NHS
Institute for Innovation and Improvement

Annual Report and Accounts
of the NHS Institute for Innovation and Improvement 2011-12

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of the NHS Institute for Innovation and Improvement 2011-12

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Introduction and Foreword

Last year was, for the NHS Institute, another active year of change and success. Many of our achievements over the year are detailed within the body of the report and we would encourage you to read through to see how diverse and unique much of our work continues to be. We should however, highlight in this introduction that all our activities have taken place in the context of the radical reforms of the NHS as a result of the Health and Social Care Act (2012) with all its concomitant uncertainties and new demands for change across the service.

The NHS Institute will be closing on 31 March 2013, and so during the year we saw internal changes in the NHS Institute gather pace as we prepare for closure of the business. There are also plans for the establishment of a new Improvement Body, as part of the NHS Commissioning Board. However, the specific form and function of the new body is not yet agreed, neither is there agreement on those improvement activities across the NHS that may transition into it. At this point the only known fact is that the NHS Institute will close on 31 March 2013.

These profound changes inevitably have influenced our programme of work over the last year and in particular our approach to supporting our NHS customers.

As for many working in the NHS, our staff have seen many changes through the year, not least the departure of Bernard Crump and Yve Buckland, our previous chief executive and chair. Leaving in September and December 2011 respectively, they had led the organisation from its inception to its current position and we are grateful to them for their commitment and effort over the years. This was followed by the departure of our Interim Managing Director, Julian Nettel, at the end of July 2012, when Rod Anthony, Director of Corporate Services and Finance, took over as Accounting Officer. Moving through the transition of the organisation we are working hard to keep our staff up to speed with developments and well informed about the future. While recognising how challenging the environment currently is, we are grateful to them for their unerring enthusiasm and efforts to deliver our existing and new programmes and services to the NHS, our partners worldwide and our sponsors at the Department of Health (DH).

Our activities over the year have primarily been targeted at helping our NHS customers achieve necessary change in the light of the QIPP and reform agendas. New programmes developed in year include Health & Social Care System Support, the latest in the Productive Series – Productive General Practice, our development offering for commissioners, a programme to deliver Leading Large Scale Change and work to support the new Health and Wellbeing Boards. Our Mobilisation team, in partnership with the Dementia Action Alliance, called a wide range of stakeholders to action to make a significant impact in the reduction in appropriate prescribing of antipsychotics for people with dementia – *The Right Prescription.* This list of activities is by no means exhaustive but demonstrates the range and diversity of our work, and our ability to respond to our customers and their changing requirements.

This year was our first of direct income generation which supplemented our grant in aid funding. Demand for our services came from provider and commissioner organisations as well as health providers from across the world. It's also been a year when we have continued to embrace technology – through an innovative partnership we have developed an e-learning portal for The Productive Series and have started to use social media to inform our customers of our activities and to share their work. Towards the end of 2011-12 we worked with the DH on High Impact Innovations – work which derives directly from the Chief Executive Review of Innovation Health and Wealth, and for the new NHS Commissioning Board on a new change model for the NHS to ensure the service has the skills, capacity and resources to deliver improved services and efficiencies at scale and pace.

In the final year of the existence of the NHS Institute in its current form, we look forward to working with existing and new customers knowing that whatever the coming months bring, the legacy of the NHS Institute will be valued and built upon for the future of the service.

Rod Anthony, Accounting Officer

Tony Butterworth, Interim Chair

Management Commentary and Review of Activity

2011-12 Highlights

Below are some of the key achievements from the past year. More detailed information on these and other highlights from 2011-12 is included later in this report.

Putting patient and staff experience at the heart of service improvement (p12)	Almost 5,000 people visited our online *Transforming Patient Experience: the essential guide* in the first two weeks after its launch.
Supporting general practice to increase productivity whilst maintaining high quality care (p13)	The benefits experienced by Productive General Practice test sites included a 57% reduction in blood test resource costs and an 82% reduction in the time taken to retrieve prescriptions requests.
Helping to release nurses' time to spend on direct patient care (p15)	The Prime Minister stated in January 2012 that *releasing time to care* (The Productive Ward) will help free up nurses' time to spend on frontline activities and that the aim is for the programme to be rolled out across the NHS by April 2013.
Building safety improvement capability at all levels of the NHS (p16)	2011-12 saw the eighth wave of Leading Improvement in Patient Safety and three more cohorts of the Patient Safety Leaders' programme, with past participants demonstrating excellent results.
Developing the core improvement skills necessary for the NHS to achieve QIPP (p18)	More than 350 people participated in our Organising for Quality and Value programme. Following attendance one organisation has freed up beds and achieved savings of more than £158,000.
Tackling CCGs' authorisation and commissioning challenges (p19)	Our Development for Commissioners programme encourages CCGs to build evidence for authorisation whilst looking beyond to the local development of safe and effective commissioning.
Supporting emerging leaders (p21)	The NHS Vanguard Programme resulted in 55 successful QIPP projects and participants shared their learning with almost 2,500 colleagues.
Building and strengthening relationships with the NHS across England (p23)	Our Solutions teams and work programmes were realigned to the new SHA footprints and demand for our services has come from a wide range of organisations including SHAs, foundation trusts, GP practices and community trusts.
Galvanising the NHS to reduce the inappropriate prescribing of antipsychotics (p26)	Our call to action – The Right Prescription – engaged large numbers of people and secured their commitment to take action. At 31 March 2012 our call to action online community had 700 active members and 1,000 signed up for our expert webinars.
Providing all staff with the knowledge, skills and behaviours needed to improve health and care (p29)	The Leadership Framework (LF) was launched by the Secretary of State for Health in June 2011 and by 31 March 2012 the LF Self Assessment Tool had been downloaded over 22,000 times.
Helping organisations across the globe to improve healthcare (p31)	Our activities worldwide continued to grow in 2011-12, with significant activity in Scotland, Europe, Scandinavia, Australasia, Canada, the United States and the Middle East.
Spreading our message across the NHS (p34)	By 31 March 2012 the number of subscribers to our monthly e-newsletter had risen by more than 10,000 since the previous March to 52,680 and we had well over 3,500 followers on Twitter (this has since risen to more than 6,000).

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 i-House, University of Warwick Science Park, Millburn Hill Road, Coventry, CV4 7HS.

During 2011-12 a small number of our staff were also based in London and Manchester.

Risks

During 2011-12, the Board, Audit and Risk Management Committee and Executive Team 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 covers three elements – the running of the business, the close down of the special health authority and the transition to successor bodies. It 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:

- due to current uncertainty and lack of clarity on evolving priorities, the inability to demonstrate value for money to customers or the Department of Health as funder
- delay in clear roadmap for transition activities, leading to a loss of public value within functions that are transferred to successor bodies
- uncertainty of the change process leading to loss of key personnel, a reduction in the control environment within the special health authority and lack of focus on current necessary deliverables
- failure to deliver on business priorities because of delays in the approval process arising from imposed restrictions, impacting our ability to meet the requirements outlined in our business plan to service the health sector at scale and pace
- failure to forecast and plan activities accurately leading to a loss of financial management and control during a time of significant business change.

Environmental, social and community policies

In 2011-12 we continued to strive to reduce the NHS Institute's carbon footprint and improve our environmental sustainability.

- We moved into a new building in January 2012, which has been refurbished to include energy efficiency measures such as movement sensitive lighting and appliances and facilities that give us more efficient, sustainable premises. We have also significantly reduced our office space in London, saving on cost and energy use.
- Our new building offers us the flexibility to run more events in house, helping the NHS Institute to manage the impact of its events better.
- We have continued to increase the use of virtual meetings using teleconferencing and webinar technology.

Management Commentary and Review of Activity *(continued)*

- We encourage our suppliers to act sustainably, for example by conforming to our travel policies.
- We continue to manage our travel policy to encourage the most sustainable forms of travel.
- We ensure all stationery supplies are of good environmental standards, including 100% recycled paper.
- We encourage staff to turn off appliances and reduce energy use within the office.
- All non-confidential paper waste is re-cycled, confidential waste is managed through a waste management supplier and re-cycling waste bins are placed in our kitchen areas.
- We continue to monitor our carbon footprint and identify opportunities to implement further measures.

Our internal 'i-active' programme continues to promote healthy living and working amongst our staff. We also participate in the 'bike to work' scheme. We have a no-smoking policy on the premises of our new building.

We have provided support to a local college that provides vocational training and development for young people with special needs, by giving their students interview experience and talking to them about the world of work. We hope to be able to extend this further by offering some work experience or shadowing opportunities to interested students to complement their studies.

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 2011-12 the following percentages of hours were lost through sickness absences:

	2011-12
Quarter 1	2.91%
Quarter 2	3.22%
Quarter 3	2.41%
Quarter 4	2.46%

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. Our Equality and Diversity policy is available on our website.

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 Director of Corporate Services and Finance, who acts as the link between the staff and Executive Team and facilitates two way communication between them.

Regular team briefs are held by the Executive Team, which staff can attend in person or online and which are recorded and summarised in writing for those unable to attend. Staff members are encouraged to raise questions and concerns at these briefings. 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, additional methods of communication have been used, including a series of staff workshops about the future. We have also run a series of 'Next Steps' sessions to help prepare employees for the future. These have included sessions on writing CVs, interview techniques, pensions and setting up as a business or social enterprise. This programme will continue and additional workshops will be added according to the needs of our employees. We also work in line with the DH ALB HR Framework on matters affecting employees through the ALB and NHS changes.

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.

Management Commentary and Review of Activity *(continued)*

Information governance and security

Information governance within the NHS Institute is a key consideration in the areas of risk management, project appraisal and control/system reviews. We recognise that the quality and security of data plays a significant role in providing assurance to our stakeholders that information is managed competently and securely.

During 2011-12, we took the opportunity to review the approach adopted, levels of compliance achieved and resources invested. In particular, the organisational context and role is recognised; the NHS Institute will cease to exist as a special health authority by March 2013 and as a non-frontline organisation we do not hold patient level information. Consequently the new approach balances the importance of information governance against the effective deployment of organisational resources.

The review included taking advice and receiving recommendations from specialist lawyers and consultants in data protection and information governance. As a result:

- IG training and CRM data cleanses have been re-prioritised
- there has been a raised awareness of information governance
- a plan has been implemented to raise the current standards.

This will continue through the 2012-13 financial year.

This work has been undertaken with reference to internal audit and it is expected that standards will continue to rise during 2012-13.

Progress against targets

Each business area within the NHS Institute included individual performance objectives in our 2011-12 business plan. Performance against these objectives has been reported and approved on a quarterly basis by the NHS Institute Board and by our senior sponsor at the Department of Health. Across all business areas the business plan contains a total of 48 metrics. At year end 35 of these were rated green, six were rated amber and seven are now agreed as not applicable.

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

Design and Innovation

Patient Experience and Involvement

This programme has continued to stimulate efforts to put patient experience and involvement at the centre of NHS care. We published the *What Matters to Patients* research (with the King's Fund and King's College London), and also launched *Transforming Patient Experience: the essential guide* – an online resource to enable better understanding and optimal use of patient and staff experiences to improve services. This resource received almost 5,000 visits within the first two weeks of launch, with its success having a positive effect on another initiative – *The Patient Feedback Challenge* – a scheme backed by a £1m fund aiming to support widespread development and spread of exemplary patient experience work that is happening across the NHS. The team has continued to build the Patient Experience Network (PEN) with another 110 members joining in 2011-12.

Joined-up care

Central to good patient experience is joined-up care. This suite of products helps eliminate the duplication, inefficiency and waste which can create a poor experience as patients pass between organisations on their healthcare journey. Although launched in the autumn of 2010, it remains very popular with a total of 3,289 downloads of resources in 2011-12.

Ambulatory and Emergency Care (AEC) Network

It has been identified that admissions to hospital beds could be reduced significantly through introducing same day emergency care models, which would avoid unnecessary overnight stays for emergency patients. The AEC Delivery Network, in partnership with the College of Emergency Medicine, the Society of Acute Medicine and the Royal College of Nursing, is working with 25 NHS organisations. It is supporting them to accelerate their implementation of high quality AEC services, through topic specific workshops, virtual and national events, a platform for sharing good practice, plus individual advice and support.

"Our Ambulatory Care unit evolved even faster in 2011, because of our involvement in the Ambulatory Emergency Care Delivery Network."

Participating trust: AEC Mid-term review, January 2012

Measurement for Improvement

Effectively measuring improvement is critical and is often perceived by NHS staff to be difficult. Our measurement team has created a simple seven step process which is easy to follow and has made a massive difference for many NHS staff.

"The film revolutionised my approach to measurement - it's now easy!"

Improvement Lead

National Innovation Centre (NIC)

The NIC works nationally and internationally with innovators in industry, academia and the NHS, to speed the development and diffusion of healthcare technology innovations. It has continued to receive a number of innovation submissions. Some highlights include:

- supporting a new splinting device to immobilise a fractured neck of femur
- an ambulance carry chair to move patients in a way that is safe and easy but that also helps ambulance crews avoid the risk of injuring themselves and possibly further injuring their patients.

Management Commentary and Review of Activity *(continued)*

Innovation Challenge Prizes

The NHS Chief Executive's report *Innovation Health and Wealth,* published in December 2011, stated that the NHS is increasing its commitment to the NHS Innovation Challenge Prizes as part of its investment in innovative practice. The Challenge Prizes recognise and reward ideas that tackle some of the most challenging areas in healthcare.

Professor Sunil Shaunak, Professor of Infectious Diseases, Imperial College London, remarked: *"The public recognition of creativity amongst NHS staff is the goal of these new Challenge Prizes. They should become a shining example of how to transform exciting and innovative ideas into better health for patients."*

The first wave was completed and prize money of almost £200,000 was shared between:

- Manchester Royal Infirmary, for a home haemodialysis service
- MRC Cancer Cell Unit, Cambridge, for the invention of the Cytosponge
- NHS Bristol for the ScriptSwitch, which reduces prescribing waste.

The second wave saw a record number of applications. Three new challenges were added to the third wave, which was open until 1 June when applications were assessed by an expert panel of judges.

Care Homes Programme

Following requests from care homes in the UK and internationally we have been working with a range of colleagues including the Social Care Institute for Excellence (SCIE) who have extensive experience and knowledge in the sector, to develop an improvement programme for care homes. The emphasis is on identifying easy to use tools to deliver improvements, centred around resident and staff experience, which will have the potential to:

- empower staff to make the improvements that residents and their families want, more easily and more quickly
- improve safety
- improve internal systems and working relationships
- create efficiencies to release more time to care for residents.

"We have recognised the need to make some improvements in our care homes for a long time but have never been sure a) where to start and b) have not had the tools to do this. This programme will enable us to make these improvements."

Head of Care Homes – Brunelcare

Productive General Practice

Development of the Productive General Practice programme continued in the first half of 2011-12 and the first modules were available from autumn 2011. It is designed to support general practice continue to deliver high quality care whilst meeting increasing levels of demand and diverse expectations. The modules were developed in partnership with NHS Scotland and co-designed and tested by GPs, practice managers, nurses, receptionists and patients.

Productivity gains experienced by test sites included:

- extra nursing capacity identified worth £11,232
- time taken to retrieve prescriptions requests reduced by 82%, releasing 12.5 hours of staff time per week
- turnaround time for medical reports reduced by 43%
- 57% reduction in blood test resource costs
- 82% reduction in nurse sickness and absence
- more accurate staff planning – avoiding £15,000 of planned staff expenditure year on year.

We received significant interest from practices who are keen to implement the programme, as well as clinical commissioning groups (CCGs) planning roll out across their local area. For the first time the NHS Institute is working with delivery partners and four have been carefully selected to provide a package of implementation support for practices.

In 2011 the Department of Health provided support for the spread of Productive General Practice across six CCG areas. In each of these 25 practices are being supported. We provided training for CCG staff who are helping them with implementation.

In 2012-13 we are looking forward to seeing how these, and other practices that embark on Productive General Practice, reap benefits for their staff and patients.

Productive Care

The year 2011-12 saw an increase in the uptake of The Productive Series, as trusts moved closer to meeting the overall objective of the Productive Care national QIPP workstream - to ensure that patients are cared for in the most appropriate 'productive' environment, whether on a ward, in a theatre or in their own homes.

As the lead organisation for the workstream, two of our goals in 2011-12 were to focus more on working with patients and to maximise the use of system levers.

Working with patients

Patient care remains at the heart of The Productive Series. In 2011-12 we worked closely with patients, the National Association of LINks Members, emerging Healthwatches, patient and public involvement leads and patient experience leads. These groups helped us to involve patients more in the improvements organisations are making through The Productive Series. From this two new publications were produced in 2011-12:

- *Putting patients first – The Productive Series*
  Aimed at patients, carers and staff, this publication shares a series of case studies from NHS trusts that are implementing The Productive Series. Each example highlights best practice for improving care for patients.
- *The Fifteen Steps Challenge: Quality from a patient's perspective (The Productive Ward)*
  This challenge contains prompt questions across four categories that are underpinned by Care Quality Commission standards. It helps organisations work

Management Commentary and Review of Activity *(continued)*

more collaboratively with patients and carers to gain a better understanding of how patients feel about their care and what organisations can do to increase patient confidence.

During 2012 *The Fifteen Steps Challenge* has been released for The Productive Mental Health Ward and Productive Community Services programmes.

System levers

We have worked successfully with a number of significant system stakeholders:

- Care Quality Commission – having mapped the benefits of The Productive Series to the Care Quality Commission's *Essential standards of quality and safety,* a number of organisations are already using the data they collect for their Productive programmes as evidence for their Care Quality Commission submissions. In 2012-13 we will work with these organisations to help spread this practice nationally.
- Foundation Trust Governors' Association – an *Essential Briefing for Governors* was published to demonstrate the benefits that The Productive Series can deliver and the action that governors can take to support the series in their trusts.
- Appointments Commission – we attended the Appointments Commission's Induction Session in early 2012, to spread the importance of The Productive Series amongst recent senior appointments. We are continuing to work with the commission to explore further opportunities to work together.

In 2011-12 we saw a number of other important developments for The Productive Series.

Prime Minister's announcement

In January 2012 the Prime Minster announced that a greater focus is required in quality and nursing care, in order to benefit staff, patients and relatives. He stated that *Releasing time to care* (The Productive Ward) will help free up nurses' time to spend on frontline activities. The aim is for the programme to be rolled out across the NHS by April 2013 – this is one of the four aims we are striving towards as part of the Productive Care national QIPP workstream.

Financial benefits

Following the release of the Rapid Impact Assessment of The Productive Ward: *Releasing time to care* study in 2011, a new publication was released – *Calculating the financial benefit of The Productive Ward: Releasing time to care - a 'How to guide' to support the Rapid Impact Assessment.* This 'How to' guide aims to support organisations to undertake their own rapid impact assessment of The Productive Ward using the same methodology used by the workstream in 2011.

Productives Integration

A new tool is under development to help health and social care teams to work together to provide more integrated care, using The Productive Series. Productives Integration will guide teams through various steps to understand the roles and culture of others and work through barriers so that they recognise which Productive modules will help them become more integrated as a team. The tool will be launched later in 2012.

The Productives e-learning

We entered an exciting partnership with the Virtual College, which has used our combined expertise to create an e-learning programme for The Productive Series. The programme will provide a progressive learning tool designed to inform beginners about what The Productive Series is, through to accrediting a leader with experience in implementing strategic transformation within an organisation. The e-learning programme provides an important opportunity to increase spread and adoption of The Productive Series across the NHS at pace, and also gives learners the opportunity to build online CPD points, as well as gain City & Guilds qualifications.

The first introductory module was released across NHS England, with further modules to be launched during 2012.

Safer Care

Our Safer Care team continued to work with staff at every level of the NHS. The aim is to build an NHS where every member of staff has the passion, confidence and skills to eliminate harm to patients.

Leading Improvement in Patient Safety (LIPS)

LIPS is a major, organisationally based programme spread over nine months that works with both executive level and frontline teams. Participants build the capability to transform care and align their efforts to an organisational level aim and the wider safety agenda. By 31 March 2012 more than 150 teams had attended the programme.

Trusts continued to see results following their participation, for example:

- Northumbria Healthcare NHS Foundation Trust has seen a reduction in harm rates from 112 to 38 per 1,000 bed days in just over two years
- an acute trust has demonstrated a real reduction in harm rates to patients from an average of 65 to 36 per 1,000 bed days.

The eighth wave of the national LIPS programme began in November 2011 and involved 100 people from 14 organisations, including acute, mental health and paediatric. Participating trusts included those new to LIPS and those that were involved in previous waves, saw the impact and sent additional teams.

Feedback from LIPS core module delegates in March 2012 included:

"I do feel that in the last couple of days it has come together and I have lots of ideas about how to apply these techniques when I return to work."

One chief executive commented:

"I was worried that the team had taken on too much, but they've come up with a really good plan that I have complete faith in."

Patient Safety Leaders' programme

This programme provides deep practical support and guidance for individuals on the successful application of safety improvement tools and techniques. Accredited by the University of Derby, it helps participants to identify, implement and measure improvement projects. Three cohorts were run in 2011-12.

Management Commentary and Review of Activity *(continued)*

After participating in PSL a senior nurse at one acute trust led a project to change the way handovers were done on her ward, with the following results:

- an average saving of 20 trained staff minutes per handover – so a reinvestment of one trained nurse hour per day
- a saving on health care support worker time of an average 146 minutes per handover – a reinvestment of 7.3 health care assistant hours per day
- the Care Quality Commission commented positively on the new system during an audit.

This work was featured in a Nursing Times article in July 2011.

"I would recommend the PSL programme to anyone who wants to make a practical, positive difference to patient safety in their own trust."

Louise Jacox, Ward Senior Sister, George Eliot Hospital

Building Safety Improvement Skills (BaSIS)

The BaSIS programme aims to offer a set of improvement skills and a level of understanding about harm to equip individuals to lead improvement. Developed originally for Foundation Year 1 and 2 doctors, BaSIS was refined in 2011-12 to be equally applicable for general practice and core medical trainees. During the year 58 delegates from 16 trusts participated. At one event 89% of participants agreed or strongly agreed that the NHS Institute is the provider of choice in this field and 95% felt that they had left the event with the skills needed to implement an improvement programme.

After attending a previous BaSIS course, three junior doctors then at Chesterfield Royal Hospital developed and introduced a falls assessment checklist sticker, which is now used routinely by junior doctors undertaking falls assessments at the trust.

"I feel very fortunate to have been given the opportunity to go on the BaSIS programme. It is good to get an understanding of the causes of patient harm right at the beginning of your career."

Chris Phillips, Junior Doctor

Commissioning for Safer Care

This two day programme delivered in 2011-12 provided commissioning leaders and their teams with new ideas and the skills and confidence needed to achieve sustained reductions in harm to patients. It empowered commissioners to work with providers to drive forward improvements in quality and safety.

Safe and Productive Care for Older People

In February 2012 the Safer Care and Productive Series teams started work with 18 trusts committed to improving the care of older people. The need for this work was highlighted in 2011-12 by the Health Service Ombudsman's report, into care of the elderly and in a Patients Association dossier published in November 2011.

The programme launched in February was attended by more than 60 people and was supported by facilitator training. 97% of attendees reported that they were confident that they could apply the learning to their work.

Each organisation hosted a visit from NHS Institute experts to assess progress and provide advice to ensure successful implementation of improvements. This programme integrates the approaches of The Productive Ward, 'harm free' care (see below) and the LIPS programme in a way that helps frontline staff achieve more for their patients.

'Harm free' care

'Harm free' care is the national roll out of the Safety Express QIPP programme. It helps teams in their aim to eliminate harm from pressure ulcers, falls, catheter acquired urinary tract infections and blood clots through one plan building on existing improvement work. Our Safer Care team is involved in this initiative through building capability for safety improvement amongst frontline staff and embedding the principles of 'harm free' care in all of our Safer Care programmes.

ThinkGlucose

During 2011-12 ThinkGlucose spread beyond NHS England, to Scotland and Wales. Through working with partners from mental health and community hospitals, we tailored the package to be applicable in a wider range of hospital settings.

As a result of ThinkGlucose implementation teams' requests for additional support with project and change management, a *ThinkGlucose Programme Planning Tool* has been developed with acute, community and mental health hospitals. This tool will be an integral part of all future ThinkGlucose delivery.

National Awards for NHS Trusts

Ten NHS trusts have received national recognition for their ThinkGlucose service improvement. The awards covered the following categories: best emergency/ inpatient initiative, best safer care initiative, clinical service design and team of the year. Sheffield Teaching Hospitals NHS Foundation Trust won the award for Best Improvement in Quality and Safety at the BMJ Group Awards. After four months, harmful events had fallen by 31% and hypoglycaemic episodes by 28%. Prescription and administration errors were also reduced. Dudley Group of Hospitals NHS Foundation Trust's ThinkGlucose programme reached the final judging stages for the LEAN Healthcare Awards organised by Virtual College.

Embracing technology

In February 2012 University Hospital Southampton NHS Foundation Trust successfully launched DiAppBetes on iTunes App store, which incorporates ThinkGlucose.

Organising for Quality and Value

The Organising for Quality and Value programme continues to deliver the core improvement skills capability and capacity necessary for NHS organisations to achieve their QIPP objectives. Participants work on a real life improvement project during the programme, applying what they've learnt. Over 350 health experts including dentists, health visitors and social care professionals, attended programmes throughout 2011-12.

Management Commentary and Review of Activity *(continued)*

The programme has enabled many organisations to improve their services and reduce costs. Below are two examples showing the impact participation in the programme has produced:

- Yorkshire and Humber Specialist Commissioning Group, based with NHS Barnsley, identified that children needing long term ventilation were spending 49 weeks longer than necessary in intensive care. The trust has improved the discharge process so these children now go home much sooner. This has freed up beds and achieved savings of more than £158,000. This project has been chosen by the Specialist Commissioning Group as one of its QIPP initiatives.
- Only 55% of home visits by health visitors were made within 10-14 days of birth at the Community Health Services Division of Barts and the London NHS Trust, against a target of 95%. Now, thanks to this service improvement project, the target has been exceeded.

Children and Young People's Emergency and Urgent Care

The year started with the publication of the *Whole System Approach to Improving Emergency and Urgent Care for Children and Young People.* This has supported the whole system diagnostic visits by our team across the pathway experienced by children and young people seeking emergency and urgent care. Reading, Milton Keynes, Southampton and Buckinghamshire have all commissioned visits this year.

Health and education have continued to work together with young people in embedding the NHS Institute's Emergency and Urgent Care Lesson Plan which was profiled within the Department of Health's School Nursing Strategy (2012). Building on this success a lesson plan aimed at younger children has been developed.

Facilitation of events by experienced children's professionals with service improvement skills has been in demand and bespoke events were run across the country in 2011-12.

East of England commissioned work focused on the children's assessment services, resulting in the publication of the first national standards in this area and a tool highlighting what children, young people and families want from these services. Benchmarking, peer reviews and a shared learning event have embedded these resources in practice.

Dr Melanie Clements, Consultant Paediatrician and National Clinical Lead for the CYP Emergency and Urgent Care programme highlights: *"We must continue to ensure that children are kept on the agenda. We have done so much, but there is so much more to do."*

Development for Commissioners

The NHS Institute's Development for Commissioners programme progressed significantly during 2011-12. Building on our joint work with the RCGP, in co-production with a number of clinical commissioning

groups (CCGs) across England, the NHS Institute developed a whole systems approach. This incorporates diagnostic resources and a tailored development programme to help CCGs achieve authorisation and tackle their most pressing commissioning challenges. Crucial support for local CCG leaders as they undertake new roles with wide-ranging responsibilities has also been a key feature of our work.

Authorisation *and* commissioning challenges

What became apparent from working with CCG development partners was the importance of enabling a simultaneous focus on authorisation and getting on with tackling particular local commissioning challenges. So, our offer encourages CCGs to build evidence for authorisation whilst looking beyond this immediate challenge to produce organisations that feel confident in leading the local development of safe and effective commissioning, which focuses on outcomes and is built on strong partnerships across health and social care and with patients and the public.

The pace of the agenda for CCGs and the balanced focus of our resources and inputs have led to a strong pull for support, with paid commissions from localities including Devon, Southampton, Kent, Nottinghamshire, Birmingham, Manchester and Yorkshire. CCGs identified the particular strengths of the NHS Institute's commissioning programme as the fact that this is both clinically-led and developed in, by and for the NHS. Our focus on engaging with the wider primary care team and use of extensively tested solutions built by the NHS Institute has attracted very positive feedback from CCGs on the clarity and impact that our support brings.

Our close working with, and delivery on behalf of, the Department of Health and NHS Commissioning Board has ensured a national connectivity to developments coupled with the credibility we've built working on the ground with CCGs undertaking their organisational development journeys.

Taking ownership of the Quality, Innovation, Productivity and Prevention (QIPP) agenda

Our focus in 2012-13 is on scaling up delivery capacity and ensuring our support enables CCGs to own and lead their local response to the QIPP challenge of improving quality, driving up outcomes and using innovation to reduce costs and use resources more effectively.

Health and Social Care System Support

Both partnership programmes, Health and Social Care System Support (HSCSS) and Healthy Places, Healthy Lives (HPHL) had significant success during 2011-12.

Designed to encourage joint working and shared decision making across health and social care, local government and the third sector, and to support large scale change, the benefits of both programmes are being felt by communities across the country.

HSCSS is a unique, phased support programme to help the leaders of local government and the NHS, working across a specific geographical area, to respond to national policy and understand how working collectively can support faster implementation of major change initiatives for the benefit of the people they serve. Working with evolving and changing

Management Commentary and Review of Activity *(continued)*

systems, the programme was piloted across the North East health and social care community. This work led to the production of a detailed reflection report for each system which usefully highlights areas for leadership development and system improvement and has been seen as helpful in assisting joint working to meet the requirements of the new health and social care landscape.

By 31 March 2012 the HSCSS programme had already supported Health and Wellbeing Board development, CCGs to design their organisational development plans, and chief executive officer communities to create a compelling narrative and vision. During 2012-13 the programme will be offered nationally.

Learning and Development

Leading Large Scale Change (LSC)

In response to the interest generated by the publication of *Leading Large Scale Change: a practical guide,* the Leadership and Development teams delivered a series of six free web seminars covering various aspects of LSC from the model of large scale change to creating contagious commitment to a large and varied audience from across the NHS and partner organisations. To further support the NHS and local authority colleagues to deliver LSC in healthcare, the team has designed a *Leading LSC support programme,* commenced in May 2012.

NHS Vanguard Programme

A very successful six month accelerated development programme for 66 emerging NHS leaders and their executive sponsors was commissioned by The Emerging Leaders' workstream of the National Leadership Council (now part of the NHS Leadership Academy's portfolio). The programme blended face-to-face interaction with seminars and action learning being delivered virtually. The programme resulted in 55 successful QIPP projects and participants shared their learning with over 2,494 colleagues.

Health and Wellbeing Boards (HWBs)

The NHS Institute led a ground breaking piece of cross sector development work to support the establishment of Health and Wellbeing Boards – a key policy delivery mechanism for the Government's reform plans. Working with 100 of the 150 boards making up eleven 'learning sets', we delivered five virtual action learning sets for each set (55 sessions in total), together with three major national learning and sharing events. The outputs of this work will critically inform the ongoing and successful formation of HWBs.

Advanced Improvement in Quality and Safety Programme (AIQS)

Our first cohort of AIQS attracted 18 medics, surgeons, pharmacists, nurses and managers. All completed the programme and delivered an improvement project within their organisation, with 12 receiving a postgraduate certificate in quality and safety. A further 16 have been recruited, all of whom have registered for the postgraduate certificate to become advanced improvement practitioners. Many students have presented their work nationally and internationally, with one project being featured by NICE.

Management Commentary and Review of Activity *(continued)*

Development Framework

Extensive internal and external development and mapping has taken place to create the final test version of the development framework and we are working with three foundation trusts to refine and build the content and test the language and application. The result is a unique world class framework based on evidence of what really works in building sustainable innovation and improvement capability.

Accreditation Framework for NHS Institute programmes

The NHS Institute has developed and implemented a quality assurance and accreditation framework to support its products and services. Drawing on the standards developed by Skills for Health for the delivery of learning, the framework supports both our own staff and delivery partners to become quality assured and accredited against the nationally recognised standards of good practice. Our accreditation framework also supports the development of programme content. When used in conjunction with the NHS Institute Development Framework, it is possible to accredit those going through our programmes at foundation, practitioner or advanced practitioner level.

The Improvement Faculty

As at 31 March 2012 the Improvement Faculty had 260 Fellows. A successful two day event in October 2011 offered over 90 Fellows the opportunity to hear from leaders in improvement including Jim Easton and Goran Henriks. A Quality Improvement Clinic hosted by Peter Lachman also proved extremely popular. A series of three masterclasses provided opportunities for learning, networking and challenging debate for improvement champions from across the NHS.

Healthcare Scientists

During 2011, the NHS Institute worked with Professor Sue Hill, Chief Scientific Officer, to define a range of interventions which could support the development of the healthcare scientist workforce. A two day accelerated learning event was held in November 2011 followed by a public narrative workshop in January 2012.

Following the success of these events, a development programme was designed to build on the learning and further develop knowledge and skills for the healthcare scientist workforce.

Virtual Learning

The NHS Institute has now taken its Productive Series into a virtual learning mode through an innovative partnership with the Virtual College (see the Productive Care section). This model lays the foundations for a commercial offer and at 31 March 2012 we had over 100 registered users. We are working with the BMJ group to build our commercial virtual proposition and we will shortly launch of a range of offers as part of the NHS Institute's virtual learning strategy.

Healthwatch

As part of a project commissioned by the Department of Health, the Local Government Association, the NHS Institute and Regional Voices worked together to identify the support needs of local Healthwatch in pathfinder areas. This work incorporated surveys and case studies which were progressed through a learning event in London in April.

Management Commentary and Review of Activity *(continued)*

Solutions

Following the changes to the SHA boundaries and the establishment of the new SHA clusters, we realigned our Solutions team and work programmes to these new footprints. During 2011-12 the SHAs remained a very important part of the NHS Institute's improvement support, with the continuation of the SHA network for regional improvement leaders and targeted support in line with each region's priority for improvement and quality.

North

2011-12 was a year of building on the significant relationships and networks already in place across the North of England with special reference to AQuA (Advancing Quality Alliance) and regional Health Innovation and Education Clusters (HIECs).

The North East was our test site for a new Health and Social Care System Support (HSCSS) approach, based on our learning and understanding of large scale change.

The health and social care systems across the following areas participated in a reflective diagnostic which then led to ongoing support for health and wellbeing boards and emerging clinical commissioning groups:

- County Durham and Darlington
- Teesside
- Sunderland
- Gateshead
- South Tyne and Wear
- Northumberland.

Following the successful HSCSS diagnostic within County Durham and Darlington we supported the system with its provider development workstream, including its care closer to home steering group and the public patient and carer working groups specifically looking at patient engagement and experience.

At the request of NHS North West we delivered a highly successful programme of nine generic training courses over 15 days attended by 240 staff and eight networking events attended by over 100 staff in total, supporting spread and adoption of improvement techniques and The Productive Series.

An open access Organising for Quality and Value programme was run across the whole of the North of England as well as measurement support, as part of our capacity and capability building of improvement skill development.

Across Yorkshire we supported the HIEC and local organisations in the continuation of their successful Productive Series network.

London

The Solutions Team in London continued to deliver programmes of work to support the QIPP requirements. The focus of our work has been to build capability and capacity in improvement skills and leave a lasting legacy. The team delivered a number of programmes during 2011-12 including:

- five Organising for Quality and Value programmes which have developed 120 frontline NHS staff and leaders to have the core skills required to lead an improvement programme

- a support programme for NHS trusts to energise and refocus the implementation of The Productive Series in acute, mental health and community healthcare settings
- we developed and delivered a number of partnership agreements between the NHS Institute and NHS trusts that supported the development of their staff to deliver more productive healthcare
- in addition to supporting the London health system, the London Solutions Team has also supported the delivery of local programmes in other areas and delivery of national programmes including The Productive Leader, accelerated learning events and Thinking Differently
- the team also 'hosts' the National Maternity Improvement Team for the NHS Institute. It has supported three SHA clusters over the last year in building capability and capacity to deliver better maternity care.

Midlands and East

Demand for NHS Institute support and resources remained strong throughout 2011-12, led by paid commissions from each of the three strategic health authorities that make up the NHS Midlands and East cluster.

East of England SHA commissioned a series of seven accelerated design events to support clinical commissioning groups (CCGs) to progress a range of key issues critical to the successful establishment of these new entities locally.

West Midlands SHA followed a similar theme seeking to support the new primary care landscape with three large scale *Planning for Authorisation* sessions for CCGs across the region.

East Midlands SHA commissioned a series of inputs for each of the five QIPP locality clusters in the patch. These included new cohorts of Organising for Quality and Value to skill up local service improvement leaders, a number of innovation themed masterclasses and our highly rated junior doctors' safety programme, BaSIS (see the Safer Care section).

Demand for The Productive Series remained strong in a number of organisations, particularly community services after their recent reconfiguration. They are undertaking this work either from scratch or refreshing and reinvigorating existing efforts so that the full benefits of the programme are realised. In our first year of operating sales, organisations across the Midlands and East showed particularly high demand for those NHS Institute programmes that are focused on driving up quality, value, outcomes and patient engagement. Safer Care has never enjoyed a better profile and organisations such as Shrewsbury and Telford Hospitals NHS Trust have demonstrated their commitment to this area with inputs that engage clinicians and managers from board to ward levels.

South

Solutions South developed a number of formal partnerships during 2011-12 with NHS organisations across the region, which will see several programmes of work continue through to March 2013. In particular, we have worked closely with South Central SHA to deliver a programme that actively supports their plans to improve quality, innovation, productivity and prevention. This has supported the continued accelerated implementation of The Productive Series and has included the delivery of a number of creativity and

Management Commentary and Review of Activity *(continued)*

sustainability workshops aimed at promoting innovation within nursing teams and senior managers.

Several events were delivered for NHS South West including an accelerated design event for commissioning support, a clinical networks self assessment day and more recently a planning event to identify sustainable approaches to improving services for vulnerable adults across the South of England.

The NHS Institute continued to support organisations within the region to further build their improvement capacity and capability, including Productive Community Services with two South East Coast trusts, The Productive Operating Theatre, pathway work in relation to maternity and children and young people, engagement by organisations with the LIPS patient safety work and some diagnostic work in relation to administrative excellence, identifying strategic options for creating sizeable efficiencies in back office functions.

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.

Also in the last quarter of 2011-12, the NHS Institute established a new working arrangement with a number of quality assured delivery partners to promote and deliver Productive General Practice across the South of England. The signs are that there is significant interest in this from a number of general practices and CCGs in the region.

Integrated business process and customer relationship management

2011-12 was our first formal year of direct income generation and we achieved in year gross sales of £3.5m with additional orders extending into 2012-13. The demand for our services has arisen from a wide range of organisations including SHAs, foundation trusts, GP practices and community trusts. In order to effectively respond to demand, four regionally based sales and delivery teams were created, each led by an area director, with the responsibility to generate income and delivery to our customers' requirements. A central sales team respond to tenders and gather background information for the regional teams. All sales leads and opportunities have been recorded and tracked in our customer relationship management system, Oracle CRM, providing a central resource to develop targeted communication campaigns. Our CRM system is now being used by a much wider staff group and all customer information is located and aligned with the sales process.

Underpinning sales and delivery has been our integrated business planning (IBP), which links the key elements of delivery, sales and product management into a coherent operational plan. Using IBP we have, for example, been able to launch Productive General Practice and deploy accredited partners to sell and deliver programmes of support for GP practices and CCGs. Also, IBP allowed us to identify workforce and product requirements early in the sales process, ensuring that delivery to the service was executed efficiently and on time.

Mobilisation

Call to action

During 2011-12 the NHS Institute's Mobilisation team, in partnership with the Dementia Action Alliance, called a wide range of stakeholders to action to make a significant impact in the reduction in appropriate prescribing of antipsychotics for people with dementia – *The Right Prescription.* The goal was that all people with dementia who are on antipsychotics will have had a clinical review by 31 March 2012 and there is clear evidence that the call to action is having a significant impact and that clinical reviews are taking place. By 31 March 2012 in people with a diagnosis of dementia who are on antipsychotics approximately 80% had had a review and more GPs are completing audit returns, indicating a growing appreciation of and commitment to the topic.

In 2011-12 we did a great deal of work to engage large numbers of people to secure their commitment to take action, including the development of resources and skills for good practice in this area. This included the following:

- creation of a junior doctors' induction pack – adopted by 70% of medical directors
- contact with 2,000 GPs through a Doctors.Net GP education microsite
- reaching 25,000 nurses via the CNO bulletin and link into acute hospitals group
- engaging care home leaders – the five major providers are working together with the two major pharmacy chains
- a Royal Pharmaceutical Society resource pack – best practice and improvement guide (includes audit tool for monitoring improvement) which is being spread to 40,000 pharmacists. The skills development resource on 'critical communication' that we have developed with the RPS will give pharmacists the skills and confidence to challenge prescribing behaviours on a wider scale
- the ten regional SHA dementia leads are engaged and active in the call to action
- we have reached other health and social care professionals via our expert webinar series – 1,000 people registered for these between December 2011 and March 2012
- our call to action online community had 700 active members as at 31 March 2012
- the launch of the commissioning guide and regional call to action events were attended by 2,000 people
- the call to action was identified by the Cabinet Office as a case study of best practice in wholesale engagement across the system towards a community goal
- the work had strong ministerial support and endorsement through Paul Burstow.

We also built strong foundations for a call to action in shared decision making, starting with people with end stage kidney disease. This was launched in June 2012.

Mobilising leadership

Between April 2011 and 31 March 2012 more than 10,000 leaders from the NHS and its partner organisations were exposed to the ideas and leadership approaches emerging from the QIPP mobilisation workstream, which is led by the NHS Institute.

During 2011-12 the team focused on education and building capacity of key leaders in skills of mobilising, in order to support the delivery of QIPP and other priorities in the NHS Outcomes Framework.

Management Commentary and Review of Activity *(continued)*

Demand for this remained high and following a review of the format of this training, we moved from intensive two and three day training to a one day 'basics' public narrative programme from January 2012.

The NHS Change Model

During the final two months of the year a team, comprising staff from the NHS Institute, NHS Improvement and the Department of Health were charged with creating a unifying change model for the NHS.

From *Design of the NHS Commissioning Board – 'The scale of transformation needed in the NHS in order to deliver improved quality from available resources is huge. It requires an evidence-based, systematic and skilled application of change management approaches in order to achieve it'.*

In response to this the change model was designed to take account of successful change management and transformation over recent years in the NHS. Taking the best of what has been learned and the skills that we already have, by aligning eight component parts, the NHS Change Model is fit for purpose to use at every level of the NHS. During the challenging financial times we face the NHS Change Model will help bring about the changes required to improve services and increase productivity and efficiency as well as enhancing the patient experience – all at scale and pace.

Consultation on work in progress on the developing model with over 400 people helped us ensure compatibility with what is known to work in transformational activities. This work will continue for the next 18 months following a launch in May 2012.

High Impact Innovations

Following the publication of the *Innovation Health and Wealth* report, and the priorities identified, we worked to complete the first phase of a number of implementation support packages which promote spread and adoption of five high impact innovations.

3millionlives

3millionlives is about transformational change, building services for people with long term conditions, supporting them with technology where needed and building new business models. When implemented effectively as part of a whole system redesign of care, telehealth and telecare can alleviate financial pressures on the NHS and social care and improve people's quality of life through better self-care in the home setting.

The benefits are not just related to the individual recipient and their families. These services are also cost effective, evidenced in the recent Whole Systems Demonstrator (WSD) programme (the largest randomised control trial of telecare and telehealth) which proved that telehealth could provide:

- 45% reduction in mortality rates
- 20% reduction in emergency admissions
- 15% reduction in A&E visits
- 14% reduction in elective admissions
- 14% reduction in bed days
- 8% reduction in tariff costs.

Digital first

Led by the Department of Health, digital first is an initiative that will support the NHS in driving down the level of inappropriate and unnecessary face-to-face contacts. Currently face-to-face contact accounts for nearly 90% of all healthcare interactions; every 1% reduction in this will save up to £200m.

While face-to-face contact is central to much of clinical medicine, it is unnecessary for every interaction. Digital first will encourage people who use electronic media as part of their daily lives to use email for non-confidential communications, or to have a remote consultation using telephone or online technology, offering a convenient, high quality and lower cost alternative to unnecessary face-to-face interaction.

Intra-operative fluid management as part of enhanced recovery

The intra-operative fluid management workstream focuses on using minimally invasive fluid management technologies. Their use contributes to improved patient outcomes, particularly as part of a wider enhanced recovery programme. The technologies are designed to monitor the fluid status of a patient during surgery and provide information to allow the anaesthetist to optimise each patient's fluid balance. This helps to improve patient outcomes and speed up a patient's recovery after surgery.

The benefits of the use of such technologies in appropriate procedures across the NHS can be significant. However, to date only a small number of organisations are using them. Over the coming year the NHS Institute will be helping to drive forward spread and adoption of intra-operative fluid management technologies into practice across the NHS.

Support for carers of people with dementia

In England today there are around 750,000 people with dementia and this number is growing all the time. What this means is that an estimated 600,000 people in the UK today are acting as the primary carers for people with dementia. This care giving often takes place without any support from anyone. For many families what began as a labour of love turns into a nightmare of isolation, financial hardship, ill health and social stigma. The costs of caring are significant and carers save the UK public purse £6billion. The NHS Institute is helping the NHS to improve the commissioning and provision of support for carers of people with dementia in line with NICE/SCIE guidelines, by providing excellent examples of how this has been done and practical guidance on implementation.

Management Commentary and Review of Activity *(continued)*

Child in a Chair in a Day

We will support and empower patients and carers by giving them the knowledge and confidence they need to improve current provision of children's wheelchair and mobility services. One focus will be on procurement processes and quality assurance for commissioners and providers to streamline and optimise their services.

Leadership

Our leadership programmes were 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. During 2011-12 we continued to deliver leadership development activities whilst working alongside the National Leadership Council (NLC) to set up the new NHS Leadership Academy.

The Academy will further develop and will bring together our existing national leadership programme work with that of the former NLC, along with a new range of commissions and activities in a single, comprehensive hub for leadership excellence.

Work to bring the Academy to life included setting up governance, finance, staffing structure, and a vision, strategy, business plan and physical space. An evidence base was also collated which looked at the work which has been done so far to make sure none of this is lost as the Academy is set up.

Graduate Management Training Scheme

In September, 150 trainees joined the award winning NHS Graduate Management Training Scheme. The scheme continued with its high retention rate, with 82 per cent of all those graduating in 2011 securing an NHS job.

Following the redesign and refresh of the scheme last year, trainees in all specialisms now undertake a postgraduate certificate in leadership for service improvement which brings them all closer to the business of improving patient care.

Following efforts to increase the diversity, the 2011-12 year's graduate scheme consisted of 33 per cent candidates from a black and minority ethnic (BME) background as well as 25 per cent in-service candidates (including ten individuals from a clinical background).

2011-12 saw the scheme continue to be recognised as one of the top graduate schemes in the country. It was rated as first in the Guardian Top 300 and fifth in the Times Top 100, also winning the HR Employer of Choice for the seventh time as well as plaudits for its innovative use of social media.

Leadership Framework

In June 2011 the Leadership Framework (LF) was launched in by the Secretary of State to ensure that all staff can have the leadership knowledge, skills and behaviours needed to improve health and care.

Following the launch, the team worked extensively with organisations and individuals to increase adoption of the framework across healthcare. This included working with the clinical professions to embed clinical leadership into professional, regulatory and educational standards. As a result of this work, the Royal Pharmaceutical

Society published a contextualised version of the Leadership Framework and other professional bodies are intending to do the same.

Alongside this work was done to encourage use within the workplace, through the promotion of the framework and resources to support individuals and organisations to practically apply the framework:

- the LF Self Assessment Tool (including a clinical and medical version) was downloaded over 22,000 times by the end of March 2012
- over 1,350 individuals registered to use the 360° feedback tool in under six months and over 650 individuals registered as facilitators for this.

The Leadership Framework is being used to underpin local, regional and national programmes to develop leadership capacity.

Breaking Through

The Breaking Through workstream saw a number of developments in 2011-12. The third cohort of Top Talent – a programme designed to support senior BME staff to achieve director level roles – graduated in January 2012. Twenty-one BME and women NHS managers took part in the programme, which involved academic learning and secondment opportunities at or near director level. More than £4.7 million of savings was achieved by the participants' projects during the programme.

In December 2011, 80 BME senior managers from the NHS and adult social services met at an event jointly organised by the Breaking Through, the Association of Directors of Adult Social Services (ADASS), the Local Government Association (LGA), and the National Skills Academy. The event looked at why there is a lack of BME leaders in the health and social care sectors and what can be done to enhance representation.

February 2012 saw the launch of a pilot project to improve conflict resolution in NHS work environments. In partnership with the Tutu Foundation UK, the project enabled NHS managers to improve mediation and conflict resolution in their organisations using an ancient African philosophy called 'Ubuntu'.

An event was held in February in response to a report commissioned by the Academy to look at the issue of the lack of women doctors in clinical leadership roles. The event, which was attended by high profile delegates from across healthcare, looked at what could be done to enhance female representation, especially in CCGs.

Board Development

The focus of our provision for boards and senior leaders was on improving the performance of senior leaders across the service. The coaching registers and board development tool continued to be widely accessed. In addition, key work was undertaken on working with boards and senior leaders across sectors.

Board Development Tool

Eight NHS organisations undertook and completed the new version of the Foundation Trust Board Development Tool process.

Place based leadership

Place based leadership work became operational at 11 sites, all focused on developing the capacity of NHS leaders and Local Authority Members/Officers

Management Commentary and Review of Activity *(continued)*

to develop system leadership in complex environments. The team worked closely with the Department of Health and the Local Government Improvement and Development body to use learning from the first wave of activity to develop a new offer focused on the development of Health and Wellbeing Boards.

The Local Authority Peer Review Scheme

The Local Authority Peer Review Scheme went through a large amount of reorganisation and as a result saw the Local Government Improvement and Development body committing to this work as an important approach to leadership development with an expression of further interest in using peers from across geographic boundaries for the work.

Coaching

A third cohort of the Coaching Supervision programme commenced in October 2011 and 49 internal coach supervisors were trained. The internal supervisors provide a cost effective internal resource to supervise internal coaches and quality assure coaching practice.

The NHS Institute Executive and Team Coach registers assisted the National Leadership Council's Commissioning Leadership workstream in supporting a funded offer for GP Consortium Leaders; and participants of the NLC Top Leader programme with the one-to-one coaching register and team coaching to CCG senior teams.

The NHS Coaching Summit was a national CPD event in March 2012 for internal coaches and supervisors. It was well attended with over 140 delegates from across the service.

NHS Institute Worldwide

The global recession hit improvement budgets in most markets in which the Worldwide team operates. Symptoms included reduced budgets and many reorganisations of customer structures and responsibilities.

Despite this, our foothold across the globe strengthened during 2011-12 with the following significant activities and achievements.

Scotland

The latest addition to The Productive Series – Productive General Practice – was launched across the country with new videos and modules produced specifically for the Scottish market.

A series of workshops to introduce and promote ThinkGlucose involving clinicians from the programme also took place in Scotland.

Scottish improvement work and the whole civil service in Scotland went through many changes as funding streams were either reduced or refocused, creating uncertainty in the customer base. Relationships have now been strengthened and Worldwide is actively exploring partnership approaches to assist the Scottish health improvement community in developing new approaches to the changing landscape.

Europe and Scandinavia

Work in the Republic of Ireland continued from 2010-11 with the training of two further cohorts of The Productive Operating Theatre practitioners taking place during 2011-12. This is to support the Royal College of Surgeons in Ireland and the Health Service

Executive (HSE) with full country roll out. The Productive Ward was piloted in eight hospitals across the country with the view to full country roll out. Our first year working on the NHS Institute International Fellowship Programme with Waterford Institute of Technology and the Republic of Ireland Health Service Executive was successful. We look forward to the second year of this educational project.

We continued to work closely with our colleagues in NHS Northern Ireland. Activity included further Productive Operating Theatre training and discussions around introducing Productive Community Services and Large Scale Change across the board.

NHS Wales, as well as rolling out many of our Productive Series programmes, implemented ThinkGlucose across one health board in South Wales. We had interest from another Welsh health board for roll out of this programme. The Safer Nursing Care Tool also attracted interest in Wales.

Antwerp University Hospital in Belgium is one year into implementation of The Productive Ward.

Our clients in Sweden have been implementing The Productive Mental Health Ward. We were asked to deliver further training specifically to Stockholm County Council.

Hvidovre hospital was the first hospital in Denmark to implement The Productive Ward programme. From the beginning there was excellent engagement with their senior managers and doctors. Eighteen months on the team was invited to present a series of five posters at a major quality and safety conference held in Denmark in 2012.

Our work within the Netherlands has grown tremendously, with the translation of The Productive Ward into Dutch and the sign up of nine hospitals to the programme.

The NHS Institute entered into a Memorandum of Understanding with ANAP, the Healthcare Improvement institute in France. Based on common aims and similar approaches, ANAP and the NHS Institute believe that short term discussions and sharing of experience between peers may be of benefit. A programme of work to find a delivery partner in France has also been undertaken.

Exploratory talks took place with organisations in Eastern Europe to gauge the suitability of our products within this region.

Australasia

Queensland Health in Australia commenced their state-wide implementation of The Productive Series, with training being held in various locations for The Productive Operating Theatre, The Productive Ward and Productive Community Services.

We engaged with a hospital in New South Wales around The Productive Ward, our first in this state. Work continued country-wide with some hospitals taking up more than one productive programme. Work also commenced at federal level with Health Workforce Australia, and they noted great interest in Helen Bevan's Large Scale Change programmes.

In New Zealand we delivered booster sessions on Productive Community Services, which is running well following its early pilot stages. We are developing a good relationship with the Health Quality and Safety Council who will be taking over the

Management Commentary and Review of Activity *(continued)*

running of the Productive Series programmes within the country. This relationship will also introduce Experience Based Design and Large Scale Change programmes into New Zealand.

There was significant interest in Productive General Practice during the year and work was done to ensure the correct delivery mechanisms are in place.

Canada

Further spread of The Productive Ward in the territory of Manitoba took place in 2011 with the addition of more than 2,000 additional Productive Ward bed licenses.

New relationships were forged and training delivered in British Columbia and Ontario, with British Columbia showing interest in a pilot Large Scale Change programme.

The first formal international contract for the online Sustainability Tool was sold to Toronto.

In addition the NHS Institute provided training and workshops on a range of topics including Experienced Based Design and The Productive Mental Health Ward.

United States of America

Current business development activity in the North Western United States is managed primarily through CareOregon.

Further spread of The Productive Ward continues in Oregon state and beyond, and relations have been further strengthened through the secondment for six months of Lizzie Cunningham, an Associate at the NHS Institute.

Middle East

Qatar purchased The Productive Operating Theatre and training took place in March 2012, with ongoing implementation support planned. It is hoped that a deeper and long lasting relationship will be established with our colleagues from Hamid Medical Corporation.

Other

The Productive Ward was introduced into third sector hospices and work is ongoing to develop offerings within this and the social care sector.

Work was undertaken to use the intellectual property of the NHS Institute within other areas of government, for the benefit of the taxpayer and to bring back learning into the NHS.

Knowledge Management

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

NHS Institute Alert

NHS Institute Alert, a monthly email digest of articles and journals on service improvement and change management, continues to be popular with subscriptions rising to 36,000 per month by March 2012. The service 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 2011-12, 2,366 people comprising mainly NHS staff, joined these seminars. The web seminars covered a broad range of topics including Lean techniques and approaches, Productive Community Services and leading large scale change.

The KM team has supported the implementation and development of a knowledge content management system to classify existing digital assets of the NHS Institute. The system provides a repository of the NHS Institute know-how regarding innovation and improvement in healthcare and is a key element of the legacy from the NHS Institute.

Networks

NHS Live

NHS Live is the NHS Institute's free national learning network. Its online project directory comprises more than 850 frontline improvement projects from across the NHS. During 2011-12 we continued to maintain and update the directory to ensure it is relevant and useful for NHS improvers.

In March 2012, more than 16,000 NHS frontline innovators received the NHS Live monthly newsletter, an increase of over 7,000 people since March 2011. The newsletter included features on popular topics from the NHS Live project directory, information on health promotion events, frontline improvement case stories, free web seminars, and news of the latest tools, products and events from the NHS Institute.

During 2011-12, NHS Live ran a series of free web seminars to help NHS Live members manage their new and existing improvement projects, giving them the opportunity to talk to experts and exchange ideas and challenges with NHS colleagues. In total more than 1,000 frontline staff registered for the seminars which covered:

- an introduction to budgeting and forecasting
- getting funding for your project
- communicating and marketing your project
- project management
- measurement for improvement and return on investment
- partnership working
- an introduction to innovation
- the Productive Leader
- the NHS Leadership Framework and leadership self assessment tool.

NHS Institute monthly e-newsletter

Our monthly e-newsletter keeps our contacts in NHS England and beyond up to date with products, events, tools and news from the NHS Institute. It remains very popular with the distribution increasing from 41,742 in March 2011 to 52,680 by the beginning of April 2012, an increase of 26%.

Social media

During 2011-12 we increased our use of social media, particularly LinkedIn and Twitter. There are a number of LinkedIn groups established for participants in our programmes, including our Leadership programmes and others such as Productive General Practice. The number of followers

Management Commentary and Review of Activity *(continued)*

of the NHS Institute on Twitter increased to more than 3,500 by 31 March 2012 and has since risen to more than 6,000. A number of our senior executives are now regularly tweeting.

Key national events

During the year we attended a number of high profile national conferences, carefully chosen to aid the spread and adoption of our improvement programmes and bring the NHS Institute's work to new people and audiences. Some key events that we attended during the year are:

- NHS Confederation Annual Conference
- International Forum on Safety and Quality in Healthcare
- RCGP Conference
- NHS Alliance Conference
- RCN Congress
- Patient Safety Congress
- NHS Employers
- HFMA Annual Conference
- NAPC Conference.

Director of Corporate Services and Finance Commentary

Financial performance

The accounts on pages 60 to 100 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.

2011-2012 Finances at a glance

This report includes the financial information for the year ended 31 March 2012. The NHS Institute was required to achieve a number of key and statutory financial targets:

- To maintain its revenue expenditure within a limit of £54,158,000. This was achieved.
- The NHS Institute was required to maintain its capital expenditure within a limit of £1,250,000. This was achieved.
- To maintain its net cash outgoings from operating activities within a limit of £54,044,000. This was achieved.
- In addition to the key statutory targets, the NHS Institute is expected to undertake its business in accordance with the Department for Business Innovation and Skills (BIS) payment targets. 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 65% (by value) and 60% (by number) of its non-NHS trade payables within five days. 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 in the goods receipting of purchase orders and approval of invoices. The NHS Institute has maintained the prior years performance levels in overall terms.

Financial Position at 31 March 2012

The financial year 2011-12 once again proved to be a challenging one with continued uncertainty about the future of the NHS Institute having a significant impact on our operations. We started the year with a plan to close the special health authority by 31 March 2012 and were evaluating options for the transfer of many of its frontline support functions into a new more commercially and customer focused business. This closure deadline was initially extended to June 2012, and then in December 2011 it was extended to 31 March 2013.

It has been agreed by the NHS Commissioning Board that there will now be a new Improvement Body that will subsume many of the functions of existing NHS bodies that operate across the improvement landscape, including many of the functions of the NHS Institute. The extension of time before closure is to allow for a managed transition to this new body and an orderly closedown of the special health authority. Plans to convert the NHS Institute to an alternative form in its own right are now on hold. Against this changing backdrop the NHS Institute achieved an underspend against its projected costs of £4.3m, this is explained in more detail below.

Subject to the comments below, during the year the NHS Institute drew down its full resource and 83% of its cash grant funding limit 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.

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

The underspend reported reflects a number of factors:

- Once again the continued uncertainty led to a conscious decision to restrict budgets across the business to create resource headroom to adapt to changing priorities, to allow the NHS Institute to make provisions in the accounts to cover the associated restructuring costs of closure required (in accordance with IFRS) and to provide the necessary funds to enable a smooth transition of the business into successor bodies. A reserve was set aside of £3m for this purpose. This reserve was largely unspent at 31 March 2012.
- During the year the Cabinet Office efficiency restrictions were continued across Government on many categories of expenditure. In particular the restrictions on the use of professional services had an adverse impact on the business. The NHS Institute continued with its strategy to deliver improvement support to the frontline NHS through a series of improvement grants to authorities and trusts. The internal controls and processes established to ensure that grants were properly administered were reviewed and improved and the requirements of Government accounting were met. This led to a delay in the delivery of QIPP support, and during the year some grants had to be recovered from grantees where they were unable to fully utilise the grant in accordance with the grant agreements and within agreed timeframes.
- We saw the uncertainty affect the timing of a number of programmes across the business, which have now been deferred into 2012-13. This includes commercial programmes within our Solutions and Worldwide businesses where both costs and income have been deferred. In addition the changes that occurred within the National Innovation Centre (NIC) in 2011 had an adverse impact on the level of development awards paid out in the year and this is explained fully on page 56.

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

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

Due to the planned closure of the NHS Institute it is not appropriate to adopt the going concern principle in the preparation of these accounts and this is explained more fully in note 1.18 to the accounts.

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

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 required to be transitioned to successor bodies.

The leadership directorate of the NHS Institute transferred to the new NHS Leadership Academy from 1 July 2012. A significant amount of work was completed to ensure that the transfer was done in a robust and orderly manner.

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 and the establishment of the new Improvement Body. This process will continue during 2012-13, and has been set out in more detail within the NHS Institute 2012-13 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 and other priorities in the NHS and activities to facilitate the transfer of functions to the new Improvement Body and other successor bodies. Due to the changing nature of the assumptions on which the plan was written, the plan was revised following the first quarter of 2012-13, as agreed with the Department and the ALB Transition Team.

Remuneration Report – Annual Report and Accounts 2011-12

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 David Bower (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 Head of HR and OD acts as secretary of the Remuneration Committee.

The Accounting Officer 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 executive directors are subject to an appraisal process 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.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 and now via the Department of Health with appointment letters issued by the Secretary of State for Health. The NHS Institute has its own HR service but also obtains guidance and advice when necessary from appropriate sources.

Performance conditions

For all senior managers below executive director level the NHS Institute 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 Department of Health* will usually consider afresh the question of who should be appointed to the office. However, it is likely to consider favourably a second term of appointment without competition for people whose performance has been appraised as consistently good during their first term. If reappointed, further terms will only be considered after open competition, subject to a maximum 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 Department of Health*. Their appointment will also be terminated if, in accordance with regulations they become disqualified for appointment. In addition the Department of Health* 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 (eg a failure to disclose such an interest).

*Formerly arranged by the Appointments Commission.

Remuneration Report – Annual Report and Accounts 2011-12 *(continued)*

The following list provides examples of matters which may indicate to the Department of Health* 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 Department of Health* 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, eg between a chair and a chief executive or between an appointee and the rest of the board.
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 Department of Health* regarding their continued appointment.

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

5. Remuneration

The chair and non-executive members 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 (2011-12) 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.

*Formerly arranged by the Appointments Commission.

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 Department of Health* 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.

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, 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 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 executive director.

*Formerly arranged by the Appointments Commission.

Remuneration Report – Annual Report and Accounts 2011-12 *(continued)*

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

Name	Title	Start Date	Review Date
Rod Anthony	Director of Corporate Services and Finance	1 August 2008	31 March 2013
Helen Bevan	Chief of Service Transformation	1 July 2005	Not applicable
Carol Black	Non-executive Director	15 February 2006	31 March 2013
David Bower	Non-executive Director and Chair of the Remuneration Committee	17 November 2011	31 March 2013
Yve Buckland	Chair	1 July 2005	Left 31 December 2011
Tony Butterworth	Non-executive Director and Interim Chair (wef 1 January 2012)	1 July 2005	31 March 2013
Michael Cawley	Director of Finance and Business Services	1 October 2005	Left October 2011
Richard Colley	Non-executive Director	17 November 2011	31 March 2013
Bernard Crump	Chief Executive	1 July 2005	Left 30 September 2011
Michael Deegan	Non-executive Director	1 July 2005	30 June 2013
Simone Jordan	Chief Operating Officer and Deputy Chief Executive	1 October 2005	On secondment from 23 August 2010
Michael Lander	Non-executive Director	1 March 2009	Left 30 September 2011
Joe Liddane	Non-executive Director and Chair of Audit and Risk Management Committee	1 March 2009	28 February 2013
Julian Nettel	Interim Managing Director	1 July 2011	Left 31 July 2012
Noorzaman Rashid	Non-executive Director	1 October 2007	31 March 2013

Remuneration Report – Annual Report and Accounts 2011-12 *(continued)*

Salaries and Allowances

	2011-12				2010-11			
Name and Title	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 (Chief Executive)	130-135 See note 3	0	3	130-135	165-170	4	7	175-180
Julian Nettel (Interim Managing Director)	85-90 See note 4	0	0	85-90	0	0	0	0
Simone Jordan (Deputy Chief Executive and Chief Operating Officer)	0 See note 5	0	0	0	50-55 See note 5	3	3.7	55-60
Helen Bevan (Director of Service Transformation)	125-130	0	0	125-130	125-130	3	0	125-130
Rod Anthony (Director of Corporate Services and Finance and Accounting Officer)	125-130	0	0	125-130	120-125	0	0	120-125
Yve Buckland (Chair and Chair of Shadow Nominations Committee)	45-50 See note 6	0	0	45-50	60-65	0	0	60-65
Tony Butterworth (Non-executive Director to 31 Dec 2011 and Interim Chair thereafter)	20-25 See note 7	0	0	20-25	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)	0-5 See note 8	0	0	0-5	5-10	0	0	5-10
David Bower (Non-executive Director)	0-5 See note 9	0	0	0-5	0	0	0	0
Richard Colley (Non-executive Director)	0 See note 10	0	0	0	0	0	0	0
See note 11 **Band of highest paid Director's total (£000)**		195-200				165-170		
Median total £		34,348				35,757		
Remuneration ratio		6:1				5:1		

Notes:

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

Remuneration Report – Annual Report and Accounts 2011-12 *(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 2012 (bands of £5,000)	Lump sum at age 60 related to accrued pension at 31 March 2012 (bands of £5,000)	Cash equivalent transfer value at 31 March 2012 £000	Cash equivalent transfer value at 31 March 2011 £000	Real increase in cash equivalent transfer value £000	Employer's contribution to stakeholder pension £000
Bernard Crump (Chief Executive until 30 September 2011)	(0-2.5)	(0-2.5)	65-70	195-200	0 See note 1	1,271	0 See note 1	0
Helen Bevan (Director of Service Transformation)	0-2.5	0-2.5	45-50	135-140	860	759	79 See note 2	0
Rod Anthony (Director of Corporate Services and Finance)	0-2.5	0 See note 3	5-10	0 See note 3	94	58	35 See note 2	0

Notes:

1. No transfer value is available as Bernard Crump retired during the year and is in receipt of his benefits.
2. The factors used to calculate CETVs in 2012 have changed. The new factors are higher than previous factors and it is expected that for some members the CETV will have increased by more than was expected since 31 March 2011.
3. The lump sum is shown as nil as membership is of the NHS Pension Scheme 2008 Section.
4. Simone Jordan commenced a secondment with East Midlands Strategic Health Authority on 23 August 2010 and the pension calculations are fully disclosed in their annual report.

Pension Benefits *(continued)*

Cash Equivalent Transfer Value

A Cash Equivalent Transfer Value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the members' accrued benefits and any contingent spouse's pension payable from the scheme. A CETV is a payment made by a pension scheme or arrangement to secure pension benefits in another pension scheme or arrangement when the member leaves a scheme and chooses to transfer the benefit accrued in the former scheme. The pension figures shown relate to the benefits that the individual has accrued as a consequence of their total membership of the pension scheme, not just their service in a senior capacity to which the disclosure applies.

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

Real Increase in CETV

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

Rod Anthony
Accounting Officer
NHS Institute for Innovation and Improvement
31 October 2012

Accounts

Statement of Accounting Officer's Responsibilities

Under the National Health Service Act 2006 and directions made thereunder by the Secretary of State with the approval of HM Treasury, the NHS Institute 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 Rod Anthony as the interim Accounting Officer for the NHS Institute for Innovation and Improvement 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 and in the case of the NHS Institute management have deemed it inappropriate to presume that the NHS Institute will continue in operation and this is explained more fully in note 1.18 to the accounts.

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

Annual Governance Statement for the year ended 31 March 2012

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 Governance Framework

The governance framework consists of the systems, processes, culture and values by which the NHS Institute is directed and controlled and the activities through which it accounts to and engages with Parliament and the public. It enables the NHS Institute to monitor progress against its strategic objectives and to consider whether those objectives have led to the delivery of its services. The governance framework includes the system of internal control and the risk management processes, including arrangements for information governance. It needs to take account of the environment in which the NHS Institute operates, and the risks it faces.

3. Governance arrangements

In *NHS Institute for Innovation and Improvement – Directions 2005* (and amended 2007), the Secretary of State sets out the functions of the NHS Institute. The *NHS Institute for Innovation and Improvement – Regulations 2005* sets out the membership and procedures of the organisation. The NHS Institute was established 'to support the NHS and its workforce in accelerating the delivery of world class health and healthcare for patients and the public by encouraging innovation and developing capability at the front line' (NHS Institute Framework Document issued by the Secretary of State for Health).

The board of the NHS Institute 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 Interim Managing Director and Accounting Officer is appointed by the chair and the non-executive directors and together they appoint the executive directors. The Interim Managing Director and Accounting Officer left his post on 31 July 2012 and was replaced by Rod Anthony, Director of Corporate Services and Finance.

Annual Governance Statement for the year ended 31 March 2012 *(continued)*

The board's composition at 31 March 2012 was as follows:

Professor Tony Butterworth CBE
– Interim Chair

Professor Dame Carol Black
– Non-executive Director

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

Richard Colley
– Non-executive Director

Michael Deegan CBE
– Non-executive Director

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

Noorzaman Rashid
– Non-executive Director

Julian Nettel
– Interim Managing Director
Left his post 31 July 2012

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

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

The board is supported by:

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

Committees of the Board:

There are four 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 financial 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), Richard Colley 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 39-46.

The Executive Committee

The Executive Committee is responsible for the executive management of the NHS Institute. It comprised of the Interim Managing Director (left 31 July 2012), executive directors, NHS Institute directors and area directors and met weekly throughout 2011-12.

Annual Governance Statement for the year ended 31 March 2012 *(continued)*

New Improvement Body Programme Board

The NHS Institute Change Board ceased as a committee in November 2011 and The New Improvement Body Programme Board was established to create some separation between the day-to-day business of the NHS Institute and those activities associated with creating the new Improvement Body. A new Improvement Body Change Board, external to the NHS Institute, has been established to bring the new body into being.

The NHS Institute Worldwide Shadow board also ceased to exist at the end of November 2011 as it was agreed that it had completed its remit of overseeing the growth of the Worldwide business, which is now becoming mainstreamed within the domestic business. It is considered essential that worldwide and domestic activity is aligned under a common set of purposes as the NHS Institute's transition proceeds further.

Attendance at meetings

All committee meetings during the year were quorate. The Board meeting dates and minutes which include attendance at meetings can be found by accessing **http://www.institute.nhs.uk/organisation/about_nhsi/board_meeting_dates_and_minutes.html**

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 company 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.

Annual Governance Statement for the year ended 31 March 2012 *(continued)*

4. 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 2012 and up to the date of approval of the annual report and accounts, and accords with HM Treasury guidance.

5. 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 NHS Institute's Board Assurance Framework 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 Audit and Risk Management Committee approves the Internal Audit programme of work annually which is flexed as necessary to reflect the changing risks. The results of this work have been reported to the Audit and Risk Management Committee throughout the year and have shown a reliable system of internal control except for some non-compliances with internal control and governance procedures within the National Innovation Centre (NIC) which are highlighted in section 9.

The work plan delivered by Internal Audit included:

- financial systems/financial ledger/financial management
- payroll
- risk management
- grants governance
- guidance on transitional governance arrangements.

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 and management undertaken by the Executive Committee
- regular Audit and Risk Management Committee and Board consideration of key strategic risks
- risk owners being identified across the NHS Institute
- a programme of work to enhance the core financial management system and processes as well as provide for better management information that 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.

Annual Governance Statement for the year ended 31 March 2012 *(continued)*

6. The risk and control framework

Audit and Risk Management Committee

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 and the main risks are detailed on page 8 of the annual report. 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.

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 Committee with particular attention given to the enhanced risks associated with delivering objectives through grant partner organisations
- prioritisation of those risks
- assessing the effectiveness of the mitigation actions
- a programme of presentations by executives to the Audit and Risk Management Committee on key risk areas.

Board Assurance

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.

The Board of the NHS Institute recognises that given the changes affecting the business and the uncertainty about delivery of services through successor bodies, that 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 in relation to 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 respect of ensuring that the grants are used for the purposes 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.

Due to the uncertainty about the future of the NHS Institute, no formal assessment of the Board's effectiveness was completed during the year although this was kept under continuous review.

Annual Governance Statement for the year ended 31 March 2012 *(continued)*

Control environment

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 continued. 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.

It was anticipated that the number of single tender actions would increase towards the end of the financial year and into the new financial year due to the final year of operation as a special health authority and the requirements of transition. Procurement retain oversight over all single tender actions to ensure value for money and an additional control was introduced to obtain agreement from the Chair of the Audit Committee (who would liaise with the other non-executive directors as appropriate) for all single tender actions over £100k.

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

Pension arrangements

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.

Sustainability

The NHS Institute has proactively engaged in strategies to reduce emissions of greenhouse gases, reduce waste, reduce water consumption and make procurement more sustainable, with activities including the creation of a social movement group for sustainability and participation in the NHS day of action for sustainability. It was anticipated that the NHS Institute would include a full sustainability report within the annual report for 2011-12 but this has not been included as the NHS Institute has claimed an exemption due to falling below the threshold for whole time equivalent (WTE) staff of 250 people. This is due to the flexible working arrangements for many staff which mean that at any one time a maximum of 188 people can be working within the NHS Institute offices.

7. Information Governance

Information Governance (IG) within the NHS Institute is a key consideration in the areas of risk management, project appraisal and control/system reviews. 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. Management information provided to the Board is quality assured through joint working between finance and operations.

Annual Governance Statement for the year ended 31 March 2012 *(continued)*

In summer 2011, the NHS Institute took the opportunity to review the approach adopted, levels of compliance achieved and resources invested. In particular the organisational context and role is recognised; the NHS Institute will cease to exist as a special health authority by March 2013 and as a non-frontline organisation the NHS Institute does not hold patient level information. Consequently the new approach balances the importance of information governance against the effective deployment of organisational resources.

The review has included taking advice and receiving recommendations from specialist lawyers and consultants in data protection and information governance. As a result:

- the IG Manager role has been absorbed by a member of the Customer Relationship Manager (CRM) support team
- the scope of the latest version of the NHS Connecting for Health Information Governance Toolkit (IGT) which contains mandatory compliance requirements has been downgraded for submission
- IG training and CRM data cleanses have been re-prioritised
- awareness of information governance has been raised
- a plan has been implemented to raise the current standards.

This will continue through the 2012-13 financial year.

This work has been undertaken with reference to Internal Audit and the IGT v9.0 submission at the end of March 2012 showed an improvement position in comparison to the v8.0 submission.

8. Business Model

During 2011-12, the NHS Institute continued to evolve its business model with a structure capable of adapting easily to change in the medium term with the emphasis on helping our customers to achieve major efficiency savings whilst improving the quality of service across the NHS.

The NHS Institute submitted a business case to the Department of Health in April 2011, requesting approval for the NHS Institute to establish a new Improvement Body as a more independent and commercially focused company. In August 2011, the Department of Health agreed the principle that a new business model was appropriate to the NHS Institute, subject to a number of conditions which would be addressed through developing a detailed implementation plan.

During summer 2011, it became apparent that the emerging needs of the new NHS Commissioning Board would need to be aligned with the proposed new Improvement Body. There was an acknowledgement that the NHS Institute is one of a number of bodies that support innovation and improvement work, but that a single model of transformational change should be led by the NHS Commissioning Board. The successor to the NHS Institute, together with other NHS improvement and innovation focused businesses, would therefore need to be reorganised to support this objective. With the development of this emerging model, it was necessary to reconsider the proposed closure programme for the special health authority, to achieve a greater level of integration between the NHS Commissioning Board's requirements and the new Improvement Body than was originally considered within the business case submitted in April 2011.

Annual Governance Statement for the year ended 31 March 2012 *(continued)*

The Secretary of State approved a revised date for the closure for the special health authority of 31 March 2013. This change will allow for a reasonable timeline to enable a managed closure of the NHS Institute and for the special health authority to meet its obligations relating to delivery responsibilities and transfer of assets and functions where appropriate.

Restricted spend

The Government's efficiency measures and controls which included freezes on external recruitment, the use of consultants and expenditure on marketing and communications also carried over into this financial year and continued to disrupt planned activities and delivery of services.

Grant funding

The NHS Institute once again pursued the alternative model of providing grant funding to enabling partner organisations to achieve their QIPP targets based on provision of improvement grants. Grants were provided to partner organisations based upon 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 again resulted in significant activity in the second half of the financial year, particularly during the final quarter. 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.

With the continuation of the strategy of delivering support to QIPP through the application of improvement grants across the service, together with the likelihood of this approach enduring into a successor to the NHS Institute, the NHS Institute reviewed the controls and operation of the grant awarding and monitoring process. Key enhancements put into place have been greater engagement of the Executive Committee in approving all grants paid and the establishment of a Grant Monitoring Group as a sub group of the Executive Committee to maintain the satisfactory progress and outcomes of grant funded activities.

Independent Assurance

During the year it was noted by Internal Audit that there have been further improvements in our financial control and financial management of the business in another difficult year of uncertainty about the organisation's future. Concerns have been raised over the grants process in the audit completion report and these have been addressed by the actions described in the paragraph above.

In particular, the NHS Institute has taken steps to identify and report on the material financial challenges that the NHS Institute must address in order for the future new Improvement Body to be viable and the Executive Team's remit of committing significant time and energy to dealing with the current uncertain environment needs to be managed so as not to deflect attention from addressing the underlying financial issues.

The programme and strategic risks of transition are reviewed and assessed at every Audit and Risk Management Committee. During this period of change, a greater level of reliance is being placed on robust financial management and control systems to ensure risks are properly understood and are well managed.

In addition, the Audit and Risk Management Committee has received reports and updates from a number of material improvement grants, including presentations from grantees.

Annual Governance Statement for the year ended 31 March 2012 *(continued)*

2012-13 funding

The NHS Institute has had its funding for 2012-13 confirmed and as plans for transition to alternative successor organisations are progressing management considers that it is not appropriate to continue to adopt a going concern basis in the preparation of the annual report and financial statements and has therefore made the necessary adjustments in preparing the annual report and financial statements and this is explained more fully in note 1.18 to the accounts. The NHS Institute 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.

Performance reviews

The NHS Institute used a balanced scorecard approach for the 2011-12 business plan and performance monitoring reports for each of the business areas were based on that framework. Due to the restrictions in place during the course of the financial year, each business area has taken 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.

Each quarter the NHS Institute's performance and risk management are reviewed with the departmental sponsor, who formally writes an accountability review letter to me. I am pleased to say that despite the uncertainties and restructuring, the letters written during 2011-12 have always been very positive and supportive of our work.

9. Review of effectiveness

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

Whilst our head of internal audit has noted the non compliances with internal control and governance procedures, within the NIC he has otherwise concluded that his overall opinion for 2011-12 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 governance 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 65% (by value) and 60% (by number) of its non-NHS trade payables within five days.

Annual Governance Statement for the year ended 31 March 2012 *(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.

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

Control Issue

Our internal assurance processes have brought to light that there have been some non-compliances with internal control and governance procedures within the NHS Institutes National Innovation Centre (NIC) during 2011. These non-compliances are in relation to the management and oversight of a number of development awards paid out by the NIC during 2010 and 2011, and in the application process surrounding a specific EU grant to support the EU Decipher programme.

These non-compliances have been investigated independently of management to determine a complete understanding of the nature of the events and the quantum of any potential financial risk exposures.

A new management team has been established within the NIC and the control and governance arrangements have been reviewed and strengthened to ensure that there is no risk of a re-occurrence.

The NHS Institute has supported internal auditors in a comprehensive review of all development awards paid out during the period in question. This independent review has shown that in many cases it appears that the expected oversight and support to grantees subsequent to the payment of awards was lacking during 2011. The review has, however, shown that awards were used for the purpose of the original grant and that the risk of impropriety or irregularity is very low. The failure of the support and oversight processes may give rise to a risk that value for money can't be secured. Given the inherent risky nature of the innovation projects and the long lead times in bringing ideas to market, it is too early to tell whether this is the case. Assurance has been received from all the projects that the development awards have been applied to the original purpose and that demonstrable benefits have been achieved – for example with the development of working prototypes that are now being tested in the market. The long term benefits derived from launching and delivering innovations into the market will take time to determine.

Having identified these non-compliances and weaknesses, the NHS Institute has improved the control environment and now adopts a more robust approach to the development award process and subsequent oversight and support. A non-executive director with experience in the technology innovation sector is now tasked to provide pro-active support and advice to the management team in the NIC and executive level oversight of the NIC has been strengthened.

The matter of a grant application to the EU in support of the Decipher Programme is still being independently investigated by NHS Protect. No taxpayer or EU funds have been lost and all funds paid out have been recovered. Due to the nature of this investigation we are unable to comment any further. The NIC is no longer engaged with the Decipher programme.

Overview

The Audit and Risk Management Committee has considered the governance and control issues that arise from the

Annual Governance Statement for the year ended 31 March 2012 *(continued)*

planned closure of the NHS Institute as special health authority and the transition of functions to successor bodies. The Committee has also considered the specific transition risks and has made recommendations to the Board which have been accepted.

It is essential that the Committee continues to assess and improve controls even though the special health authority is planned to close. They will ensure that the NHS Institute's control mechanisms are reviewed and updated to address risks as they arise. 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 complies with the Corporate Governance in Central Government Departments: Code of Good Practice 2011 in so far as it relates to the NHS Institute as a Special Health Authority. This statement gives an overview of the governance within the NHS Institute and concludes that there is generally a sound system of governance that supports the achievement of the NHS Institute's policies, aims and objectives.

Rod Anthony

Director of Corporate Services and Finance, and Accounting Officer

NHS Institute for Innovation and Improvement

31 October 2012

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 2012 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 under International Standards on Auditing (UK and Ireland). Those standards require me and my staff to comply with the Auditing Practices Board's Ethical Standards for Auditors.

Scope of the Audit of the Financial Statements

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

I am required to obtain evidence sufficient to give reasonable assurance that the expenditure and income 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 2012 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 thereunder by the Secretary of State.

Emphasis of matter

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

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 Management Commentary for the financial year for which the financial statements are prepared is consistent with the financial statements.

Matters on which I report by exception

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

- adequate accounting records have not been kept or returns adequate for my audit have not been received from branches not visited by my staff; or
- the financial statements 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 Governance Statement does not reflect compliance with HM Treasury's guidance.

Report

In January 2012 the NHS Institute for Innovation and Improvement ('the Institute') advised me that it had identified a potentially serious breakdown of internal control in one area of its operations dealing with grants, which may have put substantial amounts of public funds at undue risk. The Institute reported its concerns to NHS Protect, the provider of counter-fraud services to the NHS, and also commissioned an internal investigation.

The investigation identified significant shortfalls in the control exercised by the Institute over its management and handling of an application it had made to the EU for a funding award for the Decipher programme. The Institute's investigation also identified significant shortfalls in control over its management and oversight of a number of grant awards it had paid out during 2010 and 2011. These control weaknesses have exposed the Institute to an increased risk of financial loss and improper or irregular transactions occurring. In light of these issues, the Institute has since taken steps to strengthen its internal control and governance arrangements.

Through its investigations, the Institute has obtained assurance that these issues have not given rise to any material financial loss. The Institute has obtained assurance that the sums it has paid out as grant awards have been properly applied to the purposes intended and, while doubt as to the achievement of full value for money cannot be ruled out, in each case, the Institute has obtained assurance that some benefit has been obtained from the grant awards paid. The Institute has disclosed this matter in its Governance Statement accompanying these 2011-12 financial statements.

I have considered these issues and the findings of the Institute's investigation and have concluded that there is no impact on my audit opinion on these financial statements, which is unqualified. I note, however, that the grant application to the EU remains under investigation by NHS Protect. I will consider the findings of this investigation as part of my audit of the 2012-13 financial statements, and will consider the need to issue a further report on this matter.

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

5 November 2012

Annual Account of the NHS Institute for Innovation and Improvement for the year ended 31 March 2012

Statement of Net Comprehensive Expenditure for the year ended 31 March 2012

	Notes	2011-12 £000	2010-11 £000
Programme costs	2.2	**56,397**	70,015
Operating income	5	**(6,813)**	(9,776)
Net operating cost		**49,584**	60,239
Net resource outturn	4.1	**49,584**	60,239

All income and expenditure is derived from continuing operations

The notes at pages 66 to 102 form part of these accounts.

Annual Account of the NHS Institute for Innovation and Improvement for the year ended 31 March 2012 *(continued)*

Statement of Financial Position as at 31 March 2012

	Notes	31 March 2012 £000	31 March 2011 £000
Non-current assets:			
Property, plant and equipment	6.1	**459**	368
Intangible assets	6.2	**419**	1,198
Non-current receivables	7.2	**0**	7
		878	1,573
Current assets:			
Receivables	7.1	**3,070**	4,064
Cash and cash equivalents	8	**1,504**	4,086
		4,574	8,150
Payables	9	**(5,938)**	(5,443)
Net current (liabilities)/assets		**(1,364)**	2,707
Non-current assets less net current liabilities		**(486)**	4,280
Non-current liabilities:			
Provisions	10	**(5,859)**	(5,841)
Total assets less total liabilities		**(6,345)**	(1,561)
Taxpayers' equity			
General fund		**(6,345)**	(1,726)
Revaluation reserve		**0**	165
Total taxpayers' equity		**(6,345)**	(1,561)

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

The notes at pages 66 to 102 form part of these accounts.

The financial statements on pages 62 to 65 were considered by the Audit and Risk Management Committee on 25 October 2012.

Rod Anthony
Accounting Officer
31 October 2012

Annual Account of the NHS Institute for Innovation and Improvement for the year ended 31 March 2012 *(continued)*

Statement of Changes in Taxpayers' Equity for the year ended 31 March 2012

		General fund[1] £000	Revaluation reserve[2] £000	Total reserves £000
Balance at 1 April 2010		962	309	1,271
Changes in taxpayers' equity for 2010-11				
Net gain/(loss) on revaluation of property, plant and equipment	6.1	0	37	37
Non-cash charges (cost of capital)		0	0	0
Transfers between reserves		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)
		57,370	0	57,370
Balance at 31 March 2011		**(1,726)**	**165**	**(1,561)**
Balance as at 1 April 2011		(1,726)	165	(1,561)
Changes in taxpayers' equity for 2011-12				
Net gain/(loss) on revaluation of property, plant and equipment	6.1	**0**	**0**	**0**
Transfers between reserves[3]		**165**	**(165)**	**0**
Net operating cost for the year		**(49,584)**	**0**	**(49,584)**
Total recognised income and expense for 2011-12		**(49,419)**	**(165)**	**(49,584)**
Net Parliamentary funding		**44,800**	**0**	**44,800**
Balance at 31 March 2012		**(6,345)**	**0**	**(6,345)**

1 The General fund represents the net assets vested in the NHS Institute for Innovation and Improvement (stated at historical cost less accumulated depreciation at that date), the surplus or deficit generated from notional charges and trading activities and Parliamentary Funding provided.

2 The revaluation reserve contains the equity movement arising from the revaluation of Property, Plant and Equipment.

3 The transfer between reserves relates to the disposal of non-current assets.

The notes at pages 66 to 102 form part of these accounts.

Annual Account of the NHS Institute for Innovation and Improvement for the year ended 31 March 2012 *(continued)*

Statement of Cash Flows for the year ended 31 March 2012

	Notes	**31 March 2012 £000**	31 March 2011 £000
Net cash (outflow) from operating activities	11.2	**(46,532)**	(55,965)
Cash flows from investing activities			
Payments to acquire non-current intangible assets		**(384)**	(668)
Payments to acquire non-current property, plant and equipment		**(466)**	(175)
Net cash (outflow) from investing activities		**(850)**	(843)
Net cash (outflow) before financing		**(47,382)**	(56,808)
Cash flows from financing activities			
Payments in respect of finance leases		**0**	0
Net Parliamentary funding		**44,800**	57,370
(Decrease)/increase in cash and cash equivalents		**(2,582)**	562

The notes at pages 66 to 102 form part of these accounts.

Notes to the Accounts

1 Accounting policies

The financial statements have been prepared in accordance with the 2011-12 Government Financial Reporting Manual (FReM) issued by HM Treasury and in accordance with the National Health Services Act 2006. The accounting policies contained in the FReM apply International Financial Reporting Standards as adapted or interpreted for the public sector context. Where the FReM permits a choice of accounting policy, the accounting policy which is judged to be most appropriate to the particular circumstances of the NHS Institute for Innovation and Improvement for the purpose of giving a true and fair view has been selected. The particular policies adopted are described below. They have been applied consistently in dealing with items that are considered material to the accounts.

1.1 Accounting conventions

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

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

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

1.2 Income

The main source of funding for the NHS Institute is Parliamentary grant from the Department of Health from Request for Resources 1 within an approved cash limit, which is credited to the general fund. Parliamentary funding is recognised in the financial period in which it is received. Income other than Parliamentary grant is shown net of VAT.

Income in respect of services provided is recognised when, and to the extent that performance occurs and is measured at the fair value of the consideration receivable. Operating income relates directly to the operating activities of the NHS Institute. It principally comprises fees and charges for services provided on a full-cost basis to external customers. Where income is received for a specific activity which is to be delivered in the following financial year, that income is deferred.

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

Notes to the Accounts *(continued)*

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 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 at the point at which the grant agreement is signed by the grantee as at this point a purchase order is raised and goods receipted which results in an automatic accrual until the grant is paid. Larger grant payments may be phased through in instalments to ensure that entities do not carry significant cash balances therefore avoiding an inefficient use of public money.

The FReM for 2011-12 contained a change in the interpretation of IAS20 Accounting for Government Grants on the return obligations of grants with conditions. A return obligation does not arise until such time as it is expected that the condition will be breached and a liability is not recognised until that time. An assessment was made by the NHS Institute as at 31 March 2012 as to any grants falling into this category and a small amount of recoveries were accounted for as accrued income within 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.

1.6 Property, plant and equipment

Recognition

Property, plant and equipment is capitalised if:

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

or;

- Collectively, a number of items have a cost of at least £5,000 and individually have a cost of more than £250, where the assets are functionally interdependent, they had broadly simultaneous purchase dates, are anticipated to have simultaneous disposal dates and are under single managerial control.

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

Valuation

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

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

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.

1.7 Intangible non-current assets

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

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

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

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

1.8 Depreciation, amortisation and impairments

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

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

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

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

1.9 Asset Lives

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

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

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

In light of this announcement the NHS Institute has reassessed the asset lives and accelerated the depreciation relating to its property, plant and equipment and intangible assets. The asset lives are now only considered to be one year.

1.10 Contingent Liabilities

A contingent liability is:

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

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

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

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

1.11 Losses and special payments

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

Notes to the Accounts *(continued)*

categories, which govern the way each individual case is handled. Further information can be found at www.hm-treasury.gov.uk.

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

1.12 Segmental analysis

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

1.13 Leases

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

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

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

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

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

1.14 Provisions

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

1.15 Cash and Cash Equvialants

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

1.16 Pension costs

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

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

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

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

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. Actuarial assessments are undertaken in intervening years between formal valuations using updated membership data are accepted as providing suitably robust figures for financial reporting purposes. However, as the interval since the last formal valuation now exceeds four years, the valuation of the scheme liability as at 31 March 2012, is based on detailed membership data as at 31 March 2010 updated to 31 March 2012 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

Notes to the Accounts *(continued)*

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

c) Scheme provisions

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

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

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

Annual increases are applied to pension payments at rates defined by the Pensions (Increase) Act 1971, and are based on changes in retail prices in the twelve months ending 30 September in the previous calendar year. From 2011-12 the Consumer Price Index (CPI) will be used to replace the Retail Prices Index (RPI).

Early payment of a pension, with enhancement, is available to members of the scheme who are permanently incapable of fulfilling their duties effectively through illness or infirmity. A death gratuity of twice final year's pensionable pay for death in service, and five times their annual pension for death after retirement is payable.

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

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

1.17 Financial Instruments

i Financial assets

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

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

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

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

ii Financial liabilities

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

Financial liabilities are initially recognised at fair value.

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

iii Foreign exchange

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

Notes to the Accounts *(continued)*

1.18 Going Concern

The Statement of Financial Position at 31 March 2012 shows a negative £6,345,000 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 2012-13, 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 Interim Managing Director in order to assess organisational performance and make informed decisions. The reportable segments for the financial year 2011-12 remained the same as for 2010-11 with seven reportable segments.

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 provided a range of interventions to help build leadership capability across the NHS. This included:

- The Board Development Team who provided a range of capability programmes for whole boards and individual senior leaders, as well as strengthening the provision of coaching for senior leaders. There was also a focus on building commissioning capabilities;
- International Programmes which offered 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 developed and promoted their work in association with the Academy of Medical Royal Colleges;
- Building Leadership Capacity recruited fresh new talent and developed high calibre individuals into innovative, accomplished leaders through a portfolio of three programmes, each of which uniquely contributed to the NHS talent pool:
  - NHS Graduate Scheme continued to recruit high calibre graduates onto the award winning scheme;
  - Gateway to Leadership attracted talent into the NHS from other sectors by recruiting on its programme;
  - Breaking Through Programme recruited NHS managers from black and minority ethnic backgrounds.

The leadership directorate transferred to the new National Leadership Academy from 1 July 2012.

Notes to the Accounts *(continued)*

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 the Interim Director of Delivery and is supported by the Area Directors. NHS Institute Solutions will build on the support links with stakeholders across the NHS to ensure that what is delivered remains relevant. NHS Institute Solutions will actively engage with the NHS Institute's stakeholders and act on feedback to improve solutions.

Thought Leadership

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

NHS Institute Worldwide

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

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

2.2 Segmental Programme costs for the year ended 31 March 2012

	Notes	Corporate 2011-12 £000	Design 2011-12 £000	Leadership 2011-12 £000	Learning 2011-12 £000	Solutions 2011-12 £000	Thought Leadership 2011-12 £000	Worldwide 2011-12 £000	Total 2011-12 £000	Total 2010-11 £000
Non-executive members' remuneration		124	0	0	0	0	0	0	124	132
Other salaries and wages – staff, seconded, contract and agency	3.1	2,636	2,181	2,144	2,143	3,604	1,097	176	13,981	16,347
Graduate scheme remuneration		0	0	10,220	0	0	0	0	10,220	12,716
Capital: Depreciation and amortisation (owned assets)	6.1, 6.2	694	455	38	185	180	0	7	1,559	2,717
Disposals		80	1	0	0	47	0	0	128	24
Auditors' remuneration:		0	0	0	0	0	0	0	0	0
Statutory external audit fees[1]		66	0	0	0	0	0	0	66	79
Internal audit and counter fraud		64	0	0	0	0	0	0	64	52
Other finance costs:		0	0	0	0	0	0	0	0	0
Bad debt provision[3]		0	0	0	0	0	0	(52)	(52)	39
Foreign currency losses		0	0	0	0	0	0	2	2	0
General losses and fruitless payments[2]		(15)	1	2	(32)	5	8	0	(31)	106
Travel and Subsistence		220	151	743	244	350	125	20	1,853	1,668
Course fees		72	114	3,303	155	33	31	0	3,708	3,350
Contract for services		1,722	85	113	(17)	450	54	125	2,532	1,979
Individual contractors		32	20	127	5	19	0	575	778	1,709
Grants		0	2,195	4,838	1,805	2,584	1,189	0	12,611	9,178
Professional Fees[4]		102	594	541	135	85	229	6	1,692	4,258
Other Programme costs[5]		3,073	577	2,063	764	525	8	152	7,162	15,661
		8,870	6,374	24,132	5,387	7,882	2,741	1,011	56,397	70,015

1 The statutory audit fee for 2011-12 is £66,000.
2 Includes reversal of NHS credit note provision from 2010-11.
3 Includes release of bad debt provision from 2010-11.
4 The NHS Institute has paid out £566k in relation to development awards during 2011-12 (£1,550k 2010-11) and these are shown in the design business directorate as part of professional fees.
5 Other Programme costs mainly consists of ICT related expenditure, in year provisions for restructuring and lease commitments, room hire and conferences.

2.3 Segmental Operating Income for the year ended 31 March 2012

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

	Corporate 2011-12 £000	Design 2011-12 £000	Leadership 2011-12 £000	Learning 2011-12 £000	Solutions 2011-12 £000	Thought Leadership 2011-12 £000	Worldwide 2011-12 £000	Total 2011-12 £000	Total 2010-11 £000
Programme income									
Fees and Charges[1]	51	644	1,850	337	1,103	1,496	816	6,297	8,503
Other	0	0	0	18	498	0	0	516	1,273
Total	51	644	1,850	355	1,601	1,496	816	6,813	9,776

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

Department of Health	0	544	297	120	51	1,445	0	2,457	3,771
Total	0	544	297	120	51	1,445	0	2,457	3,771

1 Fees and charges includes £4,758k (2010-11 £4,450k) in relation to income received to provide funding for specific programmes and £1,539k (2010-11 £2,917k) in respect of services for which a fee is charged.

2.4 Segmental Statement of Net Comprehensive Expenditure for the year ended 31 March 2012

	Corporate 2011-12 £000	Design 2011-12 £000	Leadership 2011-12 £000	Learning 2011-12 £000	Solutions 2011-12 £000	Thought Leadership 2011-12 £000	Worldwide 2011-12 £000	Total 2011-12 £000	Total 2010-11 £000
Programme costs	8,870	6,374	24,132	5,387	7,882	2,741	1,011	56,397	70,015
Operating income	(51)	(644)	(1,850)	(355)	(1,601)	(1,496)	(816)	(6,813)	(9,776)
Net operating cost	8,819	5,730	22,282	5,032	6,281	1,245	195	49,584	60,239

2.5 Segmental Statement of Financial Position year ended 31 March 2012

	Corporate 31 March 2012 £000	Design 31 March 2012 £000	Leadership 31 March 2012 £000	Learning 31 March 2012 £000	Solutions 31 March 2012 £000	Thought Leadership 31 March 2012 £000	Worldwide 31 March 2012 £000	Intercompany adjustment 31 March 2012 £000	Total 31 March 2012 £000	Total 31 March 2011 £000
Non-current assets:										
Property, plant and equipment	433	0	26	0	0	0	0	0	459	368
Intangible assets	190	21	0	191	17	0	0	0	419	1,198
Non-current receivables	0	0	0	0	0	0	0	0	0	7
	623	21	26	191	17	0	0	0	878	1,573
Current assets:										
Receivables	16,775	780	481	158	347	305	446	(16,222)	3,070	4,064
Cash and cash equivalents	1,225	0	0	0	0	0	279	0	1,504	4,086
	18,000	780	481	158	347	305	725	(16,222)	4,574	8,150
Current liabilities:										
Payables	(1,000)	(1,980)	(10,531)	(4,354)	(2,665)	(1,277)	(353)	16,222	(5,938)	(5,443)
Net current assets/(liabilities)	17,000	(1,200)	(10,050)	(4,196)	(2,318)	(972)	372	0	(1,364)	2,707
Total assets less current liabilities	17,623	(1,179)	(10,024)	(4,005)	(2,301)	(972)	372	0	(486)	4,280
Non-current liabilities:										
Provisions	(5,727)	(5)	(112)	(14)	(1)	0	0	0	(5,859)	(5,841)
Total assets less total liabilities	11,896	(1,184)	(10,136)	(4,019)	(2,302)	(972)	372	0	(6,345)	(1,561)
Taxpayers' equity										
General fund	11,896	(1,184)	(10,136)	(4,019)	(2,302)	(972)	372	0	(6,345)	(1,726)
Revaluation reserve	0	0	0	0	0	0	0	0	0	165
	11,896	(1,184)	(10,136)	(4,019)	(2,302)	(972)	372	0	(6,345)	(1,561)

Notes to the Accounts *(continued)*

3.1 Staff numbers and related costs

	2011-12 £000	2010-11 £000
Salaries and wages – staff on the NHS Institute payroll	**8,606**	9,392
Seconded, contract and agency staff	**3,766**	5,509
Salaries and wages – recharges to other NHS organisations	**(365)**	(647)
Social security costs	**870**	877
Employer contributions to NHS Pension scheme	**1,104**	1,216
Total salaries and wages	**13,981**	16,347

	2011-12 Average WTE	Restated 2010-11 Average WTE[2]
Salaries and wages – staff on the NHS Institute payroll[1]	**166.3**	185.4
Seconded, contract and agency staff	**79.7**	93.4
Salaries and wages – recharges to other NHS organisations	**(3.2)**	(5.6)
Total average whole time equivalent (WTE)	**242.8**	273.2

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.
2 The secondee WTE for 2010-11 has been restated to reflect the revised calculation for 2011-12.

3.2 Exit packages for staff leaving in 2011-12

Exit package cost band (including any special payment element)	2011-12 *Number of compulsory redundancies	2011-12 *Number of other departures agreed	2011-12 Total number of exit packages by cost band	2010-11 *Number of compulsory redundancies	2010-11 *Number of other departures agreed	2010-11 Total number of exit packages by cost band
	Number	Number	Number	Number	Number	Number
<£20,001	0	7	7	0	1	1
£20,001 - £40,000	0	2	2	0	1	1
£40,001 - £100,000	0	2	2	0	0	0
£100,001 - £150,000	0	0	0	0	0	0
£150,001 - £200,000	0	0	0	0	0	0
>£200,001	0	1	1	0	0	0
Total number of exit packages by type	0	12	12	0	2	2
Total resource cost (£000s)	0	656	656	0	28	28

Redundancy and other departure costs have been paid in accordance with the provisions of the NHS Scheme except for one employee who left the NHS Institute via the Mutually Agreed Resignation Scheme (2010-11, two employees). This disclosure reports the number and value of exit packages taken by staff leaving in the year and the expense associated with these departures may have been recognised in part or full in a previous period. Where the NHS Institute has agreed early retirements, the additional costs are met by the NHS Institute and not by the NHS pensions scheme. Ill-health retirement costs are met by the NHS pensions scheme and are not included in the table above.

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

3.3 Expenditure on staff benefits

The amount spent on staff benefits to 31 March 2012 totalled £14,106 (2010-11 £33,146).

3.4 Retirements due to ill-health

During 2011-12 there were no early retirements from the NHS Institute on the grounds of ill-health (2010-11 nil).

3.5 Capitalisation of staff costs

No staff costs were capitalised during 2011-12 (2010-11 nil).

Notes to the Accounts *(continued)*

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

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

The Department for Business Innovation and Skills were the governing body for the payment targets during 2011-12 and for 2010-11. The NHS Institute are required to pay all suppliers within five days of receipt of a correctly rendered invoice unless other payment terms are agreed and the above table reports the performance of the NHS Institute against this target during 2011-12.

The NHS Institute has paid 71% (by value) and 60% (by volume) of all invoices within the five day target. 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 in the goods receipting of purchase orders and approval of invoices. The NHS Institute has maintained the prior years performance levels in overall terms.

	Number 2010-11	£000 2010-11
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 NHS Institute did not incur any interest charges during 2011-12 under the Late Payment of Commercial Debts (Interest) Act 1998, (2010-11 £160.10).

4.1 Reconciliation of net operating cost to net resource outturn

	2011-12 £000	2010-11 £000
Net operating cost for the financial year	**49,584**	60,239
Net resource outturn	**49,584**	60,239
Revenue resource limit	**54,158**	67,303
Under spend against revenue resource limit	**4,574**	7,064

4.2 Reconciliation of gross capital expenditure to capital resource limit

	2011-12 £000	2010-11 £000
Gross capital expenditure	**999**	850
Less – Book value of non-current assets disposed	**(128)**	(27)
Adjustment for loss on disposal of non-current assets	**128**	27
Net resource outturn	**999**	850
Capital resource limit	**1,250**	1,240
Under spend against capital resource limit	**251**	390

5 Operating income

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

	2011-12 £000	2010-11 £000
Programme income[1]		
Fees and charges[2]	**6,297**	8,503
Other	**516**	1,273
Total	**6,813**	9,776

1 Included in the above numbers is income received from the Scottish Parliament £73k (2010-11 £469k) and the Northern Ireland Assembly £20k (2010-11 £nil).
2 Fees and charges includes £4,758k (2010-11 £5,586k) in relation to income received to provide funding for specific programmes and £1,539k (2010-11 £2,917k) 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 IFRS 8.

	NHS England extended services £000	NHS Institute Worldwide £000	2011-12 Total £000	2010-11 Total £000
Income	**96**	**1,443**	**1,539**	2,917
Less direct costs and overheads	**14**	**1,301**	**1,315**	1,830
Contribution	**82**	**142**	**224**	1,087
Less apportionment of central overheads	**16**	**141**	**157**	452
Profit	**66**	**1**	**67**	635

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 2011-12.

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, however due to the economic downturn and the closure announcement of the NHS Institute as a special health authority sales for NHS Institute Worldwide have been adversely affected and a break even position has been reported.

Notes to the Accounts *(continued)*

6 Non-current Assets

6.1 Property, plant and equipment

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

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

1 An announcement was made in July 2010 that the NHS Institute would close as a special health authority and in light of this announcement 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 and the affect of this has continued into 2011-12.

2 No indexation has been applied during 2011-12 due to the move to a newly valued premises.

6.2 Intangible assets

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

	Assets under construction £000	Software Licences £000	Information Technology Web based Websites £000	Information Technology Web based Tools £000	Total £000
Gross cost at 31 March 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 and in light of this announcement the NHS Institute has reassessed the asset lives and accelerated the depreciation relating to its intangible assets and the affect of this has continued into 2011-12.

Notes to the Accounts *(continued)*

7 Receivables

7.1 Current receivables

	31 March 2012 £000	31 March 2011 £000
NHS receivables	**1,078**	512
Trade receivables – non-NHS	**636**	741
Allowance for irrecoverable debts	**(153)**	(80)
VAT amount due	**323**	712
Prepayments	**686**	283
Accrued income	**493**[1]	1,885
Other receivables	**7**	11
	3,070	4,064

7.2 Non-current receivables

	31 March 2012 £000	31 March 2011 £000
Prepayments	**0**	7
	0	7

Total receivables	**3,070**	4,071

1 Contained within accrued income is £33k (2010-11 £1,703k) relating to the recovery of Government Grants. The reduction year-on-year is as a result of a change in the interpretation of IAS20 Accounting for Government Grants contained within the FReM for 2011-12 and explained within the grants payable accounting policy.

8 Cash and cash equivalents

	31 March 2011 £000	Change during the year £000	31 March 2012 £000
Cash at the bank	4,086	**(2,582)**	**1,504**
	4,086	**(2,582)**	**1,504**

9 Trade payables and other payables

	31 March 2012 £000	31 March 2011 £000
NHS payables	1,085	1,112
Trade payables (revenue)	2,035	2,162
Tax and social security	0	(1)
Trade payables (capital)	157	8
Accruals	391	287
Deferred income	2,004	1,558
Other payables	266	317
	5,938	5,443

10 Provisions for liabilities and charges

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

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

2 An announcement was made in July 2010 that the NHS Institute would close as a special health authority on 31 March 2012 and this was subsequently extended to 31 March 2013.

In 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 were made during 2010-11 totalling £4.8m. An additional provision of £0.6m has been made during 2011-12 to cover additional redundancies as a result of the transfer of the Leadership directorate from the NHS Institute to the new National Leadership Academy from 1 July 2012.

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

Notes to the Accounts *(continued)*

10 Provisions for liabilities and charges *(continued)*

	Legal claims[1] 2010-11 £000	Restructuring[2] 2010-11 £000	Other[3] 2010-11 £000	Total 2010-11 £000
At 31 March 2010	170	0	820	990
Arising during the year	0	4,870	29	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	4,870	849	5,841

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

2 An announcement was made in July 2010 that the NHS Institute would close as a special health authority on 31 March 2012.

In light of this announcement, and after active engagement with the Department of Health, a detailed plan was put into 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 had been reported as being due within one year, however the extension of the closure until 31 March 2013 means that the majority of payments will be made during the financial year 2012-13.

3 Included in Other provisions is the provision for the restoration of Coventry House to its original condition at the end of the lease period which ended in December 2011 and a provision where the NHS Institute has contracted for services with indirect workers and has provided for tax relating to their employment status.

11.1 Movements in working capital other than cash

	31 March 2012 £000	31 March 2011 £000
(Decrease) in receivables	**(1,001)**	(1,163)
(Increase)/Decrease in payables	**(346)**	4,483
	(1,347)	3,320

11.2 Reconciliation of operating costs to operating cash flows

	31 March 2012 £000	31 March 2011 £000
Net operating cost before interest for the year	**49,584**	**60,239**
Adjust for non-cash transactions	**(1,687)**	**(2,743)**
Adjust for movements in working capital other than cash	**(1,347)**	**3,320**
Increase in provisions	**(18)**	**(4,851)**
Net cash outflow from operating activities	**46,532**	**55,965**

11.3 Reconciliation of net cash flow to movement in net debt

	31 March 2012 £000	31 March 2011 £000
(Decrease)/Increase in cash in the period	**(2,582)**	**562**
Fixed asset additions/disposals	**871**	**823**
Depreciation/impairment/indexation	**(1,559)**	**(2,680)**
(Increase)/Decrease in payables	**(495)**	**4,477**
Decrease in receivables	**(1,001)**	**(1,163)**
Increase in provisions	**(18)**	**(4,851)**
Movement in net debt	**(4,784)**	**(2,832)**

12 Contingent liabilities

At 31 March 2012, there were no known contingent liabilities (2010-11 £nil).

13 Capital commitments

At 31 March 2012, there was one capital commitment amounting to £4k (2010-11 £124k).

14 Commitments under finance leases

At 31 March 2012, there were no known commitments under finance leases (2010-11 £nil).

Notes to the Accounts *(continued)*

15 Commitments under operating leases

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

	2011-12 £000	2010-11 £000
Property rental – including headquarters and other properties	**484**	600
Other operating leases	**15**	27
	499	627

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.

		2011-12 £000	2010-11 £000
Land and buildings	Operating leases which expire:		
	Within 1 year[1]	**357**	217
	Within 5 years	**682**	0
		1,039	217
Other leases	Operating leases which expire:		
	Within 1 year	**0**	9
		0	9

1 The NHS Institute's future commitment under operating leases has been revised for 2011-12 in light of the new lease agreement for i-House based in Coventry meaning that there will now be a lease liability until 2015. The NHS Institute will be liable until 31 March 2013 where upon the future lease commitments will fall to the Department of Health.

16 Other commitments

The NHS Institute has not entered into any additional non-cancellable contracts which are not operating leases (2010-11 £nil).

17 Losses and special payments

During 2011-12 62 cases of losses and special payments were approved totalling £15,857 (in 2010-11 there were 65 cases totalling £36,583). Additionally, 50 exchange rate fluctuations were approved with an overall loss of £2,299. (In 2010-11 34 exchange rate fluctuations were approved with an overall loss of £71).

17.1 Reconciliation of net exchange differences

	31 March 2011 £000	Change during the year £000	31 March 2012 £000
Foreign exchange gains	(8)	**3**	(5)
Foreign exchange losses	8	**(1)**	7
	0	**2**	**2**

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 2011-12 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.

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

Notes to the Accounts *(continued)*

	2011-12 Receivables £000	2011-12 Payables £000	2011-12 Income £000	2011-12 Expenditure £000
Nottinghamshire County Teaching PCT	63			
Nottingham University Hospitals NHS Trust		101		101
Oxford Radcliffe Hospitals NHS Trust		75		
Royal Berkshire Hospitals NHS Foundation Trust		75		
South Central Strategic Health Authority				200
South East Coast Strategic Health Authority				435
South Tees Hospitals NHS Foundation Trust				625
University Hospital of South Manchester NHS Foundation Trust				2,103
West Midlands Strategic Health Authority				117

	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		

	2010-11 Receivables £000	2010-11 Payables £000	2010-11 Income £000	2010-11 Expenditure £000
Mid Staffordshire NHS Foundation Trust				146
Mid Yorkshire Hospital NHS Trust				213
NHS Business Services Authority		83		
NHS North West Leadership Academy				
NHS Pension Scheme (own staff employers & 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	

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.

Notes to the Accounts *(continued)*

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

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

19 Post balance sheet events

The National Leadership Council established the new National Leadership Academy on 1 July 2012 and the NHS Institute's leadership business directorate transferred to the new NHS Leadership Academy at this time.

As discussed in the remuneration report, Rod Anthony was appointed as Accounting Officer on 31 July 2012.

The Secretary of State approved a revised date for the closure of the special health authority of 31 March 2013.

The financial statements were considered by the Audit and Risk Management Committee on 25 October 2012. 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 3rd 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 2012 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 2012		
Denominated in £ Sterling	**3,302**	**3,530**
Other	**93**	**13**
Gross Financial Asset/Liability	**3,395**	**3,543**
At 31 March 2011		
Denominated in £ Sterling	5,943	3,508
Other	39	83
Gross Financial Asset/Liability	5,982	3,591

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	**2011-12**	**2011-12**
Cash at bank and in hand	**1,504**	**1,504**
NHS receivables – net of credit note provision	**1,078**	**1,078**
Trade receivables – non-NHS (net of provision)	**483**	**483**
Other receivables	**330**	**330**
Total at 31 March 2012	**3,395**	**3,395**
Financial liabilities: Loans and Payables		
NHS payables	**1,085**	**1,085**
Trade payables – non-NHS	**2,192**	**2,192**
Other payables	**266**	**266**
Total at 31 March 2012	**3,543**	**3,543**
Financial assets: Loans and Receivables	**2010-11**	**2010-11**
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	2,170	2,170
Other payables	317	317
Total at 31 March 2011	3,599	3,599

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 2012 £000	31 March 2011 £000
Less than one year	3,543	3,591
Total at 31 March 2012	3,543	3,591

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	1,112	0	1,914
Balances with local authorities	324	0	259
Balances with other NHS bodies	186	0	980
Balances with public corporations and trading funds	0	0	0
Sub-total intra-governmental balances	1,622	0	3,153
Balances with bodies external to government	1,448	0	2,785
At 31 March 2012	3,070	0	5,938

	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	7	2,439
At 31 March 2011	4,064	7	5,443

Notes to the Accounts *(continued)*

22 Grant payments

During 2011-12 the NHS Institute granted funds to various organisations in order to support the Department of Health achieving key strategic deliverables such as QIPP. An analysis of the grant payments made is shown below.

22.1 Grant Payments – public sector

	2011-12 £000	2010-11 £000
Basingstoke and North Hampshire Hospital NHS Foundation Trust	**0**	23
Berkshire East Community Health Services	**0**	12
Berkshire West Community Health Services	**0**	12
Berkshire Healthcare NHS Foundation Trust	**0**	23
Buckinghamshire Healthcare NHS Trust	**110**	35
Calderdale and Huddersfield NHS Foundation Trust	**0**	2
Cambridge University Hospitals NHS Foundation Trust	**576**	704
Central Manchester University Hospitals NHS Foundation Trust	**727**	280
Chelsea & Westminster Hospital NHS Foundation Trust	**132**	1,406
Community Health Oxfordshire/Oxfordshire PCT	**0**	23
County Durham and Darlington Foundation Trust	**153**	312
East Midlands Strategic Health Authority	**25**	0
Hampshire Community Healthcare	**0**	23
Hampshire Partnership NHS Foundation Trust	**0**	23
Heatherwood and Wexham Park Hospitals Foundation Trust	**0**	23
Hull and East Yorkshire Hospitals NHS Trust	**775**	0
Imperial College Healthcare NHS Trust	**200**	0
Kettering General Hospital NHS Foundation Trust	**300**	59
Medway NHS Foundation Trust	**0**	401
Mid Yorkshire Hospitals NHS Trust	**0**	244
Milton Keynes Community Health Services	**0**	23
Milton Keynes General Hospital NHS Foundation Trust	**0**	23
NHS Direct	**0**	5
NHS East of England Strategic Health Authority (on behalf of NHS Midlands and East)	**495**	0
NHS Isle of Wight	**0**	35
NHS London Strategic Health Authority	**295**	0
NHS North East Strategic Health Authority	**125**	0
NHS Redbridge	**0**	2
NHS South East Coast Strategic Health Authority	**435**	0
NHS South Central Strategic Health Authority	**200**	0
North Middlesex University Hospital	**0**	57
NHS West Midlands Strategic Health Authority	**125**	0
North West Strategic Health Authority	**0**	1,220
Nuffield Orthopaedic Centre NHS Trust	**0**	12
Oxford Radcliffe Hospital NHS Trust	**0**	160
Oxfordshire and Buckinghamshire Mental Health Foundation Trust	**0**	23

	2011-12 £000	2010-11 £000
Papworth Hospital NHS Foundation Trust	50	0
Portsmouth Hospitals NHS Trust	0	23
Queen Elizabeth Hospital NHS Foundation Trust	0	2
Queen Victoria Hospital NHS Foundation Trust	0	225
Ridgeway Partnership (Oxfordshire Learning Disability NHS Trust)	0	12
Royal Berkshire NHS Foundation Trust	0	23
Royal Surrey County Hospitals NHS Foundation Trust	11	225
Salford Royal NHS Foundation Trust	0	231
Sheffield Teaching Hospitals Foundation Trust	0	16
Solent Healthcare (NHS Southampton City)	0	23
South Tees Hospital NHS Foundation Trust	625	1,044
South West Health Innovation Education Cluster	70	0
Southampton University Hospitals NHS Trust	0	12
Sussex Community Health NHS Trust	40	0
Taunton and Somerset NHS Foundation Trust	0	625
University College London NHS Foundation Trust	37	50
University Hospital of South Manchester Foundation Trust	2,103	0
Weston Area Health NHS Trust	0	50
Winchester and Eastleigh Healthcare NHS Trust	0	23
	7,609	7,749

22.2 Grant Payments – private sector

	2011-12 £'000	2010-11 £'000
Academy of Medical Royal Colleges	0	43
Alzheimer's Society	84	0
College of Emergency Medicine	357	0
National Leadership and Innovation Agency for Healthcare	50	24
North West Employers	323	0
Patient Experience Network	159	0
Royal College of General Practitioners	179	1,979
Royal College of Physicians	752	43
Royal College of Surgeons Edinburgh	0	5
Royal Pharmaceutical Society	68	0
South West Health Innovation Education Cluster	0	662
Thames Valley Health Innovation Education Cluster/Oxford Health NHS FT	0	12
The Kings Fund	0	6
University of Derby	37	65
University of Southampton	0	0
Virtual College	400	0
WESSEX Health Innovation Education Cluster (The University of Southampton)	19	69
West Midlands Health Innovation Education Cluster	1,352	329
	3,780	3,237
Total grants paid	11,389	10,986

Notes to the Accounts *(continued)*

23 IFRS disclosure

23.1 Early adoption of IFRS's, amendments and interpretations

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

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

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

IFRS 7 Financial Instruments: Disclosures

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

IFRS 9 Financial Instruments

A new standard intended to replace IAS39. The effective date is for accounting periods beginning on, or after 1 January 2015.

IFRS 13 Fair Value Measurement

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

IAS 1 Presentation of Financial Statements

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

IAS 19 Employee Benefits

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

IAS 32 Offsetting Financial Assets and Financial Liabilities

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

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

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.

Unless exempt or falling outside the scope of reporting under the Greening Government commitments (or other successor policy), the requirement to produce a sustainability report to be included within the Management Commentary, reporting performance against sustainability targets for greenhouse gas emissions, waste minimisation and management and the use of finite resources and their related expenditure.

Introduction of a Governance Statement to incorporate and replace the current Statement on Internal Control (SIC).

Chapter 11 Income and Expenditure

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

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

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