NHS Improvement

Trust Development Authority

2020/21 Annual Report

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

THE NHS CONSTITUTION
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HC 1028

NHS Trust Development Authority

Annual Report and Accounts 2020/21

For the period 1 April 2020 to 31 March 2021

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A view from our Chair, Sir Andrew Morris

I have the privilege of having worked in the NHS for approaching 50 years – two thirds of the service's entire lifespan.

In that time, I have seen both great achievement and great pressure in plentiful measure. But I have never witnessed either things on such a consistent basis and colossal scale as during the COVID-19 pandemic.

Along with the rest of the NHS family, there was no part of the provider eco-system which wasn't affected.

Challenges which have built up for decades were exposed and magnified.

On a societal level, the health inequalities which already meant many of our neighbours – even our colleagues – could expect to enjoy fewer years of healthy life, were brought to the fore, with COVID-19 disproportionately affect those people living with obesity, Type 2 diabetes and other long term conditions, and those from certain ethnic communities.

And for the NHS specifically, our aging estates and equipment, and long-term workforce deficits – particularly in the nursing and medical workforce – which were already providing barriers to implementing modern models of care, in the context of the pandemic provided obstacles to effective, rapid and sustainable response.

But at the same time, it was the long-term strengths of the NHS as a means of providing healthcare which meant that the response we have seen to the pandemic has – as the Health and Science Select Committees concluded - been amongst the best and most innovative in the world.

We began the financial year responding to the first wave, with a mission to massively expand critical care capacity to ensure everyone who could clinically benefit could be provided with ventilation, and to muster the workforce to provide that care and the various other aspects of support a frightened public required.

We ended the financial year emerging from the very difficult second wave but having delivered over 26 million doses of highly-effective vaccines to those people – including our own staff – who are most vulnerable by virtue of their age, clinical condition or occupation.

In between, the NHS made a huge contribution to the scientific response to COVID-19, helping to find effective treatments through the RECOVERY trial and then rapidly deploy them, saving lives here and around the world.

And amongst all that, as others have observed and as detailed again in this report, the NHS continued to maintain urgent non-COVID-19 care, and has taken every window available to it to recover those less-urgent services which unfortunately, but inevitably, had to take a back seat during the most pressured periods.

Similarly, we have continued to take those opportunities which have presented themselves to improve non-COVID-19 care and achieve better outcomes for patients for the future, in line with the NHS Long Term Plan.

From implementing new models of care like Urgent Community Response and 24/7 mental health crisis lines, to bringing on new treatments for conditions such as spinal muscular atrophy, mantle cell lymphoma, cystic fibrosis and multiple sclerosis, the NHS locally, regionally and nationally has continued to abide by its enduring principle of working for better health for everyone.

Importantly, there are few, if any, of these things where the NHS has acted alone.

The year I joined the NHS it was implementing the 1973 NHS Reorganisation Act. Many more reviews, reports, policy papers, plans, Acts of Parliament and other changes have followed in the intervening years. There have however been relatively few of those which have been such an expression of the will of the service on the ground, in the way the majority of the Health and Care Bill currently before Parliament is.

The principles of partnership working to which it seeks to give statutory underpinning – both within the NHS and between the NHS and other local services – were developed in pre-pandemic times but have been shown to be vital in practice over the last two years.

As we look ahead to 2022/23 at time of writing, those partnerships – hopefully with Parliamentary backing to remove the last obstacles and disincentives – will continue to be vital in delivering a post-COVID-19 recovery, and importantly in making in-roads into some of those long-term challenges we face before the pandemic hit.

Delivering a plan for the workforce to deliver that will be a critical enabler for that renewed focus on both quality and sustainability of services in the future, but also to the immediate morale of our staff who have faced such a difficult two years. Those staff deserve our continued and fulsome thanks and praise, and they can be assured of receiving that. But they also need the confidence that things will improve in the future if we expect them to continue to sacrifice their present.

If we achieve nothing else over the coming months, getting the workforce plan right will give us the strongest platform on which to build for the future.

Andrew Morris
Chair, NHS Improvement

About NHS TDA

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 (ICSs) 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 NHS trusts (non-foundation) and to support other providers with a view to improving the quality and financial sustainability of NHS services.

We have a mandate from government, which in 2020/21 brought together the annual mandate to NHS England and the annual remit for NHS Improvement. This prioritised the NHS response to COVID-19 and continued progress in delivering the NHS Long Term Plan.

As a custodian 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 worked as a single organisation, as is permitted under the legislation governing our activities.

NHS Improvement is governed by its Board which provides strategic leadership and accountability 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 can be found from page 57.

We have 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. National directors, either reporting to the NHS England CEO or COO, operate across both organisations, and national teams provide expertise, support and intervention.

Our integrated regional teams, led by regional directors with a single reporting line to the COO, are responsible for the performance of all NHS organisations in their region in relation to quality, finance and operational performance. They work closely with sustainability and transformation partnerships (STPs) and ICSs to ensure the performance and sustainability of NHS trusts and foundation trusts are considered and supported in system-wide plans and decisions for improving health services and health outcomes for their local communities.

We support and rely on local healthcare professionals making decisions about services in partnership with patients and local communities. NHS Improvement works closely with other partners, such as Health Education England (HEE), NHS Digital, Care Quality Commission (CQC), and the National Institute for Health and Care Excellence (NICE) to ensure services are safe, effective, and clinically and financially sustainable.

Detail on how we assure the activity of our organisation can be found from page 82. For further information about how we operate please visit our website.

Our recommendations for new primary legislation to support implementation of the NHS Long Term Plan, including provision for ICSs and legally merging NHS England and NHS Improvement, were included in the government's draft Health and Care Bill.[1]

[1] https://www.gov.uk/government/publications/health-and-care-bill-factsheets/health-and-care-bill-information

Performance Report

Professor Stephen Powis
Interim CEO of NHS Improvement, and Accounting Officer

26 January 2022

Interim Chief Executive's overview, Professor Stephen Powis

As the first clinician to serve as Chief Executive of NHS Improvement, it will come as no surprise that I start this overview by paying tribute to every single one of my colleagues – whether in clinical, supporting or managerial roles – for their incredible and inspiring response to COVID-19.

Like Sir Andrew, I have had the privilege of spending many years in and around the NHS in a variety of roles. Over those years I have witnessed incredible advances in clinical care, alongside countless examples of compassion and kindness shown by colleagues to people at some of the most worrying times of their lives.

However, nothing in my career to date has compared to the quantum of pride I have felt in my colleagues during the pandemic. The tenacity we have seen from NHS staff – not just to doggedly keep going in an ever-changing and at times ever-worsening situation, but at all times to try and find ways to improve and innovate, to do things better, and to provide better outcomes and experiences for patients – has been incredible.

It has manifested in many ways: the huge increase in critical care capacity and the upskilling and redeployment of staff to work in them; the remodelling of hospitals and separation of COVID-19 and non- COVID-19 services; the rapid rollout of alternative, safe ways for people to access therapy and support in the community; and the adoption of 111 Online, 111 First, clinical assessment services and far closer working between ambulance trusts and other local services, to ensure that patients have been able to access the right care in the most appropriate place and the discovery and deployment of new treatments discovered and deployed first by the NHS.

Over the 2020/21 financial year colleagues also found a way to respond to 8.7 million ambulance incidents, 17.5 million A&E attendances and over five million emergency admissions, provide over 11 million courses of elective treatment, 18 million diagnostic tests and two million urgent cancer checks, and support millions of adults and children through the full range of mental health services.

This is addition to the incredibly impressive rollout of the COVID-19 vaccine programme – started in hospitals and with much of the early focus on Trust-led large vaccination services, but actually very much a whole-system effort with GPs and then community pharmacists delivered the lion's share of doses, and latterly community providers leveraging their particular expertise in delivering school-based services.

While I know my pride in what the NHS has collectively done is shared by colleagues, I know too that this contribution has come at huge personal cost for so many of them, not least – but certainly not only – those providing direct patient care.

Trusts and other employers have stepped up their health and wellbeing support offers, supplemented by the national health and wellbeing offer and mental health hubs. The NHS has continued to recruit tens of thousands of additional colleagues, but it is an inescapable truth that

the pandemic has taken a heavy toll on a workforce which was already running to keep up with rising demand and high vacancy rates.

In common with health services around the world, the NHS now faces the even more difficult challenge of simultaneously continuing to respond to the demands of the pandemic, while also planning and working to recover and improve for the future.

The ambitions set out in the NHS Long Term Plan in January 2019 remain our 'North Star' – in particular our drive to prevent more avoidable deaths and disability through conditions like heart disease and Type 2 diabetes.

In many cases, we have – through the necessity of the pandemic – made much faster progress on some of them than we had planned. In particular, and in addition to those examples cited by Sir Andrew, in the past 18 months we have seen both the power of digital and data solutions, and how quickly we can move to adopt them when we need to.

These have helped us and other staff do their jobs more effectively, like the NHS datastore, and the software to support the vaccination programme, but importantly there's been a strong offer for patients too. We have made years' worth of progress on rolling out the means to help people receive monitoring, support or treatment more easily at home.

COVID-19 oximetry and virtual wards is an obvious example, helping people to recover from the virus in their own home, with the confidence that their condition is being monitored and they will be called in if needed. But we've seen similar innovation in non-COVID-19 care too.

The NHS has made tens of thousands of digital spirometers available, helping children and young people with cystic fibrosis to monitor their condition at home.

By procuring a national video consultation platform for secondary care, we've seen a huge expansion in people choosing this option, avoiding 2.9 million unnecessary hospital attendances and 35,000 Emergency Department (ED) visits in just 12 months, saving patients 2.1 million hours of waiting time in total.

And in primary care, we've rolled out take-home blood pressure monitoring, reducing the time patients need to spend in a GP's surgery, as well as improving the accuracy of readings and therefore the timeliness of interventions.

Inevitably, however, progress on other objectives has inevitably been set back. New challenges – such as supporting those suffering Long-COVID-19 and addressing the additional mental health burden caused by all the pandemic has meant for individuals – have come to the fore.

Despite the incredible effort staff have made, the scale of the elective recovery challenge in particular – while an inevitable consequence of a pandemic - is huge and one I am confident as an NHS we will rise to. As a clinician I am acutely aware that every number on the waiting list represents a member of the public potentially living with a painful or life-limiting condition, potentially deteriorating, and almost certainly experiencing anxiety over when they will be seen and treated.

As we look to the future, the NHS will continue to tackle those health inequalities which were surfaced in the public's consciousness by the pandemic and continue to exist in routine care. We have an opportunity to leverage the learning and tools developed in response to COVID-19 and through the vaccination programme to address this, and in the long term to prevent ill-health and improve outcomes.

NHS staff always find a way through challenges – the pandemic experience is simply the latest and most noticeable example of that. But it's unfair – and ultimately counter-productive – to ask them to keep working at the pace they have for the last two years.

We need the right number and skill mix of staff to be able to deliver the models and quality of care we want to deliver for patients, and we need a workforce plan to deliver that.

The Secretary of State made an important commitment last year to finalise a long-term workforce supply plan by the Spring. It's crucial we get this right, and we will be working very closely with Government and other colleagues, especially in Health Education England, to ensure that it meets the future needs of the NHS, so that the NHS can meet the future needs of patients and the public.

Stephen Powis Interim CEO of NHS Improvement, and Accounting Officer.

How we measure performance

The NHS Constitution sets out the rights of patients, the public and staff. We measure and monitor performance against a wide range of constitutional performance standards and publish statistics relating to these core constitutional standards on the NHS England website[2] every month.

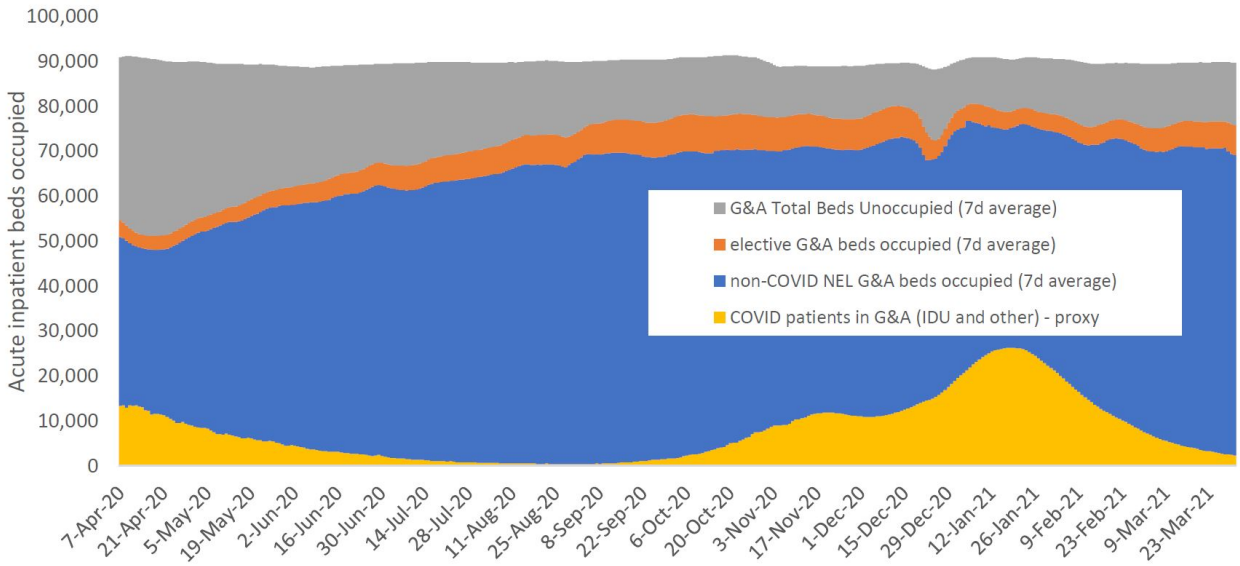
[2] https://www.england.nhs.uk/statistics/statistical-work-areas/combined-performance-summary/

Performance

The COVID-19 pandemic severely affected countries across the world throughout 2020/21 and represents the largest public health emergency in the history of the NHS. More than 400,000 people seriously ill with COVID-19 were treated in NHS hospitals in England, while new innovative treatments were developed and rolled out by the NHS, alongside new technology to support people safely at home where appropriate. The NHS in England was also the first to deliver COVID-19 vaccination outside trials, going on to deliver the biggest vaccination programme in NHS history.

However, the NHS was never a COVID-19 only service. Even at the highest peaks of occupancy for inpatients with COVID-19, there were always at least twice as many inpatients in hospitals for other reasons, as shown in the chart below.

Inpatient activity for those with and without COVID-19 in 2020/21



During 2020/21, the NHS provided over 275 million appointments in general practice, in addition to the 19.8 million COVID-19 vaccinations delivered by primary care networks. Over 11 million referral-to-treatment pathways were completed, including 1.9 million requiring admission to hospital. Over 18 million diagnostic tests were performed across imaging, endoscopy and physiological measurements (in addition to nearly 16 million PCR tests in hospitals for COVID-19).

Over two million people were urgently referred for suspected cancer in 2020/21, with more than 275,000 starting a first treatment for cancer.

Over one million patients accessed Improving Access to Psychological Therapies (IAPT) services in 2020/21, and 31,550 women accessed specialist perinatal mental health services. Over 420,000 children and young people were treated through NHS-commissioned mental health community services, and over 10,000 started treatment for an eating disorder.

The NHS 111 service answered 9.4 million calls, while the ambulance service received eight million 999 calls, attending 7.9 million incidents and transporting five million of those to hospitals. There were 17.5 million attendances at emergency departments, with 5.4 million emergency admissions, and same-day emergency care (SDEC) services supported 6.8 million patients to be treated and returned home on the same day.

Staff across the NHS rose to the challenge presented by the new virus, while maintaining a wide breadth and quality of services for all patients wherever possible. The following overview describes the scale and breadth of changes made and services delivered, both for COVID-19 and in line with the NHS Long Term Plan. The subsequent sections, from page 22, then provide additional detail of the NHS' response to the COVID-19 pandemic, alongside the progress made on multiple key priorities.

NHS England and NHS Improvement work together as a single organisation and have therefore written a joint performance report, rather than one specifically for NHS England. Unless stated otherwise, the values quoted in this report, for example in relation to future funding, are done so at an overall NHS England and NHS Improvement level.

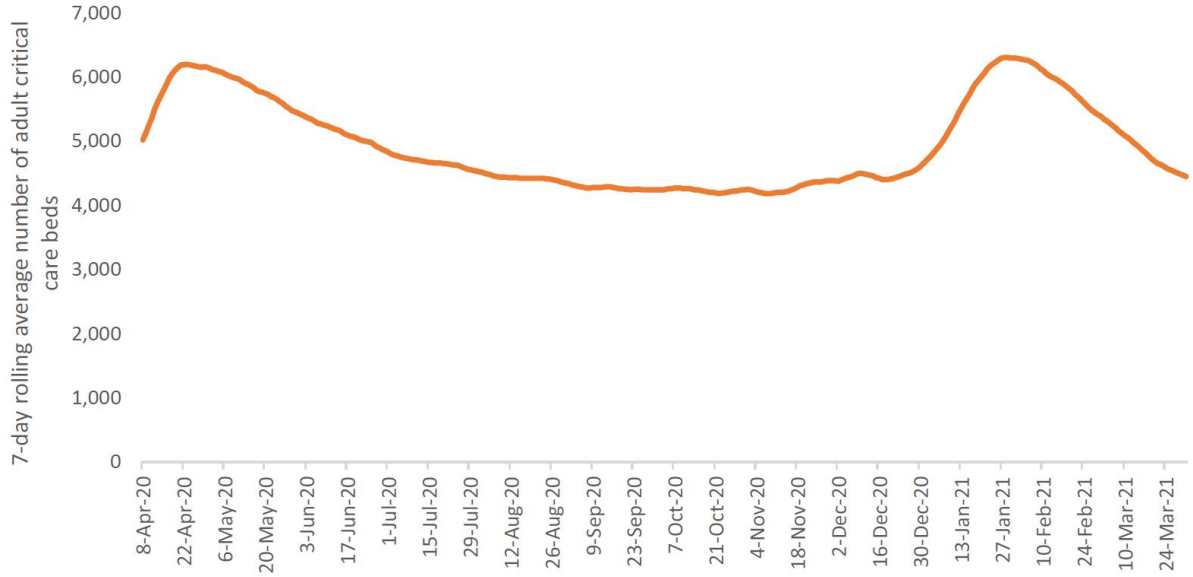
Overview

The year of 2020/21 will always be defined by the COVID-19 pandemic. But the NHS remains committed to the NHS Long Term Plan, published in January 2019, which set out an ambitious 10-year programme of phased improvements to NHS services and outcomes, led by NHS England and NHS Improvement.

The NHS treated over 400,000 people seriously ill with COVID-19 in 2020/21. At the peak in January 2021 over 34,000 NHS hospital inpatient beds were occupied by patients with a COVID-19 diagnosis, with almost 4,000 new COVID-19 positive admissions every day. This required new ways of working, with staff upskilling to take on new roles, working alongside volunteers, people returning to the service and students electing to join frontline services early.

Acute care settings were reconfigured to maintain infection prevention and control standards for patient safety; while hospitals were able to increase their capacity of critical care facilities at pace and made use of mutual aid to maximise this capacity to ensure there was always a bed for anyone who needed one. A video platform was made available to all providers over five weeks at the start of 2020/21, facilitating one of the most significant shifts in outpatient care delivery in a century. Seven Nightingale Hospitals across England were set up at pace to ensure that additional capacity was available in the event that it should be required.

The number of adult critical care beds available in NHS acute hospitals in England surged at pace when demand for inpatient care for patients with COVID-19 was highest (7-day rolling average)



Outside hospitals, COVID-19 ‘Oximetry at home’ and COVID-19 ‘virtual ward’ models were rapidly implemented to support self-management and monitoring at home for silent hypoxia. Post-COVID-19 assessment services were established to assess people with long-term effects of COVID-19, while GP practices completely transformed their operating model, enabling increased use of remote triage and remote consultations where appropriate.

NHS hospitals and primary care teams were also at the forefront of recruitment into and delivery of clinical trials to identify effective COVID-19 treatments, benefiting patients across the NHS and around the world. This helped build the evidence for treatments such as dexamethasone (estimated to have saved approximately 22,000 lives in the UK and close to one million lives globally between July 2020 and March 2021) and tocilizumab.

In December 2020, the NHS began the biggest vaccination deployment in its history, becoming the first health service globally to deliver the Pfizer/BioNTech and Oxford/Astra-Zeneca vaccines outside a trial. As of 31 March 2021, the NHS had administered nearly 26 million first doses in England, across a network of vaccination sites providing safe and easy access for the whole population, outperforming all other large countries in terms of the proportion of the population vaccinated.

At the same time, the 2020/21 NHS Annual Influenza Vaccination Programme was the most successful in its history, achieving over 80% uptake in the population aged 65 and over. This is while expanding the programme in 2020 to include 50 to 64-year olds and school pupils in Year 7.

Cancer service were prioritised throughout the pandemic. The use of ‘COVID-19-friendly’ treatments helped to reduce patient visits to healthcare settings, and COVID-secure cancer surgical hubs maximised the use of available capacity. The introduction of colon capsule endoscopy, where patients swallow a camera, was rapidly accelerated to avoid the more invasive

colonoscopy where appropriate. NHS cancer screening services continued where it was clinically safe for them to do so, with clear advice given to continue NHS screening services for the highest risk groups and to provide as much routine and preventative work as could be delivered safely. To address a drop in the number of people coming forward with potential cancer symptoms, the NHS established a cancer recovery taskforce with participation from across the cancer community to help restore referrals to pre-pandemic levels. Cancer charities also supported a major NHS media campaign to encourage people with possible cancer symptoms to come forward.

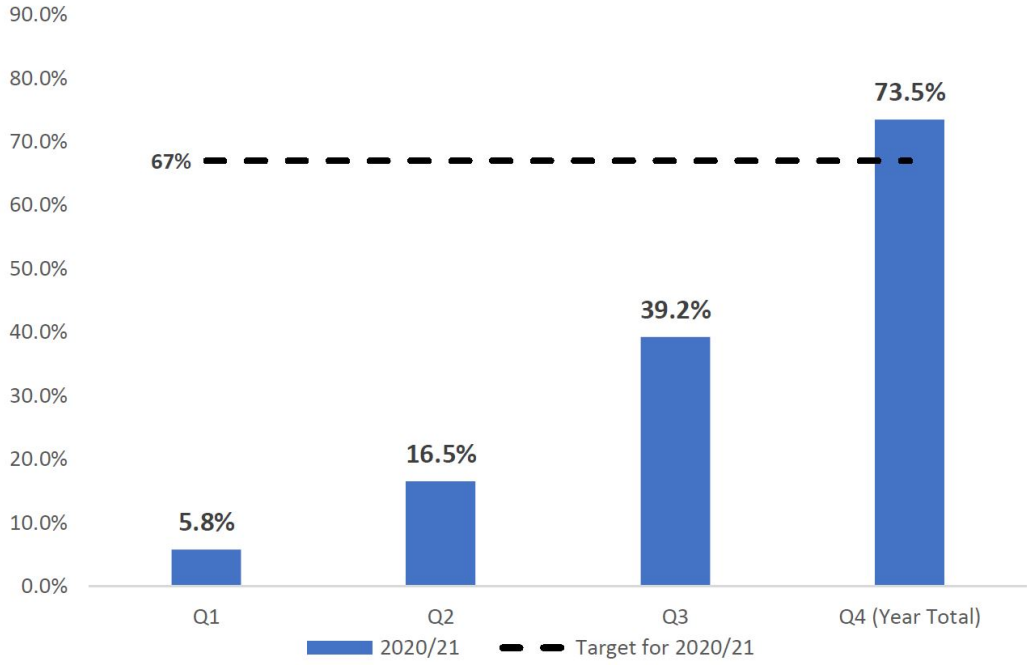
Many areas had to postpone non-urgent/non-cancer elective care due to observed or projected pressure from COVID-19. To accelerate recovery of these services, the Adopt and Adapt programme was established in June 2020 for endoscopy, CT/MRI, theatres, outpatients and cancer. Waiting list prioritisation and validation supported prioritisation of patients on waiting lists according to clinical need. Use by GPs of Advice and Guidance from specialist secondary care almost doubled, helping to avoid unnecessary referrals. The coverage of the First Contact Practitioner model to provide direct access to physiotherapists for patients with back pain, arthritis and other musculoskeletal (MSK) conditions exceeded the NHS Long Term Plan ambition.

Although the first lockdown impacted referral routes and access rates, mental health services remained open and local services worked rapidly to respond to the changing context. The national access rate for children and young people for 2019/20 was already ahead of the 2020/21 ambition (36.8% vs 36% target), and in 2020/21 was even higher at 39.6%. Specialist community perinatal mental health services have now been rolled out in every part of England. Over three-fifths of children and young people referred with eating disorders accessed treatment within four weeks for routine referrals or within one week for urgent referrals.

IAPT waiting time standards continued to be met during 2020/21, and the recovery rate for March 2021 was above the 50% target. The national standard for 60% of people to start treatment for Early Intervention in Psychosis (EIP) within two weeks was exceeded in March 2021, with a performance of over 73% in quarter 4.

The NHS supports fair access to services for people with a learning disability and autistic people. We therefore worked with primary care to ensure a choice of COVID-19 vaccination sites; made reasonable adjustments to mental health helplines; and published resources for healthcare staff. We issued clinical guidance and letters to ensure that DNACPR (do not attempt cardiopulmonary resuscitation) decisions are not made inappropriately. At the end of March 2021 there were fewer adults and fewer children and young people with a learning disability, autism or both in a mental health inpatient setting than in March 2020. Ensuring people with learning disabilities receive regular care will help tackle inequality in outcomes, and the target for those on a GP learning disability register over the age of 14 years to receive an annual health check was exceeded for 2020/21.

The percentage of annual health checks completed against a target of 67% by end of 2020/21, quarterly data for 2020/21



Maternity services continued to provide a full range of antenatal, intrapartum and postnatal care during the pandemic, with some modifications. The NHS Antenatal and Newborn screening programmes (ANNB) have been largely unaffected by the pandemic through the efforts of providers to continue these time-critical services.

Since 2010, the stillbirth rate in England has decreased by 25%, exceeding the 2020 ambition. In 2019, the stillbirth rate in England reached its lowest level on record at 3.8 stillbirths per 1,000 births, a decrease from 5.1 stillbirths per 1,000 births in 2010. The neonatal mortality rate over 24 weeks' gestation shows a 29.4% reduction between 2010 and 2019, which is excellent news. The rate of brain injuries at or soon after birth fell from 5.1 in 2017 to 4.2 per 1,000 births in 2018 and the rates of infants with hypoxic ischaemic encephalopathy fell by 15% between 2014 and 2019.

Following the Ockenden report of the independent review of maternity services at Shrewsbury and Telford Hospital NHS Trust, we have worked with trusts to implement the seven 'immediate and essential actions' identified by the report, underpinned by more than £95 million of extra funding which will be invested to improve maternity safety across England.

Most routine child, young people and adult immunisations continued, and immunisations delivered by primary care continued as usual. NHS Child Health Information Services providers continued with minimal disruption. The Digital Child Health Programme's National Events Management Service (NEMS), which can share ANNB and child immunisation data between clinical settings, is now live, covering over 50% of children aged up to five years.

Overall staff numbers are growing, and retention rates are improving across clinical groups. The overall health and wellbeing scores in the NHS Staff Survey[3] improved significantly in 2020, and the latest Workforce Race Equality Standard[4] data shows some improvement, but we still have a long way to go.

The pandemic means it is not possible to directly compare 2020/21 to previous years, but thanks to the tireless efforts of staff across the NHS working in multiple new ways, key services were maintained for anyone who needed them. More detail is provided in the following sections.

Management and treatment of COVID-19

NHS hospitals and primary care teams have been at the forefront of recruitment into and delivery of clinical trials which have identified effective COVID-19 treatments, benefiting patients across the NHS and around the world. More than a million people have taken part in COVID-19 research in the UK. National Institute for Health Research (NIHR) sponsored trials, such as RECOVERY and REMAP-CAP, have been pivotal in generating key evidence for the mortality and recovery benefits from dexamethasone (now standard in the treatment of hospitalised patients with COVID-19 requiring oxygen) and tocilizumab. Dexamethasone is estimated to have saved approximately 22,000 lives in the UK and close to one million lives globally between July 2020 and March 2021 (extrapolated from modelling in Aguas et al, 2021).

NHS England and NHS Improvement led the UK-wide commissioning and delivery arrangements for the timely rollout of treatments to eligible patients. The Research to Access Pathway for Investigational Drugs for COVID-19 (RAPID C-19) collaboration has ensured UK-wide adoption of these effective COVID-19 therapies in an average of just six days from material research findings becoming available to treating patients.

The NHS rapidly implemented COVID-19 ‘Oximetry at home’ and COVID-19 ‘virtual ward’ models, offering supported self-management and monitoring at home for silent hypoxia (where blood oxygen levels fall without obvious symptoms) and supported discharge of inpatients with COVID-19 respectively. All CCGs had set up a COVID-19 ‘Oximetry at home’ service by the end of December 2020 and over 90% of systems had established COVID-19 virtual wards by March 2021, with over 100,000 patients estimated to have benefited.

Better clinical understanding of the disease also enabled improvements in care for our most severely unwell patients. Treatment changed as clinicians learned more about COVID-19, so that more patients were cared for using non-invasive ventilation in general wards, rather than being sedated on a mechanical ventilator in intensive care.

Post COVID-19 assessment services were established to assess people with long-term effects of COVID-19 and direct them to effective treatment pathways, including a digital self-management platform.

[3] https://www.nhsstaffsurveys.com/
[4] https://www.england.nhs.uk/about/equality/equality-hub/equality-standard/

COVID-19 vaccination deployment

In December 2020, the NHS began the biggest vaccination deployment in its history, becoming the first health service globally to deliver the Pfizer/BioNTech and Oxford/Astra-Zeneca vaccines outside a trial. As of 31 March 2021, the NHS had administered nearly 26 million first doses in England, outperforming all other large countries in terms of the proportion of the population vaccinated. This extraordinary achievement, managed alongside winter pressures and the demands of treating patients with COVID-19, would not have been possible without the dedication of tens of thousands of NHS staff and volunteers.

A network of vaccination sites was designed to provide the capacity required and ensure safe and easy access for the whole population. It comprises a fully supplied network of 232 hospital hubs, 1,511 local vaccination services and 173 vaccination centres, ensuring that over 99% of the population in England live within 10 miles of an NHS vaccination service. In a small number of very rural areas, the vaccination centre is a mobile unit.

Following Joint Committee on Vaccination and Immunisation (JCVI) recommendations to prioritise the most vulnerable, the vaccination programme reached ambitious milestones – offering vaccinations to approximately 12 million people in England in the four priority groups within 10 weeks of the first vaccination, and all over-50s and high-risk groups by 15 April 2021. The programme started vaccinating cohort 10 (40 to 49 years) in April 2021, with all remaining adults aged 18 to 49 years offered a first dose by 31 July 2021. The NHS started delivering booster vaccinations in the autumn of 2021.

Addressing health inequalities has been a priority. Local engagement and collaboration across the NHS, local authorities and voluntary, community and faith sectors have ensured vaccination services can operate in underserved communities and given rise to new approaches such as opening vaccination sites in places of worship and working with trusted community voices to increase confidence and improve uptake.

Primary and community health services

Primary care providers across general practice, community pharmacy, dentistry and optometry were significantly impacted by COVID-19 during 2020/21. The need to protect patients and staff from the risk of COVID-19 infection created new challenges in delivery. A new operating model for general practice was introduced, enabling increased use of remote triage and remote consultations, where appropriate. Over 600 urgent dental centres were introduced to maintain access to urgent care while routine face-to-face services were paused. Over 4,000 optical practices remained open, providing urgent and essential care while routine services were suspended. In addition, the COVID-19 urgent eye care service (CUES) pathway was developed, involving optical practices acting as urgent eye care hubs to provide triage and remote consultations. Over 80 CCGs commissioned a CUES service from primary care optometry.

A range of social distancing and other measures enabled most community pharmacies to remain open. A national home delivery service was commissioned to support clinically extremely

vulnerable patients to have their medicines delivered, later extended to provide support to patients advised to self-isolate by NHS Test and Trace. During 2020/21 around five million deliveries were made to support vulnerable patients, avoiding the need for them to visit a GP or pharmacist to collect medicines. General practice supported patients who were advised to shield by PHE because they are clinically extremely vulnerable to COVID-19 and provided care to patients with COVID-19 infection in the community.

As part of the measures to support general practice, the COVID-19 Support Fund[5] was launched in August 2020 to assist with the additional costs of the COVID-19 response borne by practices between March and end of July that year. Following this initial package of support, we allocated an additional £150 million of revenue to CCGs, covering November 2020 to March 2021, through ICSs under the General Practice COVID-19 Capacity Expansion Fund, which supported systems in their pandemic response, with a focus on seven priority goals and the COVID-19 vaccination programme. This fund was extended from 1 April until 30 September 2021, with a further £120 million committed.

To support primary care networks (PCNs) – groupings of GP practices, typically serving a population of 30,000 to 50,000 people – with the leadership and management of the COVID-19 response, additional funding for PCN clinical directors has been provided from January to June 2021.

General practice

The five-year GP contract deal and the NHS Long Term Plan have delivered increasing investment for general practice. General practice funding rose by 8% in 2019/20 – more than twice as quickly as for the rest of the NHS. This meant the overall £12 billion investment target announced in the General Practice Forward View[6] was delivered a year ahead of schedule.

Throughout the pandemic GP practices were able to remain open to the public by completely transforming their operating model, treating patients through telephone and online consultations. Where patients needed to be seen face-to-face, commissioners established ‘hot-sites’ for people presenting with any flu or COVID-related symptoms.

PCNs firmly established themselves as an integral part of the primary care landscape: 99% of practices were part of a PCN during 2020/21, and they have played a critical part in the COVID-19 response, not least in delivering vaccination. Through the Enhanced Health in Care Homes framework, PCNs – working with community services – provided enhanced clinical support to care homes, including the establishment of a named clinical lead.

Social prescribing services have begun in all PCNs, with over 1,500 social prescribing link workers responding to 458,195 social prescribing referrals.

[5] https://www.covid19support.org.uk/
[6] https://www.england.nhs.uk/gp/gpfv/

The Additional Roles Reimbursement Scheme supports progress towards the government's commitment to provide an additional 50 million appointments in general practice by 2024/25. In addition, the Access Improvement Programme has helped practices reduce waiting times for routine appointments and work with NHSX and NHS Digital to enable improvements to general appointment data recording.

Financial and practical support for the implementation of online consultation systems, messaging and video consultation capabilities has increased alongside the continued availability of face-to-face appointments in general practice. Online consultation systems provide an additional route for patients to contact their GP practice and to support practices with triage – helping patients to receive care from the right person first time with the right level of urgency, using the appointment method that meets their needs.

Continued progress has also been made towards the government's commitment for an additional 6,000 full-time equivalent doctors in general practice. Record numbers of new GPs are being trained, and work continues with HEE to support more trainees into under-doctored areas. The range of nationally-funded schemes to retain qualified GPs in practice was expanded during the year, including the New to Partnership Payment scheme which despite the pandemic approved applications for 488 new partners for general practice. Newly qualified GPs now have the offer of a fellowship scheme on qualification, supported by a growing pool of experienced GP mentors.

Around 1,600 retired GPs returned to registered practice to support the emergency effort. Many of these were among the 2,000 GPs and 158 pharmacists recruited to the NHS 111 COVID-19 Clinical Assessment Service, delivering over 500,000 calls in the course of the pandemic with the pharmacist team delivering almost 50,000 calls to support concerns about medicines and manging symptoms of minor illness. The process for these GPs to return to longer-term practice was simplified and now offers support for the costs of childcare and caring responsibilities for returning GPs. Over the past year, this contributed to an increase of 608 doctors in general practice (438 full-time equivalent). Retention, however, remains a critical issue.

The health and wellbeing of our primary care people has been a focus throughout the year; looking after them to enable them to look after others. Bespoke coaching provided support for individual and team psychological wellbeing and resilience, and access to other support in place (national, system and local).

Take-up of the coaching offer has been strong, with over 9,000 coaching sessions with 3,300 people either completed or booked since April 2020. The service is accessible to all primary care staff.

Community pharmacy

Pharmacy also played a major role throughout the year. There were 326,000 referrals from NHS 111 to community pharmacy for urgent medicines supply and 223,000 referrals for minor illness consultation as part of the NHS community pharmacist consultation service. Community pharmacies were physically open throughout and supported patients and the public with advice on

how to manage their health and wellbeing, relieving pressure on other parts of the healthcare system.

Community pharmacies are supporting the wider COVID-19 testing strategy, led by NHS Test and Trace, with 95% of pharmacies participating in the Pharmacy Collect service to provide access to lateral flow device tests.

Tobacco and alcohol interventions developed with stakeholders during 2019/20 were rolled out in 2020/21 at early implementer sites, with smoking cessation activities incorporated into the community pharmacy contract.

Dentistry and optometry

Risks from dental care requiring aerosol generating procedures were mitigated through enhanced infection, prevention and control guidance issued by PHE and detailing the need for higher-grade personal protective equipment (PPE). The NHS rapidly set up 600 urgent dental centres across England so patient services could be maintained whilst protecting patient safety. Our key priority remains to maximise safe access to dental services that protects the public and profession and is in line with current clinical guidance from UKHSA.

Optometry services have recommenced and now have access to appropriate enhanced PPE requirements. Activity has grown steadily, and we have seen a return towards pre COVID-19 levels of activity.

Voluntary, community and social enterprise organisations

Voluntary, community and social enterprise organisations (VCSE) are critical partners in health and care, and engagement with the sector has been invaluable in supporting the NHS response to COVID-19. The sector has mobilised huge numbers of volunteers, often pivoting away from their normal activity to provide much needed support in a time of crisis.

In March 2020, we commissioned Royal Voluntary Service and GoodSAM[7] to deliver NHS Volunteer Responders (NHSVR). This programme was developed at pace to support people shielding from COVID-19 and to support NHS services. Just under 400,000 volunteers stepped forward to carry out tasks such as delivering shopping and medication, providing lifts to medical appointments, delivering medical equipment and telephone chats to combat loneliness. By 31 March 2021 they had completed more than 1.7 million tasks and supported 165,000 people.

We encourage NHSVR volunteers to raise any concerns about the wellbeing of the clients they support. To date the programme's safeguarding team have worked with local agencies to manage in excess of 10,000 issues, mostly relating to food poverty or emotional wellbeing.

NHSVR has adapted to the changing demands of the pandemic; for example, delivering pulse oximeters to support remote monitoring of patients at risk. In January 2021, 70,000 volunteers responded to our call for steward volunteers to support the COVID-19 vaccination programme.

[7] https://nhsvolunteerresponders.org.uk/the-goodsam-app

As we move out of the pandemic, we are working with local systems to harness the benefits of NHSVR and increase volunteering capacity available to ICSs.

The VCSE sector has also provided additional support within NHS services. St John Ambulance has provided extra ambulance capacity, support in emergency departments and trained vaccinators to support the COVID-19 vaccination programme. The British Red Cross, Age UK and Royal Voluntary Service also assisted with hospital discharge, ensuring that patients received the help they needed to settle back in at home. The disaster relief charity RE:ACT provided support across different parts of the NHS with services providing porters, support to staff in intensive care units with COVID-19 patients, and mortuary assistance. At a local level many VCSE organisations have also offered services to assist the NHS.

Urgent and emergency care

Accelerating the urgent and emergency care reform agenda during 2020/21 enabled services to respond to unprecedented demand and pressures, by improving access to advice for patients outside hospital, improving safe care pathways within hospitals and enabling timely discharge into the community.

Demand for urgent and emergency care services was lower in comparison with the previous year, with on average approximately 47,800 unplanned attendances per day in 2020/21. This compares with a daily average of around 68,400 attendances in 2019/20 – a reduction of just under a third. Emergency admissions via A&E were also lower compared with the previous year, with on average 1,800 fewer admissions per day (a reduction of 13.8%). Annual performance against the four-hour standard for unplanned attendances (excluding Clinical Review of Standards pilot sites) was 86.6% in 2020/21, up from 84.2% in 2019/20.

The winter period (defined as November through to February) is traditionally the most challenging for the NHS, with spikes in respiratory and gastrointestinal illnesses, and this year COVID-19. There were on average 46,200 attendances per day during winter 2020/21, down from a daily average of around 69,500 in 2019/20. A&E performance stood at 81.6%, in line with the previous winter's average performance of 81.4%.

Although nationally the levels of demand on urgent and emergency care services decreased in 2020/21, particularly for minor injuries and illnesses, the complexity and severity of presentations was considerably increased as a result of COVID-19. At the peak of January 2021, over 34,000 NHS hospital inpatient beds were occupied by patients with a COVID-19 diagnosis, with almost 4,000 new COVID-19 positive admissions recorded every day. Safe care in these circumstances, particularly for patients requiring advanced respiratory support, was a significant operational challenge, with acute care settings needing to reconfigure their staffing and capacity to maintain infection prevention and control standards and maximise critical care capacity. Acute providers were supported in their efforts by the NHS Nightingale programme as well as independent sector and community providers offering additional capacity, staff and resources as part of a co-ordinated system response.

Nationally, ambulance services met two of the six response times standards, introduced by the Ambulance Response Programme, in 2020/21 and saw improvements from 2019/20 across all six standards. All ambulance trusts regularly achieve the Category 1 90th centile standard for those patients needing the most urgent care, with a national improvement of 2.4% against last year's performance.

Throughout the pandemic, the National Ambulance Co-ordination Centre has provided 24/7 co-ordination and mutual aid support across the ambulance services.

NHS 111 demand comparisons are skewed by COVID-19, but NHS 111 received 0.4% fewer calls in 2020/21 and answered 10.4% more calls within 60 seconds against the previous year, with 52.5% of calls receiving clinical advice (0.3% down on 2019/20).

The accelerated development of NHS 111 First to provide a single point of contact for patients has enabled people needing an emergency department appointment to get a timed slot so that they can be seen as safely and conveniently as possible. Working as part of the NHS family, NHS 111 has been able to make direct appointments at increasing numbers of GP practices, pharmacies and urgent treatment centres (UTCs) – as well as send an ambulance for people with a serious or life-threatening condition. The number of UTCs has increased to 186 across England, with NHS 111 able to book appointments in 170 of them.

Same day emergency care services (SDEC) supported 6.8 million patients to be treated and returned home on the same day during 2020/21. From mid-December 2020, direct referrals via NHS 111 to SDEC were launched to improve admissions into secondary care, and 147 services can now receive direct referrals via NHS 111.

Reducing in-hospital length of stay by discharging patients as soon as they no longer meet the criteria to reside, significantly helped to improve capacity constraints and enhance patient experience. The proportion of beds occupied with long-stay patients (21+ days) reduced by around 4% from 18.5% in March 2020 to 14.6% in March 2021.

In 2020/21 a total of £450 million of capital funding was provided to make upgrades and improve facilities in emergency departments across the country. Of this, £300 million was allocated to 175 smaller UEC capital schemes, releasing 2,603 additional waiting spaces, 832 treatment spaces for patients with major conditions, 212 resuscitation spaces and 1,390 extra SDEC spaces into the system to improve capacity. Further benefits have been realised, such as schemes to increase mental health triage capacity, improve ventilation to reduce nosocomial infection and new technology to support NHS 111 First. The remaining £150 million was allocated for major refurbishment programmes at 25 emergency departments facing significant estate or capacity constraints, with work continuing with these EDs into 2021/22.

Transformation of elective care

The Elective Care Transformation Programme is providing national support to regions and systems to transform and recover elective care services affected by the COVID-19 pandemic.

The Adopt and Adapt programme was established in June 2020 to support and accelerate elective activity recovery. Blueprints for five workstreams (endoscopy, CT/MRI, theatres, outpatients and cancer) were drawn up with support from stakeholders, clinicians and national workstreams, and adapted and applied by regions according to local needs.

The NHS Long Term Plan committed to redesigning outpatient services to avoid the need for a third (30 million) of face-to-face hospital outpatient visits by 2023/24, with a national scale-up of video consultations planned across this period. A significant national effort achieved the rollout of a video platform available to all providers over five weeks at the start of 2020/21. This enabled three million video consultations to be held in secondary care with an estimated one million more delivered using other platforms. In total, 21.5 million virtual appointments were delivered, including both telephone and video consultations, accounting for around 30% of outpatient attendances. This represents one of the most significant shifts in outpatient care delivery in a century. The use of virtual consultation also saved 550 million patient travel miles and avoided around 112,000 tonnes of CO_2 emissions, while importantly reducing risk to both patients and staff.

Across the country, 23 pilot areas are leading implementation of patient-initiated follow-up, allowing people to access follow-up care sooner where needed and avoiding low-value routine follow-ups, which releases clinical capacity for other patients.

Throughout 2020/21, the Outpatient Transformation Programme has been working with leading clinicians to equip local systems with specialty-specific, clinically-led resources to transform outpatient services in high-volume areas such as eye care, dermatology and MSK. This has enabled local teams to measure and forecast progress, and communicate the benefits to staff, patients and the public.

Waiting list validation and prioritisation support the prioritisation of patients on secondary care waiting lists according to clinical need. Validation (a technical process) was carried out by acute providers to ensure patients were accurately recorded on waiting lists. Clinical prioritisation of patients on admitted (surgical) waiting was carried out using a process developed with stakeholders.

First Contact Practitioner provides direct access for patients with back pain, arthritis and other MSK conditions to physiotherapists with enhanced skills based in GP practices. The NHS Long Term Plan set an ambition to have 100% coverage by 2023/24, with 50% coverage in 2020/21. PCNs' workforce plans indicate progress has been faster, with 73.3% coverage achieved by March 2021.

Advice and Guidance (A&G) supports primary care clinicians to access specialist secondary care advice without the need for referral. This advice is often provided within 48 hours of request and in most cases avoids the need for a follow-on referral to secondary care. During 2020/21 GP usage of A&G almost doubled, with the total number of A&G requests via the Electronic Referral System alone exceeding one million. Including all other platforms, number of requests are estimated to be 1.58 million for 2020/21, leading to around 1,040,000 unnecessary face-to-face outpatient attendances being avoided.

Mental health

2020/21 was the final year of delivery of the Five Year Forward View for Mental Health. Access, recovery and referral to treatment time targets had improved in 2019/20; however, COVID-19 impacted on the achievement of some of the 2020/21 commitments. Although the first lockdown impacted referral routes and access rates, mental health services remained open and local services worked rapidly to respond to the changing context. Referrals were returning to pre-pandemic levels ahead of December 2020, and the 'Help Us Help You' campaign included a focus on mental health to encourage people to continue to come forward for support.

Evidence about the impact of other emergency situations (and the increase in referrals following the first lockdown) indicates that COVID-19 will result in increased mental health needs for the foreseeable future, increasing pressures on the system and the need for continued expansion of services as set out in the NHS Long Term Plan. It has been agreed that, of the £500 million of additional funding for mental health announced in November 2020 to support 2021/22 activity, over £300 million will be spent on NHS mental health services. Further, over £100 million will be spent on growing the mental health workforce. The remaining amount will be spent on wider mental health recovery, such as mental health prevention and promotion in local authorities.

Specialist community perinatal mental health services, which have now been rolled out in every part of England, saw a total of 31,550 women. While this is below the 2020/21 target of 47,000, this figure is expected to improve in 2021/22 as the impact of COVID-19 on usual routes of referral lessens.

All CCGs met the Mental Health Investment Standard in 2020/21.

The national access rate for children and young people for 2019/20 was already ahead of the 2020/21 ambition (36.8% vs 36% target), and in 2020/21 was even higher at 39.6%. Eighty additional mental health support teams were operational by the end March 2021, bringing the total number of teams to 183, with coverage of 15% across approximately 3,000 education settings.

Quarter 4 2020/21 data for children and young people's eating disorder waiting times shows 72.7% of patients accessed treatment within four weeks (routine referrals) and 70.5% within one week (urgent referrals). In 2020/21 NHS England funded an additional 18 eating disorder services to implement the early intervention model 'First Episode Rapid Early Intervention for Eating Disorders (FREED)' for 16 to 25-year olds, which will assist in early identification and providing support for people in the early stages of an eating disorder.

The 95% waiting time standard was due to come into effect at the end of 2020/21. While the waiting times have reduced significantly since the start of the programme, performance has been impacted by an increase in referrals with more children and young people starting treatment than ever before.

Progress continued towards providing Improving Access to Psychological Therapies (IAPT) for adults and older adults needing psychological therapies. During March 2021, IAPT waiting time standards continued to be met, with 92.3% of people entering treatment having waited less than

six weeks (against a standard of 75%) and 98.8% of people entering treatment having waited less than 18 weeks (against a standard of 95%). The recovery rate for March 2021 was 52.4%, above the 50% target.

The national standard for 60% of people to start treatment for Early Intervention in Psychosis (EIP) within two weeks was exceeded in March 2021, with a performance of 73.4% in quarter 4.

In 2020/21, £42 million transformation funding was awarded to early implementer sites to test new models of integrated primary and secondary mental healthcare for people with severe mental illnesses.

In March 2020, fewer than 50% of areas had 24/7 mental health crisis care, and most were not accessible to the public without a referral. As part of the response to COVID-19, all parts of the country accelerated progress to have in place 24/7 all-age, urgent NHS mental health helplines that are open to the public. Anyone can now find their local number for mental health crisis care online.[8] Having rapidly established the lines, areas are now working to improve the operation of the service.

Work continued towards eliminating inappropriate adult acute out-of-area placements, which occur when a person is admitted to hospital outside their usual network of care due to a lack of available beds locally. Good progress was being made against the national out-of-area placements trajectory, particularly in areas that had previously experienced some of the most consistent pressures. However, during 2020/21, COVID-19 led to increased pressures on mental health services in terms of rising acuity and operational constraints from infection prevention and control requirements. A new £50 million fund was allocated to mental health services as part of the government's 'Staying Mentally Well Winter Plan' to reduce pressures on inpatient beds, boost capacity and support good quality discharge from inpatient settings. The expected impact is likely to mean these increased pressures continue in the short term. Therefore, while systems are committed to ending inappropriate out-of-area placements as soon as possible, the safety of patients remains the priority. Although the pandemic has made the ambition more challenging, £87 million of additional funding will be allocated in 2021/22 to support hospital discharge.

Funding was allocated to four additional sites to develop specialist mental health services for rough sleepers, bringing the total to 11 sites nationally, ahead of the 2020/21 target of 10 sites, and work has continued on the newly funded problem gambling mental health support clinics.

The dementia diagnosis rate was 61.6% in March 2021 against a target of 66.7%. This level of performance reflects the impact of COVID-19 and additional funding is being allocated to local areas to assist services in recovering this trajectory in 2021/22.

NHS England and NHS Improvement published the Advancing Mental Health Equalities Strategy,[9] and commenced engagement with Black, Asian and Minority Ethnic (BAME) patients, carers, staff and organisations to help shape the upcoming Patient and Carers Race Equality Framework.

[8] http://www.nhs.uk/urgentmentalhealth
[9] https://www.england.nhs.uk/publication/advancing-mental-health-equalities-strategy/

Learning disability and autism

The pandemic has highlighted and exacerbated health inequalities experienced by people with a learning disability and autistic people. There has been a higher rate of death from COVID-19, and at a younger age, for people with a learning disability than in the general population and a disproportionate impact on people's mental health and wellbeing, particularly as routines, care and support changed due to restrictions.

During 2020/21, we supported fair access to services for people with a learning disability and autistic people: we worked with primary care to ensure a choice of COVID-19 vaccination sites; made reasonable adjustments to mental health helplines; published resources for healthcare staff and issued clinical guidance and letters to ensure that DNACPR (do not attempt cardio-pulmonary resuscitation) decisions are not made inappropriately. Accessible information has included an easy read vaccine invitation letter and co-produced guidance on reasonable adjustments, as well as training materials and resources for vaccinators.

As part of the Learning Disability Mortality Review (LeDeR), we introduced a 'train the trainer' programme, working with voluntary and charitable sector partners to train carers of people with a learning disability in the Restore 2™ mini (adapted from Restore2™) tool used to recognise the soft signs of physical deterioration and to improve communication between carers, healthcare staff and GPs.

We published a new LeDeR policy in March 2021, which now includes autistic people in the review programme and a commitment that focused reviews will be completed for every person from a BAME background. During the year there was excellent performance on the completion of LeDeR reviews and by the end of March 2021 CCGs had completed 96% of eligible reviews.[10]

Annual health checks are an important part of tackling health inequalities experienced by people with a learning disability. In the 12 months to December 2020, 167,919 annual health checks were completed (54.5% of people on a GP learning disability register compared to 51.9% in the 12 months to March 2020). In 2020/21 we increased investment for primary care to use GP learning disability registers and to complete annual health checks.

In 2020 a dedicated autism team was established in the programme to support NHS Long Term Plan autism commitments: improving access to and quality of autism diagnostic pathways, reducing physical health inequalities and improving mental healthcare. The team has commissioned autism research and supported the development of an autism-specific health check in primary care and the publication by NHS Digital, since August 2020, of experimental autism diagnostic waiting time statistics.

[10] Includes notifications that are at least six months old and therefore due to have been completed. Notifications of deaths of children under 18 are not included as these are reviewed by the Children's Mortality Review Programme. Reviews may be placed on hold where there are other statutory processes and investigations taking place.

Reducing reliance on inpatient care

At the end of March 2021, there were 2,190 people with a learning disability, autism or both in a mental health inpatient setting: 40 fewer than in March 2020 and a 24.4% reduction since March 2015. The number of children and young people in an inpatient setting at the end of March 2021 was 255, an increase of 6% from the end of March 2020.

Care (education) and treatment reviews (C(E)TRs) are helping to reduce the number of people in an inpatient setting. More than 80% of community C(E)TRs led to a decision not to admit the person to hospital. In January 2021 we published a (C(E)TR) COVID-19 addendum to help ensure that C(E)TRs continue to happen, with enhanced elements for children and young people in response to the pandemic. We have developed alternatives to mental health inpatient care, including a £3 million investment to support health-funded short breaks.

To support improvements in the quality of mental health inpatient care for people with a learning disability and autistic people, in January 2021 we published host commissioner and commissioner oversight visits guidance.[11] We have developed keyworker pilots for children and young people with the most complex needs in 13 local systems, where the role of senior children's intervenor has been introduced to safeguard young people in long-term segregation within inpatient settings.

More action on health inequalities and prevention of ill-health

In 2020/21 we further developed our approach to prevention, with a focus on tacking health inequalities. A full update on how we are working to reduce health inequalities can be found from page 161.

For the first time, the NHS has commissioned a lifestyle weight management service, through the NHS Digital Weight Management Programme. This programme aims, through GP referral, to reduce health inequalities using a targeted approach to engage people with higher rates of obesity or those less likely to participate in lifestyle change programmes. These include younger (working) age adults, people of non-white ethnicity men, and those from more deprived communities, who we know also experience poorer outcomes from COVID-19. The programme is being rolled out fully in 2021/22.

Progress was made on implementing the alcohol and tobacco dependence interventions outlined in the NHS Long Term Plan. Due to the impact of COVID-19, however, early implementer sites, which were intended to test models of care and provide learning for future rollout, could not run for the full financial year as expected. The programme has consequently been extended into 2021/22. Supported by two new clinical networks, we began to identify potential sites for the rollout of alcohol care teams in areas of greatest need, based on deprivation and alcohol-related mortality.

The Latent Tuberculosis Infection (LTBI) Testing and Treatment Programme was affected by COVID-19 in the first six months of 2020/21. The second half of the year focused on supporting

[11] https://www.england.nhs.uk/wp-content/uploads/2021/01/Host-commissioner-guidance.pdf

CCGs with the greatest number of high-risk patients at increased risk of developing active TB to restart their LTBI testing and treatment programmes.

NHS Diabetes Prevention Programme

The need for primary care to focus on COVID-19 led to a significant drop in referrals to the NHS Diabetes Prevention Programme at the start of the year. In response, a direct-to-consumer model was rapidly stood up, enabling people to self-assess their risk using the Diabetes UK risk score and access support if eligible.

Given the inequalities in who develops type 2 diabetes and the poorer outcomes for those of South Asian and Black ethnicity, a focused engagement campaign using social media and other approaches was launched to raise awareness in and boost uptake from these groups.

The NHS Diabetes Prevention Programme supported 84,000 people in 2020/21 and continues to scale up, as we aspire to support up to 200,000 people per year.

Non-cancer NHS screening

The NHS Antenatal and Newborn Screening programmes (ANNB) have been largely unaffected by the pandemic through the efforts of providers to continue these time-critical services. The Newborn Hearing Screening programme continues to tackle a small backlog of audiological assessments, which increased slightly during the two lockdowns in summer 2020. A toolkit developed with support from PHE has helped identify babies whose screen or audiology assessment were delayed.

NHS Abdominal Aortic Aneurysm (AAA) Programme service providers temporarily paused invitations in March 2020. Nationally agreed principles and operational guidance were developed and issued to providers to inform recovery plans for local NHS AAA screening services and these outlined the need to prioritise men at greatest risk of AAA rupture/AAA-related death when ultrasound screening restarted. Data indicates this prioritisation was effective with all 38 AAA providers resuming screening services aligned to technical and restoration guidance.

NHS Diabetic Eye Screening Programme providers paused routine invitations for screening for approximately three months but, via clinical risk stratification, maintained provision for those at high risk, including pregnant women. Operational guidance was developed with support from PHE, but capacity remains affected due to social distancing, infection prevention and control measures and venue availability for an already vulnerable population. Intervals in invitation for some low-risk groups were also extended.

NHS immunisations and public seasonal flu programmes

The 2020/21 NHS Annual Influenza Vaccination Programme was the most successful in its history, achieving over 80% uptake in the population aged 65 and over. The programme was also expanded in 2020 to include 50 to 64-year olds and school pupils in Year 7. For the first time a call/recall service was commissioned nationally to help with the increase in demand and to supplement local call and recall services delivered by GP practices.

The NHS school flu programme achieved 61.7% uptake nationally despite the expansion to secondary schools and the complexities and disruptions associated with COVID-19 related school closures. For the first time, school vaccination providers were commissioned to offer an alternative seasonal flu vaccine to children whose parents/guardians withheld consent to the nasally administered live attenuated influenza vaccine on grounds of porcine gelatine content. Most routine child, young people and adult immunisations continued, with the exception of the shingles immunisation programme for older adults due to shielding guidance. However, those who missed their window of eligibility for the vaccination during lockdown were subsequently able to access vaccinations.

Routine childhood immunisations in primary care continue to be delivered, with regional commissioners working closely with GPs and local CHIS to identify those who are eligible but have not received their vaccine. Published vaccine coverage data for 2020[12] continued to show a decline in vaccine uptake and coverage in childhood immunisation programmes which is consistent with decreases in previous reporting periods.

Preparation for changes to the neonatal BCG vaccine schedule continued during the year, to support the introduction of an evaluative pilot by PHE for severe combined immunodeficiency screening as part of the NHS newborn bloodspot programme.

The most recent data[13] showed a moderate decrease (~0.6%) in the routine immunisations – 6-in-1 polio containing vaccine, meningococcal B (Men B) and rotavirus – compared to the same period 12 months prior. This reflects the early impact of the COVID-19 pandemic and the introduction of social distancing from late March 2020, when some of this cohort would have been scheduled for completing doses. Vaccinations measured at 24 months intervals – MMR1, Hib/Men C and Men B booster – were largely unaffected, with small decreases likely to have been caused by COVID-19 measures.

Delivery of the school immunisation programmes were paused because of school closures from 23 March 2020, which significantly affected uptake of the HPV vaccination. The latest PHE report on vaccine uptake[14] and coverage data shows that 64.7% of Year 9 females completed the two-dose HPV vaccination course in 2019/20 compared with 83.9% in 2018/19.

[12] https://digital.nhs.uk/data-and-information/publications/statistical/nhs-immunisation-statistics/england---2020-21
[13] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/978503/hpr0721_COVER_v2.pdf
[14] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/927694/hpr1920_HPV-vc.pdf

NHS Child Health Information Services providers continued with minimal disruption. The Digital Child Health Programme's NEMS, which can share ANNB and childhood immunisation data between clinical settings, is now live, covering over 50% of children aged up to five years. As more services (including GP IT suppliers) adopt the system changes required to interoperate with NEMS, more information will be shared across clinical settings, ensuring greater oversight, safeguarding and opportunistic delivery of childhood screening and immunisations.

Maternity and neonatal services

Maternity services continued to provide a full range of antenatal, intrapartum and postnatal care during the pandemic, with some modifications to manage the challenges, including infection prevention and control and, at times, staff shortages. The pandemic also limited capacity within trusts to deliver transformation initiatives to improve services.

We are committed to reducing the rates of stillbirth, maternal and neonatal mortality and preterm births. The latest outcome data demonstrates that encouraging progress has been made towards our national safety ambition to halve these by 2025. Since 2010, the stillbirth rate in England has decreased by 25%, exceeding the 2020 ambition. In 2019, the stillbirth rate in England reached its lowest level on record at 3.8 stillbirths per 1,000 births, a decrease from 5.1 stillbirths per 1,000 births in 2010.

The neonatal mortality rate over 24 weeks' gestation shows a 29.4% reduction in the rate between 2010 and 2019, which is excellent news. The rate of brain injuries at or soon after birth has fallen from 5.1 in 2017 to 4.2 per 1,000 births in 2018 and the rates of infants with hypoxic ischaemic encephalopathy has fallen by 15% between 2014 and 2019.

The maternal mortality rate for 2016 to 2018 is 9% lower than the 2009 to 2011 baseline, having increased between 2012 to 2014 and 2014 to 2016. However, there is a need for additional work in some areas, particularly around health inequalities. Statistically significant differences remain in the maternal mortality rates between women living in the most deprived areas and those living in the least deprived areas. The Chief Midwifery Officer for England and the National Specialty Advisor for Obstetrics are leading work with national partners to develop an equity strategy which will focus on women and their babies from BAME groups and those living in the most deprived areas. By 2024, 75% of Black and Asian women and a similar proportion of women who live in the most deprived areas will receive continuity of carer from their midwife throughout pregnancy, labour and the postnatal period. In advance of this, most women from BAME backgrounds and also from the most deprived areas will be placed on a continuity of carer pathway by March 2022, under measures set out in the 2021/22 planning guidance.[15]

The NHS Long Term Plan includes a range of initiatives with a focus on improvements in maternity care that will further support achievement of the ambition, including full implementation of Saving Babies' Lives Version 2 and rollout of maternal medicine networks and Maternity Digital Care

[15] https://www.england.nhs.uk/operational-planning-and-contracting/

Records. This empowers women to make informed decisions about their care and makes it easier for clinicians to share information.

Despite these achievements, there is still much to be done to meet the national ambition and support the transformation of services in line with the Ockenden report of the independent review of maternity services at the Shrewsbury and Telford Hospital NHS Trust. The report highlighted the variation that exists between trusts and systems. We have worked with trusts to implement the seven 'immediate and essential actions' identified by the report. This is underpinned by more than £95 million of extra funding which will be invested to improve maternity safety across England.

We have also strengthened our capacity to identify trusts that require support before serious issues arise and put that support in place, through a new national quality surveillance model and an enhanced Maternity Safety Support Programme. Seven regional chief midwives are now in post and providing extra leadership capacity.

Cancer

During 2020/21, 2,080,673 people were urgently referred for suspected cancer and 275,553 started a first treatment for cancer – 95% of them within a month of a decision to treat. When the pandemic began, the number of people coming forward with potential cancer symptoms dropped significantly. The NHS established a cancer recovery taskforce with participation from across the cancer community to help restore referrals to pre-pandemic levels. Cancer charities also supported a major NHS media campaign to encourage people with possible cancer symptoms to come forward.

NHS staff adopted new ways of working to keep cancer services running. The use of 'COVID-19-friendly' treatments helped to reduce patient visits to healthcare settings, and COVID-secure cancer surgical hubs maximised the use of available capacity. The NHS Cancer Programme also accelerated the introduction of colon capsule endoscopy, where patients swallow a camera, to manage demand for more invasive colonoscopy. These measures helped to minimise the impact of the January 2021 COVID-19 peak on cancer services. The programme continued to take forward our NHS Long Term Plan commitments, particularly those to support continuity of services. By March 2021, 73 rapid diagnostic centre pathways were operational, and people in 17 areas were able to access targeted lung health checks in mobile units in places like supermarket carparks. The NHS Cancer Programme also launched a £15 million funding call to identify the next generation of innovations in cancer diagnosis.

NHS cancer screening

NHS cancer screening services continued where it was clinically safe for them to do so. Where necessary, aspects of the screening and treatment pathways were temporarily paused following local decisions. Our advice for the services included:

- Continue to deliver NHS screening services to the highest risk groups.
- Increase diagnostic pathway activity to reduce the existing backlog, followed by rebooking of any deferred appointments.
- Continue to provide as much routine and preventative work as can be delivered safely, including NHS screening services.

Restoration of these services has been supported nationally, with people prioritised according to their risks.

Before COVID-19, the rollout of faecal immunochemical test (FIT) home testing kits for 60 to 74-year olds led to an 8% increase in uptake in the bowel cancer screening programme. During March 2020, the issue of FIT kits and also invitations for bowel scope for 55-year olds (a flexi sigmoidoscopy test) by providers was paused. Since resuming in the autumn of 2020, providers have increased their invitation rate for screening to return the services to expected national standards for coverage. Delivering endoscopy services within the constraints of COVID-19 has affected capacity, but providers are working to jointly plan across screening and symptomatic services. Telephone specialist screening practitioner appointments were introduced rather than face-to-face. This innovative approach may continue following further evaluation of the benefits.

Following the recommendation by the UK National Screening Committee, NHS England and NHS Improvement decommissioned bowel scope screening. This service was only available to 60% of the registered population in England and had not been rolled out in other parts of the UK. Those who were waiting for their bowel scope were invited to take a home FIT test in April 2021. The FIT bowel screening programme will continue to roll out for 50 to 59 year-olds over the next four years.

In March 2020, the 78 NHS breast screening providers paused routine screening for three months, while screening continued for women with very high risk. Following the resumption of screening in the autumn of 2020, services are working to return the screening programme to national standards for invitations and coverage. To support this capital funding of £20 million has been invested for modifications to mobile breast cancer units, to ensure care can continue as safely as possible, and a further £50 million secured to support providers through restoration and recovery plans.

The NHS cervical screening programme continued, and by the end of 2020/21 the volume of participants entering the programme pathway was returning to pre COVID-19 levels, although population coverage performance remains around 10% below the 80% national performance standard. Throughout 2020/21 we remained committed to supporting the development and implementation of initiatives to improve coverage. This included a new national service specification to further increase the accessibility of cervical screening through services within integrated sexual health settings.

The NHS People Plan

In every region and at every level, local NHS leaders faced difficult choices on how best to deploy and support staff during the pandemic, to deliver care to patients suffering from COVID-19. At the same time, they were each learning how to deal with personal challenges and impacts. Sadly, a number of NHS staff lost their lives during the pandemic, and many NHS staff experienced the loss of loved ones.

Throughout this period of uncertainty, the four NHS People Plan themes[16] gave us a common framework and clear direction. Responding to the extraordinary demands of the pandemic, we acted on feedback from systems and regional teams to identify a number of NHS People Plan 2020/21 actions. This made sure our collective efforts were focused on the things that would make the most difference to the workforce: supporting staff to be safe and well; ensuring their voices were heard; delivering safe staffing for the COVID-19 response and vaccination programme; and sustaining other services with greater use of innovation, technology and new ways of working. National guidance and support were closely aligned to these priorities through widespread engagement across the NHS system, staff networks and other stakeholders.

Overall staff numbers are growing, and retention rates are improving across clinical groups, but we still have a long way to go. Many people are exhausted from COVID-19 and will need time, space and practical support to recover fully. Although the overall health and wellbeing scores in the NHS Staff Survey[17] improved significantly in 2020, the proportion of staff reporting work-related stress increased from 40.3% to 44%. And while the latest Workforce Race Equality Standard[18] data shows some improvement, we need to make further progress on addressing inequalities. That is why our people priorities for 2021/22, as set out in the national planning guidance,[19] build on the People Plan 2020/21: action for us all[20] and are informed by what we have learnt during the pandemic. They aim to embed more preventive health and wellbeing approaches, tackle inequalities, lock in beneficial changes and new ways of working, and boost efforts to attract and retain more people.

Every part of the system has a part to play, both in delivery and holding each other to account. NHS staff also provide invaluable feedback and insight, both at a national level through the NHS Staff Survey and more regular Pulse[21] checks, and through the national, regional and local staff networks that have developed rapidly over the last year.

Having a voice that counts is one of the themes of our NHS People Promise, which helps keep us focused on what is needed to make the NHS the best place to work that it can be. It also provides a way to judge progress year by year, with the annual NHS Staff Survey being aligned to its seven themes in 2021.

[16] https://www.youtube.com/watch?v=992Rwsq4EYI
[17] https://www.nhsstaffsurveys.com/
[18] https://www.england.nhs.uk/about/equality/equality-hub/equality-standard/
[19] https://www.england.nhs.uk/publication/2021-22-priorities-and-operational-planning-guidance/
[20] https://www.england.nhs.uk/ournhspeople/
[21] https://www.england.nhs.uk/nhs-people-pulse/

Working together with systems and employers, significant progress has been made in 2020/21 towards delivering the NHS People Promise,[22] but this is a multi-year improvement process and there is still much to do – for example, in addressing longstanding inequalities.

A snapshot of 2020/21

Through widespread upskilling and multiprofessional working, staff were redeployed to support critical care and the vaccination programme. This included 3,775 people who returned to work in the NHS, supported by an additional 3,159 full-time equivalent nurses who remained within the NHS through improved retention, and 11,200 nurses who joined through international recruitment. 11,100 additional healthcare support workers and over 400 medical support workers were recruited. At the peak of the pandemic, we also had more than 2,500 military colleagues deployed in the NHS. Over 40,000 students, learners and trainees stepped forward and were available to support the COVID-19 response, including nursing, midwifery and allied health professional students, and 3,800 final year medical students were deployed early through HEE's Foundation Interim Year doctor initiative.

The NHS Cadets scheme progressed towards its goal of enrolling 10,000 young people by 2023, establishing its first advanced sites in London, Birmingham and the Wirral, with a further two in Liverpool.

Embedding the focus on the health and wellbeing of NHS staff during and beyond the pandemic, a wellbeing guardian role has been introduced in each NHS trust, strengthening board awareness and accountability for staff health and wellbeing. Over one million health and wellbeing risk assessments were carried out to keep staff safe, including 96% of ethnic minority staff. All local systems are in the process of implementing mental health hubs. The Supporting our NHS People[23] health and wellbeing resources are available to all NHS staff and have received cross-industry awards. Tackling inequalities remains as important as ever, and despite the pandemic the first disabled staff network summit was held, giving disabled colleagues a national forum for the first time.

Digitally-enabled care

NHSX is an organisation formed from teams within the Department of Health and Social Care (DHSC) and NHS England and NHS Improvement. In its second year of operation, NHSX continues to set the strategic, policy and delivery objectives for digital transformation throughout the NHS and adult social care sectors. Using the levers of NHS England and NHS Improvement and the DHSC, it supports NHS and care organisations to digitise their services, connect the health and social care systems through technology, and transform the way patient care is delivered at home, in the community and in hospitals.

[22] https://www.england.nhs.uk/ournhspeople/online-version/lfaop/our-nhs-people-promise/the-promise/
[23] https://www.england.nhs.uk/supporting-our-nhs-people/

NHSX has played a critical role in the response to the pandemic. It led the creation of the NHS Datastore,[24] which enabled the NHS to route ventilators and billions of items of PPE to where they were most urgently needed, and enabled world-class research into COVID-19. NHSX also undertook significant work on the tech and data underpinnings of the vaccination programme and developed systems and capabilities now widely used throughout the NHS and by Test and Trace, including text-messaging systems to contact those self-isolating at home and test kit home delivery services.

Within the wider system, NHSX took action to ensure the NHS could continue to deliver remotely, ranging from enabling the provision of 40,000 laptops to the system to ensuring 99% of GP practices had the capability to provide online and video consultations. Wider transformation has enabled better patient care, most notably through decisions to enable the summary care record to carry additional information. In addition, 11,000 tablet computers were delivered to care homes to equip staff and improve care for residents, and discounts for broadband services were negotiated for care homes as part of the work to digitise the adult social care sector and connect it to the NHS.

NHSX's NHS AI Lab supports the testing, evaluation and scale of promising artificial intelligence (AI)-driven technologies through the £140 million AI in Health and Care Award, including automating early lung cancer detection and developing deep learning software that could improve the NHS Breast Cancer Screening Programme. The lab also launched the COVID-19 Chest Imaging Database[25] with the British Society of Thoracic Imaging and Royal Surrey NHS Foundation Trust, which rapidly grew to be one of the largest collections for medical imaging in the UK. The database will support better understanding of coronavirus and develop technology which will enable the best care for patients hospitalised with a severe infection.

Comprehensive coverage of integrated care systems

The COVID-19 pandemic accelerated closer integration and partnership working between different health and care organisations, local government and voluntary sector partners across every part of the country. Partners worked collaboratively within their STPs and ICSs to develop mutual aid arrangements, to put in place new services to respond to the pandemic at pace, and to identify and support people at greatest risk from COVID-19.

In response to this and to support further collaboration, we published Integrating care: next steps to build strong and effective ICSs across England.[26] As well as testing options for legislative change, this paper highlighted key components of an effective ICS and set out how systems and their constituent organisations would embed and enhance such collaborative ways of working. This built on several years of developments as well as detailed conversations with system leaders, people who use and work in services, and those who represent them, to reflect their priorities for

[24] https://www.england.nhs.uk/contact-us/privacy-notice/how-we-use-your-information/COVID-19-response/nhs-COVID-19-data-store/
[25] https://www.nhsx.nhs.uk/COVID-19-response/data-and-COVID-19/national-COVID-19-chest-imaging-database-nccid/
[26] https://www.england.nhs.uk/publication/integrating-care-next-steps-to-building-strong-and-effective-integrated-care-systems-across-england/

future improvements to health and care through integrated working. Following the paper's publication, we undertook further extensive engagement with systems and membership bodies to refine its recommendations for legislation and to inform the development of future guidance and implementation support for ICSs.

The 2021/22 planning guidance set out some of the things that ICSs, and the organisations within them, should do to meet ambitions from 2022. During 2020/21, 28 further ICSs were formally designated and became operational where STPs had previously been in place: 42 ICSs in total now serve the whole of England, each with a partnership board bringing together local leaders and an independent chair. This met the important NHS Long Term Plan commitment that all parts of England would be served by an ICS by April 2021.

How NHS England and NHS Improvement supported the wider NHS

Emergency Preparedness, Resilience and Response (EPRR)

NHS response to COVID-19

The primary focus of 2020/21 was the continued response to the COVID-19 pandemic, which we declared as a Level 4 national incident in January 2020. Incident co-ordination centres have been operating regionally and nationally, with command, control, co-ordination and communication arrangements in place to ensure that the National Incident Response Board and the supporting national cell structure has a clear line of sight to the impact of the pandemic across the NHS. The EPRR team led our and the wider NHS's response to the pandemic.

During wave 1, Nightingale Hospitals were established to provide additional capacity for the acute sector. It is a success that they were not required to care for large numbers of inpatients. Initially introduced in London, but implemented in other regions of the country too, these centres provided additional critical care support, increased medical ward-based provision, step-down care to facilitate discharge from acute hospitals, and additional diagnostic and outpatient capacity. They were rapidly stood up again for winter and some have also been supporting the COVID-19 vaccine rollout.

Significant planning was undertaken following wave 1 to prepare the NHS for a second wave in the autumn/winter. Systems mobilised their response to wave 2 of COVID-19 demand based on common escalation principles, with a mutual aid approach at system and regional level to meet surge demand. Each of our regions worked with the ICS/STPs within their footprint to develop an escalation and surge plan – with common actions to take.

In November 2020, a national Critical Care Capacity Panel was established, which reviewed capacity in the most pressured regions and systems and, where required, co-ordinated safe patient transfers between regions so patients requiring critical care could move to less pressurised units.

On 25 March 2021, the national incident level for the NHS COVID-19 response was reduced from Level 4 to Level 3. National incident infrastructure remained in place, but the management of the incident shifted from national co-ordination to a regional level. Local outbreaks and variants of concern continued to be closely monitored.

As a result of the Omicron variant, the incident level was again raised to level 4 in December 2021.

Britain's exit from the European Union (EU)

The UK exited the EU on 31 January 2020, starting a transition period until 31 December 2020. We have overseen an NHS EU Exit End of Transition Programme supported by the EPRR team nationally, as part of a single, shared operational readiness and response structure alongside COVID-19, restoration of services and winter. Only minor impacts have been experienced by the NHS.

The incident response phase of the programme ran until the end of July 2021 to maintain oversight of the NHS's operational response to EU exit and ensured that any actions required in relation to future changes in trading relationships between the UK, the EU and the rest of the world are embedded as business as usual within directorates.

Other Incidents

In June, several people were very sadly stabbed in a park in Reading, resulting in three fatalities. This was later confirmed to be a terrorist incident. South Central Ambulance Service and local hospitals supported the response, with NHS mental health services supporting the community to recover from the incident.

In October, a company providing reagents to NHS laboratories experienced a backlog of dispatching orders, following the implementation of a new automated picking system in its UK warehouse. Contingency arrangements were put in place and the national EPRR team provided co-ordination and oversight of the incident, working with pathology networks, DHSC and the devolved administrations to ensure urgent orders were prioritised.

Reinforced autoclaved aerated concrete (RAAC) is a type of concrete plank that was extensively used in public sector construction during the 1970s and 1980s. The planks are principally used to provide support to structures such as roofs and are significantly weaker than normal concrete. EPRR teams supported estates subject matter experts in identifying RAAC in the NHS estate so that trusts and providers assess/monitor potential risks and ensure items have appropriate mitigating plans in place.

EPRR and Estates national teams collaborated to help providers safely manage increasing volumes of infectious waste. Action taken included the creation of a co-ordinating central logistics cell and publication of a standard operating procedure for COVID-19 waste.

The national EPRR team also supported the health response to heatwave and cold weather alerts issued by the Met Office, stabbings of members of the public in Birmingham and of paramedics in Wolverhampton, incidents of supply disruption to the NHS and the response to high severity cyber alerts issued by NHS Digital.

Productivity and efficiency

Our Commercial Medicines Directorate (CMD) supports patients to access clinically effective and innovative medicines, while safeguarding the sustainability of the NHS medicines budget. CMD's work is aligned with three key policy documents: the NHS Long Term Plan,[27] the Voluntary Scheme for Branded Medicines Pricing and Access[28] and the NHS Commercial Framework for New Medicines.[29] The framework outlines the purpose and principles on which NHS commercial medicines activity will be based, defining clear roles and responsibilities, and detailing how pharmaceutical companies can engage with the NHS.

The NHS continues to play a key role in enabling the UK to take a global lead on the challenge of antimicrobial resistance – recognising how medicines can mitigate future healthcare risks.

In December 2020, the first two products to use a new 'subscription-style' payment model were selected. This new model will incentivise companies to invest in this critical area, to help secure a pipeline of future treatment options for NHS patients.

In 2020/21, the Commercial Medicines Unit (CMU) surpassed the full-year savings forecast of £238 million against a backdrop of reduced spend on medicines in NHS trusts throughout the previous financial year. This has been managed through close monitoring of CMU framework performance and uptake. Similarly, total savings achieved through the smart procurement of adalimumab biosimilars reached £500 million, compared with the cost of the drug under patent.

Alongside work to support the security of the medicines supply chain through the pandemic, CMD also brokered a series of interim agreements that enabled patients to access dozens of 'COVID-friendly' cancer treatments that were safer to use, by reducing hospital visits or the impact on an individual's immune system. The CMD, working closely with partners at NICE, also concluded a series of deals securing patient access to innovative healthcare technologies, including:

- onasemnogene abeparvovec – the first gene therapy for spinal muscular atrophy (SMA) following access to nusinersen for children with SMA secured in 2019/20
- GRAIL – a world-first pilot of a blood test that may spot more than 50 types of cancer
- Siponimod – a first oral treatment for secondary progressive multiple sclerosis
- KTE-X19 – a CAR-T therapy for the treatment of mantle cell lymphoma through a first full-access deal in Europe to provide treatment via the Cancer Drugs Fund
- the 'transformative' triple combination therapy Kaftrio – benefiting thousands of people with cystic fibrosis.

[27] https://www.longtermplan.nhs.uk/
[28] https://www.gov.uk/government/publications/voluntary-scheme-for-branded-medicines-pricing-and-access
[29] https://www.england.nhs.uk/publication/nhs-commercial-framework-for-new-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 can improve patient outcomes and experience and enable organisations to provide care more efficiently.

In 2020/21 the Accelerated Access Collaborative (AAC), hosted by NHS England and NHS Improvement, provided patients with access to proven innovations through its work. The COVID-19 pandemic was a catalyst that sparked new partnerships, and accelerated research and the speed at which innovations were adopted across the health and social care system. The AAC and the Beneficial Changes Network commissioned an independent review to identify learning and recommend how potentially beneficial changes can become day-to-day practice.

NHS research focused on recruiting into urgent public health COVID-19 studies and then to vaccine studies. In 2020/21 over one million people were recruited into COVID-19 research studies. This research led to the identification of five treatments that improved outcomes for patients admitted to hospital with COVID-19 and importantly also identified which treatments did not show benefit.

National research priorities, beginning with stroke, mental health and learning disability and autism, were identified once non-COVID research resumed.[30]

The 41 most promising AI technologies were funded, with 15 real-world deployments across more than 80 NHS sites supported through the £140 million AI in Health and Care Award.[31] The NHS Long Term Plan commitment to publish the MedTech Funding Mandate was met and this launched on 1 April 2021 to accelerate uptake of selected NICE-approved medical devices, diagnostics and digital products.

[30] https://www.nihr.ac.uk/covid-19/nihr-response-to-covid-19-timeline.htm
[31] https://www.nhsx.nhs.uk/ai-lab/ai-lab-programmes/ai-health-and-care-award/

Delivering a net zero National Health Service

This year, the NHS embarked on a journey to identify the most credible yet ambitious date that the health service could reach net zero emissions. This undertaking was informed by a robust analytical process, the guidance of an expert panel, and a national call for evidence which garnered nearly 600 submissions from patients, staff and members of the public. Delivering a 'net zero' National Health Service was published in October 2020 and marked a world-first commitment to deliver a national net zero health service.

Two clear and feasible targets were identified, that together comprise a more ambitious remit than even the broadest of the scopes set by the greenhouse gas protocol:

- for the emissions we control directly (the NHS carbon footprint), net zero by 2040, with an ambition to reach an 80% reduction by 2028 to 2032
- for the emissions we can influence (our NHS carbon footprint plus), net zero by 2045, with an ambition to reach an 80% reduction by 2036 to 2039.

The most up-to-date carbon footprint, alongside a detailed overview of the interventions and trajectories required to meet these targets, and a breakdown of carbon emissions by activity types, is available within Delivering a 'net zero' National Health Service.[32] For the 2020/21 financial year, the NHS is projected to have achieved a 62% reduction in emissions, significantly exceeding the 37% requirement for 2020 outlined in the Climate Change Act.

For further information on the NHS's response to climate change and sustainability, please see Appendix 5 on page 177.

[32] https://www.england.nhs.uk/greenernhs/wp-content/uploads/sites/51/2020/10/delivering-a-net-zero-national-health-service.pdf

Support for providers

Provider collaboratives

Support was given to help providers work together through collaborative groups. Working with providers and systems across the country, guidance was developed setting out our expectations regarding providers collaborating at scale. Best practice examples, and how they can be adapted to different local circumstances, as well as lessons learnt from those at the leading edge, have been described.

Supporting trust boards to collaborate as part of systems

The practical steps to support trust boards to collaborate in the interest of systems, delivering on the commitments we made in Integrating care: next steps to building strong and effective integrated care systems across England are outlined below.[33]

We have drafted an updated code of governance for NHS trusts that sets out a framework for corporate governance in a context of system working and collaboration, along with an addendum to the guide on foundation trust governors' duties and new guidance under the NHS provider licence that sets clear expectations for collaboration in key areas, and the governance arrangements required to support that.

In 2021/22 further work is planned to gather stakeholder views on these and support trust boards to ensure the final code, addendum and guidance are widely understood and implemented.

Supporting rural acute hospitals

The NHS Long Term Plan commits to developing a standard model of delivery in smaller acute hospitals serving rural and coastal populations. These relatively remote 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. The size and location of these hospitals often contribute to challenges in workforce and other operational areas.

Support is needed to help unblock the barriers these hospitals face, often as unintended consequences of historical policy decisions. Work on some elements of this was paused during 2020/21, but smaller rural hospitals contributed to national policy development across several areas, including systems policy and the development of provider collaboratives, updating guidance on provider governance, and the NHS's role is addressing health inequalities. Whether smaller rural hospitals have cost structures that should be considered in future financial settlements is being explored.

Provider projects

Provider projects involve focused deep dives to understand the challenges of implementing national policy at provider level on behalf of national and regional teams who ask for support.

[33] https://www.england.nhs.uk/publication/integrating-care-next-steps-to-building-strong-and-effective-integrated-care-systems-across-england/

Activity was paused during the first six months of 2020/21 due to COVID-19. Subsequently the following projects were completed:

- understanding the approaches used for COVID-19 and non COVID-19 patient pathways on behalf of the South regional team, to share best practice from other regions to support providers to respond to wave 2 of the pandemic
- reducing inappropriate out-of-area placements in mental health providers on behalf of the North West and North East regional teams, improving understanding of the factors driving these and sharing interventions and best practice to help reduce them.

Mergers and acquisitions

The NHS Long Term Plan committed NHS Improvement to "a more proactive role in supporting collaborative approaches between trusts" that wish to explore formal merger or acquisition. Bespoke support is offered to trusts considering or proceeding with mergers or acquisitions and helps ensure clarity about the intended benefits. 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. It is anticipated that the CMA will review significantly fewer NHS mergers or acquisitions.

All plans for mergers or acquisitions that meet the transactions threshold set out in the transactions guidance are assessed, 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. Risk assurance processes help identify risks early and support tailored work programmes proportionate to the risks in each case.

Significant transactions assured include:

- Poole Hospital NHS Foundation Trust and The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust merged on 1 October 2020 to create University Hospitals Dorset NHS Foundation Trust.
- Guy's and St Thomas' NHS Foundation Trust acquired Royal Brompton and Harefield NHS Foundation Trust on 1 February 2021 to create a newly expanded Guy's and St Thomas' NHS Foundation Trust.
- Western Sussex Hospitals NHS Foundation Trust acquired Brighton and Sussex University Hospitals NHS Trust on 1 April 2021, with the newly enlarged trust renamed as University Hospitals Sussex NHS Foundation Trust.
- Manchester University NHS Foundation Trust formally acquired the North Manchester General Hospital site and services of Pennine Acute Hospitals NHS Trust on 1 April 2021.

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.

Metric	Period	Standard	Performance
Referral to treatment			
Proportion of patients beginning elective hospital treatment within 18 weeks of referral	March 2021	92%	64.4%
Number of patients waiting more than 52 weeks		0	436,127
Diagnostics			
Proportion of patients waiting longer than 6 weeks for diagnostic tests	March 2021	1%	24.3%
Accident and emergency			
Proportion of patients discharged, admitted or transferred within 4 hours of attending A&E (all types of A&E department)	March 2021	95%	86.1%
Major emergency departments (type 1)			80.1%
Cancer			
Proportion of patients with suspected cancer receiving first outpatient consultation within 2 weeks of GP referral (all cancer symptoms)	March 2021	93%	91.3%
Breast cancer symptoms		93%	76.9%
Proportion of patients receiving first cancer treatment within 31 days of diagnosis		96%	94.7%
Proportion of patients receiving second or subsequent cancer treatment (surgery) within 31 days of decision to treat		94%	86.4%
Proportion of patients receiving second/subsequent treatment (drug therapy) within 31 days of decision to treat		98%	99.1%
Proportion of patients receiving second/subsequent treatment (radiotherapy) within 31 days of decision to treat		94%	97.9%
Proportion of patients receiving first cancer treatment within 62 days of urgent GP referral for suspected cancer		85%	73.9%
Proportion of patients receiving first cancer treatment within 62 days of urgent referral from NHS Cancer Screening Programme		90%	75.0%

Metric	Period	Standard	Performance
Ambulance			
Average (mean) response time for people with life-threatening injuries and illness (Category 1)	March 2021	7 minutes	6 minutes 47 seconds
Response time for people with life-threatening injuries and illness (Category 1) – average for 90th centile		15 minutes	11 minutes 58 seconds
Average (mean) response time for other emergencies (Category 2)		18 minutes	18 minutes 26 seconds
Response time for other emergencies (Category 2) – average for 90th centile		40 minutes	36 minutes 21 seconds
Response time for urgent care (Category 3) – average for 90th centile		120 minutes	113 minutes 45 seconds
Response time for less urgent care (Category 4) – average for 90th centile		180 minutes	175 minutes 21 seconds
Infection control			
Number of MRSA bloodstream infections	2020/21	0	694
Number of *Clostridium difficile* infections		-	12,501
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 7 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 these statistics were paused to release capacity across the NHS to support the response to COVID-19.

Chief Financial Officer's Report

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

The revenue resource limit for NHS TDA is £225.7 million (2019/20: £225.1 million). NHS TDA's net expenditure for the year was £220.8 million (2019/20: £223.5 million). The under spend against the revenue resource limit is £4.9 million (2019/20: £1.6million).

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

Main categories of spend

	2020/21 £m	2019/20 £m	Reference to accounts
Operating revenue	(16.4)	(28.7)	Note 3
Staff	137.7	140.9	Note 4
Purchase of goods and services	98.6	110.4	Note 5
Depreciation and impairment charges	0.9	0.9	Note 5
Total	**220.8**	**223.5**	

The decrease in operating revenue is mainly due to a reduction in income to support the intensive support team programmes, which has been funded instead through grant in aid funding in 2020/21, and a reduction in NHS Leadership Academy (NHSLA) training due to COVID-19 related disruptions and subsequent reduction/rescheduling of courses.

The largest area of spend is staff costs, representing 62% of net expenditure in 2020/21 (2019/20: 63%).

Purchase of goods and services spend relates to education and training costs largely relating to NHSLA (£32.2 million), programme support costs including intensive support to NHS provider organisations and the Getting It Right First Time (GIRFT) programme (£26.2 million).

Parliamentary cash funding received was £197.7 million.

Net liabilities at 31 March 2021 were £47.7 million (31 March 2020: net liabilities £24.5 million). The increase in net liabilities is mainly due to an increase in trade and other payables due to timing of invoices, combined with a reduction in current assets relating to the cash and cash equivalents balance and the receivables balance.

Statement of payment practices

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

Payment practices

	2020/21		2019/20	
	Number	**£000**	**Number**	**£000**
Non-NHS payables				
Total non-NHS trade invoices paid in the year	7,340	49,106	11,263	52,357
Total non-NHS trade invoices paid within target	6,997	46,682	10,569	49,980
% of non-NHS trade invoices paid within target	**95%**	**95%**	**94%**	**95%**
NHS payables				
Total NHS trade invoices paid in the year	1,334	54,440	1,717	35,865
Total NHS trade invoices paid within target	1,205	52,943	1,587	34,755
% of NHS trade invoices paid within target	**90%**	**97%**	**92%**	**97%**

More detail of how money has been spent in 2020/21 can be found in the main accounts.

Julian Kelly
Chief Financial Officer of NHS England and NHS Improvement

Accountability Report

Professor Stephen Powis
Interim CEO of NHS Improvement, and Accounting Officer

26 January 2022

The Accountability Report sets out how we meet key accountability requirements to Parliament and comprises three key sections:

The Corporate Governance Report

This sets out how we have governed the organisation during 2020/21, 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 57.

The Remuneration and Staff Report

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 99.

The Parliamentary Accountability and Audit Report

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 124.

Corporate Governance Report

Directors' Report

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 and Monitor'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 has agreed should be decisions that can only it can take.

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 DHSC and other stakeholders to best promote the continued success and growth of NHS trusts and NHS foundation trusts and other aspects of the healthcare sector.

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. The Board is further strengthened by the addition of a non-voting associate non-executive director.

During the year, the Board reviewed the Board governance framework introduced in April 2019 to support the model of joint working with NHS England, involving shared national directors and functions and integrated regional teams. The review resulted in some changes to the framework to improve the two Boards' oversight of both organisations, while also fulfilling their separate duties, including the delivery of ICSs and the NHS Long Term Plan. The changes made included the

establishment of the time-limited Board committee, the National Incident Response Board, on 1 April 2020 to manage NHS England's and NHS Improvement's response to the COVID-19 incident. Further information on the Board governance framework can be found on page 60.

Board members

Directors who served on the NHS Improvement Board during the year, along with their attendance at Board meetings, are listed in the table below. Board members biographical details may be viewed on our website.[34]

During the year, the Secretary of State for Health and Social Care approved the transfer of Laura Wade-Gery's non-executive directorship to NHS England and Professor Sir Munir Pirmohamed's non-executive directorship to NHS Improvement. At the request of the Secretary of State, Baroness Dido Harding stepped away from her role as Chair to focus her efforts on NHS Test and Trace. Sir Andrew Morris was appointed the Vice Chair of NHS Improvement and stepped in as Acting Chair in Baroness Harding's absence.

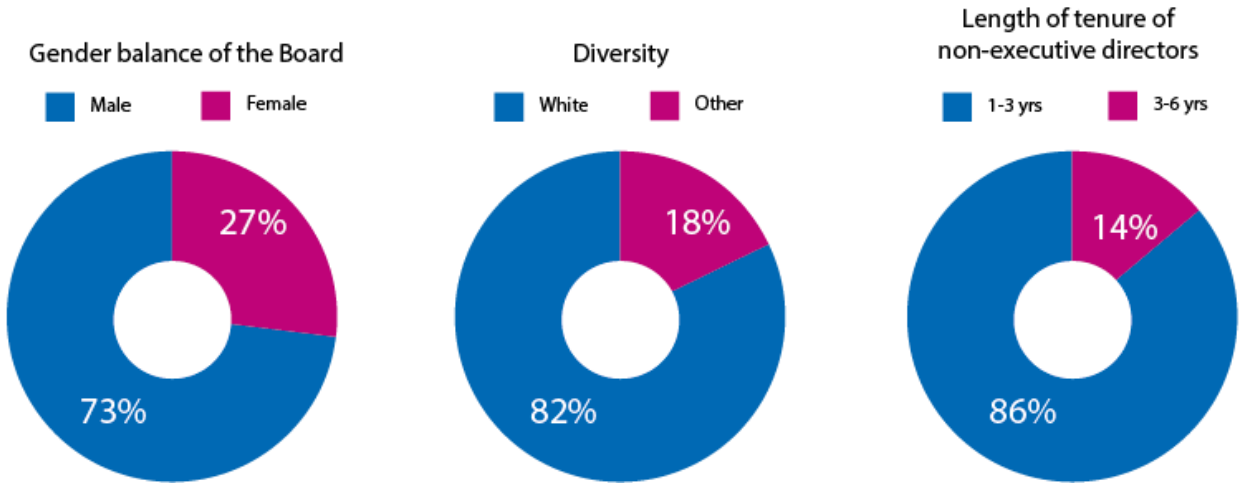
Sir David Behan, Chair of Health Education England, continued to serve as an associate (non-voting) non-executive director during the year and his term has been extended to March 2022.

Members	Role	Term ends/notes	Number of eligible Board meetings attended
Baroness Dido Harding[35]	Chair	29 October 2021	3/7
Amanda Pritchard[36]	Chief Operating Officer and Chief Executive	Until 31 July 2021	7/7
Sir Andrew Morris[37]	Vice Chair	31 July 2023	7/7
Dr Timothy Ferris	Non-Executive Director	Left on 9 May 2021	6/7
Lord Patrick Carter of Coles	Non-Executive Director and Senior Independent Director	31 March 2022	7/7
Wol Kolade	Non-Executive Director	31 March 2022	7/7
Prof Sir Munir Pirmohamed[38]	Non-Executive Director	31 December 2023	3/3
Sir David Behan	Associate (non-voting) Non-Executive Director	31 March 2022	7/7
Julian Kelly CB	Chief Financial Officer		6/7
Ruth May	Chief Nursing Officer		6/7
Prof Stephen Powis[39]	National Medical Director		7/7
Former member	**Role**		
Laura Wade-Gery[40]	Non-Executive Director	Left on 6 November 2020	4/4

[34] https://www.england.nhs.uk/about/board/nhs-improvement-board/board-members/
[35] Baroness Dido Harding stepped away from her role as the Chair on 5 November 2020 to focus her efforts on Test and Trace.
[36] Amanda Pritchard was the joint Chief Operating Officer and the Chief Executive for NHS Improvement for the whole of 2020/21 and on until 31 July 2021.
[37] Sir Andrew Morris was appointed Vice Chair on 12 November 2020.
[38] Professor Sir Munir Pirmohamed's directorship was transferred from NHS England to NHS Improvement on 6 November 2020.
[39] Professor Stephen Powis was appointed Interim Chief Executive on 1 August 2021.
[40] Laura Wade-Gery's directorship was transferred to NHS England on 6 November 2020.

Board diversity

The charts below shows the composition of the Board members by gender, diversity and tenure as of 31 March 2021.



Appointments

The Chair and non-executive directors are appointed by the Secretary of State for Health and Social Care. Non-executive directors are appointed to both Monitor and NHS TDA. As non-executive directors for Monitor they hold statutory office under Schedule 8 to the Health and Social Care Act 2012 and as non-executive directors for NHS TDA they hold statutory office under the National Health Service Trust Development Regulations 2012.

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

On 1 April 2020 Lord Ara Darzi's non-executive directorship was transferred to NHS England; Professor Sir Munir Pirmohamed's non-executive directorship was transferred to NHS Improvement from NHS England on 6 November 2020. On the same day, Laura Wade-Gery's non-executive directorship was transferred to NHS England. This was to enable Laura Wade-Gery to lead NHS Digital as their Chair while ensuring her contribution to the NHS England and NHS Improvement Boards continued.

To focus her efforts on Test and Trace, Baroness Dido Harding stepped away from her role as Chair on 5 November 2020. As Laura Wade-Gery transferred to the NHS England Board, the non-executive directors appointed Sir Andrew Morris as the new Vice Chair and Andrew stepped up as the Acting Chair in Baroness Dido Harding's absence.

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 England cannot delegate its functions to NHS Improvement, and vice versa. The joint NHS England and NHS Improvement Board governance framework in place reflects this but was refined during the year to strengthen the joint oversight and assurance of the organisations while enabling the Boards to retain their own board and board committees. The Boards and the Board committees continue to operate and meet in common allowing the organisations to meet together, have joint discussions while having separate membership and taking 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 74.

The Board committee structure seeks to align with the organisation's long-term strategic approach and is underpinned by a clear division of responsibilities and accountabilities. In June 2020, the Boards agreed to streamline the governance framework and reduce the number of Board committees to five, in addition to the time-limited COVID-19 National Incident Response Board. The changes included the disbandment of the Delivery, Quality and Performance Committees and Strategy Committees, merger of the Remuneration and People Committees to form the new People, Remuneration and Nominations Committees and replacement of the NHS England Statutory Committee and the NHS Improvement and Provider Oversight Committee with a new System Oversight Committee.

Due to the COVID-19 pandemic, establishment of the System Oversight Committee was delayed and the duties delegated to the NHS England Statutory Committee reverted to the NHS England Board and the NHS Improvement Provider Oversight Committee was retained and continued to exercise its functions, duties and powers during 2020/21.

An overview of the Board and Executive Committee framework in place during the reporting period is shown on the next page and individual Board committee reports can be found on pages 65 to 73. A report detailing the business considered by the Board committees is provided to each Board meeting and the terms of reference for each committee are on our website.

NHS Improvement Board governance framework and committees

NHS Improvement Board

Committees operating as a committee-in-common with NHS England

Audit and Risk Assurance Committee	People, Remuneration and Nominations Committee	Digital Committee	Quality and Innovation Committee	Provider Oversight Committee	COVID-19 National Incident Response Board
Main responsibilities					
• Provide an independent and objective view of internal control, governance and risk management including overview of internal and external audit services, governance, risk management, counter fraud and financial reporting.	• Oversee the delivery of the overall people strategy for the NHS. • Oversee the implementation of key provisions in the NHS People Plan. • Approve the framework and policy for executives for submission to DHSC. • Approve individual executive remuneration packages. • Approves employee policies. • Review employee engagement initiatives. • Exercise NHS TDA's powers in relation to chairs and non-executive directors of NHS trusts.	• Ensure effective delivery of the digital commitment of the NHS Long Term Plan. • Ensure alignment of technology initiatives and spend across the system to ensure they are focused on commitments of the NHS Long Term Plan.	• 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. • Oversee implementation of innovation strategies	• Oversee the development and delivery of NHS Improvement's oversight and regulatory policy. • Approve formal regulatory action and intervention, including entry and exit of trusts in special measures. • Approve transactions for trusts in segment 4 or rated as high risk.	• Oversee the organisation's response to the COVID-19 incident and EU Exit Programme. • Oversee NHS operational delivery and performance in relation to incident recovery in light of the commitments publicly set out in the NHS Long Term Plan and the NHS People Plan.

Executive HR Group.	Trust Appointments and Approvals Committee .	Regional Trust Appointments and Approvals Committees
Joint Finance Advisory Group (NHS Improvement and NHS England)	The group has no executive responsibility and has been formed to ensure that both organisations are working from a common understanding of the financial targets and financial performance of the entire health system.	

NHS Executive Group

The NHS Executive Group includes the corporate and regional directors of each of the directorates of the joint organisation. The group is chaired by the Chief Executive of NHS England 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 group is supported by several other management groups and processes.

Key Board roles and responsibilities

The Chair is responsible for the leadership and effectiveness of the Board. Part of their role is to ensure 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 Board Governance to agree joint board training and development sessions.

Throughout the reporting period Amanda Pritchard, as the Chief Executive of NHS Improvement, was responsible for providing strategic leadership and the implementation of the agreed strategy and objectives. As the Chief Executive, Amanda was also the Accounting Officer for NHS Improvement and held responsibility for ensuring that public funds were properly safeguarded and are used in line with NHS Improvement's functions and responsibilities as set out in HM Treasury guidance Managing Public Money. Laura Wade-Gery was Vice Chair from 1 April 2020 to 6 November 2020 when her directorship was transferred to NHS England. Sir Andrew Morris took over as Vice Chair on 12 November 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. The Chief Executive is supported by their senior leadership team and together they are responsible for the implementation and execution of NHS Improvement's strategy.

Senior Independent Director

In addition to the role of non-executive board member, the Senior Independent Director 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, while 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 organisation to deliver its strategic objectives.

Board activity and administration

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

Board meetings are generally pre-scheduled on a rolling basis. 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 the NHS England and NHS Improvement Boards during the year were:[41]

Strategy:

- development of the COVID-19 Vaccination Deployment Programme.
- NHS Recovery Programme
- endorsement of work to support the NHS to embed and accelerate clinical innovations that had arisen in response to COVID-19
- approval of the publication of the NHS People Plan
- development of ICSs
- NHS England and NHS Improvement Operating Model.
- work to address quality of care and patient safety issues considered, including work to address the issues identified in the Independent Medicines and Medical Devices Safety Review and actions in response to the Shrewsbury and Telford Hospital NHS Trust independent maternity review
- approval of the recommendations in Professor Sir Mike Richards' report: Diagnostics: Recovery and Renewal
- the review of the digital, data and technology landscape across the NHS considered
- endorsement of the National Tariff proposals
- support for the ambitions for delivering a 'Net Zero' NHS
- approval of the financial framework as it evolved through 2020/21
- approval of the approach to oversight of NHS providers and commissioners for 2020/21 and the consultation on the System Oversight Framework for 2021/22.

[41] Where applicable the individual boards have made the decisions.

Performance:

- the organisation's response to COVID-19 and the associated recovery and restoration of NHS services
- The COVID-19 Vaccination Deployment Programme
- operational, quality and financial performance of NHS providers and the commissioning sector.

Leadership and people:

- update on work to ensure the NHS is inclusive, diverse and a good place to work, including the work programme for addressing the impact of COVID-19 on black, Asian and minority ethnic staff and health inequalities
- NHS England's and NHS Improvement's ways of working considered
- endorsement of the staff health and wellbeing offer for all NHS staff
- approval of the 2020/21 Slavery and Human Trafficking statement.

Governance and risk:

- approval of changes to the Board governance framework and terms of reference for the Board committees, including the establishment of the COVID-19 National Incident Response Board
- approval of a revised Joint Corporate Risk Register (JCRR)
- received regular EU exit updates.

Review of board effectiveness and performance evaluation

In line with best practice, an evaluation of the Board's and its committees' effectiveness should be conducted annually. An informal review of the effectiveness of the Board and the Committees was carried out in early 2020 and this was then supported by a formal internal governance review carried out by the internal auditors, Deloitte in May 2020. The findings from both reviews resulted in a number of changes to the governance structure which were agreed by the Boards in June 2020. Details of these changes can be found on page 60.

This year, Board members completed a Board and Board Committee evaluation questionnaire, the result of which has been fed into a larger piece of work on board governance led by the current Senior Independent Director for NHS England, Mike Coupe. The outcome of this review will be considered, and actions taken forward as part of the work programme for the coming year.

It is recognised that the Chair's effectiveness is also vital to the operation and effectiveness of the Board. During the year Baroness Dido Harding stepped away from her role as Chair to focus her efforts on Test and Trace. Sir Andrew Morris was appointed the Vice Chair of NHS Improvement and stepped in as Acting Chair in Baroness Harding's absence. As the NHS Improvement Board meet in common with NHS England's Board, it was informally agreed that the chair of NHS England, Lord David Prior, would take the lead on Board meetings and many of the board-related matters. As a result it was agreed that it would not be appropriate to carry out a performance review of Sir Andrew Morris.

Board committees

COVID-19 National Incident Response Board

Role of the committee

On 1 April 2020 NHS England and NHS Improvement Boards each established a time-limited[42] (for the duration of the COVID-19 incident) Board Committee, the COVID-19 National Incident Response Board (the COVID-19 Board). The COVID-19 Board is responsible for the strategic direction and providing oversight of NHS England's and NHS Improvement's response to the COVID-19 incident.

Committee members

The COVID-19 Board met an average of three times per week during 2020/21, with members attending most of these meetings.

Members	Comment
Amanda Pritchard (Chair)	
Julian Kelly CB (Deputy Chair)	
Prof Stephen Powis (Deputy Chair)	
Dr Jonathan Berger	Interim Chief Medical Officer, NHS Digital
Ian Dodge	
Simon Enright	Director of Communications
Matthew Gould	National Director Digital Transformation and Chief Executive NHSX
Stephen Groves	Director of EPRR (National)
Prerana Issar	Chief People Officer
Dr Nikita Kanani	Medical Director for Primary Care
Dr Emily Lawson	
Ruth May	
Claire Murdoch	National Director Mental Health
Pauline Philip	National Director Emergency and Elective Care
Prof Keith Willett	Strategic Incident Director
Seven regional representatives	Rotational between Regional Directors and their senior teams

Attendees

In addition, the Director General, DHSC, and the Deputy Director, National Infection Service, PHE were invited to attend these meetings to support delivery of the government's cross-departmental strategy and approach to COVID-19.

[42]The COVID-19 National Incident Response Board was established for an initial term of 1 April to 31 September 2020. On 1 October 2020, the Boards approved an extension to its operation from 1 October 2020 to 31 March 2021 to continue to oversee the NHS's operational response to COVID-19.

Principal activities during the year

The COVID-19 Board oversaw NHS England's and NHS Improvement's response to the COVID-19 incident and NHS operational delivery and performance in relation to incident recovery. To support this, the COVID-19 Board operated as the key oversight and assurance forum for the work carried out through the following NHS England and NHS Improvement COVID-19 incident response cells:

- Safe Hospital and Urgent and Emergency Care Services
- Out of Hospital
- Flu Vaccine Delivery and Screening
- COVID-19 Vaccine Delivery
- NHS Workforce Capacity Building
- Supply Chain and Physical Capacity
- Nightingale Hospitals
- Testing
- Infection, Prevention and Control
- Mental Health, Learning Disability and Autism
- Data Analytics and Reporting
- Clinical Safety
- Communications
- Finance
- Digital/NHSX
- Improvement
- Health Inequalities.

Audit and Risk Assurance Committee (ARAC)

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 ARAC.

Committee members

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

Members	Number of eligible meetings attended
Wol Kolade (Chair)	7/7
Sir Andrew Morris	7/7

Good governance provides that an audit and risk committee should consist of three independent non-executive directors. As the committee meets in common with NHS England's committee, the majority of items considered are joint NHS England and NHS Improvement business and together there are four non-executive directors involved in deliberations, and it was agreed, and supported by the internal auditors, that the committee should comprise of two non-executive directors. This is also a time-limited arrangement pending legislative changes to the organisations. 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 committee's duties.

Attendees

Additional attendees are invited to attend meetings to assist with committee business. For 2020/21 these included, among others, the Chief Executive Officer, the Chief Financial Officer, the Chief Operating Officer, the Director of Governance and Legal, the Director of Financial Control as well as representatives from the external auditors the National Audit Office (NAO), the internal auditors (Price Waterhouse Coopers to 30 June 2020 and Deloitte LLP from 1 July 2020) and DHSC. The committee is able to meet with the internal and external auditors without management when required and the auditors have full access to the organisations.

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:

- considered management of risk through COVID-19 incident and recovery
- considered the COVID-19 financial governance arrangements and commercial activity related to COVID-19 business cases
- approved the internal audit plan and considered regular progress reports from the internal auditors
- reviewed NHS England's and NHS Improvement's JCCR
- approved review changes in accounting policies and areas of significant estimation or judgement
- assessed the integrity of NHS TDA's and Monitor's consolidated provider and consolidated foundation trust financial reporting
- approved NHS TDA's and Monitor's, consolidated provider and consolidated NHS foundation trust 2019/20 Annual Report and Accounts
- received updates on delivery of the objectives set out in the Economic Crime Strategy – Tackling Fraud Bribery and Corruption
- approved Governance Manual Changes for 2020/21, including approval of the joint NHS England and NHS Improvement Standing Financial Instructions.

Internal audit

The internal auditor, Deloitte LLP, plays an important part in supporting the assurance role of both the NHS England and NHS Improvement committees. Deloitte LLP was appointed the joint NHS Improvement and NHS England internal auditor from 1 July 2020, replacing NHS Improvement's previous internal auditor, Price Waterhouse Coopers.

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

Committee members

The committee met three times and the following table details membership, and the number of meetings attended by each member during the year:

Members	Number of eligible meetings attended	Comments
Dr Timothy Ferris (Chair)	2/3	Chair from 6 November 2020
Simon Eccles	3/3	Chief Clinical Information Officer
Matthew Gould	3/3	Chief Executive, NHSX
Hugh McCaughey	3/3	National Director of Improvement
Amanda Pritchard	2/3	
Former members		
Laura Wade-Gery[43]	1/1	Left on 5 November 2020

[43] Laura Wade-Gery's directorship was transferred to NHS England on 6 November 2020.

Attendees

Additional attendees are invited to attend meetings to assist with committee business. For 2020/21 these included, among others, the Chief Executive of NHS Digital and non-executive directors of NHS Digital and NHS Resolution.

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:

- the digital and technology priorities, governance and spending to support the COVID-19 response
- updates on the review of the digital, data and technology landscape across the NHS
- operating model for digitally enabled transformation in ICSs.

NHSX

NHSX is responsible for providing digital and technology input into the implementation plan for the NHS Long Term Plan, the NHS 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.

People, Remuneration and Nominations Committee

Role of the committee

The committee's role is to set an overall people strategy and oversee the delivery of the NHS People Plan and provide the Board with assurance and oversight of all aspects of strategic people management and organisational development. The committee is also responsible for people and organisational development policies and ways of working designed to ensure the workforce of NHS Improvement is appropriately engaged and motivated, including workforce engagement. The committee also reviews the organisation's gender pay gap and ensures that NHS England and NHS Improvement develop policies and actions to reduce this, and reviews progress in increasing BAME representation at senior levels within the organisation and initiatives relating to diversity and inclusion.

The committee ensures that NHS England and NHS Improvement have a single formal, robust and transparent remuneration policy that is in line with DHSC's Executive and Senior Manager Pay Framework for Arm's Length Bodies (DHSC'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 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 (TAAC) and the Regional TAAC.

The committee meets in common with NHS England's People, Remuneration and Nominations Committee, delegates certain functions to the Executive HR Group, the Trust Approvals and Appointments Committee and the Reginal Trust Approvals and Appointments Committees, and receives regular reports from the group and the sub-committees on cases considered and approved.

Committee members

The committee met three times and the following table details the membership, and the number of meetings attended by each member during the year:

Members	Number of eligible meetings attended	Comments
Sir Andrew Morris (Chair)	3/3	
Lord Patrick Carter of Coles	1/3	
Sir David Behan (non-voting)	3/3	
Former members		
Baroness Dido Harding	0/2	To 9 March 2021

Committee attendees

Additional attendees are invited to attend meetings to assist with committee business. For 2020/21 these included the Chief People Officer and Director of Human Resources and Organisation Development.

Principal activities during the year

Reports considered by the committee included:

- considered new ways of working and learnings from the COVID-19 response
- reviewed the NHS England and NHS Improvement staff survey and check-in surveys during the COVID-19 incident
- considered NHS England's and NHS Improvement's Diversity and Inclusion Strategy and Culture Change Plan, including the approach to diversity and inclusion through COVID-19 and accelerating action and change in NHS England and NHS Improvement.
- reviewed the NHS People Plan and NHS People Promise and received regular updates on implementation
- approved, in line with DHSC recommendation, annual salary increases for executive senior managers (ESMs) and medical colleagues on local pay arrangements

- approved an annual salary increase for employees not on Agenda for Change terms and conditions
- approved the publication of the NHS England and NHS Improvement gender and ethnicity pay gap reports
- considered the approach to succession planning and talent management for NHS England and NHS Improvement staff.

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 TAAC and the Regional TAACs.

TAAC consists of the Committee Chair, the Chief Operating Officer/Chief Executive of NHS Improvement and two regional directors (rotating annually). Its remit includes approval of NHS trust chair appointments and NHS trust termination cases. During the year, TAAC considered 51 cases.

There is a regional TAAC for each of the seven regions and the membership is made up of the regional director, senior members of the regional director's team and a member of the national Senior Appointments and Resourcing Team. Each of these committees is, among 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.

Quality and Innovation Committee

Role of the committee

This committee's primary role is to assist the Board in ensuring that areas concerning patient safety, the quality of care provided to patients and patient experience are improving and developing to meet the needs of patients in England. In doing so the committees will ensure strategies are continually improving quality, safety and experience of care.

The committee meets in common with NHS England's Quality and Innovation Committee.

Committee members

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

Members	Number of eligible meetings attended	Comments
Dr Timothy Ferris (Chair)	5/5	
Prof Sir Munir Pirmohamed[44]	4/4	From 6 November 2020
Prof Stephen Powis	5/5	
Ruth May	5/5	
Aidan Fowler	1/2	National Director of Patient Safety, from 9 March 2021
Patient and Public Voice members	5/5	

Committee attendees

Additional attendees are invited to attend meetings to assist with committee business. For 2020/21 these included the Director of Clinical Policy, Quality and Operations and the Head of Quality Strategy.

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 within the context of delivering the NHS Long Term Plan. In doing this the committee has considered:

- the impact and lessons learned from the COVID-19 pandemic
- quality oversight and governance updates, both internally and cross-system
- proposals for strategic oversight of NHS quality issues and performance
- updates on the implementation of the NHS Patient Safety Strategy and related systems
- updates on the Maternity Transformation Programme and governance and oversight arrangements for maternity services
- lessons and actions from independent reviews into maternity services.

Other items considered include:

- regular updates from the Executive Quality Group and National Quality Board
- governance of the Healthcare Safety Investigation Branch (HSIB)
- the development of a new NHS quality dashboard
- patient experience.

[44] Professor Sir Munir Pirmohamed's directorship was transferred from NHS England to NHS Improvement on 6 November 2020.

Provider Oversight Committee

Role of the committee

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

Committee members

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

Members	Number of eligible meetings attended	Comments
Amanda Pritchard (Chair)	10/11	
Prof Stephen Powis (Deputy Chair)	9/11	National Medical Director
Miranda Carter	9/11	Director of Provider Development
Sandra Easton	9/11	Director of Operational Finance and Performance
Julian Kelly CB	6/11	
Prerana Issar	0/11	Chief People Officer
Hugh McCaughey	10/11	National Director of Improvement
Seven regional directors of strategy and transformation*		
Simon Rogers	7/7	Senior Legal Director, non-voting (from 13 October 2020)
Former members		
Kate Moore	4/4	NHS Improvement General Counsel, non-voting (left on 30 September 2020)

*The Director of Strategy and Transformation or equivalent from each region is a member of the committee

Committee attendees

Additional attendees are invited to attend meetings to assist with committee business. For 2020/21 these included the Director of Intensive Support, Director of Oversight and Planning, and regional senior oversight and regulation leads (or equivalent).

Principal activities during the year

During the year the committee considered the following:

- revisions to the entry and exit criteria for the Maternity Safety Support Programme
- revised criteria for exiting special measures for finance
- the development of the System Oversight Framework for 2021/22
- the oversight arrangements and support levers for independent providers

  changes to the FT Annual Reporting Manual requirements for 2021/22

  regular reports on providers in special measures for quality and/or financial reasons, or at the risk of entering the regime.

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

- the outcome of a review of the NHS Improvement transaction guidance
- options for collaboration between providers
- the proposed merger of Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust and Poole Hospital NHS Foundation Trust
- the proposed acquisition of Royal Brompton & Harefield NHS Foundation Trust by Guy's and St Thomas' NHS Foundation Trust
- the proposed acquisition of Pennine Acute NHS Trust (Bury, Oldham and Rochdale sites) by Salford Royal NHS Foundation Trust
- the transaction classification for the proposed acquisition of North Manchester General Hospital by Manchester University NHS Foundation Trust
- strategic case review for the proposed acquisition of Brighton and Sussex University Hospitals NHS Trust by Western Sussex Hospitals NHS Foundation Trust.

On 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 exiting special measures.

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 bodies 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 should 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 actual or perceived functional conflicts 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. 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 Health and Social Care Act 2012);
- 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 that 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 2020/21 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 is managed by the NHS England Standing Orders, NHS Improvement 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 commencement 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 our website.[45]

Details of related party transactions, where NHS England 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 150.

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 2020/21.

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 for the financial year ending 31 March 2021 was published on our website[46] in 25 March 2021.

Our strategy on tackling fraud, bribery and corruption can be found on our website.[47]

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 UK General Data Protection Regulation (GDPR).

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 an 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 2021, no notifiable incidents had occurred relating to the loss of personal data.

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.

[45] https://www.england.nhs.uk/publication/our-board-members-register-of-interests/
[46] https://www.england.nhs.uk/wp-content/uploads/2021/03/agenda-item-13.2-slavery-and-human-trafficking-statement.pdf
[47] https://www.england.nhs.uk/publication/tackling-fraud-bribery-and-corruption-economic-crime-strategy-2018-2021/

Events after year-end

Dr Timothy Ferris stepped down as a Non-Executive Director for NHS Improvement on 9 May 2021 and took on the role of joint National Director of Transformation from 10 May 2021.
To ensure the NHS Improvement Board is duly constituted, Rakesh Kapoor's non-executive directorship has temporarily been transferred from NHS England to NHS Improvement to 31 March 2022.

The Secretary of State for Health and Social Care also approved the extensions of Andrew Morris' non-executive directorship to 31 July 2023, Professor Sir Munir Pirmohamed's non-executive directorship to 31 December 2023, and Wol Kolade's and Lord Patrick Carter of Coles' respective non-executive directorship terms to 31 March 2022.

Amanda Pritchard was appointed Chief Executive of NHS England on 1 August 2021 and stepped down from the NHS Improvement Board on 31 July 2021.

Professor Stephen Powis has been appointed as the Interim Chief Executive of NHS Improvement from 1 August 2021 until such time that NHS Improvement is abolished and formally merged into a single entity known as NHS England, in 2022/23.

Statement of Accounting Officer's responsibilities

Under the National Health Service Act 2006 (as amended), 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 2020)[48] and in particular to:

- observe the Accounts Direction issued by 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
- confirm that the Annual Report and Accounts are fair, balanced and understandable and take personal responsibility for the Annual Report and Accounts and the judgements required for determining that they are fair, balanced and understandable.

The Accounting Officer of DHSC has designated me as the 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 May 2021).[49]

As the Accounting Officer for NHS TDA, I have taken the steps that I ought to have taken to make myself aware of any relevant audit information and to establish that NHS TDA's auditors are aware of that information. So far as I am aware, there is no relevant audit information of which the auditors are unaware.

I confirm that there was adequate and sufficient handover from the previous Accounting Officer to provide me with the assurances required to make these statements.

Professor Stephen Powis

Interim CEO of NHS Improvement, and Accounting Officer. 26 January 2022

[48] https://www.gov.uk/government/publications/government-financial-reporting-manual-2020-21
[49] https://www.gov.uk/government/publications/managing-public-money

Governance statement

The NHS Improvement 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 2020/21 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, while 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 mandate 2020/21

The government's 2020/21 mandate with NHS England and NHS Improvement sets out the expectations for NHS England and NHS Improvement to deliver objectives framed heavily in the context of the response to the COVID-19 pandemic.

The primary focus for the 2020/21 mandate was to support the government in managing the response to COVID-19 and to contribute to research and innovation in prevention and treatment, while ensuring that everyone affected by it receives the very best possible NHS treatment. Alongside this NHS England and NHS Improvement would seek to deliver progress on the NHS Long Term Plan and government priorities as far as possible within the context of the primary objective.

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.[50]

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 chair, 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	NHS Improvement's executive directors are appointed by the Board and the appointments are approved by the Secretary of State for Health and Social Care.
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, the Chief Executive's private 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.
	N/A	5.9	The Board and Accounting Officer should be supported by an audit and risk assurance committee, comprising at least three members.	ARAC is comprised of at least two non-executive board members. The committee meets in common with NHS England's ARAC and consequently there are in total more than three non-executive directors involved in deliberations. The majority of business considered by the Committee is joint NHS England and NHS Improvement business. In addition, this arrangement is pending legislative changes to the organisations.

[50] 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 57.

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

Following the move to closer working in 2019/20 with the establishment of a single leadership model, the NHS England and NHS Improvement operating model has developed to reflect this and to describe how different parts of the NHS work together to deliver both nationally agreed and locally owned priorities to improve health and patient care. It reflects the nature of the NHS as a nationally funded, democratically accountable system with aligned governance and accountability structures, while also recognising partnerships with devolved local leadership. It describes national, regional and system accountabilities and how NHS England and NHS Improvement support delivery of improved health outcomes for patients and citizens locally.

The government's draft Health and Care Bill proposes several structural changes for the NHS, most notably creating ICSs as NHS statutory bodies and formally merging NHS England and NHS Improvement. These proposals build on many years of practical changes already made. Similarly, the NHS England and NHS Improvement operating model has been evolving over recent years to reflect this direction of travel and will continue to adapt as ICSs mature.

As ICSs mature, the balance of activities that take place nationally, in regions and in ICSs will shift in line with the principle of subsidiarity and accountability for delivery and will increasingly sit with systems, supported by NHS England and NHS Improvement.

By working in a more integrated way at all levels 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 and will continue to be updated. 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, illustrated on page 85. This provides the mechanism for employees to manage risk and control as well as provide assurance over the delivery of services.

Assurance activity	How does it add value?
Organisational change framework Guidelines for assessing and implementing major changes across the organisation.	The framework provides a consistent approach to thinking about the impact of organisational change, including on 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, Scheme of Delegation and Rules of Procedure These documents protect both the organisation's interests and 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.
Third-party assurance framework Guidelines for the assurance required for managing third 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 has 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 2020/21, the corporate governance and compliance team have worked with teams across the organisation to embed controls and underpin processes including by:

- in line with the Standards of Business Conduct Policy ensuring that officers undertook Staff Declarations and Assurance Certifications despite the pressures on teams through responding to the COVID-19 pandemic
- targeted interventions with teams to ensure the timely completion of priority 1 actions arising from internal audit reviews.

Management assurance

Throughout 2020/21, the Board has been provided with regular updates through the Integrated Performance Report on the implementation of the priorities and programmes committed to in the NHS Long Term Plan. The report integrates performance against constitutional standards, NHS Long Term Plan commitments and workforce and quality metrics.

In addition, the ARAC considers the outcomes of internal audit reviews of programmes and the Strategic Risk Group 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 and emergency care and primary care.

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 management and the Board. 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

The NHS England and NHS Improvement Boards are responsible for ensuring delivery of the strategies and goals outlined in their 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 Improvement's ARAC is responsible for reviewing the establishment and maintenance of an effective system of governance, risk management and internal control covering NHS Improvement'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 ARAC based on its work programme. The Boards discuss the most significant risks and actions identified to mitigate their likelihood and impact. Each year, the ARAC evaluates the effectiveness of the risk management framework and approves the annual internal audit plan for the following year.

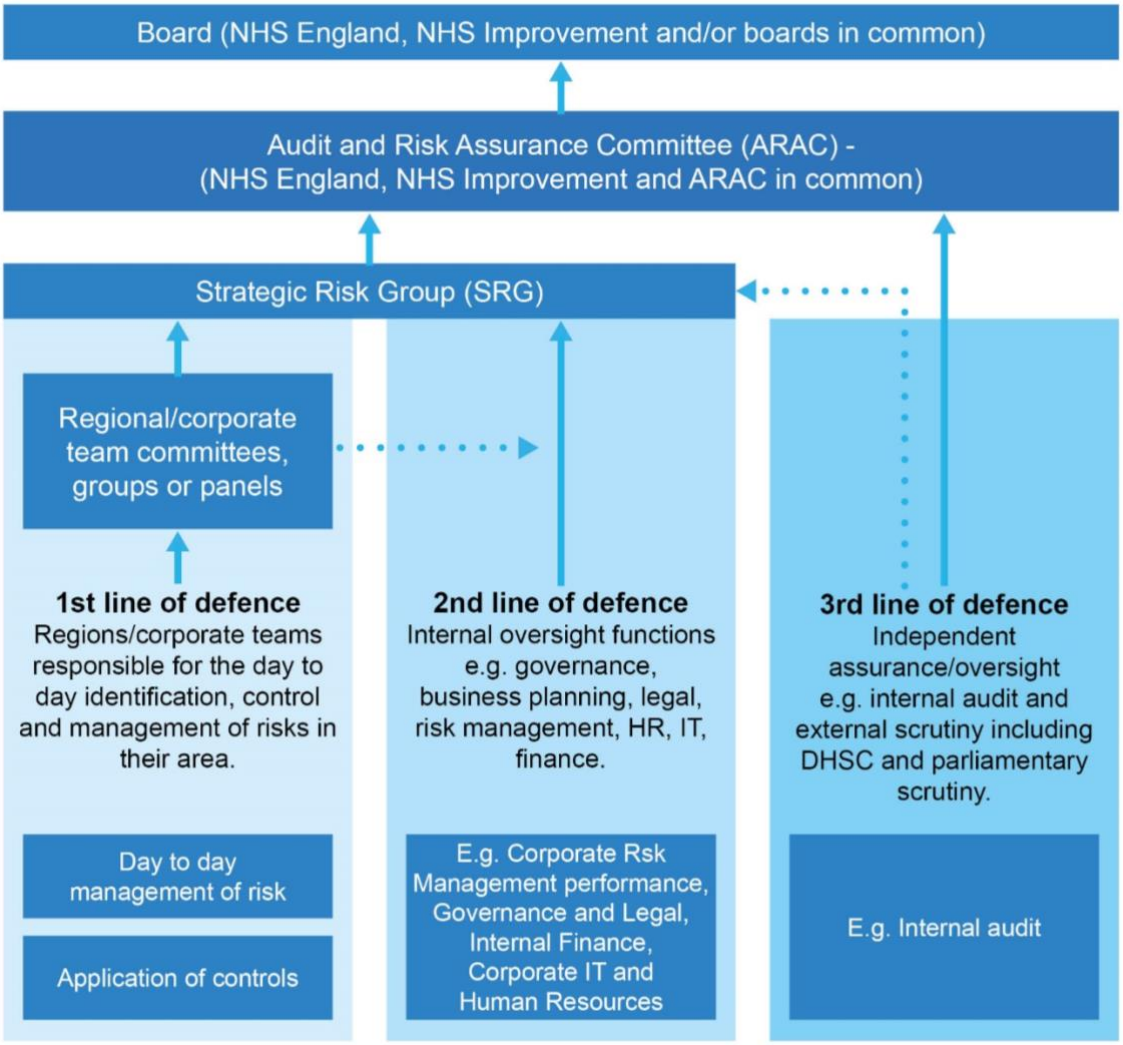
The position of Chief Risk Officer/Senior Responsible Officer (SRO) for risk for NHS England and NHS Improvement has been delivered by the Chief Financial Officer for 2020/21 to further ensure senior sponsorship for risk at executive level.

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 Strategic Risk Group has met over the year and is responsible for providing assurance to the committee about how risks across the joint organisation are being managed.

The Strategic Risk Group reviews risks escalated to it and considers which risks should be managed through the JCRR and associated processes. The committee oversees implementation of NHS England's and NHS Improvement's joint risk management framework. The NHS Executive also periodically reviews the JCRR and when appropriate undertakes deeper dives. 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 (ie 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:



Risk and control framework

In 2020/21 NHS England and NHS Improvement have continued to embed their joint risk management framework to ensure that employees follow a single process for identifying and managing risks that may threaten delivery of services and achievement of objectives. This 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 on a dedicated electronic platform have continued throughout 2020/21. We aim to continually improve our risk management maturity and risk culture year-on-year.

Principal risks

In 2020/21 the NHS Executive undertook a full review of the JCRR in the context of the management of the COVID-19 incident. 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. For the most part of 2020/21, the principal risks facing NHS England and NHS Improvement included:

Risk description	Key mitigation(s) in place included
Pandemic causes increased non-COVID-19 healthcare needs: Population outcomes impacted, and some patients face longer waits. Some NHS Long Term Plan deliverables may need rephasing.	• Continued and regular data-gathering and analysis to monitor and report service restoration and performance. In particular, bed capacity for core, surge and super-surge scenarios. • Incident governance structure in place with clear escalation for system-wide risks. • BAU operational and performance management of NHS organisations and systems to support restoration.
NHS workforce: The NHS workforce growth could not be sufficient to meet the challenges of recovery in the NHS and the NHS Long Term Plan.	• **Supply programme** including Bringing Back Staff programme; supporting entry to the NHS; potential NHS Reserve model and Landmark programme. • **Retention programme** to develop tailored support for groups most at risk of leaving including: BAME staff; early and late careers; international staff; and returners; and the most challenged systems. Principally working with systems and adopting a continuous improvement methodology. • **Staff safety programme** aimed at reducing sickness absence and ensuring staff feel safe at work, as well as acceleration of innovative and more flexible ways of working.
Healthcare inequalities: Relative access to NHS services among those living in deprivation, people from ethnic minorities, and people in 'health inclusion' groups, compared to the wider population.	• The operational planning guidance outlined five priority areas for systems on health inequalities (inclusive service restoration, digital exclusion, data completeness, preventative programmes, and leadership). • Supporting the COVID-19 Vaccine Cell on uptake by ethnic minorities, deprived communities, and those in health inclusion groups. • Health Inequalities Improvement Board is supporting oversight on health inequalities work.
Future progression of COVID-19: If wider government action is unsuccessful, including mitigation of infection growth via Test and Trace, available NHS capacity could be exceeded during potential further waves. Care quality could be compromised. COVID-19 related legal challenges could impact the work of the NHS and NHS England and NHS Improvement.	• Delivery of the COVID-19 Vaccination Deployment Programme. • Surge capacity plans in place across all regions. • Prioritisation plans and guidance agreed in advance in the event of uncontrolled outbreaks or surge activity. • Robust governance process including the National Incident Response Board.
Supply chain fragility: The fragility of suppliers, along with increased global demand, affects price and availability across all NHS settings.	• Multi-layered approach, led by DHSC, to ensure any continuity of supply issues are managed. This includes dedicated freight channels and support, and national stock build across multiple areas (including for PPE, medicines, intensive care consumables, consumer packaged goods). • Key categories of goods and services have dedicated teams managing supply and demand. • National Supplies Disruption Service support is provided, in conjunction with DHSC, to ensure emergency continuity of supplies.

Risk appetite

In 2020/21 NHS England and NHS Improvement have continued 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. This sets out rights to which patients, the 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 taxpayers. 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
- 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, ie different regions face different circumstances and some areas are very challenged
- trade-off between risks is understood/assessment of unintended impacts on other risks is undertaken (ie whether a risk 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 have been considered
- counterfactual risks have been considered to ensure management applies any learning before taking the risk
- we can demonstrate significant and measurable potential benefits (ie 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
Operational performance (across the system)	Medium
Innovation	High
Finance	Low
Compliance	Medium
Reputation	Low
Operational delivery (across NHS England and NHS Improvement)	Medium

COVID-19

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

The Corporate Risk Team supported development and management of the COVID-19 risks included in the JCRR overseen by the National Incident Response Board and NHS Executive as appropriate.

Freedom to Speak Up in secondary care

Listening to NHS workers who speak up is central to improving staff experience and patient care. The main issues that workers spoke up to us about were: patient safety (regarding working conditions); individual employment matters (which are outside our remit); and concerns about governance at NHS trusts.

Underlining the importance of Freedom to Speak Up (FTSU) during such a pressured year for the NHS, we provided 31 NHS trusts with support to improve their FTSU arrangements. This included reviewing board papers; supporting executive FTSU leads; analysing data; making recommendations for improvement; and running board development workshops.

Qualifying disclosures received during 2020/21 and action taken

Between 1 April 2020 and 31 March 2021, 175 whistleblowing disclosures were made to us relating to secondary care organisations. Twenty-three (13%) of these were concerns relating to the NHS and government response to the pandemic, particularly the provision of PPE for staff.

We take all the cases we receive very seriously and took action in 66 (38%) of them.

We took no action in 103 (59%) of cases, largely because the issue being raised was already known about and being addressed by our regional teams, we did not have sufficient detail to take action or we considered that local resolution was the most appropriate way forward. Six cases remain under review.

Quality oversight and assurance

Quality is defined in its simplest context as care that is safe, effective and brings a positive experience for patients. Quality is at the heart of all we do in the NHS and is therefore considered within all policy programmes and functions – for example, patient safety, cancer and mental health – where defined and specific monitoring and assurance processes are in place to ensure high quality of care is delivered.

Assuring the quality of services

The NHS England and 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 by securing continuous improvement in the quality of services and outcomes in relation to the safety of services, the effectiveness of services and the quality of the experience for patients.

Escalating quality issues and shared 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 the EQG. This group is co-chaired by the National Medical Director and Chief Nursing Officer and brings together regional medical directors, regional chief nurses, directors of clinical quality and senior national colleagues, including the Directors for Patient Safety, Clinical Effectiveness, Patient Experience and Quality. 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 EQG receives routine quarterly reports from the regional teams and provides a forum to share intelligence and escalate quality risks. It takes collective action to address risks and issues by co-ordinating national and regional action, escalating to the Quality and Innovation Committee if required.

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 NHS Patient Safety Strategy; and patient experience functions including complaints and surveys.

National measures for quality

A 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 committee discusses potential causes and directs a bespoke analysis. The Committee also conducts thematic reviews and deep dives based on the above inputs and intelligence from members. This analysis is used to determine what strategic actions are needed to initiate or 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. Throughout 2020/21, the Quality and Innovation Committee has focused on the following areas:

- the impact and lessons learned through the COVID-19 pandemic
- lessons and actions from independent reviews into maternity services
- implementation of the NHS Patient Safety Strategy and related systems
- structures and services related to specialised commissioning
- quality oversight and governance updates both internally and across systems
- 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 regional chief nurses to escalate issues to the EQG, while also observing regional EPRR escalation processes. The EQG is meeting virtually and continues to take regional reports.

NHS Oversight Framework for 2020/21

The NHS Oversight Framework brought together into a single document the separate oversight approaches for provider trusts and CCGs. The framework outlined several key principles that characterise NHS England's and NHS Improvement's approach:

- working with and through ICSs, wherever possible, to tackle problems
- a greater emphasis on system performance and quality of care outcomes, alongside the contributions of individual healthcare providers and commissioners to system goals
- matching accountability for results with improvement support, as appropriate
- greater autonomy for ICSs and organisations with evidence of collective working and a track record of successful delivery of NHS priorities, including tackling inequality, health outcomes and access
- compassionate leadership behaviours, that underpin all oversight interactions.

During 2020/21, in response to the COVID-19 pandemic, regional teams have worked with and through system leaders to ensure that oversight was proportionate and co-ordinated across a system.

A new comprehensive NHS System Oversight Framework for 2021/22[51] has been developed, building on the approach outlined prior to the pandemic, and reinforcing the vision of system-led delivery of integrated care, as set out in the NHS Long Term Plan, the Integrating Care and Integration and Innovation papers, and the 2021/22 Operational Planning Guidance.

The new NHS System Oversight Framework will:

- provide clarity on how NHS England and NHS Improvement will monitor performance and describe how identified support needs will be co-ordinated and delivered
- be used by NHS England and NHS Improvement's regional teams to guide oversight of ICSs at system, place-based and organisation level
- describe how NHS England and NHS Improvement will work with the Care Quality Commission (CQC) and other partners at national, regional and local levels to ensure our activities are aligned.

NHS England and NHS Improvement will continue to work with ICSs, providers, commissioners and NHS partner organisations over the course of 2021/22 to further develop the approach to oversight for future years, as ICSs, placed-based partnerships and provider collaboration arrangements become further embedded.

STPs and ICSs

The COVID-19 pandemic accelerated closer integration and partnership working between different health and care organisations, local government and voluntary sector partners across every part of the country. Partners worked collaboratively within their STPs and ICSs to develop mutual aid arrangements, to put in place new services to respond to the pandemic at pace and to identify and support people at greatest risk from COVID-19.

To support further collaboration, NHS England and NHS Improvement published Integrating Care: Next steps to build strong and effective ICSs across England. In addition to testing options for legislative change, this paper highlighted key components of an effective ICS and set out how systems and their constituent organisations would embed and enhance collaborative ways of working in future. This built on several years of developments as well as detailed conversations with system leaders, people who use and work in services and those who represent them, to reflect their priorities for future improvements to health and care through integrated working. Following the paper's publication, NHS England and NHS Improvement undertook further extensive engagement with systems and membership bodies to refine their recommendations for legislation and to inform the development of future guidance and implementation support to ICSs.

[51] https://www.england.nhs.uk/publication/system-oversight-framework-2021-22/

During 2020/21, 28 further ICSs were formally designated and became operational where STPs had previously been in place. In total, 42 ICSs now serve the whole of England, each with a partnership board bringing together local leaders, and an independent chair. This met an important NHS Long Term Plan commitment that all parts of England would be served by an ICS by 1 April 2021.

The 2021/22 planning guidance[52] set out some of the things that ICSs, and the organisations within them, should do to meet ambitions from 2022.

Other assurance

Cyber and data security

NHSX provides strategic direction for cyber security and works to strengthen cyber resilience across health and care. NHS Improvement work closely with NHS England and NHSX to ensure organisations comply with relevant standards, protect patient data, and can respond effectively in the event of a data breach.

Working in partnership with NHS Digital and the National Cyber Security Centre (NCSC), NHSXs' strategy has been to increase central monitoring, assurance and regulation to hold organisations to account, while simultaneously centrally procuring services to assist local organisations to improve their cyber security posture and reduce overall risk. This programme of work has significantly increased the cyber resilience of the NHS.

In 2020/21, as part of the COVID-19 emergency response, NHSX further increased its direct central support to the system. Working in partnership with NHS Digital and NCSC through the COVID-19 Cyber Security Action Plan, additional measures were put in place to minimise the threat of a cyber attack or major IT outage, and to ensure that if such an event did happen, organisations would be supported to get back up and running as quickly as possible. The core element of the action plan delivered by NHS Digital provided direct and speedy technical remediation of cyber security vulnerabilities to organisations critical to the COVID-19 response. Additional elements of the action plan included accelerating delivery of key service improvements, centralised protective monitoring and increased incident response capacity.

To aid immediate technical remediation, NHSX allocated £11.6 million capital funding to 99 NHS organisations, to help address critical infrastructure weaknesses. Regional digital transformation teams worked with local organisations to identify and prioritise the available capital investment, ensuring prioritisation was consistent with local plans for digital transformation.

NHS Digital's Cyber Security Operations Centre (CSOC) has been enhanced, giving it greater oversight and threat detection, by integration of additional data and threat feeds to detect and protect against ransomware and COVID-19 phishing efforts. NHS Digital is working to accelerate

[52] https://www.england.nhs.uk/publication/2021-22-priorities-and-operational-planning-guidance/

the on-boarding of priority feeds into the CSOC so that protective monitoring services can be delivered to critical national services and capabilities.

The Network and Information Systems (NIS) Regulations have continued to be used to increase compliance in the NHS, specifically in relation to managing unsupported systems, and to improve responses to high severity cyber alerts.

NHS England's Ageing Well teams form part of the NHSX-funded Better Security Better Care Programme, which provides a range of tailored local and national support to help adult social care providers complete the Data Security and Protection Toolkit (DSPT), improving their overall data and cyber security. The DSPT helps organisations understand their data and cyber security risks and measures their compliance with mandatory cyber standards relevant to their sector.

The Cyber Associates Network (CAN), established in partnership with NHS Digital, continues to be the leading network for cyber security professionals working in the health and care sector. The CAN Virtual conference events held in October 2020 were attended by more than 700 members of the network, providing key opportunities for collaboration and knowledge sharing.

Information governance

A joint information governance (IG) operating model across NHS England, NHS Improvement and NHSX has been established to ensure organisations remain compliant in relation to data protection, records management and information security activities.

Since the start of the COVID-19 pandemic the Corporate IG and NHSX IG teams have worked in alignment to support NHS England, NHS Improvement and NHSX with implementation of appropriate governance controls around the acquisition and use of data required to manage the pandemic. This has culminated in providing advice and guidance, including but not limited to supporting the completion of data protection impact assessments, data processing agreements, data sharing agreements and provision of data notices associated with the following high profile initiatives:

- the COVID-19 Datastore and Foundry platform
- the OpenSafely Platform which supports NHS England and NHS Improvement to evaluate linked, de-identified GP data and support research associated with the pandemic
- the National Immunisation Management Service (NIMS) which manages the vaccination service
- provision and acquisition of data under the Control of Patient Information Regulations 2002 (COPI) notices
- ongoing support to the COVID-19 Vaccination Programme including vaccination passport/certification.

The teams continue to provide support in all other areas of NHS England and NHS Improvement work to ensure that business as usual processes continue. Work to streamline the data flows from NHS Digital to support NHS England and NHS Improvement is ongoing. The GIRFT programme

has recently transferred from the Royal National Orthopaedic Hospital to NHS Improvement and work on the NHS Improvement Model Hospital continues to ensure that continuous improvement in practice is maintained.

The Corporate Records and Information Management team have been deployed since March 2020 to lead on the records management programme for the COVID-19 Programme Management Office, which included a rigorous training programme, audits and the creation of a COVID-19 Electronic Records Management System. The objective was to ensure our COVID-19 records will be accessible when required for future lessons learned and legal enquiries and inquiries.

Business critical models

NHS England and NHS Improvement recognise the importance of quality assurance across the full range of their analytical work and have an 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 operate a register of business critical models and audit of the quality assurance strategy associated with them, overseen by a committee of experienced analysts. To date all relevant NHS England and NHS Improvement models in the register have passed.

Business critical models operated by NHS England and NHS Improvement include:

Name of model	Type
Workforce-activity model	Planning
COVID-19 bed demand model	Forecasting
COVID-19 bed demand model aggregate approach	Forecasting
COVID-19 Early Warning System (short-term forecasts)	Forecasting
GP referral analysis	Procurement and Commercial
Elective Incentive Scheme 2020/21 baseline and actual value calculation	Allocation
COVID-19 Vaccination Programme: supply and phasing model	Planning
COVID-19 Vaccination Programme: Demand Model	Planning

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
- guiding managers and staff on improvements in internal controls
- focusing audit activity on key business risks.

Our internal audit service, provided by Deloitte LLP, 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.

In 2020/21 NHS England and NHS Improvement moved to a single internal audit provider.

The Head of Internal Audit Opinion for 2020/21 is set out from page 98.

External audit

During the year, the Audit and Risk Assurance Committee (ARAC) has worked constructively with the NAO Director responsible for health and their 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 ARAC 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 2020/21 we have worked to build controls into management processes previously identified as requiring improvement:

Cancer Drugs Fund

The Cancer Drugs Fund (CDF) operates with a fixed budget of £340 million, with any expenditure beyond this being subject to an expenditure control mechanism requiring companies benefiting from the fund to repay a proportionate rebate. As part of continual improvements of the CDF an internal audit was conducted to review the data validation processes in the CDF. Following the recommendations in the audit we have enhanced our data validation processes and procedures to ensure that CDF expenditure is correctly recorded.

Assurance framework for business critical models

The formal assessment of the quality assurance of analytical models was not completed for the 2019/20 report. This work was recovered later in the year and the assessment of business critical models for 2020/21 has been completed and is reported on page 94.

Review of economy, efficiency, and effective use of resources

Financial performance monitoring

In 2020/21 the financial position across the commissioning system has been reported monthly using the Integrated Single Financial Environment (ISFE) reporting system and supporting information collections.

This has enabled a detailed monthly review by NHS England and NHS Improvement regional and national finance leadership teams, and the CFO.

Individual CCG and direct commissioning financial performance is monitored against key performance indicators (KPIs), with a focus on the underlying financial position of organisations and the presentation of any risks and mitigations, in addition to the reported forecast and year-to-date position.

NHS England and NHS Improvement have aligned financial performance monitoring across the commissioner and provider sectors. At all levels the organisation assesses the combined financial and operational position at the local level and the NHS nationally, resulting in joint reporting and review. Increasingly these commissioner and provider positions are combined to review the performance of local systems as a whole; this is in readiness for the anticipated statutory basis for integrated care boards in 2022/23.

Central programme costs

One-year allocations were agreed for 2020/21 for our central programme resources which cover a variety of operational commitments and charges for depreciation. We reviewed these allocations in

light of COVID-19 impacts and revised allocations where appropriate. The majority of the service development funding 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. Some of this service development funding is also utilised by the corporate directorates to support operational commitments.

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 (eg professional services and consultancy), onward 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. If government makes changes to these spend controls, this is communicated along with updated guidance and training, and the changes are reflected in the commercial and procurement systems to ensure the correct workflow is being followed.

Counter fraud

NHS England and NHS Improvement directly employs a counter fraud team which investigates allegations of fraud related to our functions and ensures that appropriate anti-fraud arrangements are in place.

The ARAC receives regular updates regarding the counter fraud function, including on prospective counter fraud work, the outcomes of reactive investigations and an annual Counter Fraud Report. The committee also reviewed and approved the updated Tackling Fraud, Bribery and Corruption policy.

The Director of Financial Control has day-to-day operational responsibility for the NHS England and NHS Improvement counter fraud function, and the CFO provides executive support and direction.

The NHS Counter Fraud Authority (NHSCFA) undertakes an annual high-level estimate of the amount vulnerable to fraud, bribery and corruption, affecting the whole of the NHS, which the NHSCFA and its partners including NHS England and NHS Improvement hold the responsibility for tackling.

During 2020/21 NHS England and NHS Improvement have been working with key partners such as the DHSC, NHSCFA, NHS BSA and others. A major focus of this work was to understand, assess and address any new or emerging fraud risks associated with the COVID-19 response.

Head of Internal Audit opinion

In the context of the overall environment for 2020/21, in my opinion the framework for governance is effective, except for the need to continue work to embed the business critical models framework.

The design of the risk management framework at the year-end provides the foundation of a framework to take the organisation forward during 2021/22.

With respect to the internal control environment, progress has been made in addressing outstanding internal audit actions. On this basis, the framework for internal control has been appropriately implemented in the organisation through 2020/21, except for the need to address significant weaknesses in the control frameworks for clinical off-payroll workers, and business critical models, both of which NHS England and NHS Improvement are aware of. There remains a requirement to further embed the third-party assurance framework to obtain assurance over the delivery of services.

The recommendations raised by internal audit have been accepted by management, actions have been agreed to address these and considerable focus continues to be placed on the implementation of the actions in a timely manner.

Their opinion is based on the underlying internal audit programme of work, designed to address the specific assurance requirements of the NHS England Board and focused on areas of risk identified by management. The planned internal audit programme, including revisions to the programme during the year, has been reviewed and approved by the Audit and Risk Assurance Committee (ARAC). Results of internal audit work, including action taken by management to address issues included in internal audit reports, have been regularly reported to management and ARAC.

It should be noted that the COVID-19 pandemic led to a rapidly evolving risk environment during 2020/21 with ongoing significant impacts on the prioritisation of NHS England's and NHS Improvement's aims and resources and changes to the internal control framework.

Summary

Over the year we have continued to build on our approach to governance, risk and internal controls and it is positive that internal audit actions are being closed in a timely manner. We remain committed to delivering improvements in the areas highlighted in the audit opinion and work is already underway to prepare for the proposed legislative changes which will impact the health sector in 2022.

Staff report

Our people

We rapidly deployed over 50% of our people to different areas of our business. We have ensured support has been in place for our staff through our health and wellbeing offers, kit and equipment, enhanced communications, and temporary policy changes to enable them to do their best work.

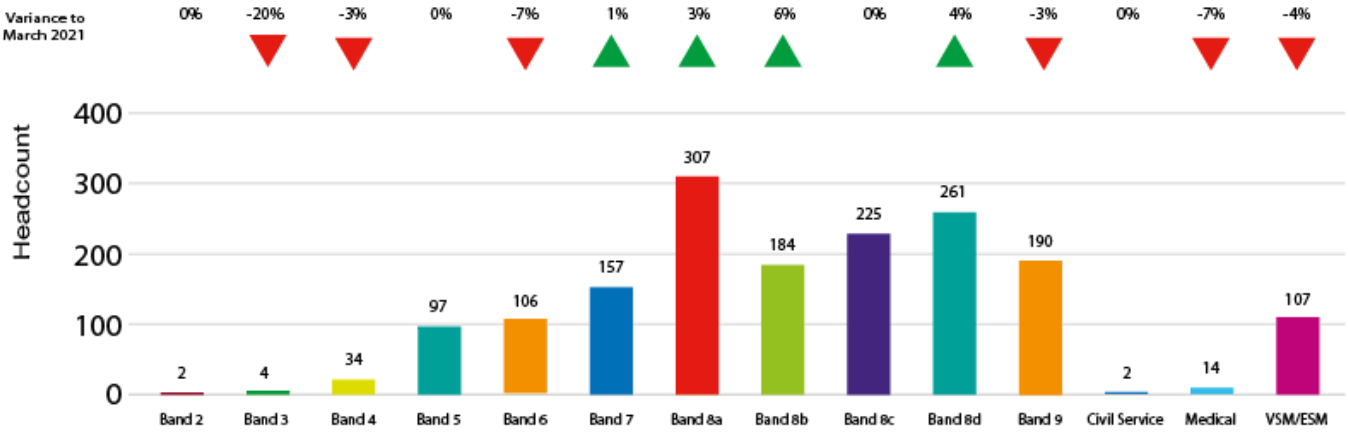
Staff numbers

On 31 March 2021, NHS Improvement directly employed 1,700 staff of whom 1,602 were permanently employed and 98 were employed on fixed-term contracts. 45% of directly employed staff worked locally in our seven regions.

Detail on staff numbers and costs for NHS Improvement are presented from page 109.

The chart below shows headcount by pay band at 31 March 2021. The headcount of permanent and fixed-term staff in NHS Improvement decreased by 1% since 2019/20.

All staff by grade



Staff turnover

Turnover has dropped significantly in 2020/21 compared to previous years. Headcount has increased, and we saw a large reduction in the number of people leaving the organisation.

Joint working had an impact too, as there was an increase in the number of people who were made permanent staff as at 1 April 2020.

Staff turnover %

	April 2018 to March 2019	April 2019 to March 2020	April 2020 to March 2021
NHS England	14.0%	13.2%	**4.88%**
NHS TDA	14.9%	15.2%	**4.65%**
Monitor	19.4%	29.5%	**4.13%**
Total	**14.7%**	**14.0%**	**4.85%**

Response to the COVID-19 pandemic

The COVID-19 pandemic dominated our priorities throughout 2020/21 and had a significant impact on our ways of working. We rapidly deployed over 50% of our people to different areas of our business. A majority of our staff were asked to work from home from late March 2020 in line with government guidance. We have ensured support has been in place for our staff through our health and wellbeing offers, kit and equipment, enhanced communications and temporary policy changes to enable them to do their best work.

Approximately 600 staff were identified as 'essential office based workers', each of whom underwent a risk assessment.

We established a working structure which included a successful daily group from corporate services teams to help plan and initiate responses to the developing pandemic, this included trade union colleagues.

We quickly developed additional support materials for staff including online guidance, enhanced communications (including a fortnightly all staff briefing), guidance and frequently asked questions (FAQs). We ran a regular 'Check In' survey for all staff to ensure we were aware of any concerns and developed tools and materials in response to support our staff. We also built 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.

Key activity continued to be focused around the COVID-19 incident, while maintaining other business critical services. A key focus was resourcing and included enabling a number of our staff to be redeployed to support COVID-19 related activity such as our EPRR unit and regional response teams. We developed a fast-track approach to recruitment. A number of our staff who were due to leave at the end of 2019/20 deferred their leaving date to bolster our response to COVID-19.

As the pandemic progressed, it was clear that working patterns had changed by necessity and from June onwards we began an engagement exercise 'Exchange' with our staff to help think through how we might reset our working patterns in the future. As a result of this, our priority for 2021/22 is to develop our future ways of delivery.

Employment policies

We have a range of employment policies to support our staff in line with our ambition to be an employer of choice. Following the Joint Working Programme in 2019, which brought NHS England, NHS TDA and Monitor together, we continued work to harmonise key employment policies across the organisations, to ensure consistency in the way staff were managed and rewarded. We have worked in partnership with recognised trade unions to achieve this and will continue this work into 2021/22.

To support our people during the pandemic we have agreed some temporary employment changes in consultation with trade unions.

Partnership working

The National Partnership Forum, established in 2018, meets quarterly and provides strategic direction for other important sub-groups who work together on specific issues including: Policy; Organisational Change; Equality and Diversity and the Health and Safety Committee.

During the COVID-19 pandemic, partnership working with our trade unions has been instrumental to helping us shape and develop a range of support products for line managers and staff. These products included a comprehensive internal communications strategy; health and wellbeing packages and webinars; individual and corporate risk assessments; smarter working products aimed at supporting virtual working; the 'Exchange' crowdsourcing platform and FAQs.

Trade union facility time disclosures

We will fulfil our obligations under the Trade Union (Facility Time Publication Requirements) Regulations 2017 for the year 2020/21 by reporting the information to form part of the government's public sector trade union facility time data.[53]

a) Trade union representative – the total number of employees who were trade union 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 – the figures requested in the first column of the table below will determine the percentage of the total pay bill spent on paying employees who were trade union representatives for facility time during the relevant period:

Description	Figures
Provide the total cost of facility time	£74,743
Provide the total pay bill	£385.6m
Provide the percentage of the total pay bill spent on facility time, calculated as: (total cost of facility time ÷ total pay bill) x 100	0.02%

d) Paid trade union activities – as a percentage of total paid facility time hours, how many hours were spent by employees who were trade union representatives during the relevant period on paid trade union activities:

Description	Figures
Time spent on paid trade union activities as a percentage of total paid facility time hours calculated as:	
(total hours spent on paid trade union activities by trade union representatives during the relevant period ÷ total paid facility time hours) x 100	9.6%

[53] These activities cross NHS England and NHS Improvement and because the data cannot be split, we have provided a figure for both organisations.

Equality, diversity and inclusion

COVID-19 and Black Lives Matters helped to further highlight the inequalities in our society. The founding principle of the NHS is about social justice. The adverse impact of COVID-19 on BAME people led inevitably to a refocus of our equality, diversity and inclusion (EDI) priorities for 2020. In line with the NHS response to COVID-19, our work has followed the frame of:

- protecting staff
- supporting staff (including supporting their health and wellbeing)
- engaging staff (including communications, staff networks and representation in decision making).

We took immediate actions to enhance our engagement with our BAME colleagues to inform our response and plans, including:

- a listening programme through an internal survey to understand what difficulties and challenges COVID-19 posed for them, what support and help we could offer
- engagement with the BAME staff network.

As a result, we put the following in place.

Protecting staff

We developed an individual risk assessment to give a framework to discussions with each person about their health and risk factors. This was to support conversations about working from home and how to mitigate adverse impact from any exposure to COVID-19 risks. While the risk assessment is for our staff, we put a particular emphasis on those at risk and in the vulnerable categories.

Supporting staff

We developed and published a guidance document for managers on how to have effective 1:1 conversations with their staff, emphasising the importance of putting inclusion and compassion at the centre of every conversation. We reviewed and refocused the products offered by our internal health and wellbeing workstream and, for example, produced a financial wellbeing toolkit. We ran health and wellbeing sessions focused on resilience and supporting working parents. We introduced reasonable adjustment passports for disabled colleagues.

Engaging staff

We established an Equality Impact Assessment (EQIA) Specialist Group to support the recovery phase by acting as a reference group/sounding board. The group was specifically set up to increase the contribution of colleagues who are not normally involved (eg staff network members, those working on the Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) across the organisation and colleagues leading on EDI for the whole NHS) to get as wide a voice as possible involved and some different perspectives on what we need to do.

We established a new Equalities Advisory Group to co-ordinate our current EDI work and collect the messages we are hearing. We aligned HR and OD business partner teams to the nine staff networks to amplify their work and ensure staff voices are heard by building their lived experience into policies and practices.

In March 2020 we agreed to set an aspirational target to achieve 19% BAME representation at all levels by 2025. Later in the year we agreed accelerated efforts to address the disproportionate impacts on our BAME people through local actions in regions and national directorates, and the adoption of the BAME talent strategy to support BME colleagues progress in their career pathways.

This is the first year that the WDES has been rolled out across all ALBs, including NHS England and NHS Improvement. The WDES underpins our commitment to ensure disability equality is a priority for our organisation. The implementation of WDES is captured in our NHS People Promise under 'We are compassionate and inclusive', which supports our goal 'We are open and inclusive'. Our focus will be on the following two areas which from expert advice we know can have significant impact:

- Reasonable adjustments: to ensure the policy and process exceeds the current practice standards and that they reflect our new ways of working as a result of COVID-19, mental health and flexible working arrangements.
- Senior level visibility: our senior leaders speak out about what it looks and feels like to work in the NHS with a disability and take on an advocacy responsibility for disability equality.

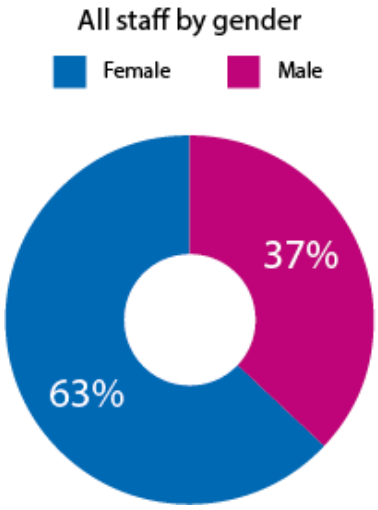
Our commitment to engaging with our people is strong and we believe it is key to our organisation culture of being compassionate and inclusive. Our ambition is to have a diverse workplace where all our people feel they are genuinely part of an organisation that cares about them and supports them to bring their whole self to work every day.

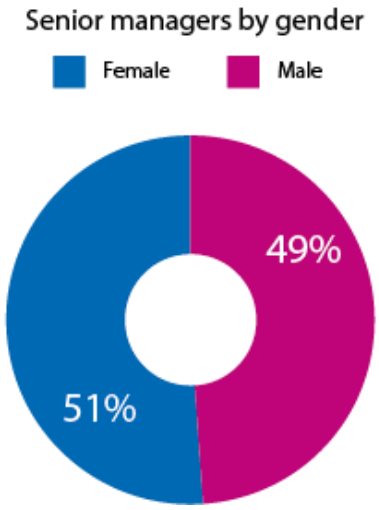
Enhanced efforts have been placed on our staff networks, enabling a sense of belonging in our organisation. The staff networks provide insights based on personal lived experiences on issues such as policy development, improving facilities and accessibility, our ways of working, health and wellbeing, and feedback on what it looks like and feels like to work in our organisation.

Looking forward, the NHS People Plan has set out our clear actions on addressing inequalities through our core practices. The NHS People Plan theme of belonging in the NHS has made inclusion and leadership the two core components of our EDI work.

Gender of all staff and senior managers

The gender profile of the total ‘on payroll’ workforce is unchanged from 2019/20. There has been a 12% reduction in the number of female senior managers to 51%. The gender diversity of Board members is set out on page 59.





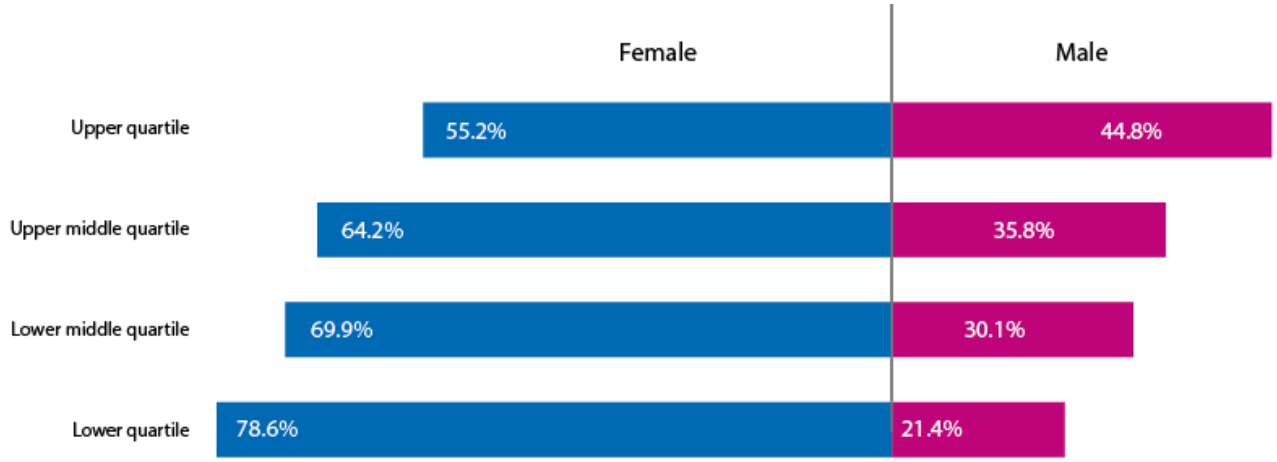
Gender pay gap

Based on the government’s methodology, the mean gender pay gap across NHS England and NHS Improvement is 16.7%, an improvement from 18.3% in the prior year.

Year	Mean gender pay gap
2020	16.7%
2019	18.3%
2018	19.5%

Pay quartiles by gender in NHS England and NHS Improvement on 31 March 2020

The proportion of males and females in each pay quartile 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.

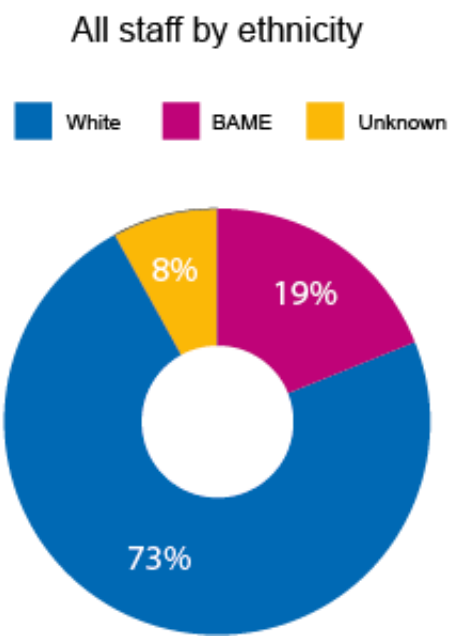
Our Gender Pay Action Plan includes specific priorities around recruitment practice, reward and recognition, flexible working, developing talent pipelines and intersectionality. The Gender Pay Gap Report is available on our website.[54]

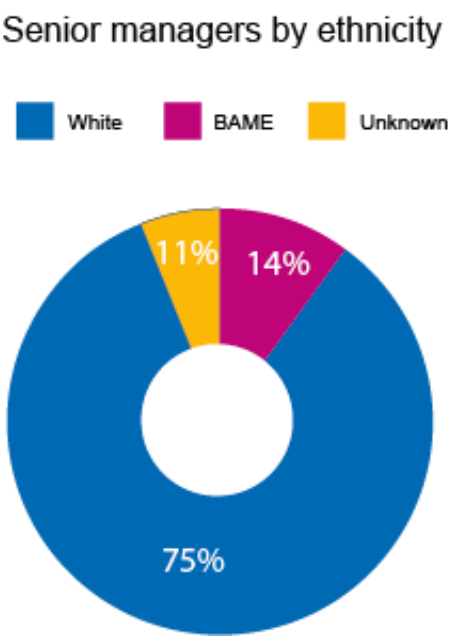
Ethnicity of all staff and senior managers

The proportion of people employed by NHS Improvement who consider themselves to be from a BAME heritage has increased from 18% (in 2019/20) to 19%. The proportion of senior managers who identify as BAME has gone down from 17% to 10%.

We continue to use the annual publication of the WRES data return as a driver for improvements in the working lives of BME staff. NHS England and NHS Improvement are working to ensure that within five years at least 19% of all senior staff are from BME backgrounds. See page 159 for more information on WRES.

For information on board diversity please see page 59.

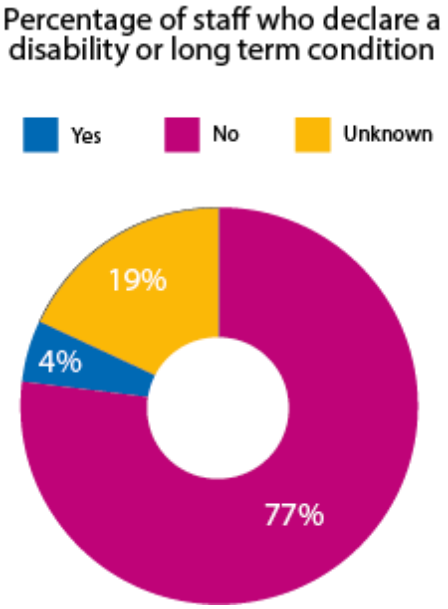


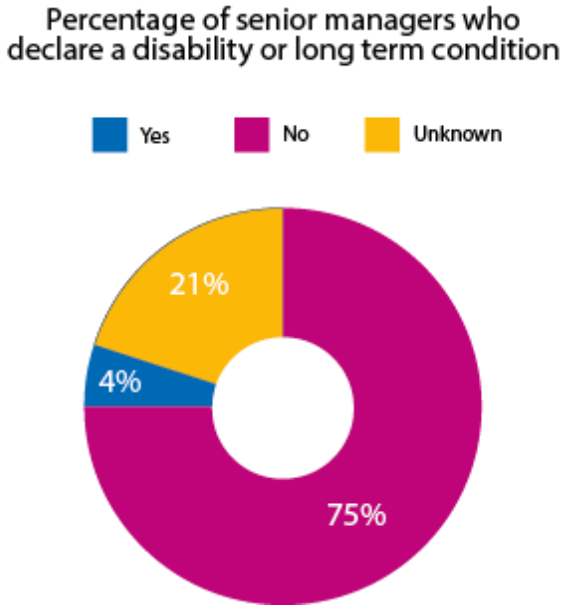


[54] https://www.england.nhs.uk/publication/gender-pay-gap-report-2020/

Declarations of disability or long-term conditions

We have continued to work with our Disability and Wellbeing Network (DAWN) Network to support employees within the workplace and strive to ensure that decisions relating to employment practices are objective, free from bias and based solely on work criteria and individual merit. These principles are reinforced in our joint Recruitment and Selection policy and our Equality, Diversity and Inclusion in the Workplace policy. The percentage of staff who have declared a disability or long-term condition are given in the charts below.

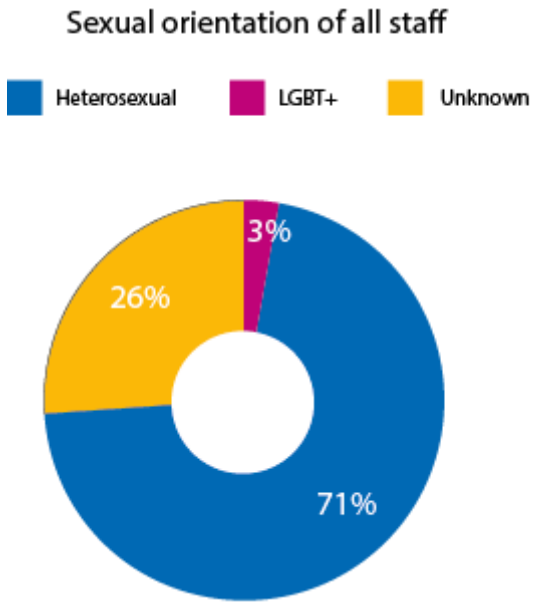


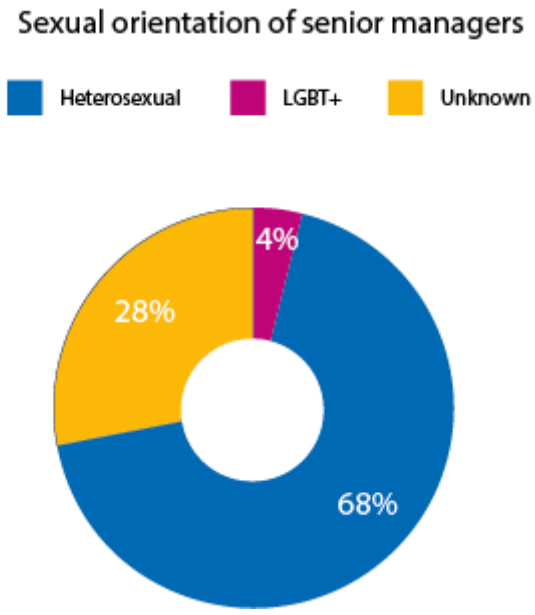


As a Disability Confident Employer, recognised by the Department for Work and Pensions, we continue to work towards fulfilling our commitments to employ more disabled staff, and support disabled staff to work, develop and progress.

Sexual orientation of staff and senior managers

The percentage of staff who disclose their identity as lesbian gay bisexual and transgender + (LGBT+) is given in the charts below:





Talent management and development

The key priority for the organisation, was to ensure it was set up to be able to fully support the COVID-19 response. We supported the rapid deployment of staff with over 3,000 colleagues placed in COVID-19 cells. Other examples of how the organisation adapted to the pandemic include:

- developing online induction programmes for new starters
- rapid review of the recruitment processes to reduce the time for appointments to critical roles
- supporting the fortnightly board level briefing to all staff.

We developed an overarching People Plan for NHS England and NHS Improvement to provide oversight of the organisational priorities. The plan was developed in conjunction with regional and national directorates to ensure the ambitions for all areas were included.

To create opportunities for talented staff to progress their careers, a new whole organisation talent development strategy was introduced with a specific agreed approach to talent and development to support our BAME colleagues. This is helping us realise our ambition of 19% BAME representation at all levels of the organisation by 2025.

We have created HR and OD dashboards covering a wide range of topics from diversity and inclusion and flexible working to pay and workforce change. These help the organisation to access clear and up to date information that allow us to understand our key challenges.

We have continued to update and improve our range of initiatives to support learning and development. These include a Virtual Leadership Ambassador programme to support effective leadership in a remote working environment and a dedicated area of the intranet to bring together key learning and development interventions including a revised coaching and mentoring offer for all staff.

A new leadership and management development programme was developed for launch at the start of 2021/22 to support new and experienced managers to develop their skills, incorporating health and wellbeing as a core principle.

To improve recruitment services across the organisation we surveyed recruiting managers and collated feedback which provided evidence to drive real change. We created a process flow, guidance, training videos and an intranet site to communicate and educate about the improvements. This led to the creation of talent pools for eight different job families that have been identified as key skills needed across the organisation. The talent pools are advertised externally and have over 3,000 internal and external candidates who recruiting managers can draw from as part of their campaigns.

Our approach to apprenticeships continues to make progress with over 100 apprentices currently in training. We have partnered with NHS organisations in Leeds to create a cohort of data analyst apprentices who will be able to share experience and skills, so creating a future talent pool of a

much-needed skill. We have 44 data analysts in training with the remaining apprentices focused on leadership and management disciplines.

Staff engagement and feedback

In addition to regular temperature checks throughout the year we carried out a full staff survey and analysed the results. They were shared with the organisation to influence our future working practices through our local people action plans and enabled us to better understand the different experiences of colleagues, including those who selected a protected characteristic in the survey. This was used to inform our returns relating to WRES, WDES and Stonewall Workplace Equality Index.

Workplace health, safety and wellbeing

In supporting our colleagues through the pandemic, we have specifically positioned health and wellbeing at the forefront of our decision making; we have supported and equipped colleagues to work safely from home, agreeing temporary changes to staff policies where required; we have put systems and processes in place to support our colleagues continue to, or return to, work in our office environments if required; and we have significantly increased our staff-related communications. Throughout the year we designed and delivered 10 health and wellbeing virtual webinars for colleagues and will continue to build on this with a schedule of events that will run through 2021/22. The Health and Safety Committee has met regularly throughout the period to ensure that people and estates issues have been managed coherently.

The additional Our NHS People health and wellbeing support has been a welcome addition to our already comprehensive 24/7 health and wellbeing offer. In relation to our status as a Mindful Employer we have designed and piloted our own Mental Health Awareness Programme and continue to have over 120 Mental Health First Aiders within the organisation.

Employee benefits and staff numbers

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 (subject to audit)

	2020/21		
	Permanently employed number	Other number	Total number
NHS TDA	1,478	156	1,634
Monitor	110	6	116
Total NHS Improvement	**1,588**	**162**	**1,750**

	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**

Employee benefits (subject to audit)

	2020/21			
	Permanent employees £000	Other £000	Total £000	2019/20 total £000
Salaries and wages	100,643	6,957	107,600	110,969
Social security costs	12,469	-	12,469	12,337
Employer pension costs	17,604	-	17,604	17,610
Gross employee benefits expenditure	**130,716**	**6,957**	**137,673**	**140,916**
Administration costs	62,958	1,384	64,342	71,525
Programme costs	67,758	5,573	73,331	69,391
Total net employee benefits	**130,716**	**6,957**	**137,673**	**140,916**

Sickness absence

Sickness absence rates for 2020/21 are published on the NHS Digital website.[55]

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

Exit packages, severance payments and off-payroll engagements

Expenditure on consultancy and contingent labour

NHS TDA spent £4.8 million on consultancy expenditure; an increase of £2.6 million since 2019/20 (2019/20: £2.2 million).

Expenditure on contingent labour, including agency staff and secondees, was £2.1 million; a decrease of £1.5 million since 2019/20 (2019/20: £3.6 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. It is recognised that in some specific circumstances the use of off-payroll workers, working alongside our on-payroll workforce, can be helpful. For some of our time-limited programmes, short-term contracts are appropriate.

The following tables identify off-payroll workers engaged by NHS TDA as at March 2021.

Off-payroll engagements longer than six months

Off-payroll engagements as at 31 March 2021, 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 2021	11
Of which, the number that have existed:	
for less than 1 year at the time of reporting	9
for between 1 and 2 years at the time of reporting	2
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

New off-payroll engagements

New off-payroll engagements or those that reached six months in duration, between 1 April 2020 and 31 March 2021, for more than £245 per day and that last longer than six months are as follows:

	NHS TDA (number)
Total number of new engagements, or those that reached six months in duration, between 1 April 2020 and 31 March 2021	49
Of which:	
Number assessed as caught by IR35	49
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

Off-payroll board member/senior official engagement

Off-payroll engagements of Board members and/or senior officials with significant financial responsibility between 1 April 2020 and 31 March 2021 are shown in the table below:

	NHS TDA (number)
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 who have been deemed 'Board members and/ or senior officials with significant financial responsibility' during the financial year	20

Further detail on commercial approvals, and steps we have taken to improve procurement practices and compliance in this area within NHS Improvement during the year, can be found in our governance statement from page 79.

Exit packages

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.

Exit packages agreed during the year (subject to audit)

	2020/21			2019/20		
	Compulsory redundancies	Other agreed departures	Total	Compulsory redundancies	Other agreed departures	Total
	Number	Number	Number	Number	Number	Number
Less than £10,000	-	-	-	6	2	**8**
£10,001 to £25,000	3	-	**3**	14	1	**15**
£25,001 to £50,000	1	-	**1**	10	-	**10**
£50,001 to £100,000	1	-	**1**	9	1	**10**
£100,001 to £150,000	1	-	1	8	1	**9**
£150,001 to £200,000	-	-	-	8	-	**8**
Over £200,001	-	-	-	-	-	**-**
Total	**6**	**-**	**6**	**55**	**5**	**60**
Total cost (£000)	**302**	**-**	**302**	**3,619**	**228**	**3,847**

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 on page 69.

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 2020/21 was £255,000 to £260,000 (2018/19: £285,000 to £290,000). This was 4.3 times the median remuneration of the workforce, which was £60,058 (2019/20: £58,073; 5.0).

In 2020/21, no employees received pro-rata remuneration in excess of the highest-paid member of the Board (2019/20: none). Remuneration ranged from £7,883 to £260,000 (2019/20: £7,883 to £287,000).

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 DHSC through the ESM pay framework for ALBs.

It is NHS England and NHS Improvement policy to pay salaries that are appropriate to recruit senior managers with the necessary skills, capability and experience for the effective running of a more than £149 billion organisation, while 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 the People, Remuneration and Nominations Committees. Final decisions are made by the DHSC ALB Remuneration Committee 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 2020/21. 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 and HM Treasury.

No payments were made to any senior manager to compensate for loss of office in 2020/21.

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

Senior managers' service contracts

Name and title	Date of appointment	Notice period	Provisions for compensation for early termination	Other details
Amanda Pritchard Chief Executive Officer of NHS Improvement Chief Operating Officer – Joint	1 August 2019	6 months	Option to provide taxable pay in lieu of part or all of the notice period	
Ian Dodge National Director for Primary Care, Community Services and Strategy – Joint	7 July 2014	6 months		
Dr Emily Lawson Chief Commercial Officer – Joint	1 April 2020	6 months		
Professor Stephen Powis National Medical Director – Joint	1 March 2018	6 months		
Julian Kelly CB Chief Financial Officer – Joint	1 April 2019	6 months		
Ruth May Chief Nursing Officer – Joint	7 January 2019	6 months		
Prerana Issar Chief People Officer – Joint	1 April 2019	6 months		
Matthew Gould CMG MBE National Director for Digital Transformation – Joint	1 July 2019	6 months		

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 within the Remuneration Reports of all three entities and the costs are split equally between NHS England and NHS Improvement, with NHS Improvement costs being split at a ratio of 2:1 TDA-to-Monitor.

Remuneration (salary, benefits in kind and pensions) 2020/21 (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) Pension-related benefits (bands of £1,000)[56]	(f) TOTAL (a to e) (bands of £5,000)
	£000	£s	£000	£000	£000	£000
Amanda Pritchard Chief Executive Officer and Chief Operating Officer[57]	255-260	0	0	0	60	315-320
Ian Dodge National Director for Primary Care, Community Services and Strategy[58]	170-175	0	0	0	0	170-175
Dr Emily Lawson Chief Commercial Officer[59]	230-235	0	0	0	0	230-235
Professor Stephen Powis National Medical Director	225-230	0	0	0	0	225-230
Julian Kelly CB Chief Financial Officer	205-210	0	0	0	50	255-260
Ruth May Chief Nursing Officer	180-185	0	0	0	385	565-570
Prerana Issar Chief People Officer	230-235	0	0	0	53	280-285
Matthew Gould CMG MBE National Director for Digital Transformation[60]	100-105	0	0	0	42	140-145

[56] The value of pension benefits accrued during the year is calculated as the real increase in pension multiplied by 20, less the contributions made by the individual. The real increase excludes increases due to inflation or any increase or decrease due to a transfer of pension rights. This value derived does not represent an amount that will be received by the individual. It is a calculation that is intended to provide an estimation of the potential benefit of being a member of the pension scheme.

[57] The salary for Amanda Pritchard is 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.

[58] The position title for Ian Dodge was updated to National Director for Primary Care, Community Services and Strategy from 01 April 2020.

[59] Dr Emily Lawson commenced in the role of Chief Commercial Officer on 01 April 2020; immediately prior to that she held the role of National Director of Transformation and Corporate Development.

[60] 80% of the salary costs for Matthew Gould are recharged to NHS England and NHS Improvement from DHSC where he is also formally employed and retains a post. As such, the above figures disclose 80% of salary and pension benefits, with DHSC disclosing the remaining 20%. The full year equivalent salary is £125,000-£130,000.

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) Pension-related benefits (bands of £1,000)	(f) TOTAL (a to e) (bands of £5,000)
	£000	£s	£000	£000	£000	£000
Ian Dalton Chief Executive Officer[61]	260-265	0	0	0	0	260-265
Stephen Hay Deputy Chief Executive and Executive Director of Regulation[62]	200-205	0	0	0	0	200-205
Dr Kathy McLean Executive Medical Director and Chief Operating Officer[63]	275-280	0	0	0	0	275-280
Amanda Pritchard Chief Executive Officer and Chief Operating Officer[64]	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 CB Chief Financial Officer[65]	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[66]	230-235	0	0	0	52	280-285
Matthew Gould CMG MBE National Director for Digital Transformation[67]	0	0	0	0	0	0

[61] 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.
[62] 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 in the salary range of £180,000-£185,000 in May 2019 as compensation for loss of office and this is included in the salary band disclosed within the table.
[63] 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 in the salary range of £260,000-£265,000 in April 2019 as compensation for loss of office and this is included in the salary band disclosed within the table.
[64] Amanda Pritchard commenced in both posts on 1 August 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.
[65] Julian Kelly CB formally commenced in the joint post on 1 April 2019.
[66] Prerana Issar commenced in the joint post on 1 April 2019.
[67] Matthew Gould 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.

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 2021 (bands of £5,000)	Lump sum at pension age related to accrued pension at 31 March 2021 (bands of £5,000)	Cash Equivalent Transfer Value at 31 March 2020[68]	Real Increase in Cash Equivalent Transfer Value	Cash Equivalent Transfer Value at 31 March 2021	Employers contribution to partnership pension
	£000	£000	£000	£000	£000	£000	£000	£000
Amanda Pritchard Chief Executive Officer and Chief Operating Officer	2.5-5	(2.5)-0	75-80	130-135	1,040	48	1,142	0
Ian Dodge National Director for Strategy and Innovation[69]	N/A	N/A	N/A	N/A	211	N/A	N/A	0
Dr Emily Lawson Chief Commercial Officer[70]	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Professor Stephen Powis National Medical Director[71]	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Julian Kelly CB Chief Financial Officer	2.5-5	N/A	5-10	N/A	48	21	99	0
Ruth May Chief Nursing Officer[72]	15-17.5	50-52.5	90-95	270-275	1,508	392	1,939	0
Prerana Issar Chief People Officer	2.5-5	N/A	5-10	N/A	47	17	98	0
Matthew Gould CMG MBE National Director Digital Transformation[73]	0-2.5	N/A	45-50	N/A	683	22	732	0

[68] As per previous submissions, the column Cash Equivalent Transfer Value at 31 March 2020 is the uninflated value whereas the real Increase in CETV is the employer funded increase.
[69] Ian Dodge chose to opt out of the NHS Pension Scheme on 1 December 2019.
[70] Dr Emily Lawson chose not to be covered by the NHS Pension arrangements during the reporting year.
[71] Professor Stephen Powis chose not to be covered by the NHS Pension arrangements during the reporting year.
[72] Ruth May chose to opt out of the NHS Pension Scheme on 1 October 2020.
[73] 80% of the pension costs for Matthew Gould are recharged to NHS England and NHS Improvement from DHSC where he is also formally employed and retains a post. As such, the above figures disclose 80% of pension benefits, with DHSC disclosing the remaining 20%.

Cash Equivalent Transfer Values (CETV) (subject to audit)

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 into 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

Past and present employees are covered by the provisions of the two NHS Pension Schemes. Details of the benefits payable and rules of the schemes can be found on the NHS Pensions website.[74] Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State for Health and Social Care in England and Wales. They are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to that scheme for the accounting period.

In order that the defined benefit obligations recognised in the financial statements do not differ materially from those that would be determined at the reporting date by a formal actuarial

[74] http://www.nhsbsa.nhs.uk/pensions

valuation, Treasury's Financial Reporting Manual requires that "the period between formal valuations shall be four years, with approximate assessments in intervening years". An outline of these follows:

a) Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2021 is based on valuation data as at 31 March 2020, updated to 31 March 2021 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant Government Financial Reporting Manual 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 scheme was completed as at 31 March 2016. The results of this valuation set the employer contribution rate payable from April 2019 to 20.6% of pensionable pay. The 2016 funding valuation was also expected to test the cost of the scheme relative to the employer cost cap that was set following the 2012 valuation. In January 2019, the government announced a pause to the cost control element of the 2016 valuations, due to the uncertainty around member benefits caused by the discrimination ruling relating to the McCloud case.

The government subsequently announced in July 2020 that the pause had been lifted, and so the cost control element of the 2016 valuations could be completed. The government has set out that the costs of remedy of the discrimination will be included in this process. HM Treasury valuation directions will set out the technical detail of how the costs of remedy will be included in the valuation process. The government has also confirmed that the government actuary is reviewing the cost control mechanism (as was originally announced in 2018). The review will assess whether the cost control mechanism is working in line with original government objectives and reported to government in April 2021. The findings of this review will not impact the 2016 valuations, with the aim for any changes to the cost cap mechanism to be made in time for the completion of the 2020 actuarial valuations.

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 Health and Social Care 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 the table below. 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 2020/21 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 2021	Notice period	Provisions for compensation for early termination	Other details
Baroness Dido Harding Chair	30 October 2017	7 months	3 months	None	
Sir David Behan Associate (non-voting) Non-Executive Director	1 February 2019, tenure renewed on 1 February 2021	12 months	3 months	None	Chair of Health Education England
Lord Patrick Carter of Coles Non-Executive Director and Senior Independent Director	1 April 2016	12 months	3 months	None	
Dr Timothy G Ferris MD, MPH Non-Executive Director	1 August 2018	1 months	3 months	None	Waived entitlement to remuneration
Wol Kolade Non-Executive Director	1 August 2018	12 months	3 months	None	Waived entitlement to remuneration
Sir Andrew Morris Non-Executive Director and Vice Chair	1 August 2018	28 months	3 months	None	Vice Chair effective 12 November 2020
Laura Wade-Gery Non-Executive Director	1 August 2018	0 months	3 months	None	Transferred to NHS England on 6 November 2020
Professor Sir Munir Pirmohamed Non-executive director	6 November 2020	33 months	3 months	None	

Non-executive director remuneration (including salary entitlements)

Salaries and allowances 2020/21 (subject to audit)

Name	Position	Salary (bands of £5,000)	Benefits in kind to nearest £100	Total (bands of £5,000)
		£000	£00	£000
Baroness Dido Harding[75]	Chair	30-35	-	30-35
Sir David Behan[76]	Associate (non-voting) Non-Executive Director	0-5	-	0-5
Lord Patrick Carter of Coles	Non-executive Director	5-10	-	5-10
Dr Timothy G Ferris MD, MPH[77]	Non-executive Director	0-5	-	0-5
Wol Kolade[78]	Non-executive Director	0-5	-	0-5
Sir Andrew Morris[79]	Non-executive Director	25-30	-	25-30
Laura Wade-Gery[80]	Non-executive Director	0-5	-	0-5
Professor Sir Munir Pirmohamed[81]	Non-executive Director	0-5	-	0-5

Salaries and allowances 2019/20 (subject to audit)

Name	Position	Salary (bands of £5,000)	Benefits in kind to nearest £100	Total (bands of £5,000)
		£000	£00	£000
Baroness Dido Harding	Chair	60-65	-	60-65
Sir David Behan[82]	Associate (non-voting) Non-Executive Director	0-5	-	0-5
Lord Patrick Carter of Coles	Non-executive Director	5-10	-	5-10
Professor the Lord Ara Darzi of Denham	Non-executive Director	5-10	-	5-10
Richard Douglas CB[83]	Non-executive Director and Deputy Chair	10-15	-	10-15
Dr Timothy G Ferris MD, MPH[84]	Non-executive Director	0-5	-	0-5
Wol Kolade	Non-executive Director	0-5	-	0-5
Sir Andrew Morris	Non-executive Director	5-10	-	5-10
David Roberts CBE[85]	Associate (non-voting) Non–Executive Director	0-5	-	0-5
Laura Wade-Gery	Non-executive Director	5-10	-	5-10

[75] Baroness Dido Harding stepped away from her role as the Chair on 5 November 2020 to focus her efforts on Test and Trace and the National Institute for Health Protection. The full year equivalent salary is £60,000-£65,000.
[76] Sir David Behan, Chair of Health Education England, became an Associate (non-voting) Non-Executive Board member of NHS Improvement from 1 February 2019 and has waived his entitlement to non-executive director remuneration.
[77] Dr Timothy Ferris waived his entitlement to non-executive director remuneration in the band of £5,000-£10,000.
[78] Wol Kolade waived his entitlement to non-executive director remuneration in the band of £5,000-£10,000.
[79] Sir Andrew Morris was appointed as Vice Chair from 12 November 2020 and became acting Chair from this date also to cover Baroness Dido Harding's leave of absence.
[80] Laura Wade-Gery transferred to NHS England on 6 November 2020. The full year equivalent salary is £5,000-£10,000.
[81] Professor Sir Munir Pirmohamed transferred to NHS Improvement from NHS England on 6 November 2020. The full year equivalent salary is £5,000-£10,000.
[82] Sir David Behan, Chair of Health Education England, became an Associate (non-voting) Non-Executive Board member of NHS Improvement from 1 February 2019.
[83] Richard Douglas is also an Associate (non-voting) Non-Executive Board Member of NHS England.
[84] Timothy Ferris and Wol Kolade have waived their entitlement to non-executive director remuneration in the band of £5,000-£10,000.
[85] David Roberts CBE, 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.

Parliamentary Accountability and Audit Report

All elements of this report are subject to audit

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 two main sources of income in 2020/21, for which further details are contained in the financial statements:

- recharges for services delivered to Monitor and NHS England which are based on a proportion of actual costs incurred
- NHS Leadership Academy training income which is recognised based on the timing of the underlying training.

Regularity of expenditure: Losses and special payments

Losses and special payments are items that Parliament would not have contemplated when it agreed funds for NHS TDA or passed legislation. By their nature they are items that ideally should not arise and are therefore subject to special control procedures compared to the generality of payments. They are divided into different categories, which govern the way that individual cases are handled.

Losses (subject to audit)

The total number of NHS TDA losses cases, and their total value, was as follows:

	Total number of cases 2020/21 number	Total value of cases 2020/21 £000	Total number of cases 2019/20 number	Total value of cases 2019/20 £000
Administrative write-offs	-	-	-	-
Fruitless payments	167	151	-	-
Stores losses	-	-	-	-
Book keeping losses	-	-	-	-
Constructive loss	-	-	-	-
Cash losses	-	-	-	-
Claims abandoned	-	-	-	-
Total	**167**	**151**	**-**	**-**

Special payments (subject to audit)

The total number of NHS TDA special payments cases, and their total value, was as follows:

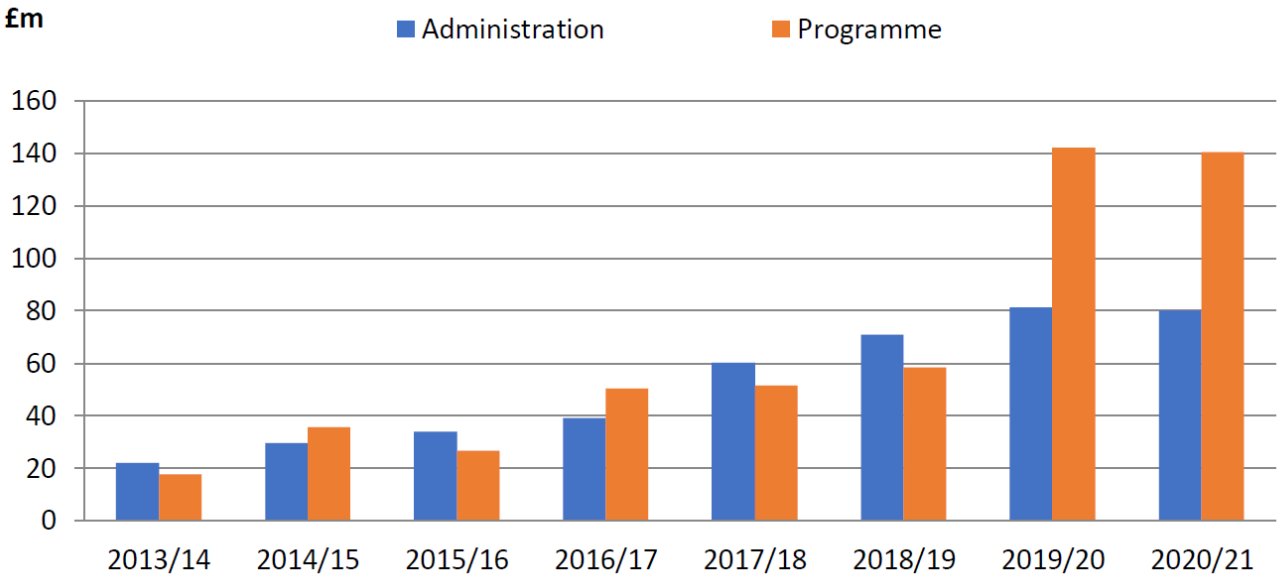
	NHS TDA			
	Total number of cases 2020/21	Total value of cases 2020/21	Total number of cases 2019/20	Total value of cases 2019/20
	number	£000	number	£000
Compensation payments	1	98	-	-
Compensation payments Treasury approved	-	-	-	-
Extra contractual payments	-	-	-	-
Ex gratia payments	-	-	-	-
Extra statutory extra regulatory payments	-	-	-	-
Special severance payments Treasury approved	-	-	-	-
Total	**1**	**98**	**-**	**-**

Long-term expenditure trend

The below table 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 Houses of Parliament

Opinion on financial statements

I certify that I have audited the financial statements of the NHS Trust Development Authority for the year ended 31 March 2021 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. The financial reporting framework that has been applied in their preparation is applicable law and International Accounting Standards as interpreted by HM Treasury's Government Financial Reporting Manual.

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 2021 and of the NHS Trust Development Authority's net expenditure for the year then ended;
- have been properly prepared in accordance with the National Health Service Act 2006 and Secretary of State directions issued thereunder.

Opinion on regularity

In my opinion, in all material respects, the 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 for opinions

I conducted my audit in accordance with International Standards on Auditing (ISAs) (UK), applicable law 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 2019. I have also elected to apply the ethical standards relevant to listed entities. I am independent of the NHS Trust Development Authority in accordance with the ethical requirements that are relevant to my audit of 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

In auditing the financial statements, I have concluded that the NHS Trust Development Authority's use of the going concern basis of accounting in the preparation of the financial statements is appropriate.

Based on the work I have performed, I have not identified any material uncertainties relating to events or conditions that, individually or collectively, may cast significant doubt on the NHS Trust Development Authority's ability to continue as a going concern for a period of at least twelve months from when the financial statements are authorised for issue.

My responsibilities and the responsibilities of the Accounting Officer with respect to going concern are described in the relevant sections of this certificate.

The going concern basis of accounting for the NHS Trust Development Authority is adopted in consideration of the requirements set out in International Accounting Standards as interpreted by HM Treasury's Financial Reporting Manual, which require entities to adopt the going concern basis of accounting in the preparation of the financial statements where it anticipated that the services which they provide will continue into the future.

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 certificate thereon. The Accounting Officer is responsible for the other information. My opinion on the financial statements does not cover the other information and except to the extent otherwise explicitly stated in my certificate, I do not express any form of assurance conclusion thereon. In connection with my audit of the financial statements, my responsibility is to read the other information and, in doing so, consider whether the other information is materially inconsistent with the financial statements or my knowledge obtained in the audit or otherwise appears to be materially misstated. If I identify such material inconsistencies or apparent material misstatements, I am required to determine whether this gives rise to a material misstatement in the financial statements themselves. 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, based on the work undertaken in the course of the audit:

- the parts of the Accountability Report to be audited have been properly prepared in accordance with Secretary of State directions made under the National Health Service Act 2006; and
- the information given in the Performance and Accountability Reports for the financial year for which the financial statements are prepared is consistent with the financial statements.

Matters on which I report by exception

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 material misstatements in the Performance and Accountability reports. 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
- certain disclosures of remuneration specified by HM Treasury's Government Financial Reporting Manual are not made; 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.

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 in accordance with the applicable financial reporting framework and for being satisfied that they give a true and fair view;
- such internal controls as the Accounting Officer determines are necessary to enable the preparation of financial statement to be free from material misstatement, whether due to fraud or error.
- assessing the NHS Trust Development Authority's ability to continue as a going concern, disclosing, as applicable, matters related to going concern and using the going concern basis of accounting unless the Accounting Officer anticipates that the services provided by the NHS Trust Development Authority will not continue to be provided in the future.

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.

My objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue a certificate that includes my opinion. 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.

I design procedures in line with my responsibilities, outlined above, to detect material misstatements in respect of non-compliance with laws and regulation, including fraud.

My procedures included the following:

- Inquiring of management, NHS England and NHS Improvement's head of internal audit and those charged with governance, including obtaining and reviewing supporting documentation relating to the NHS Trust Development Authority's policies and procedures relating to:
    - identifying, evaluating and complying with laws and regulations and whether they were aware of any instances of non-compliance;
    - detecting and responding to the risks of fraud and whether they have knowledge of any actual, suspected or alleged fraud; and
    - the internal controls established to mitigate risks related to fraud or non-compliance with laws and regulations including the NHS Trust Development Authority's controls relating to the National Health Service Act 2006 and Managing Public Money;
- discussing among the engagement team regarding how and where fraud might occur in the financial statements and any potential indicators of fraud. As part of this discussion, I identified potential for fraud in the following areas: revenue recognition, the posting of unusual journals, and the allocation of costs between Monitor, the NHS Trust Development Authority and NHS England using management recharges;
- obtaining an understanding of the NHS Trust Development Authority's framework of authority as well as other legal and regulatory frameworks that the NHS Trust Development Authority operates in, focusing on those laws and regulations that had a direct effect on the financial statements or that had a fundamental effect on the operations of the NHS Trust Development Authority. The key laws and regulations I considered in this context included the National Health Service Act 2006, Managing Public Money, Employment Law, and Tax Legislation.

In addition to the above, my procedures to respond to identified risks included the following:

- reviewing the financial statement disclosures and testing to supporting documentation to assess compliance with relevant laws and regulations discussed above;
- enquiring of management, the Audit and Risk Assurance Committee and in-house legal counsel concerning actual and potential litigation and claims;
- reading minutes of meetings of those charged with governance and the Board;
- in addressing the risk of fraud through management override of controls, testing the appropriateness of journal entries and other adjustments; assessing whether the judgements made in making accounting estimates are indicative of a potential bias; and evaluating the business rationale of any significant transactions that are unusual or outside the normal course of business. As part of my work on management override of controls, I also tested the allocation of costs between Monitor, the NHS Trust Development Authority and NHS England using management recharges; and
- in addressing the risk of fraud in revenue recognition, through 100 per cent testing of income received through significant contracts; substantive sample testing of income transactions recorded in the last month of the financial year and of cash receipts received in the first month of the subsequent financial year, to confirm whether revenue has been recognised in the

correct financial year; and reviewing the volume and value of credit notes and debt write-offs processed during the year and after the year-end for any unusual trends.

I also communicated relevant identified laws and regulations and potential fraud risks to all engagement team members and remained alert to any indications of fraud or non-compliance with laws and regulations throughout the audit.

A further description of my responsibilities for the audit of the financial statements is located on the Financial Reporting Council's website.[86] This description forms part of my certificate.

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.

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.

Report

I have no observations to make on these financial statements.

Gareth Davies **Date**

Comptroller and Auditor General

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

[86] www.frc.org.uk/auditorsresponsibilities

Annual Accounts

Professor Stephen Powis
Interim CEO of NHS Improvement, and Accounting Officer

26 January 2022

Statement of comprehensive net expenditure for the year ended 31 March 2021

	Note	2020/21 £000	2019/20 £000
Other operating revenue	3	16,398	28,672
Total operating revenue		**16,398**	**28,672**
Staff costs	4	137,673	140,916
Purchase of goods and services	5	98,602	110,411
Depreciation and amortisation charges	5	929	850
Total operating expenditure		**237,204**	**252,177**
Net expenditure for the financial year		**220,806**	**223,505**
Comprehensive net expenditure for the year		**220,806**	**223,505**

All operations are continuing.

There were no other recognised gains or losses for the financial year.

The notes on pages 136 to 150 form part of these accounts.

Statement of financial position as at 31 March 2021

	Note	31 March 2021 £000	31 March 2020 £000
Non-current assets:			
Property, plant and equipment	7.1	239	354
Intangible assets	7.2	5,778	3,106
Total non-current assets		**6,017**	**3,460**
Current assets:			
Trade and other receivables	8	15,101	23,692
Cash and cash equivalents	9	3,574	8,891
Total current assets		**18,675**	**32,583**
Total assets		**24,692**	**36,043**
Current liabilities			
Trade and other payables	10.1	72,156	59,716
Provisions	5	88	-
Total current liabilities		**72,244**	**59,716**
Net current liabilities		**(53,569)**	**(27,133)**
Non-current liabilities			
Trade and other payables	10.2	101	824
Total non-current liabilities		**101**	**824**
Total net liabilities		**(47,653)**	**(24,497)**
Financed by taxpayers' equity			
General fund		(47,653)	(24,497)
Total taxpayers' equity		**(47,653)**	**(24,497)**

The notes on pages 136 to 150 form part of these accounts.

Professor Stephen Powis, Interim CEO of NHS Improvement and Accounting Officer

26 January 2022

Statement of cash flows for the year ended 31 March 2021

	Note	2020/21 £000	2019/20 £000
Cash flows from operating activities			
Net operating cost	SoCNE	(220,806)	(223,505)
Adjustments for non-cash transactions			
Depreciation and amortisation	5	929	850
Provisions arising during the year		88	-
Pension contribution rate increase		-	5,538
Loss on disposal	7.1	6	34
(Increase)/decrease in trade and other receivables	8	8,591	(14,361)
Increase/(decrease) in trade payables and other current liabilities	10	11,717	28,893
Net cash outflow from operating activities		**(27,633)**	**(43,746)**
Cash flows from investing activities			
(Payments) for property, plant and equipment	7.1	(57)	(146)
(Payments) for intangible assets	7.2	(3,435)	(868)
Net cash inflow/(outflow) from investing activities		**(3,492)**	**(1,014)**
Cash flows from financing activities			
Net parliamentary funding	SoCTE	197,650	210,233
Net cash generated from financial activities		**197,650**	**210,233**
Net increase/(decrease) in cash and cash equivalents		(5,317)	6,668
Cash and cash equivalents at the beginning of the financial year		**8,891**	**2,223**
Cash and cash equivalents at the end of the financial year	9	**3,574**	**8,891**

The notes on pages 136 to 150 form part of these accounts.

Statement of changes in taxpayers' equity for the year ended 31 March 2021

	General fund	
	2020/21	2019/20
	£000	£000
Opening taxpayer's equity	**(24,497)**	**(16,763)**
Comprehensive net expenditure for the year	(220,806)	(223,505)
Grant-in-aid received	197,650	215,771
Closing taxpayer's equity	**(47,653)**	**(24,497)**

The notes on pages 136 to 150 form part of these accounts.

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 Monitor, NHS TDA, Patient Safety including the National Reporting and Learning System, the Advancing Change team and the Intensive Support Teams.

About the NHS Trust Development Authority

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

NHS TDA is a special health authority within DHSC and domiciled in the UK with its registered office at Wellington House, 133-155 Waterloo Road, London SE1 8UG.

The financial statements have been prepared in accordance with the accounts direction issued by the Secretary of State for Health and Social Care and the Government Financial Reporting Manual (FReM) issued by HM Treasury. The accounting policies contained in the FReM apply International Financial Reporting Standards 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 NHS TDA for the purpose of giving a true and fair view has been selected. The particular policies adopted by NHS TDA are described below. They 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 England, NHS TDA and Monitor. The underlying legal entities of NHS England, NHS TDA and Monitor remained in place. The Health and Social Care Bill was introduced to the House of Commons on 6 July 2021. The policy intention of DHSC is to merge the functions of the three statutory bodies into a single body. The bill introduced to the House of Commons aims to achieve this by transferring the functions of NHS TDA and Monitor into NHS England. Should the legislation be passed the existing underlying functions will remain the same.

In line with the guidance issued by DHSC, NHS TDA's 2020/21 accounts have been prepared on a going concern basis. NHS TDA activities continue to be resourced by DHSC which has approved NHS TDA's 2021/22 budget and there is no evidence to suggest that the activities of NHS TDA will not continue to be financed by DHSC 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 the 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.

1.3.2 Non-current asset valuations

In accordance with HM Treasury's Financial Reporting Manual (10.1.14), NHS TDA has opted to adopt depreciated historical cost as a proxy for value for assets that have short useful economic lives or low values.

1.4 Revenue and funding

The main source of funding for the special health authority is the parliamentary grant from DHSC within an approved cash limit, which is credited to the general fund. Parliamentary funding is recognised in the financial period in which it is received.

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.

Recharges for services delivered to Monitor 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 ongoing basis throughout the year; NHS TDA recognises the associated revenue over time.

Leadership Academy training income

Training income is received from a number of organisations and individuals and is recognised in line with the timing of delivery of training.

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 which is an unfunded defined benefit scheme. The NHS Pension Scheme is an unfunded, multi-employer defined benefit scheme 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.

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 historical 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.

Assets under construction comprise assets currently being developed and not yet in use. Assets under construction are not amortised.

1.8 Amortisation and depreciation

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 three and five years.

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

- plant and machinery – five years
- information technology assets – between three and five years
- furniture and fittings assets – between five 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 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 cost.

Financial assets measured at amortised cost 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. The majority of receivables are with other DHSC group bodies, which are guaranteed by the department and, therefore, no expected credit losses are recognised.

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 that do enable estimates of the impact of the standard to be made.

Definition of a lease

IFRS 16 brings some changes to the definition of a lease compared to IFRIC 4 and IAS 17 currently. HM Treasury has decided that, as a practical expedient, entities will grandfather in their current assessment of whether a contract contains a lease. Given the practical expedient it is not

expected that this part of IFRS 16 will have a material impact. The key impact will be in changing the accounting for arrangements currently identified as leases.

Lessee accounting: single model of accounting

For lessees, the current (IAS 17) distinction between operating leases and finance leases is removed. Under IFRS 16, a right-of-use asset and lease liability are included in the statement of financial position for all leased assets. Leased assets for NHS TDA mainly comprise property leases. The estimated annual lease charges within agreements are c£2.5 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.

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 HSIB (a subset of programme activities). Assets and liabilities are not split in this way so not reported here.

2020/21	Administration	Programme	HSIB	Total
	£000	£000	£000	£000
Revenue	(1,730)	(14,667)	(1)	(16,398)
Expenditure	81,901	137,120	18,183	237,204
Net operating costs	**80,171**	**122,453**	**18,182**	**220,806**

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**

Administration

The financial objective of the NHS TDA is to manage the recurrent costs of management and administration within the allocation of £81,451,000. This funding covers staff, accommodation and other running costs.

Programme

The NHS TDA received an allocation of £144,282,000 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, £11,278,000 relates to revenue from NHS England.

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. For information on the activities of HSIB during the year please see the 2020/21 Annual Review on their website.[87]

3. Revenue

	2020/21	2019/20
	£000	£000
Administration revenue		
Recharge to NHS England for joint working costs	1,014	2,664
Revenue in respect of seconded staff	399	1,449
Other miscellaneous revenue	317	1,365
Total administration revenue	**1,730**	**5,478**
Programme revenue		
Provision of emergency care improvement programme and elective care intensive support	5,364	10,365
Provision of NHS Leadership Academy training	2,974	6,708
Recharge to NHS England for joint working costs	4,900	3,454
Revenue in respect of seconded staff	385	673
Other miscellaneous revenue	1,045	1,994
Total programme revenue	**14,668**	**23,194**
Total revenue	**16,398**	**28,672**

4. Employee benefits

	2020/21	2019/20
	£000	£000
Salaries and wages	107,319	107,427
Social security costs	12,469	12,337
Employer contributions to the NHS Pensions Scheme	17,604	17,610
Termination benefits	281	3,542
Total cost of staff	**137,673**	**140,916**

More detailed disclosures on staff costs are contained in the Remuneration Report.

[87] https://www.hsib.org.uk/who-we-are/reports-and-publications/#annual-review-202021

5. Operating expenditure

	Note	2020/21 £000 Admin	2020/21 £000 Programme	2020/21 £000 Total	2019/20 £000 Admin	2019/20 £000 Programme	2019/20 £000 Total
Purchase of goods and services							
Auditors' remuneration for NHS TDA		53	-	53	53	-	53
Auditors' remuneration for consolidated accounts of NHS providers		110	-	110	110	-	110
Chair and non-executive members		116	-	116	108	15	123
Education and training		377	31,868	32,245	755	33,377	34,132
Programme support costs		5,309	20,885	26,194	1,598	30,165	31,763
Legal fees		155	829	984	279	1,027	1,306
Consultancy and other professional fees		4,172	14.344	18.516	3,911	11,373	15.284
Establishment expenses		1,168	4,490	5,658	1,657	9,469	11,126
Supplies and services – general		609	6,574	7,183	653	3,613	4,266
Premises		4,325	2,420	6,745	4,289	4,151	8,440
Transport		22	86	108	1,242	2,292	3,534
Provisions expense		-	88	88	-	-	-
Miscellaneous expenditure		285	317	602	108	166	274
Total purchase of goods and services		**16,701**	**81,901**	**98,602**	**14,763**	**95,648**	**110,411**
Depreciation and amortisation charges							
Depreciation	7.1	105	61	166	165	222	387
Amortisation	7.2	753	10	763	413	50	463
Total depreciation and amortisation		**858**	**71**	**929**	**578**	**272**	**850**
Total operating expenditure	SoCNE	**17,559**	**81,972**	**99,531**	**15,341**	**95,920**	**111,261**

Presentation of operating expenditure has been amended from 2019/20 to better reflect the categories of spend. 2019/20 amounts have been re-presented in the revised categories.

6. Operating leases

	31 March 2021	31 March 2020 restated
	£000	£000
Minimum lease payments	2,358	2,023
Total	**2,358**	**2,023**
Payable		
No later than one year	1,158	1,544
Between one and five years	1,274	2,874
After five years	27	89
Total	**2,459**	**4,507**

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 a difference between in-year charges and future annual commitments figures seen in this note.

2019/20 minimum lease payments have been restated to exclude service charge elements and allow a truer comparison between years.

7. Non-current assets

7.1 Property, plant and equipment

2020/21	IT equipment	Furniture, fixtures, and office equipment	Total
	£000	£000	£000
Cost or valuation at 1 April 2020	950	674	1,624
Additions	57	-	57
Disposals	(38)	(23)	(61)
Cost or valuation at 31 March 2021	**969**	**651**	**1,620**
Accumulated depreciation at 1 April 2020	759	511	1,270
Charged during the year	117	49	166
Disposals	(38)	(17)	(55)
At 31 March 2021	**838**	**543**	**1,381**
Net book value at 31 March 2020	191	163	354
Net book value at 31 March 2021	**131**	**108**	**239**

Prior year	IT equipment	Furniture, fixtures, and office equipment	Total
	£000	£000	£000
Cost or valuation at 1 April 2019	923	617	1,540
Additions	27	119	146
Disposals	-	(62)	(62)
Cost or valuation 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**

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

7.2 Intangible assets

2020/21	Software purchased	IT assets under construction	Software internally generated	Total
	£000	£000	£000	£000
Cost or valuation at 1 April 2020	130	2,193	1,592	3,915
Additions	-	1,018	2,417	3,435
Disposals	(12)	-	-	(12)
At 31 March 2021	**118**	**3,211**	**4,009**	**7,338**
Amortisation at 1 April 2020	120	-	689	809
Charged during the year	10	-	753	763
Disposals	(12)	-	-	(12)
At 31 March 2021	**118**	**-**	**1,442**	**1,560**
Net book value at 31 March 2020	10	2,193	903	3,106
Net book value at 31 March 2021	**-**	**3,211**	**2,567**	**5,778**

Prior year	Software purchased	IT assets under construction	Software internally generated	Total
	£000	£000	£000	£000
Cost or valuation at 1 April 2019	130	1,478	1,439	3,047
Additions	-	715	153	868
Reclassifications	-	-	-	-
At 31 March 2020	**130**	**2,193**	**1,592**	**3,915**
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**

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

8. Trade receivables and amounts falling due within one year

	31 March 2021	31 March 2020
	£000	£000
Contract receivables	10,254	16,016
Prepayments	4,328	6,769
VAT	519	907
Total	**15,101**	**23,692**

The decrease in contract receivables reflects the timing of invoicing for operating income and the overall reduction in operating income from the prior year.

9. Cash and cash equivalents

The following balances at 31 March were held at:	31 March 2021	31 March 2020
	£000	£000
Opening balance	8,891	2,223
Net change in cash and cash equivalent balances	(5,317)	6,668
Closing balance	**3,574**	**8,891**
Made up of:		
Cash with Government Banking Service	3,574	8,891
Cash and cash equivalents as in statement of financial position	**3,574**	**8,891**

The cash and cash equivalents balance include only cash.

10. Trade payables and other liabilities

10.1 Trade payables and other current liabilities due within one year

	31 March 2021	31 March 2020
	£000	£000
Other taxation and social security	3,244	3,035
Trade payables	23,059	20,279
Accruals	42,812	35,725
Contract liabilities	3,041	677
Trade and other payables	**72,156**	**59,716**

10.2 Trade payables and other non-current liabilities due within one year

	31 March 2021	31 March 2020
	£000	£000
Contract liabilities	101	824
Trade and other payables	**101**	**824**

11. Commitments

The commitment below comprises an agreement with The Royal National Orthopaedic NHS Trust (RNOH) relating to the GIRFT programme. There is no commitment beyond 31 March 2021.

	31 March 2021	31 March 2020
	£000	£000
Payable		
No later than one year	-	10,604
Between one and five years	-	-
After five years	-	-
Total	**-**	**10,604**

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

	31 March 2021	31 March 2020
	£000	£000
Financial assets held at amortised cost	14,347	25,814
Total at 31 March 2021	**14,347**	**25,814**

12.3 Financial liabilities

	31 March 2021	31 March 2020
	£000	£000
Financial liabilities held at amortised cost	69,115	59,039
Total at 31 March 2021	**69,115**	**59,039**

13. Events after the reporting period

Our recommendations for new primary legislation to support implementation of the NHS Long Term Plan, including provision for ICSs and legally merging NHS England and NHS Improvement, were included in the government's draft Health and Care Bill.[88]

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 and 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 NHS Pension Scheme.

Since the setup 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 DHSC Minister, Board member, key manager or other related parties has undertaken any material transactions with the NHS TDA (2019/20 NIL).

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

[88] https://www.gov.uk/government/publications/health-and-care-bill-factsheets/health-and-care-bill-information

Appendices

Appendix 1: How we have delivered on the government's mandate to the NHS

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

The 2020/21 mandate was set during the start of the pandemic. It had a primary objective to support the COVID-19 response and four further objectives. Alongside these core objectives was a requirement to ensure robust financial performance for 2020/21. To assess performance against these objectives, 30 deliverables were agreed with DHSC for assurance.

This assessment of performance against the 2020/21 mandate captures our broad assessment of performance for the unique circumstances of the 'pandemic year' following assessments by policy teams at NHS England and NHS Improvement and DHSC.

In summary, as of 31 March 2021 NHS England and NHS Improvement were on track to deliver 90% of the commitments in the mandate with plans in place to address the remaining commitments.

Objective 1: Support the government to delay and mitigate the spread of COVID-19 and to contribute to research and innovation in prevention and treatment, while ensuring that everyone affected by it receives the very best possible NHS treatment.

Early in the pandemic, NHS England and NHS Improvement took key actions to plan the response and prepare the NHS to treat patients with COVID-19. In January 2020 the NHS triggered a Level 4 national incident, putting national command and control arrangements in place to direct the pandemic response. From February local NHS organisations were asked to make key preparations so they could care for COVID-19 positive patients.

Redeploying capacity was integral to our pandemic response. Using a range of measures across primary, secondary and community services and in partnership with different sectors, the NHS successfully expanded critical care capacity by around 50%, with some areas surging to over 80%. At the peak of the first wave, there were 18,974 COVID-19 positive inpatients. In January 2021, there were 34,336 COVID-19 positive inpatients.

Laboratory capacity and testing have been critical elements of the work to mitigate the spread of COVID-19. NHS England and NHS Improvement led Pillar 1 of the COVID-19 Testing Programme and took significant steps to keep patients and staff as safe as possible, with over 82 million lateral flow devices distributed to patient-facing staff. New technologies were also rolled out across the service, including rapid testing in emergency departments, saliva testing for asymptomatic staff and antibody testing.

NHS England and NHS Improvement also rapidly implemented lifesaving COVID-19 treatments such as dexamethasone for people in hospital, and Tocilizumab for people in critical care, significantly reducing the risk of death from the disease. We also worked with partners to support continuity of medicine supply to patients.

The development and deployment of COVID-19 vaccines have been a key part of preventing the spread of the virus. Throughout the summer and autumn of 2020, the NHS planned the biggest vaccination programme in its history. By 31 March 2021, through a network of over 250 hospital hubs, 2,300 local vaccination services and 230 vaccination centres, the NHS had administered 29,973,324 first and second vaccine doses, outperforming most large, developed countries.

To tackle the long-term effects of COVID-19, NHS England and NHS Improvement have also established care systems and the NHS 'Your Covid Recovery' website for Long COVID-19, setting up 83 clinics by March 2021 to offer patients specialist assessment. A Long COVID-19 Taskforce made up of people with lived experience of the disease, NHS staff and researchers has also been established, along with £50 million investment into research of the condition.

Objective 2: Ensure progress towards the effective implementation of the NHS Long Term Plan, including the commitments and trajectories set out in the National Implementation Plan and NHS People Plan, to be published later in the year, and maintain and enhance public confidence in the NHS.

Although elements of implementation of the NHS Long Term Plan were paused as resources were targeted at the pandemic response, progress was made in a number of areas, including the rollout of digital care in primary and secondary care and the expansion of access to mental health services.

In primary care, digital care services have been transformed with over 99% of GP practices offering video consultation alongside phone and walk-in services. All NHS secondary care providers now have video consultation services, too. This has meant that NHS England and NHS Improvement have exceeded the key goal to deliver at least 25% of consultations virtually by July 2020, helping to meet commitments in the NHS Long Term Plan.

Mental health services remained open throughout the pandemic with referrals returning to pre COVID-19 levels by December 2020. By March 2021, nearly three-quarters of people referred had started treatment for Early Intervention in Psychosis (EIP) within two weeks, exceeding the national standard. Also, access to services for children and young people exceeded the target for 2020/21, with additional support provided by 80 mental health teams across 3,000 education settings.

During the pandemic, cancer has remained a priority across the NHS with over three million people urgently referred and over 760,000 cancer treatments carried out since March 2020. Following the early dip in referrals caused by the pandemic, urgent cancer referrals then recovered strongly with the highest recorded number in March 2021.

As a result of significant disruption caused by the pandemic, the NHS has seen a decrease in A&E department attendances. Meeting the four-hour waiting time standard has also been challenging for services operating in socially distanced circumstances. To address these issues and help manage demand, money was invested to upgrade A&E facilities. In December 2020 the NHS

successfully launched the NHS 111 First triage programme to provide clinical expertise and advice to patients on the phone and help assess whether they need to attend A&E.

By necessity, a considerable number of elective services were disrupted in many countries, including the UK, during the pandemic. The total NHS waiting list for March 2021 stood at 4.95 million. NHS services have worked hard to maintain essential care and tackle backlogs, at the same time as providing care for COVID-19 positive patients. As a result of public information campaigns like 'Help us to Help You', which invited the public to use NHS services, and initiatives to support the provision of socially distanced care, redesign patient pathways and prioritise workforce capacity in frontline services, we have seen elective activity and outpatient attendances recover. Between January and March 2021, over three million operations were completed. This activity was delivered alongside providing care to more than 150,000 COVID-19 positive patients.

To support NHS staff during the pandemic NHS England and NHS Improvement also published the NHS People Plan for 2020/21 to ensure staff were looked after and could be assisted to work in new ways. Support for staff included provision of COVID-19 vaccines and risk assessments with particular focus on the needs of ethnic minority staff. NHS England and NHS Improvement also played a key role in supporting staff networks for marginalised groups, including disabled, ethnic minority and LGBTQ groups, to promote a shared sense of belonging in the workforce. On workforce sustainability, the NHS saw staff numbers increase by over 4% in 2020/21.

Objective 3: With support from government, help ensure delivery of its wider priorities, which include manifesto commitments to further improve the experience of NHS patients, working with local government to support integration and the sustainability of social care through the Better Care Fund, and contributing to planning for life outside the EU once the current transition period ends.

NHS England and NHS Improvement have supported the government's manifesto commitment to recruit a total of 50,000 nurses through international recruitment and a comprehensive retention programme. For international recruitment, we developed an ethical and sustainable programme to recruit international nurses by March 2024. On retention, NHS England and NHS Improvement have been on track to deliver their 2020/21 target but there is some uncertainty as result of, among other things, staff burnout during the pandemic.

As part of the response to COVID-19, the NHS provided support to care homes through mutual aid that included an offer of infection prevention and control support. To deliver this, the Better Care Fund Team worked with local government, adult social care, NHS regional teams and PHE to develop and implement care home support plans in every part of England.

The pandemic accelerated closer integration between different health and care organisations in each ICS. Working collaboratively, NHS organisations, local councils and other organisations helped shield vulnerable people, developed pathways to protect capacity for urgent non COVID-19 care and provided clear, consistent messages to local residents. As part of accelerated integration, NHS England and NHS Improvement also delivered on the NHS Long Term Plan commitment that all parts of England are served by an ICS by April 2021.

Tackling health inequalities within communities is a key priority for the NHS, but these have been exacerbated by the pandemic. In 2020/21, NHS England and NHS Improvement created a Health Inequalities Improvement function that reflects the inequalities commitments set out in the NHS Long Term Plan. As part of this work, a national advisory group of leaders was established from within and beyond the NHS to advise on how NHS England and NHS Improvement can increase the scale and pace of actions to tackle health inequalities.

Objective 4: Deliver the public health functions that the Secretary of State for Health and Social Care has delegated to NHS England to exercise under section 7A of the NHS Act 2006

Despite the significant challenges of the pandemic for NHS public health programmes, such as screening and immunisation, NHS England and NHS Improvement prioritised the most immediately critical programmes while ensuring patient safety. This included adapting service models to ensure the continuation of services where it was safe to do so, such as for childhood and school immunisation programmes.

The 2020/21 NHS Annual Influenza Vaccination Programme was the most successful in the history of the programme with the highest levels of uptake ever seen, including over 80% uptake in the population aged over 65 years. Building on that success, the programme was also expanded in-year to include 50 to 64-year olds.

Objective 5: Share all information with government that is necessary to enable progress against this mandate to be effectively monitored, and to support the Secretary of State in fulfilling wider statutory functions, including in respect of COVID-19

Sharing information with government has been an essential part of our pandemic response and supporting the Secretary of State to fulfil his functions. Senior NHS officials supported ministers on the pandemic response, attending some COBR meetings and making regular appearances at government press conferences.

NHS England and NHS Improvement also published real-time information on daily COVID-19 admissions, bed occupancy and mortality in hospitals, as well as weekly updates on COVID-19 vaccinations by characteristics such as age, gender and ethnicity.

The Foundry Platform was also developed to provide information on the rapidly evolving COVID-19 situation, including identifying risks for vulnerable populations and areas where numbers of cases were growing.

Financial objectives

2020/21 has been an extraordinary year for NHS finances with significant uncertainty and reforms to the financial regime made in-year to support the pandemic response and to ensure the NHS successfully operated within allocated budgets. NHS England and NHS Improvement reported an underspend for 2020/21 of c.£5.6 billion against the total budget of £149.5 billion.

Appendix 2: Meeting our Public Sector Equality Duty (PSED)

Advancing equality and the COVID-19 pandemic

The Equality and Human Rights Commission (EHRC) and the Government Equalities Office (GEO) suspended enforcement of the regulations that require the annual publication of equality information, gender pay gap reporting and equality objectives for the 2019/20 reporting period.[89] In view of the adverse equality impacts of the COVID-19 pandemic, NHS England and NHS Improvement extended the existing equality objectives until the end of March 2022, recognising that it was not possible to undertake effective engagement with key stakeholders to develop revised equality objectives because of the impact of, and focus on, the COVID-19 pandemic during 2020/21. However, in light of the pandemic, NHS England and NHS Improvement added a new equality objective focused on ensuring that the equality and health inequality impacts of COVID-19 were fully considered, and that clear strategies were developed and implemented for the NHS workforce and patients.

Our equality objectives for 2020/21 and 2021/22

The equality objectives for NHS England and NHS Improvement for 2020/21 addressed our role as an NHS system leader and commissioner, and our own role as an employer. The seven overall objectives are:

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 Health and Social Care Act 2012.
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 (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.
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.
7. To ensure that the equality and health inequality impacts of COVID-19 are fully considered and that clear strategies are developed and implemented for the NHS workforce and patients. To ensure that the proposed 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.

[89] https://www.gov.uk/guidance/gender-pay-gap-reporting-changes-to-enforcement

Advancing equality for patients and an increased focus on addressing health inequalities

In July 2020, NHS England, with support from system leaders, published the letter 'Third phase of NHS response to COVID-19'.[90] This letter was supported by detailed guidance, 'Implementing phase 3 of the NHS response to the COVID-19 pandemic', which was published in August 2020.[91] This guidance and the associated letter identified that in wave 1 of the pandemic "COVID-19 had shone a harsh light on some of the health and wider inequalities that persist in our society". The guidance also identified that like nearly every health condition, it had become increasingly clear that COVID-19 has had a disproportionate impact on many who already face disadvantage and discrimination.

The guidance noted that the impact of the virus had been particularly detrimental on people living in areas of greatest deprivation, on people from BAME communities, older people, men, those who are obese and who have other long-term health conditions, people with a learning disability and other inclusion health groups, those with a severe mental illness and those in certain occupations.[92] It also noted that COVID-19 risked further compounding inequalities which had already been widening. The guidance set out eight urgent actions to address equality and health inequalities.[93] During financial year 2021/22, NHS England and NHS Improvement continued to track progress and issues relating to delivery of the eight urgent actions.

At the end of March 2021, NHS England and NHS Improvement published 'Planning and implementation guidance for 2021/22'. This set out five key priority actions for the NHS to tackle health inequalities:

- Priority 1: Restore NHS services inclusively
- Priority 2: Mitigate against digital exclusion
- Priority 3: Ensure datasets are complete and timely
- Priority 4: Accelerate preventative programmes that proactively engage those at greatest risk of poor health outcomes
- Priority 5: Strengthen leadership and accountability[94].

In 2020/21, NHS England and NHS Improvement also made a strategic decision to establish a new division to provide an expanded focus on tackling health inequalities; a Director of Health Inequalities was appointed, and the Health Inequalities Improvement Team was established in the last quarter of 2020/21.

[90] https://www.england.nhs.uk/coronavirus/publication/third-phase-response/
[91] https://www.england.nhs.uk/publication/implementing-phase-3-of-the-nhs-response-to-the-covid-19-pandemic/
[92] https://www.england.nhs.uk/about/equality/equality-hub/action-required-to-tackle-health-inequalities-in-latest-phase-of-covid-19-response-and-recovery/
[93] https://www.england.nhs.uk/publication/implementing-phase-3-of-the-nhs-response-to-the-covid-19-pandemic/
[94] https://www.england.nhs.uk/wp-content/uploads/2021/03/B0468-implementation-guidance-21-22-priorities-and-operational-planning-guidance.pdf

National Advisor for LGBT Health

During 2020/21, the National Advisor for LGBT Health and their team continued to work on a number of priorities to reduce health inequalities and to improve the experience of healthcare for LGBT+ people and to address the inequalities of experience of the LGBT+ NHS workforce.

This work focused on three key areas: improving data collection and monitoring, education, training and workforce development and supporting the NHS to deliver LGBT+ inclusive services. In 2020/21, we worked with NHS England's Insight and Feedback team to include, for the first time, an inclusive question on gender identity and trans status in the GP Patient Experience Survey. This work enabled us to better understand the experiences of trans and non-binary people in primary care and will support better data collection and monitoring in other settings. We commissioned a partnership of LGBT+ community organisations to work on 'Phase 2' of the Rainbow Badge project to build on this successful initiative, by developing a quality assurance framework to support NHS trusts in their work to address LGBT+ health inequalities and to ensure an inclusive workplace for their LGBT+ staff. We also commissioned Anglia Ruskin University to undertake a mapping exercise to identify best practice in LGBT+ education and training; guidance and recommendations will be published in 2021/22 on the approach to workforce development required to address LGBT+ health inequalities.

Development of the Equality and Inclusion Team focused on workforce

With the launch of the People Directorate in April 2020, the Equality and Inclusion Team was established. For the first time there was a team in NHS England and NHS Improvement whose mandate was to provide the national strategic direction on making the NHS a place where everyone experiences belonging, by focusing on equality and inclusion. The NHS workforce is not immune to the inequalities that pervade society at large and it was clear during the pandemic that there were groups within the workforce who were disproportionately affected by both the virus and the collateral impacts of the emergency and pandemic response.

Workforce Race Equality Standard

Since 2015, NHS England has been leading on the strategic approach for workforce race equality across the NHS. The WRES[95] supports NHS organisations (as well as independent providers of NHS services) 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. The focus has now evolved toward trust accountability to support and deliver meaningful change for BAME staff that leads to better representation, the closing of disciplinary and pay gaps, and an improved experience relative to non-BAME colleagues. Two frameworks underpinning this work are: (i) the Model Employer[96] strategy to increase BAME representation across the NHS workforce pipeline and at leadership levels; and (ii) A Fair Experience for All[97] framework to support NHS organisations in closing the ethnicity gap in the application of

[95] https://www.england.nhs.uk/about/equality/equality-hub/equality-standard/
[96] https://www.england.nhs.uk/wp-content/uploads/2019/01/wres-leadership-strategy.pdf
[97] https://www.england.nhs.uk/wp-content/uploads/2019/07/closing-the-ethnicity-gap.pdf

disciplinary action between staff groups. The 2020 WRES Report[98] was published in March 2021 during the COVID-19 pandemic, which disproportionately impacted BAME staff, and signals clearly, as the NHS People Plan 2020/21 did, that actions must be prioritised to address the disparities. The report is the sixth publication since the WRES was mandated and continues to cover all nine indicators. It also compares data against previous years.

Workforce Disability Equality Standard

The WDES[99] was launched in 2019 following extensive engagement, which included disabled staff, stakeholders, leaders and national bodies. The 10 metrics compare the experiences of disabled and non-disabled staff annually and are published and reviewed by trusts locally. A national WDES report is produced with analysis of trends and key findings. The WDES applies to NHS trusts and has been extended to ALBs in 2020. Like the WRES, the WDES supports NHS trusts and ALBs to identify and close the gaps in experience between disabled and non-disabled staff. The focus of work includes developing and strengthening staff networks, responding to the impact of COVID-19 on disabled staff and developing a WDES five-year strategy.

[98] https://www.england.nhs.uk/wp-content/uploads/2021/02/Workforce-Race-Equality-Standard-2020-report.pdf
[99] https://www.england.nhs.uk/about/equality/equality-hub/wdes/

Appendix 3: Reducing health inequalities in 2020/21

During 2020/21 the COVID-19 pandemic and recovery[100] shone a brighter light on health inequalities and the adverse and disproportionate impact of the pandemic on certain groups[101] – people living in the 20% most deprived areas and BAME groups – and highlighted the urgent need to prevent people dying and manage ill-health in groups that experienced the worst health inequalities in access, experience and outcomes as outlined in the NHS Long Term Plan[102] and the criteria set by the Secretary of State.

In July 2020, we issued the third phase letter on NHS response to COVID-19,[103] which outlined an urgent call for action to the NHS to work collaboratively with local communities and partners to implement eight urgent actions to address inequalities in NHS provision and outcomes. In March 2021, we took further steps in hardwiring health inequalities through the 2021/22 priorities and operational planning guidance.[104]

Analysis of key data demonstrated statistically significant disparities for deprivation and ethnicity during the first wave of COVID-19. Most noticeable was the fall in proportionate share of emergency admissions for Pakistani and Bangladeshi groups. Cancer indicators also showed statistically significant disparities in the recovery of services by age, deprivation, ethnic group and tumour type. This issue was given significant prominence, and there have been encouraging signs of recovery more recently, with virtually no disparities showing in the October 2020 data.

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

In June 2020 we established a Health Inequalities Task and Finish Group to help us set out proposals for inclusion in the next phase of the COVID-19 recovery work. The group comprised primarily NHS leaders from across the system, to focus on what specific, measurable actions could and should be taken by the NHS. Proposals included actions to progress the relevant recommendations for NHS services set out in the PHE report Beyond the data: understanding the impact of COVID-19 on BAME groups[105] and impact on deprived neighbourhoods and on inclusion groups more widely.

The group developed a set of eight urgent actions on health inequalities[106] for systems to take as part of the organisation's third phase of its response to COVID-19.

In December 2020, we recruited a National Director for Health Inequalities to lead the work across NHS England and NHS improvement and the wider NHS. The National Health Inequalities Improvement Programme (NHIIP) is leading the drive for exceptional quality healthcare for all

[100] https://future.nhs.uk/NationalCOVID19VaccineEquality
[101] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/892376/COVID_stakeholder_engagement_synthesis_beyond_the_data.pdf
[102] https://www.longtermplan.nhs.uk/
[103] Report template - NHSI website (england.nhs.uk)
[104] https://www.england.nhs.uk/publication/2021-22-priorities-and-operational-planning-guidance/
[105] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/892376/COVID_stakeholder_engagement_synthesis_beyond_the_data.pdf
[106] https://www.england.nhs.uk/wp-content/uploads/2020/08/C0716_Implementing-phase-3-v1.1.pdf

through equitable access, excellent experience and optimal outcomes. This is based on a social movement approach, closing the health inequality gap through quality improvement (QI) capability and capacity building from boards to frontline, underpinned by a leadership culture which promotes and enables QI and continuous learning. The measurable outcome for the programme is to ensure five years of extra healthy life expectancy by 2035 (NHS Long Term Plan[107]).

We have continued to track progress and issues relating to delivery of these actions, working as a super matrix across NHS England and NHS Improvement to hardwire health inequalities across the organisation through the following 10 priorities:

1. system leadership/extensive partner engagement
2. build capable national Health Inequalities Improvement Team
3. Health Inequalities Improvement Dashboard
4. performance framework – health inequalities lens
5. payments and incentives – health inequalities lens
6. mobilise professional networks
7. communications strategy and plan
8. conclude eight urgent actions delivery
9. health inequalities improvement framework
10. continue to contribute to NHS England and NHS Improvement recovery planning.

We implemented several governance and accountability mechanisms for engaging with national, regional and local stakeholders on the health inequalities agenda. The Health Inequalities Improvement Board meets monthly and provides internal governance, assurance and accountability for the delivery of the NHIIP. Membership of the NHIIP consists of NHS England and NHS Improvement programme directors and regional SROs for health inequalities. The Health Inequalities Clinical Network meets fortnightly and its membership comprises clinical leaders including relevant NHS England and NHS Improvement national clinical directors/national specialty advisors, and is responsible for providing clinical and professional advice and challenge and shaping individual deliverables.

The Health Inequalities Forum[108] is a forum for nominated health inequalities leads within systems, regions, NHS trusts and PCNs to share updates, showcase learning and improvements, and outline any issues, challenges and risks to implementing and delivering on the health inequalities improvement agenda. This forum meets on a fortnightly basis.

We have continued work with our new and existing partners – NHS Race and Health Observatory,[109] King's Fund on the role of the NHS in tackling poverty,[110] The Health Foundation

[107] https://www.longtermplan.nhs.uk/
[108] https://future.nhs.uk/connect.ti/EHIME
[109] NHS Race and Health Observatory - NHS Confederation
[110] The NHS's role in tackling poverty | The King's Fund

on the newly launched health anchor learning networks,[111] PHE on the health inequalities COVID-19 resources for local authorities.[112]

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

Throughout the development of the eight urgent actions[113] the importance of strengthening the quality of data collected and developing health inequality indicators was emphasised. Action 2 on indicator development and the Recovery of Critical Services Dashboard and action 7 on improving data quality have been key drivers for the development of metrics.

Absolute Gradient of Inequality (AGI) Dashboard

In 2020/21 we continued to build on the work of the health inequalities indicator 106 for chronic ambulatory care sensitive conditions and urgent care sensitive conditions[114] to help ICSs, CCGs and PCNs monitor and plan improvements in NHS equity performance, which formed the basis of the Equality and Health Inequalities (EHI) Right Care Packs. The data from the packs now forms the basis of the AGI Dashboard, which will be merged into the national Health Inequalities Improvement Dashboard.

Programmes continued to develop health inequalities indicators as part of the delivery against the NHS Long Term Plan commitments. These include indicators for outcomes, experience and access for major programmes. In 2020/21, we agreed NHS Long Term Plan headline indicators for health inequalities, and these are now being finalised.

We are now in the process of developing a transparent national Health Inequalities Improvement Dashboard to drive improvement in equitable access, excellent experience and optimal outcomes. We are also strengthening health inequalities performance reporting.

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

During 2020/21, the third phase letter on NHS response to COVID-19[115] outlined an urgent call for action to the NHS to work collaboratively with local communities and partners to implement eight urgent actions to address inequalities in NHS provision and outcomes. Key evidence of effective interventions to reduce health inequalities is benchmarked below against each of the eight urgent actions.

Action 1: Protect the most vulnerable from COVID-19

We have worked in partnership with the COVID-19 Vaccination Deployment Programme through the Vaccine Equality Workstream to increase the uptake among underserved communities, working with the community and voluntary sector, faith leaders and organisations, to address

[111] https://haln.org.uk/
[112] COVID-19: public health | Local Government Association
[113] https://www.england.nhs.uk/wp-content/uploads/2020/08/C0716_Implementing-phase-3-v1.1.pdf
[114] https://www.england.nhs.uk/wp-content/uploads/2019/10/nhs-of-ccg-metrics-technical-annex-3-1920-v1.3.pdf
[115] Report template - NHSI website (england.nhs.uk)

issues and concerns and fears around the COVID-19 vaccine, with targeted focus on Black African, Pakistani and Bangladeshi groups, inclusion health groups and people living in the most deprived areas. The Vaccine Equality Workstream work has supported vaccination centres and sites to be established across a range of community and places of worship venues, including food banks, community centres, mosques and churches. Over 300 places of worship, including Black church organisations, expressed an interest in supporting the vaccine uptake strategy. We supported an initiative led by Churches Together in England, Evangelical Alliance and Your Neighbour in a churches campaign involving 50 churches to demonstrate the swell of support from faith leaders in Black communities.

We launched a C19 Vaccine Equalities Tool that enables local/system colleagues to drill data down to Local Super Output Authority (LSOA) level and a 'How to do it guide' to support the development of 'pop-up sites' in communities. In March we launched an Equalities Connect and Exchange Hub[116] to capture, connect, share and spread good practice. We also supported JCVI cohort 6 with a homelessness and rough sleeping mobilisation support pack, along with similar resources to support people with learning disabilities and autism.

Optimising vaccine uptake has ensured ongoing focus and engagement with places of worship as vaccination sites, out-of-hours vaccination, outreach and in-reach into the communities and targeted, culturally and linguistically appropriate communications.

We have worked to ensure our NHS workforce at risk of COVID-19 infection were risk assessed and reasonable adjustments, where necessary, were made. Key at-risk groups were staff working on the frontline and from a BAME community, and people from the most deprived areas.

Ramadan guide[117]

In preparation for the start of Ramadan, we developed a guide to channel communities' energies to dispel misinformation and amplify positive messages; take the vaccination service into the heart of community at the opportune times and places while supporting NHS colleagues who will be fasting.

Action 2: Restore NHS services inclusively

In December 2020, we commissioned Ipsos MORI and the Strategy Unit to carry out a rapid evidence review and some primary research to better understand the influences of patient barriers, behaviour and decision-making for minority and vulnerable groups in seeking help and accessing NHS services, in the context of the COVID-19 pandemic. We have shared relevant performance data with regional colleagues, to support local quality improvement. Work is ongoing to develop similar indicators for diagnostic services, mental health, specialised commissioning and children's health. A Health Inequalities Workstream was created under the Long COVID Programme Board to ensure equitable access, excellent experience and optimal outcomes from the Long COVID Service

[116] FutureNHS Collaboration Platform; https://future.nhs.uk/NationalCOVID19VaccineEquality/viewdocument?docId=97850853
[117] https://www.england.nhs.uk/coronavirus/publication/supporting-covid-19-vaccine-uptake-during-ramadan/

for communities affected by health inequalities, especially those with a learning disability, those from the most deprived communities and those from ethnic minority communities.

Action 3: Develop digitally enabled care pathways in ways which increase inclusion, including reviewing who is using new primary care, outpatients and mental health digitally enabled pathways by 31 March 2020

As part of the third phase of the NHS response to COVID-19, we asked ICSs to develop digitally enabled care pathways in ways which increase inclusion, including reviewing who is using new primary, outpatient and mental health digitally enabled care pathways. This included system reviews on how the blend of different channels of engagement has affected different population groups, prototype auditing, and developing links with other relevant organisations to help learn, shape and strengthen work to ensure digital transformation is inclusive.

Action 4: Accelerate preventative programmes which proactively engage those at greatest risk of poor health outcomes

Learning disability health checks (target: 67% by 31 March 2021)

We have consistently communicated the continuing priority of delivering the annual health check (AHC) for those with a learning disability throughout the pandemic. This includes by:

- maintaining the Learning Disability Health Check Directed Enhanced Service throughout the last year and revising the 2020/21 Quality and Outcomes Framework (QOF) QI Module: Improving care of people with a learning disability
- introducing an incentive for completion of the AHC within the PCN Investment and Impact Fund
- reiterating the importance of learning disability health checks in primary care bulletins and webinars
- enabling practices to be paid within the legislation for conducting a ‘blended’ AHC (part virtual, part face-to-face when permissible) and continuing this throughout 2021/22
- working with regional teams, CCGs, transforming commissioning boards (TCB) and GP practices to support improvement
- working with stakeholders such as Mencap and Learning Disability England (LDE) to support messaging and communication to people with a learning disability and their families/carers
- national team awarding nine exemplar sites funding to trial innovative approaches to improve AHC uptake among people with a learning disability and in particular, increase uptake from ethnic minority communities, young people aged 14–17 years and Traveller communities

- including recovery of learning disability health checks as one of the seven top priorities for primary care in the GP capacity funding letter, supported by the £150 million COVID Capacity Expansion Fund.

Our incentives and initiatives to support the delivery of the AHC for those with learning disability will continue in the next financial year. We will assess how each can be improved, and how more frequent updates to health check performance data could support more nuanced and localised approaches to drive improvements.

Health checks for people with a severe mental illness (target: 60% by 31 March 2021)

Through the NHS Long Term Plan, the NHS has committed to delivering 390,000 comprehensive annual physical health checks and follow-up interventions to people with severe mental illness (SMI). The target for 2020/21 was this for 60% of people on the General Practice SMI register. At the end of 2020/21, 27% of people with SMI had received their check. Delivery was significantly impacted during the COVID-19 pandemic, due to reduced capacity in primary care and social distancing requirements. From 2021/22, all elements of the health check are incentivised in the GP QOF. All ICSs have received additional funding totalling £12 million to commission tailored outreach to support uptake of health checks and vaccinations.

Continuity of maternity carer (target: 35% by 31 March 2021)

The NHS Long Term Plan committed to prioritising continuity of carer for those from BAME groups, as well as for women living in the most deprived areas. Continuity of carer models help reduce baby loss, preterm births, hospital admissions and the need for unwarranted intervention during labour, and improve women's experience of care. The pandemic has resulted in staffing constraints in maternity units and this hampered their ability to reorganise their midwifery staffing into continuity teams. In March 2021, there were 371 continuity of carer teams in place where each midwife provides all three elements of midwifery care; this represents coverage for 15–17% of all pregnant women. There were also 263 teams placed in areas of deprivation and 246 teams placed in areas where many BAME women live. In 2021/22 we will begin piloting an enhanced model of continuity of carer for women in the most deprived areas of England, which enables these women to have more time with their midwife.

The COVID Vaccination Equalities Tool[118] (COVID vaccination data through the National Immunisation Management Service (NIMS)) has linked detailed patient-level data on ethnicity and deprivation. This dashboard is updated daily and being shared with regions, ICSs and directors of public health. There is an aspiration to develop a tool for flu like the COVID Vaccination Equalities Tool.

[118] https://future.nhs.uk/NationalCOVID19VaccineEquality/viewdocument?docId=97850853

Action 5: Particularly support those who suffer mental ill-health

In 2020/21 we saw demonstrable improvements in the quality of submissions to the national Mental Health Services Data Set (MHSDS), which includes the requirement for protected characteristics to be recorded. Further data quality (DQ) guidance on how to flow data on protected characteristics to the MHSDS, and a DQ dashboard on protected characteristics for use by regions, systems, and providers, are in development.

In 2020/21 we saw further advances in the IAPT recovery rate for BAME communities, building on the positive trend.

We published our first Advancing Mental Health Equalities Strategy[119] in October 2020, which outlines the short and longer-term actions we will take to advance equalities in access, experience and outcomes in mental health services.

Action 6: Strengthen leadership and accountability.

During 2020/21, we ensured that strengthening leadership and accountability on health inequalities was a priority. All seven regions nominated an SRO to lead on health inequalities across their region. We asked all systems and NHS organisations to identify a named executive board member responsible for tackling health inequalities in every NHS organisation, CCG and system. To support the new roles within NHS organisations and systems, we developed a framework 'A well-led approach to tackling health inequalities',[120] which was an advisory note on implementing the urgent actions to address inequalities in NHS provision and outcomes. We ran four webinars between December 2020 and January 2021to share the well-led approach, harness engagement with leads and information regarding ongoing support.

We are supporting the NHS Race and Health Observatory's commission of the King's Fund to develop insights into what is required from senior healthcare leaders to tackle health inequalities. The recommendations will inform a new Health Inequalities Leadership Framework.

With primary care we have defined the roles and responsibilities of 'health inequalities leads' for PCNs. In our joint working with the Royal College of General Practice we continue to develop a Health Inequalities training programme (of which one module will focus on leadership).

In July 2020, each NHS Board was asked to publish action showing how over the next five years its board and senior staffing will match overall BAME composition of its overall workforce or its local community. This work is overseen by the NHS England and NHS Improvement People Directorate.

[119] https://www.england.nhs.uk/publication/advancing-mental-health-equalities-strategy/
[120] https://future.nhs.uk/connect.ti/EHIME

Action 7: Ensure datasets are complete and timely

Data remains critical for understanding need, monitoring progress, and developing and evaluating the impact of interventions. Improvements in this area have been a key enabler for the progress achieved as part of Phase 3. All NHS organisations are asked, therefore, to continue to improve the collection and recording of ethnicity data across primary care, outpatients, A&E, mental health, community services, and specialised commissioning.

NHS Digital has created a new synthetic ethnicity dataset for primary care patients.[121] This is about providing an ethnicity category for each NHS patient number and includes combining known ethnicity data from the Hospital Episode Statistics Dataset and the GDPPR (GPES Data for Pandemic Planning and Research). This has improved ethnicity coding so that over 90% of NHS numbers have an ethnic group assigned to them. A similar synthetic dataset is being considered for disability. This work is about strengthening patient demographics, for linking with other datasets to facilitate health inequalities analysis.

Action 8: Collaborate locally in planning and delivering action to address health inequalities

In 2020/21 we asked ICSs to support and oversee the delivery of the eight actions, understand the population needs and build partnerships to address health inequalities. All systems have submitted their updated system plans on how they have addressed health inequalities, outlining key achievements, areas outstanding for 2021/22, plans for delivering outstanding commitments and key learning to date. We have commissioned a CSU to provide a thematic review of the system plans and collate a support offer from the central team as part of the 2021/22 delivery. During 2020/21, we delivered a workshop with the top 10 CCGs receiving additional funding through the CCG allocation formula and a task and finish group is taking forward the resulting recommendations. We supported systems to support NHS organisations seeking to serve as effective ‘anchor’ institutions. In February 2021, in partnership with the Health Foundation, we launched the ‘Health Anchors Learning Network’ (HALN).[122] We continue to develop activities to tackle workforce supply issues, while supporting economic recovery and tackling health inequalities. This includes working with two regions to test approaches to enhancing youth employment. We commissioned the King’s Fund to review the role of the NHS in tackling poverty.[123]

The Health Equity Programme was launched to tackle health inequalities by funding 41 projects led by ICSs to identify and target at-risk groups. Areas have chosen different local priorities from homelessness and deprivation to specific ethnic minority groups and those digitally excluded. For example, in Surrey Heartlands, tech angels will help people with the latest virtual opportunities like apps and online groups, and in Bath, North East Somerset, Swindon and Wiltshire rough sleepers, Gypsies, boaters and Travellers will be among those helped to access the flu vaccine.

[121] https://digital.nhs.uk/data-and-information/areas-of-interest/ethnicity

[122] https://haln.org.uk/

[123] The NHS’s role in tackling poverty | The King's Fund

Criterion 4: Improve prevention, access and effective use of services for inclusion health groups

During 2020/21 we worked on the NHS COVID-19 response programme with the Homelessness Health team and Vaccine Equalities team to support the targeted delivery of the vaccine through increasing uptake among underserved communities and inclusion health groups. Key delivery has focused on the GP Registration Campaign: Access cards. In partnership with several organisations we distributed 'access cards', both physical and digital, which supported the message that everyone is entitled to register with a GP. On the back of the card is the NHS England and NHS Improvement Customer Contact Centre number for people to use if they have been refused registration. VCSE organisations can get physical copies of the access card from their local Healthwatch, to share with the communities they work with, or download a digital copy of the access card[124] from the Future NHS platform. Some VCSE partners received batches of the cards to distribute directly to their service users. We have also developed a Twitter graphic for social media.[125] We supported JCVI cohort 6 with a homelessness and rough sleeping mobilisation support pack, which covers GP receptionist training[126] and GP practice website review to include a statement that you can register without ID or address. We also recommended practices join the Safe Surgeries initiative[127] run by Doctors of the World. This reassures people that immigration status will not be checked, and they are in a safe space. We supported the development and implementation of the Inclusion Health Self-Assessment Tool for PCNs.[128]This tool produces posters that give clear information about how to register with a GP and can be downloaded and printed. The 'Welcome to General Practice' poster[129] can be personalised with practice-specific information. The 'Please come and register with your local GP' poster[130] can be displayed in any prominent places where people go for advice and support.

We employed a senior nurse lead for homeless and inclusion health, who has been instrumental in supporting the delivery of services for inclusion health groups. We have continued our call to action to ensure 'inclusion health is every nurse's/clinician's business' is aligned to the applying all our health guidance;[131] worked with Leeds Gate (a Gypsy, Roma and Traveller (GRT) organisation) and Leeds Community Healthcare on an inclusive service resource and with Queens Nursing Institute and Focussed Care CIC on broader inclusion resources; and produced rapid reads for inclusion health groups, including one specific for GRT communities, asylum seekers and refugees. We continue our work with the Inclusion Health Strategic Working Group and the Health and Wellbeing Alliance members, where key groups working on the inclusion health agenda are represented. We will continue to develop a robust programme of work on inclusion health.

[124] https://future.nhs.uk/HomelessHealthCOVID19/view?objectId=91739173
[125] https://future.nhs.uk/HomelessHealthCOVID19/view?objectId=91739237
[126] https://www.pathway.org.uk/4403-2/
[127] https://www.doctorsoftheworld.org.uk/what-we-stand-for/supporting-medics/safe-surgeries-initiative/
[128] https://www.inclusion-health.org/pcn/
[129] https://future.nhs.uk/HomelessHealthCOVID19/view?objectId=91739269
[130] https://future.nhs.uk/HomelessHealthCOVID19/view?objectId=91739205
[131] https://www.gov.uk/government/publications/inclusion-health-applying-all-our-health/inclusion-health-applying-all-our-health

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

During 2020/21 we continued to drive forward leadership of the health system to take urgent action to reduce health inequalities for vulnerable groups disproportionately impacted by the COVID-19 pandemic. We have ensured that increasing the pace and scale of progress rests on clear and accountable leadership at all levels, in the local place with PCNs, local government, NHS providers and local diverse community and voluntary sector; through systems and ICSs/CCGs; and regionally through the regional directors and regional SROs for health inequalities, as outlined in the regional operating model and nationally, through super matrix working with our national programmes.

The various health inequalities governance networks, forums and boards identified above are key drivers for engagement and supporting assurance that we are delivering at pace and scale, to meet the needs of our vulnerable groups facing the harshest health inequalities and of our diverse populations.

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

We continued to track progress and issues relating to delivery of these actions, working as a super matrix across NHS England and NHS Improvement to hardwire health inequalities across the organisation. This approach has formed the basis of the five priorities on health inequalities for systems and NHS providers as outlined in the 2021/22 planning guidance.

- Priority 1: Restoring NHS services inclusively: where performance reports will be broken down by patient ethnicity and Indices of Multiple Deprivation (IMD) quintile, focusing on under-utilisation of services, waiting lists, immunisation screening and late cancer presentations.
- Priority 2: Mitigating against ‘digital exclusion’ – ensuring providers offer face-to-face care to patients who cannot use remote services; and ensure more complete data collection to identify who is accessing face-to-face/telephone/video consultations (data broken down by patient age, ethnicity, IMD, disability status, etc).
- Priority 3: Ensuring datasets are complete and timely – to continue to improve data collection on ethnicity across primary care/outpatients/A&E/mental health/community services and specialised commissioning.
- Priority 4: Accelerating preventative programmes; covering flu and COVID-19 vaccinations; AHC for people with a SMI and learning disabilities; supporting the continuity of maternity carers; and targeting long-term condition diagnosis and management.
- Priority 5: Strengthening leadership and accountability – supporting system, PCN and NHS provider health inequalities leads to access training and a wider support offer, including utilising a new Health Inequalities Leadership Framework currently being developed.

Appendix 4: Working in partnership with people and communities

Throughout 2020/21 our focus has been on working with people and communities to respond to the COVID-19 pandemic, particularly communities who have been disproportionately affected by the virus. As with many organisations we have adapted rapidly to deliver engagement activities online, while being mindful of digital exclusion. We have done this through new and existing networks and partnerships with communities, the VCSE sector, ALBs and government departments. By working collaboratively, both internally and externally, we have responded rapidly and engaged with marginalised communities, aiming to mitigate any further disadvantage. A key success has been creating new networks across organisations to support the COVID-19 response and enabling shared learning from good practice across the country. Our Homelessness and Inclusion Health Network and Community Champions Network are two examples where we have facilitated the development of new connections between the VCSE sector and public sector, to respond quickly and effectively to issues such as vaccine hesitancy and GP access.

We have continued to support and advise professionals working across health and care, to ensure public participation is embedded into ways of working. This includes supporting staff to engage during the pandemic and in the recovery of services, through online training, networks, events, resources and webinars. Internally this has included assuring NHS England's duty to involve the public in commissioning (section 13Q of the NHS Act 2006). In addition, we have delivered a programme to almost 500 senior leaders to build a culture that embraces working with people and communities to advance equality and reduce health inequalities. This programme was delivered in direct response to evidence that showed the disproportionate impact of COVID-19 on some communities. It has led to the development of a new, internal network of engagement, equality and equity champions and a refresh of resources and training available to colleagues. The champions are senior managers; part of their role is to highlight the benefits of working with people and communities.

In response to the government's Health and Social Care Bill White Paper, we began engaging with a range of stakeholders to review existing statutory guidance for NHS England and CCGs, and to consider approaches to working with people and communities in ICSs. This work is at an early stage and will continue into 2021/22.

Working with the VCSE sector

Over the past year the VCSE sector has helped us understand the impact of the pandemic on our most vulnerable communities. At a national level, the VCSE Health and Wellbeing Alliance and the Voluntary and Community Sector Emergency Partnership amplified the voices of communities who experience the greatest health inequalities to inform national policy and delivery. Meanwhile consultation and co-production with the VCSE, faith and community groups made COVID-19 messaging more accessible and supported the vaccination rollout.

We know that relationships with the sector play a vital role and we supported this through our VCSE leadership programme and initiatives to forge connections at ICS level. Working with DHSC

and PHE, we have also provided Starting Well funding to 19 VCSE organisations to improve children's health outcomes in areas of high deprivation, and within ethnic minority communities.

Homelessness and inclusion health

During 2020/21, we led the COVID-19 response for homelessness and inclusion health. We rapidly set up a range of networks and working groups to support this work, following emergency measures put in place to safeguard people experiencing homelessness during the pandemic. We responded to the needs of stakeholders in a variety of ways, including:

- online 'sharing the learning' sessions, focused on good practice in involving people experiencing homelessness and inclusion health groups
- commissioning insightful research to fill gaps in knowledge
- working with partners to hear the voices of vulnerable people
- webinars with VCSE partners on topics including safeguarding and trauma-informed care.

Over 1,000 professionals from across the system joined our FutureNHS online network to share information, resources and good practice, and make connections with partners. This programme facilitated effective partnerships across the NHS, VCSE sector, local authorities, ALBs and government to identify and respond quickly to people's needs.

Rapid engagement on experiences of shielding

We carried out an important engagement exercise with people who were advised to shield during COVID-19. This enabled us to hear first-hand experiences from a range of people about shielding and the impact it had on their lives. Feedback from the focus groups was presented to government to inform future shielding policies and decision-making.

Over 160 people were involved in 14 focus groups, which we delivered with VCSE sector partners. We heard from a variety of people who were shielding, including young people, people from ethnic minorities, people with a learning disability; autistic people, condition-specific groups and parent carers. The focus groups identified several themes, which were highlighted in our feedback report, including:

- the impact of shielding on people's mental health
- mixed experiences of support and access to services
- the vital role of family, friends and carers
- the significant financial impact of shielding
- concern for some about the safety of returning to work and education
- the impact for disabled people and their families, in both the short and long term.

Some people who were shielding said they wanted to play a more active part in the response to the pandemic, so we introduced a new peer support volunteer role to enable people who were shielding to support each other.

Primary care networks

In 2020/21 our programme to support PCNs focused on working in partnership with people and communities. We launched a new webinar programme called 'Building inclusive PCNs in partnership with people and communities', with a variety of sessions that anyone working in a PCN could attend. We set up several pilot projects focused on involving people and communities, to share the learning from effective engagement approaches that had a positive impact in places such as Morecambe Bay and Nottingham. We worked with the National Association for Patient Participation, Patients Association, Healthwatch England and National Voices to advance patient participation groups and ensure that they are more inclusive and reach out to people who are under-represented.

The Inclusion Health Self-Assessment Tool was launched to help PCNs identify people and communities within their populations who they may not be reaching. On completion of the tool, a tailored report is generated. It outlines different resources and contacts to support PCNs to plan their approaches, reach out to communities and address health inequalities.

The tool, funded by NHS England and NHS Improvement, was developed by organisations specialising in work with inclusion health groups and people experiencing health inequalities (Friends, Families and Travellers, Homeless Link, Doctors of the World, National Ugly Mugs and Stonewall Housing), with input from PCNs.

We worked in partnership with several organisations to distribute new GP 'access cards', in response to issues identified by specific inclusion health groups around registering with a GP. Many people who experience health inequalities can face barriers when trying to register so the cards highlight that everyone in England is entitled to register with a GP, even if they do not have proof of ID, address or immigration status.

Marginalised communities

In collaboration with Working with Everyone we engaged with people from communities who experience the greatest difficulty in accessing healthcare and those who may have poorer outcomes from care and treatment. We wanted to capture their thoughts about the measures taken to prevent the spread of COVID-19 and to seek their views about COVID-19 vaccination.

We delivered online engagement sessions with people who use drugs (current or former), people experiencing homelessness, adult survivors of childhood sexual abuse and exploitation, GRT communities, migrants/refugees, sex workers and former prisoners. All participants were supported to take part in the online sessions and signposted to advocacy services.

Work with young people

We launched the NHS Cadets scheme in partnership with St John Ambulance, enabling 14 to 18-year olds from deprived communities to volunteer in health and care. It involved 400 young people across 19 locations. Our aim by 2023 is to have 10,000 cadets, developing their first aid, mental health, leadership and communication skills, and volunteering within health and care. We have worked to engage young people from under-represented groups. This includes people who are not in employment, education or training (NEET), people from ethnic minorities and those who would not ordinarily consider volunteering or a career in the NHS.

From October 2020 to March 2021, we worked with young people aged under 18 years as health information champions. They provided accurate and timely COVID-19 and mental health and wellbeing messages for their peers using digital platforms. Messages were agreed locally, and 50 young people enhanced their social action skills and developed creative communications materials.

Networks and forums

The NHS Citizen Advisory Group is made up of Patient and Public Voice (PPV) partners who are involved in programmes across the organisation. Members have given feedback and direction on work programmes to ensure the needs of people and communities are met. This includes feedback on how to record protected characteristics in primary care and commenting on the prevention programme.

The group meets every two months and has also introduced regular ‘hot topic’ discussions around quickly evolving programmes such as the COVID-19 vaccination programme and the government’s Health and Care Bill White Paper and what it means for people and communities. This enabled rapid and timely feedback from PPV partners, which helped with the ongoing development of programmes.

The NHS Youth Forum, delivered by the British Youth Council and made up of 25 young people aged 14–24 years from diverse backgrounds across England, has been active throughout 2020/21. Between April and June, the forum responded to COVID-19 in several ways. Members took an active role in bringing health condition-specific information for young people into one accessible place, to enable young people to easily access relevant COVID-19 information. It also created a mental health toolkit in partnership with St John Ambulance, in direct response to the mental health implications of the pandemic for children and young people.

Members worked with peers and #iwill ambassadors to update PHE guidance on shielding and social distancing to make it relevant and accessible for young people. They also led and contributed to social media campaigns focused on COVID-19 and its impact on young people.

Other youth-led projects carried out in 2020/21 included research and resource development into:

- medical students' education into health inequalities of minority groups
- the experiences of education of young people with special educational needs, disabilities and long-term conditions
- improving access to healthcare for young trans and non-binary people.

Learning Disability and Autism Advisory Group

The Learning Disability and Autism Advisory Group has also supported us to fill several information gaps around COVID-19, including information about COVID-19 vaccines for people with a learning disability and autistic people. We have been involved in advising on and developing information for people with a learning disability and autistic people, such as short films and easy read materials. One of the films, which explains the vaccine, has been watched over 26,000 times.

The advisory group has also explored barriers to using NHS 111, including the NHS 111 First initiative, faced by people with a learning disability and autistic people. In addition, they have supported the new Autism Team to develop their work around diagnosis.

Another key achievement of the advisory group has been the change to the name and scope of the 'Learning from Lives and Deaths – people with a learning disability and autistic people (LeDeR) policy'. The policy, which previously looked at the deaths and lives of people with a learning disability only, now also includes autistic people.

Appendix 5: Sustainability

The past year has highlighted a range of opportunities to improve our sustainability performance. Most employees have been working remotely, leading to a 90% reduction in business travel emissions. Some business travel has remained necessary for employees supporting the response to the COVID-19 pandemic. A small number of essential office-based workers have continued to work from our offices. As the majority of our sites are multi-occupancy buildings, these may have remained open for other tenants, but overall we have seen significant reductions in energy use, water use and waste.

This year we developed our Interim Green Plan, which outlines our initial steps to achieve net zero while recognising that the lessons learnt from the last 12 months provide an opportunity to accelerate our progress. In preparation for this, and ahead of the publication of our full Green Plan, we have completed a number of actions over the course of this year. These include working with our primary landlord, NHS Property Services (NHS PS), to conduct and review energy audits across our corporate estate, ensuring all staff are equipped to work effectively remotely and placing sustainability at the heart of our plans for future ways of working ‘Working Together’.

Sustainability report

Scope

The reporting of greenhouse gas emissions in this sustainability report covers TDA only. The TDA corporate estate consists of multi-occupancy buildings. Where we share space with NHS England or are a tenant of a government department or other ALB, energy, waste and water information will be reported within their annual reports and published on their respective websites to avoid double counting.

Greenhouse gas emissions

Scope 1 emissions

		2018/19	2019/20	2020/21
Non-financial indicators (tCO_2e)	Emissions from organisation-owned fleet vehicles	-	-	2
Total scope 1[132,133]		**-**	**-**	**2**
Financial indicators	Expenditure on scope 1 business travel	-	-	£3,330

Scope 3 emissions

		2018/19	2019/20	2020/21
Non-financial indicators (tCO_2e)	Road travel (tCO_2e)	373	375	55
	Rail travel (tCO_2e)	326	221	7
	Air travel (domestic only)	12	14	1
Total scope 3[134] (tCO_2e)		**711**	**609**	**63**
Total (tCO_2e)		**711**	**609**	**65**

ICT waste

We maintain the use of ICT equipment for as long as possible. When items become obsolete, we work in partnership with other organisations to responsibly and sustainably process our ICT waste. This may be through approved authorised treatment facilities, following Waste Electrical and Electronic Equipment (WEEE) Regulations or using corporate recycling schemes. All partner organisations operate a zero waste to landfill policy.

[132] Scope 1 emissions arise from organisation owned and operated vehicles, plant and machinery
[133] Business travel undertaken in a salary sacrifice lease vehicle was reported within Scope 3 emissions in previous years.
[134] Scope 3 emissions arise from official business travel by vehicles not owned by the organisation

Sustainable procurement

With the publication of the NHS Net Zero Report, the NHS affirmed the need to take action on climate change and set ambitious reduction targets, including a commitment that before the end of the decade, the NHS will no longer purchase from suppliers that do not meet or exceed our commitment to net zero.

Our commitments to deliver a net zero health service go beyond carbon reduction. It is imperative that alongside our environmental efforts, we make every effort to stamp out modern slavery throughout our supply chain. We also have a duty to use the money spent through the NHS to generate more social value for the communities that we serve, reducing health inequalities and improving the wider determinants of health.

Within TDA, we have integrated metrics that measure these benefits and include them as part of our procurement evaluations. We are aligned with central government's procurement policy note on social value, mandating that a minimum weighting of 10% of the total score for social value should be applied in central government procurements, and have adopted this into the NHS England and NHS Improvement Procurement Strategy. Procurements carried out by TDA have trialled the approach throughout 2020/21 and from April 2021 all procurements carried out by TDA must include a minimum weighting of 10% on social value.

Our sustainable procurement programme continues to grow, and TDA is committed to leading by example across the wider health system.

Supporting sustainability across the NHS

Alongside making an ambitious and world-leading commitment to deliver a national net zero health service, the NHS response to the climate crisis across this recent financial year has also been informed by the COVID-19 pandemic. The NHS has demonstrated an impressive capacity to adapt and endure in an emergency, and some elements of the COVID-19 response have also supported the response to climate change. The Outpatient Transformation Programme has granted patients greater control and convenience in relation to their NHS hospital or clinic appointments, by offering telephone or video consultations. This means less time travelling to hospital appointments, reducing both the NHS's carbon footprint and air pollution. Other activities, such as efforts to procure and ensure appropriate access to PPE, may have increased the NHS carbon footprint. There are ongoing activities to create more sustainable PPE, including a pilot to increase the use of reusable gowns. Other key activities from 2020/21 include:

- the establishment of the NHS Sustainability Board, which convenes leaders from priority areas to monitor and drive delivery of the decarbonisation of the NHS, and reports into the NHS public board on a bi-annual basis
- the development of a data and metrics framework. This will support regular reporting against carbon trajectories at an increased level of fidelity, disaggregated by region and by system, to support monitoring and accountability

- the £50 million NHS Energy Efficiency Fund has been used to upgrade lighting across the NHS estate. This will save the NHS £14.3 million and 34 thousand tonnes of CO_2 emissions per year
- commitments to appoint cycle-to-work leads in every hospital, to ensure that staff have the option to participate in active methods of travel, and for hospitals to shift to purchasing all electricity from renewable sources.

NHS England and NHS Improvement are also currently preparing the Health and Social Care Adaptation Report, in collaboration with PHE.

The Greener NHS national programme

In response to the UK Climate Change Act (2008), the Sustainable Development Unit (SDU) was formed to better understand the links between health, healthcare and climate change.

It developed and published the first carbon footprint of a healthcare system and responded to a range of issues from climate change and health adaptation, to air pollution and plastic waste reduction. In 2020, the NHS's first Chief Sustainability Officer was appointed, and the SDU transformed into the Greener NHS programme, expanding to support the ambition to deliver the world's first net zero national health service. This ambition is important for three reasons:

- climate change threatens the health of the public and impacts on the NHS's ability to deliver high quality care
- the response to climate change results in unprecedented health benefits, through cleaner air, healthier diets and more liveable communities
- there is strong support from the system's 1.3 million staff, who know that in the future, a world-leading healthcare system will be a sustainable healthcare system.

The case, the targets and a strategy for achieving them were laid out in Delivering a Net Zero National Health Service.[135] This report builds on over a decade of work from staff and clinicians across the system and draws on advice from a Net Zero Expert Panel and the Lancet Countdown.

The Greener NHS team is currently developing refreshed green plan guidance and building capacity, at national and regional level, to deliver the interventions identified in Delivering a Net Zero National Health Service. Short delivery focused reports addressing specific work areas are planned for publication in 2021. Delivery against this guidance, and the outlined carbon trajectories set out in Delivering a Net Zero National Health Service, will be assured by the NHS Sustainability Board.

In 2021/22, the NHS will launch the National Chief Sustainability Officer's Clinical Fellow Scheme, to support the design of patient focused low carbon models of care, protecting the health of patients and the public, now and in the future.

[135] https://www.england.nhs.uk/greenernhs/wp-content/uploads/sites/51/2020/10/delivering-a-net-zero-national-health-service.pdf

Appendix 6: Acronyms

A

A&E Accident and Emergency
AAA abdominal aortic aneurysm
AAC Accelerated Access Collaborative
ACRA Advisory Committee of Resource Allocations
AHC annual health check
A&G Advice and Guidance
AI artificial intelligence
ALB arm's length body
AME annually managed expenditure
ANNB NHS Antenatal and Newborn screening programmes
ARAC Audit and Risk Assurance Committee
ARP Ambulance Response Programme
AVC additional voluntary contribution

B

BAME Black, Asian and Minority Ethnic
BAU business as usual

C

CAN Cyber Associates Network
CCG clinical commissioning group
CDF Cancer Drugs Fund
CEO chief executive officer
C(E)TR care (education) and treatment review
CETV Cash Equivalent Transfer Value
CIO chief information0Officer
CMD Commercial Medicines Directorate
CMU Commercial Medicines Unit
COO chief operating officer
CPAG Clinical Priorities Advisory Group
CQC Care Quality Commission
CSAS Cervical Screening Administration Service
CSOC Cyber Security Operations Centre
CSOPS Civil Servant and Other Pension Scheme
CSU commissioning support unit
CUES COVID-19 urgent eye care service

D

DAWN Disability and Wellbeing Network
DHSC Department of Health and Social Care
DNACPR do not attempt cardiopulmonary resuscitation
DSP Data Security and Protection
DSPT Data Security and Protection Toolkit

E

EDI equality, diversity and inclusion
EHRC Equality and Human Rights Commission
EIP Early Intervention in Psychosis
EPRR Emergency Preparedness, Resilience and Response
EQG Executive Quality Group
EQIA equality impact assessment
ESM executive senior manager

F

FIT faecal immunochemical test
FOI Freedom of Information
FREED First Episode Rapid Early Intervention for Eating Disorders
FReM Financial Reporting Manual
FTE full-time equivalent

G

GAM Group Accounting Manual
GDPR General Data Protection Regulation
GEO Government Equalities Office
GIRFT Getting It Right First Time
GRT Gypsy, Roma and Traveller

H

HEE Health Education England

I

IAPT Improving Access to Psychological Therapies
ICO Information Commissioner's Office
ICS integrated care system
IFRS International Financial Reporting Standard
IG information governance
IMD Indices of Multiple Deprivation
ISFE Integrated Single Financial Environment

J

JCRR Joint Corporate Risk Register
JCVI Joint Committee on Vaccination and Immunisation

JWP Joint Working Programme

K

KPI key performance indicator

L

LeDeR Learning Disability Mortality Review
LGBT+ lesbian, gay, bisexual, transgender +
LSOA Local Super Output Authority

M

MHSDS Mental Health Services Data Set
MSK musculoskeletal

N

NAO National Audit Office
NCSC National Cyber Security Centre
NEET not in employment, education or training
NEMS National Events Management Service
NHIIP National Health Inequalities Improvement Programme
NHS BSA NHS Business Services Authority
NHSCFA NHS Counter Fraud Authority
NHS IMAS NHS Interim Management and Support
NHS PS NHS Property Services
NHS SBS NHS Shared Business Services
NHSVR NHS Volunteer Responders
NICE National Institute for Health and Care Excellence
NIHR National Institute for Health Research
NIMS National Immunisation Management Service
NIS Network and Information Systems
NSDR National Supply Disruption Response

P

PCN primary care network
PCSE Primary Care Support England
PCSPS Principal Civil Service Pension Scheme
PHE Public Health England
PHSO Parliamentary and Health Service Ombudsman
PPE personal protective equipment
PPV Patient and Public Voice
PRP performance related pay
PSED Public Sector Equality Duty
PSF Provider Sustainability Fund

Q

QI quality improvement
QOF Quality and Outcomes Framework

R

RAAC reinforced autoclaved aerated concrete
RDEL Revenue Department Expenditure Limit

S

SCCL Supply Chain Coordination Limited
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
SDU Sustainable Development Unit
SFI Standing Financial Instructions
SMA spinal muscular atrophy
SMI severe mental illness
SRO senior responsible officer
STP sustainability and transformation partnership

T

TCB transforming commissioning board

U

UISPC Unified Information Standard for Protected Characteristics
UTC urgent treatment centre

V

VCSE voluntary, community and social enterprise

W

WDES Workforce Disability Equality Standard
WEEE Waste Electrical and Electronic Equipment
WGA whole of government accounts
WRES Workforce Race Equality Standard

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