NHS
Institute for Innovation and Improvement

Annual Report and Accounts
of the NHS Institute for Innovation and Improvement 2012-13

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of the NHS Institute for Innovation and Improvement 2012-13

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Contents

Introduction and Foreword

The NHS Institute for Innovation and Improvement closed as a Special Health Authority on 31 March 2013. The continuing activities of the NHS Institute were transferred to NHS Commissioning Board from 1 April 2013. Accounting Officer responsibility for these continuing activities, including the completion and agreement of these final accounts and their submission to parliament, became the responsibility for the Accounting Officer for NHS Commissioning Board from that date.

Where ever possible these Annual Report and Accounts have acknowledged the oversight, accountability and assurances provided by the NHS Institute's Accounting Officer during the financial year 2012/13, as well as the formality of the responsibilities of the Accounting Officer for NHS Commissioning Board from 1 April 2013.

As we started the year we were acutely aware of the challenges we would face given our main objectives were to close the NHS Institute successfully and to offer our full support to the creation of the new improvement body, NHS Improving Quality.

We also recognised that we had a significant amount of work still to do within the service. And so the complexity of the situation and the likelihood of losing expertise and experience of staff as they looked to the future, were not lost on us. On reading the contents of this year's report you will see that despite these challenges, the range of activities the NHS Institute has been involved in is very impressive.

Information is contained within the body of the report on all our new work. Highlights include the NHS Patient Feedback Challenge and Transforming Patient Experience, both of which demonstrate the increasing emphasis on the experience of healthcare for patients as well as outcomes. Similarly, the 15 Steps Challenge toolkits, based on a simple idea of seeing the care environment through the patient's eyes, have been very well received and widely implemented.

The eighth wave of Leading Improvement in Patient Safety finished during the year with a final cohort bringing the total number of teams that had participated to over 150. Most have seen patient safety levels improve and levels of harm reduce, some with dramatic results. Our offering for commissioners has also been well received with over two thirds of CCGs taking up the support offer.

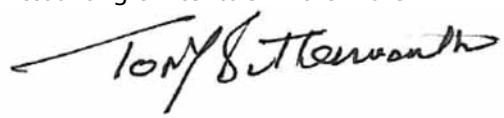
Of increasing importance to the health and social care arena is an integrative whole system approach and two of our programmes have had an impact in this area this year. Health and Social Care System Support successfully supported a number of health and social care systems bringing leaders together to develop joint working on the most significant challenges in their locality. Based on the use of proven methodology and tools (from The Productive Series and our safety work and other initiatives) Care Homes Wellbeing and Care Homes Connect were developed and are now being implemented to deliver improvement and strengthen communications and relationships for the benefit of clients.

Many of us were involved this year in the inception and development of the NHS Change Model. Working in partnership with colleagues in other improvement organisations, from the Department of Health and the NHS, this exciting initiative has created the NHS's first single model of change and it has been well used and received by early adopters. It has the support of the many hundreds of people who were engaged in its development.

Of course, this year our attention was also on working towards the closure of the NHS Institute. This undoubtedly put pressure on our staff as they continued to deliver services to the NHS, to work on closedown activities and to think about their own futures. At times this was difficult with late decision making outside of our control having a deleterious effect. Yet despite this, enthusiasm for our work remained high and our staff were as committed to the task in hand as ever. We owe them a debt of gratitude and respect for all their hard work and resilience over this and previous years.

The continued pressures faced by the NHS and the response we received to our latest work demonstrate the service's need and desire for new and different high impact, innovative improvement solutions. This stands NHS Improving Quality in good stead for the years ahead and we are proud to hand over the powerful legacy of our work here at the NHS Institute from the last seven years.

Rod Anthony
Accounting Officer to 31 March 2013



Tony Butterworth
Interim Chair to 31 March 2013

Management Commentary and Review of Activity

Description of the business

The NHS Institute for Innovation and Improvement was set up on 1 July 2005 under the NHS Institute for Innovation and Improvement (Establishment and Constitution) Order 2005 which was laid before Parliament on 2 June 2005.

The NHS Institute was established as a Special Health Authority under the National Health Service Act 1977 and was an arm's length body sponsored by the Department of Health.

The NHS Institute was based at i-House, University of Warwick Science Park, Millburn Hill Road, Coventry, CV4 7HS.

During 2012-13 a small number of our staff were also based in London and Manchester.

Risks

During 2012-13 the NHS Institute Board, Audit and Risk Management Committee and Executive Team continued to develop and review our Strategic Risk Management and Assurance Framework. Internal and external auditors were consulted in creating the framework and used it to inform their audit approach.

The NHS Institute's strategic risk register covered three elements – the running of the business, the closedown of the Special Health Authority and support for the establishment of NHS Improving Quality. It identified the most significant risks for the organisation and included action plans to address them. The principal risks and uncertainties facing the NHS Institute as a Special Health Authority were identified in a number of categories and are summarised below:

- **Communications risks** including inconsistency of messages provided to staff, stakeholders and customers.
- **HR risks** including ensuring sufficient staff to manage workload, retaining staff loyalty and motivation in the face of uncertainty and possible legal consequences.
- **Risks to customer relationships** including timescales for informing customers of closure and prospective successor operations as well as reputation and operational risk due to closure.
- **IPR risks** including control procedures and mechanisms regarding IPR management and possible breach of terms by suppliers/ partners.
- **Risks around strategic decisions** such as maintaining confidence and productivity during uncertainty and the effect on relationships and commercial activity.
- **Information and knowledge management risks** including managing contracts to ensure they weren't terminated too early or re-entered into when not required, maintaining user access to restricted website content and ensuring essential legacy data wasn't lost.
- **Strategic risks** including inability to close down some programmes due to awaiting direction from NHS Improving Quality and risks to a managed closure.

Management Commentary and Review of Activity *(continued)*

Environmental, social and community policies

In 2012-13 we continued to strive to reduce the NHS Institute's carbon footprint and improve our environmental sustainability.

- The i-House building includes energy efficiency measures such as movement sensitive lighting.
- After moving to the new building in January 2012 we ran more events in house, helping the NHS Institute to manage the environmental impact of its events better.
- We encouraged the use of virtual meetings using teleconferencing and webinar technology.
- We encouraged our suppliers to act sustainably, for example by conforming to our travel policies.
- We continued to manage our travel policy to encourage the most sustainable forms of travel.
- We ensured all stationery supplies were of good environmental standards, including 100% recycled paper.
- We encouraged staff to turn off appliances and reduce energy use within the office.
- All non-confidential paper waste was re-cycled and confidential waste was managed through a waste management supplier.
- We had in kitchen re-cycling including segregated bins for food waste and any recyclable food packaging and encouraged visitors to support our recycling systems.
- Our internal 'i-active' programme continued to promote healthy living and working amongst our staff and we operated a no-smoking policy on our premises.

Financial information

Our employees became members of the NHS Pension Scheme on joining the NHS Institute, unless they chose to opt out. Please refer to the remuneration report and financial accounts in this document for information on how pension liabilities are to be treated. Auditors only carried out standard auditing work, and received no additional payments.

Disclosure of relevant audit information

We confirm that, so far as we are aware, there is no relevant audit information of which the NHS Institute's auditors are unaware, and we have taken all the steps that we ought to have taken to make ourselves aware of any relevant audit information and to establish that the NHS Institute's auditors are aware of that information.

Employee matters

We had a full suite of policies on employee matters which were available on our website.

These were used effectively in the day-to-day management of our workforce.

Reporting related to the Review of Tax Arrangements of Public Sector Appointees

As part of the *Review of Tax Arrangements of Public Sector Appointees* published by the Chief Secretary to the Treasury on 23 May 2012, the NHS Institute is required to present the following two sets of data:

Management Commentary and Review of Activity *(continued)*

Table 1: In relation to off payroll engagements at a cost of over £58,200 per annum that were in place as of 31 January 2012

Number in place on 31 January 2012	17
Of which:	
Number that have since come onto the Organisation's payroll	0
Of which:	
Number that have since been re-negotiated/re-engaged to include contractual clauses allowing the (department) to seek assurance as to their tax obligations	3
Number that have not been successfully re-negotiated, and therefore continue without contractual clauses allowing the (department) to seek assurance as to their tax obligations	0
Number that have come to an end	14
Total	**17**

Table 2: For all new off-payroll engagements between 23 August 2012 and 31 March 2013, for more than £220 per day and more than six months

Number of new engagements	0
Of which:	
Number of new engagements which include contractual clauses giving the department the right to request assurance in relation to income tax and National Insurance obligations	0
Of which:	
Number for whom assurance has been accepted and received	0
Number for whom assurance has been accepted and not received	0
Number that have been terminated as a result of assurance not being received	0
Total	**0**

Sickness absence data

During the period 2012-13 the following percentages of hours were lost through sickness absences:

	2012-13
Quarter 1	4.11%
Quarter 2	1.37%
Quarter 3	1.67%
Quarter 4	1.10%

Management Commentary and Review of Activity *(continued)*

Employment, training, career development and promotion of disabled persons

The NHS Institute aimed to be recognised as an organisation which provided good employment opportunities for people with disabilities. All individuals applying for employment received equal treatment, and were considered solely on their ability to carry out the duties of the post. Our Equality and Diversity policy was available on our website.

Communication and consultation with employees

We communicated with our employees and kept them up to date on financial, economic and other factors affecting the organisation, in a number of ways. This was particularly important during the last 12 months as we moved towards the closure of the NHS Institute.

Given the notice to close, and in compliance with the Section 188 of the Trade Union and Labour Relations (Consolidation) Act 1992 (TULR(C)A), the NHS Institute wrote to the Staff Partnership Forum (SPF) Representatives and Unions (MiP, Unison, BMA and Unite) on 24 September to formally advise them that the NHS Institute was being abolished and would therefore be closing on 31 March 2013.

Following the above an individual letter was sent to each employee notifying individuals that they were formally at risk of redundancy and that the letter signified the start of a consultation period. The very small number of staff who had six months' contractual notice were also notified that they would be given notice on 1 October 2012 and were informed of the implications of this.

The relevant notice was also given to the Secretary of State with the submission of an HR1 Form reflecting the minimum consultation period of 90 days.

The following activities were part of the consultation process:

- Regular SPF meetings – ensuring that each team had a nominated representative who fed back to their team and to the SPF.
- SPF agendas and minutes were sent to MIP as part of the NHS Institute's arrangement with unions.
- Posting of SPF minutes on the NHS Institute's intranet pages for all staff to view and comment on.
- A system for dealing with staff FAQs.
- Individual 1:1 meetings between line managers with staff.
- Updates in the NHS Institute's weekly internal newsletter, I-News.
- Chief Executive/MD all staff briefings (including options for WebEx/dial in), with each meeting supported by a recording and notes.
- Two day-long all staff events.
- Open access to HR.
- Executive meetings which had a regular item on HR matters.
- Establishment of a corporate closedown group which fed into the DH Closedown team and which included an HR slot to raise staff concerns.

Management Commentary and Review of Activity *(continued)*

As part of the NHS Institute's closure programme and planned reduction in activities, two phases of voluntary redundancy took place during 2012-13 and all applications were recommended and approved by both the NHS Institute's Workforce in Transition Group (WIT) and Remuneration Committee and approved (where relevant) by the Department of Health's Governance Assurance Committee (GAC). A final set of redundancies was signed off relating to individuals who had been retained by the NHS Institute as business critical to the NHS Institute closedown to ensure there were no unnecessary risks.

In November the creation of the Delivery Team as part of NHS Improving Quality was announced along with the proposal to 'lift and shift' (through a Transfer Scheme under the direction of the Secretary of State) any remaining employees (ie those who have not found suitable alternative employment or taken voluntary redundancy) as at 31 March 2013 to the Delivery Team. A consultation paper about this was sent to all employees on 4 December.

On 21 December the consultation period closed and employees were issued with a letter confirming that either their voluntary redundancy application had been approved, they would be leaving under RETs or would be transferred to the Delivery Team. This was with the exception of the small number already serving six months' notice, who were consulted with individually.

Staff support

Given the unprecedented duration (c four years) of the changes and the significant impact on staff, the NHS Institute, in consultation with staff, provided a support programme called 'Next Steps', which offered a range of workshops including getting started with searching for employment, impressing at interviews, presentation skills, self-employment, LinkedIn, transition from public to private sector and start your own consultancy, as well as 1:1 coaching. The programme was supplemented by additional modules such as 'You're Hired' – a simulated recruitment campaign, and other personal development workshops, for example Myers Briggs Type Indicator.

The NHS Institute also made full use of other resources such as the Money Advice Service and local employment agencies which arranged an agency recruitment fair. The aim of this was to ensure that appropriate support was given to individuals and groups of staff. This reflected the obligations of the NHS Institute as an employer but also endorsed the NHS Institute's philosophy of being an excellent and innovative employer which treated its staff with dignity and respect.

Relationship and communication with the Department of Health

The NHS Institute had from its inception a strong and positive relationship with the Department of Health (DH). This was provided through a number of channels:

- The sponsor team at the DH had the formal responsibility for overseeing our work and holding us to account for delivery against our business plan.
- Individual programme teams within the Department liaised with their colleagues in equivalent teams in the NHS Institute.

- As an arm's length body (ALB) the NHS Institute had a positive relationship with the Department's ALB team.

Personal data related incidents

During 2012-13 there were no personal data related incidents that required reporting to the Information Commissioner.

Progress against targets

As this was the NHS Institute's final year of operation, the 2012-13 business plan outlined three main objectives:

1. Closure of the NHS Institute as a Special Health Authority.
2. Support for the creation of the new improvement body, NHS Improving Quality.
3. Delivery of services to the NHS during 2012-13.

The first two of these objectives are covered in the introduction and foreword to this report and in the Annual Governance Statement.

Some of our key achievements in terms of 2012-13 programme delivery are detailed in the following pages.

Design and Innovation

- The **NHS Spread and Adoption Tool** is a web application to help the NHS increase the pace and scale of uptake for new innovations and supports the 'spread of innovation' component of the NHS Change Model. Over 3,000 people accessed the tool within two weeks of its launch.
- The **National Innovation Centre** (NIC) continued to provide support to a range of innovators developing high impact technology and service innovations, which this year included innovations in 3D ultrasound imaging, children's mobility services, high impact orthopaedic innovations, and online mental health services.
- The **Ambulatory and Emergency Care Delivery Network** is now on its third cohort. There are now 32 teams within the network made up of over 90 NHS organisations, meaning that more patients are being diagnosed, treated and discharged on the same day, and also that these organisations meet the requirements of new best practice tariffs.
- The **Experience Based Design** (ebd) approach brings patients and staff together to share the role of improving care and re-designing services. The NHS remained eager to implement ebd and the NHS Institute held three national introductory workshops and worked directly with teams to make the service improvements that patients really want.
- Over 2,200 people participated in crowd sourcing to determine the best projects for the **NHS Patient Feedback Challenge**. Nine projects shared £1 million to spread excellent patient experience improvement practice across the NHS.
- Over 73,841 people have visited our online **Transforming Patient Experience: the essential guide** since its launch in April 2012.

Management Commentary and Review of Activity *(continued)*

- The Innovation Health and Wealth report committed the NHS to build pace and scale for use of existing technologies and innovations. The NHS Institute worked to support this by creating online resources attracting over 21,000 visits, for **High Impact Innovation** areas including dementia, access to technology, children's mobility and intra-operative fluid management.
- Key areas yielding **NHS Innovation Challenge Prize** awards this year included reduction of falls, clinical obstructive pulmonary disease improvement, telemedicine, medicines management, preterm surveillance and early diagnosis of brain tumours. A partnership challenge with Janssen Healthcare Innovation to provide better dementia care and treatment was launched in February 2013.
- The **Care Homes Programme** was developed to strengthen communications and relationships within care homes (Care Homes Wellbeing) and also between care homes and the wider health and care community (Care Homes Connect) with the ultimate aim of improving the experience for care home residents. Care Homes Connect was developed in consultation with six health and care communities and nine care homes volunteered as test sites for Care Homes Wellbeing.

Productive Care (The Productive Series)

- During the year, the Productive Care National QIPP workstream continued to support the national roll out of **The Productive Series** programmes, working with the Department of Health, strategic health authorities and frontline organisations.
- The development of a national data collection template for strategic health authorities and organisations showed an increase of spread of The Productive Series across the NHS (especially **The Productive Ward** at 78% and 90% in some regions).
- The **15 Steps Challenge** series of toolkits was launched for a variety of healthcare settings including acute, acute mental health, community, clinic and children and young people.
- A new tool, the **Productive Integration Workshop Guide**, was released to support teams to integrate care focused on the needs of their patients.
- The **Productives e-learning** programme grew with the addition of **The Productive Leader** – ensuring that this important programme can be accessed using a virtual approach.
- **Productive General Practice** continued to spread with nearly 150 practices in England now signed up to the programme and 400 registered in Scotland.
- The Department of Health sponsored six CCGs in order to learn lessons about spreading Productive General Practice across a CCG area. This pilot ended in March 2013 and will provide valuable insights into critical success factors for successfully spreading the programme.

- There was a strong focus on increasing national implementation rates for **The Productive Mental Health Ward**; uptake of the programme is now at 68% across the NHS.
- **Productive Community Services Executive Support** package was implemented across a number of organisations, helping to ensure that organisations put the foundations for successful implementation in place before starting organisational roll out.

Safer Care and 'Harmfree' care

- Almost 400 people participated in a Safer Care hosted national **Leading the Outcomes for Patient Safety** event in January 2013. Case studies and workshops were developed to help staff make a real difference to patient safety.
- The national roll out of the pilot Safety Express QIPP saw development of the **'harm free' care** programme during 2012-13, through which the four most common patient harms are addressed with one cross organisational plan. Healthcare professionals and leaders were engaged with web seminars and events covering key patient safety improvement topics.
- The eighth wave of **Leading Improvement in Patient Safety** (LIPS), was completed in 2012-13 with over 150 teams across all waves demonstrating dramatic improvements in patient safety, eg a mental health trust reducing physical violence by over 50% and an acute trust reducing hospital acquired pneumonias by 50% and the overall rate of harm by 28%.
- The Safer Care team worked in partnership with NHS South colleagues to design and deliver a **Patient Safety Leader** programme for the cluster as part of 'harm free' care programme delivery. In October 2012 a practical five day programme of topics for safety improvement was delivered to 50 organisations across NHS South.
- A third cohort of postgraduate doctors in training in the East Midlands area engaged in the **Building Safety Improvement Skills** (BaSIS) programme during 2012-13. Thirty participants have completed the two day programme. They are now working on safety improvement projects and applying the learning within their own organisations.
- Three more cohorts of the **Patient Safety Leaders'** (PSL) programme were completed in 2012-13, with participants demonstrating excellent results including the introduction of Situation Background Assessment Recommendation (SBAR) on a ward that generated staff time benefits of over seven hours of health care assistant and one hour of trained nurse time per day.
- A series of web seminars to develop improvements in quality and safety in a care home setting were held in January 2013. Demonstrating a successful collaboration between the Safer Care and the Care Homes teams at the NHS Institute, the web seminars were delivered by subject experts with a wealth of experience in safety improvement in this setting.

Management Commentary and Review of Activity *(continued)*

Development for Commissioners

- The **Development for Commissioners** programme focused on helping CCGs and their leaders prepare for the commissioning challenges they will face as key players in the new NHS landscape.
- The NHS Commissioning Board included over thirty elements of the programme, such as workshops, within the national CCG learning and support tool.
- Almost 1,000 individuals (over 80% from CCGs and PCTs) joined our **Commissioning Workshop Series** that was designed to help prepare for authorisation and develop commission plans.
- Well over two thirds of all CCGs took up the programme's support offer.
- Our **Leadership Series** of intensive workshops, also featuring in the national learning and support tool, specifically supported key CCG senior leaders with the responsibilities and challenges of their new roles. This attracted 250 of the most senior CCG leaders.
- Nearly 2,000 people either participated live or downloaded sessions from our **commissioning webinar programme** that operated throughout most of the last year. These weekly punchy one hour sessions provided an overview on key topics and proved to be a particularly popular and attractive format.
- Additionally, through paid for commissions, we worked closely with a number of individual CCGs on their development journey and preparation for authorisation.
- Early results from an independent evaluation of the Development for Commissioners programme confirmed very strong impact of delivery, with organisations and individuals able to describe their learning and how they've applied and acted upon this. The evaluation also reports a consistently high regard amongst participants for the quality of facilitation by the team.

Health and Social Care System Support

- The **Health and Social Care System Support** (HSCSS) team supported a number of health and social care systems in 2012-13. The most successful work was undertaken across Nottingham and Nottinghamshire County. The team interviewed over 60 leaders from across local government and NHS organisations, following the production of a reflection report based around our understanding of large scale change.
- In February 2013 the Nottingham system took the report forward by working together in an interactive workshop reviewing how the system structures, processes and patterns of behaviour need to change to deliver transformational change.
- During 2012 the **Healthy Places, Healthy Lives** (HPHL) programme provided support through its HPHL partnerships and HPHL Knowledge Share. HPHL online enabled transfer of skills, knowledge and experience and provided links to others nationally with similar interests and challenges.

- From April 2012 the HPHL team ran five webinars with a total registration of 430 people. In addition to the spread of knowledge and experience of the presenters, valuable networking took place between those taking part in the webinars and extensive sharing of information and learning was achieved.
- As part of the HPHL spread of learning across partnerships, an online community of practice supporting 'Connecting Communities' (C2) projects across England was formed and online meetings were held approximately every two weeks. This included communities in Scotland and across England sharing best practice and challenges that have an impact on health and wellbeing across communities.
- During the latter part of the year from September and up to year end the team supported the implementation of the connecting communities methodology in partnership with public health, service providers and residents in the community.

Learning and Development

- Following the inaugural 2010-2011 **NHS Vanguard** programme, NHS South of England and NHS Yorkshire and the Humber commissioned the NHS Institute to provide an accelerated development programme for 200 NHS leaders (100 emerging leaders and their local partner sponsors).
- Twenty five teams from around the country and one international team participated in the six month **Leading Large Scale Change** programme, which provided a mixture of workshops, virtual learning and team coaching to support leaders make change a reality. Nine of these teams took up the offer of a further three months' 'next steps' which provided further coaching and support to deliver their large scale change project.
- In 2012, 14 students completed the 12 month PG certificated **Advanced Improvement in Quality and Safety** (AIQS) programme, bringing the total number who have completed the programme to over 40. All quality improvement projects have been posted on the website and many have gone on to present their work to other audiences.
- The **Improvement Faculty** membership has now increased to over 250 clinical leaders and managers, with a further 40 honorary members.
- The **Innovation and Improvement Development Framework** that was completed in 2011-2012 can be used to map the knowledge and competencies delivered to NHS staff through a range of quality improvement learning programmes. A complementary prototype online assessment was also piloted successfully in the workplace.

Management Commentary and Review of Activity *(continued)*

- Our **Accreditation Framework** was developed to provide an assurance framework to support the NHS Institute's products and services. When used in conjunction with the Development Framework it is possible to accredit those going through our programmes at foundation, practitioner or advanced practitioner level. Research and subsequent draft proposals have been developed and have been archived for NHS Improving Quality.
- The NHS Institute's ground breaking piece of cross sector work to support the establishment of **Health and Wellbeing Boards**, commissioned by the Department of Health, continued in 2012-13 culminating in a complex learning event in November for over 270 participants. We continued delivery of the action learning sets for the programme, each of which developed several resources which have been shared across the shadow boards.
- The Learning and Development team was also commissioned to design and provide development programmes for **Healthcare Scientists** and, as part of a tripartite agreement with Patient Voices and the Local Government Association, for the **Healthwatch** pathfinders.

ThinkGlucose

- Successful implementation of **ThinkGlucose** continued during 2012-13 and an additional tool – the **ThinkGlucose Programme Planning Tool** – was launched. This is a comprehensive Excel tool to inform the next steps of a ThinkGlucose campaign which brings together a range of resources for large scale service improvement.
- A Welsh health board embarked on the ThinkGlucose programme in 2012 and its successes and the impacts on blood glucose management has spread the programme's reputation. As a result, another Welsh health board has now engaged its four district general hospitals and a community hospital in the programme.

Organising for Quality and Value

- **Organising for Quality and Value** is a foundation level development programme in service improvement skills and is proven to deliver the skills and techniques necessary for individuals to support their organisations deliver sustainable improvement.
- Participants work on a real life improvement project, applying what they've learned on the programme to the real challenges within their organisation.
- During 2012-13 a further six waves were delivered. This included training our delivery partners to continue delivering this successful programme.

Children and Young People's Emergency and Urgent Care

- As a result of the success of the lesson pack which aimed to educate children and young people in secondary schools about health services and how to use them, a lesson pack for primary schools was developed.
- The pack was rolled out to over 19,000 primary and special schools in England.

- It will educate a minimum of 735,000 children and their families about NHS services and how to use them wisely, as well as how to provide feedback and participate in service development.
- It will empower a minimum of 40,000 teachers with information about health and the NHS.
- If this pack prevented just one Emergency Department (ED) attendance per primary school (at £75 per ED attendance) savings to the NHS would be over £1.4million.

Delivery

North

- The HSCSS programme was successfully delivered across all health and social care systems in the North East in addition to support to Calderdale and Huddersfield health and social care strategic 10 year plan and training in personal and team productivity and efficiency for Central Manchester Foundation Trust.
- A bespoke improvement programme was developed for York Foundation Trust, using core NHS Institute tools and techniques, alongside creative support for a neighbourhood care team collaborative across the Vale of York.

South

- We delivered a comprehensive improvement programme tailored to the needs of Kent and Medway NHS and Social Care Partnership Trust, utilising key NHS Institute programmes and associated experiential learning sets.
- The two year partnership with South Central SHA was completed as well as the second year of the partnership and support package with Plymouth Hospitals NHS Trust and delivery of the Commissioning Development programme to NHS Devon, Plymouth and Torbay.

London

- The UCLH Productive Outpatients methodology was supported with training and coaching for seven groups of outpatient clinics to develop local capacity and capability in key NHS Institute improvement methodologies.
- Training and coaching was provided to Pathway Improvement Leads at Central London Community Healthcare (CLCH) and we delivered Organising for Quality and Productive Ward coaching programmes for Kingston NHS Trust.
- We supported Homerton University Hospital NHS Foundation Trust with Experience Based Design methodology to redesign sickle cell services.

Midlands and East

- Building capability was a consistent theme for delivery and we worked with several CCGs to support their preparation for authorisation, using board level organisation development for several of the emerging CCGs.
- We delivered a series of Organising for Quality cohorts for local improvement leads and accelerated learning events which resulted in commitment to progress action plans and undertake sustainable change.
- Hertfordshire and Nottinghamshire adopted our Health and Social Care System Support programme (HSCSS) providing a thorough diagnostic of partnership working.

Management Commentary and Review of Activity *(continued)*

Thought Leadership

Calls to action

- We successfully brought together leaders from the renal and shared decision making community and built commitment towards a shared goal of undertaking shared decision making at 'scale and pace'.
- With input from patients and clinicians, we developed a better practice statement for a good shared decision making friendly renal unit. An expert group was also established to consider the measurement of shared decision making. These measures were rolled out across renal units in England by March 2013.
- **The Right Care** call to action was launched in October 2012, in partnership with the Dementia Action Alliance and with high profile support from the Minister for Care Services, the CEO of the Alzheimer's Society, key acute trust chief executives and national clinical leaders. To date 75 acute trusts (out of 162) have signed up.
- The **Getting started on becoming dementia friendly-D-Kit** for acute hospitals was produced, incorporating a baseline audit review, national standards, metrics and links to good practice resources.
- **The Right Prescription** call to action made a significant contribution to an average 52% reduction in clinical prescribing of antipsychotics.
- Care homes worked in partnership with the large pharmacy providers (eg Boots) to undertake medication reviews. The Right Prescription care home group reported in March 2012 that an audit of 1,990 care home residents living across seven different care home organisations showed that 72 per cent have had a clinical review since May 2011, 11.8 per cent have had antipsychotics reduced and 25 per cent have had them stopped.
- Almost 7,000 GPs were engaged through a Doctors.net campaign. Doctors.net reported this was their second most successful campaign, with data suggesting GPs increased clinical reviews of their patients who were on antipsychotic medication.
- Economic analysis was produced for **The Right Prescription** and **The Right Care** providing the case for change for commissioners.

NHS Change Model

- In March 2012 work started with colleagues from the Department of Health, improvement organisations and the NHS to build the early NHS Change Model and define its components.
- The prototype of the model was shared with c400 people in April 2012 who provided their views and input, enabling the visual of the model and associated language to be finalised.
- The model was launched in June 2012 with accompanying resources available on the new Change Model website. A workshop was also held to introduce the model to the Executive Team of the NHS Commissioning Board.

- A fortnightly webinar series introducing the NHS Change Model and its components began in September 2012, with each webinar attracting up to 200 participants and more than 1,000 people registering in total for the seven webinars held between September and December. A further series of webinars began in January 2013.
- The @NHSchange Twitter account was established in June and had more than 2,000 followers. A fortnightly Twitter club began in August to discuss a range of topics related to the model and at its peak attracted more than 70 participants and c450 tweets per hour.
- The #NHSchange Twitter hashtag was established and is now widely used to discuss change in the NHS. It generated more than 10,000 tweets and more than 11 million impressions since launch.
- In August 2012 the development of a polarity management resource began to support users of the model to align the eight components.
- In September 2012 a range of 'early mover' sites were selected and these were supported to apply the model to a local priority.
- The Change Model team provided resources and expertise to the team of young clinicians and managers leading NHS Change Day, held on 13 March 2013.
- From May 2012 the Change Model team was involved in delivering many local, national and international group briefings to introduce the model and guide its application in a wide range of settings.

NHS Institute Worldwide

- Worldwide continued to work with NHS Scotland to re-invigorate the profile of The Productive Series as part of ongoing partnership working. After the successful co-development of Productive General Practice we supported NHS Scotland in a successful implementation and roll out of the programme.
- Following a successful conference organised in Australia in May, we received our first orders from New South Wales.
- In New Zealand we gained our first order for Productive General Practice from Mid Central District Health Board and negotiations took place with other DHBs to spread and adopt this programme.
- The Productive Ward has been rolled out across four provinces in Canada – Saskatchewan, Manitoba, British Columbia and Ontario. A number of NHS Institute products also feature in the Masters in Quality available through Toronto University.
- There has been widespread implementation of The Productive Ward across 14 hospital systems in the North West United States.
- In Qatar we saw full implementation and consolidation of The Productive Operating Theatre and this programme was also implemented for the first time in the United States at Legacy Good Samaritan hospital in Portland, Oregon.

Management Commentary and Review of Activity *(continued)*

- In Ireland the national implementation programme for The Productive Ward gathered pace and the Health Service Executive won the Lean Academy 'International Productives' award. The NHS Institute/Waterford Institute of Technology International Fellowship completed a successful second year.
- In Scandinavia, The Productive Ward was translated into Danish and rolled out in additional hospitals including the internationally recognised Rigshospitalet in Copenhagen. Agreement was reached for the translation of The Productive Mental Health Ward into Swedish with a view to national roll out across Sweden.
- In Belgium and Netherlands more hospitals began implementation of The Productive Ward and The Productive Mental Health Ward. The Productive Ward implementation in Antwerp University Hospital was a finalist in the Red Cross 'Excellence in Hospital Management' awards in December 2012 hosted by the President of the European Union.
- The Productive Ward and Productive Community Services were implemented in a number of hospices, including all Marie Curie Hospices.
- An International Productive Times was published in April 2012, which included stories and case studies from some of our international customers.

Leadership

- The Leadership directorate of the NHS Institute was transferred out of the organisation to the new NHS Leadership Academy, hosted by University Hospital of South Manchester NHS Foundation Trust (UHSM) on 1 July 2012.
- The transfer included the human and financial resources, products and assets of the NHS Institute's Leadership directorate including the following programmes: Board Development, Emerging Leaders including the Graduate Management Trainee Scheme (GMTS), Leadership for Equality, Gateway to Leadership, Breaking Through.
- The transfer of assets included the office and IT equipment used in the NHS Institute's London office, relevant books, stationery, publications and laptops relating to GMTS Assessment centre. The transfer also included the TUPE transfer of 20 staff to UHSM pending further re-organisation of the NHS Leadership Academy.

Knowledge Management and legacy

- **NHS Institute Alert**, a monthly email digest of articles and journals on service improvement and change management, grew its circulation to 41,000 subscribers. This year the NHS Institute Alert was enriched with recommendations from Twitter followers and other connections.
- Other services included **Article of the Month, Guest Editorials** and **Expert on Call** – a free monthly web seminar where leading thinkers shared their knowledge and discussed ideas with attendees. In 2012-13,1,644 people participated in seminars on topics ranging from the contribution that integration can make to healthcare reforms, learning from leaders of social movements and the cost and quality agenda.
- The Knowledge Management team led the implementation of a content management system that is a repository for the know-how of NHS Institute staff. Over the past six months the system was populated with 20,739 documents.
- A cloud based version of the knowledge repository (Alfresco) will enable the legacy of the NHS Institute to be utilised by NHS Improving Quality and its Delivery Team in future work with the NHS.
- A DVD was created of the key NHS Institute products and this was distributed to staff and NHS chief executives as a lasting legacy.

Networks and communications

- The circulation for our monthly e-newsletter rose from 52,680 at the beginning of April 2012 to 62,725 by the end of the year.
- The NHS Institute's Twitter following increased from 3,500 on 31 March 2012 to more than 9,500 at the end of the year and many more individuals and programmes within the NHS Institute were tweeting regularly by the close of 2012-13.
- During the year we attended a number of carefully selected high profile national conferences to aid the spread and adoption of our programmes and tools, including:
  - NHS Confederation Annual Conference
  - International Forum on Safety and Quality in Healthcare
  - NHS Alliance Conference
  - RCN Congress
  - Patient Safety Congress
  - HFMA Annual Conference
  - NAPC Conference
  - Commissioning 2012
  - Acute General Medicine.

Director of Corporate Services and Finance Commentary

Financial performance

The accounts on pages 45 to 81 have been produced in accordance with the direction given by the Secretary of State dated 1 June 2007, in accordance with Schedule 15 of the NHS Act 2006, and in a format as instructed by the Department of Health with the approval of HM Treasury.

2012-13 Finances at a glance

This report includes the financial information for the year ended 31 March 2013. The NHS Institute was required to achieve a number of key and statutory financial targets:

- To maintain its revenue expenditure within a limit of £32,184,000. This was achieved.
- The NHS Institute was required to maintain its capital expenditure within a limit of £1,605,000. This was achieved.
- To maintain its net cash outgoings from operating activities within a limit of £38,717,000. This was achieved.
- In addition to the key statutory targets, the NHS Institute was expected to undertake its business in accordance with the Department for Business Innovation and Skills (BIS) payment targets. The NHS Institute was required to pay all non-NHS trade payables within five days of receipt of a correctly rendered invoice, unless other payment terms had been agreed. In this respect the NHS Institute paid 62% (by value) and 67% (by number) of its non-NHS trade payables within five days. The NHS Institute maintained the prior year's performance levels in overall terms.

Financial position at 31 March 2013

The financial year 2012-13 once again proved to be a challenging one with continued uncertainty about the future of the NHS Institute having a significant impact on our operations.

It was agreed by the NHS Commissioning Board that there would be a new Improvement Body called NHS Improving Quality that would subsume many of the functions of existing NHS bodies that operated across the improvement landscape, including many of the functions of the NHS Institute. This year there has been a managed transition to this new body and an orderly closedown of the Special Health Authority. Against this changing backdrop the NHS Institute achieved an underspend against its projected cost of £6.6m. This is explained in more detail below.

Subject to the comments below, during the year the NHS Institute drew down its full resource and 83% of its cash grant funding limit. These were fully invested in supporting those activities which underpinned the achievement of our corporate objectives. The NHS Institute also undertook a number of other improvement and innovation activities on behalf of the Department of Health which were funded through invoicing for services. Again, this income was fully invested into the projects supporting those services.

The underspend reported reflects a number of factors:

- Once again the continued uncertainty led to a conscious decision to restrict budgets across the business to create resource headroom to adapt to changing priorities, to allow the NHS Institute headroom to cover the associated restructuring costs of closure and to provide the necessary funds to enable a smooth transition of the business into successor bodies. A reserve was set aside of £3m for this purpose. This reserve was largely unspent at 31 March 2013.

Director of Corporate Services and Finance Commentary *(continued)*

- During the year the Cabinet Office efficiency restrictions were continued across Government on many categories of expenditure. In particular the restrictions on the use of professional services had an adverse impact on the business. The NHS Institute continued with its strategy to deliver improvement support to the frontline NHS through a series of improvement grants to authorities and trusts. The internal controls and processes established to ensure that grants were properly administered were reviewed and improved and the requirements of Government accounting were met. This led to a delay in the delivery of QIPP support, and during the year, some grants had to be recovered from grantees where they were unable to fully utilise the grant in accordance with the grant agreements and within agreed timeframes.
- All programmes across the business were planned and resourced with closure in mind with the majority of programmes being scheduled to finish by the end of quarter three.

Despite the uncertainty and the emergent underspend on resources, the NHS Institute was able to respond in a robust and measured way to ensure that the impact on its ability to support the NHS in delivering its QIPP targets and other priorities were kept to a minimum. This was particularly critical in a year when the NHS Commissioning Board was evaluating the improvement support needed by the NHS and, as a result, concluded that it wished to retain many of the services of the NHS Institute, albeit within the umbrella of NHS Improving Quality.

The issues described above necessitated the continuing application of further controls and procedures, to ensure that the financial management of the business remained strong and to provide assurances to the Audit and Risk Management Committee and the Board over the identification and management of financial risks. The final financial position is outside the tolerances established in our Framework Document, which permits an underspend of 2% against its total funding without formal notification to the Department. The Department was, however, informed of this position through regular and improved financial reporting of our forecasts and projections, combined with a deeper analysis of the monitoring of performance against targets.

Due to the closure of the NHS Institute it is not appropriate to adopt the going concern principle in the preparation of these accounts.

Other matters

As part of the plan to abolish the Special Health Authority, the NHS Institute actively engaged with the Department of Health over the transfer of those improvement and leadership activities that were required to be transitioned to successor bodies and on the 1 July 2012 the Leadership Directorate of the NHS Institute transferred to the National Leadership Academy.

The NHS Institute continued to improve its internal control and management information systems. The business plan for 2012-13 had three main strands: activities to support the closure of the Special Health Authority, delivery of activities to continue to support QIPP and other priorities in the NHS and activities to facilitate the transfer of functions to NHS Improving Quality and other successor bodies.

Remuneration Report – Annual Report and Accounts 2012-13

This report is subject to audit.

Details of the membership of the Remuneration Committee

The NHS Institute had a Remuneration Committee consisting of non-executive directors David Bower (Chair) and Professor Tony Butterworth. All other non-executive directors had a standing invitation to attend.

The Accounting Officer and one other executive member were also in attendance.

In the final year of closedown the committee's remit was to:

Oversee the arrangements for those executive directors who were remunerated under the National Very Senior Managers Pay (VSMP) Framework.

Consider recommendations made by the NHS Institute's Workforce in Transition (WIT) committee which was specifically set up to manage significant employment issues during the organisation's closedown. This included reviewing recommendations from the WIT regarding Voluntary Redundancies (VRs) and making recommendations to the DH Governance and Audit Committee (GAC).

Oversee and ensure that appropriate actions were taken regarding terms and conditions and legal employment processes for executive directors particularly whilst going through considerable change.

Performance conditions

For all senior managers below executive director level the NHS Institute had in place a personal objective-setting process with line managers, which linked into the annual appraisals and review process.

The executive directors took the lead on this process within their individual areas.

Executive directors were also subject to performance review in line with the VSM Pay Framework. Executive director performance related pay payments were non-consolidated and non-pensionable.

Remuneration Report Summary and explanation of policy on duration of contracts, and notice periods and termination payments for chairs and non-executive members of The NHS Institute for Innovation and Improvement

Terms and Conditions

1. 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 chairs and members of the NHS Institute for Innovation and Improvement were governed by the NHS Institute for Innovation and Improvement Regulations 2005.

2. Employment Law

The appointments were not within the jurisdiction of Employment Tribunals. Neither was there any entitlement for compensation for loss of office through employment law.

3. Reappointments

Chairs and non-executive members were eligible for reappointment at the end of their period of office, but they had no right to be reappointed. The Department of Health would usually consider afresh the question of who should be appointed to the office. However, it was likely to consider favourably a second term of appointment without competition for people whose performance was appraised as consistently good during their first term. If reappointed, further terms would only be considered after open competition, subject to a maximum service of ten years with the same organisation and in the same role.

4. Termination of appointment

Regulation 5 of the Regulations sets out the grounds on which the appointment of the Chair and non-executive members may be terminated. A Chair or non-executive member could resign by giving notice in writing to the Secretary of State or the Department of Health. Their appointment would also be terminated if, in accordance with regulations they became disqualified for appointment. In addition the Department of Health could terminate the appointment of the Chair and non-executive members on the following grounds:

- if it was of the opinion that it was not in the interests of the NHS Institute or the health service that they should continue to hold office
- if the chair or non-executive member did not attend a meeting of the Special Health Authority for a period of three months
- if the chair or non-executive member did 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 (eg a failure to disclose such an interest).

The following list provides examples of matters which may have indicated to the Department of Health that it was no longer in the interests of the health service that an appointee continued in office. The list is not intended to be exhaustive or definitive; the Department of Health would consider each case on its merits, taking account of all relevant factors.

a) If an annual appraisal or sequence of appraisals was unsatisfactory.

b) If the appointee no longer enjoyed the confidence of the Board.

c) If the appointee lost the confidence of the public.

d) If a chair appointee failed to ensure that the Board monitored the performance of the Special Health Authority in an effective way.

e) If the appointee failed to deliver work against pre-agreed targets incorporated within their annual objectives.

Remuneration Report – Annual Report and Accounts 2012-13 *(continued)*

f) If there was a terminal breakdown in essential relationships, eg between a chair and a chief executive or between an appointee and the rest of the board.

g) When a new chair was appointed to a board he/she would be expected to review the objectives of all board members and could, at the time of their next appraisal, make a recommendation to the Department of Health regarding their continued appointment.

There is no provision in the NHS Institute's annual accounts for the early termination of any non-executive's appointment.

5. Remuneration

The chair and non-executive members were entitled under the Act to be remunerated by the Special Health Authority for so long as they continued to hold office as chair or non-executive member.

They were entitled to receive remuneration only in relation to the period for which they held office. There was no entitlement to compensation for loss of office.

6. Current rate for chair and non-executives

The rate (2012-13) of remuneration payable to the chair of the NHS Institute for Innovation and Improvement was £63,048 pa for up to three days a week. The rate of remuneration payable to members was £7,881 pa for approximately two days per month with an additional £5,254 pa for the chair of the Audit and Risk Management Committee.

7. Tax and National Insurance

Remuneration was taxable under Schedule E, and subject to Class 1 National Insurance contributions. Any queries on these arrangements should be taken up with the Inspector of Taxes or the Contributions Agency respectively.

8. Allowances

Chairs and non-executive members were also eligible to claim allowances, at rates set centrally, for travel and subsistence costs necessarily incurred on Special Health Authority business.

9. Public speaking

On matters affecting the work of the Special Health Authority, chairs and non-executive members could not normally make political speeches or engage in other political activities. In cases of doubt, the guidance of the Department of Health was sought.

10. Conflict of interest

NHS boards are required to adopt the Codes of Conduct and Accountability, published in April 1994. The Codes require chairs and board members to declare on appointment any business interests, position of authority in a charity or voluntary body in the field of health and social care, and any connection with bodies contracting for NHS services. These must be entered into a register which is available to the public at public Board meetings.

Remuneration Report – Annual Report and Accounts 2012-13 *(continued)*

11. Indemnity

The Special Health Authority was empowered to indemnify the chair and non-executive members against personal liability which they may incur in certain circumstances whilst carrying out their duties. HSC 1999/104, which is available from the National Archives.

The NHS Institute took out a policy of Directors and Officers liability insurance in consultation with the NHS Litigation Authority having regard to the NHS England and international nature of its work.

For executive directors of the NHS Institute for Innovation and Improvement

Terms and Conditions

1. Basis for appointment

Executive directors were appointed on a permanent basis under a contract of service at an agreed salary, eligibility to claim allowances for travel and subsistence costs, at rates set by the NHS Institute for expenses incurred necessarily on its behalf. Executive directors acting in an interim capacity were normally appointed on the basis of a fixed term agreement. They were not entitled to a performance related award but were entitled to all other allowances and benefits.

2. Termination of appointment

On the grounds of incapacity of an executive director, the NHS Institute would give six months' notice once sick pay has been exhausted. The notice for termination for any other substantive reason was six months. During the year there were no payments for compensation for the early termination of any contract of employment to any executive director.

Remuneration Report – Annual Report and Accounts 2012-13 *(continued)*

Details of the service contract for each senior manager who has served during the year

Name	Title	Start Date	Review Date[1]
Rod Anthony	Interim Managing Director and Director of Corporate Services and Finance	1 August 2008	Not applicable
Helen Bevan	Chief of Service Transformation	1 July 2005	Not applicable
Julian Denney	Director of Planning and Performance and Assistant Chief Executive	8 June 2012	Not applicable
Carol Black	Non-executive Director	15 February 2006	Not applicable
David Bower	Non-executive Director and Chair of the Remuneration Committee	17 November 2011	Not applicable
Tony Butterworth	Chair	1 July 2005	Not applicable
Richard Colley	Non-executive Director	17 November 2011	Not applicable
Michael Deegan	Non-executive Director	1 July 2005	Not applicable
Simone Jordan	Chief Operating Officer and Deputy Chief Executive	1 October 2005	On secondment from 23 August 2010. Transfers to HEE 01/04/2013
Joe Liddane	Non-executive Director and Chair of Audit and Risk Management Committee	1 March 2009	Not applicable
Julian Nettel	Interim Managing Director	1 July 2011	Left 31st July 2012
Noorzaman Rashid	Non-executive Director	1 October 2007	Not applicable

Notes:
1. Due to the closure of the NHS Institute, a review date for service contract for senior managers is not applicable.

Remuneration Report – Annual Report and Accounts 2012-13 *(continued)*

Salaries and Allowances

Name and Title	2012-13 See note 1 Salary (bands of £5,000) £000	See note 2 Very Senior Managers bonus payments £000	Benefits in kind £000	Total (bands of £5,000) £000	2011-12 See note 1 Salary (bands of £5,000) £000	See note 2 Very Senior Managers bonus payments £000	Benefits in kind £000	Total (bands of £5,000) £000
Rod Anthony (Interim Managing Director/Director of Finance and Corporate Services)	125-130	0	0	125-130	125-130	0	0	125-130
Julian Denney (Director of Planning and Performance and Assistant Chief Executive)	115-120 See note 3	0	0	115-120	0	0	0	0
Helen Bevan (Director of Service Transformation)	125-130	0	0	125-130	125-130	0	0	125-130
Bernard Crump (Chief Executive)	0 See note 4	0	0	0	130-135 See note 4	0	3	130-135
Julian Nettel (Interim Managing Director)	30-35	0	0	30-35	85-90 See note 5	0	0	85-90
Simone Jordan (Deputy Chief Executive and Chief Operating Officer)	0 See note 6	0	0	0	0 See note 6	0	0	0
Yve Buckland (Chair and Chair of Shadow Nominations Committee)	0 See note 7	0	0	0	45-50 See note 7	0	0	45-50
Tony Butterworth (Non-executive Director to 31 Dec 2011 and Interim Chair thereafter)	60-65	0	0	60-65	20-25 See note 8	0	0	20-25
Michael Deegan (Non-executive Director)	5-10	0	0	5-10	5-10	0	0	5-10
Noorzaman Rashid (Non-executive Director)	5-10	0	0	5-10	5-10	0	0	5-10
Carol Black (Non-executive Director)	5-10	0	0	5-10	5-10	0	0	5-10
Joe Liddane (Chair of Audit Committee)	10-15	0	0	10-15	10-15	0	0	10-15
Michael Lander (Non-executive Director)	0 See note 9	0	0	0	0-5 See note 9	0	0	0-5
David Bower (Non-executive Director)	5-10	0	0	5-10	0-5 See note 10	0	0	0-5
Richard Colley (Non-executive Director)	15-20 See note 11	0	0	15-20	0	0	0	0
See note 12 **Band of highest paid Director's total (£000)**		190-195				195-200		
Median total £		40,157				34,348		
Remuneration ratio		5:1				6:1		

Notes:

1. Executive directors' salaries included non-consolidated, non-pensionable performance related elements.
2. There were no very senior managers bonuses paid in year (relating to the prior year) and the bonuses paid in 2011-12 are separately identified.
3. Julian Denney was appointed as an Executive Director on 8 June 2012.
4. Bernard Crump retired from his post on 30 September 2011 and included within the salary above is a payment in lieu of notice.
5. Julian Nettel commenced his post on 1 July 2011 and was remunerated for three days a week through contract arrangements with Julian Nettel Consulting Ltd. Julian left his post on 31 July 2012.
6. Simone Jordan commenced a secondment with East Midlands Strategic Health Authority on 23 August 2010 and her full salary has been recharged.
7. Yve Buckland left her post on 31 December 2011.
8. Tony Butterworth commenced his post on 1 January 2012.
9. Michael Lander left his post on 30 September 2011.
10. David Bower commenced his post on 17 November 2011.
11. Richard Colley commenced his post on 17 November 2011 and during 2012-13 took on additional non-executive director responsibility for the NHS Institute's National Innovation Centre.
12. Also disclosed is the median remuneration of the NHS Institute's staff and the ratio between this and the mid-point of the banded remuneration of the highest paid director which in this case is the Interim Managing Director (2011-12 Interim Managing Director). The calculation is based on the full-time equivalent staff of the NHS Institute as at 31 March 2013 and is worked out on an annualised basis.

Remuneration Report – Annual Report and Accounts 2012-13 *(continued)*

Pension Benefits

Name and Title	Real increase in pension at age 60 (bands of £2,500)	Real increase in pension lump sum at aged 60 (bands of £2,500)	Total accrued pension at age 60 at 31 March 2013 (bands of £5,000)	Lump sum at age 60 related to accrued pension at 31 March 2013 (bands of £5,000)	Cash equivalent transfer value at 31 March 2013 £000	Cash equivalent transfer value at 31 March 2012 £000	Real increase in cash equivalent transfer value £000	Employer's contribution to stakeholder pension £000
Rod Anthony (Interim Managing Director/ Director of Finance and Corporate Services)	0-2.5	0 See note 1	5-10	0 See note 1	123	94	27	0
Helen Bevan (Director of Service Transformation)	0-2.5	0-2.5	45-50	140-145	916	860	36	0
Julian Denney (Director of Planning and Performance and Assistant Chief Executive)	See note 2	See note 2	20-25	65-70	415	See note 2	See note 2	0

Notes:
1. The lump sum is shown as nil as membership is of the NHS Pension Scheme 2008 Section.
2. Julian Denney was appointed as an Executive Director on 8 June 2012 and pension disclosures have been made where numbers are available.

Pension Benefits *(continued)*

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 figures, and 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.

Redundancy

Julian Denney left the NHS Institute on 31 March 2013 on early retirement through redundancy as part of the NHS Institute's voluntary redundancy programme. The costs of this were £162,096.52.

Rod Anthony's fixed term contract was extended for a period of three months to 30 June 2013, as part of the NHS Institute's final closedown arrangements at which point he will be made compulsory redundant at a cost of £41,667.

David Nicholson

Accounting Officer from 1 April 2013

NHS Commissioning Board

18 June 2013

Accounts

Statement of Accounting Officer's Responsibilities

Under the National Health Service Act 2006 and directions made thereunder by the Secretary of State with the approval of HM Treasury, the NHS Institute was 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 HM Treasury. The accounts were prepared on an accruals basis and gave 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 Interim Managing Director 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 Accounting Officer is required to comply with the requirements of the Government Financial Reporting Manual and in particular to:

- observe the accounts direction issued by the Secretary of State, including the relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis;
- make 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; and
- prepare the financial statements on a going concern basis, unless it is inappropriate to presume that the NHS Institute will continue in operation.

The Interim Managing Director'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.

Annual Governance Statement for the year ended 31 March 2013

1. Scope of responsibility

As Accounting Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of the NHS Institute's policies, aims and objectives, whilst safeguarding the public funds and departmental assets for which I am personally responsible, in accordance with the responsibilities assigned to me in the Accounting Officer Memorandum. As Accounting Officer, I am accountable to Parliament and the Secretary of State for Health. Our annual business plan was agreed with our Department of Health senior departmental sponsor, who monitored achievement against the plan in regular performance review meetings. The senior departmental sponsor had an open invitation to Board and Audit and Risk Management Committee meetings and also received copy minutes of these meetings.

2. The governance framework of the organisation

The governance framework consisted of the systems, processes, culture and values by which the NHS Institute was directed and controlled and the activities through which it accounted to and engaged with Parliament and the public. It enabled the NHS Institute to monitor progress against its strategic objectives and to consider whether those objectives led to the delivery of its services. The governance framework included the system of internal control and the risk management processes, including arrangements for information governance. It needed to take account of the environment in which the NHS Institute operated, and the risks it faced.

Governance arrangements

In *NHS Institute for Innovation and Improvement – Directions 2005* (and amended 2007), the Secretary of State sets out the functions of the NHS Institute. The *NHS Institute for Innovation and Improvement – Regulations 2005* sets out the membership and procedures of the organisation. The NHS Institute was established '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 issued by the Secretary of State for Health).

The board of the NHS Institute provided strategic leadership to the organisation and was the body responsible for ensuring that strategic objectives were met. Membership of the board consisted of both executive and non-executive directors. The board was led by a non-executive chair and non-executive directors were appointed by the Secretary of State. The Accounting Officer was nominated by the chair and the non-executive directors appointed by the Department of Health and together the Board appointed the executive directors.

The board's composition at 31 March 2013 was as follows:

Professor Tony Butterworth CBE
– Interim Chair

Professor Dame Carol Black
– Non-executive Director

David Bower
– Non-executive Director and Interim Chair of the Remuneration Committee

Annual Governance Statement for the year ended 31 March 2013 *(continued)*

Richard Colley
– Non-executive Director

Michael Deegan CBE
– Non-executive Director

Joe Liddane
– Non-executive Director and Chair of the Audit and Risk Management Committee

Noorzaman Rashid
– Non-executive Director

Dr Helen Bevan OBE
– Executive Director (Chief of Service Transformation)

Rod Anthony
– Executive Director (Director of Corporate Services and Finance and Accounting Officer)

Julian Denney
– Executive Director and Company Secretary (Director of Planning and Performance and Assistant Chief Executive).

Committees of the Board:

There were four formal committees of the NHS Institute Board.

The Audit and Risk Management Committee

The Audit and Risk Management Committee routinely met bi-monthly and was responsible to the board for developing and overseeing effective arrangements for all aspects of internal control and financial reporting within the NHS Institute. As part of this remit it was also responsible for maintaining an appropriate relationship with external and internal auditors. As such, the committee was the principal body, below the board, for carrying out scrutiny of policy and processes within the NHS Institute. It was this remit which distinguished the work of the Audit and Risk Management Committee from the other groups advising the board.

Core members were: Joe Liddane (Chair), Richard Colley and Noorzaman Rashid. All other non-executive directors were welcome to attend.

The Remuneration Committee

Details of the Remuneration Committee are contained within the Remuneration Report on pages 23-30.

The Executive Committee

The Executive Committee was responsible for the executive management of the NHS Institute. It was comprised of the executive directors and other NHS Institute senior managers and met weekly throughout 2012-13.

New Improvement Body Programme Board

The new Improvement Body Programme Board was established within the NHS Institute during 2012-13 to create some separation between the day-to-day business of the NHS Institute (including its closure) and those activities associated with supporting the creation of the new Improvement Body (NHS Improving Quality).

Attendance at meetings

All committee meetings during the year were quorate. The possible and actual attendance records for the members of the Board and the various committees are shown on next page.

Annual Governance Statement for the year ended 31 March 2013 *(continued)*

Board	Role	Possible	Actual
Rod Anthony	Executive	4	4
Helen Bevan	Executive	4	3
Julian Denney	Executive	4	4
Karen Lynas (to 30 June 2012 only)	Director	1	0
Lynne Maher	Director	4	1
Julian Nettel (to 30 June 2012 only)	Executive	1	1
Lynne Winstanley	Director	4	4
Carol Black	Non-executive	4	0
David Bower	Non-executive	4	3
Tony Butterworth	Non-executive and Chair	4	4
Richard Colley	Non-executive	4	4
Mike Deegan	Non-executive	4	1
Joe Liddane	Non-executive	4	4
Noorzaman Rashid	Non-executive	4	2
Jim Easton	DH Sponsor	1	1
George Leahy	DH Sponsor	4	3

Audit and Risk Management Committee	Role	Possible	Actual
Joe Liddane	Non-executive and Chair	7	7
Rod Anthony	Executive	7	7
Richard Colley	Non-executive	7	6
Noorzaman Rashid	Non-executive	7	3
Julian Nettel (to 30 June 2012 only)	Executive	3	2
Tony Butterworth	Non-executive	7	5

Remuneration Committee	Role	Possible	Actual
David Bower	Non-executive and Chair	3	3
Tony Butterworth	Non-executive	3	3
Rod Anthony	Executive	3	3
Giselle Lockett	Head of HR	3	3
Julian Nettel (to 30 June 2012 only)	Executive	1	1
Carol Black	Non-executive	3	0
Mike Deegan	Non-executive	3	1

Annual Governance Statement for the year ended 31 March 2013 *(continued)*

Name of auditor

The Comptroller and Auditor General is the statutory auditor of the NHS Institute for Innovation and Improvement.

Declaration 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.

The declarations of interest made by board members were recorded in the minutes of board meetings and a declaration of interest form was completed. A register of interests was kept and maintained by the company secretary, and is available for public inspection. The chair would ask whether there were any 'declarations of interest' at the start of each board meeting. Whenever an interest was declared which could amount to a conflict of interest, the member concerned did not take any part in the relevant discussion or decision at the meeting.

For details of the declarations of interest, please refer to the register of interests and to the minutes of the public board.

Board performance

The Board Assurance Framework, together with the associated strategic and high level risk registers, mapped the key objectives of the NHS Institute and identified the risks to their achievement. It also identified the internal control mechanisms to manage the risks. Finally, it identified and examined the key sources of assurance, identifying where gaps in control and/or assurance existed.

The Board of the NHS Institute recognised that given the changes affecting the business, in particular its planned closure, and the creation of NHS Improving Quality, this impacted on the risks facing the business and the Board's attitude to risk management. In order to move forward positively and to ensure that critical services were maintained and preserved for the future benefit of the NHS and to support QIPP, it was accepted that there needed to be a much greater involvement of the Board in the active management of risk during the year. An example of this was the Board seminar held in January 2013 which, on the recommendation of the Audit and Risk Management Committee, considered the detailed strategic risks and mitigations.

Due to the closedown of the NHS Institute on 31 March 2013, no formal assessment of the Board's effectiveness was completed during the year although this was kept under continuous review.

3. The story this year

Closure

A Closure Team was established by the Executive Committee at the start of the financial year to support functional leads with closure activities, to ensure consistency of messages to all stakeholders including staff, the Department of Health and the NHS Commissioning Board and to manage closure risk. Arrangements have been made with the NHS Commissioning Board for a small team to remain in place following formal closure on 31 March 2013 to complete closure activities and to ensure that the annual report is promptly laid before Parliament.

The Executive Team's priorities were to support staff through the changes and to ensure that the legacy of the NHS Institute was preserved. This legacy work focused on supporting the transition of activities and assets to NHS Improving Quality and, where appropriate, to other organisations where important products and services can continue to the benefit of the NHS.

Annual Governance Statement for the year ended 31 March 2013 *(continued)*

The preservation of the NHS Institute legacy has been achieved through the recording of information and knowledge on a database system.

This year has been a fundamental one for the staff of the NHS Institute. With the planned closure and transition of activities to NHS Improving Quality, supporting our staff through the change and helping them to come to terms with a new and different future has been critical. During the year we have seen the following:

Staff in post 1 April 2012	171
Leavers to other NHS organisations	(27)
Leavers to other organisations	(2)
Voluntary redundancies	(71)
Transferring to NHS Improving Quality	71

This transition was helped by a detailed 'next steps' programme for our staff to help them prepare for their futures and to provide a range of supporting activities and outplacement help on a personal basis. This was well attended by staff and received very positive feedback. As a result, our staff positively came to terms with the changes and were able to see positive futures.

Transfer of the Leadership function

On 1 July 2012 the Leadership function within the NHS Institute transitioned to the National Leadership Academy which is hosted by University Hospital of South Manchester NHS Foundation Trust. Documentation included a business transfer agreement, a perpetual licence of copyright, a perpetual licence of trademarks and a deed of assignment of contracts.

All risks identified were mitigated on this transfer.

Establishment of the new Improvement Body – NHS Improving Quality (NHS IQ)

Work continued during 2012-13 to align the emerging needs of the NHS Commissioning Board with the NHS IQ. Support was given to the work programme at a senior level by the NHS Institute as it was acknowledged that the NHS Institute was one of a number of bodies that support innovation and improvement work which would transfer across into NHS IQ. Recruitment to NHS IQ took place with systems and processes operational by 1 April 2013.

NHS IQ has not been a source of significant employment opportunity for NHS Institute staff due to the headquarters location in Leeds and the limited number of roles available.

Establishment of the Delivery Team

The establishment of a transition team to become a delivery arm of the NHS IQ was announced in November 2012 which meant that any NHS Institute staff who had not secured their future arrangements elsewhere by 31 March 2013 would 'lift and shift' into the Delivery Team where their future was secure for up to another year. This Delivery Team would ensure some continuity of resource and capability during a transitional period whilst the NHS IQ established key team arrangements for delivery of improvement programmes to support the NHS Commissioning Board and the domain priorities.

The NHS Institute were engaged with the other legacy bodies to develop the systems and processes and to gain an understanding on how staff would be utilised during the initial phase of engagement of the Delivery Team.

Annual Governance Statement for the year ended 31 March 2013 *(continued)*

4. Corporate governance

Audit and Risk Management Committee

The Audit and Risk Management Committee was responsible for reviewing risk management activity and the effectiveness of the internal control framework under delegation of the Board and the main risks are detailed on page 5 of the annual report. It received regular reports from the internal auditors and will receive an annual management letter from the external auditors to supplement the regular updates that they also provide. The Audit and Risk Management Committee also received information from other internal and external sources to aid the Committee in fulfilling its functions.

During the year the Audit and Risk Management Committee was actively involved in the effective operation of the Board Assurance Framework and has regularly reviewed the Strategic Risk Register. The Audit and Risk Management Committee has also reviewed the framework to ensure that it remained fit for purpose. This has involved:

- review of the key operational risks as identified in the business planning process
- review of the key closedown/transition risks as identified by the closedown team
- identification of strategic risks through the Executive Committee with particular attention given to the enhanced risks associated with delivering objectives through grant partner organisations
- prioritisation of those risks
- assessing the effectiveness of the mitigation actions
- written assurances from directors and senior managers confirming compliance with the system of internal control

It was essential that the Committee continued to assess and improve controls even though the organisation was to close. It ensured that the NHS Institute's control mechanisms were reviewed and updated to address risks as they arose. Consideration was also given to the coverage of the internal audit programme with flexibility to meet any emerging risks and the progress on implementing both internal and external audit recommendations. Responsibility for oversight of this work, on behalf of the Board, remained with the Audit and Risk Management Committee.

Control environment

Three sub-committees of the Executive Team were established during the year to ensure that the appropriate control mechanisms were in place. These were the Workforce In Transition Group (WIT) which looked at resource planning and management, the Operational Management Group (OMG) which looked at the delivery of programmes and the Grant Monitoring Group (GMG) which gave oversight and support to the grants process. The triangulation of these committees and the combining of the board and performance reports into one report also helped to strengthen the accounting and financial management at the NHS Institute as well as assuring the quality of the data being provided to the Board.

It was anticipated that the number of single tender actions would increase during 2012-13 due to the final year of operation as a Special Health Authority and the requirements of transition. Procurement retained oversight over all single tender actions to ensure value for money and an additional control was introduced to obtain agreement from the Chair of the Audit Committee (who would liaise with the other non-executive directors as appropriate) for all single tender actions over £100k.

Annual Governance Statement for the year ended 31 March 2013 *(continued)*

Control measures were in place to ensure that all of the NHS Institute's obligations under equality, diversity and human rights legislation were complied with.

Performance reviews

The NHS Institute used a balanced scorecard approach for the 2012-13 business plan and performance monitoring reports for each of the business areas were based on that framework. Due to the restrictions in place during the course of the financial year, each business area took responsibility for reporting to the Board on how they were going to deliver for the current financial year and each programme was reviewed in detail by the Operational Management Group.

Each quarter the NHS Institute's performance and risk management were reviewed with the departmental sponsor, who formally wrote an accountability review letter. I am pleased to say that despite the uncertainties and closedown focus, the letters written during 2012-13 were always very positive and supportive of our work.

Pension arrangements

As an employer with staff entitled to membership of the NHS Pension Scheme, control measures were in place to ensure all employer obligations contained within the scheme regulations were complied with. This included ensuring that deductions from salary, employer's contributions and payments into the scheme were in accordance with the scheme rules, and that member pension scheme records were accurately updated in accordance with the timescales detailed in the regulations. The assurance over these arrangements was through the NHS Business Services Authority who provided the NHS Institute payroll and pensions administration services.

Sustainability

The NHS Institute proactively engaged in strategies to reduce emissions of greenhouse gases, reduce waste, reduce water consumption and make procurement more sustainable, with activities including the creation of a social movement group for sustainability and participation in the NHS day of action for sustainability. The NHS Institute has claimed an exemption due to falling below the threshold for whole time equivalent (WTE) staff of 250 people and therefore the sustainability report has not been included in the Annual Report and Accounts for 2012-13.

5. Other information

Information Governance

Information Governance (IG) within the NHS Institute was a key consideration in the areas of risk management, project appraisal and control/system reviews. The NHS Institute recognised that the quality and security of data had a significant role in providing assurance to its stakeholders that information was managed competently and securely.

During the year, the NHS Institute maintained its information governance procedures, maintaining the levels of compliance achieved and resources invested. The organisational context and role was recognised; the NHS Institute ceased to exist as a Special Health Authority on 31 March 2013 and as a non-frontline organisation the NHS Institute did not hold patient level information. Consequently, the approach continued from last year balances the importance of information governance against the effective deployment of organisational resources.

Annual Governance Statement for the year ended 31 March 2013 *(continued)*

The review included taking advice and receiving recommendations from the Department of Health, the Information Commissioner's Office and our internal auditors to ensure we met the recommended standards in data protection and information governance. As a result:

- the process of transferring and archiving of information assets during the closedown process was co-ordinated via the Closure Team
- the NHS Connecting for Health Information Governance Toolkit (IGT) which contains mandatory compliance requirements was not submitted this year since the organisation ceased to exist after 31 March 2013
- IG training continued and work on data cleanses for the CRM system continued
- there was continued awareness of information governance issues

This work was undertaken with reference to internal audit and the IGT v9.0 submission.

Restricted spend

The Government's efficiency measures and controls which included freezes on external recruitment, the use of consultants and expenditure on marketing and communications continued into the 2012-13 financial year and continued to disrupt planned activities and delivery of services. During the second quarter some of the restrictions were lifted but this did not have any significant bearing on the NHS Institute.

Grant funding

The NHS Institute once again pursued the model of providing improvement grant funds to enable partner organisations to achieve their QIPP targets. Grants were provided to partner organisations based upon clear QIPP plans with deliverables aligned to improvement and efficiency targets, and monitoring processes were established to ensure the grants' objectives were being achieved. This again resulted in significant activity in the second half of the financial year. All activity was closely monitored and grant sums repaid if it became clear that commitments could not be delivered in accordance with the grant conditions.

The NHS Institute reviewed the controls and operation of the grant awarding and monitoring process. Key enhancements put into place were, greater engagement of the Executive Committee in approving all grants paid and the oversight by the Grant Monitoring Group as a sub-group of the Executive Committee to maintain the satisfactory progress and outcomes of grant funded activities.

6. Risk assessment

The purpose of the system of internal control

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

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

The system of internal control has been in place in the NHS Institute for the year ending 31 March 2013 and up to the date of approval of the annual report and accounts, and accords with HM Treasury guidance.

Annual Governance Statement for the year ended 31 March 2013 *(continued)*

Effectiveness of the system of internal control

My opinion on the effectiveness of a system of internal control is based on evidence primarily provided to me from oversight by the Audit and Risk Management Committee on behalf of the Board.

- The NHS Institute's Board Assurance Framework ensured that strategic and operational risks were identified, appropriately managed and effectively communicated across the NHS Institute.

The work was informed by external and internal audit. The results of work undertaken by internal audit were reported to the Audit and Risk Management Committee throughout the year and showed a reliable system of internal control.

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

- the identification of key risks through the business planning process
- the identification of closedown/transition risks through the functional leads and led by the closedown team
- risk assessment and management undertaken by the Executive Committee
- regular Audit and Risk Management Committee and Board consideration of key strategic risks
- risk owners being identified across the NHS Institute
- a programme of work to enhance the core financial management system and processes as well as provide for better management information that strengthened our risk management approach
- programmes of training that were provided to all staff in relation to health and safety, fire risks, counter fraud awareness and information governance.

7. Significant issues

There were no significant issues to note for 2012-13.

The matter noted last year as being investigated by NHS Protect has been concluded and no action is necessary.

8. Accounting Officer Opinion

As Accounting Officer, I have responsibility for reviewing the effectiveness of the system of governance. My review is informed in a number of ways. The Head of Internal Audit provided 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.

His overall opinion for 2012-13 was of significant assurance based upon the rolling programme of work.

External audit places reliance on internal audit work and performs work independently to assess the level of assurance.

Executive managers within the organisation who had responsibility for the development and maintenance of the system of governance also provided me with assurance.

The Assurance Framework itself provided me with evidence that the effectiveness of controls that managed the risks to the organisation achieving its principal objectives had been reviewed.

Annual Governance Statement for the year ended 31 March 2013 *(continued)*

One of the other targets that the NHS Institute was expected to measure was its performance against the Department for Business Innovation and Skills (BIS) payment target. Within this, the NHS Institute was required to pay all non-NHS trade payables within five days of receipt of a correctly rendered invoice, unless other payment terms had been agreed. In this respect the NHS Institute paid 62% (by value) and 67% (by number) of its non-NHS trade payables within five days.

Whilst the NHS Institute continued to be focused on achieving this target, the Audit and Risk Management Committee agreed that assuring governance around payment of invoices during the closedown year of the NHS Institute which could cause delays to payments, was more important to the overall governance controls within the NHS Institute.

My review confirms that the NHS Institute complied with the spirit of the *Corporate Governance in Central Government Departments: Code of Good Practice 2011* in so far as it related to the NHS Institute as a Special Health Authority. This statement gives an overview of the governance within the NHS Institute and concludes that there was generally a sound system of governance that supported the achievement of the NHS Institute's policies, aims and objectives.

Rod Anthony

Accounting Officer to 31 March 2013

NHS Institute for Innovation and Improvement

12 June 2013

The NHS Institute for Innovation and Improvement closed as a Special Health Authority on 31 March 2013. The continuing activities of the NHS Institute were transferred to NHS Commissioning Board from 1 April 2013. Accounting Officer responsibility for these continuing activities, including the completion and agreement of these final accounts and their submission to parliament, became my responsibility as the Accounting Officer for NHS Commissioning Board from that date.

In fulfilling this duty I have relied on the statements and assurances of the Accounting Officer for the NHS Institute in the period to 31 March 2013 including his comments contained within the Annual Governance Statement. I have also relied on the oversight of the NHS Institute's own Audit and Risk Management Committee during the financial year, as well as the Audit Committee of NHS Commissioning Board who have reviewed these Annual Report and Accounts and have received the management report from the external auditors at their meeting on 13 May 2013.

David Nicholson

Accounting Officer from 1 April 2013

NHS Commissioning Board

18 June 2013

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 year ended 31 March 2013 under the National Health Service Act 2006. The financial statements comprise: the Statements of Comprehensive Net Expenditure, Financial Position, Cash Flows, Changes in Taxpayers' Equity; and the related notes. These financial statements have been prepared under the accounting policies set out within them. I have also audited the information in the Remuneration Report that is described in that report as having been audited.

Respective responsibilities of the Accounting Officer and auditor

As explained more fully in the Statement of Accounting Officer's Responsibilities, the Accounting Officer is responsible for the preparation of the financial statements and for being satisfied that they give a true and fair view. My responsibility is to audit, certify and report on the financial statements in accordance with the National Health Service Act 2006. I conducted my audit in accordance with International Standards on Auditing (UK and Ireland). Those standards require me and my staff to comply with the Auditing Practices Board's Ethical Standards for Auditors.

Scope of the audit of the financial statements

An audit involves obtaining evidence about the amounts and disclosures in the financial statements sufficient to give reasonable assurance that the financial statements are free from material misstatement, whether caused by fraud or error. This includes an assessment of: whether the accounting policies are appropriate to the NHS Institute for Innovation and Improvement's circumstances and have been consistently applied and adequately disclosed; the reasonableness of significant accounting estimates made by the NHS Institute for Innovation and Improvement; and the overall presentation of the financial statements. In addition I read all the financial and non-financial information in the Annual Report to identify material inconsistencies with the audited financial statements. If I become aware of any apparent material misstatements or inconsistencies I consider the implications for my certificate.

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

Opinion on regularity

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

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

(continued)

Opinion on financial statements

In my opinion:

- the financial statements give a true and fair view of the state of the NHS Institute for Innovation and Improvement's affairs as at 31 March 2013 and of its net resource outturn for the year then ended; and
- the financial statements have been properly prepared in accordance with the National Health Service Act 2006 and directions issued thereunder by the Secretary of State.

Emphasis of matter

Without qualifying my opinion, I draw attention to the disclosures made in note 1 to the financial statements relating to going concern. The NHS Institute for Innovation and Improvement closed on 31 March 2013. As a consequence the financial statements have been prepared on a basis other than going concern. Details of the impact of this on the financial statements are provided in Note 1 to the financial statements.

Opinion on other matters

In my opinion:

- the part of the Remuneration Report to be audited has been properly prepared in accordance with the Secretary of State's directions issued under the National Health Service Act 2006; and
- the information given in the Management Commentary and Review of Activities and the Director of Corporate Services and Finance Commentary for the financial year for which the financial statements are prepared is consistent with the financial statements.

Matters on which I report by exception

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

- adequate accounting records have not been kept or returns adequate for my audit have not been received from branches not visited by my staff; or
- the financial statements and the part of the Remuneration Report to be audited are not in agreement with the accounting records and returns; or
- I have not received all of the information and explanations I require for my audit; or
- the Governance Statement does not reflect compliance with HM Treasury's guidance.

Report

I have no observations to make on these financial statements.

Amyas C E Morse

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

25 June 2013

Annual Account of the NHS Institute for Innovation and Improvement for the year ended 31 March 2013

Statement of Comprehensive Net Expenditure for the year ended 31 March 2013

	Notes	**2012-13 £000**	2011-12 £000
Programme costs	2.2	**32,780**	56,397
Operating income	5	**(6,646)**	(6,813)
Net operating cost		**26,134**	49,584
Net gain on transfer by absorption[1]		**(580)**	0
Net resource outturn	4.1	**25,554**	49,584

There was no other comprehensive expenditure in the year.

1 The leadership business directorate transferred from the NHS Institute on 1 July 2012 to the National Leadership Academy. As such the redundancy provision for this business directorate has been transferred and removed from the accounts of the NHS Institute.

These accounts include the activities for the leadership business directorate up until 30 June 2012 when the function transferred to the National Leadership Academy.

Annual Account of the NHS Institute for Innovation and Improvement for the year ended 31 March 2013 *(continued)*

Statement of Financial Position as at 31 March 2013

	Notes	31 March 2013 £000	31 March 2012 £000
Non-current assets:[1]			
Property, plant and equipment	6.1	**0**	459
Intangible assets	6.2	**0**	419
Non-current receivables		**0**	0
		0	878
Current assets:			
Receivables	7.1	**1,481**	3,070
Cash and cash equivalents	8	**2,280**	1,504
		3,761	4,574
Payables	9	**(3,476)**	(5,938)
Net current (liabilities)/assets		**285**	(1,364)
Non-current assets less net current liabilities		**285**	(486)
Non-current liabilities:			
Provisions	10	**0**	(5,859)
Total assets less total liabilities		**285**	(6,345)
Taxpayers' equity			
General fund		**285**	(6,345)
Revaluation reserve		**0**	0
Total taxpayers' equity		**285**	(6,345)

1 The NHS Institute non-current assets will only run to 31 March 2013. Reclassification to current assets has not been shown on the face of the statement of financial position to aid prior year comparisons.

2 These accounts include activities for the leadership business directorate up until 30 June 2013 when the function transferred to the National Leadership Academy. A provision of £0.6m was transferred.

The notes at pages 49 to 81 form part of these accounts.

The financial statements on pages 45 to 48 were considered by the NHS Institute Audit and Risk Management Committee meetings on 14th and 28th March 2013. They were also considered by the Audit Committee of NHS Commissioning Board on 13 May 2013.

David Nicholson

Accounting Officer from 1 April 2013

NHS Commissioning Board

18 June 2013

Annual Account of the NHS Institute for Innovation and Improvement for the year ended 31 March 2013 *(continued)*

Statement of Changes in Taxpayers' Equity for the year ended 31 March 2013

	Notes	General fund[1] £000	Revaluation reserve[2] £000	Total reserves £000
Balance at 1 April 2011		(1,726)	165	(1,561)
Changes in taxpayers' equity for 2011-12				
Net gain/(loss) on revaluation of property, plant and equipment	6.1	0	0	0
Transfers between reserves[3]		165	(165)	0
Net recource outturn for the year		(49,584)	0	(49,584)
Total recognised income and expense for 2011-12		(49,419)	(165)	(49,584)
Net Parliamentary funding		44,800	0	44,800
Balance at 31 March 2012		**(6,345)**	**0**	**(6,345)**
Balance as at 1 April 2012		(6,345)	0	(6,345)
Changes in taxpayers' equity for 2012-13				
Net gain/(loss) on revaluation of property, plant and equipment	6.1	**0**	**0**	**0**
Transfers between reserves		**0**	**0**	**0**
Net recource outturn for the year		**(25,554)**	**0**	**(25,554)**
Total recognised income and expense for 2012-13		**(25,554)**	**0**	**(25,554)**
Net Parliamentary funding		**32,184**	**0**	**32,184**
Balance at 31 March 2013		**285**	**0**	**285**

1 The General fund represents the net assets vested in the NHS Institute for Innovation and Improvement (stated at historical cost less accumulated depreciation at that date), the surplus or deficit generated from notional charges and trading activities and Parliamentary Funding provided.
2 The revaluation reserve contains the equity movement arising from the revaluation of Property, Plant and Equipment.
3 The transfer between reserves relates to the disposal of non current assets.

These accounts include the activities for the leadership business directorate up until 30 June 2012 when the function transferred to the National Leadership Academy.

The notes at pages 49 to 81 form part of these accounts.

Annual Account of the NHS Institute for Innovation and Improvement for the year ended 31 March 2013 *(continued)*

Statement of Cash Flows for the year ended 31 March 2013

	Notes	31 March 2013 £000	31 March 2012 £000
Net cash (outflow) from operating activities	11.2	**(31,092)**	(46,532)
Cash flows from investing activities			
Payments to acquire non-current intangible assets		**(229)**	(384)
Payments to acquire non-current property, plant and equipment		**(87)**	(466)
Net cash (outflow) from investing activities		**(316)**	(850)
Net cash (outflow) before financing		**(31,408)**	(47,382)
Cash flows from financing activities			
Payments in respect of finance leases		**0**	0
Net Parliamentary funding		**32,184**	44,800
Increase/(decrease) in cash and cash equivalents		**776**	(2,582)

These accounts include the activities for the leadership business directorate up until 30 June 2012 when the function transferred to the National Leadership Academy.

The notes at pages 49 to 81 form part of these accounts.

Notes to the Accounts *(continued)*

1 Accounting policies

The financial statements have been prepared in accordance with the 2012-13 Government Financial Reporting Manual (FReM) issued by HM Treasury and in accordance with the National Health Services Act 2006. The accounting policies contained in the FReM apply International Financial Reporting Standards as adapted or interpreted for the public sector context. Where the FReM permits a choice of accounting policy, the accounting policy which is judged to be most appropriate to the particular circumstances of the NHS Institute for Innovation and Improvement for the purpose of giving a true and fair view has been selected. The particular policies adopted are described below. They have been applied consistently in dealing with items that are considered material to the accounts.

1.1 Accounting conventions

These accounts are prepared under the historical cost convention, modified to account for the revaluation of property, plant and equipment 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.

In July 2010, the Government announced its intention to close the NHS Institute for Innovation and Improvement on 31 March 2012. They also announced that they would consider a transfer of some of its functions out of the arm's length body sector. The Secretary of State then approved a revised date for the closure of the special health authority of 31 March 2013. The NHS Institute for Innovation and Improvement has now closed.

Due to this management considers it not appropriate to continue to adopt the going concern basis in preparing the annual report and financial statements.

1.2 Income

The main source of funding for the NHS Institute is Parliamentary grant from the Department of Health from Request for Resources 1 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. Income other than Parliamentary grant is shown net of VAT.

Income in respect of services provided is recognised when, and to the extent that performance occurs and is measured at the fair value of the consideration receivable. 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. Where income is received for a specific activity which is to be delivered in the following financial year, that income is deferred.

The NHS Institute will accrue other income as receivables in the financial year where the income generating activity has been completed but an invoice has not yet been raised.

The NHS Institute provides for bad debts in its accounts when invoices are 90 days overdue or where information has been received relating to specific invoices or customers that put the income at risk of not being received. All debts at 31 March 2013 are considered recoverable.

1.3 Expenditure

Expenditure on goods and services is recognised when, and to the extent that they have been received, and is measured at the fair value of those goods and services. Expenditure is recognised in operating expenses except where it results in the creation of a non-current asset such as property, plant and equipment.

Notes to the Accounts

1.4 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.

1.5 Grants Payable

The NHS Institute engaged in grant funding activities to partner organisations (the grantees) when it was deemed necessary to support the delivery of local and national QIPP targets as set by the Department of Health. This objective was clearly stated in the contract terms, conditions and grant monitoring processes, whereby grantees had freedom to disburse the grants in the most effective way to deliver the stated grant objectives.

Grants made by the NHS Institute have been recognised at the point at which the grant agreement was signed by the grantee as at this point a purchase order was raised and goods receipted which resulted in an automatic accrual until the grant was paid. Larger grant payments have been phased through in instalments to ensure that entities did not carry significant cash balances therefore avoiding an inefficient use of public money.

1.6 Property, plant and equipment

Recognition

Property, plant and equipment is capitalised if:

- it is held for use in delivering services or for administrative purposes;
- it is probable that future economic benefits will flow to, or service potential will be supplied to, the NHS Institute;
- it is expected to be used for more than one financial year;
- the cost of the item can be measured reliably; and
- the item cost at least £5,000;

or;

- Collectively, a number of items have a cost of at least £5,000 and individually have a 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.

Where a large asset includes a number of components with significantly different asset lives, the components are treated as separate assets and depreciated over their individual useful economic lives.

Valuation

All property, plant and equipment is measured initially at cost, representing the cost directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management. All assets are measured subsequently at fair value. Revaluations are performed with sufficient regularity to ensure that carrying amounts are not materially different from those that would be determined at the end of the reporting period. Fair values are determined as follows:

- Land and non-specialised buildings – market value for existing use
- Specialised buildings – depreciated replacement cost, modern equivalent asset basis.

Notes to the Accounts *(continued)*

Properties in the course of construction for service or administration purposes are carried at cost, less any impairment loss. Cost includes professional fees but not borrowing costs, which are recognised as expenses immediately, as allowed by IAS 23 for assets held at fair value. Assets are revalued and depreciation commences when they are brought into use.

IT equipment, transport equipment, furniture and fittings, and plant and machinery that are held for operational use are valued at fair value.

An increase arising on revaluation is taken to the revaluation reserve except when it reverses an impairment for the same asset previously recognised in expenditure, in which case it is credited to expenditure to the extent of the decrease previously charged there. A revaluation decrease is recognised as an impairment charged to the revaluation reserve to the extent that there is a balance on the reserve for the asset and, thereafter, to expenditure. Gains and losses recognised in the revaluation reserve are reported in the Statement of Changes in Taxpayers' Equity.

Subsequent expenditure

Where subsequent expenditure enhances an asset beyond its original specification, the directly attributable cost is capitalised. Where subsequent expenditure restores the asset to its original specification, the expenditure is capitalised and any existing carrying value of the item replaced is written-out and charged to operating expenses.

1.7 Intangible non-current assets

Intangible assets are non-monetary assets without physical substance, which are capable of sale separately from the rest of the NHS Institute's business or which arise from contractual or other legal rights. They are recognised only when it is probable that future economic benefits will flow to, or service potential be provided to, the NHS Institute; where the cost of the asset can be measured reliably, and where the cost is at least £5,000 (or at least £250 if related to expenditure which will form part of the overall NHS Institute information and communication network).

Intangible assets acquired separately are initially recognised at fair value. Software that is integral to the operation of hardware is capitalised as part of the relevant item of property, plant and equipment. Software that is not integral to the operation of hardware is capitalised as an intangible asset. Expenditure on research is not capitalised: it is recognised as an operating expense in the period in which it is incurred.

Internally-generated assets are recognised if, and only if, there is the technical feasibility, intention and availability of resources to complete the asset; the ability to use or sell the asset to generate probable future economic benefits or service potential, and the ability to measure the development expenditure. The amount initially recognised is the sum of the expenditure incurred from the date when the criteria for recognition are initially met. Where no internally-generated intangible asset can be recognised, the expenditure is recognised in the period in which it is incurred.

Following initial recognition, intangible assets are carried at fair value by reference to an active market, or, where no active market exists, at replacement cost if the asset is not yet available for use or amortised replacement cost if it is, as a proxy for fair value.

1.8 Depreciation, amortisation and impairments

Freehold land, assets under construction or development, investment properties, stockpiled goods and assets held for sale are not depreciated/amortised.

Otherwise, depreciation and amortisation are charged to write off the costs or valuation of property, plant and equipment and intangible non-current assets, less any residual value, on a straight-line basis over their estimated remaining useful lives. The estimated useful life of an asset is the period over which the NHS Institute expects to obtain economic benefits or service potential from the asset. Estimated useful lives and residual values are reviewed each year end, with the effect of any changes recognised on a prospective basis. Assets held under finance leases are depreciated over the shorter of the lease term and the estimated useful life.

At each reporting period end, the NHS Institute checks whether there is any indication that any of its property, plant and equipment or intangible non-current assets have suffered an impairment loss. If there is indication of an impairment loss, the recoverable amount of the asset is estimated to determine whether there has been a loss and, if so, its amount. Intangible assets not yet available for use are tested for impairment annually.

If there has been an impairment loss, the asset is written down to its fair value, with the loss charged to the revaluation reserve to the extent that there is a balance on the reserve for the asset and, thereafter, to expenditure. Where an impairment loss subsequently reverses, the carrying amount of the asset is increased to the revised estimate of the recoverable amount but capped at the amount that would have been determined had there been no initial impairment loss. The reversal of the impairment loss is credited to expenditure to the extent of the decrease previously charged there and thereafter to the revaluation reserve.

1.9 Asset Lives

The NHS Institute's assets were depreciated evenly over the expected useful life from the start of the quarter following the quarter in which the asset was acquired:

Furniture and Fittings	7 years
Information Technology	3 years
Leasehold Improvements	over the life of the lease.

An announcement was made in July 2010 that the NHS Institute would close as a Special Health Authority on 31 March 2012, and closure was subsequently delayed until March 2013.

In light of this announcement the NHS Institute has reassessed the asset lives and accelerated the depreciation relating to its property, plant and equipment and intangible assets so that all assets are zero value at 31 March 2013.

1.10 Contingent Liabilities

A contingent liability is:

- a possible obligation that arises from past events and whose existence will be confirmed only by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the NHS Institute, or
- a present obligation that is not recognised because it is not probable that a payment will be required to settle the obligation or the amount of the obligation cannot be measured sufficiently reliably.

A contingent liability is disclosed unless the possibility of a payment is remote.

A contingent asset is a possible asset that arises from past events and whose existence will be confirmed by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the NHS Institute. A contingent asset is disclosed where an inflow of economic benefits is probable.

Notes to the Accounts *(continued)*

Where the time value of money is material, contingencies are disclosed at their present value.

1.11 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. Further information can be found at www.hm-treasury.gov.uk.

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

1.12 Segmental analysis

A segment is a distinguishable component of the NHS Institute that is engaged in providing services that are subject to risks and rewards that are different from those of other segments. The primary segments have been determined by reference to the NHS Institute's management approach to its business activities. The analysis of the segments is included in the notes to the accounts.

1.13 Leases

Leases are classified as finance leases when substantially all the risks and rewards of ownership are transferred to the lessee. All other leases are classified as operating leases.

Property, plant and equipment held under finance leases are initially recognised, at the inception of the lease, at fair value or, if lower, at the present value of the minimum lease payments, with a matching liability for the lease obligation to the lessor. Lease payments are apportioned between finance charges and reduction of the lease obligation to achieve a constant rate of interest on the remaining balance of the liability. Finance charges are recognised in the Statement of Net Comprehensive Expenditure.

Operating lease payments are recognised as an expense on a straight-line basis over the lease term. Lease incentives are recognised initially as a liability and subsequently as a reduction of rentals on a straight-line basis over the lease term.

Contingent rentals are recognised as an expense in the period in which they are incurred.

Where a lease is for land and buildings, the land and building components are accounted for separately. Leased land is treated as an operating lease. Leased buildings are assessed as to whether they are operating or finance leases. This is due to a change in requirements under IAS 17.

1.14 Provisions

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

1.15 Cash and Cash Equivalents

Cash is cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours. The NHS Institute does not hold any cash equivalents.

1.16 Pension Costs

Past and present employees are covered by the provisions of the NHS Pensions Scheme. Details of the benefits payable under these provisions can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. The scheme is an unfunded, defined benefit scheme that covers NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State, in England and Wales. The scheme is not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, the scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS Body of participating in the scheme is taken as equal to the contributions payable to the scheme for the accounting period.

In order that the defined benefit obligations recognised in the financial statements do not differ materially from those that would be determined at the reporting date by a formal actuarial valuation, the FReM requires that "the period between formal valuations shall be four years, with approximate assessments in intervening years". An outline of these follows:

a) Accounting valuation

A valuation of the scheme liability is carried out annually by the scheme actuary as at the end of the reporting period. Actuarial assessments are undertaken in intervening years between formal valuations using updated membership data and are accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2013, is based on the valuation data as 31 March 2012, updated to 31 March 2013 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

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

b) Full actuarial (funding) valuation

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the scheme (taking into account its recent demographic experience), and to recommend the contribution rates.

The last published actuarial valuation undertaken for the NHS Pension Scheme was completed for the year ending 31 March 2004. Consequently, a formal actuarial valuation would have been due for the year ending 31 March 2008. However, formal actuarial valuations for unfunded public service schemes were suspended by HM Treasury on value for money grounds while consideration is given to recent changes to public service pensions, and while future scheme terms are developed as part of the reforms to public service pension provision due in 2015.

Notes to the Accounts *(continued)*

The Scheme Regulations were changed to allow contribution rates to be set by the Secretary of State for Health, with the consent of HM Treasury, and consideration of the advice of the Scheme Actuary and appropriate employee and employer representatives as deemed appropriate.

The next formal valuation to be used for funding purposes will be carried out at as at March 2012 and will be used to inform the contribution rates to be used from 1 April 2015.

c) Scheme provisions

The NHS Pension Scheme provided defined benefits, which are summarised below. This list is an illustrative guide only, and is not intended to detail all the benefits provided by the Scheme or the specific conditions that must be met before these benefits can be obtained:

The Scheme is a "final salary" scheme. Annual pensions are normally based on 1/80th for the 1995 section and of the best of the last three years pensionable pay for each year of service, and 1/60th for the 2008 section of reckonable pay per year of membership. Members who are practitioners as defined by the Scheme Regulations have their annual pensions based upon total pensionable earnings over the relevant pensionable service.

With effect from 1 April 2008 members can choose to give up some of their annual pension for an additional tax free lump sum, up to a maximum amount permitted under HMRC rules. This new provision is known as "pension commutation".

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. From 2011-12 the Consumer Price Index (CPI) will be used to replace the Retail Prices Index (RPI).

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. A death gratuity of twice final year's pensionable pay for death in service, and five times their annual pension for death after retirement is payable

For early retirements other than those due to ill health the additional pension liabilities are not funded by the scheme. The full amount of the liability for the additional costs is charged to the employer.

Members can purchase additional service in the NHS Scheme and contribute to money purchase AVC's run by the Scheme's approved providers or by other Free Standing Additional Voluntary Contributions (FSAVC) providers.

1.17 Financial Instruments

i Financial assets

Financial assets are recognised in the Statement of Financial Position when the NHS Institute becomes party to the financial instrument contract or, in the case of trade receivables, when the goods or services have been delivered. Financial assets are de-recognised when the contractual rights have expired or the asset has been transferred. Financial assets are initially recognised at fair value. Fair value is determined by reference to quoted market prices where possible, otherwise by valuation techniques.

As available for sale financial assets, the NHS Institute's investments are measured at fair value. With the exception of impairment losses, changes in value are taken to the revaluation reserve. Accumulated gains or losses are recycled to the Statement of Net Comprehensive Expenditure on de-recognition. The NHS Institute does not hold any available for sale assets.

Loans and receivables are non-derivative financial assets with fixed or determinable payments which are not quoted in an active market. After initial recognition, they are measured at amortised cost using the effective interest method, less any impairment. Interest is recognised using the effective interest method. This is the rate that exactly discounts estimated future cash receipts through the expected life of the financial asset to the net carrying amount of the financial asset.

At the Statement of Financial Position date, the NHS Institute assesses whether any financial assets are impaired. Financial assets are impaired, and impairment losses recognised if there is objective evidence of impairment as a result of one or more events which occurred after the initial recognition of the asset and which has an impact on the estimated future cash flows of the asset. For financial assets carried at amortised cost, the amount of the impairment loss is measured as the difference between the asset's carrying amount and the present value of the revised future cash flows discounted at the asset's original effective interest rate. The loss is recognised in the Statement of Net Comprehensive Expenditure.

ii Financial liabilities

Financial liabilities are recognised in the Statement of Financial Position when the NHS Institute becomes party to the contractual provisions of the financial instrument or, in the case of trade payables, when the goods or services have been received. Financial liabilities are de-recognised when the liability has been discharged, that is, the liability has been paid or has expired.

Financial liabilities are initially recognised at fair value.

After initial recognition, financial liabilities are measured at amortised cost using the effective interest method. The effective interest rate is the rate that exactly discounts estimated future cash payments through the life of the asset to the net carrying amount of the financial liability. Interest is recognised using the effective interest method.

iii Foreign exchange

The NHS Institute has foreign currency income and expenditure which results in transactional currency exposures. These exposures arise from sales or purchases in currencies other than sterling. The NHS Institute's currency exposure is limited by the expectation that any balance will mature within 30 days of its first arising.

1.18 Going Concern

Due to the abolition, management considers it is not appropriate to continue to adopt the going concern basis in preparing the annual report and financial statements and has therefore made the necessary adjustments in preparing the annual report and financial statements.

Notes to the Accounts *(continued)*

2 Segmental analysis

The reporting segments have been identified based upon the internal reports that are regularly reviewed by the NHS Institute's Exective Committee in order to assess organisational performance and make informed decisions. The reportable segments for the financial year 2012-13 have changed with the learning and solutions business areas being combined into one business area known as delivery.

The NHS Institute is required to produce a Statement of Net Comprehensive Expenditure and a Statement of Financial Position for each reportable segment. Transactions between reportable segments have been recorded in the NHS Institute's accounts by utilising an intercompany balancing account which creates payables/receivables as appropriate in each segment such that each segment has a balanced trial balance.

2.1 Descriptions of segments

Corporate

The Corporate Directorate supports the Board and other business directorates by providing the services listed below. The NHS Institute's work in relation to NHS Improving Quality is also reported through this business directorate:

1. Finance
2. Procurement
3. Human Resources
4. Information Communications Technology
5. Marketing and Communications
6. Estates
7. Corporate Secretarial and Legal
8. Planning, Performance and Risk Management

Design

NHS Institute Design is a national hub for the application of thought leadership on innovation and improvement for the NHS. It uses a robust, accelerated innovation process to test and develop high impact solutions that are valued and relevant for the NHS in its ambition to increase quality and productivity, delivering an exceptional patient experience whilst reducing cost.

Leadership

The Leadership Directorate provides a range of interventions to help build leadership capability across the NHS. This includes:

- The Board Development Team who provide a range of capability programmes for whole boards and individual senior leaders, as well as strengthening the provision of coaching for senior leaders. There is also a focus on building commissioning capabilities;
- International Programmes which offer development opportunities for senior leaders in the NHS by working with healthcare organisations and individuals internationally to share latest thinking around leadership;
- The Enhancing Medical Engagement Project Team develops and promotes their work in association with the Academy of Medical Royal Colleges;

- Building Leadership Capacity recruits fresh new talent and develops high calibre individuals into innovative, accomplished leaders through a portfolio of three programmes, each of which uniquely contributes to the NHS talent pool:
  - NHS Graduate Scheme continues to recruit high calibre graduates onto the award winning scheme;
  - Gateway to Leadership attracted talent into the NHS from other sectors by recruiting on its programme;
  - Breaking Through Programme recruited NHS managers from black and minority ethnic backgrounds.

The Leadership Directorate transferred to the new National Leadership Academy on 1 July 2012.

Delivery

NHS Institute Delivery exists to support NHS organisations and patients through the delivery and implementation of a range of service options that meet cost and quality challenges. This is achieved through a regional structure, controlled and headed by the Interim Director of Delivery and is supported by the Area Directors. NHS Institute Delivery will build on the support links with stakeholders across the NHS to ensure that what is delivered remains relevant. NHS Institute Delivery will actively engage with the NHS Institute's stakeholders and act on feedback to improve solutions.

Thought Leadership

The NHS Institute will initiate and lead national programmes of work. The objective is to manage and improve the strategic relationships to improve understanding and recognition of the NHS Institute and therefore, its contribution to the national improvement efforts of the NHS. This part of the business will also provide world class expertise in large scale change and mobilisation improvement. The team will support Department of Health co-ordinated effort and local regional teams, acting as a source of energy, inspiration and ideas for change.

NHS Institute Worldwide

The NHS Institute founded the commercial entity NHS Institute Worldwide with the view to delivering four key principals:

1. to develop and enhance further the status of global reputation of the NHS Institute, with the associated benefits to the core business;
2. to contribute and make a difference to hundreds of thousands of patients across the globe, in line with the NHS Institute's core mission;
3. to enhance intellectual property exploitation of the NHS Institute, through the creation of a more commercial vehicle that has the appropriate capability, capacity and culture within the context of the NHS;
4. to contribute to the NHS Institute financially.

2.2 Segmental Programme costs for the year ended 31 March 2013

	Notes	Corporate 2012-13 £000	Design 2012-13 £000	Leadership 2012-13 £000	Delivery 2012-13 £000	Thought Leadership 2012-13 £000	Worldwide 2012-13 £000	Total 2012-13 £000	Total 2011-12 £000
Non-executive members' remuneration		131	0	0	0	0	0	131	124
Other salaries and wages – staff, seconded, contract and agency	3.1	2,451	1,745	426	4,985	1,274	152	11,033	13,981
Graduate scheme remuneration		0	0	1,886	0	0	0	1,886	10,220
Capital: Depreciation and amortisation (owned assets)	6.1, 6.2	634	128	26	246	0	0	1,034	1,559
Disposals		3	0	0	0	0	0	3	128
Auditors' remuneration:									
Statutory external audit fees[1]		64	0	0	0	0	0	64	66
Internal audit and counter fraud		58	0	0	0	0	0	58	64
Other finance costs:									
Bad debt provision		0	0	0	0	0	(27)	(27)	(52)
Interest Payable		3	0	0	0	0	0	3	0
Foreign currency losses		0	0	0	(4)	0	2	(2)	2
General losses and fruitless payments		1	1	0	9	0	0	11	(31)
Travel and Subsistence		236	170	226	407	113	10	1,162	1,853
Course fees		34	35	426	114	55	0	664	3,708
Contract for services		1,888	257	4	19	67	85	2,320	2,532
Individual contractors		(138)	13	86	20	20	568	569	778
Grants		(479)	77	(5)	2,316	889	0	2,798	12,611
Professional Fees[2]		0	1,475	61	352	68	0	1,956	1,692
Other Programme costs[3]		5,453	1,974	338	933	348	71	9,117	7,162
		10,339	5,875	3,474	9,397	2,834	861	32,780	56,397

1 The statutory audit fee for 2012-13 is £64,000.
2 The NHS Institute has paid out £1.4m in relation to development awards during 2012-13; (£566k 2011-12) and these are shown in the design business directorate as part of professional fees.
3 Other Programme costs include £1m for Patient Challenge Feedback awards; Closedown costs of £1.6m; Redundancy costs of £1.5m, as well as ICT related expenditure, lease rent, room hire and conferences.

2.3 Segmental Operating Income for the year ended 31 March 2013

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

	Corporate 2012-13 £000	Design 2012-13 £000	Leadership 2012-13 £000	Delivery 2012-13 £000	Thought Leadership 2012-13 £000	Worldwide 2012-13 £000	Total 2012-13 £000	Total 2011-12 £000
Programme income								
Fees and Charges[1]	75	2,448	164	1,865	799	906	6,257	6,297
Other	(152)	154	0	47	0	340	389	516
Total	(77)	2,602	164	1,912	799	1,246	6,646	6,813

An analysis of operating income comprising more than 10% of the total NHS Institute's income is detailed below:

Department of Health	(88)	2,566	(86)	751	796	0	3,939	2,457
Total	(88)	2,566	(86)	751	796	0	3,939	2,457

1 Fees and charges includes £4,974k (2011-12 £4,758k) in relation to income received to provide funding for specific programmes and £1,283k (2011-12 £1,539k) in respect of services for which a fee is charged.

2.4 Segmental Statement of Comprehensive Net Expenditure for the year ended 31 March 2013

	Corporate 2012-13 £000	Design 2012-13 £000	Leadership 2012-13 £000	Delivery 2012-13 £000	Thought Leadership 2012-13 £000	Worldwide 2012-13 £000	Total 2012-13 £000	Total 2011-12 £000
Programme costs	10,339	5,875	3,474	9,397	2,834	861	32,780	56,397
Operating income	77	(2,602)	(164)	(1,912)	(799)	(1,246)	(6,646)	(6,813)
Net operating cost	10,416	3,273	3,310	7,485	2,035	(385)	26,134	49,584
Net gain on transfer by absorption	0	0	(580)	0	0	0	(580)	0
Net resource outturn	10,416	3,273	2,730	7,485	2,035	(385)	25,554	49,584

2.5 Segmental Statement of Financial Position as at 31 March 2013

	Corporate 31 March 2013 £000	Design 31 March 2013 £000	Leadership 31 March 2013 £000	Delivery 31 March 2013 £000	Thought Leadership 31 March 2013 £000	Worldwide 31 March 2013 £000	Intercompany adjustment 31 March 2013 £000	Total 31 March 2013 £000	Total 31 March 2012 £000
Non-current assets:									
Property, plant and equipment	0	0	0	0	0	0	0	0	459
Intangible assets	0	0	0	0	0	0	0	0	419
Non-current receivables	0	0	0	0	0	0	0	0	0
	0	0	0	0	0	0	0	0	878
Current assets:									
Receivables	911	1,432	377	(841)	413	380	(1,191)	1,481	3,070
Cash and cash equivalents	2,219	0	0	0	0	61	0	2,280	1,504
	3,130	1,432	377	(841)	413	441	(1,191)	3,761	4,574
Current liabilities:									
Payables	(3,441)	(832)	47	(240)	(103)	(98)	1,191	(3,476)	(5,938)
Net current assets/(liabilities)	(311)	600	424	(1,081)	310	343	0	285	(1,364)
Total assets less current liabilities	(311)	600	424	(1,081)	310	343	0	285	(486)
Non-current liabilities:									
Provisions	0	0	0	0	0	0	0	0	(5,859)
Total assets less total liabilities	(311)	600	424	(1,081)	310	343	0	285	(6,345)
Taxpayers' equity									
General fund	(311)	600	424	(1,081)	310	343	0	285	(6,345)
Revaluation reserve	0	0	0	0	0	0	0	0	0
	(311)	600	424	(1,081)	310	343	0	285	(6,345)

Notes to the Accounts *(continued)*

3.1 Staff numbers and related costs

	2012-13 £000	2011-12 £000
Salaries and wages – staff on the NHS Institute payroll	**6,870**	8,606
Seconded, contract and agency staff	**2,840**	3,766
Salaries and wages – recharges to other NHS organisations	**(297)**	(365)
Social security costs	**709**	870
Employer contributions to NHS Pension scheme	**911**	1,104
Total salaries and wages	**11,033**	13,981

	2012-13 Average WTE	2011-12 Average WTE
Salaries and wages – staff on the NHS Institute payroll[1]	**130.1**	166.3
Seconded, contract and agency staff	**61.0**	79.7
Salaries and wages – recharges to other NHS organisations	**(2.9)**	(3.2)
Total average whole time equivalent (WTE)	**188.2**	242.8

1 The NHS Institute has a WTE limit for staff set by the Department of Health of 307 relating to staff on the NHS Institute payroll.

Notes to the Accounts *(continued)*

3.2 Exit packages for staff leaving in 2012-13

Exit package cost band (including any special payment element)	2012-13 *Number of compulsory redundancies	2012-13 *Number of other departures agreed	2012-13 Total number of exit packages by cost band	2011-12 *Number of compulsory redundancies	2011-12 *Number of other departures agreed	2011-12 Total number of exit packages by cost band
	Number	Number	Number	Number	Number	Number
<£20,001	0	13	13	0	7	7
£20,001 - £40,000	0	13	13	0	2	2
£40,001 - £100,000	0	18	18	0	2	2
£100,001 - £150,000	0	11	11	0	0	0
£150,001 - £200,000	0	7	7	0	0	0
>£200,000	0	5	5	0	1	1
Total number of exit packages by type	0	67	67	0	12	12
Total resource cost (£000s)	0	5,796	5,796	0	656	656

Redundancy and other departure costs have been paid in accordance with the provisions of the NHS Scheme. During 2012-13 no members of staff have left the NHS Institute via the Mutually Agreed Resignation Scheme (2011-12, one employee). This disclosure reports the number and value of exit packages taken by staff leaving in the year and the expense associated with these departures may have been recognised in part or full in a previous period. Where the NHS Institute has agreed early retirements, the additional costs are met by the NHS Institute and not by the NHS pensions scheme. Ill-health retirement costs are met by the NHS pensions scheme and are not included in the table above.

No payments have been made for compensation on early retirement or for loss of office (paid or receivable) under the terms of an approved Compensation Scheme.

This analysis excludes the cost of the Leadership transfer as this will be disclosed in their accounts.

3.3 Expenditure on staff benefits

The amount spent on staff benefits to 31 March 2013 totalled £758 (2011-12 £14,106).

3.4 Retirements due to ill-health

During 2012-13 there were no early retirements from the NHS Institute on the grounds of ill-health (2011-12 nil).

3.5 Capitalisation of staff costs

No staff costs were capitalised during 2012-13 (2011-12 nil).

3.6 Department for Business Innovation and Skills Payment Target – measure of compliance

	Number 2012-13	£000 2012-13
Total non-NHS bills paid 2012-13	**5,990**	**18,198**
Total non-NHS bills paid within target	**4,007**	**11,272**
Percentage of non-NHS bills paid within target	**66.9%**	**61.9%**
	Number	**£000**
Total NHS bills paid 2012-13	**400**	**5,625**
Total NHS bills paid within target	**264**	**4,406**
Percentage of NHS bills paid within target	**66.0%**	**78.3%**

The Department for Business Innovation and Skills were the governing body for the payment targets during 2012-13 and for 2011-12. The NHS Institute are required to pay all suppliers within five days of receipt of a correctly rendered invoice unless other payment terms are agreed and the above table reports the performance of the NHS Institute against this target during 2012-13.

The NHS Institute has paid 66% (by value) and 67% (by volume) of all invoices within the 5 day target. 2012-13 has been a difficult year for the NHS Institute due it being a wind down year. The Audit and Risk Management Committee took the decision that proper control and governance in relation to payments in the final year of operation should take preference over meeting the target. 99% of invoices by quantity and value have been paid within 30 days.

	Number 2011-12	£000 2011-12
Total non-NHS bills paid 2011-12	7,740	25,315
Total non-NHS bills paid within target	4,663	16,516
Percentage of non-NHS bills paid within target	60.2%	65.2%
	Number	**£000**
Total NHS bills paid 2011-12	454	10,063
Total NHS bills paid within target	280	8,595
Percentage of NHS bills paid within target	61.7%	85.4%

The NHS Institute incurred interest charges during 2012-13 under the Late Payment of Commercial Debts (Interest) Act 1998 of £3,473, (2011-12 £nil).

4.1 Reconciliation of net operating cost to net resource outturn

	2012-13 £000	2011-12 £000
Net operating cost for the financial year	**26,134**	49,584
Net gain on transfer by absorption	**(580)**	0
Net resource outturn	**25,554**	49,584
Revenue resource limit	**32,184**	54,158
Under spend against revenue resource limit	**6,630**	4,574

Notes to the Accounts *(continued)*

4.2 Reconciliation of gross capital expenditure to capital and resource limit

	2012-13 £000	2011-12 £000
Gross capital expenditure	**161**	999
Less – Book value of non-current assets disposed	**(128)**	(128)
Adjustment for loss on disposal of non-current assets	**128**	128
Net resource outturn	**161**	999
Capital resource limit	**1,605**	1,250
Under spend against capital resource limit	**1,444**	251

5 Operating income

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

	2012-13 £000	2011-12 £000
Programme income[1]		
Fees and charges	**6,257**	6,297
Other	**389**	516
Total	**6,646**	6,813

1 Included in the above numbers is income received from the Scottish Parliament £3k (2011-12 £73k) and the Northern Ireland Assembly £9k (2011-12 £20k).

The following information is provided for fees and charges purposes and is not disclosed to comply with IFRS 8.

	NHS England extended services £000	NHS Institute Worldwide £000	2012-13 Total £000	2011-12 Total £000
Income	**18**	**1,283**	**1,301**	1,539
Less direct costs and overheads	**1**	**1,124**	**1,125**	1,315
Contribution	**17**	**159**	**176**	224
Less apportionment of central overheads	**4**	**105**	**109**	157
Profit	**13**	**54**	**67**	67

The financial objective of the NHS England extended services is full cost recovery. The aim year on year is to break even and a small profit has been made for the period to 31 March 2013.

NHS Institute Worldwide sales aim to recover full direct cost plus a percentage mark up. The financial objective of the NHS Institute Worldwide is to make a profit, and a small profit has been made for the period to 31 March 2013.

6 Non-current Assets

6.1 Property, plant and equipment

	Assets under construction £000	Leasehold improvements £000	Furniture & fittings £000	Information Technology Hardware £000	Information Technology Leased assets £000	Total £000
Cost or valuation at 31 March 2012	0	275	151	1,150	164	1,740
Additions – purchased	0	0	0	14	0	14
Disposals	0	0	0	(949)	(164)	(1,113)
Indexation[2]	0	0	0	0	0	0
Gross cost at 31 March 2013	0	275	151	215	0	641
Accumulated depreciation at 31 March 2012	0	0	151	966	164	1,281
Charged during the year	0	275	0	198	0	473
Disposals	0	0	0	(949)	(164)	(1,113)
Indexation[2]	0	0	0	0	0	0
Accumulated depreciation at 31 March 2013	0	275	151	215	0	641
Net book value:						
Total at 31 March 2013	0	0	0	0	0	0
Assets Financing						
Owned – purchased (net book value)	0	0	0	0	0	0

	Assets under construction £000	Leasehold improvements £000	Furniture & fittings £000	Information Technology Hardware £000	Information Technology Leased assets £000	Total £000
Cost or valuation at 31 March 2011	0	2,868	151	1,051	164	4,234
Additions – purchased	275	0	0	191	0	466
Reclassifications	(275)	275	0	0	0	0
Disposals	0	(2,868)	0	(92)	0	(2,960)
Indexation[2]	0	0	0	0	0	0
Gross cost at 31 March 2012	0	275	151	1,150	164	1,740
Accumulated depreciation at 31 March 2011	0	2,868	87	747	164	3,866
Charged during the year[1]	0	0	64	311	0	375
Disposals	0	(2,868)	0	(92)	0	(2,960)
Indexation[2]	0	0	0	0	0	0
Accumulated depreciation at 31 March 2012	0	0	151	966	164	1,281
Net book value:						
Total at 31 March 2012	0	275	0	184	0	459
Assets Financing						
Owned – purchased (net book value)	0	275	0	184	0	459

1 An announcement was made in July 2010 that the NHS Institute would close as a Special Health Authority and In light of this announcement the NHS Institute reassessed the asset lives and accelerated the depreciation relating to its property, plant and equipment. The effect of this has continued into 2012-13.

2 No indexation has been applied during 2012-13; (2011-12 £nil) due to the move to a newly valued premises.

Notes to the Accounts *(continued)*

6.2 Intangible assets

	Assets under construction £000	Software Licences £000	Information Technology Web based Websites £000	Information Technology Web based Tools £000	Total £000
Gross cost at 31 March 2012	18	1,505	1,982	1,388	4,893
Additions – purchased	78	20	49	0	147
Reclassifications	(96)	20	49	28	1
Disposals	0	(817)	(251)	(185)	(1,253)
Impairment	0	0	0	0	0
Gross cost at 31 March 2013	0	728	1,829	1,231	3,788
Accumulated amortisation at 31 March 2012	0	1,183	1,981	1,310	4,474
Charged during the year	0	359	97	87	543
Reclassifications	0	0	0	19	19
Disposals	0	(814)	(249)	(185)	(1,248)
Impairment	0	0	0	0	0
Accumulated amortisation at 31 March 2013	0	728	1,829	1,231	3,788
Net book value:					
Total at 31 March 2013	0	0	0	0	0
Assets Financing					
Owned – purchased (net book value)	0	0	0	0	0

	Assets under construction £000	Software Licences £000	Information Technology Web based Websites £000	Information Technology Web based Tools £000	Total £000
Gross cost at 31 March 2011	70	1,522	2,048	1,654	5,294
Additions – purchased	203	251	0	79	533
Reclassifications	(136)	129	0	7	0
Disposals	(119)	(397)	(66)	(352)	(934)
Impairment	0	0	0	0	0
Gross cost at 31 March 2012	18	1,505	1,982	1,388	4,893
Accumulated amortisation at 31 March 2011	0	1,135	1,772	1,189	4,096
Charged during the year[1]	0	445	268	464	1,177
Reclassifications	0	0	0	7	7
Disposals	0	(397)	(59)	(350)	(806)
Impairment	0	0	0	0	0
Accumulated amortisation at 31 March 2012	0	1,183	1,981	1,310	4,474
Net book value:					
Total at 31 March 2012	18	322	1	78	419
Assets Financing					
Owned – purchased (net book value)	18	322	1	78	419

1 An announcement was made in July 2010 that the NHS Institute would close as a Special Health Authority and in light of this announcement the NHS Institute has reassessed the asset lives and accelerated the depreciation relating to its property, plant and equipment. The effect of this has continued into 2012-13.

7 Receivables

7.1 Current receivables

	31 March 2013 £000	31 March 2012 £000
NHS receivables	**654**	1,078
Trade receivables – non-NHS	**355**	636
Allowance for irrecoverable debts	**0**	(153)
VAT amount due	**310**	323
Prepayments	**85**	686
Accrued income	**77**	493
Other receivables	**0**	7
	1,481	3,070

8 Cash and cash equivalents

	31 March 2012 £000	Change during the year £000	31 March 2013 £000
Cash at the bank (Held with Government Banking Service)	1,504	**776**	**2,280**
	1,504	**776**	**2,280**

9 Trade payables and other payables

	31 March 2013 £000	31 March 2012 £000
NHS payables	**946**	1,085
Trade payables (revenue)	**1,728**	2,035
Tax and social security	**0**	0
Trade payables (capital)	**0**	157
Accruals	**290**	391
Deferred income	**0**	2,004
Other payables	**512**[1]	266
	3,476	5,938

1 Contained within Other payables is an accrual of £491k related to redundancy payments (2011-12 £Nil).

Notes to the Accounts *(continued)*

10 Provisions for liabilities and charges

	Legal claims[1] 2012-13 £000	Restructuring 2012-13 £000	Other[4] 2012-13 £000	Total 2012-13 £000
At 31 March 2012	14	4,814[2]	1,031	5,859
Arising during the year	0	0	0	0
Utilised during the year	(14)	(4,234)	(233)	(4,481)
Reversed unused	0	0	(798)	(798)
Transfers under absorption accounting	0	(580)[3]	0	(580)
At 31 March 2013	0	0	0	0
Expected timing of cash flows:				
Within 1 year	0	0	0	0

1 The NHS Institute settled all legal claims during 2012-13 and utilised the provision.

2 An announcement was made in July 2010 that the NHS Institute would close as a Special Health Authority on 31 March 2012 and this was subsequently extended to 31 March 2013.
In the light of this announcement, provisions relating to the staff redundancy cost and associated pension costs were made during 2010-11 totalling £4.8m.

3 An additional provision of £0.6m was made during 2011-12 to cover additional redundancies as a result of the transfer of the Leadership Directorate from the NHS Institute to the National Leadership Academy from 1 July 2012, this provision was transferred to the National Leadership Academy on 1 July 2012. All restructuring was utilised during 2012-13.

4 Included in other provisions is a provision where the NHS Institute has contracted for services with indirect workers and has provided for the tax relating to their employment status. HMRC investigation concluded that the provision is no longer required and this provision has been released. A provision was made during 2011-12 for the restoration of i-House to its original condition at the end of the lease. An accrual has been provided for this and the provision has been utilised.

	Legal claims[1] 2011-12 £000	Restructuring[2] 2011-12 £000	Other[3] 2011-12 £000	Total 2011-12 £000
At 31 March 2011	122	4,870	849	5,841
Arising during the year	14	600	305	919
Utilised during the year	(76)	(656)	(97)	(829)
Reversed unused	(46)	0	(26)	(72)
At 31 March 2012	14	4,814	1,031	5,859
Expected timing of cash flows:				
Within 1 year	14	4,814	1,031	5,859

1 The NHS Institute made a provision during 2011-12 to cover legal fees in relation to an independent investigation, to assess any potential financial irregularities within the National Innovation Centre.

2 An announcement was made in July 2010 that the NHS Institute would close as a Special Health Authority on 31 March 2012 and this was subsequently extended to 31 March 2013.
In the light of this announcement, and after active engagement with the Department of Health, a detailed plan is in place which sees a change to the activities of the NHS Institute. Some activities will transfer to other organisations, some will cease altogether and some will transfer into a successor body for the NHS Institute. This plan includes a downsizing of the business and in accordance with IAS 19 provisions relating to the staff redundancy cost and associated pension costs were made during 2010-11 totalling £4.8m. An additional provision of £0.6m was made during 2011-12 to cover additional redundancies as a result of the transfer of the Leadership Directorate from the NHS Institute to the National Leadership Academy from 1 July 2012.

3 Included in other provisions is a provision where the NHS Institute has contracted for services with indirect workers and has provided for the tax relating to their employment status. A provision was made during 2011-12 for the restoration of i-House to its original condition at the end of the lease.

11.1 Movements in working capital other than cash

	31 March 2013 £000	31 March 2012 £000
(Decrease)/Increase in receivables	**(1,589)**	(1,001)
Decrease/(Increase) in payables	**2,305**	(346)
	716	(1,347)

11.2 Reconciliation of operating costs to operating cash flows

	31 March 2013 £000	31 March 2012 £000
Net operating cost before interest for the year	**26,134**	**49,584**
Adjust for non-cash transactions	**(1,617)**	**(1,687)**
Adjust for movements in working capital other than cash	**716**	**(1,347)**
Decrease/(Increase) in provisions	**5,279**	**(18)**
Transfers out through absorption accounting	**580**	**0**
Net cash outflow from operating activities	**31,092**	**46,532**

11.3 Reconciliation of net cash flow to movement in net debt

	31 March 2013 £000	31 March 2012 £000
Increase/(decrease) in cash in the period	**776**	(2,582)
Fixed asset (additions)/disposals	**157**	871
Depreciation/impairment/indexation	**(1,035)**	(1,559)
Decrease/(Increase) in payables	**2,462**	(495)
Decrease in receivables	**(1,589)**	(1,001)
Decrease/(Increase) in provisions	**5,279**	(18)
Transfers out through absorption accounting	**580**	0
Movement in net debt	**6,630**	(4,784)

12 Contingent liabilities

At 31 March 2013, there were no known contingent liabilities (2011-12 £nil).

13 Capital commitments

At 31 March 2013, there was no known capital commitments, (2011-12 £4k).

14 Commitments under finance leases

At 31 March 2013, there were no known commitments under finance leases (2011-12 £nil).

Notes to the Accounts *(continued)*

15 Commitments under operating leases

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

	2012-13 £000	2011-12 £000
Property rental – including headquarters and other properties	**414**	484
Other operating leases	**2**	15
	416	499

Commitments under non-cancellable operating leases:

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

		2012-13 £000	2011-12 £000
Land and buildings	Operating leases which expire:		
	Within 1 year[1]	**0**	357
	Within 5 years	**0**	682
		0	1,039
Other leases	Operating leases which expire:		
	Within 1 year	**0**	0
		0	0

1 The lease for i-House is held by the secretary of state and will remain so after 31 March 2013. There has been a change of occupancy from 1 April 2013 from the NHS Institute for Innovation and Improvement to the NHS Improving Quality, which is being hosted by NHS Commissioning Board. The current mutual break clause has been renegotiated from 31st December 2014 to 31st March 2014.

16 Other commitments

The NHS Institute has not entered into any additional non-cancellable contracts which are not operating leases (2011-12 £nil).

17 Losses and special payments

During 2012-13 24 cases of losses and special payments were approved totalling £10,874 (in 2011-12 there were 62 cases totalling £15,857). Additionally, 45 exchange rate fluctuations were approved with an overall loss of £800. (In 2011-12 50 exchange rate fluctuations were approved with an overall loss of £2,299).

17.1 Reconciliation of net exchange differences

	31 March 2012 £000	Change during the year £000	31 March 2013 £000
Foreign exchange gains	(5)	**3**	**(2)**
Foreign exchange losses	7	**(4)**	**3**
	2	**(1)**	**1**

The reconciliation of net exchange differences has been included in the NHS Institute's accounts based on requirements set out in IAS 21.

18 Related parties

18.1 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 2012-13 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. Only those entities where balances at year end exceeded £50,000 or total transactions have exceeded £100,000 are disclosed.

	2012-13 Receivables £000	2012-13 Payables £000	2012-13 Income £000	2012-13 Expenditure £000
City and Hackney Teaching PCT				169
Department of Health		512	3,940	
East Cheshire NHS Trust				180
HM Revenue & Customs – Other taxes and duties	310			1,457
Hull and East Yorkshire Hospitals NHS Trust	576			
Imperial College Healthcare NHS Trust				123
NHS Pension Scheme (Own staff employers and employees contributions)				1,806
Nottinghamshire Healthcare NHS Trust				105
Salford Royal NHS Foundation Trust				382
South Staffordshire Healthcare NHS Foundation Trust		154		
South Tees Hospitals NHS Foundation Trust				721
University Hospital of South Manchester NHS Foundation Trust			112	
West Midlands Strategic Health Authority			157	

Notes to the Accounts *(continued)*

	2011-12 Receivables £000	2011-12 Payables £000	2011-12 Income £000	2011-12 Expenditure £000
Blackpool, Fylde & Wyre NHS Foundation Trust			143	
Buckinghamshire Hospitals NHS Trust				110
Cambridge University Hospitals NHS Foundation Trust				576
Central Manchester University Hospitals NHS Foundation Trust				727
County Durham and Darlington NHS Foundation Trust				154
Department of Health	918		2,671	
East Midlands Strategic Health Authority	57		268	
East of England Strategic Health Authority			452	495
Heart of England NHS Foundation Trust			220	
HM Revenue & Customs – Other taxes and duties	324		2,653	2,821
Hull and East Yorkshire Hospitals NHS Trust				775
Imperial College Healthcare NHS Trust				207
Kettering General Hospital NHS Foundation Trust				300
London Strategic Health Authority			135	295
National Insurance Fund (Employers and employees contributions)				2,585
NHS Business Services Authority		95		
NHS Pension Scheme (Own staff employers and employees contributions)		256		3,230
North East Strategic Health Authority		63	244	185
Nottinghamshire County Teaching PCT	63			
Nottingham University Hospitals NHS Trust		101		101
Oxford Radcliffe Hospitals NHS Trust		75		
Royal Berkshire Hospitals NHS Foundation Trust		75		
South Central Strategic Health Authority				200
South East Coast Strategic Health Authority				435
South Tees Hospitals NHS Foundation Trust				625
University Hospital of South Manchester NHS Foundation Trust				2,103
West Midlands Strategic Health Authority				117

The balances are all unsecured and are expected to be settled in cash. No debts have been written off in respect of related parties during the year.

18.2 In addition to the above, the following related parties are also recorded:

- Rod Anthony (Director of Corporate Services and Finance) is a Non-Executive Director for Solihull Care Trust and Non Executive Director and Vice Chair of Birmingham and Solihull NHS PCT Cluster.
- Simone Jordan (Deputy Chief Executive and Chief Operating Officer) is on secondment at East Midlands Strategic Health Authority.

19 Post balance sheet events

The financial statements were considered by the Audit Committee of NHS Commissioning Board on 13 May 2013. This annual report and accounts has been authorised for issue on the date the accounts were certified by the Comptroller and Auditor General.

20 Financial instruments

IAS 32, Financial Instruments: Presentation, 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. Because of the way Special Health Authorities are financed, the NHS Institute is not exposed to the degree of financial risk faced by other 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 IAS 32 mainly applies. The NHS Institute has limited powers to borrow or invest surplus funds. 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.

Market risk

Market risk is the possibility that financial loss might arise as a result of changes in such measures as interest rates and stock market movements. The NHS Institute has limited powers to borrow or invest surplus funds. 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.

Liquidity risk

Liquidity risk is the possibility that the NHS Institute might not have funds available to meet its commitments to make payments. 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.

Credit risk

Credit risk is the possibility that other parties might fail to pay amounts due to the NHS Institute. The nature of the NHS Institute's business means that it has a low exposure to credit risk. In order to manage this risk the NHS Institute undertakes credit checks on its new non-NHS customers. In the event of late payment of debt the NHS Institute, through its third party service provider, pursues a policy of written reminders which culminate in referral to a debt collection agency if required.

The maximum exposures as at 31 March 2013 are in receivables from customers, as disclosed in the receivables note.

Notes to the Accounts *(continued)*

Interest-rate risk

All of the NHS Institute's financial assets and 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 foreign currency income and expenditure which results in transactional currency exposures. These exposures arise from sales or purchases in currencies other than sterling. The NHS Institute's currency exposure is limited by the expectation that any balance will mature within 30 days of its first arising.

Other issues

The NHS Institute does not hold any financial assets as collateral.

20.1 Analysis of Financial Assets and Liabilities

	Financial Assets £000	Financial Liabilities £000
Currency		
At 31 March 2013		
Denominated in £ Sterling	**3,485**	**3,185**
Other	**114**	**1**
Gross Financial Asset/Liability	**3,599**	**3,186**
At 31 March 2012		
Denominated in £ Sterling	3,302	3,530
Other	93	13
Gross Financial Asset/Liability	3,395	3,543

20.2 Financial Assets and Liabilities by category

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

	Book value £000	Fair value £000
Financial assets: Loans and Receivables	**2012-13**	**2012-13**
Cash at bank and in hand	**2,280**	**2,280**
NHS receivables – net of credit note provision	**654**	**654**
Trade receivables – non-NHS (net of provision)	**355**	**355**
Other receivables	**310**	**310**
Total at 31 March 2013	**3,599**	**3,599**
Financial liabilities: Loans and Payables		
NHS payables	**946**	**946**
Trade payables – non-NHS	**1,728**	**1,728**
Other payables	**512**	**512**
Total at 31 March 2013	**3,186**	**3,186**
Financial assets: Loans and Receivables	**2011-12**	**2011-12**
Cash at bank and in hand	1,504	1,504
NHS receivables – net of credit note provision	1,078	1,078
Trade receivables – non-NHS (net of provision)	483	483
Other receivables	330	330
Total at 31 March 2012	3,395	3,395
Financial liabilities: Loans and Payables		
NHS payables	1,085	1,085
Trade payables – non-NHS	2,192	2,192
Other payables	266	266
Total at 31 March 2012	3,543	3,543

In accordance with IAS 32, the fair value of short term financial assets and liabilities (held at amortised cost) are not considered significantly different to fair value.

20.3 Maturity of Financial Liabilities

	31 March 2013 £000	31 March 2012 £000
Less than one year	**3,186**	3,543
Total at 31 March 2013	**3,186**	3,543

Notes to the Accounts *(continued)*

21 Intra-government balances

	Receivables: Amounts falling due within one year £000	Receivables: Amounts falling due after more than one year £000	Payables: Amounts falling due within one year £000
Balances with other central government bodies	338	0	512
Balances with local authorities	0	0	0
Balances with other NHS bodies	625	0	432
Balances with public corporations and trading funds	0	0	0
Sub-total intra-governmental balances	963	0	944
Balances with bodies external to government	518	0	2,532
At 31 March 2013	1,481	0	3,476

	Receivables: Amounts falling due within one year £000	Receivables: Amounts falling due after more than one year £000	Payables: Amounts falling due within one year £000
Balances with other central government bodies	1,112	0	1,914
Balances with local authorities	324	0	259
Balances with other NHS bodies	186	0	980
Balances with public corporations and trading funds	0	0	0
Sub-total intra-governmental balances	1,622	0	3,153
Balances with bodies external to government	1,448	0	2,785
At 31 March 2012	3,070	0	5,938

22 Grant payments

During 2012-13 the NHS Institute granted funds to various organisations in order to support the Department of Health achieving key strategic deliverables such as QIPP. An analysis of the grant payments made is shown below.

22.1 Grant Payments – public sector

	2012-13 £000	2011-12 £000
Buckinghamshire Healthcare NHS Trust	0	110
Cambridge University Hospitals NHS Foundation Trust	0	576
Central Manchester University Hospitals NHS Foundation Trust	0	727
Chelsea & Westminster Hospital NHS Foundation Trust	95	132
County Durham and Darlington Foundation Trust	0	153
Derby Hospitals NHS Foundation Trust	50	0
East Midlands Strategic Health Authority	0	25
Homerton University Hospital NHS Foundation Trust	20	0
Hull and East Yorkshire Hospitals NHS Trust	0	775
Imperial College Healthcare NHS Trust	38	200
Kettering General Hospital NHS Foundation Trust	0	300
NHS East of England Strategic Health Authority (on behalf of NHS Midlands and East)	0	495
NHS London Strategic Health Authority	0	295
NHS North East Strategic Health Authority	60	125
NHS South East Coast Strategic Health Authority	0	435
NHS South Central Strategic Health Authority	70	200
NHS West Midlands Strategic Health Authority	0	125
Oxford University Hospitals NHS Trust	75	0
Papworth Hospital NHS Foundation Trust	0	50
Royal Berkshire NHS Foundation Trust	75	0
Royal Surrey County Hospitals NHS Foundation Trust	0	11
Salford Royal NHS Foundation Trust	382	0
South Tees Hospital NHS Foundation Trust	611	625
South West Health Innovation Education Cluster	0	70
Sussex Community Health NHS Trust	0	40
Sussex Partnership NHS Foundation Trust	19	0
University College London NHS Foundation Trust	0	37
University Hospital of South Manchester Foundation Trust	15	2,103
	1,510	7,609

Notes to the Accounts *(continued)*

22.2 Grant Payments – private sector

	2012-13 £000	2011-12 £000
Alzheimer's Society	**26**	84
College of Emergency Medicine	**41**	357
Foundation of Nursing Studies	**20**	0
National Leadership and Innovation Agency for Healthcare	**0**	50
National Voices	**10**	0
North West Employers	**0**	323
Patient Experience Network	**0**	159
Primary Care Commissioning Community Interest Company (PCC CIC)	**816**	0
Royal College of General Practitioners	**0**	179
Royal College of Physicians	**0**	752
Royal Pharmaceutical Society	**0**	68
The Association of Chief Nurses	**337**	0
The Nuffield Trust	**24**	0
The Renal Association	**242**	0
University of Bristol	**87**	0
University of Derby	**0**	37
University of Southampton	**38**	0
University of Warwick	**222**	0
Virtual College	**126**	400
WESSEX Health Innovation Education Cluster (The University of Southampton)	**0**	19
West Midlands Health Innovation Education Cluster	**932**	1,352
	2,921	**3,780**
Total grants paid	**4,431**	**11,389**

23 IFRS disclosure

23.1 Early adoption of IFRS's, amendments and interpretations

The NHS Institute have not adopted any IFRS's, amendments or interpretations early.

23.2 IFRS's, amendments and interpretations in issue but not yet effective, or adopted

IAS 8, Accounting Policies, Changes in Accounting Estimates and Errors, require disclosures in respect of new IFRS's, amendments and interpretations that are, or will be applicable after the accounting period. There are a number of IFRS's, amendments and interpretations issued by the International Accounting Standards Board that are effective for financial statements after this accounting period. The following have not been adopted early by the NHS Institute:

IFRS 7 Financial Instruments: Disclosures

Amendment to allow for better comparisons between financial statements. The effective date is for accounting periods beginning on or after 1 January 2013. Also an amendment to improve the disclosure requirements in relation to transferred financial assets which is effective for accounting periods beginning on or after 1 July 2011.

IFRS 9 Financial Instruments

A new standard intended to replace IAS 39. The effective date is for accounting periods beginning on, or after 1 January 2015.

IFRS 13 Fair Value Measurement

IFRS 13 applies when other IFRS's require or permit fair value measurements. The new requirements are effective for accounting periods beginning on, or after 1 January 2013.

IAS 1 Presentation of Financial Statements

Amendment to the existing standard to improve disclosures to users of the accounts. The effective date is for accounting periods beginning on, or after 1 June 2012.

IAS 19 Employee Benefits

The amendments will improve the recognition and disclosure requirements for defined benefit plans and modify the accounting for termination benefits. The new requirements are effective for accounting periods beginning on or after 1 January 2013.

IAS 32 Offsetting Financial Assets and Financial Liabilities

Amendments to clarify the application of offsetting requirements. The amendments are effective for accounting periods beginning on or after 1 January 2014.

None of these new or amended standards and interpretations are likely to be applicable or are anticipated to have future material impact on the financial statements of the NHS Institute.

Notes to the Accounts *(continued)*

23.3 Major FReM (Government Financial Reporting Manual) changes for 2012-13

In addition, the following changes to the FReM, which will be applicable for accounting periods beginning on 1 April 2012:

Chapter 4 Accounting Boundaries

The application of merger accounting for the public sector context.

None of these changes to the FReM are anticipated to have a future material impact on the financial statements of the NHS Institute.

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