NHS
Institute for Innovation and Improvement

Annual Report and Accounts
of the NHS Institute for Innovation and Improvement 2009-10

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of the NHS Institute for Innovation and Improvement 2009-10

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Introduction and Foreword

Yve Buckland, Chair
NHS Institute for Innovation
and Improvement

Bernard Crump,
Chief Executive
NHS Institute for Innovation
and Improvement

2009-10 has been another successful year for the NHS Institute. We have widened the reach and breadth of activity within the NHS and are now working with over 90% of NHS organisations in some capacity.

The NHS' financial landscape changed for us all early in the year when we learned of the challenges we face over the next few years. Our plans to become a more commercial organisation in light of proposed funding changes were put on hold, and subsequently modified, as we looked at how we might transition to become the NHS' improvement agency, focussing our efforts entirely on helping the NHS respond to the cost and quality agenda.

Introduction and Foreword *(continued)*

During the year we have developed a number of new products for the NHS and enhanced and further developed others. These include new programmes in Safer Care; The Productive Series, through which we launched The Productive Operating Theatre and Productive Community Services; Delivering Quality and Value where we delivered ThinkGlucose, radiology pathway, OncoAlert and high impact changes for four pathways. Details for all of these initiatives are contained within this report. We have developed our skills to measure return on investment of implementation of our products and to calculate cost benefit. This increases the desirability of our products and so in turn, is encouraging adoption and spread.

Our discussion with NHS partners in the autumn told us that what they wanted from us was not more products for improvement and innovation, but help with implementation of existing products. To that end we commenced an internal restructuring programme which will see an increase in our workforce as we seek to work with the NHS in their organisations to ensure the impact and benefits of implementation of our products are delivered and fully realised. This is a good point at which to mention our staff whose efforts and commitment have been outstanding this year once again. We have seen significant change and both of us are impressed and grateful for their response which has been positive and 'can-do' as ever.

Communicating with the NHS is a complex business and we are constantly looking to improve our efforts. During the year we introduced a programme of web seminars which are proving very popular, negating as they do, the need for travel while encouraging networking and learning. Our networks continue to grow and over 25,000 individuals receive our monthly update. The implementation of a customer relationship management system in year is helping us stay in touch with our customers and their interests. We also commenced a project to consider a new web platform as our audience (we receive 20,000 unique visits to the site per week) demand increasing technology and functionality and ever more information.

Our work with our sponsors at the Department of Health (DH), has this year included initiatives to look at productivity, particularly around the Quality, Innovation, Productivity and Prevention (QIPP) agenda, the High Impact Actions for Nursing and Midwifery, the policy on single sex accommodation, community services as part of their Transforming Community Services initiative, and of course, leadership. We commenced a programme of work mid-year – Organising for Quality - to develop the skills required for effective and sustainable service improvement in NHS organisations. This has been well received by those wishing to ensure they have both the will and skill to increase productivity and efficiency for their health community. Our impact worldwide has been felt with increasing sales overseas, reflecting the changing nature and need for improvement and innovation globally.

In a year of high activity we have focussed our efforts on continuing to deliver high impact products and initiatives to the NHS; increasing productivity and value for money. We will celebrate a successful year in 2009-10 with a keen eye on a changing future – a new government, an Arm's Length Body (ALB) review, financial constraints and increasing pressure to demonstrate our impact – while we continue to focus on helping the NHS meet the expectations of patients through the delivery of safe, high quality, productive and efficient care.

Management Commentary and Review of Activity

2009-10 Highlights

Below are some of the key achievements from the past year. More detailed information on these and other highlights from 2009-10 is included later in this report.

Defending and promoting high quality care in a tighter economic climate (p14)	We are leading on the Productive Care national QIPP workstream and are involved in all 12 workstreams.
Identifying High Impact Actions which have the potential to transform care and reduce costs (p25)	Following the launch of High Impact Actions for Nursing and Midwifery in autumn 2009, 600 ideas were submitted in just three weeks.
Supporting NHS teams to re-design and streamline the way they work (p15)	Two new programmes in The Productive Series were launched in 2009. The Productive Operating Theatre has the potential to help the NHS save more than £400m per year and early figures from Productive Community Services show a gain of between 25% and 30% in time spent on direct patient care.
Building capacity and capability for improvement (p27)	The Organising for Quality programme was launched to build capacity and capability for improvement amongst clinical and operational staff. To date 228 NHS staff have been trained.
Ensuring a high quality experience for patients with diabetes admitted to hospital (p18)	Since its launch in summer 2009, 76% of trusts have taken up our ThinkGlucose product, which aims to improve the experience of people with diabetes who are admitted to hospital.
Advancing the progress of patient safety and quality of care (p21)	The Improvement Faculty for Quality and Patient Safety now has a membership of 147 Fellows.
Providing a quick and easy channel for NHS staff to give their views (p25)	Over 4,600 NHS staff gave feedback via the National NHS Innovation survey, which was the first of its kind. We are looking to repeat the survey in 2010-11.
Introducing improvement principles into professional training (p28)	5,678 students from 23 professional groups received teaching in service improvement in the last academic year, thanks to the Improvement in Pre-registration Education project.
Promoting the involvement of doctors in the leadership of health services (p31)	The Medical Leadership Competency Framework (MLCF) was included in the General Medical Council's *Tomorrow's Doctors* publication and in postgraduate training.
Highlighting examples of excellence and innovation in health and social care (p34)	The Health and Social Care Awards, the largest peer-to-peer scheme of its kind, received 4,000 entries in 2009, an increase of over 30% on the previous year.

Management Commentary and Review of Activity *(continued)*

Description of the business

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

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

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

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

Risks

During 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 in creating the framework and used it to inform their audit approach.

The principal risks and uncertainties facing the NHS Institute have been identified as:

- political and organisational uncertainty, giving rise to the risk that we fail to achieve the correct balance between informed strategic choice and prompt strategic action
- inability to demonstrate compelling value to customers or funders
- insufficient capacity and skills to meet the requirements outlined in our mission statement to service the health sector at scale and pace
- insufficient flexibility to respond to the changing health service environment (both funding and market)
- inability in a more contested environment to challenge from competitive behaviour, together with an over-reliance on 'potential competitors' as partners
- uncertainty of the change process leads to loss of key personnel and lack of focus on current necessary deliverables
- insufficient understanding of our customer's requirements and our ability to satisfy those requirements, or the competitive landscape, with the result that our market potential isn't fully realised.

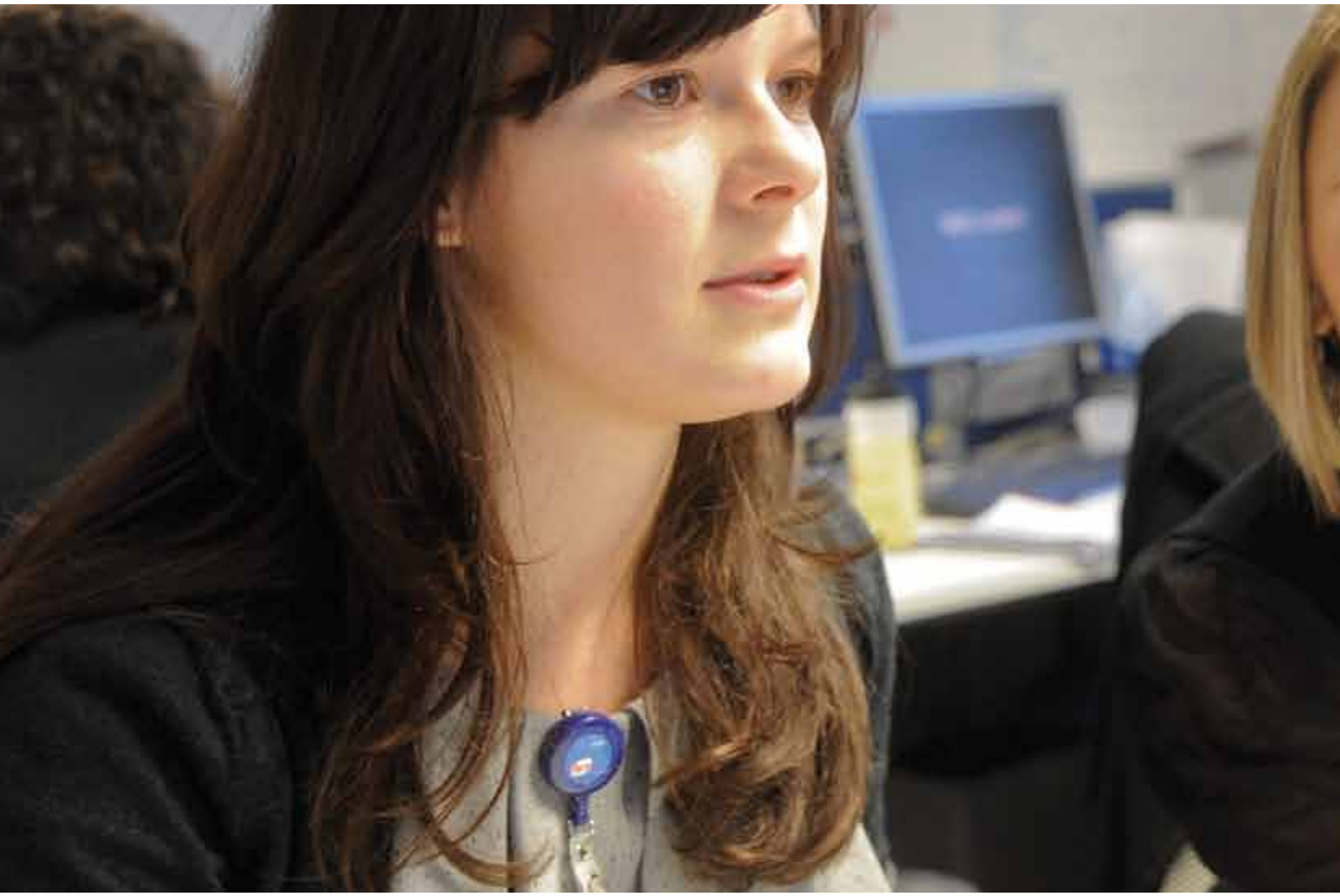
Environmental, social and community policies

We are continuing to work to reduce our carbon footprint and introduce sustainability policies. A sustainable development action plan has been developed and as part of our procurement principles we endeavour to incorporate environmental and social considerations into our selection process for suppliers and encourage suppliers to minimise the environmental effects associated with supplying their goods and services.

Management Commentary and Review of Activity *(continued)*

Specific measures have included:

- paperless recruitment and tendering processes
- ensuring that environmentally friendly stationery supplies are sourced and procured and that stationery orders are tightly managed
- auditing the compliance of staff to the directive to shut down computers at the end of the day
- procurement from ITC equipment suppliers with 'green' credentials
- reducing the number of general waste bins from office areas and replacing them with more paper recycling bins
- introduction of new confidential waste bins, a battery disposal scheme and kitchen recycling bins
- eliminating the purchasing of bottled water for NHS Institute meetings and events
- identifying joint projects with the University of Warwick Sustainability Officer
- increased use of 'virtual' meetings and events to reduce unnecessary travel.



Management Commentary and Review of Activity *(continued)*

We operate a work experience scheme for school children and display artwork in our Coventry premises produced by students from Warwickshire College. A selection of pieces from the college's annual exhibition is loaned to us each year, with the aim of demonstrating the link between creativity and innovation.

In addition, our internal 'i active' programme has continued to promote healthy living and healthy working amongst our staff over the last year through a range of activities aimed at encouraging physical, psychological and social wellbeing.

Financial information

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

Management Commentary and Review of Activity *(continued)*

Disclosure of relevant audit information

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

Employee matters

We have a full suite of policies on employee matters which are available on our website. These are used effectively in the day-to-day management of our workforce. One example of this effectiveness can be seen below in relation to our sickness absence procedure.

Sickness absence data

During the period 2009-10 the following percentages of hours were lost through sickness absences, compared to 2008-09:

	2009-10	2008-09
Quarter 1	2.16%	2.90%
Quarter 2	1.05%	2.31%
Quarter 3	1.30%	1.86%
Quarter 4	0.69%	1.76%

Employment, training, career development and promotion of disabled persons

The NHS Institute aims to be recognised as an organisation which provides good employment opportunities for people with disabilities. All individuals applying for employment receive equal treatment, and are considered solely on their ability to carry out the duties of the post. We work towards ensuring that people with disabilities have appropriate access to the workplace and its facilities and are provided with training and development opportunities consistent with their skills and abilities. Our policies and procedures for recruitment and selection, training, development and appraisal are Equality Impact Assessed to ensure that they provide, so far as is practicable, equality of opportunity for people with disabilities.

Our policies in relation to employment of people with disabilities and equality and diversity are available on our website.

Communication and consultation with employees

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

Staff are made aware of financial, economic, and other factors affecting the organisation via a weekly Executive Update in our internal newsletter and a regular Team Brief given by our Chief Executive, which staff can attend in person or view on the intranet. Employees are encouraged to ask questions and make suggestions at these briefings as well as via our Chief Executive's six-weekly 'open house', during which staff can book a one-to-one appointment with Bernard Crump to discuss issues relating to the NHS Institute's business. During the period of transition that the organisation has been going through in the latter part of 2009-10, an additional 'transition briefing' has been regularly emailed to all staff to keep them

Management Commentary and Review of Activity *(continued)*

up-to-date with the latest developments, with employees being encouraged to feed back suggestions or queries either by email, via line managers or by using suggestion boxes placed in each of our offices. Employee involvement in the performance of the organisation is also encouraged through personal development reviews, through which personal objectives are set in line with corporate objectives.

Information governance and security

Information governance (IG) is embedded within the NHS Institute as a key component of the risk management, performance monitoring, integrated governance and quality. The NHS Institute recognises that the quality and security of data plays a significant role in providing assurance to its stakeholders that information is managed competently and securely.

The NHS Institute complies with the requirements of the NHS Connecting for Health (CfH) Information Governance Toolkit (IGT) and achieved approval of V7.0 in November 2009.

Over the past year the NHS Institute has been working closely with the Department of Health's Arms Length Body Information Governance Forum for best practice and information on new NHS requirements in information assurance. The DH has been reviewing ALB Information Assurance requirements with seminars and workshops provided in conjunction with the Cabinet Office and CESG. The IG Steering group is proving to be an invaluable resource with bi-monthly meetings to update all representatives on current IG workstreams, supporting collaboration and fully consulted approaches.

Clear accountability has been established with the implementation of NHS Institute information asset registers. Policies have also been updated in line with legislative changes.

All staff successfully passed the NHS Institute's annual mandatory information governance training using the level one National School of Government Protecting Information module and all Information Asset Owners (IAOs)/Heads of Service and Executive Team members have passed level two. Future audits will be carried out in conjunction with Internal Audit to ensure we have addressed all areas of Information Assurance for compliance with the IGT.

The implementation of privacy impact assessments (PIAs) is currently underway with a specification outline drafted using a Legal Data Protection consultant. To ensure the PIA is an embedded mandatory tool for all teams to use prior to initiating any new project, process, or system the tool will be developed using SharePoint and will be available on the intranet as an internal resource.

The information governance awareness programme has made NHS Institute staff more conscious of working practices affecting the organisation's reputation and aware of actions that should be taken to mitigate any possible risk. Generally, information governance support for various workstreams has increased with an increasing number of requests for involvement in projects.

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

Management Commentary and Review of Activity *(continued)*

We are pleased to report that the NHS Institute has had no material security or governance breaches for the period 2009-10.

Progress against targets

2009-10 was a year of significant progress. This was measured using balanced scorecards for each area of the organisation, which contain a total of 89 metrics rating performance in five areas – our customers, our partners and stakeholders, our products, our organisation and staff and finance and public value. Of these, 72 were rated green and 17 were rated amber.

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

Quality, Innovation, Productivity and Prevention (QIPP)

As previously described, the NHS Institute is well positioned to support the NHS' response to the quality and productivity challenge with tried and tested programmes. Since the challenge was set out by David Nicholson in his annual report, we have been both working to ensure that all our work is aligned with the QIPP agenda and to support the 12 national QIPP workstreams.

The NHS Institute is taking the lead on the Productive Care national workstream. This aims to support and enable greater clinical staff productivity in provider organisations in a way that delivers the real cash savings necessary for QIPP, including the movement of staff from acute to community settings. The core activities of this workstream relate to the wholesale implementation of programmes and initiatives that are already proven to deliver quality and cost improvements in local NHS settings. Following a rigorous assessment of the Evidence Database, The Productive Series was identified as amongst the most compelling examples of well established tools for improving both quality and productivity and, as a result, it features prominently in the work of the Productive Care workstream.

To align with the need to take an evidence-based approach to the QIPP challenge, the NHS Institute took a leading role in the High Impact Actions for Nursing and Midwifery initiative and is currently working on another ideas channel – Measurement for Quality and Cost – to find examples of how the NHS is measuring and evaluating for improvement, and using the information to influence decision making.

In December, NHS Evidence launched a new collection of examples showcasing how quality and productivity can be improved across the NHS. Six of these are highlighted as 'recommended' as they are considered to have the highest cost saving impact, and three of these are NHS Institute projects – The Productive Ward, the Fractured Neck of Femur Rapid Improvement Programme and the Stroke Pathway: Delivering through Improvement. The home page of the NHS Evidence website also has links to both the Better Care, Better Value (BCBV) indicators and to the High Impact Actions for Nursing and Midwifery.

Guides to help both commissioners and providers to make optimum use of the BCBV indicators to improve quality and reduce cost in their organisation were published in December 2009. The NHS Institute followed the publication and attendant publicity with a series of web seminars. These offered over

Management Commentary and Review of Activity *(continued)*

400 interested parties the opportunities to find out more and ask questions of both NHS Institute experts and colleagues within the NHS who had practical experience of improving service through the use of the indicators.

The Productive Series

The Productive Series supports NHS teams to redefine and streamline the way they manage their work. This produces significant and lasting improvements, not only in the way teams handle their workload, but also in the extra time they can give to patients. These improvements are driven by the staff themselves, using tools and techniques that help them to save time and resources. The programmes are designed to empower frontline staff to ask difficult questions about practice and to influence the way they work on a day-to-day basis.

Achievements

There have been a number of highlights for the programmes in The Productive Series during 2009-10. These are outlined below.

The Productive Ward

An increasing number of specialist departments, such as maternity, critical care and paediatrics are successfully implementing the programme. The NHS Institute worked with these teams to share their learning via a series of weekly newspapers.

The Productive Ward: *Releasing time to care Learning and Impact Review* (led by the National Nursing Research Unit at King's College, London) highlighted the impact the programme has made and demonstrated how it can help organisations to meet the future challenges facing the NHS.

The Productive Mental Health Ward

The NHS Institute is providing programme implementation support to 57% of mental health organisations across the NHS.

A national conference highlighted the significant impact the programme has had on organisations. For example, levels of staff sickness at Rampton Hospital's Jade Ward dropped from 14% to as low as 1% after The Productive Mental Health Ward was implemented.

The Productive Community Hospital

The NHS Institute is providing programme implementation support to 42% of community hospitals with inpatient beds.

Principles from the programme have been successfully applied to wheelchair services.

The Productive Leader

Over 50% of NHS organisations have registered their interest in the programme. A number of them now have trained facilitators and project managers to deliver the programme in their organisation.

In 2010-11 we will produce a series of case studies to illustrate the benefits the programme has delivered to NHS organisations.

The NHS Institute has been working in collaboration with the Department of Health to ascertain how The Productive Series can support the NHS in 'delivering same-sex accommodation' (DSSA). This important collaboration has resulted in a collection of supplements that will help NHS teams to deliver high quality same-sex accommodation by using Productive methodology.

Management Commentary and Review of Activity *(continued)*

In 2010, we will be launching the Module Impact Framework, which has been recognised as the 'missing link' in The Productive Series. For the first time, organisations will have the opportunity to measure their efficiency, the impact on staff experience and the contribution that the programmes have made to the skills development of staff. It will give NHS organisations the robust evidence they need to demonstrate return on investment when implementing a Productive programme.

Products Launched

In 2009-10 the series expanded with the introduction of two new programmes: The Productive Operating Theatre and Productive Community Services.

The Productive Operating Theatre

Launched in September 2009, The Productive Operating Theatre focusses on helping theatre teams to improve the patient experience and outcomes of care. Over 500 delegates attended the launch event, which was supported by Lord Ara Darzi. To date, 42% of acute trusts have ordered boxed sets in preparation for programme implementation. A number of strategic health authorities (SHAs) have indicated they will require support from the NHS Institute in 2010-11.

Productive Community Services

Working jointly with the Department of Health's Transforming Community Services team, Productive Community Services was launched in October 2009 with the support of Jim Easton, National Director for Improvement and Efficiency, who is also our sponsor at the Department of Health. Approximately 500 delegates attended the event. The programme helps frontline community services teams to increase the amount of time they spend in direct contact with patients. Early figures show a typical gain of between 25% and 30% in the proportion of time staff spend on direct patient care. To date, there has been a 64% uptake of Productive Community Services boxed sets by NHS community services providers. A number of trusts and SHAs have confirmed they will require support from the NHS Institute in 2010-11.

Management Commentary and Review of Activity *(continued)*

Delivering Quality and Value

Rapid Improvement Programmes

Using the key characteristics of high performing organisations, the Delivering Quality and Value team has been working on High Volume Care Rapid Improvement Programmes. The aim is to help NHS trusts to improve the quality and efficiency of care quickly.

Achievements

Caesarean section

- The Delivering Quality and Value team supported 20 trusts, the majority of which have seen a reduction in C-section rates.
- Blackpool, Fylde and Wyre Hospitals NHS Foundation Trust reduced its rate from 28% to 22%.
- Royal West Sussex NHS Trust increased its success rate for women attempting vaginal birth after C-section from 26% to 84%.
- In 2010-11, South East Coast SHA is planning to roll out our C-section toolkit across all trusts.

Emergency and urgent care for children and young people

- System-wide, ten emergency and urgent care processes have been transformed (one per SHA).
- Wirral University Teaching Hospital NHS Foundation Trust has seen a reduction in A&E attendances (down 4% from last year).
- All sites have whole-system project groups in place. Links have been made with Urgent Care boards and all now have children and young people on their agenda.
- Organisations on the Rapid Improvement Programme have set the goal to achieve a:
  - 25% reduction in A&E attendances
  - 25% reduction in admissions.

Cholecystectomy

- Ten trusts have received support and all have seen improvements.
- Northern Lincolnshire and Goole Hospitals NHS Foundation Trust increased its day case rate from 2% to 80%.
- The normative tariff for cholecystectomy will be based on our Focus On: Cholecystectomy publication.
- We are currently developing a kit to support improvements in day surgery rates.

Orthopaedics (fractured neck of femur and primary hip and knee replacement)

- Ten trusts have been supported for each pathway and all have seen improvements.
- South Tyneside NHS Foundation Trust managed to eliminate cancelled operations and reduce the average length of stay for patients from eight days to six (hips) and from 11.5 days to seven (knees).
- The NHS Institute has been using Rapid Improvement Programme methodology to work on falls and fractures alongside the Department of Health. This work has highlighted variation in quality, identified best practice and demonstrated the impact of the best practice tariff on fragility hip fracture.

- We will be partnering with the Department of Health's Enhanced Recovery Programme (ERP) during 2010-11, rolling out the ERP and the principles of the Rapid Improvement Programme in each SHA.

Adult mental health admissions/ Psychiatric intensive care

- Sixteen trusts have received support (eight on each pathway). The aim is to work towards consistent, robust outcome measures and spread the principles of the high volume care programme.
- The programme builds on, and strengthens, current support from critical national stakeholders (the Mental Health Czar, the Department of Health, the National Association of Psychiatric Intensive Care Units, and the National Mental Health Development Unit).
- It is linked with the Payment by Results (PbR) quality outcome development project. The reason for linking these two initiatives is to develop quality outcomes for PbR mental health clusters within the natural network of the Rapid Improvement Programme.

Ambulatory and short stay emergency care (adults, including frail older people) – South East Coast SHA only

- East Sussex Hospitals NHS Trust (Eastbourne District General Hospital) is working on pulmonary embolism and cellulitis pathways.
- The percentage of pulmonary embolism patients with a zero day length of stay has increased from 4% in 2008-09 to 9% in 2009-10. The percentage of cellulitis patients with a zero day length of stay has increased from 3% in 2008-09 to 10% in 2009-10.
- Ashford and St. Peter's Hospitals NHS Trust (St. Peter's site) is working on pulmonary embolism and community-acquired pneumonia (CAP). The percentage of CAP patients with a zero day length of stay has increased from 6% in 2008-09 to 8% 2009-10. Ambulatory care will be a major component of the redesigned Emergency Department at the trust.

Products Launched

ThinkGlucose

- Launched in summer 2009, ThinkGlucose aims to ensure that the NHS delivers a high quality experience to hospital patients who have diabetes as a secondary diagnosis.
- Seventy-six per cent of trusts have taken up the core offer with positive outcomes. One trust that has taken ThinkGlucose to heart is East and North Hertfordshire NHS Trust. *"It's essential we improve the care, experience and outcome of people with diabetes who are admitted into hospital."*

  Kate Malhaffey, diabetes inpatient specialist nurse.

Management Commentary and Review of Activity *(continued)*

Transforming Radiology Services Kit: Focus on Booking Processes

- The kit was launched in May 2009, with the aim of helping to identify areas for improvement and providing the solutions and tools to deliver these improvements. It received much positive feedback: *"In one afternoon we mapped our booking processes, highlighted areas for improvement and developed action plans, thanks to this very quick and simple toolkit. Both patients and staff have benefited from reduced did not attend (DNA) rates, shortened time taken for vetting and booking requests, and improved staff education and morale through greater involvement."*

  Amanda Bisset, Clinical Director and Consultant Radiologist at Northampton General Hospital NHS Trust.
- A second kit, Transforming your Radiology Services: Focus on Reporting Processes was launched in March 2010. It has been developed to help organisations rapidly understand current reporting processes.

Focus on: Sick patients with suspected cancer/OncoAlert

- Focus on: Sick patients with suspected cancer was launched in June 2009 providing hospital teams with guidance on how to improve the management of emergency patients who are suspected of having cancer.
- A supporting toolkit, OncoAlert, was launched in November 2009. It is a simple and effective CD-ROM that includes a variety of tools and templates which cancer teams can use to make pathway improvements. OncoAlert aims to help hospital teams focus on faster diagnosis and treatment of sick patients with suspected cancer.

High Impact Change

- Four pathways (acute stroke, fractured neck of femur, emergency and urgent care for children and young people, and ambulatory and short stay emergency care) have been recommended by the Department of Health as having the potential to deliver high impact change. The evidence case studies have been published on the NHS Evidence website.

Safer Care

The Safer Care team aims to build an NHS where every member of staff has the passion, confidence and skills to eliminate harm to patients. It works with NHS organisations, practitioners, patients and their relatives, academics and safety improvement experts to develop products and programmes that deliver patient safety improvement. The team assists NHS organisations at a strategic and operational level, helping to build the capacity and capability for safety improvement. Programmes equip participants with the skills, tools and techniques they need to make real improvement at every level, from whole-systems to individual wards, practices and departments.

During 2009-10, the Safer Care team concentrated on three key areas:

- continuing to develop new products and programmes
- refining, improving and consolidating existing initiatives and helping the NHS to implement these locally
- ensuring its work is closely aligned with, and reflects, the national QIPP agenda.

Management Commentary and Review of Activity *(continued)*

Achievements

Training and coaching

- In 2009-10 Safer Care team members spent time training, developing and coaching NHS teams on a planned and ad hoc basis, mainly delivered to strategic health authorities and/or NHS organisations in their areas as part of the team's core offering.

Generic curriculum for patient safety

- The team worked with the Royal College of Surgeons of Edinburgh and the Academy of Medical Royal Colleges to develop a generic curriculum for patient safety.

New Trigger Tools and Web Portal

- The Safer Care team has developed Trigger Tools and associated web portals to measure harm in primary care and paediatrics.
- The Trigger Tool web portal was launched in 2009 to capture and analyse results from case note reviews. This online tool supports the use of the Trigger Tools in acute, paediatric and primary care and is being used with considerable success across more than 100 NHS trusts and an increasing number of GP practices. It allows organisations to measure their rates of harm, identify areas for improvement and track progress of initiatives over time.

Management Commentary and Review of Activity *(continued)*

Improvement Faculty for Quality and Patient Safety

- A new Improvement Faculty for Quality and Patient Safety was introduced in 2008 to provide support, enable learning and maximise adoption of best practice through programmes of ongoing learning. The faculty has continued to grow and now has a membership of 147 Fellows. It holds two national conferences annually, as well as masterclasses and learning web seminars.
- The Safer Care team has made particular use of the skills and experience of the Safer Care Teaching Faculty and Improvement Faculty Fellows. The Fellows are highly experienced, respected leaders in their fields who have championed improvement methodologies and practices. Many are also part of the NHS Institute's Teaching Faculty and have therefore contributed to our programmes, products and approaches and led many seminars on our behalf.

Continued success of Leading Improvement in Patient Safety

- The fifth wave of the acute Leading Improvement in Patient Safety (LIPS) programme got underway in 2009-10 and recruitment to the sixth wave was successful. To date, nearly 100 trusts have undertaken the acute LIPS programme, with many sending more than one team. Participants report the following successes:
  - Northumbria Healthcare NHS Foundation Trust reduced cases of C.Difficile by 180 a year. This equates to 60 lives saved and a six-figure annual cost saving.
  - George Eliot Hospital had the worst hospital standardised mortality ratios (HSMR) in the country at 138. By March 2009, it had reduced this figure to 84 (the average is 100). It has also reduced the average number of cases of C. Difficile from 17 to 7.
  - Catheter-related bloodstream infections at Royal Brompton and Harefield NHS Trust were reduced from 16 to 4 in just six months.
  - Liverpool Heart and Chest Hospital NHS Trust increased compliance with head elevation for patients needing ventilation from 80% in September 2008 to 100% in January 2009. This contributes to the ventilator bundle, which reduces rates of ventilator-acquired pneumonia to almost zero.

Products Launched

Advanced Improvement for Quality and Safety programme

- The Advanced Improvement for Quality and Safety programme was co-produced with the service and was delivered to 14 participants over the course of the year. The year long programme is for senior staff leading patient safety improvement in their organisations, it has been accredited by the University of Derby and provides 30 credits towards an MSc in Advanced Practice.

Patient Safety Leaders' programme

- The Safer Care team developed the first Patient Safety Leaders' programme for staff with an interest in safety improvement. During 2009-10 two programmes were delivered (one in pilot form) to a total of 36 participants. The programme has also been accredited by the University of Derby and provides 30 credits towards an MSc in Advanced Practice.

LIPS programmes

- A new LIPS programme for general practice has been introduced. This builds on the highly acclaimed parallel programme for acute trusts. LIPS is an internationally acknowledged programme which helps organisations to systematically improve patient safety.
- Building on the success of the acute LIPS programme, the first LIPS programme for mental health was developed.

Products to support the use of SBAR

- Products have been developed to support the use of SBAR (Situation-Background-Assessment-Recommendation), including a series of DVDs, a user guide and quick reference pads. The aim of SBAR is to improve communications between professionals at key moments, such as escalation of care and patient handovers.

Building Safety Improvement Skills programme

- The Building Safety Improvement Skills (BaSIS) programme for junior doctors is the first national approach to embedding patient safety improvement within medical training. In 2010, the programme held a two-day national event attended by 85 junior doctors.

Commissioning for Health Improvement

The Commissioning for Health Improvement team aims to fulfil one of the main priorities for the NHS Institute which is to accelerate the achievements of world class commissioning. It has developed a number of products and is continuing to work with primary care trusts (PCTs) to improve these products.

Achievements

The Commissioning Development Programme (CDP)

- This has been the main delivery mechanism for the NHS Institute's commissioning development support to PCTs during 2009-10.
- Typically, each strategic health authority (SHA) receives four days of input. The programmes are delivered to teams of five or six participants from each PCT in the SHA.
- CDPs have been delivered, or are currently underway, in 7 out of 10 SHAs. The content of each programme is negotiated and agreed with each SHA sponsor, and a representative group of PCT commissioners is also usually involved.
- The programme takes participants through the commissioning cycle. It applies the NHS Institute's tools and approaches at each stage, either generically or to specific issues, such as obesity, stroke, primary care and mental health.
- To date, 740 individuals (mainly across PCTs) have been involved in these programmes.

Management Commentary and Review of Activity *(continued)*

Bespoke Commissioning Development Programmes

- In 2009-10, the Commissioning for Health Improvement team delivered 30 bespoke support programmes according to PCT clients' needs.
- Converting the world class commissioning vision into real improvements for patients requires extensive redesign of care pathways. Our support programmes use a facilitated process to achieve specific aims and to help PCTs gain maximum benefit from our Improving Patient Pathways suite of products:
  - Prioritise Commissioning Opportunities, including the Opportunity Locator and Priority Selector online prioritisation tools.
  - Project Delivery for Commissioners.
  - Innovation for Commissioners, incorporating Commissioning to Make a Bigger Difference, Thinking Differently and Experience Based Design.
  - Prioritise Commissioning Opportunities for practice based commissioners.
  - PBC Compact development.

Products Launched

Healthy Places, Healthy Lives

- Tackling health inequalities is one of the most complex and important tasks facing primary care trusts and local authorities. The new Healthy Places, Healthy Lives programme was launched in January 2010 and aims to identify, develop and spread joint public service and commissioner-led actions that lead to improvements in the factors that determine health. It addresses the recommendations of Sir Michael Marmot's review of Health Inequalities post-2010 *Fair Society, Healthy Lives*. Ultimately, the programme will help to improve world class commissioning and local area agreements outcomes.
- We will be working with two leading improvement agencies to support the programme: The Improvement and Development Agency (IDeA) for local government and the Health Inequalities National Support Team. The latter has been working with a group of 13 communities, known as the 'Baker's Dozen', whose gap in mortality rates represents 40% of the national gap.
- Healthy Places, Healthy Lives brings together 30 local partnerships to work together. They come from all SHAs/ regions and offer a rich mix of learning. Participants are connected to all major health improvement programmes (Core Cities, Triple Aim, etc.) and face a range of challenges, including teenage pregnancy, obesity, smoking, domestic violence and crime. Healthy Places, Healthy Lives enables partners to adopt a more holistic strategy to long term wellbeing as a way of meeting new targets for reducing inequalities. Fellows represent a wide spectrum of public services, including health, policing, fire service, and local government.

Making Innovation Happen

Innovation is regarded as an essential component in the next phase of NHS reform. This year, our Innovation Practice team continued to make significant headway in embedding innovation as a central component of service delivery. An increase in the use of existing Innovation products, such as *Thinking Differently* and *The Sustainability Toolkit and Guide*, demonstrates the proactive spread and adoption of innovation in 2009-10. One Thinking Differently masterclass attendee recently won a trust award for innovation.

Achievements

Experience Based Design (ebd)

First launched in January 2009, ebd brings patients and staff together to share the role of improving care and re-designing services. It has now been rolled out across the service and the impact from the pilot sites is being realised. In 2009-10, we started to tell the success stories. One site has already been deemed 'excellent' after identifying 40 improvements as a result of ebd and a set of case studies has now been published in *The ebd approach – Concepts and Case Studies* book. A series of four masterclasses and a live web seminar for all NHS staff, hosted by a pilot site representative, is spreading learning and participation. Further work will continue next year to develop products that help frontline staff implement ebd.

Management Commentary and Review of Activity *(continued)*

Creating the Culture for Innovation

In the current economic climate, Creating the Culture for Innovation balances the reality of reduced resources against the demand from patients for even better experiences of care. Innovation can help to meet patient expectations, and this programme summarises what the key cultural facets are within organisations that encourage innovation. A printed resource based on this model – *Creating the Culture for Innovation: Guide for Executives* – was published this year. It will shortly be followed by a guide aimed at frontline staff.

NHS Innovation Survey

The NHS Innovation Survey was the first of its kind. Over 4,600 NHS staff gave detailed feedback on how they have been working to improve their service to patients. The results will be used to help the NHS Institute create a baseline for the innovation work currently being done. This will enable us to develop better products and services for frontline staff, based on an accurate measure of the extent to which innovation needs to be built on and facilitated nationally.

Innovation Practitioner Programme

The programme was piloted this year in order to build capability within the NHS, and empower staff to become effective change-agents. It aims to create accredited innovation practitioners who have an in-depth knowledge of innovation methodologies. They should be able to employ these methodologies in their daily working lives to actively promote innovative thinking.

The Innovation Practitioner Programme applies core innovation skills to real projects, ranging from a virtual vein simulator to improving access to psychological therapies. The successfully accredited innovators received their awards in November 2009 from Professor Tony Butterworth (Specialist Adviser on nursing and non-medical professions, NHS Employers and Non-executive Director of the NHS Institute). Following this successful pilot, the Innovation Practice team is preparing to run the programme across Yorkshire and the Humber SHA.

High Impact Actions For Nursing and Midwifery

High Impact Actions for Nursing and Midwifery is a joint initiative led by the chief nurses from the 10 strategic health authorities in collaboration with the Royal College of Midwives, Royal College of Nursing, the Nursing and Midwifery Council, Leaders in Nursing, The Queen's Nursing Institute, Unite (incorporating CPHVA), the NHS Institute for Innovation and Improvement and the Department of Health. In autumn 2009, nurses and midwives were invited to share their successful ideas for improving quality and reducing costs, so that these initiatives could eventually be implemented across the NHS. Six hundred ideas were put forward in just three weeks, reflecting the level of passion that nurses and midwives have for improving the care they provide to patients. Each high impact action sets out the scale of the challenge and the opportunities for improving quality and patient experience and reducing cost to the NHS. A selection of High Impact Actions, and learning captured so far, has been made available in the publication *High Impact Actions for Nursing and Midwifery*. A full resource of all of the actions submitted is also available on our website. For the next phase, the Innovation Practice team is working with 'demonstrator' sites to gain an in-depth understanding of the impacts created. Using this knowledge, we will

Management Commentary and Review of Activity *(continued)*

produce a programme and tools to facilitate the large scale spread and implementation of High Impact Actions for Nursing and Midwifery across the whole of the NHS.

Products Launched

The National Innovation Centre is a division of Innovation Practice which focusses on how new technologies can tackle clinical needs. This year's highlights include:

- Sticksafe – This product compels the user to re-sheath contaminated needles and ensures safe separation of the used needle from the syringe before disposal. Sticksafe reduces the risk of needlestick injury by over 50%. An additional safety feature allows single-handed needle uncapping and recapping. This product represents potential savings to the NHS of over £160 million and is now available via the NHS supply chain
- a redesigned kidney bowl costing far less than existing products
- a unique Innovation Management Infrastructure – This has been adopted by the Department for Business, Innovation and Skills for replication across other Government departments
- Vnus Closure – a new varicose vein procedure now in use at over 40 trusts
- an HCAI (healthcare associated infection) productivity tool, enabling the development of temporary isolation units, is now on the verge of high volume production
- a scorecard tool has been adopted by the NHS Supply Chain for the front-end of its own business
- National Innovation Centre (NIC) Showcase content is being adopted by NHS Evidence and the NHS for re-distribution via their own channels, to encourage and help spread innovation activity across the NHS.

Management Commentary and Review of Activity *(continued)*

A strategy for mobilising the NHS leadership community and workforce at scale for quality and cost improvement

Utilising theories from social movement and mobilisation campaigns, this is a strategy to call the NHS workforce and leadership community to action in support of quality and cost improvement. To complement the technical QIPP workstreams this will engage NHS staff to tackle the challenges through innovation and with commitment. We have already had wide engagement to date, and more than 1,000 local, regional and national leaders have helped to shape the approach; improvement and innovation leads, clinical leaders, leadership leads, communications leads and finance leaders... this work continues and the momentum is gaining.

Living our Local Values

This project was initiated as a direct result of High Quality Care for All and the publication of the draft NHS Constitution. A set of six national values surfaced through conversations with staff, patients and the public. The NHS Institute was commissioned by the Department of Health to provide a suite of support materials and signposts to resources to be made available to NHS organisations to enable them to develop and embed values locally and use their work on values to drive improvements.

Using principles of co-design and co-production, the Values team worked with three field test sites, and 22 learning partners from across the NHS to design and test the materials through a series of accelerated change events. This resulted in the production of the Values Development Resource which is a 'how to' guide for local use which over 80 organisations are now using.

Organising for Quality

This was a new programme launched in 2009.

The Fundamentals for Quality Improvement suite of products aims to provide NHS staff with a solid foundation in quality and service improvement methods and techniques and a range of tools with which to design and implement effective and sustainable improvement projects. They can be accessed on our website.

The Organising for Quality and Value: Delivering Improvement programme aims to provide both clinical and operational staff within the NHS with:

- the capacity and capability to implement service improvement projects
- the confidence to develop creative, innovative ways of meeting patient needs and improving quality of care
- up-to-date knowledge and hands-on experience of using tried and tested service improvement tools and techniques.

Learning

The work of the Learning team encompasses a variety of projects which aim to increase the service improvement capabilities of NHS staff.

Achievements

The primary programmes provided by the Learning team in 2009-10 were:

Workforce Matters

Workforce Matters is the NHS Institute's improvement capability-building programme for senior human resource and workforce development leaders. It is now in its second testing phase in the NHS South West region. The programme is designed to deliver high impact leadership development to equip HR and workforce leaders with the improvement expertise, confidence and scope for career development required to deliver 21st century healthcare. In the NHS South West pilot, each of the 24 participants was required to complete a personal impact project, addressing the quality and productivity challenges of their local health system. As a result of this work, the projected return on investment is potentially £10 million in efficiency gains.

Improvement in pre-registration education

Since it was piloted in four universities in 2006, the pre-registration project has spread to 47 Higher Education Institutions (HEIs). In the last academic year, 5,678 students from 23 professional groups received teaching in basic theories and tools of service improvement, as well as undertaking an improvement project within their practice setting.

External evaluation demonstrates the success of the project. Comments from students include:

"…I now take time to consider each patient as an individual"

"…this has had a significant impact on my feelings about my responsibility to initiate change in the NHS"

"…surely this should be mandatory?"

The Fellowship Programme

Eighteen senior members of staff from the NHS and two staff from health related organisations have now taken part in the NHS Institute Fellowship scheme.

e-Learning for Improvement

The NHS Institute's Introduction to Improvement e-learning package is now fully available via the NHS Evidence repository and is expected to become part of the Learning Management System, a system for accessing e-learning and recording who has completed which courses, later this year. The package is aimed at staff bands 1-4 primarily, but forms a good introduction to service improvement for all.

Specialist Collection for Improvement

The online specialist library collection went live on the NHS Evidence website in November 2009. The collection pulls together a substantial amount of evidence that underpins all aspects of improvement work.

Management Commentary and Review of Activity *(continued)*

Knowledge Management

The Knowledge Management (KM) team continue to advise and support NHS Institute teams in capturing and transferring lessons learned using a range of knowledge management tools and techniques to support the implementation of products and share learning across the wider NHS.

For instance, the team played a central role in designing the networking and knowledge sharing elements of national and regional events for the Delivering Quality and Value (DQV) Focus on Rapid Improvement in Orthopaedic Programme in 2009 so that SHAs and trusts could share what had worked well and identify solutions to implementation challenges. At the end of the programme the team facilitated a retrospective review with the project team to capture the successful and less successful elements of the programme in order to shape this work moving forward.

Leadership

The Leadership programmes continued to attract high calibre professionals to the NHS, with the Graduate Schemes' entrance benchmark reaching an all-time high. The Medical Leadership team made serious strides in engaging doctors in management and leadership of health services, whilst more than 150 senior NHS leaders were coached by the Board Development team over the year.

During last year, the leadership unit became aligned to the National Leadership Council's (NLC) new development infrastructure to support the Emergent Leaders workstream, contributing to the NLC's overall purpose of transforming leadership capacity and capability throughout the system.

Achievements

Graduate Management Training Schemes

The 2009 trainee intake was marked by a sharp increase in the quality of applicants to the Graduate Management Scheme. Although the NHS Institute's entry requirement is at an all-time high, we were able to offer places to an extra 40 graduates who reached our benchmark bringing the total to 280 trainees.

The Informatics specialism is now a fully-fledged programme. The pilot scheme was a complete success and the specialism recruited 19 trainees to start in September 2009.

The Graduate Scheme has been enhanced to ensure that it remains fit-for-purpose. New features include:

- an improved welcome event, aimed at retaining new trainees during the critical induction period
- the development of Talent Studio, an online performance management system
- a multi-disciplinary 11-day foundation programme
- new and updated specialism competencies
- an orientation focus on the patient journey.

Awards

Our Graduate Training Scheme has been recognised as one of the best in the country. It has received various awards over the last year, including:

- Times Top 100 (2009) – ranked sixth Employer of Choice
- Times Top 100 (2005, 2006, 2008 and 2009) – HR Graduate Employer of Choice
- AGR Awards, Graduate Selection and Assessment Award 2009.

Management Commentary and Review of Activity *(continued)*

Gateway to Leadership

First launched in 2002, the Gateway to Leadership programme has recruited more than 180 managers to the NHS, with 26 participants joining the programme during the 2009-10 period.

By sourcing new talent from the private sector and other areas of the public sector, the programme enables people with the best senior management potential to progress to the highest level of the NHS. Gateway to Leadership focusses on widening the managerial skills base by recruiting senior leaders from outside the organisation to complement the strengths of existing teams. Recruits to a wide range of senior roles across the country were attracted by the Gateway programme, illustrating the effectiveness of our advertising and recruitment campaigns.

Breaking Through

The Breaking Through programme aims to identify, develop and support talented managers from black and minority ethnic (BME) backgrounds to move to the next level of their career.

Management Commentary and Review of Activity *(continued)*

The programme commissioned thorough research which aims to understand the organisational barriers that deter black and minority ethnic employees from rising to positions of authority and influence in the NHS. The study provides invaluable information to support the Leadership team's future plans.

Another important development has been the implementation of Towards Strategies for Success, a one-week programme designed to support staff at Agenda for Change Bands 7 and above. The programme explores the challenges faced by a BME person and the impact on their performance of working within a predominantly white organisation.

Breaking Through has doubled the number of participants on its second cohort. Four of its top talent participants have now progressed to substantial board level roles.

Enhancing Engagement in Medical Leadership

This joint project with the Academy of Medical Royal Colleges aims to help create an organisational culture where doctors seek to be more engaged in the management and leadership of health services and senior leaders genuinely seek the involvement of doctors in improving services for patients across the UK. Highlights over the past year include:

- the inclusion of the Medical Leadership Competency Framework in the General Medical Council's *Tomorrow's Doctors* publication (standards for undergraduate education) and the development of guidance for medical schools on integrating these competences into curricula
- the inclusion of the Medical Leadership Competency Framework in postgraduate training through each Medical Royal College's review of specialty curricula. This has been accompanied by the development of e-learning materials to support trainees and clinical tutors
- identifying a strong link between medical engagement and organisational performance. This has been achieved by comparing data collected from several trusts using the Medical Engagement Scale and performance data collected from Dr Foster, the National Patient Safety Agency and the Care Quality Commission
- being shortlisted for the BMJ Excellence in Healthcare Education category at the BMJ Group Awards.

Board Development Team

The focus of the NHS Institute's provision for boards and senior leaders is on leadership for improvement – inspiring senior leaders to transform the quality of care. This offering forms part of the NHS Institute's wider support for organisations, teams and individuals to achieve transformation through quality, innovation, productivity and prevention.

Achievements

Our support is available as initiatives aimed at individuals or whole teams. Particular highlights for 2009-10 include:

- providing executive coaching to over 150 senior NHS leaders and procuring a new register of executive coaches for individuals and teams
- the Innovations in Healthcare programme. Preliminary evaluations of the programme are very positive and suggest significant productivity improvements in the participating organisations
- delivering the Board Development Tool to 38 organisations (both commissioner and provider) and developing a bespoke version for foundation trusts.

Networks

SHA Network

The NHS Institute has developed and consolidated its connection with the NHS during 2009-10 via our Operating Plan, which detailed five programmes of input that were delivered within each of the 10 regions. We worked directly with the 10 strategic health authorities to gain greater understanding of the culture and priorities within each region and ensured that the delivery style and context were aligned to their regional way of working. In addition, the selection of pilot sites for all new areas of work was agreed with the SHAs.

We continued to develop the SHA Improvement Network, extending its membership to SHA Safer Care leads. We also developed our thinking around and understanding of the support required for health systems, developing a practical approach to support whole systems based on our learning from the Academy for Large Scale Change (see below).

Our Field Team carried on its work at an organisational level to increase knowledge and understanding of the NHS Institute's work and to raise awareness of the impact our programmes can have within NHS trusts and PCTs.

Academy for Large Scale Change

Achievements

The NHS Institute has succeeded in promoting and achieving tangible change across many healthcare sites. However, to ensure these changes are sustainable and long term, they must be large scale. In other words, the thinking behind them must be fully 'invested in' by staff across strategic health authorities which cover multiple sites and large geographic areas. In order to achieve this, leaders need to build specific skills. The Academy for Large Scale Change worked with a group of 72 participants, representing SHAs in England. They underwent a year long structured learning programme, which was applied to a specific priority project for their authority. Some projects included:

- reducing waiting times for both consultant and non-consultant planned care pathways in NHS South Central
- mainstreaming tele-healthcare to empower service users in NHS West Midlands
- improving the diagnosis and treatment of stroke for the population of Yorkshire and the Humber, thereby reducing unnecessary, premature deaths by 600 a year
- tackling health problems, and increased A&E admissions associated with excessive alcohol consumption in the North West, by introducing specialist alcohol nurses to implement preventative and educational measures.

Management Commentary and Review of Activity *(continued)*

The Academy for Large Scale change was also identified as a key driver for integrating the QIPP agenda across SHAs. Academy members are now being equipped to deliver elements of this with optimal effectiveness.

Learning from the Academy, as well as case studies of large scale change methodologies explaining how they were applied to specific projects, will be factored into a specialist resource which will be made available to the wider NHS next year.

Patient Engagement and the Practice Partner Network

Achievements

- In 2009-10, the Practice Partner Network (PPN) interacted with the NHS Institute 915 times and participated in 72 NHS Institute programmes. Fifty-seven NHS trusts belong to the PPN. These are forward thinking organisations that are poised and ready to test and rapidly pilot new concepts.
- **The Patient Experience Learning Programme** – 45 trusts are now taking part in the programme, with participation from a range of NHS teams, from directors of nursing to change management leads. It is a one year course and includes a workplace project to demonstrate and directly apply new skills learned from a variety of approaches including face-to-face sessions, a service safari and web lectures.
- **The Patient Experience Online Network** – the network has been launched to share the latest thinking on maximising patient, carer and staff service experience. Both this and the above programme are supported by the Department of Health's Patient and Public Engagement and Experience Network.
- **Incorporating patient engagement into Productive Community Services** – this supports the co-design process to ensure that opportunities to engage with patients and staff are embedded in the Productive Community Services programme.This has resulted in a patient perspective guide which builds on the existing ebd approach, a training programme, support tools and evaluation.
- **Armchair Involvement: using new technologies to engage people in service improvement** – new technologies have the ability to transform health services and engage the public, patients, staff and carers in new and more effective ways for service improvement. Technology alone is not the answer, so armchair involvement is about participation and engagement, first and foremost, with a primary emphasis on exploring existing forums. This armchair involvement website has been updated this year to include emerging technologies, such as online collaborative technology (e.g. Google Wave) and micro blogging (e.g. Twitter). It also includes an A-Z of technologies, inspiration from outside healthcare and a chance to share learning.

- **Decision support for prostate cancer patients** – In October 2009, NHS Institute Chief Executive, Bernard Crump, officially launched the Urology Decision Support programme. It was launched at a reception in the House of Commons, attended by patients, staff and stakeholders who had been involved in the development of the programme. There are approximately 34,000 new diagnoses of prostate cancer each year and over half of men in their 60s have some symptoms of benign prostatic hyperplasia (BPH), or enlarged prostate. Currently, there is no evidence that one treatment is more effective than another, but each has different side effects so support in decision making is of particular importance. The project has been led by Mary Archer, Chairman of the Cambridge University Teaching Hospitals NHS Foundation Trust with the NHS Institute's support.

NHS Live

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

Achievements

Improvement project directory - NHS Live's improvement project directory has continued to grow and now comprises 1,336 frontline improvement projects, registered by NHS staff. It is searchable by region and keyword. The directory provides frontline innovators with a source of potential solutions to issues they are facing, an opportunity to promote and share their ideas, knowledge and experience, and inspiration and learning from other frontline NHS staff.

Community membership – membership of the NHS Live community has risen to more than 13,000 frontline enthusiasts, innovators and improvers from across the NHS. In 2009 a monthly newsletter was introduced which includes features and updates on NHS Live projects and news of the latest tools, products and events from the NHS Institute.

Regional seminars – during 2009-10, NHS Live ran a successful series of regional seminars, providing training and development opportunities and aimed at strengthening the capability of frontline NHS staff to innovate and support the radical re-thinking of services. These were attended by a total of 275 frontline staff.

Satisfaction and buy-in – in a recent members' survey 82% of respondents said they were 'satisfied or very satisfied' with the NHS Live network and 77% said they read the newsletter. ***"NHS Live has been absolutely invaluable in helping me to keep up-to-date, and network face-to-face, as well as virtually."*** **(NHS Live member)**

Health and Social Care Awards

The Health and Social Care Awards 2009 were run as a partnership between the NHS Institute, the Department of Health and the ten strategic health authorities. The 14 categories were designed to recognise breakthrough ideas from frontline staff that improve care and access to services. They also recognised where partnership working between the NHS, social care and external organisations has made improvement ideas a reality. The awards received 4,000 applications, an increase of over 30% on the previous year.

Management Commentary and Review of Activity *(continued)*

NHS Alert

Launched to the wider NHS in June 2009, NHS Institute Alert is a current awareness service focussed around healthcare improvement. The service covers nine topics (commissioning, cost and quality, improvement, innovation, knowledge improvement and research, leadership, management of change, patient experience, and patient safety). NHS Institute Alert is available via our website, RSS feeds, and monthly newsletter. On 30 June 2009, 198 people were subscribing to the newsletter. As of 1 March 2010, there were 8,831 subscribers.

Related services include Article of the Month, Guest Editorials, and Expert on Call - a monthly web seminar, launched in August 2009. Expert on Call topics have included service improvement tools, innovation culture, and patient safety. To date, 532 people, mainly NHS staff, have participated in Expert on Call.

International work

The aim of our international work is to enhance the global reputation of the NHS and make a difference to patients across the globe, while bringing back the best learning from around the world for the benefit of NHS England. During 2009-10 we have seen significant progress, including commercial success that has contributed revenue to the NHS Institute. The Productive Series has been implemented in many countries, including New Zealand and Canada, and we have strengthened our relationships with improvement organisations such as the Institute for Healthcare Improvement (IHI) and private health providers, for example Kaiser Permanente. In the coming year this part of our organisation will be focussed on bringing learning and initiatives from other countries back into NHS England to contribute to the QIPP agenda.

Director of Corporate Services and Finance Commentary

Financial performance

The accounts on pages 49 to 104 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.

2009-10 Finances at a glance

This report includes the financial information for the year ended 31 March 2010. The NHS Institute was required to achieve a number of key and statutory financial targets:

- To maintain its revenue expenditure within a limit of £70,255,000. **This was achieved.**
- To maintain its capital expenditure within a limit of £1,800,000. **This was achieved.**
- To maintain its net cash outgoings from operating activities within a limit of £70,292,000. **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 payables 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 82% (by value) and 91% (by number) of its non-NHS trade payables within 30 days of receipt of goods or valid invoice, whichever was the latter. This is a deterioration of performance against last year, however, this is due to the switch over to the new finance system. In the seven months from 1 September 2009 to 31 March 2010, the comparable performance was 89% (by value) and 94% (by number). This improvement will continue into 2010-11.

  In addition we seek to pay small and medium sized enterprises (SME's) within 10 days. During the year, 52% of non-NHS invoices (by value) and 64% (by number) were paid within 10 days.

Financial Position at 31 March 2010

In 2009-10 the NHS Institute achieved an underspend against its financing of £1.3m.

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

The underspend reported reflects the financial contribution received from our commercial activities – sales of extended offers to the NHS and sales of goods and services outside the NHS through our successful and growing Worldwide business. This position is within the tolerances established in our Framework Document, which permits an underspend of two percent against its total funding without formal notification to the Department. The Department have, however, been informed of this position through our regular financial reporting of our forecasts and projections.

Given the current economic climate this financial position is positive and reflective of an approach in which the management and board of the NHS Institute have positively sought to mitigate the pressures on public finances by seeking alternative sources of income.

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

At 31 March 2010, the NHS Institute had Net Assets of £1.3m. This is a reflection of the contribution described above.

Other matters

Having successfully established a new financial and business system from 1 April 2009, this year has seen the further bedding-in of that system, and the realisation of its benefits. The key benefit has been the support to the pipeline approval processes with the improvement in the level of financial management and control at project level. Also, significant progress has been achieved with the greater management information and control derived from the electronic purchase order processing functionality.

Together these have strengthened the level of management information available, improved our ability to predict and control expenditure, helped us demonstrate improved value for money and have streamlined monthly and year end processes. In particular, this has contributed significantly to our ability to continue to successfully meet the challenge of faster close of the year end and period 9 accounts.

Having made this step change, we will make further step changes during 2010-11. We will focus on further improvements to the breadth and depth of management information and reporting, as we reconfigure around the new business model, and improve the accuracy of our detail phasing of projections to enhance in year performance monitoring. These are both considered essential as we anticipate the challenges of the new business model. We will also look closely at our own internal efficiency and effectiveness in support of the operational efficiency programme in 2010.

Governance Structure

Governance Arrangements

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

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

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

The Board's composition at 31 March 2010 was as follows:

Dame Yve Buckland
Chair and Chair of the Shadow Nominations Committee

Professor Dame Carol Black
Non-executive Director

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

Michael Deegan CBE
Non-executive Director

Michael Lander
Non-executive Director

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

Noorzaman Rashid
Non-executive Director

Professor Bernard Crump
Chief Executive

Simone Jordan
Executive Director (Chief Operating Officer and Deputy Chief Executive)

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

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

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

Governance Structure *(continued)*

Committees of the Board

There are 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: Joe Liddane (Chair), Michael Lander and Noorzaman Rashid. All other non-executive directors are welcome to attend.

The Remuneration Committee

Details of the Remuneration Committee are contained within the Remuneration Report on pages 40-48.

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) while the NHS Institute is a special health authority, to oversee the process for the appointment of all executive directors (including the chief executive) of the NHS Institute and all directors of wholly owned subsidiaries of the NHS Institute (including the chair and chief executive), and to make recommendations to the NHS Institute board in respect of appointments to NHS Institute board committees. Members are: Dame Yve Buckland (chair) and Professor Tony Butterworth.

Name of auditor

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

Declaration of Interest

The NHS Code of Accountability requires board members to declare any interests that are relevant and material to the NHS body of which they are a member. Any members appointed subsequently make this declaration upon their appointment. The declarations of interest made by board members are recorded in the minutes of board meetings and a declaration of interest form is completed. A register of interests is kept and maintained by the corporate secretary, and is available for public inspection. This register is kept up to date as forms are submitted and also by means of an annual review.

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

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

Bernard Crump
Chief Executive and Accounting Officer
NHS Institute for Innovation and Improvement
1 June 2010

Remuneration Report – Annual Report and Accounts 2009-10

This report is subject to audit.

Details of the membership of the Remuneration Committee

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

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

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

The committee's remit is to:

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

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

Remuneration of senior managers follows two national policies:

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

All other staff – Agenda for Change.

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

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

Remuneration Report – Annual Report and Accounts 2009-10 *(continued)*

Performance conditions

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

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

Terms and Conditions

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

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

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

4. Termination of appointment
Regulation 5 of the Regulations sets out the grounds on which the appointment of the Chair and non-executive members may be terminated. A Chair or non-executive member may resign by giving notice in writing to the Secretary of State or the Appointments Commission. Their appointment will also be terminated if, in accordance with regulations they become disqualified for appointment.

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

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

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

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

Remuneration Report – Annual Report and Accounts 2009-10 *(continued)*

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

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

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

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

6. Current rate for chair and non-executives
The rate (2009-10) of remuneration payable to the chair of the NHS Institute for Innovation and Improvement is £63,048 pa for up to three days a week. The current rate of remuneration payable to members is £7,881 pa for approximately two days per month with an additional £5,254 pa for the chair of the Audit and Risk Management Committee.

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

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

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

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

Remuneration Report – Annual Report and Accounts 2009-10 *(continued)*

11. Indemnity

The special health authority is empowered to indemnify the Chair and non-executive members against personal liability which they may incur in certain circumstances whilst carrying out their duties. HSC 1999/104, which is available from the NHS Institute for Innovation and Improvement, gives details.

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

For executive directors of the NHS Institute for Innovation and Improvement

Terms and Conditions

1. Basis for appointment

Executive directors are appointed on a permanent basis under a contract of service at an agreed salary, an entitlement to a lease car and eligibility to claim allowances for travel and subsistence costs, at rates set by the NHS Institute for expenses incurred necessarily on its behalf.

Executive directors acting in an interim capacity are normally appointed on the basis of a fixed term agreement. They are not entitled to a lease car or performance related award but would be entitled to all other allowances and benefits.

2. Termination of appointment

On the grounds of incapacity of an executive director, the NHS Institute will give six months' notice once sick pay has been exhausted. The notice for termination for any other substantive reason is six months. There is no provision for compensation included in the NHS Institute's Annual Accounts for the early termination of any executive director.

Remuneration Report – Annual Report and Accounts 2009-10 *(continued)*

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

Name	Title	Start Date	Review Date
Yve Buckland	Chair	1 July 2005	30 June 2013
Mike Collier	Vice-Chair and Chair of Audit and Risk Committee	1 October 2005	Left 24 September 2009
Carol Black	Non-executive Director	15 February 2006	14 February 2014
Tony Butterworth	Non-executive Director	1 July 2005	30 June 2012
Michael Deegan	Non-executive Director	1 July 2005	30 June 2013
Noorzaman Rashid	Non-executive Director	1 October 2007	30 September 2011
Joe Liddane	Non-executive Director and Chair of Audit and Risk Committee	1 March 2009	28 February 2013
Michael Lander	Non-executive Director	1 March 2009	28 February 2013
Bernard Crump	Chief Executive	1 July 2005	Not applicable
Simone Jordan	Chief Operating Officer and Deputy Chief Executive	1 October 2005	Not applicable
Paul Allen	Director of Leadership	1 September 2005	left 31 August 2009
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
Rod Anthony	Acting Director of Corporate Services and Finance	1 August 2008	30 September 2010

Remuneration Report – Annual Report and Accounts 2009-10 *(continued)*

Salaries and Allowances

Name and Title	2009-10 See note 1 Salary (bands of £5,000) £000	2009-10 Other remuneration (bands of £5,000) £000	2009-10 Benefits in kind £000	2008-09 See note 1 Salary (bands of £5,000) £000	2008-09 Other remuneration (bands of £5,000) £000	2008-09 Benefits in kind £000
Bernard Crump (Chief Executive)	175-180	0	7	175-180	0	5
Simone Jordan (Deputy Chief Executive and Chief Operating Officer)	130-135	0	5	130-135	0	5
Helen Bevan (Director of Service Transformation)	125-130	0	0	130-135	0	0
Michael Cawley (Director of Finance and Business Services)	65-70 See note 2	0	0	35-40 See note 2	0	2
Paul Allen (Director of Leadership)	50-55 See note 3	0	0	115-120	0	0
Rod Anthony (Acting Director of Corporate Services and Finance)	120-125 See note 4	0	0	80-85	0	0
Yve Buckland (Chair and Chair of Shadow Nominations Committee)	60-65	0	0	60-65	0	0
Tony Butterworth (Non-executive Director)	5-10	0	0	5-10	0	0
Mike Collier (Vice-Chair and Chair of Audit Committee)	5-10 See note 5	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	5-10	0	0
Carol Black (Non-executive Director)	5-10	0	0	5-10	0	0
Joe Liddane (Chair of Audit Committee)	10-15 See note 6	0	0	0-5	0	0
Michael Lander (Non-executive Director)	5-10 See note 7	0	0	0-5	0	0

Notes:
1. Executive directors' salaries included non-consolidated, non-pensionable performance related elements.
2. Michael Cawley left his post on 31 July 2008 on secondment to East Midlands Strategic Health Authority. The NHS Institute continue to fund an element of this salary.
3. Paul Allen left his post on 31 August 2009.
4. Rod Anthony commenced his post on 1 August 2008.
5. Mike Collier left his post on 24 September 2009.
6. Joe Liddane commenced his post on 1 March 2009 and was appointed as Chair of the Audit Committee on 1 October 2009.
7. Michael Lander commenced his post on 1 March 2009.

Remuneration Report – Annual Report and Accounts 2009-10 *(continued)*

Pension Benefits

Name and Title	Real increase in pension at age 60 (bands of £2,500)	Real increase in pension lump sum at aged 60 (bands of £2,500)	Total accrued pension at age 60 at 31 March 2010 (bands of £5,000)	Lump sum at age 60 related to accrued pension at 31 March 2010 (bands of £5,000)	Cash equivalent transfer value at 31 March 2010 £000	Cash equivalent transfer value at 31 March 2009 £000	Real increase in cash equivalent transfer value £000	Employer's contribution to stakeholder pension £000
Bernard Crump (Chief Executive)	0-2.5	0-2.5	60-65	185-190	1,330	1,204	66	0
Simone Jordan (Deputy Chief Executive and Chief Operating Officer)	0-2.5	7.5-10	25-30	85-90	500	421	58	0
Helen Bevan (Director of Service Transformation)	0-2.5	2.5-5	40-45	125-130	815	708	72	0
Michael Cawley (Director of Finance and Business Services)	0-2.5	0-2.5	20-25	70-75	386	323	15	0
Paul Allen (Director of Leadership)	0-2.5	0-2.5	5-10	15-20	117	102	4	0
Rod Anthony (Acting Director of Corporate Services and Finance)	0-2.5	See note 1	0-5	See note 1	42	11	31	0

Notes:
1. The lump sum is shown as nil as membership is of the NHS Pension Scheme 2008 Section.

Pension Benefits *(continued)*

Cash Equivalent Transfer Value

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

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

Real Increase in CETV

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

Bernard Crump
Chief Executive and Accounting Officer
NHS Institute for Innovation and Improvement
1 June 2010

Accounts

Statement of Accounting Officer's Responsibilities

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

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

In preparing the accounts, the Accounting Officer is required to comply with the requirements of the Government Financial Reporting Manual and in particular to:

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

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

Statement on Internal Control for the year ended 31 March 2010

1. Scope of responsibility

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

2. The purpose of the system of internal control

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

- Identify and prioritise the risks to the achievement of departmental policies, aims and objectives.
- Evaluate the likelihood of those risks being realised and the impact should they be realised, and
- Manage them efficiently, effectively and economically.

The system of internal control has been in place in the NHS Institute for the year ended 31 March 2010 and up to the date of approval of the annual report and accounts, and accords with Treasury guidance.

3. Capacity to handle risk

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

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

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

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

- The identification of key risks through the business planning process.
- Risk assessment workshops involving the Executive team.
- Regular Audit and Risk Management Committee and Board consideration of key strategic risks.
- Risk register owners identified across the NHS Institute.
- A programme of work to enhance the core financial management system and processes as well as provide for better management information that strengthens our risk management approach.

Statement on Internal Control for the year ended 31 March 2010 *(continued)*

- Programmes of training that have been provided to all staff in relation to health and safety, fire risks, counter fraud awareness and information governance.

In line with best practice, constructive suggestions were obtained from internal audit on the approach and development of the Board Assurance Framework which has been reviewed and revised during the year.

4. The risk and control framework

The Audit and Risk Management Committee is responsible for reviewing risk management activity and the effectiveness of our internal control framework under delegation of the Board. It receives regular reports from the internal auditors and will receive an annual management letter from the external auditors to supplement the regular updates that they also provide. The Audit and Risk Management Committee also receives information from other internal and external sources to aid the Committee in fulfilling its functions.

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

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

- Review of the key operational risks as identified in the business planning process.
- Identification of strategic risks through the Executive Team.
- Prioritisation of those risks.
- Assessing the effectiveness of the mitigation actions.

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

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

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

As an employer with staff entitled to membership of the NHS Pension Scheme, control measures are in place to ensure all employer obligations contained within the Scheme regulations are complied with. This includes ensuring that deductions from salary, employer's contributions and payments into the Scheme are in accordance with the Scheme rules, and that member pension scheme records are accurately updated in accordance with the timescales detailed in the regulations.

The NHS Institute has proactively engaged in strategies to reduce carbon emissions. A Sustainable Development Policy and Plan was written in July 2009 and in order to measure the success of this policy and to gather data to allow the NHS Institute to

Statement on Internal Control for the year ended 31 March 2010 *(continued)*

prove a commitment to carbon reduction, work has been ongoing to establish a process for measurement and review with the added dimension of looking for cost savings. The NHS Institute has calculated its carbon footprint as at 31 March 2010 and will continue this work into 2010-11 to benchmark itself against other organisations and actively work towards a carbon reduction target.

5. Information Governance

The NHS Institute has an Information Governance framework for the management of information. The purpose of this strategy is to put in place the people, resources, the culture and the processes necessary to ensure the information needs support the core purpose of the NHS Institute. By ensuring information is dealt with legally, securely, efficiently and effectively in the course of NHS Institute business the NHS Institute will achieve a standard of excellence in Information Governance.

To achieve this, information and records are:

- Held securely and confidentially.
- Obtained fairly and efficiently.
- Recorded accurately and reliably.
- Used effectively and ethically.
- Shared appropriately and lawfully.

All information processing will be undertaken in accordance with relevant legislation and best practice. The NHS Institute has set policies and procedures to ensure that appropriate standards are defined, implemented and maintained.

Basic Information Governance training, provided by the National School of Government has been introduced for all NHS Institute staff with an advanced level course for senior managers and Information Asset Owners.

The post of Information Asset Manager has been established, which has significantly helped to raise the awareness of this important subject and an Information Governance Board chaired by an NHS Institute Director meets quarterly.

The NHS Institute currently reports on Information Governance to the Department of Health via the Connecting for Health Information Governance Toolkit. This is an online toolkit designed to provide assessments on the process, management, people and system requirements surrounding Information Governance and is itself based upon the requirements of ISO/IEC 27000 family of standards on Information Security Management Systems. The Department of Health approve our progress and application of the best practice and legislative requirements around Information Security Management Systems. The NHS Institute currently holds a toolkit rating of 80% whilst continuing to make improvements.

6. Other Information

During the year, the NHS Institute has been working with the Department of Health and other stakeholders to determine its future business model with a renewed emphasis on helping our customers to achieve major efficiency savings whilst improving the quality of service across the NHS – a goal defined by the Department of Health as a focus on quality, innovation, productivity and prevention (QIPP). A significant amount of activity has been undertaken in 2009-10 in preparation for the new business model including a reconfiguration of the financial system with effect from 1 April 2010.

The establishment of process owners throughout the business will also expediate a smooth transition to the new ways of working.

Statement on Internal Control for the year ended 31 March 2010 *(continued)*

Last year I reported that we were planning to change our status from a Special Health Authority in preparation for a more commercially focused operating business. This change has been put on hold whilst we re-engineer our business to support the NHS in delivering the stretching QIPP goals.

Our internal control systems demonstrated their effectiveness when it was brought to my attention that there had been some failings in compliance with financial, procurement and best practice procedures regarding third party contracting arrangements within the National Innovation Centre. Internal audit were contracted to perform additional detailed testing and as a result recommendations were made which have been immediately acted upon.

During the year it was noted by both Internal and External audit that there have been further improvements in our finance control and financial management of the business as well as a smooth transition to our new finance system which has improved the effectiveness of key controls and given greater accessibility to information. However, recognising the impact of the new business model and potentially a more challenging, commercial future, they both noted that there needs to be further improvements. In particular, improving the accuracy of detailed phased forecasts for income, costs and cash flow and a requirement to heighten the level of scrutiny of financial reporting at the Board. During 2010-11 the Audit and Risk Management Committee will pay close attention to monitoring the establishment of plans and delivering the improvements considered necessary.

The NHS Institute used a balanced scorecard approach for the 2009-10 business plan and performance monitoring reports for each of the business areas were based on that framework. During the course of the financial year the NHS Institute began to change its business model again and in developing the 2010-11 plan a balanced scorecard approach has again been used, based on the new business model. It is intended to monitor performance using the balanced scorecard during 2010-11.

7. Review of effectiveness

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

His overall opinion for 2009-10 was of significant assurance, and this was corroborated 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 also provide me with assurance.

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

Statement on Internal Control for the year ended 31 March 2010 *(continued)*

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.

There have been no material issues raised during these reviews, but they highlight the need to continue to assess and improve controls. They will ensure that the NHS Institute's control mechanisms are reviewed and updated to address any risks that arise from any such changes. Consideration is also given to the coverage of the Internal Audit programme with flexibility to meet any emerging risks and the progress on implementing both Internal and External audit recommendations. Responsibility for oversight of this work, on behalf of the Board, remains with the Audit and Risk Management Committee.

During 2009-10 we have further strengthened our monthly management information and the control processes around our allocation of resources to projects and programmes. There is a greater depth of challenge and review of performance by budget holders and this is reported to the Board. We have achieved our financial and other targets as a result against a back drop of a rapidly changing business environment and financial uncertainty.

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

Bernard Crump
Chief Executive and Accounting Officer
NHS Institute for Innovation and Improvement
1 June 2010

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 2010 under the National Health Service Act 2006. These comprise the Operating Cost Statement, the Statement of Financial Position, the Statement of Cash Flows, the Statement of Changes in Taxpayers' Equity and the related notes. These financial statements have been prepared under the accounting policies set out within them. I have also audited the information in the Remuneration Report that is described in that report as having been audited.

Respective responsibilities of the Accounting Officer and auditor

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

Scope of the Audit of the Financial Statements

An audit involves obtaining evidence about the amounts and disclosures in the financial statements sufficient to give reasonable assurance that the financial statements are free from material misstatement, whether caused by fraud or error. This includes an assessment of: whether the accounting policies are appropriate to the NHS Institute for Innovation and Improvement's circumstances and have been consistently applied and adequately disclosed; the reasonableness of significant accounting estimates made by the NHS Institute for Innovation and Improvement; and the overall presentation of the financial statements.

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

Opinion on Regularity

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

Opinion on financial statements

In my opinion:

- the financial statements give a true and fair view of the state of the NHS Institute for Innovation and Improvement's affairs as at 31 March 2010 and of its net expenditure, changes in taxpayers' equity and cash flows for the year then ended; and
- the financial statements 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.

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

Opinion on other matters

In my opinion:

- the part of the Remuneration Report to be audited has been properly prepared in accordance with the National Health Service Act 2006 and directions made thereunder by the Secretary of State with the approval of HM Treasury; and
- the information given in the Management Commentary, Acting Director of Corporate Services and Finance commentary and Governance Structure included within the Annual Report for the financial year for which the financial statements are prepared is consistent with the financial statements.

Matters on which I report by exception

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

- adequate accounting records have not been kept; or
- the financial statements are not in agreement with the accounting records or returns; or
- I have not received all of the information and explanations I require for my audit; or
- the Statement on Internal Control does not reflect compliance with HM Treasury's guidance.

Report

I have no observations to make on these financial statements.

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

9 June 2010

Annual Account of the NHS Institute for Innovation and Improvement for the year ended 31 March 2010

Operating Cost Statement for the year ended 31 March 2010

	Notes	2009-10 £000	2008-09 £000
Programme costs	2.2	**83,232**	79,863
Operating income	5	**(14,240)**	(7,431)
Net operating cost before interest		**68,992**	72,432
Interest payable		**0**	0
Net operating cost		**68,992**	72,432
Net resource outturn	4.1	**68,992**	72,432

All income and expenditure is derived from continuing operations

The notes at pages 62 to 104 form part of these accounts.

Annual Account of the NHS Institute for Innovation and Improvement for the year ended 31 March 2010 *(continued)*

Statement of Financial Position as at 31 March 2010

	Notes	**31 March 2010 £000**	31 March 2009 £000	31 March 2008 £000
Non-current assets:				
Property, plant and equipment	6.1	**1,536**	2,462	2,498
Intangible assets	6.2	**1,887**	2,139	2,632
Non-current receivables	7.2	**126**	129	1
		3,549	4,730	5,131
Current assets:				
Receivables	7.1	**5,108**	4,193	7,833
Cash and cash equivalents	8	**3,524**	5,070	574
		8,632	9,263	8,407
Payables	9.1	**(9,920)**	(13,131)	(13,737)
Net current (liabilities)		**(1,288)**	(3,868)	(5,330)
Non-current assets less net current liabilities		**2,261**	862	(199)
Non-current liabilities:				
Payables	9.2	**0**	(51)	(67)
Provisions	10	**(990)**	(781)	(752)
Total assets less total liabilities		**1,271**	30	(1,018)
Taxpayers' equity				
General fund		**962**	(273)	(1,288)
Revaluation reserve		**309**	303	270
Total taxpayers' equity		**1,271**	30	(1,018)

The notes at pages 62 to 104 form part of these accounts.

The financial statements on pages 58 to 61 were considered by the Audit and Risk Management Committee on 27 May 2010.

Bernard Crump
Accounting Officer
1 June 2010

Annual Account of the NHS Institute for Innovation and Improvement for the year ended 31 March 2010 *(continued)*

Statement of Changes in Taxpayers' Equity for the year ended 31 March 2010

	General fund[1] £000	Revaluation reserve[2] £000	Total reserves £000
Balance at 31 March 2008	(1,288)	270	(1,018)
Restated balance as at 1 April 2008	(1,288)	270	(1,018)
Changes in tax payers' equity for 2008-09			
Net gain/(loss) on revaluation of property, plant and equipment	0	76	76
Non-cash charges (cost of capital)	(109)	0	(109)
Transfers between reserves	43	(43)	0
Net operating cost for the year	(72,432)	0	(72,432)
Total recognised income and expense for 2008-09	(72,498)	33	(72,465)
Net Parliamentary funding	73,513	0	73,513
Balance at 31 March 2009	**(273)**	**303**	**30**
Restated balance as at 1 April 2009	(273)	303	30
Changes in tax payers' equity for 2009-10			
Net gain/(loss) on revaluation of property, plant and equipment	**0**	**69**	**69**
Non-cash charges (cost of capital)	**(128)**	**0**	**(128)**
Transfers between reserves	**63**	**(63)**	**0**
Net operating cost for the year	**(68,992)**	**0**	**(68,992)**
Total recognised income and expense for 2009-10	**(69,057)**	**6**	**(69,051)**
Net Parliamentary funding	**70,292**	**0**	**70,292**
Balance at 31 March 2010	**962**	**309**	**1,271**

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

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

The notes at pages 62 to 104 form part of these accounts.

Annual Account of the NHS Institute for Innovation and Improvement for the year ended 31 March 2010 *(continued)*

Statement of Cash Flows for the year ended 31 March 2010

	Notes	**31 March 2010 £000**	31 March 2009 £000
Net cash (outflow) from operating activities	11.2	**(70,026)**	(67,486)
Cash flows from investing activities			
Payments to acquire non-current intangible assets		**(1,363)**	(1,114)
Payments to acquire non-current property, plant and equipment		**(443)**	(361)
Net cash (outflow) from investing activities		**(1,806)**	(1,475)
Net cash (outflow) before financing		**(71,832)**	(68,961)
Cash flows from financing activities			
Interest paid		**0**	0
Payments in respect of finance leases	9	**(6)**	(56)
Net Parliamentary funding		**70,292**	73,513
(Decrease)/increase in cash and cash equivalents	8	**(1,546)**	4,496

The notes at pages 62 to 104 form part of these accounts.

Notes to the Accounts

1 Accounting policies

The financial statements have been prepared in accordance with the 2009-10 Government Financial Reporting Manual (FReM) issued by HM Treasury, and in accordance with the National Health Services Act 2006. The accounting policies contained in the FReM apply International Financial Reporting Standards as adapted or interpreted for the public sector context. Where the FReM permits a choice of accounting policy, the accounting policy which is judged to be most appropriate to the particular circumstances of the NHS Institute for Innovation and Improvement for the purpose of giving a true and fair view has been selected. The particular policies adopted are described below. They have been applied consistently in dealing with items that are considered material to the accounts.

1.1 Accounting conventions

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

Acquisitions and discontinued operations

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

1.2 Income

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

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

1.3 Expenditure

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

Notes to the Accounts *(continued)*

1.4 Taxation

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

1.5 Capital charges

The treatment of property, plant and equipment and intangible assets in the accounts is in accordance with the principal capital charges objective to ensure that such charges are fully reflected in the cost of capital. The interest rate applied to capital charges in the financial year 2009-10 was 3.5% (2008-09 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.

1.6 Non-current 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 Property, plant and equipment 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 Assets in the course of construction are carried at historic cost. Construction cost is considered to be a satisfactory proxy for fair value. On completion, the asset is transferred to the appropriate asset category and treated as any other asset in that category.

b. Intangible assets

Recognition

Intangible assets are non-monetary assets without physical substance which are capable of being sold separately from the rest of the NHS Institute's business or which arise from contractual or legal rights. They are recognised only where it is probable that future economic benefits will flow to, or service potential be provided to, the NHS Institute where the cost of the asset can be measured reliably.

Software which is integral to the operation of hardware e.g. an operating system, is capitalised as part of the relevant item of property, plant and equipment. Software which is not integral to the operation of hardware e.g. application 'software', is capitalised as an intangible asset.

Internally generated intangible assets

Internally generated goodwill, brands, publishing titles, customer lists and similar items are not capitalised as intangible assets.

Expenditure on research is not capitalised.

Expenditure on development is capitalised only where all of the following can be demonstrated:

- the project is technically feasible to the point of completion and will result in an intangible asset for sale or use;
- the NHS Institute intends to complete the asset and sell or use it;
- the NHS Institute has the ability to sell or use the asset;
- how the intangible asset will generate probable future economic or service delivery benefits e.g. the presence of a market for it or its output, or where it is to be used for internal use, the usefulness of the asset;
- adequate financial, technical and other resources are available to the NHS Institute to complete the development and sell or use the asset; and
- the NHS Institute can measure reliably the expenses attributable to the asset during development.

Measurement

Intangible assets are recognised initially at cost, comprising all directly attributable costs needed to create, produce and prepare the asset to the point that it is capable of operating in the manner intended by management. Subsequently intangible assets are measured at fair value. Increases in asset values arising from revaluations are recognised in the revaluation reserve, except where, and to the extent that, they reverse an impairment previously recognised in operating expenses, in which case they are recognised in operating income. Decreases in asset values and impairments are charged to the revaluation reserve to the extent that there is an available balance for the asset concerned, and thereafter are charged to operating expenses. Gains and losses recognised in the revaluation reserve are reported in the Operating Cost Statement as an item of 'other income'. Intangible assets held for sale are measured at the lower of their carrying amount or 'fair value less costs to sell'.

c. Property, plant and equipment

Measurement

All property, plant and equipment assets are measured initially at cost, representing the costs directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management. All assets are measured subsequently at fair value. For freehold and leasehold properties fair value is based on periodic, but at least quinquennial, rolling valuations performed by external independent valuers less

Notes to the Accounts *(continued)*

subsequent depreciation and impairment losses. The valuations are performed with sufficient regularity to ensure that the carrying value does not differ significantly from fair value at the Statement of Financial Position date.

Equipment is stated at historical cost less subsequent depreciation.

The carrying value of property, plant and equipment is reviewed for impairment in periods if events or changes in circumstances indicate the carrying value may not be recoverable.

Subsequent valuation

Where subsequent expenditure enhances an asset beyond its original specification, the directly attributable cost is added to the asset's carrying value. Where subsequent expenditure is simply restoring the asset to the specification assumed by its economic useful life then the expenditure is charged to operating expenses.

Revaluation and impairment

Increases in asset values arising from revaluations are recognised in the revaluation reserve, except where, and to the extent that, they reverse an impairment previously recognised in operating expenses, in which case they are recognised in the Operating Cost Statement. Decreases in asset values and impairments are charged to the revaluation reserve to the extent that there is an available balance for the asset concerned, and thereafter are charged to operating expenses. Gains and losses recognised in the revaluation reserve are reported in the Operating Cost Statement as an item of 'other income'.

d. Depreciation and amortisation

Depreciation is charged on each individual asset as follows:

i Intangible assets are amortised, on a straight line basis, over their expected useful economic lives in a manner consistent with the consumption of economic or service delivery benefits. For all intangible assets currently held the expected useful economic life is three years.

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

iii Items of property, plant and equipment are depreciated over their remaining useful economic lives in a manner consistent with the consumption of economic or service delivery benefits. Property, plant and equipment which has been reclassified as 'Held for Sale' ceases to be depreciated upon the reclassification.

iv 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 aquired:

Furniture and fittings	7 years
Information technology	3 years
Leasehold improvements	Over life of lease

1.7 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.

1.8 Segmental analysis

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

1.9 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.

1.10 Leases

Finance leases

Where substantially all risks and rewards of ownership of a leased asset are borne by the NHS Institute, the asset is recorded as Property, Plant and Equipment and a corresponding liability is recorded. The value at which both are recognised is the lower of the fair value of the asset or the present value of the minimum lease payments, discounted using the interest rate implicit in the lease. The implicit interest rate is that which produces a constant periodic rate of interest on the outstanding liability. The asset and liability are recognised at the inception of the lease, and are de-recognised when the liability is discharged, cancelled or expires. The annual rental is split between the repayment of the liability and a finance cost. The annual finance cost is calculated by applying the implicit interest rate to the outstanding liability and is charged to finance costs in the Operating Cost Statement.

Operating leases

Other leases are regarded as operating leases and the rentals are charged to operating expenses on a straight-line basis over the term of the lease. Operating lease incentives received are added to the lease rentals and charged to operating expenses over the life of the lease.

Notes to the Accounts *(continued)*

Leases of land and buildings

Where a lease is for land and buildings, the land component is separated from the building component and the classification for each is assessed separately. Leased land is treated as an operating lease.

1.11 Provisions

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

1.12 Employee benefits

Short-term employee benefits

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

Retirement benefit costs

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

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

a) Full actuarial (funding) valuation

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the scheme (taking into account its recent demographic experience), and to recommend the contribution rates to be paid by employers and scheme members. The last such valuation, which determined current contribution rates was undertaken as at 31 March 2004 and covered the period from 1 April 1999 to that date. The conclusion from the 2004 valuation was that the scheme had accumulated a notional deficit of £3.3 billion against the notional assets as at 31 March 2004.

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

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

b) Accounting valuation

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

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

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

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

c) Scheme provisions

In 2009-10 the NHS Pension Scheme provided defined benefits, which are summarised below. This list is an illustrative guide only, and is not intended to detail all the benefits provided by the Scheme or the specific conditions that must be met before these benefits can be obtained:

Annual Pensions

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

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

Pensions Indexation

Annual increases are applied to pension payments at rates defined by the Pensions (Increase) Act 1971, and are based on changes in retail prices in the twelve months ending 30 September in the previous calendar year.

Notes to the Accounts *(continued)*

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

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

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

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

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

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

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

1.13 Financial Instruments

i Financial assets
Financial assets are recognised in the Statement of Financial Position when the NHS Institute becomes party to the financial instrument contract or, in the case of trade receivables, when the goods or services have been delivered. Financial assets are derecognised 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 operating costs'; '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.

Cash and cash equivalents
The components that make up cash and cash equivalents are not analysed in the financial statements as the NHS Institute only holds cash.

Impairment of financial assets
At the Statement of Financial Position 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 asset's carrying amount and the present value of the revised future cash flows discounted at the asset's original effective interest rate. The loss is recognised in the 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.

Notes to the Accounts *(continued)*

ii Financial liabilities

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

Financial liabilities are initially recognised at fair value.

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 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 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.

2 Segmental analysis

The reporting segments have been identified based upon the internal reports that are regularly reviewed by the NHS Institute's Chief Executive in order to assess the organisation's performance and make decisions.

2.1 Descriptions of segments

NHS Institute programmes

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. The key offerings being Delivering Quality and Value, Making Innovation Happen, Safer Care, Productive Series and Commissioning for Health Improvement.

Department of Health

The NHS Institute work closely with the Department of Health to support the National Quality, Innovation, Productivity and Prevention (QIPP) agenda to work with all NHS organisations and demonstrate how service improvement tools can be used to drive up quality, drive out inefficiencies and drive down costs.

Non-NHS England

Non-NHS England handles demand for the NHS Institute's products and services for all organisations outside of the NHS England boundary with the overall objective of achieving at least full cost recovery.

Leadership

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

- The Board Development Team provides a range of capability programmes for whole boards and individual senior leaders, as well as strengthening the provision of coaching for senior leaders. There is also a focus on building commissioning capabilities;
- International Programmes which offer development opportunities for senior leaders in the NHS by working with healthcare organisations and individuals internationally to share latest thinking around leadership;
- The Enhancing Medical Engagement Project Team develops and promotes their work in association with the Academy of Medical and Royal Colleges;
- Building Leadership Capacity recruits fresh new talent and develops high calibre individuals into innovative, accomplished leaders through a portfolio of three programmes, each of which uniquely contributes to the NHS talent pool:
    - i NHS Graduate Scheme continues to recruit high calibre graduates onto the award winning scheme;
    - ii Gateway to Leadership attracts talent into the NHS from other sectors by recruiting on its programme;
    - iii Breaking Through Programme recruits NHS managers from black and minority ethnic backgrounds.

National Innovation Centre

The aim of the National Innovation Centre (NIC) is to encourage innovation activity across the NHS. The aim is to bring the latest advances in heathcare technology to the NHS. The NIC partners with private companies to speed up the process and to ensure that measured benefits are delivered to both patients and the NHS.

Notes to the Accounts *(continued)*

2.2 Segmental Programme costs

	Notes	NHS Institute programmes 2009-10 £000	Department of Health support for QIPP 2009-10 £000	Non-NHS England 2009-10 £000	Leadership 2009-10 £000	National Innovation Centre 2009-10 £000	Total 2009-10 £000	Total 2008-09 £000
Non-executive members' remuneration		137	0	0	0	0	137	129
Other salaries and wages – staff, seconded, contract and agency	3.1	13,899	184	202	2,667	778	17,730	11,528
Other salaries and wages – graduate scheme		0	0	0	12,297	0	12,297	10,913
Capital: Depreciation and amortisation (owned assets)	6.1, 6.2	2,479	0	0	44	222	2,745	1,659
Depreciation leased assets	6.1	6	0	0	0	0	6	65
Loss on impairment		9	0	0	0	5	14	18
Disposals		15	0	0	0	0	15	191
Capital charges interest		(78)	(1)	5	(47)	(7)	(128)	(109)
Auditors' remuneration:								
Statutory external audit fees[1]		77	0	0	0	0	77	60
Internal audit and counter fraud		58	0	0	0	0	58	61
Other finance costs:								
Bad debt provision		4	0	40	0	0	44	(45)
Foreign currency (gains)/ losses		(28)	0	3	2	1	(22)	12
Unwinding of discount		0	0	0	0	0	0	14
General losses & fruitless payments		0	0	0	1	0	1	72
Other Programme costs		23,285	1,557	761	15,033	9,622	50,258	55,295
		39,863	1,740	1,011	29,997	10,621	83,232	79,863

1 The statutory audit fee for 2009-10 is £70,000 with £7,000 relating to additional statutory work carried out in relation to transition to International Financial Reporting Standards (IFRS).

2.3 Segmental Operating income

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

	NHS Institute programmes 2009-10 £000	Department of Health support for QIPP 2009-10 £000	Non-NHS England 2009-10 £000	Leadership 2009-10 £000	National Innovation Centre 2009-10 £000	Total 2009-10 £000	Total 2008-09 £000
Programme income							
Fees and charges[1]	4,251	1,495	984	2,874	4,029	13,633	7,313
Other	56	0	546	5	0	607	118
Total	4,307	1,495	1,530	2,879	4,029	14,240	7,431

1 Fees and Charges includes £9,844k (2008-09 £4,272k) in relation to income received to provide funding for specific programmes and £3,789k (2008-09 £3,041k) in respect of services for which a fee is charged.

2.4 Segmental Operating cost statement

	NHS Institute programmes 2009-10 £000	Department of Health support for QIPP 2009-10 £000	Non-NHS England 2009-10 £000	Leadership 2009-10 £000	National Innovation Centre 2009-10 £000	Total 2009-10 £000	Total 2008-09 £000
Programme costs	39,863	1,740	1,011	29,997	10,621	83,232	79,863
Operating income	(4,307)	(1,495)	(1,530)	(2,879)	(4,029)	(14,240)	(7,431)
Net operating cost	35,556	245	(519)	27,118	6,592	68,992	72,432

Notes to the Accounts *(continued)*

2.5 Segmental assets & liabilities

	NHS Institute programmes 31 March 2010 £000	Department of Health support for QIPP 31 March 2010 £000	Non-NHS England 31 March 2010 £000	Leadership 31 March 2010 £000	National Innovation Centre 31 March 2010 £000	Total 31 March 2010 £000	Total 31 March 2009 £000
Non-current assets:							
Property, plant and equipment	1,532	0	0	4	0	1,536	2,462
Intangible assets	1,398	0	0	76	413	1,887	2,139
Non-current receivables	126	0	0	0	0	126	129
	3,056	0	0	80	413	3,549	4,730
Current assets:							
Receivables	2,464	(10)	487	1,646	521	5,108	4,193
Cash and cash equivalents	3,305	65	(292)	1,204	(758)	3,524	5,070
	5,769	55	195	2,850	(237)	8,632	9,263
Current liabilities							
Payables	(6,689)	(55)	(195)	(2,873)	(108)	(9,920)	(13,029)
Net current (liabilities)	(920)	0	0	(23)	(345)	(1,288)	(3,766)
Total assets less current liabilities	2,136	0	0	57	68	2,261	964
Non-current liabilities							
Payables	0	0	0	0	0	0	(51)
Provisions	(865)	0	0	(57)	(68)	(990)	(883)
Total assets less total liabilities	1,271	0	0	0	0	1,271	30
Taxpayers' equity							
General fund	962	0	0	0	0	962	(273)
Revaluation reserve	309	0	0	0	0	309	303
	1,271	0	0	0	0	1,271	30

3.1 Staff numbers and related costs

	2009-10 £000	2008-09 £000
Salaries and wages – staff on the NHS Institute payroll[1]	**8,935**	7,600
Seconded, contract and agency staff	**7,501**	2,441
Salaries and wages – recharges to other NHS organisations	**(631)**	(234)
Social security costs	**791**	717
Employer contributions to NHS Pension scheme	**1,134**	1,004
Total salaries and wages	**17,730**	11,528

	2009-10 Average WTE	2008-09 Average WTE
Salaries and wages – staff on the NHS Institute payroll[2]	**189.1**	176.2
Seconded, contract and agency staff	**108.4**	39.8
Salaries and wages – recharges to other NHS organisations	**(9.0)**	(2.8)
Total average whole time equivalent (WTE)	**288.5**	213.2

1 This includes a provision for the costs of holiday due not taken at the balance sheet date £72k (2009 £102k).
2 The NHS Institute has a WTE limit for staff set by the Department of Health of 194 relating to staff on the NHS Institute payroll.

Expenditure on staff benefits

The amount spent on staff benefits during 2009-10 totalled £45,154 (2008-09 £47,494).

Retirements due to ill-health

During 2009-10 there were no early retirements from the NHS Institute on the grounds of ill-health (2008-09 nil).

Early retirements and redundancies

During 2009-10 there were no early retirements or redundancies (2008-09 nil).

Capitalisation of staff costs

No staff costs were capitalised during 2009-10 (2008-09 nil).

Notes to the Accounts *(continued)*

3.2 Better Payment Practice Code – measure of compliance

	Number	£000
Total Non-NHS bills paid 2009-10	**20,236**	**61,118**
Total Non-NHS bills paid within target	**18,321**	**49,912**
Percentage of Non-NHS bills paid within target	**90.5%**	**81.7%**
	Number	**£000**
Total NHS bills paid 2009-10	**814**	**11,403**
Total NHS bills paid within target	**479**	**8,133**
Percentage of NHS bills paid within target	**58.8%**	**71.3%**
	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 NHS Institute did not pay any interest during 2009-10 or 2008-09 under the Late Payment of Commercial Debts (Interest) Act 1998.

4.1 Reconciliation of net operating cost to net resource outturn

	2009-10 £000	2008-09 £000
Net operating cost for the financial year	**68,992**	72,432
Net resource outturn	**68,992**	72,432
Revenue resource limit	**70,255**	72,890
Under spend against revenue resource limit	**1,263**	458

4.2 Reconciliation of gross capital expenditure to capital resource limit

	2009-10 £000	2008-09 £000
Gross capital expenditure	**1,534**	1,326
Less – Book value of non-current assets disposed	**(15)**	(191)
Adjustment for loss on disposal of non-current assets	**15**	191
Net resource outturn	**1,534**	1,326
Capital resource limit	**1,800**	2,044
Under spend against capital resource limit	**266**	718

5 Operating income

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

	2009-10 £000	2008-09 £000
Programme income[1]		
Fees and charges	**13,633**[2]	7,313
Other	**607**	118
Total	**14,240**	7,431

1 Included in the above numbers is income received from The Scottish Parliament £608k (2008-09 £448k), The National Assembly for Wales £50k (2008-09 £61k) and the Northern Ireland Assembly £48k (2008-09 £59k).
2 Fees and charges includes £9,844k (2008-09 £4,272k) in relation to income received to provide funding for specific programmes and £3,789k (2008-09 £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 IFRS8.

	NHS England extended services £000	Non-NHS England £000	2009-10 Total £000	2008-09 Total £000
Income	**2,259**	**1,530**	**3,789**	3,041
Less direct costs and overheads	**1,225**	**1,011**	**2,236**	2,554
Contribution	**1,034**	**519**	**1,553**	487
Less apportionment of central overheads	**480**	**270**	**750**	403
Profit/(loss)	**554**	**249**	**803**	84

The financial objective of the NHS England extended services is full cost recovery. The aim year on year is to break even and the profit made in 2009-10 is in part to make up for the loss incurred in 2008-09 (£158k).

Non-NHS England (worldwide sales) recover full direct cost plus a percentage mark up. The financial objective of Non-NHS England is to make a profit. This was achieved.

Notes to the Accounts *(continued)*

6 Non-current Assets

6.1 Property, plant and equipment

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

1 The NHS Institute is currently renegotiating the terms of the lease for Coventry House and has accelerated the depreciation on Leasehold improvements as a result. This has resulted in an increase of depreciation charged in the year of £536k.

6.1 Property, plant and equipment *(continued)*

	Leasehold improvements £000	Furniture & fittings £000	Information Technology		Total £000
			Hardware £000	Leased assets £000	
Cost or valuation at 31 March 2008	2,533	0	780	164	3,477
Additions – purchased	0	151	344	0	495
Indexation	107	0	0	0	107
Gross cost at 31 March 2009	2,640	151	1,124	164	4,079
Accumulated depreciation at 31 March 2008	709	0	177	93	979
Charged during the year[2]	272	1	271	65	609
Indexation	29	0	0	0	29
Accumulated depreciation at 31 March 2009	1,010	1	448	158	1,617
Net book value:					
Total at 31 March 2009	1,630	150	676	6	2,462

2 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 year by £104k.

	Leasehold improvements £000	Information Technology		Total £000
		Hardware £000	Leased assets £000	
Cost or valuation at 31 March 2007	2,308	711	44	3,063
Additions – purchased	33	69	120	222
Indexation	192	0	0	192
Gross cost at 31 March 2008	2,533	780	164	3,477
Accumulated depreciation at 31 March 2007	415	33	29	477
Charged during the year	259	144	64	467
Indexation	35	0	0	35
Accumulated depreciation at 31 March 2008	709	177	93	979
Net book value:				
Total at 31 March 2008	1,824	603	71	2,498

Notes to the Accounts *(continued)*

6.2 Intangible assets

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

1 The NHS Institute has commenced work on the development of a new website, as a result the depreciation on the existing website has been accelerated. This has resulted in an increased amortisation charge in the year of £179k.

6.2 Intangible assets *(continued)*

	Assets under construction £000	Software Licences £000	Information Technology Websites £000	Information Technology Web based Tools £000	Total £000
Gross cost at 31 March 2008	0	711	1,103	1,364	3,178
Additions – purchased	119	275	356	81	831
Reclassifications	0	0	204	(204)	0
Disposals	0	0	(126)	(349)	(475)
Impairment	0	0	(29)	0	(29)
Gross cost at 31 March 2009	119	986	1,508	892	3,505
Accumulated amortisation at 31 March 2008	0	110	147	289	546
Charged during the year[2]	0	257	468	390	1,115
Reclassifications	0	0	35	(35)	0
Disposals	0	0	(67)	(217)	(284)
Impairment	0	0	(11)	0	(11)
Accumulated amortisation at 31 March 2009	0	367	572	427	1,366
Net book value:					
Total at 31 March 2009	119	619	936	465	2,139

2 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 £446k.

Notes to the Accounts *(continued)*

6.2 Intangible assets *(continued)*

	Information Technology			
	Software Licences £000	Websites £000	Web based Tools £000	Total £000
Gross cost at 31 March 2007	300	365	846	1,511
Additions – purchased	411	738	518	1,667
Gross cost at 31 March 2008	711	1,103	1,364	3,178
Accumulated amortisation at 31 March 2007	50	6	86	142
Charged during the year	60	141	203	404
Accumulated amortisation at 31 March 2008	110	147	289	546
Net book value:				
Total at 31 March 2008	601	956	1,075	2,632

7 Receivables

7.1 Current receivables

	31 March 2010 £000	31 March 2009 £000	31 March 2008 £000
NHS receivables	**2,485**	995	1,517
Trade receivables – Non-NHS	**451**	267	913
Provision for irrecoverable debts	**(41)**	(15)	(63)
VAT amount due	**1,216**	1,522	1,001
Prepayments	**424**	1,294	4,448
Accrued income	**554**	121	13
Other receivables	**19**	9	4
	5,108	4,193	7,833

7.2 Non-current receivables

	31 March 2010 £000	31 March 2009 £000	31 March 2008 £000
Prepayments	**126**	129	1
	126	129	1
Total receivables	**5,234**	4,322	7,834

8 Cash and cash equivalents

	31 March 2008 £000	Change during the year £000	31 March 2009 £000	**Change during the year £000**	**31 March 2010 £000**
Cash at the Office of the Paymaster General	574	4,496	5,070	**(1,546)**	**3,524**
	574	4,496	5,070	**(1,546)**	**3,524**

9 Trade payables and other payables

9.1 Current payables

	31 March 2010 £000	31 March 2009 £000	31 March 2008 £000
NHS payables	**2,066**	698	601
Trade payables (revenue)	**2,868**	2,684	3,190
Tax and social security	**0**	0	1
Trade payables (capital)	**2**	277	424
Accruals	**1,059**	7,014	6,744
Deferred income	**3,563**	2,436	2,425
Finance lease	**0**	6	55
Other payables	**362**	16	297
	9,920	13,131	13,737

9.2 Non-current payables

	31 March 2010 £000	31 March 2009 £000	31 March 2008 £000
Finance lease	**0**	0	7
Other payables	**0**	51	60
	0	51	67
Total payables	**9,920**	13,182	13,804

Notes to the Accounts *(continued)*

10 Provisions for liabilities and charges

	Pensions for former staff £000	Legal claims £000	Other £000	Total £000
At 31 March 2009	0	175	606[1]	781
Arising during the year	0	0	214[2]	214
Utilised during the year	0	(5)	0	(5)
Reversed unused	0	0	0	0
Unwinding of discount	0	0	0	0
At 31 March 2010	**0**	**170**	**820**	**990**
Expected timing of cash flows:				
Within 1 year	0	170	820[3]	990
Over 5 years	0	0	0	0

1 Included in Other provisions is the provision for the restoration of Coventry House to original condition at the end of the lease period which is currently being renegotiated by the NHS Institute.
2 The NHS Institute has contracted for services with indirect workers and has provided for tax relating to their employment status within Other provisions.
3 The NHS Institute has reassessed the timings of the cashflows for the indirect worker provision and concluded that the liability falls due within one year.
4 The NHS Institute received a damages claim for personal injury during 2007-08 and received advice from solicitors to increase the provision in 2008-09.

	Pensions for former staff £000	Legal claims £000	Other £000	Total £000
At 31 March 2008	115	106	531[1]	752
Arising during the year	0	70[4]	61[2]	131
Utilised during the year	(115)	(1)	0	(116)
Reversed unused	0	0	0	0
Unwinding of discount	0	0	14	14
At 31 March 2009	0	175	606	781
Expected timing of cash flows:				
Within 1 year	0	175	97	272
Over 5 years	0	0	509	509

10 Provisions for liabilities and charges *(continued)*

	Pensions for former staff £000	Legal claims £000	Other £000	Total £000
At 31 March 2007	1,265	0	809[1]	2,074
Arising during the year	40	106[4]	159[2]	305
Utilised during the year	(854)	0	(361)	(1,215)
Reversed unused	(336)	0	(96)	(432)
Unwinding of discount	0	0	20	20
At 31 March 2008	115	106	531	752
Expected timing of cash flows:				
Within 1 year	115	106	97	318
Over 5 years	0	0	434	434

11.1 Movements in working capital other than cash

	31 March 2010 £000	31 March 2009 £000
Increase/(decrease) in receivables	**912**	(4,384)
Decrease in payables	**2,981**	1,150
	3,893	(3,234)

11.2 Reconciliation of operating costs to operating cash flows

	31 March 2010 £000	31 March 2009 £000
Net operating cost before interest for the year	**68,992**	72,432
Adjust for non cash transactions	**(2,650)**	(1,824)
Adjust for movements in working capital other than cash	**3,893**	(3,234)
(Increase)/decrease in provisions	**(209)**	112
Net cash outflow from operating activities	**70,026**	67,486

Notes to the Accounts *(continued)*

11.3 Reconciliation of net cash flow to movement in net debt

	31 March 2010 £000	31 March 2009 £000
(Decrease)/increase in cash in the period	**(1,546)**	4,496
Fixed asset additions/disposals	**1,519**	1,135
Depreciation/impairment/indexation	**(2,697)**	(1,664)
Decrease in payables	**3,262**	1,353
Increase/(decrease) in receivables	**912**	(4,384)
(Increase)/decrease in provisions	**(209)**	112
Movement in net debt	**1,241**	1,048

12 Contingent liabilities

At 31 March 2010, there were no known contingent liabilities (2008-09 £nil).

13 Capital commitments

At 31 March 2010, the value of contracted capital commitments was £113k (2008-09 £nil).

14 Commitments under finance leases

	Gross investment in lease		Present value of minimum lease payments	
	31 March 2010 £000	31 March 2009 £000	**31 March 2010 £000**	31 March 2009 £000
Amounts payable under finance leases comprise:				
Finance leases which expire:				
within 1 year	**0**	6	**0**	6
Total	**0**	6	**0**	6

15 Commitments under operating leases

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

	2009-10 £000	2008-09 £000
Hire of plant and machinery	**1**	18
Property rental – including headquarters and other properties	**640**	677
Other operating leases	**45**	53
	686	748

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.

		2009-10 £000	2008-09 £000
Land and buildings	Operating leases which expire:		
	Within 1 year[1]	**570**	714
	between 1 and 5 years	**0**	2,417
	after 5 years	**0**	449
		570	3,580
Other leases	Operating leases which expire:		
	Within 1 year	**33**	35
	between 1 and 5 years	**27**	27
		60	62

1 The NHS Institute are currently renegotiating the terms of the lease for Coventry House and the London office and this is reflected in the calculation of future lease commitments.

16 Other commitments

The NHS Institute has not entered into any additional non-cancellable contracts which are not operating leases (2008-09 £nil).

17 Losses and special payments

During 2009-10 39 cases of losses and special payments were approved totalling £9,672 (in 2008-09 there were 12 cases totalling £23,209). Additionally, 29 exchange rate fluctuations were approved with a net overall loss of £18,118 (in 2008-09 86 exchange rate fluctuations were approved with a net overall loss of £12,392). However overall a net foreign currency exchange surplus of £22,492 was recorded.

Notes to the Accounts *(continued)*

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 2009-10 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.

	2009-10 Receivables £000	2009-10 Payables £000	2009-10 Income £000	2009-10 Expenditure £000
Barnsley Hospital NHS Foundation				147
Basingstoke & North Hampshire Foundation NHS Trust				135
Blackpool Fylde & Wyre Hospitals NHS Trust				151
Cambridge University Hospital NHS Foundation Trust				185
Central Manchester & Manchester Childrens University Hospital NHS Trust[1]				954
Central Manchester University Hospitals NHS Foundation Trust				153
Chelsea & Westminster NHS Foundation Trust	121			418
Department of Health	1,216		7,667	137
Department of Health – Connecting for Health	476	68		124
Derby PCT			275	
Ealing PCT		74		268
East & North Hertfordshire NHS Trust			105	
East Sussex Hospital NHS Trust				117
Great Ormond Street Hospital NHS Trust				210
Greenwich PCT		60		
Haringey Teaching PCT		100		100
Heart of England NHS Foundation Trust	304			126
Leeds PCT				181
Leeds Teaching Hospitals NHS Trust		67		222
Leicestershire County & Rutland PCT		77		
Manchester PCT				101
Mid Essex PCT		64		
Mid Staffordshire NHS Foundation Trust		206		266
National Patient Safety Agency				530

Notes to the Accounts *(continued)*

	2009-10 Receivables £000	2009-10 Payables £000	2009-10 Income £000	2009-10 Expenditure £000
NHS Business Service Authority		113		274
NHS East of England SHA		146	789	159
NHS London SHA	190		201	
NHS North West SHA				168
NHS South Central SHA			101	
NHS South East Coast SHA			235	
NHS South West SHA			198	
NHS West Midlands SHA			121	
NHS Yorkshire and the Humber SHA	79		168	
Northamptonshire Healthcare NHS Foundation Trust		60		
Nottingham City PCT		52		
Nottingham University NHS Trust				597
Nottinghamshire County Teaching PCT				107
Oldham PCT		60		
Salisbury NHS Foundation Trust				308
South Western Ambulance Service NHS Trust				100
St Georges Healthcare NHS Trust		80		208
Surrey PCT				109
University College London Hospital NHS Foundation Trust	54			
University Hospital of North Staffordshire Trust		77		189
University Hospitals South Manchester Foundation Trust			521	
West Hertfordshire Hospitals NHS Trust		52		
West Middlesex University NHS Trust		90		374

1 Includes innovation hubs funding of £529k (2008-09 £838k) within expenditure and £nil (2008-09 £120k) within payables.

Notes to the Accounts *(continued)*

18 Related parties *(continued)*

	2008-09 Receivables £000	2008-09 Payables £000	2008-09 Income £000	2008-09 Expenditure £000
Department of Health	289		1,925	472
Kings College Hospital NHS Foundation Trust	252			215
NHS Purchasing & Supply Agency			1,426	
NHS East of England SHA			171	
NHS East Midlands SHA		137		134
NHS North West SHA		95		
NHS South East Coast SHA			1,191	
NHS West Midlands SHA			228	
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[1]		222		1,044
East & North Hertfordshire PCT				110
NHS National Institute for Health & Clinical Excellence				200
Cambridge University Hospital NHS Foundation Trust				122
Central Manchester University Hospital NHS Foundation Trust				193
Chelsea & Westminster Hospital NHS Foundation Trust				300
Oxford Radcliffe Hospitals NHS Trust				116
Royal Berkshire NHS Foundation Trust				145
Salisbury NHS Foundation Trust				473

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

19 Post balance sheet events

The financial statements were considered by the Audit and Risk Management Committee on 27 May 2010. This annual report and accounts has been authorised for issue on the date the accounts were certified by the Comptroller and Auditor General.

20 Machinery of Government changes

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 1st April 2009. As part of the process of establishing NHS Evidence the functions of the National Library for Health (NLH), 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.

The information disclosed relates to 2008-09 only as the National Library for Health was absorbed into NHS Evidence on 1 April 2009 and ceased to exist in its own right.

20.1 Operating Cost Statement for the year ended 31 March 2009

		2008-09		
	Notes	Including NLH £000	NLH Changes £000	As audited £000
Programme costs	a	89,988	10,125	**79,863**
Operating income	a	(9,656)	(2,225)	**(7,431)**
Net operating cost before interest		80,332	7,900	**72,432**
Interest payable		0	0	**0**
Net operating cost		80,332	7,900	**72,432**

Notes to the Accounts *(continued)*

20.2 Statement of Financial Position as at 31 March 2009

		2008-09		
	Notes	Including NLH £000	NLH Changes £000	As audited £000
Property, plant and equipment	b	2,519	57	**2,462**
Intangible assets	c	2,341	202	**2,139**
Non-current receivables	d	263	134	**129**
Total non-current assets		5,123	393	**4,730**
Receivables	e	4,323	130	**4,193**
Cash and cash equivalents		5,070	0	**5,070**
Total current assets		9,393	130	**9,263**
Total assets		14,516	523	**13,993**
Payables	f	(13,176)	(45)	**(13,131)**
Total current liabilities		(13,176)	(45)	**(13,131)**
Non-current payables	g	(64)	(13)	**(51)**
Provisions		(781)	0	**(781)**
Total non-current liabilities		(845)	(13)	**(832)**
Total liabilities		(14,021)	(58)	**(13,963)**
Total assets less total liabilities		495	465	**30**
General Fund		192	465	**(273)**
Revaluation Reserve		303	0	**303**
Total Taxpayers' Equity		495	465	**30**

20.3 Statement of Financial Position as at 31 March 2008

		2007-08		
	Notes	Including NLH £000	NLH Changes £000	As audited £000
Property, plant and equipment	b	2,600	102	**2,498**
Intangible assets	c	2,632	0	**2,632**
Non-current receivables	d	265	264	**1**
Total non-current assets		5,497	366	**5,131**
Receivables	e	8,179	346	**7,833**
Cash and cash equivalents		574	0	**574**
Total current assets		8,753	346	**8,407**
Total assets		14,250	712	**13,538**
Payables	f	(14,654)	(917)	**(13,737)**
Total current liabilities		(14,654)	(917)	**(13,737)**
Non-current payables	g	(125)	(58)	**(67)**
Provisions		(752)	0	**(752)**
Total non-current liabilities		(877)	(58)	**(819)**
Total liabilities		(15,531)	(975)	**(14,556)**
Total assets less total liabilities		(1,281)	(263)	**(1,018)**
General Fund		(1,551)	(263)	**(1,288)**
Revaluation Reserve		270	0	**270**
Total Taxpayers' Equity		(1,281)	(263)	**(1,018)**

a Expenditure incurred and income received relating to NLH.

b Finance lease asset relating to hosting services.

c Two capitalised software licences.

d Prepayment greater than one year.

e Prepayment less than one year.

f Payable less than one year relating to finance lease asset for hosting services.

g Payable greater than one year relating to finance lease asset for hosting services.

Notes to the Accounts *(continued)*

21 Financial instruments

IAS 32, Financial Intruments: Presentation, requires disclosure of the role that financial instruments have had during the period in creating or changing the risks an entity faces in undertaking its activities. Because of the way special health authorities are financed, the NHS Institute is not exposed to the degree of financial risk faced by business entities. Also, financial instruments play a much more limited role in creating or changing risk than would be typical of the listed companies to which IAS 32 mainly applies. The NHS Institute has limited powers to borrow or invest surplus funds. Financial assets and liabilities are generated by day to day operational activities rather than being held to change the risks facing the NHS Institute in undertaking its activities.

Market risk

Market risk is the possibility that financial loss might arise as a result of changes in such measures as interest rates and stock market movements.The NHS Institute has limited powers to borrow or invest surplus funds. Financial assets and liabilities are generated by day to day operational activities rather than being held to change the risks facing the NHS Institute in undertaking its activities.

Liquidity risk

Liquidity risk is the possibility that the NHS Institute might not have funds available to meet its commitments to make payments. The NHS Institute's net operating costs are financed from resources voted annually by Parliament. The NHS Institute largely finances its capital expenditure from funds made available from government under an agreed capital resource limit. The NHS Institute is not, therefore, exposed to significant liquidity risks.

Credit risk

Credit risk is the possibility that other parties might fail to pay amounts due to the NHS Institute. The nature of the NHS Institute's business means that it has a low exposure to credit risk. In order to manage this risk the NHS Institute undertakes credit checks on its new Non-NHS customers. In the event of late payment of debt the NHS Institute, through its 3rd party service provider, pursues a policy of written reminders which culminate in referral to a debt collection agency if required.

The maximum exposures as at 31 March 2010 are in receivables from customers, as disclosed in the receivables note.

Interest-rate risk

All of the NHS Institute's financial assets and financial liabilities carry nil or fixed rates of interest. The NHS Institute is not, therefore, exposed to significant interest rate risk.

Foreign currency risk

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

Other issues

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

21.1 Analysis of Financial Assets and Liabilities

	Financial Assets £000	Financial Liabilities £000
Currency		
At 31 March 2010		
Denominated in £ Sterling	**7,654**	**5,194**
Other	**0**	**102**
Gross Financial Asset/Liability	**7,654**	**5,296**
At 31 March 2009		
Denominated in £ Sterling	7,848	3,303
Other	0	95
Gross Financial Asset/Liability	7,848	3,398
At 31 March 2008		
Denominated in £ Sterling	4,025	4,156
Gross Financial Asset/Liability	4,025	4,156

Notes to the Accounts *(continued)*

21.2 Financial Assets and Liabilities by category

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

	Book value £000	Fair value £000
Financial assets: Loans and Receivables		
Cash at bank and in hand	**3,524**	**3,524**
NHS receivables	**2,485**	**2,485**
Trade receivables – Non-NHS (net of provision)	**410**	**410**
Other receivables	**1,235**	**1,235**
Total at 31 March 2010	**7,654**	**7,654**
Financial liabilities: Loans and Payables		
NHS payables	**2,066**	**2,066**
Trade payables – Non-NHS	**2,868**	**2,868**
Other payables	**362**	**362**
Total at 31 March 2010	**5,296**	**5,296**
Financial assets: Loans and Receivables		
Cash at bank and in hand	5,070	5,070
NHS receivables	995	995
Trade receivables – Non-NHS (net of provision)	252	252
Other receivables	1,531	1,531
Total at 31 March 2009	7,848	7,848
Financial liabilities: Loans and Payables		
NHS payables	698	698
Trade payables – Non-NHS	2,684	2,684
Other payables	16	16
Total at 31 March 2009	3,398	3,398
Financial assets: Loans and Receivables		
Cash at bank and in hand	574	574
NHS receivables	1,517	1,517
Trade receivables – Non-NHS (net of provision)	850	850
Other receivables	1,084	1,084
Total at 31 March 2008	4,025	4,025
Financial liabilities: Loans and Payables		
NHS payables	601	601
Trade payables – Non-NHS	3,269	3,269
Other payables	347	347
Total at 31 March 2008	4,217	4,217

In accordance with IAS 32, the fair value of short term financial assets and liabilities (held at amortised cost) are not considered significantly different to fair value since in the calculation of book value, the expected cash flows have been discounted by the Treasury discount rate of 2.2% in real terms.

21.3 Maturity of Financial Liabilities

	31 March 2010 £000	31 March 2009 £000	31 March 2008 £000
Less than one year	5,296	3,398	4,217
Total	5,296	3,398	4,217

22 Intra-government balances

	Receivables: Amounts falling due within one year £000	Receivables: Amounts falling due after more than one year £000	Payables: Amounts falling due within one year £000	Payables: Amounts falling due after more than one year £000
Balances with other central government bodies	3,848	0	4,086	0
Balances with local authorities	0	0	0	0
Balances with other NHS bodies	665	0	2,129	0
Balances with public corporations and trading funds	0	0	0	0
Sub-total intra-governmental balances	4,513	0	6,215	0
Balances with bodies external to government	595	126	3,705	0
At 31 March 2010	5,108	126	9,920	0

Notes to the Accounts *(continued)*

22 Intra-government balances *(continued)*

	Receivables: Amounts falling due within one year £000	Receivables: Amounts falling due after more than one year £000	Payables: Amounts falling due within one year £000	Payables: Amounts falling due after more than one year £000
Balances with other central government bodies	2,512	0	2,392	0
Balances with local authorities	0	0	0	0
Balances with other NHS bodies	494	0	1,742	0
Balances with public corporations and trading funds	0	0	0	0
Sub-total intra-governmental balances	3,006	0	4,134	0
Balances with bodies external to government	1,187	129	8,997	51
At 31 March 2009	4,193	129	13,131	51

	Receivables: Amounts falling due within one year £000	Receivables: Amounts falling due after more than one year £000	Payables: Amounts falling due within one year £000	Payables: Amounts falling due after more than one year £000
Balances with other central government bodies	4,700	0	3,961	0
Balances with local authorities	0	0	0	0
Balances with other NHS bodies	1,346	0	1,242	0
Balances with public corporations and trading funds	0	0	0	0
Sub-total intra-governmental balances	6,046	0	5,203	0
Balances with bodies external to government	2,659	1	9,406	67
At 31 March 2008	8,705	1	14,609	67

23 First time adoption of IFRS

Reconciliation of Taxpayers' Equity at 31 March 2009

	Note	UK GAAP[i] 31 March 2009 £000	Effect of transition to IFRS £000	IFRS 31 March 2009 £000
Property, plant and equipment	a	3,805	(1,343)	2,462
Intangible assets	b	619	1,520	2,139
Non-current receivables	c	0	129	129
Total non-current assets		4,424	306	4,730
Receivables	c	4,322	(129)	4,193
Cash and cash equivalents		5,070	0	5,070
Total current assets		9,392	(129)	9,263
Total assets		**13,816**	**177**	**13,993**
Payables	d	(12,908)	(223)	(13,131)
Total current liabilities		(12,908)	(223)	(13,131)
Non-current payables	e	0	(51)	(51)
Provisions	f	(684)	(97)	(781)
Total non-current liabilities		(684)	(148)	(832)
Total liabilities		**(13,592)**	**(371)**	**(13,963)**
Total assets less total liabilities		**224**	**(194)**	**30**
General Fund	g	(64)	(209)	(273)
Revaluation Reserve	h	288	15	303
Total Taxpayers' Equity		**224**	**(194)**	**30**

Notes to the Accounts *(continued)*

23 First time adoption of IFRS *(continued)*

Reconciliation of Taxpayers' Equity at 1 April 2008 (date of transition to IFRS)

	Note	UK GAAP[i] 31 March 2008 £000	Effect of transition to IFRS £000	IFRS 31 March 2008 £000
Property, plant and equipment	a	4,383	(1,885)	2,498
Intangible assets	b	601	2,031	2,632
Non-current receivables	c	0	1	1
Total non-current assets		4,984	147	5,131
Receivables	c	7,834	(1)	7,833
Cash and cash equivalents		574	0	574
Total current assets		8,408	(1)	8,407
Total assets		**13,392**	**146**	**13,538**
Payables	d	(13,428)	(309)	(13,737)
Total current liabilities		(13,428)	(309)	(13,737)
Non-current payables	e	0	(67)	(67)
Provisions	f	(657)	(95)	(752)
Total non-current liabilities		(657)	(162)	(819)
Total liabilities		**(14,085)**	**(471)**	**(14,556)**
Total assets less total liabilities		**(693)**	**(325)**	**(1,018)**
General Fund	g	(950)	(338)	(1,288)
Revaluation Reserve	h	257	13	270
Total Taxpayers' Equity		**(693)**	**(325)**	**(1,018)**

a Thirteen tangible assets under previous UK GAAP are required to be disclosed as intangible assets under IFRS. Also, the rent free period at the commencement of the lease for the headquarters building was not spread across the life of the lease under UK GAAP and has now been spread under IFRS. Finally, IFRS requires disclosure of assets leased as property, plant and equipment. There is one finance lease disclosed as a result of this.

b Thirteen tangible assets under previous UK GAAP are required to be disclosed as intangible under IFRS.

c Prepayments (receivables) greater than one year are disclosed separately.

d Contains finance leased assets recognised under IFRS previously classified as revenue, holiday pay accrual and the spread of the rent free period across the life of the lease.

e Finance lease and rent free elements greater than one year.

f Provision for making good the leasehold building at the end of the lease is recognised under IFRS but did not qualify for recognition under previous UK GAAP.

23 First time adoption of IFRS *(continued)*

g The adjustments to the general fund are as follows:

	Note	On adoption £000	31 March 2009 £000
Finance lease additions	a	(156)	(62)
Finance lease depreciation	a	131	65
Depreciation on owned assets	a	24	6
Leasehold making good provision		95	98
Holiday pay provision		244	102
Total adjustment to general fund		338	209

h The spread of the rent free period over the lease has increased the asset value under IFRS and the subsequent indexation thereon.

i The UK GAAP numbers have been adjusted by the Machinery of Government change as detailed in note 20.

Notes to the Accounts *(continued)*

24 IFRS disclosure

24.1 Early adoption of IFRSs, amendments and interpretations

The NHS Institute has adopted IFRS 8, operating segments, early. The effective date of the standard was for accounting periods beginning on, or after 1 January 2010. The adoption affects disclosure requirements only. See Notes 2.2-2.5.

24.2 IFRSs, amendments and interpretations in issue but not yet effective, or adopted

IAS8, accounting policies, changes in accounting estimates and errors, require disclosures in respect of new IFRSs, amendments and interpretations that are, or will be applicable after the reporting period. There are a number of IFRSs, amendments and interpretations issued by the International Accounting Standards Board that are effective for financial statements after this reporting period. The following have not been adopted early by the NHS Institute:

IFRS9 financial instruments

A new standard intended to replace IAS39. The effective date is for accounting periods beginning on, or after 1 January 2013.

IFRS8 operating segments

Amendments to the existing standard. The effective date is for accounting periods beginning on, or after 1 January 2010.

IAS1 presentation of financial statements

Amendments to the existing standard. The effective date is for accounting periods beginning on, or after 1 January 2010.

IAS7 statements of cash flow

Amendments to the existing standard. The effective date is for accounting periods beginning on, or after 1 January 2010.

IAS17 leases

Amendments to the existing standard. The effective date is for accounting periods beginning on, or after 1 January 2010.

IAS24 related party disclosures

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

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

24.3 Major FReM (Government Financial Reporting Manual) changes for 2010-11

In addition, the following are changes to the FReM, which will be applicable for accounting periods beginning on 1 April 2010:

Chapter 8 impairments

Adaption of IAS36 impairment of assets.

Chapter 11 income and expenditure

Removal of cost of capital charging.

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

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