NHS
Institute for Innovation
and Improvement

A Portrait of Progress —
Annual Report and Accounts of the NHS Institute for Innovation and Improvement 2008 – 2009

Our Vision — Transforming good ideas into workable solutions for the NHS

Our Mission — The NHS Institute for Innovation and Improvement supports the NHS to transform healthcare for patients and the public by rapidly developing and spreading new ways of working, new technology and world-class leadership

Cover image —
Oliver Warren, General Surgery Registrar
Hillingdon Hospital NHS Trust

NHS Institute for Innovation and Improvement — Annual Report and Accounts for the period 1 April 2008 – 31 March 2009

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Introduction and Foreword

We are proud of what has been another hugely successful year for the NHS Institute. We have broadened our offering to the NHS by prioritising safety, continuing our work to deliver world-class commissioning and by developing the leaders of today and nurturing those of tomorrow.

We have also undertaken significant change of our own; our change programme will enable us to be more customer focused and service led. We are also moving to a new way of operating and delivering our products and programmes in a more customer-focused way.

If we look back over some of the key areas of our work, we can see how they are making a real difference thanks to the hard work of our staff and associates. The Leading Improvement in Patient Safety (LIPS) programme has engaged 73 organisations in 2008/09; we are actively working with 105 acute trusts in England on The Productive Ward; The Productive Leader has attracted a great deal of interest with over 1,200 senior leaders and assistants attending three national events to learn how to get started with the programme.

The Delivering Quality and Value team engaged 161,000 doctors in the High Volume Care programme and The NHS Better Care, Better Value indicators have highlighted a productivity improvement opportunity for the NHS of over £3bn. Our leadership programmes continue to thrive and new schemes have been launched and we were delighted to see high levels of top calibre applicants yet again, for our graduate management scheme, which was recognised as number five in The Times top 100 list of graduate schemes.

To ensure we learn not just from each other, we have widened our horizons and engaged specialists from other industries. Aviation has provided us with safety and leadership insights in the past year and has shaped our work around human factors. Our innovation activities and programmes have been enhanced by input from prominent manufacturers and logistics leaders, and with our ability to carefully craft the key messages and translate them into every day language for frontline health teams, we have seen many positive changes which ultimately lead to better patient experiences.

World-class commissioning is a key area of work for 2009/10 and we have taken large strides in 2008 to enable us to deliver. Toolkits have been developed for boards and their organisations, prioritising commissioning opportunities as well as patient pathways, project delivery and strategic implementation. The Patient Pathways Guide alone has been downloaded 3,000 times and we hope this is a springboard towards world-class commissioning status.

Managing our budget wisely and efficiently is essential for the future of the NHS Institute. 2008/09 saw the introduction of the pipeline process which scrutinises product development, potential impact of our products on the NHS and the optimum resource allocation required to unlock maximum value. We will be updating our customers about our pipeline decisions throughout the year and look forward to their input about what will help them meet their national and regional challenges.

We would like to recognise the contribution of two non-executive directors of our board whose terms of office came to an end – Andrew Smith and David Bower – and extend our thanks to them for their unstinting efforts to advance our organisation.
We are pleased to welcome Joe Liddane and Michael Lander to the Board who bring new experience and expertise. Joe, a chartered accountant has wide experience in financial and management consultancy, while Michael is an expert in change management and education.

We are delighted to be working with over 92% of NHS organisations and we want that number to grow alongside our reputation for delivering quality products which have a significant effect for frontline staff, executive teams and, ultimately, patients. The contents of this report demonstrate in more detail many of the significant developments we have delivered this year for the NHS with some excellent case studies. We would like to thank those who have taken part for their contribution. We would urge you to find our more about our work by visiting our website at **www.institute.nhs.uk**

Bernard Crump, Chief Executive
NHS Institute for Innovation and Improvement

Yve Buckland, Chair
NHS Institute for Innovation and Improvement

Management Commentary

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 3 June 2005.

The NHS Institute is established as a special health authority under the National Health Service Act 1977 and is an Arm's Length Body sponsored by the Department of Health.

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

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

Risks

During the last financial year the NHS Institute continued to develop its Risk Management and Assurance Framework. All areas of the business developed a risk register which identified their most significant risks and created action plans to address them. In addition, the board, Audit and Risk Management Committee and executive team developed and reviewed the NHS Institute's Strategic Risk and Assurance Framework.

Internal and external auditors were consulted with in creating the framework and used it to inform their audit approach.

Stakeholder relationships

Last year we worked with NHS organisations to help build capability for transformational change, by using our products and partnerships built through our networks.

NHS 60 engaged over 1,000 staff at July's event, addressed by Lord Darzi. Our relationship with the Institute for Health Improvement in the USA has also been maintained.

Environmental, social and community policies and achievements

We are working to reduce our carbon footprint and contribute to strategies which reduce carbon emissions. As well as operating a cycle to work scheme, we recycle paper, ink cartridges, telephones and plastic.

Our partnerships with local education establishments encourage health and education in the community.

Financial information

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.

Sickness absence data

During the period 2008/09 the following percentages of hours were lost through sickness absences:

Q1	2.90%	Q3	2.31%
Q2	1.86%	Q4	1.76%

Information governance and security

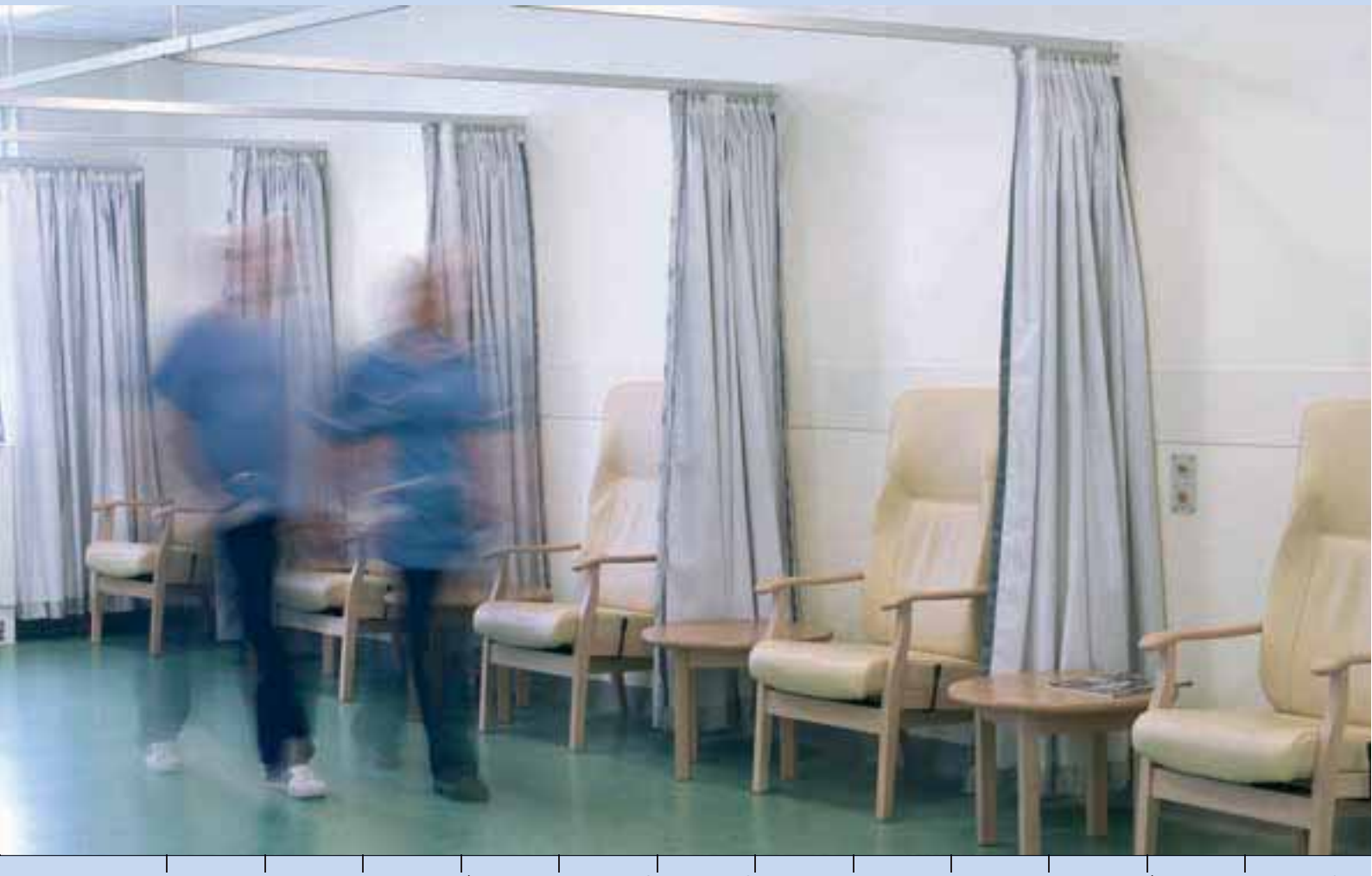
Following a number of high profile incidents of data losses in other public sector organisations last year, the NHS Institute rigorously reviewed its data governance and data security procedures/policies and continues to do so on an ongoing basis. All USB data sticks and laptops in use now come with encrypted technology as part of the standard build/ issue, all policies were reviewed and updated, staff awareness was heightened and training, currently being developed, will be introduced within the next financial year (1st quarter). We have identified all data assets which are undergoing risk analysis and we are introducing centralised access control systems. Work in this important area will be continued through the newly created post of Information Manager.

We are pleased therefore to report that the NHS Institute has had no material security or governance breaches for the period 2008/2009.

As part of our strategy of creating a more customer focused and commercially responsive organisation we are currently reviewing options for a change to a new constitutional form. If and when such a change is implemented, our governance arrangements will need to be modified accordingly.

"The NHS Institute is like Sat Nav. Before that existed you had to do lots of preparation work in advance, printing directions and looking on the map. Then your directions would almost get you there but you would lose your way just before reaching your destination. The Sat Nav just gets you straight there with no preparation, it does all the hard work for you. And that's what the NHS Institute does. It finds the best examples of how things are working across the country and gives you a shortcut so you can go straight to where you are aiming for – better services and better patient care."

Robert Middleton, Consultant Orthopaedic Surgeon
Royal Bournemouth Hospital



2008/09 was a strong year of progress and change

We were rated using 28 high level metrics. Of these, 25 were rated green, two were rated amber and one was rated red. Our green metrics included No Delays Product Uptake, and No Delays Impact and National Impact, Implementation of Cabinet Office Recommendations and NHS Footprint.

The red metric relates to the Better Care, Better Value Indicators – most of the adverse movement can be explained by an increase in activity and improved recording of activity by frontline organisations. We will be moving to a scorecard approach in 2009/10 to provide us with a more flexible approach to measurement.

Some of our key achievements during the last year include:

— working with over 92% of NHS organisations
— launching The Productive Leader
— building on the Communications for Health Improvement programme, including launching the PCT Portal
— we have over 37,000 people registered with our web channel (our target for 2009/10 is to double this)
— developing our 'pipeline' process which scrutinises resources associated with product development and their potential impact. Taking this process forward will be a key focus over the next year to ensure our products have an identified customer need, water-tight business case and maximum impact for the service, thus creating significant public value.

Our 2008 corporate survey of senior stakeholders found that:

— 89% had heard of the NHS Institute
— 78% were aware of at least one of our products
— 43% have had direct contact with us, up from 37% in 2007.

Leadership

This business area at the NHS Institute comprises three main areas: Building Leadership Capacity, Board Level Development and Medical Engagement and International Relations.

Building Leadership Capacity

The NHS Graduate Training Scheme was voted 5th in The Times Top 100 Graduate Employers in 2008, its highest ever placing, and is now the number one scheme in the public sector. Following a successful pilot this year, the informatics scheme will become a full national graduate scheme in July 2009. Applications for the 2009 scheme overall are up by over 95% year-on-year.

The Breaking Through Top Talent programme was launched in 2008, offering high potential leaders from black and minority ethnic schemes the opportunity to gain experience in director level positions for 18 months, supported by a comprehensive development programme.

Board Level Development

A diagnostic instrument was successfully launched for NHS trust boards which assists in identifying specific development needs. During 2008, this was taken up by 29 trusts and 3,000 NHS leaders. In association with Monitor, 2008 also saw the launch of a three-day development programme for non-executive directors from foundation trusts.

Medical Engagement and International Relations

In association with the Academy of Medical Royal Colleges, the NHS Institute has been finalising the approval of the medical leadership and management competency framework with the regulatory and professional bodies i.e. GMC and PMETB.

The National Innovation Centre (NIC)

This strand of the NHS Institute works to bring innovative healthcare technology to the patient. In order to stimulate demand for innovative technology in the NHS, and to help commercial organisations develop products to meet those demands, the NIC works with NHS staff to articulate and validate important clinical needs. Commercial organisations, that have existing or prospective technology to address those needs, can then share their solutions.

Additionally, the NIC supports innovative organisations in creating a solution.

The key achievements over the last financial year:

— developed a comprehensive set of web tools to support innovation development
— achieved ISO9001 accreditation of web-based innovation management tools
— acceptance by DIUS as suitable for use in other government departments
— provided support to ten innovators of cutting-edge device technologies
— development of HCAI isolation technologies in partnership with DH.

Looking forward

In March this year we signed strategic partnership agreements with ten strategic health authorities (SHAs). They have agreed to fund 'NHS-wide' services and products for the next five years which are available to all NHS England staff, along with a broader programme of work for 2009/10.

This will include access to our website and more than 200 of our publications and 300 of our tools for improvement. This is an important landmark which gives us a firm foundation on which to progress.

As we move forward, we are simplifying our offering by grouping them into the following five areas; Delivering Quality & Value, Making Innovation Happen, Safer Care, Productive Series and Commissioning for Health Improvement. Each SHA will choose from this menu, and our activities will increasingly be more commercially focused.

Progressing with our governance arrangements, we have developed a model for our new organisational form which will allow us to trade as a legal entity with the NHS and other types of health economies. We are improving our internal systems with the introduction of a CRM (customer relationship management) system. We are also implementing a new finance management system by Agresso which will allow us to work with a financial model and account for income and expenditure more accurately, and provide staff and customers with management information to run successful organisations.

In 2009/10 our work will touch every NHS commissioning and provider organisation and their board, and tens of thousands of clinicians and frontline staff. We look forward to helping those individuals maximise their impact to improve services and care.

Chief Finance Officer Commentary

The past financial year has been a challenging one which has seen the business respond to achieve all statutory financial targets, as well as building and improving on the previous year's performance. This has delivered the financial investment necessary to achieve our corporate objectives and to put in place improvements to act as foundations for the future.

Financial performance

2008/2009 finances at a glance

During the year ended 31 March 2009 the NHS Institute was required to achieve a number of statutory financial targets:

— to maintain its revenue expenditure within a limit of £80,790,000
This was achieved

— the NHS Institute was required to maintain its capital expenditure within a limit of £2,274,000
This was achieved

— to maintain its net cash outgoings from operating activities within a limit of £81,879,000
This was achieved

— in addition to the key statutory targets, the NHS Institute is expected to undertake its business in accordance with the Better Payment Practice Code. The NHS Institute is required to meet the better payment practice code target of paying all non-NHS trade creditors within 30 days of receipt of goods or a valid invoice (whichever is later) unless other payment terms have been agreed. In this respect the NHS Institute paid 89.7% (by value) and 93.0% (by number) of its non-NHS trade creditors within 30 days of receipt of goods or valid invoice, whichever was the later. This was an improvement on 2007/08 performance

— during the year, the Prime Minister set an additional target for public sector organisations to settle payments to small and medium-sized businesses (SMEs) within a much tighter 10-day target. The systems at SBS were not able to differentiate between SMEs and other businesses, therefore the NHS Institute sought to pay all suppliers as quickly as possible to deliver on this new target.

The accounts on pages 53 to 85 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.

Other matters

Having met its key statutory financial targets for 2008/09, the NHS Institute has delivered the financial investment necessary to support the achievement of its corporate objectives in the year. In addition, work has been completed during the year to make the NHS Institute compliant with the requirements for the introduction of International Financial Reporting Standards with effect from 1 April 2009.

A specific exercise has taken place to review the NHS Institute's fixed assets which has resulted in the recording of some impairments, disposals and a change in the period over which the IT assets are depreciated from five to three years. At the same time, the business has been preparing itself for the significant changes that are likely to be taking place from 1 April 2010. The year has therefore been a particularly challenging one for the organisation.

The implementation of a new finance system, together with associated new processes, which went live on 1 April 2009, has been a major achievement. This will ensure that there remains a continued focus on further developing management information, improved financial controls, strong governance and robust assurance processes that will stand us in good stead for the future, as well as enabling the emerging business as we become much more commercially and customer focused.

How do we become world leaders in innovation in healthcare?

Over the last 60 years, the NHS has become one of the best and most admired healthcare systems in the world. Today, the NHS and its staff have much to be proud of, providing quality care free of charge for all.

The NHS Institute for Innovation and Improvement aims to help NHS organisations meet this challenge by creating innovative and practical tools, systems and training. We create programmes and networks to ensure these products are not only helpful, but also reach the maximum number of NHS staff.

Our efforts are focused on increasing quality of care for patients, through improvement, innovation and working to increase efficiency and value from resources. International interest in our work has increased over the year and demonstrates that health improvement and innovation is a global issue.

Commissioning for Health Improvement

Accelerating the achievement of world-class commissioning is the overall aim of the Commissioning for Health Improvement team.

The team is responsible for developing and refining products that can be used by primary care trusts to speed up their journey towards becoming world-class commissioners. The products are also relevant to strategic health authorities as the regional leaders of the NHS.

The focus for the financial year 2008/09 has been on increasing technical capability for the operational commissioner, developing the skills of senior leaders for working with partners and signposting to relevant support and guidance.

Key achievements in 2008/09:

— launching the PCT Portal
— 600 people signing up to the Turning Data into Information for Improvement programme
— the Strategy Development and Implementation web page achieving 5,000 hits
— over 1,000 downloads of Prioritise Commissioning Opportunities and Project Delivery for Commissioners
— Commissioning Patient Pathways Guide being downloaded around 3,000 times
— nearly 700 users of the online world-class commissioning data packs.

Academy for Large Scale Change

The NHS is ever evolving and to help support high impact changes the NHS Institute has designed the Academy of Large Scale Change. As the first of its kind, the academy is a pioneering initiative to help support NHS leaders create optimal conditions needed to implement major changes across healthcare systems and make them run as smoothly as possible.

The academy focuses on supporting leaders to put into practice their strategic plans in their regional areas, to achieve the best healthcare through transformational change. It provides and stimulates thought leadership, models for change, international debate and sharing of expertise on leading faster and more sustainable change on a large scale.

The programme started in October 2008, and already has 81 of the most influential leaders in the NHS and the department of health involved as members.

Key achievements in 2008/09:

— creating the Academy for Large Scale Change and launching in October 2008
— holding two additional learning events with international leadership in January and February 2009 and ongoing support via a team of expert coaches
— creating and supporting a close community website for information sharing and discussion
— aligning participants' work with emerging policy from the Department of Health
— at the first Academy for Large Scale Change meeting of 2009, 95% said they have been introduced to new concepts and theories, 96% said the event has challenged their thinking/practice (56% strongly agree), 91% said they are well prepared to take the next steps in their LSC efforts.

iLinks

iLinks is a programme which makes NHS Institute for Innovation and Improvement products accessible and easy to use by NHS partners.

It tests out routes of access to NHS Institute resources and ways of delivering the toolkits and training.

Working very closely across NHS organisations, the team has developed a range of tools and approaches to support this.

A Step by Step Guide to Tackling your Challenges

This enables busy staff to get a quick overview of which of the NHS Institute's products can help them tackle some of the challenges they face.

The Handbook of Quality and Service Improvement Tools

A handy guide to the top 75 tools, theories and techniques.

Your Guide to the NHS Institute Tools and Support

This is a guide to the entire range of NHS Institute tools and support. All of which are available to help NHS organisations deliver service improvement.

Using the NHS Institute's 'Work Process Methodology of Designing', test sites were established to identify what delivery approaches make it easy for NHS colleagues to use the NHS Institute's products. This involved working closely with these healthcare providers and examining a range of approaches that the NHS Institute can use to meet their needs, including:

— training and delivery of service improvement tools and techniques
— consultancy support within NHS organisations
— alignment of NHS Institute products into packages.

Key achievements in 2008/09:

— development of a six module foundation programme in service improvement with a full complement of resources
— delivering the programme to 58 clinical staff and managers
— showcasing the NHS Institute products to over 300 NHS staff
— raising awareness and usage of NHS Institute products through providing training.

Practice Partner Network

The Practice Partner Network (PPN) is a group of highly motivated and enthusiastic NHS trusts which help the NHS Institute understand the challenges facing the wider health service.

This helps ensure that our new products are responsive to the needs of trusts, helping them to improve service design and quality. It provides the NHS Institute with an efficient dissemination process which can quickly pilot new products before they are rolled out to the wider NHS to improve patient care.

A special relationship with the network has been built to inform the development of new tools to be used in trusts, with the network being the 'eyes and ears' within the wider health service.

Over the past year, the PPN has grown considerably and has helped to develop a number of the NHS Institute products.

Key achievements in 2008/09:

— helping the development of the Radiology Service Kit
— informing the Think Glucose tool development
— helping to develop Productive Community Services
— helping with the development of the Leading Improvement in Patient Safety (LIPS) programme
— PPN members accessing a number of our events including the Facilitation Skills Crash Course and Clinical Systems Improvement for Theatre Teams.

Satish Rao, Consultant in Paediatric Respiratory Medicine — Birmingham Children's Hospital

Satish Rao is working to transform the sleep service at Birmingham Children's Hospital, with the help of iLinks training from the NHS Institute for Innovation and Improvement.

The sleep service helps children with a range of conditions which are causing them significant sleep problems. Children spend a night at the hospital to take part in a sleep study which allows clinicians to assess what treatment is needed. In some cases this may result in a child's adenoids and tonsils being removed, or in other cases patients may need to use a respiratory machine at home to help them sleep.

Satish said: "We've known for a long time that sleep deprivation in adults affects their quality of work and more recent studies have shown a similar impact for children. Lack of sleep can significantly affect a child's development so it is vital that we address this."

Currently the sleep service conducts around 50 – 60 sleep studies per year and due to capacity can only treat children with obvious and significant sleep problems. Satish aims to transform the service to be more patient-centred, more cost-effective and increase capacity.

"My vision for the service is that eventually it becomes a preventative rather than reactive service. I would like to grow the service so that we can see more patients and reach those with less prominent sleep problems rather than just the worst affected. I would also like to make it a nurse and physio-led service to make it more cost efficient."

In autumn 2008, Satish prepared a business case and was able to secure funding for a dedicated nurse, who will start in spring 2009. During this time Satish was invited to attend a course run by the NHS Institute aimed at helping clinicians transform services.

"The training could not have come at a better time," said Satish. "As a doctor I was not taught how to transform and manage services and I was finding it difficult to know how to do it effectively. If an asthma patient comes to see me, I have a mental checklist to work through but to improve the service as a whole, I had no practical framework to refer to.

"I attended six one-day sessions which have been extremely useful. The training has given me a framework to work to and provided me with practical tools to help me come up with new ideas and develop and measure the service. For example, it has shown me how to involve stakeholders which I would otherwise not have known how to approach.

"We have moved through the 'define and scope' stage and are currently working through 'measurement and evaluation'. We need to understand the scope of the demand and how we can work towards meeting this. The NHS Institute training I received is equipping me with the tools to plan how to radically change the sleep service."

Satish Rao, Consultant in Paediatric Respiratory Medicine
Birmingham Children's Hospital

How do we get maximum value from our resources?

Working wisely and efficiently with resources is essential to delivering the best care for patients. Helping trusts to improve quality while getting the maximum out of their resources is a key aim of the NHS Institute for Innovation and Improvement.

Our frameworks, products and networks help trusts to identify areas for improvement in efficiency and encourage working together to share best practice on using resources most effectively.

We believe that helping NHS organisations unlock maximum value from the resources available will ensure the NHS is a world leader for healthcare.

Delivering Quality and Value

The Delivering Quality and Value programme aims to help improve the efficiency and quality of care across the whole of the NHS.

Helping trusts to look at how they can maximise their resources to bring their services up to the highest level, is central to achieving this. We continuously develop tools to help trusts identify key areas for improvement and provide them with workable solutions so they can measure their success and enhance the care they offer.

Over the past year we have been working to identify how top performing organisations in the NHS deliver the highest quality care with the best use of resources.

Using this best practice, a series of improvement programmes have been developed.

Key achievements in 2008/09:

— the NHS Better Care, Better Value indicators now highlighting a productivity improvement opportunity for the NHS of over £3bn
— 70 NHS organisations joining the High Volume Care Rapid Improvement Programme
— there were 161,000 online doctor interactions with the High Volume Care programme in 2008
— there were 71,799 page views of the High Volume Care website in February 2009 – up 10.23% from November 2008.

The Field Team

We are constantly developing tools for strategic health authorities (SHAs) to help them develop as organisations and help their local trusts improve services. The Field Team helps them to identify areas for service improvement and directs them to the relevant solutions.

Each member of the Field Team has been in a senior management role in the NHS. Their skills and experience, coupled with close relationships with NHS organisations within each SHA area, equips them to recognise the issues they face and how they operate.

Working closely with each SHA means that we have a greater understanding of their organisational requirements and current ways of working. This enables us to suggest the most appropriate solutions for each organisation and to develop further products to meet their needs.

A key achievement during 2008/09 has been:

— running a successful pilot of the Client Relationship Management System, allowing a clear understanding of which NHS Institute teams are working with each NHS organisation.

Delivering Through Improvement

A successful programme of change for improvement needs to be driven forward by highly skilled, effective leadership.

Delivering Through Improvement supports chief executives with their transformational change programme to help them achieve the best possible outcome.

The programme is developed in partnership with the Chief Executives' Network and is responsive to the specific needs of trusts to help them carry out successful transformations. It has reached 36 NHS chief executives from provider organisations so far, meaning that transformational changes across the country are being managed by highly skilled leaders.

The Delivering Through Improvement programme strengthens leadership skills in order to deliver change programmes seamlessly, from developing a vision and strategy, through to implementation. To support transformational change, the programme advises building a strong senior management team and addressing the challenges that will be faced.

Key achievements in 2008/09:

— engaging 18 chief executives with the second Delivering Through Improvement programme
— carrying out workshops on excellent customer care in partnership with O2 and John Lewis
— partnering with Microsoft on succession planning and talent management workshops
— supporting the second cohort of chief executives in developing a transformation vision, strategy and plan through transformation story telling
— helping chief executives build their leadership skills for improvement
— developing chief executives' coaching skills to enable them to coach their own staff to improve their performance.

SHA Joint Improvement Strategy

The SHA Joint Improvement Strategy consists of a network of directors and service improvement leads from all 10 strategic health authorities (SHAs) in England and the NHS Institute. Members work with us continually to influence our portfolio of products and to jointly develop a strategic approach to service improvement.

The network meets on a regular basis to shape the services we provide to ensure they meet the priorities of SHAs and the trusts they work with. Helping to inform new products means that the products we provide are responsive and can help shape services to provide the best care possible for patients.

It provides a chance to share success stories, best practice and demonstrate how each SHA has been implementing products to transform services. This leads to greater cohesion across the NHS, whilst encouraging consistency in approaches to service change and a high level of service quality.

The SHA Joint Improvement Strategy defined and developed the Academy for Large Scale Change, which helps to equip senior NHS and Department of Health managers in their role as strategic leaders of service transformation. More than 80 of the most senior leaders of service improvement in the NHS are members of the academy.

Key achievements in 2008/09:

— defining and developing the Academy for Large Scale Change
— fortnightly 'webex' meetings consistently having high attendance (average 80% SHA representation)
— understanding each of the 10 SHA approaches to improvement and innovation.

Robert Middleton, Consultant Orthopaedic Surgeon — Royal Bournemouth Hospital

The Royal Bournemouth Hospital has transformed its orthopaedic service using the 'Focus On: Primary Hip and Knee Replacement' product, part of a series which aims to improve quality of patient care and create services which offer better value for money.

Consultant Orthopaedic Surgeon, Robert Middleton, led the changes. He convinced the board of the Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust to buy a disused building adjacent to the hospital to set up a specialist hip and knee unit. The building was extensively refurbished and opened in May 2007.

"I wanted to radically improve the effectiveness and productivity of the service. We found the Focus On programme on the NHS Institute's website, and used this as a blueprint to create the changes.

"The NHS Institute's programme provided a strong but flexible approach which we followed to dramatically change the service and patient experience. It gave us practical ways to make improvements which had a real impact. It showed us better ways of organising services and encouraged us to think of different ways to approach things."

The service was measured on a weekly basis to quickly evaluate what progress was being made. Within a few months the changes were showing an increase in productivity and patient satisfaction.

One of the key challenges Robert had to overcome was that many staff were wary or suspicious about the changes. He explains: "To deal with this I looked for individuals who were very enthusiastic. They didn't need to be senior members of the team, they just had to have the passion for bringing about these changes for the benefit of the patients.

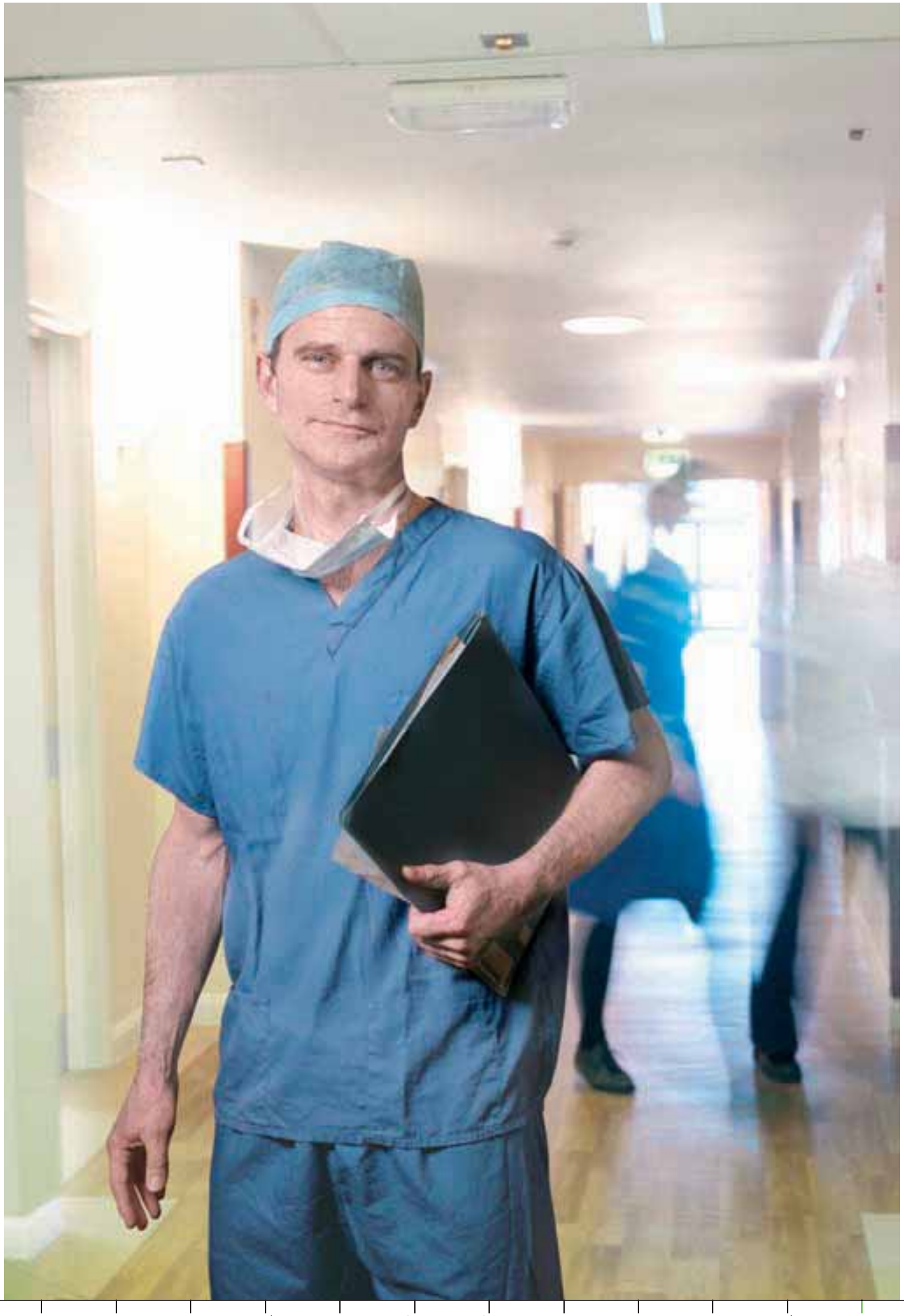
"I tasked members of staff to come up with ideas for their area of the service, which empowered them and encouraged their ongoing support. They also acted as ambassadors, encouraging other staff members to embrace the changes. In a short space of time the results were clear to see. Now the unit is viewed as an extremely desirable place to work and morale is very high."

Over the last 12 months the changes have been cemented and are producing impressive results. The length of stay, for example, has radically improved for hip and knee procedures. The trust was an average performing hospital for stay length, achieving stays around two to four days longer than average at eight days, and is now one of the best performing hospitals in the country, with an average of just 4.4 days.

Other key achievements include:

— re-admission rates were reduced by 50%
— patient satisfaction has increased significantly. One demonstration of this is that now around 30% of patients write a letter of thanks to staff for their care, previously this was just 5%
— productivity has increased – surgeons who previously performed 120 procedures a year can now do 160 (within the same timescales/conditions)
— efficiency and time keeping has improved both in and out of theatre. 98% of staff now leave within ten minutes of their shift finishing. Previously staff could sometimes find themselves working over two hours after their shift should have finished.

During the last financial year, Robert and the team have been taking their story to others in the UK and beyond. In March 2009 the unit won the 'Transforming Services' award from NHS Dorset. Robert has become closely involved with the NHS Institute and has been appointed as clinical lead in hip and knee replacement in England. He now visits hospitals to implement 12-week Rapid Improvement Projects to transform other orthopaedic services.



Robert Middleton, Consultant Orthopaedic Surgeon
Royal Bournemouth Hospital

How can we grow and develop the most effective leaders?

The NHS is one of the world's largest and most complex organisations. We need the very best leaders at all levels to create a world-class service for patients and staff.

We recognise the importance of leaders in delivering quality, raising standards and transforming services. We also understand the huge demands placed on them. Learning and development support is offered to current, experienced leaders as well leaders of the future who are just starting out in their careers. Knowledge, skills and confidence is gained through a range of development opportunities, including education programmes and one-to-one coaching.

Graduate Management Training Scheme

The graduate scheme develops future leaders of the health service, equipping them with the skills and practical experience to build a successful career in the NHS. Four specialisms are now offered in HR, finance, general management and informatics. In 2008 the scheme was re-designed to include a common foundation programme attended by all new participants of the scheme.

The scheme continues to build on its reputation as one of the country's top graduate training programmes.

Key achievements in 2008/2009:

— the scheme rose to fifth place in The Times 2008 Graduate Employment Survey, overtaking the BBC and civil service to be the highest ranking public sector scheme
— the HR specialism of the graduate scheme won the coveted HR Graduate Employer of Choice at The Times Graduate Recruitment Awards 2008; knocking previous winner Marks & Spencer off the top spot, and winning for the third time since the awards were launched in 2004
— the Target Jobs Employer of Choice Graduate Survey 2008, sponsored by Citi, ranked the scheme as second for public sector organisations.

Gateway to Leadership

Gateway to Leadership provides a source of new and diverse talent to the NHS by recruiting aspiring senior leaders from the private sector and other public sector organisations. This outside perspective brings fresh and innovative thinking to healthcare and plays a key role in improving services for patients.

Following a rigorous selection process, successful candidates are placed into middle management positions in local NHS trusts, supported by a learning and development programme over two years.

As well as hiring the best new talent, we work to facilitate candidates' fusion into the health service, enabling them to settle in quickly and effectively. To help NHS organisations utilise this opportunity, we contribute to the cost of employing senior managers through the gateway scheme for the first two years.

Key achievements in 2008/2009:

— recruiting 21 leaders from other sectors onto the 2008 Gateway to Leadership scheme and 30 onto the 2009 scheme
— establishing common learning and development modules to foster closer working relationships with participants on the Breaking Through programme.

Enhancing Engagement in Medical Leadership

The engagement of doctors in leading and managing NHS services is critical for delivering improved services for patients. In their daily work, doctors have opportunities to influence the planning and delivery of care as medical practitioners whilst exercising leadership and management skills.

To support them in this role, we have developed the Medical Leadership Competency Framework which outlines the leadership competencies that doctors require. Aimed at undergraduate and postgraduate medical students, this framework seeks to embed leadership skills and combine them with medical training.

The Medical Leadership Competency Framework has been developed alongside the Academy of Medical Royal Colleges (AoMRC). It also informs training methods to develop required leadership skills, helps identify competency gaps through self assessment and feedback and assists the planning of career progression.

Key achievements in 2008/2009:

— finalising the approval of the Medical Leadership and Management Competency Framework with regulatory professional bodies
— publishing several research documents around developing leadership
— piloting analysis to establish the degree of medical engagement in leadership already
— starting to build leadership into the core medical curriculum.

Breaking Through

The Breaking Through programme helps to ensure the NHS has a diverse and representative workforce at all levels, in particular from black and minority ethnic backgrounds. The focus is on giving aspiring leaders the skills, knowledge and confidence for career progression.

Three distinct programmes are offered and accessed according to need. These are the Transformational Leadership Programme, Towards Strategies For Success and the Top Talent Programme. Each programme contains an education component, often supported by coaching and mentoring. In the case of Top Talent, participants are given the opportunity to spend 18 months in a director level position or equivalent as a means of gaining hands-on experience as a senior leader.

Key achievements in 2008/2009:

— the launch of the Top Talent Programme with 14 participants
— a 40% increase in recruitment onto the 2009 programme
— the appointment of regional co-ordinators to support strategic health authorities' BME development initiatives.

Board Development

At a national level we have been contributing to the design of the new Leadership Council. We have also been providing leadership development support for priorities such as world-class commissioning through a range of tools for NHS organisations to access to support Board development.

Over the last year, our collaboration with NHS regions saw the development and piloting of a development programme for non-executive directors. We have also helped local regions build their own internal coaching capability, as well as continuing to provide one-to-one coaching support for new senior leaders through our coaching faculty. Innovation and improvement has featured strongly in our work with senior leaders. This includes benchmarking against other healthcare systems and working with NHS Institute colleagues on Delivering Through Improvement, a transformational programme for chief executives.

Key achievements in 2008/2009:

— the board diagnostic and development process being rolled out to 29 NHS Trusts
— over 3,000 NHS leaders accessing the Leadership Qualities Framework and the 360 feedback instrument
— over 700 hours of one-to-one coaching being delivered through our coaching faculty.

Chris Burke, Chief Executive — Stockport NHS Foundation Trust

Dr Chris Burke, Chief Executive of Stockport NHS Foundation Trust, has increased the efficiency of the trust's board members and senior managers with the help of The Productive Leader.

Part of The Productive Series, The Productive Leader was developed in 2008 to allow managers and directors to communicate more effectively with each other and work in a more efficient way.

The trust's Stepping Hill Hospital, was a pilot site in 2008, helping shape the programme. Chris explains: "We believed we were working fairly efficiently, but there is always room to improve, so I was intrigued to see how The Productive Leader could help us."

The programme gave the trust clear, simple steps to improve the effectiveness of communication between senior staff and ensure meetings were focused and action orientated.

Chris said: "Previously, meetings could be without focus, people not relevant were sometimes invited, and there was not always sufficient preparation carried out. Emails can easily dominate someone's working life. There's a tendency to either try to react to each one as it appears, or have hundreds sitting in your inbox with no way of effectively dealing with them.

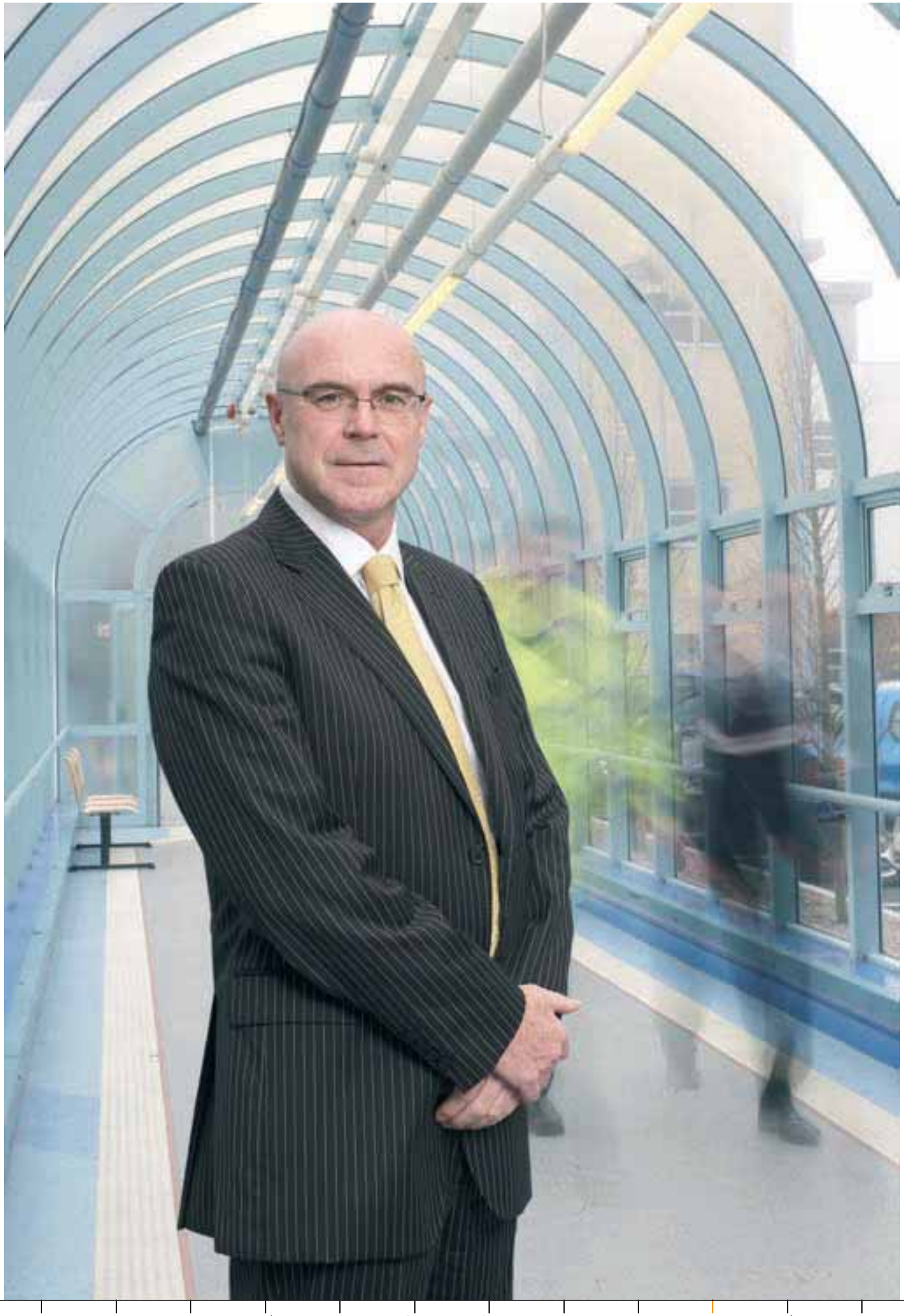
"Since introducing The Productive Leader principles, all our meetings have a clear focus, have actions which are swiftly put in place, and are disciplined in terms of time keeping. We have worked with everyone on emails too. Now people don't just copy everyone in to their emails and they have a clear title, with obvious and realistic actions.

"It has made a huge difference and I am extremely impressed with the product, especially now it has been refined as a result of the findings of the pilots. It represents our efforts across the hospital to improve efficiency and most importantly, the patient experience, through standardising the way we do things."

The trust has also begun to implement The Productive Ward to areas of the hospital with great success. One of the key challenges has been getting staff to sustain the changes in working practice they have learned. It has taken discipline and commitment, but as Chris explains, it brings real benefits: "Underpinning the programme are key modules of development, which equip people with important skills such as action planning. It takes real discipline to sustain the principles, but we continue to put the effort in to keep us on track.

"One of the learnings we fed back at the pilot stage was that initially personal assistants were not included in the programme. This limited the impact of improvements. Now that they are involved they play a key role in the success of how trusts implement the programme and it is helping their personal development too."

In January 2009 Chris delivered a masterclass to NHS leaders in the North West explaining the benefits the initiative can bring. He is a keen advocate of the programme: "Change is always going to make some people wary and getting everyone working to one single structure is a real challenge. But the results are impressive and well worth the effort. It frees up vital time to focus on leading the organisation and delivering the best possible care. We're aiming for excellence as the standard."



Chris Burke, Chief Executive
Stepping Hill Hospital

How can we help the NHS deliver the best possible care for patients?

For the last 60 years NHS staff have worked tirelessly to deliver the best possible care for patients. Increasingly the NHS is looking to involve patients and the public in how we shape the future of our services, and the quality of care is a paramount objective for all.

The NHS Institute for Innovation and Improvement's work helps NHS organisations improve patient safety and the quality of care. Our programmes and products offer practical tools to measure existing services, providing frameworks to bring about change and ideas to involve patients by sharing the advice and experience of others.

Safer Care

Improving the safety of patient care is at the heart of our activities. The team's experienced associates engage with specialist clinicians and frontline staff to deliver world-class programmes and enable shared learning.

NHS professionals have a real desire to improve patient outcomes and are supported by Safer Care through a number of products:

Leading Improvement in Patient Safety (LIPS) programme

This comprehensive programme builds capability and capacity within an acute setting. It enables organisations to record and subsequently improve their safety measures whilst developing priority change processes. We have partnerships with 66 acute trusts which are embedding, as a priority, their patient safety activities into their service improvement agendas.

Improving Safety in General Practice

Whilst patient safety reporting in general practice is a common activity, we are working with 38 GPs on live testing to develop a specific Global Trigger Tool (GTT) for primary care. This will allow more meaningful measurement of harm and give a comprehensive appraisal of each surgery's safety issues for the first time. The relationship and trust between patients and their GP is already very positive, but the GTT and the obvious desire of doctors to gain a clearer understanding of their safety position will add to this confidence.

The Improvement Faculty for Patient Safety and Quality

Improving patient safety and quality of care is the main aim of the improvement faculty. The first wave is now 54-strong and will see the sharing of best practice alongside support from specialists at workshops and events.

Key achievements in 2008/09:

— establishing and delivering successive LIPS programmes for acute trusts – the fourth cohort started in February 2009
— developing and piloting the Global Trigger Tool to measure the rate of harm in general practice. Over 4,600 data entries have been made
— testing a LIPS programme for primary care
— modifying and testing the Global Trigger Tool to measure rate of harm in paediatrics and mental health
— capturing compelling patient stories and hospital case studies of patient safety improvements which can be viewed via the Safer Care web pages
— bringing together 54 senior improvement practitioners from clinical and managerial backgrounds to the improvement faculty, to enhance capability building, knowledge sharing and learning on a peer-to-peer basis
— engaging junior doctors in key areas of safety improvement with development partners, including Salford NHS Foundation Trust, Wigan NHS Trust and the North West Deanery.

Patient and Public Involvement (PPI)

Putting patients and the public at the heart of service improvement helps us to create the best possible services to meet the population's health needs.

We aim to listen to people's experiences and ideas, and transform them into practical solutions, and help keep NHS services flexible and responsive.

In addition we partner with and support the NHS to improve the way that they involve and engage patients and the public. We do this by using a range of programmes including:

Service User Associate Project

This initiative involves service users as part of research teams, working with the NHS Institute and clinical staff to direct new ways of working.

Armchair Involvement

Armchair Involvement places access to NHS service improvement at the fingertips of the public by encouraging service users to share their thoughts, suggestions and experiences through online networks, blogs and new media.

Informed Decisions

The informed decisions projects bring together experts and patients to share experiences and expertise and develop tools to help people make well-informed decisions about their health.

Key achievements in 2008/09:

— developing the Experience Based Design programme
— taking forward Armchair Involvement
— developing the Engaging Children and Young People Rapid Improvement Programme
— encouraging over 2,000 PPI CHAIN members to share learning and updates
— hosting the Department of Health/Strategic Health Authority Patient and Public Involvement Leads Network
— bringing together experts and patients to develop Informed Decisions in Urology and knee tools to support people to make shared decisions about their health.

Experience Based Design

The Experience Based Design (EBD) approach, supports the creation of partnerships that empower patients. It involves patients, carers and staff in re-designing services based on their actual experiences of care pathways by providing a mechanism whereby patients' views can contribute fully to the change process.

The EBD approach provides patients and staff with powerful new tools for improving care in the ways that matter most to the people who use and deliver healthcare services. It is already being used in a wide variety of settings and has led to improvements in dignity, safety, efficiency and timeliness of care.

"The thing that amazed me is how much can actually be achieved – simply because we're working as equals alongside staff, sharing ideas." (Patient).

The EBD approach guide and tools book and a DVD showing how teams have innovatively applied EBD with great results are available now.

Key achievements in 2008/09:

— over 500 people participating in masterclasses to launch The EBD Approach
— a high level of media attention, reaching over 151,000 people through articles appearing in over 12 publications including The Guardian, Health Service Journal, Nursing Times, Healthcare Today and Primary Care Today
— excellent feedback received from users of The EBD Approach.

"Through EBD we're seeing a new dynamic emerge between individual doctors, clinicians and patients. It's different and deeper than anything I've seen before." (Trust CEO).

Chris Billington, Charge Nurse — Blackpool, Fylde and Wyre Hospitals NHS Foundation Trust

Chris Billington, charge nurse at Blackpool Victoria Hospital's A&E department, is helping transform the care of patients admitted with sepsis.

Sepsis is the body's inflammatory response against infection which, in significant cases, can affect the whole body, causing systemic inflammatory response syndrome, which may result in death. In the UK around 36,800 patients die each year from severe sepsis.

The team at Blackpool Victoria Hospital were inspired by the NHS Institute for Innovation and Improvement's 'Surviving Sepsis' campaign, which highlights best practice and puts staff in touch with others who have already made similar improvements.

Chris explains: "Identifying patients with sepsis can be very difficult as staff may not know what to look for. But diagnosing it quickly is crucial – catching it early can minimise the effect it has and can prevent a significant number of deaths."

A&E staff formed an action group and developed the 'sepsis bundle' screening and care pathway, which provides eight clear and simple steps to improving diagnosis and treatment. "The key to its success is how simple and easy it is to follow the process," said Chris.

"We've used guidance from the NHS Institute's website and adapted it to produce our own pathway. All the staff have really got behind it and communicating with them has been key. We want to catch cases right from triage, so everyone plays an important role."

The pathway was introduced in December 2008. While it is very early days, Chris is confident about its future: "It is too early to make any conclusions yet, but we are conducting audits every two months so we can closely track progress. Staff have embraced it and we are refining it as we go along. And we have lots of ideas to adapt it too, such as working with ambulance staff.

"The pathway means better care for patients, as they are both diagnosed and treated in a faster and simpler way. We are excited about the benefits it can bring and hope to roll it out across the hospital once it is fully established."

The initiative is just one element of the trust's drive to improve the quality of care. A quality framework was developed at the end of 2008 and the organisation is aiming to be one of the UK's top performing trusts for patient care and safety.

Chris Billington, Charge Nurse
Blackpool Victoria Hospital

How can we share best practice and celebrate the NHS' achievements?

During the year we have delivered a number of events, the aims of which have been to inspire and inform those working in the NHS. Some of these events are in support of our products, for example the Thinking Differently workshop, and aim to educate about the process of improvement and innovation.

Other events have been about sharing learning and developing networks with an emphasis on best practice. At each of the events we have been involved in, we have encouraged feedback so that we can continually improve delivery for future participants.

Success in healthcare delivery and innovation should be celebrated. The annual Health and Social Care Awards, which we run in partnership with the Department of Health, help us to highlight successful innovative projects from around the country.

Health and Social Care Awards

The Health and Social Care Awards (H&SCA) highlight the excellence in innovation in the NHS and Social Services and are an excellent demonstration of how passionate staff are about embracing innovation and improvement for the benefit of patients.

Staff-led improvements often involve working with local, external organisations to make improvement ideas a reality and the awards recognise these partnerships.

The H&SCA are a joint scheme with the Department of Health and during the year we re-introduced the regional level awards. This was in celebration of the NHS' 60th anniversary and the success of the regional awards has ensured their continuation for 2009/10.

The winners from each of the 14 categories in each strategic health authority region are entered into the running for the national awards, of which there are 14 categories. Last year's national ceremony was held at Wembley Stadium and we were pleased to be joined by the Right Honourable Alan Johnson, Secretary of State for Health and David Nicholson, CEO of the NHS.

National winner 2008 – Service Transformation category

Improving Access to Psychological Therapies Team, Doncaster.

In Doncaster it was recognised that only a small percentage of people with mental health problems were receiving any form of treatment.

A psychological therapy centre was set up by the primary care trust, the mental health trust and local organisations to improve access to mental health services.

In its first 18 months, the service has seen over 5,000 patients and levels of patient satisfaction are high. Staff have benefited from collaborative working and the development of new skills.

NHS Live

NHS Live is our national learning network. It is open to everyone in the NHS and aims to support and encourage innovation by sharing improvement stories from across the NHS. In addition, NHS Live runs a year-round programme of events, both national and regional, to inspire and motivate.

During the last financial year NHS Live ran 21 regional events reaching more than 550 delegates, as well as two successful national events – 'NHS Live: Energising Innovation' in July (see adjacent for more details) and 'Innovation Live' in November. The latter was our first event with NESTA (National Endowment for Science, Technology and the Arts) and saw over 500 delegates attending.

NHS Live has held regional events around the country covering a range of topics. These include a number of extremely successful Thinking Differently events, run in partnership with the Innovation team. Over the last year there has been an increase in the awareness and demand for NHS Live events; regional events are now frequently fully booked within hours of launch.

The NHS Live online project directory has a rapidly expanding number of improvement stories, with 1,026 projects registered on the database.

Other key achievements of the Health and Social Care Awards programme include:

— the launch of the first NHS Live Award programme to support the winner and finalists from the 2008 NHS Live Award at the national Health and Social Care Awards. The programme is an 18-month development opportunity that aims to understand and encourage 'spread' of the award winning projects
— more than 700 applications have been received for the 2009 NHS Live Award
— in addition to those listed above, NHS Live worked in partnership with a small number of strategic health authorities to deliver events. These events were planned following requests from these organisations
— a new seminar called 'Evaluating for Success' was added to the 'For Success' series and 'Finance for Non-financial Managers' was created in response to a need identified by the NHS Live community.

NHS 60

In 2008 we celebrated 60 years of the NHS. This was an excellent opportunity to celebrate the achievements of the last 60 years, while also looking forward to how we can continue to innovate and improve.

NHS organisations across the country held celebrations in their local and regional communities. The NHS Institute's event at Wembley Stadium, run by NHS Live, provided a national focal point for the anniversary. 'Energising Innovation' was held on 1 July 2008 and was attended by over 850 delegates from around the UK.

The event was hosted by Radio Five Live's Victoria Derbyshire. Chief Executive David Nicholson looked back over the achievements of recent years and talked about the changes to come, while Lord Darzi highlighted key themes of his NHS Next Stage Review Final Report. Other inspirational speakers included Don Berwick, President/CEO of the Institute for Health Improvement, percussionist Dame Evelyn Glennie and MP Anne Keen.

The event was a resounding success and delegates found the day both informative and motivating.

How can we find better ways of working?

Every day NHS staff have ideas about improving the care they deliver through better ways of working. Many of the NHS Institute for Innovation and Improvement's products are designed to help frontline staff act on their ideas.

Our practical and pragmatic approaches help develop confidence from the frontline, enabling all staff to play a role in service transformation.

We encourage all staff to think in new ways, challenging existing processes. We show them how to develop their ideas, how to test them out and how to turn them into fully-fledged projects. Working in partnership with NHS organisations around the country, we are helping improve services to meet the challenging demands of the population's health needs.

Thinking Differently

NHS leaders and frontline teams have used Thinking Differently to fundamentally re-think pathways of care and service delivery to not only improve, but transform health services.

Thinking Differently provides a range of tools and techniques to support staff through a process which takes them from the development of ideas right through to implementation and innovation in health services.

"I'm using it all the time now – I can't think of another set of tools that's better at getting ideas and actions out of people." Improvement Leader.

Key successes in 2008/09:

— over 15,000 copies of the book are being used by NHS staff
— over 200 copies have been purchased by organisations outside of the NHS
— nearly 2,500 NHS staff have received master class training in using the concepts, tools and techniques
— Thinking Differently has been translated into Danish for use by improvement teams in Denmark
— a short film made to describe Thinking Differently attracted requests for further information from over 250 viewers on the first day, a level usually only achieved during the first month of release.

The Productive Series

The Productive Series is a range of innovative leadership methods which puts NHS staff at the forefront of re-designing services. Through using the insight and commitment of staff, the schemes improve the quality of care for patients. They are simple to understand, and encourage improved team working and engagement.

Within the series there are three ward-based programmes:

The Productive Ward Releasing Time to Care — improves the efficiency and effectiveness of ward-based care by empowering staff to be more productive. It releases more time for nurses to spend on patient care, creates calmer wards, reduces patient complaints and increases safety.

The Productive Mental Health Ward — delivers the benefits as above in a mental health setting, and also increases therapeutic engagement with patients, reduces patient handover time by a third, and achieves a significant improvement in quality of care.

The Productive Community Hospital — improves the effectiveness, safety, reliability and productivity of the care delivered by community hospitals. The programme has increased the availability of hospital staff to admit patients by between two and ten hours a day.

Key achievements in 2008/09:

— the number of trusts actively working to implement The Productive Ward programmes went from 25% to 70% by February 2009
— a further 15% of trusts have received information about the modules
— real benefits are being seen by hospitals using the schemes. The showcase ward in Portsmouth Hospitals NHS Trust has reported that no patient has developed a pressure ulcer whilst in their care. The trust is also seeing an average reduction of 30% in the patient falls rate for those wards implementing the programme
— another trust has reduced its spending on stock items by 37%
— many trusts, such as Medway NHS Foundation Trust, are showing a reduction in staff sickness absence
— Medway NHS Foundation Trust is just one hospital reporting increased patient satisfaction – on one of its wards, only one written complaint has been received since staff began the programme in January 2008.

The Productive Leader

The Productive Leader focuses the energies of NHS leaders on value-adding activities. It can give leaders back as much as one day a week and their PAs back six hours a week.

Key Achievements in 2008/09:

— staff from 246 NHS organisations have attended a Productive Leader event in the last 12 months
— a further 116 NHS organisations have registered on The Productive Leader website to get started with the programme.

Pilot sites have shown a wide range of improvements, including:

— 70% of meetings starting on time, up from 25%, saving two hours a week
— 60% of meetings have clear, action-focused agenda, up from 10%
— 100% of leaders trained to use email effectively, up from 5%.

Extending the Productive Series

During the last year progress was also made by establishing two new programme areas, both of which will go into the piloting phase in 2009.

The Productive Operating Theatre — aims to give frontline NHS organisations and staff the knowledge and practical tools they need to dramatically improve theatre performance, develop high quality leadership and measure improvements.

Productive Community Services — aims to create an improvement approach for community service providers to make a real difference for patients. It will include an Opportunity Scanner to identify areas to improve and a toolkit to support staff to maximise their time for effective patient care.

"The Productive Mental Health Ward is helping us re-design the way we work so we can spend more time on direct patient care. It helps us look at the systems, processes and care we provide and shows us how to reduce wastage. The programme and the resources available are having a really positive impact and we have already seen many improvements. We are involving users in deciding on the changes, which is leading to improvements in service user satisfaction levels."

Mary Mumvuri, Assistant Nursing Director
South London and Maudsley NHS Foundation Trust

Clinical Systems Improvement

Clinical Systems Improvement (CSI) is evidence-based operations management. It aims to provide a foundation of knowledge and evidence, usually theoretical, to enhance management and transformation techniques.

The knowledge and evidence is adapted to the healthcare setting from systems engineering, psychology and other disciplines and improves clinical processes at the heart of service delivery.

CSI informs the design of processes to improve health outcomes by reducing delays and avoiding wasting time and resources.

To help build capability, we are also supporting the establishment of a National Centre for Clinical Systems Improvement at Warwick University. This has developed CSI capability in the NHS, making it more evenly spread across the country and enabling a greater knowledge base for service re-design.

We have also worked with individual NHS organisations to help them identify how they can use CSI training to accelerate quality improvement, and provide world-class patient care.

Key achievements in 2008/09:

— 150 NHS staff have been trained in using CSI tools and techniques through the national centre
— a number of targeted CSI courses have been developed and delivered to NHS organisations
— CSI courses have been customised for operating theatre teams
— master classes have been developed for chief executives and medical directors
— bespoke CSI courses have been developed to support key products including The Productive Ward which has reached 900 members of staff.

Social Movement Thinking

Social Movement Thinking is a new approach to large scale transformation which engages staff at grassroots level, motivating them to support and implement changes.

This approach aims to build energy and momentum behind change, focusing on practical, staff-led transformations rather than classic, framework-driven approaches.

Over the last 24 months, we have been working with academics from University College London, around the practical application of social movements at NHS field test sites.

The work with the field test sites has shown that this approach can energise and mobilise staff, empowering them to take action, raise morale and increase positive thinking, foster creativity and lead to achievements benefiting both patients and staff.

Many NHS leaders are becoming increasingly aware of the benefits of applying social movement theory to drive change. Feedback from programme participants demonstrates how effective the approach is in practically transforming care.

A new publication 'The Power of One, The Power of Many: Bringing Social Movement Thinking to Health and Healthcare Improvement' represents almost seven years of research by NHS Institute staff and our academic partners. It investigates how social movement thinking can be incorporated into healthcare improvement practice to create more effective, compelling, and faster change for patients and the public.

We are currently working on another publication: 'Social Movement Principles for Courageous Healthcare Leaders', which will form part of the resources for supporting large scale change across Strategic Health Authorities.

Mary Mumvuri, Assistant Nursing Director — South London and Maudsley NHS Foundation Trust

Assistant Nursing Director Mary Mumvuri has been improving inpatient services at South London and Maudsley NHS Foundation Trust with the help of The Productive Mental Health Ward.

The trust has 70 hospital-based wards and community units, and cares for mental health service users across three main hospitals – Bethlem, Lambeth and Maudsley.

The programme aims to improve the efficiency and effectiveness of ward-based care by empowering frontline staff to be more productive and improve the quality of care. It features a number of leadership, foundation and process modules, as well as web resources, practical tools and case studies.

Mary explained: "We are working hard to improve the quality of care across the trust. We began implementing The Productive Mental Health Ward – Releasing Time to Care in late 2008 because we realised it could help us achieve our vision."

Ward managers were asked to apply to be part of a pilot and six wards were chosen. Funding was then secured from NHS London to recruit two full-time improvement facilitators who joined in November 2008. A range of staff attended training run by the NHS Institute for Innovation and Improvement to learn how to implement the modules, and teams visited hospitals in Nottingham and North Staffordshire to see first-hand how the programme could work.

"One of the key drivers for us was that we wanted to spend more time caring for service users," said Mary. "After all, that's why we got into the job in the first place. The NHS Institute programme has really helped because it looks at the systems, processes and care we provide and shows us how to reduce wastage. It is helping us re-design the way we work to spend more time on direct patient care.

"Even though we are only in the early stages we have already seen many improvements. For example, on one ward the amount of time spent on direct care has risen from 25% to 40%. We are protecting time with service users and reducing interruptions. In one case, we have reduced the number of interruptions from 464 to 65 over a five month period.

"And we are involving users in deciding on the changes. It's all leading to improvements in service user satisfaction levels."

Raising staff morale is also a key part of the programme. By introducing a debrief at the end of each shift, staff are able to discuss any problems and talk through their concerns. Staff are asked to rate their stress levels as red, amber or green at the end of their shift. During the last two months there has been a significant reduction in stress levels, as well as a reduction in staff sickness and absence.

Mary said: "The programme and the resources available are having a really positive impact. Ultimately, it's the staff who make these changes happen and our staff are working incredibly hard."

Mary Mumvuri, Assistant Nursing Director
Maudsley Hospital

How can we equip staff with the skills and knowledge to maximise their impact?

We are working with partners to embed innovation in the development of all NHS staff, from future leaders through to colleagues working on the frontline.

This includes providing access to healthcare knowledge and evidence, supporting skills development, introducing relevant networks to share best practice and encouraging research projects into innovative ways of working.

We also work to support role development in the NHS; helping staff to maximise their capability and manage their workload more effectively. This puts innovation into the hands of those who can practically transform patient care.

National Library for Health

Delivering high quality care requires a huge wealth of knowledge support. The National Library for Health (NLH) provides a bank of health knowledge to help individuals make the informed decisions and deliver the most appropriate care and advanced services.

The NLH aims to be 'the best, most trusted health-related knowledge service in the world'. With over one million customers a month, the library works to provide an innovative, skilled and technology-enabled service to all.

The Library is currently involved in a change programme which is committed to modernising NHS information services and making it as easy to access as possible.

NLH reached its tenth birthday in March 2009 and has now been incorporated into the National Institute for Health and Clinical Excellence, where it has been re-named NHS Evidence.

NHS Institute Fellowship Scheme

The NHS Institute Fellowship Scheme accelerates the development of future leaders in innovation and service improvement.

The scheme aims to equip the participants with the knowledge, skills and networks to enable them to implement innovation in their work.

The fellows are from diverse backgrounds in healthcare, and current fellows have roles in medicine, nursing, microbiology, librarianship, management and pharmacy.

During the fellowship period, participants undertake a number of training activities. These are aimed at developing an in-depth understanding of improvement science as well as participating in personal development initiatives to help them become effective change agents.

Over the past year, fellow projects have included: addressing the unnecessary weekend admission of patients with abdominal pain, robotic testing for MRSA and reducing medicine administration errors.

Past fellows have continued to work with us this year, contributing to the delivery of the Leading Improvement in Patient Safety and Commissioning for Health Improvement programmes as well as working with our human resources team to help the NHS Institute become a healthier workplace.

The main achievement of the NHS Institute Fellowship Scheme in 2008/09 is the recruitment of six new fellows from over 80 applications.

Workforce Matters

Workforce Matters is a new programme designed to help staff across the NHS develop their roles to maximise their improvement capability.

The professional development programme highlights the benefits of role re-design, such as how to manage an increased workload and personal development opportunities.

We have developed this programme with the help of human resources managers from NHS East Midlands. It is responsive to the needs of primary care trusts and foundation trusts to help them build greater capability across the workforce.

To achieve this, the programme includes suggestions for group projects, master classes, reflective practices and personal development opportunities.

Key achievements in 2008/09:

— generation of significant interest from the Department of Health about the programme
— adoption by a second SHA and generation of interest from a third
— receipt of interest to run a second programme in the East Midlands
— influenced the development of the assurance framework for world-class commissioning
— generating coverage in the Chartered Institute of Personnel and Development (CIPD) journal 'People Management'
— working with the CIPD to develop the NHS perspective on the behaviours for future HR leaders
— inspiring the development of a doctorate programme in strategic human resources and workforce development with Skills for Health and King's College, London.

How can we use skills and experience from other sectors?

We form effective partnerships with the private and other sectors to maximise our support to the NHS. Working with innovative companies, the aim is to bring the most advanced healthcare innovations and technologies to the frontline; giving patients the best care available.

Recognising that we don't want to be reinventing the wheel, partnerships with other sectors enable us to look at innovation and development from an alternative perspective, finding ideas that can be adopted and adapted for healthcare.

National Innovation Centre

The National Innovation Centre (NIC), hosted by the NHS Institute for Innovation and Improvement, brings the latest advances in healthcare technology to the NHS.

The NIC works closely with the private sector to speed up the development of new, innovative products to meet the needs of the NHS.

This means working with private companies that have a solution, or partnering with innovative organisations to develop a bespoke solution to a healthcare problem or need.

Working with frontline staff, the NIC helps to identify the need for new technology solutions to help deliver the safest and most efficient care for patients.

Partnerships with private companies allow the NIC to utilise the sector's specialist skills, knowledge and latest technology innovations, to help the NHS deliver world-class care for patients.

With support from the Department of Health (DH), academia and the NHS, the NIC recently launched the Innovation Management Process. This framework helps innovators to manage the development of products, making them a reality. The management process is available on and offline, and showcases success and good ideas.

The NIC established two new hubs, adding to the nine regional Innovation Hubs, which focus specifically on facilitating technology development and adoption, by working at a more grassroots level.

The Innovation Hubs primarily support trusts and their staff to identify and develop innovations that will benefit patients. It also facilitates the commercialisation of innovations coming out of the NHS, including supporting staff who have a pre-market product and protecting their Intellectual Property.

The Adoption Hub — engages NHS trusts to encourage uptake of the latest products and procedures available through the NIC. The hub improves the understanding of how technologies are adopted and has produced several guides on the process. It also maps out the 'Technology Adoption Landscape' to help trusts identify where they can use innovations.

The Training Hub — is based at Chelsea and Westminster NHS Trust and works with universities and industry to recognise and create advanced training programmes using technology from the emerging technologies sector.

Key achievements in 2008/09:

— providing support to ten innovators of cutting-edge device technologies
— developing healthcare associated infection isolation technologies in partnership with the Department of Health
— developing a comprehensive set of web tools to support innovation development
— acceptance of programmes by the Department for Innovation, University and Skills as suitable for use in other government departments
— achieving ISO9001 accreditation for web-based tools.

Dan Daly, Director —
Lein Applied Diagnostics Ltd, Reading

Dan Daly of Lein Applied Diagnostics has been working with the National Innovation Centre (NIC) to develop an innovative non-invasive glucose test for people with diabetes.

Part of the NHS Institute for Innovation and Improvement, the NIC works with private companies to support them in developing healthcare innovations.

Dan is developing a hand-held glucose meter which will transform the lives of around 2.5 million people in the UK who have diabetes. The meter, which will have the look and feel of a mobile phone, is held up to the eye and uses a beam of light to test the person's glucose levels. This is more convenient and pain-free compared to the traditional finger prick method.

"We set up the company six years ago, after developing products in the optical telecommunications industry," explained Dan. "Our vision was to apply the same technologies to a healthcare setting.

"We realised that we could develop a product to radically change the way diabetes sufferers check their glucose levels. The current method of taking a finger prick and then testing the blood is painful, time-consuming and very inconvenient, especially when you bear in mind that some people with diabetes have to check their glucose levels several times each day."

The National Innovation Centre has played a key role in helping the company to take the product from the initial idea, through to the prototype stage, and through initial clinical testing. Dan said: "We've had a lot of support from the National Innovation Centre in taking the development forward. They've put us in touch with relevant clinical experts, have made valuable contacts within the wider NHS and have given us financial support to conduct clinical trials and develop the components necessary to make the device smaller.

"Their help has been key in driving the innovation forward and we hope to take the meter to the market in about two years' time. Our vision for the product is to make life easier for the many people who have diabetes by giving them a pain-free and no-fuss way to check their glucose levels."

Dan is a keen advocate of the support the National Innovation Centre provides to companies. "I would definitely recommend using the help available through the centre. Many companies believe it is almost impossible to break into the NHS, due to its scale and complexity, but the National Innovation Centre gives you a way in and a first point of contact which is invaluable."

Dan Daly, Director, Lein Applied Diagnostics
University of Reading

Governance Structure

Governance Arrangements

In 'NHS Institute for Innovation and Improvement – Directors 2005' (and amended 2007), the Secretary of State sets out the functions of the NHS Institute. The 'NHS Institute for Innovation and Improvement – Regulations 2005' sets out the membership and procedures of the organisation.

The NHS Institute was established 'to support the NHS and its workforce in accelerating the delivery of world-class health and healthcare for patients and the public by encouraging innovation and developing capability at the frontline' (NHS Institute Framework Document issued by the Secretary of State for Health).

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

The board's composition at 31 March 2009 was as follows:

Dame Yve Buckland	Chair and Chair of Shadow Nominations Committee
Mike Collier CBE	Vice-chair and Chair of the Audit and Risk Management Committee
Professor Dame Carol Black	Non-executive Director
Professor Tony Butterworth CBE	Non-executive Director and Chair of the Remuneration Committee
Mike Deegan CBE	Non-executive Director
Michael Lander	Non-executive Director
Joe Liddane	Non-executive Director
Noorzaman Rashid	Non-executive Director
Professor Bernard Crump	Chief Executive Officer
Simone Jordan	Executive Director (Chief Operating Officer and Deputy Chief Executive)
Paul Allen	Executive Director (Director of Leadership Development)
Dr Helen Bevan OBE	Executive Director (Chief of Service Transformation)
Rod Anthony	Executive Director (Acting Chief Finance Officer)

The board is supported by Julian Denney, Company Secretary.

Committees of the Board

There are three formal committees of the NHS Institute Board.

The Audit and Risk Management Committee

The Audit and Risk Management Committee routinely meets bi-monthly and is responsible to the board for developing and overseeing effective arrangements for all aspects of internal control and financing reporting within the NHS Institute. As part of this remit it is also responsible for maintaining an appropriate relationship with external and internal auditors. As such, the committee is the principal body, below the board, for carrying out scrutiny of policy and processes within the NHS Institute. It is this remit which distinguishes the work of the Audit and Risk Management Committee from the other groups advising the board. Core members are: Mike Collier (Chair) and Noorzaman Rashid. Andrew Smith was a core member until his resignation in January 2009 and has been replaced by Joseph Liddane. 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 46-49.

The Shadow Nominations Committee

This Committee was created in March 2009. Its role is to work with the Appointments Commission in relation to the process for the appointment of all non-executive directors of the NHS Institute (including the chair), to oversee the process for the appointment of all executive directors (including the Chief Executive) of the NHS Institute and all directors of wholly owned subsidiaries of the NHS Institute (including the chair and chief executive), and to make recommendations to the NHS Institute board in respect of appointments to NHS Institute board committees. Members are: Dame Yve Buckland (Chair), Mike Collier and Professor Tony Butterworth.

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.

Bernard Crump, Chief Executive and Accounting Officer
NHS Institute for Innovation and Improvement
10 June 2009

Remuneration Report —
Annual Report and Accounts 2008 – 2009

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

The NHS Institute has a Remuneration Committee consisting of non-executive directors David Bower (chair) covering the period April 2008 to November 2008 who was then succeeded by Tony Butterworth as Chair; Professor Dame Carol Black and Mike Deegan.

All other non-executive directors have a standing invitation to attend. The chief executive, the deputy chief executive/chief operating officer and the board secretary are also in attendance.

The committee meets as required and its remit is to:

1. Establish procedures for developing policy on Executive and senior staff remuneration
2. Recommend to the Board terms of service and remuneration for the chief executive, executive directors and senior staff
3. Ensure that appropriate systems and processes are in place for job evaluation, individual performance appraisal and contractual arrangements for senior staff.

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

— Very Senior Managers (VSM) Pay Framework (VSMPF)

All other staff

— Agenda for Change.

The NHS Institute falls into category 2 of the VSM Pay Framework and executive directors are subject to an appraisal process (agreed by the Department of Health) which supports the requirements of the VSM Pay Framework.

All senior managers below executive directors are subject to the arrangements required by Agenda for Change and the Knowledge and Skills Framework.

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

The NHS Institute has its own HR service but also obtains its guidance and advice from the Department of Health when required.

Performance conditions

For all senior managers below executive director level the NHS Institute complies with and follows the procedures as set out in the NHS National Terms and Conditions of Service – Agenda for Change and has in place a personal objective-setting process with line managers which links into the annual appraisals and review process and supports the Knowledge and Skills Framework.

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

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

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

Terms and Conditions

1. Statutory Basis for Appointment
   Chairs and non-executive members of Special Health Authorities hold a statutory office under the National Health Service Act 1977. Their appointment does not create any contract of service or contract for services between them and the Secretary of State or between them and the Special Health Authority. The appointment and tenure of office of chairs and members of the NHS Institute for Innovation and Improvement are governed by the NHS Institute for Innovation and Improvement Regulations 2005.

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

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

4. Termination of appointment
   Regulation 5 of the Regulations sets out the grounds on which the appointment of the Chair and non-executive members may be terminated. A Chair or non-executive member may resign by giving notice in writing to the Secretary of State or the Appointments Commission. Their appointment will also be terminated if, in accordance with regulations they become disqualified for appointment. In addition the Appointments Commission may terminate the appointment of the Chair and non-executive members on the following grounds:
   - — if it is of the opinion that it is not in the interests of the NHS Institute or the health service that they should continue to hold office
   - — if the chair or non-executive member does not attend a meeting of the special health authority for a period of three months
   - — if the chair or non-executive member does not properly comply with the requirements of the regulations with regard to pecuniary interests in matters under discussion at meetings of the special health authority (e.g. a failure to disclose such an interest).

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

a) If an annual appraisal or sequence of appraisals is unsatisfactory

b) If the appointee no longer enjoys the confidence of the Board
c) If the appointee loses the confidence of the public
d) If a chair appointee fails to ensure that the Board monitors the performance of the special health authority in an effective way
e) If the appointee fails to deliver work against pre-agreed targets incorporated within their annual objectives
f) If there is a terminal breakdown in essential relationships, e.g. between a chair and a chief executive or between an appointee and the rest of the board
g) When a new chair is appointed to a board he/she will be expected to review the objectives of all board members and may, at the time of their next appraisal, make a recommendation to the Commission regarding their continued appointment
h) 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 (2008/2009) of remuneration payable to the chair of the NHS Institute for Innovation and Improvement is £62,117 pa for up to three days a week. The current rate of remuneration payable to members is £7,765 pa for approximately two days per month with an additional £5,176 pa for the chair of the Audit and Risk Management Committee.

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

8. Allowances
Chairs and non-executive members are also eligible to claim allowances, at rates set centrally, for travel and subsistence costs necessarily incurred on special health authority business.

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

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

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.

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 annual salary, an entitlement to a lease car and eligibility to claim allowances for travel and subsistence costs, at rates set by the NHS Institute for expenses incurred necessarily on its behalf. Executive directors acting in an interim capacity are normally appointed on the basis of a fixed term agreement. They are not entitled to a lease car or performance related award but would be entitled to all other allowances and benefits.
2. **Termination of appointment**
   On the grounds of incapacity of an executive director, the NHS Institute will give six months' notice once sick pay has been exhausted. The notice for termination for any other substantive reason is six months. One payment of £20,000 was made to an executive director for early termination during the 2008–09 financial year. There is no provision for compensation included in the NHS Institute's Annual Accounts for the early termination of any executive director.

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

Name	Title	Start Date	Review Date
Yve Buckland	Chair	1 July 2005	30 June 2009
Mike Collier	Vice-chair and Director of Audit and Risk Committee	1 October 2005	30 September 2009
Carol Black	Non-executive Director	15 February 2006	14 February 2010
David Bower	Non-executive Director	1 July 2005	Left 30 November 2008
Tony Butterworth	Non-executive Director	1 July 2005	30 June 2012
Michael Deegan	Non-executive Director	1 July 2005	30 June 2009
Andrew Smith	Non-executive Director	15 February 2007	Left 1 February 2009
Noorzaman Rashid	Non-executive Director	1 October 2007	30 September 2011
Joe Liddane	Non-executive Director	1 March 2009	28 February 2013
Michael Lander	Non-executive Director	1 March 2009	28 February 2013
Bernard Crump	Chief Executive	1 July 2005	Not applicable
Simone Jordan	Deputy Chief Executive and Director of Learning	1 October 2005	Not applicable
Paul Allen	Director of Leadership	1 September 2005	Not applicable
Helen Bevan	Director of Service Transformation	1 July 2005	Not applicable
Michael Cawley	Director of Finance and Business Services	1 October 2005	On secondment from 1 August 2008
Roderick Anthony	Acting Chief Finance Officer	1 August 2008	1 October 2009
Maire Smith	Director of Technology and Product Innovation	1 September 2005	Left 31 January 2009

Salaries and Allowances

The following sections provide details of the remuneration and pension interests of the most senior officials in the NHS Institute and are subject to audit.

	2008/2009			2007/2008		
Name and Title	See note 1 Salary (bands of £5,000) £000	Other remuneration (bands of £5,000) £000	Benefits in kind £000	Salary (bands of £5,000) £000	Other remuneration (bands of £5,000) £000	Benefits in kind £000
Bernard Crump (Chief Executive)	175-180	0	5	160-165	0	4
Simone Jordan (Deputy Chief Executive and Chief Operating Officer)	130-135	0	5	115-120	0	4
Helen Bevan (Chief Officer Service Transformation)	130-135	0	0	120-125	0	0
Maire Smith See note 2 (Director of Technology and Product Innovation)	100-105	100-105	1	115-120	0	0
Michael Cawley (Director of Finance and Business Services)	35-40 See note 3	0	2	110-115	0	4
Paul Allen (Director of Leadership)	115-120	0	0	110-115	0	0
Roderick Anthony (Acting Chief Finance Officer)	80-85 See note 4	0	0	0	0	0
Yve Buckland (Chair and Chair of Shadow Nominations Committee)	60-65	0	0	60-65	0	0
David Bower (Non-executive Director)	5-10 See note 5	0	0	5-10	0	0
Tony Butterworth (Non-executive Director)	5-10	0	0	5-10	0	0
Mike Collier (Vice-chair and Chair of Audit Committee)	10-15	0	0	10-15	0	0
Michael Deegan (Non-executive Director)	5-10	0	0	5-10	0	0
Noorzaman Rashid (Non-executive Director)	5-10	0	0	0-5 See note 6	0	0
Carol Black (Non-executive Director)	5-10	0	0	5-10	0	0
Andrew Smith (Non-executive Director)	5-10 See note 7	0	0	5-10	0	0
Joe Liddane (Non-executive Director)	0-5 See note 8	0	0	0	0	0
Michael Lander (Non-executive Director)	0-5 See note 9	0	0	5-10	0	0

Notes:

1. Executive directors' salaries included non-consolidated, non pensionable performance related elements.
2. Maire Smith left her post on 31 January 2009. In addition to basic salary, other contractual remuneration and benefits in kind received during the year, she also received an additional payment of £20,000 (included in other remuneration) on termination of her contract.
3. Michael Cawley left his post on 31 July 2008 on secondment to East Midlands Strategic Health Authority.
4. Roderick Anthony commenced his post on 1 August 2008.
5. David Bower left his post on 30 November 2008.
6. Noorzaman Rashid commenced his post on 1 October 2007.
7. Andrew Smith left his post on 31 January 2009.
8. Joe Liddane commenced his post on 1 March 2009.
9. Michael Lander commenced his post on 1 March 2009.

Pension Benefits

Name and Title	Real increase in pension at age 60 (bands of £2,500)	Real increase in pension lump sum at age 60 (bands of £2,500)	Total accrued pension at age 60 at 31 March 2009 (bands of £5,000)	Lump sum at age 60 related to accrued pension at 31 March 2009 (bands of £5,000)	Cash equivalent transfer value at 31 March 2009 £000	Cash equivalent transfer value at 31 March 2008 £000	Real increase in cash equivalent transfer value £000	Employer's contribution to stakeholder pension £000
Bernard Crump (Chief Executive)	0-2.5	5-7.5	55-60	175-180	1,204	888	294	0
Simone Jordan (Deputy Chief Executive and Chief Operating Officer)	2.5-5 See note 1	12.5-15 See note 1	20-25	80-85	485	314	159	0
Helen Bevan (Chief Officer Service Transformation)	0-2.5	5-7.5	35-40	115-120	708	508	187	0
Maire Smith (Director of Technology and Product Innovation)	0-2.5	2.5-5	5-10	15-20	0	0 See note 2	0	0
Michael Cawley (Director of Finance and Business Services)	0-2.5	0-2.5	20-25	60-65	323	244	17	0
Paul Allen (Director of Leadership)	0-2.5	2.5-5	5-10	15-20	102	55	45	0
Roderick Anthony (Acting Chief Finance Officer)	0-2.5	See note 3	0-5	See note 3	11	0	0	0

Notes:

1. Member purchasing additional years at own cost.
2. The CETV as at 31 March 2008 has been re-stated as it was provided in error by the NHSPA and subsequently disclosed in the 2007–08 remuneration report.
3. The lump sum is shown as nil as membership is of the NHS Pension Scheme 2008 Section.

Pension Benefits

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.

It is not possible for a pension member to have a CETV if they are a member of the 1995 Section of the NHS Pension Scheme and over the age of 60.

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

Real Increase in CETV

This reflects the increase in CETV effectively funded by the employer. It takes account of the increase in accrued pension due to inflation, contributions paid by the employee (including the value of any benefits transferred from another scheme or arrangement) and uses common market valuation factors for the start and end of period. There was a change in the factors used to calculate CETV as a result of the Occupational Pension Scheme (Transfer Value Amendment) regulations coming into force on 1 October 2008. These placed responsibility (following actuarial advice) for the calculation method for CETV on pension scheme managers or trustees. Further regulations from the Department of Works and Pensions to determine CETV from Public Sector Pension Schemes came into force on 13 October 2008.

Disclosure of relevant audit information

As Accounting Officer I confirm that:

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

Bernard Crump, Chief Executive and Accounting Officer
NHS Institute for Innovation and Improvement
10 June 2009

Accounts

Statement of Accounting Officer's Responsibilities

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

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

In preparing the accounts, the 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
— prepare the financial statements on a going concern basis, unless it is inappropriate to presume that the NHS Institute will continue in operation.

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

Statement on Internal Control for the year ended 31 March 2009

1. Scope of responsibility

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

2. The purpose of the system of internal control

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

- identify and prioritise the risks to the achievement of departmental policies, aims and objectives
- evaluate the likelihood of those risks being realised and the impact should they be realised
- 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 2009 and up to the date of approval of the annual report and accounts, and accords with Treasury guidance.

3. Capacity to handle risk

My opinion on the existence of a system of internal control is based on evidence primarily provided to me from oversight by the Audit and Risk Management Committee. It is informed by the work of External and Internal Audit together with the work that has been undertaken in maintaining and updating the Assurance Framework for the NHS Institute and monitoring the key risks within that framework. The results of work undertaken by Internal Audit have been reported to the Audit and Risk Management Committee throughout the year and have shown a good system of internal control. Responsibility for overall oversight of the work, on behalf of the Board, remains with the Audit and Risk Management Committee. The NHS Institute demonstrates leadership and a positive approach to risk management through:

- the identification of key risks through the business planning process
- risk assessment workshops involving the executive team
- regular Audit and Risk Management Committee and Board consideration of key strategic risks
- the recruitment of staff to ensure the NHS Institute is able to manage the risks it faces
- a programme of control and process work that supports and develops the NHS Institute's existing business model. 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. Programmes of training have been provided to all staff in relation to health, safety and fire risks.

Statement on Internal Control for the year ended 31 March 2009 (continued)

4. The risk and control framework

The Audit and Risk Management Committee is responsible for reviewing risk management activity under delegation of the Board. It receives regular reports from the internal auditors and will receive an annual management letter from the external auditors, together with information from other sources deemed necessary for the committee to fulfil this function. The 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 review and assurance mechanisms identifying where gaps in control and/or assurance exist.

Throughout the year, the Audit and Risk Management Committee has been informed about the ongoing maintenance of the Assurance Framework and Strategic Risk Register. This has involved:

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

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

5. Data Security

Each unit in the NHS Institute has identified its information assets, has been trained in the importance of considering the likelihood and impact of risks to those assets, and has developed documented action plans to mitigate those risks. Remaining higher level risks are highlighted centrally. Processes have been established to review the status and action plans on at least an annual basis.

6. Review of effectiveness

As Accounting Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review is informed in a number of ways. The head of internal audit provides me with an opinion on the overall arrangements for gaining assurance through the Assurance Framework and on the controls reviewed as part of the internal audit work. His overall opinion for 2008/09 was of significant assurance, and this was confirmed in the work and comments of external audit. Executive managers within the organisation who have responsibility for the development and maintenance of the system of internal control provide me with assurance. The Assurance Framework itself provides me with evidence that the effectiveness of controls that manage the risks to the organisation achieving its principal objectives have been reviewed.

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

These reviews highlight the need to continue to assess controls. They will ensure that the NHS Institute's control mechanisms are reviewed and updated to address any risks that arise from any such changes. Responsibility for oversight of this work, on behalf of the Board, remains with the Audit and Risk Management Committee.

Statement on Internal Control for the year ended 31 March 2009 (continued)

7. Other Information

During the year, the NHS Institute has been working with the Department of Health and other stakeholders to determine its potential future business model and how the funding for its activities will evolve into a more commercial framework. This has built on work started during 2007/08, and has had an impact on our approach to our review of controls and the Board Assurance Framework. In light of this, a significant amount of activity has been undertaken in 2008/09 in preparation for anticipated changes to our business model. A new finance system went live on 1 April 2009, a revised balanced scorecard approach has been implemented across all business units (to be effective from 1 April 2009), and we have revised our approach to corporate risk management. We are currently working on establishing new systems and processes to manage more effectively a greater range of customer relationships. It is likely that in order to better manage the risks associated with operating in a more commercial environment, that the NHS Institute will change its status away from a Special Health Authority and Arm's Length Body of the Department of Health. This has been a significant amount of work during the year and has involved a number of Board level workshops covering the key areas and to evolve our risk management framework. These workshops have helped to identify the new and emerging risks as well as to consider actions and plans to manage and mitigate those risks. Our internal and external auditors have supported these processes – for example, we have used the internal audit services to provide independent assurance over the specification and implementation of the new system, and we have kept external auditors appraised of progress.

Bernard Crump, Chief Executive and Accounting Officer
NHS Institute for Innovation and Improvement
10 June 2009

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 2009 under the National Health Service Act 2006. These comprise the Income and Expenditure Account, the Balance Sheet, the Cash Flow Statement and Statement of Recognised Gains and Losses and the related notes. These financial statements have been prepared under the accounting policies set out within them. 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

The Chief Executive as Accounting Officer is responsible for preparing the Annual Report, which includes the Remuneration Report, and the financial statements in accordance with the National Health Service Act 2006 and directions made thereunder by the Secretary of State with the approval of HM Treasury and for ensuring the regularity of financial transactions. These responsibilities are set out in the Statement of Accounting Officer's Responsibilities.

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

I report to you my opinion as to whether the financial statements give a true and fair view and whether the financial statements and the part of the Remuneration Report to be audited have been properly prepared in accordance with the National Health Service Act 2006 and directions made thereunder by the Secretary of State with the approval of HM Treasury. I report to you whether, in my opinion, the information, which comprises the Management commentary, Director of Finance commentary and Governance Structure, included in the Annual Report is consistent with the financial statements. I also report whether in all material respects, the expenditure and income have been applied to the purposes intended by Parliament and the financial transactions conform to the authorities which govern them.

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

In addition, I report to you if the NHS Institute for Innovation and Improvement has not kept proper accounting records, if I have not received all the information and explanations I require for my audit, or if information specified by HM Treasury regarding remuneration and other transactions is not disclosed.

I review whether the Statement on Internal Control reflects the NHS Institute for Innovation and Improvement's compliance with HM Treasury's guidance, and I report if it does not. I am not required to consider whether this statement covers all risks and controls, or form an opinion on the effectiveness of the NHS Institute for Innovation and Improvement's corporate governance procedures or its risk and control procedures.

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

Basis of audit opinions

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

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

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

Opinions

In my opinion:

— the financial statements give a true and fair view, in accordance with the National Health Service Act 2006 and directions made thereunder by the Secretary of State with the approval of HM Treasury, of the state of the NHS Institute for Innovation and Improvement's affairs as at 31 March 2009 and of its net resource outturn, recognised gains and losses and cash flows for the year then ended

— the financial statements and the part of the Remuneration Report to be audited have been properly prepared in accordance with the National Health Service Act 2006 directions made thereunder by the Secretary of State with the approval of HM Treasury

— information, which comprises the Management Commentary, Director of Finance Commentary and Governance Structure included within the Annual Report, is consistent with the financial statements.

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.

Report

I have no observations to make on these financial statements.

Amyas C E Morse, Comptroller and Auditor General
National Audit Office
151 Buckingham Palace Road
Victoria
London
SWIW 9SS
15 June 2009

Annual Account of the NHS Institute for Innovation and Improvement for the year ended 31 March 2009

Operating Cost Statement for the year ended 31 March 2009

	Notes	2008–09 £000	2007–08 £000
Programme costs	2.1	90,128	79,750
Operating income	4	(9,656)	(6,555)
Net operating cost before interest		80,472	73,195
Interest payable		0	1
Net operating cost		80,472	73,196
Net resource outturn	3.1	80,472	73,196

All income and expenditure is derived from continuing operations.

Statement of Recognised Gains and Losses for the year ended 31 March 2009

	Notes	2008–09 £000	2007–08 £000
Unrealised (gain) on the indexation of fixed assets	11.2	(74)	(151)
Recognised (gains) for the financial year		(74)	(151)

The notes on pages 64 to 85 form part of these accounts.

Annual Account of the NHS Institute for Innovation and Improvement for the year ended 31 March 2009

Balance Sheet as at 31 March 2009

	Notes	31 March 2009 £000	31 March 2008 £000
Fixed assets:			
Intangible assets	5.1	821	601
Tangible assets	5.2	3,907	4,383
		4,728	4,984
Current assets:			
Debtors	6	4,586	8,706
Cash at bank and in hand	7	5,070	574
		9,656	9,280
Creditors: amounts falling due within one year	8	(13,011)	(14,300)
Net current (liabilities)		(3,355)	(5,020)
Total assets less current liabilities		1,373	(36)
Provisions for liabilities and charges	9	(684)	(657)
		689	(693)
Taxpayers' equity			
General fund	11.1	(401)	950
Revaluation reserve	11.2	(288)	(257)
		(689)	693

The notes on pages 64 to 85 form part of these accounts.
The financial statements on pages 61 to 63 were considered by the Audit and Risk Management Committee on 4 June 2009.

Bernard Crump, Accounting Officer
— 'NHS Institute for Innovation and Improvement'

10 June 2009.

Annual Account of the NHS Institute for Innovation and Improvement for the year ended 31 March 2009

Cash Flow Statement for the year ended 31 March 2009

	Notes	2008–09 £000	2007–08 £000
Net cash (outflow) from operating activities	12	(75,708)	(76,002)
Servicing of finance			
Interest paid		0	(1)
Net cash (outflow) from servicing finance		0	(1)
Capital expenditure and financial investment:			
(Payments) to acquire intangible fixed assets		(759)	(48)
(Payments) to acquire tangible fixed assets		(916)	(1,753)
Net cash (outflow) from investing activities		(1,675)	(1,801)
Net cash (outflow) before financing		(77,383)	(77,804)
Financing			
Net parliamentary funding	11.1	81,879	76,575
Increase/(decrease) in cash in the period	7	4,496	(1,229)

The notes on pages 64 to 85 form part of these accounts.

Notes to the Accounts
1. Accounting Policies

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

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

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

1.2 Income
Income is accounted for applying the accruals convention. 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.

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 recovery basis to external customers. Where income is received for a specific activity which is to be delivered in the following financial year, that income is deferred.

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

1.4 Capital charges
The treatment of fixed assets in the account is in accordance with the principal capital charges objective to ensure that such charges are fully reflected in the cost of capital. The interest rate applied to capital charges in the financial year 2008–09 was 3.5% (2007–08: 3.5%) on all assets less liabilities, except for donated assets and cash balances with the Office of the Paymaster General (OPG), where the charge is nil.

1.5 Fixed assets
a. Capitalisation
All assets falling into the following categories are capitalised:

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

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

iii Tangible assets where they are capable of being used for more than one year, and they:
- — individually have a cost equal to or greater than £5,000
- — collectively have a cost of at least £5,000 and an individual cost of more than £250, where the assets are functionally interdependent (including IT assets plugged into a single network), they had broadly simultaneous purchase dates, are anticipated to have simultaneous disposal dates and are under single managerial control; or

— form part of the initial equipping and setting-up cost of a new or leasehold building, irrespective of their individual or collective cost.

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

b. Valuation

Intangible fixed assets

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

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

Tangible fixed assets

Tangible fixed assets are stated at the lower of replacement cost and recoverable amount. On initial recognition they are measured at cost (for leased assets, fair value) including any costs such as installation directly attributable to bringing them into working condition. They are restated to current value each year.

The carrying value of tangible fixed assets is reviewed for impairment in periods if events or changes in circumstances indicate the carrying value may not be recoverable.

i Land and buildings (including dwellings) valuations are carried out by the District Valuer of HM Revenue and Customs government department at five yearly intervals in accordance with Financial Reporting Standard 15 (FRS 15). Between valuations price indices appropriate to the category of asset are applied to arrive at the current value. The buildings indexation is based on the All in Tender Price Index published by the Building Cost Information Service (BCIS). The land index is based on the residential building land values reported in the Property Market Report published by the Valuation Office. The valuations were carried out in accordance with the Royal Institute of Chartered Surveyors (RICS) Appraisal and Valuation Manual insofar as these terms are consistent with the agreed requirements of the Department of Health and HM Treasury.
The valuations have been carried out primarily on the basis of depreciated replacement cost for specialised operational property and existing use value for non-specialised operational property. In respect of non-operational properties, including surplus land, the valuations have been carried out at open market value. The value of land for existing use purposes is assessed to existing use value. The valuations do not include notional directly attributable acquisition costs nor have selling costs been deducted, since they are regarded as not material.
To meet the underlying objectives established by the Department of Health, the following accepted variations of the RICS Appraisal and Valuation Manual have been required:

— specialised operational assets have been valued on a replacement rather than modern substitute basis
— no adjustment has been made to the cost figures of operational assets in respect of dilapidations
— additional alternative open market value figures have been supplied only for operational assets scheduled for imminent closure and subsequent disposal.

ii Operational equipment is valued at net current replacement cost through annual uplift by the change in the value of the GDP deflator. Equipment surplus to requirements is valued at net recoverable amount.
iii Assets in the course of construction are valued at current cost, using the index as for land and buildings. These assets include any existing land or buildings under the control of a contractor.
iv Subsequent revaluations to donated fixed assets are taken to the donated asset reserve.
v All adjustments arising from indexation and five yearly revaluations are taken to the revaluation reserve. All impairments resulting from price changes are charged to the Statement of Recognised Gains and Losses. Falls in value when newly constructed assets are brought into use are also charged there. These falls in value result from the adoption of ideal conditions as the basis for depreciated replacement cost valuations.

c. Depreciation and amortisation

Depreciation is charged on each individual fixed asset as follows:

i Intangible assets are amortised, on a straight line basis, over the estimated lives of the assets.
ii Purchased computer software licences are amortised over the shorter of the term of the licence and their useful economic lives.
iii Land and assets in the course of construction are not depreciated.
iv Buildings are depreciated evenly on their revalued amount over the assessed remaining life of the asset as advised by the District Valuer. Leaseholds and leasehold improvements are depreciated over the primary lease term.
v Each equipment asset is depreciated evenly over the expected useful life from the start of the quarter following the quarter in which the asset was acquired:

	Years
Furniture and fittings	7–10
Transport equipment	7
Information Technology	3

1.6 Donated fixed assets

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

1.7 Stocks and work in progress

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

1.8 Losses and special payments

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

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

1.9 Pension costs

Past and present employees are covered by the provisions of the NHS Pensions Scheme. Details of the benefits payable under these provisions can be found on the NHS Pensions website at http://www.nhsbsa.nhs.uk/pensions. The Scheme is an unfunded, defined benefit scheme that covers NHS employers, General Practices and other bodies, allowed under the direction of the Secretary of State, in England and Wales. The scheme is not designed to be run in a way that would enable NHS bodies to identify their share of the underlying Scheme assets and liabilities.

Therefore, the Scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS Institute of participating in the Scheme is taken as equal to the contributions payable to the Scheme for the accounting period.

The Scheme is subject to a full actuarial valuation every four years (until 2004, based on a five year valuation cycle), and a FRS 17 accounting valuation every year. An outline of these follows:

a) Full actuarial (funding) valuation

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the Scheme (taking into account its recent demographic experience) and to recommend the contribution rates to be paid by employers and Scheme members. The last such valuation, which determined current contribution rates was undertaken as at 31 March 2004 and covered the period from 1 April 1999 to that date.

The conclusion of the 2004 investigation was that the Scheme had accumulated a notional deficit of £3.3 billion against the notional assets as at 31 March 2004. However, after taking into account the changes in the benefit and contribution structure effective from 1 April 2008, the Scheme actuary reported that the employer contributions could continue at the existing rate of 14% pensionable pay. On the advice from the Scheme actuary, Scheme contributions may be varied from time to time to reflect changes in the scheme's liabilities. Up to the 31 March 2008, the vast majority of employees paid contributions at the rate of 6% of pensionable pay. From 1 April 2008, employees' contributions are on a tiered scale from 5% up to 8.5% of their pensionable pay depending on total earnings.

b) FRS 17 Accounting valuation

In accordance with FRS 17, a valuation of the Scheme liability is carried out annually by the Scheme actuary at the Balance Sheet date by updating the results of the full actuarial valuation.

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

The valuation of the Scheme liability as at 31 March 2009, is based on detailed membership data as at 31 March 2006 (the latest midpoint) updated to 31 March 2008 with summary global member and accounting data.

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

Scheme provisions as at 31 March 2009

The Scheme is a 'final salary' scheme. Annual pensions are normally based on 1/80th of the best of the last three years' pensionable pay for each year of service. A lump sum normally equivalent to three years' pension is payable on retirement. Annual increases are applied to pensions payments at rates defined by Pensions (Increase) Act 1971, and are based on changes in retail prices in the 12 months ending 30 September in the previous calendar year. On death, a pension of 50% of the member's pension is normally payable to the surviving spouse.

Early payment of 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, less pension already paid, subject to a maximum amount equal to twice the member's final year's pensionable pay less their retirement lump sum for those who die 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 income and expenditure account at the time the NHS Institute commits itself to the retirement, regardless of the method of payment.

1.10 Financial Instruments

i Financial assets

Financial assets are recognised on the Balance Sheet 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

Financial assets are classified into the following categories: financial assets 'at fair value through net operating cost'; 'held to maturity investments'; 'available for sale' financial assets and 'loans and receivables'. The classification depends on the nature and purpose of the financial assets and is determined at the time of initial recognition.

Financial assets at fair value through net operating costs
Embedded derivatives that have different risks and characteristics to their host contracts, and contracts with embedded derivatives whose separate value cannot be ascertained, are treated as financial assets at fair value through net operating costs. They are held at fair value, with any resultant gain or loss recognised in the Operating Cost Statement. The net gain or loss incorporates any interest earned on the financial asset.

Held to maturity investments
The NHS Institute does not have any held to maturity assets.

Available for sale financial assets
Available for sale financial assets are non-derivative financial assets that are designated as available for sale or that do not fall within any of the other three financial asset classifications. They are measured at fair value with changes in value taken to the revaluation reserve, with the exception of impairment losses. Accumulated gains or losses are recycled to the net Operating Cost Statement on de-recognition.

Loans and receivables
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.

Fair value is determined by reference to quoted market prices where possible, otherwise by valuation techniques.

The effective interest rate 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 Balance Sheet date, the NHS Institute assesses whether any financial assets, other than those held at 'fair value through net operating costs' 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 assets' carrying amount and the present value of the revised future cash flows discounted at the assets' original effective interest rate. The loss is recognised in the net Operating Cost Statement and the carrying amount of the asset is reduced directly, or through a provision for impairment of receivables.

If, in a subsequent period, the amount of the impairment loss decreases and the decrease can be related objectively to an event occurring after the impairment was recognised, the previously recognised impairment loss is reversed through the Operating Cost Statement to the extent that the carrying amount of the receivable at the date of the impairment is reversed does not exceed what the amortised cost would have been had the impairment not been recognised.

ii Financial liabilities

Financial liabilities are recognised on the Balance Sheet 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

Financial liabilities are classified as either financial liabilities 'at fair value through net operating costs' or other financial liabilities.

Financial liabilities at fair value through net operating cost

Embedded derivatives that have different risks and characteristics to their host contracts, and contracts with embedded derivatives whose separate value cannot be ascertained, are treated as financial liabilities at fair value through net operating costs. They are held at fair value, with any resultant gain or loss recognised in the Operating Cost Statement. The net gain or loss incorporates any interest earned on the financial asset.

Other financial liabilities

After initial recognition, all other 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.

1.11 Research and development

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

1.12 Foreign exchange

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

1.13 Leases

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

1.14 Provisions

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

Notes to the Accounts
2. Programme Costs

2.1 Programme costs

	Notes	2008–09 £000	2008–09 £000	2007–08 £000
Non-executive members' remuneration			129	124
Other salaries and wages	2.2		12,937	10,577
Supplies and services – general			30	36
Establishment expenses			4,930	3,798
Premises and fixed plant			1,904	1,391
External contractors			3,541	1,706
Capital: Amortisation	5.1	257		60
Depreciation	5.2	1,391		735
Loss on impairment	5.2	19		0
Disposals	5.2	191		0
Capital charges interest		(99)		(128)
			1,759	
Auditors' remuneration:				
Statutory external audit fees[1]			60	43
Non-statutory external audit fees			0	11
Internal audit fees			61	57
Other finance costs:				
Bad debt provision		(45)		63
Foreign currency losses		12		16
Unwinding of discount		12		17
General losses and fruitless payments		72		4
			51	
Miscellaneous:				
Redundancy and early retirement costs		0		(288)
Residual NHSU activities transferred		(1,041)		1,041
Other		198		161
			(843)	
Commissioning expenditure	2.3		65,569	60,326
			90,128	79,750

[1]The statutory audit fee for 2008–09 is £45,000 with £15,000 relating to additional statutory work carried out in 2007–08.

Notes to the Accounts
2. Programme Costs (continued)

2.2 Staff numbers and related costs

	2008–09 £000	2007–08 £000
Salaries and wages – staff on the NHS Institute payroll	8,579	7,362
Seconded, contract and agency staff	2,650	1,823
Salaries and wages – recharges to other NHS organisations	(234)	(198)
Social security costs	809	612
Employer contributions to NHS Pension scheme	1,133	968
NHS Institute employees	12,937	10,567
NHSU residual employees	0	10
Total salaries and wages	12,937	10,577

	2008–09 Average WTE	2007–08 Average WTE
Salaries and wages – staff on the NHS Institute payroll[1]	194.7	163.3
Seconded, contract and agency staff	43.9	28.0
Salaries and wages – recharges to other NHS organisations	(2.8)	(2.4)
NHS Institute employees	235.8	188.9
NHSU residual employees	0	0.5
Total average Whole Time Equivalent (WTE)	235.8	189.4

[1]The NHS Institute has a WTE limit for staff set by the Department of Health of 217 relating to staff on the NHS Institute payroll.

Expenditure on staff benefits
The amount spent on staff benefits during 2008–09 totalled £47,494 (2007–08: £11,514).

Retirements due to ill-health
During 2008–09 there were no early retirements from the NHS Institute on the grounds of ill-health.

Early retirements and redundancies
During 2008–09 there were no early retirements or redundancies.

Notes to the Accounts
2. Programme Costs (continued)

2.3 Commissioning expenditure

	2008–09 £000	2008–09 £000	2007–08 £000
Building leadership capability[1]		2,300	5,710
Building leadership capacity – pay	10,913		11,349
Building leadership capacity – non-pay	9,843	20,756	8,506
Delivering for Improvement		544	1,478
Care Outside Hospital[2]		163	1,011
Safer Care		2,047	1,343
No Delays[3]		354	1,878
Delivering Quality and Value		2,190	1,624
Joint working with Strategic Health Authorities		912	893
National Innovation Centre		10,764	898
Strategic Partnership		524	8,239
Productive Series[5]		5,330	596
National Library for Health[6]		8,846	3,290
Commissioning for Health Improvement[7]		1,960	7,425
New Business Model (pilot)		347	89
Corporate Organisation Development in the NHS		539	480
Other – included in business plan (51 projects)		7,993	497
Other – included in business plan (64 projects)			5,020
		65,569	60,326

1. The reduction in Building Leadership capability expenditure reflects the move of certain programmes out of the NHS Institute's. responsibility. In addition, a one-off SHA programme was run during 2007-08.
2. The Care Outside Hospital programme of work was completed during 2008-09.
3. The No Delays Achiever programme of work was completed during 2008-09.
4. The PCT Development programme of work was completed during 2007-08.
5. Clinical systems improvement work is included within the Productive Series.
6. The National Library for Health transferred to the NHS Institute on 1 April 2007 from NHS Connecting for Health and will transfer to the National Institute for Clinical Excellence on 1 April 2009.
7. The Commissioning for Health Improvement programme of work was launched in 2008-09.

2.4 Better Payment Practice Code – measure of compliance

	Number	£000
Total non-NHS bills paid 2008–09	20,199	64,905
Total non-NHS bills paid within target	18,783	58,235
Percentage of non-NHS bills paid within target	93.0%	89.7%
	Number	**£000**
Total NHS bills paid 2008–09	773	10,466
Total NHS bills paid within target	415	6,216
Percentage of NHS bills paid within target	53.7%	59.4%

The Late Payment of Commercial Debts (Interest) Act 1998. £Nil interest was paid under this legislation (2007–08: £674.98).

Notes to the Accounts

3.1 Reconciliation of net operating cost to net resource outturn

	2008–09 £000	2007–08 £000
Net operating cost for the financial year	80,472	73,196
Net resource outturn	80,472	73,196
Revenue resource limit	80,790	73,531
Under spend against revenue resource limit	318	335

3.2 Reconciliation of gross capital expenditure to capital resource limit

	2008–09 £000	2007–08 £000
Gross capital expenditure	1,528	1,768
Less – Book value of assets disposed	(191)	0
Adjustment for loss on disposal of fixed assets	191	0
Net resource outturn	1,528	1,768
Capital resource limit	2,274	2,044
Underspend against capital resource limit	746	276

4 Operating income

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

	2008–09 £000	2007–08 £000
Programme income[1]		
Fees and charges	9,538[2]	6,533
Other	118	22
Total	9,656	6,555

[1]Included in the above numbers is income received from The Scottish Parliament £448k (2007–08: £98k), The National Assembly for Wales £61k (2007–08: £84k) and the Northern Ireland Assembly £59k (2007–08: £10k).

[2]Fees and charges includes £6,497k in relation to income received to provide funding for specific programmes and £3,041k 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 SSAP 25.

	NHS England extended services £000	Non-NHS England £000	Total £000
Income	2,182	859	3,041
Less direct costs and overheads	2,021	533	2,554
Contribution	161	326	487
Less apportionment of central overheads	319	84	403
Profit/(loss)	(158)	242	84

The financial objective of the NHS England extended services is full cost recovery. This was not achieved due to the additional start up costs associated with the new business model and extended services in particular. Due to the nature of these start up costs, this loss will be made good in 2009–10.

The financial objective of non-NHS England is to make a small profit. This was achieved.

Overall the new business model did however, taking both together, achieve full cost recovery.

5 Fixed assets

5.1 Intangible fixed assets

	Software licences £000
Gross cost at 31 March 2008	711
Additions – purchased	477
Gross cost at 31 March 2009	**1,188**
Accumulated amortisation at 31 March 2008	110
Charged during the year[1]	257
Accumulated amortisation at 31 March 2009	**367**
Net book value:	
Total at 31 March 2009	**821**
Net book value:	
Total at 31 March 2008	601

[1]The NHS Institute has changed its estimation technique for calculating the useful economic life of software licences which has resulted in a reduction of the asset life from five to three years where this is shorter than the term of the licence. This has resulted in an increased amortisation charge in year of £103k.

5.2 Tangible fixed assets

	Information Technology			Furniture and fittings	Assets under construction	Leasehold improvements	Total
	Websites £000	Web-based tools £000	Hardware £000	£000	£000	£000	£000
Cost or valuation at 31 March 2008	1,104	1,364	780	0	0	2,427	5,675
Additions – purchased	286	151	344	151	119	0	1,051
Impairment	(29)	0	0	0	0	0	(29)
Disposal	(126)	(349)	0	0	0	0	(475)
Indexation	0	0	0	0	0	103	103
Gross cost at 31 March 2009	1,235	1,166	1,124	151	119	2,530	6,325
Accumulated depreciation at 31 March 2008	147	289	177	0	0	679	1,292
Charged during the year[1]	394	464	271	1	0	261	1,391
Impairment	(10)	0	0	0	0	0	(10)
Disposal	(67)	(217)	0	0	0	0	(284)
Indexation	0	0	0	0	0	29	29
Accumulated depreciation at 31 March 2009	464	536	448	1	0	969	2,418
Net book value: Total at 31 March 2009	771	630	676	150	119	1,561	3,907
Net book value: Total at 31 March 2008	957	1,075	603	0	0	1,748	4,383

[1]The NHS Institute has changed its estimation technique for depreciating Information Technology assets, this has resulted in a reduction of the asset life from five to three years. This has resulted in an increase in the depreciation charged in the year by £447k.

6 Debtors

6.1 Amounts falling due within one year

	2008–09 £000	2007–08 £000
NHS debtors	995	1,517
Trade debtors – non-NHS	267	913
Provision for irrecoverable debts	(15)	(63)
VAT amount due	1,522	1,080
Prepayments	1,424	5,241
Accrued income	121	13
Other debtors	9	4
	4,323	8,705

6.2 Amounts falling due after more than one year

	2008–09 £000	2007–08 £000
Prepayments	263	1
	263	1
Total debtors	4,586	8,706

7 Analysis of changes in cash

	At 31 March 2008 £000	Change during the year £000	At 31 March 2009 £000
Cash at the Office of the Paymaster General	574	4,496	5,070
	574	4,496	5,070

Notes to the Accounts

8 Creditors amounts falling due within one year

	2008–09 £000	2007–08 £000
NHS creditors	698	601
Trade creditors – non-NHS	2,674	3,269
Tax and social security	0	1
Capital accruals	277	424
Accruals	6,912	7,294
Deferred income	2,436	2,425
Other creditors	14	286
	13,011	14,300

9 Provisions for liabilities and charges

	Pensions for former staff £000	Legal claims £000	Other £000	Total £000
At 31 March 2008	115	106	436	657
Arising during the year	0	70[1]	61[2]	131
Utilised during the year	(115)	(1)	0	(116)
Reversed unused	0	0	0	0
Unwinding of discount	0	0	12	12
At 31 March 2009	**0**	**175**	**509**	**684**
Expected timing of cash flows:				
Within 1 year	0	175	0	175
Over 5 years	0	0	509	509

[1] The NHS Institute has received a damages claim for personal injury during 2007–08 and has received advice from solicitors to increase the provision in 2008–09.
[2] The NHS Institute has contracted for services with indirect workers and has provided for tax-relating to their employment status.

10.1 Movements in working capital other than cash

	2008–09 £000	2007–08 £000
(Decrease)/increase in debtors	(4,120)	6,716
Decrease/(increase) in creditors (excluding capital accruals)	1,142	(4,567)
	(2,978)	2,149

10.2 Reconciliation of net cash flow to movement in net debt	2008–09 £000	2007–08 £000
Increase/(decrease) in cash in the period	4,496	(1,229)
Net fixed asset additions/disposals	1,337	1,768
Depreciation/impairment/indexation	(1,593)	(645)
Decrease/(increase) in creditors (including capital accruals)	1,289	(4,533)
(Decrease)/increase in debtors	(4,120)	6,716
(Increase)/decrease in provisions	(27)	1,325
Movement in net debt	1,382	3,402

11 Movements on reserves

11.1 General fund

	2008–09 £000	2007–08 £000
Balance at 31 March 2008	950	4,233
Net operating costs for the year	80,472	73,196
Net parliamentary funding	(81,879)	(76,575)
Revaluation transfer	(43)	(32)
Non-cash items: Capital charge interest	99	128
Balance at 31 March 2009	(401)	950

11.2 Revaluation reserve

	2008–09 £000	2007–08 £000
Balance at 31 March 2008	(257)	(138)
Indexation of fixed assets	(74)	(151)
Transfer to general fund of realised elements of revaluation reserve	43	32
Balance at 31 March 2009	(288)	(257)

12 Reconciliation of operating costs to operating cash flows

	2008–09 £000	2007–08 £000
Net operating cost before interest for the year	80,472	73,195
Adjust for non-cash transactions	(1,759)	(667)
Adjust for movements in working capital other than cash	(2,978)	2,149
(Increase)/decrease in provisions	(27)	1,325
Net cash outflow from operating activities	75,708	76,002

13 Contingent liabilities

At 31 March 2009, there were no known contingent liabilities (2007–08: £nil).

14 Capital commitments

At 31 March 2009, the value of contracted capital commitments was £nil (2007–08: £nil).

15 Commitments under operating leases

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

	2008–09 £000	2007–08 £000
Hire of plant and machinery	18	26
Property rental – including headquarters and other properties	680	667
Other operating leases	61	45
	759	738

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.

		2008–09 £000	Re-stated 2007–08 £000
Land and buildings			
Operating leases which expire:	within 1 year	717	691
	between 1 and 5 years	2,417	2,592
	after 5 years	449	923
		3,583	4,206
Other leases			
Operating leases which expire:	within 1 year	43	60
	between 1 and 5 years	32	75
		75	135

16 Other commitments

The NHS Institute has not entered into any additional non-cancellable contracts which are not operating leases (2007–08: £nil).

17 Losses and special payments

During 2008–09, 12 cases of losses and special payments were approved totalling £23,209. Additionally, 86 exchange rate fluctuations were approved with a net overall loss of £12,392. (In 2007–08 there were 9 cases totalling £3,475.)

18 Related parties

The NHS Institute is a Special Health Authority established by order of the Secretary of State for Health. The Department of Health is regarded as a controlling related party. During 2008–09, 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.

	Debtors £000	Creditors £000	Income £000	Expenditure £000
Department of Health	289		1,938	472
King's College Hospital NHS Foundation Trust	252			215
NHS Purchasing and Supply Agency			1,426	
NHS East Midlands SHA		137	162	134
NHS East of England SHA			271	
NHS London SHA			513	
NHS North East SHA			132	
NHS North West SHA		95	252	
NHS South Central SHA			147	
NHS South East Coast SHA			1,308	
NHS South West SHA			199	
NHS West Midlands SHA			427	
NHS Yorkshire and The Humber SHA			313	
Nottingham University Hospitals NHS Trust		111		345
West Middlesex University Hospitals NHS Trust		60		
NHS Business Services Authority		71		291
Central Manchester and Manchester Children's University Hospitals NHS Trust See note 1		222		1,044
East and North Hertfordshire PCT				110
NHS National Institute for Health and Clinical Excellence				200
Health Protection Agency UK				105
Birmingham Women's NHS Foundation Trust				101
Cambridge University Hospital NHS Foundation Trust				122
Central Manchester University Hospital NHS Foundation Trust				193
Chelsea and Westminster Hospital NHS Foundation Trust				300
Guy's and St Thomas' Hospital NHS Foundation Trust				190
Oxford Radcliffe Hospitals NHS Trust				258
Royal Berkshire NHS Foundation Trust				145
Salisbury NHS Foundation Trust				473
Sheffield Children's NHS Foundation Trust				119

No debts have been written off in respect of related parties during the year.

Notes: 1. Includes Innovation hubs funding of £838,314 within expenditure and £120,000 within creditors.

19 Post Balance Sheet events

The Darzi report, 'High Quality Care for all', published in June 2008, recommended the establishment of NHS Evidence. Subsequently the National Institute for Health and Clinical Excellence (NICE) was asked to setup, host and run NHS Evidence from 1 April 2009. As part of the process of establishing NHS Evidence the functions of the National Library for Health, which was hosted by the NHS Institute were transferred to NICE. The transfer took place on 1 April 2009. The annual recurring resource allocation of £7.9m was transferred together with 18.5 wte staff. 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

FRS 29, Financial Instruments: Disclosures, 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 business entities. Also, financial instruments play a much more limited role in creating or changing risk than would be typical of the listed companies to which FRS 29 mainly applies.

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 2009 are in receivables from customers, as disclosed in the debtors 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 2009		
Denominated in £ Sterling	7,848	3,291
Other	0	95
Gross Financial Asset/Liability	7,848	3,386
At 31 March 2008		
Denominated in £ Sterling	4,025	4,156
Gross Financial Asset/Liability	4,025	4,156

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 as at 31 March 2009 is as follows:

	Book value £000	Fair value £000
Financial assets: Loans and Receivables		
Cash	5,070	5,070
NHS debtors	995	995
Trade debtors – non-NHS (net of provision)	252	252
Other debtors	1,531	1,531
Total at 31 March 2009	7,848	7,848
Financial liabilities: Loans and Receivables		
NHS creditors	698	698
Trade creditors – non-NHS	2,674	2,674
Other creditors	14	14
Total at 31 March 2009	3,386	3,386

In accordance with FRS 29, 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

	2008–09 £000
Less than one year	3,386
Total at 31 March 2009	3,386

21 Intra-government balances

	Debtors: Amounts falling due within one year	Debtors: Amounts falling due after more than one year	Creditors: Amounts falling due within one year
	£000	£000	£000
Balances with other central government bodies	2,512	0	2,392
Balances with local authorities	0	0	0
Balances with other NHS bodies	494	0	1,742
Balances with public corporations and trading funds	0	0	0
Sub-total intra-governmental balances	3,006	0	4,134
Balances with bodies external to government	1,317	263	8,877
At 31 March 2009	4,323	263	13,011

	Debtors: Amounts falling due within one year	Debtors: Amounts falling due after more than one year	Creditors: Amounts falling due within one year
	£000	£000	£000
Balances with other central government bodies	4,700	0	3,961
Balances with local authorities	0	0	0
Balances with other NHS bodies	1,346	0	1,242
Balances with public corporations and trading funds	0	0	0
Sub-total intra-governmental balances	6,046	0	5,203
Balances with bodies external to government	2,659	1	9,097
At 31 March 2008	8,705	1	14,300

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