatment target of 92% for incomplete pathways, achieving 90.02% at the end of the year – the lowest performance since they started to underperform against the target in 2015. Sustained high demand for emergency inpatient care meant many providers struggled to deliver planned activity as elective capacity was displaced or cancelled. GP referrals increased by 6.2% compared to last year. As a result, the elective waiting list reached a record 3.55 million at the end of 2016/17, a 6.2% increase on 2015/16. In March 2017, 1,513 patients were waiting over a year for treatment compared to 865 in March 2016.

Cancer waiting times

Providers met all cancer waiting-time standards in Quarter 4 except for the 62-day (urgent GP referral) target for first treatment, where they achieved 81.1% against the 85% target; this has not been met since 2013/14. We worked with partners to reduce diagnostic delays, and are continuing to work with NHS England to introduce the 28-day faster diagnosis standard for cancer patients.

Infection control

Providers reported 4,634 *Clostridium difficile* cases, 10.2% (525 cases) fewer than last year. They reported 314 MRSA cases, an increase of 5.4% (16 cases) on last year.

For more details of NHS trusts' operational performance, see Table 1, page 44.

73% of providers thought NHS Improvement was doing well in supporting trusts on operational performance.

Source: Ipsos MORI stakeholder perception survey, December 2016

Operational productivity

As well as helping providers improve the quality of care, we make sure that trusts are deploying staff productively, managing the NHS estate efficiently and getting the best deal on supplies. Lord Carter's review of NHS productivity in acute trusts found that reducing unwarranted variation in every area of the hospital could save the NHS at least £5 billion in efficiencies by 2020/21. Our operational productivity programme is now supporting all trusts to implement Lord Carter's 87 recommendations to reduce variation, make savings and efficiencies and improve services.

Building on Lord Carter's approach to understand what a good acute trust looks like, we have begun a **review of community and mental health trusts**, working closely with a cohort of 23. We intend to use our findings to help develop an 'optimal model' NHS community or mental health trust and work with these trusts to move toward this. Lord Carter is overseeing the review in his role as a non-executive director of NHS Improvement.

Key fact

By the end of 2016/17, the Model Hospital had more than 2,000 active users.

Our **Model Hospital** is a digital information service designed to help acute trusts identify opportunities to improve their productivity and efficiency. They can see how they are performing individually as well as how they compare nationally and to smaller peer groups.

Designed to be easy to navigate, anyone in the NHS from board to ward can use it to view hospital activity data from five perspectives:

- board-level oversight
- clinical service lines
- operational
- people
- patient services.

Purchase price index and benchmarking tool

The tool aims to ensure trusts secure the best deals on products they buy by giving full transparency on the volume purchased and price paid by each trust. Taunton and Somerset NHS Foundation Trust identified £625,000 of savings as a result.

The government provided an extra £60 million over three years to expand and accelerate our **Getting It Right First Time** (GIRFT) programme. Led by frontline clinicians, GIRFT aims to improve care quality by identifying and reducing unwarranted variations in service and practice. A partnership with the Royal National Orthopaedic Hospital NHS Trust, which hosted the pilot programme, we have extended GIRFT to more than 30 specialties. By helping trusts to improve patient outcomes and deliver efficiencies such as fewer unnecessary procedures, it could save at least £1.3 billion over three years.

Cemented hip replacements for patients over 65

The recommendation to adopt cemented hip replacements for patients over 65 has led to a 10% increase in the use of this method, saving an estimated £4.4 million by reducing readmission rates, among other benefits.

We helped **hospital pharmacies** identify opportunities to switch to infliximab and entarecept, 'biosimilar' medicines developed as less expensive alternatives to existing branded medicines that are just as effective, and which saved £104 million by April 2017. Non-specialist acute hospitals across England vary in how many days' supply of medicines they hold in stock – from over 36 days to under 10, according to data from NHS benchmarking. Using the Model Hospital portal to track progress on reducing stockholding days, we helped reduce the median level of stockholding by one day, making a one-off saving for the NHS of £14.5 million.

By supporting providers to better manage their **estates**, we helped the NHS save upwards of £165 million in 2016/17.

An eight-month e-rostering pilot project enabled Plymouth Hospitals NHS Trust to make more effective decisions and better plan its daily safe staffing requirements. It used care hours per patient day – a nursing and care worker deployment measure

recommended by Lord Carter – matched to more timely and accurate assessments of actual patient need rather than relying on crude historical ratios. This helped reduce the cost per caring hour through less reliance on agency staff (down from 5% to 2%) while improving patient care. We are now exploring how we can ensure hospital wards use e-rostering more effectively and how the technology can help with rostering for doctors, allied health professionals and pharmacists.

By creating more efficient pathology and imaging networks across the country, we can save £210 million over the next three years. Through evidence and data gathering, we worked with providers to identity such pathology networks. University College London Hospitals NHS Foundation Trust, Royal Free London NHS Foundation Trust and an independent provider, The Doctors Laboratory, have formed a new organisation to consolidate pathology services, Health Services Laboratories. North Middlesex University Hospital NHS Trust is among its first customers. Health Services Laboratories expects to move into a new central London hub by summer 2017.

We worked with all providers through the 44 sustainability and transformation partnerships to identify opportunities where consolidating corporate services could deliver savings and more efficient, high quality services. By reducing variation in the costs and efficiency of corporate services, the NHS could save £270 million over the next three years.

Strategic change

We want to ensure that every local area has health and care services that are clinically, operationally and financially sustainable. We support providers to design and implement services that best meet the needs of their communities.

This includes helping develop new care models designed to break down barriers between primary and secondary care, between physical and mental health, and between health and social care. With NHS England, we jointly lead the new care models programme, and specifically lead on collaborations between acute care providers. We also support reconfigurations of services.

With our national partners we helped trusts and local health and care systems produce sustainability and transformation plans to advance key elements of The NHS five year forward view, the shared vision for the NHS published in 2014. We set local expectations on where to focus and what detail to provide, and reviewed plans to identify areas that might need extra support. Despite constrained growth in funding, all 44 plans included commitments on prevention, improving cancer outcomes, expanding access to mental health services, strengthening general practice and developing more integrated urgent care services. We are providing continuing support to the small number of sustainability and transformation partnerships that want to evolve quickly into ‘accountable care systems’ – mature partnerships of commissioners, providers and local authorities that can make effective decisions collectively.

We contributed with our national partners to deciding priorities for the next two years contained in Next steps on the NHS five year forward view, published in March 2017. We also contributed to the plans in Implementing the five year forward view for mental health, published in July 2016, designed to improve access and outcomes, deliver seven day services, reduce inequality and achieve efficiency gains. We committed to building a sustainable model of improvement to support delivery of the Five Year Forward View for Mental Health and beyond, and asked Northumberland, Tyne and Wear Mental Health NHS Foundation Trust to be our main strategic partner for this work. Other partners supporting our work during the initial phase are:

- Birmingham and Solihull Mental Health NHS Foundation Trust
- Cheshire and Wirral Partnership Mental Health Foundation Trust
- East London NHS Foundation Trust
- Devon Partnership NHS Trust
- Tees, Esk and Wear Valleys NHS Foundation Trust
- Lancashire Care NHS Foundation Trust
- Mersey Care NHS Foundation Trust
- Hertfordshire Partnership University NHS Foundation Trust.

The initial phase will produce guidance to support other trusts (mental health, acute, community) with the components required to embed improvement. This is a unique piece of work from partners that have solid experience of implementing improvement.

We accredited the first four foundation trusts to lead **foundation groups**, and published guidance for other foundation trusts thinking about doing the same. Models for foundation groups differ but may, for example, involve trusts joining together under a successful NHS provider's umbrella and sharing management skills, clinical expertise and back office functions. The aim is to improve their clinical and financial viability, creating better and more sustainable services for patients. Our accreditation process considered the quality of services on offer, the trusts' management, the potential risks they face and the benefits that trusts will get from being part of a group.

The first four foundation trusts we accredited to lead foundation groups are:

- Guy's and St Thomas' NHS Foundation Trust
- Northumbria Healthcare NHS Foundation Trust
- Royal Free London NHS Foundation Trust
- Salford Royal NHS Foundation Trust.

Where commissioners are considering novel contracting arrangements to support the introduction of new care models, we and NHS England are working closely to ensure that any potential risks are identified and provide assurance that the new arrangements meet the overall needs of the local health system. Reviews of the

collapse of NHS Cambridgeshire and Peterborough Clinical Commissioning Group's contract with Uniting Care Partnership in 2015 found that commissioners, providers and regulatory bodies did not have a full shared understanding of the contract risks. We are working with national partners and the vanguards pioneering new care models to identify issues raised by such contracts and test possible solutions. With NHS England we developed the **Integrated Support and Assurance Process (ISAP)** to co-ordinate our approach to trusts and clinical commissioning groups (CCGs) involved in transactions for complex contracts. These are contracts that may have an unusual financial value or take a novel form, where bidders may be partners seeking to become a new legal entity to allow greater collaboration, or which significantly affect current NHS providers. We published guidance outlining the process and lessons learned from past complex contracts, as well as important risk management questions for organisations to consider. At the end of 2016/17, ISAP was being used to review seven proposed new commissioning and contracting arrangements for new care models.

We continued to offer advice and support to commissioners and providers to help resolve local issues within the rules on **commissioning, choice and competition**.

We published guidance on choice in mental health in April 2016 after receiving queries and complaints from people who felt choice was not working properly for some mental health services. From speaking to service users, patient groups and commissioners, we identified four principles to ensure choice in mental health works and helps people to choose the provider that best meets their needs.

We concluded our investigation of a complaint from Care UK about the commissioning of elective care services at the North East London Treatment Centre by NHS Barking and Dagenham CCG, NHS Havering CCG, NHS Redbridge CCG and NHS Waltham Forest CCG. The issues related to the CCGs' process to select Barking, Havering and Redbridge University Hospitals NHS Trust as a provider of elective care services at the treatment centre, and the proposed pricing arrangements. During the investigation the CCGs told us they had decided not to award the contract to Barking, Havering and Redbridge University Hospitals NHS Trust. The CCGs instead extended the contract of the Centre's current operator for a further 15 months to ensure the continuity of services for patients. We accepted binding undertakings from the CCGs, and ended our investigation.

A significant part of our advisory role is to ensure planned mergers that work well for patients can go ahead smoothly and effectively. During the year we advised a wide range of organisations considering mergers and joint ventures, as well as some considering ways to collaborate through committees in common and shared executive appointments. For example, we provided competition support to high-profile transactions in Manchester and Birmingham, and worked with the Competition and Markets Authority (CMA) to help ensure transactions that did not affect competition were not reviewed unnecessarily.

We estimate that this work resulted in substantial savings to providers that were able to reduce their spending on external advisers and in some cases avoid the need to file a merger notification with the CMA and pay a merger fee. We provided this advice alongside our statutory role advising the CMA on the patient benefits of proposed mergers.

Many trusts are considering merging in pursuit of better integrated, higher quality, more cost-effective care. In May 2016, working with Aldwych Partners and Cass Business School, we used existing research and interviews with senior trust executives to generate guides that will help senior executives and clinicians decide whether a merger is the right choice to deliver improvements for patients, and if so how to ensure it is successful.

When foundation trusts or NHS trusts decide to go ahead with **significant transactions,** such as mergers and acquisitions, we evaluate their proposals. Our review can help trusts decide whether a particular transaction makes sense in terms of care quality, finance, operational issues and – where relevant – choice and competition. We aim to identify risks early and tailor a work programme proportionate to the risks in each case. We try to maximise the chances of success and minimise disruption to trusts, balancing potential risks against the need to support rapid change.

We assessed several significant transactions during the year:

- Mersey Care NHS Foundation Trust acquired Calderstones Partnership NHS Foundation Trust to provide better managed care pathways for people with acute and severe mental illness, learning disabilities and addictions. The transaction was completed on 1 July 2016.

- Birmingham Children's Hospital NHS Foundation Trust acquired Birmingham Women's Hospital NHS Foundation Trust to form Birmingham Women's and Children's NHS Foundation Trust, and deliver improved quality outcomes and longer-term financial sustainability. This was completed on 1 February 2017.
- Peterborough and Stamford Hospitals NHS Foundation Trust acquired Hinchingbrooke Health Care NHS Trust to form North West Anglia NHS Foundation Trust, and ensure clinical and financial sustainability. This was completed on 1 April 2017.
- South Essex Partnership University NHS Foundation Trust merged with North Essex Partnership University NHS Foundation Trust to form Essex Partnership University NHS Foundation Trust on 1 April 2017.
- Greater Manchester West Mental Health NHS Foundation Trust acquired Manchester Mental Health and Social Care NHS Trust to form Greater Manchester Mental Health NHS Foundation Trust on 1 January 2017.

54% of providers thought NHS Improvement was doing well in supporting trusts on strategic change.

Source: Ipsos MORI stakeholder perception survey, December 2016

Leadership and improvement capability

We want trusts to build strong leadership and the capability to continuously improve their services so they are sustainable for the future. We aim to improve the working environment for NHS leaders and revitalise the systems of talent management and leadership development.

To help us achieve this we set up a **Faculty of Improvement**, a senior advisory group including internationally recognised clinicians, to guide us in creating an improvement movement across the NHS, inform our strategy and accelerate our work programme.

We take four approaches to promoting improvement:

- direct interventions – for example, our intensive support teams provide evidence-based support in emergency and elective care
- supportive interventions – such as coaching people through improvement work
- building resilience – for example, through our Advancing Change and Transformation Academy's programmes
- partnership model – such as the culture programme.

The health and care system needs action at every level to develop the leaders and skills to improve services in the short term and for the next 20 years. ***Developing people – improving care***, which we published with 12 other national health and care organisations, provides a framework to equip and encourage staff to deliver continuous improvement in local health and care systems – and gain pride in and joy from their work. We want team leaders at every level to develop improvement and leadership capabilities among their staff and themselves. The framework focuses on:

- developing systems leadership for staff working with partners in local health and care systems
- establishing quality improvement methods, drawing on staff and service users' knowledge and experience
- practising inclusive and compassionate leadership
- talent management to fill senior roles.

We intend to update the framework regularly based on feedback from teams using it. And we have pledged to follow its principles ourselves.

Sir Peter Carr Award

The Sir Peter Carr Award makes available £30,000 for a clinician and manager partnership to invest in their professional development over a year to help achieve a shared improvement objective. Both the winners and up to five shortlisted partnerships will receive access to mentoring, networks, personal development and improvement skill-building.

Key facts

62% of foundation trusts and NHS trusts want support to change their culture.

70% of chief operating officers say culture and effecting change are the main topics they need support with.

We are working with the King's Fund to offer trusts a **culture programme** that provides practical support and resources, developed and tested with help from three pilot trusts. The programme is based on national and international evidence identifying elements and behaviour needed for high quality care cultures. It comprises three phases: diagnosing a trust's cultural issues; developing a collective leadership strategy to respond to them; and implementing changes. Sandra Drewett, Director of Human Resources and Organisation Development for East London NHS Foundation Trust, one of the pilots, said: "The diagnostics are an intervention in themselves – they've highlighted the importance of leadership and the key cultural elements which underpin it".

Almost 100 trusts took part in the **QSIR** programmes run by our Advancing Change and Transformation Academy (ACT). QSIR (quality, service improvement and redesign), based on tried and tested tools and approaches, provides clinical and non-clinical staff with the know-how to design and implement more efficient, patient-centred services. In 2016/17 we tailored programmes specifically for teams drawing up sustainability and transformation plans. Our QSIR College is designed to develop candidates to become associate members of the QSIR teaching faculty and to upskill other staff in their local systems.

Key fact

Our Provider Leadership Committee made 302 NHS trust chair and non-executive appointments. This included 113 new appointments, of which 16 were chairs, and 189 reappointments or extensions, of which 32 were chairs.

ACT's **Transformational Change through System Leadership** programmes are for senior teams from health and care systems that want to move beyond basic service improvement principles to tackle large-scale change involving multiple stakeholders: 21 such teams took part in these programmes in 2016/17.

Trusts have found it harder to recruit nurses into director roles, so we designed with London South Bank University a **programme for aspiring nurse directors**. It is aimed at experienced deputy directors of nursing or those in comparable positions who have the potential to become executive nurses within 12 to 18 months.

Key fact

More than 130 deputy directors of nursing have been through our professional nurse leadership and development programme.

The programme prepares them for leadership at board level by developing their understanding of the executive nurse role while broadening their skills and knowledge. It covers topics such as using data from clinical audits for improvement, strategic thinking around national policy, how to take collective responsibility for board decisions, and styles of leadership.

With five NHS trusts we have formed a five-year **partnership with Virginia Mason Institute** in Seattle, a non-profit organisation specialising in healthcare transformation and continuous improvement. The trusts' leaders and clinicians receive tools and hands-on support, including coaching and mentoring. The trusts aim to become leaders in quality and safety, maximise value by reducing waste, empower staff to make changes and create a culture of continuous improvement, sharing their learning and experience.

Learning from Virginia Mason Institute: Leeds Teaching Hospitals NHS Trust

Using techniques from the Virginia Mason Institute, the trust made improvements including:

- reducing theatre tray set-up time from 59 minutes to 9 minutes
- cutting sterilisation costs by 37% by reducing the number of theatre trays required and the tools on each tray
- increasing availability of the bladder scanner by 100%
- cutting the theatre list scheduling team's time spent on rescheduling cancelled appointments from 80% to 10%
- identifying £500,000 of stock efficiencies in one service area.

Defining what makes a trust well led is an important part of the oversight role we share with CQC. Together we consulted trusts on a new **well-led framework** through which to assess a trust's leadership, management and governance. The new framework will reflect the principles in *Developing people – improving care* and recent research on effective leadership.

Key fact

To support the launch of the National Maternal and Neonatal Health Safety Collaborative we organised a campaign of more than 90 tweets, which recorded 217,300 views. Our campaign on seven day services achieved 64,000 Twitter views.

To raise the profile of the improvement movement in the NHS, we launched a **Year of Improvement** in July 2016 at our **Inspiring Improvement** event to tell NHS staff about the support we can offer them. They told us how important it is to share experience of improving patient care, whether a small change on one ward or an organisation-wide programme. We therefore developed an **Improvement Hub** as part of our website, with hundreds of improvement tools, resources and ideas contributed from across the health sector. NHS staff can use the hub to collaborate and explore ideas with colleagues, share their own improvement stories or tell us about improvement resources they have seen elsewhere.

Two-thirds of our Executive Committee trained as **mental health first aiders** accompanied by the Secretary of State for Health, Jeremy Hunt. This was led by our Executive Director of Nursing, Ruth May, and received NHS-wide support and a call for more patient-facing NHS staff to be trained in these skills.

73% of providers thought NHS Improvement does well at supporting their organisation to improve.

Source: Ipsos MORI stakeholder perception survey, December 2016

Sector performance: NHS trusts

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

Table 1: Operational performance of the NHS trust sector against key national standards

Metric	Period	Standard (%)	Performance (%)
Referral to treatment			
18 weeks incomplete	March 2017	92	89.33
52 week waits (numbers)		0	726
Diagnostics			
Number of diagnostic tests waiting longer than 6 weeks	March 2017	1	1.03
Accident and emergency			
All types of performance	Quarter 4	95	84.06
Type 1 performance		95	77.92
Cancer			
2 week GP referral to first outpatient – cancer	Quarter 4	93	94.7
2 week GP referral to first outpatient – breast symptoms		93	92.4
31 day wait from diagnosis to first treatment		96	97.3
31 day second or subsequent treatment – surgery		94	94.2

31 day second or subsequent treatment – drug		98	98.9
31 day second or subsequent treatment – radiotherapy		94	96.7
62 day urgent GP referral to treatment for all cancers		85	80.1
62 day urgent GP referral to treatment from screening		90	90.2
Ambulance			
Category A call – emergency response within 8 minutes	YTD March 2017		
Red 1 calls		75	68.65
Red 2 calls		75	62.45
Category A call – ambulance vehicle arrives within 19 minutes		95	89.91
Infection control			
MRSA (numbers)	YTD March 2017	0	118
Clostridium difficile (numbers)		-	1,807
Mixed sex accommodation (numbers)	March 2017	0	4,108
Mental health			
Proportion on care programme approach discharged from inpatient care who were followed up within 7 days	Quarter 4	95	96.00
Proportion admitted to inpatient service who had access to crisis resolution/home treatment teams	Quarter 4	95	98.77
Proportion with a delayed transfer of care	March 2017	7.5	6.50
Proportion of Improving Access to Psychological Therapies (IAPT) patients completing treatment who moved to recovery		50	Not available

Financial performance

Revenue

We track NHS trusts' financial performance on a monthly basis. The information revealed another exceptionally challenging year for NHS trusts, as demand for services reached a record level. Despite these external challenges, trusts in aggregate reported an improved financial position compared to last year. They presented a deficit of £968 million (a deficit of £967 million on a control total basis), a £382 million improvement on last year. The number of trusts reporting a deficit reduced from 59 in 2015/16 to 55 in 2016/17.

The improvement was mainly attributable to additional funding for NHS trusts, as well as tighter financial controls:

- We asked all providers to strengthen their financial discipline. As part our 'financial reset' (see page 21), we introduced financial control totals that set the minimum level of financial performance for individual trusts: 76 out of the 82 NHS trusts that existed at the year-end accepted their control totals, and 51 achieved them.
- Accepting the control totals allowed NHS trusts access to the £1.8 billion Sustainability and Transformation Fund, of which they received £600 million. This supported many providers in returning to a more sustainable financial footing.
- Introducing agency controls (see page 22) in October 2015 helped NHS trusts reduce their reliance and spending on agency staff. An annual reduction of £255 million in agency staff costs was reported in 2016/17.

However, challenges remain. We asked all providers to focus on improving efficiency. NHS trusts reported a total of £1.134 billion cost savings for 2016/17. This was the same level as last year, but fell short of their planned cost savings by £131 million, indicating further scope for improvement.

Table 2 details NHS trusts' reported financial position by sector. The acute sector experienced the most significant level of financial pressure: 85% of acute trusts were in deficit at the year end.

Table 2: Reported financial position of the NHS trust sector for the year ended 31 March 2017

NHS trust sector	2016/17			Number of trusts	Number of trusts in deficit	% of trust sector
	Plan £m	Outturn £m	Variance £m			
Acute	(707)	(967)	(260)	53	45	85
Ambulance	(6)	2	8	5	2	40
Community	9	(8)	(17)	13	4	31
Mental Health	2	5	3	13	4	31
Total	**(702)**	**(968)**	**(266)**	**84**	**55**	**65**

Brackets denote deficit.

At the start of the financial year there were 86 NHS trusts. On 1 April 2016, Birmingham Community Healthcare NHS Trust and Sussex Community NHS Trust became foundation trusts and have been excluded from the figures reported during the year. Two NHS trusts became foundation trusts on 1 May 2016 (see page 48).

Capital

Hospital buildings, equipment and information systems must be in a suitable condition to deliver modern patient care and respond to future service strategy needs. We are committed to ensuring that patients who rely on NHS trusts' services can expect high quality services.

We published the *Capital regime, investment and property business case approval guidance* for providers in November 2016, which updated the capital delegated limits for NHS trusts. We approved 15 full business cases (FBCs) totalling just over £459 million and a further 12 strategic outline cases (SOCs) and outline business cases (OBCs) that were outside the delegated authority of individual NHS trusts. (In 2015/16, we approved 28 FBCs totalling £1,195 million and 32 SOCs and OBCs.)

In total, NHS trusts spent £1,133 million on capital projects during 2016/17 (2015/16: £1,396 million) in a planned and managed way to improve their infrastructure.

Cash

Accessing finance is crucial for NHS trusts to improve and operate services, particularly those with a revenue deficit. In 2016/17, we worked with all NHS trusts forecasting revenue deficits and supported them in accessing the revenue financing required to fund operating deficits and working capital requirements. All NHS trusts that required revenue cash support received sufficient cash to meet immediate operating requirements. In 2016/17, 58 NHS trusts required access to cash financing of £1.584 billion to support forecast revenue account deficit positions and operational working capital. (In 2015/16, 39 NHS trusts accessed £955 million.)

Assessing NHS trusts for foundation status

Our regulation directorate assesses NHS trusts' applications for foundation trust status. We authorised two foundation trusts from 1 May 2016: Mersey Care and Wirral Community. At 31 March 2017 there were 156 NHS foundation trusts in total, over 65% of all trusts.

Implementing management contracts at challenged providers

We brokered an agreement for Western Sussex Hospitals NHS Foundation Trust to provide management support to help Brighton and Sussex University Hospitals NHS Trust address its financial and quality concerns.

We are developing additional management contracts for:

- Salford Royal NHS Foundation Trust, which assumed the management of The Pennine Acute Hospitals NHS Trust in April 2017 with a view to a subsequent acquisition.
- Alder Hey Children's NHS Foundation Trust, which assume management of some services at Liverpool Community Health NHS Trust, agreed in April 2017.

NHS trusts in special measures

Where CQC identifies serious failures in the quality of care and is concerned that an NHS trust's management cannot make the necessary improvements without support, the Chief Inspector of Hospitals may recommend that the trust is placed in special measures. This is a set of specific interventions designed to improve care quality and leadership. Such interventions typically include assigning a 'buddy'

organisation and an improvement director to the trust, as well as developing ‘quality improvement plans’.

One of our objectives is to continuously improve care quality, helping to create the safest, highest quality health and care service, with the aim of removing all providers from special measures by 2020. We have given significant support both to trusts in special measures and those at risk of entering special measures.

Similarly, where an NHS trust has not agreed a control total and is planning a significant deficit, or if it has deviated significantly from its agreed control total, we may place it in financial special measures to provide a rapid recovery plan. To exit financial special measures, a trust’s board must agree with us a recovery plan and details of how it will be achieved.

During 2016/17, 12 NHS trusts were in special measures due to concerns about quality of care, and four of them exited (see Table 3 below). Seven NHS trusts were in special measures due to financial concerns, and one of them exited (see Table 4).

Table 3: NHS trusts in special measures for quality in the year to 31 March 2017

Trust	Date entering special measures	Reason for entering special measures	Date of leaving special measures	Reason for remaining in or exiting special measures
North Cumbria University Hospitals NHS Trust	July 2013	Keogh review: concerns about mortality rates.	March 2017	Recommendation by Chief Inspector of Hospitals to exit special measures after an inspection report published in March 2017.
Hinchingbrooke Health Care NHS Trust	January 2015	CQC inspection identified concerns about patient safety, leadership, culture and staff engagement.	August 2016	Recommendation by Chief Inspector of Hospitals to exit special measures after an inspection report published in August 2016.
Wye Valley NHS Trust	October 2014	CQC inspection found concerns about urgent care, safeguarding, medicines management, training, governance and risk management and the trust's leadership.	October 2016	Recommendation by Chief Inspector of Hospitals to exit special measures following an inspection report published in November 2016.
Barking, Havering and Redbridge University Hospitals NHS Trust	December 2013	CQC inspection concerns about emergency care, leadership and finance.	March 2017	Recommendation by Chief Inspector of Hospitals to exit special measures following an inspection report published in March 2017.
Barts Health NHS Trust	March 2015	CQC inspection found concerns about leadership, staff engagement and patient safety.	N/A	Recommendation by Chief Inspector of Hospitals to remain in special measures after the CQC inspection report published in January 2017.

East Sussex Healthcare NHS Trust	October 2015	CQC inspection found concerns about medicines management, learning from incidents, staff engagement and culture.	N/A	Recommendation by Chief Inspector of Hospitals to remain in special measures after the CQC inspection report published in January 2017.
West Hertfordshire Hospitals NHS Trust	September 2015	CQC inspection found concerns about the safety of the emergency department and maternity unit and a lack of risk management and learning from incidents.	N/A	Recommendation by Chief Inspector of Hospitals to remain in special measures after the CQC inspection report published in March 2017.
London Ambulance Service NHS Trust	November 2015	CQC inspection found concerns about staffing, medicines management and governance.	N/A	Recommendation by Chief Inspector of Hospitals to remain in special measures after the CQC follow-up inspection and report published on 20 January 2017.
Walsall Healthcare NHS Trust	January 2016	CQC inspection found concerns about maternity staffing, the emergency department and trust governance.	N/A	Recommendation by Chief Inspector of Hospitals to remain in special measures after the CQC inspection report published in January 2016.
Worcestershire Acute Hospitals NHS Trust	December 2015	CQC inspection found concerns about the safety of the emergency department, maternity, surgery and children's and young people's service.	N/A	Recommendation by Chief Inspector of Hospitals to remain in special measures after the CQC inspection report published in November 2016.
Brighton and Sussex University Hospitals NHS Trust	August 2016	CQC inspection found concerns about culture, governance and leadership.	N/A	The trust was placed in special measures in August 2016 and has not yet received a follow-up inspection.
The Princess Alexandra Hospital NHS Trust	October 2016	CQC inspection found concerns about safety, responsiveness and leadership.	N/A	The trust was placed in special measures in October 2016 and has not yet received a follow-up inspection.

Note: trusts highlighted in blue exited special measures.

Table 4: NHS trusts in financial special measures in the year to 31 March 2017

Trust	Date entering financial special measures	Reason for entering financial special measures	Date of leaving financial special measures	Reason for remaining in or exiting financial special measures
Croydon Health Services NHS Trust	August 2016	The trust did not agree its control total and was planning a significant deficit.	February 2017	The trust met all the exit criteria.
Maidstone and Tunbridge Wells NHS Trust	August 2016	The trust did not agree its control total and was planning a significant deficit.	N/A	The trust has not yet met all the exit criteria.
North Bristol NHS Trust	September 2016	The trust did not agree its control total and was planning a significant deficit.	N/A	The trust has not yet met all the exit criteria.
Barts Health NHS Trust	September 2016	The trust had agreed its control total but had a significant negative variance against the control total plan and was forecasting a significant deficit.	N/A	The trust has not yet met all the exit criteria.
Brighton and Sussex University Hospitals NHS Trust	October 2016	The trust had agreed its control total but had a significant negative variance against the control total plan and was forecasting a significant deficit.	N/A	The trust has not yet met all the exit criteria.
East Sussex Healthcare NHS Trust	October 2016	The trust had agreed its control total but had a significant negative variance against the control total plan and was forecasting a significant deficit.	N/A	The trust has not yet met all the exit criteria.
University Hospitals of North Midlands NHS Trust	March 2017	The trust had agreed its control total but had a significant negative variance against the control total plan and was forecasting a significant deficit.	N/A	Recently entered financial special measures and is currently in the recovery planning stage.

Note: trusts highlighted in blue exited special measures.

Building NHS Improvement

Sustainability report

Monitor and NHS TDA are committed to long-term sustainable development. We acknowledge the potential impact that our activities may have on the environment, so will ensure that effective environmental management and sustainable development become an integral part of our work. The core purpose of Monitor and NHS TDA working as NHS Improvement is to help local providers of NHS services work towards a sustainable future that also delivers high quality care.

Table 5: NHS Improvement's greenhouse gas emissions

		2016/17	2015/16
Non-financial indicators (kg)	Total emissions for Scope 2 (Energy Indirect) Emissions	N/A	N/A
	Total gross emissions for Scope 3 Official Business Travel Emissions – Monitor	93*	66*
	Total gross emissions for Scope 3 Official Business Travel Emissions – NHS TDA	182*	123*
Related energy consumption (KWh)	Electricity: non-renewable	N/A	N/A
	Gas	N/A	N/A
	Expenditure on energy	N/A	N/A
Financial indicators (£000s)	Expenditure on official business travel – Monitor	379	318
	Expenditure on official business travel – NHS TDA	2,436	1,282

* This is the total of all measurable emissions for which data is available. Monitor and NHS TDA staff may claim for taxis, or train journeys booked personally when travelling on business but identifying the emissions from these has not been possible due to data limitations.

The increase in business travel emissions for NHS TDA reflects the increase in staff and services transferred from NHS England and the development of national workstreams. The increase for Monitor relates to an increase in regional travel reflecting a change to a more regionally focused operating model.

Monitor and NHS TDA are committed to managing their 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 DH. The main areas of environmental impact are building use (energy and water), transport and travel, waste and procurement.

Monitor occupies three full floors of Wellington House in London; the space at Wellington House is leased from DH and as such the sustainability figures (including Scope 2, waste management and finite resource consumption) for the space Monitor occupies will be reported in DH's annual report.

As at 31 March 2017 NHS TDA had office space in 10 sites throughout England. All are in multiple occupancy buildings and there are no more than 80 staff members on any single site. Six of the 10 sites are managed by NHS Property Services, which is currently exempt from the government reporting procedures and therefore does not hold the required reporting data. In its latest annual stewardship report, NHS Property Services highlighted its work with NHS England, 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.

DH publishes sustainability data in its annual report but does not report on the smaller arm's length bodies (ALBs) individually.

We reviewed NHS Improvement's estate footprint as a whole in 2016/17 and will continue to do so as the organisation's activity evolves.

Monitor and NHS TDA are committed to using its resources efficiently, economically and effectively, avoiding waste and reducing CO_2 emissions. The organisations continue to invest in technologies and new ways of working to:

- ensure we encourage staff to use public transport by promoting season ticket loans and central systems for booking rail travel
- reduce the use of paper and print by harnessing wireless and mobile technology to move towards a paper-light environment
- recycle on all sites
- reduce the need for physical meetings and travel by installing additional video conference units at each site and promoting the use of telephone conference technology.

Learning from complaints

When we make mistakes we are committed to being open and honest, and learning from them. This year we received 14 complaints about NHS Improvement.

Nine complaints were about how we handled whistleblowing cases, three of which we partly upheld on the basis that our communication with the whistleblower could have been better. These three whistleblowing matters were all handled in 2015/16, and we have already made changes to address how we handle whistleblowing cases. Although we did not uphold the remaining six complaints about whistleblowing, we recognise that these are partly caused by misunderstanding about the nature of our role and frustration that we are not able to resolve individual disputes between employee and employer. We are confident that the case review service recently launched by the Office of the National Guardian will help promote good practice in handling staff concerns at a local level. We look forward to supporting the Office of the National Guardian in this and other aspects of its role.

We partly upheld three other complaints on the basis that our communication could have been better. We recognise the need to continually review how we can improve our communication with individual stakeholders who contact us.

Business plan for 2016/17

Most (71%) of our business plan actions for 2016/17 were successfully achieved by the end of the financial year. There were minor delays to the remaining actions, all of which we consider we can recover during the first quarter of 2017/18. Early in the year, delays tended to be due to a lack of internal resource, but this decreased during the year due to planned recruitment. A small proportion of publication delays were the result of restrictions introduced for the pre-election purdah period.

96% of providers said they know NHS Improvement ‘very well’ or ‘a fair amount’.

Source: Ipsos MORI stakeholder perception survey, December 2016

Financial commentary

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

NHS TDA's net expenditure for the year was £89.2 million (2015/16: £58.5 million). The main categories of spend are shown in Table 6.

Table 6: Main categories of spend

	2016/17 £m	2015/16 £m	Reference to accounts
Operating revenue	(8.1)	(1.4)	Note 4
Staff	43.1	27.1	Note 5
Purchase of goods and services	15.1	10.8	Note 6
Depreciation and impairment charges	0.2	0.2	Note 6
Provisions expense	-	0.1	Note 6
Other operating expenditure	38.9	21.7	Note 6
Total	**89.2**	**58.5**	

The largest area of spend is staff costs, representing 48% of net expenditure in 2016/17 (2015/16: 46%). The increase in proportion of staff costs is mainly due to the transfer of staff from NHS England.

Purchase of goods and services spend relates to property (£2.3 million), business expenses (£6.9 million) and professional fees (£5.9 million). More detail can be found in Note 6 to the accounts.

Other operating expenditure includes expenditure provided to NHS trusts and partners. Costs in 2016/17 have significantly increased from last financial year at £38.9 million (2015/16: £21.7 million) due to the expansion in these programmes and the transfer of functions.

Parliamentary funding received was £89.4 million revenue and £500,000 capital. Net liabilities at 31 March 2017 were £24.9 million (31 March 2016: net liabilities

£4.5 million). The increase in net liability is mainly due to the increase in year-end payables due to activities in Quarter 4 of the year not having been invoiced during the year.

Statement of payment practices

NHS TDA is required to pay its non-NHS and NHS trade payables in accordance with the Confederation of British Industry (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. NHS TDA's performance against this target is shown in Table 7.

Table 7: Payment practices

	2016/17		2015/16	
	Number	**£000**	**Number**	**£000**
Non-NHS payables				
Total non-NHS trade invoices paid in the year	2,573	12,684	2,102	8,507
Total non-NHS trade invoices paid within target	2,520	12,390	2,081	8,320
% of non-NHS trade invoices paid within target	**98%**	**98%**	**99%**	**99%**
NHS payables				
Total NHS trade invoices paid in the year	1,210	35,104	393	18,000
Total NHS trade invoices paid within target	1,176	34,059	384	17,700
% of NHS trade invoices paid within target	**97%**	**97%**	**98%**	**98%**

More detail of how money has been spent in 2016/17 can be found in the main accounts.

For a review of our activities and performance against business objectives during the year, see pages 10 to 55. Our strategy for 2016 to 2020 is published on our

website[2] and describes how we intend to help providers stabilise finances, achieve expected levels of quality and recover operational performance while beginning to transform local health and care services to ensure their long-term sustainability. Its five interconnected themes are quality of care, finance and use of resources, operational performance, strategic change, and leadership and improvement capability.

Our performance against our business plan for 2016/17 is set out on page 55. Our business plan for 2016/17 is published on our website[3] and focuses on our role in helping the NHS address its two main priorities – short-term operational improvement and longer-term sustainability.

Jim Mackey
Chief Executive
4 July 2017

[2] https://improvement.nhs.uk/about-us/corporate-publications/publications/our-2020-objectives/
[3] https://improvement.nhs.uk/about-us/corporate-publications/publications/business-plan-2016-17/

Accountability report

Corporate governance report

Directors' report

The annual report and accounts have been reviewed in detail by NHS Improvement's Executive Committee, Audit and Risk Assurance Committee and Board. At each point it has been confirmed that the annual report and accounts, taken as a whole, are considered to be fair, balanced and understandable. They provide the information necessary for NHS Improvement's stakeholders to assess NHS Improvement's business model, performance and strategy.

Board

Biographical details of directors in post at 31 March 2017 are provided below.

Ed Smith CBE, FCA, CPFA, Hon DUniv, Hon LLDs (Chairman)

Ed Smith is the Lead Non-Executive Director for the Department for Transport, Pro-Chancellor and Chairman of Council at the University of Birmingham, a Member of the Competition and Markets Authority panel and a Member of Council and Treasurer of Chatham House. He spent 30 years at PricewaterhouseCoopers in senior positions including Global Assurance Chief Operating Officer and Strategy Chairman.

Bob Alexander (Executive Director of Resources/Deputy Chief Executive)

Bob Alexander was Chief Executive of NHS TDA until he was appointed Executive Director of Resources/Deputy Chief Executive of NHS Improvement on 1 April 2016. Before joining NHS TDA, he was the Finance Director of NHS South of England and Director of NHS Finance at DH from 2007. He has held senior financial positions in both the public and private sectors.

Professor Dame Glynis Breakwell DBE DL (Senior Independent Director)

Professor Dame Glynis Breakwell is Vice-Chancellor of the University of Bath and one of Europe's leading social psychologists. She is an active public policy adviser and researcher specialising in leadership, identity processes and risk management. Dame Glynis holds a number of senior national and international positions and acts as an adviser to the higher education sector, government organisations, multinational corporations and not-for-profit organisations.

Laura Carstensen (Non-Executive Director)

Laura Carstensen has worked in both the public and private sectors, including as director of an NHS foundation trust. She is a Non-Executive Director and Chair of both the Audit Committee of Park Group PLC and the Values & Ethics Committee of The Co-operative Bank plc, and currently serves as a trustee of the National Museum Liverpool.

Lord Patrick Carter of Coles (Non-Executive Director)

Lord Carter has pursued a successful career in business and in public service. He founded Westminster Health Care in 1985 and built it into a leading provider of care to both the private and public sectors in the UK. He has served on the boards of US and UK healthcare, insurance and technology companies, and currently holds a number of chairman roles. He was made a life peer in 2004.

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 and a consultant surgeon at Imperial College Hospital NHS Trust and the Royal Marsden NHS Trust. In January 2016, Professor Darzi was awarded the Order of Merit for exceptionally meritorious service towards the advancement of medicine. He holds a number of senior roles in the healthcare sector.

Richard Douglas CB (Non-Executive Director)

Richard Douglas was formerly the Director-General, Finance and Investment at the Department of Health and has extensive experience of working across Whitehall. He was DH's sponsor for a number of national ALBs, including NHS England, Monitor and the NHS TDA.

Sarah Harkness (Non-Executive Director)

Sarah Harkness is an experienced finance professional who started in banking and has worked at the highest level in a range of roles and organisations. She previously served as Non-Executive Director of Rotherham Priority Health NHS Trust and of NHS North of England. She is a Non-Executive Director of JRI Orthopaedics Ltd and Pro-Chancellor of the University of Sheffield.

Stephen Hay (Executive Director of Regulation/Deputy Chief Executive)

Stephen Hay was previously responsible for the monitoring, compliance and intervention regime for NHS foundation trusts at Monitor. He joined Monitor in 2004 and previously worked with KPMG. 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.

Jim Mackey (Chief Executive)

Jim Mackey is on secondment from his position as Chief Executive of Northumbria Healthcare NHS Foundation Trust. He is a qualified accountant and has a keen interest in quality of care, especially patient and family experience. He has taken part in several national reviews and projects, including the Dalton review of NHS performance in 2014.

Ruth May (Executive Director of Nursing)

Ruth May was Nursing Director at Monitor before being appointed Nursing Director of NHS Improvement. She began her career with a variety of nursing roles before becoming a theatre sister at Frimley Park Hospital, and was Regional Chief Nurse and Nurse Director for the Midlands and East region of NHS England. Ruth led the 'Stop the Pressure' campaign, improving care for patients and delivering cost savings to the NHS.

Dr Kathy McLean (Executive Medical Director)

Kathy McLean was Medical Director of NHS TDA before being appointed Medical Director of NHS Improvement. Before joining NHS TDA she was the Clinical Transitions Director working with Sir Bruce Keogh building the NHS Commissioning

Board, now NHS England. Her work has focused on building clinical leadership and expertise across the system.

Sigurd Reinton CBE (Non-Executive Director)

Sigurd Reinton was until 2013 a director of NATS Holdings, the main air navigation service provider in the UK. 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 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.

Caroline Thomson (Non-Executive Director, Deputy Chair)

Caroline Thomson holds a number of board positions, including Chair of Digital UK, Non-Executive Director and Chair of the Remuneration Committee of VITEC plc and Non-Executive Director of CN Media Group. She previously spent 12 years as a member of the Executive Board of the BBC. She is a member of the Council of the University of York and a trustee of the English National Ballet and The Conversation.

Executive Committee

Helen Buckingham (Executive Director of Corporate Affairs)

Following almost 21 years in the NHS, which Helen joined as a regional finance management trainee in 1992, she joined Monitor, the healthcare sector regulator, as Chief of Staff in April 2013 before becoming Executive Director of Corporate Affairs. Much of her career has been spent in commissioning and system leadership roles: immediately before joining Monitor she was Deputy Chief Executive of the Kent and Medway Primary Care Trust Cluster and Director of Operations and Delivery for the Area Team. She is currently on secondment as a Senior Fellow at the Nuffield Trust.

Dale Bywater (Executive Regional Managing Director Midlands and East)

Dale Bywater was Director of Delivery and Development (Midlands and East) at NHS TDA until 31 March 2016, when he became Executive Regional Managing Director (Midlands and East). Before that, he was National Director of Provider

Delivery in the Department of Health. He spent the first 10 years of his career working in a variety of senior operational roles in NHS acute hospitals.

Ben Dyson (Executive Director of Strategy)

Ben Dyson joined NHS Improvement in June 2016 on secondment from the Department of Health. Before that, he was Director of the NHS Group at the Department of Health, with responsibility for managing the relationship with NHS England and NHS Improvement and helping ministers develop policy in key areas including NHS provider policy, primary care, devolution and clinical priorities. From 2007 to 2012, Ben also led the department's work to champion improvements in health and healthcare for people with learning disabilities.

Anne Eden (Executive Regional Managing Director South)

Anne Eden was Director of Delivery and Development (South) at NHS TDA on secondment from Buckingham Healthcare NHS Trust until she became Executive Regional Managing Director (South). She started her career as an NHS management trainee and has more than 30 years' experience in the NHS, including in acute and teaching hospitals, mental health, community and specialist services.

Steve Russell (Executive Regional Managing Director London)

Steve Russell was on the NHS Top Leaders Programme and Deputy Chief Executive at Barking, Havering and Redbridge NHS Trust before being appointed Executive Regional Managing Director (London). Between 2011 and 2013 he was Chief Operating Officer for South London Healthcare NHS Trust, having come from Northumbria Healthcare NHS Foundation Trust where he was Executive Director of Medicine and Emergency Care.

Lyn Simpson (Executive Regional Managing Director North)

Lyn Simpson was Director of Delivery and Development (North) at NHS TDA until she became Executive Regional Managing Director (North). Based on an important foundation of nurse, health visitor and midwife posts, she has successfully pursued an extensive and progressive career in the NHS in a series of director and trust board-level positions across a range of healthcare settings.

Adam Sewell-Jones (Executive Director of Improvement)

Adam Sewell-Jones joined Monitor on 8 August 2015 as Executive Director of Provider Sustainability before being appointed Executive Director of Improvement. He has 23 years' experience in the NHS, most recently as Deputy Chief Executive at Basildon and Thurrock University Hospitals NHS Foundation Trust where he was responsible for strategy and the transformation programme.

Jeremy Marlow (Executive Director of Operational Productivity)

Jeremy Marlow joined NHS Improvement on secondment as Executive Director of Operational Productivity in June 2016. His role then transferred to NHS Improvement from 1 February 2017. Before this, he was Director of Productivity and Efficiency at the Department of Health. He previously had a varied career in the Civil Service, including Principal Private Secretary to three different Secretaries of State and Director of Strategy.

Management of information risk and personal data related incidents

During 2016/17, no personal data incidents were reported to the Information Commissioner's Office.

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 NHS TDA to prepare for each financial year a statement of accounts in the form and on the basis set out in the Accounts Direction. The accounts are prepared on an accruals basis and must give a true and fair view of the state of affairs of NHS TDA and of its 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*[4] 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 a going concern basis.

The Accounting Officer of the Department of Health has designated the Chief Executive as Accounting Officer of 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 NHS TDA's assets, are set out in *Managing public money*,[5] published by 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 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.

[4] www.gov.uk/government/publications/government-financial-reporting-manual-2016-to-2017
[5] www.gov.uk/government/publications/managing-public-money

Annual governance statement 2016/17

NHS Improvement's Board is committed to achieving high standards of integrity, ethics and professionalism across all our areas of activity. As a fundamental part of this commitment, we support and adopt best practice standards of corporate governance in the statutory framework. This annual governance statement sets out how we have managed and controlled our resources in 2016/17 to enable this.

In July 2015, the Secretary of State announced the creation of NHS Improvement, which is the operational name for the organisation that from 1 April 2016 brings together Monitor, the NHS Trust Development Authority (NHS TDA), the Patient Safety function from NHS England, the Advancing Change team from NHS Improving Quality, and the Intensive Support Teams from NHS Interim Management and Support (IMAS) to make a single integrated enterprise.

As this report covers the period from 1 April 2016 until 31 March 2017, it refers to NHS Improvement throughout. Although Monitor and the NHS TDA remain separate legal entities, since 1 April 2016 the boards of Monitor and NHS TDA have identical membership, and meet jointly as one NHS Improvement Board.

NHS Improvement's governance framework

The Board

The Board's role is to lead the organisation by setting its strategy, including the vision, mission and values, and agreeing the framework within which operational decisions will be taken.

Board composition

NHS Improvement's Board consists of a chair and at least four non-executive directors appointed by the Secretary of State for Health. The chief executive and other executive directors, who are Board members, are appointed by the non-executive directors, subject to the Secretary of State for Health's consent. The number of executive directors on NHS Improvement's Board must not exceed the number of non-executive directors.

From 1 April 2016, the membership of the NHS TDA and Monitor boards has been identical and the two boards meet jointly to form the NHS Improvement Board.

Table 8: NHS Improvement Board

Name	Position
Ed Smith[1]	Chairman
Caroline Thomson[2]	Deputy Chair
Professor Dame Glynis Breakwell	Senior Independent Director
Lord Patrick Carter	Non-Executive Director
Lord Ara Darzi	Non-Executive Director
Richard Douglas	Non-Executive Director
Sarah Harkness	Non-Executive Director
Sigurd Reinton	Non-Executive Director
Jim Mackey[3]	Chief Executive
Bob Alexander	Executive Director of Resources/Deputy Chief Executive
Stephen Hay	Executive Director of Regulation/Deputy Chief Executive
Kathy McLean	Executive Medical Director
Ruth May	Executive Director of Nursing

[1] Ed Smith will step down as the Chairman of the Board in July 2017.
[2] Caroline Thomson will step down from the Board on 31 August 2017.
[3] Jim Mackey's appointment as Chief Executive will conclude on 31 October 2017.

The Chief Executive, Jim Mackey, was appointed with effect from 1 November 2015 for a period of two years. His appointment will conclude on 31 October 2017, following which a new chief executive will be appointed. Ed Smith was appointed Chairman of Monitor and Chairman-designate of the NHS TDA on 1 August 2015 for a period of three years; he became Chairman of the NHS TDA on 1 December 2015. He will step down from both boards in July 2017 to allow a new chair to be appointed in time to lead the search for a new chief executive. Laura Carstensen, a non-executive director, stepped down from the Board on 30 June 2017. In addition, Caroline Thomson, Deputy Chair and a non-executive director, has decided to step down from the Board on 31 August 2017.

Accordingly, at the date of this report, NHS Improvement's Board is made up of seven non-executive directors and five executive directors as set out on the next page.

The Board is satisfied that no individual or group of individuals dominates the Board's decision-making. Collectively, the non-executive directors bring a valuable range of experience and expertise as they all currently occupy, or have occupied, senior positions in the healthcare sector, in the commercial sector and in public life. The General Counsel and the Head of Governance attend all Board meetings. Other members of NHS Improvement's executive team attend Board meetings as appropriate to make presentations on pertinent matters arising from their respective directorates.

Non-executive directors

NHS Improvement's non-executive directors are independent of management and have no cross directorships or significant links that could materially interfere with the exercise of their independent judgements. Arrangements for handling any possible conflicts of personal interest are set out in NHS Improvement's Rules of Procedure.[6]

Board members' terms and conditions of appointment are available on request from the Head of Governance.

Key roles and responsibilities

Ed Smith, as the Chairman, is responsible for leading the Board and ensuring its effectiveness. The Chief Executive, Jim Mackey, is responsible for leadership and day-to-day management of the organisation and the execution of NHS Improvement's strategy.

Caroline Thomson is Deputy Chairman and Professor Dame Glynis Breakwell is the Senior Independent Director. Both appointments were made on 29 September 2016. Key areas of responsibility are outlined on the following page.

[6] https://improvement.nhs.uk/about-us/corporate-publications/publications/nhs-improvements-rules-procedure/

Table 9: Key roles and responsibilities

Position	Role
Chairman	• provides effective leadership and management of NHS Improvement's Board • ensures that NHS Improvement's Board, as a whole, plays a full and constructive part in developing and determining NHS Improvement's strategy and overall objectives • acts as the guardian of NHS Improvement's Board decision-making processes • ensures that NHS Improvement's Board has the information and advice needed to discharge its statutory duties • ensures that NHS Improvement, including the Chief Executive and other executive team members, communicates effectively with stakeholders, and that members of NHS Improvement's Board develop an understanding of NHS Improvement's major stakeholders.
Chief Executive	• leads and manages NHS Improvement as an organisation, including its staff and work programmes • proposes and develops NHS Improvement's strategy and overall objectives, in close consultation with the Chairman and the rest of Board • is responsible, with the executive team, for implementing the decisions of the Board and its committees • promotes and conducts NHS Improvement's affairs with the highest standards of integrity, probity and corporate governance • leads the communications programme with stakeholders, jointly with the Chairman.
Deputy Chairman	• the principal role of the Deputy Chairman is to deputise for the Chairman at meetings of the Board and to support the Chairman in his role.
Senior Independent Director	• works closely with the Chairman, acts as a sounding board and provides support • makes herself available for confidential discussions with other Board members who may have concerns they believe have not been properly considered by the Board as a whole • acts as a point of contact for stakeholders with concerns that have not been resolved through the normal channels, or for which such contact is inappropriate • relays to the non-executive directors their observations and any views they may have received from stakeholders.

How the Board operates

NHS Improvement's governance framework is set out in the Rules of Procedure,[7] bringing together key governance principles used by Monitor and NHS TDA, and is available on NHS Improvement's website.

To discharge its duties effectively, the Board has a formal schedule of matters reserved for its decision. These include:

- establishment and maintenance of NHS Improvement's strategic direction – reviewing, contributing to and approving NHS Improvement's vision, mission and values
- approval of NHS Improvement's corporate and business plans, including the distribution of NHS Improvement's financial allocation as set out in the annual business plan and any subsequent material change to this
- approval of NHS Improvement's risk management strategy/framework, including the determination of NHS Improvement's risk appetite
- approval of all NHS Improvement significant regulatory policies before consultation with stakeholders and any material amendments following responses to consultation
- determination of any operational decision considered to be policy-determining (that is, having strategic implications) and/or very high risk.

The Board delegates certain responsibilities to board committees, the Chief Executive and other executives. To ensure clear lines of accountability between the Board and the executive team, the Scheme of Delegation (Annex C to the Rules of Procedure) defines individual and committee responsibilities.

NHS Improvement's Board has agreed a Code of Ethical Practice (Annex A to the Rules of Procedure), which provides a high level statement of the standards of practice expected of NHS Improvement's Board members and its staff. The code explicitly reflects the 'Statement of Common Purpose' agreed in light of the findings

[7] https://improvement.nhs.uk/about-us/corporate-publications/publications/nhs-improvements-rules-procedure/

of the Mid Staffordshire NHS Foundation Trust public inquiry, and recognises the importance of the principles and values identified in the NHS Constitution. NHS Improvement is committed to taking all these into account in all its decisions and actions.

Information required for the Board to operate

The Board has agreed a classification of the information it requires to carry out its duties. Having specifically considered the nature and quality of information required in each of these categories, the Board is content it receives information that ensures it is kept fully up to date on the issues arising that affect NHS Improvement.

The Rules of Procedure govern the information to be submitted to formal Board meetings. Executive committee members maintain regular contact with all the non-executive directors and hold informal meetings with them to discuss issues affecting NHS Improvement.

In addition to internal advice, the Board may request independent and external professional advice on any matter relating to the discharge of its duties. NHS Improvement meets the costs of any such advice, subject to the agreement between NHS Improvement and DH on funding for unforeseen circumstances that may arise during a financial year.

Head of Governance

The Head of Governance is responsible for:

- advising the Board on all corporate governance matters
- ensuring that Board procedures are followed
- ensuring good information flow between the Board and its committees
- facilitating induction programmes for non-executive directors.

Any questions to stakeholders may have on corporate governance matters should be addressed to the Head of Governance at NHS Improvement's office address.

Board effectiveness

Board meetings and attendance

Attendance of the Chairman, individual non-executive directors and executive Board members at relevant Board and committee meetings during 2016/17 was as outlined below.

Table 10: Board and committee meetings and attendance

Name	Board Max 7 meetings	Audit and Risk Assurance Committee Max 5 meetings	Nominations and Remuneration Committee Max 4 meetings	Technology and Data Assurance Committee* Max 4 meetings
Ed Smith	7	N/A	N/A	N/A
Dame Glynis Breakwell	5	N/A	3	N/A
Laura Carstensen	6	4	N/A	N/A
Lord Patrick Carter	5	N/A	N/A	N/A
Lord Ara Darzi	5	N/A	N/A	N/A
Richard Douglas[1]	7	5	N/A	3
Sarah Harkness	7	5	N/A	N/A
Sigurd Reinton	6	N/A	4	4
Caroline Thomson[2]	7	N/A	2	1
Jim Mackey	7	N/A	N/A	N/A
Bob Alexander	6	N/A	N/A	
Stephen Hay	7	N/A	N/A	N/A
Ruth May	7	N/A	N/A	N/A
Kathy McLean	7	N/A	N/A	N/A

[1] Richard Douglas joined the Technology and Data Assurance Committee on 4 July 2016.
[2] Caroline Thomson joined the Technology and Data Assurance Committee on 22 February 2017.
* The Technology and Data Assurance Committee also has two independent members.

Induction

All non-executive directors who join the Board receive a detailed induction comprising information about NHS Improvement, its structure, operations and corporate governance; meetings with executive and senior management; and visits to NHS providers.

Performance evaluation

The Board sets objectives for both the Chairman and the Chief Executive. The Chairman sets objectives for individual Board members. The Chief Executive sets objectives for the executive team against the objectives set for the Board and in relation to the delivery of the organisation's business plan. The chairman conducted one-to-one interviews with each non-executive director aiming to assess the effectiveness of the Board.

Board and executive development

In 2016, the Board engaged the services of Eva Beazley, Director of The Leadership Gallery, to develop a board effectiveness framework and an executive coaching and development programme to support NHS Improvement's Board and executive team. Ms Beazley is an independent facilitator with no other connections to NHS Improvement.

Ms Beazley worked with the Board to develop a board effectiveness framework (BEF) as a model of good governance and leadership for the Board and its committees. The BEF was applied at all Board sessions as a continuous learning and improvement tool; in addition, a series of 'time out' sessions were held through the year to help build the executive team around specific business issues.

Compliance with corporate governance codes of good practice

NHS Improvement reviews its compliance against the Code of good practice for corporate governance in central government departments, the UK corporate governance code and the NHS foundation trust code of governance. Where they apply to NHS Improvement, NHS Improvement has complied with the main principles of each of these codes from 1 April 2016 to 31 March 2017, except for the following:

Table 11: Compliance with codes of good practice

Cabinet Office Code of Good Practice	NHS Foundation Trust Code of Governance	UK Corporate Governance Code	NHS Improvement position
N/A	**B.2.11** It is a requirement of the Health and Social Care Act (the 2012 Act) that the chairperson, the other non-executive directors and – except in the case of the appointment of a chief executive – the chief executive, are responsible for deciding the appointment of executive directors.	**B.7.1** All directors of FTSE 350 companies should be subject to annual election by shareholders. **B.7.2** The board should set out to shareholders in the papers accompanying a resolution to elect a non-executive director why they believe an individual should be elected.	NHS Improvement's executive directors were appointed by the Board as part of the determination of NHS Improvement's organisation design and the appointments approved by the Secretary of State for Health.
N/A	**C.3.6** The NHS foundation trust should appoint an external auditor for a period of time which allows the auditor to develop a strong understanding of the finances, operations and forward plans of the organisation.	**C.3.6** The audit committee should have primary responsibility for making a recommendation on the appointment, reappointment and removal of the external auditor.	Given the statutory composition of Monitor and NHS TDA, the Comptroller and Auditor General, supported by the National Audit Office, acts as external auditor.

Conflicts of interest

The work of NHS Improvement involves the potential for conflicts of interest, including: (i) conflict of personal interest, (ii) conflict between the exercise of different functions (including those of Monitor and the NHS Trust Development Authority) and (ii) conflict between the interests of NHS Improvement and other bodies. Arrangements for handling any possible personal conflicts of interest are set out in NHS Improvement's Rules of Procedure. We have agreed joint partnership arrangements with other healthcare regulatory bodies to manage any possible conflicts that might occur with them.

In relation to functions, NHS Improvement is vigilant for the possibility of either an actual or perceived functional conflict of interest, whereby a directorate exercising

one set of functions might prefer or adopt a particular course of action or decision that conflicts, actually or potentially, with the functions or decision-making of a different directorate. In particular, when exercising the statutory functions of Monitor (one of the constituent bodies of NHS Improvement), NHS Improvement has duties under section 67 of the 2012 Act to:

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

For these purposes, we distinguish between (i) 'functional conflicts', that is, situations which by virtue of the 2012 Act constitute an actual or perceived conflict and so must be treated as such; for example, when exercising our competition and pricing functions, we must ignore our functions with regard to imposing additional licence conditions on NHS foundation trusts; and (ii) situations which are in reality not conflicts but operational manifestations of the overlap between different NHS Improvement functions: these will be addressed and resolved by NHS Improvement legitimately and reasonably balancing competing interests.

Where we have resolved a conflict of interest in a case falling within section 67 of the 2012 Act, we must publish a statement setting out the nature of the conflict, the manner in which it was resolved and the reasons for deciding to resolve it in that manner. No such conflict was identified in 2016/17, so, no statements were published.

Committees

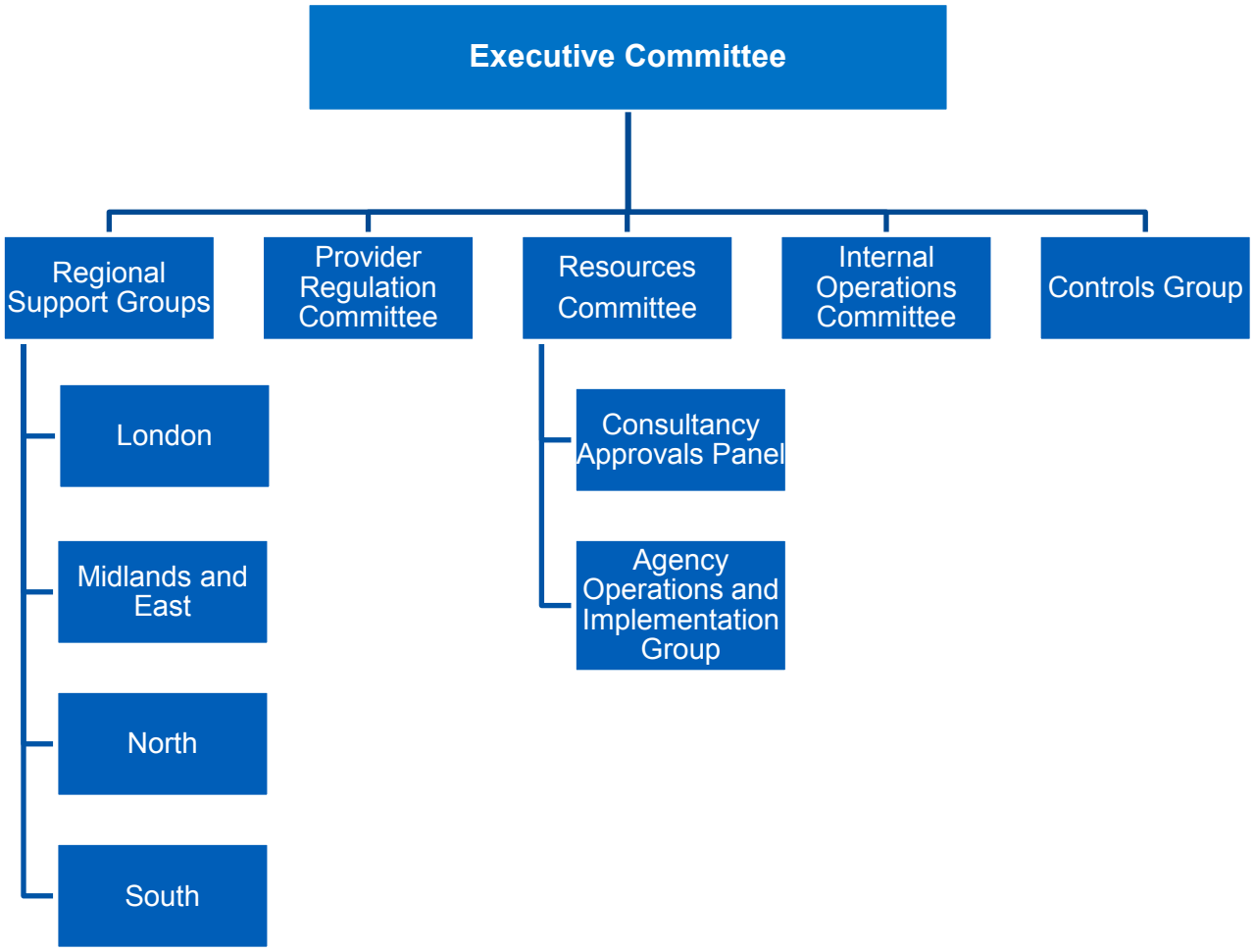
The Board is assisted by a number of Board committees. Each committee is responsible for reviewing and overseeing activities within its particular terms of reference, which are reviewed regularly during the year by the Head of Governance and by the Board as appropriate.

Table 12: Board committees

Board				
	↓	↓	↓	↓
	Audit and Risk Assurance Committee	**Nominations and Remuneration Committee**	**Provider Leadership Committee**	**Technology and Data Assurance Committee**
Chairman	Richard Douglas	Professor Dame Glynis Breakwell	Caroline Thomson	Sigurd Reinton
Composition	Non-executive directors	Non-executive directors	Non-executive directors, Executive Director of Resources /Deputy Chief Executive, Executive Director of Corporate Affairs	Non-executive director, two independent members
Role of the Committee	Reviews and monitors: the integrity of the financial statements; the effectiveness of internal controls and risk management systems; and governance processes. Manages the relationship with the internal and external auditors.	Develops policy on executive remuneration. Determines the remuneration packages of directors for approval by the Secretary of State of Health. Leads process for succession planning and Board appointments.	Approves appointments of chairs and non-executive directors of NHS trusts and appoints charity trustees. Suspends and terminates appointments in NHS trusts. Approves pay and other remuneration requests for designated staff in NHS trusts.	Provides independent assurance on information strategy and associated project proposals. Provides assurance on key decisions or recommendations which have critical strategic significance or would materially impact risk.
Operational Productivity Programme Delivery Group	Chairman: Lord Carter	Provides oversight and assurance of the implementation of the Carter Review on behalf of the Board of NHS Improvement.		
Improvement Faculty	Chairman: Lord Ara Darzi	Advises and enables the creation of an improvement movement across the NHS in England.		

The Board delegates the day-to-day running of the organisation to the Chief Executive, who is assisted in his role by the Deputy Chief Executives and the Executive Committee, comprising the executive Board members and others who report directly to the Chief Executive. Following the creation of NHS Improvement, the governance framework below the Executive Committee reflects the merged organisations as follows:

Figure 1: NHS Improvement governance framework below the Executive Committee



Board committees

Membership and principal matters considered by each committee during 2016/17

Table 13: Audit and Risk Assurance Committee

Membership:	Key duties:
Richard Douglas (Chair) Laura Carstensen[1] Sarah Harkness	• appointing and managing the relationship with the internal auditors • commissioning and receiving reports from the internal auditors on the adequacy of NHS Improvement's internal control systems • considering all relevant reports from the Comptroller and Auditor General, NHS Improvement's external auditor, including reports on NHS Improvement's accounts, achievement of value for money and the responses to any management letters issued by them • in-depth review of NHS Improvement's risk profile on report to the Board on managing and mitigating current and emerging risks.
Attendees: • Executive Director of Resources/ Deputy Chief Executive • Director of Finance • Head of Internal Audit • External auditor (Comptroller and Auditor General; National Audit Office (NAO) on his behalf)	
The Head of Governance or their nominee acts as secretary to the committee The Committee met five times in 2016/17 All non-executive directors have access to the minutes of all the committee's meetings. Following each Audit and Risk Assurance Committee meeting, the committee's chair presents a report to the Board.	**Key matters considered included:** • creation of an Assurance and Risk Management Framework (Framework) and the Strategic and High Level Operational Risk Register (the Register) • regular review of risk reports and changes to the Framework and the Register • a number of individual deep dive risk reviews • reports from the internal auditors, which consider and approve the internal audit plan, review individual internal audit reports and monitor progress to address recommendations raised in internal audit reports • review the findings of the external auditors, NAO, in respect of the audit or Monitor's and NHS TDA's financial statements.

[1] Laura Carstensen stepped down from the Board on 30 June 2017.

Table 14: Nominations and Remuneration Committee

Membership:	**Key duties:**
Professor Dame Glynis Breakwell (Chair) Sigurd Reinton Caroline Thomson[1]	• leads the process for Board appointments by evaluating the balance of skills, knowledge and experience among existing Board members and agreeing, for submission to ministers, a description of the role and capabilities required for particular appointments • oversees the pay framework for executive and senior managers. • leads on succession planning for the Board.
Attendees: • Executive Director of Regulation /Deputy Chief Executive • Director of HR, Organisation Transformation	
The Head of Governance acts as secretary to the committee The Committee met four times in 2016/17 Further details of the Nominations and Remuneration Committee and its policies can be found in the Remuneration report (see page 97)	**Key matters considered included:** • appointment of executive regional managing directors • redundancy policy • remuneration for executive and senior managers • new arrangements for the remuneration of senior posts in NHS Improvement • individual pay cases.

[1] Caroline Thomson will step down from the Board on 31 August 2017.

Table 15: Provider Leadership Committee

Membership:	Key duties:
Caroline Thomson (Chair)[1] Laura Carstensen[2] Sarah Harkness Bob Alexander Helen Buckingham[3]	• exercises NHS TDA's powers, as delegated by the Secretary of State for Health, to appoint chairs and non-executive directors of NHS trusts and appoint charity trustees, and suspend and terminate those appointments • in relation to remuneration of staff in NHS trusts, ensures consistency, equity and probity in use of public funds, takes a system-wide view of the implications of remuneration requests, and approves pay and other remuneration requests for designated staff in NHS trusts.
Attendees: • Head of Human Resources • Head of Appointments	
The Head of Governance acts as secretary to the committee The committee met five times in 2016/17	**Key matters considered included:** • the Committee's governance role in NHS trust executive HR appointment, severance and pay issues • scrutiny of individual chair appointments • NHS Workplace Race Equality Standard • arrangements for the 2016/17 appraisal of NHS trust chairs and non-executive directors • update on the development of a very senior manager pay framework • quarterly reports on appointment and remuneration activity.

[1] Caroline Thomson will step down from the Board on 31 August 2017.
[2] Laura Carstensen stepped down from the Board on 30 June 2017.
[3] Helen Buckingham is on secondment and the Executive Regional Managing Director (London) deputises in her absence.

Table 16: Technology and Data Assurance Committee

Membership:	Key duties:
Sigurd Reinton (Chair) Richard Douglas Paul Willer (independent member) Ted Woodhouse (independent member)	• supports the Board by providing independent assurance on information strategy and associated project proposals. On the basis of the information provided to it, provides assurance on key decisions or recommendations that have critical strategic significance or would materially affect risk • independent members of the Committee with significant experience in senior leadership roles in large IT organisations and/or experience of leading large complex IT systems in multifunctional organisations use this experience to test and challenge Monitor's information and IT strategy and assure the Board that it is on track and meeting its objectives.
Attendees: • Executive Director of Resources/Deputy Chief Executive • Chief Digital Officer • Chief Information Officer, NHS Improvement and NHS England • Enterprise Architect • Associate Director of Technology and Data • Chief Clinical Information Officer, NHS Improvement and NHS England	
The Head of Governance acts as secretary to the Committee The Committee met four times in 2016/17	**Key matters considered included:** • NHS Improvement IT strategy • technical integration workstream update • data security • NHS Improvement's role in enabling transformation through digitisation: real-time data NHS Improvement internal strategy delivery update and requirement to enable business systems delivery • technology and data progress update.

Executive committees

Executive Committee
Key duties: • assists the Chief Executive in making sure that NHS Improvement has a co-ordinated approach to its work, especially in providing leadership and practical help to healthcare providers • takes high-level policy decisions, focused on ensuring that NHS Improvement supports providers and holds their boards to account • focuses internally on taking high-level policy decisions and making recommendations on the actions of the subcommittees.

A number of committees assist the Executive Committee in its work. Their responsibilities are briefly outlined below.

Table 17: Supporting committees

Regional support groups			
Four regional support groups ensure that NHS Improvement adopts a consistent and appropriate approach to supporting and improving the performance of all providers of NHS services in local health systems as required. This includes using NHS Improvement's formal intervention tools, where necessary, to protect and promote patient interests. The groups apply the Single Oversight Framework by which providers are segmented in light of their performance and support is tailored accordingly.			
London	Midlands and East	North	South
Attendees at these meetings include:			
• Executive Regional Managing Director • Regional Delivery and Improvement Director(s) • Operational Regional Director of Finance or Regional Director of Finance		• Regional Chief Operating Officer • Regional Nurse Director • Regional Medical Director • A representative from the legal department	

Provider Regulation Committee	Resources Committee	Controls Group	Internal Operations Committee
Ensures that NHS Improvement supports providers of NHS services and local health systems to continuously improve their performance, holding organisations' boards to account and intervening when there is a risk that adequate healthcare services may not be delivered. This committee works closely with the regional support groups, and takes decisions in relation to regulatory policy and interventions, transactions, authorisations and accreditations, and competition-related matters.	Ensures there are appropriate overall controls on all aspects of the provider sector's spending so that the sector achieves the national priorities that have been agreed, reaches financial balance and improves its productivity, thereby performing well in the long term for patients. This externally focused committee reviews operational performance, and takes an independent view of proposals for capital investment in NHS trusts.	Approves internal requests from within NHS Improvement for major items of expenditure, ensuring that the appropriate DH and NHS Improvement Board rules are adhered to.	Assists the Executive Committee to ensure that NHS Improvement has appropriate and robust internal procedures and business processes. Responsibilities include reviewing the progress the organisation is making in achieving its performance goals and the actions set out in the annual business plan. It also ensures that NHS Improvement's resources, such as skilled employees and IT, are sufficient to deliver the strategic objectives set by the Board.

Agency Operations and Implementation Group	Consultancy Approval Panel
Assists with the implementation of a coherent, long-term strategy on the restrictions on the use of agency staff by all providers of NHS services.	Responsible for approving consultancy expenditure over £50,000 proposed by all NHS trusts and all NHS foundation trusts that receive interim support from DH or are in breach of their licence for financial reasons.

External directorships held by executive team members

Subject to certain conditions, and unless otherwise determined by the Board, executive team members are permitted to accept one appointment as a

non-executive director. As of the date of this report, none of the executive team members holds an external non-executive directorship.

Relationships with stakeholders

Stakeholder engagement

NHS Improvement meets key stakeholders on a regular basis to discuss matters relating to NHS provider policy and broader questions on health reform.

During 2016/17, Board and executive meetings were held with organisations and individuals, including ministers, special advisers and senior officials from DH, NHS England, CQC, NHS Providers, chairs, chief executives and finance directors of provider organisations.

Events

NHS Improvement regularly runs events and webinars to keep stakeholders informed and provide opportunities to discuss specific elements of the regulatory and support regime.

NHS Improvement's website

The NHS Improvement website.[8]

NHS Improvement's duties as a regulator

Duty to review regulatory burdens

Under the 2012 Act, NHS Improvement (through Monitor) is required to keep the exercise of its functions under review to ensure it does not maintain or impose regulatory burdens that it considers to be unnecessary.

Whenever we propose significant changes to our regulatory framework, we consult on them so that those we regulate may comment on possible regulatory burden. Consideration of regulatory burden also forms part of our process for carrying out impact assessments of policies and proposals.

[8] https://improvement.nhs.uk/

In 2016/17, NHS Improvement developed the Single Oversight Framework, which replaced Monitor's Risk Assessment Framework and NHS TDA's Accountability Framework. We developed our proposals and consulted with the sector on two occasions: for six weeks from the end of June; and following the publication of the initial framework we invited comments from the sector on the final document for a further three weeks.

We sought to reduce the burden on the sector by harmonising the process of data collection from NHS foundation trusts and NHS trusts under the Single Oversight Framework. We now collect all operational performance information required by the Single Oversight Framework from central NHS sources. This means that NHS foundation trusts no longer have to report performance against national targets and standards separately to NHS Improvement.

In developing the 2017/19 national tariff we considered the regulatory burdens on the sector. We made a number of large changes including moving to HRG4+, new prices and moving to a two-year tariff. While we expected there to be a burden to introducing a new currency design and other policy changes, this was seen as similar to the year-on-year changes that the sector has previously been asked to adopt.

By moving to a two-year tariff, as there would only be minor changes to prices and no changes to policies, we expected the regulatory burden of implementing the second year of the tariff to fall considerably. Feedback from the sector broadly welcomed these proposals, although some concerns were raised regarding inflation assumptions and limits to the adoption of new drugs and devices through the high cost list. We considered these and felt that the gains from additional certainty still outweighed the risks.

Duty to carry out impact assessments

Under section 69 of the 2012 Act, NHS Improvement (through Monitor) must publish an impact assessment (or a statement explaining why an assessment is not necessary), when proposing to do something likely to have a significant impact on those who provide healthcare services for the purposes of the NHS, those who use these services, or the general public, or would be likely to involve a major change to the activities of Monitor itself or the standard conditions of the provider licence.

In 2016/17, we undertook an impact assessment under section 69 of our proposed new national tariff for NHS services for the period April 2017 to March 2019. We concluded that the policies in the proposed tariff (such as fixing tariff rules for two years) would have a positive impact for providers, commissioners and patients in providing certainty regarding the tariff over two years, and there was little or no material difference in the overall impact resulting from changes to the tariffs themselves. We published this impact assessment as part of our statutory consultation notice on the proposed tariff, and following consultation this tariff is now in force.

We decided to adopt the 2017/18 and 2018/19 national tariffs as proposed, with effect from 1 April 2017.

Macpherson recommendations on quality assurance of models

The Macpherson report (2013) made a number of recommendations relating to the processes, culture and environment within which business-critical analytical models are quality assured. Government departments and ALBs, such as NHS Improvement, are required to implement these recommendations. In 2015/16 Monitor identified four business-critical models, and NHS TDA did not identify any business-critical models. NHS Improvement has a framework for identifying business critical models on an ongoing basis.

Under this framework, we identified five business critical models in 2016/17. Four of these models were business critical last year and one (the control totals impact assessment model) is new.

Information about the five business-critical models and the systems NHS Improvement has in place to provide appropriate quality assurance is given below.

Table 18: Quality assurance processes for business-critical models

Model	Quality assurance processes in place
The **long-term financial model** (LTFM) has two uses. The first is to highlight the financial history, current financial position and financial forecasts of foundation trust applicants. It is also used to stress test the assumptions used by applicant trusts when assessing whether the applicants are financially viable. The second is for considering proposed mergers, in a way similar to that used in the foundation trust application process. The model is business critical because financial viability is a key criterion for foundation trust authorisation and in the risk rating of transactions.	The LTFM was developed internally by a modelling expert and has been externally audited by modelling experts on a number of occasions. All changes to the model go through a documented model update process, including segregation of duties and multiple-stage review processes. Large-scale changes to complex parts of the model are typically performed and/or reviewed by external modelling experts, although such changes are rare.
The **NHS Improvement tariff calculation model** is used to calculate the prices and related data points in NHS Improvement's national tariff document. The model is business critical because the outputs are used to calculate what a provider of NHS services gets paid (by commissioners) for performing these services. It covers approximately £30 billion of NHS expenditure.	The tariff calculation model has undergone quality assurance in three stages: 1. an internal quality assurance process 2. publishing the model as part of our consultation on the National Tariff Payment System, which gave stakeholders the opportunity to review the model and feed back their comments and observations. Some minor amendments were made to the model as a result of this feedback 3. auditing by KPMG; its recommendations have been incorporated into the model.

The **pricing impact assessment model** is used to assess the expected impact of proposed changes to national prices. It is used to calculate the effect on income and expenditure for providers and commissioners as a result of changes to national prices or pricing rules. The model supports our statutory duty to perform an impact assessment of changes to the National Tariff Payment System. It is business critical because its outputs are used to calculate what a provider of NHS services gets paid (by commissioners) for performing these services	The pricing impact assessment model was developed by analysts at NHS Improvement. The model has been quality assured in four ways: • each part of the model was reviewed internally by an analyst not involved in creating that part of the model • key model results were validated against analysis by NHS England analysts • model outputs for a sample of organisations were compared with internal analysis by those organisations • the model was audited by KPMG and its recommendations incorporated into the model.
The **GP referral analysis model** is used to analyse whether a merger between providers of NHS elective care services is likely to give rise to competition concerns. The model comprises a series of files containing software algorithms that analyse Hospital Episode Statistics (HES) data. The model is business critical because it provides a foundation for our strategic advice and early input to foundation trusts and trusts considering mergers, to ensure that transactions are well planned and work well for patients.	The GP referral analysis model was developed internally by modelling experts. All changes to the model have been documented and a change process has been created. A version control system is in place for analytical auditing. The model has been internally quality assured. Further, any supplementary analysis added to the model will be quality assured using the formal change process.

In line with the recommendations of the Macpherson review, model owners in NHS Improvement are accountable for implementing appropriate quality assurance procedures for their analytical models. We have also been working to ensure we have an appropriate organisational framework for reviewing and reporting on these models, and a working group of suitably qualified staff co-ordinates our Macpherson process. This group advises on the quality assurance procedures for models in line with the Macpherson recommendations and the identification of business-critical models. It interacts directly with model owners as required.

Further, all models have a model senior responsible officer (MSRO). MSROs are responsible for ensuring that quality assurance proportional to risk has taken place

and any identified risk and assurance issues are reported through our risk management process (see Risk and control framework for further details; page 92).

Harris recommendations on assurance regarding statutory arrangements

The Harris report, published in 2013, recommended greater assurance at board and departmental level that all statutory functions in the health and social care landscape established by the 2012 Act are being exercised appropriately. NHS Improvement's Board is content that it understands the fundamental principle of public law that, where a function has been conferred by statute on a public authority, the public authority may not, unless expressly permitted to do so, further delegate the performance of that function to another body. Further, the Board is fully cognisant of the fact that Monitor and NHS TDA remain separate legal entities with separate powers and functions, and understands how these differences can be made to work in harmony in the furtherance of NHS Improvement's mission to help the NHS meet its short term challenges and secure its future.

Head of Internal Audit Opinion 2016/17

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. Internal Audit is fully independent and remains free from interference in determining the scope of internal auditing, performing work and communicating results.

For the three 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 Governance, Key Financials, Cyber Security, Operational Productivity and IT Service Management. We also reviewed specific risks associated with areas of NHS Improvement within each internal audit.

- In the case of governance: moderate
  - We reviewed governance as part of the reviews of Governance, Special Measures, Business Continuity Planning, Financial Improvement Programme and Programme Management.
- In the case of control: moderate
  - We reviewed controls in place, throughout the audits contained within the audit plan.

Therefore, in summary, my overall opinion is that I can give moderate assurance to the Accounting Officer that Monitor and NHS TDA have had adequate and effective systems of control, governance and risk management in place for the reporting year 2016/17.

Internal control – statement from Jim Mackey, NHS Improvement's Chief Executive

As Accounting Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of NHS Improvement's policies, aims and objectives. These are set out in the National Health Service Act 2006, the 2012 Act and NHS Improvement's corporate strategy[9] and business plan.[10] In doing so, I must safeguard the public funds and assets in accordance with the responsibilities assigned to me in *Managing public money*[11] and the latest accounts direction from DH.

Purpose of the system of internal control

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives.

The system of internal control is based on an ongoing process designed to:

- identify and prioritise the risks to the achievement of NHS Improvement's policies, aims and objectives
- evaluate the likelihood of those risks being realised and the impact should they be realised
- manage risks efficiently, effectively and economically.

[9] https://improvement.nhs.uk/about-us/corporate-publications/publications/our-2020-objectives/
[10] https://improvement.nhs.uk/about-us/corporate-publications/publications/business-plan-2016-17/
[11] /www.gov.uk/government/publications/managing-public-money

The system of internal control has been in place in NHS Improvement for the year ended 31 March 2017 and up to the date of approval of the annual report and accounts, and accords with HM Treasury guidance.

Risk and control framework

We created a unified framework (our **assurance and risk management framework**) for managing risk within NHS Improvement to ensure that members of staff from NHS TDA, Monitor and transferring functions from NHS England adhere to a single process for identifying, analysing, evaluating and controlling the risks that threaten the delivery of NHS Improvement's critical success factors. Our new framework is aligned with the overarching principles of HM Treasury's Orange Book and informed by DH's risk management policy, ISO 31000 *Risk Management Principles and Guidelines* and the UK Corporate Governance Code.

In implementing the framework we looked again at our network of risk and performance champions across the organisation and reappointed risk and performance leads within each directorate/region, providing them with updated roles, responsibilities and training materials to drive improvement. Our risk/performance leads have continued to share good practice, provide information on new and existing risks, and co-ordinate and support the embedding of an appropriate risk management culture within the organisation.

Throughout the transition to NHS Improvement, both directorate and strategic risk registers and accompanying quarterly risk reports have continued to be regular agenda items at Executive Committee meetings and at the Internal Operations Committee to ensure appropriate discussion of risks. This has enabled formal escalation of risks for the attention of senior management and for further review and challenge at the Audit and Risk Assurance Committee and the Board.

Following the development of NHS Improvement's strategic framework and 2016/17 business plan, our executive team conducted a strategic risk workshop to identify and assess the principal risks threatening our priorities, objectives and operating model. Our annual Board risk workshop challenged and reviewed our approach to risk management and overall risk exposure.

Principal risks facing NHS Improvement during 2016/17

Our review of NHS Improvement's annual business plan identified that the organisation faced significant risks in 2016/17.

Table 19: Principal risks and mitigation

Risk	Mitigation: what did NHS Improvement do to manage the risk?
NHS Improvement integration Risks associated with transforming the organisation (for example, the magnitude and extent of cultural and operational changes required; the pace of change needed; and/or the challenges embedding new cultures, systems and structures) while developing and delivering NHS Improvement's work programme.	• An integration programme was established in October 2015 to oversee the transition period. In May 2016, a strategic change programme was established to ensure risks associated with change activities were managed. • The programme included projects to implement the final parts of the operating model including organisational development and cultural priorities, and the Single Oversight Framework and improvement model, and finalising NHS Improvement's new structure and estate. • The programme delivered against the above projects and transferred the remaining work to business as usual in November 2016. • To help with the detailed design of NHS Improvement's organisational divisions and ways of working, an operating model working group was established. It first met in January and now meets on a fortnightly basis to take the programme forward.
Joint/partnership working Risk that we fail to align our operational actions and strategic approach with other ALBs, leading to confusion, duplication or omissions and threatening collaborative working initiatives.	• NHS Improvement has continued to work closely with partners to share intelligence and identify, develop and implement effective strategies to address significant challenges; for example, implementation of the Single Oversight Framework, issuing of the planning guidance and publication of the statutory consultation documents for the national tariff for 2017/18 to 2018/19.
NHS Improvement capacity and capability Risk that we are unable to recruit, develop or retain key talent resulting in NHS Improvement lacking the knowledge, skills, capacity, culture and ability to deliver our business	• We continue to develop our strategy to recruit, retain and develop high quality people with the range of skills and experience that will enable us to deliver on our commitment to the service to provide leadership and practical support. • Although we are below complement in some

plan/continue to meet our priorities and responsibilities and transform services.	areas, our recruitment activities continue to progress in line with agreed plans. • We promote a culture of flexible working and equip staff accordingly when working remotely at provider sites, to build a positive, supportive working environment.
Availability and supply of sector workforce (including culture, leadership and improvement capability) Risk that the NHS lacks capacity and/or capability (the right skills and the right number of staff in the most appropriate settings) resulting in deterioration of operational performance, decline in the safety/quality of service provision and/or threat to financial sustainability and the delivery of the expected transformation within the NHS.	Developments in 2016/17: • provider-level reviews and assessment on workforce completed with risk rating of plans and delivery • workforce toolkit tested and support offer to organisations • provider support offer on workforce through regional teams • development of the project initiation document and plans to support workforce priorities of supply, retention, efficiency and role development; strong engagement plan • agreement with ALBs on supply and workforce numbers in nursing and midwifery; further work on medical and allied health professional staff in progress • agreement with DH on NHS Improvement programme of work on nursing workforce to focus on apprentices, participation and retention • review and assessment of safer staffing input data and assessment of risk organisations and associated actions • safe, sustainable and efficient staffing draft improvement resources published for engagement • further review and assessment of triggers in line with regional performance review meetings; focusing on agency and locum staffing • provider review process started for new roles (nursing associate).
Balancing quality, finance and operational performance Risk that we fail to balance quality, finance and access priorities appropriately, leading to an inability to maintain and improve	• The most distressed trusts are subject to special measures. • We have a suite of regulatory tools, including powers to change board leadership, appointment of improvement directors and buddy trusts, contingency

performance against core quality and access standards while achieving financial balance.	planning teams and trust special administrators. • A new model of management intervention is being developed, following the model of super buddying established between Guy's and St Thomas' Foundation Trust and Medway NHS Foundation Trust. • A diagnostic toolkit is being developed to accelerate identification of underlying causes of issues at trusts and solution design.

Capacity to handle risk

NHS Improvement's Board has responsibility for ensuring delivery of our strategies and goals as outlined in the 2016/17 business plan. When setting these strategies and goals, the Board considers NHS Improvement's specific statutory functions as outlined in legislation relating to its component parts of Monitor and NHS TDA and Board members' understanding, working knowledge and experience of the healthcare system (the latter being informed by, among other things, Board workshops).

When the strategies and goals have been established, detailed plans are drawn up for each strategy area with input from all staff. Risks against achievement of goals and strategies are reported to the Board on a quarterly basis. NHS Improvement's internal auditors categorise our business in three systems (operational systems, support systems and the governance framework). The internal audit team considers the risks to NHS Improvement in relation to these and this directs internal audit priorities, which are reflected in the annual internal audit plan.

NHS Improvement's Audit and Risk Assurance Committee considers risks faced by the organisation on a quarterly basis and reports its conclusions directly to the NHS Improvement Board. The internal audit team makes its own regular reports to the Audit and Risk Assurance Committee based on its work programme. The Board discusses the most significant risks and the actions identified to mitigate the likelihood and impact of those risks. On an annual basis, the Audit and Risk

Assurance Committee evaluates the effectiveness of the risk management framework and approves the annual internal audit plan for the following year.

Review of effectiveness

As Accounting Officer, I have responsibility for reviewing the effectiveness of the system of internal control. This review is informed by the work of the internal auditors and Executive Committee members who have responsibility for the development and maintenance of the internal control framework, and comments made by the external auditors in their management letter and other reports.

NHS Improvement continues to enhance its internal controls environment above and beyond the minimum levels required. Our management team continues to ensure that appropriate and relevant controls are embedded in all areas of our work.

Internal audit work covering compliance and intervention processes continues to provide me with adequate assurance that effective controls are either in place or being developed to a high degree of sophistication. NHS Improvement's Board has maintained strategic oversight and review of internal control and risk management arrangements through regular reports by directors on their areas of responsibility and through specific papers for discussion at Audit and Risk Assurance Committee and Board meetings.

The Audit and Risk Assurance Committee, which meets on a quarterly basis, has considered:

- individual internal audit reports and management responses
- the internal auditor's annual report and opinion on the adequacy of our internal control system. The internal auditor's opinion gave moderate assurance for 2016/17 (on a rating scale of substantial, moderate, limited and unsatisfactory)
- National Audit Office audit reports and recommendations
- regular reports on NHS Improvement's corporate risk register, including the identification of risks to the organisation's system of internal control and information about the controls that have been put in place to mitigate these risks.

Any data losses experienced by the organisation would be reported to the Audit and Risk Assurance Committee. No such incidents occurred in 2016/17.

To my knowledge, and based on the advice I have received from those managers with designated responsibilities for managing risks and the risk management system, I am not aware of any significant internal control problems for 2016/17. As Accounting Officer for Monitor and NHS TDA, I have gained assurance of the adequacy of Monitor and NHS TDA's internal control environment from individual assurances given to me by each member of the Executive Committee as to the adequacy of the internal control environment in their own directorate.

Jim Mackey
Chief Executive
4 July 2017

Remuneration and staff report

Remuneration report

From 1 April 2016 NHS TDA and Monitor shared a joint Board under the organisational name of NHS Improvement. This report includes details of the joint Board; more information is contained in the financial statements of each entity.

Remuneration policy

The remuneration of Monitor and NHS TDA employees, including the Chief Executive, is agreed or ratified by the Nomination and Remuneration Committee, while the Chairman's salary is determined by the Secretary of State for Health. The membership of the Remuneration Committee comprises three non-executive directors and other members as from time to time agreed by the Chairman of the committee. Other non-executive directors attend by invitation. No member is involved in any decisions or discussion as to their own remuneration. In reaching its recommendations, the committee has regard for the following considerations:

- DH pay remit guidance
- need to recruit, retain and motivate suitably able and qualified staff
- funds available from DH
- requirement to deliver performance targets.

In April 2016, the Senior Salaries Review Body made certain recommendations on very senior manager (VSM) salaries, mainly that DH determines the appropriate level of increase for VSM salaries.

Service contracts

Appointments are made on merit on the basis of fair and open competition. Unless otherwise stated, the executive team identified in this report holds appointments which are open-ended.

Notice periods and termination costs

The required notice periods for the executive team are given in Table 19. There are no other 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, the Civil Service severance compensation scheme or DH terms and conditions.

Table 20: Executive team notice periods update

	Notice period
Jim Mackey, Chief Executive	*
Robert Alexander, Deputy Chief Executive and Executive Director of Resources	6 months
Stephen Hay, Deputy Chief Executive and Executive Director of Regulation	6 months
Ruth May, Executive Director of Nursing	6 months
Dr Kathy McLean, Executive Medical Director	6 months
Helen Buckingham, Executive Director of Corporate Affairs	3 months
Dale Bywater, Executive Regional Managing Director (Midlands and East)	6 months
Ben Dyson, Executive Director of Strategy	3 months
Anne Eden, Executive Regional Managing Director (South)	1 months
Andrew Hines, Acting Executive Regional Managing Director (London) for the period 1 April 2016 to 31 July 2017	3 months
Jeremy Marlow, Executive Director of Operational Productivity	3 months
Adrian Masters, Executive Director of Strategy for the period 1 April 2016 to 30 June 2016	6 months
Steve Russell, Executive Regional Managing Director (London)	3 months
Adam Sewell-Jones, Executive Director of Improvement	3 months
Lyn Simpson, Executive Regional Managing Director (North)	6 months
Mark Turner, Acting Executive Regional Director (London) deputy to Andrew Hines for the period 1 April 2016 to 30 June 2016	3 months

* Jim Mackey is on secondment from Northumbria Healthcare NHS Foundation Trust NHS TDA is able to give Northumbria Healthcare NHS Foundation Trust two months' notice to terminate the secondment agreement.

Salary and pension entitlements

The following sections provide details of the remuneration and pension interests of the executive team and Board. These figures are subject to audit. Senior managers are salaried and are entitled to annual pay progression subject to individual performance against objectives.

From 1 April 2016 NHS TDA and Monitor shared a joint Board under the organisational name of NHS Improvement. Table 20 shows the total remuneration; 50% of the 2016/17 costs are charged to NHS TDA and 50% to Monitor. This proportion was deemed reasonable following review of activities between the two organisations.

Table 21: Salary, benefits in kind and pension benefits

Name and position	Salary (bands of £5,000)	Benefits in kind to nearest £100	All pension-related benefits	Total (bands of £5,000)
	£000	£00	£000	£000
Board executives				
Jim Mackey[1] Chief Executive	220-225	119	29	260-265
Robert Alexander Deputy Chief Executive and Executive Director of Resources	170-175		97	265-270
Stephen Hay[2] Deputy Chief Executive and Executive Director of Regulation	190-195		-	190-195
Ruth May Executive Director of Nursing	145-150		84	230-235
Dr Kathy Mclean[3] Executive Medical Director	180-185		-	180-185

Executive team				
Helen Buckingham Executive Director of Corporate Affairs (for the period 1 April 2016 to 17 March 2017)	110-115		44	155-160
Dale Bywater Executive Regional Managing Director (Midlands and East)	155-160		98	255-260
Ben Dyson[4] Executive Director of Strategy (from 1 June 2016)	105-110		50	155-160
Anne Eden Executive Regional Managing Director (South)	170-175		-	170-175
Andrew Hines[5] Acting Executive Regional Managing Director (London) (for the period 1 April 2016 to 31 July 2016)	45-50		101	145-150
Jeremy Marlow[6] Executive Director of Operational Productivity	75-80		52	125-130
Adrian Masters[7] Executive Director of Strategy (for the period 1 April 2016 to 30 June 2016)	40-45		14	50-55
Steve Russell[8] Executive Regional Managing Director (London) (from 1 August 2016)	110-115		83	195-200
Adam Sewell-Jones[9] Executive Director of Improvement	150-155	76	59	215-220

Lyn Simpson[10] Executive Regional Managing Director (North)	155-160		22	180-185
Mark Turner[11] Deputy to the Acting Executive Regional Managing Director (London) (deputy to Andrew Hines for the period 1 April 2016 to 30 June 2016)	30-35		12	40-45

Information above has been subject to audit.

[1] Jim Mackey is on secondment from Northumbria Healthcare NHS Foundation Trust from 1 November 2015 as joint Chief Executive of NHS TDA and Monitor. He left the NHS Pension Scheme on 1 October 2010 and all pensions-related benefits disclosures relate to a payment in lieu of employer's contributions to the NHS Pension Scheme.

[2] In addition to his salary, Stephen Hay received a payment in lieu of annual leave in the banding £0-£5,000.

[3] In addition to her salary, Dr Kathy McLean received a payment in lieu of annual leave in the banding £0-£5,000.

[4] Ben Dyson is on secondment from the Department of Health to Monitor from 1 June 2016.

[5] Andrew Hines stepped down from his role as Acting Executive Regional Managing Director (London) on 31 July 2016. His annualised salary would have been in the band £135,000 to £140,000.

[6] Jeremy Marlow was seconded from the Department of Health for the period 1 August 2016 to 31 January 2017 and on the payroll from 1 February 2017. His annualised salary is within the band £140,000 to £145,000.

[7] Adrian Masters left his role as Executive Director of Strategy on 30 June 2016. His annualised salary would have been in the band £160,000 to £165,000.

[8] Steve Russell's annualised salary is within the band £165,000 to £170,000.

[9] Adam Sewell-Jones' benefit in kind relates to his lease car.

[10] In addition to her salary, Lyn Simpson received a payment in lieu of annual leave in the banding £0 to £5,000.

[11] Mark Turner stepped down from his role as Deputy to the Acting Executive Regional Managing Director (London) on 30 June 2016. His annualised salary would have been in the band £120,000 to £125,000.

Table 22: The full charge to NHS TDA only for 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)
	£000	£000	£00	£000	£000
Jim Mackey[1] Chief Executive (appointed as joint Chief Executive of NHS TDA and Monitor commencing 1 November 2015, seconded from Northumbria Healthcare NHS Foundation Trust)	50-55		20		50-55
Robert Alexander Deputy Chief Executive (for the period 1 April 2015 to 31 October 2015 Robert Alexander was Chief Executive of NHS TDA. From 1 November 2015 he became Deputy Chief Executive of NHS TDA)	170-175	5-10		58	235-240
Elizabeth O'Mahony Director of Finance (appointment began 1 April 2015)	135-140	5-10		60	200-205
Dr Kathy McLean Medical Director	180-185			8	190-195
Peter Blythin Director of Nursing	150-155			1	150-155

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)
Ralph Coulbeck[2] Director of Strategy (left NHS TDA on 31 March 2016)	95-100			(11)	85-90
Robert Checketts[3] Director of Communications (left NHS TDA on 5 January 2016)	80-85	5-10		(17)	70-75
Dale Bywater Director of Delivery and Development (Midlands and East)	155-160	5-10		(20)	140-145
Anne Eden[4] Acting Director of Delivery and Development (South) (seconded from Buckinghamshire Healthcare NHS Trust; the appointment commenced on 1 April 2015)	170-175			(2)	170-175
Alwen Williams CBE[5] Director of Delivery and Development (London) (seconded to Barts Health NHS Trust from 1 June 2015 to3 January 2016 and left NHS TDA on 3 January 2016)	25-30			216	240-245
Lyn Simpson Director of Delivery and Development (North)	155-160			4	160-165

The information has been subject to audit

[1] Jim Mackey is on secondment from Northumbria Healthcare NHS Foundation Trust from 1 November 2015 as joint Chief Executive of NHS TDA and Monitor. From this date onwards, 50% of his remuneration is disclosed in NHS TDA's remuneration report and 50% in Monitor's remuneration report. He left the NHS Pension Scheme on 1 October 2010. Salary disclosed comprises two elements: his salary for five months within the band of £45,000 to £50,000 and a payment in lieu of employer's contributions to the NHS Pension Scheme within the band £5,000 to £10,000. His full-time annualised salary is within the band £215,000 to £220,000, and his payment in lieu of employer's pension contributions is within the band £25,000 to £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 to £120,000. His 2015/16 pension-related benefits are associated with the NHS Pension Scheme.

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

[4] The notice period disclosed for Anne Eden is the period 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 NHS TDA on 3 January 2016. Her annualised salary would have been in the band £160,000 to £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 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.

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

The value of pension benefits accrued during the year is calculated as the real increase in pension multiplied by 20, the real increase in any lump sum less the contributions made by the individual. The real increase excludes increases due to inflation or any increase or decrease due to a transfer of pension rights.

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.

Since 1 April 2016 NHS TDA and Monitor have shared a joint Board, and the costs are shared 50:50 between the two entities. To reflect the joint working arrangements and to avoid distorting the pay multiple disclosures, NHS TDA has calculated the pay multiples using the full salary of the senior managers and the non-executive members disclosed in the remuneration tables rather than the 50% cost incurred by NHS TDA. The prior year comparatives have not been changed as only the Chief Executive (from November 2015) and the Chair (December 2015) were shared appointments, which had a minimal impact on the 2015/16 calculations.

The banded remuneration of the highest paid director in NHS TDA in the financial year 2016/17 was £230,000 to £235,000 (2015/16: £180,000 to £185,000). This was 3.7 times the median remuneration of the directly employed workforce which was £62,509 (2015/16: 3.2 times, with a median remuneration of £57,069).

In 2016/17, no employee received remuneration in excess of the highest paid director (2015/16: none). Remuneration ranged from £5,000-£10,000 to £230,000-£235,000 (2015/16: £5,000-£10,000 to £180,000-185,000).

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 ratio between the highest paid director and the median remuneration of the workforce has increased from the previous year by 0.5. Since 1 April 2016 NHS TDA and Monitor have had a joint Board and 100% of costs are disclosed in the pay multiples of each entity.

The pay multiples information above has been subject to audit.

Chairman and non-executive directors

Non-executive directors are appointed by the Secretary of State for a term of four years. All remuneration paid to the Chairman and non-executive directors is non-pensionable. The benefits in kind given to the Chairman and non-executive directors are disclosed in Table 22. The monetary value of benefits in kind covers any payments (for business expenses or otherwise) or other benefits provided by NHS TDA or Monitor (as applicable) that are treated by HM Revenue and Customs as a taxable emolument. These figures are subject to audit.

Since 1 April 2016 NHS TDA has shared a joint Board with Monitor under the name of NHS Improvement. Table 23 shows the total remuneration; 50% of the 2016/17 costs are charged to NHS TDA.

Table 23: Benefits in kind for the Chairman and non-executive directors 2016/17

Name	Position	Salary (bands of £5,000)	Benefits in kind to nearest £100	Total (bands of £5,000)
		£000	£00	£000
Ed Smith CBE	Chair	60-65		60-65
Sir Peter Carr CBE[1]	Deputy Chair (on 31 May 2016 Sir Peter Carr stood down from the role of joint Deputy Chair of NHS TDA and Monitor)	5-10		5-10
Professor Dame Glynis Breakwell DBE DL	Senior Independent Director	5-10		5-10
Laura Carstensen	Non-Executive Director	5-10		5-10
Lord Patrick Carter of Coles	Non-Executive Director	5-10		5-10
Professor the Lord Ara Darzi of Denham	Non-Executive Director	5-10		5-10
Richard Douglas CB	Non-Executive Director	10-15		10-15
Sarah Harkness	Non-Executive Director	5-10		5-10
Sigurd Reinton CBE	Non-Executive Director	5-10		5-10
Caroline Thomson	Deputy Chair	5-10		5-10

[1] Sir Peter Carr's annualised remuneration would have been in the band £50,000 to £55,000.

Table 24: The full charge to NHS TDA only for 2015/16

Name	Position	Salary (bands of £5,000)	Benefits in kind (to nearest £100)	Total (bands of £5,000)
		£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
Sir Peter Carr CBE	Deputy Chair (on 30 November 2015 Sir Peter Carr stood down from the role of Chair of NHS TDA and became Deputy Chair)	50-55	-	50-55
Dame Christine Beasley	Non-Executive Director (resigned from NHS TDA board on 31 March 2016)	10-15	-	10-15
Sarah Harkness	Non-Executive Director	10-15	-	10-15
Crispin Simon[2]	Non-Executive Director (resigned from NHS TDA Board on 31 December 2015)	5-10	-	5-10
Caroline Thomson	Non-Executive Director	5-10	-	5-10

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 NHS TDA's remuneration table and 50% in Monitor's remuneration table. His annualised remuneration is within the band £100,000 to £105,000 (50% of this, £50,000 to £55,000, would be applicable to his NHS TDA duties).
[2] Crispin Simon's annualised remuneration would have been in the band £5,000 to £10,000.

Table 25: Executive directors' pensions and cash equivalent transfer values (CETV)

Name	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 2017 (bands of £5,000)	Lump sum at pension age related to accrued pension at 31 March 2017 (bands of £5,000)	CETV at 31 March 2016	CETV at 31 March 2017	Real increase in CETV
	£000	£000	£000	£000	£000	£000	£000
Jim Mackey Chief Executive	-	-	-	-	-	-	-
Robert Alexander Deputy Chief Executive and Executive Director of Resources	5.0-7.5	15.0-17.5	45-50	135-140	834	992	158
Stephen Hay Deputy Chief Executive and Executive Director of Regulation	-	-	35-40	0-5	641	641	-
Ruth May Executive Director of Nursing	2.5-5	7.5-10	55-60	165-170	849	947	98
Dr Kathy McLean[1] Medical Director	-	-	75-80	225-230	1,617	1,617	-

Helen Buckingham Executive Director of Corporate Affairs	2.5-5	0-2.5	10-15	0-5	84	113	18
Dale Bywater Executive Regional Managing Director (Midlands and East)	5.0-7.5	0-2.5	40-45	110-115	597	665	68
Ben Dyson Executive Director of Strategy	2.5-5	2.5-5	0-5	0-5	12	46	23
Anne Eden[1] Executive Regional Managing Director (South)	-	-	70-75	215-220	1,510	1,510	-
Andrew Hines Acting Executive Regional Managing Director (London)	0-2.5	0-2.5	40-45	105-110	552	631	26
Jeremy Marlow Executive Director of Operational Productivity	2.5-5	5-7.5	20-25	55-60	271	327	39
Adrian Masters Executive Director of Strategy	0-2.5	0-2.5	35-40	0-5	574	591	10
Steve Russell Director of Delivery and Development (South)	2.5-5.0	2.5-5.0	45-50	115-120	508	570	41

Adam Sewell-Jones Executive Director of Improvement	2.5-5	0-2.5	5-10	0-5	22	57	24
Lyn Simpson Executive Regional Managing Director (North)	0-2.5	5.0-7.5	70-75	210-215	1,459	1,544	86
Mark Turner Deputy to the Acting Executive Regional Managing Director (London)	0-2.5	0-2.5	10-15	0-5	153	161	6

Information above has been subject to audit.

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

[1] Kathy McLean, Anne Eden and Stephen Hay did not contribute to the NHS Pension Scheme during the reporting year.

Cash equivalent transfer values

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

The CETV is the amount paid by one pension scheme or arrangement to secure pension benefits in another pension scheme or arrangement when a pension scheme member leaves and chooses to transfer the benefits accrued from their previous scheme.

The pension figure shown relates to the benefits that the individual has accrued as a consequence of their total membership of the pension scheme, not just their service in a senior capacity to which disclosure applies.

Real increase in cash equivalent transfer values

This reflects the increase in CETV effectively funded by the employer. It does not include 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

NHS pensions

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 scheme's underlying assets. Further details of the NHS pension liabilities can be found in the notes to the annual accounts, and details of the senior managers' pension liability is shown in the remuneration and pension benefits tables in the remuneration report.

Civil Service pensions

Joint executive team appointments employed by Monitor and recharged to NHS TDA have pension benefits provided through the Civil Service pension arrangements. Further details of Monitor's pension arrangements can be found in Monitor's annual report and accounts.

Table 26: NHS TDA exit packages for 2016/17

Exit package cost band	Number of compulsory redundancies	Number of other departures agreed	Total number of exit packages by cost band
<£10,000	3	-	3
£10,000–£25,000	-	-	-
£25,001–£50,000	1	-	1
£50,001–£100,000	1	-	1
£100,000–£150,000	-	-	-
£150,001–£200,000	-	-	-
Total number of exit packages by type	5	-	5
Total resource cost (£000)	**153**	**-**	**153**

During 2015/16 NHS TDA provided one exit package, a compulsory redundancy costing £305,000. The exit package disclosure has been subject to audit.

Details of off-payroll engagements

Following the *Review of tax arrangements of public sector appointees*[12] published by the Chief Secretary to the Treasury on 23 May 2012, Monitor and NHS TDA must publish information on highly paid and/or senior off-payroll engagements.

The information contained in the tables below includes all off-payroll engagements as at 31 March 2017 for more than £220 per day and that last longer than six months for Monitor. All such appointments 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.

[12] www.gov.uk/government/publications/review-of-the-tax-arrangements-of-public-sector-appointees

Table 27: Off-payroll engagements at 31 March 2017

Number of existing engagements as at 31 March 2017	**1**
Of which...	
Number that have existed for less than one year at time of reporting	1
Number that have existed for between one and two years at time of reporting	
Number that have existed for between two and three years at time of reporting	-
Number that have existed for between three and four years at time of reporting	-
Number that have existed for four or more years at time of reporting	-
Number of new engagements, or those that reached six months in duration, between 1 April 2016 and 31 March 2017	**1**
Number of the above which include contractual clauses giving NHS TDA the right to request assurance in relation to income tax and National Insurance obligations	1
Number for whom assurance has been requested	1
Of which…..	
Number for whom assurance has been received	1
Number for whom assurance has not been received	-
Number that have been terminated as a result of assurance not being received	-
Number of off-payroll engagements of Board members and/or senior officials with significant financial responsibility, during the financial year	**0**
Number of individuals who have been deemed 'Board members and/or senior officials with significant financial responsibility' during the financial year. This figure must include both off-payroll and on-payroll engagements	26

Staff report

Recruitment

After the process of integrating the organisations that came together as NHS Improvement and creating our new operating structures, we began a broad range of recruitment activity from July 2016. This included the ongoing appointment of existing staff affected by change and external recruitment.

In addition to recruiting to new posts, we backfilled vacant posts arising from normal staff turnover. We varied the basis on which we engaged new staff to include permanent appointments, fixed-term appointments and secondments.

Table 28: Average staff numbers in the year to 31 March 2017

2016/17			
Average staff numbers	**Total**	**Permanently employed**	**Other**
Number of staff (TDA)	444	407	37
Number of staff (Monitor)	550	509	41
Total (NHS Improvement)	**994**	**916**	**78**

Analysis of staff costs has been subject to audit and detailed in Note 5 to the financial statements.

All this activity resulted in levels of recruitment significantly over and above what is normal for an organisation of NHS Improvement's size and complexity. The recruitment team supported the appointment of about 450 staff between September 2016 and March 2017, and the level of recruitment remains high. Some issues arose in delivering all the appointments in a timely manner. A number of factors contributed to this in addition to the impact of the integration itself, including the implementation of an online recruitment system across the organisation, with resulting changes to processes and systems.

To address these issues, our recruitment team brought together a collaborative co-design group, supported by a member of the Improvement Directorate and comprising members of the HR team, the NHS Business Services Authority, line managers and newly recruited staff. Through a series of four quality improvement

workshops, the group designed and implemented 10 tests for change using a recognised improvement method, with the intention of reducing the time to hire.

Table 29: Number of senior managers by pay band as at 31 March 2017

Pay band	Total	Permanently employed	Other
TDA contract			
Very senior managers (VSM)	51	44	7
Monitor contract			
VSM	23	23	0
1.2	1	1	0
1.1	20	19	1
Total Monitor	**44**	**43**	**1**
Total NHS Improvement	**95**	**87**	**8**

Employee policies

Some of our staff have declared disabilities and, where a staff member develops a disability during employment, we take full account of our responsibilities in relation to reasonable adjustments.

No individual is treated detrimentally due to any protected characteristic during their employment with NHS Improvement.

We have a range of employment policies which support all staff, and which have been agreed with trade unions and the staff forum. We regularly review all policies to make sure they fully comply with the most recent legislative changes, national terms and conditions of employment and best practice.

Table 30: Gender of staff as at 31 March 2017

Staff category	Female	Male
TDA contract		
Directors	3	5
Other VSMs	22	21
Other staff	326	177
Total TDA	**351**	**203**
Monitor contract		
Directors	3	3
Other VSMs	9	8
Other staff	230	206
Total Monitor	**242**	**217**
Total NHS Improvement	**593**	**420**

Equal opportunities and diversity

We are committed to providing equality of opportunity for both current and prospective staff: everyone who works for us, or applies to work for us, should be treated fairly and valued equally. Providing equality of opportunity means that an individual's diversity is viewed positively. In recognising that everyone is different, we value equally the unique contribution that individual experience, knowledge and skills can make.

Our equality and diversity policy aims to ensure 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. It also aims to ensure we abide by the statutory regulations regarding human rights and discrimination.

Table 31: Ethnicity of staff as at 31 March 2017

	Number of staff (TDA contract)	Number of staff (Monitor contract)	Number of staff (NHS Improvement total)
White	427	296	723
Mixed race	10	8	18
Asian or Asian British	39	66	105
Black or Black British	28	16	44
Other	4	7	11
Did not state/undisclosed	46	66	112
Total	**554**	**459**	**1,013**

Health and safety

We are committed to ensuring, by all practical means, the health, safety and wellbeing of our staff, visitors and others affected by our activities. In 2016/17 we set up a health and wellbeing network chaired by the Director of Organisational Effectiveness with representatives from across the organisation. Its overarching aim is to improve staff's health, safety and wellbeing. All staff did mandatory health and safety training, including those recently joining the organisation. We trained a network of 41 mental health first aiders across the organisation to provide timely and accessible peer support.

Social, community and human rights

We produce a regular staff newsletter as well as providing an intranet site that is regularly updated with information on matters of concern to staff. We have a good relationship with regional trade union officers, and we hold regular Joint Consultative and Negotiation Committee meetings to consider issues likely to affect staff. In addition, we involve other staff representatives through a staff forum. We have set up several other groups to engage staff in helping shape our responses to issues that affect their employment, wellbeing and development.

Staff survey

NHS Improvement conducted its first all-staff survey in November 2016. A total of 727 people responded (81%). One of the highest scores (78% agree or strongly agree) indicated that staff cared about the future of NHS Improvement. The overall engagement score was low (51%) prompting significant work by the executive and organisational development team at local and national level. Each directorate has a staff survey action group, which works on local initiatives but also supports national engagement activity. The primary focus both locally and nationally includes work on strategic alignment, communication and individual development.

Sickness absence

Table 32: Sickness absence

Staff absence due to sickness	January to December 2016
TDA contract	
Total days lost	1,429
Average working days lost per employee	3.8
Monitor contract	
Total days lost	1,383
Average working days lost per employee	2.6
NHS Improvement	
Total days lost	2,812
Average working days lost per employee	3.2

Parliamentary accountability and audit report

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 NHS TDA. This information is subject to audit opinion.

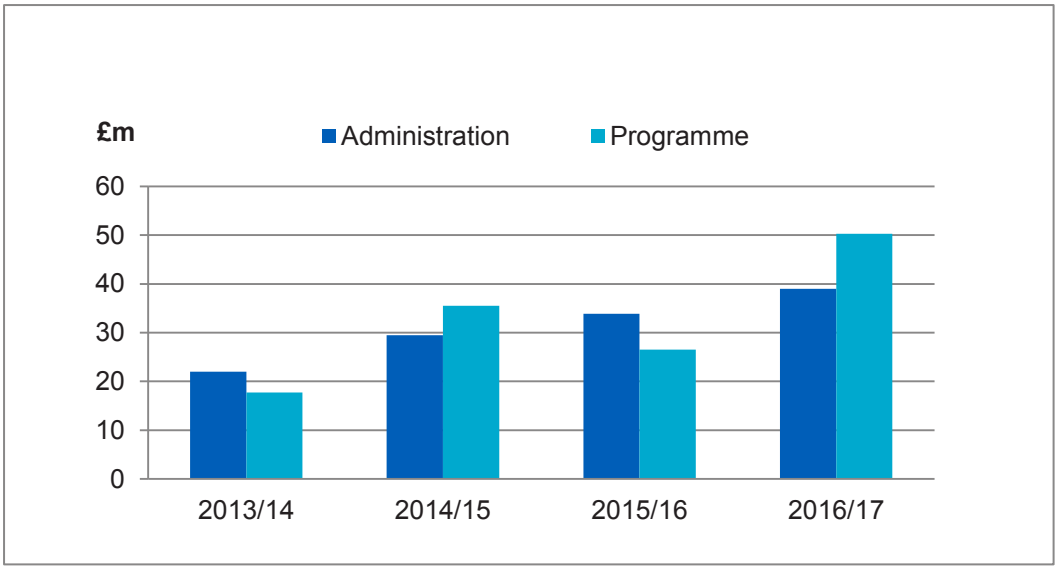
Cost allocation and charges for information

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

Long-term expenditure trend

Figure 2 sets out the trend in net expenditure since financial year 2013/14. NHS TDA's expenditure during this period reflects the statutory duties set out in the Health and Social Care Act 2012.

Figure 2: Trend in net expenditure since 2013/14



Jim Mackey
Chief Executive
4 July 2017

Certificate and report of the Comptroller and Auditor General to the Houses of Parliament

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 2017 and of the net expenditure for the year then ended;
- have been properly prepared in accordance with the National Health Service Act 2006 and Secretary of State directions issued thereunder.

Opinion on regularity

In my opinion, in all material respects the 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.

Basis of opinions

I have audited the financial statements of NHS Trust Development Authority for the year ended 31 March 2017 under the National Health Service Act 2006. The financial statements comprise the:

- Statement of comprehensive net expenditure;
- Statement of financial position;
- Statement of cash flows;
- Statement of 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 Accountability Report including the Remuneration and Staff Report and the Parliamentary Accountability Disclosures that are described in those reports and disclosures as having been audited.

The regularity framework described in the table below has been applied.

Regularity Framework	
Authorising legislation	National Health Service Act 2006
HM Treasury and related authorities	Managing Public Money

Overview of my audit approach

Matters significant to my audit

I consider the following areas of particular audit focus to be those areas that had the greatest effect on my overall audit strategy, the allocation of resources in my audit and directing the efforts of the audit team in the current year. I have also set out how my audit addressed these specific areas in order to support the opinion on the financial statements as a whole and any comments I make on the results of my procedures should be read in this context.

Key audit matters	My response and conclusion
Management Override of control: International Standard on Auditing (UK and Ireland) 240 *The auditor's responsibilities relating to fraud in an audit of financial statements* states that there is a risk in all entities that management override controls to perpetrate fraud. The standard requires that auditors perform audit procedures to address this risk in the following areas: Journal entries; Bias in accounting estimates; and Significant unusual transactions.	I identified a risk because International Standards on Auditing (UK and Ireland) require that I consider this risk. I reviewed a sample of journals for appropriateness and considered management's accounting estimates and significant judgements for evidence of bias. I also included an element of unpredictability in our testing plans. I am satisfied that this risk has not materialised.
Integration of new functions: As part of the creation of NHSI on 1 April 2016, new functions (including responsibilities for patient care) were transferred into NHS Trust Development Authority.	I identified an integration risk as the transfer in of new functions will have a material impact on the financial statements and on the disclosures contained within them. It will also impact on the information presented in the Annual Report.

I reviewed the appropriateness of management's processes and procedures and accounting treatment adopted in recognising new transactions and functions. This included a review of transfer agreements. I tested the opening balances and amounts transferred to NHS Trust Development Authority to satisfy myself that these had been correctly recorded.

I considered the remit and activities of the functions transferred into NHS Trust Development Authority and confirmed that these conform to the authorities that govern them.

The areas of focus were discussed with the Audit and Risk Assurance Committee; their report on matters that they considered to be significant to the financial statements is set out in the Governance Statement on pages 67 to 97.

Application of materiality

I applied the concept of materiality in both planning and performing my audit, and in evaluating the effect of misstatements on my audit and on the financial statements. This approach recognises that financial statements are rarely absolutely correct, and that an audit is designed to provide reasonable, rather than absolute, assurance that the financial statements are free from material misstatement or irregularity. A matter is material if its omission or misstatement would, in the judgement of the auditor, reasonably influence the decisions of users of the financial statements.

Based on my professional judgement, I determined overall materiality for NHS Trust Development Authority's financial statements at £1,700,000 which is approximately 2% of gross expenditure, a benchmark that I consider to be the principal consideration for users in assessing the financial performance of the NHS Trust Development Authority.

As well as quantitative materiality there are certain matters that, by their very nature, would, if not corrected influence the decisions of users, for example, any errors reported in the Accountability Report. Assessment of such matters would need to have regard to the nature of the misstatement and the applicable legal and reporting framework, as well as the size of the misstatement.

I applied the same concept of materiality to my audit of regularity. In planning and performing audit work in support of my opinion on regularity and evaluating the impact of any irregular transactions, I took into account both quantitative and qualitative aspects that I consider would reasonably influence the decisions of users of the financial statements.

I agreed with the Audit and Risk Assurance Committee that I would report to it all uncorrected misstatements identified through my audit in excess of £35,000, as well as differences below this threshold that in my view warranted reporting on qualitative grounds.

There were no unadjusted audit differences reported to the Audit and Risk Assurance Committee.

Scope of my audit

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 NHS Trust Development Authority's circumstances and have been consistently applied and adequately disclosed
- the reasonableness of significant accounting estimates made by the Accounting Officer and
- the overall presentation of the financial statements.

In addition I read all the information and non-financial information in the Performance Report, Accountability Report and Parliamentary and Accountability disclosures 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 report.

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.

Other matters on which I report

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 directions made by the Secretary of State under the National Health Service Act 2006; and
- the information given in the Performance Report and in the 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;
- 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;
- 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.

Consistency of information in the Annual Report

Under International Standards on Auditing (UK & Ireland), I am required to report to you if, in my opinion, information in the Annual Report is:

- materially inconsistent with the information in the audited financial statements; or

- apparently materially incorrect based on, or materially inconsistent with, the knowledge of the entity that I acquired in the course of performing my audit; or
- otherwise misleading.

In particular, I am required to consider:

- whether I have identified any inconsistencies between the knowledge that I acquired during the audit and the directors' statement that they consider the Annual Report is fair, balanced and understandable; and
- whether the Annual Report appropriately discloses those matters that I communicated to the Audit and Risk Assurance Committee which I consider should have been disclosed.

I have nothing to report arising from this duty.

The directors' assessment of principal risks and future prospects

Under International Standards on Auditing (UK & Ireland), I am required to report to you if I have anything material to add, or to draw attention to, in relation to the directors' disclosures in the Annual Report and financial statements:

- confirming that they have carried out a robust assessment of the principal risks facing NHS Trust Development Authority, including those that would threaten its business model, future performance, solvency or liquidity;
- describing those risks and explaining how they are being managed or mitigated;
- on whether they considered it appropriate to adopt the going concern basis, and their identification of any material uncertainties to the entity's ability to continue over a period of at least twelve months from the date of approval of the financial statements; and
- explaining how they have assessed the prospects of the entity, over what period they have done so and why they consider that period to be appropriate, and their statement as to whether they have a reasonable expectation that NHS Trust Development Authority will be able to continue in operation and meet its liabilities as they fall due over the period of their assessment, including any related disclosures drawing attention to any necessary qualifications or assumptions.

I have nothing material to add, or to draw attention to, on these matters.

Responsibilities of the Accounting Officer for the financial statements

As explained more fully in the Statement of Accounting Officer's Responsibilities, the Accounting Officer is responsible for the preparation of NHS Trust Development Authority's financial statements and for being satisfied that they give a true and fair view.

Auditor's responsibilities for the audit of the financial statements

My responsibility is to audit and express an opinion on the financial statements in accordance with the applicable law. 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.

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

12 July 2017

Financial statements

Statement of comprehensive net expenditure for the year ended 31 March 2017

	Note	2016-17 £000	2015-16 £000
Other operating revenue	4	8,068	1,412
Total operating revenue		**8,068**	**1,412**
Staff costs	5	43,077	27,091
Purchase of goods and services	6	15,082	10,799
Depreciation and impairment charges	6	236	232
Provision expense	6	(22)	73
Other operating expenditure	6	38,903	21,709
Total operating expenditure		**97,276**	**59,904**
Net operating costs for the financial year		**89,208**	**58,492**
Other comprehensive net expenditure		-	-
Total comprehensive net expenditure for the year		**89,208**	**58,492**

The notes on pages 134 to 157 form part of these accounts.

Statement of Financial Position as at 31 March 2017

	Note	31 March 2017 £000	31 March 2016 £000
Non current assets			
Property, plant & equipment	8.1	246	438
Intangible assets	8.2	81	60
Total non-current assets		**327**	**498**
Current assets			
Trade and other receivables	9	3,192	759
Cash and cash equivalents	10	1,625	4,805
Total current assets		**4,817**	**5,564**
Total assets		**5,144**	**6,062**
Current liabilities			
Trade and other payables	11	29,989	10,470
Provisions	12	71	93
Total current liabilities		**30,060**	**10,563**
Net current liabilities		**(25,243)**	**(4,999)**
Total net liabilities		**(24,916)**	**(4,501)**
Financed by taxpayers' equity			
General fund		(24,916)	(4,501)
Total taxpayers' equity		**(24,916)**	**(4,501)**

The financial statements and the notes on pages 134 to 157 were signed on behalf of the NHS Trust Development Authority by:

Chief Executive Officer
NHS Trust Development Authority
4 July 2017

Statement of Changes in Taxpayers' Equity for the year ended 31 March 2017

	Note	General Fund £000
Balance at 31 March 2016		**(4,501)**
Changes in taxpayers' equity for 2016-17		
Comprehensive net expenditure for the year	SoCNE	(89,208)
Net parliamentary funding	SOCF	68,793
Balance at 31 March 2017		**(24,916)**
Balance at 31 March 2015		**(7,891)**
Changes in taxpayers' equity for 2015-16		
Net operating cost for the year	SoCNE	(58,492)
Net parliamentary funding	SOCF	61,882
Balance at 31 March 2016		**(4,501)**

The notes on pages 134 to 157 form part of these accounts.

Statement of Cash Flows for the year ended 31 March 2017

	Note	2016-17 £000	2015-16 £000
Cash flows from operating activities			
Net operating cost	SOCNE	(89,208)	(58,492)
Adjustments for non-cash transactions			
Depreciation, amortisation and impairements	6	236	232
Provisions arising during the year	12	71	93
Provisions reversed unused	12	(93)	(20)
Increase in trade and other receivables	9	(2,433)	(495)
Increase in trade payables and other current liabilities		19,493	1,858
Provisions utilised	12	-	(70)
Net cash inflow / (outflow) from operating activities		**(71,934)**	**(56,894)**
Cash flows from investing activities			
(Payments) for property, plant and equipment		(23)	(244)
(Payments) for intangible assets		(16)	(47)
Net cash inflow / (outflow) from investing activities		**(39)**	**(291)**
Cash flows from financing activities			
Net parliamentary funding	SoCTE	68,793	61,882
Net financing		**68,793**	**61,882**
Net (decrease)/ increase in cash and cash equivalents		(3,180)	4,697
Cash and cash equivalents at the beginning of the period		**4,805**	108
Cash and cash equivalents at the end of the period	10	**1,625**	**4,805**

The notes on pages 134 to 157 form part of these 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 in accordance with Section 232(Schedule 15, paragraph 3) of 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 NHSI which took effect from 1 April 2016, 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.

In line with the guidance issued by the Department of Health the NHS TDA's 2016-17 accounts have been prepared on a going concern basis. The NHS TDA continues to be resourced by the Department of Health which has approved the NHS TDA's 2017/18 budget and there is no evidence to suggest that the NHS TDA will not continue to be financed by the Department of Health through parliamentary funding for the foreseeable future (at least 12 months from the date of signing the accounts). 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.

The Patient Safety and NHS IQ functions transferred from NHS England on 1 April 2016. No assets and liabilities have been transferred from NHSE to the NHS TDA. The financial statements include the current year transactions for the transferring functions and these transactions comply with the NHS TDA's accounting policies.

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 Apportionment of costs.

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

1.5.2 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 2017 were based on the NHS TDA's best professional judgement in line with IAS 37 and details of provisions can be seen in note12.

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

1.8 **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 1.4.1.

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 2.70% (previously minus 1.55%);
- Medium term – minus 1.95% (previously minus 1.00%);
- Long term – minus 0.8% (previously minus 0.8%).

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 of trade and other payables and other financial liabilities. They are initially recognised at fair value and subsequently at amortised cost in accordance with IAS 39.

1.15 **Value Added Tax**

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

1.16 **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 2016-17. The application of the Standards as revised would not have a material impact on the accounts for 2016-17, were they applied:

- IFRS 9 Financial Instruments: Application required for accounting periods beginning on or after January 2018, but not adopted by the FReM: early adoption is therefore not permitted.

- IFRS 15 Revenue from contracts with customers: Application required for accounting periods beginning on or after January 2018, but not adopted by the FReM: early adoption is therefore not permitted.

- IFRS 16 Leases: Application required for accounting periods beginning on or after January 2019, but not adopted by the FReM: early adoption is therefore not permitted.

- IFRIC 22 Foreign Currency Transactions and Advance Consideration – Application required for accounting periods beginning on or after 1 January 2018.

2. Pension costs

Past and present employees are covered by the provisions of the two NHS Pension Schemes. Details of the benefits payable and rules of the Schemes can be found 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. Therefore, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to that scheme for the accounting period.

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

a) 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 2017, is based on valuation data as 31 March 2016, updated to 31 March 2017 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.

b) 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.

The next actuarial valuation is to be carried out as at 31 March 2016. This will set the employer contribution rate payable from April 2019 and will consider the cost of the Scheme relative to the employer cost cap. There are provisions in the Public Service Pension Act 2013 to adjust member benefits or contribution rates if the cost of the Scheme changes by more than 2% of pay. Subject to this 'employer cost cap' assessment, any required revisions to member benefits or contribution rates will be determined by the Secretary of State for Health after consultation with the relevant stakeholders.

3. Operating segments

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

	Administration		Programme		HSIB		Total	
	2016-17 £000	2015-16 £000	2016-17 £000	2015-16 £000	2016-17 £000	2015-16 £000	2016-17 £000	2015-16 £000
Revenue	(1,757)	(1,187)	(6,311)	(225)	-	-	(8,068)	(1,412)
Expenditure	40,877	35,136	55,182	24,768	1,217	-	97,276	59,904
Net operating costs	**39,120**	**33,949**	**48,871**	**24,543**	**1,217**	**-**	**89,208**	**58,492**
Assets	4,876	5,914	113	148	155	-	5,144	6,062
Liabilities	(5,799)	(3,172)	(24,045)	(7,391)	(216)	-	(30,060)	(10,563)
Net assets / (liabilities)	**(923)**	**2,742**	**(23,932)**	**(7,243)**	**(61)**	**-**	**(24,916)**	**(4,501)**

Administration
The financial objectives of the NHS TDA is to manage the recurrent costs of management and administration within the allocation of £39,193,000 this funding covers staff, accomodation and other running costs.

Programme
The NHS TDA received an allocation of £48,925,000 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.

HSIB
The Healthcare Safety Investigation Branch (HSIB) is a new organisation that was established in 2016/17. The purpose of the organisation is to improve patient safety through effective and independent investigations that do not apportion blame of liability. HSIB utilised a resource of £1,300,000.

4. Revenue

	2016-17	2015-16
	£000	£000
Administration revenue		
Other fees and charges	225	-
Other miscellaneous revenue	828	59
Rental revenue recovery	38	81
Revenue in respect of seconded staff	666	1,047
Total administration revenue	**1,757**	**1,187**
Programme revenue		
Other miscellaneous revenue	477	161
Provision of emergency care improvement programme and elective care intensive support	5,636	-
Revenue in respect of seconded staff	198	64
Total programme revenue	**6,311**	**225**
Total revenue	**8,068**	**1,412**

The new income stream for the emergency care improvement programme and elective care intensive support is as a result of the functions that have transferred from NHS England.

5. Employee benefits and staff numbers

5.1. Employee benefits

	2016-17			2015-16
	Total £000	Permanently employed £000	Other £000	Total £000
Gross expenditure				
Salaries and wages	36,290	26,465	9,825	22,393
Social security costs	3,173	3,170	3	2,047
Employer contributions to NHS BSA - Pensions Division	3,461	3,458	3	2,651
Termination benefits	153	153	-	-
Total gross expenditure	**43,077**	**33,246**	**9,831**	**27,091**
Administration expenditure				
Salaries and wages	26,673	22,061	4,612	22,342
Social security costs	2,653	2,652	1	2,041
Employer contributions to NHS BSA - Pensions Division	2,906	2,906	-	2,644
Termination benefits	153	153	-	-
Total administration expenditure	**32,385**	**27,772**	**4,613**	**27,027**
Programme expenditure				
Salaries and wages	9,617	4,404	5,213	51
Social security costs	520	518	2	6
Employer contributions to NHS BSA - Pensions Division	555	552	3	7
Termination benefits	-	-	-	-
Total programme	**10,692**	**5,474**	**5,218**	**64**

5.2. Average Staff Numbers

	2016-17			2015-16
	Total	Permanently employed	Other	Total
Average Staff Number	**444**	**407**	**37**	326
Administration staff	378	358	20	325
Programme staff	66	49	17	1

5.3. Ill health retirements

	2016-17 Total	2015-16 Total
Number of persons retired early on ill health grounds	1	1

There were no additional pensions liabilities accrued in the year (2015-16 NIL).

5.4. Exit Packages agreed

	2016-17 Total	2015-16 Total
Number of other departures agreed		
Exit package cost band		
<£10,000	3	-
£10,000 - £25,000	-	-
£25,000 - £50,000	1	-
£50,000 - £100,000	1	-
£100,000- £150,000	-	-
£150,000- £200,000	-	-
> £200,000	-	1
Total number of exit packages by type	5	1
Total resource cost (£000s)	153	305

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

5.5. Severance payments

There were no severance payments in 2016-17 and 2015-16.

6. Operating expenditure

	Note	2016-17	2015-16
		£000	£000
Purchase of goods and services			
Administration costs			
Auditors' remuneration		50	45
Business travel		1,382	1,236
Consultancy		-	17
Establishment expenses		1,001	1,186
External contract staffing		133	-
Information and communications		1,705	1,297
Premises		2,283	2,377
Professional fees		354	704
Sub-total		**6,908**	**6,862**
Programme costs			
Business travel		1,054	46
Consultancy		6	120
Establishment expenses		853	51
External contract staffing		258	19
Information and communications		346	-
Premises		65	-
Professional fees		5,592	3,701
Sub-total		**8,174**	**3,937**
Total purchase of goods and services	SoCNE	**15,082**	**10,799**

The programme costs have increased as a result of the transfer of functions from NHS England and new programmes. Within the Programme professional fees £3,545,000 relates to the Transformation programme and £1,723,000 relates to the Operational Productivity programme (2015-16 £2,420,000 and NIL respectively).

Depreciation and impairment charges			
Administration costs			
Depreciation	8.1	206	195
Amortisation	8.2	21	34
Impairments and reversals of intangible assets	8.2	9	3
Total depreciation and impairment charges	SoCNE	**236**	**232**
Provision expense			
Administration costs			
Provision expense	12	(22)	73
Total provision expense	SoCNE	**(22)**	**73**

	Note	2016-17	2015-16
		£000	£000
Other operating expenditure			
Administration costs			
Miscellaneous Expenditure		1,274	819
Non-executive members' remuneration		98	124
Sub-total		**1,372**	**943**
Programme costs			
Miscellaneous Expenditure		2,366	635
Funding provided to NHS trusts and partners:			
Emergency care improvement programme		1,697	-
Intervention and support to NHS Trusts		5,985	5,875
Operational productivity		2,035	-
Patient Safety Collaboratives		8,224	-
Special Measures		10,707	5,509
Trust transactions and sustainable solutions		6,517	8,747
Sub total		**37,531**	**20,766**
Total other operating expenditure	SoCNE	**38,903**	**21,709**
Total operating expenditure	SoCNE	**54,199**	**32,813**

7. Operating leases

	2016-17	2015-16
	£000	£000
Payments recognised as an expense		
Minimum lease payments	70	41
Total	**70**	**41**
Payable		
No later than one year	10	11
Between one and five years	-	-
After five years	-	-
Total	**10**	**11**

Included in the Administration Premises expenditure in note 6 is £1503,000 of costs paid to NHS Property Services for the occupation of seven sites, and £486,000 to the Department of Health for the occupation of two sites (2015-16 £1,954,000 and £450,000 for one site, respectively). They are operated under a memorandum of understanding.

8. Non-current assets

8.1 Property, plant and equipment

2016-17	Information technology	Furniture & fittings	Total
	£000	£000	£000
Cost or valuation			
At 1 April 2016	580	174	**754**
Additions purchased	-	23	**23**
Impairments charged to SOCNE	-	(23)	**(23)**
At 31 March 2017	**580**	**174**	**754**
Depreciation			
At 1 April 2016	276	40	**316**
Charged during the year	168	38	**206**
Impairments charged to SOCNE	-	(14)	**(14)**
At 31 March 2017	**444**	**64**	**508**
Net book value at 31 March 2016	304	134	**438**
Net book value at 31 March 2017	**136**	**110**	**246**

2015-16	Information technology	Furniture & fittings	Total
	£000	£000	£000
Cost or valuation			
At 1 April 2015	487	174	**661**
Additions purchased	93	-	**93**
At 31 March 2016	**580**	**174**	**754**
Depreciation			
At 1 April 2015	116	5	**121**
Charged during the year	160	35	**195**
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**

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

The total impairment charge for the year has been charged direct to the Statement of Comprehensive Net Expenditure.

8.2 Intangible assets

2016-17	Software purchased	Licences & trademarks	Development expenditure	Websites	Total
	£000	£000	£000	£000	£000
Cost or valuation					
At 1 April 2016	10	-	-	53	63
Additions purchased	-	-	-	42	42
At 31 March 2017	**10**	**-**	**-**	**95**	**105**
Amortisation					
At 1 April 2016	3	-	-	-	**3**
Charged during the year	4	-	-	17	**21**
At 31 March 2017	**7**	**-**	**-**	**17**	**24**
Net book value at 31 March 2016	7	-	-	53	**60**
Net book value at 31 March 2017	**3**	**-**	**-**	**78**	**81**

2015-16	Software purchased	Licences & trademarks	Development expenditure	Websites	Total
	£000	£000	£000	£000	£000
Cost or valuation					
At 1 April 2015	10	16	77	-	**103**
Additions purchased	-	-	-	53	**53**
Impairments charged to SOCNE	-	(16)	(77)	-	**(93)**
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)**
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.

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 availiable 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 2017 (2015-16 NIL).

9. Trade receivables and amounts falling due within one year

	31 March 2017	31 March 2016
	£000	£000
NHS receivables	1,152	395
NHS prepayments and accrued revenue	1,043	148
Non-NHS receivables	136	3
Non-NHS prepayments and accrued revenue	459	10
VAT	348	180
Other receivables	54	23
Trade and other receivables	**3,192**	**759**

10. Cash and cash equivalents

	31 March 2017	31 March 2016
	£000	£000
Opening balance	4,805	108
Net change in year	(3,180)	4,697
Closing balance	**1,625**	**4,805**
Made up of		
Cash with Government Banking Service	1,625	4,805
Commercial banks and cash in hand	-	-
Current investments	-	-
Cash and cash equivalents as in Statement of Financial I	**1,625**	**4,805**

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

	31 March 2017	31 March 2016
	£000	£000
NHS payables	4,098	4,881
NHS accruals and deferred revenue	20,624	2,840
Non-NHS payables	1,595	877
Non-NHS accruals and deferred revenue	3,662	1,872
Social security and pension payables	10	-
Trade and other payables	**29,989**	**10,470**

12. Provisions

	2016-17	2015-16
	£000	£000
Balance at 1 April 2016	93	90
Arising during the year	71	93
Utilised during the year	-	(70)
Reversed unused	(93)	(20)
Balance at 31 March 2017	**71**	**93**
Expected timing of cash flows:		
No later than one year	71	93
Later than one year and not later than five years	-	-
Later than five years	-	-

A provision arose during 2016-17 in relation to performance related pay of very senior managers; the 2015-16 provision for very senior managers performance related pay was reversed unused.

13. Commitments

The authority has extended a contract relating to the provision of accounting services which commenced on 28 January 2013 until 31 March 2019. The cost of the contract for the year was £42,000 (2016-17 £30,000).

The authority entered into a contract relating to the provision of human resource services commencing on 1 April 2013 on a rolling basis with a termination notice period of six months. The total cost of the contract for the year was £350,000 (2015-16 £61,485).

14. Financial instruments

14.1 Financial risk management

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

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

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

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

Credit risk
Because the majority of the Authority's revenue comes from funds voted by Parliament and from other NHS bodies the Authority has low exposure to credit risk. The maximum exposures as at 31 March 2017 are in receivables from customers, as disclosed in the trade and other receivables.

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

14.2 Financial assets

	2016-17	2015-16
	£000	£000
Trade and other receivables	1,288	398
Other receivables	402	203
Cash at bank and in hand	1,625	4,805
Total at 31 March 2017	**3,315**	**5,406**

14.3 Financial liabilities

	2016-17	2015-16
	£000	£000
Trade and other payables	29,989	10,470
Total at 31 March 2017	**29,989**	**10,470**

15. Contingencies

At 31 March 2017 there were no known contingent assets or liabilities (31 March 2016: NIL)

16. Events after the reporting period

There are no events after the reporting period to report.

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

17. Related Parties

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

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

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

	Payments to related party	Receipts from related party	Amount owed to related party	Amounts due from related party
	£000	£000	£000	£000
2016-17				
HM Revenue & Customs	3,170	-	9	348
Imperial College Healthcare NHS Trus	1,257	-	689	-
Monitor	795	213	1,400	1,024
National Health Service Pension Sche	3,458	-	1	-
Northumbria Healthcare NHS FT	896	5	238	15
2015-16				
HM Revenue & Customs	2,036	-	-	180
National Health Service Pension Sche	2,641	-	-	-
Northumbria Healthcare NHS FT	458	-	80	20

During the year no Department of Health Minister, Board member, key manager or other related parties has undertaken any material transactions with the NHS TDA (2015-16 NIL).

18. Resource limits

18.1 Revenue resource limit

	2016-17	2015-16
	£000	£000
Net operating costs for the financial period	89,208	58,492
Revenue resource limit	89,918	61,178
Under spend against revenue resource limit	**710**	**2,686**

18.2 Capital resource limit

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

	2016-17	2015-16
	£000	£000
Charge against capital resource limit (gross capital expe	65	146
Capital resource limit	500	500
Under spend against revenue resource limit	**435**	**354**

18.3 Under/(over) spend against cash limit

	2016-17	2015-16
	£000	£000
Total charge to cash limit	68,793	61,882
Cash Limit Drawn from DH	68,793	61,882
Under/(over) spend against cash limit	-	**-**

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

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