NHS Improvement

# NHS Trust Development Authority

# 2019/20

# Annual Report

Health and high quality care for all, now and for future generations

THE NHS CONSTITUTION
the NHS belongs to us all

HC 1058

# NHS Trust Development Authority

Annual Report and Accounts 2019/20

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# A view from Baroness Dido Harding, Chair

Within our NHS Constitution there is one section which is particularly striking. It reads: "[the NHS] works at the limits of science – bringing the highest levels of human knowledge and skill to save lives and improve health. It touches our lives at times of basic human need, when care and compassion are what matter most."

Coronavirus has tested the NHS in ways that were unimaginable last year, when my foreword described the task ahead to deliver our Long Term Plan, but they are perhaps encapsulated by that remarkable constitution.

In facing up to COVID-19, I believe we have shown both the strength and value of our NHS as well as the vison we've set for its future.

It is hard not to become emotional when considering what has happened in the past year as we've met this challenge unlike any other in our history.

Alongside fear and anxiety for loved ones and the difficulties of new restrictions and rules, have been logistical challenges needing to be met to provide the best possible healthcare we can, on the frontline of the service and as NHS England and NHS Improvement.

This is not, of course, just the organisational difficulties in providing safe services in our hospitals, clinics, care homes and communities. It's also the sacrifices made by staff, in some cases living away from their families or putting themselves in harm's way to provide compassionate care and to keep people safe.

The public too has bolstered our response to COVID-19 in countless ways, but most significantly by understanding what we needed to do and helping us to do it.

With us, our patients have learned new technology which has allowed us to provide remote care, kept away while we adapted our buildings and approaches, and changed their lives to help protect the NHS so our staff could treat those most in need. I can assure you that did not go unnoticed and we are enormously grateful.

With support from the entire nation, the NHS has transformed how it works, how we support our workforce and colleagues, how we learn, how we innovate. Achievements we thought would take years, have taken, in some cases, mere days.

But the cost has been high - colleagues, patients, friends and loved ones have died and their loss is immeasurable.

There are no easy ways to express the awe and gratitude I've felt from seeing the commitment and sacrifices made at every level across our NHS, from cleaners to chief executives, labs to distribution hubs, clinics to care homes. You continue to be the very best ambassadors of our NHS. Perhaps the reaction from the public says it better – not just the heart-warming clapping at 8pm we saw earlier this year but the numbers who, inspired by your example, have come forward to join, and in some cases rejoin, the ranks of our NHS.

We head into the next year with trepidation but also determination to continue the restoration of services impacted by COVID-19, while pushing on with the work we've committed to in our Long Term Plan.

Some of that has accelerated rapidly through our response to the COVID-19 outbreak, such as providing access to online consultation to GPs - 90% of practices now have access to online consultation while 99% offer video consultation capability. Our redesign of outpatient care, to avoid the need 30 million face-to-face hospital outpatient visits by 2023/24, similarly accelerated so that the use of video consultation in secondary care achieved universal coverage in England in just four weeks.

In 2019/20, more people than ever before were referred urgently with suspected cancer - 2.4 million compared with 2.2 million in 2018/19, and 1 million in 2010/11. Of them, 167,000 patients started treatment, a 2% increase on the previous year.

While this report has been finalised, our efforts to support cancer services affected by COVID-19 to recover and encourage people with possible symptoms who haven't come forward to do so have gathered pace. A new campaign to bolster these launches shortly.

The importance of our work in addressing health inequalities, supporting vulnerable groups, and tackling the common causes of premature mortality, including diabetes and obesity, has also been thrown into a stark light during. An update of what began during 2019/20 is contained within this report and will continue to be a priority.

Finally, I'd like to thank everyone at NHS England and NHS Improvement, including our board members and non-executive directors, who have worked tirelessly over the past year. In unprecedented times, your passion and professionalism in leading and supporting the service have been incredible.

**Baroness Dido Harding,**
*Chair of NHS Improvement*

# About NHS Trust Development Authority

NHS Improvement is responsible for overseeing NHS foundation trusts, NHS trusts and some independent providers. We support them to give patients consistently safe, high quality, and responsive care within local integrated care systems that are financially sustainable. By holding providers to account and, where necessary, intervening, we help the NHS to meet its operational goals and its longer term strategy.

NHS Improvement is the operational name for the organisation that brings together Monitor, and the NHS Trust Development Authority (NHS TDA).

NHS TDA's role is to provide support, oversight and governance for (non-foundation trust) NHS trusts and also to provide support to other providers with a view to improving the quality and financial sustainability of NHS services.

The Government's 2019/20 accountability framework[1] brought together the annual mandate to NHS England and the annual remit for NHS Improvement. This framework prioritised delivery of the first year of the NHS Long Term Plan and addressed issues associated with the United Kingdom's exit from the European Union.

The NHS Constitution establishes the principles and values of the NHS in England and unites patients, the public and staff in a shared ambition for health and high quality care for all, now and for future generations. As a custodian of the values of the NHS Constitution, we are committed to putting patients at the heart of everything we do, promoting transparency and equity while ensuring the most efficient use of public taxpayer resources.

## How we operate

Since 1 April 2019 NHS England and NHS Improvement have come together as a single organisation, as is permitted under the legislation governing our activities.

NHS Improvement is governed by a Board which provides strategic leadership and accountability for the organisation to Government, Parliament and the public. The NHS Improvement Board is the statutory board of both Monitor and NHS TDA and is supported by committees which undertake detailed scrutiny in their respective areas of responsibility and provide it with regular reporting and formal assurance. NHS Improvement has aligned and streamlined its board committee structures to work more closely with NHS England. Further details about our Board, its committees and membership are presented from page 37.

We have moved to a single leadership model under the overall leadership of the Chief Executive Officer (CEO) of NHS England and a single Chief Operating Officer (COO), who also serves as the CEO of NHS Improvement. New national director roles, either reporting to the NHS England CEO or COO, operate across both organisations.

1 https://www.gov.uk/government/publications/nhs-accountability-framework-2019-to-2020

We have created integrated regional teams, led by regional directors with a single reporting line to the COO. They are responsible for the performance of all NHS organisations in their region in relation to quality, finance and operational performance. National teams provide expertise, support and intervention.

During the year, our regional teams strengthened their collaboration with Sustainability and Transformation Partnerships (STPs) and Integrated Care Systems (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.

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.

Our proposals to Parliament for new primary legislation to support implementation of the NHS Long Term Plan include legally merging NHS England and NHS Improvement.

Because a system-wide approach is taken to ensuring clinically and financially sustainable services, NHS Improvement is committed to working closely with other partners, such as Health Education England (HEE), Public Health England (PHE) and NHS Digital, at national and regional level.

Detail on how we assure the activity of our organisation is presented in this annual report from page 61. For further information about how we operate please visit our website.[2]

2 www.england.nhs.uk/about/

# Performance Report

Amanda Pritchard
Accounting Officer
15 January 2021

# Chief Executive's overview

This annual report is the first since NHS England and NHS Improvement came together as a single organisation in April 2019, and my first as Chief Executive and Accounting Officer for NHS Improvement.

When I joined the organisation in July 2019, it was with the over-riding priority of turning the NHS Long Term Plan into real improvements on the ground. Those priorities have by necessity shifted as the COVID-19 pandemic took hold, but it would be remiss not to begin by highlighting some of the many achievements from the first year of the Long Term Plan.

In primary care, 1,250 Primary Care Networks were established to lead the recruitment of tens of thousands of extra staff. We made substantial progress on the commitment that every part of England will be covered by an Integrated Care System (ICS) by April 2021, with more than 60% of the population now covered by 29 ICSs.

We have expanded and invested in our urgent and emergency care services, through the roll out of the same day emergency care model to 90% of acute hospitals and continued improvements to NHS 111 services - including the establishment of 24/7 Clinical Assessment Services, direct booking into GPs, pharmacies and Urgent Treatment Centres and full coverage for the online service.

We also rolled out Targeted Lung Health Checks and established over 40 Rapid Diagnostic Centres to catch cancers earlier, expanded access to liaison and perinatal mental health services, achieved our target of 100,000 people accessing the Diabetes Prevention Programme and established the atrial fibrillation demonstrator programme to identify and treat more people with heart conditions before they cause a stroke.

The percentage of core services in NHS acute care rated as good or outstanding by the Care Quality Commission (CQC) improved from 72% to 75%. The CQC individual key questions ratings also showed some improvement, with the proportion rated as good for safety rising from 61% to 63%, and for well-led from 68% to 70%. With our support, the number of trusts in special measures for quality reasons decreased by four during the year, as four trusts exited and none entered.

NHS England and NHS Improvement have continued their alignment, coming together at both local and national level, providing co-ordinated clinical and operational leadership to the NHS at this vital time.

All of this progress was of course against the backdrop of what was already shaping up to be the busiest year the NHS had seen, with more people than ever before coming forward for primary care appointments, urgent and emergency care and rapid cancer checks.

The NHS faced considerable challenges in the final quarter of 2019/20, with resources focussed on managing the COVID-19 pandemic. As part of the response to the pandemic, the number of 999 calls answered in March 2020 was over 17% higher than March 2019, and almost three million calls were made to NHS111 in March 2020 – over double the number made in March 2019. We maintained the number of patients seen in Accident and Emergency (A&E) up until February 2020. A&E performance improved to 84.3% by March 2020, in part due to the decrease in attendances that month.

Good progress was made during 2019/20 to reduce the number of patients waiting the longest for elective treatment. In each month of the year to February 2020 the total number of patients

waiting more than 52 weeks was lower than at the same time in 2018/19. As a result of actions necessary to respond to the pandemic, the number of patients waiting more than 52 weeks increased to 3,097 in March 2020.

The NHS has consistently met and exceeded waiting times standards for access to talking therapies for depression and anxiety this year, with over 87% of patients waiting less than 6 weeks for treatment and almost 98% waiting less than 18 weeks. In addition, almost 72% of patients experiencing a first episode of psychosis were seen within two weeks, exceeding the 56% standard. Children and young people have had greater access to mental health services than they did in 2018/19, with almost 37% of those with a diagnosable mental health condition accessing NHS-funded community services.

On top of these existing pressures, the final month of the year was overtaken by the extraordinary financial demands created by the COVID-19 pandemic. Despite the combined impact of these factors, the year-end financial deficit, once adjusted for technical adjustments, was comparable to the previous year and represents continued progress by the provider sector. Trusts delivered £2.8 billion of efficiency and once again maintained the level of agency spending at a level similar to the previous year, consolidating the trend of reduced spending achieved over recent years which has been supported by our initiatives. This is a considerable achievement by trusts, given the high demand, the pressures caused by the pandemic as well as the continued high levels of vacant posts.

The NHS is – and always has been - based on people, problem-solving and partnerships. This has rarely been more evident and important than in 2020. Our NHS people have been nothing short of incredible throughout. Their skill and professionalism have never been in doubt. It is their bravery, their self-sacrifice, and their dedication which have inspired the largest outpouring of public appreciation that I can ever remember.

But we must also acknowledge that this huge effort comes at a cost. Many of our colleagues have been physically and emotionally exhausted, and it is our responsibility to support them. That's why the appointment of a Chief People Officer in Prerana Issar, and the first instalments of the NHS People Plan, were so important. Together we are determined not only to deliver the extra health and wellbeing services to help staff through this period, but also over the longer term to grow and support our workforce so that the NHS can achieve our shared aims for improving patient care.

The pandemic has shown us that we make the most progress and deliver the best results for patients when we work together.

It is clear that COVID-19 will cast a long shadow. But it is also clear that the NHS is capable of not just weathering the storm, but of staying and making ever more progress on the course we set for ourselves in the NHS Long Term Plan.

**Amanda Pritchard**

*CEO of NHS Improvement and Accounting Officer*

# How we measure performance

The NHS Constitution sets out the rights of patients, public and staff. We measure and monitor performance against a wide range of standards. We publish statistics relating to these core standards on the NHS England website[3] every month.

3 www.england.nhs.uk/statistics/statistical-work-areas/combined-performance-summary

# Performance Overview

The NHS Long Term Plan, published in January 2019, set out a 10-year programme of practical phased improvements to NHS services and outcomes, including a number of specific commitments to invest the agreed NHS five-year revenue settlement.

This performance overview provides a brief summary of progress made on: prevention and health inequalities; care quality, access and outcomes; ensuring NHS staff get the backing they need; and using taxpayers' investment to maximum effect. Together, our work programmes encapsulate the objectives set out in the Government's accountability framework to the NHS for 2019/20. Further information is available on page 136.

The COVID-19 pandemic had a major impact on the NHS in the last quarter of the year, intensifying in March 2020 and into the new financial year. This needed an unprecedented and coordinated emergency response. From January 2020 NHS England and NHS Improvement, in partnership with the Department of Health and Social Care (DHSC), scaled up its response ensuring that every coronavirus patient who needed specialised inpatient care was able to receive it. A new remote COVID-19 Response Service (CRS), accessible via 111, was swiftly established with over 1,500 retired clinicians recruited to provide clinical assessment. Resources supporting clinical and operational teams on the front line were redeployed, which in some cases meant accelerating parts of the Long Term Plan. So while the long term priorities remain the same, the phasing of them has and will change. See page 23 for more detail on the NHS response to COVID-19.

## A new service model for primary and community health services

During 2019/20 NHS England and NHS Improvement continued to invest more in primary care services, expand the number of people working in primary care, and make practical improvements to services and premises. We are on track to see real terms expenditure on primary medical and community service grow to almost £28.8 billion by 2023/24, having exceeded the 2019/20 £23.2 billion target by November 2019.

By 1 July 2019 1,250 Primary Care Networks (PCNs) were established with a PCN clinical director appointed to each. PCNs are groups of GP practices (typically with a population of between 30,000 and 50,000 people) working together with colleagues in wider primary care, social care and the voluntary sector, to develop expanded community multidisciplinary teams that are focused on delivering services for their specific patient populations. They are crucial pillars in the national Covid vaccination campaign.

Contributing to the goal of providing an additional 50 million extra appointments within general practice by 2024/25, this year saw increased financial and practical support for the roll out of online consultation (to support triage) and video consultation capabilities in general practice. This work was accelerated rapidly from February 2020 as part of the NHS response to the COVID-19 outbreak, with 90% of practices now having access to online consultation capability and 99% to video consultation capability by the end of 2020. This is a significant increase from the previous levels of 30% and 3% in December 2019. A major programme to

help meet the Government's new target of 6,000 additional GPs across the NHS (compared with the March 2019 baseline) was announced in February 2020. In conjunction with HEE we have continued to increase the numbers of GP trainees working in general practice during 2019/20, as well as the number of doctors returning to practice. The number of new doctors choosing general practice as a career is now at an all time high. In addition, in the 12 months leading up to December 2019, there was a growth of 1,473 headcount (199 FTE) doctors working in general practice. This is in addition to the GPs who have returned to registered practice since the COVID-19 pandemic.

We have continued to expand the personalised care programme, to provide people with choice and control over their own care, improve outcomes and deliver efficiency savings. The 2019/20 goal of 70,000 people with a personal health budget (PHB) was achieved by the second quarter of the year, exceeding our mandate commitment for PHBs two years early. A new legal right to a PHB was launched in December 2019 for people who access certain kinds of mental health support and for people who need to use a wheelchair. We estimate this could benefit a further 100,000 people by 2023/24.

By the end of 2023/24, 900,000 people will have benefited from social prescribing. Starting in 2019/20 we provided funding via the Additional Roles Reimbursement Scheme within the PCN contract, for over 1,000 additional trained link workers by March 2021, with the intention that numbers recruited will rise further by March 2024.

The Ageing Well programme is supporting the roll out of Enhanced Health in Care Homes (EHCH) to strengthen support for the people who live and work in care homes. Requirements for delivery were included in the Primary Care Network Directed Enhanced Service (DES) in 2020/21 and in the 'Update to the GP Contract Agreement 2020/21 – 2023/24[4]. Complementary EHCH requirements for relevant providers of community physical and mental health services have been included in the NHS Standard Contract[5]. Key elements of the EHCH model due for delivery in October 2020 have been fast-tracked across the country in response to the COVID-19 pandemic.

## Mental health

In 2019/20 the NHS once again met the Mental Health Investment Standard which guarantees that real terms funding for mental health grows faster than that for the NHS overall. Mental health, access, recovery and referral to treatment time targets made good progress in 2019/20 and (prior to the COVID-19 pandemic) were on track to be achieved as expected by 2020/21. Among key achievements, there are now specialist perinatal mental health community services in place in every locality. Data from March 2020 indicates that the national access rate for children and young people's mental health for 2019/20 was exceeded (36.8% vs 34% target), and the access rate is already ahead of the 2020/21 ambition. A further 123 mental health support teams were confirmed in July 2019 and were introduced in 57 sites around the country during 2019/20, bringing the total number of sites to 73.

4 https://www.england.nhs.uk/wp-content/uploads/2020/02/update-to-the-gp-contract-agreement-2021-2324-v2.pdf (P40-46)
5 https://www.england.nhs.uk/nhs-standard-contract/20-21/

Quarter 4 2020/21 data for children and young people's eating disorder waiting times shows 84.4% of patients accessing treatment within four weeks (routine referrals) and 80.5% within one week (urgent referrals).

Progress continued on increasing access to individual placement support services and to Improving Access to Psychological Therapies (IAPT) for adults and older adults needing psychological therapies. IAPT waiting time standards continued to be met, with 87.1% of people entering treatment in March 2020 having waited less than six weeks (against a standard of 75%), and 97.7% of people entering treatment having waited less than 18 weeks (against a standard of 95%). The IAPT recovery rate was 47.7%, which was below the 50% target, and likely attributable to COVID-19. More recent data (May 2020) demonstrates delivery of the 50% recovery target is back to 50.6%.

The national standard for 56% of people to start treatment for Early Intervention in Psychosis (EIP) within two weeks was exceeded in March 2020, with performance of 71.9%.

In 2019/20, we awarded £70 million transformation funding to 12 early implementer sites to test new models of integrated primary and secondary mental health care for people with severe mental illnesses. All hospitals with 24/7 consultant-led A&E departments now have a liaison mental health service, and all areas of the country are implementing plans to expand their crisis services coverage.

Further progress has been made towards eliminating reliance on inappropriate adult acute out of area placements. During 2019/20, additional assurance was implemented for the ten most challenged providers, which successfully reduced their use of inappropriate out of area placements by approximately 11,500 out of area bed days (or just under 30%) between Q4 2018/19 and Q4 2019/20. We are continuing to work closely with providers to deliver the ambition to end inappropriate adult acute out of area placements, while also factoring in the impact of the pandemic on increasing acuity of patients and local demand for beds.

Three newly-funded problem gambling mental health support clinics started to see patients during the year, and the NHS opened its first specialist clinic for children and young people with severe or complex behavioural issues associated with gaming, gambling and social media. Funding was allocated to seven sites to develop specialist mental health services for rough sleepers.

A new Advancing Mental Health Equalities Taskforce was launched in 2019/20. The immediate priorities of the Taskforce relate to data quality improvement, metrics development and establishing the Patient and Carers Race Equality Framework.

The dementia diagnosis rate continued to be exceeded during 2019/20, with a 67.4% achievement by March 2020 against the 66.7% standard.

## Learning disability

Improving the health of people with a learning disability and/or autism remains a key priority for the NHS. The NHS Long Term Plan commits to reducing reliance on specialist inpatient care for children and adults with a learning disability, autism or both. The number of people in an inpatient setting reduced by 27% from 2,895 in March 2015 to 2,105 at the end of March 2020. The number of children and young people in an inpatient setting at the end of March 2020 was 215, a reduction of 26% from the end of March 2019. A priority going forward is the number of children and young people who have autism and no learning disability, accounting for 79% of under 18 inpatients.

The NHS Long Term Plan commits to improving the uptake of annual health checks for people with a learning disability, so at least 75% are receiving a health check each year by 2023/24. New additional payments for GPs and PCNs to identify patients with a learning disability and to undertake annual health checks are being introduced and a national campaign to improve uptake will be launched.

More Learning Disabilities Mortality Reviews (LeDeR) than ever were completed in 2019, following investment of a further £5 million. At the end of March 2020, CCGs had completed 63% of eligible reviews (those not otherwise subject to statutory investigations or reviews or on hold to enable families to take part) within six months of notification. LeDeR is now the largest such body of evidence in the world, reviewed at an individual level, and it has led to the introduction of the Oliver McGowan mandatory training on learning disability and autism.

## More NHS action on inequalities and preventing ill health

During 2019/20, we took action on health inequalities, in line with the commitments set out in the NHS Long Term Plan (2019)[6], and the criteria set by the Secretary of State. A fuller update can be found in appendix 3 on page 143.

During 2019/20, we worked with national and regional stakeholders to develop tobacco and alcohol interventions, being rolled out in 2020/21 at Early Implementer Sites (EIS). We also incorporated smoking cessation activities into the community pharmacy contract.

Diabetes is a leading cause of premature mortality, resulting in over 22,000 additional deaths each year and doubling an individual's risk of cardiovascular disease including heart attacks, heart failure, angina and stroke. The NHS Diabetes Prevention Programme (NHS DPP) is the world's first nationwide Type 2 diabetes prevention programme. Emerging outcomes data shows a mean weight loss in those who completed the programme of 3.3kg. Reductions in weight and HbA1c[7] compare favourably to those reported in recent studies and indicate likely future reductions in participant type 2 diabetes incidence. We have supported 120,000 people to access the NHS DPP in 2019/20 and are on the way to support 200,000 people per year. Following procurement of a new NHS DPP Provider Framework we have now rolled out digital services to complement face to face services across 45% of England.

This year we have licenced, developed and begun roll out of Healthy Living, a digital self-management programme for those living with Type 2 diabetes, which will ultimately be

6 NHS Long Term Plan – Chapter 2: Prevention and Health Inequalities - https://www.longtermplan.nhs.uk/

7 HbA1c is measured by clinicians to ascertain an overall picture of diabetic patients' blood glucose levels over a period of weeks/months

available universally. The number of structured education places has expanded to support people newly diagnosed with diabetes, to understand how to look after themselves well and reduce the risks of diabetes related complications.

## Maternity and neonatal services

Safe childbirth outcomes in England are at record levels. The stillbirth rate decreased by 21% between 2010 and 2018. The extra lives saved means the NHS met its own ambitious 20% target two years ahead of the 2020 deadline. The national maternity safety ambition is to reduce stillbirths, neonatal deaths, maternal deaths and brain injuries at birth by 20% by 2020 and 50% by 2025.

The latest neonatal mortality rate, for February 2020, was 2.8 per 1,000 live births. 5.1% lower than 2010, with further reduction now required. The latest data for 2015-17 shows a reduction in the rate of maternal deaths from 9.2 deaths per 100,000 maternities, down from 10.6 in 2010, with the target to reduce this further to 5.3 in 2025. Maternal mortality rates are influenced by multiple factors such as cardiac conditions, obesity, smoking, complex social factors and inequalities. Rates among women from Black, Asian and Minority Ethnic (BAME) backgrounds are up to five times those of white women, which is why we aim to provide continuity of carer to 75% of BAME women and those from the 10% most deprived neighbourhoods by 2024.

There are however continuing serious concerns about maternity services in a small number of providers, including Shrewsbury and Telford Hospital NHS Trust and East Kent Hosptals University NHS Foundation Trust, where NHS Improvement has commissioned independent reviews. Teams from NHS Improvement and NHS England will be working intensively with those providers to ensure they follow best practices in relation to safety, with independent scrutiny from both CQC or the new Healthcare Safety Investigation Branch (HSIB).

Serious brain injuries fell from 5.4 per 1,000 births in 2014 to 5.1 in 2017. Trends in brain injury rate are however currently difficult to interpret due to the measure's immaturity and likely improvements in data quality.

The NHS has rolled out a general practice campaign to encourage parents to have their children vaccinated against measles mumps and rubella. The seasonal flu vaccine was made available to all 600,000 primary school aged children in year 6 for the first time in 2019/20. Infants born on or after 1 January 2020 now only need two injections for the pneumococcal conjugate vaccine as opposed to three. The human papillomavirus HPV test achieved full geographic coverage in December 2019. All 12 and 13-year-olds are offered the HPV vaccine, and a catch-up programme is available for eligible people up to age 25.

## Cancer

Cancer survival and patient experience of NHS care are both the highest they have ever been. In 2019/20 more people than ever before were referred urgently with suspected cancer: 2.4 million compared to 2.2 million in 2018/19, and 1 million in 2010/11. 167,000 patients went on to start treatment, a 2% increase on the previous year. This growth is welcome as it allows earlier diagnosis and treatment, but it also places increased pressure on services.

The NHS modernised key aspects of its national cancer screening programmes. 2.9 million breast cancer screenings were carried out during the 12 months to the end of December 2019. People eligible for bowel cancer screening are now being sent a testing kit that is more sensitive to risk signs and easier to use than the previous version. By December 2019, more than 45,000 extra kits were being returned every month – a 7.8% increase. The introduction of rapid diagnostic centres (RDC) aims to speed up diagnosis and offer a clear referral route for patients with non-specific symptoms that could indicate cancer, and 23 RDCs were 'live' by January 2020. In addition, the GP contract includes a new specification for PCNs to support the earlier diagnosis of cancer.

## Outpatient transformation and planned care

The NHS Long Term Plan committed to re-design outpatient care to avoid the need for a third (30 million) of face-to-face hospital outpatient visits by 2023/24, saving patients' time, freeing up clinical capacity, and averting the need for up to £1.1 billion in new expenditure. National scale up of video conferencing for outpatient care was planned across the period of the Long Term Plan. As part of the NHS response to COVID-19, accelerated progress has been made on the use of video consultation in secondary care, achieving universal coverage in England in four weeks. As a result, nearly a quarter of all outpatient appointments in the last week of March were completed virtually without patients having to leave home, up from 4% in the first full week of January.

An early priority for outpatient transformation is the re-design of ophthalmology services, which is the largest outpatient specialty by volume. Early work began in 2019/20 to design and scope this activity with leading ophthalmologists, hospital chief executives and patient representatives feeding into the design of new pathways. Re-design of musculoskeletal, dermatology and cardiology outpatient services will follow in 2021.

## Development of the NHS People Plan

The Interim NHS People Plan[8] was co-developed with national leaders and partners and published in June 2019. With a strong focus on the challenges specific to the NHS workforce, and setting out clear ambitions on how NHS staff will be bolstered and supported to deliver 21st century care, the plan was well received across the healthcare sector.

Underpinned by a commitment of almost £900 million by 2024, the NHS People Plan includes a major programme to help meet the Government's new target of 6,000 additional GPs across the NHS workforce, and a further 6,000 non-GP direct patient care staff, in addition to the 20,000 previously committed to. It was supplemented by a further publication setting out core priorities and actions on workforce, published in July 2020.

For information on our progress in these areas, see Appendix 2 on equality, and Appendix 4 on reducing health inequalities, from page 140.

Metrics will be developed to track progress on the NHS People Plan nationally, regionally, by STP, ICS and, where applicable, by individual trust and/or PCN.

8 https://www.longtermplan.nhs.uk/wp-content/uploads/2019/05/Interim-NHS-People-Plan_June2019.pdf

As part of the NHS response to COVID-19, the Bringing Back Staff (BBS) programme's aim is to recall as many staff as possible to the NHS. Over 5,635 recently retired clinicians have been deployed in acute frontline services and 2,557 have been passed to NHS 111 for deployment. As at 1 June 2020, 1,600 GPs had also returned to registered practice to support the NHS response to COVID-19.

## Equipping the NHS to offer digitally-enabled care

NHSX is an organisation formed from the teams of DHSC, NHS England and NHS Improvement to drive the digital transformation of care. It reports into DHSC and NHS England and NHS Improvement. It is delivering several key products and services and guiding the overall digital ecosystem in partnership with NHS Digital and others. Its work during 2019/20 includes:

### NHS.uk

The NHS website (www.nhs.uk) continues to be the UK's largest health website, with more than 50 million visits a month. It provides thousands of clinically validated articles, videos and tools to help people make the best choices about their health, care and wellbeing and reduce pressure on frontline services.

In 2019/20 significant improvements were made to the overall site including:

- New content throughout; expansion of the highly used medicines information.
- Redesign of the 'Mental health and wellbeing' information.
- A new Find a Service tool.
- A new system for submitting ratings and reviews.

The website provides key content for reuse to increase reach and quality of health information for people in England, with over 2000 organisations signed up to use our content.

### NHS Login

NHS Login is a single, secure login enabling swift access to the NHS App, and other health and social care apps and websites wherever there is the NHS login button. Launched alongside the NHS App, NHS Login provides citizens with safe access to digital health services online.

### Supporting the NHS response to COVID-19

As part of the NHS response to COVID-19 in the last quarter of 2019/20, work was accelerated on implementing digital alternatives to traditional face-to-face appointments. In addition to the progress that has been made on the use of video consultation in secondary care described on page 20, we have seen a rapid uptake in usage of video consultations in urgent and emergency care, community, mental health and ambulance services, and on behalf of DHSC, NHSX is now supporting its use in the care sector.

## Comprehensive coverage of Integrated Care Systems

ICSs are the practical way that NHS organisations, local authorities, the voluntary sector and others will work together in every part of England to deliver the commitments set out in the NHS Long Term Plan. In June 2019, the coverage of these systems grew to include South East London, Oxfordshire (part of a single system with Buckinghamshire and Berkshire West) and the whole of the North East. There are now 29 ICSs in total, serving more than 60% of England's population and more ICSs will cover the whole of England by April 2021.

In 2019/20, NHS England and NHS Improvement set out the operational, leadership and governance arrangements needed in every system by 2021 in order to co-ordinate system-wide transformation and collectively manage system performance. Working in collaboration with a wide range of stakeholders, we have set out a new way of working referred to as 'system by default'. This is intended to support the transition to the agreed NHS England and NHS Improvement operating model and 100% ICS coverage by 2021. We are providing direct support to all health and care systems as they mature against the criteria in the ICS matrix framework, and through our new 'Accelerator' programme.

# How we supported the wider NHS

## Emergency Preparedness, Resilience and Response (EPRR)

### The NHS response to COVID-19

During 2019/20 we have responded to a range of threats to patient and public safety, drawing on the experience and expertise in our EPRR teams. Of these incidents, dominant has been the NHS's response to the COVID-19 pandemic. This emergency, unprecedented in scale and complexity, was declared a Level 4 national incident on 30 January 2020. NHS England and NHS Improvement provides strategic direction, co-ordination and oversight of the NHS operational response, in line with the EPRR national framework.

Established EPRR response coordination processes were enhanced including national Strategic and Incident Directors, Incident Management Teams and Incident Co-ordination Centres (ICCs) at national and regional levels, and in individual organisations. An NHS England and NHS Improvement COVID-19 National Incident Response Board (chaired by the Chief Operating Officer and consisting of a committee of the NHS Executive and NHS England and NHS Improvement Boards) was established to oversee the NHS response to COVID-19 and set direction and policies. DHSC is represented on the incident response board, to help ensure coordination with the work of other agencies, such as PHE's responsibility for COVID-19 testing and infection control guidance, and DHSC's leadership on Personal Protective Equipment (PPE) procurement and supplies.

Our arrangements continue to evolve and anticipate developments, whilst ensuring an effective flow of information.

### Britain's exit from the EU

Significant work went into preparation for the UK's departure from the European Union (EU). Incident Management Teams have also used trained volunteers from other parts of the organisation recruited under the NHS England and NHS Improvement reservist scheme. Work to help the NHS prepare for EU Exit during 2019 in conjunction with DHSC and wider government helped improve transparency regarding medicines supply chains.

### November London Bridge terrorist attack

On 29 November 2019 the NHS was once again required to respond to a terrorist attack. Two people tragically lost their lives on London Bridge, and the London Ambulance Service treated a number of people at the scene and conveyed people to hospitals. The NHS continues to work with cross government and local partners to ensure that those affected by the incident receive care and psychosocial support.

### Other incidents

Throughout 2019/20, before the pandemic, the NHS responded to the threat of high consequence infectious diseases (HCIDs) both in England and overseas, including the threat to the UK from the Ebola outbreak in the Democratic Republic of Congo, repatriation of workers suspected of being exposed to Lassa Fever, and one case of Monkeypox.

In 2019 the NHS also responded to several other incidents including listeria contamination and the home parenteral nutrition shortage.

NHS England and NHS Improvement continue to build resilience in key sectors of health, for example through the tendering of the National Ambulance Resilience Unit contract awarded to the West Midlands Ambulance Service University NHS Foundation Trust.

## Productivity and efficiency

As part of our commitment to improving productivity throughout the health and care system, we are developing and implementing e-rostering and e-job planning to deploy the NHS clinical workforce to best effect, improving workforce productivity by an estimated £1.45 billion.

The NHS England and NHS Improvement Commercial Medicines Directorate (CMD) has been established to support patients to access the latest innovative and most clinically effective new medicines, while securing maximum value for the NHS and taxpayers. The work of the CMD is aligned with two key policy documents: the NHS Long Term Plan and the Voluntary Scheme for Branded Medicines Pricing and Access. Working alongside DHSC, NHS England and NHS Improvement are delivering a range of measures for England as set out in the Voluntary Scheme agreed with the pharmaceutical industry that started on 1 January 2019. The five-year scheme is designed to manage the branded medicines bill whilst supporting innovation and better patient outcomes through improved access to the most transformative and cost-effective new medicines. A key success during 2019/20 was the successful roll out of the Adalimumab smart procurement, where we are on track to deliver a total of over £280m of savings, despite around 16% growth in use.

The CMD has also successfully negotiated several innovative commercial agreements at fair and responsible prices, supported by NICE, and which have made new and promising treatments available for NHS patients. These include:

- Ocrelizumab in multiple sclerosis.
- Nusinersen in spinal muscular atrophy.
- Cerliponase in Batten disease.
- A deal with Vertex Pharmaceuticals to make available all three of their UK-licensed cystic fibrosis medicines.

## Research and innovation

Research and innovation are a core part of the NHS. Organisations active in research often provide higher quality care for all patients, while innovation improves outcomes, patient experience and efficiency. We hosted the Accelerated Access Collaborative (AAC) in 2019/20 and more than 440,000 patients benefited from new tests and treatments made available through its work. For example, Heartflow – which creates a digital 3D model of the heart and avoids the need for invasive procedures – was offered in hospitals and reduced the need for invasive tests. We took measures to support AAC's mandate to speed up access of proven innovation to patients, including the launch of a £140 million award to encourage the safe deployment and testing of the most promising artificial intelligence technologies in the NHS.

## Sustainability

For information on environmental matters, including NHS England and NHS Improvement's impact on the environment, please see appendix 5 on page 151. In January 2020 we launched a programme to set a feasible and measurable path to becoming a net zero health service. This blueprint was formally adopted by NHS England and NHS Improvement in October 2020[9].

## Support for providers

### Rural acute hospitals

Smaller rural acute hospitals play a vital role in providing health and care services to around 20% of the population across England; they also contribute significantly to their communities' economic and social development. These hospitals' size and relative remoteness often contribute to challenges in workforce and other operational areas. These same challenges are leading to considerable innovation. In the NHS Long Term Plan we committed to developing a new operating model for small rural hospitals and we are supporting them to do so.

Launched in July 2019, our three-year initiative is based on five themes:

- The future vision for small hospitals operating in rural and remote environments.
- What is needed to ensure safe and high quality care across integrated patient pathways?
- How can we build, flex and retain a rural workforce for the future?
- What is driving the financial challenges facing smaller rural hospitals, and how can we address these?
- How can we support the adoption and spread of digital solutions?

9 https://www.england.nhs.uk/greenernhs/publication/delivering-a-net-zero-national-health-service/

Small rural hospitals in every region are sharing the challenges they face, and the innovative ways they are delivering care in their emergency departments, maternity wards, and through digital solutions. We have been establishing a virtual peer learning network for small rural hospitals. We have also been looking into whether smaller rural hospitals have cost structures which require changes to CCG allocations and the national tariff and have worked with HEE to address the geographic distribution of specialty doctors and training places across England. Planned work to accelerate the spread of effective patient transfer methods was postponed in response to COVID-19.

### Providers working effectively as part of systems

During 2019/20 we worked to clarify what it means to be a strong and successful provider trust in the context of system working, how this aligns with organisational accountabilities, and the changes needed to support and enable providers to work in this way.

This work is a key enabler of the NHS Long Term Plan and our commitment to establish ICSs across the country.

The three aims of our work to support providers to work effectively as part of systems are:

- Setting clear expectations – what it means in practice to be a successful provider in the context of the NHS Long Term Plan's vision of organisations working together to integrate care and promote population health.
- Creating and enabling a national policy framework – ensuring any further changes needed to support and enable trusts to work with others in this way.
- Resolving challenges – setting out how we should work with local systems to resolve challenges where a provider is not working with others in this way.

We have been working with other national bodies such as the Care Quality Commission, systems, and provider representatives. During 2020/21 we will undertake the next phase of the work, learning the lessons of the COVID-19 response and working with stakeholders to ensure NHS England and NHS Improvement supports providers to work effectively as part of systems.

### Mergers and acquisitions

We committed in the NHS Long Term Plan to adopting 'a more proactive role in supporting collaborative approaches between trusts' that wish to explore formal merger or acquisition.

We 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. Chiefly, this relates to transactions where the Competition and Markets Authority (CMA) is undertaking a review.

Recent policies and guidance have reduced the scope for competition to act as a driver of quality, and legislative proposals stemming from the NHS Long Term Plan include the intention to remove the CMA's jurisdiction to review NHS transactions. We therefore anticipate that the CMA will review significantly fewer NHS mergers or acquisitions.

Transactions present major opportunities to change services in ways that improve patient care. We plan to develop updated transaction guidance that will set new expectations for planning demonstrable patient benefits as part of mergers or acquisitions.

Monitoring and evaluating benefits post-merger are crucial for implementing mergers successfully and realising the expected benefits. We developed guidance and a practical tool 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.

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 stakeholders, articulate clearly how they will deliver clinical improvements for patients, and have the capacity and capability to achieve the planned benefits.

Through our risk assurance processes, we aim to identify risks early and tailor a work programme that is proportionate to the risks in each case.

We assured several significant transactions during the year:

- Cumbria Partnership NHS Foundation Trust and North Cumbria University Hospitals NHS Trust merged on 1 October 2019 to create North Cumbria Integrated Care NHS Foundation Trust.
- Aintree University Hospital NHS Foundation Trust and Royal Liverpool and Broadgreen University Hospitals NHS Trust merged on 1 October 2019 to create Liverpool University Hospitals NHS Foundation Trust.
- 2GETHER NHS Foundation Trust and Gloucestershire Care Services NHS Trust merged on 1 October 2019 to create Gloucestershire Health and Care NHS Foundation Trust.
- Basildon and Thurrock University Hospitals NHS Foundation Trust, Southend University Hospital NHS Foundation Trust and Mid Essex Hospital Services NHS Trust merged on 1 April 2020.
- Luton and Dunstable University Hospital NHS Foundation Trust and Bedford Hospital NHS Trust merged on 1 April 2020 to create Bedfordshire Hospitals NHS Foundation Trust.
- University Hospital Bristol NHS Foundation Trust and Weston Area Health NHS Trust merged on 1 April 2020 to create University Hospitals Bristol and Weston NHS Foundation Trust.
- Somerset Partnership NHS Foundation Trust and Taunton and Somerset NHS Foundation Trust merged on 1 April 2020 to create Somerset NHS Foundation Trust.
- Black Country Partnership NHS Foundation Trust acquired the services, assets and liabilities of Dudley and Walsall Mental Health Partnership NHS Trust on 1 April 2020 to create the Black Country Healthcare NHS Foundation Trust.

During 2018/19 we published additional guidance for trusts considering the creation of subsidiaries or material changes to existing subsidiaries. We committed to reviewing the guidance following one year of operation and we expect to publish updated and more detailed guidance in 2020/21.

We recognise that transactions are a significant undertaking, particularly during the planning stage, and trusts may need help with their development. The level of 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.
- Helping to develop strategic business cases.
- Stakeholder management and communication support.
- Competition and advisory support.
- Advice, tools and guidance.
- Disseminating good practice.

Where a trust has identified that a change in organisational form such as a merger may be required to achieve long-term sustainability, we may support it to do this. During 2019/20, we provided support to several providers, and the nature of our support varied according to the needs of each situation. Some examples include:

- Supporting the Dudley health system consider options for organisational form in moving towards putting in place an integrated care provider (ICP) contract, to deliver integrated services outside of hospital.
- Working with stakeholders across Greater Manchester to support the Pennine Acute Hospitals NHS Trust to move towards its stated long-term aim that its North Manchester General Hospital would become part of a single hospital service operated by Manchester University NHS Foundation Trust and that its remaining sites would become part of Salford Royal NHS Foundation Trust. In 2019/20 this included the creation of new governance arrangements allowing Manchester University NHS Foundation Trust to provide operational oversight of services at North Manchester General from 1 April 2020, with services at the other Pennine Acute sites continuing to be overseen by Salford Royal NHS Foundation Trust as part of the Northern Care Alliance NHS Group.

## 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 mirrors the NHS foundation trust licence condition and includes requirements on good governance.

On 24 June 2019, we issued an NHS-controlled provider licence to East Kent Medical Services Ltd. It is controlled by one NHS foundation trust and holds contracts to provide elective and outpatient healthcare services. It has subsequently been regulated under the risk assessment framework for independent sector providers of NHS services in accordance with our published policy. As at 31 March 2020 there are two NHS-controlled providers, the other being Wiltshire Health and Care LLP.

## Operational performance of the NHS trust and foundation trust sectors against key national standards

We closely track NHS trusts' and foundation trusts' performance to help them address operational and financial performance issues and improve quality of patient care. Throughout the year we analyse performance at individual 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.

## 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 2020 | 92% | 79.7% |
| Number of patients waiting more than 52 weeks | | 0 | 3,097 |
| **Diagnostics** | | | |
| Proportion of patients waiting longer than 6 weeks for diagnostic tests | March 2020 | 1% | 10.2% |
| **Accident and emergency** | | | |
| Proportion of patients discharged, admitted or transferred within 4 hours of attending A&E (all types of A&E department) | March 2020 | 95% | 82.8% |
| **Cancer** | | | |
| Proportion of patients with suspected cancer receiving first outpatient consultation within 2 weeks of GP referral (all cancer symptoms) | Quarter 4 2019/20 | 93% | 91.6% |
| Proportion of patients urgently referred for breast symptoms (where cancer was not initially suspected), seen within two weeks of referral. | | 93% | 85.6% |
| Proportion of patients receiving first cancer treatment within 31 days of diagnosis | | 96% | 95.9% |
| Proportion of patients receiving second or subsequent cancer treatment (surgery) within 31 days of decision to treat | | 94% | 90.9% |
| Proportion of patients receiving second/subsequent treatment (drug therapy) within 31 days of decision to treat | | 98% | 98.7% |
| Proportion of patients receiving second/subsequent treatment (radiotherapy) within 31 days of decision to treat | | 94% | 96.0% |
| Proportion of patients receiving first cancer treatment within 62 days of urgent GP referral for suspected cancer | | 85% | 75.6% |
| Proportion of patients receiving first cancer treatment within 62 days of urgent referral from NHS Cancer Screening Programme | | 90% | 80.5% |
| **Ambulance** | | | |
| Average (mean) response time for people with life-threatening injuries and illness (Category 1) | March 2020 | 7 minutes | 8 minutes 7 seconds |
| Response time for people with life-threatening injuries and illness (Category 1) – average for 90th centile | | 15 minutes | 14 minutes 22 seconds |
| Average (mean) response time for other emergencies (Category 2) | | 18 minutes | 32 minutes 6 seconds |
| Response time for other emergencies (Category 2) – average for 90th centile | | 40 minutes | 69 minutes 1 second |
| Response time for urgent care (Category 3) – average for 90th centile | | 120 minutes | 219 minutes 42 seconds |
| Response time for less urgent care (Category 4) – average for 90th centile | | 180 minutes | 276 minutes 37 seconds |
| **Infection control** | | | |
| Number of MRSA bloodstream infections | 2019/20 | 0 | 263 |
| Number of Clostridium difficile infections | | - | 7,813 |
| **Mixed sex accommodation** Number of breaches of the mixed sex accommodation guidance | February 2020* | 0 | 4,929 |
| **Mental health** | | | |
| Proportion of people on care programme approach discharged from inpatient care who were followed up within seven days | Quarter 3 2019/20* | 95% | 95.5% |
| Proportion of people admitted to inpatient services who had access to crisis resolution/home treatment teams | Quarter 3 2019/20* | 95% | 97.1% |

The collection and publication of statistics marked* was paused to release capacity across the NHS to support the NHS response to COVID-19.

# Chief Financial Officer's Report

## Allocations

The financial statements for the year ending 31 March 2020 are presented later in this document and show the performance of the NHS TDA. Over the course of 2019/20 NHS England and NHS Improvement (of which the NHS TDA is a part) have come together as a single organisation to better support the NHS and help improve care for patients. The revenue resource limit is £225.1 million (2018/19: £132.3 million). NHS TDA's net expenditure for the year was £223.5 million (2018/19: £128.9 million). The under spend against the revenue resource limit is £1.6m (2018/19: £3.3m).

The main driver of the increase in resource limit is the transfer of the NHS Leadership Academy to NHS TDA from Health Education England on 1st April 2019. This transfer was to enable closer working between the work of the NHS Leadership Academy and NHS Improvement's People function, particularly in the area of executive and non-executive leadership and talent across the NHS.

The main categories of spend are shown in the table below.

| Main categories of spend | 2019/20 £ million | 2018/19 £ million | Reference to accounts |
|---|---|---|---|
| **Operating revenue** | (28.7) | (37.0) | Note 3 |
| **Staff** | 140.9 | 96.5 | Note 4 |
| **Purchase of goods and services** | 76.0 | 26.4 | Note 5 |
| **Depreciation and impairment charges** | 0.9 | 0.6 | Note 5 |
| **Other operating expenditure** | 34.4 | 42.4 | Note 5 |
| **Total** | **223.5** | **128.9** | |

The decrease in operating revenue is mainly due to a reduction in income to support the Get it Right First Time (GIRFT) programme which has been funded through grant in aid funding in 2019/20 partially offset by the addition of NHS Leadership Academy training income.

The largest area of spend is staff costs, representing 63% of net expenditure in 2019/20 (2018/19: 75%). The increase in staff costs is mainly due to the transfer in of NHS Leadership Academy staff from 1 April 2019.

Purchase of goods and services spend relates to premises (£5.9 million), business expenses (£55.6 million) and professional fees (£14.5 million). More detail can be found in Note 5 to the accounts.

Other operating expenditure of £34.4 million (2018/19: 42.4 million) includes expenditure provided to NHS trusts and partners.

Parliamentary cash funding received was £210.2 million with £5.5 million of notional funding received to cover additional NHS pension contribution charges. More details can be found in the accounts.

Net liabilities at 31 March 2020 were £24.5 million (31 March 2019: net liabilities £16.8 million). The increase in net liabilities is mainly due to an increase in trade and other payables due to timing of invoices, which is offset by an increase in the current assets relating to the cash and cash equivalents balance and the receivables balance.

As detailed in note 1.2, the accounts have been prepared on a going concern basis.

## 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 the below table.

### Payment practices

| | 2019/20 | | 2018/19 | |
|---|---|---|---|---|
| | **Number** | **£000** | **Number** | **£000** |
| **Non-NHS payables** | | | | |
| Total non-NHS trade invoices paid in the year | 11,263 | 52,357 | 5,089 | 26,413 |
| Total non-NHS trade invoices paid within target | 10,569 | 49,980 | 4,999 | 25,713 |
| **% of non-NHS trade invoices paid within target** | **94%** | **95%** | **98%** | **97%** |
| | | | | |
| **NHS payables** | | | | |
| Total NHS trade invoices paid in the year | 1,717 | 35,865 | 1,702 | 70,036 |
| Total NHS trade invoices paid within target | 1,587 | 34,755 | 1,627 | 69,323 |
| **% of NHS trade invoices paid within target** | **92%** | **97%** | **96%** | **99%** |

## Financial sustainability

The NHS Long Term Plan sets out five tests for the NHS to meet as we move onto a sustainable financial path whilst delivering core service improvements. Responding to COVID-19 has meant that the timeline for delivering on these tests and delivering all of the NHS Long Term Plan service improvements will be evaluated over the coming months. The NHS has started to put down the foundations of financial sustainability, with the number of NHS providers reporting a deficit falling by half – 53 in 2019/20 against 107 in 2018/19.

## Financial priorities for 2020/21

We will focus on continuing to support the NHS with the resources needed to respond to COVID-19, ensuring that finance is not a barrier to fighting the virus and making sure the NHS comes through this with a pathway to financial sustainability and delivery of the NHS Long Term Plan goals.

**Julian Kelly**
*Chief Financial Officer*

# Our priorities for 2020/21

The NHS Long Term Plan, published in January 2019, will continue to be our focus over the coming years.

Our focus during 2020/21 will be on the continued response to COVID-19, while supporting systems in the restoration of other services that were affected by the COVID-19 pandemic.

We will work with the Government and local systems on the journey to delivering the commitments in the NHS Long Term Plan.

# Accountability Report

Amanda Pritchard
Accounting Officer
15 January 2021

The **Accountability Report** sets out how we meet key accountability requirements to Parliament.

It comprises three key sections:

**The Corporate Governance Report** sets out how we have governed the organisation during 2019/20, including membership and organisation of our governance structures and how they support achievement of our objectives. The report includes the Directors' Report, the Statement of Accounting Officer's Responsibilities and the Governance Statement and starts from page 37.

**The Remuneration and Staff Report** sets out our remuneration policies for non-executive directors and executive directors and how these policies have been implemented for the reporting period, including salary information and pension liabilities. It also provides further detail on remuneration and staff and starts from page 82.

**The Parliamentary Accountability and Audit Report** brings together key information to support accountability to Parliament, including a summary of fees and charges, contingent liabilities and the Certificate and Report of the Comptroller and Auditor General to the House of Commons. The report starts from page 105.

# Corporate Governance Report

## Directors' Report

### The role of the Board

The Board is accountable to the Secretary of State for Health and Social Care for all aspects of NHS Improvement's activities and performance, including those activities carried out in the exercise of NHS TDA's statutory functions. It has reserved key decisions and matters for its own decision, including setting the strategic direction of NHS Improvement, overseeing the delivery of the agreed strategy, determining the approach to risk, agreeing the framework within which operational decisions are taken and establishing the culture and values of the organisation. These are functions and matters that the Board have agreed should be decisions that can only be taken by them. They are set out in the Scheme of Delegation as Statutory Functions, Duties and Powers Reserved to the Board.

Key responsibilities to support its strategic leadership to the organisation include:

- 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 the Department for Health and Social Care 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.

### The Board

The composition of the Board is essential to its success in providing strong and effective leadership. NHS Improvement's Board members bring a wide range of experience, skills and perspectives to the Board. They have strong leadership experience and together set the strategic direction of the organisation and ensure there is robust and open debate during Board deliberations.

From 1 April 2016, the membership of NHS TDA and Monitor boards has been identical and the two boards meet jointly to form the NHS Improvement Board. The NHS Improvement Board is comprised of the Chair, at least four non-executive directors and four executive directors. The number of executive directors on the Board must not exceed the number of non-executive directors. During the year two non-voting associate non-executive directors have also attended the Board.

To support the model of joint working with NHS England, involving shared national directors and functions and integrated regional teams, a new Board governance framework has been introduced. This new framework enables the two Boards to have full oversight of both

organisations, whilst also fulfilling their separate duties, and together they support and challenge the delivery of ICSs and the NHS Long Term Plan. This framework was temporarily changed in April 2020 to manage the COVID-19 incident, with the introduction of the time limited Board committee, the National Incident Response Board, further information on which can be found on page 23.

## Board members

Directors who served on NHS Improvement's Board during the year and their attendance at Board meetings are listed in the table on page 39 and biographical details may be viewed on the website[10].

During the year, the Secretary of State for Health and Social Care approved the transfer of Professor Lord Ara Darzi of Denham's non-executive directorship to NHS England. Richard Douglas CB stepped down from the Board on 31 March 2020.

Julian Kelly was appointed as the joint Chief Financial Officer of NHS England and NHS Improvement from 1 April 2019. Ian Dalton, Chief Executive, left the organisation on 31 August 2019, stepping down as the accounting officer in July. Bill McCarthy, Regional Director for the North West region, was made the Accounting Officer on an interim basis until the end of August 2019. Amanda Pritchard joined as the joint Chief Operating Officer of NHS England and NHS Improvement on 31 July and took on the role of the Chief Executive of NHS Improvement and Accounting Officer on 1 September 2019.

The term for the cross-associate directorship arrangements with NHS England came to an end in early March 2020. As NHS England's and NHS Improvement's Boards meet in common it was agreed that David Roberts, the Vice-Chair of NHS England, associate (non-voting) non-executive directorship on NHS Improvement's Board was no longer required. David Behan, chair of Health Education England, continues as an associate (non-voting) non-executive director for the duration of his term.

10 https://improvement.nhs.uk/about-us/leadership/

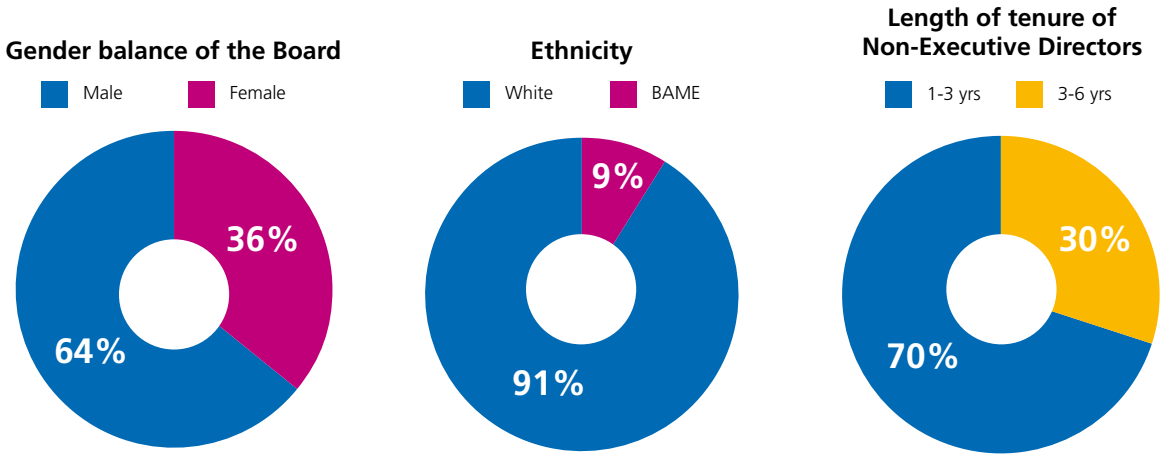
## Board members

| Member | Role | Term ends/notes | Number of eligible Board meetings attended |
|---|---|---|---|
| Baroness Dido Harding | Chair | 30 October 2021 | 5(5) |
| Laura Wade-Gery[11] | Deputy Chair | 31 July 2021 | 4(5) |
| Lord Patrick Carter of Coles | Non-Executive Director (Senior Independent Director) | 30 June 2021 | 4(5) |
| Dr. Timothy Ferris | Non-Executive Director | 31 July 2021 | 5(5) |
| Wol Kolade | Non-Executive Director | 31 July 2021 | 4(5) |
| Sir Andrew Morris | Non-Executive Director | 31 July 2021 | 4(5) |
| David Behan | Associate (non-voting) Non-Executive Director | 31 January 2021 | 4(5) |
| Amanda Pritchard[12] | Chief Operating Officer | Joined on 31 July 2019 | 4(4) |
| Julian Kelly[13] | Chief Financial Officer | Joined on 1 April 2019 | 4(5)[18] |
| Ruth May | Chief Nursing Officer | | 4(5)[18] |
| Prof. Stephen Powis | National Medical Director | Joined on 1 April 2019 | 5(5) |
| **Former members:** | | | |
| Richard Douglas CB[14] | Deputy Chair | Left on 31 March 2020 | 5(5) |
| Prof. the Lord Ara Darzi of Denham[15] | Non-Executive Director | Left on 31 March 2020 | 3(5) |
| David Roberts CBE[16] | Associate (non-voting) Non-Executive Director | Left on 4 March 2020 | 5(5) |
| Ian Dalton[17] | Chief Executive | Left on 31 August 2019 | 1(1) |

11 Laura Wade-Gery took over as the Deputy Chair on 1 April 2020.
12 Amanda Pritchard joined the Board on 1 August 2019.
13 Julian Kelly joined the Board on 1 April 2019.
14 Richard Douglas CB stepped down from the Board on 31 March 2020.
15 Professor the Lord Ara Darzi of Denham's directorship was transferred to NHS England on 1 April 2020.
16 David Robert's Associate (non-voting) Non-Executive directorship came to an end on 31 March 2020.
17 Ian Dalton stepped down as the Chief Executive on 31 August 2019.
18 Due to ongoing work on the organisation's response to COVID-19 a number of Executive Directors sent their apologies for the March 2020 Board meetings as their sole focus was COVID-19 response work.

## Board Diversity

The charts below show composition of the Board members by gender, diversity and tenure as of the date of this report.




## Appointments

The Chair and non-executive directors are appointed by the Secretary of State for Health and Social Care. The Chief Executive is appointed by the Secretary of State and the chair and non-executive directors. The other executive directors are appointed by the Board, subject to the consent of the Secretary of State.

Non-executive directors are appointed to both Monitor and NHS TDA for a period of no more than four years. As non-executive director for Monitor they hold statutory office under Schedule 8 to the Health and Social Care Act 2012 and as non-executive director of NHS TDA they hold statutory office under the National Health Service Trust Development Regulations 2012.

On 1 April 2020, Professor Lord Ara Darzi of Denham's non-executive directorship was transferred to NHS England from NHS Improvement and the appointment will continue until 31 July 2021 when his second term with NHS Improvement would have ended. The rationale behind the transfer is to ensure better balance of the number of non-executive directors on the two boards and provide continuity.

Julian Kelly took on the role as the joint Chief Financial Officer for NHS England and NHS Improvement from 1 April 2019 and Amanda Pritchard joined the organisations on 31 July 2019 as the joint Chief Operating Officer. Amanda took on the role of the Chief Executive and Accounting Officer of NHS Improvement from 1 September 2019.

## The governance structure

Although the organisations operate as one, under the current statutory framework NHS England and NHS Improvement cannot legally have one joint board or joint board committees. Each organisation retains its given statutory functions and NHS Improvement cannot delegate its functions to NHS England, and vice versa. The joint NHS England and NHS Improvement board governance framework in place throughout the year reflects this. It has been designed to enable the Boards together to have full oversight of the organisations whilst retaining their own board and board committees.

The Boards and the board committees therefore operate and meet in common. This allows the organisations to meet together, have joint discussions whilst having separate membership and take their own decisions. There are established procedures in place for dealing with any situations in which a director may find they have a direct or indirect functional, operational or personal interest that conflicts with that of either organisation. Further detail on the Separation of Functions and Conflicts of Interest policy can be found on page 56.

Each Board has been supported in its assurance and oversight of the organisation by eight Board committees, of which all but one have been operating as a committee-in-common. The Board committee structure seeks to align the organisation's long-term strategic approach and is underpinned by a clear division of responsibilities and accountabilities. The committees are all board committees but for reporting purposes three committees, Digital, People and Quality and Innovation, had a dotted reporting line into the Delivery, Quality and Performance Committee, the committee which in 2019/20 was responsible for the oversight of the delivery of the NHS Long Term Plan.

An overview of the Board and Executive Committee framework is shown on the next page and individual Board Committee reports can be found on pages 46 to 56. A report detailing the business considered by the Board Committees is provided to each Board meeting and the terms of references for each Committee are on the website.

## New NHS Improvement governance framework and committees in 2019/20

The new Board and Committees framework formally commenced from 1 April 2019.

**NHS Improvement Board**

| NHS Improvement only Committee | Committees operating as a committee-in-common with NHS England | | | |
|---|---|---|---|---|
| **Provider Oversight Committee** | **Audit and Risk Assurance Committee** | **Delivery, Quality and Performance Committee** | **Strategic HR and Remuneration Committeer** | **Strategy Committee** |
| | | **Main responsibilities** | | |
| Approves formal regulatory action and intervention, including entry and exit of trusts in special measures.<br><br>Approves transactions for trusts in segment 4 or high risk rated.<br><br>Considers regulatory policy. | Provide an independent and objective view of internal control, governance and risk management - including overview of internal and external audit services, governance, risk management and financial reporting. | Review financial and operational performance of the NHS.<br><br>Review delivery and impact of the NHS Long Term Plan.<br><br>Oversee the implementation and delivery of the new NHS financial framework. | Approve the framework and policy for executives.<br><br>Approve individual executive remuneration packages.<br><br>Approve employee policies.<br><br>Review employee engagement initiatives. | Advise and make recommendations on system-wide leadership to the overall NHS. |

| Digital Committee | People Committee | Quality and Innovation Committee |
|---|---|---|
| These committees are Board committees but as they have been delegated oversight of specific areas of the NHS Long Term Plan they reported into the Delivery, Quality and Performance Committee as this committee had overall responsibility for the delivery of the NHS Long Term Plan. | | |
| **Main responsibilities** | | |
| Ensure effective delivery of the digital commitment of the NHS Long Term Plan.<br><br>Ensures alignment of technology initiatives and spend across the system to ensure they are focused on commitments of the NHS Long Term Plan. | Oversee the delivery of the overall people strategy for the NHS.<br><br>Oversee the implementation of key provisions in the NHS People Plan.<br><br>Exercise NHS TDA's powers in relation to chairs and non-executive directors of NHS Trusts. | Determine whether the NHS is maintaining and improving the quality of patient care and health outcomes within the context of delivering the NHS Long Term Plan.<br><br>Oversee implementation of innovation strategies. |

| Trust Appointments and Approvals Committee | Regional Trust Appointments and Approvals Committees |
|---|---|

| | |
|---|---|
| **Joint Finance Advisory Group (NHS Improvement and NHS England)** | The group is advisory only 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. |

## NHS Executive Group

The NHS Executive Group includes corporate and regional directors of each of the directorates of the joint organisation. The Group is chaired by the NHS England CEO and advises on the development and implementation of national policies and programmes, NHS performance and performance of the joint organisation and any other matters that require executive level oversight. The NHS Executive Group is supported by a number of other management groups and processes.

## Key Board roles and responsibilities

Baroness Dido Harding as Chair is responsible for the leadership and effectiveness of the Board. She ensures that new board members receive a tailored induction suited to each director's existing knowledge and experience and works with the chair of NHS England and the Head of Governance (which is a joint role) to agree joint board training and development sessions.

Amanda Pritchard, as the Chief Executive of NHS Improvement, is responsible for providing strategic leadership and the implementation of the agreed strategy and objectives. As the Chief Executive Amanda is also the Accounting Officer for NHS Improvement and is responsible for ensuring that public funds are properly safeguarded and are used in line with NHS Improvement's functions and responsibilities as set out in HM Treasury guidance Managing Public Money. Richard Douglas CB was the Deputy Chair, a role which Laura Wade-Gery took over on 1 April 2020. Lord Carter is the Senior Independent Director.

Their key areas of responsibility are:

**Chair**

Responsible for the leadership and effectiveness of the Board. This involves encouraging a culture of openness and debate to allow the Board to both challenge and support management. The Chair is also responsible for the Board governance, Board performance and stakeholder engagement.

**Chief Executive**

Responsible for the day-to-day leadership of the organisation and the delivery of the strategy. She is supported by the senior leadership team and together they are responsible for the implementation and execution of NHS England's and NHS Improvement's strategy.

**Senior Independent Director**

In addition to the role of non-executive board member, the senior independent director, Lord Carter, acts as confidante to the Chair and an intermediary for other Board members. The senior independent director also performs the annual evaluation of the Chair's performance.

**Non-executive Directors**
Support executive management, whilst providing constructive challenge and rigour and bring sound judgement and objectivity to the Board's decision-making process. Monitor the delivery of strategy within governance framework as set by the Board. Their independence is reviewed annually, and all make monthly declarations of interest. All non-executive directors are considered to be independent.

**Executive Directors**
Executive Directors support the Chief Executive in leading the organisations to deliver its strategic objectives.

## Board activity and administration

The Board meets in common with NHS England's Board and there were five scheduled Board meetings in common during the year. Each Board meeting is divided into a public and a private session. Members of the public can attend and observe the public sessions, which are also available to watch live, or after the event, on our website. The agenda, papers and minutes for the public sessions are published on the website. In addition, there were a number of Board calls where the non-executives were updated on the organisations' response to the COVID-19 pandemic.

All Board meetings are pre-scheduled on a rolling basis. The Board culture is one of openness and collaboration and the Chair ensures that all directors have an opportunity to contribute to debates. There are also regular meetings between the Chair and the non-executive directors and between the Chief Executive and the non-executive directors to allow discussions about the effectiveness of the Board and general matters and views to be shared.

## Key items considered by NHS England and NHS Improvement boards during the year[19]

### Strategy

- Approved the publication of the NHS Long Term Plan implementation framework.
- Approved the publication and implementation of the NHS's patient safety strategy.
- Endorsed a number of items in relation to primary care.
- Approval of the NHS recommendations to Government and Parliament for an NHS Integrated Care Bill.
- Approval of digital-first primary care consultation outcome.
- Endorsed the National Tariff proposals.
- Considered a five year framework for GP contract reform.
- Approved items no longer to be routinely prescribed in primary care.
- Approved the transfer of the Supply Chain Company Limited.

19 where applicable the individual boards have made the decisions.

### Performance

- Reviewed regular financial and operational performance updates.
- Received regular updates on providers currently in special measures or at risk of entering special measures.
- Considered the NHS operational planning and contracting guidance for 2020/21.
- Updates on the organisations' response to COVID-19.

### Leadership and people

- Considered key aspects of the People Plan.
- Received regular progress updates on the integration with NHS England.
- Approval of measures to address pension issues.

### Governance and risk

- Approved a new joint corporate risk register and risk appetite.
- Received regular EU exit updates.
- Approved terms of reference for the Board Committees.

## Review of Board effectiveness and performance evaluation

Good governance provides that an evaluation of the performance of the board and its committees, together with the effectiveness of the chair and non-executive directors, should be carried out annually. During the year an informal review of the effectiveness of the Board and the Committees was carried out. This was then supported by a formal internal governance review carried out by NHS England's internal auditors, Deloitte in May 2020. The findings from both reviews and changes made to the governance structure was considered and agreed by the Boards in June 2020 and a summary will be provided in the next annual report.

# Board Committees

## Audit and Risk Assurance Committee

### Role of the Committee

The Committee's primary role is to assist the Board in fulfilling its oversight responsibilities in relation to financial reporting, systems of internal control and risk management processes. This includes an overview of the quality and integrity of NHS England's and NHS Improvement's financial reporting and the management of the internal and external audit services.

The Committee meets in common with NHS England's Audit and Risk Assurance Committee.

### Committee members

The Committee met five times and the following table details membership and the number of meetings attended by each member during the year:

| Member | Number of eligible meetings attended during the year | Comment |
|---|---|---|
| Wol Kolade (Chair) | 2/5 | Chair from 1 April 2020 |
| Sir Andrew Morris | 4/5 | |
| **Previous member** | | |
| Richard Douglas CB | 4/5 | Chair to 31 March 2020 |

Wol Kolade is the Chair of the Committee and as the managing partner of a private equity firm has valuable and recent financial experience. As a committee there is a good balance of skills and knowledge covering accountancy, finance (both public and private) and clinical services. The Board is therefore satisfied that the members possess the financial knowledge and commercial experience to carry out the Committees duties.

### Attendees

Additional attendees are invited to attend meetings to assist with committee business. For 2019/20 these included, among others, the Chief Executive of NHS England, the Chief Executive of NHS Improvement and Chief Operating Officer, the Chief Financial Officer, the National Director: Transformation and Corporate Development, the Director of Governance and Legal Services, the Director of Financial Control as well as representatives from the external auditors the National Audit Office (NAO), the internal auditors Price Waterhouse Coopers and DHSC. The internal auditors meet regularly with the Committee without management present. The external auditors have also met with the Committee on one occasion during the year.

## Principal activities during the year

As part of ensuring the integrity of the organisation's financial statements, systems of internal control and risk management processes, the Committee:

- Approved the internal audit plan and considered regular progress reports from the internal auditors.
- Approved the new joint Risk Management Framework, considered the Joint Corporate Risk Register and risk appetite for submission to the Boards and agreed a programme of risk deep-dives.
- Considered accounting matters, disclosures and judgements in relation to the financial statements, including the impact of IFRS16 - leases.
- Considered reports from the external auditors, the NAO, on their audit planning report, the achievement of value for money and findings of the audit of the financial statements of Monitor, NHS TDA and the consolidated provider accounts.
- Assessed the integrity of Monitor's, NHS TDA's, consolidated provider and consolidated foundation trust financial reporting.
- Approved of Monitor's, NHS TDA's, consolidated provider and consolidated foundation trust 2018/19 annual report and accounts.
- Reviewed arrangements for counter fraud, including the approval of joint NHS England and NHS Improvement Tackling Fraud, Bribery and Corruption: Policy and Corporate Procedures.
- Reviewed the Economic Crime Strategy.
- Reviewed the framework for Third Party Assurance.
- Considered adoption of standards for Portfolio and Project Management and assurance reports against them.

## Internal audit

The internal auditor, Price Waterhouse Coopers, plays an important part in supporting the assurance role of the Committees.

At the start of each financial year the Committee approves an annual plan of internal audit activity, which is structured to align with key strategic priorities and key risks and is developed with input from management. At each meeting the Committee receives an independent assurance from the internal auditor and reviews the result of that work together with management's progress in strengthening and enhancing internal controls where areas for improvement have been identified. The Committee works closely with the Head of Internal Audit and their teams who have full access to the organisation.

## Financial reporting

As part of ensuring the integrity of the organisation's financial statements the Committee received regular updates on accounting matters, disclosures and judgements and reviewed management's approach to managing any issues and risks. They also received regular progress updates from the external auditors, the NAO, on the audit of the financial statements.

## Digital Committee

### Role of the Committee

The Committee's role is to provide advice and, where appropriate, make recommendations on strategic implications of technology within the context of the NHS Long Term Plan, and to ensure effective delivery of digital commitments and alignment of technology initiatives and spend across the system to focus on those commitments in the NHS Long Term Plan. The Committee is also responsible for providing assurance on the operating model and governance of digital implementation within the remit of NHS England, NHS Improvement, NHS Digital and other Arms Length Bodies (ALBs).

The Committee meets in common with NHS England's Digital Committee.

### Committee members

The Committee met four times and the following table details membership and the number of meetings attended by each member during the year:

| Member | Number of eligible meetings attended during the year | Comment |
|---|---|---|
| Laura Wade-Gery (Chair) | 4/4 | |
| Dr. Timothy Ferris | 3/4 | |
| Simon Eccles | 3/4 | Chief Clinical Information Officer |
| Matthew Gould CMG MBE | 3/4 | National Director Digital Transformation and Chief Executive NHSX |
| Hugh McCaughey | 3/4 | National Director of Improvement |
| **Previous members** | | |
| Will Smart | 1/1 | Chief Information Officer. Left the organisations in September 2019 |

### Attendees

Additional attendees are invited to attend meetings to assist with committee business. For 2019/20 these included, among others, the Chief Executive of NHS Digital and non-executive directors of NHS Digital.

### Principal activities during the year

Considerable time was spent during the year to consider the model for digital transformation, the digital transformation programme portfolio and an update on a number of associated transformation programmes. Other reports to the Committee included:

- Digital advice to STPs/ICSs for NHS Long Term Plan development.
- Accelerating Implementation of the Local Health and Care Records Programme.
- Theory of change regarding adoption of new technologies.
- Proposals for patient empowerment.
- Strategic screening platform and short term solutions.
- Screening Programme in NHSX.
- Digital Aspirant Programme.

### NHSX

NHSX is responsible for providing digital and technology input into the NHS Long Term Plan implementation plan, the People Plan, and 2020/21 financial prioritisation. The Committee received regular updates from the National Director Digital Transformation (also the Chief Executive of NHSX) including updates on NHSX's portfolio prioritisation process.

## Delivery, Quality and Performance Committee

### Role of the Committee

The Committee's role was to oversee operational, quality and financial planning and performance of the provider sector and oversee the delivery of the NHS Long Term Plan. It considers the annual capital plan for NHS providers, approves change and capital schemes submitted by NHS providers and monitors their revenue and capital expenditure. It also scrutinises the performance of NHS Improvement.

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

### Committee members

The Committee met five times and the following table details membership and the number of meetings attended by each member during the year:

| Member | Number of eligible meetings attended during the year | Comment |
|---|---|---|
| Baroness Dido Harding (Chair) | 5/5 | |
| Richard Douglas CB | 5/5 | |
| Lord Patrick Carter | 3/5 | |
| Wol Kolade | 4/5 | |
| Laura Wade-Gery | 3/3 | |
| Amanda Pritchard | 3/3 | Member from 1 August 2019 |
| Julian Kelly | 5/5 | |
| Ruth May | 5/5 | |
| Prof. Stephen Powis | 5/5 | |
| **Previous members** | | |
| Tim Ferris | 0/1 | |

### Principal activities during the year

In supporting the financial position across the wider NHS, the Committee has together with NHS England's Delivery, Quality and Performance Committee considered the following core reports during the year:

- Operational, quality and financial performance of NHS providers and the commissioning sector.
- Operational planning reports for the winter period.
- NHS trusts receiving intensive support.
- The implementation of the NHS Long Term Plan.
- The 2018/19 annual performance assessment of each Clinical Commissioning Group.
- National operational plan for specialised services in 2019/20 and 2020/21.
- The approach to establishing ICSs.
- Deep dive into EU Exit readiness.
- The joint NHS England and NHS Improvement 2019/20 business plan.
- Updates on NHS England's and NHS Improvement's joint working programme including the new operating model.

Prior to the submission to the DHSC and HM Treasury the Committee approved the following business cases:

- Northumberland, Tyne and Wear NHS Foundation Trust Strategic Outline Case.
- South West London and St George's Mental Health NHS Trust Estates Modernisation Programme.
- Mid and South Essex STP Strategic Outline Case: reconfiguration of hospital services at the Mid and South Essex Acute Hospitals.
- Calderdale & Huddersfield NHS Foundation Trust - reconfiguration of hospital services at Calderdale and Huddersfield Acute Hospitals.

## Strategic Human Resources, Nominations and Remuneration Committee

### Role of the Committee

The remuneration of executive and senior managers (ESMs) is governed by the DHSC's Executive and Senior Manager Pay Framework for ALBs (DHSC's pay framework). Working together with NHS England's Strategic HR and Remuneration Committee, the Committee's role is to ensure the two organisations have a single formal, robust and transparent remuneration policy that is in line with DSHC's pay framework. The Committee considers and approves remuneration, benefits and terms of service for senior executives covered by DHSC's pay framework before submission to DHSC for approval. The Committee's role also involves employee remuneration and engagement matters.

The Committee is also responsible for people and organisational development policies, ways of working designed to ensure the workforce of NHS Improvement is appropriately engaged and motivated, including staff engagement. The Committee also reviews the organisation's gender pay gap and ensures that NHS Improvement develops policies and actions to reduce the gender pay gap, reviewing progress to increase BAME representation at senior levels within the organisation and initiatives relating to diversity and inclusion.

The Committee delegates certain functions to the Executive HR Group and receives regular reports from this group on cases considered and approved.

## Committee members

The Committee met four times and the following table details membership and the number of meetings attended by each member during the year:

| Member | Number of eligible meetings attended during the year |
|---|---|
| Laura Wade-Gery (Chair) | 4/4 |
| Lord Patrick Carter of Coles | 2/4 |
| Baroness Dido Harding | 4/4 |

## Committee attendees

Additional attendees are invited to attend meetings to assist with committee business. For 2019/20 these included the CEO, National Director: Transformation and Corporate Development and Director of Human Resources and Organisation Development.

## Principal activities during the year

Reports considered by the Committee included:

- Proposals for a joint NHS England and NHS Improvement ESM pay framework.
- Approved the total individual remuneration for senior executives and other senior employees whose proposed salary was in excess of £150,000.
- The proposed ESM structure for NHSX and the People Directorate.
- Approved, in line with DHSC recommendation, annual salary increases for ESMs.
- Approved an annual salary increase for employees not on Agenda for Change terms and conditions.
- Received regular progress updates on the Joint Working Programme.
- Approved, as part of the Joint Working Programme, redundancy payments.
- Approved the joint NHS England and NHS Improvement Strategic inclusion and diversity policy.
- Approved the publication of the gender pay gap report.
- Reviewed progress made against the Workforce Race Equality Standards.

### Other

The Committee also had an informal session with the NHS England and NHS Improvement People Committees and NHS England's Strategic HR and Remuneration Committee on the new joint NHS England and NHS Improvement operating model and culture.

## Provider Oversight Committee

### Role of the Committee

The Committee is responsible for providing strategic oversight of transactions and investments, regulatory policies and decision, including those relating to special measures.

### Committee members

The Committee met 11 times and the following table details membership and the number of meetings attended by each member during the year:

| Member | Number of eligible meetings attended during the year | Comment |
|---|---|---|
| Amanda Pritchard (Chair) | 6/8 | Chief Executive, NHS Improvement, and Chief Operating Officer. Member from 1 August 2019 |
| Julian Kelly | 8/11 | |
| Prof. Stephen Powis | 8/11 | |
| Prerana Issar | 1/11 | Chief People Officer |
| Hugh McCaughey | 8/11 | National Director of Improvement |
| Kate Moore | 10/11 | NHS Improvement General Counsel, non-voting |
| Miranda Carter | 11/11 | Director of Provider Development |
| Sandra Easton | 5/5 | Director of Operational Finance and Performance. Member from October 2019. |
| 7 regional Directors of Strategy and Transformation | | |
| **Previous members** | | |
| Ian Dalton | 2/2 | Chief Executive, NHS Improvement to 31 August 2019 |
| Keziah Halliday | 5/6 | Director of Oversight and Assessment. Member until October 2019. |

### Committee attendees

Additional attendees are invited to attend meetings to assist with committee business. For 2019/20 these included the Director of Intensive Support and regional Senior Oversight and Regulation Leads (or equivalent).

### Principal activities during the year

During the year the Committee considered the following:

- The development of groups, where trusts collaborate to take advantage of combined capacity and scale in a number of areas.
- The development of a new NHS Oversight Framework for providers and clinical commissioning groups.
- The process to manage non-submission of Cost Collections.
- The approach to the development of provider policy.

With regard to transactions involving NHS foundation trusts and NHS trusts, the Committee considered:

- The proposed acquisition of Royal Liverpool and Broadgreen University Hospitals NHS Trust by Aintree University Hospital NHS Foundation Trust.
- Strategic case reviews of Pennine transactions and Pennine Acute Hospitals NHS Trust – Interim Solution.
- Proposed acquisition of North Cumbria University Hospitals NHS Trust by Cumbria Partnership NHS Foundation Trust.
- Longer term solutions for the sustainability of services at Isle of Wight NHS Trust.
- Proposal by Frimley Health NHS Foundation Trust to establish a wholly-owned subsidiary to deliver estates, facilities, procurement and other services.

At recommendations made by the Regions, the Committee approved:

- A number of trusts being placed in special measures, for quality and/or financial reasons.
- A number of trusts existing special measures.

The Committee also received regular reports on providers in special measures or at the risk of entering the regime and considered proposals to update the risk assessment framework for independent sector providers of NHS services.

## People Committee

### Role of the Committee

Meeting together with NHS England's People Committee, the Committee's role was to work collaboratively with national partners to oversee and challenge the delivery of the overall people strategy for NHS providers.

The Committee also exercises NHS TDA's powers in relation to NHS trusts and other duties delegated to the organisation by the Secretary of State for Health and Social Care and has delegated certain functions to two sub-committees, the Trust Appointments and Approvals Committee and the Regional Trust Appointments and Approval Committee.

## Committee members

The Committee met four times and the following table details membership and the number of meetings attended by each member during the year:

| Member | Number of eligible meetings attended during the year | Comment |
|---|---|---|
| Sir Andrew Morris (Chair) | 4/4 | |
| Sir David Behan | 4/4 | Chair of Health Education England |
| Prerana Issar | 4/4 | Chief People Officer |
| Amanda Prichard | 0/2 | Member from 1 August 2019 |

## Committee attendees

Additional attendees are invited to attend meetings to assist with committee business. For 2019/20 these included the Chair of NHS Improvement and representatives from the Senior Appointments and Resourcing Function and the Leadership Academy.

## Principal activities during the year

In its work to oversee and challenge the delivery of the overall people strategy for NHS providers, the Committee's key considerations included:

- Progress in delivering the 2019/20 actions from the Interim People Plan.
- Updates on the development of the full People Plan.
- Updates from the Leadership Academy.
- The main findings and recommendations arising from the Lord Holmes[20] review into opening up public appointments to disabled people and regular progress updates on actions being taken by NHS England and NHS Improvement in response to the findings.
- Approved the introduction of a common chair competency and appraisal framework.

## Statutory function

The Board has delegated NHS TDA's powers, as delegated by the Secretary of State for Health and Social Care, to appoint chairs and non-executive directors of NHS trusts, and suspend and terminate those appointments to the Committee. The Committee is also responsible for specific matters relating to remuneration and termination of office in NHS trusts. To assist the Committee in carrying out these duties, it has established and delegated certain of these duties to two sub-committees, the Trust Approvals and Appointments (TAAC) and the Regional TAACs.

TAAC consists of the Committee Chair, the Chief Operating Officer/Chief Executive and two Regional Directors (rotating annually). Their remit includes approval of NHS trust chair appointments and NHS Trust termination cases. During the year TAAC considered 43 cases. There is a Regional TAAC for each of the seven regions and the membership is made up of

20 https://www.gov.uk/government/publications/the-lord-holmes-review

the Regional Director, senior members of the Regional Directors team and a member of the national Senior Appointments and Resourcing team. Each of these committees are, amongst other things, responsible for approving NHS trust non-executive director appointments and proposed salaries for very senior managers at NHS trusts whose proposed salary exceeds a certain amount. At each meeting the People Committee received a report of approvals made by the two sub-committees.

The People Committee has retained certain aspects of the appointments functions such as the approval of policies and procedures and during the year considered:

- Proposals to align remuneration for chairs and non-executive directors of NHS trusts and NHS foundation trusts.
- The development of a revised pay framework for very senior managers.

## Quality and Innovation Committee

### Role of the Committee

This Committee's primary role is to provide strategic oversight of NHS quality issues and performance, including assurance of reporting and escalation mechanisms between regional and corporate directors, and establishing a quality improvement culture across NHS England and NHS Improvement.

### Committee members

The Committee met four times and the following table details membership and the number of meetings attended by each member during the year:

| Member | Number of eligible meetings attended during the year |
|---|---|
| Professor the Lord Ara Darzi of Denham (Chair) | 4/4 |
| Dr. Timothy Ferris | 3/4 |
| Prof. Stephen Powis | 4/4 |
| Ruth May | 4/4 |
| Patient and Public Voice members | 3/4 |

### Committee attendees

Additional attendees are invited to attend meetings to assist with committee business. For 2019/20 these included National Director of Patient Safety, Head of Quality Strategy and the Director of Clinical Policy, Quality and Operations.

### Quality of patient care

A large part of the Committee's remit is to monitor and determine whether the NHS is maintaining and improving the quality of patient care and health outcomes with the context of delivering the NHS Long Term Plan. In doing this the Committee has considered:

- Proposals for strategic oversight of NHS quality issues and performance, including assurance of reporting and escalation mechanisms between regional and corporate directorates.
- Quality metrics and reporting.
- Governance arrangements for the implementation of the NHS Patient Safety Strategy.
- The role of learning disabilities nurses in delivering the NHS Long Term Plan.

### Other

Other items considered included:

- Regular updates from the Executive Quality Group.
- Updates on the Learning Disability Mortality Review Programme.
- Updates on Freedom to Speak Up issues and cases.
- Patient stories.

More information on the Quality and Innovation Committee can be found in our governance statement from page 71.

## Strategy Committee

It was decided that rather than having a formal committee, seminar style sessions were held with external presenters and attendees to consider key future development areas and/or topics that would assist in moving the strategic agenda for the NHS forward. Two such sessions were held. The first considered health and care data and the second session covered integrated care policy.

## Board disclosures

### Functions in the joint working arrangements – separation and conflict of interest

NHS England and NHS Improvement's joint working arrangements involve the exercise of statutory functions of the organisation's constituent bodies in an aligned way under a single operating model. Directorates and teams within the new structure may be performing both NHS England and NHS Improvement functions. NHS England, Monitor and NHS TDA however remain separate bodies with distinct statutory roles and responsibilities. In some cases, the functions and decision-making of those bodies must remain independent and separate, to ensure compliance with the bodies' respective statutory functions and/or to avoid inherent conflicts of interest that would arise if the functions were exercised by the same part of the organisation ('functional conflicts'). In addition, even where a standing separation of functions is not required, the exercise of different functions by the same directorate or team may give rise to an actual or potential conflict in an individual case ('operational conflicts').

NHS England and NHS Improvement must ensure the effective discharge of their respective statutory functions in accordance with public law principles and be able to identify and manage the risk of conflict (real or perceived) appropriately and transparently. To manage this the organisations have a Separation of Functions and Conflicts of Interest policy which provides guidance for staff on managing functional and operational conflicts. This policy is not concerned with the declaration and management of personal interests held by individuals. Such conflicts continue to be dealt with in accordance with the Standards of Business Conduct policy which applies to the NHS as a whole.

In addition to the issues raised by joint working, NHS Improvement is vigilant about the possibility of either an actual or perceived functional conflict of interest arising from the exercise of its different statutory functions, 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.

With a view to complying with those duties, NHS Improvement now applies the Separation of Functions and Conflicts of Interest policy referred to above to such conflicts. NHS Improvement continues to recognise there is a difference between cases where there is an actual or reasonably perceived conflict arising from the exercise of different functions, and situations which are in reality not conflicts but operational manifestations of the overlap between different NHS Improvement functions: these will be Board disclosures 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 2019/20 and to the date of this report, so no statements were published.

## Register of Board members interests

Personal interests held by Board and Committee members are managed according to NHS England's Standing Orders, NHS Improvement's Rules of Procedure and the joint standards of Business Conduct policy. The organisation also maintains a register of members' interests to ensure that potential conflicts of interests can be identified and addressed before Board and Committee discussions. Board members and executives are also required at the start of each Board and Committee meeting to declare any personal interest they might have in any business on the agenda and abstain from relevant Board or Committee discussion as required. Where potential conflicts arise, they are recorded in the Board and Committee minutes along with any appropriate action to address them. Any interests declared are then recorded on the register and signed off by the Board and executives on a regular basis. A copy of the register of interest is available on the website[21].

Details of related party transactions, where NHS Improvement has transacted with other organisations during the year to which a Board or an executive is connected, are set out in Note 14 on page 134.

## Directors' third-party indemnity provisions

NHS Improvement has appropriate directors' and officers' liability insurance in place for legal action against, among others, its executive and non-executive directors. NHS Improvement did not indemnify any director during 2019/20.

## Human Rights

NHS England and NHS Improvement support the Government's objectives to eradicate modern slavery and human trafficking. A joint NHS England and NHS Improvement Slavery and Human Trafficking Statement[22] for the financial year ending 31 March 2020 was published in May 2020. Our strategy on tackling fraud, bribery and corruption can be found on the website[23].

## Disclosure of personal data-related incidents

NHS England and NHS Improvement follow the NHS Digital Data Security and Protection (DSP) incident reporting process guidance in the reporting of incidents. This is in line with data protection legislation following the introduction of the General Data Protection Regulation (GDPR) in May 2018.

The 'Guide to the Notification of Data Security and Protection Incidents' was released in September 2018. This sets out the reporting requirements for NHS organisations where a potential or actual incident may lead to a personal data breach defined under the Data Protection Act 2018 and GDPR. The new scoring criteria references the circumstances where notification to the Information Commissioner's Office (ICO) may not be necessary and has resulted in a reduction in the number of incidents classified as notifiable.

As at 31 March 2020, no incidents had occurred relating to the loss of personal data.

21 https://www.england.nhs.uk/publication/our-board-members-register-of-interests/
22 https://www.england.nhs.uk/safeguarding/slavery-human-trafficking-statement/
23 https://www.england.nhs.uk/publication/tackling-fraud-bribery-and-corruption-economic-crime-strategy-2018-2021/

## Disclosure of information to auditors

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.

## Directors' responsibility 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 the business model, performance and strategy.

## Events after year-end

On 1 April 2020, the NHS England and NHS Improvement Boards established a time limited board committee, the COVID-19 National Incident Response Board, to provide oversight of the NHS England and NHS Improvement response to COVID-19 pandemic.

# Statement of Accounting Officer's responsibilities

Under the National Health Service Act 2006, the Secretary of State for Health and Social Care (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 income and expenditure, Statement of Financial Position 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 (HM Treasury, December 2019)[24] and in particular to:

- observe the Accounts Direction issued by the DHSC, including the relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis;
- make judgements and estimates on a reasonable basis;
- state whether applicable accounting standards, as set out in the Government Financial Reporting Manual, have been followed and disclose and explain any material departures in the financial statements;
- prepare the financial statements on a going concern basis; and
- confirm that the Annual Report and Accounts as a whole is fair, balanced and understandable and take personal responsibility for the Annual Report and Accounts and the judgements required for determining that it is fair, balanced and understandable.

The Accounting Officer of the DHSC has designated me as Accounting Officer for NHS TDA. The responsibilities of the Accounting Officer, including responsibilities 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 (HM Treasury, July 2013, as amended March 2018[25].

As the Accounting Officer, I have taken all the steps that I ought to have taken to make myself aware of any relevant audit information and to establish that the Comptroller and Auditor General is aware of that information. So far as I am aware, there is no relevant audit information of which the Comptroller and Auditor General is unaware.

24 https://www.gov.uk/government/publications/government-financial-reporting-manual-2018-to-2019
25 https://www.gov.uk/government/publications/managing-public-money

# Governance Statement

NHS Improvement's Board is committed to achieving high standards of integrity, ethics and professionalism across all our areas of activity. As a fundamental part of this commitment, we support and adopt best practice standards of corporate governance in the statutory framework. This annual governance statement sets out how we have managed and controlled our resources in 2019/20 to enable this.

As Accounting Officer, I have responsibility for the system of internal controls supporting and enabling the achievement of NHS Improvement's aims and objectives, whilst safeguarding the public funds and assets for which I am personally responsible in accordance with Managing Public Money and as set out in my Accounting Officer appointment letter.

## The Government's Accountability Framework 2019/20

The Government's 2019/20 Accountability Framework with NHS England and NHS Improvement incorporates the statutory annual mandate to NHS England and annual remit for NHS Improvement. The framework sets out the expectations for NHS England and NHS Improvement to deliver the first year of the NHS Long Term Plan and address the immediate needs associated with EU exit.

The 2019/20 Accountability Framework is aligned with the long-term vision and direction for the health service and sets out a single set of objectives for NHS England and NHS Improvement. This reflects our shared responsibility for leading the NHS in implementing the NHS Long Term Plan.

## Governance arrangements and effectiveness

### Governance framework

The Rules of Procedure brings together all key strands of governance and assurance; including Standing Orders, Standing Financial Instructions (SFI), Scheme of Delegation, Standards of Business Conduct Policy, Joint Risk Management Framework and three lines of defence model. During 2019/20 work has been undertaken to harmonise the governance processes across NHS England and NHS Improvement wherever possible.

## Assessment against the Corporate Governance in Central Government Departments: Code of Good Practice 2017 Compliance Checklist

As part of implementing best practice, an assessment is undertaken each year against the Corporate Governance in central Government departments: Code of good practice 2017 (HM Treasury). NHS Improvement is compliant against the provisions of the code, with the following exceptions[26]:

| Ref | NHS foundation trust code of governance - code provision | Ref | Cabinet Office code of good practice – code provision | Exception |
|---|---|---|---|---|
| **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. | | N/A | For NHS TDA, the Chief Executive is appointed by the Secretary of State for Health and Social Care, and other executives are appointed by NHS TDA's Chief Executive. |
| **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 | | N/A | 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 | 4.7 | Through the Board Secretariat, the Department provides the necessary resources for developing the knowledge and capabilities of Board members, including access to its operations and staff. | This responsibility is shared between the Chair, Chief Executive's Office and Board Secretary. |
| | N/A | 4.11 | The Board Secretary's responsibilities include: Arranging induction and professional development of Board Members. | This responsibility is shared between the Chair, Chief Executive's office and Board Secretary. |
| | N/A | 5.5 | The Head of Internal Audit is periodically invited to attend Board meetings, where key issues are discussed relating to governance, risk management, or control issues across the department and its ALBs. | The Head of Internal Audit routinely attends meetings of the ARAC. |

26 It should be noted that the following provisions in the code are not applicable to NHS Improvement: Sections 1, 2.3, 2.11, 3.3a, 3.3b, 3.3c, 3.6e, 3.7, 3.8, 3.9, 3.14, 3.19, 4.9, 4.12, 4.13, 4.14, 5.7, 5.8 and 6.

## Board arrangements

Information on our Board and its Committees is set out from page 37.

## NHS England and NHS Improvement's joint operating model

In 2019/20 NHS England and NHS Improvement moved to a single leadership model under the Chief Executive Officer of NHS England and a single Chief Operating Officer (COO), who is also the Chief Executive Officer and Accounting Officer of NHS Improvement.

The NHS England CEO holds responsibility for the overall leadership of the NHS in England. The COO's responsibilities include the operational delivery of the NHS in England and the NHS Long Term Plan.

As set out on page 37 new national director roles have been established, either reporting to the NHS England CEO or COO. Seven regional teams have been established to carry out the functions of both NHS England and NHS Improvement in each of their localities; this supports the local systems to provide more joined up and sustainable care for patients. With responsibility for the quality, financial and operational performance of all NHS organisations in their region, they support teams to improve services for patients, as well as supporting local transformation by developing further the identity of STPs and ICSs.

By working in a more integrated way at all levels of our health and care services ('system by default'), we will deliver better outcomes for patients, better value for taxpayers and better job satisfaction for our staff.

## Harris Review

The Harris review recommended greater assurance at board and departmental level that all statutory functions in the health and social care landscape are being exercised appropriately. As part of the new operating model, a detailed register of these core statutory duties and powers has been developed. This provides clarity about the legislative requirements associated with each function, including any restrictions of delegation of those functions. Responsibility for each duty and power has been clearly allocated to a national director (or equivalent) and the register is regularly reviewed by the Director of Governance and Legal. The Board is cognisant that Monitor and NHS TDA remain separate legal entities with separate powers and functions.

## Corporate assurance

The Corporate Assurance Framework, set out below, provides for continuous and reliable assurance on organisational stewardship and the management of significant risks to organisational success and the delivery of improved, cost effective, public services.

NHS Improvement has continued to use the three lines of defence model. This provides the mechanism for employees to manage risk and control as well as provide assurance over the delivery of services.

| Assurance activity | What is it? | What Value does it give? |
|---|---|---|
| **Organisational Change framework** | Guidelines for assessing and implementing major changes across NHS England. | The framework provides a consistent approach to thinking about the impact of organisational change, including people, infrastructure, financial and legal issues. |
| **Risk Management framework** | Our approach to managing risk, including tools and methodologies for identifying, assessing, documenting and reporting risk | The framework enables a consistent approach to be taken across the organisation, allowing identification of cross-directorate risks and challenges. It provides a mechanism for managers to identify risks with a route of escalation to those accountable. |
| **SFIs, Rules of Procedure & Scheme of Delegation** | These documents protect both the organisation's interests and protect officers from possible accusation that they have acted less than properly | Together, these documents ensure that our financial transactions, accountabilities and responsibilities are carried out in accordance with the law and Government policy in order to achieve probity, accuracy, economy, efficiency and effectiveness. |
| **Programme Management framework** | The policies, tools, methodology and resources that provide an approach to managing, controlling and assuring the delivery of projects and programmes in the organisational portfolio | Provides staff with a framework to manage, control and deliver projects and programmes. Provides the organisation with consistency of reporting and monitoring, confidence of delivery of outcomes to enable decision making and better resource control. |
| **3rd Party Assurance framework** | Guidelines for the assurance required for managing 3rd party contracts | Ensures directorates responsible for major contracts assign a Contract manager and put arrangements in place to monitor supplier performance. Obtains assurance over the services provided. |
| **Corporate Policy framework** | The methodology and approach for creating, maintaining and amending policies | Provides an approach to help ensure policy documents are not developed in isolation, so they are balanced against the priorities of the organisation. |

We work with the support of both our internal and external auditors to strengthen and embed our assurance framework. Each directorate and region have designated leads with responsibility for ensuring that risk management, implementation of internal audit actions and other key assurance activities are carried out and approved by the relevant senior director, including appropriate regular reporting and exception escalation processes. The leads link with the governance, audit and risk teams to provide increased focus, accountability and improved communication at operating level across the organisation.

During 2019/20, the corporate compliance team has worked with teams across the organisation to embed controls and underpin processes including:

- Introducing a harmonised Standards of Business Conduct Policy across NHS England and NHS Improvement to ensure that staff were working to consistent requirements.
- The introduction of electronic platforms for risk management, staff declarations and the completion of management actions arising from internal audit reviews.

## Management Assurance

Throughout 2019/20, the Board has been provided with regular updates on the implementation of the priorities and programmes that were committed to in the NHS Long Term Plan. Matters relating to individual programmes were also considered within the formal committees of the Board, including the Delivery, Quality and Performance Committee.

In addition, the Audit and Risk Assurance Committee considers the outcomes of internal audit reviews of programmes and the Executive Risk Management Group (ERMG) reviews our corporate risks which can include causes, consequences, controls and actions relating to individual programmes.

Underpinning the above corporate governance arrangements, individual programme boards and oversight groups meet frequently, with the attendance of representatives from national and regional teams, each with responsibility for delivery of their programme, for example Urgent & Emergency Care, Primary Care etc. The Audit and Risk Assurance Committee receives reports on their adherence to good programme governance standards.

### Assuring the quality of data and reporting

The Board has agreed the information it requires in order to carry out its duties. This performance information is subject to scrutiny by both management and the Delivery, Quality and Performance Committee. The Board is confident that the data presented in the performance reports has been through appropriate review and scrutiny, and that it continues to evolve to meet changing organisational needs.

## Risk governance

NHS England's and NHS Improvement's Boards are responsible for ensuring delivery of the strategies and goals outlined in the joint 2019/20 business plan.

Detailed plans are drawn up for each area with input from staff and risks against their achievement are reported to the Boards. The internal audit team consider the risks to NHS England and NHS Improvement and this directs the internal audit priorities reflected in the annual internal audit plan.

NHS England's Audit and Risk Assurance Committee is responsible for reviewing the establishment and maintenance of an effective system of governance, risk management and internal control covering all of NHS England's activities. The Committee considers risks faced by the joint organisation on a bi-annual basis and reports conclusions directly to the Boards. 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.

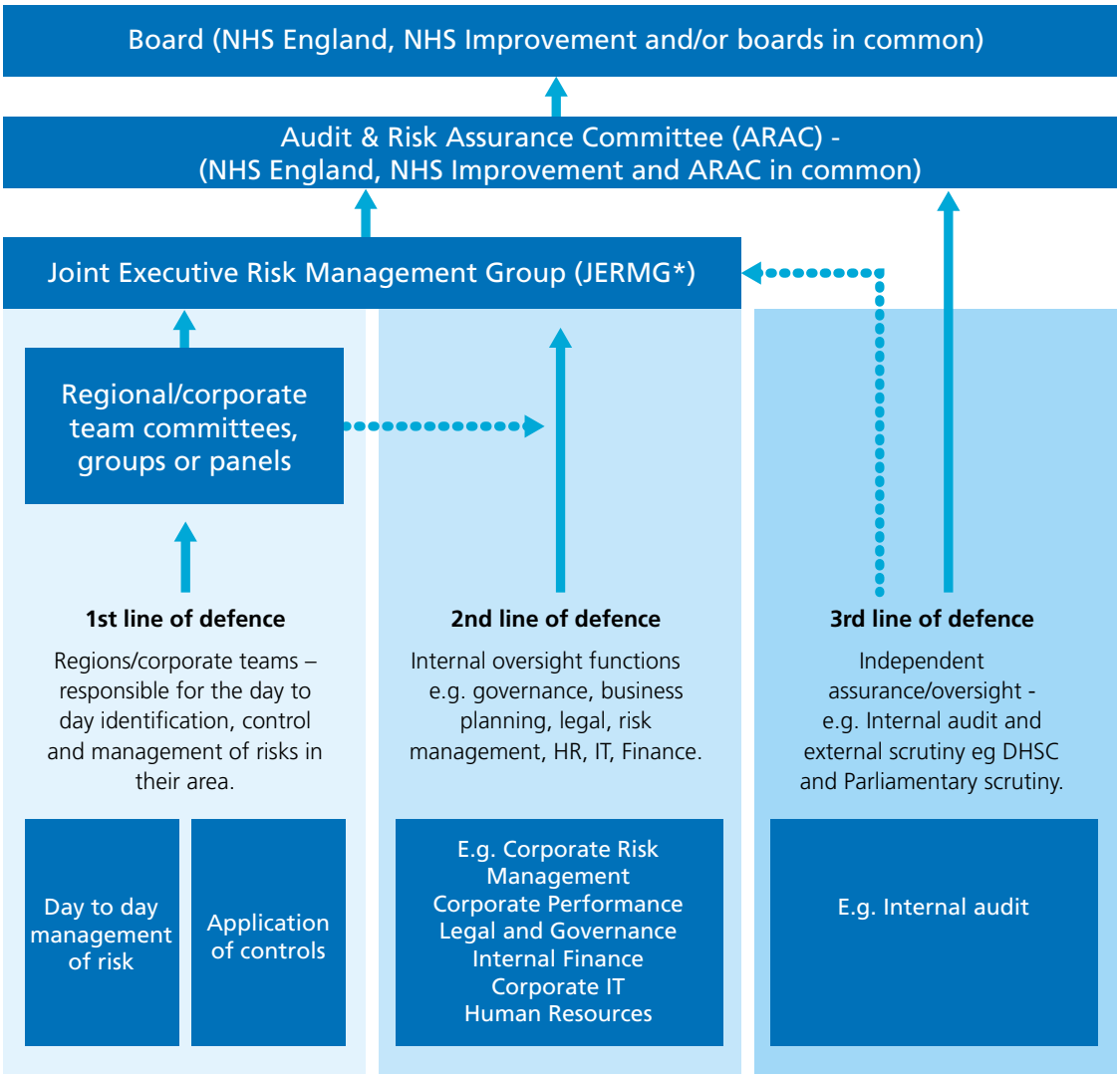
The internal audit team provides regular reports to the Audit and Risk Assurance Committee based on its work programme. The Boards discuss the most significant risks and actions identified to mitigate their likelihood and impact. Each year, the Audit and Risk Assurance Committee evaluates the effectiveness of the risk management framework and approves the annual internal audit plan for the following year.

The position of Chief Risk Officer/Senior Responsible Officer (SRO) for risk for NHS England and NHS Improvement has been delivered by the National Director of Transformation and Corporate Development for 2019/20 to further ensure senior sponsorship for risk at executive level. From April 2020 this role has passed to the Chief Financial Officer.

The executive team owns the corporate risks and nominates a responsible officer for each one. The approach is supported by the joint NHS England and NHS Improvement risk management framework which underpins the monitoring and management of risk. The joint executive risk management group (JERMG) has met quarterly over the year and is responsible for providing assurance to the Committee about how risks across the joint organisation are being managed. The JERMG reviews all risks escalated to it and considers which risks should be managed through the Joint Corporate Risk Register (JCRR) and associated processes. JERMG also oversees implementation of NHS England's and NHS Improvement's new joint risk management framework. The NHS Executive also periodically reviews the JCRR and when appropriate undertakes deeper dives. From April 2020, the JERMG is subsumed into the NHS Executive, where there is a regular standing item to discuss the JCRR. The National Incident Response Board also considers the strategic risks in responding to the COVID-19 incident and these are fed into the JCRR where relevant and reported to the NHS Executive.

Our executives are responsible for managing risk at a directorate/regional level (i.e. at the project delivery and day-to-day operational level). Each directorate therefore also holds its own risk register and reviews its risks on a regular basis.

The joint risk management framework mirrors the three lines of defence of our overarching assurance framework:




* From April 2020, the JERMG is subsumed into the NHS Executive

## Risk and Control Framework

In 2019/20 NHS England and NHS Improvement developed a joint risk management framework to ensure that all employees follow a single process for identifying and managing risks that may threaten delivery of services and achievement of objectives. This new framework 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 directorate risk leads have continued to share good practice, provide information on new and existing risks, and co-ordinate and support the embedding of an appropriate risk management culture. Improvements in the quality of directorate risk registers and the JCRR, migrated onto an electronic platform throughout 2019/20, have continued. We aim to continually improve our risk management maturity and risk culture year-on-year.

## Principal Risks

In 2019/20 the NHS Executive undertook a full review of the three organisations' existing risk exposure and potential future risks, developing a JCRR. The JCRR considers a full cross section of risks to the organisations in their combined aims including strategic risks, reputational risks, financial risks, operational risks and risks to the achievement of the organisations' shared objectives, as well as external threats.

Outside of the COVID-19 incident and for the most part of 2019/20, the principal risks facing NHS England and NHS Improvement included:

| Risk description | Key mitigation(s) in place included |
|---|---|
| **EU Exit:** There is a risk that EU Exit may result in disruption of day to day operations of the health and care system because the UK's future relationship with the EU is not adequately resolved before the end of the Implementation Period | • Single NHS England and NHS Improvement EU Exit function<br>• National guidance for the NHS<br>• National and local EPRR and business continuity plans |
| **NHS Workforce Capacity:** Workforce interventions do not address the full gap between workforce demand and supply | • NHS People Plan<br>• National People Board<br>• Primary Care Oversight Group<br>• General Practice Forward View |
| **Urgent and Emergency Care:** Demand for urgent and emergency care exceeds the capacity available to meet it, undermining providers' ability to meet performance targets | • National oversight process<br>• Capacity planning reviews<br>• Same Day Emergency Care (SDEC) Accelerator programme<br>• Frequent monitoring of demand and drivers<br>• Winter planning |
| **Demand for Elective Care:** Demand exceeds the capacity available to meet it, undermining providers' ability to meet performance and access targets | • National and regional monitoring<br>• RightCare programme comprehensively implemented to reduce unwarranted variation |
| **Primary Care and System Transformation:** Failure to achieve the ambitions for all integrated care systems in the NHS Long Term Plan and the five key service changes; boost hospital care, redesign and reduce pressure on emergency hospital services, more personalised care, digitally enabled primary and outpatient care, and a focus on population health | • NHS England and NHS Improvement System Transformation Board<br>• Primary Care Long Term Plan, GP contract, and General Practice Forward View commitments monitored through the Primary Care Strategic Oversight Group<br>• Establishment and development of PCNs |

## Risk Appetite

In 2019/20 NHS England and NHS Improvement developed a joint approach to risk appetite, which we have defined as 'the amount of risk that we are willing to seek or accept in the pursuit of long-term objectives.'

The risk appetite is grounded in the NHS Constitution. The NHS Constitution sets out rights to which patients, public and staff are entitled, and pledges which the NHS is committed to achieve, together with responsibilities which the public, patients and staff owe to one another to ensure the NHS operates fairly and effectively.

NHS England and NHS Improvement believe no risk exists in isolation from others and that risk management is about finding the right balance between risks and opportunities to act in the best interests of patients and tax payers. Our approach to risk appetite involves risk trade-off conversations and a consideration of the counterfactual - giving us a flexible framework within which we can try new things, make agile decisions and find a balance between boldness and caution, risk and reward, cost and benefit. It also aims to provide a balance between an approach which is excessively bureaucratic and burdensome and one which lacks rigour.

When balancing risks, we will tolerate some more than others. For example, we will seek to minimise avoidable risks to patient safety in the delivery of quality care. In the case of innovation or proof of concept we are prepared to take managed 'moderate to high risk' on the proviso that the following has been undertaken:

- An assessment of what and where the current risks are.
- That the potential future impact has been understood and agreed.
- Rapid cycle monitoring is in place to enable swift corrective action should things go wrong.
- Consideration of the system's ability to respond i.e., different regions face different circumstances and some areas are very challenged.
- Trade-off between risks is understood / assessment of unintended impacts on other risks undertaken (i.e., whether it will lead to an increase or reduction in other categories of risk).
- Cost–benefit analysis and stated preference is undertaken.
- Reliability and validity of data used to make the assessment has been considered.
- Counterfactual risks have been considered to ensure management apply any learning before taking the risk.
- We can demonstrate significant and measurable potential benefits (i.e., enhanced efficiency and/or value-for-money delivery).

Categories of risk, alongside stated tolerances, are summarised in the table below:

| Category of Risk | Tolerance |
|---|---|
| Patient Safety and Quality of Care | Very Low |
| Performance (operational and financial) | Moderate |
| Innovation | Moderate to High |
| Finance | Low |
| Compliance and Regulatory risk | Moderate |
| Reputation | Low to Moderate |
| Operational risk | Moderate |

### COVID-19

NHS England's and NHS Improvement's risk management approach has adapted to support management of the NHS response to the level 4 incident, COVID-19.

The Corporate Risk Team supported development and management of the COVID-19 Strategic Risk Register overseen by the National Incident Response Board. These risks are now recorded within the JCRR.

## Freedom to Speak Up

Listening to NHS staff who speak up helps improve staff experience and patient care. NHS staff raised concerns with us, at a similar level to previous years: 182 compared to 190 in 2018/19. These numbers do not necessarily indicate increasing problems. They could equally reflect staff awareness of the importance of speaking up and know how to do so.

The primary reasons for contacting us were discontent with their local employer's response and/or concern they may suffer detriment by raising their issues directly with their local employer.

### Whistleblowing in the provider sector

In November 2019 NHS England and NHS Improvement launched our whistleblower support scheme to help whistleblowers return to work in primary and 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. We have received 12 applications under this new scheme, who will benefit from coaching and have access to training and work placements or shadowing where appropriate. This scheme provides a useful opportunity to further understand the difficulties that whistleblowers face and how, through the People Plan, we can use the learning from the scheme to better support workers who speak up.

Most of the cases we received related to bullying and harassment, patient safety, and issues related to leadership and or the board of the respective organisation. These cases indicate that barriers remain to staff feeling free to speak up, however we are working with the National Guardian's Office (NGO) to remove these barriers. This includes working with the NGO to review how we can use data to identify key indicators of effectiveness in Freedom to Speak Up (FTSU) arrangements, trialling an approach in the Model Hospital.

The board guidance and self-assessment tool that we jointly published with the NGO in 2018 was updated this year in the light of feedback from trusts that used it, producing a more useful resource for assessing and improving FTSU arrangements and culture. From this, we have specifically supported 26 trusts this year to improve their FTSU arrangements and culture, ranging from reviewing their board papers and discussions with executive FTSU leads to running board development workshops on FTSU. This work aligns the importance of improving leadership culture and valuing the views of staff, which is a key focus of our People Plan.

We take the cases we receive very seriously and took enforcement action in 160 (88%) of them, as shown in the below diagram. This included 10 cases (almost 6%) 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 14 (8%) cases because the individual raising

a concern did not provide enough information, the information related solely to an individual employment matter (in which we have no jurisdiction) or the concerns were about earlier matters and not indicative of current problems.

**Qualifying disclosures (103) ***

| Action taken (89) | Enquiries to the trust (47) | Further action taken (14) | No action taken (14) |
|---|---|---|---|
| Communication with individual (65) | Closed with no further action (23) | Provided improvement support (4) | Insufficient detail (2) |
| Referred to CQC (24) | Closed following action (14) | Oversaw external investigation (10) | No permission to act on information received (3) |
| Enquiries to CQC (7) | Ongoing enquiries (10) | Ongoing initial assessment (3) | Ongoing initial assessment (3) |
| | | | Historic - no current indicators of concern (6) |

**Non-Qualifying disclosures (79)***

| Action taken (71) | Enquiries to the trust (18) | Further action taken (1) | No action taken (8) |
|---|---|---|---|
| Communication with individual (65) | Closed with no further action (17) | Provided advice (1) | Insufficient detail (4) |
| Referred to CQC (4) | Closed following action (1) | | Individual employment matter (1) |
| Enquiries to CQC (3) | | | Ongoing initial assessment (1) |
| | | | Historic - no current indicators of concern (2) |

*NB: multiple actions may have been taken in some cases: for example, we may have engaged with an individual and referred to an alternative body.

This year we have received an increasing number of cases relating to individual employment matters, which are outside our remit. However, in some cases where an individual case has potentially indicated broader issues with HR practice and governance, we have made enquiries to a trust to understand how they have acted on the recommendations from the letter from NHS Improvement's Chair, Baroness Dido Harding, in May 2019, which made recommendations for all trusts to improve their people practices. These recommendations followed the independent review into the tragic death of Amin Abdullah at Imperial College Healthcare NHS Trust.

## Clinical assurance

### Assuring the quality of services

The Boards of NHS England and of NHS Improvement have both established Quality and Innovation Committees to meet in common to support the discharge of each Board's respective duties and powers and their combined responsibilities for quality.

The Quality and Innovation Committee's duties can be described across four broad functions:

### The escalation of quality issues and sharing of learning

The Committee facilitates the sharing of data and intelligence about quality risks and issues and the sharing of learning and best practice at national level. The Quality and Innovation Committee has been supported in doing this by regional routine reporting which is filtered up through a new group – the Executive Quality Group co-chaired by the National Medical Director and Chief Nursing Officer bringing together the Regional Medical Directors, Regional Chief Nurses and senior national colleagues. This builds on the arrangements that have been in place for several years in NHS England and NHS Improvement prior to the joint working arrangements.

The Executive Quality Group (EQG) receives routine quarterly reports from the Regional Teams. It takes actions to address any risks and issues raised in these reports by coordinating national and regional action and will escalate to the Quality and Innovation Committee if required.

Working in conjunction with the Executive Quality Group the Quality and Innovation Committee:

- Oversees the identification and deployment of appropriate resources to tackle escalated quality risks and issues, and supports quality improvement activities at national level.
- Escalates quality risks and issues to the Delivery, Quality and Performance Committee if required.
- Refers national cross-system quality risks and issues to the National Quality Board[27].

### Assurance of quality functions and duties

The Quality and Innovation Committee seeks assurance from executives that robust mechanisms are in place to manage quality functions, including that quality risks and issues are managed at regional to national levels. It also receives reports and updates on relevant NHS England and NHS Improvement quality functions, programmes and initiatives. This includes statutory functions such as arrangements for safeguarding and controlled drugs; clinical effectiveness functions such as the commissioning of national clinical audits; patient safety functions and implementation of the patient safety strategy; and patient experience functions including complaints and surveys.

### National measures for quality

A small and manageable number of quality indicators are selected to show national trends over time and provide a balance across the domains of quality (effective, safe and positive experience) and across care settings.

The Quality and Innovation Committee indicator set uses high-level indicators aligned to the NHS Long Term Plan. When any of these selected indicators shows significant deterioration or moderation in the rate of improvement, the Quality and Innovation Committee discusses potential causes and directs a bespoke analysis.

27 The National Quality Board brings together the clinical leadership for quality for NHS England, NHS Improvement, CQC, PHE, NICE, HEE, NHSD, DHSC and Healthwatch

## Thematic reviews

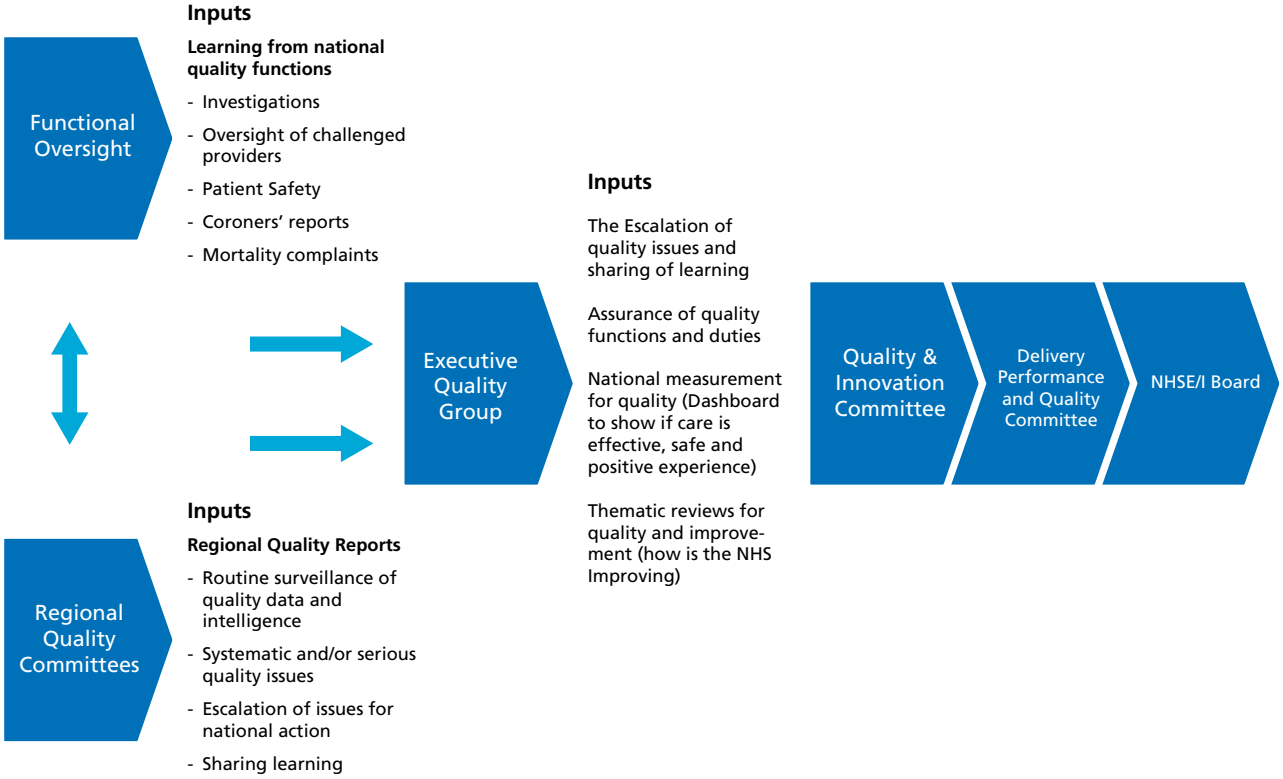
Based on the above inputs and intelligence from members, the Committee also conducts thematic reviews and deep dives. This analysis is used to determine what strategic actions are needed to initiate/accelerate improvement. The Board also looks at national improvement programmes, their models for improvement and how they are ensuring those improvements result in better outcomes for patients.

Since its establishment the Quality and Innovation Committee has also focussed on the following areas:

- Lessons and actions from the Gosport Independent Review Panel report.
- Quality of inpatient mental health services for children and young people.
- Implementation of the Patient Safety Strategy for the Learning Disability nursing profession and its importance in providing high quality care to people with learning disabilities and autistic people.
- Revised Quality and Innovation Committee data dashboard.

During the COVID-19 pandemic, NHS England and NHS Improvement have adapted their quality and safety functions in a proportionate manner that supports the focus on the response to COVID-19 while at the same time ensures the oversight of quality is maintained. It is the responsibility of Regional Medical Directors and Chief Nurses to escalate issues to the EQG, whilst also observing regional EPRR escalation processes. The EQG is meeting virtually and continues to take regional reports.

### NHS England and NHS Improvement Quality Governance and Oversight



## STPs and ICSs

In 2019/20, NHS England and NHS Improvement set out the operational, leadership and governance arrangements that should be in place in every system by 2021.

Over the last year STPs and ICSs have continued to strengthen and develop their governance arrangements. To support this, the minimum requirements for the establishment of ICSs have been agreed and published as part of the 2020/21 planning guidance and NHS Long Term Plan Implementation Framework.

We have engaged with health and care systems and membership bodies to discuss the principles that underpin ICSs. The aim of this work is to provide further clarification and guidance to the health system on the operating arrangements of ICSs in future, to support all STPs to become ICSs by April 2021.

A new ICS accountability and performance framework is being developed to consolidate current accountability arrangements and provide a consistent and comparable set of performance measures. It will include an 'integration index' which will measure the progress being made on integration. ICSs will agree system-wide objectives and be accountable for their performance against these objectives.

## Duty to review regulatory burdens

Under the 2012 Act, NHS Improvement is required to keep the exercise of 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 the process for carrying out impact assessments of policies and proposals.

## NHS Oversight Framework 2019/20

### Oversight of NHS foundation trusts and NHS trusts

In 2019/20 NHS England and NHS Improvement merged their regional teams. Working with the NHS England's Oversight and Assessment Team, who have been responsible for the annual assessment of CCGs, we developed the NHS Oversight Framework for 2019/20. This replaced the separate provider Single Oversight Framework[28] and the CCG Improvement and Assessment Framework.

No material changes were made to the mechanics of provider (or CCG) oversight. The information used, triggers of concern and the approach to assessing their support needs remained the same.

28 https://improvement.nhs.uk/resources/single-oversight-framework/

The published framework sets out a new way of working, including:

- NHS England and NHS Improvement teams speaking with a single voice, setting consistent expectations of systems and their constituent organisations.
- A greater emphasis on system performance, alongside the contribution of individual healthcare providers and commissioners to system goals.
- Oversight teams working with and through system leaders, wherever possible, to tackle problems.
- Matching accountability for results with improvement support, as appropriate.
- Greater autonomy for systems with evidenced capability for collective working and track record of successful delivery of NHS priorities.

In March 2020, at the onset of the COVID-19 pandemic, we chose to relax certain elements of our regulatory approach in order to free up resources at NHS providers. We worked with colleagues across NHS England and NHS Improvement to issue guidance covering many elements of oversight, including:

- Changing oversight interactions with organisations and systems to remote rather than face-to-face.
- Relaxing organisations' internal governance requirements where appropriate.
- Adjusting annual reporting requirements.
- Suspending certain data collections.

These elements are designed to provide assurance over provider performance and governance during 'normal' operations across the NHS. However, given the severity and the unprecedented nature of the situation, we considered that these could be suspended to provide additional resource and operational freedoms to providers. Further information of the actions taken can be found on our website[29].

### Independent Provider oversight

In February 2020 NHS Improvement formally consulted on a series of proposed updates to the Risk Assessment Framework for Independent Providers.

Where possible the proposals have been designed to reduce the burden of regulation for licensed providers under financial oversight by:

- Reducing and refocussing information requirements to where they add most value.
- Streamlining our approach to ensure it is timely, efficient and – at busy times of the year for providers – less likely to clash with external audit activities.

Publication of a consultation response document and updated Risk Assessment Framework is currently paused due to the COVID-19 response.

29 https://www.england.nhs.uk/coronavirus/wp-content/uploads/sites/52/2020/03/C0113-reducing-burden-and-releasingcapacity-at-nhs-providers-and-commissioners.pdf

## Other assurance

### Cyber and data security

The NHSX cyber security team provides the strategic direction for cyber security in the health and social care sectors. In November 2019, the Securing Cyber Resilience Update was published, highlighting significant progress made in key areas. This included supporting NHS organisations to migrate to the Windows 10 Operating System, which is more secure and more efficient to use. The deployment of Microsoft Defender Advanced Threat Protection (ATP) now covers most Windows devices in the NHS, with the ability to detect and prevent cyber threats.

NHSX and NHS Digital have worked with the National Cyber Security Centre (NCSC) to incorporate the requirements of recognised external cyber security standards including Cyber Essentials into the Data Security and Protection Toolkit (DSPT) to form a single data and cyber security standard for the NHS. The DSPT helps organisations understand their data and cyber security risks and measures their compliance with mandatory cyber standards for their type of NHS or social care organisation.

The Network and Information Systems (NIS) Regulations have been used to increase compliance in the NHS with mandated standards such as responses to high severity cyber alerts.

NHSX allocated £23.62 million capital funding to address critical infrastructure weaknesses in NHS organisations. Using evidence gathered through NHS Digital's on-site assessments and other data available to help assess organisations' security risks, our regional teams worked with local organisations to identify priorities for available capital investment, ensuring they were consistent with local plans for digital transformation.

Working in partnership with NHS Digital, the Cyber Associates Network has been established and developed into the leading network for health and care cyber security professionals. Engagement events held in November 2019 were attended by more than 300 members of the network, providing key opportunities for networking, collaborating and knowledge sharing.

NHSX has worked with NCSC and NHS Digital to define the cyber security standards needed for the Local Health and Care Record (LHCR) localities. Security assessments and attack tree workshops have been carried out across a number of LHCR regions. A bespoke LHCR cyber security framework has also been published which provides further support and guidance to local cyber security leads.

In response to COVID-19, NHSX put in place additional measures to prevent a cyber attack or major IT outage and to make sure that, if such an event did happen, NHSX and its delivery partners could help local organisations get back up and running as quickly as possible.

### Information Governance (IG)

Work continues to develop a joint IG operating model across NHS England and NHS Improvement to ensure both organisations remain compliant in relation to data protection, records management and information security activities. The IG teams now operate as a single service and workstreams have been realigned to support specific areas: Data Governance, Corporate Records and Information Management, IG Delivery and IG Assurance and Planning, supporting national and regional teams.

We have developed a Joint Controller and Information Sharing Framework Agreement to govern the processing of personal data by the NHS England and NHS Improvement joint enterprise. We have also developed a similar agreement between the NHSX partners (NHS England, NHS Improvement and DHSC). These set out the agreed responsibilities of the organisations, establishing effective procedures to ensure that the partners in these joint working initiatives comply with data protection legislation.

A new Information Governance Assurance team has been established to undertake pro-active compliance reviews with our teams and suppliers regarding processing of personal data lawfully under GDPR and the Data Protection Act 2018.

The Corporate Records and Information Management team have been working with local records and information management coordinators to ensure we work in a compliant manner. The team continues to support all relevant statutory and public inquiries including the Infected Blood Inquiry, the Gosport Inquiry and the Independent Inquiry into Child Sexual Abuse.

NHS England and NHS Improvement have aligned key datasets and are continuing to review data sharing agreements with NHS Digital with a view to reducing duplication of data flows to increase efficiency and reduce cost.

### Business critical models

NHS England and NHS Improvement recognise the importance of quality assurance across the full range of its analytical work and have developed a joint approach that is consistent with the recommendations in Sir Nicholas Macpherson's review of quality assurance of Government analytical models (2013).

NHS England and NHS Improvement analysts are expected to ensure consistent performance and quality assurance across their analytical work. For business critical models, where an error would have a significant patient care or other impact, NHS England and NHS Improvement have been developing a common framework to operating a register of business critical models and auditing of the quality assurance strategy associated with them.

The diversion of analytical resources to the COVID-19 response has meant that the development of this framework, the associated register and the review of the quality assurance included in the register is in process. Provisionally, business critical models operated by NHS England and NHS improvement include:

- CCG revenue allocations models.
- CCG revenue allocations – exceptional registration change adjustment.
- Cardiovascular disease (CVD) respiratory NHS Long Term Plan commitments modelling.
- Financial trajectories model.
- GP referral analysis.
- Long Term Financial model.
- Low Priority Prescribing (LPP) indicator.
- National diabetes prevention programme budget model.
- People analysis.
- Pharmacy services fee setting to pharmacy integration fund pilot services.
- Pricing calculation model.
- Pricing impact assessment model.
- PCNs – investment and impact fund.
- Referral to treatment time ready reckoner.
- Unavoidable costs (incurred by small acute providers).

### Internal audit

The internal audit service plays a significant role in the independent review of the effectiveness of management controls, risk management, compliance and governance by:

- auditing the application of risk management and the internal control framework;
- reviewing key systems and processes;
- providing advice to management on internal control implications of proposed and emerging changes;
- being available to guide managers ad staff on improvements in internal controls; and
- focusing audit activity on key business risks.

Our internal audit service, provided by Price Waterhouse Coopers, operates in accordance with Public Sector Audit Standards and to an annual internal audit plan approved by the Audit and Risk Assurance Committee.

The internal audit service submits regular reports on the effectiveness of our systems of internal control and management of key business risks, together with recommendations for improvement by management (including an agreed timetable for action). The status of audit recommendations is reported to each meeting of the Audit and Risk Assurance Committee.

Due to the focus on COVID-19, the Committee agreed that six audits would not occur, with remaining audit days used to support the COVID-19 incident response.

In 2020/21 NHS England and NHS Improvement will move to an internal audit service provided by a single supplier.

The Head of Internal Audit Opinion for 2019/20 is set out from page 81.

### External Audit

During the year, the Audit and Risk Assurance Committee has worked constructively with the NAO Director responsible for health and his team. The work of external audit sits outside our governance arrangements but independently informs our consideration of control, compliance, governance and risk. The work of external audit is monitored by the Audit and Risk Assurance Committee through regular progress reports. These include summaries of the value for money work that is either directly relevant to our work or may provide useful insights to the Committee.

## Control issues

During 2019/20 we have worked to build controls into management processes previously identified as requiring improvement:

### Assurance framework for business critical models

Although the formal assessment of the quality assurance of analytical models has not been completed for this year's report, this should not be taken to indicate that quality assurance has not happened.

For instance, prior to the decision to adopt fixed provider payments during the COVID-19 response, work to set national tariffs was well advanced. This work included correcting a previously incorrect inclusion of a currency, relating to mental health services for Alzheimer's patients, that should have been subject to local price setting. For 2020/21 this currency has correctly been excluded from the proposed tariff, but a balancing adjustment to the total tariff quantum was omitted, meaning all national prices in the consultation tariff are 0.2% too high.

This would have meant a small but significant impact on the distribution of net resources between providers and commissioners. Checks to reconcile price setting with other budgetary analysis identified the issue and so identified an appropriate correction before the tariff was finalised for the then expected implementation.

NHS England and NHS Improvement will complete this work during 2020/21 and further embed a shared culture of quality assurance across all our analytical work.

### NHSX governance arrangements

As part of the 'Being Excellent' programme initiated in October 2019 several workstreams were established following the completion of the formative stage in December. One of the workstreams was the 'Governance and Assurance workstream'. The Programme is set to deliver in three phases, the first of which was January-March 2020. The purpose of phase one was primarily to identify gaps and opportunities, develop systems and processes to support

NHSX responsibilities, recommending and implementing delegations and enablers, as well as the professional capability required to deliver its plans. Due to the focus on responding to the COVID-19 pandemic, phase two is ongoing.

## Review of economy, efficiency and effective use of resources

### Financial performance monitoring

In 2019/20 NHS England and NHS Improvement have aligned financial performance monitoring across commissioner and provider sectors. At all levels the two organisations have been jointly assessing the combined financial and operational position across local systems and the NHS as a whole, resulting in joint reporting and review at Board level.

### Central programme costs

One-year allocations were agreed for 2019/20 for our central programme resources and service development funding. Most of this resource has been made available for direct investment to deliver on the priorities and objectives outlined in the NHS Long Term Plan, in collaboration with STPs and ICSs, and focusing on priorities such as Urgent and Emergency Care, Primary Care, Cancer and Mental Health. The remaining available funding covers a variety of other operational commitments and charges for depreciation.

### Cabinet Office efficiency controls

As part of the Government's control of expenditure, we are subject to specified expenditure controls. These controls cover a range of expenditure categories and require proposed expenditure to be approved to secure best value for money and ensure efficiency is being maximised. For expenditure above certain thresholds in specified categories (e.g., professional services and consultancy), approval is also sought from DHSC and for some cases this also requires approval from the Cabinet Office and/or HM Treasury.

In anticipation of the impact of COVID-19, additional commercial guidance was issued internally in alignment with Cabinet Office guidance to ensure control and best value for money could be secured in a timely way.

### Counter fraud

NHS England and NHS Improvement investigate allegations of fraud related to our functions, where these are not undertaken by the NHS Counter Fraud Authority (NHSCFA), in addition to ensuring that appropriate anti-fraud arrangements are in place.

The directly employed NHS England Counter Fraud Team was established in 2018. The team assumed responsibility for NHS Improvement on 1 April 2019, becoming the NHS England and NHS Improvement Counter Fraud Team. To reflect these arrangements the Tackling Fraud, Bribery and Corruption Policy and Economic Crime Strategy was reviewed, updated and approved by the Audit and Risk Assurance Committee.

The Committee receives regular updates regarding the counter fraud function, proactive counter fraud work and the outcome of reactive investigations, as well as an Annual Counter Fraud Report. The Director of Financial Control has day-to-day operational responsibility for the NHS England and NHS Improvement counter fraud function, and the Chief Financial Officer provides executive support and direction.

The NHSCFA undertakes an annual high-level estimate of the potential scale of fraud affecting the whole of the NHS. Its Strategic Intelligence Assessment for 2018/19 was recently published and reduced the estimated value of fraud from £1.27 billion to £1.21 billion which NHSCFA together with its partners have responsibility for tackling. This estimate relates to the entire NHS, 49% of this estimate relates to primary care, which is primarily but not exclusively relevant to NHS England and NHS Improvement.

A number of initiatives continue to tackle the fraud risk in primary care, including the Prescription Exemption Checking Service, the Dental Benefit Eligibility Checking Service and other contractor focussed services managed by NHSBSA on behalf of NHS England. These schemes are designed to have a significant deterrent impact, resulting in net recoveries and behavioural change benefits of £36 million in 2019/20.

## Head of Internal Audit Opinion

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.

In light of the COVID-19 outbreak it was agreed with management that not all of the planned reviews would take place, specifically: Challenged Providers, EU exit, Network Information Security Directive (phase 2); Succession Planning, Outpatient Transformation, Well-led Framework Implementation follow-up. Although these reviews have not taken place, we are able to comment on the governance, risk and controls based on the work undertaken to provide an opinion.

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 2019/20.  Some improvements are required to enhance the adequacy and effectiveness of the framework of governance, risk management and control.

# Remuneration and Staff Report

## Staff report

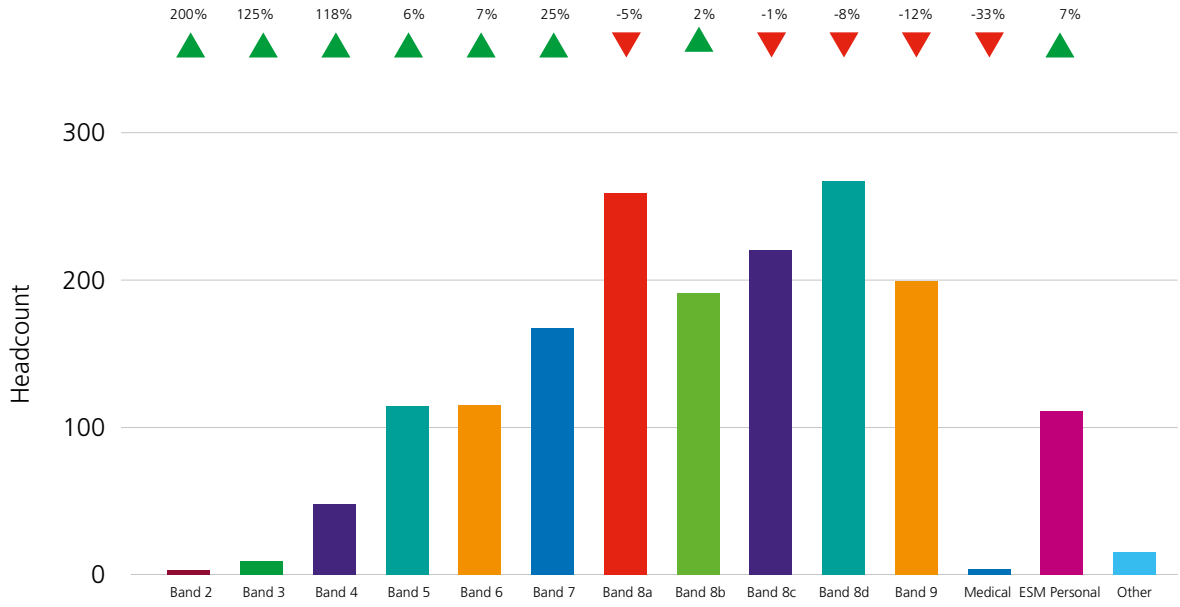
### Our people

On 31 March 2020, NHS Improvement directly employed 1,722 staff. Of these, 1,462 people were permanently employed on recurrent, open-ended contracts of employment, based around the country within our directorates and regions. A further 260 people were employed on payroll on fixed term contracts of employment.

Detail on staff numbers and costs for NHS Improvement are presented from page 90.

### All staff by grade

The headcount of permanent and fixed term staff in NHS Improvement by grade is summarised in the table below.




Our Joint Working Programme has been designed to strengthen our joint working relationship and deliver a new operating model so that collectively we can add greater value to the NHS.

The following organisational activities have been undertaken to ensure the ongoing advancement of our people to enable the continued delivery of the business plan.

## Employment policies

We have a range of employment policies to support all staff which have been consulted on with trade unions and have been regularly reviewed to ensure they are in line with legislative changes. To support the alignment of NHS England and NHS TDA and Monitor, joint policies have and are being drafted to apply across the three employers. This is with the intention of ensuring consistency in the way in which individuals are managed and rewarded. Most staff are employed on NHS terms and conditions, whilst some Monitor staff are employed under their legally contractual terms.

## Offer to Monitor staff to change pay and conditions

During 2019 all Monitor staff were given the opportunity to transfer to NHS TDA terms and conditions. This involved consultation in partnership with trade unions and extensive communication with those involved to ensure they had the necessary information and support to assist them in making the decision. The information provided included total reward statements which summarised the pay and other contractual benefits individuals would receive by either changing employer or remaining on Monitor terms. As of March 2020, 127 staff have chosen to transfer to NHS TDA terms.

## Partnership working

We work in partnership with our recognised trade unions on a range of employment related and other issues, including organisational change. A National Joint Working Partnership Forum was established in 2018 with staff-side representation from all of our recognised trade unions and management representation from our three employers.

## Trade Union (TU) facility time

Facility time is paid time off for representatives to carry out TU-related activities. The information below relates to TU facility time within NHS Improvement. Activities cross both NHS TDA and Monitor and so combined figures have been provided.

a) TU representative: the total number of employees who were TU representatives during the relevant period:

| Number of employees who were relevant union officials during the relevant period | FTE employee number |
|---|---|
| 7 | 7 |

b) Percentage of time spent on facility time (duties and activities).

| Percentage of time | Number of employees |
|---|---|
| 0% | 5 |
| 1-50% | 2 |
| 51%-99% | n/a |
| 100% | n/a |

c) Percentage of pay bill spent on facility time:

| Figures | Figures |
|---|---|
| Total cost of facility time | £6,078 |
| Total pay bill | £94.9m |
| Percentage of the total pay bill spent on facility time | 0.01% |

d) Paid TU activities:

| Figures | Figures |
|---|---|
| Time spent on paid TU activities as a percentage of total paid facility time hours | 10% |

## Equal opportunities, diversity and inclusion

A joint NHS England and NHS Improvement Diversity and Inclusion strategy, From Ambition to Action, has been developed which sets out how the organisation will work towards improving the working lives of our diverse workforce. This mirrors the NHS People Plan's ambition for the NHS to become the best employer and complies with the Workforce Race Equality Standard Model Employer guidance.

The four areas of the strategy include leadership and culture change, accountability and assurance, positive action and specialist support. Several interventions to support delivery of the strategy have been piloted and evaluated and are now being rolled out across the joint organisation.

For example, we are breaking down hierarchies through reverse mentoring programmes where people in less senior pay bands are matched with more senior managers. We have also focused on improving our recruitment practice through inclusive recruitment guidance, supported by bespoke training which has been delivered to over 1,400 staff. We carry out equality impact assessments on our policies and processes and have implemented a new reasonable adjustment process that includes a workplace adjustment passport.

## Joint working

We ensured that diversity and inclusion were embedded into decision making throughout all phases of joint working. This included carrying out equality impact assessments during the change programme, involving senior equality and diversity representatives in senior recruitment activity and bringing together and ensuring more collaboration on all staff networks and our diversity steering group.

## Our Equality Standards

To support our Public Sector Equality Duty as a joint organisation, we participate in external monitoring standards which hold us accountable for improving workforce diversity and equality. These are the Workforce Race Equality Standard (WRES), the Stonewall Workplace Equality Index, and we will be participating in the newly-launched Workforce Disability Equality Standard.

Our organisational accreditations include Disability Confident Employer, which commits us to a wide range of actions to attract, recruit, retain and support staff who are disabled and differently-abled. We are also a Mindful Employer which reflects our pledge to end stigma around mental health.

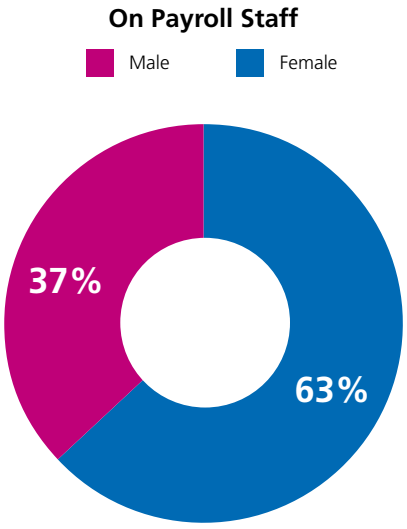
As a Stonewall Diversity Champion we draw on best practice to make our workplace safe and hospitable for colleagues of all gender identities and sexual orientations.

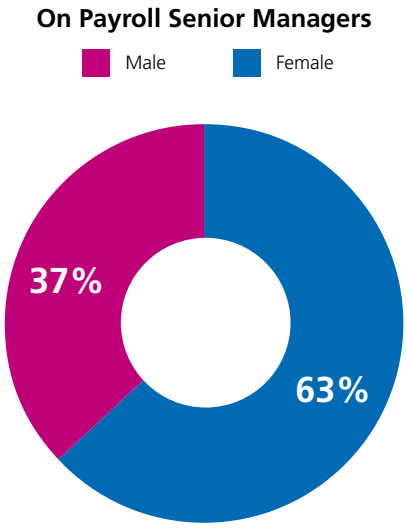
## Staff networks

We support eight diversity staff networks across the joint organisation which provide peer support, influence policy development and create space where staff can speak up about areas that need to improve. Combined membership of staff networks amounts to over 2,800 staff across both organisations. We have also supported the development of new networks including a men's mental health group, and a menopause support group.

## Gender of all staff and senior managers

The gender profile of the total 'on payroll' workforce is set out in the table below and matches the profile of senior managers, with 63% being female.



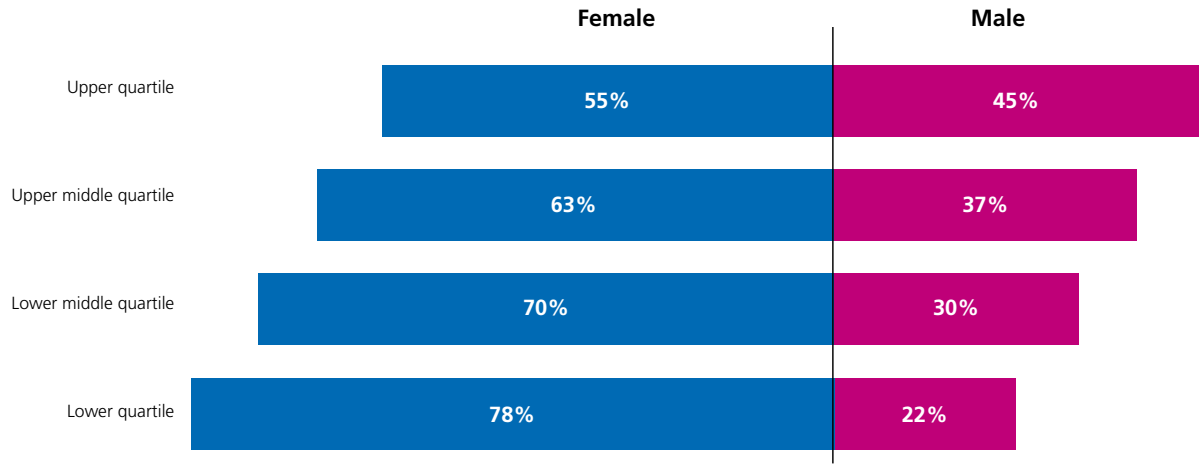

## NHS Improvement gender pay gap

Based on the Government's methodology, the median gender pay gap across NHS Improvement is 14.5% down from 15.7% the prior year.

| Year | Median gender pay gap | Mean gender pay gap |
|---|---|---|
| 2019 | 14.5% | 13.4% |
| 2018 | 15.7% | 14.3% |
| 2017 | 17.4% | 15.0% |

## Pay quartiles by gender in NHS England and NHS Improvement on 31 March 2019

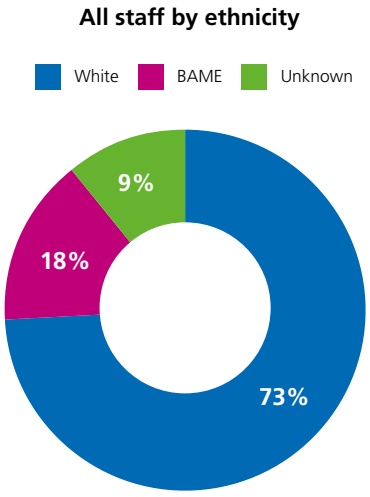
The proportion of males and females in each pay quartile in NHS England and NHS Improvement is detailed below. Women represent the majority of staff in the upper pay quartile.

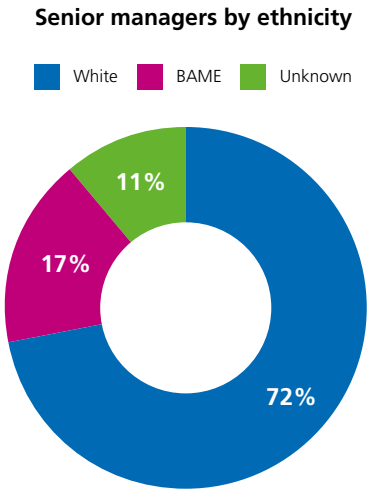



Working in partnership with our recognised trade unions and our Women's Network we continue to progress initiatives which aim to address gender equality in our workforce. Our Gender Pay Action Plan includes specific priorities around recruitment practice, reward and recognition, flexible working, developing talent pipelines and intersectionality.

## Ethnicity of all staff and senior managers

73% of all NHS Improvement staff and 72% of senior managers report themselves to be white. NHS England and NHS Improvement are working to ensure that within five years at least 19% of all senior staff are from BAME backgrounds. For information on board diversity please see page 40.

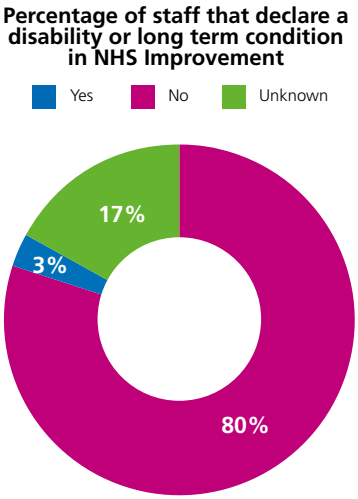


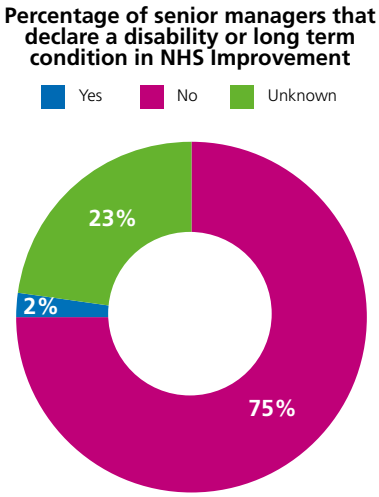



## Declarations of disability or long term conditions

We have continued to work with our DAWN Network to support employees within the workplace, and strive to ensure that all decisions relating to employment practices are objective, free from bias and based solely upon work criteria and individual merit. These principles are reinforced within our joint Recruitment and Selection policy and our Equality, Diversity and Inclusion in the Workplace policy.

The percentage of staff that have declared a disability or long-term condition are given in the tables below.

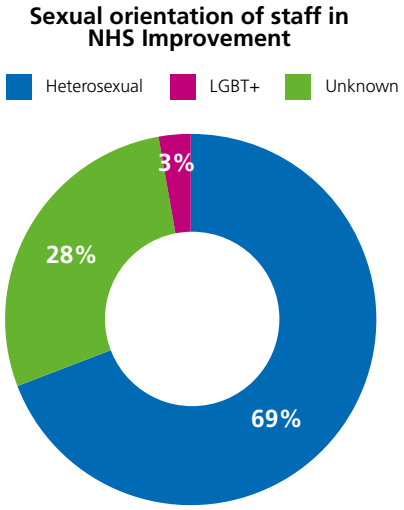


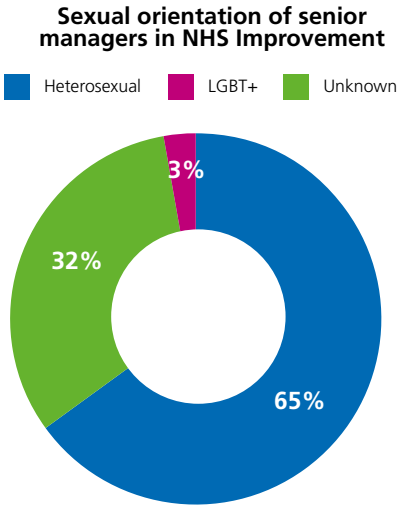




We are currently updating our status as a Disability Confident Employer, prioritising the provision of reasonable adjustments for disabled staff. This involves a major refresh of service improvement, governance and better staff training to remove barriers and increase accessibility.

## Sexual orientation of staff and senior managers

The percentage of staff that disclose their identity as LGBT+ is given in the tables below.



In 2019/20 we submitted jointly to the Stonewall Workplace Equality Index for the first time, achieving a ranking of 113th out of 500 employers in LGBT equality. This position shows the positive impact of initiatives like our joint LGBT+ staff network's Trans and Bi Ally training.

### Our culture and values

We have held culture sessions with our senior teams and introduced a series of Big Conversations to share work on culture change with colleagues.

### Talent management and development

The joint organisation integrated its talent management and development and performance management processes into a single joint process from 1 April 2019 by introducing Quarterly Objectives Reviews and Career Development Conversations. These involve line managers and staff having a rolling cycle of conversations that include monthly, quarterly and annual check-ins that help informal relationship building, facilitate more formal objective reviews and a career development conversation. This process will be reviewed in 2020/21.

We have a range of initiatives that support our staff in their development and create opportunities for talented staff to progress their careers. These include our leadership and line management development programmes, stretch assignments, job shadowing, coaching and mentoring and 360º feedback.

We have a joint approach to apprenticeships and have continued to make progress towards meeting our public sector target with 16 completions and 46 apprentices currently in training, including 2 who are substantively employed by NHS Improvement. The apprenticeships are mainly focussed on higher level degree apprenticeships. NHS Improvement continues to support 13 trainees who are part of the NHS Graduate Trainee Scheme and explore options with other ALBs supporting the scheme in the future.

### Workplace health, safety and wellbeing

We have continued to progress our Mental Health in the Workplace Strategy and have a range of services and resources in place to help support staff with their mental health. This includes a network of over 120 trained Mental Health First Aiders, access to the Work Mental Health Support Service, free access to various self-care apps and guidance and resources to help our managers.

We already had a good range of wellbeing support in place for our staff and this has been particularly important given the unprecedented impact of COVID-19 on our staff and their work. A range of resources are available for our staff including our free employee assistance programme, the support available from our occupational health provider, training and workshops on personal resilience, the NHS bereavement support service and various online resources. We have a well-established approach to identifying and managing interventions by carrying out stress and health risk assessments.

NHS Improvement has adopted the NHS England employee volunteering policy, which supports our employees to volunteer in care settings or with organisations whose work in the community contributes to improved health outcomes. Throughout 2019/20 we have been working with NHS trusts to increase the opportunities for our employees to volunteer in local hospitals, connecting with patients and enhancing their experience of care.

## Staff engagement and feedback

In recognition of 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.

As part of our move towards joint working we also conducted our first combined NHS England and NHS Improvement all-staff annual survey in January 2020.

## Response to COVID-19 Incident

The COVID-19 incident at the end of 2019/20 had, and continues to have, a significant impact on our ways of working. However, we adapted in an agile way. The implementation of Microsoft Teams as our main audio and video conferencing tool was instrumental in enabling a quick move to offsite working. We quickly developed extensive online guidance to support our staff and provided weekly updates to wide ranging frequently asked questions relating to COVID-19 and new ways of working. We were also able to build on our existing wellbeing offer to support our colleagues during this challenging time and created an online absence tracker to help understand the impact of absence and self-isolation relating to COVID-19.

Although we still implemented our new structures as planned, we moved into a new operating mode and re-prioritised all activity around the COVID-19 incident, whilst maintaining other business critical services. A key focus of this was resourcing and included enabling a number of our staff to return to front line and operational roles, redeploying as many people as possible into COVID-19 related activity such as our EPRR unit and regional response teams and developing a fast-track approach to recruiting and contracting new staff into the organisation for COVID-19 related activity. A number of our staff that were due to leave at the end of 2019/20 deferred their leaving date to bolster our response to COVID-19.

## Employee benefits and staff numbers (subject to audit)

Detail on staff numbers and costs for NHS Improvement, reflecting the split by NHS TDA and Monitor, are presented in the following tables:

### Average number of people employed

| | 2019/20 | | |
|---|---|---|---|
| | **Permanently employed number** | **Other number** | **Total number** |
| NHS TDA | 1,127 | 401 | 1,528 |
| Monitor | 200 | 7 | 207 |
| **Total NHS Improvement** | **1,327** | **408** | **1,735** |

| | 2018/19 | | |
|---|---|---|---|
| | **Permanently employed number** | **Other number** | **Total number** |
| NHS TDA | 840 | 331 | 1,171 |
| Monitor | 320 | 12 | 332 |
| **Total NHS Improvement** | **1,160** | **343** | **1,503** |

### Employee benefits

| | 2019/20 | | | |
|---|---|---|---|---|
| | **Permanent employees £000** | **Other £000** | **Total £000** | **2018/19 Total** |
| Salaries and wages | 80,348 | 30,621 | 110,969 | 77,744 |
| Social security costs | 9,490 | 2,847 | 12,337 | 9,323 |
| Employer pension costs | 13,921 | 3,689 | 17,610 | 9,472 |
| **Gross employee benefits expenditure** | **103,759** | **36,157** | **140,916** | **96,539** |
| Administration costs | 57,481 | 14,044 | 71,525 | 62,358 |
| Programme costs | 46,278 | 23,113 | 69,391 | 34,181 |
| **Total net employee benefits** | **103,759** | **36,157** | **140,916** | **96,539** |

## Sickness absence

Sickness absence rates for 2019/20 are published on the NHS Digital website[30].

## Exit packages, severance payments and off-payroll engagements

### Expenditure on consultancy and contingent labour

NHS TDA spent £2.2 million on consultancy expenditure; an increase of £1.8 million since 2018/19 (2018/19: £0.4 million).

Expenditure on contingent labour, including agency staff and secondees, is £3.6 million; an increase of £2.4 million on 2018/19 (2018/19: £1.2 million)

### Off-payroll engagements

NHS England and NHS Improvement are committed to employing a capable, talented and diverse on-payroll workforce to support the delivery of its Business Plan. It is recognised that in some circumstances the use of off-payroll workers, working alongside our on-payroll workforce, represents the most effective use of NHS resources in the organisation's pursuit of specific business objectives. To reduce running costs, use of fixed term or non-permanent roles can help reduce our future redundancy liabilities and costs. Furthermore, for some of our time-limited programmes, it makes sense to use short term contracts.

The following tables identify off-payroll workers engaged by NHS TDA as at March 2020.

### Table 1: Off-payroll engagements longer than six months

Off-payroll engagements as at 31 March 2020, covering those earning more than £245 per day and staying longer than six months are as follows:

| | NHS TDA (number) |
|---|---|
| Number of existing engagements as of 31 March 2020 | 1 |
| Of which, the number that have existed: | |
| for less than one year at the time of reporting | 0 |
| for between one and two years at the time of reporting | 1 |
| for between 2 and 3 years at the time of reporting | 0 |
| for between 3 and 4 years at the time of reporting | 0 |
| for 4 or more years at the time of reporting | 0 |

All existing off-payroll engagements, outlined above, 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, assurance has been sought.

30 https://digital.nhs.uk/data-and-information/publications/statistical/nhs-sickness-absence-rates

## Table 2: New off-payroll engagements

New off-payroll engagements or those that reached six months in duration, between 1 April 2019 and 31 March 2020, for more than £245 per day and that last longer than six months are as follows:

| | NHS TDA |
|---|---|
| Total number of new engagements, or those that reached six months in duration, between 1 April 2019 and 31 March 2020 | 1 |
| Of which: | |
| Number assessed as caught by IR35 | 1 |
| Number assessed as NOT caught by IR35 | 0 |
| | |
| Number engaged directly via Personal Service Company (PSC) contracted to department and are on departmental payroll | 0 |
| Number of engagements reassessed for consistency / assurance purposes during the year | 0 |
| Number of engagements that saw a change to IR35 status following the consistency review | 0 |

## Table 3: Off-payroll board member/senior official engagement

Off-payroll engagements of Board members and/or senior officials with significant financial responsibility, between 1 April 2019 and 31 March 2020 are shown in the table below:

| | NHS TDA |
|---|---|
| Number of off-payroll engagements of Board members, and/or senior officers with significant financial responsibility, during the financial year | 0 |
| Total number of individuals on payroll and off-payroll that have been deemed "Board members, and/or, senior officials with significant financial responsibility", during the financial year. | 29 |

Further detail on commercial approvals, and steps we have taken to improve procurement practices and compliance within NHS England during the year, can be found in our Governance Statement from page 61.

## Exit packages including severance payments (subject to audit)

NHS TDA operates robust internal controls in respect of such matters, and any proposed non-contractual severance payments would first have to be scrutinised and approved by the Executive HR Sub-Committee before being considered by DHSC and HM Treasury. Details of exit packages agreed over the year are detailed in the following tables. All contractual severance payments were subject to full external oversight by DHSC.

| NHS TDA | 2019/20 | | | 2018/19 | | |
|---|---|---|---|---|---|---|
| | Compulsory redundancies number | Other agreed departures number | Total number | Compulsory redundancies number | Other agreed departures number | Total number |
| Less than £10,000 | 6 | 2 | 8 | 0 | 1 | **1** |
| £10,001 to £25,000 | 14 | 1 | 15 | 1 | 2 | **3** |
| £25,001 to £50,000 | 10 | 0 | 10 | 1 | 0 | **1** |
| £50,001 to £100,000 | 9 | 1 | 10 | 2 | 0 | **2** |
| £100,001 to £150,000 | 8 | 1 | 9 | 2 | 0 | **2** |
| £150,001 to £200,000 | 8 | 5 | 8 | 2 | 0 | **2** |
| Over £200,001 | 0 | 0 | 0 | 1 | 0 | **1** |
| **Total** | 55 | 5 | 60 | 9 | 3 | **12** |
| **Total cost (£000)** | **3,619** | **228** | **3,847** | **1,085** | **33** | **1,118** |

This table reports the number and value of exit packages agreed in the financial year.

Exit costs are accounted for in accordance with relevant accounting standards and are paid in accordance with NHS TDA's redundancy policy.

The Remuneration Report includes the disclosure of exit payments payable to individuals named in that report.

# Remuneration Report

## Strategic HR and Remuneration Committee

Detail on the role and activity of the Strategic HR and Remuneration Committee is given in our Directors' Report from page 50.

## Pay multiples (subject to audit)

Reporting bodies are required to disclose the relationship between the remuneration of the highest paid director in their organisation and the median remuneration of the organisation's workforce.

The banded remuneration of the highest paid member of the Board in the financial year 2019/20 was £285,000 to £290,000 (2018/19: £285,000-£290,000). This was 5.0 times the median remuneration of the workforce, which was £58,073 (2018/19: £59,090: 4.9).

In 2019/20, no employees received pro-rata remuneration in excess of the highest-paid member of the Board (2018/19: none).

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

## Policy on remuneration of senior managers

The framework for the remuneration of executive directors is set by the DHSC through the Executive Senior Manager (ESM) pay framework for ALBs.

It is the policy of NHS England and NHS Improvement to pay salaries that are appropriate to recruit senior managers with the necessary skills, capability and experience necessary for the effective running of a more than £124 billion organisation, whilst recognising the importance of demonstrating pay restraint at a time of considerable pressure on NHS finances. Recommending appropriate remuneration for executive directors is undertaken by NHS England's Strategic HR and Remuneration Committee and NHS Improvement's Nomination and Remuneration Committee, with board committee meetings held in common. Final decisions are made by the DHSC ALB Remuneration Committee and Ministers and HM Treasury, where appropriate.

## Performance related pay

The performance related pay (PRP) arrangements for national (executive) directors are set out in the ESM pay framework for ALBs. They follow guidance prescribed by DHSC and are in line with HM Treasury requirements. As a local policy decision, NHS England and NHS Improvement do not currently allocate any funding for PRP non-consolidated bonus payments. In recognition of the current economic climate and the need to provide effective system leadership for the NHS, the decision was taken by the Strategic HR and Remuneration Committee and Nomination and Remuneration Committee not to allocate funds for PRP non-consolidated bonus payments for 2019/20. Secondees are subject to the terms and conditions of their employing organisation.

## Policy on senior managers' contracts

Contracts of employment for senior managers are open-ended and recurrent, unless otherwise specified. Notice periods follow the provisions of the ESM contract of employment, as applied by NHS England and NHS Improvement, of six months contractual notice. Termination payments are only able to be authorised where these are contractual and, subject to the value involved, may still require further approval from the DHSC Governance and Assurance Committee. Any proposed non-contractual special severance payment requires formal approval from the DHSC Governance and Assurance Committee and HM Treasury.

Payments were made to six senior managers to compensate for loss of office during 2019/20 and details of these payments are included in the senior manager salary and pension entitlement table on page 97.

No payments have been made to past directors and no compensation has been paid on early retirement.

## Senior managers' service contracts (not subject to audit)

| Name and Title | Date of appointment | Notice period | Provisions for compensation for early termination | Other details |
|---|---|---|---|---|
| **Ian Dalton**<br>Chief Executive Officer – NHS Improvement | 4 December 2017 | 6 months | Option to provide taxable pay in lieu of part or all of the notice period | Left NHS Improvement on 31 August 2019 |
| **Stephen Hay**<br>Deputy Chief Executive and Executive Director of Regulation - NHS Improvement | 1 October 2004 | 6 months | | Left NHS Improvement on 30 April 2019 |
| **Dr. Kathy McLean**<br>Executive Medical Director and Chief Operating Officer - NHS Improvement | 1 January 2018 | 6 months | | Left NHS Improvement on 30 April 2019 |
| **Amanda Pritchard**<br>Chief Executive - NHS Improvement<br>Chief Operating Officer – Joint | 31 July 2019 | 6 months | | |
| **Ian Dodge**<br>National Director for Strategy and Innovation – Joint | 7 July 2014 | 6 months | | |
| **Dr. Emily Lawson**<br>National Director of Transformation and Corporate Development – Joint | 1 November 2017 | 6 months | | |
| **Professor Stephen Powis**<br>National Medical Director – Joint | 1 March 2018 | 6 months | | |
| **Julian Kelly**<br>Chief Financial Officer – Joint | 1 April 2019 | 6 months | | |
| **Ruth May**<br>Chief Nursing Officer – Joint | 7 January 2019 | 6 months | | |
| **Prerana Issar**<br>Chief People Officer – Joint | 1 April 2019 | 6 months | | |
| **Matthew Gould CMG MBE**<br>National Director for Digital Transformation – Joint | 3 June 2019 | 6 months | | |

From 1 April 2019, the senior managers indicated as 'Joint' in the above table were jointly appointed across NHS England and NHS Improvement (consisting of NHS TDA and Monitor). Full salary disclosures are included in all the entity Remuneration Reports, within the underlying accounts, and the costs are split equally between NHS England and NHS Improvement. Within NHS Improvement costs are split 2:1 NHS TDA:Monitor.

## Remuneration (salary, benefits in kind and pensions) 2019/20 (subject to audit)

| Name and Title | (a) Salary (bands of £5,000) | (b) Benefits in kind (taxable) to nearest £100 | (c) Performance pay and bonuses (bands of £5,000) | (d) Long term performance pay and bonuses (bands of £5,000) | (e) All pension-related benefits (to the nearest £1,000) | (f) TOTAL (a to e) (bands of £5,000) |
|---|---|---|---|---|---|---|
| | £000 | £s | £000 | £000 | £000 | £000 |
| **Ian Dalton** Chief Executive Officer[31] | 260-265 | 0 | 0 | 0 | 0 | 260-265 |
| **Stephen Hay** Deputy Chief Executive and Executive Director of Regulation[32] | 200-205 | 0 | 0 | 0 | 0 | 200-205 |
| **Dr. Kathy McLean** Executive Medical Director and Chief Operating Officer[33] | 275-280 | 0 | 0 | 0 | 0 | 275-280 |
| **Amanda Pritchard** Chief Executive Officer and Chief Operating Officer[34] | 170-175 | 0 | 0 | 0 | 39 | 210-215 |
| **Ian Dodge** National Director for Strategy and Innovation | 170-175 | 0 | 0 | 0 | 30 | 200-205 |
| **Dr. Emily Lawson** National Director of Transformation and Corporate Development | 205-210 | 0 | 0 | 0 | 0 | 205-210 |
| **Professor Stephen Powis** National Medical Director | 220-225 | 0 | 0 | 0 | 0 | 220-225 |
| **Julian Kelly** Chief Financial Officer[35] | 205-210 | 0 | 0 | 0 | 46 | 250-255 |
| **Ruth May** Chief Nursing Officer | 175-180 | 0 | 0 | 0 | 127 | 305-310 |
| **Prerana Issar** Chief People Officer[36] | 230-235 | 0 | 0 | 0 | 52 | 280-285 |
| **Matthew Gould CMG MBE** National Director for Digital Transformation[37] | 0 | 0 | 0 | 0 | 0 | 0 |

Note: Taxable expenses and benefits in kind are expressed to the nearest £100.

31 Ian Dalton left NHS Improvement on 31 August 2019. The full year equivalent salary is £285,000-£290,000. Mr Dalton was paid a payment in lieu of notice in the salary range of £145,000-£150,000 in August 2019 as compensation for loss of office and this is included in the salary band disclosed within the table. During the period 29 June 2019 to 31 July 2019 the role of NHS Improvement's Accounting Officer was covered on an interim basis by Bill McCarthy, North West Regional Director, who received no additional remuneration as a result.

32 Stephen Hay left NHS Improvement on 30 April 2019. The full year equivalent salary is £195,000-£200,000. Mr Hay was paid a redundancy payment of £182,041.00 in May 2019 as compensation for loss of office.

33 Dr. Kathy McLean left NHS Improvement on 30 April 2019. The full year equivalent salary is £205,000-£210,000. Dr McLean was paid a redundancy payment of £262,185.00 in April 2019 as compensation for loss of office.

34 Amanda Pritchard commenced in both posts on 31 July 2019 with her salary recharged to NHS England and NHS Improvement from Guy's and St Thomas' NHS Foundation Trust where she is also formally employed and retains a post. The full year equivalent salary is £255,000-£260,000

35 Julian Kelly formally commenced in the joint post on 1 April 2019.

36 Prerana Issar commenced in the joint post on 1 April 2019.

37 Matthew Gould CMG MBE commenced in post on 1 July 2019 with his salary costs met wholly by the DHSC, where he is also formally employed and retains a post. The full year equivalent salary is £120,000-£125,000.

## Remuneration (salary, benefits in kind and pensions) 2018/19 (subject to audit)

| Name and Title | Salary (bands of £5,000) | Benefits in kind (taxable) to nearest £100 | All pension-related benefits (bands of £1,000) | TOTAL (bands of £5,000) |
|---|---|---|---|---|
| **Board executives** | **£000** | **£s** | **£000** | **£000** |
| **Ian Dalton CBE**<br>Chief Executive | 285-290 | - | 102 | 385-390 |
| **Stephen Hay**<br>Deputy Chief Executive and Executive Director of Regulation[38/46] | 195-200 | - | - | 195-200 |
| **Ruth May**<br>Executive Director of Nursing<br>NHSI's Chief Nursing Officer until 6 January 2019, from 7 January 2019 became the joint Chief Nursing Officer for NHSI and NHSE | 155-160 | - | 13 | 170-175 |
| **Dr. Kathy Mclean**<br>Executive Medical Director and Chief Operating Officer[46] | 205-210 | - | - | 205-210 |
| **Executive team** | | | | |
| **Dale Bywater**<br>Executive Regional Managing Director (Midlands and East) | 160-165 | - | 42 | 200-205 |
| **Ben Dyson**<br>Executive Director of Strategy[39] | 30-135 | - | 52 | 185-190 |
| **Anne Eden**<br>Executive Regional Managing Director (South East)[40] | 175-180 | - | - | 175-180 |
| **Jennifer Howells**<br>Executive Regional Managing Director (South West) until 14 January 2019[41] | - | - | - | - |
| **Sian Jarvis**<br>Executive Director of External Affairs (from 16 April 2018) [42] | 135-140 | - | - | 135-140 |
| **Jeremy Marlow**<br>Executive Director of Operational Productivity[46] | 140-145 | - | 47 | 190-195 |
| **Elizabeth O'Mahony**<br>Chief Financial Officer | 160-165 | - | 87 | 245-250 |
| **Steve Russell**<br>Executive Regional Managing Director (London) until 5 February[43] | 145-150 | - | 38 | 185-190 |
| **Adam Sewell-Jones**<br>Executive Director of Improvement (until 13 January 2019)Interim NHS South West Regional Director (from 14 January 2019)[38/44/46] | 155-160 | 74 | 61 | 225-230 |
| **Lyn Simpson**<br>Executive Regional Managing Director (North) | 160-165 | - | 12 | 170-175 |
| **Sir David Sloman**<br>NHS London Regional Director – a joint appointment from 6 February 2019[45] | - | - | - | - |

38 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 in the band 0-£5,000.
39 Ben Dyson was on secondment from DHSC to Monitor from 1 June 2016.
40 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 NHS England in connection with Anne Eden's employment.
41 Jennifer Howells was seconded from NHS England until 14 January 2019 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 £44,000
42 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 benefit as she does not contribute to the NHS Pension scheme.
43 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.
44 Adam Sewell- Jones benefit in kind relates to a lease car.
45 Sir David Sloman is a joint appointment with NHS England. 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.
46 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 McClean (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 Kathy McClean is included in the NHS TDA's Exit Packages table and the figures for Steven Hay, Adam Sewell-Jones and Jeremy Marlow are included in Monitor's Exit Packages table.

## Pension benefits (subject to audit)

| Name and Title | Real increase in pension at pension age (bands of £2,500) | Real increase in pension lump sum at pension age (bands of £2,500) | Total accrued pension at pension age at 31 March 2019 (bands of £5,000) | Lump sum at pension age related to accrued pension at 31 March 2019 (bands of £5,000) | Cash Equivalent Transfer Value at 31 March 2018[47] | Real Increase in Cash Equivalent Transfer Value | Cash Equivalent Transfer Value at 31 March 2019 | Employers contribution to partnership pension |
|---|---|---|---|---|---|---|---|---|
| | £000 | £000 | £000 | £000 | £000 | £000 | £000 | £000 |
| **Ian Dalton** Chief Executive Officer[48] | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A |
| **Stephen Hay** Deputy Chief Executive and Executive Director of Regulation[49] | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A |
| **Dr. Kathy McLean** Executive Medical Director and Chief Operating Officer[50] | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A |
| **Amanda Pritchard** Chief Executive Officer and Chief Operating Officer[51] | 2.5-5 | (2.5)-0 | 70-75 | 130-135 | 945 | 24 | 1,040 | 0 |
| **Ian Dodge** National Director for Strategy and Innovation[52] | 0-2.5 | N/A | 15-20 | N/A | 176 | 14 | 211 | 0 |
| **Dr. Emily Lawson** National Director of Transformation and Corporate Development[53] | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A |
| **Professor Stephen Powis** National Medical Director[54] | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A |
| **Julian Kelly** Chief Financial Officer | 2.5-5 | N/A | 0-5 | N/A | 1 | 15 | 48 | 0 |
| **Ruth May** Chief Nursing Officer[55] | 5-7.5 | 17.5-20 | 70-75 | 215-220 | 1,317 | 146 | 1,508 | 0 |
| **Prerana Issar** Chief People Officer | 2.5-5 | N/A | 0-5 | N/A | 0 | 13 | 47 | 0 |
| **Matthew Gould CMG MBE** National Director for Digital Transformation[56] | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A |

47 As per previous submissions, the column Cash Equivalent Transfer Value at 31 March 2019 is the uninflated value whereas the real Increase in CETV is the employer funded increase.
48 Ian Dalton chose not to be covered by the NHS Pension arrangements during the reporting year up until the end of his employment with NHS Improvement.
49 Stephen Hay chose not to be covered by the My Civil Service Pension arrangements during the reporting year up until the end of his employment with NHS Improvement.
50 Dr. Kathy McLean chose not to be covered by the NHS Pension arrangements during the reporting year up until the end of her employment with NHS Improvement.
51 Amanda Pritchard commenced in post on 31 July 2019, therefore the Pension Benefits disclosed are pro-rata for the period 31 July 2019 to 31 March 2020.
52 Ian Dodge chose to opt out of the NHS Pension Scheme on 1 December 2019.
53 Dr. Emily Lawson chose not to be covered by the NHS Pension arrangements during the reporting year.
54 Professor Stephen Powis chose not to be covered by the NHS Pension arrangements during the reporting year.
55 Ruth May chose to opt out of the NHS Pension Scheme on 1 May 2019 and opt back into the NHS Pension Scheme on 1 December 2019.
56 Matthew Gould CMG MBE commenced in post on 1 July 2019, with costs met wholly by the DHSC where he is also formally employed and retains a post.

## Cash equivalent transfer values (CETV)

A CETV is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time.

The benefits valued are the member's accrued benefits and any contingent spouse's (or other allowable beneficiary's) pension payable from the scheme.

A CETV is a payment made by a pension scheme or arrangement to secure pension benefits in another pension scheme or arrangement when the member leaves a scheme and chooses to transfer the benefits accrued in their former 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.

The CETV figures and the other pension details include the value of any pension benefits in another scheme or arrangement which the individual has transferred in to the NHS pension scheme. They also include any additional pension benefit accrued to the member as a result of their purchasing additional years of pension service in the scheme at their own cost. CETVs are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries.

## Real increase in CETV

This reflects the increase in CETV effectively funded by the employer. It does not include the increase in accrued pension due to inflation or 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

The majority of past and present employees are covered by the provisions of the NHS Pension Scheme.

The scheme is an unfunded defined benefit scheme and is not designed to be run in a way that would enable NHS bodies to identify their share of the scheme's underlying assets. Further details of the NHS pension liabilities can be found in the notes to the annual accounts, and details of the senior managers' pension liability is shown in the remuneration and pension benefits tables in the remuneration report.

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 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.

## Policy on remuneration of 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. The below table shows the total remuneration; two-thirds of the 2019/20 costs are charged to the NHS TDA and one-third to Monitor.

## Non-executive director service contracts

| Name and title | Date of appointment | Unexpired term at 31 March 2020 | Notice period | Provisions for compensation for early termination | Other details |
|---|---|---|---|---|---|
| **Baroness Dido Harding**<br>Chair | 30 October 2017 | 18 months | 3 months | None | |
| **Sir David Behan**<br>Associate (non-voting)<br>Non– Executive Director | 1 February 2019 | 10 months | 3 months | None | Chair of Health Education England |
| **Lord Patrick Carter of Coles**<br>Non-Executive Director and Senior Independent Director | 1 April 2016 | 15 months | 3 months | None | |
| **Professor the Lord Ara Darzi of Denham**<br>Non-Executive Director | 1 April 2016 | 15 months | 3 months | None | Transferred to NHS England on 1 April 2020 |
| **Richard Douglas CB**<br>Non-Executive Director and Deputy Chair | 1 April 2016 | n/a | 3 months | None | Left NHS Improvement 31 March 2020 |
| **Dr. Timothy G Ferris**<br>MD, MPH<br>Non-Executive Director | 1 August 2018 | 16 months | 3 months | None | Waived entitlement to remuneration |
| **Wol Kolade**<br>Non-Executive Director | 1 August 2018 | 16 months | 3 months | None | Waived entitlement to remuneration |
| **Andrew Morris**<br>Non-Executive Director | 1 August 2018 | 16 months | 3 months | None | |
| **David Roberts**<br>Associate non-voting | 5 March 2018 | n/a | 3 months | None | Term ended 4 March 2020 |
| **Laura Wade-Gery**<br>Non-Executive Director | 1 August 2018 | 16 months | 3 months | None | |

## Non-executive director remuneration (including salary entitlements)

Salaries and allowances 2019/20 (subjected to audit)

| Name of non-executive director | Position | Salary (bands of £5,000 | Benefits in kind (taxable) rounded to nearest £100 | TOTAL (bands of £5,000) |
|---|---|---|---|---|
| | | £000 | £s | £000 |
| **Baroness Dido Harding** | Chair | 60-65 | 0 | 60-65 |
| **Sir David Behan**[57] | Associate (non-voting) Non-Executive Director | 0-5 | 0 | 0-5 |
| **Lord Patrick Carter of Coles** | Non-Executive Director (Senior Independent Director) | 5-10 | 0 | 5-10 |
| **Professor the Lord Ara Darzi of Denham** | Non-executive Director | 5-10 | 0 | 5-10 |
| **Richard Douglas CB**[58] | Non-executive Director and Deputy Chair | 10-15 | 0 | 10-15 |
| **Dr. Timothy G Ferris**[59] **MD, MPH** | Non-executive Director | 0-5 | 0 | 0-5 |
| **Wol Kolade** | Non-executive Director | 0-5 | 0 | 0-5 |
| **Andrew Morris** | Non-executive Director | 5-10 | 0 | 5-10 |
| **David Roberts**[60] | Associate (non-voting) Non–Executive Director | 0-5 | 0 | 0-5 |
| **Laura Wade-Gery** | Non-executive Director | 5-10 | | 5-10 |

57 Sir David Behan, Chair of Health Education England, became an Associate (non-voting) Non-Executive Board member of NHS Improvement from 1 February 2019.
58 Richard Douglas CB is also an Associate (non-voting) Non-Executive Board Member of NHS England.
59 Dr. Timothy Ferris and Wol Kolade have waived their entitlement to Non-Executive Director remuneration in the band of £5,000-£10,000
60 David Roberts, NHS England Vice Chair, is an Associate (non-voting) Non-Executive Board member of NHS Improvement and has waived his entitlement to Non-Executive Director remuneration.

## Non-executive director remuneration (including salary entitlements)

Salaries and allowances 2018/19 (subjected to audit)

| Name of non-executive director | Position | Salary (bands of £5,000) | Benefits in kind (taxable) Rounded to nearest £100 | TOTAL (bands of £5,000) |
|---|---|---|---|---|
| | | £000 | £s | £000 |
| **Baroness Dido Harding** | Chair | 60-75 | 0 | 70-75 |
| **Sir David Behan**[61] | Associate (non-voting) Non-Executive Director | 0-5 | 0 | 0-5 |
| **Professor Dame Glynis Breakwell DBE DL** | Senior Independent Director | 5-10 | | 5-10 |
| **Lord Patrick Carter of Coles** | Non-executive Director | 5-10 | 0 | 5-10 |
| **Professor the Lord Ara Darzi of Denham** | Non-executive Director | 5-10 | 0 | 5-10 |
| **Richard Douglas CB**[62] | Non-executive Director and Deputy Chair | 10-15 | 0 | 10-15 |
| **Dr Timothy G Ferris**[63] **MD, MPH** | Non-Executive Director from 1 August 2018 | 0-5 | 0 | 0-5 |
| **Sarah Harkness**[64] | Non-Executive Director until 25 Sep 2018 | | | |
| **Wol Kolade** | Non-Executive Director from 1 August 2018 | 0-5 | 0 | 0-5 |
| **Andrew Morris**[65] | Non-Executive Director from 1 August 2018 | 5-10 | 0 | 5-10 |
| **Sigurd Reinton CBE**[66] | Non-Executive Director until 30 June 2018 | | | |
| **David Roberts**[67] | Associate (non-voting) Non–Executive Director | 0-5 | 0 | 0-5 |
| **Laura Wade-Gery**[68] | Non-Executive Director from 1 August 2018 | 5-10 | | 5-10 |

61 Sir David Behan, Chair of Health Education England, became an Associate (non-voting) Non-Executive Board member of NHS Improvement from 1 February 2019.
62 Richard Douglas CB is also an Associate (non-voting) Non-Executive Board Member of NHS England.
63 Timothy Ferris and Wol Kolade became Non-Executive Board member of NHSI from 1 August 2018 and have waived their entitlement to Non-Executive Director remuneration in the band of £5,000-£10,000
64 Sarah Harkness left NHSI on 25 September 2018 her annualised remuneration would have been in the band £5,000-£10,000.
65 Andrew Morris joined NHSI on 1 August 2018 his annualised remuneration would have been in the band £5,000-£10,000.
66 Sigurd Reinton, CBE left NHSI on 30 June 2018 his annualised remuneration would have been in the band £5,000-£10,000.
67 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.
68 Laura Wade-Gery joined NHSI on 1 August 2018 her annualised remuneration would have been in the band £5,000-£10,000.

# 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.

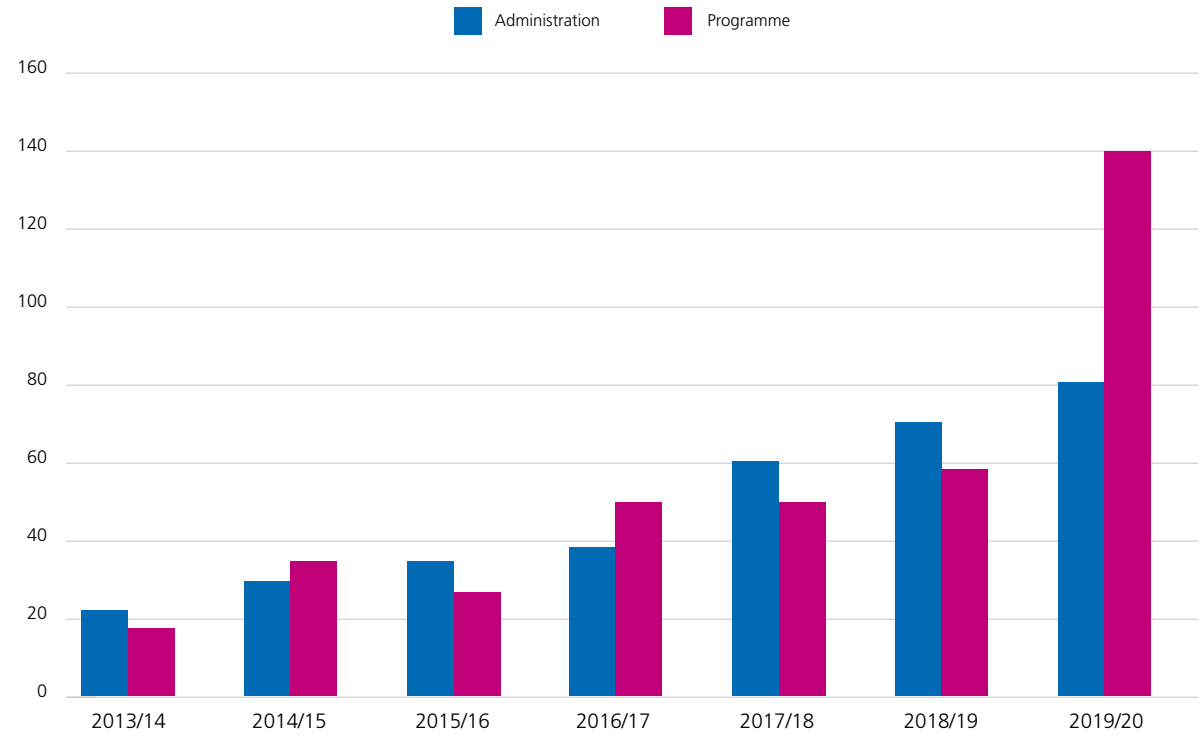
There are four main sources of income in 2019/20, for which further details are contained in the financial statements:

- Recharges for services delivered to the NHS Trust Development Authority which are based on a proportion of actual costs incurred.
- Outward secondment of staff which are based on the secondment agreements.
- Joint working costs with NHS England which are based on costs incurred.
- Emergency, Elective and Cancer Intensive Support teams for which income is received from NHS England and is recognised against costs as they are incurred in year.
- NHS Leadership Academy training income which is recognised based on the timing of the underlying training.

## Long-term expenditure trend

The table below 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. 2019/20 expenditure details are disclosed in the annual accounts.

## Trend in net expenditure since 2013/14



# 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 2020 under the National Health Service Act 2006. The financial statements comprise: the Statements of Comprehensive Net Expenditure, Financial Position, Cash Flows, Changes in Taxpayers' Equity; and the related notes, including the significant accounting policies. These financial statements have been prepared under the accounting policies set out within them. I have also audited the information in the Accountability Report that is described in that report as having been audited.

In my opinion:

- the financial statements give a true and fair view of the state of the NHS Trust Development Authority's affairs as at 31 March 2020 and of the net expenditure for the year then ended; and
- the financial statements have been properly prepared in accordance with the National Health Service Act 2006 and Secretary of St ate directions issued thereunder.

## Opinion on regularity

In my opinion, in all material respects the income and expenditure recorded in the financial statements have been applied to the purposes intended by Parliament and the financial transactions recorded in the financial statements conform to the authorities which govern them.

## Basis of opinions

I conducted my audit in accordance with International Standards on Auditing (ISAs) (UK) and Practice Note 10 'Audit of Financial Statements of Public Sector Entities in the United Kingdom'. My responsibilities under those standards are further described in the Auditor's responsibilities for the audit of the financial statements section of my certificate. Those standards require me and my staff to comply with the Financial Reporting Council's Revised Ethical Standard 2 016. 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.

## Conclusions relating to going concern

I have nothing to report in respect of the following matters in relation to which ISAs (UK) require me to report to you where

- the NHS Trust Development Authority's use of the going concern basis of accounting in the preparation of the financial statement s is not appropriate; or
- the NHS Trust Development Authority have not disclosed in the financial statements any identified material uncertainties that ma y cast significant doubt about the NHS Trust Development Authority's ability to continue to adopt the going concern basis of accounting for a period of at least twelve months from the date when the financial statements are authorised for issue.

## 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 2006.

An audit involves obtaining evidence about the amounts and disclosures in the financial statements sufficient to give reasonable assurance that the financial statements are free from material misstatement, whether caused by fraud or error. Reasonable assurance is a high level of assurance, but is not a guarantee that an audit conducted in accordance with ISAs (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.
- conclude on the appropriateness of the NHS Trust Development Authority's use of the going concern basis of accounting and, based on the audit evidence obtained, whether a material uncertainty exists related to events or conditions that may cast significant doubt on the NHS Trust Development Authority's ability to continue as a going concern. If I conclude that a material uncertainty exists, I am required to draw attention in my report to the related dis closures in the financial statements or, if such disclosures are inadequate, to modify my opinion. My conclusions are based on the audit evidence obtained up to the date of my report. However, future events or conditions may cause the NHS Trust Development Authority to cease to continue as a going concern.

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.

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

## 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. 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 direct ion s 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 Report and Accountability Report for the financial year for which the financial statements are prepared is consistent with the financial statements.

## Matters on which I report by exception

I have nothing to report in respect of the following matters which I report to you if, in my opinion:

- adequate accounting records have not been kept or returns adequate for my audit have not been received from branches not visited by my staff; or
- the financial statements and the parts of the 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** 26 January 2021

*Comptroller and Auditor General*

National Audit Office l 157-197 Buckingham Palace Road l Victoria, London, SW1W 9SP

# Annual Accounts

Amanda Pritchard
Accounting Officer
15 January 2021

## Statement of comprehensive net expenditure for the year ended 31 March 2020

| | Note | 2019/20 £000 | 2018/19 £000 |
|---|---|---|---|
| Other operating revenue | 3 | 28,672 | 36,987 |
| **Total operating revenue** | | **28,672** | **36,987** |
| | | | |
| Staff costs | 4 | 140,916 | 96,539 |
| Purchase of goods and services | 5 | 76,022 | 26,405 |
| Depreciation and amortisation charges | | 850 | 576 |
| Other operating expenditure | 5 | 34,389 | 42,412 |
| **Total operating expenditure** | | **252,177** | **165,932** |
| | | | |
| **Net operating costs for the financial year** | | **223,505** | **128,945** |
| | | | |
| **Total comprehensive net expenditure for the year** | | **223,505** | **128,945** |

All operations are continuing.

The notes on pages 116 to 134 form part of these accounts.

## Statement of Financial Position as at 31 March 2020

| | Note | 31 March 2020 £000 | 31 March 2019 £000 |
|---|---|---|---|
| **Non current assets** | | | |
| Property, plant & equipment | 7.1 | 354 | 630 |
| Intangible assets | 7.2 | 3,106 | 2,700 |
| **Total non-current assets** | | **3,460** | **3,330** |
| **Current assets** | | | |
| Trade and other receivables | 8 | 23,692 | 9,331 |
| Cash and cash equivalents | 9 | 8,891 | 2,223 |
| **Total current assets** | | **32,583** | **11,554** |
| **Total assets** | | **36,043** | **14,884** |
| **Current liabilities** | | | |
| Trade and other payables | 10.1 | 59,716 | 31,647 |
| **Total current liabilities** | | **59,716** | **31,647** |
| **Net current liabilities** | | **(27,133)** | **(20,093)** |
| **Non current liabilities** | | | |
| Trade and other payables | 10.2 | 824 | - |
| **Total current liabilities** | | **824** | - |
| **Total net liabilities** | | **(24,497)** | **(16,763)** |
| **Financed by taxpayers' equity** | | | |
| General fund | | (24,497) | (16,763) |
| **Total taxpayers' equity** | | **(24,497)** | **(16,763)** |

The financial statements and the notes on pages 116 to 134 were signed on behalf of the NHS Trust Development Authority by:

Amanda Pritchard
Chief Executive Officer
15 January 2021

## Statement of Cash Flows for the year ended 31 March 2020

| | Note | 2019/20 £000 | 2018/19 £000 |
|---|---|---|---|
| **Cash flows from operating activities** | | | |
| Net operating cost | SoCNE | (223,505) | (128,945) |
| Adjustments for non-cash transactions | | | |
| Depreciation and amortisation | | 850 | 576 |
| Pension contribution rate increase | 4.1 | 5,538 | - |
| Loss on disposal | 7.1 | 34 | - |
| (Increase)/ decrease in trade and other receivables | 8 | (14,361) | 3,434 |
| Increase/ (decrease) in trade payables and other current liabilities | 10 | 28,893 | (9,132) |
| **Net cash inflow / (outflow) from operating activities** | | **(202,551)** | **(134,067)** |
| **Cash flows from investing activities** | | | |
| (Payments) for property, plant and equipment | | (146) | (203) |
| (Payments) for intangible assets | | (868) | (2,239) |
| **Net cash inflow / (outflow) from investing activities** | | **(1,014)** | **(2,442)** |
| **Cash flows from financing activities** | | | |
| Net parliamentary funding | SoCTE | 210,233 | 131,632 |
| **Net financing** | | **210,233** | **131,632** |
| **Net increase/(decrease) in cash and cash equivalents** | | 6,668 | (4,877) |
| **Cash and cash equivalents at the beginning of the period** | | **2,223** | **7,100** |
| **Cash and cash equivalents at the end of the period** | 9 | **8,891** | **2,223** |

The notes on pages 116 to 134 form part of these accounts.

## Statement of Changes in Taxpayers' Equity for the year ended 31 March 2020

| | Note | General Fund £000 |
|---|---|---|
| **Balance at 31 March 2019** | | **(16,763)** |
| **Changes in taxpayers' equity for 2019-20** | | |
| Comprehensive net expenditure for the year | SoCNE | (223,505) |
| Net parliamentary funding | SOCF | 215,771 |
| **Balance at 31 March 2020** | | **(24,497)** |
| | | |
| **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)** |

The notes on pages 116 to 134 form part of these accounts.

# Notes to the financial statements

## 1. Accounting policies

### 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 the NHS Trust Development Authority and Monitor.

### 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. In addition to its functions in relation to NHS trusts, NHS TDA also has a role to provide support to other providers of services which are part of the health service, for the purpose of improving the quality and financial sustainability of those services.

NHS TDA is a special health authority accountable to the Department of Health and Social Care domiciled in the UK with its main office at Wellington House, 133-155 Waterloo Road, SE1 8UG.

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. The accounting policies contained in the FReM follow International Financial Reporting Standards (IFRS) as adapted or interpreted for the public sector context. Where the FReM permits a choice of accounting policy, the accounting policy which is judged to be most appropriate to the particular circumstances of the NHS TDA has been selected for the purpose of giving a true and fair view.  The particular policies adopted by the NHS TDA are described below. These have been applied consistently in dealing with items that are considered material to the accounts.

### 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.

### 1.2 Going concern

On 1 April 2019, a new joint leadership structure came into effect across NHS TDA, Monitor and NHS England. The underlying legal entities of NHS TDA, Monitor and NHS England will remain in place. Should legislation be passed to formally merge the entities, the underlying activities of NHS TDA would continue.

In line with the guidance issued by the Department of Health and Social Care, NHS TDA's 2019/20 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 NHS TDA's 2020/21 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 have worked together under the operational name of NHS Improvement and from 1 April 2019, NHS Improvement and NHS England have worked together under a similar joint arrangement. 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.

### 1.4 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. In 2019/20, £5,537,615 of funding has been credited to the general fund in respect of payments made by DHSC to the NHS Pension Scheme on NHS TDA's behalf.

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

- Intensive Support Team funding
  Income for Emergency, Elective and Cancer Intensive Support teams for which income is received from NHS England and is recognised against costs as they are incurred in year.

- Leadership Academy training income
  Training income is received from a number of organisations and individuals which is recognised in line with the timing of delivery of training.
- Recharges for services delivered to the NHS TDA and NHS England
  NHS TDA has agreements with Monitor and NHS England to provide accommodation and other joint working services. The performance obligation is the provision of access to these facilities. As such access is provided on an on-going basis throughout the year, Monitor recognises the associated revenue over time.

## 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 (NHSPS) which is an unfunded defined benefit scheme. NHSPS is an unfunded, multi-employer defined benefit schemes in which NHS TDA is unable to identify its share of the underlying assets and liabilities. NHS TDA contributes annual premiums and retains no further liability except in the case of employees who take early retirement. The scheme is accounted for as a defined contribution scheme.

In 2019/20, £5,537,615 of pension cost has been recognised relating to payments made by DHSC to the NHS Pension Scheme on NHS TDA's behalf.

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.

A small number of employees contribute to the National Employment Savings Trust (NEST) pension.

## 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.

### 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

#### 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 IFRSs, amendments and interpretations in issue but not yet effective, or adopted

International Accounting Standard 8, accounting policies, changes in accounting estimates and errors, requires disclosure in respect of new IFRSs, amendments and interpretations that are, or will be, applicable after the accounting period. There are a number of IFRSs, amendments and interpretations issued by the International Accounting Standards Board that are effective for financial statements after this accounting period.

#### 1.13.1 IFRS 16 Leases

Adoption of IFRS 16 has been deferred for the public sector by HM Treasury. However decisions have been taken by HM Treasury on key aspects of accounting which does 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. Leased assets for NHS TDA mainly comprise property leases. The estimated annual lease charges within agreements are c£5.1 million as disclosed in the operating leases note to the accounts. It is likely that NHS TDA will occupy the property for several years and that the move to IFRS 16 will have a material impact on gross assets.

#### 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. The impact on NHS TDA accounts is not expected to be material.

#### 1.13.3 IFRIC 23 Uncertainty over Income Tax Treatments

Application required for accounting periods beginning on or after 1 January 2019. The impact on NHS TDA accounts is not expected to be material.

### 1.14 Machinery of Government changes

From 1 April 2019, the NHS Leadership Academy transferred from Health Education England to NHS TDA. This has been accounted for as a transfer by absorption. No assets or liabilities transferred with the Academy and all staff and service contracts switched to NHS TDA with effect from 1 April 2019.

## 2. 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 Healthcare Safety Investigation Branch. Assets and liabilities are not split in this way so not reported here.

| 2019/20 | Administration | Programme | HSIB | Total |
|---|---|---|---|---|
| | £000 | £000 | £000 | £000 |
| Revenue | (5,478) | (23,194) | - | (28,672) |
| Expenditure | 86,866 | 146,024 | 19,287 | 252,177 |
| **Net operating costs** | **81,388** | **122,830** | **19,287** | **223,505** |

| 2018/19 | Administration | Programme | HSIB | Total |
|---|---|---|---|---|
| | £000 | £000 | £000 | £000 |
| Revenue | (5,628) | (31,356) | (3) | (36,987) |
| Expenditure | 76,118 | 77,889 | 11,925 | 165,932 |
| **Net operating costs** | **70,490** | **46,533** | **11,922** | **128,945** |

### Administration

The financial objectives of the NHS TDA is to manage the recurrent costs of management and administration within the allocation of £82,008,000. This funding covers staff, accomodation and other running costs.

### Programme

The NHS TDA received an allocation of £123,286,000 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 £23,200,000, £16,014,000 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 £19,800,000.

## 3. Revenue

| | 2019/20 | 2018/19 |
|---|---|---|
| | £000 | £000 |
| **Administration revenue** | | |
| Recharge to NHS England for joint working costs | 2,664 | - |
| Revenue in respect of seconded staff | 1,449 | 2,094 |
| Other miscellaneous revenue | 1,365 | 3,389 |
| Other fees and charges | - | 112 |
| Rental revenue recovery | - | 33 |
| **Total administration revenue** | **5,478** | **5,628** |
| | | |
| **Programme revenue** | | |
| Provision of emergency care improvement programme and elective care intensive support | 10,365 | 10,308 |
| Provision of NHS Leadership Academy training | 6,708 | - |
| Recharge to NHS England for joint working costs | 3,454 | - |
| Revenue in respect of seconded staff | 673 | 239 |
| Other miscellaneous revenue | 1,994 | 1,490 |
| Provision of the Getting It Right First Time (GIRFT) programme | - | 19,322 |
| **Total programme revenue** | **23,194** | **31,359** |
| | | |
| **Total revenue** | **28,672** | **36,987** |

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. No income was received in 2019/20 as the funding mechanism changed and the costs have instead been funded through grant-in-aid.

Due to the timing of invoices for the intensive support schemes, income recognised in this line in 2019/20 includes a material element of release of deferred income.

## 4. Employee benefits and staff numbers

### 4.1 Employee benefits

| | 2019/20 | 2018/19 restated |
|---|---|---|
| | £000 | £000 |
| **Gross expenditure** | | |
| Salaries and wages | 107,427 | 76,658 |
| Social security costs | 12,337 | 9,323 |
| Employer contributions to NHS BSA - Pensions Division | 17,610 | 9,472 |
| Termination benefits | 3,542 | 1,086 |
| **Total gross expenditure** | **140,916** | **96,539** |

In 2019/20 the employer's pension contribution rate for the NHS Pension scheme increased by 6.3%. This increase was funded by the Department of Health and Social Care which paid £5,537,615 on behalf of NHS Trust Development Authority employees in the scheme. This amount is included in the figures above.

## 5. Operating expenditure

| | Note | 2019/20 £000 | 2018/19 £000 |
|---|---|---|---|
| **Purchase of goods and services** | | | |
| **Administration costs** | | | |
| Auditors' remuneration for NHS TDA | | 53 | 50 |
| Auditors' remuneration for consolidated accounts of NHS providers | | 132 | 110 |
| Business travel | | 2,138 | 2,527 |
| Consultancy | | 884 | 304 |
| Establishment expenses | | 1,898 | 2,065 |
| Information and communications | | 840 | 637 |
| Premises | | 3,886 | 2,794 |
| Professional fees | | 3,362 | 1,215 |
| Miscellaneous expenditure | | 1 | - |
| **Sub-total** | | **13,194** | **9,702** |
| **Programme costs** | | | |
| Business travel | | 6,199 | 2,684 |
| Consultancy | | 1,274 | 88 |
| Establishment expenses | | 37,890 | 3,002 |
| Information and communications | | 4,333 | 3,212 |
| Premises | | 1,997 | 354 |
| Professional fees | | 11,130 | 7,363 |
| Miscellaneous expenditure | | 5 | - |
| **Sub-total** | | **62,828** | **16,703** |
| **Total purchase of goods and services** | SoCNE | **76,022** | **26,405** |

Within Programme professional fees there is £3,858,000 relating to the Operational Productivity programme (2018-19 £3,702,000), £2,619,000 relates to the Clinical Investigations (2018-19 £905,000), £2,166,000 that relates to NHS Leadership Academy Training (2018-19 £0), £975,000 relates to the Patient Safety programme (2018-19 £975,000), and £510,000 that relates to the Transformation programme (2018-19 £836,000).

| | Note | 2019/20 £000 | 2018/19 £000 |
|---|---|---|---|
| **Depreciation and impairment charges** | | | |
| **Administration costs** | | | |
| Depreciation | 7.1 | 165 | 101 |
| Amortisation | 7.2 | 413 | 204 |
| **Sub-total** | | **578** | **305** |
| | | | |
| **Programme costs** | | | |
| Depreciation | 7.1 | 222 | 217 |
| Amortisation | 7.2 | 50 | 54 |
| **Sub-total** | | **272** | **271** |
| | | | |
| **Total depreciation and impairment charges** | SoCNE | **850** | **576** |

| | Note | 2019/20 £000 | 2018/19 £000 |
|---|---|---|---|
| **Other operating expenditure** | | | |
| **Administration costs** | | | |
| Miscellaneous Expenditure | | 1,461 | 3,675 |
| Non-executive members' remuneration | | 108 | 80 |
| **Sub-total** | | **1,569** | **3,755** |
| | | | |
| **Programme costs** | | | |
| Miscellaneous Expenditure | | 3,219 | 2,862 |
| Non-executive members' remuneration | | 15 | - |

| | Note | 2019/20 £000 | 2018/19 £000 |
|---|---|---|---|
| **Funding provided to NHS trusts and partners:** | | | |
| Emergency care improvement programme | | 439 | - |
| Intervention and support to NHS Trusts | | 131 | - |
| Operational productivity | | 18,888 | 17,714 |
| Patient Safety Collaboratives | | - | 7,023 |
| Special measures and peer improvement | | 4,760 | 8,184 |
| NHS Leadership Academy | | 2,242 | - |
| Trust transactions and sustainable solutions | | 3,126 | 2,874 |
| **Sub total** | | **32,820** | **38,657** |
| **Total other operating expenditure** | SoCNE | **34,389** | **42,412** |
| **Total operating expenditure** | SoCNE | **111,261** | **69,393** |

The operational productivity funding to providers includes the GIRFT programme partnership with the Royal National Orthopaedic Hospital NHS Trust.

## 6. Operating leases

| | 31 March 2020 | 31 March 2019 restated |
|---|---|---|
| | £000 | £000 |
| **Payments recognised as an expense in year** | | |
| Minimum lease payments | 5,122 | 3,036 |
| **Total** | **5,122** | **3,036** |
| | | |
| **Payable** | | |
| No later than one year | 1,544 | 1,057 |
| Between one and five years | 2,874 | 1,586 |
| After five years | 89 | 214 |
| **Total** | **4,507** | **2,857** |

Prior year lease information has been restated to include arrangements within the DHSC group arising from a review of the arrangements for several buildings. There has been an increase in lease costs in 2019/20 due mainly to the transfer of NHS Leadership Academy leases.

Rent is payable in accordance with the occupancy documentation associated with each of the properties.

Many of the property arrangements are rolling agreements without a specific end date which leads to the difference between in-year charges and future commitments figures seen in this note.

## 7. Non-current assets

### 7.1 Property, plant and equipment

| 2019/20 | Information technology | Furniture & fittings | Total |
|---|---|---|---|
| | £000 | £000 | £000 |
| **Cost** | | | |
| At 1 April 2019 | 923 | 617 | 1,540 |
| Additions purchased | 27 | 119 | 146 |
| Disposals | - | (62) | (62) |
| **At 31 March 2020** | **950** | **674** | **1,624** |
| **Accumulated depreciation** | | | |
| At 1 April 2019 | 571 | 339 | 910 |
| Charged during the year | 188 | 200 | 388 |
| Disposals | - | (28) | (28) |
| **At 31 March 2020** | **759** | **511** | **1,270** |
| Net book value at 31 March 2019 | 352 | 278 | 630 |
| **Net book value at 31 March 2020** | **191** | **163** | **354** |

| 2018/19 | Information technology | Furniture & fittings | Total |
|---|---|---|---|
| | £000 | £000 | £000 |
| **Cost** | | | |
| At 1 April 2018 | 743 | 617 | 1,360 |
| Additions purchased | 193 | - | 193 |
| Disposals | (13) | - | (13) |
| **At 31 March 2019** | **923** | **617** | **1,540** |
| **Accumulated 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** |

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

## 7.2 Intangible assets

| 2019-20 | Software purchased | Assets under construction | Websites | Total |
|---|---|---|---|---|
| | £000 | £000 | £000 | £000 |
| **Cost** | | | | |
| At 1 April 2019 | 130 | 1,478 | 1,439 | 3,047 |
| Additions purchased | - | 715 | 153 | 868 |
| **At 31 March 2020** | **130** | **2,193** | **1,592** | **3,915** |
| **Accumulated amortisation** | | | | |
| At 1 April 2019 | 80 | - | 267 | 347 |
| Charged during the year | 40 | - | 422 | 462 |
| **At 31 March 2020** | **120** | **-** | **689** | **809** |
| Net book value at 31 March 2019 | 50 | 1,478 | 1,172 | 2,700 |
| **Net book value at 31 March 2020** | **10** | **2,193** | **903** | **3,106** |

| 2018-19 | Software purchased | Assets under construction | Websites | Total |
|---|---|---|---|---|
| | £000 | £000 | £000 | £000 |
| **Cost** | | | | |
| 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** |
| **Accumulated 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** |

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

## 8. Trade receivables and amounts falling due within one year

| | 31 March 2020 | 31 March 2019 |
|---|---|---|
| | £000 | £000 |
| Contract Receivables | 16,016 | 8,593 |
| Prepayments | 6,769 | 435 |
| VAT | 907 | 303 |
| **Trade and other receivables** | **23,692** | **9,331** |

## 9. Cash and cash equivalents

| | 31 March 2020 | 31 March 2019 |
|---|---|---|
| | £000 | £000 |
| **Opening balance** | 2,223 | 7,100 |
| Net change in cash and cash equivalent balance | 6,668 | (4,877) |
| **Closing balance** | **8,891** | **2,223** |
| | | |
| **Made up of** | | |
| Cash with Government Banking Service | 8,891 | 2,223 |
| **Cash and cash equivalents as in Statement of Financial Position** | **8,891** | **2,223** |

## 10. Trade payables and other liabilities

### 10.1 Trade payables and other current liabilities falling due within one year

| | 31 March 2020 | 31 March 2019 |
|---|---|---|
| | £000 | £000 |
| Other taxation and social security | 3,035 | 17 |
| Trade payables | 20,279 | 13,335 |
| Other payables | - | - |
| Accruals | 35,725 | 10,591 |
| Contract liabilities | 677 | 7,704 |
| **Trade and other payables** | **59,716** | **31,647** |

Decrease in contract liabilities mainly relates to a reduction in deferred income due to the timing of income receipts.

### 10.2. Trade payables and other non current liabilities falling due after one year

| | 31 March 2020 | 31 March 2019 |
|---|---|---|
| | £000 | £000 |
| Contract liabilities | 824 | - |
| **Trade and other payables** | **824** | **-** |

## 11. Commitments

The NHS TDA and Monitor entered into an agreement with The Royal National Orthopaedic NHS Trust (RNOH) relating to the GIRFT 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 £18,726,290.

| | 31 March 2020 | 31 March 2019 |
|---|---|---|
| | £000 | £000 |
| **Payable** | | |
| No later than one year | 10,604 | 18,379 |
| Between one and five years | - | 11,569 |
| After five years | - | - |
| **Total** | **10,604** | **29,948** |

## 12. Financial instruments

### 12.1 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.

### 12.2 Financial assets

| | 2019/20 | 2018/19 |
|---|---|---|
| | £000 | £000 |
| Financial assets held at amortised cost | 25,814 | 11,119 |
| **Total at 31 March** | **25,814** | **11,119** |

### 12.3 Financial liabilities

| | 2019/20 | 2018/19 |
|---|---|---|
| | £000 | £000 |
| Financial liabilities held at amortised cost | 59,039 | 23,943 |
| **Total at 31 March** | **59,039** | **23,943** |

## 13. Events after the reporting period

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.

## 14. 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, NHS Foundation Trusts and the National Health Service Pension Scheme.

Since the set up of NHS Improvement and the joint working with NHS England, NHS England and Monitor are considered related parties of NHS TDA.

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 (2018/19 NIL).

The remuneration of senior management and non-executives is disclosed in the Remuneration and Staff Report.

# Appendices

# Appendix 1: How we have delivered against the Government's Accountability Framework to the NHS

The Government's mandate to NHS England sets the strategic direction for NHS England, describes the Government's healthcare priorities and the contribution NHS England and NHS Improvement are expected to make within the allocated budget. It also helps to ensure the NHS is held accountable to Parliament and the public.

For 2019/20, in line with the NHS Long Term Plan and ever closer joint working between our organisations, the NHS England mandate and NHS Improvement remit letter have been combined into a single Accountability Framework. The 2019/20 Accountability Framework set out deliverables against two overarching objectives – ensuring the effective delivery of the NHS Long Term Plan and supporting Government in managing the efforts of EU exit on health and care. 68 specific deliverables were set out alongside these overarching objectives in an annex to the mandate.

Towards the end of the reporting year, the Level 4 National Incident, declared as a result of COVID-19, fundamentally transformed the way in which the NHS operated. As such, a number of deliverables from the Accountability Framework were reprioritised and, in some cases, updated or redefined as part of the COVID-19 response. Despite this, the NHS response to the emergency has continued to demonstrate the dedication and resilience of the NHS and its staff to continue to deliver in many priority areas. Across the country, thousands of staff offered to return to the NHS to support with the COVID-19 frontline response. Actions taken by the NHS to increase capacity meant there have been enough beds and respiratory support to respond to demand.

This assessment of performance against the Accountability Framework therefore captures our broad assessment of performance before the incident was declared, using assessments made during the year, and agreed between NHS England and NHS Improvement policy teams and their counterparts in DHSC.

In summary, NHS England and NHS Improvement were on track to deliver 90% of its commitments in the 2019/20 Accountability Framework with 4% considered to be off track. The remaining deliverables were either superseded by other commitments in-year or it has not been possible to assess performance because of the response to COVID-19.

## Objective 1: Ensure the effective delivery of the NHS Long Term Plan

### 1a) Laying the foundations for successful implementation of the NHS Long Term Plan

- In June 2019, NHS England and NHS Improvement published both the Interim People Plan and the NHS Long Term Plan Implementation Framework, which marked the first phase in the development of an NHS workforce implementation strategy. Following publication, NHS England and NHS Improvement oversaw strategic planning within each STP and ICS across England. Each system produced a locally-owned, clinically-led NHS Long Term

Plan implementation plan which specified their approach to meet all NHS Long Term Plan commitments and meet the Government's five financial tests. The overarching National Implementation Plan was halted as a result of COVID-19, but locally-owned, clinically led plans will be crucial when planning the recovery from the pandemic.

- NHS England and NHS Improvement worked closely with the Government to develop the National Implementation Plan and the NHS People Plan. The significant amount of work undertaken by NHS England and NHS Improvement, Health Education England and the DHSC prior to the COVID-19 incident allowed a number of the anticipated People Plan commitments to be accelerated to grow and transform the workforce and potentially capture long lasting cultural change. Specific elements that have been accelerated include:
  - An enhanced staff health and wellbeing offer, including targeted support for our BAME and most vulnerable staff, and opportunities for flexible and remote working (as outlined in the 'Making the NHS the best place to work' chapter);
  - Enhanced and expanded roles to allow staff to work beyond traditional boundaries e.g. to support critical care units (as outlined in the 'Accelerating workforce redesign' chapter); and
  - Digital transformation of outpatient appointments (as set out in the 'Releasing time for care' chapter).

  These principles will underpin effective COVID-19 recovery planning while helping deliver longer term service goals.

### 1b) Achieving financial balance

- The NHS has started to put down the foundations of financial sustainability, with the number of NHS providers reporting a deficit falling by half. We welcome the Government's announcement of a clean slate for trusts, writing off £13.4 billion in debts.
- NHS England and NHS Improvement were on course to deliver against their responsibilities to achieve financial balance across the system at mid-year including delivery of cash-releasing productivity gains of 1.1%. However, the impact of COVID-19 meant that reporting on cash-releasing productivity was suspended.
- The impact of COVID-19 has significantly impacted our ability to accurately assess delivery of cash releasing productivity gains and we are working with the department to assess how this should be captured.
- As the whole health and care system mobilised to respond to the challenge of COVID-19, this gave rise to a financial impact in the final months of 2019/20.
- Assessment for the reporting period pre-COVID-19, provides assurance that NHS England and NHS Improvement met their responsibility to achieve broad financial balance in the NHS over the reporting period and was within funding limits.
- NHS England and NHS Improvement have maintained their commitment to the Better Care Fund. Planning requirements were published in July 2019 along with allocations of the £3.84 billion NHS contribution. Plans from local areas were submitted at the end of September followed by an assurance process.

### 1c) Maintaining and improving performance, and improving the quality and safety of services

- 2019/20 was the start of the transition towards outcomes set out in the interim report on the clinically-led review of NHS access standards (published in March 2019). However, in light of continued increase in demand, meeting all core standards has been challenging. By January 2020, demand for A&E increased by 4% to reach 21,515,736 compared to 2019. More people were seen for urgent investigation of possible cancer (2,161,761 compared to 2,025,491 in 2019). Despite this the NHS managed to reduce the proportion of people waiting more than 52 weeks for treatment by 24% reaching 1,643 in January 2020 (compared to 2,169 in January 2019).
- COVID-19 had an unprecedented impact towards the end of the reporting year. The pandemic reversed progress on people waiting 52+ weeks for treatment, with 3,097 people waiting for treatment by the end of March 2020, mainly due to the postponement of non-urgent elective activity. By March 2020, the total number of people treated in A&E reached 1,531,800, a 29% reduction compared to the previous year. 181,873 people were referred for urgent investigation of possible cancer which represented a 7% reduction compared to March 2019.
- NHS England and NHS Improvement are working with DHSC to address these issues and will review performance measures through the Clinical Review of Standards to reflect the impact COVID-19 has had.
- The Clinical Review of Standards was commissioned to review NHS England's performance standards and recommend any updates and improvements to these standards. Following the publication of its interim report, NHS England and NHS Improvement began testing across all standards and progress was made in understanding the impact of the proposals to help determine possible approaches for national implementation. However, the COVID-19 response has meant plans for the publication of the findings so far and further consultation are currently postponed. This will consequently lead to an extraordinary increase in demand and the Clinical Review of Standards will need revisiting to ensure they reflect the transformation of the system.
- The COVID-19 response has disrupted our delivery but has also fast-tracked the re-design of outpatient care. Our hospitals have transformed, and we have accelerated the use of technology in GP surgeries, mental health services and hospital clinics. General practice has made changes on a remarkable scale in response to COVID-19, from a system which carried out most of its work face-to-face to providing most services remotely. Video consultations are now available in 99% of practices (from only 5% pre-COVID-19), covering 99% of the population – this is based on data from suppliers combined with intelligence gathered from practices and clinicians. The availability of online consultations in general practice grew very rapidly in 2020 in response to the COVID-19 pandemic. Online consultations are now available in more than 90% of practices, a rise from approximately 40% in March 2020. As part of the second phase of COVID-19 recovery, we are working with systems to resume non-COVID-19 urgent services. Our focus will remain on improving patient flow so that patients are seen, treated and discharged safely and quickly.

### 1d) Establishing a joint NHS England and NHS Improvement operating model to deliver integrated system leadership of the NHS

- NHS England and NHS Improvement have successfully been brought more closely together to deliver a new model of joint working strengthening their ability to support the NHS and improving its focus on the delivery of the NHS Long Term Plan.
- The implementation of the new operating model, with seven integrated regional teams, has started to deliver improvements. These seven integrated regions now have a "single conversation" with commissioners and providers – hitherto organisations sometimes received different messages. This has enabled regions to take a more holistic view of the use of NHS resources and of the support required to improve quality of care and health outcomes.
- In turn, this has helped local health and care organisations to work together and to develop integrated care systems, which now cover half of the country by population and provide more joined up care for service users – working across the NHS, local government and the voluntary sector – with a stronger focus on improving the health of populations. This partnership approach to delivering care, preventing illness and improving health has accelerated during the COVID-19 pandemic, with staff working across institutional and professional boundaries to provide services to their communities.

## Objective 2: Support Government in managing the effects of EU Exit on health and care

- NHS England and NHS Improvement effectively prepared for EU Exit, with a particular focus on readying the system for a 'no deal' EU Exit. The NHS was in a good position of readiness, despite many factors being out of our control and the reliance on contingency plans being put in place by other government departments.
- NHS England and NHS Improvement have regularly input into the DHSC preparations for EU Exit, focussing on the following key areas:
  - Testing and contributing to DHSC contingency plans to consider NHS-specific impacts
  - Making ready the health and care system by increasing alignment of the National Coordination Centre (NCC) and the National Supply Disruption Response (NSDR), and extensively engaging with the NHS.
  - Assurance of high level of system preparation by revising "baseline" assurance exercise to re-assess levels of organisational preparedness.
  - Transition to incident response with hours of operation extended, daily data reporting and a new tiered escalation model of clinical advice with seven 'shortage response groups' of subject matter experts and clinicians in place.

# Appendix 2: Meeting our Public Sector Equality Duty

## Advancing equality and the NHS Long Term Plan and developing the NHS People Plan

By addressing our health inequalities duties, in conjunction with our Public Sector Equality Duty (PSED), NHS England and NHS Improvement have taken a strategic approach to addressing both sets of legal duties. A central focus during the COVID-19 pandemic and the recovery phase is on reducing health inequalities and advancing equality within the context of COVID-19.

In January 2019, NHS England published the NHS Long Term Plan and an Equalities and Health Inequalities Impact Assessment[1] (EHIA). NHS England and NHS Improvement have worked in partnership to ensure that the commitments set out in the NHS Long Term Plan in relation to advancing equality of opportunity are effectively delivered. In June 2019, NHS England and NHS Improvement published the NHS Long Term Plan Implementation Framework together with a range of resources that support equalities and the PSED[2].

During 2019/20, NHS England and NHS Improvement worked together, with a wide range of partners, to develop the Interim People Plan. The Interim People Plan, published in June 2019[3], made a commitment to the development of a full EHIA.

In view of the COVID-19 pandemic, the Equality and Human Rights Commission (EHRC) and the Government Equalities Office (GEO) decided to suspend the requirement for annual publication of various information. This means the next statutory publication timetable will not be until after March 2021.

## Equality objectives for 2016/17 – 2020/21

NHS England's equality objectives for 2016 – 2020 addressed our role as an NHS system leader, commissioner and our own role as an employer. Each equality objective was supported by a number of targets[4]. The six overall objectives were:

1. To improve the capability of NHS England's commissioners, policy staff and others to understand and address the legal obligations under the PSED and duties to reduce health inequalities set out in the NHS Act 2006 (as amended).
2. To improve disabled staff representation, treatment and experience in the NHS and their employment opportunities within the NHS.
3. To improve the experience of Lesbian, Gay, Bisexual and Transgender People (LGBT+) patients and improve LGBT+ staff representation.
4. To reduce language barriers experienced by individuals and specific groups of people who engage with the NHS, with specific reference to identifying how to address issues in relation to health inequalities and patient safety.

1 https://www.england.nhs.uk/wp-content/uploads/2019/01/ehia-long-term-plan.pdf
2 https://www.longtermplan.nhs.uk/implementation-framework/
3 https://improvement.nhs.uk/resources/interim-nhs-people-plan/
4 https://www.england.nhs.uk/about/equality/objectives-16-20/

5. To improve the mapping, quality and extent of equality information in order to better facilitate compliance with the PSED in relation to patients, service-users and service delivery.
6. To improve the recruitment, retention, progression, development and experience of the people employed by NHS England to enable the organisation to become an inclusive employer of choice.

NHS England and NHS Improvement recognise the far reaching and adverse nature of the COVID-19 pandemic's impact on equalities and health inequalities. In light of the COVID-19 pandemic NHS England and NHS Improvement will add an additional objective to the equality objectives agreed for 2016-20, which will also be extended by a further year to cover 2020/21.

This additional equality objective is set out below.

7. To ensure that the equality and health inequality impacts of the COVID-19 are fully considered and that clear strategies are developed and implemented for the NHS workforce and patients. To ensure that the NHS People Plan and patient focused strategies reflect this and make an effective contribution to advancing equality for all protected characteristics and to reducing associated health inequalities.

## Workforce Race Equality Standard

Since 2015, NHS England has been leading the strategic approach to workforce race equality across the NHS. The Workforce Race Equality Standard (WRES)[5] supports NHS organisations to identify and close the gaps in workplace experience between BAME and white staff. Annual WRES data reports show year-on-year improvements across several WRES indicators. In 2019/20, the national WRES team published two key strategies: (i) the Model Employer[6] strategy to increase BAME representation across the NHS workforce pipeline and at leadership levels, and (ii) A Fair Experience for All[7] framework to support NHS organisations in closing the ethnicity gap in the application of disciplinary action between staff groups. The 2019 WRES report[8] was published in February 2020. The report is the fifth publication, since the WRES was mandated and covers all nine indicators. It also compares data against previous years. Following publication, NHS England and NHS Improvement pledged actions to achieve a target of 19% BAME representation within the joint organisation by 2025.

## Workforce Disability Equality Standard

In June 2019, NHS England published the final set of metrics[9] for the Workforce Disability Equality Standard (WDES) and NHS trusts have been reporting on progress against these metrics. The first Annual WDES report was published in March 2020[10]. The report provides the first national review of the NHS workforce that relates to the workplace representation and career experiences of Disabled staff.

5 https://www.england.nhs.uk/about/equality/equality-hub/equality-standard/
6 https://www.england.nhs.uk/wp-content/uploads/2019/01/wres-leadership-strategy.pdf
7 https://www.england.nhs.uk/wp-content/uploads/2019/07/closing-the-ethnicity-gap.pdf
8 https://www.england.nhs.uk/publication/workforce-race-equality-standard-data-reporting-2019/
9 https://www.england.nhs.uk/publication/nhs-workforce-disability-equality-standard-technical-guidance/
10 https://www.england.nhs.uk/publication/wdes-annual-report-2019/

## National Advisor for LGBT+ Health

In 2019, NHS England appointed a National Advisor for LGBT+ Health, as part of the Government Equalities Office LGBT+ Action Plan. The National Advisor is working on a number of priorities to reduce health inequalities for LGBT+ people and improve their experience of health and social care services.

This includes working to improve monitoring of sexual orientation, gender identity and trans status in healthcare services and ensuring professionals understand the benefits of collecting this information to improve patient care. The National Advisor has also been working across the system to improve education and training on understanding and addressing LGBT+ health inequalities; supporting the delivery of services which are more inclusive of LGBT+ individuals and addressing the inequalities of experience of the LGBT+ NHS workforce.

# Appendix 3: Reducing health inequalities

During 2019/20, NHS England and NHS Improvement have focused on a range of work programmes with the aim of addressing and reducing health inequalities in line with the commitments set out in the NHS Long Term Plan (2019)[11], NHS Long Term Plan Implementation Framework[12] and the criteria set by the Secretary of State.

### Criterion 1: An evidence-based strategic approach to reducing health inequalities based on sound governance, accountability and good partnership working

The implementation of the NHS Long Term Plan has demonstrated a strong focus on areas where healthcare intervention can make the biggest difference:

- Prevention: Smoking, alcohol and obesity (top five risk factors for premature deaths);
- Clinically: On cancer, stroke and heart disease (50% of health inequality gap);
- Multiple morbidities: Through investment in personalisation and across all programmes. Health inequalities is now central to everything we do and a range of goals are being designed to incorporate a stronger measurable focus on narrowing and reducing health inequalities.

Over the last year, in partnership with PHE, Local Government Association (LGA), Healthcare systems (ICS/STP/CCGs and NHS Providers), health and well-being, and voluntary and community sector partners, we have worked to accelerate action nationally, regionally and locally so that the NHS and healthcare systems have the tools and resources they need to address health inequalities, segment and target disadvantaged communities according to deprivation, protected group and inclusion health group.

The following have been published:

- The Health Inequalities Menu of Evidence Based Interventions and Approaches[13]
- Equality and Health Inequalities NHS RightCare packs[14]
- PHE, LGA and the Association of Directors of Public Health published their Place Based Approaches for Reducing Health Inequalities[15]
- Population Health Management (PHM) and Reducing health Inequalities sections on the National Population Health Management Academy[16]

### Criterion 2: Systematic focussed action to reduce inequalities in access, outcomes and experience, based on a defined and evolving set of metrics

The NHS Outcomes Framework Indicators for Health Inequalities Assessment (DHSC, 2015) set out 11 indicators identified for health inequalities assessment which have been used to guide reporting in 2019/20 using data available on the NHS Digital's website. Information and data on the indicators will be published on the NHS England website in July 2020.

11 NHS Long Term Plan – Chapter 2: Prevention and Health Inequalities - https://www.longtermplan.nhs.uk/
12 https://www.longtermplan.nhs.uk/implementation-framework/
13 https://www.england.nhs.uk/ltphimenu/
14 https://www.england.nhs.uk/rightcare/products/ccg-data-packs/equality-and-health-inequality-nhs-rightcare-packs/
15 https://www.england.nhs.uk/ltphimenu/placed-based-approaches-to-reducing-health-inequalities/
16 https://future.nhs.uk/connect.ti/populationhealth/groupHome

Where data is sufficiently powered, key NHS Long Term Plan programmes are developing Health Inequalities Indicators (HIIs) at England and CCG level by deprivation and protected characteristics. Once finalised HIIs will be placed on the National Performance and Population Health Dashboard (NPPHD), allowing each CCG and healthcare system to review its health inequalities data collected locally. This information will be used to inform local commissioning decisions, segment to areas of deprivation, protected groups and inclusion health groups with poorest health outcomes, isolate key clinical areas of target, and set local metrics and measure reductions in health inequalities.

The health inequalities indicator 106 for chronic ambulatory care sensitive conditions and urgent care sensitive conditions in the CCG Improvement and Assessment Framework continues to help CCGs monitor and plan improvements in NHS equity performance and forms the basis of the Equality and Health Inequalities (EHI) Right Care Packs.

### Criterion 3: Utilise and develop the evidence of effective interventions to reduce health inequalities

The Health Inequalities Menu of Evidence Based Interventions and Approaches provides a catalogue of interventions and approaches that local healthcare systems and commissioners, working with partners across the system, can draw upon to take effective action at neighbourhood, place and system-level to reduce health inequalities, through their local improvement plans. The Menu complements the content of the Place Based Approaches for Reducing Health Inequalities (PBA), published by PHE. The Menu is being developed through a phased approach, which will run through the life of the NHS Long Term Plan. The Menu will also enable us to identify where there are gaps in evidence and to develop further or commission work to fill these gaps.

Interventions in the Menu:

- Relate specifically to priorities and commitments already signalled in the NHS Long Term Plan;
- Specifically address the gap in health access and outcomes experienced between the least and most deprived populations, and other population groups such as inclusion health and protected characteristic groups most likely to experience health inequalities, and as a key enabler, this will include levelling-up access to high quality primary and community care;
- Enable local areas to identify the specific factors which are driving health inequalities in their area, including not just clinical risk, but behaviours and the underlying causes of health inequalities, also known as the wider determinants of health.

Some of these evidence-based solutions are already being implemented by local systems. For instance, Greater Manchester and other systems are implementing the targeted and enhanced midwifery led Continuity of Carer model which significantly improves outcomes for women from ethnic minority groups and women living in deprived areas.

We have continued to review available data and information to help shape policy, drive improvement and assess progress in reducing health inequalities in all major national clinical programmes such as cancer, mental health, cardiovascular disease and stroke, respiratory care, diabetes, maternity, child health and primary care.

### Criterion 4: Improve prevention, access and effective use of services for Inclusion Health groups

During 2019/20 we have continued to support programmes focusing on prevention and access to primary care medical services, and we published information and resources that aims to make it easier for patients from inclusion health groups to overcome barriers when accessing the healthcare. We have developed a new Primary Care Access Card that will replace the current provision of a leaflet supporting and empowering inclusion health groups to register with GP services without facing discrimination of access to timely healthcare services.

We have published a range of 'how to guides' to accompany the Menu of Interventions. The guides will help local health systems to work with, and design targeted solutions for, specific vulnerable groups including Gypsy, Roma and Traveller communities, LGBT+ groups, vulnerable migrants, BAME communities, rough sleepers and offenders, and religious, spiritual and faith-based groups. In partnership with PHE and the Ministry of Housing, Communities and Local Government, we have continued the implementation of the Rough Sleepers Strategy, to ensure system compliance with the Homeless Reduction Act and the implementation of the Duty to Refer on NHS providers.

We continue to review and implement the recommendations outlined in the Ministerial - Women and Equalities Select Committee Report[17] on tackling inequalities faced by Gypsy, Roma and Traveller communities. We continue with the ongoing scoping exercise identifying the equality monitoring data gathered across major NHS data sets and propose what equality data should be gathered and how.

We have worked with the Gypsy, Roma and Traveller partners to develop health inequalities learning resources which support the PCNs, STP/ICSs to address health inequalities for all inclusion health groups and in particular Gypsy, Roma and Traveller groups. The Voluntary Community and Social Enterprise (VCSE) Inclusion Health Audit Tool aims to help STPs, ICSs and local healthcare systems to identify and engage with local inclusion health groups[18].

We have recommended that CCGs report on their use of the existing inequalities adjustment and also commissioned the Advisory Committee of Resource Allocations (ACRA) to review the existing adjustment; they will need to consider a range of issues such as how the adjustment to financial allocations is used to meet objectives in this area, including the issues raised in relation to Gypsy, Roma and Traveller communities. ACRA will report in 2021.

All of our local healthcare systems are working to implement an enhanced and targeted continuity of carer model to help improve outcomes for the most vulnerable mothers and babies living in our most deprived areas.

17 https://publications.parliament.uk/pa/cm201719/cmselect/cmwomeq/360/full-report.html
18 https://www.inclusion-health.org/

### Criterion 5: Continue its leadership of the health system to reduce inequalities, including assessing whether CCGs fulfil and report on their health inequalities duties in commissioning plans and annual reports

Working with its leadership role NHS England included in the 2019/2020 CCG Improvement and Assessment Framework (IAF) a composite to help CCGs set priorities for tackling inequalities. This informs the headline assessment of CCGs together with a number of other indicators.

Local healthcare systems are prioritising action on health inequalities and have been tasked to set measurable goals with specific interventions to narrow health inequalities.

### Criterion 6: Continue to take action to reduce health inequalities as part of work to deliver, with partners, the Five Year Forward View and the mandate to NHS England

Following the launch of the NHS Long Term Plan we are making good progress with our national programmes and local systems through the development of HIIs and interventions to reduce health inequalities, which are also segmented to key groups – such as those people living in deprived areas, people from protected groups and inclusion health groups.

Further information regarding meeting our PSED is given on page 140.

# Appendix 4: Working in partnership with people and communities

During 2019/20, we have enhanced and evolved our own approaches to working in partnership with people and communities (also known as 'patient and public involvement'), whilst also providing support and leadership for the wider health and care system.

Our NHS Citizen programme, which seeks to ensure that we hear directly from the public, has developed, with a reconstituted Advisory Group bringing together representatives from all of our public voice forums, including the NHS Youth Forum, Older People's Sounding Board and National Cancer Programme Patient and Public Voices Forum.

We have ensured that patients, carers and members of the public are able to influence our work through a range of consultations, events and surveys, informing a wide range of programmes and initiatives, including implementation of NHS Long Term Plan commitments. Many of these activities have been supported by VCSE partners, and we continue to strive to include groups who may be termed 'seldom heard', in particular 'inclusion health' groups and marginalised communities.

We have undertaken a refresh of our Patient and Public Participation Policy this year, and will be completing further work on this, related policies, and the associated frameworks for each of our direct commissioning responsibilities during 2020/21. The Policy and frameworks form part of our established process for ensuring and assuring consideration of NHS England's duty to involve the public in commissioning (section 13Q of the NHS Act 2006) as well as the duties of CCGs. In September, the Board again considered the 'Public Participation Dashboard' which offers an overview of practice including commentary on the section 13Q duty. A copy of the dashboard is available as part of meeting papers.

This year we have had a particular focus on supporting the development of PCNs, seeking to ensure that they work alongside their local communities from the outset (see below).

Information about our public participation approaches, opportunities and support is available on our Involvement Hub.

### NHS Citizen including 'citizens on the margins'

During 2019/20, we have co-hosted four events with 'WE Communities', a community group formed of people from marginalised communities. These bespoke events ensure that we hear from people who experience significant barriers to accessing health services, and poorer health outcomes, including Gypsies, Roma and Traveller people, and people with experience of sex work, drug use, homelessness, and domestic violence. This year, the events have focused primarily on primary care and the development of PCNs, exploring how they can improve services with and for marginalised communities, how to ensure digital inclusion for those who may experience barriers, and how to improve access in all forms. These have been an opportunity for professionals to hear directly from people with real, often traumatic, experiences, and to work towards practical and innovative solutions together. A report of each event has been produced and shared, ensuring that the insight is available to professionals working locally and nationally on developing PCNs.

## Children and young people's participation

2019/20 has been an extraordinary year for increasing the voice and impact of young people in our decision making. Our NHS Youth Forum has gone from strength-to-strength, and we have introduced a 'Youth Expert Advisor' role to explore how we can benefit from the experience and connections of alumni members.

Significant achievements include the NHS Youth Voice Summit held in April 2019, which was co-designed and co-produced with young people. The event brought together over 200 children and young people, youth support workers and senior leaders, including members of our Joint Boards, to discuss how the NHS Long Term Plan goals can be achieved in the context of youth volunteering and social action. Outcomes from the summit include young people joining the National Children and Young People's Board, direct connections between young people and our Chairs, and a pilot reverse mentoring programme between a Youth Forum Member and our Chief People Officer, with plans to expand this over the coming year.

Going forwards, we will continue to ensure young people can shape our work. The Youth Social Action and volunteering programmes[19] were launched. This includes partnership working with St John Ambulance and NHS trusts on the NHS Cadets Programme that aims to enable 10,000 young people to develop their skills in First Aid, Mental Health and other core skills.

## Young people's inpatient mental health services

Over the last year we have been working in partnership with parents, carers, Young Minds, Rollercoaster Family Support and the Royal College of Psychiatrists' Quality Network for Inpatient Child and Adolescent Mental Health Services (QNIC) to develop a resource for parents of young people in inpatient mental health units (including secure units). This is often a distressing time for parents, being separated from a child who is often at crisis point.

We have held co-design events with parents to understand their information and support needs, especially during the critical first 24-hour period. Parents explained that they often had practical questions which went unanswered and it was agreed that a '24-hour card' setting out key questions would be a useful aid, prompting staff to sit down with parents to complete the card together. This would help to build trust between parents and staff and promote parents' involvement at all stages of inpatient care. The '24-hour card' is in the final stages of development and will be launched, alongside an online information resource for parents at different points in their journey, early in 2020/21.

The implementation of the resource will be supported through relevant service specifications and through the inclusion of the resource in QNIC's standards, which will then form part of peer reviews. It is hoped that this resource will not only support parents to have the right information at the right time but also support a cultural shift towards parents being central to their child's mental health treatment. We will continue to work with parents, families and young people with experience of inpatient mental health services during the coming year.

19 See https://www.england.nhs.uk/participation/get-involved/how/forums/nhs-youth-forum/ for more information.

## Primary Care Networks

First announced in the NHS Long Term Plan, by July, nearly all GP practices across England had signed up to a PCN. PCNs are local networks of primary and community health and care services with collective responsibility for the health and wellbeing of a defined population, usually 30-50,000 people.

In our system leadership role, we have been rolling out a support offer to PCNs to support them to work in partnership with people and communities from their inception and to establish routes for ongoing dialogue. Resources to support PCNs in assessing their own development and accessing support have made clear that to progress PCNs need to work increasingly with and empower the people they serve.

We have delivered over 15 webinars, reaching more than 1000 people directly, on topics including co-production, asset-based approaches, Patient Participation Groups, and digital inclusion. Meetings of 'inclusion health' practices and practices serving deprived communities have also been convened, as well as leading sessions at a range of events. We have supported innovative practice locally, including around access for marginalised communities and embedding coproduction, ensuring the learning can be shared nationally.

Over the coming year, we will continue to support PCNs to work in partnership with people and communities, including through training and development, professional networks and spreading good practice.

## Co-production of maternity services with service users

Co-producing safe and personal maternity care is fundamental to how we work – with service user representatives at national, regional and local level

Fifteen national Public and Patient Voice (PPV) Partners were appointed in 2019/20, meaning that each of our maternity care transformation workstreams includes service user voice. Seven PPV Partners also support co-production in every region, ensuring effective arrangements are in place to hear parents' voices and acting as members of regional Maternity Transformation Programme boards.

At a local level, 123 user-led Maternity Voices Partnerships (MVPs) have been established across England. MVPs include those using services, those providing services (maternity and neonatal staff) and those who commission services. MVPs review maternity care and co-produce improvements, so women and families are at the heart of all that we do. Examples include MVPs using the 15 Steps for Maternity Toolkit and co-producing information for people about local maternity services. MVPs are supported by National Maternity Voices who, as well as providing resources, host a series of webinars, for example on how to ensure MVPs represent the ethnic diversity of their local areas.

## Engagement with the VCSE sectors

The VCSE sectors are critical partners in health and care, and we continue to take proactive steps to ensure they are meaningfully engaged. We have worked to embed and promote our 'principles for VCSE engagement' and have extended our programme of investment and support to STPs and ICSs to enhance the integration of the sector as a strategic voice and delivery partner.

In partnership with the DHSC and PHE, we have provided grant funding to 23 organisations to support the spread and scale of programmes supporting children and young people's mental health. We have also continued to support the VCSE Health and Wellbeing Alliance, which aims to provide a voice and improve health and wellbeing for all communities. This year, the Alliance has been involved in co-designing and delivering a range of national policies and programmes including the 'menu of evidence-based interventions to reduce health inequalities', the development of PCNs, and Population Health Management approaches.

# Appendix 5: Sustainability

This year we launched the Greener NHS programme and began work to develop a Net Zero Plan for the NHS, demonstrating the commitment we have to tackling climate change as a health emergency. Tangible actions continue to take place across the NHS to cut carbon, air pollutants and avoidable single-use plastics. Delivery over this year has already seen more than 100 NHS trusts pledge to cut single-use plastic used in canteens.

Within NHS England and NHS Improvement, we are committed to long-term sustainable development and acknowledge the potential impact that our activities may have on the environment. We will ensure that sustainable development continues to be an integral part of our work and our net-zero carbon ambitions as part of our Green Plan.

A complete set of sustainability reporting data for this year will be published in our next annual report.

Some key activities from this year include:

- Participating in the Government consumer single-use plastic (CSUP) elimination scheme, working to remove CSUP from our offices over the course of this year.
- Continuing to see the benefits of ICT investment and digital ways of working with a reduction in $tCO^2e$ from business travel of 19% across NHS England, NHS Improvement and CSUs.
- Reducing paper use by a further 25%.
- Continuing to work in collaboration with NHS Property Services to progress the sustainability agenda in the non-Departmental buildings we occupy. This includes conducting energy audits across the estate, moving to renewable energy tariffs and diverting 99% of waste from landfill.

## The Sustainable Development Unit (SDU)

The SDU plays a pivotal role in embedding the principles of sustainable development into the way in which the NHS, and wider health system in England works. It supports the NHS to lead by example, in reducing its own impacts on the environment including air pollutants, plastics and carbon emissions from medicines and clinical services. The unit is jointly funded by NHS England and NHS Improvement, and PHE.

In 2019/20 the NHS launched the 'For a Greener NHS' campaign and the 'Net Zero Call for evidence' to build on the work the SDU has driven for the last twelve years. The Greener NHS campaign is engaging NHS staff in reducing the NHS' contribution to climate change. The 'Net Zero Call for evidence' has generated over 600 responses with case studies and proposals, to help shape the route to a Net Zero NHS.

An expert panel has been set up, chaired by Dr Nick Watts from the Lancet Countdown, to look at how and when the NHS could get to Net Zero. The panel will explore changes the NHS can make in its own activities, in its supply chain, and through wider partnerships, to contributing to the government's overall target for the UK.

Actions that will help cut carbon have been included in the NHS Standard Contract with trusts and the GP contract, including measures to encourage GPs to offer to lower carbon inhalers where it is clinically safe to do so; the reduction of desflurane use in general surgery; ensuring all NHS organisations have a 'Green Plan'; and ensuring all leased and purchased vehicles are low or zero emission.

The SDU has also been developing reports on the NHS contribution to delivery of the UN Sustainable Development Goals, and the level of preparedness and resilience across the health and care system for the impacts of climate change.

# Appendix 6: Glossary

| | Acronym used | Meaning |
|---|---|---|
| A | A&E | Accident and Emergency |
| | ACRA | Advisory Committee of Resource Allocations |
| | ALB | Arm's Length Body |
| | AME | Annually Managed Expenditure |
| | ARAC | Audit and Risk Assurance Committee |
| | ARP | Ambulance Response Programme |
| | ATP | Advanced Threat Protection |
| B | BAME | Black, Asian and Minority Ethnicities |
| G | CEO | Chief Executive Officer |
| | CCG | Clinical Commissioning Group |
| | CETV | Cash Equivalent Transfer Value |
| | CHC | Continuing Healthcare |
| | CIO | Chief Information Officer |
| | CMA | Competition and Markets Authority |
| | CMD | Commercial Medicines Directorate |
| | COO | Chief Operating Officer |
| | CPAG | Clinical Priorities Advisory Group |
| | CPI | Consumer Price Index |
| | CQC | Care Quality Commission |
| | CQRS | Calculating Quality Report Service |
| | CQUIN | Commissioning for Quality and Innovation |
| | CSOPS | Civil Servant and Other Pension Scheme |
| | CSUP | Consumer Single Use Plastic |
| | CRR | Corporate Risk Register |
| | CSU | Commissioning Support Unit |
| | CVD | Cardiovascular Disease |
| D | DAWN | Disability and Wellbeing Network |
| | DCO | Director of Commissioning Operations |
| | DCEO | Deputy Chief Executive Officer |
| | DEFRA | Department for Environment, Food and Rural Affairs |
| | DES | Directed Enhanced Service |
| | DHSC | Department of Health and Social Care |
| | DIL | Diversity and Inclusion Leadership |
| | DSC | Data Security Centre |
| | DSP | Data Security and Protection |
| | DSPT | Data Security Protection Toolkit |
| | DWP | Department of Work and Pensions |

| | Acronym used | Meaning |
|---|---|---|
| E | EDC | Equality and Diversity Council |
| | EHCH | Enhancing Health in Care Homes |
| | EHIA | Equality and Health Inequalities Analysis |
| | EHRC | Equality and Human Rights Commission |
| | EIP | Early Intervention in Psychosis |
| | EPRR | Emergency Preparedness, Resilience and Response |
| | EQG | Executive Quality Group |
| | ERMG | Executive Risk Management Group |
| | ESM | Executive Senior Manager |
| | ESR | Electronic Staff Record |
| | EU | European Union |
| F | FOI | Freedom of Information |
| | FReM | Financial Reporting Manual |
| | FRF | Financial Recovery Fund |
| | FSAVC | Free Standing Additional Voluntary Contributions |
| | FTE | Full Time Equivalent |
| | FTSU | Freedom to Speak Up |
| G | GAM | Group Accounting Manual |
| | GDPR | General Data Protection Regulation |
| | GEO | Government Equalities Office |
| | GIRFT | Getting It Right First Time |
| H | HCID | High Consequence Infectious Disease |
| | HII | High Impact Intervention |
| | HIIs | Health Inequalities Indicators |
| | HMRC | HM Revenue and Customs |
| | HPV | Human Papillomavirus |
| | HR | Human Resources |
| | HSIB | Healthcare Safety Investigation Branch |
| I | IAF | Improvement and Assessment Framework |
| | IAPT | Improving Access to Psychological Therapies |
| | ICO | Information Commissioners Office |
| | ICP | Integrated Care Provider |
| | ICS | Integrated Care System |
| | IFRS | International Financial Reporting Standards |
| | IG | Information Governance |
| | ISA | International Standards on Auditing |
| | ISFE | Integrated Single Financial Environment |
| | ISN | Information Standards Notice |
| J | JCRR | Joint Corporate Risk Register |
| | JERMG | Joint Executive Risk Management Group |
| L | LeDeR | Learning Disabilities Mortality Review |
| | LGA | Local Government Associations |
| | LGBT+ | Lesbian, Gay, Bisexual, Trans + |
| | LHCR | Local Health Care Record |
| | LMDP | Line Management Development Programme |
| | LMS | Local Maternity Systems |
| | LPP | Low Priority Prescribing |

| | Acronym used | Meaning |
|---|---|---|
| M | MHFA | Mental Health First Aider |
| | MHRA | Medicines and Healthcare Products Regulator Agency |
| | MoD | Ministry of Defence |
| | MRSA | Methicillin Resistant Staphylococcus Aureus |
| | MSK | Musculoskeletal |
| N | NAO | National Audit Office |
| | NARU | National Ambulance Resilience Unit |
| | NCC | National Co-Ordination Centre |
| | NCSC | National Cyber Security Centre |
| | NGD | National Data Guardian |
| | NGO | National Guardians Office |
| | NHS | National Health Service |
| | NHSCFA | NHS Counter Fraud Authority |
| | NHS DPP | The NHS Diabetes Prevention Programme |
| | NHS IMAS | NHS Interim Management and Support |
| | NHS BSA | NHS Business Services Authority |
| | NHS PS | NHS Property Services |
| | NHS SBS | NHS Shared Business Services |
| | NICE | National Institute for Health and Care Excellence |
| | NIHR | National Institute for Health Research |
| | NIS | Network and Information Systems |
| | NPPHD | National Performance and Population Health Dashboard |
| | NSDR | National Supply Disruption Response |
| O | OD | Organisational Development |
| | ONS | The Office of National Statistics |
| | OPW | Off-Payroll Workers |
| P | PCN | Primary Care Network |
| | PCSE | Primary Care Support England |
| | PCSPS | Principal Civil Service Pension Scheme |
| | PHB | Personal Health Budget |
| | PHE | Public Health England |
| | PHM | Population Health Management |
| | PHSO | Parliamentary and Health Service Ombudsman |
| | PPE | Personal Protect Equipment |
| | PPV | Patient and Public Voice |
| | PRP | Performance Related Pay |
| | PSED | Public Sector Equality Duty |
| | PSF | Provider Sustainability Fund |
| Q | QAG | Quality Assurance Group |
| | QNIC | Quality Network for Inpatient Child and Adolescent Mental Health Services |

| | Acronym used | Meaning |
|---|---|---|
| **R** | RDC | Rapid Diagnostic Centres |
| | RDEL | Revenue Department Expenditure Limit |
| | RPI | Retail Prices Index |
| **S** | SCHJDG | Specialised Commissioning and Health and Justice Delivery Group |
| | SCHJSPG | Specialised Commissioning and Health and Justice Strategy and Policy Group |
| | SDEC | Same Day Emergency Care Services |
| | SDU | Sustainable Development Unit |
| | SFI | Standing Financial Instructions |
| | SRO | Senior Responsible Officer |
| | STP | Sustainability Transformation Partnership |
| **T** | TAAC | Trust Approvals and Appointments Committee |
| | TU | Trade Union |
| **V** | VAT | Value Added Tax |
| | VCSE | Voluntary, Community and Social Enterprise |
| **W** | WDES | Workforce Disability Equality Standard |
| | WRES | Workforce Race Equality Standard |
| | WTE | Whole Time Equivalent |

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