NHS
Institute for Innovation
and Improvement

# Annual Report and Accounts
of the NHS Institute for Innovation and Improvement 2010-11

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# of the NHS Institute for Innovation and Improvement 2010-11

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# Introduction and Foreword

We are pleased to present our annual report for 2010-11 – an eventful year of contrasts for the NHS Institute. We have continued our work with the NHS, delivering solutions to help our customers deliver improving healthcare for their patients, while at the same time resurrecting earlier work carried out to investigate alternative, more commercial models for the NHS Institute following the reforms announced in July 2010. This report details many aspects of our work undertaken during the year and we hope you find it an interesting read.

During the year through our agreements with the strategic health authorities, we have worked with over 82% of NHS organisations, assisting them with the challenges of meeting the quality, improvement, productivity and prevention agenda and helping them develop the capacity and capability to improve services during testing times.

As in previous years we have commenced development of, and in many instances launched, new products and services all of which have been positively received by our customers. Again these products have been developed through consultation with the NHS to determine real need and in co-production with the NHS to ensure an exact fit. These include Joined-up care which launched in January 2011, Healthy Places, Healthy Lives, the start of Productive General Practice and expansion of the mobilisation activity to encourage direct change at scale and pace. Our continued work on the national Productive Care QIPP workstream has again highlighted our role as a lead organisation in this important area. We responded rapidly to the strengthened role for GPs in the new NHS to ensure our experience and knowledge of commissioning could be remodelled and made available for GPs, their practices and the new clinical commissioning groups. Our activity across the globe has also expanded this year.

Looking to the future and in response to the reforms, in December 2010 a Change Board was established to ensure robust governance is in place for the development of the new NHS Institute. Comprising influential individuals, representative of all sectors in the NHS, the Change Board has supported and guided the development of our business case which was submitted to the Department of Health at the end of March. On behalf of our Board we would like to thank the members for their assistance and assurance.

We are optimistic about the future, recognising that significant change is required over the next year to ensure the new organisation of the right size and structure has a firm foundation on which to build even more meaningful relationships with NHS organisations as we help them deliver the benefits of improvement and innovation to their patients.

None of this work would be possible without the unstinting dedication and hard work of our staff who have risen to the challenge of delivering through times of personal uncertainty. Their passion and energy for supporting the NHS is evident in a year in which we have delivered more activity in the NHS than ever before, their efforts are applauded by us, the Board and senior team.

2010-11 has been a year for listening, delivering, taking action and changing in response to the needs of frontline customers, patients and the public using the NHS every day.

**Yve Buckland, Chair**
NHS Institute for Innovation and Improvement

**Bernard Crump, Chief Executive**
NHS Institute for Innovation and Improvement

# Management Commentary and Review of Activity

## 2010-11 Highlights

**Below are some of the key achievements from the past year. More detailed information on these and other highlights from 2010-11 is included later in this report.**

| | |
|---|---|
| Providing implementation support to help the NHS to meet QIPP challenges (p12) | The NHS Institute provided programme implementation support for The Productive Operating Theatre to 110 organisations and for Productive Community Services to 114 organisations. |
| Helping more acute wards to re-design the way they work to increasing quality and productivity (p12) | Over 89% of acute trusts in England are now implementing The Productive Ward. |
| Inspiring nurses and midwives to improve quality and cost (p13) | Almost 2,500 nurses and midwives have signed up to implementing the High Impact Actions and 5,771 copies of *The Essential Collection* were ordered in just six months. |
| Eliminating duplication, inefficiency and waste in the patient healthcare journey (p14) | Joined-up care was launched in January 2011 and the resources have been downloaded by 3,842 people in three months. |
| Reducing health inequalities and improving population health (p19) | There are 25 Healthy Places, Healthy Lives partnerships across England, working collaboratively with local partners to reduce the health inequality gap. |
| Responding quickly to the establishment of clinical commissioning groups (p19) | Working with the Royal College of General Practitioners we founded the RCGP Centre for Commissioning to equip GPs, practices and commissioning groups with the skills, competencies and expertise to deliver effective healthcare commissioning. |
| Creating contagious commitment to change (p20) | We are supporting, advising and enabling leaders of change in the NHS to maximise results through our mobilising and organising activities. |
| Eliminating harm to patients across the NHS (p22) | Our Safer Care team reached 1,262 people from across all sectors of the NHS through its programmes in the last financial year. |
| Building improvement capacity and capability in the NHS (p23) | In 2010-11, 467 delegates completed the Organising for Quality and Value programme. |
| Developing the NHS leaders of the future through award winning training schemes (p25) | The Graduate Management Training Scheme was awarded first place in the Guardian Top 300 Graduate Employers List and several other accolades in 2010-11. |
| Spreading healthcare improvement worldwide (p28) | Our foothold across the globe strengthened during 2010-11 with NHS Institute products being implemented in Scotland, Europe, Australasia, Canada and the USA amongst others. |

# Management Commentary and Review of Activity *(continued)*

## 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 is established as a special health authority under the National Health Service Act 1977 and is an arm's length body sponsored by the Department of Health.

The NHS Institute is based at the University of Warwick: NHS Institute for Innovation and Improvement, Coventry House, University of Warwick, Coventry, CV4 7AL.

A small number of our staff are also based in London, Birmingham and Manchester.

## Risks

During 2010-11, the Board, Audit and Risk Management Committee and Executive Team have continued to develop and review the NHS Institute's Strategic Risk Management and Assurance Framework. Internal and external auditors were consulted in creating the framework and use it to inform their audit approach.

Our strategic risk register identifies the most significant risks for our organisation and includes action plans to address them. The principal risks and uncertainties facing the NHS Institute as a special health authority have been identified as:

- inability to demonstrate compelling value to customers or funders
- failure to deliver on business priorities because of delays in the approval process arising from imposed restraints, adversely impacting our ability to meet the requirements outlined in our business plan to service the health sector at scale and pace
- inability to respond to challenge from competitive behaviour in a more contested environment, together with an over-reliance on 'potential competitors' as partners
- uncertainty of the change process leads to loss of key personnel and lack of focus on current necessary deliverables
- failure to forecast and plan activities accurately leads to a loss of financial management and control during a time of significant business change.

## Environmental, social and community policies

In 2010-11 we continued to work to reduce the NHS Institute's carbon footprint and introduce sustainability policies. Actions we have taken include:

- using paperless recruitment and tendering processes, including online shortlisting
- requiring major suppliers to supply reports of their carbon reduction measures
- ensuring that environmentally friendly stationery supplies are sourced and procured with minimum travel frequency, eg all paper supplies are 100% recycled brand
- ensuring that stationery orders are tightly managed and controlled
- collecting data on staff travel to inform decision making on carbon reducing travel alternatives. A revised travel policy has been introduced to reflect the need to reduce our carbon footprint
- no purchasing of bottled water for NHS Institute meetings and events

# Management Commentary and Review of Activity *(continued)*

- introducing new signage to encourage staff to turn off appliances and a 'going green' resource on our intranet
- using the Carbon Trust Tool to calculate the NHS Institute's carbon footprint
- regular audits of staff compliance with the directive to shut down computers at the end of the day and awareness raising using the campaign 'please be green, turn off your screen'
- using paper recycling bins in place of general waste bins
- continuation of a confidential waste management system to reduce shredding, a battery disposal scheme and kitchen recycling bins
- increased use of 'virtual' meetings and ensuring that where possible events are organised to minimise travelling distances
- including a requirement to comply with Events Sustainability Standard BS8901 in our events tendering process.

More information can be found in our separate Sustainability Report, copies of which are available on request.

We continue to maintain links with our local community through a work experience scheme for school children and links with students from Warwickshire College. A selection of pieces from the college's annual exhibition is loaned to us each year to display in our offices, with the aim of demonstrating the link between creativity and innovation.

Our internal 'i active' programme continues to promote healthy living and working amongst our staff and encourages physical, psychological and social wellbeing.

## Financial information

Our employees become members of the NHS Pension Scheme on joining the NHS Institute, unless they choose 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 have a full suite of policies on employee matters which are available on our website. These are used effectively in the day-to-day management of our workforce.

## Sickness absence data

During the period 2010-11 the following percentages of hours were lost through sickness absences.

| | 2010-11 |
|---|---|
| Quarter 1 | 1.90% |
| Quarter 2 | 2.93% |
| Quarter 3 | 3.62% |
| Quarter 4 | 3.50% |

# Management Commentary and Review of Activity *(continued)*

### Employment, training, career development and promotion of disabled persons

The NHS Institute aims to be recognised as an organisation which provides good employment opportunities for people with disabilities. All individuals applying for employment receive equal treatment, and are considered solely on their ability to carry out the duties of the post. We have updated our Equality and Diversity policy to reflect legislative changes and this is available on our website.

### Relationship and communication with the Department of Health

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

- The sponsor team at the DH has the formal responsibility for overseeing our work and holding us to account for delivery against our business plan.
- Individual programme teams within the Department liaise with their colleagues in equivalent teams in the NHS Institute.
- As an arm's length body (ALB) the NHS Institute has a positive relationship with the Department's ALB team.

Following the publication of the ALB review report in July 2010, colleagues in both the NHS Institute and DH have been working together to build a business case for a successor body. This work is carried out under the overall governance of a Change Board whose membership includes:

- senior officers from the DH
- a number of NHS Institute non-executive directors
- key stakeholders from the NHS.

The Change Board is chaired by Yve Buckland, the Chair of the NHS Institute.

Our auditors are invited to Change Board meetings as observers and any Change Board decisions are communicated to the relevant parts of the DH via our sponsor team.

### Communication and consultation with employees

We communicate and consult with our employees and keep them up-to-date on financial, economic and other factors affecting the organisation in a number of ways. These include a weekly internal newsletter incorporating an executive update, our intranet, regular team meetings and one-to-one meetings with line managers. Our Staff Partnership Forum, which includes staff representatives from across the organisation, meets on a regular basis to discuss issues of key importance and relevance to our people. The Forum is chaired by the Acting Director of Corporate Services and Finance, who acts as the link between the staff and Executive Team and facilitates two way communication between them.

Our Chief Executive holds regular team briefs which staff can attend in person or online. He also holds a six-weekly 'open house', during which staff can book a one-to-one appointment with him to discuss issues relating to the NHS Institute's business. Employee involvement in the performance of the organisation is also encouraged through personal development reviews, through which personal objectives are set in line with corporate objectives.

During the period of transition that the organisation has been going through as a result of the arm's-length bodies review, an HR sub-committee has been established

# Management Commentary and Review of Activity *(continued)*

to oversee 'people' issues as part of the transition programme.

### Information governance and security

The NHS Institute recognises that quality and security of data plays a significant role in providing assurance to its stakeholders that information is managed competently and securely.

We comply with the requirements of the NHS Connecting for Health (CfH) Information Governance Toolkit (IGT) for 2011 and we have continued to attend the Department of Health's Arm's Length Body Information Governance (IG) Forums for information on IG best practice and any new national NHS requirements in information assurance. The NHS Institute IG Steering group is proving to be an invaluable resource with bi-monthly meetings to update all representatives on current IG workstreams, supporting collaboration and fully consulted approaches.

Our annual mandatory information governance training requires all staff to successfully complete the level one National School of Government Protecting Information module and all information asset owners/team heads and members of the Executive Team are required to successfully complete level two.

Accountability and responsibility is continuing to be maintained with the use of the NHS Institute information asset register.

Information Governance Champions have been nominated for each team and this has been incorporated into Business Managers' job descriptions. Regular reviews and meetings with the Business Managers ensure that information is cascaded in a timely manner.

Privacy impact assessments (PIA) support compliance with the Data Protection Act, enabling all teams to address any potential risks with using, storing or transferring personal sensitive information.

An increased vigilance in relation to information governance has been noticed with more staff requesting advice on safe information security processes and increased support requests for various workstreams to ensure IG compliance.

We are pleased to report that the NHS Institute has had no Serious Untoward Incidents for the period 2010-11 required to be reported to the ICO.

### Progress against targets

In 2010-11 the balanced scorecard approach was again used by each of the principal business areas in order to plan and measure their performance. At the NHS Institute Board meeting in November 2010 some revisions to the original metrics were agreed to reflect the substantial changes that had taken place within the NHS Institute's operating environment, and it is against this revised plan that the annual performance of the organisation has been assessed. The revised plan contains a total of 62 metrics. Of these 52 were rated green, two were rated amber and eight are not applicable at this time for the year as a whole.

Some of our key achievements during the last year are detailed in the following pages.

## The Productive Care Workstream

The Productive Series remains one of the most well known improvement programmes within the NHS. It continues to help organisations to identify significant improvements in productivity and efficiency by helping staff to improve the way they work and the care they provide to their patients, whether that is on a ward, in a theatre or in their own homes.

The Productive Care national QIPP workstream led by the NHS Institute is made up of the main programmes in The Productive Series. Working with the Department of Health we are continuing to play a key role in helping organisations roll out Productive Series programmes to meet their QIPP challenges.

### Achievements

The Productive Operating Theatre and Productive Community Services were launched in Autumn 2009 and have been extremely successful over the last 12 months.

#### The Productive Operating Theatre

- The NHS Institute provided programme implementation support to 110 organisations across the NHS.
- The programme is helping to reduce waiting lists, improve safety, staff and patient experience and achieve significant financial savings. One trust alone has reported a £2m saving through improvements to its waiting lists.
- In 2011-12 a series of case studies will be released in which theatre teams will be sharing the successes they have achieved through implementing the programme.

#### Productive Community Services

- The NHS Institute provided programme implementation support to 114 organisations across the NHS.
- Community teams are already reaping the benefits from the programme, including increasing direct care time, improving patient experience, reducing bank staff and financial savings through better stock management.
- In 2011-12 a series of case studies will be released in which community teams will be sharing the benefits the programme has delivered for them.

There were a number of other highlights for The Productive Series during 2010-11.

#### The Productive Ward

- Over 89% of acute trusts in England are now implementing The Productive Ward with an average of 63% of their wards currently completing the Foundation modules and 44% having completed them.
- *Improving healthcare quality at scale and pace – Lessons from The Productive Ward: Releasing time to care*™ programme research discussed the support NHS teams need for continued commitment and investment in the programme.
- The long awaited *Rapid Impact Assessment of The Productive Ward: Releasing time to care*™ study explored the efficiency and productivity improvements The Productive Ward programme can make across the NHS.

#### The Productive Community Hospital

The Productive Community Hospital programme is continuing to help community hospital teams across the country. A greater number of trusts are making and sustaining

# Management Commentary and Review of Activity *(continued)*

improvements in bed occupancy, ease of admissions and direct care time.

### The Productive Mental Health Ward

An increasing number of specialist mental health teams are now embracing The Productive Mental Health Ward. Amongst those who are now on board include a learning disability organisation and teams who specialise in dementia.

### The Productive Leader

Alongside executive teams, The Productive Leader is increasingly being rolled out to other management and administrative teams, whole directorates and clinical staff. Many teams are finding that the programme is helping them refine their ways of working to help meet the increasing demands and growing pressures within the NHS.

### Productive Module Impact Framework

In September 2010, the Productive Module Impact Framework was launched across the NHS to help teams demonstrate the impact that The Productive Series has on productivity, efficiency, staff experience, and skills development. As at April 2011, nearly 200 organisations were registered on the framework with over 800 staff using it. Later this year the framework will be expanded to include The Productive Operating Theatre.

*"The Productive Ward is a really important tool for improving quality and productivity. It's about getting local ownership for patient safety, patient experience and patient outcomes at work level. People put the projects together themselves so there is a real sense of local ownership. It makes the whole of QIPP real for nursing staff."*

Julie Dawes, Director of Nursing
Portsmouth Hospitals NHS Trust

The next product in the Productive Series, Productive General Practice, is currently under development by our Design team – see section below for more details.

## Design and Innovation

Our Design and Innovation business unit 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 while reducing cost.

### Achievements

#### Experience Based Design (ebd)

An additional ebd resource was made available that consists of presentations pre-loaded on a USB memory stick and a printed facilitator's guide. This enables staff and managers to lead a session on the ebd approach and its delivery. The resource contains film of patients and staff at different stages of the ebd 'journey', and detailed presenter notes enable delivery of a 30 or 60 minute facilitated workshop.

#### High Impact Actions for Nursing and Midwifery: the Essential Collection

This publication aims to highlight just some of the stories behind the original 'High Impact Actions' submissions, by providing details not only of what was done, but also 'how they did it'. A launch was held at the Chief Nursing Officer's business meetings, supported by a series of web seminars, during which stories were brought to life by some of the contributors and 'authors' of the changes published.

# Management Commentary and Review of Activity *(continued)*

*High Impact Actions – the Essential Collection* is the most popular publication that the NHS Institute has ever produced – with 5,771 physical copies shipped in the six months from August 2010 to March 2011 and 932 downloads from our website.

Almost 2,500 nurses and managers have now 'signed-up' as committed to implementing the High Impact Actions in their organisations.

Marketing and communications of the High Impact Actions work was also shortlisted for a Chartered Institute of Marketing Award in February 2011.

### Patient Experience Network

The patient experience network has released a series of four instructional videos illustrating the most significant projects from across the network. These demonstrate to NHS staff across a variety of acute and non-acute settings how they can start to more fully integrate patient experience into their work on a sustained basis. The videos cover *The Care Programme Approach for Mental Health Patients; Real Time Patient Satisfaction Surveys; Stroke Services* and *How to implement a Service Standard Manifesto.*

### Patient and Public Involvement/ Engagement

The *Welcome and Involvement Pack* is a 'crossover' product which sits within the Patient Perspective module of Productive Community Services and helps teams to create a baseline understanding of their patients' experiences. The pack provides pro-formas and guidance as templates which they can customise for delivery across their own localities. They can be customised for each service then printed out and populated with patient feedback about what is most important to them in receiving their care package. This can be accessed on our website as part of the 'Patient Perspective' module resource set.

The Patient and Public Involvement programme has delivered work this year specifically aimed at engaging GP commissioners, publishing the *Rough Guide to Patient Experience* specifically for this audience, and a guidance video.

## Products and tools launched and in development

### Joined-up care

Joined-up care was launched in January 2011 and is a suite of products which helps to eliminate the duplication, inefficiency and waste which can create a poor experience as patients pass between organisations on their healthcare journey. It consists of:

*A practical guide to making change happen* – outlining principles and methods required for successful Joined-up care.

*Making it happen: suggested tools and methodologies* – a guide to NHS Institute tools and programmes which can help NHS teams to optimise their application of Joined-up care.

*Case studies* – examples of practice in real-life contexts and tips for success from NHS sites who have successfully utilised a 'joined-up' approach.

These have had a good take up with over 3,842 downloads in three months, with a conversion rate of 81% from visit to the web pages to actually downloading a publication.

Their launch was accompanied by a series of guidance web seminars, with guest facilitators including Chris Ham, Chief Executive at

# Management Commentary and Review of Activity *(continued)*

The King's Fund. A national conference to support the programme took place in Manchester on 19 May 2011.

### New online Safer Nursing Care Tool – launched in February 2011

The Safer Nursing Care Tool (SNCT) was launched in February 2011 and is a robust valid evidence-based easy to use tool which uses acuity and dependency to help plan for future workforce requirement. It is a natural extension to the original Association of United Kingdom University Hospitals (AUKUH) Patient Care Portfolio project.

SNCT was launched via a series of web seminars, which gave a succinct and accessible introduction to the online tool, how to get optimal benefits from its use, details of how to utilise the SNCT within the Energise for Excellence framework, and learning opportunities from the direct experiences of staff who had used the tool.

### Commissioning Compacts

The use of compacts in an NHS healthcare context is relatively new and to help equip individuals for the challenge, a workshop was held in Autumn 2010, accompanied by a new publication entitled *Developing a Compact – A brief guide for Clinical Commissioners.*

### Innovation Challenge Prizes

This scheme has been created to recognise and reward ideas that tackle some of the most challenging areas of healthcare and the first wave of prize winners will be announced shortly.

There were 75 applications submitted in a relatively short window of opportunity for the first wave of applications, which lasted for four weeks from December 2010 to January 2011.

### Productive General Practice

Productive General Practice aims to support general practices in realising internal efficiencies, while maintaining quality of care and releasing time to spend on more value added activities. It is being developed in co-production with practising GPs, practice managers, practice nurses and receptionists at seven test sites along with a group of 60 development partners from the frontline of the service.

The project team includes two seconded GPs, a practice manager, and will shortly recruit a practice nurse.

In October 2010 our first development partner workshop gave GPs, practice managers, practice nurses, receptionists and other partners the chance to help shape the content and direction of the programme. In February 2011, a second workshop gave them an opportunity to review the work done so far and have further input into the programme's development.

The programme was featured on BBC News on 19 March 2011 in a piece during which GPs working on Productive General Practice outlined the benefits it will bring to practices. The item also featured Dr Clare Gerada, Chair of the Royal College of General Practitioners.

Following testing, the programme will be fully launched in Autumn 2011.

To promote Productive General Practice in the lead up to production of the final suite of products on a peer-to-peer basis, representatives of the programme are presenting at a total of 15 national events – focusing on the interests of GPs, practice managers, practice nurses and other key practice staff.

## Solutions

The changing healthcare landscape during 2010-11 saw the NHS Institute proactively instigate the Solutions business unit. In addition, many of the organisational assumptions made at the beginning of the year were subject to rapid review and modification following the publication of the White Paper *'Equity and Excellence: Liberating the NHS'* in July.

The Solutions business unit was borne out of an identified need, following a series of listening exercises conducted directly with the NHS during the reference period, and created to serve NHS organisations and patients in the delivery and implementation of a range of service options to help meet the cost and quality agenda. To quantify the current and future potential, an estimated £6bn financial saving for NHS England is possible by 2013 with the successful and wholesale integration and implementation of NHS Institute Solutions methodologies.

### Solutions North

2010-11 has been a very active year for the Solutions North team; our work programme has allowed us to work and support all NHS organisations with current products and programmes and to really start to understand the strategic and operational priorities for the region and individual organisations. We have listened to our customers and provided bespoke programmes where required utilising our current products. Within Yorkshire and the Humber we have developed a programme for maternity services building on the NHS Institute products already available and within the North East we have supported the prison health community to roll out The Productive Series. We have also tested out our health system support work with Sheffield and County Durham and Darlington and have now developed a national offer of a programme of work across health and social care systems in readiness for 2011-12. In the North West we have worked with the Advancing Quality Alliance (AQuA) to develop a group of almost 100 link associates, building capacity and capability for improvement across the NHS. Participants have had support and training in implementing a range of NHS Institute products and programmes. We have also delivered a Procurement Decision Making Event to facilitate the involvement of clinicians in procurement decisions to support the QIPP agenda.

### Solutions South

Solutions South has worked closely with SHAs in the region to deliver the work programmes that best support their plans to improve quality, innovation, productivity and prevention. This has resulted in widespread acceleration of implementation of The Productive Ward, Productive Community Services and The Productive Operating Theatre. Feedback on the impact of these programmes, both in improving working practices and productivity, has been extremely positive. In addition, many frontline staff have developed service improvement skills which allow them to address other work challenges with confidence. In a similar way to colleagues in the other Solutions areas, a high degree of activity has been seen in Solutions South developing and strengthening existing relationships with NHS provider organisations during the year, together with establishing relationships with clinical commissioning groups that

# Management Commentary and Review of Activity *(continued)*

we have yet to work directly with. Taking account of comments and feedback from our existing customers, a number of events have been run during the year to support local objectives and challenges. In addition, we have been co-developing further NHS Institute offerings, have supported the roll out of lessons from the Academy of Large Scale Change and run local events with the NHS Institute mobilisation team, to help NHS staff appreciate the challenges their local health systems face and understand their potential role in addressing those challenges for the benefit of patients and carers.

## Solutions East

Reflecting QIPP plans and priority areas, the Solutions East team has overseen delivery of very broad support to over 40 organisations covering many areas of the NHS Institute's offer with safer care and large scale change-based outputs featuring strongly. The Productive Series continued to be a mainstay of activity with very significant progress made on further roll out but also commitment to sustainability and consolidation of achievements made. Both SHA areas in the region continue to exceed their ambitious planned spread of Productive programmes. One of the tools particularly successfully deployed has been the use of Accelerated Learning Events (ALEs). The utilisation of ALEs is a method by which key individuals are assembled in one location for an intense development session focused on a particular topic or challenge, the outcome of which is consensus on priorities and local direction of travel with agreement of actions and next steps. A more detailed resume regarding the impact of a series of GP commissioning focused events can be found in the Clinical Commissioning section of this report.

## Solutions West

NHS Institute delivery and support for 2010-11 started slowly across the West and built significantly into the second half of the financial year despite the impact of the White Paper and the restrictions invoked earlier in the year. The NHS Institute engaged with organisations across the West around two main priorities – supporting and accelerating local QIPP plans and the development of local clinical commissioning arrangements.

The Productive Care workstream has been energetically embraced and recognised for its contribution to local QIPP plans across the West. Organising for Quality and Value, especially in the South West – has been used to good and wide ranging effect to enable local QIPP project and programme teams to ensure optimal success for their plans. Bespoke approaches have been effectively designed and implemented based on the large scale change methodology in both West Midlands and South West regions to engage and support communities around the scale of their QIPP challenges and to develop local responses to system reform in relation to the White Paper.

The Mobilising and Organising approach, one of the NHS Institute's most recent developments, is being used to support the End of Life Care work within the West Midlands and the national Dementia QIPP workstream led by the South West region, and is being introduced to the Emerging and Clinical Leaders networks.

## Delivering Quality and Value

### Children and Young People's Emergency and Urgent Care

The Children and Young People's Urgent Care rapid improvement programme began with 10 healthcare systems across the country in December 2009. During 2010-11 it has spread to 16 systems with all systems having developed and currently implementing whole systems pathways across multiple organisational boundaries, common assessment and management tools, referral processes and consistent patient information relating to high volume conditions experienced by children and young people.

The Emergency and Urgent Care lesson plan for 11-14 year olds was sent to every secondary school in England. There are examples where schools are incorporating the lesson plan as a routine part of Personal Health and Social Education. The lesson plan was profiled on BBC News on 13 November 2010.

The Children and Young People's Emergency and Urgent Care work was short listed in the Health Service Journal Awards for achieving quality and efficiency in children's services.

The team has worked with East of England SHA and CYP professionals to develop a set of standards for Children's Assessment Units and has secured an ongoing contract for further work (£30k) from this SHA to support the roll out and achievement of these standards.

*A Whole System Approach to Improving Emergency and Urgent Care for Children and Young People. A Practical Step by Step Guide and Resource Pack* was published in March 2011 for the wider NHS to share in the learning acquired from the programme.

### Ambulatory Emergency Care

Our updated *Directory of Ambulatory Emergency Care*, endorsed by the National Clinical Director for Emergency Care, was published in April 2010. The Directory is an innovation for urgent and emergency care which could transform care delivery for a substantial number of patients who are currently admitted to a hospital bed. The extent to which this innovation can be delivered is dependent on improved integrated working across the whole system and the potential could be extended by innovations such as remote monitoring through technological advances.

A guide entitled *How to implement the Directory of Ambulatory Emergency Care* was published in October 2010. In the first four months, requests for 3,600 copies were received.

An emergency day case rate indicator was released in December 2010 which shows acute providers their ambulatory potential as a productivity opportunity including reduction in tariff payments. This product has informed national policy with ambulatory emergency care being recognised as a significant stream of emergency care as part of the national quality indicators for emergency care for the first time.

The NHS Institute held a series of national events across the country in conjunction with SHAs and IMAS to raise awareness of ambulatory emergency care and give advice on how to implement it. The London event was opened by Simon Burns, Minister for Health.

# Management Commentary and Review of Activity *(continued)*

The ambulatory emergency care products are supported by the Department of Health, the College of Emergency Medicine and the Society for Acute Medicine.

## Healthy Places, Healthy Lives

Healthy Places, Healthy Lives is a partnership programme which helps to reduce health inequalities and improve population health.

Delivery of the programme enables the accelerated take up and learning from experience, best practice and improvement science to influence commissioners, providers, Health and Wellbeing Boards, and partners in the public sector, and meet the challenges of addressing health inequalities within their own environment.

### Achievements

**Partnerships** – there are currently 25 partnerships across the country working collaboratively with local partners to reduce the health inequality gap in their local area by addressing the conditions in which people are born, grow, live, work and age.

**Peer exchanges** – a series of online peer exchanges have enabled partnerships to share their work with each other, and allowed them to discuss areas of challenge in a supportive environment with partners such as the NHS Institute, the Marmot team, National Support Team and Local Government Improvement and Development.

**Themed online seminars** – fortnightly themed online seminars give participants the chance to find out about work taking place nationally, offer useful information from national and international leading thinkers, and provide a way to get together with colleagues and share experiences. Topics have included Joint Strategic Needs Assessments and Leading Change. 264 people have participated to date.

**Learning events** – the Healthy Places, Healthy Lives team has run three national learning events focusing on the new health landscape, providing support to help mobilise communities act on a large scale, productive partnering, transforming community development and community engagement. The three learning events were attended by 233 people.

## Clinical Commissioning

Our response to the reforms in respect of the move to develop clinical commissioning to be led by clinical commissioning groups took shape quickly. We recognised that the value of existing knowledge and experience and products developed by the NHS Institute for PCT commissioners would, with some fine-tuning, have similar value for the new commissioners. It was with this in mind that we sought a partner organisation well rooted in general practice to work with jointly and to ensure alignment with future requirements and product development.

Working with the Royal College of General Practitioners we founded the RCGP Centre for Commissioning which launched in December 2010. The Centre was developed to equip GPs, practices and clinical commissioning groups with the skills, competencies and expertise to deliver effective healthcare commissioning which ensures patient focused, safe, high quality healthcare and improved local health outcomes. This symbiotic partnership makes excellent use of the experience and expertise of both partners for the benefit of GPs as individuals, in the practices and in commissioning groups.

The Centre has achieved much in its short life. Achievements to date include:

- undertaking an online survey with GPs to determine their knowledge of commissioning, their preferred learning styles and their understanding of commissioning support currently available
- development of the Commissioning Competency Framework – an educational tool to determine the range of knowledge skills and tools required by GPs for successful commissioning. The framework also provides a diagnostic tool to help individuals identify development needs
- recruitment of 50 clinical commissioning champions who are developing training resources and support tools, and who are working with GPs and other healthcare professionals to help them with the challenges ahead
- delivery of 16 'Foundations for Effective Commissioning' workshops across the country to identify development needs, consider the wider needs of GPs, practices and clinical commissioning groups, and to help individuals to develop their roles as commissioners
- in collaboration with five health communities across East of England we designed and led a series of Accelerated Design Events (ADE) that focused on GP-led commissioning. Over 500 local clinical leaders and key stakeholders from across the health and social care community were brought together to explore and develop solutions to tackle complex issues and local priorities. Key challenges addressed included managing large scale change and delivering more for less whilst improving quality and safety. Participants left with further clarity and consensus on the local direction of travel in responding to *Liberating the NHS* as well as a plan for action.

One of the accelerated design events took place in Welwyn Garden City on 9-10 February 2011. It attracted over 100 participants with 46 out of 50 local GP practices across West Herts sending two representatives, demonstrating a very high level of engagement based on the success of other events. As a consequence of the event, 86% participants either agreed or strongly agreed that *"I have a better understanding of what we need to do to make progress with GP consortia"*. Over the course of the ALEs, on average 85% would recommend programmes like this to their peers.

## Thought Leadership

### Creating contagious commitment for change

The core focus of the Thought Leadership team is to enable large scale improvement efforts and to help create conditions, skills and energy for change at an unprecedented scale and pace, so that improvements in quality and productivity are delivered across the NHS.

The three key aims are:

- to keep NHS improvement practice fresh, relevant and at the leading edge
- to support, advise and enable leaders of change to maximise results
- to support other teams and leaders within the NHS Institute, QIPP national workstreams and SHAs in the delivery of quality and cost improvements.

During 2010 the team focused on learning skills of mobilising and organising and testing their applicability in an NHS context. They increased the number of people actively engaged and working towards the incorporation of social movement and community organising methods to over

# Management Commentary and Review of Activity *(continued)*

2,000, actively involving service users and the voluntary sector in this work. This was done through the delivery of coaching workshops, intensive skilling workshops on community organising training and intensive one-to-one coaching to assist local organising projects support delivery of their QIPP objectives.

Early in 2011, the team undertook a strategic review of the work undertaken during this discovery and development phase, reflecting on what had been learnt to date, what SHA colleagues had felt worked well and taking the capacity of the team into consideration. From this work a strategy was developed to ensure maximum impact across the NHS to create contagious commitment for change at the scale and pace necessary to deliver QIPP.

It was decided to give intensive support to two 'calls to action' which form part of the QIPP workstreams and have been identified as being able to deliver quality and cost improvements. Giving intensive support to two 'calls to action' will enable them to create change at scale and pace. It was agreed that the National Team would focus on, and give intensive support to, projects to improve dementia and end of life care. These 'calls to action' are to focus on taking agreed action gained through shared values that will create significant change. The dementia call to action will focus on supporting the work to eliminate the inappropriate prescribing of anti-psychotic drugs. The End of Life team are working closely with the End of Life QIPP workstream team on how best they can support end of life care for people in care homes.

Plans to work with colleagues to help enable and support them in their endeavours for shared decision making becoming the norm are under discussion. Support and coaching in using social movement and community organising methods and principles are also being shared with the Energise for Excellence team to enable them to realise their vision of at least 200,000 nurses, midwives and health visitors to have answered their 'call to action' to improve quality, reduce harm and reduce cost.

Local calls to action, developed as part of the early development phase, continue to be supported through the facility of a virtual platform whereby they can share information with their growing constituencies and other projects. This will be a key mechanism for the calls to action.

The team is continuing to deliver training to leaders to coach them on how to enable others to achieve common purpose through shared values and commitment. Very senior leaders, emerging leaders, clinical leaders and clinical commissioning groups are the principle targets for this engagement to give them the skills and understanding to be able to support and personally engage with this model for change. 2011-12 plans include the use of the Barry Oshry Power and Systems model to ensure power works more effectively within systems. This helps leaders better understand the world in which they operate. It focuses on systemic conditions rather than personalities and allows people to see the underlying issues standing in the way of their success.

Helen Bevan, Chief of Service Transformation, recently accepted an invitation from Nick Hurd, Minister for Civil Society, to join the Community Organisers and Community First Expert Reference Group and is the only member representing the health service.

## Safer Care

The Safer Care team aspires to build an NHS where every member of staff has passion, confidence and skills to eliminate harm to patients. The team works with board members and senior leaders, senior and junior doctors, nurses, pharmacists and patient safety leaders.

### Achievements

In 2010-11, the Safer Care team reached 1,262 staff from across all sectors of the NHS through their programmes.

#### Leading Improvement in Patient Safety (LIPS)

This is a comprehensive organisation based modular programme that runs over nine months. LIPS builds safety improvement skills in a multi-disciplinary team of frontline staff from organisations. These teams focus on implementing improvements in clinical systems in order to deliver against the system level safety aim that is agreed with the executive team. A two day Executive Quality and Safety Academy (EQSA) works with the chief executive and a team of directors. They develop a practical strategy to support the transformation of quality and safety in their organisation.

During 2010-11 Acute LIPS waves VI and VII have completed the full programme. These waves have involved trusts new to LIPS plus teams from those who have participated before and want to increase their capacity to deliver safety improvements.

*"I would like to take this opportunity to thank you and the team for a brilliant series of patient safety events. Being new in post, I had strong reservations about signing up (and being non-clinical, doubted the relevance of the content for my role). I could not have been more wrong. I work with a number of LIPS graduates who couldn't have spoken more highly about the improvement methodology and techniques taught during the course and now see that* ***anyone*** *working in a healthcare environment would benefit from signing up for LIPS. My colleagues from critical care and outreach have been equally enthused and inspired. A big thank you goes to all the speakers."*

Originally designed for acute trusts, LIPS has now been contextualised for delivery to GP practice teams and those from mental health. Teams from ambulance and community trusts have also attended and benefited from translating the learning into their setting. A total of 113 GP practices have now completed the programme and 14 mental health trusts.

We have surveyed around 400 general practice staff attending our LIPS events and the results indicated that before participation, even amongst early adopter practices, there was a considerable lack of awareness, culture and skills for improvement. By the end of the programmes, there has been a 64% confidence shift in feeling able to improve any patient safety problem within the practice.

#### Commissioning for Safer Care

This recently developed product has been delivered in one SHA area with a further one to be delivered in April. This product will be spread across the country via the RCGP Centre for Commissioning.

In addition since 2009 we have delivered bespoke primary care safety improvement events and workshops to 3,267 staff particularly from general practice. These have included introductory workshops;

# Management Commentary and Review of Activity *(continued)*

webinars, BMJ masterclasses; GP vocational training schemes, LMCs and international conferences.

### The Patient Safety Leaders' programme

This modular action based programme teaches a deep practical understanding of improvement science applied to safety projects which are assessed at the end of the four months.

### Advanced Improvement for Quality and Safety (AIQs)

The second cohort of 20 experienced improvers are nearing the end of this year long action based programme, which includes assessment of a significant improvement project and carries formal accreditation.

### Trigger tools

We have developed and delivered a range of trigger tools to enable organisations to identify, understand and measure harm in their practice. These build on the acute trigger tool developed by the Institute for Healthcare Improvement and enable a valuable insight into everyday harm that is not easily detected by incident reporting. There are now online tools that are being used regularly by staff from primary care, mental health, paediatrics and community hospitals as well as acute hospitals.

The trigger tool portal offers a facility for teams to safely record their findings and generate charts that assist in demonstrating improvement.

### The Improvement Faculty for Quality and Patient Safety (The Improvement Faculty)

The Faculty currently has a membership of 200 NHS staff of all backgrounds. It offers opportunities to learn more about improvement, share and peer review improvement work and to network with like minded clinicians and managers.

### Building Safety Improvement Skills (BaSIS)

This programme works with Foundation Year 1 and Foundation Year 2 junior doctors to build basic improvement skills and understanding. This group of staff sees the services we run with fresh eyes and is enthusiastic about learning how to make the systems they work in safer. They also learn that they are part of a wider team and take that important concept with them as well as the improvement skills.

## Learning

### Organising for Quality and Value

The Delivering Improvement Programme is one of the NHS Institute's key approaches in building improvement capacity and capability in the NHS. It incorporates training in the use of a suite of tools and techniques considered to be fundamentals in quality improvement. It also aims to aid personal development through a programme facilitator who provides support for delegates as they progress through the programme and apply their learning to their individual projects.

#### Achievements

The programme was launched in 2009 and 228 NHS staff were trained in the first year. The programme's popularity has grown with approximately 467 delegates having completed the programme in 2010-11. The programme continues to be extremely well evaluated by participants and their leaders report on the positive impact on their organisation. In a recent random sample of evaluations, 100% of respondents selected

# Management Commentary and Review of Activity *(continued)*

either ‘strongly agree’ or ‘agree’ when asked if the learning will help them make improvements in their work.

The NHS Institute has developed a rigorous quality assurance process for those delivering the programme and currently 29 staff are supporting the programme nationally.

### Accelerated Learning Events

Accelerated Learning Events bring together large groups of key multi-professional stakeholders to create a common agenda and shared understanding of a problem or challenge that can only be collectively addressed. The approach builds energy and momentum for change, cutting much time out as previously such endeavours would have entailed months of meetings and silo planning. The NHS Institute has become recognised as the expert in running these events and in 2010-11 we ran a series of high profile national ALEs as well as regional events to support specific local agendas.

#### Achievements

On 5/6 January 2011, an ALE took place at our Coventry headquarters. This was a collaboration between the NHS Institute, the National Leadership Council and the Department of Health, during which 80 delegates considered *Identifying the Leadership Development Solutions for GP Consortia Leaders*. The Secretary of State for Health, Andrew Lansley attended the event which evaluated positively for both content and organisation.

At a local level, an ALE was held at Salford NHS Foundation Trust on 31 March 2011. This event, which took the format of a decision making workshop, considered *Quality Products at a Lower Price* and was attended by 87 members including chief executives, medical directors and finance directors from 10 trusts in the North West. The output from this successful event was to increase working together to develop a new approach to procurement, with the ultimate aim of achieving estimated savings of around £5m per trust.

### ThinkGlucose

#### Achievements

2010-11 has been an exciting year for the ThinkGlucose team. As well as working extensively across the NHS in England, an extended package of support has been successfully delivered to NHS Dumfries and Galloway in NHS Scotland.

Highlights of the work within the NHS include a rapid improvement event across the new structure of integrated care in Buckinghamshire Healthcare which has brought two acute and five community hospitals together. The spread of ThinkGlucose across the South Central SHA area is also happening through a virtual platform to share learning and experience via NHS networks.

There are many good examples from across the country of quality of care having been improved and significant cost reductions achieved through the introduction of ThinkGlucose. For instance, on the four ThinkGlucose pilot wards at Portsmouth Hospitals, the inappropriate use of intravenous insulin was recognised and stopped which, if replicated across the trust, could result in cost savings of £495,720 per annum. In addition, the four wards saw a 75% reduction in delayed discharges for patients with a secondary diagnosis of diabetes which, if repeated across the trust, could result in the approximate savings of £44,000 each year. There was also a significant impact on readmission rates for this group of patients with the rate falling by 30%.

# Management Commentary and Review of Activity *(continued)*

ThinkGlucose has been cited as recommended guidance to help trust comply with the latest Department of Health 'Never Events' list for 2011-12, which has a new indicator of mal-administration of insulin. ThinkGlucose and the NHS Institute are publication partners with the new NICE quality standards for adults with diabetes. These were launched at Diabetes UK Annual Professionals Conference at Excel in London. The standard, published on 31 March 2011, is now available on the NICE website.

## Leadership

Our leadership programmes are designed to identify and develop inspirational and innovative leaders, with the skills, competencies and commitment to continuously improve the NHS in order to provide a world class service for patients.

We have supported the National Leadership Council to transform leadership capacity and capability throughout the system. A significant portion of our work during the year has been to develop and gain adoption for the **NHS Leadership Framework**, a single leadership development framework for all staff in the NHS irrespective of discipline, role or function. It is underpinned by a consistent set of guiding principles which reflects the values of NHS staff, embodies the NHS constitution, and represents the foundation of leadership behaviour for staff throughout the NHS. It combines and builds on the Leadership Qualities Framework and the Medical and Clinical Leadership Frameworks, and is expected to be launched during 2011.

The Leadership team has actively responded to consultations on the future architecture of Leadership and Leadership training following publication of the White Paper, *'Liberating the NHS'*.

### Achievements

#### Management Training Schemes

In September, 150 trainees joined the **NHS Graduate Management Training Scheme**. The 2011 scheme has been refreshed and refocused with the support of key stakeholders to incorporate QIPP principles. By the end of the year, it had been awarded:

- first place in the Guardian Top 300 Graduate Employers List
- fifth place in the Times Top 100 Graduate Employers List
- Best HR Graduate Employer – Times Top 100
- Best Public Sector Graduate Employer – Target Jobs Graduate Recruitment Awards
- a finance trainee (Simon Watts) achieved first place in the world for his CIMA strategic exams.

A methodology for measuring the **Return on Investment** of individual trainees has been developed, and will become part of every trainee's programme from September 2011.

Approval to recruit to the 2011 scheme was not given until late in 2010, and expenditure restrictions were tight. The team successfully rose to these challenges, and applications received were higher than ever, at more than 15,000. The team also successfully refreshed the whole assessment process to include the new Leadership Framework, QIPP, emotional intelligence and motivation to join the NHS.

A six week **pilot internship programme** attracted 27 graduates, at the end of which nine had secured positions in the NHS.

A new contract was established with Electronic Staff Record (ESR) whereby the scheme can track the careers of its alumni since the 2002 intake.This is the first time ever there has been robust data highlighting the career paths of trainees, salary levels, locations and type of organisations.

To encourage peer support, ease the tracking of alumni, and enable easier communication with current and past participants, an alumni website has been created, and LinkedIn groups established for Gateway to Leadership, Breaking Through, trainees, alumni, assessors and internship participants.

Due to Department of Health restrictions, there was no recruitment to the **Gateway to Leadership** or **Breaking Through** programmes for 2010. However, funding and approval for **coaching and mentoring programmes** for Breaking Through participants was received in February, and the team put a series of successful and over-subscribed sessions in place before the year end.

95% of Gateway participants and 87% of trainees who completed our Leadership programmes during 2010-11 found roles in the public, voluntary, social care and third sectors. Breaking Through's Top Talent cohort 2 concluded in December 2010 and 70% have secured roles at a higher level than when they commenced the programme.

### Enhancing Engagement in Medical Leadership

This joint project with the Academy of Medical Royal Colleges aims to engage clinicians in the management and leadership of health services, with the ultimate aim of improving services for patients across the UK. Work to create a Faculty of Medical Leadership and Management, into which the Enhancing Engagement programme will be transferred, came to fruition and the Faculty was formally launched on 1 April 2011.

Key publications:

- *Medical Chief Executives in the NHS: Facilitators and Barriers to Their Career Progress* – findings from interviews with 22 medical chief executives in England.
- *Medical Leadership Competency Framework (MLCF)* 3rd edition July 2010.
- *Guidance for Undergraduate Medical Education: Integrating the Medical Leadership Competency Framework* – developed in collaboration with a consortium of five medical schools.
- *The 21st Century doctor: Understanding the doctors of tomorrow* summarises the discussions of 11 Medical Professionalism roadshows held with medical students.
- *Engaging Doctors: What can we learn from trusts with high levels of medical engagement* – key findings from seven trusts.

Other activities in 2010-11 include:

- the launch of LeAD (e-learning for medical leadership) in June – 50 e-learning sessions
- submissions to Health Professions Council, General Pharmaceutical Council, and General Dental Council consultations to encourage greater leadership coverage within regulatory standards
- development of the Clinical Leadership Competency Framework (CLCF), adapting the MLCF for the wider clinical professions including contextual examples in practice submitted by the professions themselves

# Management Commentary and Review of Activity *(continued)*

- development of *Guidance for Curriculum Development: Integrating the CLCF into Professional Education and Training.*

### Board Development Team

The focus of our provision for boards and senior leaders is on leadership for improvement. Much of our activity was curtailed after restrictions on expenditure were imposed in July, but our coaching registers and board development tools have continued to be widely accessed. In addition, key work has been undertaken on working with boards and senior leaders across sectors.

### Board Development Tool (BDT)

- 10 NHS organisations undertook and completed the Board Development Tool process.
- The BDT for foundation trusts was developed and piloted with three trusts.
- We led on the design of a BDT for primary care providers and piloted it with two organisations.

### Diversity and Inclusion Board Development Programme

We led on the project management of the Diversity and Inclusion Board Development Programme for the National Leadership Council and undertook independent evaluation and a post programme review.

### Local Authority Peer Review Scheme

Together with Local Government Improvement and Development (LGID) we designed and delivered this programme, which is open to chairs, chief executives and other senior leaders of public sector organisations. External evaluation reports that the programme is a *"substantive, timely and potentially groundbreaking learning opportunity for NHS Leaders and their boards...and has enhanced the leadership and partnership skills of NHS Leaders".*

### Coaching

Despite the professional services recruitment freeze, our coaching offer has continued to attract individual and team coaches. The executive coach register is now in its second year and coaches benefited from two development days.

Our first NHS coaching supervisors graduated in September 2010, part of our work to give the NHS its own internal coaching and coaching supervision capability. We now have 21 qualified internal coaching supervisors and we will be running a third cohort in October 2011.

We continue to host an SHA Coaching Leads Network, a forum for sharing and learning.

We have continued to support the National Leadership Council Emerging Leaders workstream, and work has included:

- setting up a Quality Assured Framework of coaching supervisors for use by SHAs and a regional coaching evaluation methodology for ten SHAs
- providing access to our coaching registers for GP Pathfinders, on behalf of the Commissioning Leadership workstream, and for the Top Leaders programme participants.

### Leadership Qualities Framework (LQF)

More than 17,000 people have used the LQF in its current form. It will be decommissioned when the new Leadership Framework is launched during 2011.

## NHS Institute Worldwide

Our foothold across the globe strengthened during 2010-11 with the following significant activities and achievements.

### Scotland

Our partners in NHS Scotland are working with us to jointly develop the latest in The Productive Series – Productive General Practice. In addition, NHS Scotland has implemented The Productive Leader and Productive Community Services this year. Critical themes which emerged from the Scottish health service have been productivity and efficiency and this will shape the way service improvement takes place.

### Europe and Scandinavia

We have worked in the Republic of Ireland through the provision of training and support for The Productive Operating Theatre (TPOT). The Royal College of Surgeons in Ireland has worked with the Health Service Executive (HSE) to implement TPOT in the eight hospitals across the country. In parallel, the first two Irish hospitals have been trained in The Productive Ward. This year also saw the launch of the first NHS Institute International Fellowship Programme with Waterford Institute of Technology and the Republic of Ireland HSE.

Our work in Sweden commenced with a pilot of The Productive Mental Health Ward programme in Lund and Stockholm counties sponsored by the Swedish Association of Local Authorities and Regions. Evaluation by the University of Stockholm has already demonstrated benefits for patients and the hospitals.

In the Netherlands the first two hospitals commenced training for The Productive Ward.

### Australasia

Agreement was reached with Queensland Health for implementation of a state-wide implementation of The Productive Series as a key driver for their efficiency improvement programme.

We have agreed work in Victoria and Western Australia and will be looking to develop relationships with national bodies, the private sector and with New South Wales.

In New Zealand, Productive Community Services has been implemented in seven key districts as a result of a joint trial during the early stages of its development. New Zealand has now implemented The Productive Operating Theatre, The Productive Ward and The Productive Leader as well as a number of other programmes covered under the partnership agreement with the New Zealand Ministry of Health.

### Canada

In 2010 NHS Institute Worldwide established successful partnerships with a number of Canadian organisations across several provinces. The results of this collaboration included continued spread of The Productive Ward across Saskatchewan and Ontario and its introduction in Manitoba.

In addition, the NHS Institute has provided training and seminars on a range of topics including innovation and patient engagement. In November 2010 the NHS Institute hosted a visit to England for 22 surgeons and clinical leaders from Canada who were keen to learn about the latest thinking and best practice in surgery from the NHS in England.

### United States of America

Current business development activity in the North Western United States is managed

# Management Commentary and Review of Activity *(continued)*

primarily through CareOregon (a non-profit Community Benefit Organisation which helps ensure that the population, regardless of income or social circumstance, have access to high quality healthcare with the aim of providing access to high quality, cost-effective and culturally competent care).

As part of the overall US campaign we are developing the 'partnership' relationship in Oregon to enable us to reach senior state and federal government healthcare decision makers. This supports 'on the ground' business development activity and delivery as managed with CareOregon. CareOregon has completed roll out of The Productive Ward and is currently looking at agreements for The Productive Leader and The Productive Operating Theatre.

## Knowledge Management

The Knowledge Management (KM) team continues to support NHS Institute teams in sharing and disseminating learning and knowledge to the wider NHS.

### Achievements

NHS Institute Alert, a monthly email digest of articles and journals on service improvement and change management, continues to be popular with subscriptions rising by 15,000 this year to 24,075 people per month. Following a review in November 2010 the service now covers eight cost and quality focused topics (commissioning for improvement, raising quality whilst reducing cost, learning from improvement science, inspiring innovation, increasing productivity, building leadership capacity, improving patient experience and improving patient safety). NHS Institute Alert is available via our website, RSS feeds, and monthly newsletter.

Related services include Article of the Month, Guest Editorials and Expert on Call – a free monthly web seminar where leading thinkers in the NHS Institute and beyond share their insights from research or product development. In 2010-11, 890 people comprising mainly NHS staff, have joined these seminars.

The KM team has also been involved in leading the specification and development of a knowledge content management system to classify existing digital assets of the NHS Institute. The system will provide a repository of the NHS Institute know-how regarding innovation and improvement in healthcare and support the efficient working of the NHS Institute in responding to customers' needs.

## Networks

#### NHS Live

NHS Live is the NHS Institute's free, national learning network which aims to stimulate innovation from the NHS frontline, encourage innovative partnerships and networks, and create mechanisms for the diffusion and adoption of innovation.

### Achievements

**Improvement project directory** – the NHS Live team has carried out a 'cleanse' of its online project directory during 2010-11, contacting all project leads to verify and update the details held to ensure that the directory continues to be relevant and useful for NHS innovators and improvers. In doing this we have established that projects are continuing to go from strength to strength. Some have been adopted across whole regions whilst others have become fully commissioned services in their own right. The project directory is searchable by region

and keyword, and currently comprises more than 800 NHS frontline improvement projects.

**Community membership** – around 10,000 NHS frontline innovators receive the NHS Live monthly newsletter which includes features on popular topics from the NHS Live project directory, frontline improvement case stories and news of the latest tools, products and events from the NHS Institute.

**Online seminars** – in early 2011, NHS Live ran a series of free online seminars to help NHS Live members manage their improvement projects and provide an opportunity for members to discuss ideas and challenges with NHS colleagues. 228 frontline staff registered for the seminars, which covered *an introduction to budgeting and forecasting, getting funding for your project,* and *communicating and marketing your project.*

### Academy for Large Scale Change

The reconnection event of the Academy for Large Scale Change was held in York on 17 and 18 June 2010, six months after the end of the Academy. Participants and their guests (over 90 people) came together to see where their large scale efforts have taken them over the past two years. Jim Easton, NHS National Director for Improvement and Efficiency, encouraged participants to develop and renew an individual and collective sense of energy and commitment for large scale change.

Although the Academy has come to an end, it is very evident that this group of people will be key as we move to mobilise the NHS for the future.

Paul Plsek, Director of the Academy, has collated the learning and outputs from the Academy to create a guide, *Leading Large Scale Change: What the NHS Academy for Large Scale Change learnt about and how you can apply these principles to your own healthcare setting.* The introduction and epilogue have been written by our Chief of Service Transformation, Helen Bevan, and the content includes contributions and examples of large scale change from all ten regions. The guide will be published in early 2011-12.

### SHA Joint Improvement Strategy – Link Directors Network

We continue to meet via fortnightly web seminar with link directors from the ten strategic health authorities.

### Health and Social Care Awards

The awards were once again run in partnership with the strategic health authorities, with national finalists in six categories being selected from the regional winners. The categories this year were based on QIPP core principles. Despite restrictions on the marketing and communication of the awards, c1,500 entries were received from across England.

### NHS Institute monthly e-newsletter

Our e-newsletter brings our contacts from NHS England and beyond up-to-date with products, events, tools and news from the NHS Institute and has gone from strength to strength during 2010-11. In May 2010, 30,718 people received the newsletter. By March 2011 this number had risen to 41,742.

# Director of Corporate Services and Finance Commentary

## Financial performance

The accounts on pages 45 to 93 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.

### 2010-11 Finances at a glance

This report includes the financial information for the year ended 31 March 2011. The NHS Institute was required to achieve a number of key and statutory financial targets:

- To maintain its revenue expenditure within a limit of £67,303,000. This was achieved.
- The NHS Institute was required to maintain its capital expenditure within a limit of £1,240,000. This was achieved.
- To maintain its net cash outgoings from operating activities within a limit of £64,098,000. This was achieved.
- In addition to the key statutory target, the NHS Institute is expected to undertake its business in accordance with the Department for Business Innovation and Skills (BIS) payment target. The NHS Institute is required to pay all non NHS trade payables within five days of receipt of a correctly rendered invoice, unless other payment terms have been agreed. In this respect the NHS Institute paid 73% (by value) and 66% (by number) of its non-NHS trade payables within five days. Previously performance was measured against the Better Payment Practice Code (BPPC) which required all invoices to be paid within 10 days. The NHS Institute has maintained its performance compared to last year under the 10 day target and is continuing to work towards meeting the five day payment target.

### Financial Position at 31 March 2011

The financial year 2010-11 proved to be quite an eventful one with a combination of announcements and actions outside the control of the management of the NHS Institute that significantly changed the business plan. Against this backdrop the NHS Institute achieved an underspend against its financing of £7m.

During the year the NHS Institute drew down its full resource and 90% of its cash grant funding limit and 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:

- The announcement, in the Summer of 2010, that the NHS Institute is to be abolished as a special health authority created an uncertain environment within which to plan expenditure for 2010-11. A conscious decision was made to restrict budgets across the business to create resource headroom to allow the NHS Institute to make provisions in the accounts to cover the associated restructuring costs of closure required (in accordance with IFRS). The budgets were recast to ensure that the NHS Institute did not exceed the annual revenue resource limit set by the Department of Health after taking into account the maximum possible provision.
- During the year restrictions were applied across Government on the use of professional services. This necessitated a complete rethink of the agreed 2010-11 business plan and its objectives to support the NHS to deliver against the QIPP targets. Rather than directly contracting improvement experts in the deployment of support resource across the NHS, the NHS Institute had to deliver these resources through a series of improvement grants to those NHS businesses. New internal controls and processes had to be established to ensure that grants were properly administered and that the requirements of Government accounting were met.

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

This led to a delay in the delivery of QIPP support, and as a consequence 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.

In the context of the above it is impressive that the NHS Institute was able to respond in a robust and measured way to ensure that the implications of the decision to abolish the NHS Institute as a special health authority, together with the application of procurement restrictions during 2010-11, were managed in a way to minimise the impact on the NHS Institute's ability to support the NHS in delivering its QIPP targets.

The issues emerging during the year necessitated the 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. As a consequence of this the final financial position is outside the tolerances established in our Framework Document, which permits an underspend of two per cent against its total funding without formal notification to the Department. The Department has, however been informed of this position through our regular and improved financial reporting of our forecasts and projections.

In July 2010, when the Government announced its intention to close the NHS Institute for Innovation and Improvement as a special health authority they also announced that they would consider a transfer of some of its functions out of the arm's length body sector. The management of the NHS Institute has been told that final abolition is now not likely before 30 June 2012. The final decision on closure is dependent on the passage of legislation and therefore whether the NHS Institute will close and which functions will transfer to successor bodies, and any resulting timetable for closure, has yet to be finally decided.

Having considered the circumstances described above, and from discussion with the Department of Health, management's expectation is that the NHS Institute for Innovation and Improvement will continue to operate in its current form for at least the next 12 months.

However, due to the abolition announcement 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.

### Other matters

As part of the plan to abolish the special health authority, the NHS Institute has been actively engaging with the Department of Health over the transfer of those improvement and leadership activities that are to be retained and transitioned to successor bodies.

With this transition in mind, the NHS Institute has continued to improve its internal control and management information systems. In part this is about maintaining the value of NHS Institute products and services pending agreement on their future, together with responding to the challenges that remain to be dealt with during the interim period up to the closure of the special health authority. This process will continue during 2011-12, and has been set out in more detail within the NHS Institute 2011-12 Business Plan that has been approved by the Department of Health. This business plan has three main strands – activities to support the closure of the special health authority, delivery activities to continue to support QIPP in the NHS and activities to facilitate the transfer of functions to successor bodies.

An agreed plan has been put in place that will, as a consequence of the above, deliver a significant downsizing of the business that is transferred into a successor body. A provision has been made in these accounts that reflects the restructuring costs of this downsizing.

# Governance Structure

## Governance Arrangements

In 'NHS Institute for Innovation and Improvement – Directors 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 provides strategic leadership to the organisation and is the body responsible for ensuring that strategic objectives are met. Membership of the board consists of both executive and non-executive directors. The board is led by a non-executive director chair and non-executive directors are appointed by the Secretary of State. The chief executive officer is appointed by the chair and the non-executive directors and together they appoint the executive directors.

The board's composition at 31 March 2011 was as follows:

**Dame Yve Buckland**
Chair and Chair of the Shadow Nominations Committee

**Professor Dame Carol Black**
Non-executive Director

**Professor Tony Butterworth CBE**
Non-executive Director and Chair of the Remuneration Committee

**Michael Deegan CBE**
Non-executive Director

**Michael Lander**
Non-executive Director

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

**Noorzaman Rashid**
Non-executive Director and Chair of the Worldwide Shadow Board

**Professor Bernard Crump**
Chief Executive and Chair of the Executive Committee

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

**Rod Anthony**
Executive Director
(Acting Director of Corporate Services and Finance)

The board is supported by
**Julian Denney**, Company Secretary

# Governance Structure *(continued)*

### Committees of the Board

There are five formal committees of the NHS Institute Board.

### The Audit and Risk Management Committee

The Audit and Risk Management Committee routinely meets bi-monthly and is responsible to the board for developing and overseeing effective arrangements for all aspects of internal control and financing reporting within the NHS Institute. As part of this remit it is also responsible for maintaining an appropriate relationship with external and internal auditors. As such, the committee is the principal body, below the board, for carrying out scrutiny of policy and processes within the NHS Institute. It is this remit which distinguishes the work of the Audit and Risk Management Committee from the other groups advising the board. Core members are: Joe Liddane (Chair), Michael Lander and Noorzaman Rashid. All other non-executive directors are welcome to attend.

### The Remuneration Committee

Details of the Remuneration Committee are contained within the Remuneration Report on pages 36-44.

### The Shadow Nominations Committee

The role of the Shadow Nominations Committee is to work with the Appointments Commission in relation to the process for the appointment of all non-executive directors of the NHS Institute (including the chair) while the NHS Institute is a special health authority, to oversee the process for the appointment of all executive directors (including the chief executive) of the NHS Institute and all directors of wholly owned subsidiaries of the NHS Institute (including the chair and chief executive), and to make recommendations to the NHS Institute board in respect of appointments to NHS Institute board committees. Members are: Dame Yve Buckland (Chair) and Professor Tony Butterworth.

### Executive Committee

The Executive Committee is responsible for the executive management of the NHS Institute. It comprises the chief executive, executive directors, NHS Institute directors and area directors and meets weekly.

### NHS Institute Worldwide – Shadow Board

The Worldwide Shadow Board is responsible for the oversight, development and performance management of the NHS Institute's Worldwide business. It meets every six weeks and members are Noorzaman Rashid (Chair) and David Bower.

# Governance Structure *(continued)*

## The NHS Institute Change Board

Under the terms of the ALB Review 2011-12 will be the last year for the NHS Institute to operate as a special health authority. In order to prepare for the change and in particular to oversee the business case for the creation of a successor body, a Change Board was set up in January 2011 with representation drawn from the NHS, Department of Health and NHS Institute itself.

## 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 are recorded in the minutes of board meetings and a declaration of interest form is completed. A register of interests is kept and maintained by the corporate secretary, and is available for public inspection. This register is kept up-to-date as forms are submitted and also by means of an annual review.

The chair will ask whether there are any 'declarations of interest' at the start of each board meeting. Whenever an interest is declared which could amount to a conflict of interest, the member concerned does not take any part in the relevant discussion or decision at the meeting.

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

**Bernard Crump**
Chief Executive and Accounting Officer
NHS Institute for Innovation and Improvement
28 June 2011

# Remuneration Report – Annual Report and Accounts 2010-11

This report is subject to audit.

## Details of the membership of the Remuneration Committee

The NHS Institute has a Remuneration Committee consisting of non-executive directors Professor Tony Butterworth (chair), Professor Dame Carol Black and Michael Deegan. All other non-executive directors have a standing invitation to attend. The membership shall be three non-executive directors and a quorum shall be two members.

The Chair of the board is not a member of the Committee and the Company Secretary acts as secretary of the Remuneration Committee.

The chief executive and one other executive director are also in attendance.

The committee's remit is to:

Be responsible for developing a policy for executive remuneration and to propose the remuneration for individual executive directors and other senior employees. The committee works to an agreed Terms of Reference.

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

Remuneration of senior managers follows two national policies:

Executive Directors and Director of Planning and Performance – Very Senior Managers (VSM) Pay Framework (VSMPF).

All other staff – Agenda for Change.

The NHS Institute falls into category 2 of the VSM Pay Framework and executive directors are subject to an appraisal process (agreed by the Department of Health) which supports the requirements of the VSM Pay Framework. All senior managers below executive directors are subject to the arrangements required by Agenda for Change and the Knowledge and Skills Framework.

The framework used by the NHS Institute in its set-up stage was the HR Best Practice and Policy Guidance for ALBs V1.0, November 2005, as issued by the Department of Health. Section 3 of this policy 'Start-Ups, Mergers and Joint Ventures' refers to the recruitment of chief executives and senior executives, with these appointments being handled by the NHS Institute's Appointments Committee, including the NHS Institute chair and/or senior department sponsor. All non-executive director appointments were agreed through the Appointments Commission. The NHS Institute has its own HR service but also obtains its guidance and advice from the Department of Health when required.

# Remuneration Report – Annual Report and Accounts 2010-11 *(continued)*

## Performance conditions

For all senior managers below executive director level the NHS Institute complies with and follows the procedures as set out in the NHS National Terms and Conditions of Service – Agenda for Change and has in place a personal objective-setting process with line managers which links into the annual appraisals and review process. The executive directors take the lead on this process within their individual areas. Executive directors are also subject to performance review in line with the VSM Pay Framework. Executive director performance-related pay payments are 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 are governed by the NHS Institute for Innovation and Improvement Regulations 2005.

2. **Employment Law**
   The appointments are not within the jurisdiction of Employment Tribunals. Neither is there any entitlement for compensation for loss of office through employment law.

3. **Reappointments**
   Chairs and non-executive members are eligible for reappointment at the end of their period of office, but they have no right to be reappointed. The Appointments Commission will usually consider afresh the question of who should be appointed to the office. However, the Appointments Commission is likely to consider favourably a second term of appointment without competition for people whose performance has been appraised as consistently good during their first term. If reappointed, further terms will only be considered after open competition, subject to a maximum 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 may resign by giving notice in writing to the Secretary of State or the Appointments Commission. Their appointment will also be terminated if, in accordance with regulations they become disqualified for appointment.

   In addition the Appointments Commission may terminate the appointment of the Chair and non-executive members on the following grounds:

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

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

a) If an annual appraisal or sequence of appraisals is unsatisfactory
b) If the appointee no longer enjoys the confidence of the Board
c) If the appointee loses the confidence of the public
d) If a chair appointee fails to ensure that the Board monitors the performance of the special health authority in an effective way
e) If the appointee fails to deliver work against pre-agreed targets incorporated within their annual objectives
f) If there is a terminal breakdown in essential relationships, e.g. between a chair and a chief executive or between an appointee and the rest of the board

# Remuneration Report – Annual Report and Accounts 2010-11 *(continued)*

g) When a new chair is appointed to a board he/she will be expected to review the objectives of all board members and may, at the time of their next appraisal, make a recommendation to the Commission regarding their continued appointment.

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

5. **Remuneration**
   The chair and non-executive members are entitled under the Act to be remunerated by the special health authority for so long as they continue to hold office as chair or non-executive member.

   They are entitled to receive remuneration only in relation to the period for which they hold office. There is no entitlement to compensation for loss of office.

6. **Current rate for chair and non-executives**
   The rate (2010-11) of remuneration payable to the chair of the NHS Institute for Innovation and Improvement is £63,048 pa for up to three days a week. The current rate of remuneration payable to members is £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 is taxable under Schedule E, and subject to Class I 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 are 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 should not normally make political speeches or engage in other political activities. In cases of doubt, the guidance of the appointments Commission should be 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 2010-11 *(continued)*

11. Indemnity
    The special health authority is 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 NHS Institute for Innovation and Improvement, gives details.

    The NHS Institute has taken 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 are appointed on a permanent basis under a contract of service at an agreed salary, an entitlement to a lease car and 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 are normally appointed on the basis of a fixed term agreement. They are not entitled to a lease car or performance related award but would be entitled to all other allowances and benefits.

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

# Remuneration Report – Annual Report and Accounts 2010-11 *(continued)*

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

| Name | Title | Start Date | Review Date |
|---|---|---|---|
| Yve Buckland | Chair | 1 July 2005 | 30 June 2013 |
| Carol Black | Non-executive Director | 15 February 2006 | 14 February 2014 |
| Tony Butterworth | Non-executive Director | 1 July 2005 | 30 June 2012 |
| Michael Deegan | Non-executive Director | 1 July 2005 | 30 June 2013 |
| Noorzaman Rashid | Non-executive Director and Chair of the Worldwide Shadow Board | 1 October 2007 | 30 September 2011 |
| Joe Liddane | Non-executive Director and Chair of Audit and Risk Committee | 1 March 2009 | 28 February 2013 |
| Michael Lander | Non-executive Director | 1 March 2009 | 28 February 2013 |
| Bernard Crump[1] | Chief Executive and Chair of the Executive Committee | 1 July 2005 | Not applicable |
| Simone Jordan | Chief Operating Officer and Deputy Chief Executive | 1 October 2005 | On secondment from 23 August 2010 |
| Helen Bevan | Chief of Service Transformation | 1 July 2005 | Not applicable |
| Michael Cawley | Director of Finance and Business Services | 1 October 2005 | On secondment from 1 August 2008 |
| Rod Anthony | Acting Director of Corporate Services and Finance | 1 August 2008 | 31 March 2012 |

1. Bernard Crump will be taking up a three month secondment at the Academy of Medical Royal Colleges to support the development of the Faculty of Medical Leadership and Management. His employment with the NHS Institute will cease on 30 September 2011.

## Salaries and Allowances

| Name and Title | 2010-11 | | | | 2009-10 | | | |
|---|---|---|---|---|---|---|---|---|
| | 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 | 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 |
| Bernard Crump[4] (Chief Executive) | 165-170 | 4 | 7 | 175-180 | 165-170 See note 2 | 11 | 6.7 | 185-190 |
| Simone Jordan (Deputy Chief Executive and Chief Operating Officer) | 50-55 See note 3 | 3 | 3.7 | 55-60 See note 3 | 125-130 See note 2 | 7 | 5.5 | 135-140 |
| Helen Bevan (Director of Service Transformation) | 125-130 | 3 | 0 | 125-130 | 125-130 | 4 | 0 | 125-130 |
| Rod Anthony (Acting Director of Corporate Services and Finance) | 120-125 | 0 | 0 | 120-125 | 120-125 | 0 | 0 | 120-125 |
| Yve Buckland (Chair and Chair of Shadow Nominations Committee) | 60-65 | 0 | 0 | 60-65 | 60-65 | 0 | 0 | 60-65 |
| Tony Butterworth (Non-executive Director) | 5-10 | 0 | 0 | 5-10 | 5-10 | 0 | 0 | 5-10 |
| 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) | 5-10 | 0 | 0 | 5-10 | 5-10 | 0 | 0 | 5-10 |

Notes:
1. Executive directors' salaries included non-consolidated, non-pensionable performance related elements.
2. Very Senior managers bonuses paid in year (relating to the prior year) have been identified separately for 2010-11 and the salary banding for 2009-10 has been amended to reflect this additional analysis for the comparative year.
3. Simone Jordan left her post on 23 August 2010 on secondment to East Midlands Strategic Health Authority.
4. Bernard Crump will be taking up a three month secondment at the Academy of Medical Royal Colleges to support the development of the Faculty of Medical Leadership and Management. His employment with the NHS Institute will cease on 30 September 2011.

# Remuneration Report – Annual Report and Accounts 2010-11 *(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 2011 (bands of £5,000) | Lump sum at age 60 related to accrued pension at 31 March 2011 (bands of £5,000) | Cash equivalent transfer value at 31 March 2011 £000 | Cash equivalent transfer value at 31 March 2010 £000 | Real increase in cash equivalent transfer value £000 | Employer's contribution to stakeholder pension £000 |
|---|---|---|---|---|---|---|---|---|
| **Bernard Crump** (Chief Executive) | 0-2.5 | 0-2.5 | 60-65 | 190-195 | 1,271 | 1,330 | (97) See note 1 | 0 |
| **Simone Jordan** (See note 2) (Deputy Chief Executive and Chief Operating Officer) | 0-2.5 | 2.5-5 | 10-15 | 35-40 | 199 | 500 | (3) | 0 |
| **Helen Bevan** (Director of Service Transformation) | 0-2.5 | 0-2.5 | 40-45 | 125-130 | 759 | 815 | (80) See note 1 | 0 |
| **Rod Anthony** (Acting Director of Corporate Services and Finance) | 0-2.5 | 0 See note 3 | 5-10 | 0 See note 3 | 58 | 42 | 15 | 0 |

Notes:

1. In the budget of 22 July 2010 the Chancellor announced that the uprating (annual increase) of public sector pensions would change from the Retail Price Index (RPI) to the Consumer Prices Index (CPI). As a result the Government Actuaries Department undertook a review of all transfer factors. The new CETV factors have been used in our calculations and are lower than the previous factors we used therefore you will find that the value of the CETV's for some members has fallen since 31 March 2010.
2. Simone Jordan left her post on 23 August 2010 on secondment to East Midlands Strategic Health Authority and the pension calculations above reflect her time at the NHS Institute only.
3. The lump sum is shown as nil as membership is of the NHS Pension Scheme 2008 Section.

## 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 figure, 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 NHS 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.

**Bernard Crump**
Chief Executive and Accounting Officer
NHS Institute for Innovation and Improvement
28 June 2011

# Accounts

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# Statement of Accounting Officer's Responsibilities

Under the National Health Service Act 2006 and directions made there under by the Secretary of State with the approval of HM Treasury, the NHS Institute is required to prepare a statement of accounts for each financial year in the form and on the basis determined by the Secretary of State, with the approval of HM Treasury. The accounts are prepared on an accruals basis and must give a true and fair view of the NHS Institute's state of affairs at the year end and of its income and expenditure, total recognised gains and losses and cash flows for the financial year.

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

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

# Statement on Internal Control for the year ended 31 March 2011

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

## 2. The purpose of the system of internal control

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

- identify and prioritise the risks to the achievement of 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 ended 31 March 2011 and up to the date of approval of the annual report and accounts, and accords with Treasury guidance.

## 3. Capacity to handle risk

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 Audit and Risk Management Committee's Board Assurance Framework (revised in February 2010) ensures that strategic and operational risks are identified, appropriately managed and effectively communicated across the NHS Institute.

The work is informed by External and Internal Audit. The results of work undertaken by Internal Audit have been reported to the Audit and Risk Management Committee throughout the year and have shown a reliable system of internal control.

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

- the identification of key risks through the business planning process
- risk assessment workshops involving the Executive team
- regular Audit and Risk Management Committee and Board consideration of key strategic risks
- risk register owners 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 strengthens our risk management approach
- programmes of training that have been provided to all staff in relation to health and safety, fire risks, counter fraud awareness and information governance.

## 4. The risk and control framework

The Audit and Risk Management Committee is responsible for reviewing risk management activity and the effectiveness of our internal control framework under delegation of the Board. It receives 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 receives information from other internal and external sources to aid the Committee in fulfilling its functions.

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

During the year the Audit and Risk Management Committee has been 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 remains fit for purpose. This has involved:

- review of the key operational risks as identified in the business planning process
- identification of strategic risks through the Executive Team with particular attention given to the enhanced risks of delivering through grant partner organisations
- prioritisation of those risks
- assessing the effectiveness of the mitigation actions.

To comply with best practice the NHS Institute has a risk and performance review process where regular reviews with Executive Directors to specifically review performance and risk within their areas of responsibility are undertaken. The findings from these reviews are summarised quarterly and presented to the Board.

A programme of control and process work that identifies process owners and supports and develops the NHS Institute's existing and emerging business models has been performed. This includes the creation of a framework to underpin sound accounting and financial management at the NHS Institute covering budgeting, forecasting and month end processes.

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

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

The NHS Institute has proactively engaged in strategies to reduce carbon emissions and has calculated its carbon footprint as at 31 March 2011 and for the comparative year ending 31 March 2010 and is actively working towards a carbon reduction target. A presentation on sustainability was

# Statement on Internal Control for the year ended 31 March 2011 *(continued)*

given to the Audit and Risk Management Committee during the year to discuss HM Treasury sustainability reporting requirements for 2010-11. A separate Sustainability Report will be prepared and reviewed as part of the Annual Report process. For 2011-12 this will be included within the Annual Report itself.

## 5. Information Governance

Information governance is embedded within the NHS Institute as a key component of the organisations of risk management, performance monitoring, integrated governance and quality compliance functions with supporting policies. The NHS Institute recognises that the quality and security of data has a significant role in providing assurance to its stakeholders that information is managed competently and securely.

The NHS Institute has met all of the mandatory compliance requirements from the NHS Connecting for Health Information Governance Toolkit (IGT) V8.0. Through further discussions with the DH following requests for information on data collection from ALBs it has been agreed that the NHS Institute will not be subject to audit although may require a review to ensure legacy of any digital continuity is in place prior to disbanding in 2012.

Over the past year the NHS Institute has been working closely with the DH Arm's Length Body IG Forum for best practice and information on new NHS requirements in Information Assurance. The DH has been reviewing ALB Information Assurance requirements with seminars and workshops provided in conjunction with the Cabinet Office and CESG supporting ALBs through transition with digital continuity.

The NHS Institute IG steering group has agreed to use the IGT to satisfy the DH Senior Departmental Sponsors (SDS) with confirmation from the DH. The DH SDS confirmed they are pleased with our current progress in Information Assurance although appropriate information security models for each ALB are still under review and awaiting further notification to meet and discuss our current compliance with the DH ALB Business Support Unit.

Clear accountability has been established with implementation of the Information Asset registers for risk management and policies updated in line with legislation changes. The NHS Institute published the Freedom of Information publication scheme last year that will demonstrate our transparency.

All NHS Institute staff have been informed of the deadline for Information Governance (IG) training completion. Many have worked through this online training already and it is anticipated that line managers will ensure successful completion by the DH extended June 2011 deadline. The NHS Institute's annual mandatory Information Governance training requires all staff to successfully complete the level one National School of Government Protecting Information module and all Information Asset Owners/ team heads and members of the Executive Committee are required to successfully complete level two.

The NHS Institute has been changing dynamically in its current working practices affecting all areas of the organisation. With compliance on national requirements satisfied, internal transitional changes are taking place that are affecting the way in which Information Assurance is controlled.

# Statement on Internal Control for the year ended 31 March 2011 *(continued)*

The NHS Institute has sponsored implementation of an Information and Knowledge Management Strategy that will support the Records Management project. The process is yet to be agreed although scope of the work has been identified which requires thorough electronic and physical data cleansing, internal audits, document classification and categorisation. Future audits will take place with Internal Audit to ensure we have addressed all areas of Information Assurance for compliance with the Information Governance Training (IGT).

Technology to support the implementation is required for efficient and effective sustainable solutions with pragmatic approaches to overcome cultural issues with change. All teams are now reviewing which new systems, projects and procedures require the Privacy Impact Assessments (PIA) to ensure we do not breach the Data Protection Act when using, storing, sending or transferring any personal or commercially sensitive information. To ensure the PIA is an embedded mandatory tool for all teams prior to initiating any new project, process or systems the tool will be further developed in the new web platform so it will be available on the intranet as an internal resource available to be used independently although will require a full review with the Data Protection Officer including a list of recommendations to mitigate any identified risks.

The IG Steering group is proving to be an invaluable resource with bi-monthly meetings updating all representatives on current IG workstreams supporting collaboration and fully consulted approaches.

The Information Governance awareness programme has improved the culture within the NHS Institute as staff vigilance of working practices affecting the organisation's reputation has increased taking actions to mitigate possible risk. There has been an increase in information security incident reporting demonstrating the increased awareness although there has been no Serious Untoward Incidents. Generally Information Governance support for various workstreams has increased with further requests to be involved in other projects across various teams.

The NHS Institute seeks to continuously improve its compliance with NHS ALB requirements through the achievement of the annual Information Governance Improvement Plan, achieving and maintaining an overall green rating in the IGT assessments until notified otherwise by the DH ALB BSU.

### 6. Other Information

At the start of the year, the NHS Institute changed its business model to establish six separate business units with a renewed emphasis on helping our customers to achieve major efficiency savings whilst improving the quality of service across the NHS – a goal defined by the Department of Health as a focus on quality, innovation, productivity and prevention (QIPP).

On the 14 June 2010 the Department of Health notified the NHS Institute about the Government's priority efficiency measures which included freezes on external recruitment, the use of consultants and expenditure on marketing and communications. These restrictions went to the heart of the business of the NHS Institute, and served to severely disrupt the planned activities. The need to reconsider the NHS Institute's operating strategy gave rise to significant delays to the delivery of services.

# Statement on Internal Control for the year ended 31 March 2011 *(continued)*

This announcement required the NHS Institute to reconsider its delivery model and an alternative model of providing grant funding to enabling partner organisations to achieve their QIPP targets based on provision of grants was developed and implemented. Grants were provided to partner organisations based on clear QIPP plans with deliverables aligned to improvement and efficiency targets, and monitoring processes established to ensure the grants' objectives were being achieved. This has resulted in significant rephasing of activity into the second half of the year and in particular taking place during the final quarter 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. Additionally receivables have been created in the Annual Account for material values where partners were unable to meet the planned grant commitments before (or reasonably soon after) 31 March 2011.

This was the first year that the NHS Institute has paid significant grants of this type. Both internal and external audit have identified where weaknesses existed within the process and an improvement plan has been put in place to eliminate these in 2011-12.

On 26 July 2010 the Department of Health published *Liberating the NHS: Report of the arm's-length bodies review* document which recommended that the NHS Institute be removed from the ALB sector, functions which support the NHS Commissioning Board in leading for quality and improvement be moved to the Board and that the NHS Institute looks for alternative commercial delivery models for the remaining functions. Since the announcement, the NHS Institute has been exploring options for a more commercially based business model.

A Change Board has been established to manage the transition and a business case has been submitted to the Department of Health.

The Board of the NHS Institute recognises that given the changes affecting the business and the uncertainty about delivery of services through successor bodies, this impacts 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 are maintained and preserved for the future benefit of the NHS and to support QIPP it is accepted that there needs to be a greater involvement of the Board in the active management of risk. An example of this is with the strategy to provide grants to NHS bodies to implement QIPP plans rather than through direct NHS Institute support. The risks associated with this are in relation to ensuring that the grants are used for the purposes set out in the grant agreements and that they are used in a timely fashion. Additional controls have been put in place to ensure that these risks were adequately managed.

During the year it was noted by both Internal and External audit that there have been further improvements in our financial control and financial management of the business in this particularly difficult year of uncertainty about the organisation's future.

In particular it was noted last year that the NHS Institute would have to improve the accuracy of detailed phased forecasts for income, costs and cash flow and to raise the level of scrutiny of financial reporting at the Board. Despite the difficulties created by the restrictions and the outcome of the ALB review, it has been noted that on all these the NHS Institute has made strong progress.

This emphasis will continue in 2011-12, particularly as it has been confirmed that in the future the core functions of the NHS Institute will transition to alternative commercial delivery models where more robust financial management and treasury controls will become paramount.

The business case for alternative delivery models considers a period of dual running in 2011-12 for the special health authority as it winds down to closure and for the successor body as it establishes itself with a more commercial delivery model. This will place a greater level of reliance on robust financial management and control systems to ensure risks are properly understood and are well managed.

The NHS Institute has had its funding for 2011-12 confirmed and plans to progress the transition to alternative successor organisations are progressing but due to the abolition announcement 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 and has considered all available information about the future of the organisation up to the date of approving the Annual Report. In doing this provisions have been made for predicted restructuring costs in accordance with IFRS.

The NHS Institute used a balanced scorecard approach for the 2010-11 business plan and performance monitoring reports for each of the business areas were based on that framework. Due to the restrictions imposed during the course of the financial year the NHS Institute revised its performance reporting with each business area taking responsibility for reporting to the Board on how they were going to deliver for the current financial year and how they were going to prepare for the future.

### 7. Review of effectiveness

As Accounting Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review is informed in a number of ways. The Head of Internal Audit provides me with an opinion on the overall arrangements for gaining assurance through the Assurance Framework and on the controls reviewed as part of the internal audit work.

His overall opinion for 2010-11 was of significant assurance.

External audit place reliance on internal audit work and perform work independently to assess the level of assurance.

Executive managers within the organisation who have responsibility for the development and maintenance of the system of internal control also provide me with assurance.

The Assurance Framework itself provides me with evidence that the effectiveness of controls that manage the risks to the organisation achieving its principal objectives have been reviewed.

One of the key targets that the NHS Institute is expected to measure is its performance against the Department for Business Innovation and Skills (BIS) payment target. Within this, the NHS Institute is required to pay all non-NHS trade payables within five days of receipt of a correctly rendered invoice, unless other payment terms have been agreed. In this respect the NHS Institute paid 73% (by value) and 66% (by number) of its non-NHS trade payables within five days. Previously performance was measured against the Better Payment Practice Code (BPPC) which required all invoices to be paid within 10 days.

# Statement on Internal Control for the year ended 31 March 2011 *(continued)*

The NHS Institute is working to improve its performance against this target by engaging with the business to ensure that systems and processes are in place to minimise delays to the goods receipting of purchase orders and approval of invoices.

It is however, important to recognise that the NHS Institute would have maintained its performance when compared to last year if the 10 day payment target had remained.

I have been advised on the implications of the results of my review of the effectiveness of the system of internal control by the Audit and Risk Management Committee. Plans to address any weaknesses and ensure continuous improvement of the system are in place.

The Committee has considered the governance and control issues that arise from the planned closure of the NHS Institute as special health authority and the transition of functions to successor bodies. The Committee has also considered the impact of a planned dual running period for both the special health authority and the new successor bodies and has made recommendations to the Board which have been accepted.

There have been no material issues raised during these reviews, but they highlight the need to continue to assess and improve controls. They will ensure that the NHS Institute's control mechanisms are reviewed and updated to address any risks that arise from any such changes. Consideration is 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, remains with the Audit and Risk Management Committee.

My review confirms that the NHS Institute has a generally sound system of internal control that supports the achievement of its policies, aims and objectives.

**Bernard Crump**
Chief Executive and Accounting Officer
NHS Institute for Innovation and Improvement
28 June 2011

# 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 2011 under the National Health Service Act 2006. These comprise the Statement of Comprehensive Net Expenditure, the Statement of Financial Position, the Statement of Cash Flows, the Statement of 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.

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

## Opinion on Regularity

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

## 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 2011 and of its net expenditure for the year then ended; and
- the financial statements have been properly prepared in accordance with the National Health Service Act 2006 and directions issued there under by the Secretary of State.

# Certificate and Report of the Comptroller and Auditor General to the Houses of Parliament *(continued)*

## 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 Introduction and Foreward, Management Commentary and Review of Activity, Director of Corporate Services and Finance Commentary and Governance Structure included within the Annual Report, for the financial year for which the financial statements are prepared is consistent with the financial statements.

## Matters on which I report by exception

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

- adequate accounting records have not been kept; or
- the financial statements are not in agreement with the accounting records or returns; or
- I have not received all of the information and explanations I require for my audit; or
- the Statement on Internal Control 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

4 July 2011

# Annual Account of the NHS Institute for Innovation and Improvement for the year ended 31 March 2011

## Statement of Net Comprehensive Expenditure for the year ended 31 March 2011

| | Notes | **2010-11 £000** | 2009-10 £000 |
|---|---|---|---|
| Programme costs | 2.2 | **70,015** | 83,232 |
| Operating income | 5 | **(9,776)** | (14,240) |
| Net operating cost | | **60,239** | 68,992 |
| Net resource outturn | 4.1 | **60,239** | 68,992 |

All income and expenditure is derived from continuing operations

The notes at pages 60 to 93 form part of these accounts.

# Annual Account of the NHS Institute for Innovation and Improvement for the year ended 31 March 2011 *(continued)*

## Statement of Financial Position as at 31 March 2011

| | Notes | 31 March 2011 £000 | 31 March 2010 £000 |
|---|---|---|---|
| **Non-current assets:** | | | |
| Property, plant and equipment | 6.1 | **368** | 1,536 |
| Intangible assets | 6.2 | **1,198** | 1,887 |
| Non-current receivables | 7 | **7** | 126 |
| | | **1,573** | 3,549 |
| **Current assets:** | | | |
| Receivables | 7 | **4,064** | 5,108 |
| Cash and cash equivalents | 8 | **4,086** | 3,524 |
| | | **8,150** | 8,632 |
| Payables | 9 | **(5,443)** | (9,920) |
| **Net current assets/(liabilities)** | | **2,707** | (1,288) |
| **Non-current assets less net current liabilities** | | **4,280** | 2,261 |
| **Non-current liabilities:** | | | |
| Provisions | 10 | **(5,841)** | (990) |
| **Total assets less total liabilities** | | **(1,561)** | 1,271 |
| **Taxpayers' equity** | | | |
| General fund | | **(1,726)** | 962 |
| Revaluation reserve | | **165** | 309 |
| **Total taxpayers' equity** | | **(1,561)** | 1,271 |

The notes at pages 60 to 93 form part of these accounts.

The financial statements on pages 56 to 59 were considered by the Audit and Risk Management Committee on 23 June 2011.

**Bernard Crump**
Accounting Officer
28 June 2011

# Annual Account of the NHS Institute for Innovation and Improvement for the year ended 31 March 2011 *(continued)*

## Statement of Changes in Taxpayers' Equity for the year ended 31 March 2011

| | | General fund[1] £000 | Revaluation reserve[2] £000 | Total reserves £000 |
|---|---|---|---|---|
| Balance at 1 April 2009 | | (273) | 303 | 30 |
| Changes in tax payers' equity for 2009-10 | | | | |
| Net gain/(loss) on revaluation of property, plant and equipment | 6.1 | 0 | 69 | 69 |
| Non-cash charges (cost of capital) | | (128) | 0 | (128) |
| Transfers between reserves | | 63 | (63) | 0 |
| Net operating cost for the year | | (68,992) | 0 | (68,992) |
| Total recognised income and expense for 2009-10 | | (69,057) | 6 | (69,051) |
| Net Parliamentary funding | | 70,292 | 0 | 70,292 |
| **Balance at 31 March 2010** | | **962** | **309** | **1,271** |
| **Balance as at 1 April 2010** | | 962 | 309 | 1,271 |
| **Changes in tax payers' equity for 2010-11** | | | | |
| Net gain/(loss) on revaluation of property, plant and equipment | 6.1 | **0** | **37** | **37** |
| Transfers between reserves[3] | | **181** | **(181)** | **0** |
| Net operating cost for the year | | **(60,239)** | **0** | **(60,239)** |
| **Total recognised income and expense for 2010-11** | | **(60,058)** | **(144)** | **(60,202)** |
| Net Parliamentary funding | | **57,370** | **0** | **57,370** |
| **Balance at 31 March 2011** | | **(1,726)** | **165** | **(1,561)** |

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 In light of the planned closure of the NHS Institute as a Special Health Authority and the announcement that the lease for Coventry House will cease earlier than anticipated the NHS Institute has reassessed the asset lives and accelerated the depreciation relating to Coventry House.

The notes at pages 60 to 93 form part of these accounts.

# Annual Account of the NHS Institute for Innovation and Improvement for the year ended 31 March 2011 *(continued)*

## Statement of Cash Flows for the year ended 31 March 2011

| | Notes | 31 March 2011 £000 | 31 March 2010 £000 |
|---|---|---|---|
| **Net cash (outflow) from operating activities** | 11.2 | **(55,965)** | (70,026) |
| **Cash flows from investing activities** | | | |
| Payments to acquire non-current intangible assets | | **(668)** | (1,363) |
| Payments to acquire non-current property, plant and equipment | | **(175)** | (443) |
| **Net cash (outflow) from investing activities** | | **(843)** | (1,806) |
| **Net cash (outflow) before financing** | | **(56,808)** | (71,832) |
| **Cash flows from financing activities** | | | |
| Payments in respect of finance leases | | **0** | (6) |
| Net Parliamentary funding | | **57,370** | 70,292 |
| **Increase/(decrease) in cash and cash equivalents** | 8 | **562** | (1,546) |

The notes at pages 60 to 93 form part of these accounts.

# Notes to the Accounts

## 1 Accounting policies

The financial statements have been prepared in accordance with the 2010-11 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 management of the NHS Institute has been told that final abolition is now not likely before 30 June 2012. The final decisions on closure have not yet been made and therefore whether the NHS Institute for Innovation and Improvement will close and which functions will transfer to successor bodies, and any resulting timetable for closure, has yet to be finally decided. As abolition has been announced, the NHS Institute for Innovation and Improvement will not continue to operate in its current form and with its current functions.

Having considered the circumstances described above, and from discussion with the Department for Health, management's expectation is that the NHS Institute for Innovation and Improvement will however continue to operate in its current form for at least the next 12 months. Due to the abolition announcement 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. The only adjustment has been to accelerate depreciation on relevant non-current assets and no other adjustments are considered necessary.

*Acquisitions and discontinued operations*

Activities are considered to be 'acquired' only if they are acquired from outside the public sector. Activities are considered to be 'discontinued' only if they cease entirely. They are not considered to be 'discontinued' if they transfer from one NHS body to another.

### 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.

# Notes to the Accounts *(continued)*

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.

## 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.

## 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 Capital charges

The treatment of property, plant and equipment and intangible assets in the accounts is in accordance with the principal capital charges objective to ensure that such charges are fully reflected in the cost of capital. For the 2010-11 reporting year there has been a change in accounting policy such that cost of capital charges are no longer applicable. Following the guidance in the 2010-11 Government Financial Reporting Manual (FReM), Cost of Capital has therefore not been calculated by the NHS Institute. The interest rate applied to capital charges in the financial year 2009-10 was 3.5% resulting into a charge to the accounts of £128k on all assets less liabilities, except for donated assets and cash balances with the Office of the Paymaster General, (OPG), where the charge was nil (see note to the accounts 2.2).

## 1.6 Grants Payable

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

Grants made by the NHS Institute are recognised on an accruals basis according to when activity is planned to be carried out by relevant partner organisations. Grant funding is provided to match recipient's needs and significant sums are phased through the year in instalments and matched to expenditure patterns to ensure that entities do not carry significant cash balances therefore avoiding an inefficient use of public money.

In the event that grantees do hold significant cash balances then these are recovered in accordance with the grant agreement, this is accounted for as accrued income in receivables.

In addition to grant income 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.

## 1.7 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.

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.

# Notes to the Accounts *(continued)*

### 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.

## 1.8 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.

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.

## 1.9 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.

## 1.10 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 |

During 2010-11 depreciation has been accelerated on all assets to report a net book value of nil as at the year end in respect of leasehold Improvements and a nil net book value as at the 2011-12 year end in respect of all other assets. This is due to the lease for Coventry House ceasing earlier than expected and the announcement that the NHS Institute will cease as a Special Health Authority in June 2012.

## 1.11 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.

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

## 1.12 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 on www.hm-treasury.gov.uk.

# Notes to the Accounts *(continued)*

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.

## 1.13 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.

## 1.14 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.

## 1.15 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. In accordance with IAS 37, provisions are only made where payment is probable and when the amount can be reliably estimated. In addition to this, provisions for staff termination benefits under IAS 19 are only made where the NHS Institute is demonstrably committed to termination of an employee or group of employees before normal retirement date, or where termination is as a result of an offer made in order to encourage voluntary redundancy.

## 1.16 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.

## 1.17 Employee benefits

*Short-term employee benefits*

Salaries, wages and employment-related payments are recognised in the period in which the service is received from employees. The cost of leave earned but not taken by employees at the end of the period is recognised in the financial statements to the extent that employees are permitted to carry forward leave into the following period.

*Retirement benefit 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, General 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.

The scheme is subject to a full actuarial valuation every four years (until 2004, every five years) and an accounting valuation every year. An outline of these follows:

a) 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 to be paid by employers and scheme members. The last such valuation, which determined current contribution rates was undertaken as at 31 March 2004 and covered the period from 1 April 1999 to that date. The conclusion from the 2004 valuation was that the scheme had accumulated a notional deficit of £3.3 billion against the notional assets as at 31 March 2004.

In order to defray the costs of benefits, employers pay contributions at 14% of pensionable pay and most employees had up to April 2008 paid 6%, with manual staff paying 5%.

Following the full actuarial review by the Government Actuary undertaken as at 31 March 2004, and after consideration of changes to the NHS Pension Scheme taking effect from 1 April 2008, his valuation report recommended that employer contributions could continue at the existing rate of 14% of pensionable pay, from 1 April 2008, following the introduction of employee contributions on a tiered scale from 5% up to 8.5% of their pensionable pay depending on total earnings. On advice from the scheme actuary, scheme contributions may be varied from time-to-time to reflect changes in the scheme's liabilities.

# Notes to the Accounts *(continued)*

b) **Accounting valuation**

A valuation of the scheme liability is carried out annually by the scheme actuary as at the end of the reporting period by updating the results of the full actuarial valuation.

Between the full actuarial valuations at a two-year midpoint, a full and detailed member data-set is provided to the scheme actuary. At this point the assumptions regarding the composition of the scheme membership are updated to allow the scheme liability to be valued.

The valuation of the scheme liability as at 31 March 2010, is based on detailed membership data as at 31 March 2008 (the latest midpoint) updated to 31 March 2010 with summary global member and accounting data.

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) Resource Account, published annually. These accounts can be viewed on the NHS Pensions website (www.nhsbsa.nhs.uk/pensions). Copies can also be obtained from The Stationery Office.

c) **Scheme provisions**

In 2008-09 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 of the benefits provided by the Scheme or the specific conditions that must be met before these benefits can be obtained:

**Annual Pensions**

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".

**Pensions Indexation**

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.

**Lump Sum Allowance**

A lump sum is payable on retirement which is normally three times the annual pension payment.

**Ill-Health Retirement**

Early payment of a pension, with enhancement in certain circumstances, is available to members of the Scheme who are permanently incapable of fulfilling their duties or regular employment effectively through illness or infirmity.

### Death Benefits

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

### Additional Voluntary Contributions (AVCs)

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

### Transfer between Funds

Scheme members have the option to transfer their pension between the NHS Pension Scheme and another scheme when they move into or out of NHS employment.

### Preserved Benefits

Where a scheme member ceases NHS employment with more than two years service they can preserve their accrued NHS pension for payment when they reach retirement age.

### Compensation for Early Retirement

Where a member of the Scheme is made redundant they may be entitled to early receipt of their pension plus enhancement, at the employer's cost.

## 1.18 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.

# Notes to the Accounts *(continued)*

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.

### 1.19 Going Concern

The Statement of Financial Position at 31 March 2011 shows a negative £1,561,000 for tax payers' equity. This reflects the inclusion of liabilities falling due in the future which, to the extent that they are not met from the NHS Institute for Innovation and Improvement's other sources of income, may only be met by future direct funding from the NHS Institute's sponsoring department, the Department of Health. This is because, under the normal conventions applying to Parliamentary control over income and expenditure, payments may not be made by the Department of Health in advance of need.

Funding for 2011-12, taking into account the amounts needed to meet the NHS Institute's liabilities falling due in that year, has already been included in the Department of Health's estimates for that year which have been approved by Parliament but due to the abolition announcement 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.

## 2 Segmental analysis

The reporting segments have been identified based upon the internal reports that are regularly reviewed by the NHS Institute's Chief Executive in order to assess organisational performance and make informed decisions. The reportable segments changed for the financial year 2010-11 due to a change in business model to establish six separate business units with a renewed emphasis on helping the NHS Institute's customers to achieve major efficiency savings whilst improving the quality of service across the NHS – a goal defined by the Department of Health as a focus on quality, innovation, productivity and prevention (QIPP). The NHS Institute has not restated the 2009-10 information to reflect the new business model due to the time and cost implications of doing so.

# Notes to the Accounts *(continued)*

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 restructuring of the NHS Institute into autonomous business units, invoked a requirement to reconfigure the way the Board of the NHS Institute and the new business units are supported from a corporate services perspective. Corporate services incorporates the following support areas:

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 provides 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 and Royal Colleges.

# Notes to the Accounts *(continued)*

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 attracts talent into the NHS from other sectors by recruiting on its programme;
- Breaking Through Programme recruits NHS managers from black and minority ethnic backgrounds.

### Learning

The challenge of the cost and quality agenda facing the NHS is to deliver productivity gains and increased efficiency. NHS staff need skills and knowledge to adopt the latest thinking and to apply innovation and improvement thinking to their own work areas. The NHS Institute's Learning business will provide high volume training on the most important NHS institute tools and generic improvement and lean methodologies to key members of the NHS workforce.

### Solutions

NHS Institute Solutions 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 four Area Directors. NHS Institute Solutions will build on the support links with stakeholders across the NHS to ensure that what we deliver remains relevant. NHS Institute Solutions will actively engage with the NHS Institute's stakeholders and act on feedback to improve solutions.

### National Support and Thought Leadership

The NHS Institute will through the National Support business area 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. National Support 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 the NHS Institute Worldwide with the view to delivering four key principals:

1. to develop and enhance further the status of the 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 2011

| | Notes | Corporate 2010-11 £000 | Design 2010-11 £000 | Leadership 2010-11 £000 | Learning 2010-11 £000 | Solutions 2010-11 £000 | Thought Leadership 2010-11 £000 | National Support 2010-11 £000 | Worldwide 2010-11 £000 | Total 2010-11 £000 | Total 2009-10 £000 |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Non-executive members' remuneration | | 132 | | | | | | | | 132 | 137 |
| Other salaries and wages – staff, seconded, contract and agency | 3.1 | 3,695 | 2,311 | 2,584 | 2,283 | 4,073 | 654 | 443 | 304 | 16,347 | 17,730 |
| Graduate scheme remuneration | | | | 12,716 | | | | | | 12,716 | 12,297 |
| Capital: Depreciation and amortisation (owned assets) | 6.1, 6.2 | 1,844 | 513 | 53 | 189 | 118 | | | | 2,717 | 2,745 |
| Depreciation leased assets | | | | | | | | | | 0 | 6 |
| Loss on impairment | | | | | | | | | | 0 | 14 |
| Disposals | | (3) | 27 | | | | | | | 24 | 15 |
| Capital charges interest | | | | | | | | | | 0 | (128) |
| Auditors' remuneration: | | | | | | | | | | | |
| Statutory external audit fees[1] | | 79 | | | | | | | | 79 | 77 |
| Internal audit and counter fraud | | 52 | | | | | | | | 52 | 58 |
| Other finance costs: | | | | | | | | | | | |
| Bad debt provision | | (40) | | | | | | | 79 | 39 | 44 |
| Foreign currency losses | | | 1 | | (1) | (2) | 1 | | 1 | 0 | (22) |
| General losses and fruitless payments | | 4 | | 21 | 64 | 17 | | | | 106 | 1 |
| Other Programme costs | | 9,751 | 4,567 | 8,217 | 1,924 | 10,784 | 1,627 | 113 | 820 | 37,803 | 50,258 |
| | | 15,514 | 7,419 | 23,591 | 4,459 | 14,990 | 2,282 | 556 | 1,204 | 70,015 | 83,232 |

1 The statutory audit fee for 2010-11 is £78,500.

# Notes to the Accounts *(continued)*

## 2.3 Segmental Operating Income for the year ended 31 March 2011

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

| | Corporate 2010-11 £000 | Design 2010-11 £000 | Leadership 2010-11 £000 | Learning 2010-11 £000 | Solutions 2010-11 £000 | Thought Leadership 2010-11 £000 | National Support 2010-11 £000 | Worldwide 2010-11 £000 | Total 2010-11 £000 | Total 2009-10 £000 |
|---|---|---|---|---|---|---|---|---|---|---|
| **Programme income** | | | | | | | | | | |
| Fees and Charges[1] | 24 | 904 | 2,900 | 134 | 3,034 | 718 | 0 | 789 | 8,503 | 13,633 |
| Other | (39) | 0 | 1 | 13 | (13) | 0 | 0 | 1,311 | 1,273 | 607 |
| **Total** | (15) | 904 | 2,901 | 147 | 3,021 | 718 | 0 | 2,100 | 9,776 | 14,240 |

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

| | Corporate | Design | Leadership | Learning | Solutions | Thought Leadership | National Support | Worldwide | Total 2010-11 |
|---|---|---|---|---|---|---|---|---|---|
| Department of Health | 341 | 815 | 239 | (40) | 1,700 | 716 | 0 | 0 | 3,771 |

1 Fees and charges includes £4,450k (2009-10 £9,844k) in relation to income received to provide funding for specific programmes and £4,053k (2009-10 £3,789k) in respect of services for which a fee is charged.

## 2.4 Segmental Statement of Net Comprehensive Expenditure for the year ended 31 March 2011

| | Corporate 2010-11 £000 | Design 2010-11 £000 | Leadership 2010-11 £000 | Learning 2010-11 £000 | Solutions 2010-11 £000 | Thought Leadership 2010-11 £000 | National Support 2010-11 £000 | Worldwide 2010-11 £000 | Total 2010-11 £000 | Total 2009-10 £000 |
|---|---|---|---|---|---|---|---|---|---|---|
| Programme costs | 15,514 | 7,419 | 23,591 | 4,459 | 14,990 | 2,282 | 556 | 1,204 | 70,015 | 83,232 |
| Operating income | 15 | (904) | (2,901) | (147) | (3,021) | (718) | 0 | (2,100) | (9,776) | (14,240) |
| **Net operating cost/(income)** | 15,529 | 6,515 | 20,690 | 4,312 | 11,969 | 1,564 | 556 | (896) | 60,239 | 68,992 |

## 2.5 Segmental Statement of Financial Position as at 31 March 2011

| | Corporate 31 March 2011 £000 | Design 31 March 2011 £000 | Leadership 31 March 2011 £000 | Learning 31 March 2011 £000 | Solutions 31 March 2011 £000 | Thought Leadership 31 March 2011 £000 | National Support 31 March 2011 £000 | Worldwide 31 March 2011 £000 | Intercompany adjustment 31 March 2011 £000 | Total 31 March 2011 £000 | Total 31 March 2010 £000 |
|---|---|---|---|---|---|---|---|---|---|---|---|
| **Non-current assets:** | | | | | | | | | | | |
| Property, plant and equipment | 368 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 368 | 1,536 |
| Intangible assets | 321 | 398 | 38 | 219 | 215 | 0 | 0 | 7 | 0 | 1,198 | 1,887 |
| Non-current receivables | 7 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 7 | 126 |
| | 696 | 398 | 38 | 219 | 215 | 0 | 0 | 7 | 0 | 1,573 | 3,549 |
| **Current assets:** | | | | | | | | | | | |
| Receivables | 495 | 1,929 | 787 | 849 | 6,655 | 134 | 11 | 645 | (7,441) | 4,064 | 5,108 |
| Cash and cash equivalents | 3,903 | 0 | 0 | 0 | 0 | 0 | 0 | 183 | 0 | 4,086 | 3,524 |
| | 4,398 | 1,929 | 787 | 849 | 6,655 | 134 | 11 | 828 | (7,441) | 8,150 | 8,632 |
| **Current liabilities:** | | | | | | | | | | | |
| Payables | (8,350) | (994) | (1,272) | (663) | (1,087) | (130) | (131) | (257) | 7,441 | (5,443) | (9,920) |
| **Net current assets/ (liabilities)** | (3,952) | 935 | (485) | 186 | 5,568 | 4 | (120) | 571 | 0 | 2,707 | (1,288) |
| **Total assets less current liabilities** | (3,256) | 1,333 | (447) | 405 | 5,783 | 4 | (120) | 578 | 0 | 4,280 | 2,261 |
| **Non-current liabilities:** | | | | | | | | | | | |
| Provisions | (5,749) | (29) | (51) | (12) | 0 | 0 | 0 | 0 | 0 | (5,841) | (990) |
| **Total assets less total liabilities** | (9,005) | 1,304 | (498) | 393 | 5,783 | 4 | (120) | 578 | 0 | (1,561) | 1,271 |
| **Taxpayers' equity** | | | | | | | | | | | |
| General fund | (9,170) | 1,304 | (498) | 393 | 5,783 | 4 | (120) | 578 | 0 | (1,726) | 962 |
| Revaluation reserve | 165 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 165 | 309 |
| | (9,005) | 1,304 | (498) | 393 | 5,783 | 4 | (120) | 578 | 0 | (1,561) | 1,271 |

# Notes to the Accounts *(continued)*

## 3.1 Staff numbers and related costs

| | 2010-11 £000 | 2009-10 £000 |
|---|---|---|
| Salaries and wages – staff on the NHS Institute payroll | **9,392** | 8,935 |
| Seconded, contract and agency staff | **5,509** | 7,501 |
| Salaries and wages – recharges to other NHS organisations | **(647)** | (631) |
| Social security costs | **877** | 791 |
| Employer contributions to NHS Pension scheme | **1,216** | 1,134 |
| Total salaries and wages | **16,347** | 17,730 |

| | 2010-11 Average WTE | 2009-10 Average WTE |
|---|---|---|
| Salaries and wages – staff on the NHS Institute payroll[1] | **185.4** | 189.1 |
| Seconded, contract and agency staff | **87.4** | 108.4 |
| Salaries and wages – recharges to other NHS organisations | **(5.6)** | (9.0) |
| Total average whole time equivalent (WTE) | **267.2** | 288.5 |

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.

### Expenditure on staff benefits

The amount spent on staff benefits to 31 March 2011 totalled £33,146 (2009-10 £38,315).

### Retirements due to ill-health

During 2010-11 there were no early retirements from the NHS Institute on the grounds of ill-health (2009-10 nil).

### Early retirements and redundancies

During 2010-11 two employees left the NHS Institute via the Mutually Agreed Resignation Scheme (MARS), which was offered following the announcement of the NHS Institute's closure, £28,147 (2009-10 nil).

### Capitalisation of staff costs

No staff costs were capitalised during 2010-11 (2009-10 nil).

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

| | Number | £000 |
|---|---|---|
| Total Non-NHS bills paid 2010-11 | **9,913** | **31,734** |
| Total Non-NHS bills paid within target | **6,567** | **23,033** |
| Percentage of Non-NHS bills paid within target | **66.2%** | **72.6%** |

| | Number | £000 |
|---|---|---|
| Total NHS bills paid 2010-11 | **572** | **6,032** |
| Total NHS bills paid within target | **255** | **3,029** |
| Percentage of NHS bills paid within target | **44.6%** | **50.2%** |

The Department of Business Innovation and Skills were the governing body for the payment targets during 2010-11 (previously the Better Payment Practice Code). From 1 May 2010 the NHS Institute were required to pay all suppliers within five days of receipt of a correctly rendered invoice and the above table reports the performance of the NHS Institute against this target during 2010-11

| | Number | £000 |
|---|---|---|
| Total Non-NHS bills paid 2009-10 | 20,236 | 61,118 |
| Total Non-NHS bills paid within target | 18,321 | 49,912 |
| Percentage of Non-NHS bills paid within target | 90.5% | 81.7% |

| | Number | £000 |
|---|---|---|
| Total NHS bills paid 2009-10 | 814 | 11,403 |
| Total NHS bills paid within target | 479 | 8,133 |
| Percentage of NHS bills paid within target | 58.8% | 71.3% |

For the year ended 2009-10 the NHS Institute was measured against the Better Payment Practice Code in terms of payments to suppliers. The Better Payment Practice Code stated that payment should be made to suppliers within ten days of receipt of a correctly rendered invoice and the above table reported the performance of the NHS Institute against this target during 2009-10.

The NHS Institute paid £160.10 in relation to interest under the Late Payment of Commercial Debts (Interest) Act 1998 (2009-10 £nil).

## 4.1 Reconciliation of net operating cost to net resource outturn

| | **2010-11 £000** | 2009-10 £000 |
|---|---|---|
| Net operating cost for the financial year | **60,239** | 68,992 |
| **Net resource outturn** | **60,239** | 68,992 |
| Revenue resource limit | **67,303** | 70,255 |
| **Under spend against revenue resource limit** | **7,064** | 1,263 |

# Notes to the Accounts *(continued)*

## 4.2 Reconciliation of gross capital expenditure to capital resource limit

| | 2010-11 £000 | 2009-10 £000 |
|---|---|---|
| Gross capital expenditure | **850** | 1,534 |
| Less – Book value of non-current assets disposed | **(27)** | (15) |
| Adjustment for loss on disposal of non-current assets | **27** | 15 |
| **Net resource outturn** | **850** | 1,534 |
| Capital resource limit | **1,240** | 1,800 |
| **Under spend against capital resource limit** | **390** | 266 |

# 5 Operating income

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

| | 2010-11 £000 | 2009-10 £000 |
|---|---|---|
| **Programme income**[1] | | |
| Fees and charges[2] | **8,503** | 13,633 |
| Other | **1,273** | 607 |
| **Total** | **9,776** | 14,240 |

1 Included in the above numbers is income received from The Scottish Parliament £469k (2009-10 £608k), The National Assembly for Wales £nil (2009-10 £50k) and the Northern Ireland Assembly £nil (2009-10 £48k).
2 Fees and charges includes £5,586k (2009-10 £9,844k) in relation to income received to provide funding for specific programmes and £2,917k (2009-10 £3,789k) in respect of services for which a fee is charged.

The following information is provided for fees and charges purposes and is not disclosed to comply with IFRS8.

| | NHS England extended services £000 | NHS Institute Worldwide £000 | 2010-11 Total £000 | 2009-10 Total £000 |
|---|---|---|---|---|
| Income | **758** | **2,159** | **2,917** | 3,789 |
| Less direct costs and overheads | **299** | **1,531** | **1,830** | 2,236 |
| Contribution | **459** | **628** | **1,087** | 1,553 |
| Less apportionment of central overheads | **102** | **350** | **452** | 750 |
| Profit | **357** | **278** | **635** | 803 |

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 during 2010-11.

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 small profit and this was achieved.

# 6 Non-current Assets

## 6.1 Property, plant and equipment

| | Leasehold improvements £000 | Furniture & fittings £000 | Information Technology | | Total £000 |
|---|---|---|---|---|---|
| | | | Hardware £000 | Leased assets £000 | |
| Cost or valuation at 31 March 2010 | 2,752 | 151 | 1,344 | 164 | 4,411 |
| Additions – purchased | 0 | 0 | 176 | 0 | 176 |
| Disposals | 0 | 0 | (469) | 0 | (469) |
| Indexation | 116 | 0 | 0 | 0 | 116 |
| **Gross cost at 31 March 2011** | 2,868 | 151 | 1,051 | 164 | 4,234 |
| Accumulated depreciation at 31 March 2010 | 1,868 | 23 | 820 | 164 | 2,875 |
| Charged during the year[1] | 921 | 64 | 396 | 0 | 1,381 |
| Disposals | 0 | 0 | (469) | 0 | (469) |
| Indexation | 79 | 0 | 0 | 0 | 79 |
| **Accumulated depreciation at 31 March 2011** | 2,868 | 87 | 747 | 164 | 3,866 |
| **Net book value:** | | | | | |
| **Total at 31 March 2011** | 0 | 64 | 304 | 0 | 368 |
| **Assets Financing** | | | | | |
| Owned – purchased (net book value) | 0 | 64 | 304 | 0 | 368 |

1 An announcement was made in July 2010 that the NHS Institute would close as a Special Health Authority. The future of the NHS Institute is being considered as part of the *Liberating the NHS: report of the arm's-length bodies review* published on 26 July 2010.

In light of this announcement and the announcement that the lease for Coventry House will cease earlier than anticipated the NHS Institute has reassessed the asset lives and accelerated the depreciation relating to its property, plant and equipment.

| | Leasehold improvements £000 | Furniture & fittings £000 | Information Technology | | Total £000 |
|---|---|---|---|---|---|
| | | | Hardware £000 | Leased assets £000 | |
| Cost or valuation at 31 March 2009 | 2,640 | 151 | 1,124 | 164 | 4,079 |
| Additions – purchased | 0 | 0 | 222 | 0 | 222 |
| Disposals | 0 | 0 | (2) | 0 | (2) |
| Indexation | 112 | 0 | 0 | 0 | 112 |
| **Gross cost at 31 March 2010** | 2,752 | 151 | 1,344 | 164 | 4,411 |
| Accumulated depreciation at 31 March 2009 | 1,010 | 1 | 448 | 158 | 1,617 |
| Charged during the year | 815 | 22 | 372 | 6 | 1,215 |
| Disposals | 0 | 0 | 0 | 0 | 0 |
| Indexation | 43 | 0 | 0 | 0 | 43 |
| **Accumulated depreciation at 31 March 2010** | 1,868 | 23 | 820 | 164 | 2,875 |
| **Net book value:** | | | | | |
| **Total at 31 March 2010** | 884 | 128 | 524 | 0 | 1,536 |
| **Assets Financing** | | | | | |
| Owned – purchased (net book value) | 884 | 128 | 524 | 0 | 1,536 |

# Notes to the Accounts *(continued)*

## 6.2 Intangible assets

| | Assets under construction £000 | Software Licences £000 | Information Technology Websites £000 | Information Technology Web based Tools £000 | Total £000 |
|---|---|---|---|---|---|
| Gross cost at 31 March 2010 | 219 | 1,469 | 1,888 | 1,096 | 4,672 |
| Additions – purchased | 353 | 53 | 87 | 181 | 674 |
| Reclassifications | (502) | 0 | 125 | 377 | 0 |
| Disposals | 0 | 0 | (52) | 0 | (52) |
| Impairment | 0 | 0 | 0 | 0 | 0 |
| **Gross cost at 31 March 2011** | 70 | 1,522 | 2,048 | 1,654 | 5,294 |
| Accumulated amortisation at 31 March 2010 | 0 | 841 | 1,301 | 643 | 2,785 |
| Charged during the year[1] | 0 | 294 | 434 | 338 | 1,066 |
| Reclassifications | 0 | 0 | 62 | 208 | 270 |
| Disposals | 0 | 0 | (25) | 0 | (25) |
| Impairment | 0 | 0 | 0 | 0 | 0 |
| **Accumulated amortisation at 31 March 2011** | 0 | 1,135 | 1,772 | 1,189 | 4,096 |
| **Net book value:** | | | | | |
| **Total at 31 March 2011** | 70 | 387 | 276 | 465 | 1,198 |
| **Assets Financing** | | | | | |
| Owned – purchased (net book value) | 70 | 387 | 276 | 465 | 1,198 |

1 An announcement was made in July 2010 that the NHS Institute would close as a Special Health Authority. The future of the NHS Institute is being considered as part of the *Liberating the NHS: report of the arm's-length bodies review* published on 26 July 2010.

In light of this announcement the NHS Institute has reassessed the asset lives and accelerating the depreciation relating to its intangible assets.

| | Assets under construction £000 | Software Licences £000 | Information Technology Websites £000 | Information Technology Web based Tools £000 | Total £000 |
|---|---|---|---|---|---|
| Gross cost at 31 March 2009 | 119 | 986 | 1,508 | 892 | 3,505 |
| Additions – purchased | 394 | 320 | 361 | 237 | 1,312 |
| Reclassifications | (294) | 163 | 25 | 106 | 0 |
| Disposals | 0 | 0 | 0 | (61) | (61) |
| Impairment | 0 | 0 | (6) | (78) | (84) |
| **Gross cost at 31 March 2010** | 219 | 1,469 | 1,888 | 1,096 | 4,672 |
| Accumulated amortisation at 31 March 2009 | 0 | 367 | 572 | 427 | 1,366 |
| Charged during the year | 0 | 474 | 730 | 332 | 1,536 |
| Reclassifications | 0 | 0 | 0 | 0 | 0 |
| Disposals | 0 | 0 | 0 | (48) | (48) |
| Impairment | 0 | 0 | (1) | (68) | (69) |
| **Accumulated amortisation at 31 March 2010** | 0 | 841 | 1,301 | 643 | 2,785 |
| **Net book value:** | | | | | |
| **Total at 31 March 2010** | 219 | 628 | 587 | 453 | 1,887 |
| **Assets Financing** | | | | | |
| Owned – purchased (net book value) | 219 | 628 | 587 | 453 | 1,887 |

# 7 Receivables

## Current receivables

| | 31 March 2011 £000 | 31 March 2010 £000 |
|---|---|---|
| NHS receivables | **512** | 2,485 |
| Trade receivables – Non-NHS | **741** | 451 |
| Allowance for irrecoverable debts | **(80)** | (41) |
| VAT amount due | **712** | 1,216 |
| Prepayments | **283** | 424 |
| Accrued income | **1,885** | 554 |
| Other receivables | **11** | 19 |
| | **4,064** | 5,108 |

## Non-current receivables

| | 31 March 2011 £000 | 31 March 2010 £000 |
|---|---|---|
| Prepayments | **7** | 126 |
| | **7** | 126 |
| **Total receivables** | **4,071** | 5,234 |

# 8 Cash and cash equivalents

| | 31 March 2010 £000 | Change during the year £000 | 31 March 2011 £000 |
|---|---|---|---|
| Cash at the bank | 3,524 | **562** | **4,086** |
| | 3,524 | **562** | **4,086** |

# Notes to the Accounts *(continued)*

## 9 Trade payables and other payables

| | 31 March 2011 £000 | 31 March 2010 £000 |
|---|---|---|
| NHS payables | 1,112 | 2,066 |
| Trade payables (revenue) | 2,162 | 2,868 |
| Tax and social security | (1) | 0 |
| Trade payables (capital) | 8 | 2 |
| Accruals | 287 | 1,059 |
| Deferred income | 1,558 | 3,563 |
| Other payables | 317 | 362 |
| | 5,443 | 9,920 |

## 10 Provisions for liabilities and charges

| | Legal claims £000 | Restructuring £000 | Other £000 | Total £000 |
|---|---|---|---|---|
| At 31 March 2010 | 170 | 0 | 820[1] | 990 |
| Arising during the year | 0 | 4,870[4] | 29[2] | 4,899 |
| Utilised during the year | (48) | 0 | 0 | (48) |
| Reversed unused | 0 | 0 | 0 | 0 |
| **At 31 March 2011** | 122 | 4,870 | 849 | 5,841 |
| **Expected timing of cash flows:** | | | | |
| Within 1 year | 122[3] | 4,870[4] | 849 | 5,841 |

1 Included in Other provisions is the provision for the restoration of Coventry House to original condition at the end of the lease period which is currently due to end in August 2011.

2 The NHS Institute has contracted for services with indirect workers and has provided for tax relating to their employment status within Other provisions.

3 The NHS Institute has received a personal injury claim during 2007-08, which was partially settled in January 2011. The remaining provision is due to be released during the first quarter of 2011-12, once the legal fees have been finalised.

4 An announcement was made in July 2010 that the NHS Institute would close as a Special Health Authority. The future of the NHS Institute is being considered as part of the *Liberating the NHS: report of the arm's-length bodies review* published on 26 July 2010.

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 new 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 have been made totalling £4.8m.

Due to the uncertainties surrounding the timing of the closure of the NHS Institute the provision for staff redundancies and the associated pension costs have been reported as being due within one year, however there is a possibility that residual payments may be made during the financial year 2012-13.

## 10 Provisions for liabilities and charges *(continued)*

| | Legal claims £000 | Restructuring £000 | Other £000 | Total £000 |
|---|---|---|---|---|
| At 31 March 2009 | 175 | 0 | 606[1] | 781 |
| Arising during the year | 0 | 0 | 214[2] | 214 |
| Utilised during the year | (5) | 0 | 0 | (5) |
| **At 31 March 2010** | 170 | 0 | 820 | 990 |
| **Expected timing of cash flows:** | | | | |
| Within 1 year | 170 | 0 | 820 | 990 |

1 Included in Other provisions is the provision for the restoration of Coventry House to original condition at the end of the lease period which is currently due to end in August 2011.

2 The NHS Institute has contracted for services with indirect workers and has provided for tax relating to their employment status within Other provisions.

## 11.1 Movements in working capital other than cash

| | **31 March 2011 £000** | 31 March 2010 £000 |
|---|---|---|
| (Decrease)/Increase in receivables | **(1,163)** | 912 |
| Decrease in payables | **4,483** | 2,981 |
| | **3,320** | 3,893 |

## 11.2 Reconciliation of operating costs to operating cash flows

| | **31 March 2011 £000** | 31 March 2010 £000 |
|---|---|---|
| Net operating cost before interest for the year | **60,239** | 68,992 |
| Adjust for non cash transactions | **(2,743)** | (2,650) |
| Adjust for movements in working capital other than cash | **3,320** | 3,893 |
| (Increase) in provisions | **(4,851)** | (209) |
| **Net cash outflow from operating activities** | **55,965** | 70,026 |

## 11.3 Reconciliation of net cash flow to movement in net debt

| | **31 March 2011 £000** | 31 March 2010 £000 |
|---|---|---|
| Increase/(Decrease) in cash in the period | **562** | (1,546) |
| Non current asset additions/disposals | **823** | 1,519 |
| Depreciation/impairment/indexation | **(2,680)** | (2,697) |
| Decrease in payables | **4,477** | 3,262 |
| (Decrease)/Increase in receivables | **(1,163)** | 912 |
| (Increase) in provisions | **(4,851)** | (209) |
| **Movement in net debt** | **(2,832)** | 1,241 |

# Notes to the Accounts *(continued)*

## 12 Contingent liabilities

At 31 March 2011, there were no known contingent liabilities (2009-10 £nil).

## 13 Capital commitments

At 31 March 2011, there were capital commitments totalling £124k (2009-10 £113k).

## 14 Commitments under finance leases

At 31 March 2011, there were no known commitments under finance leases (2009-10 £nil).

## 15 Commitments under operating leases

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

| | 2010-11 £000 | 2009-10 £000 |
|---|---|---|
| Hire of plant and machinery | 0 | 1 |
| Property rental – including headquarters and other properties | 600 | 640 |
| Other operating leases | 27 | 45 |
| | 627 | 686 |

**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.

| | | 2010-11 £000 | 2009-10 £000 |
|---|---|---|---|
| **Land and buildings** | Operating leases which expire: | | |
| | Within 1 year | 217 | 570 |
| | | 217 | 570 |
| **Other leases** | Operating leases which expire: | | |
| | Within 1 year | 9 | 33 |
| | | 9 | 33 |

## 16 Other commitments

The NHS Institute has not entered into any additional non-cancellable contracts which are not operating leases (2009-10 £nil).

## 17 Losses and special payments

During 2010-11 65 cases of losses were approved totalling £36,583 (in 2009-10 there were 39 cases totalling £9,672). Additionally, 34 exchange rate fluctuations were approved with an overall loss of £8,074. (In 2009-10 29 exchange rate fluctuations were approved with an overall loss of £18,118).

### 17.1 Reconciliation of net exchange differences

| | 31 March 2010 £000 | Change during the year £000 | 31 March 2011 £000 |
|---|---|---|---|
| Foreign exchange gains | (41) | 33 | (8) |
| Foreign exchange losses | 18 | (10) | 8 |
| | (23) | 23 | 0 |

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 2010-11 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.

| | 2010-11 Receivables £000 | 2010-11 Payables £000 | 2010-11 Income £000 | 2010-11 Expenditure £000 |
|---|---|---|---|---|
| Blackpool, Fylde & Wyre NHS Foundation Trust | | 54 | | |
| Buckinghamshire Hospitals NHS Trust | | | 147 | |
| Cambridge University Hospitals NHS Foundation Trust | | | | 704 |
| Central Manchester University Hospitals NHS Foundation Trust | | | | 285 |
| Chelsea and Westminster Hospital NHS Foundation Trust | 573 | | 540 | 867 |
| County Durham and Darlington NHS Foundation Trust | 75 | | | 238 |
| Department of Health | | | 3,771 | |
| Ealing Hospital NHS Trust | | 100 | | |
| East of England Strategic Health Authority | 372 | | 177 | |
| Health and Social Care Information Centre | | | | 485 |
| Heart of England NHS Foundation Trust | | | 494 | |
| London Strategic Health Authority | | | 324 | |
| Medway NHS Foundation Trust | | | | 401 |
| Middlesbrough, Redcar & Cleveland Community Services | | 60 | | |
| Mid Staffordshire NHS Foundation Trust | | | | 146 |

# Notes to the Accounts *(continued)*

| | 2010-11 Receivables £000 | 2010-11 Payables £000 | 2010-11 Income £000 | 2010-11 Expenditure £000 |
|---|---|---|---|---|
| Mid Yorkshire Hospital NHS Trust | | | | 213 |
| NHS Business Services Authority | | 83 | | |
| NHS Pension Scheme (own staff employers and employees contributions) | | 308 | | 308 |
| North East Strategic Health Authority | | | 170 | |
| North West Strategic Health Authority | | | 303 | 1,250 |
| Oxford Radcliffe Hospitals NHS Trust | | | | 102 |
| Papworth Hospitals NHS Foundation Trust | | 50 | | |
| Queen Victoria Hospital NHS Foundation Trust | | | | 225 |
| Royal Surrey County Hospital NHS Foundation Trust | | | | 225 |
| Salford Royal NHS Foundation Trust | | | | 230 |
| South Central Strategic Health Authority | | | 193 | |
| South Tees Hospitals NHS Foundation Trust | | | | 1,044 |
| South West Strategic Health Authority | | | 257 | |
| Taunton and Somerset NHS Foundation Trust | | | | 625 |
| University of South Manchester NHS Foundation Trust | | | 271 | |
| West Midlands Strategic Health Authority | | | 127 | |
| West Middlesex University Hospitals NHS Trust | | 173 | | |
| Yorkshire and the Humber Strategic Health Authority | | | 199 | |

| | 2009-10 Receivables £000 | 2009-10 Payables £000 | 2009-10 Income £000 | 2009-10 Expenditure £000 |
|---|---|---|---|---|
| Barnsley Hospital NHS Foundation | | | | 147 |
| Basingstoke & North Hampshire Foundation NHS Trust | | | | 135 |
| Blackpool, Fylde & Wyre NHS Foundation Trust | | | | 151 |
| Cambridge University Hospital NHS Foundation Trust | | | | 185 |
| Central Manchester & Manchester Childrens University Hospital NHS Trust[1] | | | | 954 |
| Central Manchester University Hospitals NHS Foundation Trust | | | | 153 |

# Notes to the Accounts *(continued)*

| | 2009-10 Receivables £000 | 2009-10 Payables £000 | 2009-10 Income £000 | 2009-10 Expenditure £000 |
|---|---|---|---|---|
| Chelsea & Westminster NHS Foundation Trust | 121 | | | 418 |
| Department of Health | 1,216 | | 7,667 | 137 |
| Department of Health – Connecting for Health | 476 | 68 | | 124 |
| Derby PCT | | | 275 | |
| Ealing PCT | | 74 | | 268 |
| East & North Hertfordshire NHS Trust | | | 105 | |
| East Sussex Hospital NHS Trust | | | | 117 |
| Great Ormond Street Hospital NHS Trust | | | | 210 |
| Greenwich PCT | | 60 | | |
| Haringey Teaching PCT | | 100 | | 100 |
| Heart of England NHS Foundation Trust | 304 | | | 126 |
| Leeds PCT | | | | 181 |
| Leeds Teaching Hospitals NHS Trust | | 67 | | 222 |
| Leicestershire County & Rutland PCT | | 77 | | |
| Manchester PCT | | | | 101 |
| Mid Essex PCT | | 64 | | |
| Mid Staffordshire NHS Foundation Trust | | 206 | | 266 |
| National Patient Safety Agency | | | | 530 |
| NHS Business Service Authority | | 113 | | 274 |
| NHS East of England SHA | | 146 | 789 | 159 |
| NHS London SHA | 190 | | 201 | |
| NHS North West SHA | | | | 168 |
| NHS South Central SHA | | | 101 | |
| NHS South East Coast SHA | | | 235 | |
| NHS South West SHA | | | 198 | |
| NHS West Midlands SHA | | | 121 | |
| NHS Yorkshire and the Humber SHA | 79 | | 168 | |
| Northamptonshire Healthcare NHS Trust | | 60 | | |
| Nottingham City PCT | | 52 | | |
| Nottingham University NHS Trust | | | | 597 |
| Nottinghamshire County Teaching PCT | | | | 107 |
| Oldham PCT | | 60 | | |
| Salisbury NHS Foundation Trust | | | | 308 |
| South Western Ambulance Service NHS Trust | | | | 100 |

# Notes to the Accounts *(continued)*

| | 2009-10 Receivables £000 | 2009-10 Payables £000 | 2009-10 Income £000 | 2009-10 Expenditure £000 |
|---|---|---|---|---|
| St Georges Healthcare NHS Trust | | 80 | | 208 |
| Surrey PCT | | | | 109 |
| University College London Hospital NHS Foundation Trust | 54 | | | |
| University Hospital of North Staffordshire | | 77 | | 189 |
| University Hospitals South Manchester Foundation Trust | | | 521 | |
| West Hertfordshire Hospitals NHS Trust | | 52 | | |
| West Middlesex University NHS Trust | | 90 | | 374 |

1 Includes innovation hubs funding of £592k for 2009-10 within expenditure.

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 (Acting Director of Corporate Services and Finance) is a Non-Executive Director for Solihull Care Trust.
- Simone Jordan (Deputy Chief Executive and Chief Operating Offier) is on secondment at East Midlands Strategic Health Authority.

## 19 Post balance sheet events

The financial statements were considered by the Audit and Risk Management Committee on 23 June 2011. 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 2011 are in receivables from customers, as disclosed in the receivables note.

### 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 2011 | | |
| Denominated in £ Sterling | **5,943** | **3,508** |
| Other | **39** | **83** |
| Gross Financial Asset/Liability | **5,982** | **3,591** |
| At 31 March 2010 | | |
| Denominated in £ Sterling | 7,654 | 5,194 |
| Other | 0 | 102 |
| Gross Financial Asset/Liability | 7,654 | 5,296 |

# Notes to the Accounts *(continued)*

## 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 | | |
| Cash at bank and in hand | **4,086** | **4,086** |
| NHS receivables – net of credit note provision | **512** | **512** |
| Trade receivables – non NHS (net of provision) | **661** | **661** |
| Other receivables | **723** | **723** |
| **Total at 31 March 2011** | **5,982** | **5,982** |
| Financial liabilities: Loans and Payables | | |
| NHS payables | **1,112** | **1,112** |
| Trade payables – non NHS | **2,162** | **2,162** |
| Other payables | **317** | **317** |
| **Total at 31 March 2011** | **3,591** | **3,591** |
| Financial assets: Loans and Receivables | | |
| Cash at bank and in hand | 3,524 | 3,524 |
| NHS receivables | 2,485 | 2.485 |
| Trade receivables – non NHS (net of provision) | 410 | 410 |
| Other receivables | 1,235 | 1,235 |
| Total at 31 March 2010 | 7,654 | 7,654 |
| Financial liabilities: Loans and Payables | | |
| NHS payables | 2,066 | 2,066 |
| Trade payables – non NHS | 2,868 | 2,868 |
| Other payables | 362 | 362 |
| Total at 31 March 2010 | 5,296 | 5,296 |

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 since in the calculation of book value, the expected cash flows have been discounted by the Treasury discount rate of 2.2% in real terms.

## 20.3 Maturity of Financial Liabilities

| | 31 March 2011 £000 | 31 March 2010 £000 |
|---|---|---|
| Less than one year | **3,591** | 5,296 |
| **Total** | **3,591** | 5,296 |

## 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 | 1,116 | 0 | 1,596 |
| Balances with local authorities | 0 | 0 | 387 |
| Balances with other NHS bodies | 783 | 0 | 1,021 |
| Balances with public corporations and trading funds | 0 | 0 | 0 |
| Sub-total intra-governmental balances | 1,899 | 0 | 3,004 |
| Balances with bodies external to government | 2,165 | 64 | 2,439 |
| **At 31 March 2011** | 4,064 | 64 | 5,443 |

| | 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 | 3,848 | 0 | 4,086 |
| Balances with local authorities | 0 | 0 | 0 |
| Balances with other NHS bodies | 665 | 0 | 2,129 |
| Balances with public corporations and trading funds | 0 | 0 | 0 |
| Sub-total intra-governmental balances | 4,513 | 0 | 6,215 |
| Balances with bodies external to government | 595 | 126 | 3,705 |
| At 31 March 2010 | 5,108 | 126 | 9,920 |

## 22 Grant payments

During 2010-11 the NHS Institute has granted funds to various organisations in support of the Department of Health achieving key strategic deliverables such as QIPP. An analysis of the grant payments made is shown below.

# Notes to the Accounts *(continued)*

## 22.1 Grant Payments – public sector

| | 2010-11 £000 |
|---|---|
| Basingstoke and North Hampshire Hospital NHS Foundation Trust | 23 |
| Berkshire East Community Health Services | 12 |
| Berkshire Healthcare NHS Foundation Trust | 12 |
| Berkshire West Community Health Services | 23 |
| Buckinghamshire Healthcare NHS Trust | 35 |
| Calderdale and Huddersfield NHS Foundation Trust | 2 |
| Cambridge University Hospitals NHS Foundation Trust | 704 |
| Central Manchester University Hospitals NHS Foundation Trust | 280 |
| Chelsea & Westminster Hospital NHS Foundation Trust | 1,406 |
| Community Health Oxfordshire/Oxfordshire PCT | 23 |
| County Durham and Darlington Foundation Trust | 312 |
| Hampshire Community Healthcare | 23 |
| Hampshire Partnership NHS Foundation Trust | 23 |
| Heatherwood and Wexham Park Hospitals Foundation Trust | 23 |
| Kettering General Hospital NHS Foundation Trust | 59 |
| Medway NHS Foundation Trust | 401 |
| Mid Yorkshire Hospitals NHS Trust | 244 |
| Milton Keynes Community Health Services | 23 |
| Milton Keynes General Hospital NHS Foundation Trust | 23 |
| NHS Direct | 5 |
| NHS Isle of Wight | 35 |
| NHS Redbridge | 2 |
| North Middlesex University Hospital | 57 |
| North West Strategic Health Authority | 1,220 |
| Nuffield Orthopaedic Centre NHS Trust | 12 |
| Oxford Radcliffe Hospital NHS Trust | 160 |
| Oxfordshire and Buckinghamshire Mental Health Foundation Trust | 23 |
| Portsmouth Hospitals NHS Trust | 23 |
| Queen Elizabeth Hospital NHS Foundation Trust | 2 |
| Queen Victoria Hospital NHS Foundation Trust | 225 |
| Ridgeway Partnership (Oxfordshire Learning Disability NHS Trust) | 12 |
| Royal Berkshire NHS Foundation Trust | 23 |
| Royal Surrey County Hospitals NHS Foundation Trust | 225 |
| Salford Royal NHS Foundation Trust | 231 |
| Sheffield Teaching Hospitals Foundation Trust | 16 |
| Solent Healthcare (NHS Southampton City) | 23 |
| Southampton University Hospitals NHS Trust | 12 |
| South Tees Hospital NHS Foundation Trust | 1,044 |
| Taunton and Somerset NHS Foundation Trust | 625 |
| University College London NHS Foundation Trust | 50 |
| Weston Area Health NHS Trust | 50 |
| Winchester and Eastleigh Healthcare NHS Trust | 23 |
| **Total as at 31 March 2011** | **7,749** |

### 22.2 Grant Payments – private sector

| | 2010-11 £000 |
|---|---|
| Academy of Medical Royal Colleges | 43 |
| National Leadership and Innovation Agency for Healthcare | 24 |
| Royal College of General Practitioners | 1,979 |
| Royal College of Physicians | 43 |
| Royal College of Surgeons Edinburgh | 5 |
| South West Health Innovation Education Cluster | 662 |
| Thames Valley Health Innovation Education Cluster/Oxford Health NHS FT | 12 |
| The Kings Fund | 6 |
| University of Derby | 65 |
| Wessex Health Innovation Education Cluster (The University of Southampton) | 69 |
| West Midlands Health Innovation Education Cluster | 329 |
| Total as at 31 March 2011 | 3,237 |

## 23 IFRS disclosure

### 23.1 Early adoption of IFRSs, amendments and interpretations

The NHS Institute have not adopted any IFRSs, amendments or interpretations early.

### 23.2 IFRSs, 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 IFRSs, amendments and interpretations that are, or will be applicable after the accounting period. There are a number of IFRSs, amendments and interpretations issued by the International Accounting Standards Board that are effective for financial statements after this accounting period. The following have not been adopted early by the NHS Institute:

IFRS 7 Financial Instruments: Disclosure

Two amendments to the existing standard. The effective date is for accounting periods beginning on, or after 1 January 2011 and 1 July 2011 respectively.

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 2013.

IAS 1 presentation of financial statements

Amendment to the existing standard. The effective date is for accounting periods beginning on, or after 1 January 2011.

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 2011-12

In addition, the following changes to the FReM, which will be applicable for accounting periods beginning on 1 April 2011:

### Chapter 4 Accounting Boundaries

Revision to the departmental resource accounting boundary.

### Chapters 5, 6, 7 and 11 Accounting for Capital Government Grants and Similar Financing from Non-Government Sources

Adaptation of IAS 16 and IAS 20 to align accounting treatment of capital non-exchange transactions and supplement to disclosure requirements to show how additions have been financed.

### Chapter 11 Income and Expenditure

Changes to the treatment of income and concept of ‘appropriations-in-aid’ disappears.

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

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