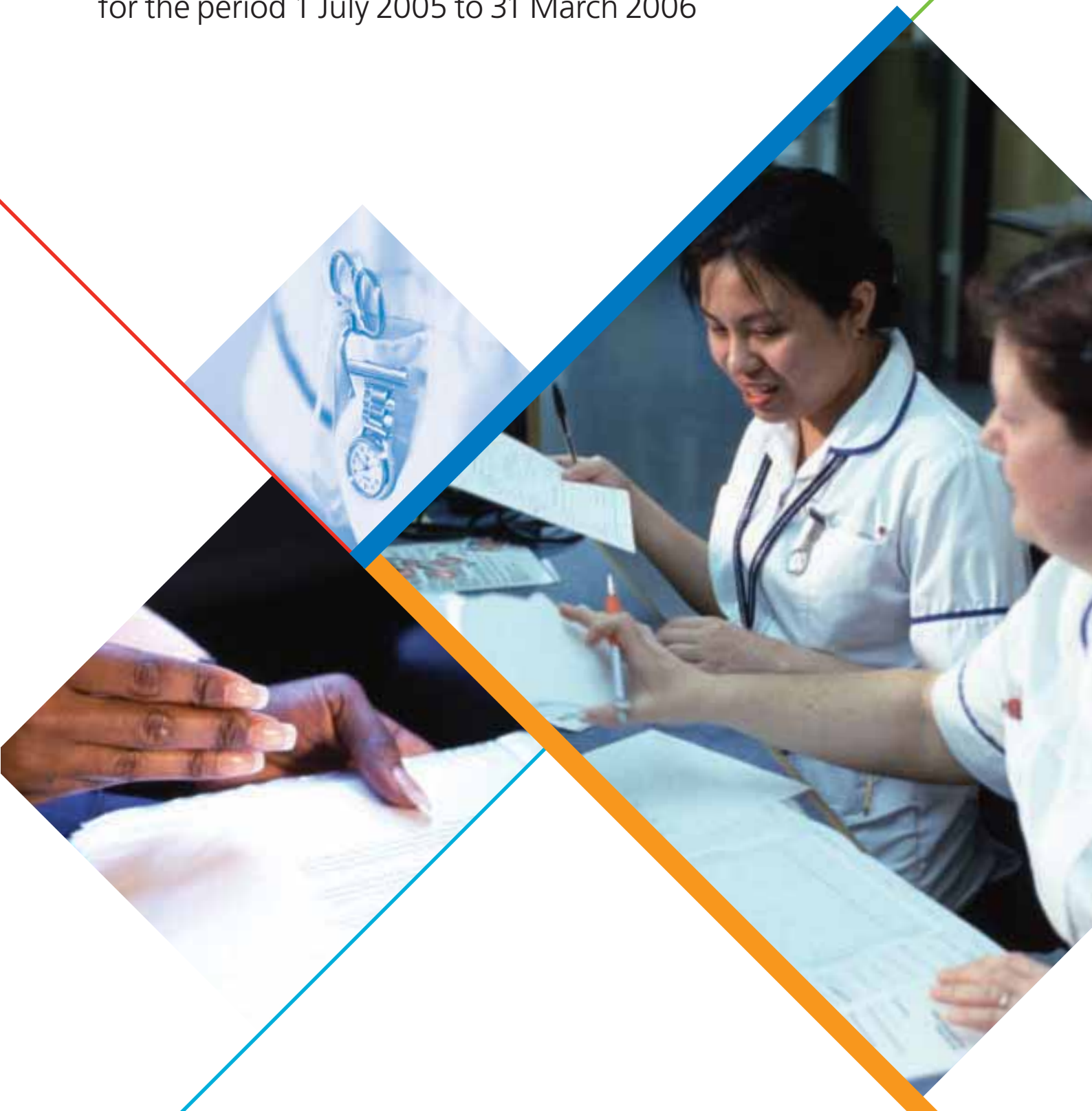
NHS
Institute for Innovation and Improvement

Annual Report and Accounts

for the period 1 July 2005 to 31 March 2006



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for the period 1 July 2005 to 31 March 2006

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Welcome from the Chair of the Board

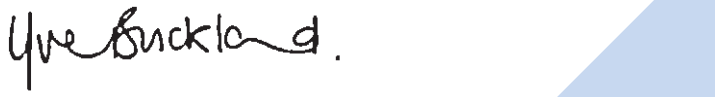
As the Chair of a new organisation, less than one year old at the time of writing this report, I am reminded of just how far we have come in such a short space of time. This progress is thanks to the hard work of Bernard Crump, our Chief Executive Officer, and his team. They have worked hard to get the NHS Institute for Innovation and Improvement ('the NHS Institute') up and running while delivering some key products in the first eight months, and also developing our first full-year plan and three-year strategy.

Our aim at the NHS Institute is to enhance the NHS through accelerating uptake of innovation technology and service improvement. On behalf of the Board, I would like to acknowledge that this has been made possible thanks to the co-operation of colleagues from across the NHS, other health agencies and non-NHS partners. We are fully committed to working alongside the NHS to support those delivering care at the front line. I believe that this has been demonstrated by our early achievements, and these signal an even stronger focus for the coming year.

As well as having been a time of development and growth for the NHS Institute, I recognise that the last few months have also been a time of concern for many in the NHS – particularly for those working on the transition to a 'patient-led NHS'. I would particularly like to acknowledge those people from within the NHS who have worked closely with us in the co-production of our early outputs.

I should thank the NHS Institute Board as well as the Sounding Board members for their wisdom and guidance on the development of our strategy. And I would also like to acknowledge the very positive relationship we have developed with our sponsor team at the Department of Health, with whom we have worked closely to get the NHS Institute operating effectively.

I believe that we have a promising future ahead of us. Although the NHS Institute is still only an infant in NHS organisation terms, we have already developed a thriving and energetic team which will have a very positive impact on healthcare improvement and innovation in the future. I invite you to read about our growth in this report and to share in our success in establishing the NHS Institute.



Dame Yve Buckland, Chair of the Board

"Our aim at the NHS Institute is to enhance the NHS through accelerating uptake of innovation technology and service improvement."

Foreword from the Chief Executive Officer

Welcome to the NHS Institute for Innovation and Improvement's first annual report.

The NHS Institute exists to improve patient care by supporting the NHS to adopt new ways of working.

We do this by supporting learning about improvement and innovation; by developing leaders who can lead service improvement; by learning about the best ways of delivering services worldwide; and by finding the ways to help people adopt these practices in the context of the NHS. We help trace the journey from an exciting new idea to a fully deployed use of that idea within the service and devise ways actively to overcome the obstacles which often prevent new ideas from being adopted.

We've made a great start on all of these during our first nine months since 1 July 2005.

First, we've recruited a great team – we will always save posts on our team for people who come from the relevant parts of the NHS. Second, we've established a new base at the University of Warwick, which is ideal for our purpose. Third, we've adopted a way of working designed to help our products have the maximum impact.

And we've set about forming the right relationships. Those relationships are with NHS organisations and their leaders, including the new Strategic Health Authorities as they establish themselves, with the Department of Health, with other national organisations tasked with helping the NHS, with educators, with the healthcare industry, and with those leading improvement in other health services around the world.

We know we have more to do to ensure people know how we can be of help to them, and we will be redoubling our efforts to listen to the service as it completes its reorganisation over the next few months. As part of this, we are setting up a practice partner network to shape our relationships with the people in the NHS and other organisations who help us with our work by giving sessions of their time and by sharing their practical and academic knowledge.

We are a small organisation. To make an impact, we need to focus. We have six current priorities; in the next year, one or two of these will be replaced and we need to hear what you would want us to focus on next. The report says more about each of our priorities.

You can hear more about our work through our regular newsletter. Please subscribe via our website at www.institute.nhs.uk. And please keep telling us what you think we should be doing – we are listening.

Bernard Crump, Chief Executive Officer

Operating and financial review

Overview

The NHS Institute came into being on 1 July 2005 under The NHS Institute for Innovation and Improvement (Establishment and Constitution) Order 2005, which was laid before Parliament on 3 June 2005. It is established as a special health authority under the National Health Service Act 1977 and is an arm's-length body sponsored by the Department of Health.

In *NHS Institute for Innovation and Improvement – Directions 2005* the Secretary of State set out the functions which the NHS Institute was to undertake. *NHS Institute for Innovation and Improvement – Regulations 2005* dealt with the membership and procedures of the organisation.

The NHS Institute's role is 'to support the NHS and its workforce in accelerating the delivery of world-class health and healthcare for patients and the public by encouraging innovation and developing capability at the front line' (NHS Institute framework document).

The NHS Institute has drawn on the work of the NHS Modernisation Agency, the NHS Leadership Centre and the NHS University, and the recently established National Innovation Centre. It is based at the University of Warwick:

NHS Institute for Innovation and Improvement
Coventry House
University of Warwick Campus
University Road
Coventry CV4 7AL

" to support the NHS and its workforce in accelerating the delivery of world-class health and healthcare for patients and the public by encouraging innovation and developing capability at the front line"

Governance structure

The Board of the NHS Institute is the body responsible for making the organisation's key decisions. It is made up of a Chair and a combination of Executive Directors and Non-Officer Members appointed by the Secretary of State. The Chief Executive Officer is appointed by the Chair and the Non-Officer Members; together they appoint the members who are officers of the NHS Institute.

The Board's current composition is as follows:

Dame Yve Buckland
Chair

Professor Dame Carol Black
Non-Executive Director

David Bower
Non-Executive Director

Professor Tony Butterworth CBE
Non-Executive Director

Michael Collier CBE
Non-Executive Director

Mike Deegan CBE
Non-Executive Director

Dennis Sherwood
Non-Executive Director

Professor Bernard Crump
Chief Executive Officer

Paul Allen
Executive Director
(Director of Leadership Development)

Professor Helen Bevan OBE
Executive Director
(Director of Service Transformation)

Michael Cawley
Executive Director
(Director of Finance
and Business Services)

Simone Jordan
Executive Director
(Director of Learning
and Deputy Chief Executive)

Dr Maire Smith
Executive Director
(Director of Technology
and Product Innovation)

A number of committees support the NHS Institute Board. These include:

- The Audit and Risk Management Committee, responsible to the Board for developing and overseeing effective arrangements for all aspects of internal control and financial reporting within the Institute. As part of this remit it is also responsible for maintaining an appropriate relationship with external and internal auditors. As such, the Committee is the principal body, below the Board, for carrying out scrutiny of policy and processes within the Institute. It is this remit which distinguishes the work of the Audit Committee from the other groups advising the Board. Members are: Mike Collier (Chair); Dame Yve Buckland; Professor Dame Carol Black; David Bower; Professor Tony Butterworth CBE; Mike Deegan CBE; and Dennis Sherwood.
- The Remuneration and Terms of Service Committee, details of which are contained within the Remuneration Report on pages 20–27.

Principal activities of the NHS Institute

The NHS Institute for Innovation and Improvement has been established to support the transformation of the NHS. This transformation is described in *The NHS Plan*, published by the Government in 2000, with the fundamental challenge being for the NHS to raise its game through innovation and improvement and by adopting best practice. This will accelerate the delivery of world-class healthcare for patients and the public.

The functions of the NHS Institute are:

- to identify leading-edge thinking and best practice, working closely with clinicians, academia and industry – both in the UK and around the world;
- to develop the capability of the NHS for service transformation, technology and product innovation, and leadership development and learning;
- to apply leading-edge thinking and practice to developing high-impact solutions to agreed priority programmes;
- to make a range of expert support materials readily available on a timely basis. These should help individuals, teams and organisations to adopt innovations in their day-to-day work. They should focus on how to achieve and exceed the ambitious objectives for improving health and healthcare in each local health community;
- to support the rapid adoption and spread of new ideas by providing tools to facilitate their safe local implementation, as well as guidance on practical change;
- to promote a culture of lifelong learning for all NHS staff;
- to foster a culture of continuous, practical innovation in the NHS by stimulating and empowering staff to adopt best practice and new ideas rapidly, as part of their everyday activity;
- to promote and support the rapid development, dissemination and commercialisation of the best innovations from the NHS, academia and the global healthcare industry (with great importance for the role of the National Innovation Centre and associated hubs, as described in the Healthcare Industries Task Force report);
- to facilitate the sharing of knowledge by linking leading-edge expertise – wherever it lies – with frontline skills and experience;
- to develop and maintain links with other public sector organisations, industry, academia, healthcare systems and research communities worldwide.

Our products

The NHS Institute creates NHS-specific, high-impact products. We aim to take breakthrough innovations, ideas and improvements that are proved to deliver a significant positive impact on patient care and to turn them into 'packages' that will ultimately raise awareness, ease implementation and accelerate adoption.

Working with and engaging stakeholders

In identifying and developing ideas to improve NHS performance, and in the creation of products, we actively involve frontline organisations and practitioners as well as other stakeholders and partner organisations. We encourage them both to support development and to demonstrate their buy-in and engagement. Practitioners make use of our products themselves, motivated by the evidence base we accumulate during product development and testing. Working with academia already gives us a broad perspective on the latest knowledge and thinking, and as we develop our products further we will engage and communicate with an expanding range of individuals and groups. Our commitment to working with the NHS, not outside it, will benefit everyone our work touches.

"The NHS Institute creates NHS-specific, high-impact products."

Measuring our impact

Over the past year we have developed a scorecard to measure both 'hard' and 'soft' metrics and to monitor the outcomes and benefits, impact, adoption and spread of each of our priority programmes and associated products. The scorecard information will be consolidated to enable monitoring and tracking against our objectives and business plan. It will be fully operational by 2006/07, providing us with detailed information about our successes in each priority area.

Our mission

Our mission is to improve health outcomes and raise the quality of delivery in the NHS by accelerating the uptake of proven innovation and improvements in healthcare delivery models and processes, in medical products and devices, and in healthcare leadership.

This mission will be achieved by deploying innovation and improvement that has a direct impact on:

- improving healthcare outcomes across the NHS
- improving the operating performance of the NHS, both in quality and cost
- building capability and change capacity in the NHS.

"All NHS Institute activities are driven by one goal: to improve a specific aspect of the NHS that is deemed to be valuable or relevant."

Our priority programmes

All NHS Institute activities are driven by one goal: to improve a specific aspect of the NHS that is deemed to be valuable or relevant. The benefits to be achieved were set out at the organisation's establishment, and a number of priority programmes commenced during our first nine months. The first three of these will have been completed by September 2006, while the remaining six continue to be a focus for the NHS Institute. An update for each area follows.

No Delays – achieving the 18-week target

The Department of Health has commissioned the NHS Institute's No Delays Priority Programme Team to develop products to help NHS organisations to ensure that, by 2008, patients are waiting no longer than 18 weeks between referral and treatment.

The team is working on the development of a web-based tool to enable trusts to analyse their data, to reveal the variation in their systems, to identify areas that need to be addressed in order to improve flow, and to allow trusts to prioritise resources.

Evidence from a range of programmes – including the Cancer Services Collaborative and the Improvement Partnership for Hospitals – has identified that many NHS organisations have neither the capacity nor the capability to analyse their own data and turn it into useful information for service improvement. The No Delays priority programme is proposing to solve this

problem by providing effective analysis of the data from trusts at the touch of a button. The programme will use an integrated web-based improvement tool to produce essential statistical process control charts, histograms and scatter plots. This information will then be linked to potential courses of action.

The first version of the web-based tool is known as the Patient Journey Analyser (PJA). Its components will help operational managers at the front line of services to identify the main bottlenecks in local patient pathways using currently collected national data (Hospital Episode Statistics data).

The second version of the tool (whose name remains to be confirmed) will provide:

- a series of prompts and searching questions about the potential causes of delays. (Performance management systems currently ask for progress and reasons for delays.) These informed questions will take the form of a root cause analysis – thus enabling organisations to identify steps to take to reduce delays
- easy access to a comprehensive range of tools and resources that will support improvement and change management, enabling trusts to find solutions to delays.

Delivery will take place in two phases: the first, to be completed by summer 2006, will be the analytical part, identifying the 18-week bottlenecks; the second phase, to be completed by autumn 2006, will build upon the first, incorporating further measures to tackle delays.

Long-term conditions

The Long-term conditions team's programme of activity is focused on developing high-impact solutions designed to accelerate the shift in services identified within the Department of Health's recent White Paper *Our health, our care, our say: a new direction for community services* (2006). This work is expected to continue for a significant period of time. Meanwhile, work has also begun to develop guidance from best practice to support community-based services that are responsive, effective and productive and that offer the best value for money. Analysis of high-level findings and case studies is helping to identify where primary care can improve its services. The team has been involved in a large number of observational visits to capture this learning.

A set of 'high impact changes' for primary care has been developed in partnership with the National Primary Care Development Team. Currently in draft form, the end product will support improvement across primary care and will be completed during summer 2006.

Delivering quality and value

The aim of the Delivering quality and value priority programme is to get all trusts functioning at the same level of quality and resource utilisation for the delivery of care as top-performing organisations in the UK and abroad. This will be judged by a range of quality and efficiency measures, including length of stay, admission or intervention rates, patient experience, clinical outcomes, mode of care, techniques, location of care, diagnostic protocols, staff skill levels and the use of clinical supplies.

It is essential for the programme to:

- be clinically led
- engage with a wide range of clinical and managerial professionals
- be co-produced with the NHS
- be integrated with other NHS initiatives.

The aim of Delivering Quality and Value is a paradigm shift in clinical efficiency and effectiveness, resulting in local health systems being able to provide efficient, clinically-effective and cost-effective healthcare for patients. The key deliverables we are hoping to achieve are:

- to create and widely distribute an introductory guide to the high-performing characteristics of care processes for five patient groups. These will be high-volume groups with high variability in resource utilisation and great potential for improvement;
- to deliver a more comprehensive and detailed range of advice to enable high performance for up to nine patient groups, representing a significant proportion of the NHS patient population;
- to develop a replicable methodology for defining high-performance characteristics that can be applied to other groups and pathways.

In the short term, we offered guidance to the NHS to inform the Integrated Service Improvement Planning (ISIP) process in local health communities for 2006/07 onwards. This included identifying the high-volume clinical treatments and processes that are highly variable in terms of resource utilisation and that boast the highest potential for improvement. We also:

- signposted the high-impact improvements to be made to these clinical treatments and processes;
- provided estimates of the potential savings to be made.

The areas we focused on for this initial work were:

- acute strokes;
- fractured neck or femur;
- primary hip and knee replacements;
- Caesarean sections;
- short-stay emergency care.

We are now focusing on identifying, testing and promoting a more comprehensive and detailed range of specific or system improvements across the entire patient pathway – from primary care through referral and treatment to discharge and rehabilitation – for the following Healthcare Resource Groups (HRGs) or similar groupings:

- cholecystectomies;
- urinary tract infections (as a tracker for complex elderly problems);
- acute admissions in mental health;
- fractured neck or femur;
- primary hip and knee replacements;
- acute strokes;
- Caesarean sections;
- short-stay emergency care (two days or less).

This work will be completed in time for widespread adoption by the NHS from autumn 2006 – as part of the implementation of ISIP plans for 2006/07 onwards.

The final aim of the programme will be to produce pathway guidance in a form that allows it to be applied to further pathways or other care groupings by others in the wider NHS.

Addressing healthcare-associated infections (HCAIs)

The impact of HCAIs is far-reaching, and the team has been working on specific activities to support the Department of Health's 'Saving Lives' programme, which aims to halve MRSA rates by 2008. A significant amount of this work has been done with other healthcare agencies.

Completed outputs include:

- adaptation of the 'Saving Lives' toolkit for primary and social care and mental health organisations
- the development of a tool which adapts the principles of root cause for infection control in partnership with National Patient Safety Agency
- production of a strategy for helping healthcare professionals in primary and secondary care to increase the take-up of infection control measures
- the development of tools to increase public confidence in hospital cleanliness
- the recommendation for a national development programme for infection control teams
- the start of work to develop a framework for a whole-system approach to HCAI
- delivery of a joint report with the NHS Purchasing and Supply Agency (PASA) to the Department of Health, recommending ways of getting innovations and new products to the frontline faster.

This programme will be completed during the summer of 2006.

"The aim of Delivering Quality and Value is a paradigm shift in clinical efficiency and effectiveness..."

Building capacity and capability in innovation and improvement

Service transformation

The Service Transformation Team aims to help the NHS at every level to be more confident, ambitious and radical in its approach to change, so that patient experiences and outcomes are significantly improved, and NHS organisations and staff are adaptable and prepared for change. The team's goals are:

- to encourage transformational change, equipping the NHS with best practice models, frameworks, tools and techniques
- to build specific NHS capabilities
- to help accelerate NHS improvement
- to ensure world-class delivery within the NHS Institute, using the work process methodology.

Over the coming months, the team will be working on nine priorities to help the NHS achieve service transformation:

- global best practice in innovation and improvement
- vision to delivery accelerator
- National Centre for Clinical Systems Improvement (CSI)
- CSI knowledge products (including Lean Thinking)
- models for transformational change
- experience-based design
- design rules
- products to support and accelerate change after system reform
- work process methodology.

Learning

The learning team aims to take lessons from world-class best practice in innovation and improvement in order to build capability across the NHS. The key areas of work for the team have been:

- raising the awareness of current NHS staff of innovation and improvement
- promoting the development and testing of improvement in pre-registration education for the NHS staff of the future
- providing products and tools to encourage and support innovation and improvement in the NHS
- enabling and supporting the sharing of improvement knowledge across the NHS.

The team is currently working on a number of products to be rolled out during 2006 and early 2007. Among these are modules for innovation and improvement. Prototypes will be tested by three universities by January 2007, and an evaluation report will be circulated to appropriate higher education and NHS organisations by May 2007.

Leadership

The leadership centre within the NHS Institute focuses on building capacity and capability for leadership across the NHS. In 2005/06 key strategies included the following.

Graduate Management Schemes for general management, human resources and finance trainees. These have recently undergone a strategic review as the NHS continues to reform and change; they are world-class, leading-edge and relevant to the needs of the healthcare system. The General Management Training Scheme (GMTS) and Human Resources Management Training Scheme (HRMTS) both won a 'Graduate Employer of Choice' award in the recent *Times* Graduate Recruitment Awards 2006. These training schemes have also been ranked sixth in a poll by *The Times* of the top 100 graduate employers, competing with large multinational organisations such as PriceWaterhouseCoopers, Deloitte and KPMG.

The **Breaking Through programme,** for leaders from black and minority ethnic backgrounds, providing accelerated development opportunities and mentoring support to facilitate entry to higher levels of NHS management. More than 80 people who took part in the training have so far either achieved promotion or have been offered secondments that will widen their experience and act as a gateway to future career progression. Participants have been given the confidence and skills to progress in their careers, to seek appropriate development opportunities, and to understand what is needed in order to move into more senior positions within the NHS.

The **Gateway to Leadership** programme, which recruits leaders from outside the NHS into management positions within the organisation via a structured induction programme. So far there have been 143 participants in four cohorts in a variety of roles across England and Wales. Many of them have enjoyed great success since joining the scheme and are already making changes and having a positive impact on the NHS. Of the 143 participants, there are already three chief executives or assistant chief executives, 37 directors or assistant directors and 10 general managers. The overall retention rate across all four cohorts is 82%. Thirty-six participants were successfully recruited and placed in the fourth cohort in autumn 2005 – two of them in Wales. Another 11 recruits requested a deferral and will be placed in NHS organisations later this year; work is currently underway to identify suitable roles for them.

" The learning team aims to take lessons from world-class best practice in innovation and improvement..."

A full and varied programme of development opportunities for chief executives and directors

- In 2005/06 some 30 programmes were attended by around 500 executives, and the needs for 2006/07 are currently under review. We are determined to ensure that we continue to provide senior leaders with high quality, relevant and challenging development opportunities, which enhance both individual and organisational effectiveness.
- We are gathering evidence about the success of the Leadership Qualities Framework (LQF) across the NHS, and will be reviewing it in the light of current and emerging needs. The LQF defines the capabilities and qualities of successful leaders that underpin all of our programmes.
- We are currently piloting and will be rolling out a diagnostic tool for Chairs and Boards which will enable them to review their performance against a range of role indicators – as a basis for development planning. Provision has been made for the tool to be made available online.
- We are publishing and distributing an evidence-based best practice guide for change management, to support NHS organisations during times of change and transition.
- We will be providing one-to-one coaching support for newly appointed executives via a national coaching register. We will also be rigorously assessing current and prospective coaches, to ensure that we are able to offer NHS executives the very highest standards of expertise available.

Enhancing medical engagement in leadership

This initiative has been established in response to the need to ensure that doctors acquire management and leadership skills at key stages in their training and careers. A systematic and coherent approach was required, and this initiative is part of a wider strategy for creating a culture within the health system in which doctors are more engaged in the planning, delivery and transformation of services. It is thought that this will support health improvements and efficiency gains.

The NHS Institute is facilitating a project to define the key medical leadership and management competencies, and the education framework required to deliver them. A scoping study has been undertaken to assess the current extent of medical management and leadership development provision. It has involved key stakeholders from medical schools, Royal Colleges, post-graduate and dental deaneries and the Health Foundation, as well as other national and international bodies. A steering group has been established to move the project forward; it includes representatives from a number of medical, professional and regulatory bodies, as well as other key stakeholders.

The National Innovation Centre (NIC)

The idea for a national centre for innovation was first conceived following the 2003 Wanless report, *Securing Good Health for the Whole Population*, in which the NHS was identified as 'a slow adopter of technology'. A Government report on innovation later that year recognised the potential for innovation in the NHS and the contribution this could make to UK productivity. It recommended the establishment of a national centre that would work in collaboration with local innovation networks both within and outside the health service. This plan was developed further in the 2004 Health Industry Task Force report *Better Health through Partnership: a programme for action*. It emphasised a major need to accelerate the uptake of new technology to improve the outcome for patients and to position the UK as a healthcare technology research destination of choice.

In its first nine months the National Innovation Centre (NIC) has put in place a number of mechanisms to form partnerships between the healthcare industry, academia and the NHS, with the aim of co-developing technologies that are based on clear needs and that have the potential to yield significant results.

The NIC website will be available in September 2006. It will provide a major entry point for both companies, particularly small and medium-sized enterprises, and research-based innovators of healthcare technology. Innovators will be able to map out the steps involved in bringing a potential product to market. They will have access to an information library of 'how-to' guides, real-life case studies and sources of further information, centres of excellence and NHS bodies involved in the innovation pathway.

Through a disciplined assessment process, the NIC will also consider carefully the potential application of each technological innovation proposal it receives. The NIC will then either offer direction and advice or will take the application forward for further evaluation.

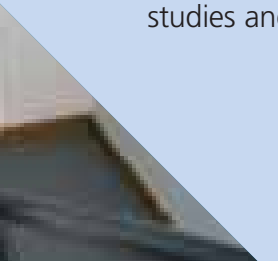
The NIC will work closely with the nine regional Innovation Hubs who will be the major conduit for delivering its aims. The NIC will also work alongside the many organisations, both within and outside the NHS, that are focused on technology development in the UK.

The NIC has established two new hubs:

- The Training Hub opened in March 2006 at the Chelsea and Westminster Hospital under the Chairmanship of Sir Ara Darzi. The Training Hub will identify and develop advanced training tools for new technological innovations.
- The second hub, the Adoption Hub, is being developed in Manchester. The Adoption Hub will test selected existing technologies in a real-life environment and, through that process, identify the factors that will assist the NHS in taking up new technologies.

Both the Training Hub and the Adoption Hub will share the NIC's aim of accelerating the adoption of new technologies in the NHS.

By supporting this closer co-operation between academia, the NHS and healthcare companies, the NIC will help bring about the significant benefits for patient health that are at the heart of its activities.



Management commentary

The NHS Institute has met all of its key statutory financial targets for 2005/06. This is a considerable achievement for a newly constituted special health authority – particularly at a time when NHS organisations have all been finding it increasingly challenging to maintain financial stability.

The first nine months have been focused on establishing the NHS Institute financial controls and assurance processes. This has involved engaging our contracted-out service providers – the NHS Shared Business Services and the Business Services Authority. The NHS Institute is continuing to work with these providers to resolve the issues identified through process review and redesign, to ensure that it deploys best practice in all aspects of finance.

The first key statutory financial target included maintaining revenue expenditure within an agreed limit of £61,912,000. The NHS Institute achieved this target, finishing the year with an underspend of £19.5 million in 2005/06. Of this, £8.5 million will be treated as year end flexibility and returned to the NHS Institute in 2006/07.

The second key statutory financial target was to maintain capital within the agreed limit of £2,480,000. The NHS Institute has achieved this target in 2005/06.

The final key statutory financial target was to maintain net cash outgoings within a limit of £61,912,000. The NHS Institute achieved this, avoiding drawing down approximately £24 million in cash during 2005/06. There will be an in-year adjustment in 2006/07 to make the necessary cash available to meet the needs of the organisation.

In addition to meeting its key statutory targets, the NHS Institute is expected to undertake its business in accordance with the Confederation of British Industry's Better Payment Practice Code. In this respect, the NHS Institute did not meet its target of 95%. It paid 83% (by value) and 71% (by number) of its non-NHS trade creditors within 30 days of goods or valid invoice (whichever was the later). And it paid 94% (by value) and 36% (by number) of its NHS trade creditors within 30 days of goods or valid invoice (whichever was the later).

Much has been achieved, but there remains a great deal more to do. The NHS Institute's focus on improving the operating performance of the NHS – in both quality and cost terms – will continue.

The full annual accounts are attached at the end of this document. Specifically:

- Details of material post-balance sheet events are listed at note 19 on page 57.
- General pension liabilities are listed under 'Accounting policies' on page 41, and pension liabilities for senior managers are included on page 26, as part of the Remuneration Report.
- The NHS Institute is audited by the National Audit Office. Auditors' remuneration for both audit and non-audit tasks is included under 'programme costs' on page 48.

Board members' Declarations of Interest

The NHS Code of Accountability requires Board members to declare any interests that are relevant and material to the NHS body of which they are a member. Any members appointed subsequently make this declaration upon their appointment.

At its first meeting, on 12 July 2005, the NHS Institute approved Standing Orders and the Board Members' Code of Conduct. These incorporate the NHS requirements for Declarations of Interest as well as the provisions of the Institute's Regulations 2005 relating to pecuniary interests (specifically, Regulation 10).

The Declarations of Interest made by Board members are recorded in the minutes and are attached to the public record of board meetings in cases where a Declaration of Interest form has been completed. A register of Declarations of Interest is kept and maintained by the Board Secretary, and is open to public inspection.

According to Standing Orders, this register is kept up to date by means of an annual review in which any changes of interest declared during the preceding 12 months are incorporated.

'Declarations of Interest' is included as an item on all Board meeting agendas. Whenever an interest is declared which could amount to a conflict of interest, the member concerned does not take any part in the relevant discussion or decision at the meeting (as required by Standing Order paragraph 6.5).

For details of the Declarations of Interest, please refer to the register of interests and to the minutes of the Board.

Remuneration Report

Details of the membership of the Remuneration and Terms of Service Committee

The NHS Institute has a Remuneration and Terms of Service Committee consisting of all non-executive directors, the Chief Executive Officer and the Deputy Chief Executive (the Director of Learning). The committee meets four times a year and, supported by the human resources department, sets, develops and clarifies remuneration and terms of service policies, and resolves any remuneration and terms of service issues.

Statement of the policy on the remuneration of senior managers for current and future financial years

The framework used by the NHS Institute during its set-up stage was *Best Practice and Policy Guidance for ALBs* [arm's-length bodies], issued by the Department of Health in November 2005. Under section 3, 'Start-Ups, Mergers and Joint Ventures', the guidance refers to the recruitment of chief executives and senior executives. It stipulates that these appointments should be handled by the NHS Institute's appointments committee, which should include the NHS Institute Chair and/or a senior department sponsor. It also specifies that all non-executive director appointments are to be agreed through the NHS Appointments Commission.

Work is currently being undertaken across the country by the Department of Health to determine remuneration levels for Chairs, non-executive directors and very senior managers. (The NHS Institute obtains its guidance and advice, as an arm's-length body, from the Department of Health.) This national research aims to build on the work already completed as part of Agenda for Change, taking into account the context of organisational changes arising from *Commissioning a Patient-led NHS*.

Performance conditions

The NHS Institute complies with the procedures set out in *Agenda for Change: NHS Terms and Conditions of Service Handbook* (2005) and has in place a personal objective-setting process with line managers which links in to the annual appraisals and review process and supports the Knowledge and Skills Framework. The executive directors take the lead in this process within their individual areas. Executive members do not receive specifically performance-related pay, but their performance is regularly monitored.

Summary and explanation of the policy on the duration of contracts, notice periods and termination payments

Terms and conditions for the Chair and all non-executive members of the NHS Institute

Statutory basis for appointment

Chairs and non-executive members of special health authorities hold a statutory office under the National Health Service Act 1977. Their appointment does not create any contract of service or contract for services between them and the Secretary of State or between them and the special health authority. The appointment and tenure of office of the Chair and members are governed by the Institute's Regulations 2005.

Employment law

The appointments of the Chair and all non-executive members are not within the jurisdiction of employment tribunals. Neither is there any entitlement for compensation for loss of office through employment law.

Reappointments

The Chair and non-executive members are eligible for reappointment at the end of their period of office, but they have no right to be reappointed. The NHS Appointments Commission will usually consider afresh the question of who should be appointed, but it is likely to consider favourably a second term of appointment without competition for people whose performance has been appraised as consistently good during their first term. If reappointed, further terms will only be considered after open competition, subject to a maximum length of service of 10 years with the same organisation and in the same role.

Termination of appointment

The NHS Institute for Innovation and Improvement Regulations 2005 sets out the grounds on which the appointment of the Chair and non-executive members can be terminated and the reasons for being disqualified. A chair or non-officer member may resign at any time during their terms of office by giving notice to the Secretary of State. The Secretary of State can terminate the tenure of office of the Chair or non-officer member on specified grounds by giving that person notice in writing to that effect.

In addition, the NHS Appointments Commission has the right to terminate the appointment of the Chair and non-executive members on the following grounds:

- If it is of the opinion that it is not in the interests of the NHS Institute or the NHS that they should continue to hold office.
- If the Chair or non-executive member does not attend a meeting of the special health authority for a period of three months.
- If the Chair or non-executive member does not properly comply with the requirements of the regulations with regard to pecuniary interests in matters under discussion at meetings of the special health authority (for example if the Chair or non-executive member fails to disclose such an interest).

The following list provides examples of matters which may indicate to the Appointments Commission that it is no longer in the interests of the health service that an appointee continue in office. The list is not intended to be exhaustive or definitive; the Commission will consider each case on its merits, taking account of all relevant factors.

- If an annual appraisal or sequence of appraisals is unsatisfactory.
- If the appointee no longer enjoys the confidence of the Board.
- If the appointee loses the confidence of the public.
- If a Chair fails to ensure that the Board monitors the performance of the special health authority in an effective way.
- If the appointee fails to deliver work against pre-agreed targets incorporated within their annual objectives.
- If there is a terminal breakdown in essential relationships – for example between a Chair and a chief executive or between an appointee and the rest of the Board.

When a new Chair is appointed to a Board, he or she will be expected to review the objectives of all Board members and may, at the time of their next appraisal, make a recommendation to the Commission regarding their continued appointment. There is no provision in the NHS Institute's annual accounts for the early termination of any non-executive member's appointment.

Remuneration

The Chair and non-executive members are entitled under the National Health Service Act 1977 to be remunerated by the special health authority for as long as they continue to hold office. They are entitled to receive remuneration only in relation to the period for which they hold office. They are not entitled to compensation for loss of office.

Current rate for the Chair and non-executive members

The current rate of remuneration payable to the Chair of the NHS Institute for Innovation and Improvement is £60,000 pa for up to three days' work per week. The current rate of remuneration payable to non-executive members is £5,673 pa for approximately 2 days' work per month.

Tax and National Insurance (NI)

Remuneration is taxable under Schedule E and is subject to Class I National Insurance contributions. Any queries about these arrangements should be taken up with HM Inspector of Taxes or the NI Contributions Agency respectively.

Allowances

The Chair and non-executive members are also eligible to claim expenses (at rates set centrally) for travel and subsistence costs necessarily incurred on special health authority business.

Public speaking
On matters affecting the work of the special health authority, the Chair and non-executive members should not normally make political speeches or engage in other political activities. If in doubt, the guidance of the NHS Appointments Commission should be sought.

Conflicts of interest
NHS Boards are required to adopt the Code of Conduct and the Code of Accountability, both first published in April 1994. They require the Chair and Board members to declare upon appointment any business interests, positions of authority in charities or voluntary bodies in the field of health and social care, and any connections with bodies contracting for NHS services. These declarations must then be entered into a register which is made available to the public.

Indemnity
The special health authority is empowered to indemnify the Chair and non-executive members against personal liability incurred under certain circumstances while carrying out their duties. *Health Service Circular 1999/104*, which is available from the NHS Institute for Innovation and Improvement, gives details.

Terms and conditions for executive directors of the NHS Institute

Basis for appointment
All executive directors are appointed on a permanent basis under a contract of service at an agreed annual salary. They are entitled to a leased car and are eligible to claim allowances (at rates set by the NHS Institute) for travel and subsistence costs incurred necessarily on the organisation's behalf.

Termination of appointment
On the grounds of incapacity of an executive director, the NHS Institute will give six months' notice once sick pay has been exhausted. The notice period for termination for any other substantive reason is six months. Notice of termination of contract of service to the NHS Institute by an executive director is three months.

No payments were made to executive directors for early termination during the 2005/06 financial year, and there is no provision for compensation included in the NHS Institute's annual accounts for the early termination of any executive director's appointment.

Contract information

The following table gives details of the service contracts of the senior managers who have served during the 2005/06 financial year.

Name	Title	Start date	Review date
Bernard Crump	Chief Executive Officer	1 August 2005	Not applicable
Simone Jordan	Deputy Chief Executive and Director of Learning	1 October 2005	Not applicable
Helen Bevan	Director of Service Transformation	1 July 2005	Not applicable
Maire Smith	Director of Technology and Product Innovation	1 September 2005	Not applicable
Michael Cawley	Director of Finance and Business Services	1 October 2005	Not applicable
Paul Allen	Director of Leadership Development	1 September 2005	Not applicable
Yve Buckland	Chair of the Board	1 July 2005	30 June 2009
David Bower	Non-Executive Director	1 July 2005	30 June 2008
Tony Butterworth	Non-Executive Director	1 July 2005	30 June 2008
Michael Collier	Non-Executive Director	1 October 2005	30 September 2009
Mike Deegan	Non-Executive Director	1 July 2005	30 June 2009
Dennis Sherwood	Non-Executive Director	1 July 2005	30 June 2009
Carol Black	Non-Executive Director	15 February 2006	14 February 2010

Salaries and allowances

The following table gives details of the salaries and allowances of the senior managers who have served during the 2005/06 financial year. The start date of senior managers is disclosed on page 24 of this report. (Please note that there are no comparatives for 2004/05, as the NHS Institute was only established as a special health authority on 1 July 2005.)

		2005/06	
	Salary (bands of £5,000)	**Other remuneration** (bands of £5,000)	**Benefits in kind** (rounded to the nearest £100)
Name and title	**£000**	**£000**	**£**
Bernard Crump (Chief Executive Officer)	100–105	0	2,900–3,000
Simone Jordan (Deputy Chief Executive and Director of Learning)	60–65	0	2,800–2,900
Helen Bevan (Director of Service Transformation)	90–95	0	0
Maire Smith (Director of Technology and Product Innovation)	65–70	0	0
Michael Cawley (Director of Finance and Business Services)	55–60	0	1,600–1,700
Paul Allen (Director of Leadership Development)	60–65	0	0
Yve Buckland (Chair of the Board)	45–50	0	100–200
David Bower (Non-Executive Director)	0–5	0	0
Tony Butterworth (Non-Executive Director)	0–5	0	0
Michael Collier (Non-Executive Director)	0–5	0	0
Mike Deegan (Non-Executive Director)	0–5	0	0
Dennis Sherwood (Non-Executive Director)	0–5	0	0
Carol Black (Non-Executive Director)	0 (See Note 1)	0	0

Note 1: There were no payments made to Carol Black in the financial year 2005/06.

Pension benefits

The following table gives details of the pension benefits of the senior managers who have served during the 2005/06 financial year.

Name and title	Real increase in pension at age 60 (bands of £2,500) £000	Lump sum at age 60 – related to real increase in pension (bands of £2,500) £000	Total accrued pension at age 60 – at 31 March 2006 (bands of £5,000) £000	Lump sum at age 60 – related to accrued pension at 31 March 2006 (bands of £5,000) £000	Cash equivalent transfer value at 31 March 2006 £000	Cash equivalent transfer value at 31 March 2005 £000	Real increase in cash equivalent transfer value £000	Employer's contribution to stakeholder pension £000
Bernard Crump (Chief Executive Officer) (See Note 1)	(0–2.5)	(2.5–5)	40–45	120–125	615	613	(7)	0
Simone Jordan (Deputy Chief Executive and Director of Learning)	0–2.5	2.5–5	15–20	55–60	251	200	16	0
Helen Bevan (Director of Service Transformation)	0–2.5	2.5–5	30–35	90–95	412	374	15	0
Maire Smith (Director of Technology and Product Innovation)	0–2.5	0–2.5	0–5	0–5	13	0	5	0
Michael Cawley (Director of Finance and Business Services)	0–2.5	2.5–5	10–15	40–45	172	129	14	0
Paul Allen (Director of Leadership Development)	0–2.5	0–2.5	0–5	0–5	11	0	5	0

Note 1: The real increases in pension, lump sum and cash equivalent transfer values for Bernard Crump are negative, as his total annual salary has decreased between the financial years 2005 and 2006.

Cash Equivalent Transfer Value

A Cash Equivalent Transfer Value (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 members' accrued benefits and any contingent spouse'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 benefit accrued in the 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 the disclosure applies.

The CETV figure, and from 2004/05 the other pension details, include the value of any pension benefits in another scheme or arrangement which the individual has transferred to the NHS pension scheme. They also include any additional pension benefit accrued to the member as a result of their purchasing additional years of pension service in the scheme at their own cost. CETVs are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries.

Real increase in CETV
This reflects the increase in CETV effectively funded by the employer. It takes account of the increase in accrued pension due to inflation, contributions paid by the employee (including the value of any benefits transferred from another scheme or arrangement) and uses common market valuation factors for the start and end of period.

Remuneration Report approved and signed by:

Bernard Crump
Chief Executive and Accounting Officer
NHS Institute for Innovation and Improvement

Dated: 10 July 2006

Accounts

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Accounts

These accounts have been produced in accordance with the direction given by the Secretary of State dated 3 June 2005, in accordance with Section 98(2) of the NHS Act 1977, and in a format as instructed by the Department of Health with the approval of HM Treasury.

History

The NHS Institute came into being on 1 July 2005 under The NHS Institute for Innovation and Improvement (Establishment and Constitution) Order 2005, which was laid before Parliament on 3 June 2005. It is established as a special health authority under the National Health Service Act 1977 and is an arm's-length body sponsored by the Department of Health.

Financial performance

The NHS Institute met the following duties for the accounting period:

Duty	Limit £'000	Outturn £'000	Duty achieved
Maintain expenditure within revenue resource limit	61,912	42,406	Yes
Maintain expenditure within capital resource limit	2,480	2,437	Yes
Remain within the cash limit set by Department of Health	61,912	37,970	Yes

Better payment practice code

The NHS Institute's performance against this target is disclosed in the Annual Report.

Going concern

The balance sheet at 31 March 2006 shows net liabilities of £10,745.000. This reflects the inclusion of liabilities falling due in the future which, to the extent that they are not to be met from the NHS Institute for Innovation and Improvement's other sources of income, may only be met by future direct funding from the Institute's sponsoring department, the Department of Health. This is because, under the normal conventions applying to parliamentary control over income and expenditure, payments may not be made by the Department of Health in advance of need.

Funding for 2006/07, taking into account the amounts needed to meet the NHS Institute's liabilities falling due in that year, has already been included in the Department of Health's estimates for that year, which have been approved by Parliament. It has accordingly been considered appropriate to adopt a going concern basis for the preparation of the NHS Institute's accounts.

Comparatives

There are no prior period comparative figures as this is the first accounting period of the NHS Institute.

Disclosure of relevant audit information

As Accounting Officer I confirm that:

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

Bernard Crump
Chief Executive and Accounting Officer
NHS Institute for Innovation and Improvement

Dated: 10 July 2006

Statement of the Board's and Chief Executive's Responsibilities

Under the National Health Service Act 1977 and directions made thereunder by the Secretary of State with the approval of Treasury, the NHS Institute is required to prepare a statement of accounts for each financial year in the form and on the basis determined by the Secretary of State, with the approval of Treasury. The accounts are prepared on an accruals basis and must give a true and fair view of the NHS Institute's state of affairs at the year end and of its income and expenditure, total recognised gains and losses and cash flows for the financial year.

The Accounting Officer for the Department of Health has appointed the Chief Executive of the NHS Institute for Innovation and Improvement as the Accounting Officer, with responsibility for preparing the NHS Institute's accounts and for transmitting them to the Comptroller and Auditor General.

In preparing the accounts, the Board and Accounting Officer are required to:

- observe the accounts direction issued by the Secretary of State, including the relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis
- make judgements and estimates on a reasonable basis
- state whether applicable accounting standards have been followed and disclose and explain any material departures in the financial statements
- prepare the financial statements on a going concern basis, unless it is inappropriate to presume that the NHS Institute will continue in operation.

The Chief Executive's relevant responsibilities as Accounting Officer, including responsibility for the propriety and regularity of the public funds and assets vested in the NHS Institute for Innovation and Improvement Special Health Authority, and for the keeping of proper records, are set out in the Accounting Officers' Memorandum issued by the Department of Health.

Statement of Internal Control for the period ended 31 March 2006

1. SCOPE OF RESPONSIBILITY

I was appointed as Accounting Officer on the establishment of the NHS Institute for Innovation and Improvement on 1 July 2005. I took up the post of Chief Executive on 1 August 2005. As Accounting Officer and Chief Executive of this Board, I have responsibility for maintaining a sound system of internal control that supports the achievement of the organisation's policies, aims and objectives. I also have responsibility for safeguarding the public funds and the organisation's assets for which I am personally responsible as set out in the Accounting Officer Memorandum.

As Accounting Officer, I am accountable to Parliament and the Secretary of State for Health through the Department of Health Commercial Directorate.

Our annual business plan is agreed with our Department of Health Senior Departmental Sponsor, who monitors achievement against the plan in regular performance review meetings. The Senior Departmental Sponsor has an open invitation to Board and Audit Committee meetings and also receives copy minutes of these meetings.

2. THE PURPOSE OF THE SYSTEM OF INTERNAL CONTROL

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to:

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

The system of internal control has not been fully in place in the NHS Institute for Innovation and Improvement for the year ended 31 March 2006. I acknowledge that there have been weaknesses during 2005/06 and that action has been taken, and continues to be taken, to address these in 2006/07.

3. CAPACITY TO HANDLE RISK

My opinion on the existence of a system of internal control is based on evidence primarily provided to me from oversight by the Audit and Risk Management Committee, Internal Audit Reports findings and the work that the Board has undertaken in respect of developing an initial Assurance Framework for the Institute.

That evidence demonstrates there remains a significant opportunity to develop and improve on the Institute's current business processes and controls.

Action has been taken to address many of the findings highlighted by the Institute's internal auditors. In addition, further actions will be undertaken during 2006/07. In particular, a financial control project has been initiated which, it is anticipated, will address process and control issues. A key feature of this project is the utilisation of the relationship with the Institute's financial services providers. In particular, focus is being given to enhancing financial control by strict adherence to standard process.

Detailed follow-up reviews of the action undertaken by the Institute will be carried out by the Institute's internal auditors. This work will form part of its internal audit programme for 2006/07. Responsibility for overall oversight of the work, on behalf of the Board, remains with the Audit and Risk Management Committee.

The Institute demonstrates leadership and a positive approach to risk management through:

- the identification of key risks through the business planning process
- risk assessment workshops involving the Executive Team and the full Board
- regular Audit Committee consideration of key strategic risks
- the ongoing development of a formal risk management strategy and supporting operational policies.

A programme of awareness training across the organisation will now be developed and implemented in 2006/07.

4. THE RISK AND CONTROL FRAMEWORK

The Audit Committee is responsible for reviewing risk management activity under delegation of the Board. It receives regular reports from the internal auditors and will receive an annual management letter from the external auditors, together with information from other sources deemed necessary for the committee to fulfil this function.

Throughout the year the Audit Committee has been informed about the development of an initial Assurance Framework, which has involved:

- review of the key operational risks as identified in the business planning process
- identification of strategic risks through the Executive Team and the Board
- prioritisation of those risks.

The resultant assurance framework was adopted by the Board in March 2006. This maps the initial key objectives of the Institute and identifies the risks to the achievement of these and also identifies the internal control mechanisms to manage the risks. It identifies and examines the review and assurance mechanisms, and identifies where gaps in control and/or assurance exist.

Section 3 (Capacity to handle risk) has already highlighted the opportunity for the Institute's current business processes and controls to be developed and improved.

As a new organisation, the framework has identified a number of areas where controls and assurance mechanisms need to be strengthened. These are all now being actively pursued and actions will be addressed in 2006/07.

5. REVIEW OF EFFECTIVENESS

As Accounting Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review is informed in a number of ways. The head of internal audit provides me with an opinion on the overall arrangements for gaining assurance through the Assurance Framework and on the controls reviewed as part of the internal audit work. The work of internal audit, as referred to in section 3, means that the head of internal audit has given limited assurance in respect of the business processes and controls currently in place.

Executive managers within the organisation who have responsibility for the development and maintenance of the system of internal control provide me with assurance. The Assurance Framework itself provides me with evidence that the effectiveness of controls that manage the risks to the organisation achieving its principal objectives have been reviewed. My review is also informed by reliance on reports from the internal and external auditors and other reviews.

I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the Audit Committee. A plan to address weaknesses and ensure continuous improvement of the system is in place.

These reviews have identified a number of areas for concern during the course of the year, particularly around the impact of legacy organisation issues and the implementation of an effective system of financial control. Section 3 highlighted that the recommendations relating to these issues are being systematically addressed in 2006/07, primarily through a financial control project. Responsibility for oversight of this work, on behalf of the Board, remains with the Audit and Risk Management Committee.

Bernard Crump
Chief Executive and Accounting Officer
NHS Institute for Innovation and Improvement

Dated: 10 July 2006

The Certificate and Report of the Comptroller and Auditor General to the Houses of Parliament

I certify that I have audited the financial statements of the NHS Institute for Innovation and Improvement for the period ended 31 March 2006 under the National Health Service Act 1977. These comprise the Operating Cost Statement, the Balance Sheet, the Cashflow Statement and Statement of Recognised Gains and Losses and the related notes. These financial statements have been prepared under the accounting policies set out within them.

Respective responsibilities of the Chief Executive and auditor

The Chief Executive is responsible for preparing the Annual Report, the Remuneration Report and the financial statements in accordance with the National Health Service Act 1977 and directions made thereunder by the Secretary of State with the approval of the Treasury and for ensuring the regularity of financial transactions. These responsibilities are set out in the Statement of Chief Executive's Responsibilities.

My responsibility is to audit the financial statements in accordance with relevant legal and regulatory requirements, and with International Standards on Auditing (UK and Ireland).

I report to you my opinion as to whether the financial statements give a true and fair view and whether the financial statements and the part of the Remuneration Report to be audited have been properly prepared in accordance with the National Health Service Act 1977 and directions made thereunder by the Secretary of State with the approval of the Treasury. I also report whether in all material respects the expenditure and income have been applied to the purposes intended by Parliament and the financial transactions conform to the authorities which govern them. I also report to you if, in my opinion, the Annual Report is not consistent with the financial statements, if the Institute has not kept proper accounting records, if I have not received all the information and explanations I require for my audit, or if information specified by relevant authorities regarding remuneration and other transactions is not disclosed.

I review whether the statement on pages 25 to 27 reflects the Institute's compliance with HM Treasury's guidance on the Statement on Internal Control, and I report if it does not. I am not required to consider whether the Accounting Officer's statements on internal control cover all risks and controls, or form an opinion on the effectiveness of the Institute's corporate governance procedures or its risk and control procedures.

I read the other information contained in the Annual Report and consider whether it is consistent with the audited financial statements. This other information comprises only the unaudited part of the Remuneration Report and the operational and Financial Review. I consider the implications for my report if I become aware of any apparent misstatements or material inconsistencies with the financial statements. My responsibilities do not extend to any other information.

Basis of audit opinion

I conducted my audit in accordance with International Standards on Auditing (UK and Ireland) issued by the Auditing Practices Board. My audit includes examination, on a test basis, of evidence relevant to the amounts, disclosures and regularity of financial transactions included in the financial statements and the part of the Remuneration Report to be audited. It also includes an assessment of the significant estimates and judgements made by the Chief Executive in the preparation of the financial statements, and of whether the accounting policies are most appropriate to the Institute's circumstances, consistently applied and adequately disclosed.

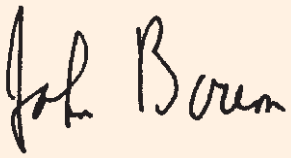
I planned and performed my audit so as to obtain all the information and explanations which I considered necessary in order to provide me with sufficient evidence to give reasonable assurance that the financial statements and the part of the Remuneration Report to be audited are free from material misstatement, whether caused by fraud or error and that in all material respects the expenditure and income have been applied to the purposes intended by Parliament and the financial transactions conform to the authorities which govern them. In forming my opinion I also evaluated the overall adequacy of the presentation of information in the financial statements and the part of the Remuneration Report to be audited.

Opinions

In my opinion:

- the financial statements give a true and fair view, in accordance with the National Health Service Act 1977 and directions made thereunder by the Secretary of State with the approval of the Treasury, of the state of the NHS Institute for Innovation and Improvement's affairs as at 31 March 2006 and of its surplus, recognised gains and losses and cashflows for the period then ended
- the financial statements and the part of the Remuneration Report to be audited have been properly prepared in accordance with the National Health Service Act 1977 and directions made thereunder by the Secretary of State with the approval of the Treasury; and
- in all material respects the expenditure and income have been applied to the purposes intended by Parliament and the financial transactions conform to the authorities which govern them.

I have no observations to make on these financial statements.



John Bourn
Comptroller and Auditor General, National Audit Office
157–197 Buckingham Palace Road, London SW1W 9SP

13 July 2006

ANNUAL ACCOUNT OF THE NHS INSTITUTE FOR INNOVATION AND IMPROVEMENT FOR THE PERIOD ENDED 31 MARCH 2006

Operating Cost Statement for the period ended 31 March 2006

	Notes	2005–06 £000
Programme costs	2	42,450
Operating income	4	(44)
Net operating cost before interest		42,406
Interest payable		0
Net operating cost		42,406
Net resource outturn	3.1	42,406

All income and expenditure is derived from continuing operations

Statement of Recognised Gains and Losses for the period ended 31 March 2006

There were no recognised gains and losses for the period, other than those shown within the operating cost statement.

The notes at pages 33 to 51 form part of these accounts

ANNUAL ACCOUNT OF THE NHS INSTITUTE FOR INNOVATION AND IMPROVEMENT
FOR THE PERIOD ENDED 31 MARCH 2006

Balance Sheet as at 31 March 2006

	Notes	31 March 2006 £000
Fixed assets:		
Intangible assets	5.1	227
Tangible assets	5.2	2,050
		2,277
Current assets:		
Debtors	6	1,426
Cash at bank and in hand	7	2
		1,428
Creditors: amounts falling due within one year	8.1	(8,995)
Net current (liabilities)		(7,567)
Total assets less current liabilities		(5,290)
Provisions for liabilities and charges	9	(5,455)
		(10,745)
Taxpayers' equity		
General Fund	11.1	(10,745)
		(10,745)

The accounts on pages 33 to 51 were considered by the Board on 16 June 2006

Bernard Crump
Accounting Officer

Date: 10 July 2006

ANNUAL ACCOUNT OF THE NHS INSTITUTE FOR INNOVATION AND IMPROVEMENT FOR THE PERIOD ENDED 31 MARCH 2006

Cash Flow Statement for the period ended 31 March 2006

	Notes	2005–06 £000
Net cash (outflow) from operating activities	12	(35,531)
Servicing of finance		
Interest paid		0
Net cash (outflow) from servicing finance		0
Capital expenditure and financial investment:		
(Payments) to acquire intangible fixed assets		(227)
(Payments) to acquire tangible fixed assets		(2,210)
Net cash (outflow) from investing activities		(2,437)
Net cash (outflow) before financing		(37,968)
Financing		
Net Parliamentary funding	11.1	37,970
Increase in cash in the period	7	2

The notes at pages 33 to 51 form part of these accounts.

Notes to the Accounts

1 Accounting policies

The financial statements have been prepared in accordance with the Government Financial Reporting Manual issued by HM Treasury, the NHS Capital Accounting Manual and the NHS Special Health Authority Manual for Accounts. The particular accounting policies adopted by the NHS Institute are described below. They have been consistently applied in dealing with items considered material in relation to the accounts.

1.1 Accounting Conventions

This account is prepared under the historical cost convention, modified to account for the revaluation of tangible fixed assets and stock where material, at their value to the business by reference to current cost. This is in accordance with directions issued by the Secretary of State for Health and approved by HM Treasury.

Acquisitions and Discontinued Operations

Activities are considered to be 'acquired' only if they are acquired from outside the public sector. Activities are considered to be 'discontinued' only if they cease entirely. They are not considered to be 'discontinued' if they transfer from one NHS body to another. Where an NHS body is abolished and the activities and residual responsibilities are transferred to the NHS Institute this transfer is accounted for using merger accounting principles.

1.2 Income

The main source of funding for the NHS Institute is Parliamentary grant from the Department of Health from Request for Resources within an approved cash limit, which is credited to the general fund. Parliamentary funding is recognised in the financial period in which it is received.

Operating income relates directly to the operating activities of the NHS Institute. It principally comprises fees and charges for services provided on a full-cost basis to external customers. It includes both income appropriated-in-aid and income to the Consolidated Fund which HM Treasury has agreed should be treated as operating income. Where income is received for a specific activity which is to be delivered in the following financial year, that income is deferred.

1.3 Taxation

The NHS Institute is not liable to pay corporation tax. Expenditure is shown net of recoverable VAT. Irrecoverable VAT is charged to the most appropriate expenditure heading or capitalised if it relates to an asset.

1.4 Capital charges

The treatment of fixed assets in the accounts is in accordance with the principal capital charges objective to ensure that such charges are fully reflected in the cost of capital. The interest rate applied to capital charges in the financial year 2005-2006 was 3.5% on all assets less liabilities, except for donated assets and cash balances with the Office of the Paymaster General, (OPG), where the charge is nil.

1.5 Fixed Assets

a. Capitalisation

All assets falling into the following categories are capitalised:

i Intangible assets where they are capable of being used for more than one year and have a cost, individually or as a group, equal to or greater than £5,000.

ii Purchased computer software licences are capitalised as intangible fixed assets where expenditure of at least £5,000 is incurred.

iii Tangible assets which are capable of being used for more than one year, and they:

- individually have a cost equal to or greater than £5,000;
- collectively have a cost of at least £5,000 and an individual cost of more than £250, where the assets are functionally interdependent, they had broadly simultaneous purchase dates, are anticipated to have simultaneous disposal dates and are under single managerial control; or
- form part of the initial equipping and setting-up cost of a new or leasehold building, irrespective of their individual or collective cost.

iv Donated fixed assets are capitalised at their current value on receipt, and this value is credited to the donated asset reserve.

b. Valuation

Intangible Fixed Assets

Intangible fixed assets held for operational use are valued at historical cost, except research and development which is revalued using an appropriate index figure. Surplus intangible assets are valued at the net recoverable amount.

The carrying value of intangible assets is reviewed for impairment at the end of the first full year following acquisition and in other periods if events or changes in circumstances indicate the carrying value may not be recoverable.

Tangible Fixed Assets

Tangible fixed assets are stated at the lower of replacement cost and recoverable amount. On initial recognition they are measured at cost (for leased assets, fair value) including any costs such as installation directly attributable to bringing them into working condition. They are restated to current value each year. The carrying values of tangible fixed assets are reviewed for impairment in periods if events or changes in circumstances indicate the carrying value may not be recoverable.

i Land and buildings (including dwellings)

Valuations are carried out by the District Valuer of HM Revenue and Customs government department at five yearly intervals in accordance with FRS 15. Between valuations price indices appropriate to the catergory of asset are applied to arrive at the current value. The buildings indexation is based on the All in Tender Price Index published by the Building Cost Information Service (BCIS). The land index is based on the residential building land values reported in the Property Market Report published by the Valuation Office. The valuations were carried out in accordance with the Royal Institute of Chartered Surveyors (RICS) Appraisal and Valuation Manual insofar as these terms are consistent with the agreed requirements of the Department of Health and HM Treasury.

The valuations have been carried out primarily on the basis of Depreciated Replacement Cost for specialised operational property and Existing Use Value for non-specialised operational property. In respect of non-operational properties, including surplus land, the valuations have been carried out at Open Market Value. The value of land for existing use purposes is assessed to Existing Use Value. The valuations do not include notional directly attributable acquisition costs nor have selling costs been deducted, since they are regarded as not material.

To meet the underlying objectives established by the Department of Health the following accepted variations of the RICS Appraisal and Valuation Manual have been required:

– specialised operational assets have been valued on a replacement rather than modern substitute basis;

– no adjustment has been made to the cost figures of operational assets in respect of dilapidations; and

– additional alternative Open Market Value figures have only been supplied for operational assets scheduled for imminent closure and subsequent disposal.

ii Operational equipment is valued at net current replacement costs through annual uplift by the change in the value of the GDP deflator. Equipment surplus to requirements is valued at net recoverable amount.

iii Assets in the course of construction are valued at current cost, using the index as for land and buildings. These assets include any existing land or buildings under the control of a contractor.

iv Subsequent revaluations to donated fixed assets are taken to the donated asset reserve.

v All adjustments arising from indexation and five-yearly revaluations are taken to the Revaluation Reserve. All impairments resulting from price changes are charged to the Statement of Recognised Gains and Losses. Falls in value when newly constructed assets are brought into use are also charged there. These falls in value result from the adoption of ideal conditions as the basis for depreciated replacement cost valuations.

c. Depreciation and Amortisation

Depreciation is charged on each individual fixed asset as follows:

i Intangible assets are amortised, on a straight line basis, over the estimated lives of the assets.

ii Purchased computer software licences are amortised over the shorter of the term of the licence and their useful economic lives.

iii Land and assets in the course of construction are not depreciated.

iv Buildings are depreciated evenly on their revalued amount over the assessed remaining life of the asset as advised by the District Valuer. Leaseholds and leasehold improvements are depreciated over the primary lease term.

v Each equipment asset is depreciated evenly over the expected useful life from the start of the quarter following the quarter in which the asset was acquired:

	Years
Furniture and Fittings	7-10
Transport Equipment	7
Information Technology	5

1.6 Donated Fixed Assets

Donated fixed assets are capitalised at their current value on receipt and this value is credited to the Donated Asset Reserve. Donated fixed assets are valued and depreciated as described above for purchased assets. Gains and losses on revaluations are also taken to the Donated Asset Reserve and, each year, an amount equal to the depreciation charge on the asset is released from the Donated Asset Reserve to the Operating Cost Statement. Similarly, any impairment on donated assets charged to the Operating Cost Statement is matched by a transfer from the Donated Asset Reserve. On sale of donated assets, the value of the sale proceeds is transferred from the Donated Asset Reserve to the General Fund.

1.7 Stocks and work in progress

Stocks and work in progress are valued at the lower of cost and net realisable value. This is considered to be a reasonable approximation to current cost due to the high turnover of stocks. Work in progress comprises goods in intermediate stages of production.

1.8 Losses and special payments

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

Losses and special payments are charged to the relevant functional headings in the operating cost statement on an accruals basis, including losses which would have been made good through insurance cover had the NHS Institute not been bearing their own risks (with insurance premiums then being included as normal revenue expenditure). However, note 17 is compiled directly from the losses and compensations register which is prepared on a cash basis.

1.9 Pension costs

Past and present employees are covered by the provisions of the NHS Pension Scheme. The Scheme is an unfunded, defined benefit scheme that covers NHS employers, General Practices and other bodies, allowed under the direction of Secretary of State, in England and Wales. As a consequence it is not possible for the NHS Institute to identify its share of the underlying scheme liabilities. Therefore, the scheme is accounted for as a defined contribution scheme and the cost of the scheme is equal to the contributions payable to the scheme for the accounting period.

The Scheme is subject to a full valuation for FRS17 purposes every four years. The last valaution on this basis took place as at 31 March 2003. The scheme is also subject to a full valaution by the Government Actuary to assess the scheme's assets and liabilities to allow a review of the employers contribution rates, this valuation took place as at 31 March 2004 and has yet to be finalised. The last published valuation on which contributions were based covered the period 1 April 1994 to 31 March 1999. Between valuations the Government Actuary provides an update of the scheme liabilities on an annual basis. The latest assessment of the liabilities of the Scheme is contained in the Scheme Actuary report, which forms part of the NHS Pension Scheme (England and Wales) Resource Account, published annually. These accounts can be viewed on the NHS Pensions Agency website at www.nhspa.gov.uk. Copies can also be obtained from The Stationery Office.

The conclusion of the 1999 valuation was that the scheme continues to operate on a sound financial basis and the notional surplus of the scheme is £1.1 billion. It was recommended that employers' contributions are set at 14% of pensionable pay with effect from 1 April 2003. On advice from the actuary the contribution may be varied from time to time to reflect changes in the scheme's liabilities. Employees pay contributions of 6% (manual staff 5%) of their pensionable pay.

The Scheme is a "final salary" scheme. Annual pensions are normally based on 1/80th of the best of the last 3 years pensionable pay for each year of service. A lump sum normally equivalent to 3 years pension is payable on retirement. Annual increases are applied to pension payments at rates defined by the Pensions (Increase) Act 1971, and are based on changes in retail prices in the twelve months ending 30 September in the previous calendar year. On death, a pension of 50% of the member's pension is normally payable to the surviving spouse.

Early payment of a pension, with enhancement, is available to members of the Scheme who are permanently incapable of fulfilling their duties effectively through illness or infirmity. Additional pension liabilities arising from early retirement are not funded by the scheme except where the retirement is due to ill-health. For early retirements not funded by the scheme, the full amount of the liability for the additional costs is charged to the Operating Cost Statement account at the time the NHS Institute commits itself to the retirement, regardless of the method of payment.

A death gratuity of twice final years pensionable pay for death in service, and up to five times their annual pension for death after retirement, less pensions already paid, subject to a maximum amount equal to twice the member's final years pensionable pay less their retirement lump sum for those who die after retirement is payable.

The Scheme provides the opportunity to members to increase their benefits through money purchase Additional Voluntary Contributions (AVCs) provided by an approved panel of life companies. Under the arrangement the employee can make contributions to enhance their pension benefits. The benefits payable relate directly to the value of the investments made.

1.10 Research and Development

Research and development expenditure is charged against income in the year in which it is incurred, except insofar as development expenditure relates to a clearly defined project and the benefits of it can reasonably be regarded as assured. Expenditure so deferred is limited to the value of future benefits expected and is amortised through the Operating Cost Statement on a systematic basis over the period expected to benefit from the project. It is revalued on the basis of current cost. The amortisation should be calculated on the same basis as used for depreciation i.e. on a quarterly basis.

1.11 Foreign exchange

Transactions which are denominated in a foreign currency are translated into sterling at the exchange rate ruling on the date of each transaction, except where rates do not fluctuate significantly, in which case an average rate for a period is used.

1.12 Leases

Assets held under finance leases and hire purchase contracts are capitalised in the balance sheet and are depreciated over their useful lives or primary lease term. Rentals under operating leases are charged on a straight line basis over the terms of the lease.

1.13 Provisions

The NHS Institute provides for legal or constructive obligations that are of uncertain timing or amount at the balance sheet date on the basis of the best estimate of the expenditure required to settle the obligation. Where the effect of the time value of money is significant, the estimated risk-adjusted cash flows are discounted using the Treasury's discount rate of 2.2% in real terms.

2.1 Programme costs

	Notes	£000	2005-06 £000
Non-executive members' remuneration			70
Other salaries and wages	2.2		16,952
Supplies and services – general			6
Establishment expenses			5,881
Transport and moveable plant			11
Premises and fixed plant			1,733
External contractors			1,489
Capital: Depreciation and amortisation		160	
Impairments		0	
Capital charges interest		(188)	
(Profit)/loss on disposal		0	
			(28)
Other finance costs – unwinding of discount			0
Auditor's remuneration:			
External Audit Fees			48
Internal Audit Fees			46
Other Fees			0
Miscellaneous			
Redundancy and early retirement costs*		725	
PCT Fitness for Purpose Scheme		750	
Residual NHSU activities transferred		3,469	
National Management Development Initiative transferred		2,122	
Other		3,148	
			10,214
Commissioning expenditure			
Building Leadership Capability		1,747	
Building Leadership Capacity		3,073	
Service Transformation		52	
Technology & Product Innovation		96	
Long Term Conditions		85	
Health Care Associated Infections		679	
No Delays		140	
Delivering Quality & Value		156	
			6,028
			42,450

* Redundancy and early retirement costs

Provision for the costs of early retirements for former NHSU employees whose terms of serverence were agreed before the abolition of the NHSU on 31 July 2005 was made in the closure accounts of the NHSU. This provision has been transferred to the NHS Institute and is shown in note 9 to these accounts. The NHSU closure accounts also include any redudancy payments made up to 31 July 2005. The redundancy and early retirement costs shown in the NHS Institute accounts relate to former NHSU employees where the severance terms were not agreed by 31 July 2005 or where redundancy payments were made after 31 July 2005.

2.2 Staff numbers and related costs

	2005-06 Total £000	Average WTE
Salaries and wages – staff on the NHS Institute payroll	3,405	98
Salaries and wages – recharges to other NHS organisations	(140)	(8)
Social security costs	716	
Employer contributions to NHSPA	955	
NHS Institute Employees	4,936	90
NHSU residual employees*	1,228	101
Graduates on training schemes	7,578	380
Salary support payments for Gateway participants	821	69
Seconded, contract and agency staff	2,389	61
Total salaries and wages	16,952	701

* NHS residual employees

Pay costs were incurred until 30 September 2005 in respect of NHSU staff engaged on closure activities. However, these costs were not accrued in the NHSU closure accounts.

The average whole time equivalent is averaged over August and September only.

Expenditure on staff benefits

The amount spent on staff benefits during the year totalled £ nil.

Retirements due to ill-health

During 2005-06 there were no early retirements from the NHS Institute on the grounds of ill-health.

2.3 Better Payment Practice Code - measure of compliance

	Number	£000
Total non NHS bills paid 2005-06	3,414	14,495
Total non NHS bills paid within target	2,408	11,956
Percentage of non NHS bills paid within target	70.5%	82.5%

	Number	£000
Total NHS bills paid 2005-06	212	22,681
Total NHS bills paid within target	76	21,280
Percentage of NHS bills paid within target	35.8%	93.8%

The Late Payment of Commercial Debts (Interest) Act 1998

	2005-06 £000
Amounts included within interest payable arising from claims made under this legislation	0
Compensation paid to cover debt recovery costs under this legislation	0
	0

3.1 Reconciliation of net operating cost to net resource outturn

	2005-06 £000
Net operating cost	42,406
Net resource outturn	42,406
Revenue resource limit	61,912
Under spend against revenue resource limit	19,506

3.2 Reconciliation of gross capital expenditure to capital resource limit

	2005-06 £000
Gross capital expenditure	2,437
NBV of assets disposed	0
(loss) on disposal of donated assets	0
Capital grants	0
Donations	0
Net capital resource outturn	2,437
Capital resource limit	2,480
Under spend against limit	43

4 Operating Income

Operating income analysed by classification and activity, is as follows:

	Appropriated in aid £000	Not Appropriated in aid £000	Total £000
Programme income:			
Fees & charges to external customers	44	0	44
Total	44	0	44

5 Fixed Assets

5.1 Intangible fixed assets

	Software Licences £000	Total £000
Additions – purchased	227	227
Indexation	0	0
Gross cost at 31 March 2006	227	227
Charged during the period	0	0
Indexation	0	0
Accumulated depreciation at 31 March 2006	0	0
Net book value:		
Total at 31 March 2006	227	227

5.2 Tangible fixed assets

	Information Technology £000	Leasehold Improvements £000	Total £000
Additions – purchased	135	2,075	2,210
Indexation	0	0	0
Gross cost at 31 March 2006	135	2,075	2,210
Charged during the period	0	160	160
Indexation	0	0	0
Accumulated depreciation at 31 March 2006	0	160	160
Net book value:			
Total at 31 March 2006	135	1,915	2,050

6 Debtors

6.1 Amounts falling due within one year

	31 March 2006 £000
NHS debtors	271
Trade debtors – Non NHS	9
Prepayments	104
VAT amount due	781
Other debtors	261
	1,426

7 Analysis of changes in cash

	At 1 July 2005 £000	Change during the year £000	At 31 March 2006 £000
Cash at OPG	0	2	2
	0	2	2

8 Creditors

8.1 Amounts falling due within one year

	31 March 2006 £000
NHS creditors	2,730
Tax and social security	0
Capital creditors	221
Other creditors	120
Accruals	5,924
	8,995

9 Provisions for liabilities and charges

	Pension for former staff £000	Legal claims £000	Total £000
Transferred from NHSU	5,568	60	5,628
Arising during the period	350	0	350
Utilised during the period	(451)	0	(451)
Reversed unused	(72)	0	(72)
Unwinding of discount	0	0	0
At 31 March 2006	**5,395**	**60**	**5,455**
Expected timing of cash flows:			
Within 1 year	5,395	60	5,455

Provision had been made in the NHSU closure accounts for pensions for former NHSU staff whose terms of severence were agreed before the abolition of the NHSU on 31 August 2005. This provision has been transferred to the NHS Institute and is shown above.

10 Movements in working capital other than cash

	2005-06 £000
Increase/(decrease) in debtors	1,426
(Increase)/decrease in creditors	(8,995)
	(7,569)

11 Movements on reserves

11.1 General Fund

	2005-06 £000
Net operating costs for the period	(42,406)
Net Parliamentary funding	37,970
Net liabilities transferred from NHSU	(6,121)
Non-cash items:	
Capital charge interest	(188)
Balance at 31 March 2006	(10,745)

12 Reconciliation of operating costs to operating cash flows

		2005-06 £000
Net operating cost before interest for the period		42,406
Adjust for non-cash transactions	2.1	28
Adjust for movements in working capital other than cash	10	(7,569)
(Increase)/decrease in provisions	9	(5,455)
Net liabilities transferred from NHSU	11.1	6,121
Net cash outflow from operating activities		35,531

13 Contingent liabilities

At 31 March 2006, there were no known contingent liabilities.

14 Capital commitments

At 31 March 2006 the value of contracted capital commitments was £nil.

15 Commitments under operating leases

Expenses of the NHS Institute include the following in respect of hire and operating lease rentals:

	2005-06 £000
Hire of plant and machinery	4
Property rental - including headquarters and other properties	635
Other operating leases	1
	640

Commitments under non-cancellable operating leases:

Commitments under operating leases to pay rentals during the year following the period of these accounts are given in the table below, analysed according to the period in which the lease expires.

		£000
Land and buildings		
Operating leases which expire:	within 1 year	55
	between 1 and 5 years	141
	after 5 years	415
		611
Other leases		
Operating leases which expire:	within 1 year	0
	between 1 and 5 years	24
	after 5 years	0
		24

16 Other commitments

The NHS Institute has not entered into any additional non-cancellable contracts (which are not operating leases).

17 Losses and special payments

There were no cases of losses and special payments approved during 2005-06.

18 Related parties

The NHS Institute is a special health authority established by order of the Secretary of State for Health.

The Department of Health is regarded as a controlling related party. During the period the NHS Institute has had a significant number of material transactions with the Department, and with other entities for which the Department is regarded as the parent Department.

	£000
Essex Strategic Health Authority	1,962
North West London Strategic Health Authority	95
North & East Yorkshire & Northern Lincoln Strategic Health Authority	65
Shropshire & Staffordshire Strategic Health Authority	125
North Bradford PCT	16
Sunderland Teaching PCT	32
South Warwickshire PCT	46
United Bristol Healthcare NHS Trust	39
Chelsea & Westminster Healthcare NHS Trust	300
South Essex Partnership NHS Trust	31
Sandwell & West Birmingham Hospitals NHS Trust	20
Bradford District Care NHS Trust	410
University Hospital Birmingham Foundation Trust	141
Department of Health	237
Appointments Commission	39
National Patient Safety Agency	20

19 Post balance sheet events

There are no material post balance sheet events.

20 Financial instruments

FRS 13, Derivatives and Other Financial Instruments, requires disclosure of the role that financial instruments have had during the period in creating or changing the risks an entity faces in undertaking its activities. The way Special Health Authorities are financed, is such that the NHS Institute is not exposed to the degree of financial risk faced by business entities. Also financial instruments play a much more limited role in creating or changing risk than would be typical of the listed companies to which FRS 13 mainly applies. The NHS Institute has limited powers to borrow or invest surplus funds and financial assets and liabilities are generated by day-to-day operational activities rather than being held to change the risks facing the NHS Institute in undertaking its activities.

As allowed by FRS 13, debtors and creditors that are due to mature or become payable within 12 months from the balance sheet date have been omitted from all disclosures other than from the currency profile.

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

Interest-rate risk
100% of the NHS Institutes's financial assets and 100% of its financial liabilities carry nil or fixed rates of interest. The NHS Institute is not, therefore, exposed to significant interest-rate risk.

Foreign currency risk
The NHS Institute has negligible foreign currency income or expenditure

Fair values
A comparison, by category, of book values and fair values of the NHS Institute's financial assets and liabilities as at 31 March 2006 is as follows:

	Book value £000	Fair value £000
Financial assets:		
Cash	2	2
Debtors over 1 year	0	0
Total	2	2
Financial assets:		
Overdraft	0	0
Creditors over 1 year:		
Early retirements*	5,395	5,395
Provision for legal cases	60	60
Loans	0	0
Total	5,455	5,455

* Fair value is not significantly different from book value since interest of 9% is paid on early retirement creditors.

21 Intra-government balances

	Debtors: Amounts falling due within one year £000	Creditors Amounts falling due within one year £000
Balances with other central government bodies	0	0
Balances with the Department of Health	189	1,176
Balances with Strategic Health Authorities	13	676
Balances with Primary Care Trusts	0	376
Balances with NHS Trusts	35	364
Balances with Special Health Authorities	0	138
Balances with Scottish NHS bodies	34	0
At 31 March 2006	271	271

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