NHS Improvement

70 YEARS OF THE NHS 1948 - 2018

NHS Trust Development Authority: Annual report and accounts 2017/18

HC1348

collaboration trust respect innovation courage compassion

NHS Trust Development Authority

Annual report and accounts 1 April 2017 to 31 March 2018

Presented to Parliament pursuant to Schedule 15, paragraph 6(3) of the National Health Service Act 2006.

Ordered by the House of Commons to be printed 12 July 2018

HC 1348

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This publication is available at https://improvement.nhs.uk/resources/

ISBN 978-1-5286-0549-6

CCS = CCS0618885474

Printed on paper containing 75% recycled fibre content minimum

Printed in the UK by the APS Group on behalf of the Controller of Her Majesty's Stationery Office

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Publication code: Corp 03/18

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 2017 to 31 March 2018. Monitor and NHS TDA continue to exist as legal entities, but this report refers mainly to NHS Improvement.

Contents

Performance report

Our work with trusts 2017/18

2017/18 was a challenging year for the NHS. Staff worked hard to care for more patients than ever while coping with high levels of vacancies. This affected the sector's performance in key areas, such as waiting times and financial targets. Overall it did not meet the A&E and referral to treatment standards, and the financial deficit grew. Nevertheless, providers made progress on efficiency and quality, and we highlight below examples of how we supported them in this.

Chair's foreword

I am pleased to introduce NHS Improvement's annual report and accounts for 2017/18, the first since I became Chair in October 2017. I am a firm believer that the NHS is a key pillar of our society, and it is an honour to join the NHS family especially in this, its 70th year. Since 5 July 1948, the NHS has shaped our nation and touched the everyday lives of us all.

In my visits to trusts since my appointment I have witnessed many times the brilliance of the NHS and the amazing people who make it what it is. Experiencing my first winter of working in the service, undoubtedly one of the most high pressure winters in the NHS's history, I could only marvel at the extraordinary efforts staff make to look after patients so well.

The NHS is a dynamic institution that has constantly evolved over the last 70 years. There are undoubtedly major challenges ahead, but huge opportunities too – as technology, clinical innovation and new care models make it possible for us to live better and longer. If we continue to face the challenges the way the NHS's original founders did, we will succeed.

NHS Improvement has a crucial part to perform in this. All change is more effective when it is well led, and we can play a material role in reshaping the way the NHS is led for the benefit of patients and staff. But it is clear to me from feedback across the service, that as the challenges and opportunities are changing, so must NHS Improvement. We need to be clearer about our core role and purpose to drive improvement within the overall system. We must align our activities more actively around the ways in which we can support the service to improve, and we must improve our ways of working with the other arm's length bodies, especially NHS England. Role modelling the collaborative, engaging leadership we hope to see across the country will be critical to our success, and to do so well we must systematically align teams, systems, processes and ways of working. We and NHS England are in the process of doing that now, and the results should become evident to the service during the next 12 months.

Such changes place significant demands on our staff, and I thank them for their patience and commitment, and for their continuing hard work in supporting trusts.

Our staff survey at the end of 2017 showed that, though we have more to do to make NHS Improvement an even better place to work, staff engagement had increased by 13% on a year earlier and almost every factor surveyed showed improvement.

I was delighted we were able to appoint Ian Dalton as our new chief executive in December. We are building a strong and productive chair–chief executive relationship. Ian has an exceptional track record with over 30 years' experience in the NHS and the wider health sector. As an outstanding leader he will further the great work that our staff have already accomplished and continue to deliver for the NHS as a whole.

I would like to thank my predecessor, Ed Smith, and Jim Mackey, as NHS Improvement's first Chair and Chief Executive, who played such key roles in establishing NHS Improvement. I am very grateful too to Richard Douglas who stepped up as Chair between Ed's departure and my arrival and to our Executive Medical Director, Kathy McLean, for stepping into the role of Interim Chief Operating Officer between Jim's departure and Ian's arrival, and for combining both roles since.

I am confident NHS Improvement will continue to help the NHS deliver high quality health and care safely and efficiently. I hope this report will give you an insight into our work during the past year.

Baroness Dido Harding
Chair of NHS Improvement
3 July 2018

Chief Executive's introduction

In its 70th year, the NHS faced continued pressure from rising demand for its services, but its staff – as they have done throughout those 70 years – met the challenge with dedication and resilience.

The proportion of trusts that the Care Quality Commission rated as 'good' rose from 39% to 45%, and those that were 'outstanding' from 6% to 6.5%. In addition, 20 trusts improved from 'inadequate' or 'requires improvement' to 'good' or 'outstanding'. Three trusts exited special measures for quality reasons and one exited special measures for finance reasons.

NHS Improvement's teams worked hard to support trusts throughout the year. We completed our falls improvement collaborative, which helped 19 trusts to reduce fall rates by 5%. As part of our national Stop the Pressure campaign, 172 trusts submitted improvement plans to eliminate pressure ulcers. Trusts in the first wave of the national maternal and neonatal health safety collaborative developed 176 improvement projects. We co-designed a learning network for heads of patient experience, which 153 trusts joined. Working with nine trusts we created a national mental health improvement model: implementing all its good practice examples would produce a world-class mental health service. We launched a major workforce retention programme, initially for 35 trusts – another 80 have joined since. We published details of actions all trusts could take quickly to improve junior doctors' working environment and morale, while our new programme for aspiring medical directors provides development, mentoring and peer support.

We have devised a wide range of measures to help trusts make the most of their resources. For example, our Model Hospital – which has more than 8,000 registered users in trusts – every month highlights potential savings from switching to high quality biosimilar medicines. Between April and December 2017, trusts saved £203 million by doing this. We worked with trusts to improve procurement and reduce price variation by making full use of the NHS's buying power, saving £291 million. From the first 20 products in our Nationally Contracted Products Programme, the NHS is on course to save £18 million a year.

With NHS England, we began formally preparing for winter in July – earlier than ever before. Trusts reported that, as a result, planning was more extensive and more effective than ever before. While of course some struggled in a challenging winter that saw the highest levels of flu this decade and severe outbreaks of norovirus, the sector as a whole recorded some notable achievements. Despite national accident and emergency performance declining by 0.7%, trusts treated 160,000 more A&E patients within four hours this winter than in the previous one.

We identify how we can help trusts improve patient services by using our Single Oversight Framework (SOF), introduced in 2016. The SOF is working well: 75% of trusts told NHS Providers they understood the SOF decision-making process well. More than half of trusts felt the support they received from us was appropriately tailored to their sector, whether acute, community, mental health or ambulance.

In the same survey, 94% of trusts wanted us to work more closely with NHS England. That is what we are going to do: as we ask local health and care systems to move to more joined-up ways of working in how they commission and deliver care, clearly we must do likewise. Our two organisations have worked together for some time in several areas, and feedback from these early approaches shows strong support for going further regionally and nationally. Though the statutory framework means a merger is not possible, we can and must speak with a single voice, remove duplicated activity and model effective joint working. From September 2018 we expect to implement new arrangements that will enable us to do this.

By then, we will once again be immersed in planning for winter. A vital part of our efforts will be ensuring that trusts and clinical commissioning groups plan realistically for emergency hospital admissions and do not underestimate non-elective demand. We are already encouraging providers and commissioners to work together on this issue.

Indeed, working together at every level will be key to the NHS's future success. Sustainability and transformation partnerships (STPs) epitomise this as they begin to play a more prominent role in managing system-wide service improvements. A number of the most mature STPs are moving to the next level of collaboration as they prepare to become integrated care systems. With help from us and NHS England, we envisage that all STPs will do this in time.

Finally I would like to thank NHS Improvement's staff for their support and hard work throughout the year in helping trusts to deliver the best possible care for patients. They have achieved an enormous amount – but much remains for us all to do.

Ian Dalton
Chief Executive of NHS Improvement
3 July 2018

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.

In working towards our objectives, we take a health system-wide approach to ensuring clinically and financially sustainable services that improve overall health outcomes and reduce health inequalities. We are committed to working closely with NHS England, the Care Quality Commission (CQC), Health Education England (HEE), Public Health England (PHE) and other partners at national, regional and local level.

Our organisation is structured across four regions – London, Midlands and East, North, and South[1] – and eight directorates:

- Communications
- Improvement
- Medical
- Nursing
- Operational Productivity
- Regulation
- Resources
- Strategy.

We have eight work programmes (see page 11) that capture all our activity: seven are sector-facing and one focuses on ensuring we have an organisation able to achieve our objectives. We undertake monitoring, intervention and support work, based on our regional model and drawing on additional expertise at a national level. The mixture of these activities varies between each work programme and between the individual activities within each work programme, depending on what they are seeking to achieve.

[1] South region is divided into South East and South West, and jointly managed with NHS England.

Performance analysis

We measure our performance against the five themes of our strategic objectives for 2020 (see page 9). These are all designed to help providers fulfil their operational plans and local health economies their sustainability and transformation plans. Our role is both to support them in achieving their objectives and to achieve specific objectives ourselves.

To focus our resources to best effect, we have developed eight main work programmes:

- quality improvement
- financial control and turnaround
- operational performance
- provider productivity
- strategic change
- workforce, leadership and improvement
- oversight, regulation and support
- developing NHS Improvement and supporting our business.

The **Single Oversight Framework**, introduced in 2016, identifies how we can help NHS trusts and foundation trusts improve patient services. 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, and our regional teams then tailor support packages for them.

We updated the framework in November 2017 based on feedback and lessons from its first year of operation. The update reflected changes in national policy and standards, other regulatory frameworks and the quality of performance data, to ensure that our oversight activities are consistent and aligned. We improved the structure and presentation of the framework, and clarified certain processes and definitions. We also made a small number of changes to the information and metrics we use to assess providers' performance, and the indicators that trigger consideration of a potential support need.

With NHS England we published **updated planning guidance** in February 2018. This explained how the extra £1.6 billion revenue funding for the NHS in the November 2017 Budget and the additional £540 million from the Department of Health and Social Care (DHSC) for core frontline services would be distributed. The guidance described how we expected commissioners and providers to adjust their existing two-year plans accordingly. It also reinforced our intention to move further towards system working in 2018/19 through sustainability and transformation partnerships (STPs) and the voluntary rollout of integrated care systems.

To support these changes national bodies must ensure they provide cohesive leadership, so we are reviewing with NHS England our approach to collaboration and joint working. Our aim is to determine where we should integrate our work, where we should collaborate more closely and where we should have distinct functions.

Quality improvement

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 four **regional teams** – for the North, Midlands and East, London and the South. They form lasting and productive relationships with trusts and support them and the wider system in implementing policy. For example, our London team helped significantly improve cancer services by working with providers to reduce the number of patients in the capital waiting longer than the national standard for diagnosis or treatment. Between June 2017 and March 2018, the number of patients with a confirmed diagnosis and decision to treat who waited more than 62 days for treatment reduced by 177 to 151. Those waiting more than 62 days for a diagnosis or decision to treat fell by 703 to 691. For local health systems in London that still faced challenges meeting the standard, recovery plans were devised and implemented.

Where the CQC identifies serious failures in the quality of care and is concerned that a trust's management cannot make the necessary improvements without support, the Chief Inspector of Hospitals may recommend the trust is placed in special measures. This is a set of specific interventions designed to improve care quality and leadership. One of our overall quality objectives is to reduce the number of trusts in **special measures for quality reasons**. Three trusts exited special measures for quality during 2017/18 (and another exited in May 2018). At 31 March 2018, 14 trusts were in special measures for quality, compared to 11 at 1 April 2017. In 2018/19 we intend to reduce the proportion of providers in special measures for quality reasons, and we are developing a plan to help the rest 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 embedding improvement directors, funding improvement programmes,

monitoring improvement plans, building leadership capacity, facilitating change and buddying with a high performance trust.

Three ways to improve patients' wellbeing

Our Midlands and East team has promoted three campaigns to improve hospital patients' wellbeing, all of which are now spreading throughout the NHS.

#endPJparalysis is a phrase first used by Professor Brian Dolan, Director, Health Service 360. The campaign encourages hospital patients to get up, dressed and moving to prevent deconditioning: a person over 80 who spends 10 days in bed will lose 10% of their muscle mass. That could be the difference between returning home or going into residential care, yet often patients are immobile for up to 90% of each day. Nottingham University Hospitals NHS Trust was one of the first to adopt the concept, and #endPJparalysis now has an international following that has generated more than 23 million Twitter impressions.

#Fit2Sit encourages frontline health professionals and paramedics to stop patients lying on trolleys and stretchers if they are well enough to sit or stand. This helps prevent loss of muscle strength, promotes speedier recovery and enables patients to get home sooner.

These campaigns follow the success of the region's **Red2Green** campaign, which minimises wasted time while a patient is in hospital to ensure they are discharged as soon as possible. Since every acute trust in the region implemented R2G, it has spread to specialist and mental health trusts and to other regions.

Four years after the introduction of special measures in 2013, we reviewed the experience of trusts that had exited the process, to help other trusts and boards concerned about deteriorating care quality. We identified five themes essential for improvement: leadership, engagement (internal and external), culture, governance

and the trust's approach to quality improvement.[2] With CQC, we published guidance on why trusts may be placed in special measures for quality reasons, what the process entails and how they can exit.[3]

Another objective is to ensure that two-thirds of trusts achieve CQC's **'good' or 'outstanding' levels of quality** in the next few years. Between 1 April 2017 and 31 March 2018, the percentage of trusts rated 'good' by CQC rose from 39.1% to 44.8% and the percentage rated 'outstanding' rose from 6.0% to 6.5%. A total of 20 trusts improved from 'inadequate' or 'requires improvement' to 'good' or 'outstanding', exceeding our own target of 17. For 2018/19 we have set a target to increase the proportion of NHS providers achieving a CQC 'good' or 'outstanding' rating when CQC re-inspects them. Our regional teams will work intensively with these providers to achieve this.

Our medical directorate worked with providers that CQC rated 'good' for patient safety, producing a collection of case studies to support peer-to-peer learning.[4] These offer practical guidance in areas such as medicines management and prescribing, improving handovers and learning from incidents.

The **NHS Seven Day Hospital Services Programme** is designed to ensure patients requiring emergency treatment receive high quality, consistent care every day of the week. By 2020, all acute trusts must ensure 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. With NHS England, we provide improvement support to trusts to help them implement these standards. We are particularly keen that trusts learn from others further advanced in implementing seven day hospital services, so together we organised five regional events for trusts to share successes and challenges, and published a summary of key themes.[5] Working with South Warwickshire NHS Foundation Trust and University Hospital

[2] *Learning from improvement: special measures for quality. A retrospective review*. November 2017. https://improvement.nhs.uk/resources/special-measures-quality-review/
[3] *Special measures for quality reasons: guidance for trusts*. December 2017. https://improvement.nhs.uk/resources/special-measures-guide-nhs-trusts-and-foundation-trusts/
[4] https://improvement.nhs.uk/resources/improving-quality-and-safety-healthcare-collection/
[5] *Seven day hospital services: challenges and solutions*. December 2017. https://improvement.nhs.uk/resources/seven-day-hospital-services-challenges-and-solutions/

Southampton NHS Foundation Trust, we assessed the costs and benefits of implementing the four priority clinical standards.[6]

Our remit for patient safety extends across all NHS-funded healthcare, including primary care, community health, mental health, ambulance and acute services. We define patient safety as the avoidance of unintended or unexpected harm to people during the provision of healthcare, and our ambition is to make the NHS the world's safest healthcare system.[7] Our patient safety team is responsible for delivering some statutory patient safety duties across the NHS.

Key facts

The **National Reporting and Learning System** is the world's largest and most comprehensive patient safety incident reporting system. It has recorded more than 17 million incidents since it began in 2003. Between October 2016 and September 2017, almost 1.9 million incidents were reported to it, a 4.7% increase between October 2015 and September 2016. 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.

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 support our own and our partners' ongoing patient safety work, and to alert the NHS to any new or unusual patient safety risks we identify. When things go wrong in care, it is vital that incidents are recorded to ensure organisations learn what went wrong and why, and act to reduce the risk of similar incidents recurring. We are responsible for collecting this information nationally via the NRLS. In 2017/18 we published the first of our **patient safety review and response reports**,[8] six-monthly summaries of how we reviewed and responded to issues reported to us.

During the next two years the **Development of the Patient Safety Incident Management System** project will devise a successor to the NRLS, which is now almost 15 years old. After wide consultation,

[6] https://improvement.nhs.uk/resources/what-impact-developing-seven-day-hospital-service/
[7] *Our approach to patient safety: NHS Improvement's focus in 2017/18*. October 2017. https://improvement.nhs.uk/resources/our-approach-to-patient-safety/
[8] https://improvement.nhs.uk/resources/patient-safety-review-and-response-reports/

this project is building prototypes for users to trial and comment on. Once live, the new system will be easier for staff and patients to use, and it will work better across the whole of healthcare.

We published six **patient safety alerts**[9] in 2017/18 to warn the NHS of emerging patient safety risks mainly identified through incident reporting, highlight newly available resources to tackle a known risk, or ask that a specific definitive action is taken to prevent patient harm. We draft our patient safety alerts 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.

A just culture

Supporting staff to be open about mistakes helps prevent errors from being repeated. *A just culture guide*[10] is a tool to help managers treat staff involved in a patient safety incident in a consistent, constructive and fair way, so they feel confident about speaking up when things go wrong rather than fearing blame.

In response to consultation, we revised our **Never Events policy** and framework. A key change was to remove the option for commissioners to impose financial sanctions associated with Never Events: we heard that this reinforced the perception of a 'blame culture'. We will align the Never Events framework with a new Serious Incident framework that we intend to publish by the end of 2018 following an engagement programme we launched in March 2018, seeking views on how and when the NHS should investigate Serious Incidents.[11]

Working with the academic health science networks (AHSNs), the **Patient Safety Collaborative (PSC)** aims to create a culture of continuous learning and improvement. It helps to define good clinical practice, shares knowledge of quality improvement methods and spreads learning from safer care initiatives from within the NHS and beyond. Led and funded by NHS Improvement and delivered regionally by the AHSNs, the 15 regional PSCs build local safety improvement capability and address local safety concerns. They are active in all care settings including maternity care, mental health, GP practices,

[9] https://improvement.nhs.uk/resources/patient-safety-alerts/
[10] https://improvement.nhs.uk/resources/just-culture-guide/
[11] *The future of NHS patient safety investigation*. March 2018. https://improvement.nhs.uk/resources/future-of-patient-safety-investigation/

acute hospitals, community health services and nursing homes. The national programme co-ordinates the work of the 15 regional PSCs and three national workstreams, which focus on safety culture, maternal and neonatal care, and deteriorating patients. These workstreams maximise the collaboratives' collective expertise and cross-sector reach to have impact and share learning across the healthcare system.

We completed our **falls improvement collaborative** begun in early 2017, which encouraged 19 trusts to reduce fall rates by 5%. After two months, one ward had reduced falls by 30%, while another went 20 days without a fall; previously it had only managed six days. Trusts taking part shared their experiences on our website,[12] and we held #improvefalls week in July 2017 to encourage other providers to tell their stories. We published a report on the incidence and economic impact of falls in hospitals.[13] Using data from the NRLS, we found there were more than 250,000 falls in 2015/16 across acute, mental health and community hospitals. We estimated the cost to the NHS, including extra treatment, length of stay and litigation, at £630 million. Evidence suggested that reducing inpatient falls by 25% to 30% could save £170 million a year.

Key facts

- Up to 25% of patients in hospital beds following a non-elective admission could be discharged immediately.
- A further 25% are in hospital because of delays.

Our **criteria-led discharge improvement collaborative** involved 13 trusts tackling delays in discharging patients who are well enough to leave hospital. We ran a 150-day **end-of-life care improvement collaborative** involving 16 trusts providing acute, community, mental health and integrated services. We helped them adopt improvement methodologies, including process mapping and plan-do-study-act cycles, to measure improvement and sustain change. Three have improved their CQC ratings to good, and we continue to support trusts in improving end-of-life care.

[12] https://improvement.nhs.uk/resources/falls-improvement-collaborative-provider-stories/
[13] *The incidence and costs of inpatient falls in hospitals*. July 2017. https://improvement.nhs.uk/resources/incidence-and-costs-inpatient-falls-hospitals/

Our nursing directorate produced an evidence-based **dementia assessment and improvement framework** to enable nursing directors and medical directors to achieve outstanding care for hospital patients with dementia. The framework consists of eight standards modelled on care for patients with dementia in organisations that CQC rated 'outstanding'. It integrates policy guidance and best practice with opinion from patients and carers.

We are helping trusts implement the **Learning from Deaths Framework**, introduced by the National Quality Board (NQB) in March 2017. As well as case studies, we produced a tool for trusts to record relevant incidents of mortality, deaths reviewed and lessons learned. We published guidance for boards – particularly non-executive directors and non-clinical executive directors – that explains their specific responsibilities and what they must do to implement NQB's guidance. We also commissioned the Royal College of Physicians to develop a standardised approach to case record review and train trusts to use it.

Key facts

- In 2015/16, 24,674 patients in the NHS in England were reported to have developed a **pressure ulcer**.
- The average length of stay in hospital for a patient with pressure ulcers is 25 days.

Our national **Stop the Pressure** programme, launched in 2016, aims to eliminate avoidable pressure ulcers in acute, community and mental health settings. We are working with frontline staff, NHS England and AHSNs to achieve this. During the year, 172 trusts submitted improvement plans to eliminate pressure ulcers across regions and spanning health and social care. We launched a national Stop the Pressure collaborative in October 2017 with 25 trusts; another 90 applied to join later. And we developed resources emphasising how nutrition and hydration prevent pressure ulcers and promote wound healing.

We lead the programme to reduce healthcare-associated **Gram-negative bloodstream infections** (GNBSIs) by 50% by March 2021. During the year we continued our focus on *E. coli* as one of the largest GNBSI groups, but extended mandatory reporting to include *Klebsiella* species and *Pseudomonas aeruginosa*. The three organisms, which cause significant mortality and morbidity in NHS patients, account for 72% of healthcare-associated GNBSIs, and interventions

effective at reducing them are likely to decrease risks from other GNBSIs. With NHS England, we asked providers and commissioners to jointly agree plans for reducing GNBSIs. We regularly add tools and case studies to the Improvement Hub on our website, and with Public Health England published suggestions on how whole health systems could tackle GNBSIs.[14] We hosted four performance improvement network events for health systems to share experiences and learn from each other.

We are working with a range of other organisations through the **Maternity Transformation Programme**, to achieve the national ambition 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 2025.

Perinatal Mortality Review Tool

We supported trusts to use the Perinatal Mortality Review Tool developed by MBRRACE-UK (Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK), launched in January 2018 for local multidisciplinary reviews of all perinatal deaths. All but six trusts with maternity services have registered to use the tool.

For example, the **national maternal and neonatal health safety collaborative** works intensively with frontline maternal and neonatal staff to provide quality improvement training and coaching. About 200 staff across the maternal and neonatal professions have already been trained in quality improvement methods. Now in its second year, the collaborative supports projects to improve clinical practices and reduce unwarranted variation. It will work with all 134 trusts in England delivering maternal and neonatal services over three years. Trusts in the first wave developed 176 improvement projects in areas such as smoke-free pregnancies, stabilising the very preterm infant, and recognising and managing deterioration in mother or baby. All improvement projects focus on nurturing a safety culture, developing reliable systems, and involving women and families to improve care. Learning will be shared through local learning systems that support local maternity systems.

[14] *Preventing healthcare-associated Gram-negative bloodstream infections: an improvement resource*. May 2017. https://improvement.nhs.uk/resources/preventing-gram-negative-bloodstream-infections/#h2-essential-standards

Maternity safety champions at trust, regional and national levels, working across organisational and service boundaries, can promote the professional cultures needed to deliver better care. They play a central role in ensuring that mothers and babies continue to receive the safest care possible by adopting best practice. We published guidance for champions at all levels, outlining role responsibilities, suggesting how to promote best practice and signposting initiatives that can offer support.

There are over 15 million people under the age of 20 in England, accounting for nearly 25% of the population. Events that occur in early life affect health and wellbeing in later life, so investing in children and young people's physical and mental health is essential. We reviewed CQC reports on the 75 trusts whose children and young people's services were rated as 'requiring improvement' or 'inadequate' at their last inspection. We used the common themes behind the poor ratings as the basis for a **framework for children and young people's services**[15] that senior nurses can use to help them achieve 'good' or 'outstanding' ratings.

In March 2018, our Board agreed a statement of intent to embed the **patient, public and carer voice** in the organisation's work. Most of our work on improving the patient experience and promoting the involvement of patients and the public is done in partnership with NHS England. For example, we co-designed and commissioned a learning network for heads of patient experience, which 153 trusts joined. We are working with Step Up to Serve on the #iwill campaign to encourage young people to volunteer in their local NHS. And we provided bespoke leadership development focused on patient experience to 18 trusts.

We expanded our nursing team during the year to provide more **intensive support to NHS mental health services** across England, appointing a deputy national clinical director for mental health, two associate national clinical directors and a head of delivery for mental health. The team works with NHS England and other system partners to support delivery of the Five Year Forward View for Mental Health and improvement in the mental health provider sector.

Many mental health service providers are meeting complex challenges with exceptional innovation, energy and creativity. We asked one – Northumberland,

[15] *Improvement and assessment framework for children and young people's health services: to support challenged children and young people's health services achieve a good or outstanding CQC rating*. February 2018. https://improvement.nhs.uk/resources/improvement-and-assessment-framework-children-and-young-peoples-health-services/

Tyne and Wear NHS Foundation Trust – to be our strategic partner, and involved eight others at different stages of improving their services, to create a **national mental health improvement model**.[16] We involved people who use services, their families and carers throughout. The model reflects the challenges and lessons learned from setbacks, as well as from successful innovations and improvements. Implementing all its good practice examples would produce a world-class mental health service.

Eliminating out-of-area placements

We set up a support team with NHS England to help local health systems eliminate inappropriate out-of-area placements for acute mental health inpatient care by April 2021. It provides expert senior clinical input, and facilitated more than 15 events between autumn 2017 and March 2018.

In October 2017 we set up our joint **national mental health safety improvement programme** with CQC, to be rolled out during 2018/19. It will offer enhanced support to trusts that CQC identifies as facing the greatest safety challenges and quality improvement support to all trusts on issues of common concern, such as restraint and restrictive practice. The programme will build on our work with nine trusts on the national mental health improvement model.

To prepare for our forthcoming **learning disability improvement standards** for trusts, we completed visits to all NHS providers of specialist learning disability services. We piloted integrating the standards with national quality checks in five trusts. We are also increasing support and oversight of learning disability and autism-related issues in acute trusts. In partnership with four trusts – one in each region – we worked with the rights-based organisation Changing Our Lives to create 'improvement grab guides', which focus on how to improve a specific area of care. With four other trusts and a film company we produced short videos to relay specific improvement messages.

NHS staff continue to raise **whistleblowing** concerns with us, usually when they are unhappy with the response they have received from their employer or are

[16] *Valued care in mental health: improving for excellence – a national mental health improvement model*. March 2018. https://improvement.nhs.uk/resources/valued-care-mental-health-improving-excellence/

worried they may suffer detriment if they raise their concern directly with their employer.

Most cases we received related to bullying and harassment, patient safety, and issues about leadership and the board. The cases indicate that barriers remain to staff feeling free to raise their concerns. We are working with the National Guardian's Office (NGO) to remove these barriers. It is a key part of the NGO's role to provide leadership and advice for Freedom to Speak Up guardians on best practice to enable staff to speak up safely. We now have Freedom to Speak Up guardians in every trust in England, and with the NGO have jointly published guidance and a self-assessment tool to help boards understand their role in ensuring staff feel able to speak up. Where the NGO has conducted a case review into speaking up at a trust, we have supported the trust with its resulting action plan. We are also piloting how we can use data to identify trusts that may need additional support with freedom to speak up.

We take the cases we receive very seriously and took action in 82% of them (see Figure 1). This included 14 cases (12%) that resulted in external investigations overseen by us and/or an external 'well-led' review into the trust's leadership and governance. We took no action in 18% of cases because the individual raising a concern did not provide enough information, we did not receive consent to use the information provided, or the information related solely to an individual employment matter, over which we have no jurisdiction.

We noticed an increase in issues raised about board members and by board members. Some resulted in external investigations overseen by us, followed by support and/or regulatory action to ensure that trust boards function well and have robust plans to address concerns.

At Wirral University Teaching Hospital NHS Foundation Trust, we received concerns from several executive directors about the chief executive and the chair. We commissioned an external investigation into these concerns, and our handling of them. The ensuing report identified that a number of governance failings at the trust during 2017 led to the breakdown of relations between the executive directors, non-executive directors, the former chair and former chief executive, and staff at all levels felt unable to speak freely about concerns they held. The report found we took timely and appropriate action to support trust executives once concerns had

been raised about the trust. The trust now has a new interim chief executive and interim chair.

We are piloting our support scheme to help whistleblowers return to work. This follows Sir Robert Francis's recommendation in *Freedom to speak up – a review of whistleblowing in the NHS* to help whistleblowers find alternative employment in the NHS and set out what this should include. In September 2017 with input from stakeholders, including whistleblowers, we launched a pilot scheme to cover the report's minimum requirements, and we continue to work with these stakeholders as the pilot scheme progresses. The scheme includes:

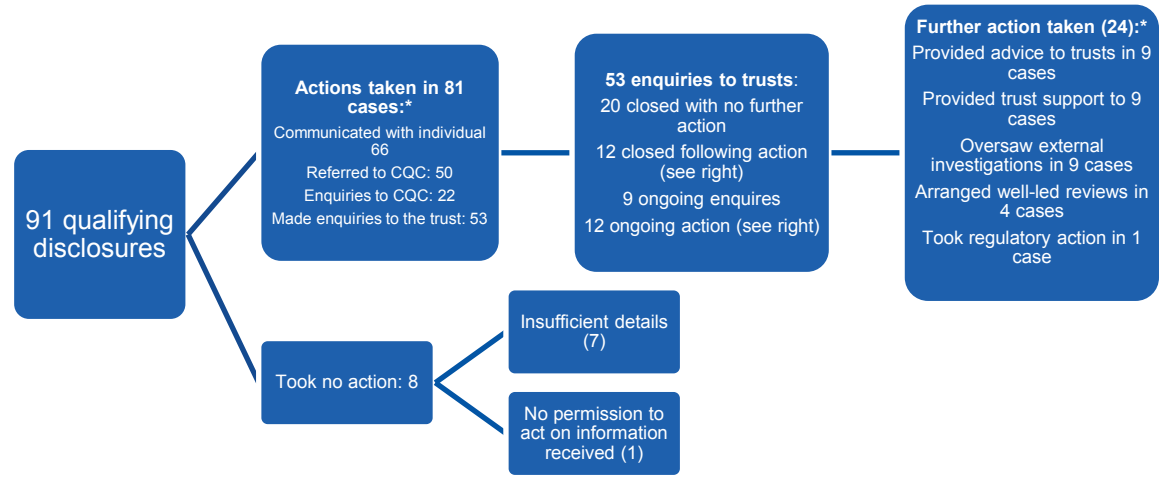
- &an application process with independent panel assessment of each application

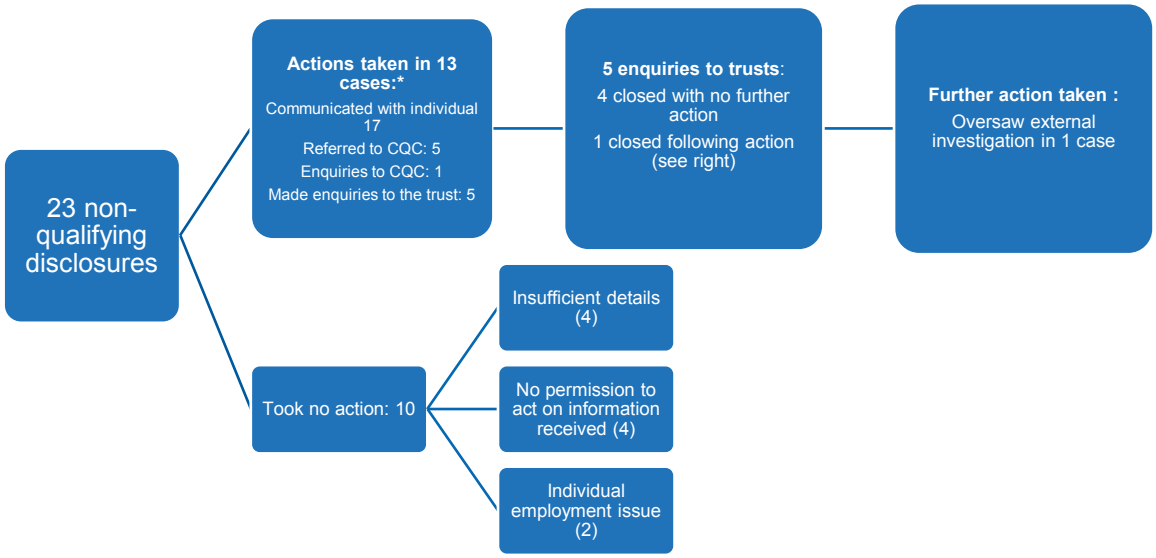
- &support to successful applicants from an external provider to develop and implement an action plan that will help them return to employment.

Many NHS employers have been supportive in offering access to library facilities, training, and shadowing and placements for those ready for these opportunities. The pilot scheme is currently supporting 10 whistleblowers. We have commissioned independent external evaluation so that lessons from the pilot can be applied to the development of the main scheme, which will be launched later in 2018. More detail is available on our website.[17]

[17] https://improvement.nhs.uk/resources/freedom-to-speak-up-whistleblowers-support-scheme/.

Figure 1: Whistleblowing cases received in 2017/18





*NB: multiple actions may have been taken in some cases: for example, we may have overseen an external investigation and then arranged a well-led review.

Financial control and turnaround

We are committed to restoring trusts to financial balance and improving their use of resources while delivering continuous improvements in the quality of patient care, as well as securing long-term clinical and financial sustainability.

The initial objective for the year, as set out in the sector financial plan, was to reduce the sector deficit from the £791 million reported in 2016/17 to £496 million for 2017/18. This was a very challenging plan which required the achievement of efficiency improvements amounting to £3.7 billion to absorb both the impact of the 2.4% inflation reflected in national tariff prices and to replace non-recurrent savings achieved in the previous year.

The 2017/18 financial year was particularly challenging for the NHS with unrelenting demand for hospital based emergency care and continuing high levels of bed occupancy putting exceptional pressures on the system particularly in the acute sector. This was compounded by an extremely difficult winter period which saw the highest levels of flu-confirmed admissions for seven years and put intense pressure on A&E services. The combined effects of these factors have affected NHS finances. The sector closed the year with a deficit of £966 million.[18] this was £175 million worse than 2016/17 and £470 million worse than the ambitious plan. This position included the significant achievement of £3.2 billion of cost improvements (equivalent to 3.7% of total operating costs). Despite the financial pressures, the majority of providers demonstrated good financial management with 133 of 234 trusts finishing the year at breakeven or in surplus.

NHS Improvement has continued to drive financial sustainability through the processes used to allocate the £1.8 billion Sustainability and Transformation Fund (STF) to trusts. To be eligible to core STF, a trust needed to meet its financial control total, which we determined using an impact assessment for a range of factors at individual trust level. In all, 212 out of 234 trusts accepted their financial control totals for 2017/18, and 151 trusts 65% delivered a full-year financial position that either met or exceeded their agreed financial control totals. There were 47 providers who received part of their initial STF allocation and a further 14 who did

[18] The £966 million is quoted after accounting for a deduction of £129 million for central adjustments. These central adjustments are not routinely split between NHS trusts and foundation trusts, therefore the figures quoted in Table 2 of the finance performance sections of the report are stated before this deduction.

not meet their control total at any point in the year but benefitted from a general distribution of the fund. The STF in 2017/18 built on progress made the previous year and again focused on sustaining services rather than transforming or enhancing them. We allocated funds mainly to trusts providing acute emergency care, as these services remained under the greatest financial and operational pressure, although some went towards sustaining non-acute services.

If a trust does not agree a control total or deviates markedly from it, if it is forecasting a significant deficit or if it experiences an exceptional financial governance failure, we may place it in **special measures for finance reasons**. We then provide bespoke intensive support to help it recover quickly. This includes appointing 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 special measures for finance reasons, a trust's board must agree with us a recovery plan and details of how it will be achieved, demonstrating that it will not adversely affect the quality of services. We published guidance for trusts on special measures for financial reasons during the year.[19] At the beginning of 2017/18, 10 trusts were in the programme; by the end of, one had successfully exited special measures and a further three had entered.

Key fact

The first three **Use of Resources reports** were published with 'shadow' ratings for January to March 2018: Northern Devon Healthcare NHS Trust and Poole Hospital NHS Foundation Trust were given a shadow rating of 'good' and Ipswich Hospital NHS Trust a shadow rating of 'requires improvement'.

We introduced **Use of Resources assessments** in autumn 2017. They are designed to help providers, national bodies and the public understand how effectively trusts are using their resources – including their finances, workforce, estates and facilities, technology and procurement – to provide high quality, efficient and sustainable care. We rate trusts' use of resources as outstanding, good, requires improvement or inadequate. We developed the assessments with CQC, which will combine our ratings with its own in an overall trust-level quality rating. The assessments will help us identify a trust's support needs as part of the Single Oversight

[19] *Special measures for finance reasons: guidance for trusts*. March 2018. https://improvement.nhs.uk/resources/special-measures-guide-nhs-trusts-and-foundation-trusts/

Framework (see page 11). We are initially focusing on acute non-specialist trusts but will include specialist acute, ambulance, mental health and community services once we have developed suitable metrics.

Eighteen trusts volunteered for Wave 2 of our **Financial Improvement Programme,** which matches ambitious management teams with external experts to enhance cost improvement programmes (CIPs). We jointly select the expert teams with the trust, maximising value for money by central procurement. The programme focuses on transferring skills and expertise to trust staff. Wave 2 built on the learning from Wave 1 and is divided into three phases: the first two identify key CIP opportunities and develop a detailed plan to achieve them, while in the third phase the external teams tailor implementation support to meet the trust's needs.

Key facts

In 2017/18:

Trusts spent £2.41 billion on **agency staff** – £90 million less than the £2.5 billion target and just over £520 million (18%) less than last year.

This means that average agency spend as a percentage of staff pay has fallen from 6% last year to 4.6% in 2017/18.

Spending on agency staff has continued to decrease since we introduced controls in 2015/16, and by the end of 2018/19 the sector will have reduced its agency staff cost by a third (over £1.2 billion a year) since we introduced rules on agency spending. Compared to last year, agency spend fell in all staff categories, especially administrative and estates but also in the nursing, medical and dental staff groups. In July 2017 we urged trusts to ensure they had in-house staff banks covering all staff groups, and to make them work collaboratively and collectively across local health systems. We followed this with practical advice on using staff banks effectively.[20] We also asked users of staff banks to tell us how their experiences of registering with, working for and getting paid by staff banks could be improved.

For the first time since controls began, monthly spending on bank staff exceeded spending on agency staff. This reflected trusts' need to manage workload in the face of increased demand, high levels of vacancies, sickness absence and staff

[20] *Making effective use of staff banks: toolkit*. December 2017. https://improvement.nhs.uk/resources/making-effective-use-staff-banks/

turnover. While the volume of temporary shifts worked grew to meet escalating demand over winter, thanks to the sector's hard work in following the agency rules, average prices paid for shifts reduced over this period. To ensure our approach to reducing agency spending takes account of the sector's needs, we set up a reference group with chief executives, nursing and medical directors, human resources directors and representatives from national bodies. We also launched a portal in the Model Hospital (see page 45) to feed back temporary staffing data to the sector to allow trusts to benchmark against their peers. Since their introduction, our controls have encouraged a greater level of workforce planning and improved value for money in this significant area of spending.

The ongoing cost of **private finance initiative** (PFI) schemes is significant for many trusts. We have therefore set up a working group to help ensure the NHS gets the best possible value from such deals – for example, by improving the way trusts manage PFI contracts. During the year we carried out a survey of how trusts manage these contracts. With DHSC and the Infrastructure and Projects Authority, we are helping providers plan for the expiry of PFI contracts and handback of PFI facilities.

Alongside DHSC we worked with trusts that have the most opportunity for **recovering costs from overseas visitors**, helping them pilot new ways of working and identify best practice. We were key contributors to the operational framework setting out the upfront charging regulations for overseas visitors not entitled to free NHS care, when it became mandatory for all trusts in October 2017. In addition, as an overseas charging price list has not existed before, we published one for trusts to create a pro-forma invoice for liable patients. Designed to support local arrangements rather than replace a trust's existing system if it already worked, the list was developed mainly by Cambridge University Hospitals NHS Foundation Trust. In collaboration with NHS England we published advice for commissioners and trusts to use in establishing their arrangements for overseas visitors and providing necessary assurances. We continue to work with trusts to help them identify liable patients and recover costs, and will be increasing our involvement with acute and mental health trusts in the next 12 months, setting a financial target to be achieved over the next two years.

We made excellent progress 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 care and 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. In 2017, 70 acute, mental health and ambulance trusts implemented patient-level costing and sent us data on £21 billion of costs. We launched a tool that allows all organisations submitting patient-level data to view their information, compare costs with peers and access reports on data quality. This rich data source, already 10 times bigger than the Hospital Episode Statistics, can be used to inform decisions about service delivery, reduce unwarranted variation and improve productivity. After consultation, we decided that all acute trusts should record the costs of their activity at a patient level from 2018/19.

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 – for instance, during winter months – and to have sustainable strategies to maintain their performance.

Throughout the year, the NHS experienced rising demand and high levels of bed occupancy. We therefore made **planning for winter** – when these trends reach a peak – a priority for 2017/18. We created a joint urgent and emergency care (UEC) programme with NHS England under a single national director, Pauline Philip. For the first time formal winter planning began in July, with local plans submitted in early September.

Our national planning focused on:

- delivering our transformation programmes, including:
  - improving access to integrated urgent care
  - increasing the number of 111 callers receiving clinical assessment
  - implementing primary care streaming in accident and emergency (A&E) departments, so that people with more minor conditions are treated by GPs
  - changing how the ambulance service operates to improve response times
- implementing a national and regional operating model
- reducing delayed transfers of care (DToCs) of patients who are ready to leave hospital, whether to go their own homes, social care or elsewhere in the NHS
- introducing standardisation and reducing variation in best practice, particularly by developing ambulatory emergency care to improve patient flow
- extending the flu vaccination programme
- in the longer term, increasing the emergency care workforce.

NHS Providers commented: “Trusts tell us that this planning has been more extensive and more effective than ever before”.

Fighting flu

The rate of flu-confirmed hospital admissions in December 2017 was the highest for seven years. With NHS England, PHE and DHSC, we:

- &directed trusts to make vaccines readily available to staff and record why those who chose to opt out of the programme did so
- &worked with providers and professionals to increase the uptake of vaccination; as a result, uptake among healthcare workers with direct patient contact was 67.6%, up from 63% the previous year.

With NHS England, PHE and clinical leaders from across the NHS we set up the **National Emergency Pressure Panel** to determine system risk levels across the country and whether these should be escalated or de-escalated. The panel made recommendations to help trusts take decisions on patient safety during the heightened winter pressures – for example, by prioritising emergency work and deferring non-urgent inpatient elective care from late December to 31 January.

In the 12 months to February 2018, **numbers attending A E** increased by 1.8% and emergency hospital admissions by 3.7%. Much of this growth was in services introduced to relieve pressure on A&E departments and GP services, such as urgent treatment centres and streamed primary care in A&E departments. Despite a very challenging winter, with the highest levels of flu this decade, several significant outbreaks of norovirus and severe weather conditions, national A&E performance for the year was only 0.7% lower than in the previous year. The NHS treated 160,000 more A&E patients within four hours this winter compared to the previous one.

Key fact

Reducing **DToCs** released 1,650 beds between February 2017 and February 2018.

The number of '**DToC beds**' – those filled by a patient whose transfer of care is delayed – fell steadily after February 2017, from 6,645 to 4,996 in February 2018. This was thanks to significant efforts by the NHS and social care following the additional money in the Budget for social care, and to tying performance metrics in the Better Care Fund to managing down DToCs. This led to the lowest level of social care DToCs in February 2018 since September 2015 and the lowest level of NHS DToCs since May 2015.

Areas with **extended access to primary care** (covering 55.4% of the population in February 2018) saw on average a 10% reduction in the number of minor attendances at A&E. We will extend coverage of primary care access to 100% of the country by October 2018, in time for next winter.

We continue to develop **111** as a first contact urgent care service where most callers can have their problem solved on the phone with advice, a prescription or a booked appointment in an urgent treatment centre or with their GP. 111 services took 28% more calls than at the same point last year, with the number of callers receiving clinical input to their advice rising from 29% at this time last year to 48.4% in March 2018.

All English ambulance services have implemented the new standards of the **Ambulance Response Programme,** and work continues to improve digital services for ambulances to increase opportunities for 'hear and treat' and 'see and treat'.

Our **Emergency Care Improvement Programme** (ECIP) played a significant role in supporting trusts to improve performance during 2017/18. It focused on agreed workstreams with more challenged systems.

Good **patient flow** across health and social care systems is crucial for the NHS to run an effective and sustainable service – and vital to cope with winter pressures. If patient flow is poor, hospitals become congested, clinical outcomes are worse, financial performance deteriorates and staff are overstretched. We have produced a

range of practical tools, best practice guidance[21] and case studies[22] to help trusts improve patient flow.

Criteria-led discharge

Criteria-led discharge is where a consultant sets a patient's discharge criteria for use by another healthcare professional such as a nurse or junior doctor. It improves patients' experience of discharge, drives patient flow and can shorten length of stay by up to two hours. To increase the use of criteria-led discharge, our nursing directorate published evidence-based principles and ran collaboratives involving 3,000 patients, gaining international interest.

Our **emergency flow improvement tool** helps trusts identify bottlenecks and stress points, enabling them to target improvement efforts at the areas likely to have the greatest impact. Since its launch in September 2017, over 500 staff from 122 acute hospitals have used the tool.

ECIP's mental health programme developed and tested an **evidence-based toolkit** to aid understanding of how people with urgent mental health needs progress through emergency departments and how their journey can be improved.

The **SAFER patient flow bundle** reduces delays for patients in adult inpatient wards, blending five elements of best practice.

Our **DToC tool** combines data from NHS organisations and local authorities in an easy-to-use 'dashboard' to show where their biggest delays are and track progress on action taken.[23]

As winter approached, we encouraged trusts to use the **patient safety checklist for A E departments** , which has been proven to improve clinical processes and reduce Serious Incidents from unrecognised patient deterioration. It was developed by University Hospitals Bristol NHS Foundation Trust. The checklist systemises the observations, tests and treatments that need to be done in a certain order, serving

[21] *Good practice guide: focus on improving patient flow*. July 2017. https://improvement.nhs.uk/resources/good-practice-guide-focus-on-improving-patient-flow/
[22] https://improvement.nhs.uk/resources/case-studies-focus-improving-patient-flow/
[23] *Flow in providers of community health services: good practice guidance*. November 2017. https://improvement.nhs.uk/resources/flow-in-providers-of-community-health-services-good-practice-guidance/

as an aide-memoire for busy staff. We provided the checklist, supporting materials and evidence of its impact on our website.

Reducing handover delays in London

With NHS England and the London Ambulance Service NHS Trust, we led a project to reduce ambulance handover delays in the capital. Between 1 October 2017 and 9 February 2018, delays of more than 60 minutes were reduced by 31% and total time lost over 15 minutes was reduced by 14.7%, compared to the same period the year before.

Handovers of emergency patients arriving at hospital by ambulance should be completed within 15 minutes. Delays adversely affect treatment and the patient's experience, and mean there are fewer ambulances available to respond to calls or major incidents. **Ambulance handover delays** may be a symptom of system-wide issues, so with NHS England we recommended action for acute and ambulance trusts, commissioners, GP practices and community services to reduce the likelihood of delays, and measures to take when ambulances are queueing.

As clinical practice has evolved, many trusts offer new services that benefit UEC and patients' experience of it. We are keen to ensure local and national data reflect these new pathways, and we are working with trusts to eliminate inconsistencies in reporting UEC activity – data we use to get a full picture of the pressures their A E departments face. We developed the **national A&E dashboard** to consolidate data from trusts' daily situation reports and share it among central NHS bodies.

North region's action on A&E

Action on A&E is a collaborative programme to improve UEC, led by our North regional team with support from ECIP. Between April and November 2017 it attracted over 1,200 people to 16 events promoting system working, at which almost every local A&E delivery board showcased an aspect of its UEC.

It is important that all patients needing access to **elective care** – whether outpatient appointments, diagnostics, inpatient or daycase treatment – are managed in line with national waiting-time standards and the NHS Constitution. Trusts and wider health systems asked us for support in devising principles and rules for managing patients on elective care pathways. We produced an elective care model access policy,[24] which promotes timely access while respecting patient choice of time and place of treatment. Our elective care guide[25] includes advice on and tools for demand and capacity planning, performance management and reporting, derived from what we have learned from helping NHS organisations achieve and sustain short waiting times for treatment. We also developed a 10-part e-learning programme to help elective care teams reduce waiting times and improve access.[26]

Using technology to increase bed capacity

A key part of our role is to help trusts develop new ways of working to improve care and meet demand. Five trusts are piloting patient flow system technology, which enables hospital staff to see real-time data on available beds so they can allocate patients to the most appropriate ward first time. They can also locate equipment and housekeeping or portering staff available to clean a bed or transport a patient. At the first pilot site, The Royal Wolverhampton NHS Trust:

- &patients were three times more likely to be allocated to an appropriate ward
- &operations cancelled due to bed unavailability reduced by 60%
- &length of stay fell by 11%.

Expected waiting times for cancer patients have only been met nationally twice since April 2014, despite trusts working hard to achieve them. With increased need for dedicated support on cancer waiting times, we set up a **cancer intensive**

[24] *Elective care model access policy*. August 2017. https://improvement.nhs.uk/resources/elective-care-model-access-policy/
[25] https://improvement.nhs.uk/resources/elective-care-guide/
[26] https://improvement.nhs.uk/resources/elective-care-e-learning-programme/

support team. It is working with our regional teams and trusts to compile good practice, which we share on our website's Improvement Hub.[27]

During the year we took part in the national response to several **major incidents**. In May 2017 we advised trusts on action to combat the WannaCry ransomware cyberattack. We and our national partners learned valuable lessons in co-ordinating and communicating our responses from this incident. After the Grenfell Tower fire in June 2017, we ensured all trusts identified any risks to their buildings and took necessary action, providing extra support to those that reported issues. When Carillion declared insolvency in January 2018, we had already drawn up extensive plans to maintain patient services without interruption at the 14 trusts with which it had contracts. This included sending our staff to the six biggest hospital sites to help.

Sector performance against key standards

Trusts demonstrated remarkable resilience despite the difficult winter, treating more people in A&E within the expected four hours than the year before – although performance against the standard slipped. The sector entered 2017/18 facing a substantial financial challenge. Higher-than-planned levels of A&E activity and high levels of bed occupancy, which affected trusts' ability to admit patients for planned care, had a further negative impact on finances. Despite employing more nursing and medical staff, the sector ended the year with a challenging level of vacancies. Performance on other key standards was mixed.

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 83.59% compared to 86.50% in the same quarter last year; 225,764 patients waited more than four hours for a bed, 27.5% more than a year ago. In total, A&E departments saw attendances increase by 3.4% and admitted 6.8% more patients than in the same quarter 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, 2.15% had been waiting longer than six weeks compared to 1.06% at the end of last year. However, the waiting list had increased by 3.4% compared to the same

[27] https://improvement.nhs.uk/improvement-hub/cancer/

time last year. The sector failed to achieve the waiting-time standard for 12 of the 15 key diagnostic tests, three more than in the fourth quarter of last year. Longer waiting times for endoscopy tests – which make up over 11% of the diagnostics waiting list – drove this overall deterioration in performance. To increase capacity further, we are working with HEE to train 200 more non-medical endoscopists during 2018.

Elective waiting times

Providers continue to miss the referral-to-treatment target of 92% for incomplete pathways, achieving 86.83% at the end of the year – a drop of 3.2% on last year. Sustained high demand for emergency inpatient care meant many providers struggled to achieve their planned activity as elective capacity was displaced or cancelled. The WannaCry cyberattack (see page 94) further reduced elective activity. The elective waiting list remained at almost record levels: at the end of the year it was 3.84 million, a 2.9% increase on 2016/17. In March 2018, 2,647 patients had been waiting over a year for treatment, compared to 1,513 in March 2017.

Cancer waiting times

Providers failed to meet three cancer waiting-time standards in Quarter 4: 14-day referral to first outpatient appointment for patients with breast symptoms; the 62-day (urgent GP referral) target for first treatment; and the 62-day screening from service referral target. 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 4,739 *Clostridium difficile* cases during 2017/18, 2.3% (105 cases) more than last year. They reported 296 MRSA cases, a decrease of 6.3% (20 cases) on last year. *E. coli* cases increased by 1.1% (446 cases) compared to 2016/17.

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

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 2018	92%	85.5%
52 week waits (numbers)			1,113
Diagnostics			
Number of diagnostic tests waiting longer than 6 weeks	March 2018	1%	2.27%
Accident and emergency			
All types of performance	Quarter 4	95%	81.22%
Type 1 performance			72.75%
Cancer			
2 week GP referral to first outpatient – cancer	Quarter 4	93%	93.70%
2 week GP referral to first outpatient – breast symptoms		93%	90.3%
31 day wait from diagnosis to first treatment		96%	97.16%
31 day second or subsequent treatment – surgery		94%	93.77%
31 day second or subsequent treatment – drug		98%	99.02%

Metric	Period	Standard	Performance
31 day second or subsequent treatment – radiotherapy		94%	96.24%
62 day urgent GP referral to treatment for all cancers		85%	81.0%
62 day urgent GP referral to treatment from screening		90%	85.7%
Ambulance			
Category 1	March 2018	7 minutes mean response; 15 minutes 90th centile response time	Mean: 00:08:32 90th centile: 00:14:39
Category 2		18 minutes mean response; 40 minutes 90th centile response time	Mean: 00:30:12 90th centile: 01:05:48
Category 3		120 minutes 90th centile response time	03:10:56
Category 4		180 minutes 90th centile response time	03:28:51
Infection control			
MRSA (numbers)	YTD March 2018	-	114
Clostridium difficile (numbers)		-	1,815
Mixed sex accommodation (numbers)	March 2018	-	849

Metric	Period	Standard	Performance
Mental health			
Proportion on care programme approach discharged from inpatient care who were followed up within 7 days	Quarter 4	95%	94.3%
Proportion admitted to inpatient service who had access to crisis resolution/home treatment teams	Quarter 4	95%	98.8%
Proportion with a delayed transfer of care	March 2018	3.5%	4.05%

Financial performance

For the first time, we compiled the consolidated accounts for the NHS trust sector, providing an audited public record of financial performance in the year. As in previous years, the accounts will be passed to DHSC before being presented to Parliament before the summer recess. We also tracked NHS trusts' financial performance on a monthly basis.

The information revealed another exceptionally challenging year for NHS trusts, with significantly increased levels of demand. Additionally, the significant pressure on emergency services and the resulting squeeze on elective work – especially during the very challenging winter months – adversely affected NHS trusts' reported financial performance. Partly as a result of these external difficulties, NHS trusts reported an adjusted financial deficit performance on a control total basis before technical adjustments of £1,078.9 million.

Although in aggregate this was a deterioration on 2016/17, most NHS trusts showed good financial management, could agree their control totals and achieved either break even or surplus at the financial year-end. We continued to manage the overall financial position through a combination of tight financial controls and additional funding for NHS trusts:

- We set challenging financial plans for 2017/18 that particularly focused on controlling costs and improving productivity.
- We continued to use control totals that set the minimum level of financial performance for individual trusts: 72 out of 80 NHS trusts accepted their control totals, and 43 achieved them.

- Accepting their control totals allowed NHS trusts access to the £1.8 billion Sustainability and Transformation Fund, of which they received £0.6 million in total. This supported many providers in returning to a more sustainable financial footing.
- Continuing the tight control of agency spending (see page 29) helped NHS trusts reduce their reliance and spending on agency staff. An annual reduction of £236 million in agency staff spend was reported in 2017/18, which built on the £255 million achieved in 2016/17.

However, challenges remain. We asked all providers to focus on improving efficiency, and NHS trusts reported a total of £1.2 billion cost savings for 2017/18. Although this was £55 million more than the previous year, 50 NHS trusts reported a shortfall against their planned cost savings, the total shortfall amounted to £217 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: 80% 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 2018

NHS trust sector	2017/18			Number of trusts	Number of trusts in deficit	% of trust sector
	Plan £m	Outturn £m	Variance £m			
Acute	(724.4)	(1,188.3)	(463.9)	51	41	80%
Ambulance	(2.2)	29.1	31.3	5	0	0%
Community	9.4	25.5	16.1	12	2	17%
Mental health	21.5	66.6	45.1	11	2	18%
Specialist	(16.2)	(11.8)	4.4	1	1	100%
Total	**(711.9)**	**(1,078.9)**	**(367.0)**	**80**	**46**	**57%**

Brackets denote deficit.

At the end of the last financial year (2016/17) there were 81 NHS trusts. During the year, this figure diminished by one as Peterborough and Stamford Hospitals NHS

Foundation Trust acquired Hinchingbrooke Health Care NHS Trust and was renamed North West Anglia NHS Foundation Trust.

The number of NHS trusts at the end of the financial year was 80.

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.

During 2017/18 the government announced just over £3.5 billion of additional capital across this year and the next five years. This includes £2.6 billion to deliver transformation schemes prioritised by STPs, £700 million to support turnaround plans in individual trusts facing the biggest performance challenges and tackle the most urgent and critical maintenance issues, and £200 million to support efficiency programmes.

We published the *Capital regime, investment and property business case approval guidance* for providers in 2016, which updated the capital delegated limits for NHS trusts and foundation trusts in financial distress. In 2017/18, we approved nine full business cases (FBCs) totalling £202 million and a further 15 strategic outline cases (SOCs) and outline business cases (OBCs) that were outside the delegated authority of individual NHS trusts (in 2016/17, we approved 15 FBCs totalling £459 million and 12 SOCs and OBCs).

In total, NHS trusts spent £1.105 billion on capital projects during 2017/18 (in 2016/17 they spent £1.133 billion) in a planned and managed way to improve their infrastructure. As in previous years, NHS trusts continued to spend less on capital projects than planned. Total capital expenditure was 31% below plan. Therefore, strengthening capital planning and forecasting remains a challenge for NHS trusts.

Cash

Accessing finance is crucial for NHS trusts to improve and operate services, particularly those with a revenue deficit. In 2017/18, 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 2017/18, 53 NHS trusts required access to cash financing of £1.523 billion to support forecast revenue account deficit positions and operational working capital. (In 2016/17, 58 NHS trusts accessed £1.584 billion.)

Provider productivity

To help providers improve the quality of care and meet financial objectives, we make sure they 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 provider productivity programme is now supporting all trusts to reduce variation, make savings and efficiencies, and improve services.

Key facts

By the end of 2017/18, the **Model Hospital** had more than 8,000 registered users in NHS provider organisations, of whom three-quarters were senior managers, directors or board-level executives.

The **Model Hospital** is a digital information service to help all trusts identify opportunities to improve their productivity. It brings together key information and data across the entire range of a trust's activity so it can compare productivity against the national average as well as its peers. We continuously review and improve the Model Hospital to meet their needs, and ran two major research projects in 2017/18 to support this. We have already seen some notable successes.

For example, our monthly 'top 10 medicines' list – derived from the Hospital Pharmacy and Medicines Optimisation Transformation Programme – helped acute non-specialist trusts identify where they could switch from prescribing and supplying high cost branded medicines to safe and equally effective biosimilar and generic versions. This allowed more patients to receive treatment for conditions including rheumatoid arthritis, bowel diseases and some forms of cancer; it saved the NHS more than £324 million in 2017/18. Bedford Hospital NHS Trust used the Model Hospital benchmarks for pathology to negotiate an improved deal with its pathology service provider, reducing costs by over £700,000. We carried out the first national benchmarking survey for imaging services, which provided a comprehensive benchmarking dataset, published on the Model Hospital, to reduce unwarranted variation.

We worked with 23 trusts as part of our review of productivity and performance in **mental health and community health services**, collecting key data we will use to develop an 'optimal model' NHS community or mental health trust. We also started a review of **ambulance services'** productivity and performance, working with all 10 ambulance trusts.

How efficient procurement saves money

Nationally Contracted Products Programme
Total NHS spending on couch rolls was £7 million in 2016: hospitals bought 23 different products, and prices varied by 40%. The programme saved 16% of the total amount spent. It saved 25% on blunt-filled syringes, 3% on examination gloves, 13% on toilet paper and 63% on temporary shoes.

Purchase price index and benchmarking(PPIB) tool
By using PPIB, Plymouth Hospitals NHS Trust negotiated lower prices and now saves 13% a day on the products it buys. King's College Hospital NHS Foundation Trust ordered £1.9 million of goods direct from suppliers, unaware that the same products were available at lower prices from NHS Supply Chain. By using PPIB, it compared prices paid by other trusts and negotiated a cost reduction of 10% with its suppliers.

Almost every NHS patient interacts at some point with pathology services, which screen for disease, check for potential health risks, diagnose conditions, monitor the progression of illnesses and play an important role in research. It is vital they are run efficiently. Our research found unwarranted variation among the NHS's 105 pathology services, so we are helping them form 29 **pathology networks.** The National Pathology Optimisation and Delivery Board has been set up with members from across the professional pathology community, and we supported the emerging networks with toolkits and case studies. Combining their clinical expertise will make it easier to achieve better value, quality care for patients and introduce a new generation of investigations. It will also save the NHS at least £200 million a year.

We work closely with providers on product procurement to make full use of the NHS's buying power. In 2017/18 the NHS saved £291 million by reducing price variation and improving procurement processes. Our **Nationally Contracted**

Products Programme purchases specific everyday hospital products on behalf of the whole NHS. From the first 20 products in the programme, the NHS is on course to save £18 million a year. The **purchase price index and benchmarking tool** (PPIB) helps providers negotiate lower prices by showing them what others have paid for similar products. Since its launch for acute trusts in autumn 2016 it has been extended to cover all trusts, and now includes more than 2 million products.

Improving clinical workforce productivity

Clinical workforce productivity contributed significantly to this year's efficiency and productivity savings. Each of the following sub-programmes worked with up to 10 trusts over six months to identify unwarranted variations and opportunities for improvement:

- &doctors – increasing the percentage of consultants with signed-off job plans, which reached 98% in some areas
- &pharmacy – one trust electronically rosters almost 90% of its pharmacy staff, to provide the right service to the right patients at the right time
- &nursing – optimising staff use through e-rostering and developing systems to match available care hours to demand
- &allied health professionals (AHPs) – increasing job planning to increase awareness of patient contact capacity.

With our support and improved staff deployment, the trusts reported reduced reliance on agency and locum cover across all clinical workforce teams.

We provided **corporate services benchmarking** reports for 2016/17 to all trust finance directors. These enable trusts to compare their corporate services functions to national, sector and STP benchmarks. Based on data from 94% of trusts, the reports are an important tool for tackling unwarranted variation. We also issued guidance and support on cost improvement plans (CIPs). By March 2018, trust CIP delivery had exceeded the original annual target by £49.7 million and was on track to exceed the stretch target of £120 million.

Our **Getting It Right First Time** (GIRFT) programme – a partnership with the Royal National Orthopaedic Hospital NHS Trust, and led by frontline clinicians – aims to improve care quality by identifying and reducing unwarranted variations in service and practice. It now covers 35 specialties. GIRFT found that by implementing networks of specialist vascular units, the NHS could save 100 lives a year and between £7.6 million and £16 million, with a further £6.5 million procurement saving. GIRFT's report on general surgery found that if more acute hospitals introduced consultant-led surgical assessments, the NHS could reduce unnecessary emergency admissions for general surgery by 30%. This was one of 20 recommendations to improve patient outcomes that together could save £160 million a year.

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.

Throughout the year our national and regional teams supported STPs as they moved from planning to implementation, and began to play a more prominent role in managing system-wide efforts to improve services. STPs have built consensus about system-wide challenges and proposed solutions, often by building on and spreading work already underway, and by managing different aspects of cross-system work in a better planned and more collaborative way. We offered support on a comprehensive range of themes and in various forms, from providing detailed subject matter expertise or identifying peer support, to organising workshops. For example, we set up an STP clinical leads network and hosted two events at which clinicians, including senior nurses, from every STP met national and regional nursing and clinical leaders to build relationships and share ideas.

With NHS England we set up a development programme for the most mature STPs to evolve into **integrated care systems** (formerly known as accountable care systems). We also developed a new approach to overseeing and supporting integrated care systems based on setting system-wide goals, which will allow them more control of funding and performance with less involvement from national bodies. Currently 10 areas are designated as ’shadow’ integrated care systems. We envisage that all STPs will evolve over time into integrated care systems, creating more robust cross-organisational arrangements to tackle the systemic challenges facing the NHS and to improve health outcomes.

How one STP is integrating services

Frimley STP's North East Hampshire and Farnham vanguard brought together primary, community, acute, mental health and social care service teams. Closer working stimulated new services and initiatives that help people manage their own health and care more effectively and receive more care and support in the community rather than hospital. For example, GP practices and other services created 'urgent care hubs' offering same-day appointments with an interdisciplinary team of GPs, nurse practitioners, orthopaedic practitioners, paramedic practitioners and other professionals. GP practices are informed of all A&E attendances so they can direct appropriate information and advice to patients, helping them access care more locally in future. Bringing together resources has meant a better service for patients and a more efficient service that has reduced hospital admissions.

In some cases, local health systems are looking to support new care models through new types of contracts for services, new payment models and/or new organisational models for providers. With NHS England we designed a process for supporting and assuring the use of innovative arrangements of this kind: the **Integrated Support and Assurance Process**. During 2017/18, we used this process to engage with 10 systems planning new contracting arrangements, with further engagement planned for 2019/20.

We offer bespoke support to trusts considering or proceeding with **mergers**. In each case we help ensure clarity about the intended benefits of mergers. Where the Competition and Markets Authority (CMA) reviews a proposed transaction, we support the trusts in developing their case for the CMA, and we advise the CMA about the likely benefits for patients. We also work to save time and resources by identifying where a proposed merger is unlikely to adversely affect patients by a loss of competition and therefore does not need a CMA review.

In 2017/18 we worked on three high-profile mergers in Manchester, Birmingham and Derby that have since been cleared by the CMA. In each case we supported the trusts in building a compelling patient benefits case, then provided the CMA with a detailed assessment of how patients were likely to benefit from the mergers. The

CMA accepted our advice to determine that the benefits of the mergers outweighed any concerns about a loss of competition between the merging trusts.

We also provided extensive analysis for several other trusts to determine that their proposed mergers would be unlikely to reduce competition. This saved the merging trusts money and reduced demands on senior managers and clinicians by enabling the trusts to proceed to a merger without preparing a notification to the CMA.

When foundation trusts or NHS trusts decide to go ahead with **significant transactions**, such as mergers and acquisitions, we evaluate their proposals.

During 2017/18, we published revised transaction guidance[28] for NHS trusts and foundation trusts, which replaced previous transactions guidance issued by Monitor and the NHS Trust Development Authority (TDA). This updated guidance included:

- &a more streamlined process with greater focus on early engagement and identifying the 'red flags' at an early stage
- &an updated risk-based assurance approach
- &lessons learned from previous mergers and acquisitions
- &guidance on capital funding
- &an overview of our mergers and acquisitions support offer.

We assess all plans for mergers or acquisitions, whether or not they require a CMA review, to ensure that trusts engage thoroughly with clinicians, articulate clearly how they will deliver clinical improvements for patients, and have the capacity and capability to achieve the planned benefits.

Our support can help trusts decide whether a particular transaction makes sense in terms of care quality, finance, operational issues, choice and competition, and ultimately whether it works well for patients. Through our risk assurance processes, we aim to identify risks early and tailor a work programme proportionate to the risks in each case.

[28] *Transactions guidance – for trusts undertaking transactions, including mergers and acquisitions*. November 2017. https://improvement.nhs.uk/resources/supporting-nhs-providers-considering-transactions-and-mergers/

We assured several significant transactions during the year:

- & Central Manchester University Hospitals NHS Foundation Trust merged with University Hospital of South Manchester NHS Foundation Trust on 1 October 2017 to form Manchester University NHS Foundation Trust
- & Mersey Care NHS Foundation Trust acquired Liverpool Community Health NHS Trust on 1 April 2018
- & University Hospitals Birmingham NHS Foundation Trust acquired Heart of England NHS Foundation Trust on 1 April 2018.

We recognise that transactions are a significant undertaking, particularly during the planning stage, and trusts may need help with their development. The level of **merger and acquisition support** that we offer trusts will differ from transaction to transaction, and is based on the level of risk associated with the transaction and the urgency with which we and the local system believe the transaction needs to proceed. The support can include:

- & assisting with due diligence
- & support to develop strategic or business cases
- & stakeholder management and communication support
- & competition and advisory support
- & advice, tools and guidance
- & disseminating good practice.

Where a trust has identified that it needs a solution to achieve long-term sustainability, we will support it to do this. During 2017/18, we provided mergers and acquisition support to several providers involved in transactions, including:

- & Colchester Hospital University NHS Foundation Trust and The Ipswich Hospital NHS Trust, where we advised on the legal structure and the business case for the transaction

- Derby Teaching Hospitals NHS Foundation Trust and Burton Hospitals NHS Foundation Trust, by providing advisory support with specific reference to the patient benefits case to the CMA and the business case for the transaction
- The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust and Poole Hospital NHS Foundation Trust, with programme support, and advisory support to their patient benefits case to the CMA and the business case for the proposed merger
- Basildon and Thurrock University Hospitals NHS Foundation Trust, Southend University Hospital NHS Foundation Trust and Mid Essex Hospital Services NHS Trust, with advisory support to the potential merger
- Greater Manchester Health and Social Care Partnership, with which we worked to identify a preferred long-term solution for Pennine Acute Hospitals NHS Trust.

Workforce, leadership and improvement

We help providers take a strategic and multiprofessional approach to safe staffing. 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.

Health and care staff make up over 13% of all people in employment in the UK, while the NHS's wage bill is nearly two-thirds of its entire budget. Despite good work already done on workforce planning, significant shortages in some staff groups in parts of the country are placing pressure on services and those who work in them, as well as on organisations' finances. We therefore helped shape the consultation document, *Facing the facts, shaping the future*, published in December 2017 by HEE, which will lead to the first national health and care **workforce strategy** for 25 years. We raised awareness of the draft strategy and the consultation process among trusts and other stakeholders.

We launched a major **workforce retention programme** in July 2017, initially for 35 trusts with the highest nursing turnover rates. Another 40 joined in October 2017, followed by a final cohort of 40 in April 2018. We provide targeted, clinically led support for the trusts to develop retention improvement plans, which include increasing opportunities for flexible working and improving career pathways. With NHS Employers we ran retention masterclasses for nursing and HR directors. Many trusts are now developing internal nursing transfer schemes – important for providing development opportunities – which they heard about at a recent masterclass (see box below). We published practical examples of how trusts can retain clinical staff, based on interviews with nursing, medical and HR directors.[29]

We lead 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 staffing** decisions. We are developing resources based on NQB's

[29] *Retaining your clinical staff: a practical improvement resource*. December 2017. https://improvement.nhs.uk/resources/retaining-your-clinical-staff-practical-improvement-resource/

Retaining staff at UCLH

University College London Hospitals NHS Foundation Trust made it easier for staff to transfer internally between jobs, offering them opportunities that lead to them staying longer. It developed an internal transfer scheme that fast-tracked nurses for sideways moves, reducing the complexity and time taken to fill roles. The process can be completed within weeks and provided the trust with rich insight into its staff and issues with particular areas. The trust can also promote internal transfer to wards or departments with high vacancy rates.

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, stakeholders and academics with representatives from the Royal College of Nursing, Royal College of Midwives, Queen's Nursing Institute, AHPs' organisations and trade unions. Each is based on the best available evidence and takes a multidisciplinary approach. During the year we published five resources, covering:

- maternity services
- services for adult inpatients in acute care
- district nursing services
- learning disability services
- mental health services.

We produced guides to annual **job planning** for consultants and AHPs, to help trusts make efficient and effective use of their time as well as matching clinical resources to the organisation's priorities.

There is growing understanding of the causes of low morale, high attrition and burnout in the medical workforce and their impact on operational performance and patient outcomes. We highlighted examples of how trusts have tackled work pressure and rota gaps.[30] With the Faculty of Medical Leadership and Management and NHS Providers, we identified eight actions all trusts could take quickly to

[30] https://improvement.nhs.uk/resources/Engaging-supporting-and-valuing-doctors-in-training-tackling-work-pressure/

Emergency care workforce programme

We developed a plan with the Royal College of Emergency Medicine, NHS England and HEE to address shortages and ensure sustainable staffing in emergency departments. Commitments included training more emergency doctors, developing the roles of advanced nurse practitioners and associate physicians and reducing attrition rates among current staff.

improve **junior doctors' working environment** and morale.[31] Professor Jane Dacre, President of the Royal College of Physicians, said: "These straightforward and simple actions are incredibly useful for trainees and senior colleagues alike".

Our approach to leadership development and improvement focuses on three key areas:

- supporting effective provider and system leadership teams
- increasing the supply of diverse and skilled leaders
- building capacity and capability for learning and improvement.

The NHS needs strong and effective leaders who can plan strategically while taking the immediate needs of staff and patients into account. We have a responsibility to nurture talent and develop future NHS leaders. Our **aspiring chief executives programme**, run in collaboration with NHS Providers and the NHS Leadership Academy, is designed to prepare those with the potential to become chief executives in the next 12 to 24 months. Two cohorts graduated in 2017; 11 of the 27 participants so far have already gone on to become trust chief executives.

We want the next generation of medical directors to feel supported and have access to development, mentoring and peer support, so they are prepared and have the best chance of success in the role. Towards the end of 2017 we launched the **aspiring medical directors programme** with regional careers masterclasses. With the Faculty of Medical Leadership and Management we published two guides: one for aspiring medical directors,[32] based on advice from those already established in the role, and the other an induction guide for those newly

[31] *Eight high impact actions to improve the working environment for junior doctors*. October 2017. https://improvement.nhs.uk/resources/eight-high-impact-actions-to-improve-the-working-environment-for-junior-doctors/

[32] *The medical director's role: a guide for aspiring medical leaders*. June 2017. https://improvement.nhs.uk/resources/the-medical-directors-role-a-guide-for-aspiring-medical-leaders/

appointed.[33] We appointed Dr Sean O'Kelly, a former trust medical director, as our **Medical Director for Professional Leadership** to work alongside clinical leaders and improve the way we engage with clinicians.

Awards to support aspiring leaders

The first winners of our annual **Sir Peter Carr Award** were Dr Rachel Pilling, consultant ophthalmologist, and Daniel Wadsworth, Deputy Head of Access, both at Bradford Teaching Hospitals NHS Foundation Trust. The award – worth £30,000 for a clinician and manager partnership to invest in their professional development – is designed to help and inspire the NHS leaders of tomorrow to improve services for patients. The winning project encourages NHS staff to complete a small task today that might take 15 seconds but may save colleagues 30 minutes by avoiding further tasks down the line, reducing frustration, increasing job satisfaction and improving patient experience.

We funded four tailor-made, six-month **internships in a non-NHS industry** for women in senior roles in the NHS, as part of a programme initiated by our former chair, Ed Smith. These were designed to help them prepare for executive director roles, develop their leadership style and improve their effectiveness.

Our **aspiring executive nurse and deputy executive nurse programmes**, designed with London South Bank University, continued to recruit experienced senior nurses and midwives in divisional leadership roles with the potential to become executive or deputy executive nurses within 12 to 18 months. A number of participants in both programmes have been promoted to those roles already. Our well-established **Next Generation Programme** ran for the fifth time in 2018. It supports senior nurses who are about to apply for executive nurse posts and is run with the NHS Leadership Academy.

Our regional nurses and nursing directorate continue to support trust chief executives in the requirement process for executive nurses. Professional development continues for first-time executive nurses once they start their post:

[33] *The medical director induction guide: supporting recently appointed medical directors*. October 2017. https://improvement.nhs.uk/resources/the-medical-director-induction-guide/

they meet the regional nurses and have access to a national action learning set with peers. Acting nurse executives can also take part in an action learning programme.

As there is no current consensus on the most effective leadership structures for AHPs, we commissioned a survey on current senior **professional leadership for AHPs** in all trusts. The findings will shed light on how AHP leadership arrangements affect quality and productivity, and on the characteristics, key skills and attributes of effective AHP leaders.

It is vital that we and CQC have a shared view of what makes a trust well led. Together with CQC we developed the **well-led framework**, which CQC uses to assess a trust's leadership, management and governance, and which we use to support trusts in improving their leadership. The framework emphasises organisational culture, improvement and system working. During the year we updated guidance on the framework, detailing our expectation that trusts carry out regular in-depth developmental reviews of their leadership and governance to identify areas they need to work on.

Key fact

Our **Provider Leadership Committee** and subcommittees made 320 NHS trust chair and non-executive appointments. This included 115 new appointments, of which 14 were chairs, and 205 reappointments or extensions, of which 35 were chairs.

Our new **board member development programme**, which builds on the experience of our previous work, began in March 2018 with the first of 12 events for executive and non-executive board members to network and share learning.

We held 12 **regional chair networks** led by executive regional managing directors, where provider chairs share best practice and discuss current challenges and regional issues. We grew a **talent database** of board-ready people across the country interested in non-executive roles in the NHS. We can match these individuals' skills and experience to help NHS providers ensure they have the best possible field of candidates for these important roles. Our **NExT Director scheme** is designed to help find and support a diverse next generation of talented people to become non-executive directors in the NHS. NExT directors are offered a placement with a trust in their area for up to 12 months. Nearly 50 placements have been taken up by women and people from

black, Asian and minority ethnic communities across our London and Midlands and East regions, who all want to be considered for non-executive roles in the future.

Talent spotting with MEET

The Midlands and East Executive Talent (MEET) scheme is developing a pool of senior staff who can be appointed to executive-level interim posts in trusts across the region. Candidates from varied backgrounds and disciplines have opportunities to accelerate their progression into substantive leadership positions. They receive regular coaching and mentoring throughout their placement. Trusts benefit from ready talent that reduces their reliance on expensive interim staff, while the region enhances its leadership capability.

Our approach to improvement and leadership development is shaped by ***Developing people – improving care***, which we published with 12 other national health and care organisations in December 2016. We and our partners took stock one year on[34] and noted work taking place to ensure systems of compassion, inclusion and improvement are at the core of the health and care system. But much remains to be done, so we launched a supporting programme of activities, #improvingtogether.[35] We also published a guide for organisations seeking to build improvement capacity and capability. It outlines a 'dosing' approach to embedding quality improvement skills, developed by the Institute for Healthcare Improvement and already used by several NHS trusts.[36]

We launched Phase 2 of our **culture programme**, developed with the King's Fund and three pilot trusts. The programme is based on national and international evidence identifying elements and behaviour needed for high quality care cultures. It offers trusts practical support and resources. Helen Farrington, Deputy Group Director of Workforce and OD at Manchester University NHS Foundation Trust, said: "The culture programme has been a fascinating journey so far. It's helped us

[34] *Developing people – improving care together. One year on*. January 2018. https://improvement.nhs.uk/resources/developing-people-improving-care-one-year/
[35] https://twitter.com/hashtag/improvingtogether
[36] *Building capacity and capability for improvement: embedding quality improvement skills in NHS providers*. September 2017. https://improvement.nhs.uk/resources/embedding-quality-improvement-skills/

carve out time to talk about the ‘way we do things around here’, which we all agree is important but in the hectic day-to-day is not always prioritised”.

Key fact

The **Q community** now has more than 2,000 members, including professionals at the front line of health and social care, patient leaders, commissioners, managers, researchers, policymakers and others.

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. In 2017 it launched the Q Lab, which brings people together to work on a single challenge for nine to 12 months. Its first topic is to look at what it would take to make peer support available to everyone who would benefit from it.

Transformational Change through System Leadership (TCSL) is a five-month development programme for very senior leaders who are working on large-scale, system-wide change. It provides access to expert, professional support and peer groups from healthcare systems across the country, and helps teams to put theory into practice as they work through their transformational change. TCSL has supported more than 100 teams that are tackling a wide range of projects across systems – for example, achieving parity of mental health and physical health services within an STP.

Key fact

By March 2018 staff from more than 46% of all NHS organisations had attended our **demand and capacity training**. Set up in 2016 to help trusts better understand demand for their services and plan sufficient capacity, 2,150 people had attended the one-day course and 700 had used the online version.

Commissioned by NHS England, our Advancing Change and Transformation (ACT) Academy provided a themed TCSL cohort for teams responsible for transforming UEC services. A two-day **Insights into Transformational Change** programme provides an intensive introduction to the key concepts, tools and techniques required to lead transformational change across systems.

Key fact

The increasing number of **QSIR** associates helps spread quality and service improvement skills rapidly across health and care organisations. By spring 2018, QSIR programmes covered:

- 20% of STPs
- 18% of all NHS providers
- 12% of all providers and CCGs combined.

First aid for mental health

With Mental Health First Aid (MHFA) we trained 24 staff nominated by their trusts to become adult MHFA instructors. The course is internationally recognised, and designed to teach people how to spot the symptoms of mental ill health and provide help on a first aid basis.

QSIR (Quality, Service Improvement and Redesign) programmes provide clinical and non-clinical staff with the tools and knowledge to design and implement more efficient, patient-centred services. **QSIR College** develops candidates to become associate members of the QSIR teaching faculty, enabling them to deliver QSIR programmes. This enables health systems to develop quality and efficiency improvement capability and build a sustainable local skills base from which to tackle the challenges identified in their sustainability and transformation plan. By May 2018, there were over 100 QSIR associates skilling up others to improve services throughout their local systems.

In spring 2018 ACT Academy ran a QSIR programme for finance professionals in partnership with the Healthcare Financial Management Association. The winners of the Sir Peter Carr Award (see page 57) took up their places on a QSIR practitioner programme, which was included in the awards package.

We expect every trust board to implement a recognised continuous improvement approach by 2020. One such approach is Lean – a quality management system derived from Japanese car manufacturing. Many health systems already use it, and a growing number of trusts have asked us for help in developing their own Lean expertise. Our new three-year **Lean programme** – open to all trusts – will support organisations to introduce Lean techniques. We have recruited a small team of in-house Lean experts, led by a director of Lean transformation, to deliver the programme, which initially will work with seven trusts from July 2018.

Using the Hub to improve

We encourage trusts to submit improvement tools, guides and shared learning to the Improvement Hub on our website. The top five most viewed resources in 2017 were:

- Helping to end PJparalysis (3,926 views)
- Creating driver diagrams for improvement projects (3,539)
- Falls improvement collaborative: your stories (2,460)
- Sepsis: 60 minutes to save a life (2,246)
- Our #endPJparalysis journey (2,070).

With five NHS trusts in 2015 we 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. After visiting one of the trusts, Surrey and Sussex Healthcare NHS Trust (SASH), in February 2018, Secretary of State for Health and Social Care Jeremy Hunt commented: "It's clear to see how much progress staff at SASH are making to improve safety and patient care through their renowned partnership with Virginia Mason. They have fantastic values – but what sets them apart is their measurement of these values, which allows patients to see for themselves how the attitudes and ethos of staff directly improves the care they receive".

Key fact

Our **social media** campaign in support of Inspiring Improvement recorded 381,900 Twitter views in the week the event took place.

More than 300 trust staff attended our second annual **Inspiring Improvement** event in July 2017 to share their experiences of improving patient care. We announced plans to launch the first national **improvement directors' network** for trust staff leading improvement in their organisations. It began in the autumn and meets four times a year in London and Leeds.

Oversight, regulation and support

Our oversight, regulation and support enable the delivery of our 2020 objectives, including helping more providers achieve CQC 'good' or 'outstanding' ratings, reducing the number of trusts in special measures and improving financial and operational performance.

Regulating providers

Our regional teams monitor providers' performance and take action to support them where their performance falls below the required standard. We identify problems early and act quickly to minimise the impact on patients.

We undertake investigations to identify the causes of financial, operational, quality and/or governance problems at trusts and to consider the support or intervention necessary to address them. Investigations will also consider whether there is evidence that the trust has not complied with the terms of the NHS provider licence. We may in particular launch an investigation when an NHS trust or foundation trust triggers a concern under the Single Oversight Framework. As part of an investigation, solutions are identified, which could involve mandated support and formal regulatory action or targeted support.

During 2017/18 we opened 14 investigations into NHS trusts and foundation trusts, and three were already open at the start of the year. We also closed 14 investigations within the year, with three trusts remaining under investigation at 31 March 2018.

This relates to investigations carried out or overseen by the central investigations team, and does not include investigations concerning pricing enforcement matters or potential breaches of the NHS regulations on procurement, patient choice and competition.

Trusts in special measures

Where CQC identifies serious failures in the quality of care and is concerned that a trust's management cannot make the necessary improvements without support, the Chief Inspector of Hospitals may recommend 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 a 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 special measures for finance reasons to provide a rapid recovery plan. To exit special measures for finance reasons, a trust's board must agree with us a recovery plan and details of how it will be achieved.

For trusts in special measures for finance reasons, we appoint a financial improvement director along with a dedicated financial recovery team to support and hold the trust to account for improving financial governance and financial control, improving productivity and efficiency, and developing and delivering robust financial recovery plans – while maintaining or improving quality.

At 31 March 2018, 20 trusts were in special measures: six for finance reasons only, eight for quality reasons only and six for both reasons. Tables 3 and 4 refer to NHS trusts only.

During 2017/18, four trusts entered special measures for quality reasons, and three exited (another exited in May 2018). Three trusts entered special measures for finance reasons, and one exited. At 31 March 2018, 14 trusts were in special measures for quality reasons. Twelve trusts were in special measures for finance reasons, which delivered an improved 2017/18 overall outturn of £118 million.

Table 3: NHS trusts in special measures for quality reasons in the year to 31 March 2018

Trust	Date entering special measures	Reason for entering special measures	Date of exiting special measures	Reason for remaining in or exiting special measures
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.	January 2018	Recommended by Chief Inspector of Hospitals to exit special measures after an inspection report published in January 2018.
The Princess Alexandra Hospital NHS Trust	October 2016	CQC inspection found concerns about safety, responsiveness and leadership.	March 2018	Recommended by Chief Inspector of Hospitals to exit special measures after an inspection report published in March 2018.
Barts Health NHS Trust	March 2015	CQC inspection found concerns about leadership, staff engagement and patient safety.	N/A	Recommended by Chief Inspector of Hospitals to remain in special measures after the CQC follow-up inspection and report published in November 2017.
East Sussex Healthcare NHS Trust	October 2015	CQC inspection found concerns about medicines management, learning from incidents, staff engagement and culture.	N/A	Recommended by Chief Inspector of Hospitals to remain in special measures after the CQC inspection report published in January 2017.
London Ambulance Service NHS Trust	November 2015	CQC inspection found concerns about staffing, medicines management and governance.	May 2018	Recommended by Chief Inspector of Hospitals to exit special measures after an inspection report published in May 2018

Walsall Healthcare NHS Trust	January 2016	CQC inspection found concerns about maternity staffing, the emergency department and trust governance.	N/A	Recommended by Chief Inspector of Hospitals to remain in special measures after the CQC inspection report published in December 2017.
Worcestershire Acute Hospitals NHS Trust	December 2015	CQC inspection found concerns about the safety of the emergency department, maternity, surgery, and the children and young people's service.	N/A	Recommended by Chief Inspector of Hospitals to remain in special measures after the CQC inspection report published in January 2018.
Brighton and Sussex University Hospitals NHS Trust	August 2016	CQC inspection found concerns about culture, governance and leadership.	N/A	The trust has not yet received a follow-up inspection.
United Lincolnshire Hospitals NHS Trust	April 2017	CQC inspection found that improvements had not been sustained and there had been an overall deterioration in quality and patient safety.	N/A	After exiting special measures in July 2014, the trust re-entered in April 2017 and has not yet received a follow-up inspection.
Isle of Wight NHS Trust	April 2017	CQC inspection raised concerns about safety of mental health provision, staffing, governance and leadership.	N/A	The trust has not yet received a follow-up inspection.
Royal Cornwall Hospitals NHS Trust	October 2017	CQC inspection found concerns about patient safety, maternity, governance and leadership.	N/A	The trust has not yet received a follow-up inspection.

Note: trusts highlighted in blue exited special measures.

Table 4: NHS trusts in special measures for finance reasons in the year to 31 March 2018

Trust	Date entering financial special measures	Reason for entering financial special measures	Date of exiting financial special measures	Reason for remaining in or exiting financial special measures
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.	July 2017	The trust 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	The trust has not yet met all the exit criteria.

Trust	Date entering financial special measures	Reason for entering financial special measures	Date of exiting financial special measures	Reason for remaining in or exiting financial special measures
United Lincolnshire Hospitals NHS Trust	September 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	The trust has not yet met all the exit criteria.
Barking, Havering and Redbridge University Hospitals NHS Trust	February 2018	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: trust highlighted in blue exited special measures.

Implementing management contracts at challenged providers

We implemented management contracts for providers:

- &we brokered an agreement for South Staffordshire and Shropshire Healthcare NHS Foundation Trust to provide management support to Staffordshire and Stoke on Trent Partnership NHS Trust to help with its quality and financial challenges

- &we helped find a long-term solution for Liverpool Community Health NHS Trust, which included helping to identify a preferred bidder to take on the services and implementing a management contract in advance of the proposed acquisition to provide ongoing support to the organisation.

Support for systems and providers

South West London acute configuration support

The configuration of acute services in South West London has been a longstanding problem. In support of the South West London STP, we developed agreed quality standards for core acute services and assessed the ability of each of the four acute trusts to meet those standards. On the basis of that work, the STP was able to confirm its broad approach to achieving clinically and financially sustainable acute services and agree a clear work programme.

Northamptonshire Sustainability and Transformation Partnership

Northamptonshire STP was placed in the bottom category of STPs after a national assessment process. We agreed to provide longer-term behavioural and strategic support as well as shorter-term support. The STP agreed principles, values and behaviours, and a supporting implementation plan. Work is progressing to agree quality standards for core acute services and a strategic vision for service development, together with changes in specific service areas.

Mid Cheshire and East Cheshire systems

We reviewed the Mid Cheshire and East Cheshire systems and their plans for future development. We developed with them a way forward that built on their separate plans to support clinical and financial sustainability. We did this by integrating the two separate sub-systems into a single system. We then helped them formalise local agreement, set up new governance arrangements and develop clear workstream plans before handing over to a new programme board to oversee implementation.

The Cheshire and Merseyside STP, key external stakeholders and national partners have endorsed this approach.

Southern Health NHS Foundation Trust

We supported Southern Health NHS Foundation Trust as it developed its clinical strategy for mental health and learning disability services. We also helped it identify the optimal organisational form to deliver the strategy, to ensure that service users can access high quality, safe, personal centred care. The trust is now working with local commissioners and the STP to take the work forward.

Regulating independent providers of NHS services

Since April 2014, all independent providers of NHS services have had to hold a provider licence unless exempt under DHSC regulations. The licence allows us to help commissioners protect essential local services if an independent provider fails. At 31 March 2018, 113 independent providers held licences, of which one will be an NHS-controlled provider from 1 April 2018.

In February 2018 we published our approach to oversight of NHS-controlled providers from 1 April 2018.[37]

With NHS England we continued to ensure commissioners consider which of their services would be at risk if a provider failed, and therefore should be designated as commissioner requested services (CRS). At 31 March 2018, there were 25 independent providers of CRS in our risk assessment and financial oversight regime. In the year to 31 March 2018 we took enforcement action against one independent provider of CRS and published enforcement undertakings which remain in place at 31 March 2018

[37] https://improvement.nhs.uk/resources/oversight-nhs-controlled-providers/

Developing NHS Improvement and supporting our business

We continue to develop our core capabilities and combine our team skills and expertise to build a cohesive and effective organisation that provides the NHS with strategic leadership and practical support.

As commissioners and providers work ever more closely across local health systems, national bodies need to be sure they offer cohesive leadership and provide local health systems with joined-up oversight and support. **Joint working between NHS Improvement and NHS England** is now taking place at all levels, including the appointment of a number of joint nursing posts and, most recently, two joint regional directors in the South East and South West who exercise leadership on behalf of both organisations. The joint working initiative helped the creation of a single UEC programme under a joint national director and the division of the country into seven UEC patches.

In January 2018, we announced that David Roberts, NHS England's Vice Chair, had been invited to attend our Board as an associate (non-voting) non-executive director. Similarly, Richard Douglas, Non-Executive Director and Chair of our Audit and Risk Assurance Committee, was invited to attend NHS England's Board as an associate (non-voting) non-executive director in February 2018.

In March 2018, we announced jointly with NHS England that we planned to work in a more integrated way to deliver better outcomes for patients, while improving our performance and efficiency. We will concentrate on building an effective model of joint working between our organisations. We will also work in a much more streamlined way to set consistent expectations of providers and commissioners, and deliver forms of support and oversight that best help local systems to meet shared goals.

We will focus on working with staff and partners on the details of how the new joint working will occur, and we will assess the impact on both our organisations to mitigate any risk. Making these improvements now will help us deliver the final stages of the Five Year Forward View, as well as continue to meet the objectives the government has set us.

In a separate project, but one that we will align with our work with NHS England, we have begun to reshape our **operating model**. We held workshops with staff and the executive team, and conducted many interviews with trust chairs, chief executives and other stakeholders.

In addition, **Dr Bill Kirkup's independent review**[38] of failings in care at Liverpool Community Health NHS Trust contained many findings relevant to NHS Improvement. We accepted all his recommendations, and our response to them represents a significant expansion of our role in supporting NHS leaders and an evolution of the way we work with other national bodies to oversee the provider sector. We are determined that our action will have lasting impact and help avoid a similar situation ever occurring again.

Key fact

Our website, launched in April 2016, recorded its millionth visit in June 2017.

During the year we finalised our **organisational values** after widespread consultation with staff. These are designed to underpin everything we do, and we try to demonstrate them in the way we behave towards each other, our partners and providers. The values are:

- collaboration and trust – working together in an open and accountable way
- respect and innovation – delivering better outcomes by listening to different perspectives
- courage and compassion – challenging and supporting ourselves and each other.

Our **business services transformation programme** worked with staff to understand our need to connect, co-ordinate, collaborate and share knowledge more effectively across the organisation and with the sector. We used staff feedback to define requirements for a new system to help us work more effectively. This system will go live in summer 2018.

[38] https://improvement.nhs.uk/news-alerts/independent-review-liverpool-community-health-nhs-trust-published/

Learning from complaints

When we make mistakes we are committed to being open and honest, and learning from them. This year we received nine complaints about NHS Improvement, two of which were resolved informally and seven of which we investigated.

Two related to our pilot whistleblower support scheme. They provided learning for us in how we engage with relevant stakeholder groups and respond to individual inquiries.

One related to our handling of a non-executive appointment at an NHS trust, which we upheld. This resulted in improvements to:

- the information we provide to applicants
- our internal process for decision-making
- how feedback is provided to unsuccessful applicants.

We also upheld a complaint about the time we took to provide a member of the public with a hard copy report in response to a request for a reasonable adjustment. This has resulted in tightening up our timescales for such matters.

We also received two complaints about decisions not to take action at trusts as a result of information provided to us by third parties. The main substance of these was not upheld. One complaint was not specifically relevant to NHS Improvement.

Business plan for 2017/18

Most (86%) of our business plan actions for 2017/18 were considered on track or successfully delivered by the end of the year. A further 10% were considered recoverable within the first quarter of 2018/19, with 3% delayed into the second quarter and a handful of projects discontinued because of changing priorities. Over the year, the main cause of project and business-as-usual delays shifted from internal resource constraints to sector or government dependencies. This reflects both our success in recruiting to vacant positions and the increased emphasis on closer working with other public sector bodies.

Sustainability report

We 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 the 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: Indicators of NHS Improvement's greenhouse gas emissions

		2017/18	2016/17
Non-financial indicators (tonne)	Total emissions for Scope 2 (Energy Indirect) Emissions	N/A	N/A
	Total gross emissions for Scope 3 Official Business Travel Emissions – Monitor	151	93*
	Total gross emissions for Scope 3 Official Business Travel Emissions – NHS TDA	336	182*
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	632	379
	Expenditure on official business travel – NHS TDA	3,569	2,436

* 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 to develop the national workstreams. The increase for Monitor relates to an increase in regional travel reflecting our shift 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 in the Greening Government Commitments and through a close association with DHSC. The main areas of environmental impact are building use (energy and water), transport and travel, waste and procurement.

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

As at 31 March 2018, NHS TDA had office space in 13 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 13 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.

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

We will continue to review NHS Improvement's estate footprint as the organisation's activity evolves.

Monitor and NHS TDA are committed to using their resources efficiently, economically and effectively, avoiding waste and reducing carbon dioxide 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.

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 annual accounts.

NHS TDA's net expenditure for the year was £111.5 million (2016/17: £89.2 million). The main categories of spend are shown in Table 6.

Table 6: Main categories of revenue and expenditure.

	2017/18 £m	2016/17 £m	Reference to accounts
Operating revenue	(18.7)	(8.1)	Note 4
Staff	70.5	43.1	Note 5
Purchase of goods and services	20.4	15.1	Note 6
Depreciation and impairment charges	0.2	0.2	Note 6
Provisions expense	(0.1)	-	Note 6
Other operating expenditure	39.2	38.9	Note 6
Total	**111.5**	**89.2**	

The increase in operating revenue is mainly due income to support the Getting It Right First Time programme and an increase in income for the Emergency Care Improvement Programme and elective care intensive support.

The largest area of spend is staff costs, representing 63% of net expenditure in 2017/18 (2016/17: 48%). The increase in staff costs is mainly due to the recruitment of staff to develop national workstreams supporting improvement, productivity and efficiency in NHS provider organisations.

Purchase of goods and services spend relates to premises (£2.9 million), business expenses (£9.2 million) and professional fees (£8.3 million). More detail can be found in Note 6 to the accounts.

Other operating expenditure of £39.2 million (2016/17: £38.9 million) includes expenditure provided to NHS trusts and partners.

Parliamentary funding received was £115.3 million revenue and £1.6 million capital.

Net liabilities at 31 March 2018 were £19.4 million (31 March 2017: net liabilities £24.9 million). The decrease in net liability is mainly due to the increase in current assets relating to revenue due to NHS TDA but not received before the year-end and an increase in the cash and cash equivalents balance.

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's 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

	2017/18		2016/17	
	Number	**£000**	**Number**	**£000**
Non-NHS payables				
Total non-NHS trade invoices paid in the year	3,417	19,340	2,573	12,684
Total non-NHS trade invoices paid within target	3,289	18,707	2,520	12,390
% of non-NHS trade invoices paid within target	**96**	**97**	**98**	**98**
NHS payables				
Total NHS trade invoices paid in the year	1,354	45,907	1,210	35,104
Total NHS trade invoices paid within target	1,239	43,650	1,176	34,059
% of NHS trade invoices paid within target	**92**	**95**	**97**	**97**

More detail of how money was spent in 2017/18 can be found in the main accounts.

For a review of our activities and performance against business objectives during the year, see pages 3 to 75. Our strategy for 2016 to 2020 is published on our website[39] 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 2017/18 is set out on page 73. Our business plan for 2017/18 is published on our website[40] and focuses on our role in helping the NHS address its two main priorities – short-term operational improvement and longer-term sustainability.

Disclosure to the auditors

So far as the Accounting Officer and the Executive Directors are aware, there is no relevant audit information of which NHS TDA auditors are unaware. The Accounting Officer and Board have taken all steps necessary to make themselves aware of any relevant audit information and to establish that NHS TDA auditors are aware of this information.

Ian Dalton
Chief Executive
3 July 2018

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

Accountability report

The accountability report sets out how NHS Improvement met key accountability requirements to Parliament in 2017/18. It comprises the following reports:

- **Corporate governance report**

  This report is made up of the Director's report, the Accounting Officer's Responsibilities and the Governance statement. Together they explain how the Board operates and how NHS Improvement's governance framework contributes to achievement of NHS Improvement's objectives.
- **Remuneration and staff report**

  This report outlines the remuneration policies for Board Directors and includes details of what Directors and senior management have been paid during the period.
- **Parliamentary accountability and audit report**

Directors' report

The Board

NHS Improvement's Board consists of a chair and at least four non-executive directors appointed by the Secretary of State for Health and Social Care. 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 and Social Care'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.

Directors who served on NHS Improvement's Board between 1 April 2017 and 31 March 2018 are listed in Table 8.

Table 8: Directors on NHS Improvement's Board between 1 April 2017 and 31 March 2018

Name	Role
Baroness Dido Harding[1]	Chair
Ed Smith[2]	Chair
Professor Dame Glynis Breakwell	Senior Independent Director
Lord Patrick Carter	Non-Executive Director
Laura Carstensen[3]	Non-Executive Director
Lord Ara Darzi	Non-Executive Director
Richard Douglas[4]	Non-Executive Director
Sarah Harkness	Non-Executive Director
Sigurd Reinton	Non-Executive Director
Caroline Thompson[5]	Non-Executive Director
David Roberts[6]	Associate (non-voting) Non-Executive Director
Ian Dalton[7]	Chief Executive
Jim Mackey[8]	Chief Executive
Bob Alexander[9]	Executive Director of Resources/Deputy Chief Executive
Stephen Hay	Executive Director of Regulation/Deputy Chief Executive
Kathy McLean[10]	Executive Medical Director and Chief Operating Officer
Ruth May	Executive Director of Nursing

[1] Baroness Dido Harding was appointed Chair on 30 October 2017.
[2] Ed Smith stepped down as Chair on 20 July 2017.
[3] Laura Carstensen stepped down on 30 June 2017.
[4] Richard Douglas led the Board as the Interim Chair from 20 July to 29 October 2017.
[5] Caroline Thompson stepped down on 31 August 2017.
[6] David Roberts was appointed Associate (non-voting) Non-Executive Director on 5 March 2018. David is the Vice-Chairman of NHS England.
[7] Ian Dalton was appointed Chief Executive on 4 December 2017.
[8] Jim Mackey stepped down as Chief Executive on 3 December 2017.
[9] Bob Alexander stepped down from the Board on 31 January 2018. From October 2017 until 31 January 2018, he worked on a two day a week basis at NHS Improvement.
[10] Kathy McLean was appointed Interim Chief Operating Officer in October 2017, a role she has now permanently taken on alongside her role as Executive Medical Director.

Biographical details of NHS Improvement's Board members in post as at 31 March 2018.

Baroness Dido Harding
Chair

Baroness Harding is currently a non-executive director on the Bank of England's Court of Directors and Chair of the Bank's Remuneration Committee. She sits in the House of Lords as a Conservative peer and is a member of the Economic Affairs Select Committee. She is a trustee of Doteveryone and a member of the UK National Holocaust Foundation Board. She was Chief Executive of TalkTalk Telecom Group plc from 2010 to May 2017. She has held a number of senior roles both in the UK and international businesses.

Appointed to the Board: 30 October 2017

Term ending: 30 October 2021

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.

Appointed to the Board: 1 April 2016

Term ending: 31 March 2020

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.

Appointed to the Board: 1 December 2016 to

Term ending: 10 December 2017, extended by Secretary of State for Health and Social Care to 30 June 2018.

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.

Appointed to the Board: 1 August 2015

Term ending: 31 July 2018

Richard Douglas CB
Non-Executive Director

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

Appointed to the Board: 1 April 2016

Term ending: 31 March 2020

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.

Appointed to the Board: 26 September 2012

Term ending: 25 September 2016, extended by the Secretary of State for Health and Social Care to 25 September 2018

David Roberts
Associate Non-Executive Director (non-voting member)

David Roberts is the Chairman of Nationwide Building Society, Chairman of Beazley plc and the Vice Chair of NHS England. David was appointed to the Board in March 2018 as a non-voting Board member. David has many years of experience on board and executive level in retail and commercial banking, both in the UK and internationally. Previous roles include directorships on the board of Lloyds Banking Group, BAA plc, Absa Group SA and Bawag PSK AG.

Appointed to the Board: 5 March 2018

Term ending: 4 March 2020

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, now Croydon Health Services 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.

Appointed to the Board: 1 January 2012

Term ending: 31 December 2015, extended by Secretary of State for Health and Social Care to 31 December 2017 and then to 30 June 2018.

Ian Dalton CBE
Chief Executive
Ian Dalton became Chief Executive of NHS Improvement on 4 December 2017. He has an exceptional track record with over 30 years' experience in the NHS and the wider health sector. He joined us from Imperial College Healthcare NHS Trust where he was Chief Executive Officer. Ian has held a number of senior provider, regional and national NHS roles throughout his career, including Chief Operating Officer and Deputy Chief Operating Officer at NHS England and Chief Executive of NHS North of England, the North East Strategic Health Authority and two acute hospital trusts.
Appointed to the Board: 4 December 2017

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.
Appointed to the Board: 1 April 2016 but a member of Monitor's Board since November 2012

Ruth May
Executive Director of Nursing
Ruth May was Nursing Director at Monitor before being appointed Executive Director of Nursing at 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.
Appointed to the Board: 1 April 2016.

Dr Kathy McLean
Executive Medical Director/Chief Operating Officer
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.
Appointed to the Board: 1 April 2016 but a member of the TDA's Board from 2012

Biographical details of NHS Improvement's Executive Committee members in post as at 31 March 2018

Details of Executive Board Directors are included in the Board biography section above. Other members of the Executive Committee include:

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 DHSC. 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 DHSC. Before that, he was Director of the NHS Group at the DHSC, 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 DHSC's work to champion improvements in health and healthcare for people with learning disabilities.

Anne Eden
Executive Regional Managing Director (South East)

Anne Eden is Executive Regional Managing Director of the South East region, a joint role established under new integrated working proposals between NHS Improvement and NHS England. This is in addition to her responsibilities as Executive Regional Managing Director (South), a role she assumed in October 2017 having been Director of Delivery and Development (South) at NHS TDA. She has more than 30 years' experience in the NHS, including in acute and teaching hospitals, mental health, community and specialist services.

Jennifer Howells
Executive Regional Managing Director (South West)

Jennifer Howells is the Executive Regional Managing Director of the South West Region, a joint role established under new integrated working proposals between NHS Improvement and NHS England in October 2017. This is in addition to her existing responsibilities as Regional Director, South West region for NHS England. Jennifer was the Regional Director of the South West region for NHS England and has many years' experience as a strategic leader in the NHS and in the private sector, in the UK and US, in mergers and acquisitions and assurance.

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 DHSC. He previously had a varied career in the Civil Service, including Director of Strategy and Principal Private Secretary to three different Secretaries of States.

Elizabeth O'Mahony
Chief Financial Officer
Elizabeth has spent most of her career in NHS finance, working across a number of provider organisations. Her portfolio of financial experience is wide-ranging and includes financial turnaround, provider development and mergers and acquisitions. She has been actively involved in the development of national financial policy for a number of years. Elizabeth's previous role was Director of Finance of the NHS TDA, having previously been Director of Finance for the South West Strategic Health Authority.

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 a foundation of nurse, health visitor and midwife posts, she has 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

Register of interests

NHS Improvement maintains a register of interests to ensure potential conflicts of interest can be identified and addressed before Board and Committee discussions. Where potential conflicts arise they are recorded in the Board or Committee minutes along with any appropriate action to address them. A copy of the register of interest is available on NHS Improvement's website.

Directors' indemnities

NHS Improvement has appropriate directors' and officers' liability insurance in place for legal action against, among others, its Executive and independent Non-Executive Directors.

Board committees

The Board is supported by a number of Board committees which form part of NHS Improvement's formal governance structure. Each committee is responsible for reviewing and overseeing activities within its terms of reference, which are reviewed regularly during the year by the Head of Governance and by the Board as appropriate.

Since 1 April 2017, the governance arrangements have been further strengthened by the establishment of a Quality Board Committee. Together with NHS England a Join Finance Advisory Group has been established with common membership of both organisations. The Board delegates the day-to-day running of the organisation to the Chief Executive, who is the organisation's Accounting Officer. Further information on the Chief Executive's governance structure is provided on pages 87 to 97.

During the year a Special Nominations Committee was created to oversee the process of appointing the new Chief Executive. Further details are provided on page 110.

Table 9: Board committees

Board				
↓	↓	↓	↓	↓
Audit and Risk Assurance Committee	**Nominations and Remuneration Committee**	**Provider Leadership Committee**	**Quality Committee**	**Technology and Data Assurance Committee**
Chair				
Richard Douglas	Professor Dame Glynis Breakwell	Sarah Harkness	Sarah Harkness	Sigurd Reinton
Composition				
Non-executive directors	Non-executive directors	Non-executive directors, two senior executives	Non-executive directors, a number of senior executives and other senior managers	Non-executive director, three independent members
Role of the Committee				
• Reviews NHS Improvement's internal controls, risk management and governance processes • Reviews and monitors the integrity of financial statements	• Develops policy on executive remuneration • Fixes the remuneration packages of senior managers • Leads the NHS Improvement process for Board appointments	• Appoints chairs and non-executive directors of NHS trusts and appoint charity trustees • Suspends and terminates appointments • Approves pay and other remuneration requests for designated staff in NHS trusts	• Discusses provider sector quality issues requiring national decision-making and action • Considers reports from regions and other groups based on a range of outputs • Reviews feedback on the effectiveness of NHS Improvement quality initiative	• Provides independent assurance on information strategy and associated project proposals
Joint Finance Advisory Group (NHS Improvement and NHS England)	Chair: Non-executive director of either NHS Improvement or NHS England	The group has no executive responsibility and has been formed to ensure that both organisations are working from a common understanding of the financial targets and financial performance of the entire health system.		
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.		

Audit and Risk Assurance Committee

Membership:

Richard Douglas (Chair)
Sarah Harkness
Sigurd Reinton [1]

Previous member during the year:
Laura Carstensen[2]

Attendees:

- Chief Financial Officer
- Executive Director of Resources/ Deputy Chief Executive
- Head of Internal Audit
- External auditor (Comptroller and Auditor General; National Audit Office (NAO) on his behalf)
- Corporate Risk Manager
- Chief Financial Accountants
- Head of Sector Financial Accounting

The Committee's chair, Richard Douglas, has significant financial experience.

The Head of Governance or their nominee acts as secretary to the committee.

The Committee met five times between 1 April 2017 and 31 March 2018.

All non-executive directors have access to the minutes of all the committee's meetings.

Between 1 April 2017 and 31 March 2018 there were no matters where the Audit and Risk Assurance Committee considered it necessary to give formal advice to the Chief Executive as the Accounting Officer of NHS Improvement.

Key duties:

Risk management

- reviewing NHS Improvement's risk profile and management of the organisations risks

Internal control

- reviewing the effectiveness of NHS Improvement's internal control systems

Financial reporting

- monitor the integrity of the internal and external financial statements of Monitor and NHS TDA
- reviewing significant reporting issues and judgements

Internal audit

- appointing and reviewing the effectiveness of the internal auditor service in the context of NHS Improvement's internal control systems
- agreeing the internal audit plan and reviewing internal audit reports

External auditor

- overseeing the relationship with the external auditors, the Comptroller and Auditor General.
- considering all relevant reports from the Comptroller and Auditor General, including reports on NHS Improvement's accounts, achievement of value for money and the responses to any management letters issued by them.

Key matters considered during the year:

- &approval of Monitor's, NHS TDA's and NHS foundation trusts' 2016/17 annual report and accounts
- &approval of changes to the organisation's risk management framework and the strategic and high level operational risk register
- &13 deep-dive risk review reports, including two follow-up reports
- &approval of the 2017/18 annual internal audit plan
- review of individual internal audit reports and monitoring of actions from the internal audits
- &the external auditors, NAO, audit planning reports in respect of the audit of Monitor's and NHS TDA's financial statements for 2017/18, and review of findings for the financial statements for 2016/17
- &the Head of Internal Audit Opinion for 2016/17
- &review and approval of the provision of internal audit services for 2018/19.

[1] Sigurd Reinton joined the Committee in May 2017.
[2] Laura Carstensen stepped down from the Board on 30 June 2017.

Nominations and Remuneration Committee

Membership:

Professor Dame Glynis Breakwell (Chair)
Lord Carter[1]
Sarah Harkness[2]

Previous members during the year:
Sigurd Reinton[3]
Caroline Thomson[4]

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 three times between 1 April 2017 and 31 March 2018 and considered 41 items by correspondence.

Key duties:
- 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 NHS Improvement's process for Board appointments.

Key matters considered during the year:
- updates on harmonisation of Monitor and NHS TDA terms and conditions
- review of Committee terms and reference
- requests for recognition of continuous service
- review of individual pay cases and recruitment of key staff.

[1] Lord Carter joined the Committee in September 2017.
[2] Sarah Harkness joined the Committee in May 2017.
[3] Sigurd Reinton stepped down from the Committee in May 2017.
[4] Caroline Thomson stepped down from the Board on 31 August 2017.

Provider Leadership Committee

Membership:

Sarah Harkness (Chair)
Adam Sewell-Jones[1]
Steve Russell[2]

Previous members during the year:
Caroline Thomson[3]
Laura Carstensen[4]
Bob Alexander[5]
Helen Buckingham[6]

Attendees:
- Head of Trust Resourcing
- Head of Non-executive Development

The Head of Governance acts as secretary to the committee.

The committee met three times between 1 April 2017 and 31 March 2018 and considered 78 items by correspondence.

Key duties:
- exercises NHS TDA's powers, as delegated by the Secretary of State for Health and Social Care, to appoint chairs and non-executive directors of NHS trusts and appoint charity trustees.
- suspends and terminates those appointments.
- approves pay and other remuneration requests for designated staff in NHS trusts.

Key matters considered during the year:
- scrutiny of individual chair appointments
- a draft report on NHS provider board membership and diversity
- a proposed approach to improving board diversity
- a proposal for an aspirant chair programme
- update on remuneration of NHS trust and Non-Executive Directors, including remuneration for dual appointments
- due diligence in Non-Executive Director appointment process
- proposed changes to the recruitment process for NHS trust Non-Executive Directors
- update on the development of a very senior manager pay framework
- quarterly reports on appointment and remuneration activity.

[1] Adam Sewell-Jones joined the Committee in May 2017.
[2] Steve Russell, the Executive Regional Managing Director (London), is a member of the Committee in the absence of Helen Buckingham who is on secondment.
3 Caroline Thomson chaired the Committee until she stepped down from the Board on 31 August 2017.
[5] Bob Alexander stepped down from the Board on 31 January 2018.
[4] Laura Carstensen stepped down from the Board on 30 June 2017.
[6] Helen Buckingham is on secondment and Steve Russell, the Executive Regional Managing Director (London), is a member of the Committee in her absence.

Technology and Data Assurance Committee

Membership:

Sigurd Reinton (Chair)
Richard Douglas
Ted Woodhouse (independent member)
Jora Gill (independent member)[1]
Simon Stone (independent member)[2]

Previous members during the year
Caroline Thompson[3]
Paul Willer (independent member)[4]

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 between 1 April 2017 and 31 March 2018.

Key duties:

- oversees the programme of work to deliver NHS Improvement's information and IT strategy; 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 NHS Improvement's information and IT strategy and assure the Board that it is on track and meeting its objectives.

Key matters considered during the year:

- &overview of 2017/18 plan and Business Transformation Programme
- &oversight and co-ordination of NHS-wide digital agenda
- updates on cybersecurity, including implementing review recommendations and update on new threats
- &update on the paperless 2020 programme
- internal audit report on IT strategy
- technology and data security update
- &NHS England and NHS Improvement joint work on integrating systems and data
- &update on Business Services Transformation Programme, including executive sponsorship

[1] Jora Gill joined the Committee in May 2017.
[2] Simon Stone joined the Committee in July 2017
[3] Caroline Thompson stepped down from the Board on 31 August 2017.
4 Paul Willer left the Committee in July 2017
&

Quality Committee

Membership:

Sarah Harkness (Chair)
Lord Ara Darzi
Ruth May
Kathy McLean
NHS National Director of Patient Safety
Executive Regional Managing Director
Regional Clinical (Medical or Nurse) Director
Quality Intelligence and Insight Director

Attendee:
- Chief Executive

The Head of Governance acts as secretary to the Committee

The Committee met once since its establishment in July 2017.

Its membership will be expanded to including Patient and Public Voice partners from April 2018.

Key duties:
- provides assurance that mechanisms are in place to identify, manage and escalate quality concerns/issues affecting the trust provider sector
- discuss live, topical quality issues where these fall within the provider sector and require national decision-making and action, taking into consideration the views of the National Quality Board
- consider reports from NHS Improvement's regions based on a range of outputs, including: Quality Surveillance Groups, risk summits, patient complaints, reporting incidents, responding to safety issues, patient and staff surveys and routine interactions with providers by NHS Improvement which focus on specific quality-rated issues and programmes.

Key matters considered during the year:
- review and approval of Committee terms of reference
- introduction of a quality dashboard
- update on the implementation of the Learning from Deaths policy
- the introduction of quality deep-dive analysis.

Board disclosures

Information governance compliance and disclosure of personal data-related incidents

NHS Improvement measures its compliance across information governance using the NHS Information Governance Toolkit (IGTK). The IGTK was submitted in March 2018, with an overall grade of 'satisfactory' and a score of 97%.

In May 2018, the Data Protection Act 1998 was replaced by the General Data Protection Regulation (GDPR) and the UK Data Protection Act 2018. A GDPR Programme Board successfully delivered organisational GDPR compliance by 25 May 2018.

There were over 25 cyber-related incidents recorded by Information Governance as a result of an internal phishing exercise targeting 250 members of staff. There were no cyber-related breaches reported by our staff. Our systems did not have any issues resulting from the Wannacry attack that affected several other NHS organisations. As a preventative measure, we brought forward planned patching, and temporarily suspended our N3 connection.

NHS Improvement has seen an increase in the number of reported incidents. The number of breaches requiring investigation by Information Governance was 24, 17 of which related to the processing of NHS Improvement data by the Business Services Authority. There were no personal data incidents requiring reporting to Information Commissioner's Office.

Priorities for 2017/18 include reducing personal data and cyber-related breaches and achieving cyber security and GDPR certification.

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 2017 to 31 March 2018, except for the following listed on the next page.

Table 10: 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 and Social Care.
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 (iii) 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 about 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:

- exercise its competition and pricing functions and 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 2017/18 and to the date of this report, so, no statements were published.

Fraud and corruption

NHS Improvement is committed to the prevention, deterrence, detection and investigation of all forms of fraud and corruption. Staff are expected to adhere to a Code of Ethical Practice and an Anti-Fraud Policy which was updated and relaunched in April 2017.

Disclosure of information to the independent auditor

Each Director of the Board at the date of approval of this report confirms that:

- so far as the Director is aware, there is no relevant audit information of which NHS Improvement's external auditor is unaware
- the Director has taken all steps that he or she ought to have taken as a director to make the Director aware of any relevant audit information and to establish that NHS Improvement's auditor is aware of that information.

Board statement

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.

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 of health reform.

Since 1 April 2017, Board and executive meetings have been held with organisations and individuals, including ministers, special advisers and senior officials from DHSC, NHS England, the 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.[41]

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

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*[42] 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 judgments 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 and Social Care 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*,[43] 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.

[42] www.gov.uk/government/publications/government-financial-reporting-manual-2017-to-2018

[43] www.gov.uk/government/publications/managing-public-money

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.

Ian Dalton
Chief Executive
3 July 2018

Annual governance statement 2017/18

NHS Improvement's Board is committed to 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 governance statement explains how the Board operates and how our governance framework contributes to achievement of our 2020 objectives (see page 9).

NHS Improvement was established on 1 April 2016 and is the operational name for an organisation that 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). 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.

This report covers the period from 1 April 2017 until 31 March 2018 and refers to NHS Improvement throughout.

NHS Improvement's governance framework

The Board

Role of the Board

The Board's role is to lead the organisation by setting its strategy, including the vision, mission and values, agreeing the framework within which operational decisions will be taken and determining the scope of NHS Improvement's activities and areas of the organisation to which it will assign high priority. In doing this the Board is responsibilities for:

- ensuring high standards of corporate governance are observed and encouraging high standards of propriety
- the effective and efficient delivery of NHS Improvement's plans and functions
- promoting quality in NHS Improvement's activities and services
- monitoring performance against agreed objectives and targets

- ensuring effective dialogue with DHSC and other stakeholders to best promote the continued success and growth of NHS trusts and NHS foundation trusts and other aspects of the healthcare sector
- ensuring that Board Members personally, and NHS Improvement corporately, observe the seven principles of public life set out by the Committee on Standards in Public Life.

Board changes

2017/18 has been a year of significant changes for NHS Improvement, including the appointments of a new chair and chief executive. Details of directors who served on the Board during the year are on pages 81 to 83.

Ed Smith, Caroline Thompson, Laura Carstensen, Jim Mackey and Bob Alexander all stepped down from the Board[43] during the year and the Board would like to thank each of them for their contribution to NHS Improvement. When Ed Smith stepped down as Chair on 20 July 2017, Richard Douglas took on the interim Chair role pending a permanent replacement. Richard held this role until 29 October 2017 when Baroness Dido Harding assumed her role as the Chair of NHS Improvement. The Board is grateful for Richard's leadership in the interim period and he continues in his role as a Non-Executive Director.

The two year secondment of the Chief Executive, Jim Mackey, concluded on 31 October 2017 and he returned to his substantive role as Chief Executive of Northumbria Healthcare NHS Foundation Trust on 1 November 2017. However until Ian Dalton, the new Chief Executive and Accounting Officer was appointed, Jim Mackey retained his formal responsibilities as NHS Improvement's Chief Executive and Accounting Officer on a part-time basis until 3 December 2017. During this time he was supported by Kathy McLean as the Interim Chief Operating Officer, a role she has since taken on permanently alongside that of Executive Medical Director. Ian Dalton joined NHS Improvement as its Chief Executive and Accounting Officer on 4 December 2017.

NHS Improvement acknowledges that between 31 October and 3 December 2017 Jim Mackey was the Chief Executive and Accounting Officer of both NHS Improvement and the Northumbria Healthcare NHS Foundation Trust. Any conflict

[43] Laura Carstensen stepped down on 30 June 2017, Ed Smith on 20 July 2017, Caroline Thompson on 31 August 2017 and Bob Alexander 31 January 2018.

of interest was carefully managed in accordance with NHS Improvement's Rules of Procedure[44] and the Code of Ethical Practice and these policies were used to manage and formally record any of Jim's conflicts during his time at NHS Improvement. Jim did not participate in or attend meetings where decisions were made on Northumbria Healthcare NHS Foundation Trust and once he returned to his role of Chief Executive of Northumbria Healthcare NHS Foundation Trust he also stopped chairing and attending meetings of the NHS Improvement Executive Committee and executive team.

Throughout this period of change in Board composition, the Board has remained confident that it is diverse and versatile and provides suitable challenge and guidance. The Board is satisfied that no individual or group of individuals dominates its 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 or in public life.

Cross associate directorship with NHS England

Since Baroness Harding was appointed Chair, she has worked closely with NHS England's chair to better align the work of NHS Improvement and NHS England. The need for more joined-up national and regional leadership between commissioners and providers has resulted in the initiative to introduce cross representation on each organisation's board. There is currently a legal barrier to a Non-Executive Director being a member of both NHS Improvement's and NHS England's Boards so Richard Douglas has been appointed an Associate (non-voting) Non-Executive Director on NHS England's Board. David Roberts, the Vice-Chair of NHS England has been appointed an Associate (non-voting) Non-Executive Director of NHS Improvement.

Further Board changes since the end of the financial year

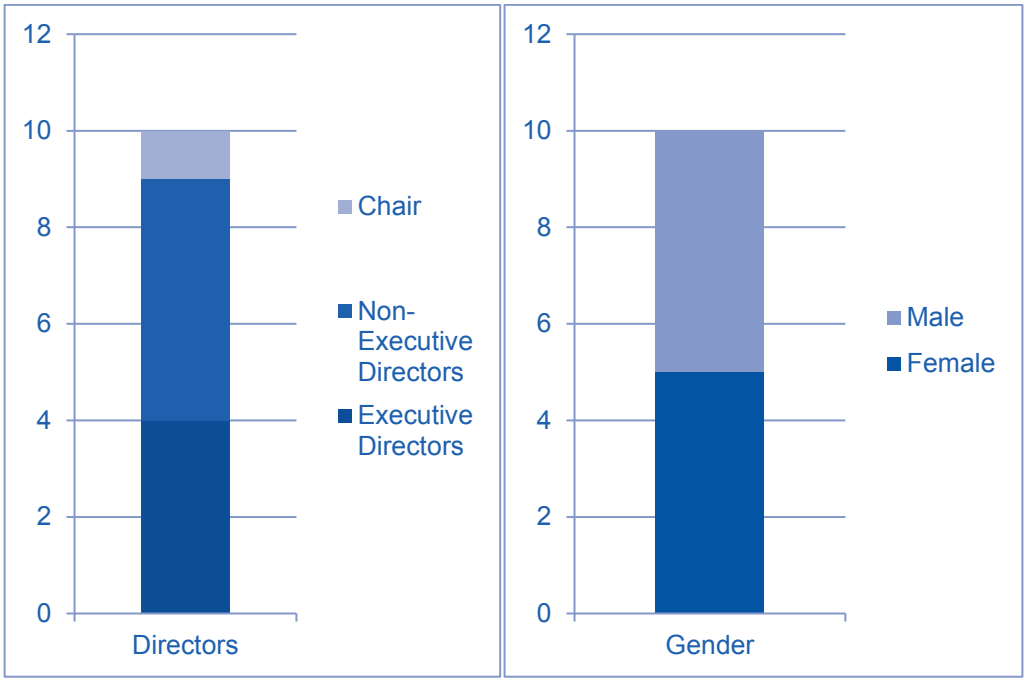
Sigurd Reinton's and Lord Carter's terms of office expire on 30 June 2018, Lord Darzi's term expires on 31 July 2018 and Sarah Harkness' appointment will come to an end in September 2018. Non-Executive Directors are appointed by the Secretary of State for Health and Social Care and an announcement regarding the appointment of new Non-Executive Directors is expected before the autumn.

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

At the date of this report, the Board has 11 Directors, comprising the Chair, six Non-Executive Directors and four Executive Directors, five Board members are female and six male. The Board composition and Non-Executive Directors' term of office are set out on pages 103 to 107.

Table 11: Board composition and diversity

The charts below show Board composition and diversity at the date of this report.



Key roles and responsibilities

Baroness Dido Harding, as the Chair, is responsible for leading the Board and ensuring its effectiveness. The Chief Executive, Ian Dalton, is responsible for leadership and day-to-day management of the organisation and the execution of NHS Improvement's strategy. Under government requirements, the Chief Executive is the Accounting Officer responsible for ensuring that the public funds are properly safeguarded and are used in line with NHS Improvement's functions and responsibilities and the requirements as set out in HM Treasury guidance *Managing Public Money*.

Richard Douglas is the Deputy Chair and Professor Dame Glynis Breakwell is the Senior Independent Director.

Their key areas of responsibility are as follows:

Position	Role
Chair	• 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 Chair and the rest of the 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 Chair.
Deputy Chair	• principally deputises for the Chair at meetings of the Board and supports the Chair in her role.
Senior Independent Director	• works closely with the Chair, 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.

Non-Executive Directors

NHS Improvement's Non-Executive Directors are appointed to the Board to contribute their independent advice and expertise as well as provide challenge to the Board's deliberations. They 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.[45]

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

Remit

NHS Improvement's governance framework is set out in the Rules of Procedure,[46] which are available on NHS Improvement's website. The remit of the Board is set out in Matters Reserved for the Board's 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.

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

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.

To further strengthen the Board's oversight of quality and quality governance arrangements in providers, a Board Quality Committee was established during the year. The purpose of this Committee is to support the Board and the Chief Executive by providing assurance that mechanisms are in place to identify, manage and escalate quality concerns/issues affecting the provider sector.

A Joint Finance Advisory Group with NHS England has also been introduced to ensure that NHS Improvement and NHS England are working from a common understanding of the financial targets and financial performance of the health system as a whole.

Details of these changes and other Board Committees are on pages 86 to 92. Details of responsibilities delegated to the Chief Executive and his supporting governance structure are on pages 114 to 116.

In further developing a closer working relationship with NHS England the intention is to hold a number of Board meetings in common to enable joint deliberations on items of business the organisations have in common. Further details on these meetings will be provided in next year's governance statement.

Information and support

The Board has agreed 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.

All Directors have access to the advice and services of the Head of Governance who is responsible for:

- advising the Board on all corporate governance matters
- ensuring that the Board operates in accordance with NHS Improvement's governance framework
- ensuring good information flow between the Board and its committees
- facilitating induction programmes for Non-Executive Directors.

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

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 DHSC on funding for unforeseen circumstances that may arise during a financial year.

Board effectiveness

Board meetings and attendance

Attendance of the Chair, Non-Executive Directors and Executive Board members at relevant Board and committee meetings between 1 April and 31 March 2018 is outlined in the table on the next page.

Table 12: Board and Committee attendance during the year

Director	Board	Audit and Risk Assurance Committee	Nominations and Remuneration Committee	Provider Leadership Committee	Technology and Data Assurance Committee*	Quality Committee
	(eligible to attend)					
Baroness Dido Harding[1]	3(3)	-	-	-	-	-
Dame Glynis Breakwell	4(6)	-	2(2)	-	-	-
Lord Patrick Carter	4(6)	-	1(1)	-	-	-
Lord Ara Darzi	2(6)	-	-	-	-	1(2)
Richard Douglas[2]	6(6)	5(5)	-	-	2(4)	-
Sarah Harkness	5(6)	4(5)	1(2)	3(3)	-	2(2)
Sigurd Reinton	6(6)	4(4)	-	-	4(4)	-
David Roberts[3]	0(1)	-	-	-	-	-
Ian Dalton[4]	2(2)	-		-	-	-
Stephen Hay	6(6)	-	-	-	-	-
Ruth May	5(6)	-	-	-	-	1(2)
Kathy McLean	6(6)	-	-	-	-	2(2)
Former Director						
Jim Mackey[5]	4(4)	-	-	-	-	-
Bob Alexander	4(5)	-	-	2(2)	-	-
Ed Smith[6]	2(2)	-	-	-	-	-
Laura Carstensen[7]	1(1)	1(1)	-	1(1)	-	-
Caroline Thomson[8]	2(2)	-	1(1)	2(2)	1(1)	-

[1] Baroness Dido Harding was appointed Chair on 31 October 2017.
[2] Richard Douglas acted as the interim Chair between 20 July and 29 October 2017.
[3] David Roberts joined the Board on 5 March 2018.
[4] Ian Dalton was appointed Chief Executive on 4 December 2017.
[5] Jim Mackey stepped down as the Chief Executive on 3 December 2017.
[6] Ed Smith stepped down as Chairman on 20 July 2017.
[7] Laura Carstensen stepped down from the Board on 30 June 2017.
[8] Caroline Thomson stepped down from the Board on 31 August 2017.
* The Technology and Data Assurance Committee also has three independent members.

The Board held 12 scheduled meetings between 1 April 2017 and 31 March 2018. There were six formal Board meetings, which when appropriate had a session in public, Board development sessions and one Board Strategy day. In addition, there were two special briefing sessions. The agenda and papers for items considered during the public sessions are on NHS Improvement's website.

The Board development sessions are held in private and the Chair and the Chief Executive work together to set the agenda for each session. The sessions are aimed at enhancing the Board's understanding of NHS Improvement and the challenges that the organisation and the sector face.

At each meeting, the Board receives the following: Chair's report, Chief Executive's report, improvement report summarising improvement highlights across the organisation, corporate report bringing together Board Committee reports, a challenged provider update and a sector performance report. Regular reports on corporate risk and performance, technology and cyber security are also considered.

NHS Improvement's Chief Financial Officer, 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.

In addition, the following key items were considered by the Board during the year:

- NHS Improvement 2017-19 Business Plan and remit letter from DHSC
- joint NHS Improvement and NHS England regional director posts in the South region
- update on joint working with the CQC and the well-led framework
- the 2017/18 priorities for NHS Improvement against the national strategic framework 'Developing people, Improving care'
- winter preparedness and emergency department performance
- merger between Central Manchester University Hospitals and NHS Foundation Trust and University Hospital of South Manchester NHS Foundation Trust
- approval of Monitor and NHS TDA annual report and accounts
- NHS Improvement's approach to patient safety strategy
- establishment of a Board Quality Committee
- updates on sustainability and transformation partnerships
- NHS Improvement's response to recommendations made in the independent review into Liverpool Community Health NHS Trust
- joint working with NHS England.

Board appointments

The Chair and Non-Executive Directors are appointed by the Secretary of State for Health and Social Care. 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 and Social Care's consent.

Non-Executive Directors are legally appointed to both Monitor and NHS TDA for a period of not more than four years. As Non-Executive Directors for Monitor they hold statutory office under Schedule 8 to the Health and Social Care Act 2012 and as Non-executive Directors of NHS TDA they hold statutory office under the National Health Service Trust Development Authority Regulations 2012.

The appointment process for Baroness Harding was carried out by DHSC. Following the conclusion of an open recruitment campaign the Minister of State for Health and Social Care wrote to the House of Commons Health Committee in October 2017 and notified them that Baroness Harding was the government's preferred candidate. The Health Committee held a pre-appointment hearing with Baroness Harding and subsequently endorsed the government's recommendation. On 30 October 2017, Baroness Harding formally took over the role as Chair for a period of four years.

For the appointment of Ian Dalton, Chief Executive, a Special Nominations Committee was established comprising the Senior Independent Director and two Non-Executive Directors from NHS Improvement, a representative from DHSC and the Chief Executive of CQC. The Committee met formally twice and, in overseeing the process of selecting the new Chief Executive, they:

- approved the job description and advertisement for the Chief Executive
- determined the timetable for the process of recruiting the Chief Executive
- determined the composition of the selection panel for the recruitment of the Chief Executive
- approved a recommended remuneration range for the post, giving due regard to any relevant legal requirements and Treasury guidance
- approved a longlist of candidates for the Chief Executive post, for presentation to the selection panel.

Following a rigorous and thorough selection process a longlist of candidates was submitted to a selection panel, which included NHS Improvement, civil service and independent members. The panel conducted the interviews and shortlisting from

which a recommendation to the Non-Executive Directors of NHS Improvement and the Secretary of State for Health and Social Care was made. On 29 November 2017 it was announced that the Secretary of State for Health and Social Care had consented to the appointment, and Ian Dalton took up the role as NHS Improvement's new Chief Executive and Accounting Officer from 4 December 2017.

As a number of Non-Executive Directors' terms of office have either come to an end or will soon expire, an extensive recruitment process has taken place during the last six months. At the start of this process, NHS Improvement identified the skills and expertise needed to complement and fill any gaps on the Board and agreed with DHSC that an external recruitment firm, Odgers Berndtson, could be used to identify candidates for up to three of the six non-executive roles. Odgers Berndtson has no other connections with NHS Improvement. The recruitment process, which has been led by DHSC, should be concluded before the end of the summer, following which DHSC will finalise its recommendations for submission to the Secretary of State and the Prime Minister for final approval.

Induction for Directors

Our induction programme provides a broad introduction to NHS Improvement and the health and social care system, and is individually tailored to different requirements and needs.

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.

Details of the new directors' induction programmes are provided below.

Baroness Harding &	Baroness Harding's induction including internal meetings with Board members and senior management, meetings with trust chairs, the chairs of NHS England and the Care Quality Commission, and politicians from the Government and from the opposition. An induction pack was also provided and to build on her knowledge and understanding of the health and social care sector. Baroness Harding has visited regional offices and trusts, including a cross- section of mental health, community, ambulance, district general hospitals and specialist trusts.
Ian Dalton &	Ian Dalton' joined us from Imperial Colleague Healthcare NHS Trust

	and has over 30 years' experience in the NHS and the wider healthcare system. His induction involved detailed briefings to allow him to quickly gain a deeper understanding of NHS Improvement at an operational level. He also had induction meetings with internal colleagues and Government ministers and to further understand at first hand the varied and many challenges have visited providers across the country.
David Roberts &	David Roberts is the Vice-Chair of NHS England. His induction therefore built on existing understanding of the health sector and focused on NHS Improvement's governance structure and on one-to-one meetings with key executives to increase his knowledge and understanding of NHS Improvement's role and challenges.

Review of Board effectiveness and 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.

Each Director completed a Board evaluation questionnaire and the results identified that overall the Board believes that it is operating reasonably effectively but there are number of areas for improvement, most particular leadership development, talent management and people strategy and, to a lesser extent, in terms of the financial position and forecast for the NHS. The feedback also indicated that Baroness Harding's leadership is effective. Her relationships and communications within the Board are constructive and encourage good discussion.

The table on the next page outlines areas of improvement identified and agreed by the Board.

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Theme	Area for recommended improvement
Finance The Board has an adequate understanding of and confidence in the assumptions underlying the financial forecasts and budgets for NHS Improvement.	Ensure the Board has clear visibility of NHS Improvement's mandate and the budget allocated to different aspects of the mandate, with regular reports on spending.
Performance NHS Improvement has set appropriate performance targets for the organisation and receives adequate information to judge achievement.	Revise the performance report to include a link between performance of the sector and NHS Improvement's progress against each work stream. Work towards a joint approach to performance management with NHS England.
Talent and succession The Board has sufficient information to form a view that NHS Improvement is recruiting, reviewing, developing and retaining talent and building leadership succession.	A succession plan will need to be developed and reviewed and monitored on an ongoing basis by the Nominations and Remuneration Committee and joint roles would need to be reviewed in common with NHS England.
People The Board receives appropriate key people measures including employee turnover, employee motivation and satisfaction.	More regular reporting to the Board of data on NHS Improvement staff.
Board effectiveness The Board has the right blend of experience and skills in terms of both executive and non-executive members.	Currently being addressed through recruitment exercise. Closer working for NHS England Board to provide access to broader skill set.

Board and executive development

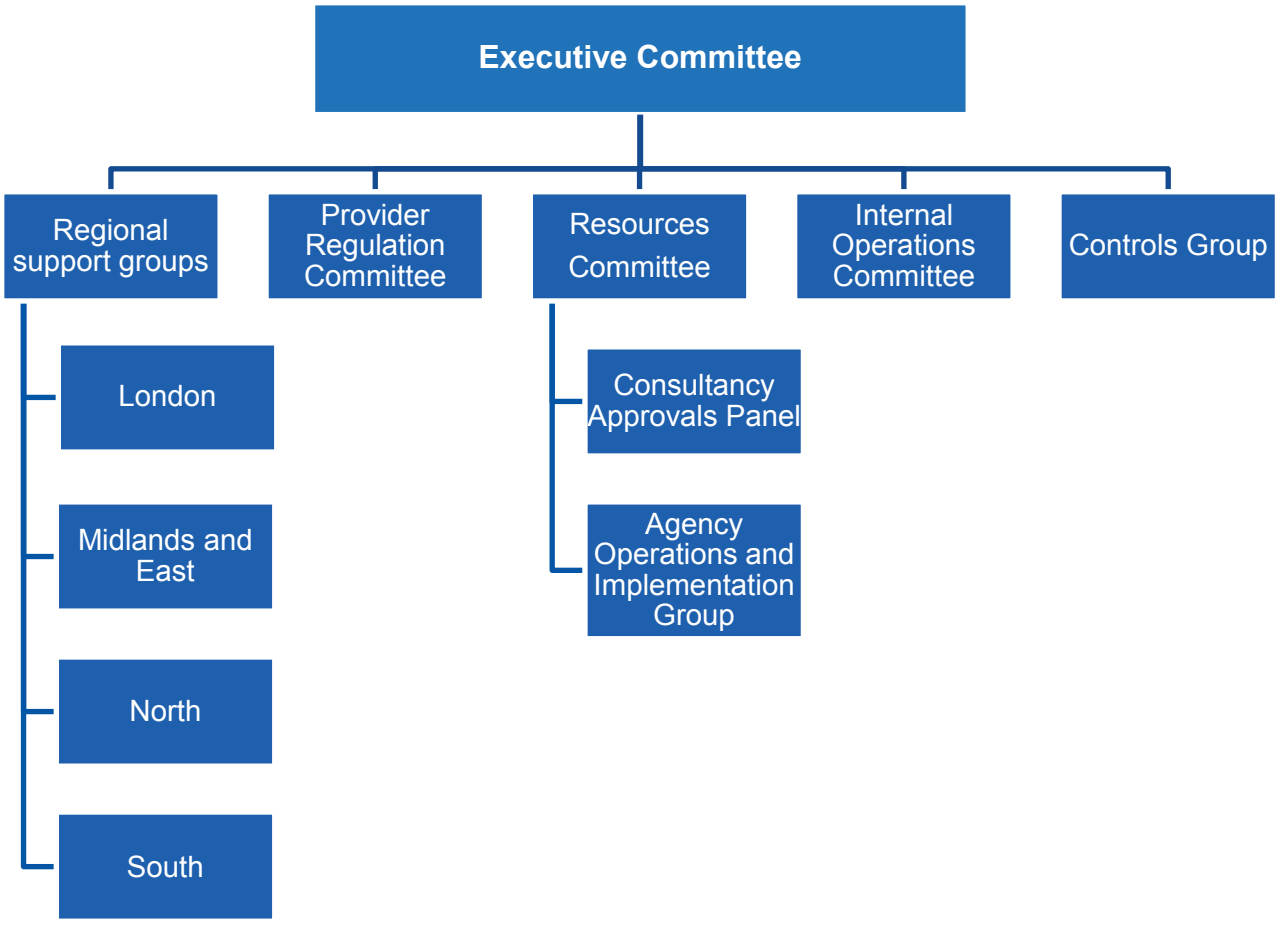
From January to the end of December 2017, the Board and senior management engaged the services of Eva Beazley, Director of The Leadership Gallery, to develop a board effectiveness framework (BEF) and an executive coaching and development programme. Ms Beazley is an independent facilitator with no other connections to NHS Improvement who worked with the Board to 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 and a series of

‘time out’ sessions were held through the year to further develop the executive team.

Executive committees

The Board delegates the day-to-day running of the organisation to the Chief Executive, who is the Accounting Officer. The Chief Executive 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. The governance framework below the Executive Committee is as follows:

Figure 2: NHS Improvement governance framework below the Executive Committee



From 1 April 2017, the Executive Committee met once a month to consider formal business. In all other weeks, informal meetings were held by the Executive team to discuss core business areas and top issues and priorities.

Executive Committee

Key duties include:

- assisting the Chief Executive to make sure NHS Improvement has a co-ordinated approach to its work, especially in providing leadership and practical help to healthcare providers
- taking high-level policy decisions, focused on ensuring that NHS Improvement supports providers and holds their boards to account
- focusing internally on high-level policy decisions and making recommendations on the actions of the sub-committees.

From 1 April 2017, the Executive Committee met once a month to consider formal business. In all other weeks, informal meetings were held by the Executive team to discuss core business areas and top issues and priorities.

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

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:

- review of segmentation of providers using the Single Oversight Framework
- determination of support for providers in segments 1 to 3
- enforcement under s.106 of the 2012 Health and Social Care Act (the 2012 Act)
- enforcement under s.105 and s.111 of the 2012 Act and making recommendations to the Provider Regulation Committee
- Makes a recommendation to the Provider Regulation Committee of green to amber rated, low to medium risk transactions

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
Duties: • segmentation • regulation (s.105 and s.111 of the 2012 Act) • special measures, contingency planning team/trust special administration • regulation policy • accreditation of foundation groups • approval of red rated/high risk and segment 4 transactions • dissolution of foundation trusts • competition cases and policy	Duties: • provider sector spending controls • capital investment (NHS trusts and foundation trusts) • annual planning • pricing • sector performance • consultancy spend • agency spend • external technology	Duties: • internal expenditure	Duties: • internal procedures and business processes • internal finance, risk and performance, information technology infrastructure and information governance • resource distribution across NHS Improvement • performance management • corporate policies

Agency Operations and Implementation Group	Consultancy Approval Panel
Trust spend on agency staff	Trust spend on consultancy

Review of NHS Improvement's operating model and senior leadership structure

In February 2018, the organisation engaged McKinsey & Company (following a tender process) to review the operating model and senior leadership structure to further develop and enhance the delivery focus of NHS Improvement and resolve any organisational gaps, duplication and inefficiencies that have emerged since the integration work in 2016. A number of areas for improvement identified can be addressed through closer working with NHS England to ensure both Boards receive better, more consistent and complete information.

A programme of work to improve NHS Improvement's organisational design while facilitating greater joint working with NHS England is therefore underway. Any changes to the governance framework following the outcome of McKinsey's review and the joint working programme with NHS England will be reported in the 2018/19 annual governance statement.

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.

NHS Improvement s duties as a regulator

Duty to review regulatory burdens

Under the 2012 Act, NHS Improvement is required to keep the exercise of its functions (as Monitor) 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.

In 2016/17, NHS Improvement developed the Single Oversight Framework, which replaced Monitor's Risk Assessment Framework and NHS TDA's Accountability Framework. We sought to reduce the burden on the sector by harmonising the way

we oversee and identify the support needed of both NHS foundation trusts and NHS trusts under the Single Oversight Framework. In 2017/18, we made minor changes to the Framework, and no significant additional burden was imposed.

In 2017/18, the 2017/19 national tariff continued in force. The regulatory burdens on the sector had been considered in the previous year as part of the development of that tariff, and there were no significant changes which required reconsideration of the regulatory burdens or proposals for a replacement tariff for 2017/18.

We considered regulatory burden as part of the development of proposals to introduce an additional licence condition for NHS-controlled providers, as set out in the impact assessment of these proposals under section 69 of the 2012 Act.

We also specifically considered regulatory burden, as part of our review of the arrangements for collection of self-certifications from NHS foundation trusts and NHS trusts under the requirements of the provider licence. We decided that trusts should continue to make the certifications but they did not need to be collected by us.

Duty to carry out impact assessments

Under section 69 of the 2012 Act, NHS Improvement (as 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 2017/18, we undertook an impact assessment under section 69 of our proposals to introduce an extra licence condition for NHS-controlled providers (eg wholly owned companies established by trusts to provide NHS services). The general assessment was that the benefits of the proposals would outweigh the likely costs. The assessment was published as part of a consultation on the proposals. Our final decision on the proposals was published in February 2018.

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 effectively. Government departments and ALBs, such as NHS Improvement, are required to implement these recommendations. NHS Improvement has a framework for identifying business-critical models on an ongoing basis, which is overseen by the Modelling Advisory Group (MAG), reporting to the Chief Economist. Under this framework, we identified five business critical models in 2017/18:

- Long Term Financial Model (LTFM)
- NHS Improvement Tariff Calculation Model
- Pricing Impact Assessment Model
- GP Referral Analysis Model
- Control Totals Impact Assessment Model

MAG meets quarterly to review this list, and to determine whether any models need to be removed from the list (i.e. they no longer meet the criteria for a business-critical model) or any new models should be added. If so, MAG provides best practice guidance for teams developing new business-critical models to ensure they fulfil the Macpherson Report requirements. MAG also actively monitors developments in existing business-critical models, provides support and guidance on best practice in quality assurance and governance, and escalates risks and issues to the Chief Economist and the Internal Operations Committee if necessary.

In the period 1 April 2017 to 31 March 2018, two existing areas required support from MAG:

- the rebuild of the Long Term Financial Model
- the rebuild and combination into one model of the Tariff Calculation Model and the Pricing Impact Assessment Model.

These models will be treated as new business-critical models once fully active, and as such have been subject to the existing quality assurance and governance scrutiny by MAG throughout their development. Once they are live they will be entered onto the list of business-critical models, replacing the existing models.

Quality assurance processes for business-critical models

Model	Quality assurance processes
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 at NHS Improvement by modelling experts, 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 Payment System document. The model is business critical because the outputs are used to determine the national prices that providers of NHS services get paid (by commissioners) for performing these services. These national prices account for roughly £36	The Tariff Calculation Model was developed internally at NHS Improvement by modelling experts. The model has undergone quality assurance in three stages: • each part of the model was reviewed internally by an analyst not involved in creating that part of the model. • the model was published as part of our consultation on the 2017/19 NTPS, which gave stakeholders the opportunity to review the model and feed back their

billion of approximately £71 billion secondary care services commissioned under the NTPS.	comments and observations. Adjustments to the model were made as a result of this feedback. • the model was audited by KPMG and 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 NTPS. It is business critical because its outputs are what a provider of NHS services gets paid (by commissioners) for performing these services.	The Pricing Impact Assessment Model was developed internally at NHS Improvement by modelling experts. 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 have been 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	The GP Referral Analysis Model was developed internally at NHS Improvement 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

because it provides a foundation for our strategic advice and early input to NHS foundation trusts and trusts considering mergers, to ensure that transactions are well planned and work well for patients.	assured. Further, any supplementary analysis added to the model will be quality assured using the formal change process.
The **Control Totals Impact Assessment Model** is used to calculate the control totals for NHS providers. The model uses a set of planning assumptions to assess the impact on providers' financial positions of expected year-on-year changes. The model is business critical because, when signed up to by providers, the control totals will represent the minimum level of financial performance required by NHS providers for the year, against which the boards, governing bodies and chief executives will be directly accountable. Trusts that do not sign up to a control total may also be subject to a lower performance assessment during the year.	The Control Totals Impact Assessment Model was developed internally at NHS Improvement by modelling experts, along with staff with expert knowledge of NHS planning assumptions. The model is internally quality assured through robust peer review. Senior staff review the outputs of the model to ensure the calculated control totals represent reasonable outputs and are based on appropriate planning assumptions. The outputs of the model are further reviewed by regional teams, which apply expert local knowledge to assess individual trust control totals.

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. 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 125).

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 2017/18

In accordance with the requirements of the UK Public Sector Internal Audit Standards, I, as the Head of Internal Audit, 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 that I must report on, I have concluded the following:

- **In the case of risk management: moderate**
  - We reviewed risk management as part of the reviews of Risk Management, Key Financial Controls, Cyber Security (Identity Access Management), General Data Protection Regulation, Workforce planning, Single Oversight Framework, Procurement and Estates. We also reviewed specific risks associated with areas of NHSI within each internal audit.
- I**n the case of governance: moderate**
  - We reviewed governance as part of our internal audit work for all 18 reviews performed in 2017/18.
- **In the case of control: moderate**
  - We reviewed controls in place, throughout the audits contained within the audit plan.

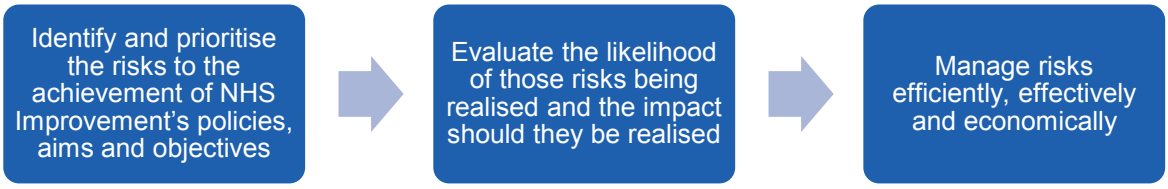
Therefore, in summary, my overall opinion is to give moderate assurance to the Accounting Officer that NHS Improvement has had adequate and effective systems of control, governance and risk management in place for the reporting year 2017/18.

Internal control – statement from Ian Dalton, 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 Health and Social Care Act 2012 and NHS Improvement's corporate strategy and business plan. In doing so, I must safeguard the public funds and assets in accordance with the responsibilities assigned to me in *Managing public money* and the latest accounts direction from DHSC.

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:



The system of internal control has been in place in NHS Improvement for the year ended 31 March 2018 and up to the date of approval of the annual report and accounts, and accords with HM Treasury guidance.

Risk and Control Framework

NHS Improvement operates a sound 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. This framework, which is updated annually, is aligned with the overarching principles of HM Treasury's Orange Book and is informed by DHSC's risk management policy, ISO 31000 Risk Management Principles and Guidelines and the UK Corporate Governance Code.

In implementing the framework, our corporate risk function and Risk and Performance Leads have continued to share good practice, provide information on new and existing risks, and co-ordinated and supported the embedding of an appropriate risk management culture.

Throughout the transition to NHS Improvement, and as we have developed and implemented our operating model and embedded our values and behaviours, 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.

Each year there is a Board risk workshop which challenges and reviews our approach to risk management and overall risk exposure.

Principal risks facing NHS Improvement during 2017/18

Our review of NHS Improvement's Business Plan 2017-19 identified that the organisation faced a number of significant risks in 2017/18:

Table 13: Principal risks and mitigation

Risk	Mitigation: what has NHS Improvement done 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.	• A series of task and finish groups and internal improvement initiatives were set up to help build NHS Improvement as an organisation following the initial restructure in 2016. Work is ongoing to revalidate the new model in light of the changes. • The programme included projects to implement the final parts of the operating model including organisational development and cultural priorities, the Single Oversight Framework and improvement model, and finalising NHS Improvement's new structure and estate. • The project to bring all entities into a single IT network was successfully concluded in Q2 (July to September) 2017/18. • Our Business Services Transformation programme (BST) was launched on 11 March 2017 to address the need for an integrated solution to enable NHS Improvement to function as a single entity, and will provide staff with the right tools and processes to do their jobs efficiently and effectively, and eliminate duplication. • The BST programme also analysed the duplication and overlap in how NHS Improvement directorates and regional teams engage with providers. The discovery phase was completed in

	July 2017 and a set of operating procedures has been developed, covering the approach to setting the improvement strategy for a provider trust, managing and co-ordinating improvement projects involving providers and co-ordinating NHS Improvement activities at a provider organisation. • An Integration/Strategic Change Programme was initially set up in January 2016 to oversee the integration and manage its risks. This programme delivered NHS Improvement's initial Target Operating Model (TOM) and facilitated the consultation process and transition of staff into the new structure. This was replaced by the Operating Model 2 (OM2) work stream and has now been replaced by an implementation network • In September 2017 a set of 10 overarching operating model principles were developed and launched and these will form the basis of the approach taken to joint working between different NHS Improvement directorates and regional teams in support of the provider sector. • In September 2017 the new values and behaviours were launched, alongside the high level purpose, objectives and ten overarching operating model principles of OM2. • In addition to cultural development, there have been many other support offers and interventions, such as: career progression, including a new talent management framework and a new coaching and mentoring framework; line manager development and induction and a new line manager website portal; leadership development including a new 'from manager to leader' programme, a new board development programme, a new NHS Improvement leadership

	community and an NHS Improvement succession plan. • NHS Improvement has appointed McKinsey & Company to work in partnership with the NHS Improvement executive team to clarify NHS Improvement's purpose and operating model and to further develop the internal organisational development work. The executive team has already conducted interviews with sector chief executives, chairs and other stakeholders on what is working well, what they find frustrating, what they think our purpose should be and what activities we should concentrate resources on to achieve this purpose.
Leadership Succession Risk Risk that we fail to sustain ourselves in the longer term should we fail to adequately manage succession planning risks. This includes vacancy risk (risk of key positions being vacant over a long period of time); readiness risk (risk of unprepared successors); and transition risk (risk of successor failure)	• A new menu of executive development opportunities (ExCo 360 launched in Q3 2017/18) • New NHS Improvement leadership community launched in September 2017 • Improvement management development programme completed and incorporated in Q3. • New line manager handbook and website portal launched in Q2 with ongoing work to ensure they are kept updated. • NHS Improvement succession plan paper discussed and agreed at the Executive Committee meeting in December 2017. • New line manager induction pilot run in Q3 and due for launch in Q1 2018/19. • New Board development programme • New 'from manager to leader' programme to be developed in Q1 2018/19 •

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 NTPS for 2017/18 and 2018/19 • On 1 October NHS Improvement and NHS England started to trial joint working arrangements in the south region, with joint regional director posts for the south east and south west. The joint regional directors ensure that NHS England and NHS Improvement are better able to speak with one voice to the system and align actions across our shared objectives. The south is developing an operating model to realise the other expected benefits of joint working, which include better use of our combined people resources, reduction of duplication and omission, increasing time spent on direct support for local health economies and improving job satisfaction for staff. • An oversight group has been set up to steer the programme, which includes both joint regional directors and representatives of the leadership of both organisations, and this group will provide updates and recommendations to both boards on a quarterly basis. • The Vice-Chair of NHS England has been appointed an associate non-executive director of NHS Improvement and the NHS Improvement deputy chairman has been appointed associate non-executive director of NHS England. • The above post holders will also co-chair a joint financial advisory group to ensure that sector financial performance and financial targets are

	only reported once.
Emergency preparedness risk Risk that an internal or external incident (including terrorism) causes significant business disruption should NHS Improvement's business continuity, major incident response, and 'duty' processes/arrangements prove inadequate	• A number of major incidents took place in 2017, including the global 'WannaCry' cyber-attack, the suicide bombing at Manchester Arena, the terror attacks at Westminster Bridge, London Bridge and Finsbury Park, and the fire at Grenfell Tower. • Throughout the year, we've reviewed and strengthened our approach to supporting the NHS during major incidents as well as ensuring our own business continuity processes are robust, updated and in line with best practice. • Measures on contingency planning and incident management have been strengthened with the development of a business continuity framework, a major incident and response policy, and amended 'duty' processes, set out on action cards. Named individuals, in areas such as communications, have been given specific responsibility for emergency response and business continuity. Simulation exercises have been held to test and further refine these processes. • The build-up of this resource has been done while working closely with NHS England to ensure that we are complementing, rather than duplicating, the legal role they have in emergency preparedness, resilience and response • A new emergency planning lead for NHS Improvement has been appointed
Cyber threat Risk that weaknesses in technology and/or data	• The global 'WannaCry' cyber-attack in May 2017 resulted in many significant actions around cyber security across the NHS. • Although the attack was not specifically aimed at

security, quality or integrity could impact NHS Improvement	the NHS (and our organisation did not suffer as we had already patched our systems and had protection in place), we took some extra precautions, including temporarily disabling certain connections in case the attack was using those links to target the NHS. We also carried out a lessons learned exercise to improve our support to the sector during major incidents, which in turn was used to improve our business continuity and incident management processes. • The move to a single IT network in Q2 (July to September 2017) considerably simplified the ability of staff across the organisation to securely share information, set up the foundations for the Business Services Transformation project, and enable, for the first time, our entire network to be protected by our intrusion protection and prevention system. It also means that ownership for our cyber security now resides with NHS Improvement as does our ability to respond to any new threats identified. • While it is clear that the risk of a cyber-attack remains high, as does the potential impact of such an attack, the corporate IT team is confident that the completion of the migration to the single network (including updating all devices to current software), reduced the likelihood. • We appointed an IT security manager in November 2017. • We have now received the results of our external penetration test from a Communications Electronic Security Group (CESG) now National Cyber Security Centre (NCSC) check certified tester. This found we had no major risks and since receipt of the report we have been actively

	addressing the medium (now all closed) and low risk Items. This process is being reviewed by IT with the IT Security Manager. • The App Check (from net app) application is now operational and both IT and the IT security manager have access to test new and updated applications, most recently our internet site following its migration from Rack Space to Azure. • The IT infrastructure manager and senior support engineer have now completed the Certified Ethical Hacking Course, and as a result are strengthening the network and server. This process is now complete. • We are on track to be Cyber Essentials Certified by May/June 2018 and Cyber Essentials Plus Certified by end of June 2018. We are also establishing an Information Security Management System as a first step to formalising ISO 27001 best practice. The IT Security Manager is leading these projects. • We now have a call-off contract with NCC Group for extra IT security support/advice when needed. • We are now registered for the NHS Digital/Microsoft Endpoint Threat Detection Service. This has been piloted, and tested in the organisation and has now been rolled out to all NHS Improvement Devices.
NHS Improvement capacity and capability Risk that we are unable to recruit, develop or retain key talent resulting in	• 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 areas, our recruitment activities continue to

lacking the knowledge, skills, capacity, culture and ability to deliver our business plan/continue to meet our priorities and responsibilities and transform services.	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. • This is an opportune time for further development in relation to leadership within NHS Improvement, with the arrival of a new chair and chief executive. • NHS Improvement will work with other national bodies, including HEE and NHS Leadership Academy, to develop an ambitious talent management and professional development offer for the provider sector. This needs to include support for the recruitment, development and career progression of trust leaders; a more structured offer around mentorship for less experienced leaders; and will take account of the role that NHS Improvement should play in managing failure, distinguishing between situations where an individual should no longer work within the NHS, and those where someone can be supported to learn and make a valuable contribution.
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)	• We have been instrumental in designing the development of an ALB working group of HEE, NHS Improvement, NHS England and DHSC analysts, which has agreed plans to refine and develop new common understandings of supply and demand assessments for the healthcare workforce in England. • Scenario models (for nursing in the first instance) that reflect both operational plans and longer term demand drivers have been developed to identify how underlying risks to demand might continue if

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.	certain scenarios were to play out; for example the possibility of leaver rates increasing as a result of the implementation of Brexit. • To mitigate the risks highlighted within the models, we have identified potential whole-time equivalent gains that could be realised via improvements in retention and increases in provider staff participation rates. This modelling approach for nursing has been agreed and presented to the Secretary of State and the plan is to extend it to other staff groups and set up processes to routinely monitor against emerging outcomes and risks, and adjust our assessments and interventions accordingly. • We have developed a workforce planning resource (the agency toolkit) to support providers with national and local workforce planning requirements. The agency toolkit will support our operational workforce planning process. • Our workforce team is directly supporting trusts (53 mental health providers, and over 50 acute and community providers) in developing and implementing improvement measures to support clinical retention and participation rates through the application of guidance and good practice. • Our operational productivity teams are supporting providers to improve workforce productivity across a number of clinical staff groups (including medical, nursing and allied health professional workforces) to support enhanced workforce productivity through a variety of methodologies. • A programme of work is underway to support trusts to realise the benefits of workforce transformation and develop a workforce which is responsive to changes in care, both now and in

	the future. • To ensure effective engagement with staff and wider system partners, we have developed a close working relationship with NHS Employers and the national social partnership forum to ensure unions interested in health (Unison, Managers in Partnership, Unite, GMB) understand our role and reasons for developing specific policies and evidence base, and regard us as a partner with the best interests of the NHS, patients and the workforce at heart. • Improving the culture and leadership within NHS providers supports retention, recruitment and workforce effectiveness, with improved morale having a direct impact on the quality of care. Through the co-creation of the national improvement and leadership development and strategy, NHS Improvement has set the direction for capacity and capability-building, including leadership development and talent management for the NHS in England. We will support this through our improvement directorate-led culture and leadership programme to help NHS providers develop cultures that enable and sustain continuous improvement and compassionate care.
Balancing quality, finance and operational performance One of our highest scoring risks remains the risk of failure to balance quality, finance and access priorities appropriately,	• The provider sector delivered a deficit of £966 million for the financial year 2017/18. This was £470 million worse than the ambitious plan set at the start of the year. The ambitious financial plans providers set at the start of the year depended on a set of assumptions around risk management, including winter costs, agreed elective /non elective activity levels, beds being freed up and delayed transfers of care reducing to at

leading to an inability to maintain and improve performance against core quality and access standards while achieving financial balance, and a high level of risk remains.

least 3.5% by September 2017. The 2017/18 financial year was particularly challenging for the NHS with unrelenting demand for hospital-based emergency care and continuing high levels of bed occupancy putting exceptional pressures on the system particularly in the acute sector. This was compounded by an extremely difficult winter period which saw the highest levels of flu-confirmed admissions for seven years and put intense pressure on A&E services. The combined effects of these factors have affected NHS finances and the position delivered.

- Providers set out plans to deliver a total of £3.7 billion savings this financial year. Against a backdrop of exceptional pressures the NHS provider sector has outperformed the wider economy by delivering an implied 1.2% productivity improvement. This was supported by cost improvements of 3.7% - equivalent to £3.2 billion of improvements for the year, £110 million higher than the same period in 2016/17.
- The urgent and emergency care position continues to be challenging with the sector experiencing significant and sustained demand pressures from flu and norovirus. The service has had to respond to the worst flu season since 2010. Rising demand and high levels of bed occupancy have affected providers' ability to admit patients who require planned care. Bed occupancy has been affected by DToC to other settings, including social care. During January there were around 99,800 bed days

across acute, community and mental health providers occupied by delayed discharge patients. Recovery plans have however been put in place with the most challenged providers to deliver improvements and attention shifted to winter resilience delivery to ensure systems are able to provide a sustainable service towards the end of the financial year. The performance position is also challenging due to the growth of the waiting list. Other national priorities are placing pressure on referral to treatment (RTT) performance. A number of actions are being taken to improve the RTT position, including deploying our intensive support team to sites requiring intensive and specialist support, regional confirmation and challenge of recovery plans, the theatre productivity improvement programme and the RTT masterclass programme. There is also a particular focus on trusts reporting 52-week waits.

- Our regional and national teams continue to work closely with providers to help manage delivery risks and maximise productivity and other opportunities. Some of this work however will be supporting non-recurrent items which do not address the longer term financial sustainability issues of the sector.
- Our quarterly sector performance report highlights how providers are performing against national finance and performance targets. It was recognised earlier in the year that there was a need for greater transparency on care quality issues that are not covered in the report. This has been

	achieved by our enhanced approach to quality oversight and governance arrangements and the establishment of a formal Quality Committee, reporting to the Board. This committee provides assurance to the Board that arrangements are in place to identify, manage and escalate quality concerns; providing an overall view on the state of quality in the trust provider sector.
Political volatility risk: There is a risk that we do not respond appropriately to political, legislative and/or regulatory change; and/or fails to engage and influence relevant audiences in government and parliament, resulting in reputational damage and/or failure to secure political acceptance of change in service models.	• We are managing this risk by working closely with DHSC and partner ALBs to anticipate potential changes in areas of government policy that affect the NHS and help ensure that service perspectives are reflected in the development of government policy. • There is regular dialogue between DHSC/ALB teams, including strategy and finance teams. • We monitor stakeholder and political reactions to ensure we react to emerging political and regulatory developments. • We continue to contribute to constructive engagement with the government and other political stakeholders. • We have a dedicated legal team to ensure full compliance with regulatory requirements. • Our code of conduct is fully embedded across the organisation. • Relevant directorate-level risk registers enable timely analysis of all risks related to political, regulatory, legislative and corporate social responsibility requirements as they affect our objectives.

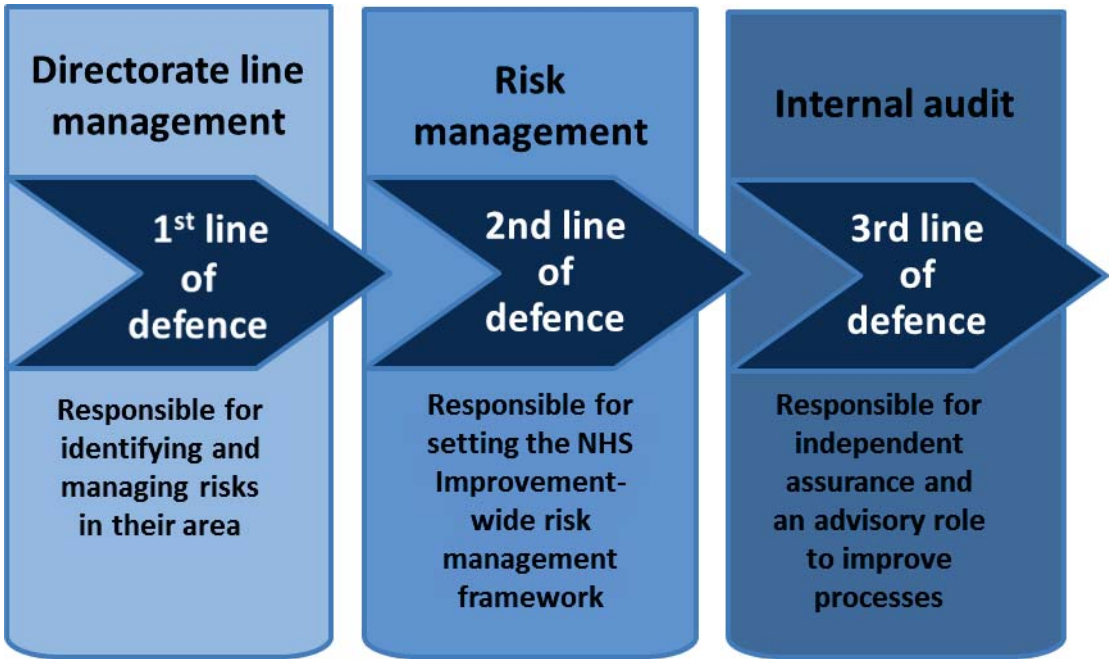
Capacity to handle risk

NHS Improvement's Board has responsibility for ensuring delivery of our strategies and goals as outlined in the 2017-19 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 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 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. Each year, 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.

The executive team owns the strategic risks and nominates a responsible officer for each one. In addition, directorate risks may be escalated to the Board via the Audit and Risk Assurance Committee. Our approach is supported by the risk management framework which underpins the monitoring and management of risk, shown below using the three lines of defence model.



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 an appropriate and high degree. 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 2017/18 (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 2017/18.

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 2017/18. As Accounting Officer for Monitor and NHS Trust Development Authority (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.

Ian Dalton
Chief Executive
3 July 2018

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 and Social Care. 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:

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

The Senior Salaries Review Body made certain recommendations on very senior manager (VSM) salaries, including that DHSC sets out 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 14. 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 DHSC terms and conditions.

Table 14: Executive team notice periods

	Notice period
Ian Dalton CBE Chief Executive from 4 December 2017	6 months
Jim Mackey, Chief Executive until 3 December 2017	*
Robert Alexander, Deputy Chief Executive and Executive Director of Resources until 31 January 2018	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 and Chief Operating Officer	6 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 East)	1 month
Jennifer Howells, Executive Regional Managing Director (South West) from 1 October 2017	**
Jeremy Marlow, Executive Director of Operational Productivity	3 months
Elizabeth O'Mahony Chief Finance Officer from 1 July 2017	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

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

** Jennifer Howells is on secondment from NHS England. NHS Improvement is able to give NHS England one month's notice to terminate the 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 15 shows the total remuneration; two thirds of the 2017/18 costs are charged to NHS TDA and one third to Monitor. This proportion was deemed reasonable following the review of activities between the two organisations.

Table 15: Salary, benefits in kind and pension benefits 2017/18

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				
Ian Dalton CBE[1] Chief Executive from 4 December 2017	90-95	-	95	185-190
Jim Mackey[2] Chief Executive until 3 December 2017	130-135	83	17	155-160
Robert Alexander[3] Deputy Chief Executive and Executive Director of Resources until 31 January 2018	110-115	-	84	190-195
Stephen Hay Deputy Chief Executive and Executive Director of Regulation	190-195	-	-	190-195
Ruth May Executive Director of Nursing	145-150	-	27	175-180
Dr Kathy Mclean[4] Executive Medical Director and Chief Operating Officer from 1 November 2017	190-195	-	-	190-195

Executive team				
Dale Bywater Executive Regional Managing Director (Midlands and East)	155-160	-	45	200-205
Ben Dyson[5] Executive Director of Strategy	125-130	-	51	180-185
Anne Eden[6] Executive Regional Managing Director (South) until 30 September 2017 and Executive Regional Managing Director(South East) from 1 October 2017	170-175	-	-	170-175
Jennifer Howells[7] Executive Regional Managing Director (South West) from 1 October 2017	-	-	-	-
Jeremy Marlow Executive Director of Operational Productivity	135-140	-	56	195-200
Elizabeth O'Mahony[8] Chief Finance Officer from 1 July 2017	110-115	-	67	180-185
Steve Russell Executive Regional Managing Director (London)	165-170	-	26	195-200
Adam Sewell-Jones Executive Director of Improvement	150-155	74	59	215-220
Lyn Simpson Executive Regional Managing Director (North)	155-160	-	20	175-180

1. Ian Dalton became Chief Executive Officer on 4 December 2017. His annualised salary is in the band £285,000 to £290,000.

2. Jim Mackey was 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. He left the post of joint Chief Executive of NHS TDA and Monitor on 3 December 2017. His annualised salary would have been in the band £225,000 to £230,000.

3. Bob Alexander stepped down from the Board on 31 January 2018. From October 2017 until 31 January 2018, he worked on a two-day-a-week basis at NHS Improvement. From 1 February 2018 Bob Alexander is on secondment to the Sussex and East Surrey STP. His annualised salary is £175,000 to £180,000.

4. In addition to her role as Executive Medical Director Dr Kathy Mclean became Chief Operating Officer from 1 November 2017. Her annualised salary is £200,000-£205,000.

5. Ben Dyson is on secondment from DHSC to Monitor from 1 June 2016.

Note: NHS Improvement and NHS England agreed to test an approach to working more closely on a regional basis. From 1 October 2017 the South region was divided into two subregions (South West and South East) with a single Regional Director providing leadership for the whole local system in each sub-region. Anne Eden, Executive Regional Managing Director NHS Improvement South, and Jennifer Howells, Regional Director NHS England South, led the South East and South West respectively. There is a reciprocal arrangement in place whereby Anne Eden is jointly employed by NHS England and Jennifer Howells is seconded from NHS England to carry out the duties of the Executive Regional Managing Directors' roles and will remain employees of their respective organisations and no remuneration costs have been transferred.

6. Anne Eden was Executive Regional Managing Director (South) until 30 September 2017. From 1 October 2017 Anne is the Executive Regional Managing Director (South East) providing leadership for the whole local system. There is no financial charge to NHS England in connection with Anne Eden's employment.

7. Jennifer Howells is seconded from NHS England for the period 1 October 2017 to 31 March 2018 at no charge to NHS Improvement. Her annualised salary would have been in the band £160,000 to £165,000 and all pension-related benefits of £109,000.

8. Elizabeth O'Mahony became Chief Financial Officer on 1 July 2017. Her annualised salary would have been in the band £150,000 to £155,000.

All pension-related benefits calculation may result in a negative figure and in line with SI 2013 No 1981 Large and Medium Sized Companies and Groups negative figures are substituted by a zero.

Table 16: Salary, benefits in kind and pension benefits 2016/17

Name and position	Salary (bands of £5,000)	Benefits in kind to nearest £100	All pension-related benefits	Total (bands of £5,000)
Board executives	**£000**	**£00**	**£000**	**£000**
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 to £5,000.

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

[4] Ben Dyson is on secondment from DHSC 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 DHSC 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.

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 one third to Monitor and two thirds to the NHS TDA. 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 two thirds cost incurred by NHS TDA.

The banded remuneration of the highest paid director in NHS TDA in the financial year 2017/18 was £285,000 to £290,000 (2016/17: £230,000 to £235,000). This was 4.8 times the median remuneration of the directly employed workforce which was £60,287 (2016/17: 3.7 times, with a median remuneration of £62,509).

In 2017/18, no employee received remuneration in excess of the highest paid director (2016/17: none). Remuneration ranged from £5,000-£10,000 to £285,000-£290,000 (2016/17: £5,000-£10,000 to £230,000-235,000).

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

The ratio between the highest paid director and the median remuneration of the workforce has increased from the previous year by 1.1. This is due to the increase in the highest salary from £230,000 - £235,000 in 2016/17 to £285,000 - £290,000 in 2017/18 and a decrease in the median remuneration from £62,509 in 2016/17 to £60,287 in 2017/18. Consequently the pay multiple moved from 3.7 in 2016/17 to 4.8 in 2017/18.

The pay multiples information above has been subject to audit.

Chair 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 Chair and non-executive directors is non-pensionable. The benefits in kind given to the Chair and non-executive directors are disclosed in Table 17. The monetary value of benefits in kind covers any payments (for business expenses or otherwise) or other benefits provided by NHS TDA or Monitor that are treated by HM Revenue and Customs as a taxable emolument. These figures are subject to audit.

Since 1 April 2016 NHS TDA has shared a joint Board with Monitor under the name of NHS Improvement. Table 18 shows the total remuneration; two-thirds of the 2017/18 costs are charged to the NHS TDA.

Table 17: Remuneration and benefits in kind for the Chair and non-executive directors 2017/18

Name	Position	Salary (bands of £5,000)	Benefits in kind to nearest £100	Total (bands of £5,000)
		£000	£00	£000
Baroness Dido Harding[1]	Chair from 30 October 2017	25-30	-	25-30
Ed Smith CBE[2]	Chair until 20 July 2017	20-25	-	20-25
Professor Dame Glynis Breakwell DBE DL	Senior Independent Director	5-10	-	5-10
Laura Carstensen[3]	Non-Executive Director until 30 June 2017	0-5	-	0-5
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[4]	Non-Executive Director and acting Chair from 20 July 2017 to 29 October 2017	25-30	-	25-30

Name	Position	Salary (bands of £5,000)	Benefits in kind to nearest £100	Total (bands of £5,000)
Sarah Harkness	Non-Executive Director	5-10	-	5-10
Sigurd Reinton CBE	Non-Executive Director	5-10	-	5-10
David Roberts[5]	Associate (non-voting) Non–Executive Director from 5 March 2018	-	-	-
Caroline Thomson[6]	Deputy Chair until 31 August 2017	0-5	-	0-5

1. The salary for Baroness Dido Harding is for the period 30 October 2017 to 31 March 2018; her annualised salary is in the band £60,000 to £65,000.
2. The salary for Ed Smith is for the period 1 April 2017 to 20 July 2017; his annualised salary is in the band £60,000 to £65,000.
3. The salary for Laura Carstensen is for the period 1 April 2017 to 30 June 2017; her annualised salary is in the band £5,000 to £10,000.
4. Richard Douglas was Acting Chair for the period 20 July 2017 to 29 October 2017, for which his additional remuneration was in the band £10,000 to £15,000 and his salary for his role as Non-Executive Board Member was in the band £10,000 to £15,000. Richard Douglas is also an Associate (non-voting) Non-Executive Board Member of NHS England.
5. David Roberts, NHS England Vice Chair, became an Associate (non-voting) Non-Executive Board member of NHS Improvement from 5 March 2018 and has waived his entitlement to Non-Executive Director remuneration.
6. The salary for Caroline Thomson is for the period 1 April 2017 to 31 August 2017; her annualised salary is in the band £5,000 to £10,000.

Table 18: Remuneration and benefits in kind for the Chair 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 19: 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 2018 (bands of £5,000)	Lump sum at pension age related to accrued pension at 31 March 2018 (bands of £5,000)	CETV at 31 March 2017	CETV at 31 March 2018	Real increase in CETV
	£000	£000	£000	£000	£000	£000	£000
Ian Dalton CBE[1] Chief Executive	0.0-2.5	5.0-7.5	25-30	80-85	426	552	30
Robert Alexander[2] Deputy Chief Executive and Executive Director of Resources	2.5-5.0	7.5-10.0	45-50	140-145	927	1,069	68
Stephen Hay[3] Deputy Chief Executive and Executive Director of Regulation	-	-	35-40	0-5	641	641	-
Ruth May Executive Director of Nursing	0.0-2.5	10.0-12.5	60-65	180-185	947	1,112	134
Dr Kathy McLean[3] Medical Director and Chief Operating Officer	-	-	75-80	225-230	1,617	1617	-

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 2018 (bands of £5,000)	Lump sum at pension age related to accrued pension at 31 March 2018 (bands of £5,000)	CETV at 31 March 2017	CETV at 31 March 2018	Real increase in CETV
	£000	£000	£000	£000	£000	£000	£000
Dale Bywater Executive Regional Managing Director (Midlands and East)	2.5-5.0	0.0-2.5	45-50	110-115	665	733	39
Ben Dyson Executive Director of Strategy	2.5-5.0	-	5.0-10.0	-	46	82	25
Anne Eden[3] Executive Regional Managing Director (South East)	-	-	70-75	215-220	1,510	1510	-
Jenifer Howells[4] Executive Regional Managing Director (South West)	2.5-5.0	0.0-2.5	40-45	35-40	411	497	18
Jeremy Marlow[2] Executive Director of Operational Productivity	2.5-5.0	0.0-2.5	25-30	60-65	338	391	24
Elizabeth O'Mahony[5] Chief Finance Officer	2.5-5.0	2.5-5.0	45-50	120-125	630	699	13

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 2018 (bands of £5,000)	Lump sum at pension age related to accrued pension at 31 March 2018 (bands of £5,000)	CETV at 31 March 2017	CETV at 31 March 2018	Real increase in CETV
	£000	£000	£000	£000	£000	£000	£000
Steve Russell[2] Executive Regional Managing Director (London)	2.5-5.0	0.0-(2.5)	40-45	105-110	553	594	11
Adam Sewell-Jones Executive Director of Improvement	2.5-5.0	-	5-10	-	58	96	25
Lyn Simpson Executive Regional Managing Director (North)	0.0-2.5	5.0-7.5	70-75	215-220	1,544	1,676	94

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. Ian Dalton joined the NHS TDA on the 4 December 2017. The values included in the Pension Benefits table for the 'Real increase in pension at age 60' and the 'Real increase in cash equivalent transfer value ' relate to the period 4 December 2017 to 31 March 2018. The 'Total accrued at pension age' and the 'Cash equivalent transfer value at 31 March 2017' and 2018 are annual figures.
2. Robert Alexander and Steve Russell's 2016/17 pensions and cash equivalent transfer values have been revised by NHS Pensions. Adam Sewell-Jones and Jeremy Marlow's pension benefits have been revised by Civil Service Pensions. The revised figures are shown in the following table.

Name	Title	Real increase in pension at pension age (bands of £2,500)	Real increase in pension lump sum at pension age (bands of £2,500)	Total accrued pension at pension age at 31 March 2017 (bands of £5,000)	Lump sum at pension age related to accrued pension at 31 March 2017 (bands of £5,000)	Cash Equivalent Transfer Value at 31 March 2016	Cash Equivalent Transfer Value at 31 March 2017	Real increase in Cash Equivalent Transfer Value
		£000	£000	£000	£000	£000	£000	£000
Robert Alexander	Deputy Chief Executive	0.0-2.5	5.0-7.5	40-45	125-130	834	927	68
Steve Russell	Director of Delivery and Development (London)	0.0-2.5	(2.5)-(5.0)	40-45	105-110	508	553	19
Jeremy Marlow	Executive Director of Operational Productivity	-	-	-	-	-	338	-
Adam Sewell-Jones	Executive Director of Improvement	2.5-5.0	-	5-10	-	22	58	24

Note: Robert Alexander left his role as Deputy Chief Executive of the NHS TDA on 31 January 2018. The values included in the Pension Benefits table for the 'Real increase in pension at age 60' and the 'Real increase in cash equivalent transfer value' relate to the period 1 April 2017 to 31 January 2018. The 'Total accrued at pension age' and the 'Cash equivalent transfer value at 31 March 2017' and 2018 are annual figures.

3. Kathy Maclean, Anne Eden and Stephen Hay did not contribute to the NHS Pension Scheme or the Civil Service Pension Scheme during the reporting year.
4. Jennifer Howells was seconded to the NHS TDA on the 1 October 2017. The values included in the Pension Benefits table for the 'Real increase in pension at age 60' and the 'Real increase in cash equivalent transfer value' relate to the period 1 October 2017 to 31 March 2018. The 'Total accrued at pension age' and the 'Cash equivalent transfer value at 31 March 2017' and 2018 are annual figures.
5. Elizabeth O'Mahony became Chief Financial Officer from the NHS TDA on the 1 July 2017. The values included in the Pension Benefits table for the 'Real increase in pension at age 60' and the 'Real increase in cash equivalent transfer value' relate to the period 1 July 2017 to 31 March 2018. The 'Total accrued at pension age' and the 'Cash equivalent transfer value at 31 March 2017' and 2018 are annual figures.

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 figures shown relate 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.

Exit packages

Table 20: NHS TDA exit packages for 2017/18

Exit package cost band	Number of compulsory redundancies	Number of other departures agreed	Total number of exit packages by cost band
<£10,000		2	2
£10,000–£25,000	1		1
£25,001–£50,000	1	1	2
£50,001–£100,000	2		2
£100,001–£150,000			
£150,001–£200,000			
Total number of exit packages by type	4	3	7
Total resource cost	**186**	**54**	**240**

During 2016/17 NHS TDA provided five exit packages that were compulsory redundancy costing £153,000.

The exit package disclosure has been subject to audit.

Details of off-payroll engagements

Following the *Review of tax arrangements of public sector appointees*[47] 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.

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

The information in the tables below includes all off-payroll engagements as at 31 March 2017 for more than £245 per day and that last longer than six months for the NHS TDA. 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.

Table 21: Off-payroll engagements at 31 March 2018

Number of existing engagements as at 31 March 2018, for more than £245 per day and that last longer than 6 months	
Of which, the numbers that have existed:	-
for less than one year at time of reporting	-
for between one and two years at time of reporting	-
for between two and three years at time of reporting	-
for between three and four years at time of reporting	-
for four or more years at time of reporting	-
Number of new engagements, or those that reached six months in duration, between 1 April 2017 and 31 March 2018, for more than £245 per day	
Number of new engagements, or those that reached six months in duration, between 1 April 2017 and 31 March 2018	-
Of which…..	-
Number assessed as caught by IR35	-
Number assessed as not caught by IR35	-
Number engaged directly (via PSC contracted to department) and are on the departmental payroll	-
Number of engagements reassessed for consistency/assurance purposes during the year	-
Number of engagements that saw a change to IR35 status following the consistency review	-
Number of off-payroll engagements of Board members and/or senior officials with significant financial responsibility, during the financial year	-
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

Consultancy expenditure

The NHS TDA spent £61,000 in 2017/18 (2016/17: £6,000) on consultancy expenditure.

Staff report

Recruitment

Following the formation of NHS Improvement, we made considerable efforts to harmonise the recruitment processes between Monitor and the NHS Trust Development Authority (TDA), with a clear focus on consistency and accuracy.

The recruitment team worked with our outsourced human resources shared services provider, NHS Business Services Authority, to develop the processes, systems and rules for the effective management of candidates, contract production, on-boarding and payroll. The team developed its core offering to include:

- &supporting the organisation with systems/interview training
- &developing an on-boarding offering to make sure all relevant background checks are completed
- &case management of 'continuous service' queries
- &payroll set-up checks.

Alongside managing roles, this led to an increase in day-to-day support activity, with over 30 training sessions for line managers, a 90% intervention rate with new starters to ensure payroll was correctly set up (and to enable payment in the first month of joining) and 50 individual continuous service investigations.

Table 22: Staff numbers as at 31 March 2018

2017/18			
Staff numbers as at 31 March 2018	**Total**	**Permanently employed**	**Other**
Number of staff (TDA)	992	780	212
Number of staff (Monitor)	377	363	14
Total (NHS Improvement)	**1369**	**1143**	**226**

Analysis of staff costs has been subject to audit and detailed in Note 3 to the financial statements.

Role activity remained consistent with the previous year, with 714 staff recruited, 60 internal/external secondments and an average headcount of 1,230 (1,186 full-time equivalents).

We expect the additional recruitment responsibilities for the Healthcare Safety Investigation Branch (which has significant growth plans) and closer working with NHS England to affect recruitment activity in 2018/19.

Table 23: Number of ESMs as at 31 March 2018

Pay band	Total	Permanently employed	Other
TDA contract			
Executive and senior managers (ESM)	75	56	19
Monitor contract			
ESM	20	19	1
Total NHS Improvement	**95**	**75**	**20**

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 our policies to make sure they fully comply with the most recent legislative changes, national terms and conditions of employment and best practice.

Most recently we published a new combined NHS Improvement flexible working policy, which was approved by the trade union representatives.

During 2017/18, the NHS TDA had at various points three local trade union representatives. Each was allowed to take off all necessary time for trade union activities. This includes:

- bi-monthly meetings (maximum two hours), plus associated reading time (maximum one hour)
- local branch meetings as and when scheduled
- support role as an accompanying colleague to formal employee meetings, as requested by individuals.

No issues have been raised in trade union meetings during 2017/18 or to the chair of those meetings, nor to taking facility time off.

Employees do not currently record their time for any work (including trade union activities), and so we cannot report on the percentage of time or pay. However, we will ask trade union representatives to record this separately in future.

All time for trade union activities is fully paid by NHS TDA as an employer.

Table 24: Gender of staff as at 31 March 2018

Staff category	Female	Male
TDA contract		
ESMs	33	42
Other staff	564	353
Total TDA	**597**	**395**
Monitor contract		
ESMs	10	10
Other staff	193	164
Total Monitor	**203**	**174**
Total NHS Improvement	**800**	**569**

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. This year there has been a clear step change in focus and action; our membership of the Employers Network for Equality and Inclusion was renewed and reinvigorated. The Inclusion Partnership was formally launched with an executive sponsor, core membership – but open to all, positive terms of reference, and objectives for 2018/19 drafted and ready for action.

We also made connections to equal opportunities and diversity in developing our values. We will undertake work next year on talent management, succession planning and equality of opportunity and diversity, while taking into account the recommendations of the Workforce Race Equality Standard and the forthcoming Workforce Disability Equality Standard, due to be implemented in autumn 2019.

Table 25: Ethnicity of staff as at 31 March 2018

	Number of staff (TDA contract)	Number of staff (Monitor contract)	Number of staff (NHS Improvement total)
White	687	254	941
Black and minority ethnic	187	87	274
Did not state/undisclosed	118	36	154
Total	**992**	**377**	**1369**

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. During the year we identified key aspects for improvement and development, and will continue to work on them as our organisation grows and changes.

Our action on staff wellbeing included:

- launching hard copy and online self-help guides for mental health on World Mental Health Day in October 2017
- training mental health first aiders
- a London-based one-day health check, during which 70 people had their physical health and wellbeing reviewed and were given action plans.

Days, activities and plans are developed by staff for staff. All staff continue to be required to undertake mandatory health and safety training, including those recently joining the organisation.

Social, community and human rights

We have direct contact with the Equality and Human Rights Commission and one of our executive directors is a member of the Equality and Diversity Council, which helps us focus rigorously on action for human rights. We have a regular staff newsletter, hold all-staff briefings and our intranet is regularly updated with information on matters of concern to staff. In addition, our Chief Operating Officer writes a weekly blog on the intranet. 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. We involve other staff representatives through a staff forum. We have set up several groups to engage staff in helping shape our responses to issues that affect their employment, wellbeing and development.

Staff survey

We conducted our second all-staff survey in November 2017. A total of 1,046 people responded (83%). The key outcome was a 13% improvement in our staff engagement score, which is now 64%.

One of the highest scores showed that staff could see their work had an impact on the NHS. However, we need to better communicate the value their work adds and the impact of the organisation as a whole. Executive directors and the leaders of each directorate drew up action plans following the survey. Key themes are:

- improving communications, particularly between functions and teams
- role modelling good leadership

- building on positive perceptions of line managers treating staff fairly and with respect
- understanding and caring about the organisation's future and purpose.

The survey recorded a 20% rise in the number of staff who believed that action would be taken as a result of the survey. We are also taking note of many qualitative comments to ensure NHS Improvement is a great place to work.

Sickness absence

Table 26: Sickness absence as at 31 March 2018

Staff absence due to sickness	January to December 2017
TDA contract	
Total days lost	3,368
Average working days lost per employee	2.1
Monitor contract	
Total days lost	933.2
Average working days lost per employee	2.25
NHS Improvement	
Total days lost	4,301.2
Average working days lost per employee	2.13

Gender pay gap

Our mean gender pay gap in hourly pay is 15.0% and the median is 17.4%. These figures are lower than the UK mean (17.4%) and median (18.4%) gender pay gap, as published by the Office for National Statistics in 2017.

Nevertheless, we recognise that we need to reduce our gender pay gap. We are working on initiatives to do this, such as our in-house leadership programme, which

is attended by increasing numbers of female employees and shows our commitment to staff development and progression.

We are proud that our Board – which includes a female chair – is gender-balanced, and we will ensure that it remains so. We will analyse our gender pay gap results in more detail to pinpoint where and what further improvements we can make.

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.

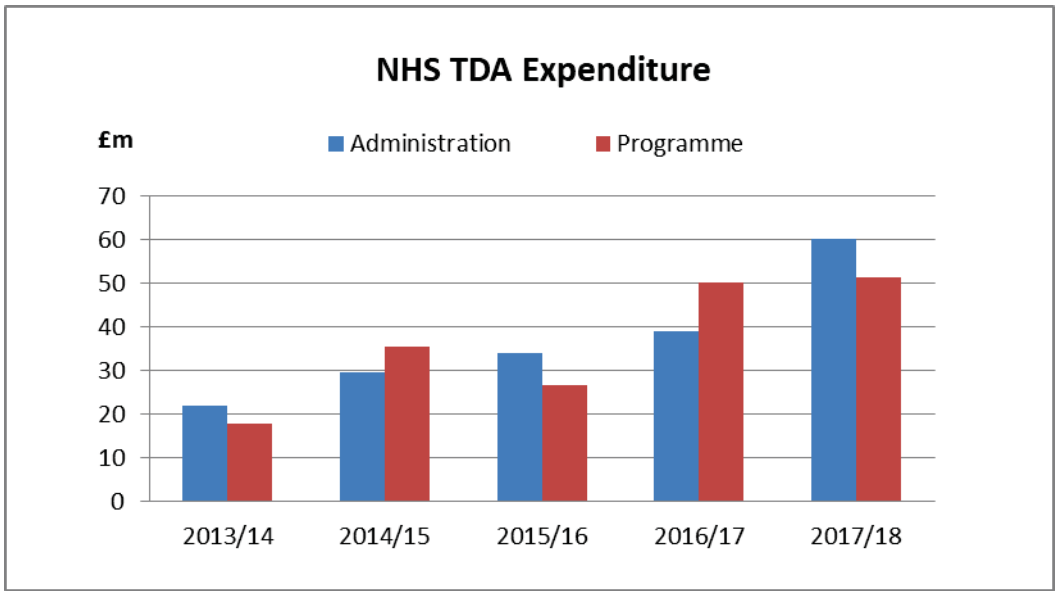
Cost allocation and charges for information

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 3 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. 2017/18 expenditure details are disclosed in the annual accounts.

Figure 3: Trend in net expenditure since 2013/14



Ian Dalton
Chief Executive
3 July 2018

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

Opinion on financial statements

I certify that I have audited the financial statements of the NHS Trust Development Authority for the year ended 31 March 2018 under the National Health Service Act 2006 and Secretary of State directions issued thereunder. The financial statements comprise: the Statements of Comprehensive Net Expenditure, Financial Position, Cash Flows, Changes in Taxpayers' Equity; and the related notes, including the significant accounting policies. These financial statements have been prepared under the accounting policies set out within them.

I have also audited the information in the Accountability Report that is described in that report as having been audited.

In my opinion the financial statements:

- give a true and fair view of the state of the NHS Trust Development Authority's affairs as at 31 March 2018 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 conducted my audit in accordance with International Standards on Auditing (ISAs) (UK) and Practice Note 10 'Audit of Financial Statements of Public Sector Entities in the United Kingdom'. My responsibilities under those standards are further described in the Auditor's responsibilities for the audit of the financial statements section of my certificate. Those standards require me and my staff to comply with the Financial Reporting Council's Revised Ethical Standard 2016. I am independent

of the NHS Trust Development Authority in accordance with the ethical requirements that are relevant to my audit and the financial statements in the UK. My staff and I have fulfilled our other ethical responsibilities in accordance with these requirements. I believe that the audit evidence I have obtained is sufficient and appropriate to provide a basis for my opinion.

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

Key audit matters

Key audit matters are those matters that, in my professional judgment, were of most significance in my audit of the financial statements of the current period and include the most significant assessed risks of material misstatement (whether or not due to fraud) that I identified.

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. These matters were addressed in the context of my audit of the financial statements as a whole, and in forming my opinion thereon, and I do not provide a separate opinion on these matters.

This is not a complete list of all risks identified by my audit but only those areas that had the greatest effect on my overall audit strategy, allocation of resources and direction of effort. I have not, for example, included information relating to the work I have performed around the apportionment of joint costs between the two entities that operate jointly a NHS Improvement.

The areas of focus were discussed with the Audit and Risk Assurance Committee; their report on matters they consider to be significant to the financial statements is set out in the Governance statement.

In this year's report, the following changes to the risks identified have been made compared to my prior year report:

Key audit matter

Integration of new functions:

In the previous year, I reported that as part of the creation of NHS Improvement (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 would have a material impact on the financial statements and on the disclosures contained within them. It would also impact on the information presented in the Annual Report.

To address this risk last year, I reviewed the appropriateness of management's processes and procedures and accounting treatment adopted in recognising new transactions and functions. The results of my testing in this area were satisfactory and no further transfer in of new functions has occurred. For this reason I have not included this item as a significant risk in 2017-18.

I have identified one significant risk for my 2017-18 audit. This item was also a risk in the previous year. I have set out below how my audit addressed this specific risk 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 matter	My response and conclusions
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 have identified this risk because International Standards on Auditing (UK) require that I consider it. I have reviewed a sample of journals, selected on the basis of risk characteristics identified, for appropriateness and considered management's accounting estimates and significant judgements for evidence of bias. I have considered whether any significant and unusual transactions have occurred during the year and concluded that there were none. In addition, I have included an element of unpredictability in my testing plan. The results of my testing in this area are satisfactory and I am satisfied that this risk has not materialised.

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 the NHS Trust Development Authority's financial statements at £2,605,180 which is approximately 2% of gross expenditure. I chose this benchmark as I consider this 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 £52,104, as well as differences below this threshold that in my view warranted reporting on qualitative grounds.

Total unadjusted audit differences reported to the Audit Committee have increased net expenditure by £363,000.

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 the 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 examine, certify and report on the financial statements in accordance with the Secretary of State directions under the National Health Service Act 2006.

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. Reasonable assurance is a high level of assurance, but is not a guarantee that an audit conducted in accordance with ISAs will always detect a material misstatement

when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in the aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of these financial statements.

As part of an audit in accordance with ISAs, I exercise professional judgment and maintain professional scepticism throughout the audit. I also:

- identify and assess the risks of material misstatement of the financial statements, whether due to fraud or error, design and perform audit procedures responsive to those risks, and obtain audit evidence that is sufficient and appropriate to provide a basis for my opinion. The risk of not detecting a material misstatement resulting from fraud is higher than for one resulting from error, as fraud may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal control.
- obtain an understanding of internal control relevant to the audit in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the NHS Trust Development Authority's internal control.
- evaluate the appropriateness of accounting policies used and the reasonableness of accounting estimates and related disclosures made by management.
- conclude on the appropriateness of management's use of the going concern basis of accounting and, based on the audit evidence obtained, whether a material uncertainty exists related to events or conditions that may cast significant doubt on the NHS Trust Development Authority's ability to continue as a going concern. If I conclude that a material uncertainty exists, I am required to draw attention in my auditor's report to the related disclosures in the financial statements or, if such disclosures are inadequate, to modify my opinion. My conclusions are based on the audit evidence obtained up to the date of my auditor's report. However, future events or conditions may cause the entity to cease to continue as a going concern.
- evaluate the overall presentation, structure and content of the financial statements, including the disclosures, and whether the consolidated financial statements represent the underlying transactions and events in a manner that achieves fair presentation.

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

I am also 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.

Audit scope

The scope of my audit was determined by obtaining an understanding of the entity and its environment, including entity-wide controls, and assessing the risks of material misstatement at the entity level.

Other Information

The Accounting Officer is responsible for the other information. The other information comprises information included in the annual report, other than the parts of the Accountability Report described in that report as having been audited, the financial statements and my auditor's report thereon. My opinion on the financial statements does not cover the other information and I do not express any form of assurance conclusion thereon. In connection with my audit of the financial statements, my responsibility is to read the other information and, in doing so, consider whether the other information is materially inconsistent with the financial statements or my knowledge obtained in the audit or otherwise appears to be materially misstated. If, based on the work I have performed, I conclude that there is a material misstatement of this other information, I am required to report that fact. I have nothing to report in this regard.

Opinion on other matters

In my opinion:

- the parts of the Accountability Report to be audited have been properly prepared in accordance with Secretary of State directions made under the National Health Service Act 2006;

- in light of the knowledge and understanding of the NHS Trust Development Authority and its environment obtained in the course of the audit, I have not identified any material misstatements in the Performance Report or the Accountability Report; and
- the information given in the Performance and Accountability Reports 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 part of the Accountability Report to be audited are not in agreement with the accounting records and returns; or
- I have not received all of the information and explanations I require for my audit.
- the Governance Statement does not reflect compliance with HM Treasury's guidance.

Report

I have no observations to make on these financial statements.

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

July 2018

Financial statements

Statement of comprehensive net expenditure for the year ended 31 March 2018

	Note	2017-18 £000	2016-17 £000
Other operating revenue	4	18,725	8,068
Total operating revenue		**18,725**	**8,068**
Staff costs	5	70,444	43,077
Purchase of goods and services	6	20,414	15,082
Depreciation and impairment charges	6	244	236
Provision expense	6	(71)	(22)
Other operating expenditure	6	39,228	38,903
Total operating expenditure		**130,259**	**97,276**
Net operating costs for the financial year		**111,534**	**89,208**
Other comprehensive net expenditure		-	-
Total comprehensive net expenditure for the year		**111,534**	**89,208**

The notes on pages 183 to 207 form part of these accounts.

Statement of Financial Position as at 31 March 2018

	Note	31 March 2018 £000	31 March 2017 £000
Non current assets			
Property, plant & equipment	8.1	755	246
Intangible assets	8.2	851	81
Total non-current assets		**1,606**	**327**
Current assets			
Trade and other receivables	9	12,765	3,192
Cash and cash equivalents	10	7,100	1,625
Total current assets		**19,865**	**4,817**
Total assets		**21,471**	**5,144**
Current liabilities			
Trade and other payables	11	40,921	29,989
Provisions	12	-	71
Total current liabilities		**40,921**	**30,060**
Net current liabilities		**(21,056)**	**(25,243)**
Total net liabilities		**(19,450)**	**(24,916)**
Financed by taxpayers' equity			
General fund		(19,450)	(24,916)
Total taxpayers' equity		**(19,450)**	**(24,916)**

The financial statements and the notes on pages 183 to 207 were signed on behalf of the NHS Trust Development Authority by:

Chief Executive Officer
NHS Trust Development Authority
3 July 2018

Statement of Changes in Taxpayers' Equity for the year ended 31 March 2018

	Note	General Fund £000
Balance at 31 March 2017		**(24,916)**
Changes in taxpayers' equity for 2017-18		
Comprehensive net expenditure for the year	SoCNE	(111,534)
Net parliamentary funding	SOCF	117,000
Balance at 31 March 2018		**(19,450)**
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)**

The notes on pages 183 to 207 form part of these accounts.

Statement of Cash Flows for the year ended 31 March 2018

	Note	2017-18 £000	2016-17 £000
Cash flows from operating activities			
Net operating cost	SOCNE	(111,534)	(89,208)
Adjustments for non-cash transactions			
Depreciation, amortisation and impairments	6	244	236
Provisions arising during the year	12	-	71
Provisions reversed unused	12	(71)	(93)
Increase in trade and other receivables	9	(9,573)	(2,433)
Increase in trade payables and other current liabilities		10,442	19,493
Provisions utilised	12	-	-
Net cash inflow / (outflow) from operating activities		**(110,492)**	**(71,934)**
Cash flows from investing activities			
(Payments) for property, plant and equipment		(679)	(23)
(Payments) for intangible assets		(354)	(16)
Net cash inflow / (outflow) from investing activities		**(1,033)**	**(39)**
Cash flows from financing activities			
Net parliamentary funding	SoCTE	117,000	68,793
Net financing		**117,000**	**68,793**
Net increase/(decrease) in cash and cash equivalents		5,475	(3,180)
Cash and cash equivalents at the beginning of the period		**1,625**	4,805
Cash and cash equivalents at the end of the period	10	**7,100**	**1,625**

The notes on pages 183 to 207 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 and Social Care 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 NHS Improvement 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 NHS Improvement but remain separate legal entities.

In line with the guidance issued by the Department of Health and Social Care the NHS TDA's 2017/18 accounts have been prepared on a going concern basis. The NHS TDA continues to be resourced by the Department of Health and Social Care which has approved an NHS TDA 2018/19 budget and there is no evidence to suggest that the NHS TDA will not continue to be financed by the Department of Health and Social Care 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 DHSC Group**

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

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

1.5 & **Critical accounting judgements and key sources of estimation uncertainty**

In the application of the NHS TDA's accounting policies, management is required to make judgements, estimates and assumptions about the carrying amounts of assets and liabilities that are not readily apparent from other sources. The estimates and associated assumptions are based on historical experience and other factors that are considered to be relevant. Actual results may differ from those estimates. The estimates and underlying assumptions are continually reviewed. Revisions to accounting estimates are recognised in the period in which the estimate is revised if the revision affects only that period; or in the period of the revision and future periods if the revision affects both current and future periods.

1.5.1 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 organisation’s 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 2018 were based on the NHS TDA's best professional judgement in line with IAS 37 and details of provisions can be seen in note 12.

1.5.3 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 1.5.2) 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 DHSC within an approved cash limit, which is credited to the general fund. Parliamentary funding is recognised in the financial period in which it is received.

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 1.5.2.

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 2.42% (previously minus 2.70%)
- medium term – minus 1.85% (previously minus 1.95%)
- long term – minus 1.56% (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 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 2017-18. The application of the Standards as revised would not have a material impact on the accounts for 2017-18, 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 Regulatory Deferral Accounts: The European Financial Reporting Advisory Group recommended in October 2015 that the standard should not be endorsed as it is unlikely to be adopted by many EU countries. Applies to first time adopters of IFRS after January 2016; therefore not applicable to DHSC group bodies.

- & 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.

- & IFRS 17 Insurance Contracts: Applications required for accounting periods beginning on or after January 2021, 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.

- & IFRIC 23 Uncertainty over Income Tax Treatments: Application required for accounting periods beginning on or after 1 January 2019.

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 is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2018, is based on valuation data as 31 March 2017, updated to 31 March 2018 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

The latest assessment of the liabilities of the scheme is contained in the report of the scheme actuary, which forms part of the annual NHS Pension Scheme Accounts. These accounts can be viewed on the NHS Pensions website and are published annually. Copies can also be obtained from The Stationery Office.

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 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 and Social Care, with the consent of HM Treasury, and consideration of the advice of the Scheme Actuary and employee and employer representatives as deemed appropriate.

The next actuarial valuation is to be carried out as at 31 March 2016 and is currently being prepared. The direction assumptions are published by HM Treasury which are used to complete the valuation calculations, from which the final valuation report can be signed off by the scheme actuary. 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 and Social Care 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; the funding of the Authority's programme activities and the activities of the The Healthcare Safety Investigation Branch.

	Administration		Programme		HSIB		Total	
	2017-18 £000	2016-17 £000	2017-18 £000	2016-17 £000	2017-18 £000	2016-17 £000	2017-18 £000	2016-17 £000
Revenue	(2,116)	(1,757)	(16,609)	(6,311)	-	-	(18,725)	(8,068)
Expenditure	62,199	40,877	64,400	55,182	3,660	1,217	130,259	97,276
Net operating costs	**60,083**	**39,120**	**47,791**	**48,871**	**3,660**	**1,217**	**111,534**	**89,208**
Assets	9,883	4,876	10,887	113	701	155	21,471	5,144
Liabilities	(11,166)	(5,799)	(29,396)	(24,045)	(359)	(216)	(40,921)	(30,060)
Net (liabilities) / assets	**(1,283)**	**(923)**	**(18,509)**	**(23,932)**	**342**	**(61)**	**(19,450)**	**(24,916)**

Administration
The financial objectives of the NHS TDA is to manage the recurrent costs of management and administration within the allocation of £61,702,000 this funding covers staff, accomodation and other running costs.

Programme
The NHS TDA received an allocation of £49,760,000 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) was established in 2016/17. The purpose of the organisation is to improve patient safety through effective and independent investigations that do not apportion blame or liability. HSIB received an allocation of £3,800,000 programme funding.

4. Revenue

	2017-18	2016-17
	£000	£000
Administration revenue		
Other fees and charges	280	225
Other miscellaneous revenue	820	828
Rental revenue recovery	33	38
Revenue in respect of seconded staff	983	666
Total administration revenue	**2,116**	**1,757**
Programme revenue		
Other miscellaneous revenue	305	477
Provision of emergency care improvement programme and elective care intensive support	8,789	5,636
Provision of the Getting It Right First Time (GIRFT) programme	7,361	-
Revenue in respect of seconded staff	154	198
Total programme revenue	**16,609**	**6,311**
Total revenue	**18,725**	**8,068**

The Getting It Right First Time (GIRFT) programme - a partnership with the Royal National Orthopaedic Hospital NHS Trust, and led by frontline clinicians - aims to improve care quality by identifying and reducing unwarranted variations in service and practice.

5. Employee benefits and staff numbers

5.1. Employee benefits

	2017-18			2016-17
	Total £000	Permanently employed £000	Other £000	Total £000
Gross expenditure				
Salaries and wages	58,376	41,564	16,812	36,290
Social security costs	5,775	5,177	598	3,173
Employer contributions to NHS BSA - Pensions Division	6,053	5,497	556	3,461
Termination benefits	240	239	1	153
Total gross expenditure	**70,444**	**52,477**	**17,967**	**43,077**
Administration expenditure				
Salaries and wages	40,538	33,202	7,336	26,673
Social security costs	4,590	4,230	360	2,653
Employer contributions to NHS BSA - Pensions Division	4,811	4,469	342	2,906
Termination benefits	240	239	1	153
Total administration expenditure	**50,179**	**42,140**	**8,039**	**32,385**
Programme expenditure				
Salaries and wages	17,838	8,362	9,476	9,617
Social security costs	1,185	947	238	520
Employer contributions to NHS BSA - Pensions Division	1,242	1,028	214	555
Termination benefits	-	-	-	-
Total programme	**20,265**	**10,337**	**9,928**	**10,692**

The apprenticeship levy was introduced in 2017-18, costs have been included within the social security costs.

5.2. Average Staff Numbers

	2017-18			2016-17
	Total	Permanently employed	Other	Total
Average Staff Number	**798**	**655**	**143**	444
Administration staff	657	551	106	378
Programme staff	141	104	37	66

The increase in staff numbers is mainly due to the recruitment of staff to develop national workstreams supporting improvement, productivity and efficiency in NHS provider organisations.

5.3. Ill health retirements

	2017-18 Total	2016-17 Total
Number of persons retired early on ill health grounds	-	1

There were no additional pensions liabilities accrued in the year (2016-17 NIL).

5.4. Exit Packages agreed

	2017-18 Total	2016-17 Total
Number of other departures agreed		
Exit package cost band		
<£10,000	2	3
£10,000 - £25,000	1	-
£25,000 - £50,000	2	1
£50,000 - £100,000	2	1
£100,000- £150,000	-	-
£150,000- £200,000	-	-
> £200,000	-	-
Total number of exit packages by type	7	5
Total resource cost (£000s)	240	153

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 2017-18 and 2016-17.

6. Operating expenditure

	Note	2017-18	2016-17
		£000	£000
Purchase of goods and services			
Administration costs			
Auditors' remuneration for NHS TDA		50	50
Auditors' remuneration for consolidated accounts of NHS providers		120	-
Business travel		1,923	1,382
Consultancy		44	-
Establishment expenses		1,522	1,001
Information and communications		2,005	1,705
Premises		2,689	2,283
Professional fees		886	487
Sub-total		**9,239**	**6,908**
Programme costs			
Business travel		1,646	1,054
Consultancy		17	6
Establishment expenses		1,509	853
Information and communications		387	346
Premises		184	65
Professional fees		7,432	5,850
Sub-total		**11,175**	**8,174**
Total purchase of goods and services	SoCNE	**20,414**	**15,082**

The 2016-17 external contract staffing balances have been reclassified as professional fees (administration £133,000, programme £258,000).

Within the Programme professional fees £2,564,000 relates to the Transformation programme and £2,954,000 relates to the Operational Productivity programme (2016-17 £3,545,000 and £1,723,000 respectively).

Depreciation and impairment charges			
Administration costs			
Depreciation	8.1	94	206
Amortisation	8.2	20	21
Impairments and reversals of intangible assets	8.1	-	9
Sub-total		**114**	**236**
Programme costs			
Depreciation	8.1	85	-
Amortisation	8.2	45	-
Sub-total		**130**	**-**
Total depreciation and impairment charges	SoCNE	**244**	**236**
Provision expense			
Administration costs			
Provision expense	12	(71)	(22)
Total provision expense	SoCNE	**(71)**	**(22)**

	Note	2017-18	2016-17
		£000	£000
Other operating expenditure			
Administration costs			
Miscellaneous Expenditure		2,653	1,274
Non-executive members' remuneration		85	98
Sub-total		**2,738**	**1,372**
Programme costs			
Miscellaneous Expenditure		2,768	2,366
Funding provided to NHS trusts and partners:			
Emergency care improvement programme		228	1,697
Intervention and support to NHS Trusts		4,168	5,985
Operational productivity		9,370	2,035
Patient Safety Collaboratives		7,000	8,224
Special measures and peer improvement		9,556	10,707
Trust transactions and sustainable solutions		3,400	6,517
Sub total		**36,490**	**37,531**
Total other operating expenditure	SoCNE	**39,228**	**38,903**
Total operating expenditure	SoCNE	**59,815**	**54,199**

Within the operational productivity funding to providers it includes £7,291,000 for the GIRFT programme partnership with the Royal National Orthopaedic Hospital NHS Trust (2016-17 NIL).

7. Operating leases

	2017-18	2016-17
	£000	£000
Payments recognised as an expense		
Minimum lease payments	253	70
Total	**253**	**70**
Payable		
No later than one year	138	10
Between one and five years	102	-
After five years	-	-
Total	**240**	**10**

Included in the Administration Premises expenditure in note 6 is £1058,000 of costs paid to NHS Property Services for the occupation of six sites, and £508,000 to the Department of Health and Social Care for the occupation of two sites (2016-17 £1,503,000 for seven sites and £486,000 respectively). They are operated under a memorandum of understanding.

8. Non-current assets

8.1 Property, plant and equipment

2017-18	Information technology	Furniture & fittings	Total
	£000	£000	£000
Cost or valuation			
At 1 April 2017	580	174	**754**
Additions purchased	245	443	**688**
Disposals	(82)	-	**(82)**
At 31 March 2018	**743**	**617**	**1,360**
Depreciation			
At 1 April 2017	444	64	**508**
Charged during the year	96	83	**179**
Disposals	(82)	-	**(82)**
At 31 March 2018	**458**	**147**	**605**
Net book value at 31 March 2017	136	110	**246**
Net book value at 31 March 2018	**285**	**470**	**755**

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**

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

The total impairment charge in 2016-17 has been charged direct to the Statement of Comprehensive Net Expenditure.

8. Non-current assets

8.2 Intangible assets

2017-18	Software purchased	Assets under construction	Websites	Total
	£000	£000	£000	£000
Cost or valuation				
At 1 April 2017	10	-	95	105
Additions purchased	120	715	-	835
At 31 March 2018	**130**	**715**	**95**	**940**
Amortisation				
At 1 April 2017	7	-	17	**24**
Charged during the year	33	-	32	**65**
At 31 March 2018	**40**	**-**	**49**	**89**
Net book value at 31 March 2017	3	-	78	**81**
Net book value at 31 March 2018	**90**	**715**	**46**	**851**

2016-17	Software purchased	Assets under construction	Websites	Total
	£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**

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

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

8.3 Profit/ (loss) on disposal of fixed assets

The NHS TDA disposed of information technology assets during the period up to the 31 March 2018 (2016-17 NIL). There was no profit or loss on the disposal.

9. Trade receivables and amounts falling due within one year

	31 March 2018	31 March 2017
	£000	£000
NHS receivables	4,578	1,152
NHS prepayments and accrued revenue	7,463	1,043
Non-NHS receivables	152	136
Non-NHS prepayments and accrued revenue	452	459
VAT	32	348
Other receivables	88	54
Trade and other receivables	**12,765**	**3,192**

The NHS accrued revenue balance includes £7,361,000 for the funding of the GIRFT programme (2016-17 NIL).

10. Cash and cash equivalents

	31 March 2018	31 March 2017
	£000	£000
Opening balance	1,625	4,805
Net change in year	5,475	(3,180)
Closing balance	**7,100**	**1,625**
Made up of		
Cash with Government Banking Service	7,100	1,625
Commercial banks and cash in hand	-	-
Current investments	-	-
Cash and cash equivalents as in Statement of Financial Position	**7,100**	**1,625**

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

	31 March 2018	31 March 2017
	£000	£000
NHS payables	9,858	4,098
NHS accruals	15,875	15,035
NHS deferred revenue	8,071	5,589
Non-NHS payables	1,255	1,595
Non-NHS accruals	5,798	3,662
Non-NHS deferred revenue	49	-
Social security and pension payables	15	10
Trade and other payables	**40,921**	**29,989**

Accruals and deferred revenue have been split in 2017-18. In 2016-17 NHS accruals and deferred revenue were disclosed as £20,624,000.

12. Provisions

	2017-18	2016-17
	£000	£000
Balance at 1 April 2017	71	93
Arising during the year	-	71
Utilised during the year	-	-
Reversed unused	(71)	(93)
Balance at 31 March 2018	**-**	**71**
Expected timing of cash flows:		
No later than one year	-	71
Later than one year and not later than five years	-	-
Later than five years	-	-

The 2016-17 provision for very senior managers performance related pay was reversed unused in 2017-18.

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 £50,000 (2016-17 £42,000).

The authority entered into a memorandum of understanding relating to the provision of human resource services commencing on 1 April 2017 on a rolling basis with a termination notice period of six months. The total cost of the contract for the year was £386,000 (2016-17 £350,000).

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 & Social Care 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 2018 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

	2017-18	2016-17
	£000	£000
Trade and other receivables	4,730	1,288
Other receivables	120	402
Cash at bank and in hand	7,100	1,625
Total at 31 March 2018	**11,950**	**3,315**

14.3 Financial liabilities

	2017-18	2016-17
	£000	£000
Trade and other payables	40,921	29,989
Total at 31 March 2018	**40,921**	**29,989**

15. Contingencies

At 31 March 2018 there were no known contingent assets or liabilities (31 March 2017: NIL)

16. Events after the reporting period

Monitor and NHS TDA announced jointly with NHS England to plan to work in a more integrated way to deliver better outcomes for patients, while improving performance and efficiency. We are working together on an effective model of joint working between our organisations. The underlying legal entities of Monitor, NHS TDA and NHS England will remain in place.

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

17. Related Parties

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

The Department of Health & Social Care (DHSC) 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.

Since the set up of NHS Improvement, NHS TDA and Monitor are considered related parties. Shared non-pay costs which are apportioned between the organisations are treated as net so that the NHS TDA only recognises the impact to the extent that it is acting as a principal.

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
2017-18				
HM Revenue & Customs	5,775	-	15	32
Imperial College Healthcare NHS Trust	1,129	-	535	21
Kings College Hospitals NHS FT	122	-	94	-
Monitor	1,175	-	1,564	41
National Health Service Pension Scheme	6,053	-	-	-
Northumbria Healthcare NHS FT	497	-	271	31
2016-17				
HM Revenue & Customs	3,170	-	9	348
Imperial College Healthcare NHS Trust	1,257	-	689	-
Monitor	795	213	1,400	1,024
National Health Service Pension Scheme	3,458	-	1	-
Northumbria Healthcare NHS FT	896	5	238	15

During the year no Department of Health & Social Care Minister, Board member, key manager or other related parties has undertaken any material transactions with the NHS TDA (2016-17 NIL).

18. Resource limits

18.1 Revenue resource limit

	2017-18	2016-17
	£000	£000
Net operating costs for the financial period	111,534	89,208
Revenue resource limit	115,262	89,918
Under spend against revenue resource limit	**3,728**	**710**

18.2 Capital resource limit

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

	2017-18	2016-17
	£000	£000
Charge against capital resource limit (gross capital expenditure)	1,523	65
Capital resource limit	1,600	500
Under spend against revenue resource limit	**77**	**435**

18.3 Under/(over) spend against cash limit

	2017-18	2016-17
	£000	£000
Total charge to cash limit	117,000	68,793
Cash Limit Drawn from DHSC	117,000	68,793
Under/(over) spend against cash limit	**-**	**-**

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

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CCS0618885474
978-1-5286-0549-6

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