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NHS Trust Development Authority: annual report and accounts 2018/19

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NHS Trust Development Authority

Annual report and accounts
1 April 2018 to 31 March 2019

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About NHS Improvement

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

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

About the NHS Trust Development Authority

NHS TDA's role is to provide support, oversight and governance for all NHS trusts in their aim of delivering what patients want; high quality services today, secure for tomorrow. The range of services provided by NHS trusts covers the entire spectrum of healthcare, from acute hospitals to ambulance services through to mental health and community providers; the size of organisation varies from very small providers through to some of the largest organisations in the NHS, and therefore each trust has a set of unique challenges. Due to this variation, we recognise that there is not going to be a 'one size fits all' solution to the challenges trusts face. Our goal is first and foremost to help each and every NHS trust to improve the services they provide for their patients.

This report covers the period from 1 April 2018 to 31 March 2019. Monitor and NHS TDA continue to exist as legal entities, but this report refers mainly to NHS Improvement.

The NHS Long Term Plan says that when organisations work together they provide better care for the public. That is why on 1 April 2019 NHS Improvement and NHS England united as one – our aim, to provide leadership and support to the wider NHS. Nationally, regionally and locally, we champion frontline staff who provide a world-class service and constantly work to improve the care given to the people of England.

Contents

Performance report

Chair's foreword

I am pleased to introduce NHS Improvement's annual report and accounts for 2018/19. It was a notable year for the NHS: we celebrated the NHS's 70th anniversary and launched the blueprint for the next 10 years with the NHS Long Term Plan, and all through the year staff stepped up to the challenge of delivering outstanding care to patients as demand for their services continues to grow.

I would like to thank everyone, from across the service and from within NHS Improvement, who worked so hard both on caring for patients today and tirelessly striving to improve their care, while developing and launching the NHS Long Term Plan and making it such a compelling vision of the future.

The plan sets out how the NHS will improve prevention and reduce health inequalities, encourage and support the very best people to come and work for it, make best use of digital technology and innovation, and ensure best value from the taxpayers' investment. It sets out how the 3.4% five-year funding settlement will help put the NHS back onto a sustainable financial path. Turning it into reality is our task now: with local NHS organisations and their partners, we must build care around patients rather than institutions, break down organisational barriers and nurture collaboration within local health and care systems.

The last year has been one of significant change for NHS Improvement too. For if we are to play our part in implementing the transformation programme, we also need to change. We have laid the foundations for that, which will see a shift from a fragmented centre of the NHS to a more integrated one as we work more closely with NHS England, and a shift in our focus from regulation to improvement here to support frontline organisations to improve.

The joint working programme has moved at pace through the year, and we end 2018/19 with a united NHS Executive team.

Such was our progress on joint working that it became apparent to the boards of both our organisations that a structure with a single chief executive and a single chief operating officer was the best way to provide effective leadership and support to the NHS. As a result, Ian Dalton decided to step down from his role as Chief Executive of NHS Improvement. We are immensely grateful to Ian for his contribution, not just to NHS Improvement but to the NHS over a career of 35 years. His commitment to patients and the NHS has been exemplary, and we would not be able to take these next steps to align our organisations without his leadership and determination. As

this report shows, Ian has done an outstanding job both in delivering 2018/19 performance and in setting up the NHS for success in the future.

I would also like to thank Stephen Hay and Dr Kathy McLean, who both stepped down from the NHS Improvement Board at the end of the year after extremely distinguished careers in the NHS. We wish them and Ian all the very best as they embark on the next phase of their lives.

As we look forward to the new financial year, NHS Improvement has a critical role in implementing the Long Term Plan. What we do and the way we do it can make a significant difference to patients now and in the future. We need to play our part in shifting the NHS's culture to focus more on people, so it embodies a just and fair learning culture, backed with robust and embedded improvement methodologies. Having recently launched the NHS's first People Plan, I believe passionately that we need to focus more of our efforts on the people dimension of the NHS, to make the NHS the best place to work in the country, to honestly address the significant workforce shortages we have, and to work together to transform the way we work in the NHS to be fit for the opportunities and challenges of the 21st century.

This will require significant work inside our organisation, as we continue to implement our joint working programme, but also NHS-wide, as we support local integrated care systems to implement the Long Term Plan.

I'd like to thank everyone in NHS Improvement who has worked so hard over the last 12 months to deliver these excellent results, and I look forward to continuing to work with them to deliver the promise of the Long Term Plan for patients, staff and taxpayers alike.

I hope this report offers an insight into the commitment and professionalism of our staff. They will, I know, play a vital role in the work we and NHS England carry out together during the year ahead.

Baroness Dido Harding
Chair of NHS Improvement

Chief Executive's introduction

The efforts of NHS staff in 2018/19 were extraordinary. Demand for services was at the highest levels ever seen: 7% more patients were admitted to hospital via accident and emergency departments in the last three months of the year than in the same period in 2017/18. Yet during winter the NHS achieved the first year-on-year improvements in key targets for five years. A&E staff saw almost 315,000 more patients within four hours than in the same quarter last year.

Better patient flow raised the quality of patient experience. The NHS significantly reduced the longest waits for treatment: though patients waiting more than 52 weeks reached a peak of 3,500 in June 2018, by the end of the year their numbers had reduced by 63%. More patients started treatment within 18 weeks than in 2017/18, as trusts provided over 1,000 extra treatments every working day. Concerted efforts to reduce the number of long-stay patients in acute hospitals released the equivalent of more than 2,000 beds, while ambulance response times radically improved – by 1 minute and 35 seconds for life-threatening calls. Among patients experiencing a first episode of psychosis, 76.2% started treatment within two weeks, well above the 53% standard.

The percentage of trusts rated as good or outstanding by the Care Quality Commission increased by 8.6%, with 59.4% now achieving one of these ratings for the overall quality of their services. With our support, the number of trusts in special measures for quality reasons decreased by one during the year, as four trusts exited and three entered.

Despite the heightened demand for emergency services and the impact of other operational pressures, the provider sector achieved one of the best financial performances in recent years. Trusts delivered significant levels of efficiency and once again reduced the cost of agency staffing, as they have every year since 2015, supported by our initiatives. This is a considerable achievement by trusts, given record demand and the number of vacant posts.

However, pleasing as all this progress is, we cannot overlook the challenges that remain to be met. The current vacancy position remains especially testing: providers have over 96,000 vacancies. Every unfilled shift poses an operational challenge on the front line, so we are focusing great effort on supporting providers to improve staff retention and sharing best practice case studies as part of the drive to reduce temporary staffing.

A&E performance remains significantly below NHS Constitution standards. The total waiting list for planned hospital care continues to grow and stood at 4 million at the year-end, a 9.7% increase on 2017/18. Providers failed to meet the standard that only 1% of patients should wait over six weeks for all 15 key diagnostic tests: 2.47% waited more than six weeks.

Overall, the sector's financial position remains challenging and needing concerted action. A fundamental financial reset was therefore implemented on 1 April 2019. NHS Improvement and NHS England's new financial regime, developed during 2018/19, will reduce the number of organisations in deficit by over 50% in 2019/20 and return all organisations to financial balance by 2023/24.

The NHS Long Term Plan, published by NHS England and NHS Improvement in January 2019, represents a significant opportunity to respond to the challenges and opportunities ahead. Turning the plan into reality is our task now. That will mean building care around patients rather than institutions, breaking down organisational barriers and nurturing collaboration within local health and care systems.

For our part, NHS Improvement and NHS England are also moving to a one-system approach to better support the whole NHS to improve care. We made enormous progress during the year in bringing NHS Improvement and NHS England together in order to provide the NHS with the coherent leadership it needs. I am delighted that we recruited exceptional leaders to join the NHS Executive Group – people who have shown determination and passion to deliver better care for patients. Some of our executive directors took the opportunity to pursue other leadership opportunities: they were extremely valuable members of our team, and I am grateful to each of them for their outstanding contributions to the NHS.

As NHS Improvement joins ever more closely with NHS England, the Board decided that a model based on two chief executives was not what was wanted in the future - that the chief executive of NHS England should become the leader of NHS Improvement as well as NHS England – and that he would be supported by a chief operating officer (COO). I have therefore decided to leave NHS Improvement to allow the new structure to be created. It has been a huge privilege to be one of the NHS's national leaders and to be NHS Improvement's chief executive. I wish the NHS's new leadership team - and especially the NHS England chief executive and new COO - well in their vital task of leading the NHS that I love through the next

stage of its evolution as it turns the Long Term Plan into reality. I am sure that through their talents, drive and passion to support the 1.1 million staff who deliver care to our patients, the NHS will continue to be a world leading healthcare delivery system.

Ian Dalton CBE
Chief Executive

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.

During 2018/19 we strengthened our **joint working with NHS England** to bring our two organisations as close together, strategically and operationally, as legislation permits. We and NHS England will continue to embed our new combined operating model. We have already created a single NHS Executive Group, which is chaired by NHS England's Chief Executive Officer (CEO) and includes membership from all the national directors from the two organisations.

We announced in March that, later in 2019, we will be moving to a single CEO and single Chief Operating Officer (COO) model, with the single COO post covering both NHS England and NHS Improvement and reporting to the CEO of NHS England.[1]

Once the new model is fully in place later this year, new national director roles, reporting to the CEO, will operate across both organisations.

We have established integrated regional teams which, from April 2019, carry out the functions of both NHS England and NHS Improvement in each of their areas. They are led by regional directors, who report to the COO. The seven regional teams will support local systems to provide more joined-up and sustainable care for patients. They will be responsible for overseeing and helping to improve the quality, financial and operational performance of all NHS organisations in their region, working closely with sustainability and transformation partnerships (STPs) and emerging integrated care systems (ICSs). They will draw on the expertise and support of the national teams to improve services for patients, as well as supporting local transformation by helping develop ICSs across the country.

NHS England and NHS Improvement, at the Prime Minister's invitation, have developed proposals for primary legislation to support implementation of the NHS

[1] For statutory purposes, the COO will also be the CEO and accounting officer of both Monitor and the NHS Trust Development Authority, reporting to the chair of NHS Improvement in these respects.

Long Term Plan. These proposals include establishing a single body responsible for all the functions of NHS England and NHS Improvement.

Working in a more integrated way, at both national and regional level, will help deliver better outcomes for patients, better value for taxpayers and better job satisfaction for our staff.

As a first step in turning the Long Term Plan's ambitions into improvements in services across the country, we and NHS England have set out how we will distribute funding, people and other resources to transform local health and care systems; how we will reduce inequalities between patients, in terms of both access to services and outcomes, and how we will keep patients informed, involved and consulted in the development, improvement and delivery of services.[2]

Our two organisations have joined with the Department of Health and Social Care to help form NHSX, which will focus on technology, data, innovation and digital capability. This new unit brings together policy, strategic skills and expertise to support the Secretary of State's technology vision and the NHS Long Term Plan.

Because we take a system-wide approach to ensuring clinically and financially sustainable services, NHS Improvement is also committed to working closely with **other partners**, such as the Care Quality Commission, Health Education England and Public Health England, at national and regional level.

During the year, we built a closer working relationship with Health Education England (HEE) on workforce matters. We have worked with HEE to develop – for approval by the Secretary of State – its mandate for 2019/20, aligning the mandate with the service priorities in the NHS Long Term Plan and with our interim NHS People Plan (see page 55). The NHS Leadership Academy transferred from HEE to the new NHS Improvement and NHS England people function on 1 April 2019.

In 2018/19, our regional teams strengthened their collaboration with STPs and ICSs across the country, to help ensure that action to improve the performance and sustainability of NHS trusts and foundation trusts forms part of system-wide plans for improving the overall quality and efficiency of local health services and improving health outcomes for local communities.

[2] *NHS England and NHS Improvement funding and resource 2019/20: supporting 'The NHS long Term Plan'* /www.england.nhs.uk/publication/funding-and-resource-2019-20/

To support continuous improvement in the quality of treatment and care, we support and rely on local healthcare professionals making decisions about services in partnership with patients and local communities.

Performance analysis

We measure our performance against our strategic objectives, which in 2018/19 were:

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, 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.

These objectives are 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 developed seven sector-facing work programmes:

- quality improvement
- financial control and turnaround
- operational performance
- provider productivity
- strategic change
- workforce, leadership and improvement
- oversight, regulation and support.

The **Single Oversight Framework** (SOF), introduced in 2016, identifies how we can help NHS trusts and NHS foundation trusts improve patient services. The framework is designed to help increase the number of trusts achieving 'good' or 'outstanding' Care Quality Commission (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 July 2018 to make it consistent with:

- recent changes to our oversight approach for NHS-controlled providers
- the access standards for people with a first episode of psychosis set out in the Five Year Forward View for Mental Health
- our approach to monitoring progress in eliminating out-of-area placements for adult mental health services
- the revised timetable for implementing new operational performance standards for ambulance services.

As the NHS moves to a more systems-based approach to delivering care through the functions of STPs and ICSs, the way that we measure and monitor performance is evolving to ensure we continue to provide a focus on delivering core performance standards and enable those systems to manage delivery.

With NHS England we brought together our data and insights into a single platform, the **Population Health and Performance Management Dashboard**. This incorporates data from monthly reporting, RightCare, the Model Hospital, the Getting It Right First Time programme and many other sources to provide a single source of information about the performance of a region, an STP, a CCG or a hospital, clarifying where the opportunities for improvement lie. We piloted it in a small number of health systems and, as stated in the NHS Long Term Plan, will extend it to all ICSs and STPs during 2019/20. We are also working with the Secretary of State's office to make this integrated dataset publicly available, to increase transparency and understanding of the NHS.

The government announced a five-year funding settlement for the NHS in June 2018, providing an additional £20.5 billion by 2023/24 to help put it on a sustainable financial footing. In response, with NHS England we published the **NHS Long Term Plan** in January 2019 (see page 49) to secure the best outcomes from this investment (see page 30). The plan frames our combined work programme for the coming five and 10 years. The Long Term Plan sets out a new approach to

workforce issues, which we are developing more fully in a People Plan for the NHS (see page 55). The Long Term Plan includes action to help return the provider sector returns to overall financial balance in 2020/21 (see page 32).

Every trust has had to agree an operational plan for 2019/20, which provides the starting point for each STP and ICS to develop its own five-year Long Term Plan implementation plan. To help with this, we and NHS England published **shared planning guidance** in January 2019, covering system planning, the financial settlement, full operational plan requirements and the process and timescales for submitting plans.

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 expertise to support trusts in improving care quality, including patient safety. Much of what we achieve can only be done in partnership with others.

The most direct way we help trusts improve care quality is through our **regional teams**, as of April 2019 fully integrated with NHS England and covering seven regions (North East and Yorkshire, North West, Midlands, East of England, London, South East, and South West). They form lasting and productive relationships with local health systems, including trusts, and support them in improving quality. The teams provide vital intelligence about the challenges and issues the system faces, which is used to inform national initiatives.

Where the Care Quality Commission (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**. Four trusts exited special measures for quality during 2018/19. At 31 March 2019, 13 trusts were in special measures for quality, compared to 14 at 1 April 2018. One exited in May 2019.

Another objective is to ensure that two-thirds of trusts will achieve CQC's **'good' or 'outstanding' levels of quality** in the next few years. Between 1 April 2018 and 31 March 2019, the percentage of trusts rated 'good' or 'outstanding' rose from 51.3% to 60.9%. Overall there was a net improvement of 18 trusts moving from 'inadequate' or 'requires improvement' to 'good' or 'outstanding'.

With NHS England and Health Education England, we commissioned a review of the **system's response to poor quality of care** and poor trainee experience at North Middlesex University Hospital NHS Trust between 2014 and 2016. The aim was to

better understand how we can support trusts facing similar challenges in future. In our response[3] we described how our three organisations, together with CQC and the General Medical Council, have improved the way we oversee, regulate and support trusts since 2016. For example, we created the Joint Strategic Oversight Group to share concerns and ensure a consistent approach to support and intervention.

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 providers of acute services 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. During the year we introduced a new way for them to measure their progress, using self-assessment that is formally assured by the trust board.

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. The NHS Long Term Plan reiterates commitments to improve patient safety and reduce harm.

In July 2018 Dr Aidan Fowler joined us as **NHS National Director of Patient Safety**. Reflecting the role's system-wide nature, he was also appointed as a Deputy Chief Medical Officer by the Chief Medical Officer and Department of Health and Social Care (DHSC). The patient safety team he leads provides clinical and non-clinical patient safety expertise for the whole NHS. It sets policy direction and works with partner organisations like other NHS bodies, CQC and DHSC to improve patient safety.

Dr Alan Fletcher was appointed as the **National Medical Examiner for the NHS** in March 2019 to oversee the introduction of the medical examiner system in England and Wales. Initially the system will ensure every death in an acute hospital is scrutinised by either a medical examiner or a coroner and in time the service will be expanded to cover deaths in other NHS and independent settings, as well as deaths in the community. The medical examiner system will ensure issues with a patient's

[3] *System response to quality concerns in providers: learning from North Middlesex University Hospital NHS Trust.* October 2018. https://improvement.nhs.uk/news-alerts/nmuh-learning-review/

care can be identified quickly to improve services for others, building on the support provided through the **Learning from Deaths**[4] programme. Medical examiners will contact families shortly after they have been bereaved so that any concerns about their loved one's care are considered at the earliest opportunity.

We consulted on a new **national patient safety strategy**[5] to realise our ambition of making the NHS the world's safest healthcare system. We will publish the finalised strategy during 2019.

Our patient safety team is responsible for delivering some statutory patient safety duties across the NHS. The first of these duties is to collect information about what goes wrong in healthcare. 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 information from these incident reports and other sources to develop policy and provide advice and guidance, particularly where there is a need to alert the NHS to any new or under-recognised patient safety risks. We also use the information to support our own and our partners' ongoing patient safety work.[6]

NRLS has recorded more than 19 million incidents since it began in 2003. Between October 2017 and September 2018, almost 2 million incidents were reported to it, a 5.1% increase on the number of incidents reported between October 2016 and September 2017. Around 97% of reported incidents are no harm or low harm incidents.[7]

We published nine **patient safety alerts**[8] in 2018/19 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 harm. We develop 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. We also publish data on compliance with patient safety alerts.[9]

[4] https://improvement.nhs.uk/resources/learning-deaths-nhs/
[5] *Developing a patient safety strategy for the NHS: proposals for consultation.* December 2018. https://engage.improvement.nhs.uk/policy-strategy-and-delivery-management/patient-safety-strategy/
[6] https://improvement.nhs.uk/resources/patient-safety-review-and-response-reports/
[7] https://improvement.nhs.uk/resources/national-patient-safety-incident-reports-27-march-2019/
[8] https://improvement.nhs.uk/resources/patient-safety-alerts/
[9] https://improvement.nhs.uk/resources/data-patient-safety-alert-compliance/

At the Secretary of State's request, we led a process to agree common standards and thresholds for all partner organisations that issue patient-safety related alerts to the NHS. We set up a **National Patient Safety Alerting Committee**[10] and agreed common criteria, standards and thresholds that will apply to future national patient safety alerts.

Our project on the **Development of the Patient Safety Incident Management System** is devising a successor to the NRLS, which is now almost 16 years old. It aims to produce a single port of call for recording, accessing, sharing and learning from patient safety incidents. During 2018 we recruited organisations to test a first functional version of the new system, capturing records of patient safety incidents, processing and analysing them, and providing data outputs and learning materials.

Never Events are patient safety incidents considered preventable when trusts follow national guidance or safety recommendations. We expect organisations that report Never Events to conduct their own investigation, so they can learn from and act on the underlying causes. We analysed local investigation reports into 38 surgical Never Events from across England that occurred between April 2016 and March 2017,[11] publishing the results to help trusts improve their patient safety, and we supported CQC's thematic review of Never Events, *Opening the door to change*.[12]

More than 400 people responded to our survey seeking views on how and when patient safety incidents should be investigated, after we found that organisations were struggling to meet the expectations of the **Serious Incident framework**.[13] These responses are informing our review of the framework to ensure that providers, commissioners and oversight bodies respond appropriately when serious incidents occur, to ensure root causes are investigated and steps taken to reduce the likelihood of them being repeated.

Working with the academic health science networks (AHSNs), the **national patient safety collaborative programme** aims to create a culture of continuous learning and improvement across England. This programme is the largest safety initiative in NHS history. It helps to drive the adoption of safe clinical practice across multiple care settings, spreading learning from safer care initiatives from within the NHS and beyond. Led and funded by NHS Improvement and delivered regionally through 15

[10] https://improvement.nhs.uk/resources/national-patient-safety-alerting-committee/
[11] *Surgical Never Events: learning from 38 cases occurring between April 2016 and March 2017*. September 2018. https://improvement.nhs.uk/resources/learning-surgical-never-events/
[12] https://www.cqc.org.uk/publications/themed-work/opening-door-change
[13] *The future of NHS patient safety investigation: engagement feedback*. November 2018. https://improvement.nhs.uk/resources/future-of-patient-safety-investigation/

patient safety collaboratives hosted by the AHSNs, the programme has focused on several leading causes of harm in addition to building local safety improvement capability. Now in its fifth year, the programme is a key component of the new patient safety strategy. In January 2019 we made recommendations for strengthening the programme after reviewing the operational delivery and impact.[14] Among notable achievements, Yorkshire and Humber patient safety collaborative for falls prevention estimated a saving of £15.7 million – a 107% return on investment – had been made by using safety huddles. West of England collaborative helped reduce 'suspicion of sepsis' mortality rates by 13% in two years, to achieve the lowest such rate in England.

High quality nursing is central to achieving the highest standards of care and will be essential to fulfilling the commitments made in the NHS Long Term Plan. Ward and unit accreditation has huge potential to enable nursing and midwifery-led quality improvement and the sharing of learning and good practice. We published guidance and tools[15] for chief nurses and those in other senior nursing and midwifery roles to design and implement **ward and unit accreditation** programmes. These will enable them to measure, evaluate and continuously improve care in the wards and units across their organisation.

Our national **Stop the Pressure** programme,[16] 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, 62 trusts took part in the 120-day pressure ulcer improvement collaborative. On International Stop Pressure Ulcer Day in November 2018, we launched a campaign with tissue viability nurses to increase healthcare professional and public awareness of the damaging impact of pressure ulcers. We developed a guide to help nurses and other healthcare professionals prevent pressure ulcers. We produced guides on the definition and measurement of pressure ulcers,[17] developed the first national pressure ulcer education curriculum[18] and published guidance on the link between

[14] *Patient safety collaboratives: a retrospective view*. January 2019. https://improvement.nhs.uk/resources/patient-safety-collaboratives/
[15] *Guide to developing and implementing ward and unit accreditation programmes*. March 2019. https://improvement.nhs.uk/resources/guide-developing-and-implementing-ward-and-unit-accreditation-programmes/
[16] http://nhs.stopthepressure.co.uk/
[17] *Pressure ulcers: revised definition and measurement*. June 2018. https://improvement.nhs.uk/resources/pressure-ulcers-revised-definition-and-measurement-framework/
[18] https://improvement.nhs.uk/resources/pressure-ulcer-core-curriculum/

nutrition, hydration and pressure ulcers[19] for nurses and other healthcare professionals.

We lead the programme to reduce healthcare-associated **Gram-negative bloodstream infections** (GNBSIs) by 50% by March 2021. During the year we reminded trust boards of their obligation to regularly monitor the occurrence of GNBSIs and to make their annual infection prevention and control report publicly available. The NHS has made great strides in reducing the number of *Clostridium difficile* infections, but the rate of improvement has slowed over recent years. Further improvement is likely to require greater understanding of individual causes across the healthcare system. We will therefore now focus on a system-wide approach to achieving objectives.[20]

We developed a **national hand hygiene policy** with infection prevention and control colleagues representing acute, community, mental health, ambulance and other specialist centres, with an accompanying practice guide[21] for NHS staff of all disciplines in all care settings.

Good experience of care, treatment and support is increasingly seen as essential to an excellent health and social care service, alongside clinical effectiveness and safety. Our **patient experience improvement framework**[22] is designed to help trusts achieve good and outstanding CQC ratings. We developed it in partnership with trust heads of patient experience in response to requests for a patient experience improvement tool. It integrates policy guidance with the most frequent reasons CQC gives for rating acute trusts 'outstanding'.

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.

For example, the **national maternal and neonatal health safety collaborative** works intensively with frontline staff to provide quality improvement training and

[19] https://improvement.nhs.uk/resources/nutrition-and-hydration/
[20] Clostridium difficile *infection objectives for NHS organisations in 2019/20 and guidance on the intention to review financial sanctions and sampling rates from 2020/21*. February 2019. https://improvement.nhs.uk/resources/clostridium-difficile-infection-objectives/
[21] *Standard infection control precautions: national hand hygiene and personal protective equipment policy*. March 2019. https://improvement.nhs.uk/resources/national-hand-hygiene-and-personal-protective-equipment-policy/
[22] *Patient experience improvement framework*. June 2018. https://improvement.nhs.uk/resources/patient-experience-improvement-framework/

coaches teams with their improvement work. Every trust with a maternity and neonatal service is participating in the collaborative. It focuses on five clinical interventions to support the national ambition in areas such as smoke-free pregnancy or care of the very preterm infant. All improvement work is helping to create conditions where a safety culture can flourish, developing reliable pathways and involving women and families to improve the safety of care.

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 now have named maternity safety champions in every national, regional and local NHS organisation involved with delivering safe maternity and neonatal care.

Our **Veterans Covenant Hospital Alliance** initiative, which ensures people who have served in the armed forces receive care specific to their needs, accredited 25 trusts as 'veteran aware'. Frontline staff receive training on veterans' needs and can direct them to local support services, so they are never disadvantaged compared to other patients. Our ambition is to have 50 veteran aware trusts accredited by the end of 2019, and we have started working with our next cohort, which includes mental health providers.

We worked with NHS England and other system partners to help implement the Five Year Forward View for Mental Health, published in 2016, and to support improvement in the **mental health** provider sector. Together we have made significant progress on implementing the Forward View's recommendations. Access to psychological therapies for people experiencing depression and anxiety (IAPT services), for children and young people with eating disorders, and for individuals experiencing first episode psychosis has improved. All access, recovery and referral to treatment time targets are either being met or are on track to be achieved as expected by 2020/21.

We began our two-year joint **national mental health safety improvement programme** with CQC. It offers enhanced support to trusts that CQC identifies as facing the greatest safety challenges. This could include, for example, bespoke help with clinical leadership, governance and culture. The programme also offers quality improvement support to all trusts on issues of common concern, such as restraint

and restrictive practice. It builds on our work with 20 trusts on the national mental health improvement model.[23]

With more than 50 other organisations we signed the **Charter for Equal Health** to mark the launch of Equally Well UK, a nationwide collaborative pledged to improve the physical health of people who have severe mental illness, whose life expectancy may be 20 years shorter than average. We co-ordinated the 'Closing the Gap' improvement collaborative of 18 trusts, which is aligned with Equally Well UK. The trusts are working on improvement projects that cover, for example, lifestyle and life skills interventions such as physical activity and healthy eating.

We developed **learning disability improvement standards**[24] to help trusts measure the quality of care they provide to people with learning disabilities, autism or both. Although people with learning disabilities or autism should have the same access to services and outcomes as their non-disabled peers, often they experience much poorer care. The four standards include outcomes created by people with learning disabilities and their families, which clearly state what they expect from the NHS. The standards reflect the strategic objectives and priorities described in national policies and programmes and reflect the work of other bodies, in particular NHS England, CQC and Health Education England.

In two cohorts we worked with 44 trusts and their system partners on a collaborative approach to achieving the national ambition to reduce hospital lengths of stay, improve patient flow[25] and prevent deconditioning by engaging **allied health professionals** (AHPs) as leaders for change. Cohort 1 reduced longer lengths of stay by 9%, compared with 2.1% in other acute trusts. We also co-ordinated AHPs to implement and evaluate the impact of health improvement projects such as smoking cessation and weight management.

Listening to NHS staff who speak up is central to improving staff experience and patient care. NHS staff continue to raise **whistleblowing** concerns with us, and more contacted us this year than in previous years: 190 compared to 114 in 2017/18. The reasons for contacting us are usually that they are unhappy with their employer's response or worried they may suffer detriment if they raise their concern

[23] *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/
[24] *The learning disability improvement standards for NHS trusts*. June 2018. https://improvement.nhs.uk/resources/learning-disability-improvement-standards-nhs-trusts/
[25] *Allied health professions supporting patient flow: a quick guide*. April 2018. https://improvement.nhs.uk/resources/allied-health-professions-ahps-supporting-patient-flow/

directly with their employer. However, the increase in numbers does not necessarily indicate increasing problems: it could equally indicate that staff are more aware of the importance of speaking up and know how to do so.

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. A key part of the NGO's role is to provide leadership and advice for Freedom to Speak Up guardians on best practice, to enable staff to speak up safely. 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 continue to pilot how we can use data to identify trusts that may need additional support with Freedom to Speak Up.

The board guidance and self-assessment tool that we jointly published with the NGO last year has highlighted the importance of leadership behaviours that support speaking up. We will update this guidance in the light of feedback we have sought from trusts that have used it, to make it even more useful for assessing and improving Freedom to Speak Up arrangements and culture.

We take the cases we receive very seriously and took action in 169 (89%) of them (see Figure 1 below). This included 20 cases (11%) 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 22 (12%) 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, in which we have no jurisdiction.

We continue to see a significant number of 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 trust boards function well and have robust plans to address concerns. The board guidance we published, and some of the cases we received, have resulted in us supporting more trusts to improve their Freedom to Speak Up arrangements and culture. All of this highlights the importance of improving leadership culture and valuing the views of our staff, which is a key focus of our interim NHS People Plan.

We are about to complete our pilot support scheme to help whistleblowers return to work in secondary care. This follows Sir Robert Francis's recommendation in

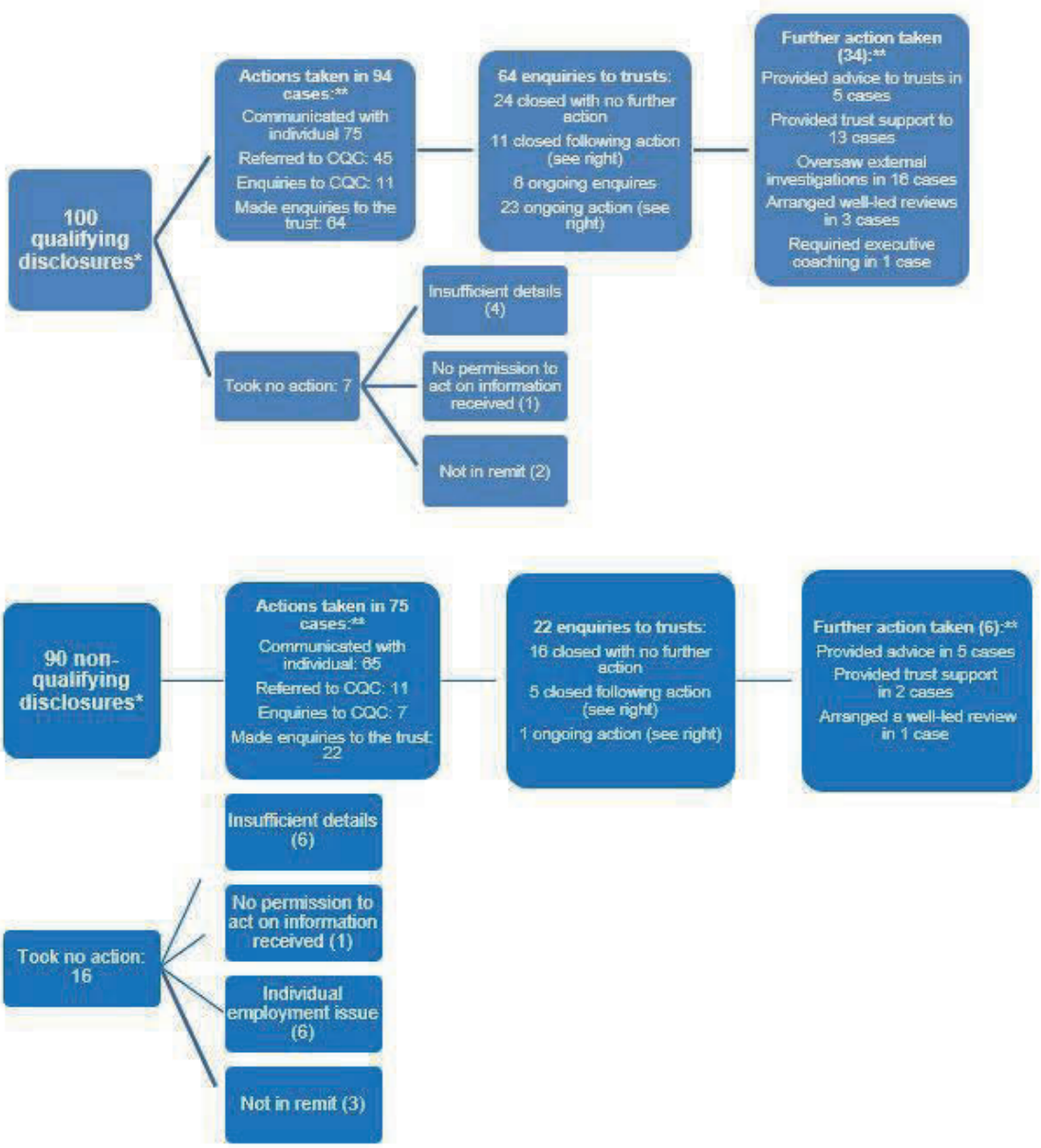
Freedom to speak up – a review of whistleblowing in the NHS to help whistleblowers find alternative employment in the NHS and set out what this should include.

Of the 10 whistleblowers who joined the scheme, one is now in employment and three benefited from six-month work placements. Participants also received training they requested and coaching support.

Many NHS employers have been supportive in offering access to library facilities, training, and shadowing and work placements for those ready for these opportunities.

We are about to receive the final phase of the independent evaluation of the pilot scheme and will use that to inform the main scheme (covering both primary and secondary care), which we aim to launch in 2019.

Figure 1: Whistleblowing cases received in 2018/19



*The government requires us to differentiate between concerns raised by staff that appear to be covered by the Public Interest Disclosure Act (PIDA) and those that do not. The very specific criteria for concerns to amount to a 'public interest disclosure' (covered by PIDA) do not affect whether we take action on the concerns raised.
**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 government announced a new **financial settlement** for the NHS in June 2018. It increased funding by £20.5 billion in real terms over five years beginning in 2019/20 – an average increase of 3.4% a year. In return, it expects the NHS to improve productivity and efficiency, address provider deficits, reduce unwarranted variation, better manage demand, and make better use of capital investment.

To help meet these tests, the NHS Long Term Plan included **reforms to the financial framework**. These will support organisations to achieve financial balance by the end of the five-year settlement and drive the continued productivity and integration necessary to ensure sustainability in the medium and long term.

The key changes are:

- Reforms to the **National Tariff Payment System**, particularly the introduction of a blended payment model for acute emergency care in 2019/20, which will move funding away from activity-based payments and ensure most funding is population-based. This will make it easier to redesign care across providers, support the move to more preventive and anticipatory care models and reduce transaction costs. During the year, we consulted on proposals for the 2019/20 tariff and published the final version in March 2019.[26]
- Measures to reset the financial framework for trusts, including transferring £1 billion from the Provider Sustainability Fund (PSF) into national prices and creating a new £1.05 billion Financial Recovery Fund (FRF) to support systems' and organisations' efforts to make all NHS services sustainable. Because of this funding, we expect the number of trusts reporting a deficit in 2019/20 to be reduced by more than half, and by 2023/24 no trust to be

[26] https://improvement.nhs.uk/resources/national-tariff/

reporting a deficit. Our ambition is that the FRF will mean the end of the control total regime and associated PSF for all trusts from 2020/21.

In addition, NHS Improvement committed in the plan to returning the provider sector to overall financial balance by 2020/21 and to deploying an accelerated turnaround process in the 30 worst financially performing trusts.

We continued to work closely with NHS England to align financial performance monitoring across both the provider and commissioner sectors. At all levels we jointly assessed the combined financial position across local systems and the NHS as a whole, resulting in joint reporting and discussion at board level.

Against an initial objective of reducing the aggregate provider sector deficit to £394 million, down from £966 million in 2017/18, the sector closed the year with a deficit of £571 million. Combined with the 2% efficiency improvements needed simply to stand still in financial terms (as reflected in national tariff prices), and the additional improvements needed to replace non-recurrent savings achieved in the previous year, this required overall **cost improvements** of £3.2 billion (equivalent to 3.6% of total operating costs). The year saw the highest levels of demand for hospital services ever seen by the NHS with higher than planned levels of emergency and elective hospital admissions. This included a challenging winter that saw a year-on-year core improvement in emergency care targets in which record numbers of emergency patients were treated in less than four hours. Despite pressure from continuing increases in demand for hospital services, the year-end financial deficit was one of the lowest in recent years and represents continued progress by the provider sector towards financial sustainability.

It is our responsibility to allocate the £2.45 billion **Provider Sustainability Fund** (PSF) to trusts. To be eligible, a trust must meet its financial control total, which we determine using an impact assessment for a range of factors at individual trust level. In all, 201 out of 230 trusts accepted their financial control totals for 2018/19, and almost 75% delivered a full-year financial position that either met or exceeded their agreed financial control totals (excluding PSF). The PSF in 2018/19 built on progress made the previous year.

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. This intensive support helps the trust improve efficiency and productivity, including how it manages its workforce and plans rotas, adapting lessons from better-performing trusts. 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. At the beginning of 2018/19, 12 trusts were in the programme. By the end of the year, three had successfully exited special measures and one had entered.

Spending on agency staff has continued to decrease as a percentage of total pay bill since we introduced controls in 2015/16. In 2018/19 trusts spent £2.40 billion on agency staff – £200 million more than the £2.2 billion target and about the same as last year. Since April 2017 agency costs have consistently been below 5% of overall pay costs and have now fallen to 4.4%. The continued reduction in the proportion of agency staff costs to total pay bill is a significant achievement in view of the record levels of demand and the extreme pressure on the acute sector. Essentially the sector has spent the same on agency staff in 2018/19 as in 2017/18 but procured 5.3% more shifts and managed the cost pressures associated with the first year of the Agenda for Change agreement, which were higher than trusts originally anticipated. By controlling agency spending, the changes of the last three years have led to more effective workforce planning, reduced agency costs per shift for all staff groups and therefore improved value for money in this area of significant spend.

We updated the agency rules in May 2018,[27] lowering the reporting thresholds for agency and bank shift sign-offs by trust executives, and shared good practice on reducing reliance on medical agency staff.[28] We continued to encourage and support trusts to use their own staff banks rather than agencies, and at the end of the financial year about £6 in every £10 spent on temporary staff was via staff banks. In addition, we consulted on new rules about how trusts recruit temporary staff into non-clinical roles, which could free another £100 million.[29]

[27] *Agency rules*. May 2018.
[28] *Reducing reliance on medical agency staff: sharing successful strategies*. June 2018.
[29] *Reducing reliance on agency staff: proposals on admin and estates and off-framework agency staff – for consultation.* February 2019.
https://improvement.nhs.uk/resources/reducing-expenditure-on-nhs-agency-staff-rules-and-price-caps/

We set up an **overseas visitor improvement programme** providing intensive support to 50 acute trusts to help them recover treatment costs from overseas patients who are not eligible for free NHS care. To standardise and bring some uniformity to the practice of establishing eligibility for free NHS care, we are developing recommended practice operational guidance. We aim to achieve 95% of the potential opportunity from overseas visitors by the end of March 2020. We are also developing a programme for mental health and community trusts to support them as they are also within the scope of the charging regulations. We help ensure the charging regulations are implemented as intended, with urgent treatment neither delayed nor denied and protections in place for the most vulnerable.

The programme to implement **patient-level costing** remains on course to enable the NHS to accurately and consistently calculate the cost of individual patient episodes of care. Patient-level information and cost data enable clinicians to review and improve how they use resources for particular groups of patients, trusts to compare the relationship between resource usage and quality of care, and the NHS to improve use of its resources. From 2018/19, most acute services will be recorded and reported at a patient level. This is an important step that follows three years of significant efforts by acute trusts. Patient-level costing is being extended to ambulance and mental health services in 2019/20 and we anticipate extending it to community health services in 2020/21.

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.

Delivering the **urgent and emergency care** reform agenda enabled the service to improve access to advice for patients outside hospital, improve care pathways within hospitals, and enabled timely discharge into the community.

NHS 111 received 5.1% more calls, and answered 1.7% more of them within 60 seconds, with 52.7% of calls receiving clinical advice. NHS 111 Online is now available across the country and includes a mobile app.

Urgent treatment centres now provide a standardised offer to patients in 113 locations, with appointments bookable through NHS 111.

The expansion in **same-day emergency care services** (SDEC) supported an 11.9% increase in zero length of stay admissions, meaning more patients are receiving the care they need without requiring an overnight hospital stay.

To support the delivery of new care models such as SDEC, £145 million capital investment was provided to 81 schemes across the country, delivering upgrades to emergency departments and improved facilities.

We particularly focused on **supporting long-stay patients** (over 21 days or more), who are often frail and elderly, to leave hospital safely. This reduces the risk of harm and helps to free beds, allowing other patients to be admitted. The number of patients in hospital with long lengths of stay (21 days or more) reduced, releasing 2,111 beds. In addition, delayed transfers of care reduced by 15.9% compared to last year. This was supported by a government investment of £240 million to local authorities for adult social care to help reduce pressure on the NHS by enabling patients to be discharged into the community or back to their own homes.

Demand for urgent and emergency care services increased by 4.1% compared to the previous year, with nearly 25 million A&E attendances. Emergency admissions via A&E increased by 6.8%, with nearly 300,000 more admissions.

The **four-hour A&E performance** metric was 88.0% and slightly below the 88.3% performance achieved in 2017/18, against the 95% target. Summer 2018 was the joint hottest on record, with the government issuing hot weather warnings in May, June and July. The heat contributed to increased demand, affecting performance. Despite lower overall performance, 780,000 more people than last year were treated within four hours.

Winter, always the most challenging period for the NHS, with outbreaks of flu, respiratory and gastrointestinal illnesses, saw an increase of over 400,000 attendances (5.1%). Despite this increased demand, 380,000 more patients were seen within four hours, with performance at 85.4% compared to 85.0% last winter.

Although ambulance arrivals increased, **ambulance services** worked with hospitals to significantly reduce ambulance handover delays. Winter data showed 10% and 22% reductions in 30-minute and 60-minute handover delays respectively, compared to winter 2017/18.

Ambulance trust performance improved against all six new response time standards introduced by the Ambulance Response Programme. All ambulance trusts now regularly achieve Category 1 standards for patients needing the most urgent care, with an average national improvement of 1 minute (12.3%) against last year's performance.

The **Elective Care Transformation Programme** supports local clinicians and commissioners to change how patients are referred to services, to improve access and quality of care.

The programme's **Elective Care Development Collaborative** has supported frontline delivery by spreading knowledge and expertise and helping to improve system capability through publications such as handbooks. Initial work in gastroenterology and musculoskeletal (MSK) services has broadened out to include dermatology, ophthalmology, diabetes, cardiology, urology, ENT, gynaecology, respiratory, general surgery, general medicine, radiology, neurology and endoscopy.

First contact practitioners (FCPs) provide direct access for patients with back pain, arthritis and other MSK conditions to physiotherapists with enhanced skills based in

GP practices. This was piloted in 41 of 42 sustainability and transformation partnerships (STPs). Interim findings showed that 97% of patients were likely or very likely to recommend FCPs to friends or family; 69% received advice on self-care or exercise; and the number of blood tests and medication prescriptions dropped. FCPs now being introduced more widely, with a minimum of three mobilised sites per STP next year.

The **Elective Care Community of Practice** is a key resource for clinical commissioning groups (CCGs), integrated care systems, STPs and providers. It had more than 1,000 members at the end of March 2019. It supports the creation, expansion and exchange of knowledge around elective care practice.

The ***Consultant to consultant good practice guide***[30] supports health economies to manage the increasing number of consultant-to-consultant referrals in elective care and reduce waiting times.

Capacity alerts help providers to spread demand between neighbouring trusts, so that it is more evenly shared, reducing waiting times. Nineteen sites began to issue capacity alerts via the NHS e-Referral System. Initial evaluation results show that pilot sites reduced referrals to providers with the longest waiting times by up to 38%. We will continue mobilisation of capacity alerts as a tool to support GPs and patients with choice at point of referral. This will provide patients with the option of selecting elective care treatment with a provider where the waiting time is shorter.

Our **High Impact Intervention for Ophthalmology** was implemented nationally, delivering timely assessment and follow-up for those most at risk of sight loss due to chronic eye conditions. By March 2019, 84% of hospital eye services had started or completed implementation and 81% of CCGs had begun a review of eye health service capacity within their area.

The number of **GP referrals for elective care** decreased by 0.4%. Total referral growth was 1.9% as at end of February, against planned growth of 2.4%. This reduced growth in demand represents a significant achievement in redesigning pathways across primary and secondary care and implementing interventions across the elective care pathway, reducing avoidable demand and ensuring patients are referred to the most appropriate healthcare setting, first time.

[30] www.england.nhs.uk/publication/consultant-to-consultant-referrals-good-practice-guide/

Rapid growth during the first half of the year in the **waiting list** and the number of patients waiting over 52 weeks was followed by a steady decrease during the second half. The total size of the waiting list increased by 5.9%, from 4.1 million in March 2018 to 4.33 million in March 2019.

Several areas of focus are supporting recovery of elective performance:

- productivity improvements in outpatients
- intensive support for waiting list management in providers
- demand management work to constrain clock starts and referral growth
- appropriate targeted usage of the independent sector.

The number of patients waiting more than 52 weeks decreased from a peak of 3,517 in June 2018 to 1,154 in March 2019, a reduction of 58.11%.

We responded to a range of potential threats to patient and public safety during the year, drawing on our experience in **emergency preparedness, resilience and response** (EPRR).

The nerve agent attack in Salisbury and subsequent incident in Amesbury prompted the launch of a comprehensive health response. For a several weeks, we provided expert support to Salisbury Hospital. Tragically there was one fatality, but all other affected patients were successfully treated for exposure to the nerve agent Novichok. The NHS was able to draw on the skills and experiences gained in the initial incident to deal with the second. Learning from these events is being incorporated into national guidance.

The Environment Agency made us aware in July 2018 that it was likely to take action against a waste management company that was significantly over its permitted waste storage levels at most of its sites. As the company held contracts with 53 trusts, the NHS had to prepare for possible disruption to collections of clinical waste, which in turn would have affected patient services. Working with NHS England and the affected sites, we set up an EPRR incident management team to implement contingency measures and transfer waste services to alternative providers. This protected patient services without interruption. In December 2018, all NHS organisations moved to new waste management contractors.

With NHS England, we established a single EU exit function to provide operational advice, specialist expertise and information to inform government preparations for a

range of scenarios. We are providing advice to the government on next steps to ensure that local leaders have the information they need to prepare for EU exit and helping to disseminate this information to the system.

Sector performance against key standards

Demand for services reached record levels, but the NHS substantially reduced the number of long waits for elective treatment and treated more elective and cancer patients. Ambulance response times substantially improved. However, A&E performance remains significantly below NHS Constitution standards, while providers failed to meet the target for key diagnostic tests. The sector achieved its best financial performance in recent years, but its overall financial position remains challenging. It delivered significant levels of efficiency and once again reduced the cost of agency staffing, although substantial workforce challenges remain. The NHS faces a critical year in 2019/20 as it begins to implement the NHS Long Term Plan.

Accident and emergency

In Quarter 4, performance against the target of treating at least 95% of patients attending A&E within four hours was 83.80%, a reduction of 0.1% compared to the same quarter last year. However, 314,594 more patients were seen within four hours than for the same quarter last year. There were 5.7 million attendances at NHS A&E departments, an increase of 7.0% on 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, 2.53% had been waiting longer than six weeks compared to 2.07% at the end of last year. In total at the end of the year, 1.0 million patients were waiting for a diagnostic test, a 2.4% increase on March 2018. The sector failed to achieve the waiting-time standard for 13 of the 15 key diagnostic tests, one more than in the fourth quarter of last year. Overall monthly activity increased by an average of 0.6% during the year. Despite performance deterioration, more diagnostic tests were carried out compared to previous years.

Elective waiting times

Providers continue to miss the referral-to-treatment target of 92% for incomplete pathways, achieving 86.26% at the end of the year – a drop of 0.6% on last year. At the end of March, the waiting list for NHS providers was 4.0 million, a 9.7% increase on a year earlier. Hospitals reduced the number of people waiting over 52 weeks for

planned treatments by 63% compared to March 2018, while 5,000 fewer operations were cancelled than in 2017/18.

Cancer waiting times

Providers failed to meet four cancer waiting-time standards in Quarter 4: 14-day GP referral to first outpatient appointment; 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. The standard is being piloted in preparation for national rollout.

Infection control

Providers reported 4,201 *Clostridium difficile* cases during 2018/19, 11.4% fewer than last year. They reported 271 MRSA cases, a decrease of 1.5% on last year. *E. coli* cases totalled 43,242, an increase of 5.3% on 2017/18.

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 improve 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 or quality concerns 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			
Proportion of patients beginning elective hospital treatment within 18 weeks of referral	March 2019	92%	85.29%
Number of patients waiting more than 52 weeks			344
Diagnostics			

Metric	Period	Standard	Performance
Proportion of patients waiting longer than 6 weeks for diagnostic tests	March 2019	1%	2.43%
Accident and emergency			
Proportion of patients discharged, admitted or transferred within 4 hours of attending A&E (all types of A&E department)	Quarter 4	95%	82.24%
Major emergency departments (type 1)			71.88%
Cancer			
Proportion of patients with suspected cancer receiving first outpatient consultation within 2 weeks of GP referral (all cancer symptoms)	Quarter 4	93%	91.79%
Breast cancer symptoms		93%	77.69%
Proportion of patients receiving first cancer treatment within 31 days of diagnosis		96%	95.71%
Proportion of patients receiving second or subsequent cancer treatment (surgery) within 31 days of decision to treat		94%	89.64%
Proportion of patients receiving second/subsequent treatment (drug therapy) within 31 days of decision to treat		98%	99.14%
Proportion of patients receiving second/subsequent treatment (radiotherapy) within 31 days of decision to treat		94%	95.97%
Proportion of patients receiving first cancer treatment within 62 days of urgent GP referral for suspected cancer		85%	75.82%
Proportion of patients receiving first cancer treatment within 62 days of urgent referral from NHS Cancer Screening Programme		90%	82.74%
Ambulance			
Average (mean) response time for people with life-threatening injuries and illness (Category 1)	March 2019	7 minutes	0:07:03
Response time for people with life-threatening injuries and illness (Category 1) – average for 90th centile		15 minutes	0:12:07

Metric	Period	Standard	Performance
Average (mean) response time for other emergencies (Category 2)		18 minutes	0:21:44
Response time for other emergencies (Category 2) – average for 90th centile		40 minutes	0:44:46
Response time for urgent care (Category 3) – average for 90th centile		120 minutes	2:20:50
Response time for less urgent care (Category 4) – average for 90th centile		180 minutes	2:59:54
Infection control			
Number of MRSA bloodstream infections	YTD March 2019	0	107
Number of *Clostridium difficile* infections		-	1,560
Mixed sex accommodation Number of breaches of the mixed sex accommodation guidance	March 2019	0	460
Mental health			
Proportion of people on care programme approach discharged from inpatient care who were followed up within seven days	Quarter 4	95%	96.70%
Proportion of people admitted to inpatient services who had access to crisis resolution/home treatment teams	Quarter 4	95%	98.74%

Financial performance

We compiled the consolidated accounts for NHS providers incorporating 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 the Department of Health and Social Care before being presented to Parliament before the summer recess. We also tracked NHS trusts' financial performance on a monthly basis.

Revenue

This information revealed another challenging year for NHS trusts, as demand for services reached the highest levels ever seen by the NHS. There was significant pressure on emergency services and the resulting squeeze on elective work,

especially during the winter months, when demand for emergency services reached further record levels, continued to put pressure on NHS trusts' reported financial performance. In the face of these external difficulties, NHS trusts reported an adjusted financial position on a control total basis, before technical and exceptional adjustments (including uncommitted Provider Sustainability Fund (PSF)), at a deficit of £1,001.7 million. Although the NHS trust sector continues to be in deficit, this was an improvement on 2017/18 and the combined provider sector position was one of the best in recent years. These improvements were achieved through sound financial management, with most NHS trusts being able to agree their control totals and the majority achieving either breakeven or surplus against these 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 2018/19 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: 66 out of 79 NHS trusts accepted their control totals, and 45 achieved them at the year end.
- Accepting their control totals allowed NHS trusts access to the £2.45 billion Provider Sustainability Fund, of which they received £705 million in total. This supported many providers in returning to a more sustainable financial footing.

Continuing the tight control of agency spending (see page 33) helped NHS trusts reduce their reliance and spending on agency staff. Despite an intense operating environment and high levels of staff vacancies the agency spend in 2018/19 remained broadly at 2017/18 levels with a £15 million decrease which built on the £236 million and £255 million savings achieved in the years 2017/18 and 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 2018/19, this was similar to the previous year (£1 million higher). Although significant, this represented an aggregate shortfall against planned cost savings, amounting to £183 million with 49 trusts falling short of their targeted savings, this indicates that there is further scope for improvement.

Table 2 details NHS trust's reported financial position by sector. The acute sector experienced the most significant level of financial pressure with 82% of acute trusts in deficit at the year-end.

Table 2: Reported financial position of the NHS trust sector for the year ended 31 March 2019

NHS trust sector	2018/19			Number of trusts	Number of trusts in deficit	% of trust sector deficit
	Plan £m	Outturn £m	Variance £m			
Acute	(766.2)	(1104.6)	(338.4)	51	42	97.8
Ambulance	9.0	17.3	8.3	5	2	0.4
Community	20.2	31.7	11.5	11	2	0.7
Mental health	18.3	67.3	49.0	11	2	0.1
Specialist	(7.0)	(13.4)	(6.4)	1	1	1.0
Total	**(725.7)**	**(1,001.7)**	**(276.0)**	**79**	**49**	**100.0**

Brackets denote deficit.

Where trusts provide a mix of services, they are categorised according to the main service they provide.

The number of trusts in deficit is taken to be trusts that reported an adjusted financial position on a control total basis, before technical and exceptional adjustments, including uncommitted Provider Sustainability Fund (PSF)

Capital

Hospital buildings, equipment and information systems must be in a suitable condition to deliver modern patient care and respond to future service needs. We are committed to ensuring that patients receive high quality services from NHS trusts.

In the 2017 spring and autumn Budgets, £3.9 billion of additional capital funding was announced (profiled over six years) including £2.9 billion for STPs: 133 of the 159 approved STP schemes totalling £2.4 billion relate to provider-led schemes; 56 of these schemes with a total value of £1.1 billion are related to NHS trusts. A further six cases with a total value of £332 million are for schemes which involve collaboration between NHS trusts and foundation trusts.

Our *Capital regime, investment and property business case approval guidance* for providers, published in 2016, updated the capital delegated limits for NHS trusts. In 2018/19, we approved four full business cases (FBCs) totalling £133 million and one strategic outline case (SOC) and five outline business cases (OBCs) that were outside the delegated authority of individual NHS trusts. (In 2017/18, we approved nine FBCs totalling £202 million and 15 SOCs and OBCs.)

In total, NHS trusts spent £1.5 billion on capital projects during 2018/19 (in 2017/18 they spent £1.1 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 4% below plan. Further action is needed to strengthen capital planning and forecasting by NHS trusts.

Cash

Accessing finance is crucial for NHS trusts to improve and operate services, particularly those with a revenue deficit. In 2018/19, 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 2018/19, 49 NHS trusts required access to cash financing of £1.4 billion to support forecast revenue account deficit positions and operational working capital. (In 2017/18, 53 NHS trusts accessed £1.5 billion.)

Provider productivity

To help providers improve the quality of care and meet financial objectives, we help make sure they are deploying staff productively, managing the NHS estate efficiently and getting the best deal on supplies. Lord Carter's reviews of NHS productivity have found that reducing unwarranted variation could save the NHS more than £6 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.

Lord Carter, a non-executive director of NHS Improvement, followed his 2016 review of acute trusts' productivity[31] with reports in 2018 on **mental health and community health services**[32] and **ambulance services**.[33] Working with 23 mental health and community health trusts, he found each demonstrated examples of good practice in service delivery and patient care. He also found across the sector significant opportunities to eliminate unwarranted variation that could save up to £1 billion in efficiencies by 2020/21. In his ambulance service review, Lord Carter found that paramedics treating more patients at the scene or referring them to services other than accident and emergency – avoiding the need for an ambulance when it is safe to do so – could improve patient care and experience. This could save the NHS £300 million a year by 2021 and a further £200 million from improvements in ambulance trusts' infrastructure and staff productivity. To address improvements in infrastructure, the standard double-crewed ambulance specification was published in March 2019. This is mandated through the NHS Standard Contract for ambulance services from 2019/20.

The **Model Hospital**[34] is a digital information service to help all trusts identify opportunities to improve the quality and productivity of local patient care. NHS staff can compare their hospital with their peers across the entire range of a trust's activity. We continuously review and improve the Model Hospital to meet users'

[31] *Operational productivity and performance in English NHS acute hospitals: unwarranted variations*. February 2016. https://www.gov.uk/government/publications/productivity-in-nhs-hospitals
[32] *NHS productivity: unwarranted variations – mental health services; community health services*. May 2018. https://improvement.nhs.uk/about-us/corporate-publications/publications/lord-carters-review-unwarranted-variations-mental-health-and-community-health-services/
[33] *Operational productivity and performance in English NHS ambulance trusts: unwarranted variations*. September 2018. https://improvement.nhs.uk/about-us/corporate-publications/publications/lord-carters-review-unwarranted-variation-nhs-ambulance-trusts/
[34] https://model.nhs.uk/

needs, and in September 2018 we released a new, easier to use version. We also launched the **Model Ambulance**, **Model Mental Health** and **Model Community Health Services** to help other sectors implement Lord Carter's recommendations. By the end of 2018/19 the Model Hospital, now three years old, covered more than 60 topic areas and had 15,000 registered users. In the NHS Long Term Plan, we committed to extending the Model Hospital to become the Model Health System, to support integrated care systems in improving the overall quality and productivity of local services.

The Pharmacy and Medicines Optimisation Programme supports trusts to get best value from the use of medicines and pharmacy services. The top 10 medicines list, available on the Model Hospital and updated monthly, highlights opportunities for trusts to make savings using safe and equally effective **better-value medicines** like biosimilar versions, and through incremental changes in clinical practice. Providers have identified significant savings: with a challenging target of £250 million in 2017/18, trusts saved the NHS £324 million. In 2018/19 we worked with them to save a further £220 million to reinvest in frontline care.

The programme supported 13 trusts with digital investment for **Electronic Prescribing and Medicines Administration**, which improves patient safety, reduces the risk of harm and ensures high quality efficient care. The initial investment of £16 million, with an additional £3 million for interoperability and medicines usage analysis enhancements, is being continued into 2019/20 to move the NHS to full e-prescribing in the future.

Our **Getting It Right First Time** (GIRFT) programme[35] – 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 currently covers 39 specialties. During the year, GIRFT published national reports on cranial neurosurgery, oral and maxillofacial surgery, cardiothoracic surgery, spinal services and urology. These identified substantial opportunities to improve patient experience and outcomes by improving practice and process. As well as reducing delays, implementing the recommendations in these reports could save more than £152 million. In addition to these national reports, GIRFT published the Getting It Right in Emergency Care advice pack and bespoke packs for trusts, to help reduce surgical litigation costs.

[35] https://gettingitrightfirsttime.co.uk/

Our research found unwarranted variation among the NHS's 122 pathology services, so we are helping them form 29 **pathology networks**. We are also helping providers of specialist diagnostic pathology services nationally to network at a scale that supports the sustainability and effectiveness of these highly complex services. Consolidating pathology services enables more consistent, clinically appropriate turnaround times, ensuring the right test is available at the right time. It makes better use of our highly skilled workforce to deliver improved, earlier diagnostic services, supporting better patient outcomes. All NHS pathology services are now actively working towards the new network configurations, and we expect implementation across the country to be complete by the deadline of 2021.[36] In 2017/18, trusts reported £33.6 million of pathology cost improvements – thought to be an underestimate of the total in-year efficiency gain. Trust plans for 2018/19 identified a further £30 million of savings.

We published guidance on **care hours per patient day** (CHPPD) for all providers.[37] CHPPD monthly data, available to providers on the Model Hospital, was then made available to the public on NHS Choices and My NHS in October 2018. CHPPD, a key recommendation of Lord Carter's 2016 review, measures the deployment of nurses, to ensure the right staff deliver the right care to the right patients at the right time. The data is broken down by trust and ward and gives ward managers, nurse leaders and hospital executives a view of how productively they deploy staff. Trusts can compare their data to address unwarranted variation.

Our procurement programme successfully implemented the **Purchase Price Index and Benchmarking (PPIB) tool**, so trusts can compare how much their neighbours have paid for commonly purchased items and capitalise on their purchasing power. By September 2018, it had contributed to NHS savings of £288 million on commonly bought items such as couch rolls, toilet rolls and temporary shoes.

A successful collaboration with NHS Supply Chain saw the first phase of the **Nationally Contracted Products programme**, which aggregates national demand to purchase products on the NHS's behalf. It saved £15 million.

The **estates and facilities** workforce made £124.6 million through recurrent savings in 2018/19, a 6.6% improvement in productivity compared to the previous year against an NHS average of 1.2%. Attendance per square metre rose 5.6% on the

[36] *NHS Improvement pathology networking in England: the state of the nation*. September 2018. https://improvement.nhs.uk/resources/pathology-networks/
[37] https://improvement.nhs.uk/resources/care-hours-patient-day-guides/

previous year. This was achieved by supporting trusts with leadership in sustainability, data analysis, efficiency, productivity, cost improvement programme (CIP) planning and contractual issues. We shared best practice and case studies on a specially created estates and facilities collaboration hub, which is actively used by the estates and facilities community. Non-clinical space in the NHS estate has reduced to 33.9% and empty space to 2.2%, exceeding targets set by Lord Carter in 2016.

Our **Corporate Services programme** helped trusts improve the costs, efficiency and effectiveness of their corporate services through CIP self-assessments, case studies and best practice guides, published as part of the corporate services productivity toolkit. By April 2019, this had helped save £180 million against a year-end target of £130 million to £170 million.

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. We also support reconfigurations of services.

With help from frontline health and care staff, patient groups and national clinical experts, we and NHS England drew up the **NHS Long Term Plan**,[38] published in January 2019. We took account of 85,000 insights from members of the public at 200 events, along with a further 2,500 submissions received from individuals and groups representing the opinions and interests of 3.5 million people.

The plan builds on the Five Year Forward View, published in 2014, and sets out how we will share control with people over their own health and care; how the NHS will improve prevention and reduce health inequalities; how we will encourage and support the very best people to join the NHS; how we can make best use of digital technology and innovation, and how we will get the best value out of taxpayers' investment in the NHS.

Since January, we have worked with local NHS organisations and their partners to develop the implementation programme. Every trust has had to agree an operational plan for 2019/20 and these provide the starting point for local health systems (sustainability and transformation partnerships (STPs) or integrated care systems) to develop their own five-year strategies, which will be published in autumn 2019.

Our aim is that all STPs will evolve over time into **integrated care systems** (ICSs) – local collaborations for improving quality, access and outcomes, and for reducing health inequalities, within a defined share of NHS resources. The Long Term Plan gives a commitment that ICSs will cover the whole of England by 2021.

[38] www.longtermplan.nhs.uk/

The second wave of ICSs was announced in May 2018:

- Gloucestershire
- Suffolk and North East Essex
- West, North and East Cumbria
- West Yorkshire and Harrogate.

These sites have joined the ICS development programme we run with NHS England, and they operated as ‘shadow’ ICSs this year. Eight from the first wave are now operating as ‘live’ ICSs, and so have greater freedoms and flexibilities in planning and organising services for the benefit of local communities.

Each ICS began implementing more integrated service models this year. Primary care networks enable them to share workforce and assets among groups of GP practices. For people with urgent care needs, ICSs have increased access to same-day appointments by more flexibly deploying nurses, pharmacists, therapists and other staff.

In North Cumbria and Dorset, primary and community hubs provide enhanced services for people who would otherwise end up in hospital. In West Berkshire, patients with a range of pain symptoms were being unnecessarily referred to outpatient clinics, waiting between seven and nine months. Now they are seen in four weeks because GPs, acute physicians, radiologists, physiotherapists, psychologists and commissioners came together across primary care, community and hospital services to better assess patients and direct them to the most appropriate care first time.

Collaborations between GP practices, community services, hospitals and local government services are bringing care closer to home and reducing unnecessary trips to hospital. Increasingly, these collaborations are widening to include other agencies such as housing associations, fire services and voluntary organisations. By broadening their partnerships, ICSs can not only go further in preventing unnecessary hospitalisation but can begin to tackle the wider determinants of health and wellbeing. For example, local partnerships have fostered schemes to improve day-to-day health and wellbeing, including the ‘Run-a-Mile Challenge’ in which children, teachers and others commit to run a mile a day regularly, as well as community-led creative activities that help to avoid social isolation and improve the local environment.

We committed in the NHS Long Term Plan to "a more proactive role in supporting collaborative approaches between trusts" that wish to explore formal merger or acquisition. We already offer bespoke support to trusts considering or proceeding with **mergers or acquisitions**. 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 2018/19 we suggested a proportionate approach for the review of pathology networks (see page 48), ensuring the CMA will review only cases with genuine potential to reduce meaningful competition. We also provided extensive analysis for several other trusts to determine that their proposed mergers would be unlikely to reduce competition.

We supported Royal Liverpool and Broadgreen University Hospitals NHS Trust and Aintree University Hospital NHS Foundation Trust to develop a high quality benefits case and prepared a detailed assessment of how patients are likely to benefit from the merger for submission to the CMA.

Monitoring and evaluating benefits post-merger are crucial for implementing mergers successfully and realising the expected benefits. We developed guidance and a practical tool[39] to help trusts plan for, oversee and conduct a merger impact evaluation. It can help trusts considering, planning or implementing a merger to develop stronger strategic and full business cases for the transaction review.

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

During the year, we published additional guidance[40] for NHS trusts and foundation trusts considering transactions involving the creation of subsidiaries or material

[39] *Guidance for evaluating merger impacts*. October 2018. https://improvement.nhs.uk/resources/supporting-nhs-providers-considering-transactions-and-mergers/

[40] *Addendum to the transactions guidance – for trusts forming or changing a subsidiary*. November 2018. https://improvement.nhs.uk/resources/supporting-nhs-providers-considering-transactions-and-mergers/

changes to existing subsidiaries. It clarifies the approval process before trusts can implement plans for subsidiaries.

We assess all plans for mergers or acquisitions that meet the transactions threshold set out in the transactions guidance, 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 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.

We assured several significant transactions during the year:

- South Staffordshire and Shropshire Healthcare NHS Foundation Trust merged with Staffordshire and Stoke-on-Trent Partnership NHS Trust on 1 June 2018 to form Midlands Partnership NHS Foundation Trust.
- Colchester Hospital University NHS Foundation Trust acquired The Ipswich Hospital NHS Trust on 1 July 2018 to form East Suffolk and North Essex NHS Foundation Trust.
- The transfer of community services from Bridgewater Community Healthcare NHS Foundation Trust to Wrightington, Wigan and Leigh NHS Foundation Trust on 1 April 2019.
- City Hospitals Sunderland NHS Foundation Trust merged with South Tyneside NHS Foundation Trust on 1 April 2019 to form South Tyneside and Sunderland NHS Foundation Trust.

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. We base it 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 could 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 2018/19, we provided mergers and acquisition support to several providers involved in transactions, including:

- The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust and Poole Hospital NHS Foundation Trust – 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 – broad advisory support and specific support to the strategic case and patient benefits case for the proposed merger
- North Cumbria University Hospitals NHS Trust and Cumbria Partnership NHS Foundation Trust – undertaking an assurance review of the strategic case for their proposed merger
- a range of support for the acquisition of Pennine Acute Hospitals NHS Trust by Salford Royal NHS Foundation Trust and Manchester University NHS Foundation Trust, in partnership with Greater Manchester Health and Social Care Partnership.

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.

Addressing workforce and leadership issues is vital to successfully implementing the NHS Long Term Plan. We and NHS England have created the post of Chief People Officer to be responsible for leading work with Health Education England and other partners to transform how the NHS plans and develops its workforce. Our chair, Baroness Dido Harding, and Julian Hartley, Chief Executive of The Leeds Teaching Hospitals NHS Trust, have led development of an **Interim NHS People Plan**,[41] which we published in June 2019.

We have taken an inclusive approach to developing the plan, setting up a national workforce group that included senior representatives from Health Education England, NHS England, the Department of Health and Social Care, Royal Colleges and other bodies, so that the plan addresses frontline workforce priorities across the service. The interim plan sets out immediate action to make the NHS a better place to work, improve our leadership culture, tackle challenges in nursing and midwifery staffing, and equip health professionals with the skills needed to deliver 21st century care. It describes how we will change our approach to workforce planning nationally and locally, including giving greater responsibility to local health systems. A full People Plan will be published once future investment in education and training has been settled through the Spending Review.

To better align priorities for education and training with the service priorities in the Long Term Plan, we worked with **Health Education England** (HEE) to develop its mandate for 2019/20. The **NHS Leadership Academy** transferred from HEE to NHS Improvement and NHS England's new people function on 1 April 2019, maximising the natural fit between its work and the people function's responsibility for executive and non-executive leadership and talent across the NHS.

[41] www.longtermplan.nhs.uk/areas-of-work/workforce/

We are committed to improving **staff retention** by at least 2% by 2025, the equivalent of 12,400 additional nurses. Working with NHS Employers, we have already helped achieve substantial improvements through targeted support for trusts with high turnover. Launched in June 2017, our retention programme involved 110 trusts in its first 12 months. They improved their nursing turnover rate by 1% on average, compared to 0.4% in trusts not taking part. Mental health trusts improved their clinical staff turnover rate by 1.1% on average, compared to 0.7% in trusts not receiving direct support. The programme is now available to all trusts.

We called on trusts to strengthen their **workforce plans** after finding that most would benefit from upgrading the way they planned their workforce. An effective workforce plan must be evidence-based and integrated with finance, activity and service plans. It should directly involve service leaders and managers. Working with workforce planners and trusts, we created a workforce planning tool[42] that details the characteristics and processes of effective workforce planning. It enables self-assessment against typical workforce planning requirements, complements and signposts existing workforce planning resources and describes how we review workforce plans. In addition, we published *Developing workforce safeguards*, comprehensive guidelines on workforce planning that include new recommendations on reporting and governance approaches.[43] Since April 2019, we assess all trusts' compliance with these recommendations.

We lead the national programme to support trusts to make **safe and sustainable staffing** decisions. We developed resources based on the expectations of the National Quality Board (NQB) that trusts will have "the right staff, with the right skills, in the right place at the right time". The eight resources were 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, allied health professionals' organisations and trade unions. Each is based on the best available evidence and takes a multidisciplinary approach. During the year we published the final three resources, covering:

- children and young people's inpatient wards[44]
- neonatal care[44]

[42] https://improvement.nhs.uk/resources/operational-workforce-planning-self-assessment-tool/
[43] *Developing workforce safeguards*. October 2018. https://improvement.nhs.uk/resources/developing-workforce-safeguards/
[44] https://improvement.nhs.uk/resources/safe-staffing-neonatal-care-and-children-and-young-peoples-services/

- urgent and emergency care.[45]

Effective **e-rostering** ensures the right staff with the right skills will be in the right place at the right time, so patients receive the care they need, and trusts can better manage their workforce and improve efficiency. We committed in the NHS Long Term Plan to support trusts to deploy e-rosters or e-job plans by 2021. Open and transparent e-rostering processes improve employee engagement, satisfaction and wellbeing, as well as retention. During the year we published a good practice guide to nursing and midwifery e-rostering[46] and shared learning from the 24 trusts in our mental health and community e-rostering improvement collaborative.[47]

Deploying the NHS workforce to its maximum potential is vital for high quality care and staff satisfaction. For example, **allied health professionals** (AHPs) are the third largest professional group in the NHS, yet their deployment and impact are not routinely monitored from ward to board. Since we published a best practice guide to AHP job planning in 2017, 76 acute trusts have implemented or partially implemented AHP job planning.

The **nursing associate** role is designed to bridge the skills gap between the healthcare support worker and more senior regulated professional, as well as provide a new route to becoming a registered nurse. On NQB's behalf, NHS Improvement led production of a resource for the safe and effective deployment of the new nursing associate role. This was completed in conjunction with the other NHS arm's lengths bodies, the Nursing and Midwifery Council (NMC), the Royal College of Nursing and a small group of provider chief nurses. Following a six-week consultation, the resource was published in January 2019 ahead of the first nursing associates being registered with NMC.[48] Our senior nursing team is providing ongoing support by hosting a monthly webinar.

Specialty and associate specialist (SAS) doctors make up 20% of medical staff, but many say they lack workplace support. We are working with HEE and other partners to improve opportunities for SAS doctors: to support them to advance as clinicians and leaders in healthcare, improve the knowledge among other healthcare

[45] https://improvement.nhs.uk/resources/safe-staffing-urgent-emergency-care/
[46] *Nursing and midwifery e-rostering: a good practice guide*. August 2018. https://improvement.nhs.uk/resources/rostering-good-practice/
[47] *The mental health and community e-rostering improvement collaborative*. August 2018. https://improvement.nhs.uk/resources/mental-health-and-community-e-rostering-improvement-collaborative-report/
[48] An improvement resource for the deployment of nursing associates in secondary care. January 2018. https://improvement.nhs.uk/resources/safe-sustainable-and-productive-staffing-nursing-associates/

professionals of what SAS doctors do, and promote SAS as an attractive career option.[49]

The **emergency care workforce** is under significant pressure, with increasing demand, rota gaps, trainee attrition and workforce burnout all contributing to an environment where achieving stability is increasingly difficult. With the Royal College of Emergency Medicine, we published good practice guidance based on measures that trusts have taken to achieve some stability in their workforce in difficult circumstances.[50]

It is more important than ever that NHS workplaces become environments that encourage and enable staff to lead healthy lives and make choices that support positive wellbeing. With NHS England and NHS Employers, we launched the **NHS workforce health and wellbeing framework**.[51] It sets standards for what NHS organisations need to do to support staff to feel well, healthy and happy at work.

Despite improvements for black and minority ethnic (BME) staff representation and experience across the NHS, a fundamental shift in culture and leadership must take place before senior teams and boards more closely represent the diversity of the local communities they serve. With NHS England we have developed a system-wide strategy that is the latest phase of the NHS **Workforce Race Equality Standard** (WRES) programme. The NHS Long Term Plan sets the ambitious challenge of ensuring the leadership of our organisations is representative of the overall BME workforce by 2028. *A model employer*,[52] published jointly with NHS England in January 2019, outlines an approach to accelerate this work across the NHS.

There has a been a particular focus on implementing WRES among the nursing and midwifery community, where 20% of staff are from a BME background (increasing to more than 50% in some areas) but only 3.5% of trust executive chief nurses.[53] Enabling BME nurses and midwives to progress is a key focus for the Chief Nursing Officer, and in 2018 we and the NHS England WRES team hosted four BME nursing and midwifery masterclasses.

[49] www.hee.nhs.uk/our-work/supporting-sas-doctors
[50] *Creating workforce stability in emergency care: expected good practice*. July 2018. https://improvement.nhs.uk/resources/emergency-care-workforce-programme/
[51] https://improvement.nhs.uk/resources/workforce-health-and-wellbeing-framework/
[52] www.england.nhs.uk/publication/a-model-employer/
[53] *WRES: an overview of workforce data for nurses, midwives and health visitors in the NHS*. March 2019. www.england.nhs.uk/publication/an-overview-of-workforce-data-for-nurses-midwives-and-health-visitors-in-the-nhs/

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 September 2018 its third cohort of 14 professionals in director-level positions joined the programme to develop the skills needed to take on a chief executive role within the next two years.

We designed our **aspiring chief operating officer programme** with Ashridge Executive Education and identified 25 senior professionals from a strong field of 130 with the potential to take on COO roles role within the next 12 to 18 months. One-third came from non-acute trusts and 65% were women.

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. Our **aspiring medical director programme** is run jointly with the NHS Leadership Academy and Faculty of Medical Leadership and Management. It has helped create a regional support system for emerging leaders and developed the talent pool for new medical director appointments. The first cohort completed the programme in October 2018.

Our **aspiring executive nurse** and **deputy executive nurse programmes** 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. We published handbooks for aspiring executive nurses[54] and ward leaders.[55]

Professionally diverse leadership teams including senior clinicians at board level increase the likelihood of meeting the complex challenges facing the NHS. We created a **clinical leadership framework**[56] to help trusts make the most of the talents of all their existing workforce. It looks at how existing structures and

[54] *Executive nurse handbook*. March 2019. https://improvement.nhs.uk/resources/executive-nurse-handbook/
[55] *The ward leader's handbook*. October 2018. https://improvement.nhs.uk/resources/ward-leaders-handbook/
[56] *Clinical leadership – a framework for action: a guide for senior leaders on developing professional diversity at board level*. January 2019. https://improvement.nhs.uk/resources/clinical-leadership-framework-action/

expectations may stand in the way of clinical staff contributing to strategic leadership.

We initiated a project to evaluate **leadership arrangements for AHPs** in trusts, following requests from directors of nursing. Findings suggested that trusts with chief AHPs providing strategic leadership see greater engagement of the AHP workforce in improving quality and productivity. The report[57] recommended trusts appoint a senior AHP with a strategic focus. It has been accessed more than 6,000 times, and more than 60 trusts have asked us for support to assess and strengthen their AHP leadership arrangements.

It is vital that we and CQC have a shared view of what makes a trust well led Together we developed the **well-led framework**, which CQC uses to review 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 published findings from more than 40 reviews,[58] highlighting the key development areas that emerged as common across multiple organisations.

We are directed to ensure that trust chairs and non-executive directors have access to development and support opportunities. We continued to co-ordinate quarterly **regional chair events** across the country for chairs to discuss topical issues and challenges with their peers and to receive an update on what is happening in their region. These have been extended to non-executive directors in some areas.

Our **board development programme**, running from January 2019 to March 2020, focuses on training trust boards to lead quality improvement at organisational level. Northumbria Healthcare NHS Foundation Trust in partnership with the King's Fund deliver the programme on our behalf.

We partnered with NHS Clinical Commissioners and NHS England to support the development of **local networks** of lay members and trust non-executive directors.

We began developing a **chair competency framework** involving chairs and subject matter experts. We are identifying key actions that chairs take to have an impact on the leadership of their trusts and the competencies required to be effective in the

[57] https://improvement.nhs.uk/resources/leadership-allied-health-professions-trusts-what-exists-and-what-matters/
[58] *Learning from developmental reviews of leadership and governance using the well-led framework*. November 2018. https://improvement.nhs.uk/resources/well-led-framework/

role. The outcome will create a consistent approach to chair appraisal across all trusts and help recruitment by clarifying the role and supporting future appointments.

We published findings from the first comprehensive **national survey of trust boards**, based on over 2,500 individual responses.[59] This will help focus efforts to improve diversity where it is most needed, recognise patterns of leadership, and support better understanding of the nature and diversity of board membership in the NHS.

We launched the **aspirant chair programme** supporting 33 women, people from BME communities and disabled non-executive directors with potential to be trust chairs by providing chair mentors and development. The **NExT Director scheme**, offering placements with providers to women and people from BME communities keen to move into non-executive director roles, continues to gain support from trusts across the country. We will now focus on extending the scheme to disabled people.

Our **Provider Leadership Committee** and subcommittees made 272 NHS trust chair and non-executive appointments. This included 112 new appointments, of which 23 were chairs, and 160 reappointments or extensions, of which 25 were chairs.

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. It provides a framework to equip and encourage staff to deliver continuous improvement in local health and care systems – and gain pride and joy from their work. During the year we published five short guides to different aspects of the framework.[60]

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. The **Q community** now has more than 2,500 members, including professionals at the front line of health and social care, patient leaders, commissioners, managers, researchers, policymakers and others. In 2018 it ran a collaborative funding programme, **Q Exchange**, to discover improvement ideas, create better links

[59] *NHS provider board membership and diversity survey findings*. October 2018. https://improvement.nhs.uk/resources/supporting-nhs-providers-improve-diversity-their-boards/
[60] https://improvement.nhs.uk/resources/developing-people-improving-care-short-guides/

between members leading improvement work and make small-scale awards to project teams chosen by the community.

Transformational Change through System Leadership provides access to expert professional support through three two-day workshops over four months. It is targeted at teams of senior leaders who are working on a transformational change as part of an STP or ICS. Teams are supported to put theory into practice as they work on their own system-wide, transformational change and interact with peers from across the country who are leading changes in their own systems. The programme has now supported over 100 healthcare teams and hundreds of individuals to develop and apply new skills.

Quality, Service Improvement and Redesign (QSIR) programmes provide clinical and non-clinical staff with the tools and knowledge to design and implement more efficient, patient-centred services. This enables health systems to develop capability in quality and efficiency improvement and build a sustainable local skills base from which to tackle the challenges identified in their sustainability and transformation plan. In the QSIR College's fifth cohort, 57 candidates graduated in 2018.

As part of an ongoing programme to help trusts reduce waiting times for patients by making better use of theatre time, we commissioned Deloitte to analyse **theatre productivity** across England. We worked closely with the Royal College of Surgeons in producing our report[61] and it supported our findings. Data submitted by 92 trusts revealed they could have used theatre time lost to late starts, early finishes and delays between operations to do up to 291,000 more operations. Our regional teams are supporting trusts with theatre improvement work, using the insights from our analysis. We are building a network of trusts that other trusts can learn from and developing a theatre scheduling tool that will be available in 2019. As we come together with NHS England, we expect trusts to have further opportunities to work with local partners to transform the way they deliver surgery, reduce waiting times and improve theatre productivity.

We piloted our **Elective Care Essentials** programme in July 2018 with 18 operational managers from acute trusts. The programme was developed to improve operational managers' knowledge and expertise regarding the key components of

[61] *Operating theatres: opportunities to reduce waiting lists*. February 2019. https://improvement.nhs.uk/resources/operating-theatres-opportunities-reduce-waiting-lists/

elective care. The programme will now run until 2020, by when we expect more than 260 operational managers will have undertaken it.

The first cohort of seven trusts in our three-year **Vital Signs** programme started work in July 2018. They chose to focus on services for frail older people. We held week-long events at each trust to identify waste in processes and design ways to eliminate it. All their staff and non-executive directors will be engaged in this improvement work over time. Senior leadership teams will be trained to support their staff to identify improvement opportunities and implement change.

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 (including patient safety), maximise value by reducing waste, empower staff to make changes and create a culture of continuous improvement, sharing their learning and experience. Warwick Business School is evaluating the impact of the partnership on the quality and efficiency of services and organisational culture in the trusts; it expects to publish its findings in spring 2021.

Oversight, regulation and support

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

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 also consider whether there is evidence that the trust has not complied with the terms of the NHS provider licence. We may launch an investigation when an NHS trust or foundation trust triggers a concern under the Single Oversight Framework (see page 18). As part of an investigation, recommended solutions are identified, which could involve mandated support and formal regulatory action or targeted support.

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 having no providers in special measures by 2020. We have given significant support both to trusts in special measures and to 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 2019, 19 trusts were in special measures: 10 for finance reasons only, 13 for quality reasons only and four for both reasons.

During 2018/19, three trusts entered special measures for quality reasons, and four exited. One trust entered special measures for finance reasons, and three exited. One trust has since exited special measures for quality reasons, in May 2019.

Table 3: NHS trusts in special measures for quality reasons in the year to 31 March 2019

Trust	Date entering special measures	Reason for entering special measures	Date of leaving special measures	Reason for remaining in or exiting special measures
Barts Health NHS Trust	March 2015	CQC inspection found concerns about leadership, staff engagement and patient safety.	February 2019	Recommended by Chief Inspector of Hospitals to exit special measures after the CQC inspection and report published in February 2019.
East Sussex Healthcare NHS Trust	October 2015	CQC inspection found concerns about medicines management, learning from incidents, staff engagement and culture.	June 2018	Recommended by Chief Inspector of Hospitals to exit special measures after the CQC inspection report published in June 2018.
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 the CQC 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	The trust completed its follow-up inspection in mid-March 2019 and is awaiting publication of the CQC report.
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.	January 2019	Recommended by Chief Inspector of Hospitals to exit special measures after the CQC inspection report published in January 2019.

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.
Shrewsbury and Telford NHS Trust	November 2018	CQC inspection found concerns about staffing, leadership and governance.	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 2019

Trust	Date entering financial special measures	Reason for entering financial special measures	Date of leaving financial special measures	Reason for remaining in or exiting financial special measures
Maidstone and Tunbridge Wells NHS Trust	August 2016	The trust did not agree its control total and was planning a significant deficit.	October 2018	The trust met the exit criteria by demonstrating it had strengthened governance and identified action plans for financial risks.
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.	July 2018	The trust achieved its 2017/18 plan and control total, had a robust plan for 2018/19 to meet the agreed control total, and strengthened leadership and governance.
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.

Trust	Date entering financial special measures	Reason for entering financial special measures	Date of leaving financial special measures	Reason for remaining in or exiting financial special measures
Isle of Wight NHS Trust	March 2018	The trust did not agree its control total and had a significant deficit. Its failure to manage its financial position effectively meant there were reasonable grounds to suspect it was in breach of the conditions with which NHS trusts must comply in relation to financial sustainability and governance.	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.
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 special measures and is currently in the recovery planning stage.

Note: trusts highlighted in blue exited special measures.

Implementing management contracts at challenged providers

We implemented a management contract for Royal Devon and Exeter NHS Foundation Trust to provide leadership support to North Devon Healthcare NHS Trust while an options appraisal on the optimum organisational model for clinically and financially sustainable services is developed.

Support for systems and providers

We provided support at these systems:

- Somerset Sustainability and Transformation Partnership (STP), where we completed a 'drivers of the deficit' review and helped identify and progress strategic solutions to financial and service challenges.
- Northamptonshire STP, where we developed principles, values and behaviours as well as quality standards for core acute services.

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 Department of Health and Social Care regulations. The licence allows us to help commissioners protect essential local services if an independent provider fails. At 31 March 2019, 111 independent providers held licences of which one is an NHS-controlled provider.

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 2019, there were 22 independent providers of CRS in our risk assessment and financial oversight regime. In the year to 31 March 2019 we took enforcement action against one independent provider of CRS and published enforcement undertakings which remain in place at 31 March 2019. We issued compliance certificates against undertakings in place with another provider and published an updated set of enforcement undertakings. At 31 March enforcement undertakings were in place with two independent providers.

Regulating NHS-controlled providers

In February 2018 we published our approach to oversight of NHS-controlled providers from 1 April 2018. These are providers that are not themselves NHS trusts or foundation trusts but hold a provider licence and are ultimately controlled by one

or more NHS trusts and/or foundation trusts, where ‘control’ is defined on the basis of International Financial Reporting Standard 10.

An NHS-controlled provider is required to hold a provider licence that includes the NHS-controlled provider licence condition which mimics the NHS foundation trust licence condition and includes requirements on good governance.

On 1 April 2018, we issued an NHS-controlled provider licence to Wiltshire Health and Care LLP. It is jointly controlled by three NHS foundation trusts and holds a contract to provide community healthcare services. It has subsequently been regulated under the Single Oversight Framework in accordance with our published policy. As at 31 March 2019 this is the only NHS-controlled provider.

Our corporate performance

Business plan for 2018/19

Most (84%) of our business plan actions for 2018/19 were considered on track or successfully delivered by the end of the financial year. Over the year, the greatest impact on delivery has arisen from our closer working arrangements with NHS England, as changes in priorities and the operating model led to a detailed review of NHS Improvement's full work programme and a subsequent suspension, re-scoping or discontinuation of some actions.

The adverse impact of internal resource constraints has decreased throughout the year with significant recruitment to new structures and greater integration between NHS Improvement and NHS England. At the end of the year, sector dependencies and changes in scope accounted for most delays.

Significant challenges remain across several priority areas. Although the delivery of our work programme has been largely positive, some elements of sector performance have not improved in line with expectations. Further work is underway in 2019/20 to clearly link actions to sector performance and better understand where our interventions have the greatest impact.

Learning from complaints

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

One related to our pilot whistleblower support scheme and provided learning for us in the information we give prospective applicants about the types of support that might be relevant.

One related to our handling of the segmentation of a trust under our Single Oversight Framework (SOF) and the information we provide about that process. This has prompted us to review:

- the information we give trusts about segmentation decision-making
- the lack of reference to relevant enforcement guidance in the SOF.

We received one complaint about an alleged leak of information to the media, which was not upheld. We received three complaints that are the subject of ongoing investigations: two about our handling of whistleblowing concerns and one about wrongly accessing information from a third party and sharing that information inappropriately.

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 Trust Development Authority (TDA) working as NHS Improvement is to help local providers of NHS services work towards a sustainable future that also delivers high quality care.

Table 5: NHS Improvement's greenhouse gas emissions

		2018/19	2017/18
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	116*	151
	Total gross emissions for Scope 3 Official Business Travel Emissions – NHS TDA	523*	336
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	317	632
	Expenditure on official business travel – NHS TDA	3245	3,569

* 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 decrease in business travel emissions for Monitor and NHS TDA reflects the organisation commitment to reducing emissions by encouraging the use of telephone and information technology communication solutions

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 the Department of Health and Social Care (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 2019, in addition to jointly occupying Wellington House, NHS TDA had office space in 10 sites throughout England. All are in multiple occupancy buildings and there are no more than 100 staff members on any single site. Six of the 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.

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

We 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.

The revenue resource limit for NHS TDA is £132.3 million (2017/18: £115.3 million). NHS TDA's net expenditure for the year was £128.9 million (2017/18: £111.5 million). The under spend against the revenue resource limit is £3.4 million (2017/18: £3.7 million). The main categories of spend are shown in Table 6.

Table 6: Main categories of spend

	2018/19 £m	2017/18 £m	Reference to accounts
Operating revenue	(37.0)	(18.7)	Note 4
Staff	96.5	70.5	Note 5
Purchase of goods and services	26.4	20.4	Note 6
Depreciation and impairment charges	0.6	0.2	Note 6
Provisions expense	0.0	(0.1)	Note 6
Other operating expenditure	42.4	39.2	Note 6
Total	**128.9**	**111.5**	

The increase in operating revenue is mainly due income to support the Get it Right First Time (GIRFT) 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 75% of net expenditure in 2018/19 (2017/18: 63%). The increase in staff costs is mainly due to the Healthcare Safety Investigations Branch developing the maternity investigations team; the strategic estates partners which is a new function joining the operational productivity directorate; and staff to develop national workstreams supporting improvement, productivity, efficiency and nursing in NHS provider organisations.

Purchase of goods and services spend relates to premises (£3.1 million), business expenses (£14.7 million) and professional fees (£8.6 million). More detail can be found in Note 6 to the accounts.

Other operating expenditure of £42.4 million (2017/18: 39.2 million) includes expenditure provided to NHS trusts and partners.

Net liabilities at 31 March 2019 were £16.8 million (31 March 2018: net liabilities £19.4 million). The decrease in net liabilities is mainly due to a large reduction in trade and other payables, which is offset by a decrease in the current assets relating to the cash and cash equivalents balance and the trade and other receivables 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 (CBI) Better Payment Practice Code. The target is to pay non-NHS and NHS trade payables within 30 days of receipt of goods or a valid invoice (whichever is the later) unless other payment terms have been agreed with the supplier. NHS TDA's performance against this target is shown in Table 7.

Table 7: Payment practices

	2018/19		2017/18	
	Number	**£000**	**Number**	**£000**
Non-NHS payables				
Total non-NHS trade invoices paid in the year	5,089	26,413	3,417	19,340
Total non-NHS trade invoices paid within target	4,999	25,713	3,289	18,707
% of non-NHS trade invoices paid within target	**98%**	**97%**	**96%**	**97%**
NHS payables				
Total NHS trade invoices paid in the year	1,702	70,036	1,354	45,907
Total NHS trade invoices paid within target	1,627	69,323	1,239	43,650
% of NHS trade invoices paid within target	**96%**	**99%**	**92%**	**95%**

More detail of how money has been spent in 2018/19 can be found in the main accounts.

For a review of our activities and performance against business objectives during the year, see pages 8 to 78. Our strategy for 2016 to 2020 is published on our website[62] 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 2018/19 is set out on page 72. Our business plan for 2018/19 is published on our website[63] and focuses on our role in helping the NHS address its two main priorities – short-term operational improvement and longer-term sustainability.

Bill McCarthy
Interim Accounting Officer
2 July 2019

[62] https://improvement.nhs.uk/about-us/corporate-publications/publications/our-2020-objectives/
[63] 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 2018/19. It comprises the following reports:

- **Corporate governance report**

  This report is made up of the Directors' 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 the 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.

- **Certificate and report of the Comptroller and Auditor General to the Houses of Parliament**.

  The Comptroller and Auditor General, an officer of the House of Commons who is independent of government, audits the financial statements presented in this Annual Report. He is supported in his role by the National Audit Office. His certificate and report provide an opinion on the 'truth and fairness' of the financial statements and on the regularity of the transactions recorded in the financial statements.

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. Two non-voting Associate Non-Executive Directors have also been appointed to the Board.

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.

In May 2018, NHS Improvement's and NHS England's boards committed to deliver a new model of joint working involving shared national director roles, integrated regional teams and new regional geographies and alignment of national functions. To support this closer alignment, the two boards adopted a new joint board governance framework in November 2018. This new framework is designed to enable the boards to have full oversight of both organisations and support and challenge the delivery of integrated care systems and the NHS Long Term Plan. It was introduced by NHS Improvement on 1 January 2019 and ran in advisory capacity alongside the existing governance framework between 1 April to 31 March 2019.

Directors who served on NHS Improvement's Board between 1 April 2018 and 31 March 2019 are listed in Table 8.

Table 8: Directors on NHS Improvement's Board between 1 April 2018 and 31 March 2019

Name	Role	Term ending
Baroness Dido Harding	Chair	30 October 2021
Richard Douglas	Deputy Chair	31 March 2020
Professor Dame Glynis Breakwell[1]	Non-Executive Director and Senior Independent Director	31 March 2019
Lord Patrick Carter[2]	Non-Executive Director	30 June 2021
Lord Ara Darzi[3]	Non-Executive Director	31 July 2021
Dr Timothy Ferris[4]	Non-Executive Director	31 July 2021
Sarah Harkness[5]	Non-Executive Director	25 September 2018
Sir Andrew Morris[6]	Non-Executive Director	31 July 2021
Sigurd Reinton[7]	Non-Executive Director	30 June 2018
Laura Wade-Gery[8]	Non-Executive Director	31 July 2021
David Roberts	Associate (non-voting) Non-Executive Director	4 March 2020
David Behan[9]	Associate (non-voting) Non-Executive Director	31 January 2021
Ian Dalton[10]	Chief Executive	
Stephen Hay[11]	Executive Director of Regulation/Deputy Chief Executive	
Kathy McLean[12]	Executive Medical Director and Chief Operating Officer	
Ruth May[13]	Chief Nursing Officer	

[1] Professor Dame Glynis Breakwell stepped down from the Board on 31 March 2019 at which point Lord Carter assumed the role as the Senior Independent Director.
[2] Lord Carter's appointment term was extended in July 2018 for a further three years to 30 June 2021.
[3] Lord Darzi's appointment term was extended in July 2018 for a further three years to 31 July 2021.
[4] Dr Ferris was appointed to the Board on 1 August 2018.
[5] Sarah Harkness stepped down from the Board on 25 September 2018.
[6] Andrew Morris was appointed to the Board on 1 August 2018.
[7] Sigurd Reinton stepped down from the Board on 30 June 2018.
[8] Laura Wade-Gery was appointed to the Board on 1 August 2018.
[9] David Behan joined the Board as an Associate (non-voting) Non-Executive Director on 1 February 2019.
[10] Ian Dalton stepped down as Chief Executive on 28 June 2019.
[11] Stephen Hay stepped down from the Board on 31 March 2019 and left NHS Improvement in April 2019.
[12] Kathy McLean stepped down from the Board and left NHS Improvement in April 2019.
[13] Ruth May was appointed Chief Nursing Officer for England on 7 January 2019.

Biographical details of NHS Improvement's Board members are available on NHS Improvement's website.[64]

[64] https://improvement.nhs.uk/about-us/corporate-publications/publications/our-board-members-register-interests/

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 Non-Executive Directors.

Board committees

On 1 January 2019, NHS Improvement introduced a new board governance framework which operated in advisory form alongside the existing Board governance framework between 1 January and 31 March 2019. The first section below outlines the existing governance framework between 1 April 2018 and 31 March 2019. The second section below provides a summary of the new governance framework and matters considered by the new committees which met in an advisory capacity between 1 January and 31 March 2019. Where existing Committees met at the same time as NHS England's corresponding committee between 1 January to 31 March 2019 an overview of business considered has been provided in the first section.

Under the new structure the Board is supported by eight committees, most of which meet in common with NHS England's corresponding committees. The meetings in common allow the two organisations to meet together at the same time with shared agendas and papers but retain the underlying legal identities. Joint discussions take place for each agenda item, but each committee takes its own decisions.

During the year the Board delegated the day-to-day running of the organisation to the Chief Executive, who during this period was also the organisation's Accounting Officer. Information on the governance structure in place between 1 April 2018 to 31 March 2019 to support the Chief Executive in his role is provided on pages 83 to 95.

Table 9: Existing Board governance framework and committees between 1 April 2018 and 31 March 2019

Board				
↓	↓	↓	↓	↓
Audit and Risk Assurance Committee	**Nominations and Remuneration Committee**	**Provider Leadership Committee**	**Quality Committee**	**Technology and Data Assurance Committee**
Chair				
Richard Douglas	Laura Wade-Gery	Sir Andrew Morris	Lord Ara Darzi	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
Main responsibilities				
• Review NHS Improvement's internal controls, risk management and governance processes • Review and monitors the integrity of financial statements	• Develop policy on executive remuneration • Fix remuneration packages of senior managers • Lead the NHS Improvement process for Board appointments	• Appoint chairs and non-executive directors of NHS trusts and appoint charity trustees • Suspend and terminates appointments • Approve pay and other remuneration requests for designated staff in NHS trusts	• Consider provider sector quality issues requiring national decision- making and action • Consider reports from regions and other groups based on a range of outputs • Review feedback on the effectiveness of NHS Improvement quality initiative	• Provide 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 decision making 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.
Joint Transition Advisory Group (NHS Improvement and NHS England)	Chair: Joanne Shaw (Non-Executive Director of NHS England	The group had no executive decision making responsibility and was formed to oversee the integration of NHS Improvement and NHS England and was disbanded in March 2019.
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 – 1 April 2018 to 31 March 2019

Under the new governance framework, the Audit and Risk Assurance Committee remains a separate NHS Improvement statutory Board committee. From 1 January 2019 some of its business are considered in meetings in common with NHS England's Audit and Risk Assurance Committee.

Membership:

- Richard Douglas (Chair)
- Professor Dame Glynis Breakwell[1]
- Wol Kolade[2]
- Andrew Morris[3]

Previous member during the year:

- Sarah Harkness[4]
- Sigurd Reinton[5]

Attendees:

- Chief Financial Officer
- Head of Internal Audit
- External auditor (Comptroller and Auditor General; National Audit Office (NAO) on his behalf)
- Corporate Risk Manager
- Chief Financial Accountant
- Assistant Director 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 four times between 1 April 2018 and 31 March 2019, of which one meeting had a meeting in common with NHS England.

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

Key duties:

The following key duties continue to be considered separately by NHS Improvement's Audit and Risk Assurance Committee

Financial reporting:

- monitor the integrity of the financial statements of Monitor, NHS TDA and consolidated NHS foundation trusts
- review significant reporting issues and judgements.

External auditor:

- oversee the relationship with the external auditors, the Comptroller and Auditor General
- consider 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.

From 1 January 2019 the following key duties will be considered jointly with NHS England's Audit and Risk Assurance Committee

Risk management

- review of NHS Improvement's and NHS England's joint risk profile and management of the organisation's risks.

Internal control:

- review the effectiveness of NHS Improvement's internal control systems.

Internal audit:

- appoint and review the effectiveness of the internal auditor service in the context of NHS Improvement's internal control systems
- agree the internal audit plan and reviewing internal audit reports.

[1] Glynis Breakwell joined the Committee on 27 September 2018 and stepped down from the Board on 31 March 2019.
[2] Wol Kolade joined the Committee on 27 September 2018.
[3] Andrew Morris joined the Committee on 27 February 2019.
[4] Sarah Harkness stepped down from the Board on 25 September 2018.
[5] Sigurd Reinton stepped down from the Board on 30 June 2018.

Audit and Risk Assurance Committee – 1 April 2018 to 31 March 2019 continued

Between 1 April 2018 and 31 March 2019 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 matters considered between 1 April 2018 and 31 March 2019:

- approval of a revised corporate strategic risk register and subsequent changes to it
- deep-dive risk reviews
- approval of 2018/19 internal audit plan
- internal audit reports, including actions for improvement
- the Head of Internal Audit Opinion for 2017/18
- reports from the external auditors in respect of their audits of Monitor's, NHS TDA's and consolidated NHS Provider account's financial statements for 2017/18
- approval of Monitor's, NHS TDA's, consolidated NHS provider; and consolidated NHS foundation trusts' 2017/18 annual report and accounts
- NHS trusts and NHS foundation trusts working capital.

Key matters considered with NHS England's Audit and Risk Assurance Committee between 1 January and 31 March 2019:

- development of a joint NHS Improvement and NHS England corporate strategic risk register
- joint internal audit arrangements with NHS Improvement's and NHS England's internal auditors.

Nominations and Remuneration Committee – 1 April 2018 to 31 March 2019

Under the new governance framework, the Nominations and Remuneration Committee remains a separate NHS Improvement statutory Board committee but from 1 January 2019 its business is considered in meetings in common with NHS England's Strategic Human Resources and Remuneration Committee.

Membership:

- Laura Wade-Gery (Chair)[1]
- Professor Dame Glynis Breakwell[2]
- Lord Carter

Previous member during the year:

- Sarah Harkness[3]

Attendees:

- General Counsel and Interim Head of HR
- Chief Executive

Additional attendees from 1 January 2019:

- Director of People and Organisational Development
- National Director: Transformation and Corporate Development

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

The Committee met three times between 1 April 2018 and 31 March 2019 and during this period considered 49 items by correspondence. One meeting was a meeting in common with NHS England.

Key duties:

From 1 January 2019 the Committee is working with NHS England's Strategic Human Resources and Remuneration Committee:

- to ensure that NHS Improvement and NHS England have a single formal and transparent remuneration policy
- to ensure that NHS Improvement and NHS England have policies and practices to ensure that their people are properly recruited, engaged and motivated, diverse, performing and developed.

The following key duties continue to be considered separately by NHS Improvement's Nominations and Remuneration Committee:

- to determine and agree with the Board the framework and policy for the remuneration of NHS Improvement's Chief Operating Officer/Chief Executive, Executive and Regional Directors, for approval by the Secretary of State for Health and Social Care
- to approve remuneration packages of individual joint Executive Directors and other employees who are on the Department of Health Pay Framework for Executive and Senior Managers in Arm's Length Bodies
- to lead 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.

[1] Laura Wade-Gery took over the Chair on 22 November 2019.
[2] Glynis Breakwell stepped down from the Board on 31 March 2019.
[3] Sarah Harkness stepped down from the Board on 25 September 2018.

Nominations and Remuneration Committee – 1 April 2018 to 31 March 2019 continued

Key matters considered between 1 April 2018 and 31 March 2019:

- annual pay uplift to Executive and Senior Managers (ESM) and non-ESM salaries
- proposed appointments and remuneration packages for Executive Directors appointed jointly by NHS Improvement and NHS England
- offer to Monitor staff to transfer to NHS TDA terms and conditions under Agenda for Change
- requests for recognition of continuous service review of individual pay cases and recruitment of key staff.

Key matters considered with NHS England's Strategic Human Resources and Remuneration Committee between 1 January and 31 March 2019:

- revised terms of references for both committees
- joint working with NHS England: update on remuneration for joint appointments for phase 3 and phase 2 appointments under joint working arrangements
- joint working with NHS England: redundancy costs
- gender pay gap reports.

Provider Leadership Committee – 1 April 2018 to 31 March 2019

Under the new governance framework, the remit of the Provider Leadership Committee was transferred to the People Committee, a sub-committee of the Delivery, Quality and Performance Committee, which meets in common with NHS England's People Committee. To ensure NHS Improvement continued to fulfil its statutory functions listed under key duties below, the Provider Leadership Committee was run in parallel with the People Committee between 1 January and 31 March 2019 and until such time the People Committee formally assumed these duties.

Membership:

- Sir Andrew Morris[1]
- Lord Ara Darzi[2]
- Lord Patrick Carter[3]
- Adam Sewell-Jones
- Steve Russell

Previous members during the year:

- Sarah Harkness[4]

Attendees:

- Head of Trust Resourcing
- Head of Non-Executive Development

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

The committee met three times between 1 April 2018 and 31 December 2018 and considered 68 items by correspondence between 1 April 2018 and 31 March 2019.

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.
- suspends and terminates those appointments.
- approves pay and other remuneration requests for designated staff in NHS trusts.

Key matters considered between 1 April 2018 and 31 March 2019:

- scrutiny and approval of individual chair appointments
- update on the development of a proposed framework for determining levels of remuneration to be paid to NHS provider chairs and non-executive directors
- updates on the development of a very senior manager pay framework
- proposal for chair appraisal programme
- briefing session for new members on the work of the Non-Executive Appointments and Trust Resourcing Teams, including the governance code on public appointments, the NHS trusts regulations, NHS TDA directions and NHS Improvement's policy on appointments function
- overview of the proposal for NHS Improvement's role in talent management and appointing and supporting NHS boards
- update on actions taken in response to the Independent review into Liverpool Community Health NHS Trust
- quarterly reports on appointment and remuneration activity.

[1] Sir Andrew Morris took over the chair on 1 August 2018.
[2] Lord Darzi joined the Committee on 1 August 2018.
[3] Lord Carter joined the Committee on 1 August 2018.
[4] Sarah Harkness stepped down from the Board on 25 September 2018.

Technology and Data Assurance Committee – 1 April to 6 June 2018

This Committee was disbanded on 6 June 2018. A new Digital Committee was set up on 1 January 2019, details of which is provided in the next section.

Membership:

- Sigurd Reinton (Chair)
- Richard Douglas
- Ted Woodhouse (independent member)
- Jora Gill (independent member)
- Simon Stone (independent member)

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 acted as secretary to the Committee.

The Committee met twice between 1 April and its disbandment on 6 June 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.

Key matters considered between 1 April and 6 June 2018:

- updates on the Personalised Health Care 2020 (PHC2020) Programme
- update on implementation of recommendations from the lessons learned review undertaken following the WannaCry Ransomware cybersecurity attack
- NHS Improvement technology and data update
- future system-wide digital governance
- an architecture and standards strategy
- NHS England and NHS Improvement joint work on integrating systems and data.

Quality Committee – 1 April 2018 to 31 March 2019

From 1 January 2019 this Committee became a sub-committee to the Delivery, Quality and Performance Committee and meets in common with NHS England's Quality Committee.

Membership:

Membership between 1 April to 31 December 2018

- Lord Ara Darzi (Chair)
- 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
- Patient and Public Voice partners

Membership post 1 January 2019:

- Lord Darzi (Chair)
- Dr Timothy Ferris
- Ruth May
- Stephen Powis
- Patient and Public Voice partners

Previous member during the year:

- Sarah Harkness[1]

Attendees:

- Representative from the Care Quality Commission
- Representative from NHS Digital

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

The Committee met four times between 1 April 2018 and 31 March 2019, of which one meeting was a meeting in common with NHS England.

Key duties:

- provide assurance that mechanisms are in place to identify, manage and escalate quality concerns/issues affecting the trust provider sector
- discuss current quality issues where these fall within the provider sector and which 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 between 1 April and 31 December 2018:

- review of the Quality Dashboard
- quarterly updates from each region on patient safety, clinical effectiveness, patient experience and resources/staffing
- review of quality and safety for urgent and emergency care for winter 2017/18
- a summary of external whistleblowing cases received and complaints about NHS Improvement
- reports on mortality rates for acute trusts
- deep dive on of life care
- briefing on the safe, sustainable staffing practice programm and policy
- status update on mixed sex accommodation.

Key matters considered with NHS England's Quality Committee between 1 January and 31 March 2019:

- a workshop on the work on Quality Committees in common
- review of the Quality Dashboard
- quarterly updates from each region on patient safety, clinical effectiveness, patient experience and resources / staffing
- update on the safe staffing faculty programme.

[1] Sarah Harkness stepped down from the Board on 25 September 2018.

Table 10: New Board governance framework and committees between 1 January and 31 March 2019

NHS Improvement Board				
NHS Improvement only Board Committee	NHS Improvement Board Committee with some business being run as a committee in common with NHS England	Committees operating as a Committee in common with NHS England		
Provider Oversight Committee	**Audit and Risk Assurance Committee**	**Delivery, Quality and Performance Committee**	**Nominations and Remuneration Committee**	**Strategy Committee**
Main responsibilities				
• Provide strategic oversight of transactions and investments, special measures policy and decisions, and regulatory policy and decisions	• Review NHS Improvement's internal controls, risk management and governance processes • Review and monitors the integrity of financial statements	• Review financial and operational performance of the NHS • Review the delivery and impact of the NHS Long Term Plan • Oversee the implementation and delivery of the new NHS financial framework	Work with NHS England to ensure that the organisations have: • a single formal and transparent remuneration policy • policies and practices to ensure that their people are properly recruited, engaged and motivated, diverse, performing and developed NHS Improvement only: • approve the remuneration policy • Lead the NHS Improvement process for Board appointments	• Provide overall strategic oversight, advice and leadership to the NHS • Make recommendations to the Board on the provision of provider system leadership to the overall NHS

Committees operating as a committee in common with NHS England		
Digital Committee	**People Committee**	**Quality Committee**

Details of these committees are provided on the next page.

In addition, two advisory groups supported the Boards.

Advisory Group	Chair	Responsibilities
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 decision making responsibility and was formed to ensure that both organisations are working from a common understanding of the financial targets and financial performance of the entire health system.
Joint Transition Advisory Group (NHS Improvement and NHS England)*	Chair: Joanne Shaw (Non-Executive Director of NHS England	The group had no executive decision making responsibility and was formed to oversee the integration of NHS Improvement and NHS England.

* This group was disbanded in March 2019 and the oversight provided by this group has been assumed into other committees.

Table 11: Delivery, Quality and Performance Committees sub-committees

Sub- committees of the Delivery, Quality and Performance Committee		
Operating as a committee in common with NHS England		
Digital Committee	**People Committee**	**Quality Committee**
Main responsibilities		
• Advise on the delivery of digital commitments of the LTP, alignment of technology initiatives and spend to ensure they are focused on LTP commitments • Provide assurance on the alignment of ALBs accountabilities and responsibilities for cross cutting digital initiatives, managing NHS organisations and ALBs implementation and operation of digital initiative	• Oversee the implementation of the key recommendations from the People Plan • Support and advise on new talent management arrangements • Support challenge and advise on initiatives for workforce improvement • Oversee the delivery of best practice support for all workforce issues NHS Improvement-only responsibilities: • Review the HEE mandate and HEE's performance against the mandate • Exercise NHS TDA's powers to appoint chairs and non-executive directors of NHS trusts and suspends and terminates those appointments • Approve pay and other remuneration requests for designated staff in NHS trusts	• Consider issues in relation to three areas of quality – safety, clinical effectiveness and patient experience – in relation to all NHS services NHS Improvement only responsibility • Support improvements in patient care through overseeing NHS Improvement's approach to improving clinical quality and identifying appropriate resources to address quality issues

Details of those Committees that met in advisory capacity between 1 January and 31 March 2019 are provided on pages 93 to 95, along with membership at date of signing off.

Delivery, Quality and Performance Committee – 1 January to 31 March 2019

This Committee meets in common with NHS England's Delivery, Quality and Performance Committee.

Membership:

- Dido Harding (Chair)
- Richard Douglas
- Lord Carter
- Wol Kolade
- Tim Ferris
- Ian Dalton
- Ruth May
- Steve Powis
- Emily Lawson

Attendees:

- Chief Financial Officer
- National Director for Emergency and Elective Care

The Head of Governance acts as secretary to the committee.

The Committee met twice between 1 January and 31 March 2019.

Key duties:

- support the financial position across the wider NHS, overseeing financial, operational capacity and workforce planning and performance for NHS providers, in the context of the need to deliver the NHS Long Term Plan
- review the delivery and impact of the NHS Long Term Plan
- oversee the implementation and delivery of the new NHS financial framework.

Key matters considered between 1 January to 31 March 2019:

- provider and Commissioner financial and operational performance
- annual system planning process for 2019/20
- implementation of the NHS Long Term Plan, including updates on the workforce implementation plan
- the Government's 2019/20 accountability framework with NHS England and NHS Improvement
- updates on EU exit assurance processes
- update on joint working with NHS England
- updated on the 2019/20 annual system planning process.

Digital Committee – 1 January to 31 March 2019

This Committee is a sub-committee to the Delivery, Quality and Performance Committee and meets in common with NHS England's Digital Committee.

Membership:

- Laura Wade-Gery (Chair)
- Hugh McCaughey
- Simon Eccles - Chief Clinical Information Officer
- Will Smart, Chief Information Officer

Attendees:

- Daniel Benton, NHS Digital
- Sarah Wilkinson, CEO NHS Digital
- Jonathan Marron, Director General DHSC
- Nigel Trout, Non-Executive Director at Resolution

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

The Committee met once between 1 January and 31 March 2019.

Key duties:

- advise on the delivery of digital commitments of the LTP, alignment of technology initiatives and spend to ensure they are focused on LTP commitments
- provide assurance on the alignment of ALB accountabilities and for cross cutting digital initiatives, managing NHS organisations and ALB implementation and operation of digital initiatives.

Key matters considered during 1 January to 31 March 2019:

- implication of the NHS Long Term Plan for the current Digital and Technology Portfolio
- cyber assurance
- compliance and enforcement mechanisms for IT standards in 2019
- update on the Data Transformation Programme
- NHS Digital Live Services Report

People Committee – 1 January to 31 March 2019

This Committee is a sub-committee to the Delivery, Quality and Performance Committee and meets in common with NHS England's People Committee.

Membership:

- Andrew Morris (Chair)
- David Behan, Chair Health Education England
- Ian Cummings, CEO Health Education England
- Prerana Issar

Attendees:

- Chief Executive, NHS England
- Representative from
- Head of Trust Resourcing and Appointments
- Representative from the NHS Leadership Academy

Future member:

- Chief Operating Officer/Chief Executive Officer of NHS Improvement

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

The Committee met once between 1 January and 31 March 2019.

Key duties:

From 1 January 2019 the Committee is working with NHS England's Strategic HR, Nominations and Remuneration Committee:

- oversee the implementation of the key recommendations from the People Plan
- support and advise on new talent management arrangements and ensure that the NHS develop a pipeline of chairs, chief executives and senior managers
- support challenge and advise on initiatives for workforce improvement
- work collaboratively with Health Education England (HEE) to recommend any changes to enhance the HEE offering to systems and providers for 2020/21
- oversee the delivery of best practice support for all workforce issues.

The following statutory duties will be considered separately by NHS Improvement's People Committee:

- 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
- suspends and terminates those appointments
- approves pay and other remuneration requests for designated staff in NHS trusts.

Key matters considered during 1 January to 31 March 2019:

- draft terms of refence
- proposals for a programme of work on defining NHS provider chair competencies and performance appraisal of chairs
- proposals for revising the onboarding offer to very senior leaders in the NHS.

Board disclosures

Information governance compliance and disclosure of personal data-related incidents

During the year, work to embed the information governance operating model and framework to ensure provision of a high quality and effective information governance service for NHS Improvement continued. Following successful implementation of the General Data Protection Regulation readiness programme in May 2018, the organisation has achieved operational compliance with new data protection legislation. Work continued during the year to enhance compliance through ongoing engagement and a new information governance assurance function was established. A joint NHS Improvement and NHS England Data Protection Officer has been appointed and provides advice and guidance on compliance with data protection legislation.

The mandatory Data Security and Protection Toolkit, launched in April 2018 and replaced the Information Governance Toolkit, was submitted at the end March 2019.

NHS Improvement saw an increase in the number of reported information governance incidents. During the year the number of breaches requiring investigation by the information governance team increased to 65 (24 in 2017/18), 28 of which related to the processing of NHS Improvement data by the Business Services Authority. The team is working closely with colleagues in the Business Services Authority to address and reduce reoccurrence through improved process and staff education. There were no personal data incidents which required reporting to the Information Commissioner's Office.

Priorities for 2019/20 includes the alignment of the NHS Improvement and NHS England information governance functions, to provide an effective, seamless information governance service across both organisations.

Cyber and data security

Continuous awareness training in information security and cyber security was provided for staff during the year and led to a reduced number of cyber-related incidents during the year. Following the Wannacry attack in May 2017, areas for improvement were identified by NHS Digital and the National Cyber Security Centre and these have been prioritised by NHS Improvement. During the year, NHS Improvement successfully achieved Cyber Essentials Plus certification; a UK

government information assurance scheme operated by the National Cyber Security Centre. Microsoft's threat protection systems, for earlier threat detection and control, was implemented and the organisation expanded its inhouse vulnerability scanning and penetration testing.

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 2018 to 31 March 2019, except for the following listed below.

Table 12: 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.3.7 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.
N/A	N/A	D.1.1 The composition of executive remuneration should reflect the notion of enhanced shareholder value by having an appropriate balance between fixed and performance related remuneration.	NHS Improvement is governed by the Department of Health and Social Care's Pay Framework for Executive and Senior Managers in Arm's Length Bodies and as such the enhancement of shareholder value is not taken into account when determining executive remuneration.

N/A	N/A	D.2.2 The remuneration committee should set the remuneration for all the executive directors and the chair.	The Nominations and Remuneration Committee approves the total remuneration package for executive directors and the chair ahead of final approval by the Secretary of State for Health and Social Care.
5.5 The Head of Internal Audit should periodically be invited to attend board meetings, where key issues are discussed relating to governance, risk management processes or controls across the department and its ALBs.	N/A	N/A	The Head of Internal Audit attends all meetings of the Audit and Risk Assurance Committee meeting.

Changes to the UK Corporate Governance Code which were published in July 2018 will come into effect for NHS Improvement's financial year ending 31 March 2020. Compliance against the revised code will be reviewed during the coming year and will reported in next year's report.

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. NHS Improvement has 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, NHS Improvement 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, NHS Improvement must ignore its 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 the organisation has 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 2018/19 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; and
- 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 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.

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 expenditure, changes in taxpayers' equity and cash flows for the financial year.

In preparing the accounts, the Accounting Officer is required to comply with the requirements of the government *Financial reporting manual* and in particular to:

- observe the accounts direction issued by the Secretary of State, including the relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis
- make 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 me 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*, published by HM Treasury.

Disclosure to the auditors

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

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

Bill McCarthy
Interim Accounting Officer
2 July 2019

Annual governance statement 2018/19

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 has operated and how the new governance framework that was introduced on 1 January 2019 has been designed to contribute to the achievement of the NHS Long Term Plan and development of integrated care systems (see page 50).

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 2018 until 31 March 2019 and refers to NHS Improvement throughout. Ian Dalton was the Accounting Officer for NHS Improvement (being the Monitor and TDA legal entities) for the 2018/19 financial year and up to 28 June 2019. Bill McCarthy, as incoming interim Accounting Officer, received assurances from Ian Dalton as part of authorising these accounts.

NHS Improvement's governance framework

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.

Changes to the Board Governance framework

A new board governance framework was introduced on 1 January 2019 and operated in parallel to some of the existing Board Committees between 1 January and 31 March 2019. The new framework has been designed to enable NHS Improvement's and NHS England's boards to have full oversight of the two organisations.

Under the current statutory framework this cannot be legally be achieved through joint boards or committees. Each organisation has to retain its respective statutory functions and can only delegate its functions to its own committees. Each Board has therefore established its own committees, but they operate as committees-in-common allowing the organisations to meet together, discuss the same topics but remain separate committees with separate membership and taking their own decisions.

Board changes

There have been several changes to the composition of the Board in 2018/19. Details of directors who served on the Board during the year are on page 81.

Sigurd Reinton's and Lord Carter's terms of office expired on 30 June 2018, Lord Darzi's term expired on 31 July 2018 and Sarah Harkness' term expired in September 2018. The Secretary of State for Health and Social Care approved the extension of Lord Carter's and Lord Darzi's terms to 30 June 2021 and 31 July 2021, respectively. The Board would like to thank Sigurd Reinton and Sarah Harkness for their valuable contribution to NHS Improvement over their two terms as directors. On 1 August 2018 Dr Timothy Ferris, Wol Kolade, Sir Andrew Morris and Laura Wade-Gery joined the Board.

In December 2018, the departures of Kathy McLean, the Executive Medical Director and Chief Operating Officer and Stephen Hay, Executive Director of Regulation and Deputy Chief Executive were announced. They have both served the NHS and wider

public sector over many decades and they have been members of NHS Improvement's Board since its establishment in April 2016. They stepped down from the Board at the end of March and left the organisation in April 2019 and the Board thank them both for their contribution to NHS Improvement and to the leadership of the wider NHS.

From 7 January 2019, Ruth May was appointed joint Chief Nursing Officer of England and NHS Improvement and is now an Executive Director on both NHS Improvements and NHS England's Board. Steve Powis was appointed the National Medical Director of England and joined NHS Improvement's Board on 1 April 2019. Julian Kelly joined both organisations and the Boards as the Chief Financial Officer of NHS Improvement and NHS England on 1 April 2019.

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.

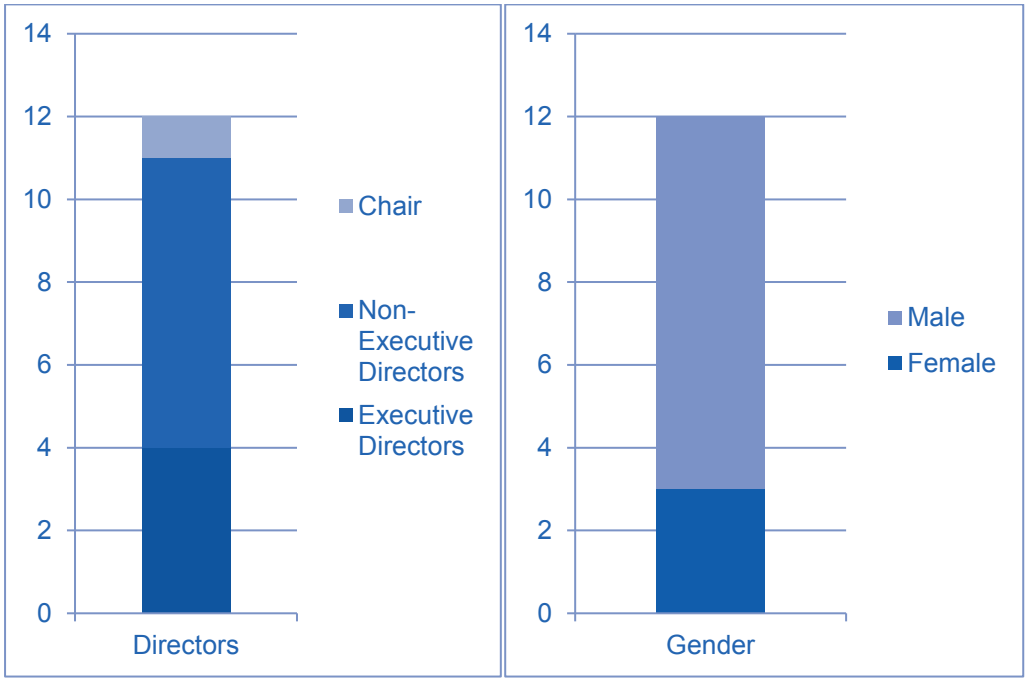
At the date of this report, the Board has 12 Directors, comprising the Chair, seven Non-Executive Directors and four Executive Directors, three Board members are female and nine are male. The Board composition and Non-Executive Directors' term of office are set out on page 81.

Associate directorships

During the year the cross-associate directorship with NHS England has continued with Richard Douglas serving as an Associate (non-voting) Non-Executive Director on NHS England's board and David Roberts, the Vice-Chair of NHS England, an Associate (non-voting) Non-Executive Director of NHS Improvement Board. On 1 February 2019, David Behan, the chair of Health Education England, also joined the NHS Improvement Board as an Associate (non-voting) Non-Executive Director.

Table 13: 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. During the year, the Chief Executive, Ian Dalton, was 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 Dame Glynis Breakwell was the Senior Independent Director up to her leaving the Board on 31 March 2019 when Lord Carter took over the role.

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[65].

Remit

During the year, NHS Improvement's governance framework was set out in the Rules of Procedure. In light of the new joint working model with NHS Improvement the Rules of Procedure was revised for 1 April 2019 and is available on NHS Improvement's website[66].

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.

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

During the year, the Board also delegated 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 defined individual and committee responsibilities. The Rules of Procedure have subsequently been revised to reflect the new governance structure and changes to delegated responsibilities by the Board to individuals.

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 assist NHS Improvement's and NHS England's board with the oversight of the integration of the two organisations a Joint Transition Advisory Group was established. This was a time limited advisory forum, acting on behalf of the two boards, to support and advise the two Chief Executives and other senior executives in the context of the Joint Working Programme. This group was disbanded in March 2019 when its duties were assumed into other committees.

The Joint Finance Advisory Group with NHS England continued to meet regularly during the year 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 83 to 95. Details of responsibilities delegated to the Chief Executive and his supporting governance structure are on pages 116 to 119.

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.

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 2018 and 31 March 2019 is outlined in the table on the next page.

Table 14: Board and Committee attendance 1 April 2018 to 31 March 2019

Directors	Board	Audit and Risk Assurance Committee	Delivery, Quality and Performance Committee	Digital Committee	Nominations and Remuneration Committee	Provider Leadership Committee/ People Committee	Technology and Data Assurance Committee*	Quality Committee
	(eligible to attend)							
Baroness Dido Harding	8(8)	-	2(2)	-	-	-	-	-
David Behan[1]	0(1)	-	-	-	-	-	-	-
Lord Patrick Carter	7(8)	-	2(2)	-	3(4)	1(1)	-	-
Lord Ara Darzi	7(8)	-	-	-	-	0(1)	-	3(3)
Richard Douglas	8(8)	4(4)	2(2)	-	-	-	2(2)	-
Dr Timothy Ferris[2]	4(6)	-	2(2)	-	-	-	-	2(2)
Wol Kolade[3]	4(6)	1(1)	2(2)	-	-	-	-	-
Sir Andrew Morris[4]	4(6)	1(1)	-	-	-	2(2)	-	-
David Roberts	8(8)	-	-	-	-	-	-	-
Laura Wade-Gery[5]	6(7)	-	-	2(2)	-	-	-	-
Ian Dalton[6]	8(8)	-	2(2)	-	-	-	-	-
Ruth May	8(8)	-	2(2)	-	-	-	-	2(4)
Former Directors								
Dame Glynis Breakwell[7]	4(8)	-	-	-	3(4)	-	-	-
Sarah Harkness[8]	2(2)	3(3)	-	-	3(4)	2(2)	-	2(2)
Sigurd Reinton[9]	1(1)	1(1)	-	-	-	-	2(2)	-
Stephen Hay[10]	7(8)	-	-	-	-	-	-	-
Kathy McLean[11]	6(8)	-	-	-	-	-	-	3(4)

[1] David Behan was appointed to the Board on 1 February 2019.
[2] Dr Timothy Ferris was appointed to the Board on 1 August 2018.
[3] Wol Kolade was appointed to the Board on 1 August 2018.
[4] Andrew Morris was appointed to the Board on 1 August 2018.
[5] Laura Wade-Gery was appointed to the Board on 1 August 2018.
[6] Ian Dalton stepped down as Chief Executive on 28 June 2019.
[7] Prof Breakwell stepped down from the Board on 31 March 2019.
[8] Sarah Harkness stepped down from the Board on 25 September 2018.
[9] Sigurd Reinton stepped down from the Board on 30 June 2018.
[10] Stephen Hay stepped down from the Board on 31 March 2019.
[11] Kathy McLean stepped down from the Board on 31 March 2019.
* The Technology and Data Assurance Committee also has three independent members.

The Board held 12 scheduled meetings between 1 April 2018 and 31 March 2019. There were eight formal Board meetings and four Board development sessions. In addition, there were two Non-Executive Director only governance 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 the challenges faced by NHS Improvement and the sector.

In developing a closer working relationship with NHS England three joint public Board meetings in common were held during the year to enable joint deliberations on items of business the organisations have in common including the integration of the two organisations, the development of the NHS Long Term Plan, development of integrated care systems and 2018/19 operational and financial plans for the NHS.

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

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 attended all Board meetings. Other members of NHS Improvement's executive team attended Board meetings as appropriate to make presentations on pertinent matters arising from their respective directorates.

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

- development of the NHS Long Term Plan
- approval of the joint working arrangements with NHS England and the new governance framework

- updates on NHS Improvement's actions in response to the independent review into Liverpool Community Health NHS Trust
- the proposed role of NHS Improvement's role in appointing and supporting NHS boards and talent management
- regular update on 2017/18 winter performance and preparedness for the 2018/19 winter period
- Proposed national tariff policies for 2019/20
- Carter review of mental health and community services
- approval of 2018/19 budget and business plan
- 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'
- approval of Monitor and NHS TDA annual report and accounts

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 recruitment of the new Non-Executive Directors was led by the Department of Health and Social Care (DHSC) who at the start of the process agreed that the external recruitment firm Odgers Berndtson services could be commissioned to assist with identifying potential candidates. NHS Improvement, which has no other connections with Odgers, and DHSC worked closely with the firm to identify candidates with skills and expertise needed to complement and fill any gaps on the Board. Following a rigorous and thorough selection process a shortlist of candidates was compiled and following an interview process DHSC submitted its recommendations to the Secretary of State for Health and Social Care and the Prime Minister for final approval of the new Non-Executive Directors. The appointment of Dr Timothy Ferris, Wol Kolade, Sir Andrew Morris and Laura Wade-Gery were approved.

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 suitably and tailored induction comprising information about NHS Improvement, its structure, operations and corporate governance; meetings with executive and senior management; and visits to NHS providers.

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, albeit it was acknowledged that the year had been dominated by the joint working with NHS England. The Board is satisfied that it is operating effectively with each Director performing well in respect of their roles on the Board and the Committees. As well as confirming where improvements have been made, or would be addressed through the new governance structure, the evaluation identified areas of focus for 2019/20. These are summarised [on the next page].

It is recognised that the Chair's effectiveness is also vital to the operation and effectiveness of the board. Accordingly, led by Lord Carter in his role as the SID, an evaluation of Baroness Harding's was carried out. Each Non-Executive Director and a number of external leaders were consulted for feedback on Baroness Harding's performance during the year. The outcome of this evaluation, which was reported back to the Board, confirmed that her leadership continues to be effective and her relationships and communications within the Board are also very constructive and she encourages good and open debate, both within and outside the Boardroom.

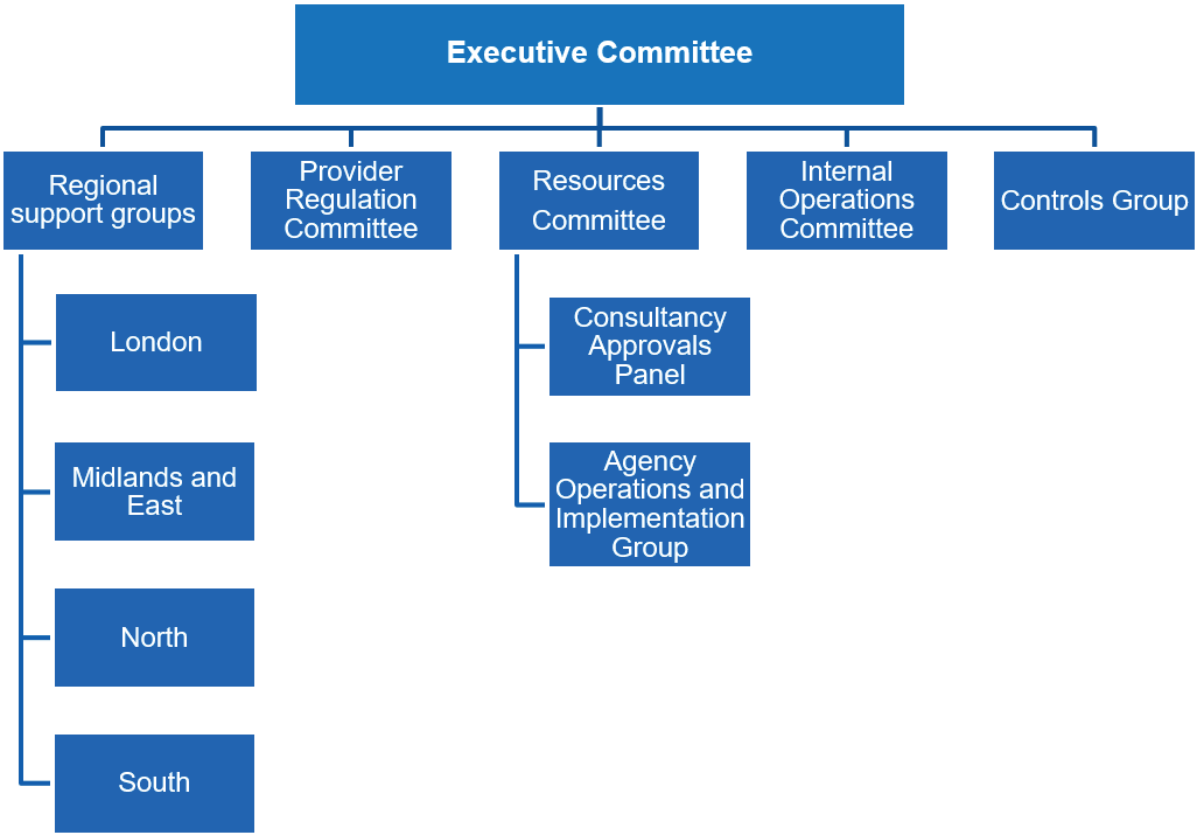
The table on the next page outlines areas of improvement identified and agreed by the Board.

Theme	Areas recommended improvement in 18/19	Focus in 19/20
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.	Continue to ensure the Board has early sight of, and an opportunity to challenge, strategy and business planning documents affecting NHS Improvement.
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 workstream. Work towards a joint approach to performance management with NHS England.	N/A
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.	The Nominations and Remuneration Committee now meet in common with NHS England's equivalent committee and their remit include oversight of the broader people agenda within both organisations and will oversee talent and succession planning going forward.
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.	More regular and consistent reporting on people metrics will be considered a part of oversight of NHS Improvement's and NHS England joint Business Plan.
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.	N/A

Executive committees

During the year the Board delegates the day-to-day running of the organisation to the Chief Executive, who is the Accounting Officer. The Chief Executive was assisted in his role by the Deputy Chief Executive, the Executive Medical Director/Chief Operating Officer and the Executive Committee, comprising the executive Board members and others who report directly to the Chief Executive. The governance framework in place during the year below the Executive Committee is as follows:

Figure 2: NHS Improvement governance framework below the Executive Committee



During the year 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.

A number of committees assisted the Executive Committee in its work during the year. 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

New Executive Group

In December 2018, NHS Improvement and NHS England announced a new Executive Group. Details of the new executive governance structure will be provided in the next annual report.

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.

During the year 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 2019/20.

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, NHS Improvement has identified five business critical models in 2018/19:

- 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 regularly to review this list, and to determine whether any models need to be removed from the list (ie 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.

2018/19 has seen three major developments:

- The Long Term Financial Model was rebuilt, and subject to an external review.
- The finalisation and implementation of the rebuilt Pricing Models was completed. MAG has decided to keep the two Pricing Models as two distinct models on the list of Business Critical Models, as that is an accurate reflection of their implementation by the Pricing Team.
- The Overall MAG Process, and the Pricing and GP Referral Analysis models were subject to NHS Improvement's internal audit process.

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.	During 2018, the LTFM was rebuilt internally at NHS Improvement by modelling experts and an external assurance review was undertaken by modelling experts. All subsequent changes to the model will go through a documented model update process, including segregation of duties and multiple-stage review processes. Any future large-scale changes to complex parts of the model will be performed and/or reviewed by external modelling experts. However, given the recent rebuild of the LTFM, this is not anticipated to be required for the foreseeable future.
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	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

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 billion of approximately £70 billion secondary care services commissioned under the NTPS.	creating that part of the model. • the model was published as part of our consultation on the 2019/20 NTPS, which has given stakeholders the opportunity to review the model and feed back their comments and observations. • the model was recently reviewed by PWC as part of the wider internal audit of the Business Critical Model process.
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 recently reviewed by PWC as part of the wider internal audit of the Business Critical Model process.
The **GP Referral Analysis Model** is used to analyse whether a merger between providers of NHS elective care services is likely to give rise to competition concerns. The model comprises a series of files containing software algorithms that analyse Hospital Episode Statistics (HES) data. The model is business critical because it provides a foundation for our strategic advice and early input to NHS foundation trusts and trusts considering mergers, to ensure that transactions are well planned and work well for patients.	The GP Referral Analysis Model was developed internally 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 assured. Further, any supplementary analysis added to the model will be quality assured using the formal change process. This model was recently reviewed by PWC as part of the wider internal audit of the Business Critical Model 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 2018/19

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.

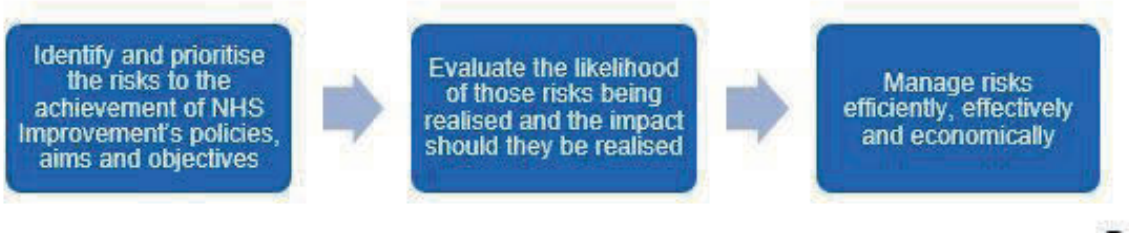
Considering the work undertaken by Internal Audit over the course of the financial year and informed by the outcomes of the work and feedback from management on their controls, governance and risk management arrangements, I conclude an overall moderate assurance for 2018/19 - some improvements are required to enhance the adequacy and effectiveness of the framework of governance, risk management and control.

Internal control – statement from Accounting Officer

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 2019 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.

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 2018/19

Our review of NHS Improvement's Business Plan 2017-19 identified that the organisation faced a number of significant risks in 2018/19, including:

Table 15: Principal risks and mitigation

Risk	Mitigation: what has NHS Improvement done to manage the risk?
Organisational transformation and joint working with NHS England Risk that organisational change specified through the joint working initiative doesn't deliver the intended benefits or leads to a failure in critical 'business as usual' activities.	In March 2018 we shared proposals around an ambition to strengthen our joint working with NHS England and together established an ambitious programme of work to take forward this commitment. Throughout 2018/19 we have continued to work on aligning our leadership and collective resources around a shared set of priorities that will add the most value to the NHS. We are also simplifying and streamlining our interface with local systems, moving to single regional teams and a single, simpler and more efficient approach to our key processes. The following mitigations and achievements were carried out in 2018/19 to manage this risk: • establishment of a Joint Working Programme and a dedicated Joint Working Integrated Programme Office (IPO) to track risks and issues, and monitor and report on progress • establishment of six dedicated design workstreams (implementation approach; communications; HR and consultation; culture, leadership and engagement, future operating model; and finance and efficiency) to (re)design business processes, systems and operating model, and to manage the programme through to implementation and into business as usual (BAU) • tailored programme risk management strategy in place to ensure risks properly identified, managed and communicated. Note: the joint working IPO operates a layered approach to risk and issue management • detailed programme risk and issues register maintained, focused on assessing the impact of joint working on BAU and on mitigating potential delivery risks associated with moving to a single operating model, governance structure and shared culture

	• individual project risk and issue registers also maintained by project leads. Material risks at project level escalated to the programme risk register. In turn, material risks at programme level used to inform changes to this overarching corporate risk • three escalation processes: regular monthly reporting; fortnightly project team meetings where risks can be identified and discussed verbally; and a fast track process where risks and issues can be escalated to weekly leadership team meetings (Friday), or up to SRO level at Monday meetings • BAU delivery tracked through the corporate performance monitoring process. To complement this, the joint working implementation team developing mitigations to any BAU impacts/BAU delivery risk as a result of the programme • operating model and ESM structure design completed, with a collective consultation period on ESM structures 15 November to 30 December 2018 • new NHS Executive Group announced on 11 December 2018. Met for the first time on 8 January 2019 and also 6 February. Joint enterprise was an important element of the agenda, with discussions focused on the development of structures below ESM level • national director recruitment process underway, and the first phase of integrated regional teams created 1 April • joint staff engagement programme (previously Project 70), with regular staff engagement sessions, a log of FAQs, frequent temperature checks, 'spotlights' on individual workstreams, an information pack and 'all staff briefings' keeping staff abreast of the programme and the change • design and delivery team, representing new corporate and regional directorates, working with the NHS Executive Group, local HR colleagues, staff and stakeholders to ensure successful transition to the new operating model. There is a strong appetite for change and a recognition that to be successful we need a new shared approach to our culture and leadership. Over the next three months, the areas we are focusing on so that we can implement our new operating model from April 2019 are: • supporting the NHS Executive Group and ESM community to transition to new leadership arrangements

	• making sure there is a robust and effective handover process in place; • aligning all teams to the new regions and corporate directorates • maintaining BAU support to the NHS and local systems.
EU Exit Risk that we are unable to support providers to plan for and manage interruption caused by the UK's withdrawal from the EU, with impact on NHS services and patients.	This risk has increased in focus due to continued uncertainty about the terms under which the UK will leave the EU; in particular, the potential impact of a no-deal Brexit on NHS service provision. This uncertainty has emphasised the importance of risk management and contingency planning for a range of outcomes. The area gaining most momentum is continuity of essential medicines and other critical goods and ensuring operational readiness through emergency planning. Other key impact areas include workforce supply and regulation; reciprocal healthcare and cost recovery; procurement and competition regulation; research and innovation; data and information governance; and public health and pandemic planning. The joint NHSI and NHSE EU Exit team is continuing to manage this risk by providing information, advice and expertise to the Department of Health and Social Care (DHSC); and through DHSC's governance, working alongside other arm's length bodies (ALBs) including Public Health England (PHE), Medicines and Healthcare products Regulatory Agency (MHRA), NHS Digital and Health Education England (HEE) to ensure the health system is prepared for EU Exit, and to mitigate the potential risks associated with the UK's withdrawal from the EU. Working with DHSC and NHS England, we continue to build the operational response should there be no Brexit deal and have established a national Operational Response Centre to co-ordinate Emergency Preparedness, Resilience and Response (EPRR) and lead on responding to any disruption to the delivery of health and care services in England, caused or affected by EU Exit. The following mitigating controls/actions have been undertaken in 2018/19: • establishment of a single EU Exit Function across NHSE and NHSI, split between strategy and

	operational readiness and led by directors with workstreams brought together as weekly executive group and workstream-specific working groups
	• regular meetings with DHSC policy workstreams (responsible for leading Brexit planning) and with the DHSC EU Exit Team
	• ensuring a clear NHS Improvement position on EU Exit in all scenarios and that this is communicated to DHSC
	• collaborating with DHSC and NHS England to issue national guidance for the NHS EU Exit response. Out of the ones that have been published, the notices that may impact the NHS are as follows:
	  • quality and safety of organs, tissues and cells if there's no Brexit deal
	  • labelling tobacco products and e-cigarettes if there's no Brexit deal
	  • batch testing medicines if there's no Brexit deal
	  • ensuring blood and blood products are safe if there's no Brexit deal
	  • submitting regulatory information on medical products if there's no Brexit deal
	  • how medicines, medical devices and clinical trials would be regulated if there's no Brexit deal
	• with NHS England/DHSC, developing joint contingency plans which will reduce overall impacts of services to patients; specifically supporting the development and implementation of suitable national EPRR and business continuity plans (and any local guidance).
	• The following actions, also joint with NHS England/DHSC, are underway:
	  • non-clinical goods and services - trust contract self-assessment conducted to assess risks around the supply of non-clinical goods and services; with DHSC and NHSE, developing guidance for trusts to manage contracts they consider to be high risk
	  • medicines - with DHSC and NHSE, released guidance to trust chief pharmacists advising on government's planning to protect continuity of supply of medicines.

Availability and supply of sector workforce Risk that NHS workforce lacks capacity and/or capability to transform	The NHS continues to face a series of workforce challenges with NHS staff numbers failing to keep pace with demand and ongoing deterioration in workforce numbers in critical areas such as nursing and mental health. A robust workforce is critical to the successful implementation of the NHS Long Term Plan, and NHS staff shortages could put long-term vision for the health sector at risk if not addressed. The following mitigations and achievements took place in 2018/19 to manage this risk:

healthcare provision leading to deterioration and/or inertia in quality, financial and/or operational performance	• 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 • Developing scenario models (for nursing in the first instance) that reflect both operational plans and longer-term demand drivers to identify how underlying risks to demand might continue if certain scenarios were to play out; for example, the possibility of leaver rates increasing as a result of the implementation of Brexit • mitigating the risks highlighted in the scenario models, by identifying 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 • developing a workforce planning resource (agency toolkit) supporting providers with national and local workforce planning requirements effectively use of staff banks and supporting our operational workforce planning process • with partner ALBs, providers and other partners, supporting work to improve training, retention, paths and leadership development for doctors. This includes implementing a strategy to support specialty and associate specialist doctors, effective implementation of exception reporting by junior doctors and an Aspiring Medical Directors programme which was completed by more than 50 medical leaders in 2018/19 • HEE will expand the number of medical school places from 6000-7500 per year; • our workforce team directly supporting trusts (53 mental health providers, and over 50 acute and community providers) developing and implementing improvement measures to support clinical retention and participation rates using guidance and good practice and supporting all providers with resources to improve retention • our operational productivity teams supporting providers to improve workforce productivity across several clinical staff groups (including medical, nursing and allied health professional workforces) through a variety of methodologies. We have published guidance using e-job planning an e-rostering effectively

	• a programme of work supporting trusts to realise the benefits of workforce transformation and develop a workforce responsive to changes in care, now and in the future • ensuring effective engagement with staff and wider system partners through developing 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 • setting the direction for capacity and capability-building, including leadership development and talent management for the NHS in England through our improvement directorate-led culture and leadership programme to help NHS providers develop cultures that enable and sustain continuous improvement and compassionate care • Commitment in the Long-Term Plan a workforce implementation plan led by a national workforce • agreed workforce modelling assessments with HEE, DH and NHS England ('single version of the truth') • building on NHS staff workflow and productivity tools (with the DHSC), Emergency Care Improvement Plan and Well-Led Framework • Demand and Capacity Planning Programme (with NHS England, Health Education England and the Leadership Academy) • workforce planning national strategies, eg National Strategy for Leadership Development and Quality Improvement, and future workforce/staffing models (with DHSC) • provider workforce assessments and operational planning support on workforce issues and roll-out of a workforce toolkit to support improved planning is.
Alignment of improvement approach Risk that action taken to improve provider quality, financial and/or operational performance leads to a deterioration in	The risk that improvements to provider quality, financial and/or operational performance lead to a deterioration in one and/or other performance areas if there isn't sufficient co-ordination remains one of our highest scoring risks. • Work is ongoing to ensure quality, finance and operational performance of trusts is considered in the round. This includes chairing joint progress check meetings with challenged providers to consider the issues holistically, for example where a trust is in special measures both for reasons of quality and finance. NHS Improvement is also considering any

one and/or other performance areas	further steps in response to the DHSC Implementation Unit ‘deep dive’ on the factors that enable trusts to sustain improvement on exiting from special measures for reasons of quality - particularly moving towards implementation of the Joint Working Programme. • There have been significant savings made through the Financial Special Measures (FSM) and Financial Improvement Programme (FIP) programmes against challenging conditions and a severe winter period. We worked with the most financially challenged trusts to identify efficient savings and ensured all trusts in FSM or receiving ‘enhanced support’ have a financial improvement director (where appropriate) along with a dedicated financial recovery team to support and hold the trust to account for improving financial governance and control, improving productivity and efficiency, and developing and delivering robust financial recovery plans while maintaining or improving quality. We began to develop a learning approach including skills and knowledge transfer and plan to look at longer term actions to develop trust leadership. • The triangulation process during annual operational planning helps to identify and tackle misalignment between activity, workforce and finance; • Regional and national teams continue to work closely with providers to help manage delivery risks and maximise productivity and other opportunities although some of this work will be supporting non-recurrent items that do not address the longer-term financial sustainability issues of the sector. • Use of resources ratings are now included in the CQC inspection regime to help maintain a balanced focus on quality, operational performance and financial performance. • Also, the work is quality led, with improvements to operational performance and financial performance linked. Getting It Right First-Time (eg Orthopaedics) is a clinically led programme to reduce unwarranted variation, improve patient outcomes and deliver efficiency and productivity improvements. • The quarterly sector performance report to the Board highlights how providers are performing against national finance and performance targets. The quality dashboard report to the board highlights key trust quality developments and trends. The Quality 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 care quality in the trust provider sector.

	• A number of initiatives focus on improving the quality of care and supporting providers where patient safety and care need to be improved. These include support packages for challenged providers and trusts in special measures; monitoring and improving patient safety and providing guidance and alerts to the system through the Patient Safety team; regular reviews with regions and the CQC through the Joint Strategic Oversight Group; support to help providers move from Inadequate or Requires Improvement to Good or Outstanding; and mapping quality governance across NHS England, NHS Improvement and other key ALBs and consideration of where they can be more joined up on system quality issues. • The Strategy Team began a project to analyse capacity, operational performance and financial outturn performance to understand key trade-offs articulated in this risk; specifically looking at how decisions made in the interest of one objective have a knock-on effect on another (for example, a focus on delivering the RTT standard might lead to providers incurring premium costs from waiting list initiatives). ICS Programme progress (specifically, improved operational and financial performance of the ten first wave ICSs and early progress in care redesign) helps provide a holistic view by focusing attention on all three dimensions of this risk simultaneously. The Government's long-term funding settlement and development of the Long-Term Plan will ensure a sharper focus on improving productivity and efficiency in the medium and long term.
Cyber threat Risk that appropriate information safeguards are not in place to protect the organisation from a sustained cyber-attack (e.g. ransom ware).	Following the global 'WannaCry' cyber-attack in May 2017 many actions were implemented, and we continuously strive to add to our current security posture to ensure cyber resilience. The risk of a cyber-attack remains high, as does the potential impact of such an attack. But NHS Improvement's corporate IT team is confident that the steps taken to harden our defences and build resilience into our infrastructure have helped to reduce that likelihood including: • an internal Phishing exercise to gauge the level of awareness of staff and their response to such an attack with findings subsequently shared with all staff and learnings put in place • building on in-house penetration and vulnerability testing of our applications and internet-facing websites

	renegotiating with the supplier Appcheck to include internal infrastructure scanning. We are now able to scan not only software but internal network devices for vulnerabilities thus helping strengthen our network
	• achieved Cyber Essentials certification through:
	  • internal review of all internet facing servers including internal penetration testing and manual reviews
	  • server hardening and upgrading of software
	  • findings from the cyber essentials scans implemented and swiftly acted on
	• in the process of finalising dates with the supplier for Cyber Essentials Plus certification for completion by February 2019. Similar process to the Cyber Essentials certification has been completed with all systems and servers being scanned for vulnerabilities and software versions and relevant patches being applied;
	• established an Information Security Management Systems group chaired by the Head of IT with oversight all information security related incidents, plans, projects, actions and policies - part of the work to formalise ISO 27001 best practice
	• using the NHS Digital/Microsoft Endpoint Threat Detection Service successfully on all devices
	• running the NHS Digital/Microsoft Advanced Threat Detection services and receiving useful security-related information to us including several threats missed by NHS Mail filters
	• an interim submission for the new Data Security and Protection Toolkit was made highlighting current progress with the aim of submitting a fully compliant toolkit by the deadline of 31 of March 2019
	• information security and cyber awareness sessions for staff from the Information Security Manager on various topics; articles in Inside Improvement, the tech & data newsletter and on the intranet to involve and educate staff about the current risks and best practices with bespoke Boar- level training by NHS Digital planned for the near future.

Capacity to handle risk

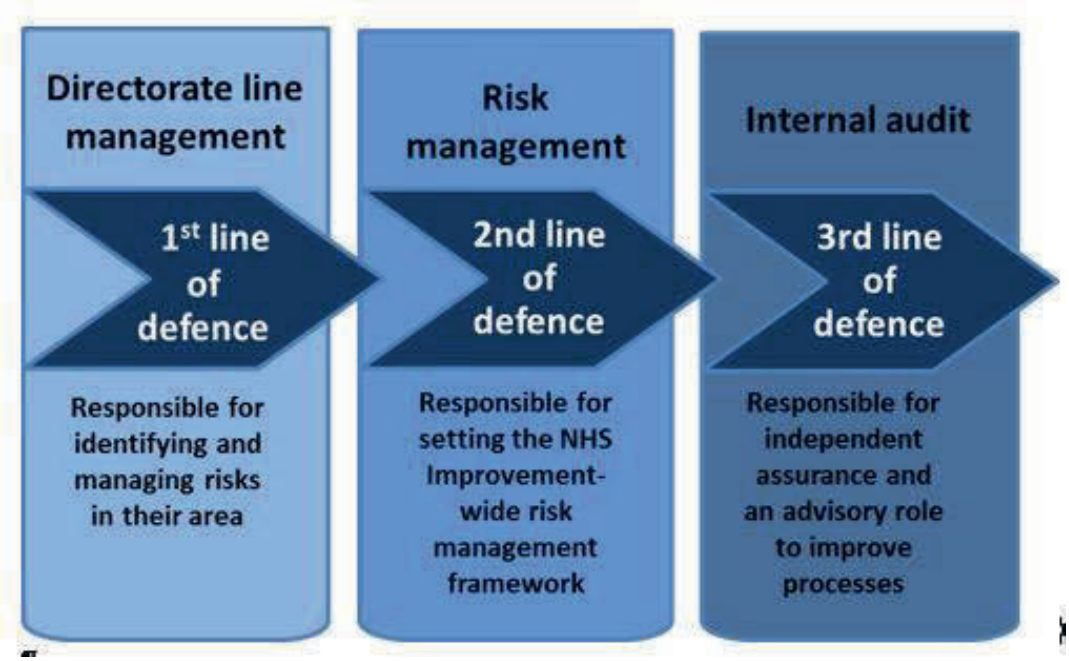
NHS Improvement's Board has responsibility for ensuring delivery of our strategies and goals as outlined in the 2017-19 business plan. When setting these strategies and goals, the Board considers NHS Improvement's specific statutory functions as outlined in legislation relating to its component parts 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 assurance and 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 2018/19.

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 2018/19. 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.

Bill McCarthy
Interim Accounting Officer
2 July 2019

Remuneration and staff report

Remuneration report

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 under the NHS Improvement Board. 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 Committee comprises three non-executive directors and other members as from time to time agreed by the Chair 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 16. 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 16: Executive team notice periods

	Notice period
Ian Dalton CBE Chief Executive	6 months
Stephen Hay, Deputy Chief Executive and Executive Director of Regulation	6 months
Ruth May, Chief Nursing Officer	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)	6 months
Jeremy Marlow, Executive Director of Operational Productivity	3 months
Elizabeth O'Mahony, Chief Financial Officer	6 months
Steve Russell, Executive Regional Managing Director (London)	6 months
Adam Sewell-Jones, Executive Director of Improvement (until 13 January 2019) Interim NHS South West Regional Director (from 14 January 2019)	3 months
Lyn Simpson, Executive Regional Managing Director (North)	6 months
Sir David Sloman, London Regional Director	6 months

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 17 shows the total remuneration; two thirds of the 2018/19 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 17: Salary, benefits in kind and pension benefits 2018/19

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**
Ian Dalton CBE Chief Executive	285-290	-	102	385-390
Stephen Hay[1/9] Deputy Chief Executive and Executive Director of Regulation	195-200	-	-	195-200
Dr Ruth May Chief Nursing Officer NHSI's Executive Director of Nursing until 6 January2019, from 7 January 2019 became the joint Chief Nursing Officer for NHSI and NHSE	155-160	-	13	170-175
Dr Kathy Mclean[9] Executive Medical Director and Chief Operating Officer	205-210	-	-	205-210
Executive team				
Dale Bywater Executive Regional Managing Director (Midlands and East)	160-165	-	42	200-205
Ben Dyson[2] Executive Director of Strategy	130-135	-	52	185-190
Anne Eden [3] Executive Regional Managing Director (South East)	175-180	-	-	175-180

Jennifer Howells[4] Executive Regional Managing Director (South West) until 14 January 2019	-	-	-	-
Sian Jarvis[5] Executive Director of External Affairs (from 16 April 2018 to 29 March 2019)	135-140	-	-	135-140
Jeremy Marlow[9] Executive Director of Operational Productivity	140-145	-	47	190-195
Elizabeth O'Mahony Chief Financial Officer	160-165	-	87	245-250
Steve Russell[6] Executive Regional Managing Director (London) until 5 February 2019	145-150	-	38	185-190
Adam Sewell-Jones[1/7/9] Executive Director of Improvement (until 13 January 2019) Interim NHS South West Regional Director (from 14 January 2019)	155-160	74	61	225-230
Lyn Simpson Executive Regional Managing Director (North)	160-165	-	12	170-175
Sir David Sloman [8] NHS London Regional Director – a joint NHSI and NHSE appointment from 6 February 2019	-	-	-	-

Information above has been subject to audit.

[1] In addition to the remuneration above Stephen Hay and Adam Sewell-Jones received a payment in lieu of annual leave both payments were in the band 0-£5,000.

[2] Ben Dyson is on secondment from DHSC to Monitor from 1 June 2016.

[3] From 1 October 2017 Anne Eden was the Executive Regional Director (South East) providing leadership for the whole local system on behalf of NHSI and NHSE. There is no financial charge to NHSE in connection with Anne Eden's employment.

[4] Jennifer Howells was seconded from NHSE until 14 January 2019 at no charge to NHSI. Her annualised salary would have been in the band £160,000 to £165,000 and all pension-related benefits of £44,000.

[5] Sian Jarvis was employed by NHSI between 16 April 2018 and 29 March 2019 her annualised remuneration would have been in the band £145,000-£150,000. There is no pension related benefits as she does not contribute to the NHS Pension scheme.

[6] Steve Russell was the Executive Regional Managing Director (London) until 5 February 2019 his annualised remuneration would have been in the band £170,000-£175,000.

[7] Adam Sewell- Jones benefit in kind relates to a lease car.

[8] Sir David Sloman is a joint appointment with NHSE. He did not take up his full joint working responsibilities until 1 April 2019 but he did undertake the responsibilities of NHS London Region Director for NHSI between 6 February and 31 March 2019. There was no charge from NHSE in 2018/19 for his services. His annualised salary would be in the bandings £245,000 - £250,000. There are no pension related benefits as he does not contribute to the NHS Pension scheme.

[9] During the year exit packages have been agreed, subject to final calculation and excluding employer's costs, which are due for payment in 2019/20. Stephen Hay (in the band £150,001- £200,000), Dr Kathy McLean (in the band £250,001- £300,000), Adam Sewell-Jones (in the band £250,001- £300,000) and Jeremy Marlow (in the band £200,001- £250,000). The figure for Dr Kathy McLean is included in the NHS TDA's Exit Packages table and the figures for Stephen Hay, Adam Sewell-Jones and Jeremy Marlow are included in the Monitor Annual Report and Accounts' Exit Packages table.

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 18: 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]	125-30	-	51	180-185

Executive Director of Strategy				
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 Financial 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.

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 2018/19 was £285,000 to £290,000 (2017/18: £285,000 to £290,000). This was 4.9 times the median remuneration of the workforce which was £59,090 (2017/18: 4.8 times, with a median remuneration of £60,287).

In 2018/19, no employee received remuneration in excess of the highest paid director (2017/18: none). Remuneration ranged from £5,000-£10,000 to £285,000-£290,000 (2017/18: £5,000-£10,000 to £285,000-£290,000).

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

The ratio between the highest paid director and the median remuneration of the workforce has increased from the previous year by 0.1. This is due to the increase in staff numbers and the subsequent change to the composition of the general workforce with the majority of the additional staff being appointed in salary ranges between £20,000-£25,000 and £55,000-£60,000.

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. Benefits in kind given to the Chair and non-executive directors are disclosed in Table 19. 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 19 shows the total remuneration; two-thirds of the 2018/19 costs are charged to the NHS TDA and one-third to Monitor.

Table 19: Remuneration and benefits in kind for the Chair and non-executive directors 2018/19

Name	Position	Salary (bands of £5,000)	Benefits in kind to nearest £100	Total (bands of £5,000)
		£000	£00	£000
Baroness Dido Harding	Chair	60-65	-	60-65
David Behan[1]	Associate (non-voting) Non–Executive Director from 1 February 2019	-	-	-
Professor Dame Glynis Breakwell DBE DL	Senior Independent 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[2]	Non-Executive Director and Deputy Chair	10-15	-	10-15
Dr Timothy G Ferris MD, MPH [3]	Non-Executive Director from 1 August 2018	-	-	-
Sarah Harkness[4]	Non-Executive Director until 25 Sep 2018	0-5	-	0-5
Wol Kolade[3]	Non-Executive Director from 1 August 2018	-	-	-
Andrew Morris[5]	Non-Executive Director from 1 August 2018	5-10	-	5-10
Sigurd Reinton CBE[6]	Non-Executive Director until 30 June 2018	0-5	-	0-5
David Roberts[7]	Associate (non-voting) Non–Executive Director	-	-	-
Laura Wade-Gery[8]	Non-Executive Director from 1 August 2018	5-10	-	5-10

1. Sir David Behan, Chair of Health Education England, became an Associate (non-voting) Non-Executive Board member of NHS Improvement from 1 February 2019.

2. Richard Douglas is also an Associate (non-voting) Non-Executive Board Member of NHSE.

3. Timothy Ferris and Wol Kolade became Non-Executive Board members of NHS Improvement from 1 August 2018 and have waived their entitlement to Non-Executive Director remuneration in the band of £5,000-£10,000.

4.Sarah Harkness left NHSI on 25 September 2018; her annualised remuneration would have been in the band £5,000-£10,000.

5. Andrew Morris joined NHSI on 1 August 2018 his annualised remuneration would have been in the band £5,000-£10,000.

6. Sigurd Reinton CBE left NHSI on 30 June 2018; his annualised remuneration would have been in the band £5,000-£10,000.

7. David Roberts, NHS England Vice Chair, has waived his entitlement to Non-Executive Director remuneration.

8. Laura Wade-Gery joined NHSI on 1 August 2018 her annualised remuneration would have been in the band £5,000-£10,000.

Table 20: 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 21: 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 2019 (bands of £5,000)	Lump sum at pension age related to accrued pension at 31 March 2019 (bands of £5,000)	CETV at 31 March 2018	CETV at 31 March 2019	Real increase in CETV
	£000	£000	£000	£000	£000	£000	£000
Ian Dalton CBE Chief Executive	5.0-7.5	7.5-10.0	30-35	90-95	552	747	137
Stephen Hay[1] Deputy Chief Executive and Executive Director of Regulation	-	-	35-40	0-5	641	641	-
Ruth May Chief Nursing Officer	0-2.5	2.5-5.0	60-65	190-195	1,112	1,317	149
Dr Kathy McLean[1] Medical Director and Chief Operating Officer	-	-	75-80	225-230	1,617	1,617	-
Dale Bywater Executive Regional Managing Director (Midlands and East)	2.5-5.0	0-2.5	50-55	115-120	733	897	118

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 2019 (bands of £5,000)	Lump sum at pension age related to accrued pension at 31 March 2019 (bands of £5,000)	CETV at 31 March 2018	CETV at 31 March 2019	Real increase in CETV
Ben Dyson Executive Director of Strategy	2.5-5.0	-	10-15	-	82	132	29
Anne Eden[1] Executive Regional Managing Director (South East)	-	-	70-75	215-220	1,510	1,510	-
Jennifer Howells Executive Regional Managing Director (South West)	0-2.5	-	40-45	35-40	497	620	67
Jeremy Marlow[3] Executive Director of Operational Productivity	2.5-5.0	-	35-40	70-75	438	533	18
Elizabeth O'Mahony Chief Financial Officer	5.0-7.5	5.0-7.5	50-55	130-135	699	903	159
Steve Russell Executive Regional Managing Director (London)	2.5-5.0	0-2.5	45-50	105-110	594	746	92

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 2019 (bands of £5,000)	Lump sum at pension age related to accrued pension at 31 March 2019 (bands of £5,000)	CETV at 31 March 2018	CETV at 31 March 2019	Real increase in CETV
Adam Sewell-Jones Executive Director of Improvement	2.5-5.0	-	10-15	-	96	152	30
Lyn Simpson[2] Executive Regional Managing Director (North)	0-2.5	2.5-5.0	75-80	225-230	1,676	-	-

Information above has been subject to audit.

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

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

2. There is no CETV for the pension of Lyn Simpson as she has now reached the pension scheme's normal retirement age.

3. Civil Service Pensions have revised Jeremy Marlow's 2017/18 pensions and cash equivalent transfer value as follows:-

Real increase in pension at pension age (bands of £2,500)	5.0-7.5
Real increase in pension lump sum at pension age (bands of £2,500)	10-12.5
Accrued pension at 31 March 2018 (bands of £5,000)	30-35
Lump sum related to accrued pension at 31 March 2018 (bands of £5,000)	70-75
Cash Equivalent Transfer Value at 31 March 2017 £'000	331
Cash Equivalent Transfer Value at 31 March 2018 £'000	438
Real increase in Cash Equivalent Transfer Value £'000	79

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 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 for Health and Social Care 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 uses an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period. It is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2019, is based on valuation data as 31 March 2018, updated to 31 March 2019 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 latest actuarial valuation undertaken for the NHS Pension Schemes was completed as at 31 March 2016. The results of this valuation set the employer contribution rate payable from April 2019. The Department of Health and Social Care has recently laid Scheme Regulations confirming that the employer contribution rate will increase to 20.6% of pensionable pay from this date.

The 2016 funding valuation was also expected to test the cost of the Scheme relative to the employer cost cap set following the 2012 valuation. Following a judgment from the Court of Appeal in December 2018 Government announced a pause to that part of the valuation process pending conclusion of the continuing legal process.

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.

The National Employment Savings Trust (NEST) pension

A very small number of employees have chosen to contribute to the NEST pension instead of the NHS pension. This is a defined contribution workplace pension scheme into which both employee and employer make contributions.

Exit packages

Table 22: NHS TDA exit packages for 2018/19

Exit package cost band	Number of compulsory redundancies	Number of other departures agreed	Total number of exit packages by cost band
<£10,000	0	1	1
£10,000–£25,000	1	2	3
£25,001–£50,000	1	0	1
£50,001–£100,000	2	0	2
£100,001–£150,000	2	0	2
£150,001–£200,000	2	0	2
£250,001-£300,000	1	0	1
Total number of exit packages by type	9	3	12
Total resource cost (£000)	**£1085**	**£33**	**£1,118**

The exit packages 2018/19 table includes an exit package for the Executive Medical Director and Chief Operating Officer in the band £250,001 - £300,000 which is disclosed in the Salary, benefits in kind and pension benefit 2018/19 table of the Remuneration Report.

During 2017/18 NHS TDA provided seven exit packages that were compulsory redundancy costing £240,000.

The exit package disclosure has been subject to audit.

Details of off-payroll engagements

Following the *Review of tax arrangements of public sector appointees*[67] published by the Chief Secretary to the Treasury on 23 May 2012, Monitor and NHS TDA must publish information on highly paid and/or senior off-payroll engagements.

The information in the tables below includes all off-payroll engagements as at 31 March 2018 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 23: Off-payroll engagements at 31 March 2019

Number of existing engagements as at 31 March 2019, 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 2018 and 31 March 2019, for more than £245 per day	
Number of new engagements, or those that reached six months in duration, between 1 April 2018 and 31 March 2019	-
Of which…..	-
Number assessed as caught by IR35	-
Number assessed as not caught by IR35	-

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

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	28

Consultancy expenditure

NHS TDA spent £392,000 in 2018/19 (2017/18: £61,000) on consultancy expenditure.

Staff report

Employee benefits

Table 24: Analysis of NHS TDA staff costs (audited table)

	2018-19			2017-18
	Total	**Permanently employed**	**Other**	**Total**
	£000	£000	£000	£000
Gross expenditure				
Salaries and wages	77,744	55,593	22,151	58,376
Social security costs	9,323	6,933	2,390	5,775
Employer contributions to NHS BSA - Pensions Division	9,472	7,146	2,326	6,053
Termination benefits	-	-	-	240
Total gross expenditure	96,539	69,672	26,867	70,444
Administration expenditure				
Salaries and wages	50,141	38,415	11,726	40,538
Social security costs	6,075	4,920	1,155	4,590
Employer contributions to NHS BSA - Pensions Division	6,142	5,042	1,100	4,811
Termination benefits	-	-	-	240
Total administration expenditure	62,358	48,377	13,981	50,179
Programme expenditure				
Salaries and wages	27,603	17,178	10,425	17,838
Social security costs	3,248	2,013	1,235	1,185
Employer contributions to NHS BSA - Pensions Division	3,330	2,104	1,226	1,242
Termination benefits	-	-	-	-
Total programme	34,181	21,295	12,886	20,265

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

Recruitment

In 2018/19 our recruitment team continued to work with our outsourced provider, the NHS Business Services Authority, to improve the processes, systems and rules for the effective management of candidates, contract production, on-boarding and payroll.

The team expanded its core offering to include:

- facilitating training sessions for recruiting managers
- creating templates for official documents and correspondence
- dealing with recruitment-related complaints and salary disputes
- developing an on-boarding offering to make sure all relevant background checks are completed before the agreed start date
- case management of 'continuous service' queries
- payroll set-up checks.

Alongside managing vacancies, day-to-day support activity in 2018/19 remained high in the following areas:

- training sessions for line managers – over 30 sessions delivered
- payroll – intervention required for 20% of new starters to correctly set up payroll to ensure they were paid in the first month of joining
  - continuous service investigations – 40 investigations carried out to ensure individuals have the correct continuous service recorded in the electronic staff record.

Table 25: Average staff numbers in the year to 31 March 2019 (subject to audit)

2018/19			
Average staff numbers	**Total**	**Permanently employed**	**Other (FTC and secondees)**
Number of staff (TDA)	1,366	944	422
Number of staff (Monitor)	311	305	6
Total (NHS Improvement)	**1,677**	**1,249**	**428**

Role activity for 2018/19 remained consistent with the previous year, with 738 hires, including 168 secondments.

In preparation for closer working between NHS Improvement and NHS England, our recruitment team worked with NHS England colleagues to review our recruitment processes.

In 2019/20 we expect additional recruitment responsibilities for the NHS Leadership Academy, with a focus on further efficiencies in the systems and processes and importantly a drive to support the organisation with quality candidate sourcing and selection.

Table 26: Number of ESMs as at 31 March 2019

Pay band	Total	Permanently employed	Other
TDA contract			
Executive and senior managers (ESM)	80	51	29
Monitor contract			
ESMs	33	32	1
Total NHS Improvement	**113**	**83**	**30**

Employee policies

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

NHS England has its own HR policies, and we want to ensure, as far as possible, that staff are managed in line with the same policies, across NHS England and the two employers that make up NHS Improvement – Monitor and TDA.

In recent months, alongside NHS England colleagues, we consulted trade unions on agreeing a consistent set of policies. Senior managers contributed to prioritising the

policies, and key ones – such as recruitment and selection and organisational change – are being addressed in the first phase. In practical terms, aligning policies is simpler between staff employed by NHS England and TDA, as both groups' basic employment terms are in line with the NHS terms and conditions of service while Monitor staff are employed on different terms. Some policies, such as flexible working and disciplinary and grievance policies, were previously agreed jointly for TDA and Monitor, and the intention is – where viable – to have agreed policies across the three employers.

Monitor pay review

During 2018 we identified any significant outliers in terms of pay among Monitor staff, in comparison with Monitor colleagues. These cases were then reviewed to identify the rationale for the differences in pay, and in some cases a pay increase was agreed.

Offer to Monitor staff to change terms and conditions

All Monitor staff are being given the opportunity to transfer to TDA (NHS) terms and conditions. HR is working with the trade unions to agree the process, timeline and support package to help staff decide whether to move.

Facilitating trade unions

We recognise three trade unions and have time-off arrangements to enable local trade union representatives to undertake the necessary activities.

We have given trade unions the opportunity to publicise their services to staff. This included Unison and MIP setting up a stand in Wellington House during lunch breaks when they could speak directly to staff about the benefits of trade union membership.

Table 27: Facility time taken by NHS TDA trade union representatives

Number of accredited representatives	2
FTE	2
Percentage of time spent on facility time – 0%	0
Percentage of time spent on facility time – 1-50%	2
Percentage of time spent on facility time – 51-99%	0
Percentage of time spent on facility time – 100%	0
Total cost of facility time	£6,078.00
Total pay bill	£94,944,069.00
Percentage of total pay bill spent on facility time	0.01%
Paid trade union activities	10%

Last year, a National Joint Working Partnership Forum was established with staff-side representation from all our recognised trade unions and management-side representation from our three employers.

Table 28: Gender of staff as at 31 March 2019

Staff category	Female	Male
TDA contract		
ESMs	32	48
Other staff	831	455
Total TDA	**863**	**503**
Monitor contract		
ESMs	12	21
Other staff	156	122
Total Monitor	**168**	**143**
Total NHS Improvement	**1,031**	**646**

Equal opportunities and diversity

In line with our commitment to providing equality of opportunity for both current and prospective staff, the Inclusion Partnership, with the support of an executive sponsor, actively engaged in the partnership's objectives for 2018/19. The Inclusion Partnership also began aligning our diversity and inclusion approach with that of NHS England. This work included joining the Inclusion Partnership with NHS England's Diversity and Inclusion Steering Group, making progress towards a joint diversity and inclusion strategy, and it opened further staff network engagement opportunities between both organisations.

We have undertaken work on the design and delivery of a joint working approach to talent management, succession planning and equality of opportunity and diversity. Taking account of the recommendations in the Workforce Race Equality Standard, the Stonewall Workplace Equality Index and the forthcoming Workforce Disability Equality Standard, due to be implemented in 2019, and in conjunction with NHS England, we:

- ensured equality and diversity representatives were present on the interview panels of our most senior appointments within the change programme
- piloted a reverse mentoring programme to create a dialogue between people from different backgrounds
- designed and implemented diversity and inclusion development opportunities for teams and staff
- continued our commitments as a mindful employer and a disability confident employer.

Table 29: Ethnicity of staff as at 31 March 2019

	Number of staff (TDA contract)	Number of staff (Monitor contract)	Number of staff (NHS Improvement total)
White	959	216	1,175
Black and minority ethnic	222	72	294
Did not state/undisclosed	185	23	208
Total	**1,367**	**311**	**1,678**

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:

- designing and developing a joint health and wellbeing strategy alongside NHS England
- raising awareness of mental health through the role of mental health first aiders
- developing and empowering our Mental Health First Aid Network, which contributes actively to delivering in-house activities by staff for staff
- continued review of the role and training of mental health first aiders, including support and quality assurance
- designing and delivering health and wellbeing interventions, including resilience awareness and skill development
- review of our approach to health and hygiene in the workplace – for example, handwashing.

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 continued our contact with the Equality and Human Rights Commission and have a good relationship with regional trade union officers. We hold regular Joint Consultative and Negotiation Committee meetings to consider issues likely to affect staff. We involve other staff representatives through several groups to engage staff in helping shape our responses to issues that affect their employment, wellbeing and development.

We continued to promote ways of acknowledging colleagues who ‘go the extra mile’, via good deed feed and thank you cards. We also designed and agreed on a joint approach to staff recognition, including award events to celebrate success, to be implemented in 2019.

Temperature checks

As part of our work to bring NHS Improvement and NHS England closer together, and recognising the importance of having dynamic and timely feedback throughout our change programme, we introduced a regular 'temperature check' to give staff an opportunity to shape how we implemented joint working.

The first temperature check was conducted in July 2018, and all staff across both organisations were invited to take part. From August to December 2018 we invited a small group of staff, selected at random, to track progress. Since January 2019 we have invited all staff to complete the temperature check each month, so we can hear more views from across our organisations and track progress.

We regularly publish results along with details of how we are addressing any concerns.

Work has also been undertaken to move towards a joint all-staff annual survey that will launch in the third quarter of 2019/20.

Sickness absence

Table 30: Sickness absence

Staff absence due to sickness	January to December 2018
TDA contract	
Total days lost	3,884.8
Average working days lost per employee	4
Monitor contract	
Total days lost	783.8
Average working days lost per employee	2.28
NHS Improvement	
Total days lost	4,668.6
Average working days lost per employee	3.55

There was one person employed by the TDA who retired on ill health grounds.

Gender pay gap

As at 31 March 2018, the mean gender pay gap in hourly pay was 14.3%, showing the difference between the mean (average) hourly rate of pay for men and women. This is an overall reduction of 0.7% compared to the mean hourly rate in 2017. The median gender pay gap is 15.7%, showing the difference between the median (mid-point) hourly rate of pay for men and women. This is an overall reduction 1.7% compared to the median hourly rate in 2017.

In addition to our legal responsibilities under the Equality Act 2010, NHS Improvement and NHS England as system leaders have acknowledged the importance of demonstrating that our approaches to the change process triggered by the joint working programme are open, fair and transparent.

We are committed to ensuring our joint working programme provides an opportunity to address gender equality issues in our workforce. A joint gender pay gap action plan is in the final stages of development.

Parliamentary accountability and audit report

Cost allocation and charges for information

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

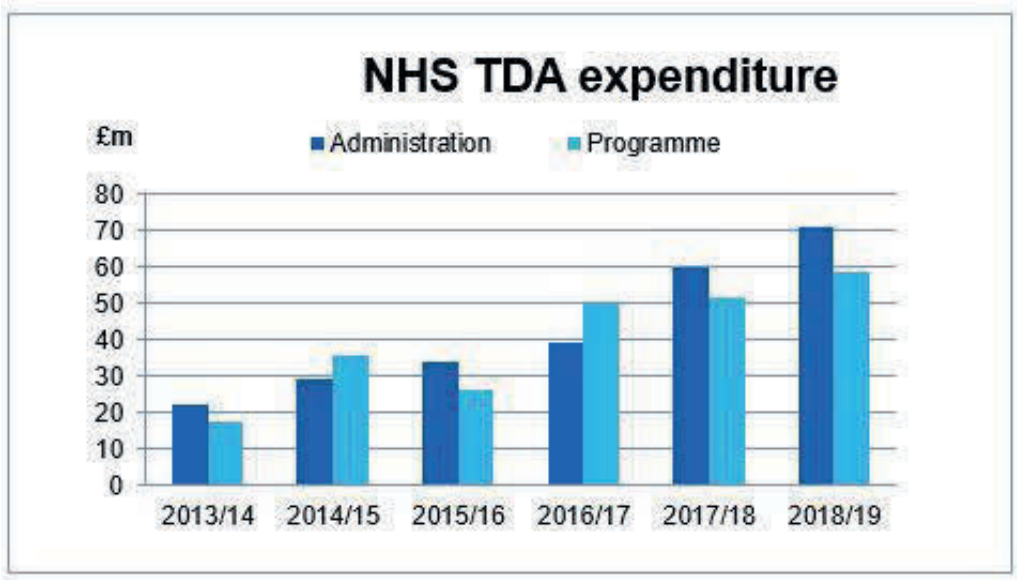
There are three main sources of income in 2018/19, for which further details are contained in the financial statements:

- programme income mainly with NHS England which is based on costs incurred
- outward secondment of staff which is based on the secondment agreements
- recharges for services delivered to Monitor which are based on a proportion of actual costs incurred;

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. 2018/19 expenditure details are disclosed in the annual accounts.

Figure 3: Trend in net expenditure since 2013/14



Bill McCarthy
Interim Accounting Officer
2 July 2019

The certificate and report of the comptroller and auditor general to the House of Commons

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 2019 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 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 2019 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.

Conclusions relating to principal risks and going concern

I have nothing to report in respect of the following information in the annual report, in relation to which the ISAs (UK) require us to report to you whether I have anything material to add or draw attention to:

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

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 as NHS Improvement, an area where my work has not identified any matters to report.

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

In this year's report one change to the risks identified has been made compared to my prior year report. This relates to the Risk of fraud in revenue recognition. I did not rebut this risk in 2018/19 because NHS TDA's income had increased significantly in the previous financial year. The risk around revenue recognition is also compounded by the adoption of IFRS 15.

I have identified two significant risks for my 2018-19 audit. I have set out below how my audit addressed these specific risks 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 1

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
- significant unusual transactions.

I have identified this risk because International Standards on Auditing (UK) require that I consider it.	
How the scope of my audit responded to the risk	I have assessed the design and implementation of controls over journals entries, accounting estimates and judgements, and significant unusual transactions. I have used data analytics to identify journal entries which demonstrate one or more characteristics of risk and tested the entries identified. I have also reviewed the appropriateness of other journal adjustments made in the preparation of the financial statements. I have evaluated significant transactions that are outside of the normal course of business or that otherwise appear to be unusual. I have reviewed current-year and prior-year accounting estimates and judgements for evidence of bias. This review included a focus on the calculation of the apportionment of shared costs between Monitor and the NHS Trust Development Authority.

	Key observations The results of my testing in this area are satisfactory and I am satisfied that this risk has not materialised.

Key audit matter 2

Risk of fraud in revenue recognition:

Under International Standard on Auditing (UK) 240 there is a presumed risk of fraud in revenue recognition. This risk is rebuttable. In previous years we have rebutted this risk. However, we did not rebut this risk in 2018/19. This is because NHS TDA's income had increased significantly in the previous financial year. The risk around revenue recognition is compounded by the adoption of IFRS 15.

How the scope of my audit responded to the risk	I have assessed the design and implementation of controls operating over NHS TDA's income streams. I have tested a sample of transactions recognised during the year, to assess whether they have been recognised in accordance with International Financial Reporting Standard 15: Revenue from Contracts with Customers. I have performed additional testing around the year-end, to confirm whether revenue has been recognised in the correct financial year, and whether the underlying activity had occurred in the year. I have performed post year-end receipts and unpaid invoices testing, to ensure that all appropriate income has been recognised. I have performed analytical procedures to verify that income had not been materially misstated. **Key observations** 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 £3,320,000 which is approximately 2% of gross expenditure. I chose this benchmark as I consider expenditure 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 £66,400, as well as differences below this threshold that in my view warranted reporting on qualitative grounds.

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

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

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 (UK) 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 (UK), 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.

- evaluate the overall presentation, structure and content of the financial statements, including the disclosures, and whether the 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 also provide those charged with governance with a statement that I have complied with relevant ethical requirements regarding independence, and to communicate with them all relationships and other matters that may reasonably be thought to bear on my independence, and where applicable, related safeguards.

From the matters communicated with those charged with governance, I determine those matters that were of most significance in the audit of the financial statements of the current period and are therefore the key audit matters. I describe these matters in my auditor's report unless law or regulation precludes public disclosure about the matter or when, in extremely rare circumstances, I determine that a matter should not be communicated in my report because the adverse consequences of doing so would reasonably be expected to outweigh the public interest benefits of such communication.

I am required to obtain evidence sufficient to give reasonable assurance that the expenditure and income recorded in the financial statements have been applied to the purposes intended by Parliament and the financial transactions recorded in the financial statements conform to the authorities which govern them.

Audit scope

The scope of my audit was determined by obtaining an understanding of the NHS Trust Development Authority 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, but does not include 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 the 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; or
- 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; or
- the Governance Statement does not reflect compliance with HM Treasury's guidance.

Report

I have no observations to make on these financial statements.

Gareth Davies
Comptroller and Auditor General
National Audit Office
157-197 Buckingham Palace Road
Victoria
London
SW1W 9SP

Date: 8 July 2019

Financial statements

NHS Trust Development Authority - Annual Accounts 2018-19

Statement of comprehensive net expenditure for the year ended 31 March 2019

	Note	2018-19 £000	2017-18 £000
Other operating revenue	4	36,987	18,725
Total operating revenue		**36,987**	**18,725**
Staff costs	5	96,539	70,444
Purchase of goods and services	6	26,405	20,414
Depreciation and impairment charges	6	576	244
Provision expense	6	-	(71)
Other operating expenditure	6	42,412	39,228
Total operating expenditure		**165,932**	**130,259**
Net operating costs for the financial year		**128,945**	**111,534**
Other comprehensive net expenditure		-	-
Total comprehensive net expenditure for the year		**128,945**	**111,534**

All operations are continuing.

The notes on pages 182 to 203 form part of these accounts.

NHS Trust Development Authority - Annual Accounts 2018-19

Statement of Financial Position as at 31 March 2019

	Note	31 March 2019 £000	31 March 2018 £000
Non current assets			
Property, plant & equipment	8.1	630	755
Intangible assets	8.2	2,700	851
Total non-current assets		**3,330**	**1,606**
Current assets			
Trade and other receivables	9	9,331	12,765
Cash and cash equivalents	10	2,223	7,100
Total current assets		**11,554**	**19,865**
Total assets		**14,884**	**21,471**
Current liabilities			
Trade and other payables	11	31,647	40,921
Total current liabilities		**31,647**	**40,921**
Net current liabilities		**(20,093)**	**(21,056)**
Total net liabilities		**(16,763)**	**(19,450)**
Financed by taxpayers' equity			
General fund		(16,763)	(19,450)
Total taxpayers' equity		**(16,763)**	**(19,450)**

The financial statements and the notes on pages 182 to 203 were signed on behalf of the NHS Trust Development Authority by:

Bill McCarthy
Interim Accounting Officer
2 July 2019

NHS Trust Development Authority - Annual Accounts 2018-19

Statement of Changes in Taxpayers' Equity for the year ended 31 March 2019

	Note	General Fund £000
Balance at 31 March 2018		**(19,450)**
Changes in taxpayers' equity for 2018-19		
Comprehensive net expenditure for the year	SoCNE	(128,945)
Net parliamentary funding	SOCF	131,632
Balance at 31 March 2019		**(16,763)**
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)**

The notes on pages 182 to 203 form part of these accounts.

NHS Trust Development Authority - Annual Accounts 2018-19

Statement of Cash Flows for the year ended 31 March 2019

	Note	2018-19 £000	2017-18 £000
Cash flows from operating activities			
Net operating cost	SOCNE	(128,945)	(111,534)
Adjustments for non-cash transactions			
Depreciation, amortisation and impairments	6	576	244
Provisions reversed unused	12	-	(71)
Decrease in trade and other receivables	9	3,434	(9,573)
Decrease in trade payables and other current liabilities	11	(9,132)	10,442
Net cash inflow / (outflow) from operating activities		**(134,067)**	**(110,492)**
Cash flows from investing activities			
(Payments) for property, plant and equipment		(203)	(679)
(Payments) for intangible assets		(2,239)	(354)
Net cash inflow / (outflow) from investing activities		**(2,442)**	**(1,033)**
Cash flows from financing activities			
Net parliamentary funding	SoCTE	131,632	117,000
Net financing		**131,632**	**117,000**
Net increase/(decrease) in cash and cash equivalents		(4,877)	5,475
Cash and cash equivalents at the beginning of the period		**7,100**	**1,625**
Cash and cash equivalents at the end of the period	10	**2,223**	**7,100**

The notes on pages 182 to 203 form part of these accounts.

NOTES TO THE ACCOUNTS

1. Accounting policies

These financial statements have been prepared in a form directed by the Secretary of State and in accordance with the Government Financial Reporting Manual (FReM) issued by HM Treasury and the Department of Health Group Reporting Manual (GAM) 2018/19. The accounting policies contained in the FReM and GAM follow International Financial Reporting Standards (IFRS) as adapted or interpreted for the public sector context. Where the FReM or GAM 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. These 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, NHS TDA's 2018/19 accounts have been prepared on a going concern basis. NHS TDA continues to be resourced by the Department of Health and Social Care which has approved a NHS TDA's 2019/20 budget and there is no evidence to suggest that 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. Critical accounting judgements and key sources of estimation uncertainty

In the application of 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.

1.3.1. Apportionment of costs

From 1 April 2016 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.

1.3.2. Critical judgements in applying accounting policies

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 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.

1.3.3. 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.

1.3.4. Assessment of impact of new accounting policies

New accounting standards applicable for 2018/19 are IFRS 9 (financial instruments) and 15 (revenue recognition).

Financial instruments (IFRS 9, effective 2018/19): NHS TDA does not deal with complex financial instruments; the main element of the standard which is potential applicable is valuations of financial asset impairments, for example bad debt provisions. However, there are none in 2018/19.

Revenue recognition (IFRS 15, effective 2018/19): revenue arrangements in NHS TDA relate to cost recharges (agreements through MOU or secondment agreement) as described in note 1.4, and income is recognised when a performance obligation is satisfied. The new standard has not had an impact on the way in which revenue is recognised, however it does impact the presentation of receivables in note 9.

1.4. Revenue and funding

The main source of funding for the special health authority is the Parliamentary grant from the 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.

The NHS TDA has interpreted the application IFRS 15 on the material revenue streams as follows:

- The largest of these arrangements relate to Getting It Right First Time (GIRFT) and Intensive Support Team funding (across Emergency, Elective and Cancer teams) for which income is received from NHS England. In line with the performance obligations within the memoranda of understandings, revenue against these projects is recognised against costs as they are incurred in year.
- The other main source of income relates to secondments; these are covered by individual agreements where the transaction price is allocated (individual's payroll costs) to the performance obligations (transfer of staff for the relevant period) in the agreement, and revenue is recognised when the performance obligations are satisfied.

1.5. Employee benefits

1.5.1. 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.

1.5.2. 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 NHS TDA commits itself to the retirement, regardless of the method of payment.

The NHS Pensions Scheme is the scheme in which the majority of employees are enrolled in with a very small number of employees contributing to the National Employment Savings Trust (NEST) pension. No present employees have pension benefits provided through the Principal Civil Service Pension Scheme (PCSPS).

1.6. Property, plant and equipment

1.6.1. 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 1.3.2.

1.6.2. 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.

1.7. 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.

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

1.9. 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.

1.10. Cash and cash equivalents

Cash is the balance held with the Government Banking Service.

1.11. Financial Instruments

The transition to IFRS 9 in 2018/19 has been completed in accordance with the Standard: following the principle of cumulative catch up. The impact of transition to the new standard was not material.

1.11.1. 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.

As set out in IFRS 9 financial assets are classified into the following categories: financial assets at amortised cost, financial assets at fair value through other comprehensive income and financial assets at fair value through the profit and loss.

NHS TDA has financial assets that are classified into the category of financial asset held at amortised costs.

Financial assets measured at amortised costs are those held within a business model where the objective is to hold financial assets to collect contractual cash flows and where the cash flow is solely payments of principal and interest. This include trade receivables, loans receivable and other simple debt instruments.

At the end of the reporting period, NHS TDA assesses whether any financial assets are impaired. Financial assets are impaired and impairment losses recognised in accordance with IFRS 9.

1.11.2. 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, cancelled or has expired.

NHS TDA has financial liabilities that are classified into the category of ‘financial liabilities measured at amortised costs comprising of trade and other payables. They are recognised in accordance with IFRS 9.

1.12. 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.

1.13. 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 2018/19. The application of the Standards as revised would not have a material impact on the accounts for 2018/19, were they applied:

1.13.1. 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. However, decisions have been taken by HM Treasury on key aspects of accounting which do enable estimates of the impact of the standard to be made.

- Definition of a lease: IFRS 16 brings some changes to the definition of a lease compared to IFRIC 4 and IAS 17 currently. HM Treasury has decided that, as a practical expedient, entities will grandfather in their current assessment of whether a contract contains a lease. Given the practical expedient it is not expected that this part of IFRS 16 will have a material impact. The key impact will be in changing the accounting for arrangements currently identified as leases.
- Lessee accounting: single model of accounting: For lessees, the current (IAS 17) distinction between operating leases and finance leases is removed. Under IFRS 16, a right-of-use asset and lease liability are included in the statement of financial position for all leased assets. Note 7 in these accounts shows typical annual lease payments for operating leases of c£0.3 million, these relate to the lease car scheme and a lease rent.
- There is a corresponding impact on the statement of comprehensive income: such assets will now be depreciated, and finance charges will be recorded. Finance lease modelling for lessees usually results in higher income and expenditure charges in the earlier parts of lease terms, as a higher proportion of the lease payment is allocated to the finance charge rather than repayment of the principal. The precise effect of this on the statement of comprehensive income will depend on the detailed guidance on the application of the standard.

1.13.2. 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.

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

2. Pension costs

Full pensions disclosure can be found in the NHS TDA Annual report and accounts within the staff report.

NHS Trust Development Authority - Annual Accounts 2018-19

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	
	2018-19 £000	2017-18 £000	2018-19 £000	2017-18 £000	2018-19 £000	2017-18 £000	2018-19 £000	2017-18 £000
Revenue	(5,628)	(2,116)	(31,356)	(16,609)	(3)	-	(36,987)	(18,725)
Expenditure	76,118	62,199	77,889	64,400	11,925	3,660	165,932	130,259
Net operating costs	**70,490**	**60,083**	**46,533**	**47,791**	**11,922**	**3,660**	**128,945**	**111,534**
Assets	6,528	9,883	7,836	10,887	520	701	14,884	21,471
Liabilities	(12,850)	(11,166)	(17,748)	(29,396)	(1,049)	(359)	(31,647)	(40,921)
Net (liabilities) / assets	**(6,322)**	**(1,283)**	**(9,912)**	**(18,509)**	**(529)**	**342**	**(16,763)**	**(19,450)**

Administration
The financial objectives of the NHS TDA is to manage the recurrent costs of management and administration within the allocation of £71,093,000 this funding covers staff, accomodation and other running costs.

Programme
The NHS TDA received an allocation of £47,085,000 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. Within the Programme Revenue figure of £31.4m, £30.7m was received from NHS England.

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 £14,072,000 (£13,800,000 revenue limit £272,000 depreciation resource limit) programme funding.

NHS Trust Development Authority - Annual Accounts 2018-19

4. Revenue

	2018-19	2017-18
	£000	£000
Administration revenue		
Other fees and charges	112	280
Other miscellaneous revenue	3,389	820
Rental revenue recovery	33	33
Revenue in respect of seconded staff	2,094	983
Total administration revenue	**5,628**	**2,116**
Programme revenue		
Other miscellaneous revenue	1,490	305
Provision of emergency care improvement programme and elective care intensive support	10,308	8,789
Provision of the Getting It Right First Time (GIRFT) programme	19,322	7,361
Revenue in respect of seconded staff	239	154
Total programme revenue	**31,359**	**16,609**
Total revenue	**36,987**	**18,725**

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.

Administration 'other miscellaneous revenue' includes a grant from ‘The Burdett Trust for Nursing’ for a study to develop and evaluate a peer shadowing programme to support the development of novice ward sisters in their first year in post.

NHS Trust Development Authority - Annual Accounts 2018-19

5. Employee benefits and staff numbers

5.1. Employee benefits

	2018-19	2017-18
	Total £000	Total £000
Gross expenditure		
Salaries and wages	77,744	58,376
Social security costs	9,323	5,775
Employer contributions to NHS BSA - Pensions Division	9,472	6,053
Termination benefits	-	240
Total gross expenditure	**96,539**	**70,444**

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

NHS Trust Development Authority - Annual Accounts 2018-19

6. Operating expenditure

	Note	2018-19	2017-18
		£000	£000
Purchase of goods and services			
Administration costs			
Auditors' remuneration for NHS TDA		50	50
Auditors' remuneration for consolidated accounts of NHS providers		110	120
Business travel		2,527	1,923
Consultancy		304	44
Establishment expenses		2,065	1,522
Information and communications		637	2,005
Premises		2,794	2,689
Professional fees		1,215	886
Sub-total		**9,702**	**9,239**
Programme costs			
Business travel		2,684	1,646
Consultancy		88	17
Establishment expenses		3,002	1,509
Information and communications		3,212	387
Premises		354	184
Professional fees		7,363	7,432
Sub-total		**16,703**	**11,175**
Total purchase of goods and services	SoCNE	**26,405**	**20,414**

Within Programme professional fees there is £836,000 that relates to the Transformation programme, £3,702,000 relates to the Operational Productivity programme and £975,000 relates to the Patient Safety programme (2017-18 M12 £2,564,000, £2,954,000, and £975,000 respectively).

Depreciation and impairment charges			
Administration costs			
Depreciation	8.1	101	94
Amortisation	8.2	204	20
Sub-total		**305**	**114**
Programme costs			
Depreciation	8.1	217	85
Amortisation	8.2	54	45
Sub-total		**271**	**130**
Total depreciation and impairment charges	SoCNE	**576**	**244**
Provision expense			
Administration costs			
Provision expense	12	-	(71)
Total provision expense	SoCNE	**-**	**(71)**

	Note	2018-19	2017-18
		£000	£000
Other operating expenditure			
Administration costs			
Miscellaneous Expenditure		3,675	2,653
Non-executive members' remuneration		80	85
Sub-total		**3,755**	**2,738**
Programme costs			
Miscellaneous Expenditure		2,862	2,768
Funding provided to NHS trusts and partners:			
Emergency care improvement programme		-	228
Intervention and support to NHS Trusts		-	4,168
Operational productivity		17,714	9,370
Patient Safety Collaboratives		7,023	7,000
Special measures and peer improvement		8,184	9,556
Trust transactions and sustainable solutions		2,874	3,400
Sub total		**38,657**	**36,490**
Total other operating expenditure	SoCNE	**42,412**	**39,228**
Total operating expenditure	SoCNE	**69,393**	**59,815**

Within the operational productivity funding to providers it includes £17,567,291 for the GIRFT programme partnership with the Royal National Orthopaedic Hospital NHS Trust (2017-18 £7,291,000).

7. Operating leases

	31 March 2019	31 March 2018
	£000	£000
Payments recognised as an expense		
Minimum lease payments	305	253
Total	**305**	**253**
Payable		
No later than one year	219	138
Between one and five years	18	102
After five years	-	-
Total	**237**	**240**

Included in the Administration Premises expenditure in note 6 is £1,053,000 of costs paid to NHS Property Services for the occupation of six sites, £585,000 to the Department of Health and Social Care for the occupation of two sites, and £13,000 to NHS England for one site. (2017-18 £1,508,000 for six sites, £508,000, and £17,000 respectively). They are operated under a memorandum of understanding.

8. Non-current assets

8.1 Property, plant and equipment

2018-19	Information technology	Furniture & fittings	Total
	£000	£000	£000
Cost or valuation			
At 1 April 2018	743	617	**1,360**
Additions purchased	193	-	**193**
Disposals	(13)	-	**(13)**
At 31 March 2019	**923**	**617**	**1,540**
Depreciation			
At 1 April 2018	458	147	**605**
Charged during the year	126	192	**318**
Disposals	(13)	-	**(13)**
At 31 March 2019	**571**	**339**	**910**
Net book value at 31 March 2018	285	470	**755**
Net book value at 31 March 2019	**352**	**278**	**630**

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**
Impairments charged to SOCNE	(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**

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

The NHS TDA disposed of £13,000 property, plant and equipment assets during the period up to the 31 March 2019 (2017-18 £82,000). There was no profit or loss on the disposal.

8. Non-current assets

8.2 Intangible assets

2018-19	Software purchased	Assets under construction	Websites	Total
	£000	£000	£000	£000
Cost or valuation				
At 1 April 2018	130	715	95	940
Additions purchased	-	1,232	875	2,107
Reclassification	-	(469)	469	-
At 31 March 2019	**130**	**1,478**	**1,439**	**3,047**
Amortisation				
At 1 April 2018	40	-	49	**89**
Charged during the year	40	-	218	**258**
At 31 March 2019	**80**	**-**	**267**	**347**
Net book value at 31 March 2018	90	715	46	**851**
Net book value at 31 March 2019	**50**	**1,478**	**1,172**	**2,700**

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**

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

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

NHS Trust Development Authority - Annual Accounts 2018-19

9. Trade receivables and amounts falling due within one year

	31 March 2019	31 March 2018
	£000	£000
Trade Receivables	-	4,730
Other receivables	-	88
Contract Receivables	8,593	-
Prepayments	435	385
Accrued Income	-	7,530
VAT	303	32
Trade and other receivables	**9,331**	**12,765**

The NHS contract receivables balance includes £3,682,905 for NHS England GIRFT Programme funding (2017-18 £7,361,000 included within accrued income).

Following the application of IFRS 15 from 1 April 2018, TDA's entitlement to consideration for work performed under contracts with customers is shown separately as contract receivables. This replaces the previous analysis into trade receivables, accrued income and other receivables. IFRS 15 is applied without restatement therefore the comparative analysis of receivables has not been restated under IFRS 15.

10. Cash and cash equivalents

	31 March 2019	31 March 2018
	£000	£000
Opening balance	7,100	1,625
Net change in cash and cash equivalentbalances	(4,877)	5,475
Closing balance	**2,223**	**7,100**
Made up of		
Cash with Government Banking Service	2,223	7,100
Cash and cash equivalents as in Statement of Financial Position	**2,223**	**7,100**

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

	31 March 2019	31 March 2018
	£000	£000
Other taxation and social security	17	14
Trade payables	13,335	12,476
Other payables	-	533
Accruals	10,591	19,778
Deferred Income	7,704	8,120
Trade and other payables	**31,647**	**40,921**

12. Provisions

	2018-19	2017-18
	£000	£000
Balance at 1 April 2018	-	71
Reversed unused	-	(71)
Balance at 31 March 2019	**-**	**-**
Expected timing of cash flows:		
No later than one year	-	71

NHS Trust Development Authority - Annual Accounts 2018-19

13. Commitments

The NHS TDA and Montior entered into an agreement with The Royal National Orthopaedic NHS Trust relating to the Getting It Right First Time Programme. TDA may terminate this Agreement for any reason upon three months' notice to RNOH or one month in special circumstances. The total cost of the contract in the year was £17,565,000.

	31 March 2019	31 March 2018
	£000	£000
Payable		
No later than one year	18,379	17,565
Between one and five years	11,569	-
After five years	-	-
Total	**29,948**	**17,565**

NHS Trust Development Authority - Annual Accounts 2018-19

14. Financial instruments

14.1 Financial risk management

IFRS 7, Financial Instruments Disclosure, requires the disclosure of the role that financial instruments have had during the period in creating or changing the risk an entity faces in undertaking its activities. Financial instruments play a much more limited role in creating or changing risk for NHS TDA than would be typical of the listed companies to which IFRS 7 mainly applies.

As NHS TDA holds no financial instruments that are either complex or play a significant role in NHS TDA's financial risk profile, NHS TDA's exposure to credit, liquidity or market risk is limited.

14.2 Financial assets

	2018-19	2017-18
	£000	£000
Trade and other receivables	-	4,730
Other receivables	-	120
Cash at bank and in hand	2,223	7,100
Total at 31 March 2019	**2,223**	**11,950**

14.3 Financial liabilities

	2018-19	2017-18
	£000	£000
Trade and other payables	31,647	40,916
Total at 31 March 2019	**31,647**	**40,916**

15. Contingencies

NHS Trust Development Authority residual liabilities in relation to South London Healthcare NHS Trust

NHS TDA holds residual liabilities for South London Healthcare NHS Trust (SLHT) in relation to claims prior to its dissolution on 30 September 2013 in respect of: Clinical Negligence in relation to Queen Mary's Hospital Sidcup Non Live clinical Services for A&E and Maternity only; SLHT personal Injury – non employees; Employment Tribunals and Employee Personal Injury Claims for employees who left SLHT prior to dissolution. The TDA pays membership contributions to NHS Resolution for relevant liabilities schemes to fund successful claims. The current NHS Resolution Clinical Negligence Balances for SLHT claims are £29,109,894; there are no outstanding claims for Liabilities to Third Parties Scheme (LTPS). Excess payments are payable only in the case of the LTPS. As there are no current live claims which may fall under the LTPS it is estimated that there will be no excesses payable in 2019/20 above the £0-10,000 range.

NHS Trust Development Authority - Annual Accounts 2018-19

16. Events after the reporting period

Joint Working between the NHS TDA, Monitor and NHS England

Monitor, NHS TDA and NHS England agreed to work in a more integrated way to deliver better outcomes for patients, while improving performance and efficiency. During 2018/19, Monitor, NHS TDA and NHS England announced a joint leadership structure which came fully into effect on 1st April 2019 and 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. This has no impact on NHS TDA accounts and no adjustments have been made as a result.

NHS Leadership Academy

During 2018/19 it was agreed that from 1 April 2019 the NHS Leadership Academy will transfer from Health Education England to NHS TDA to support the leadership and talent management requirements of the NHS Long Term Plan.

The annual report and accounts have been authorised by the Accounting Officer 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
2018-19				
HM Revenue & Customs	9,323	-	17	303
Imperial College Healthcare NHS Trust	565	28	460	-
Monitor	3,145	-	2,366	399
NHS England	8,637	33,953	889	6,450
National Health Service Pension Scheme	9,472	-	-	-
2017-18				
HM Revenue & Customs	5,775	-	14	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

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 (2017-18 NIL).