NHS
Institute for Innovation and Improvement

Annual Report and Accounts

for the period 1 April 2006 to 31 March 2007

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Contents

Welcome from the Chair of the Board

It hardly seems a year since I wrote my welcome to the NHS Institute's first Annual Report, but it has been a year packed with activity.

Our team has produced tools and techniques to help the NHS deal with the big challenges of today's healthcare. Working with partners in the NHS and elsewhere, they have been supporting improvements in care at every level. The Delivering Quality and Value Indicators show that by the end of March 2007, improvements had been made by the NHS with a value of over £75 million. Good progress has also been made in supporting the NHS to reduce delays and release time to care.

We have continued to build our reputation and influence through a number of channels, particularly our new regional Field Team, the Practice Partner Network and link arrangements with Strategic Health Authorities. The NHS Institute places enormous value on producing tools and techniques that are not only designed to help the NHS improve but are also co-produced with people working at the front line of the NHS so that they are grounded in the reality of people's working lives.

The leadership team has also maintained high standards across graduate schemes and leadership development more generally. We were delighted that the HR and General Management Schemes were listed in *The Times* survey of 2006 as the best graduate training schemes in Britain, public or private. We are working with more than half of all Primary Care Trusts on Board development and supporting NHS leaders generally through our Blue Book leadership development programmes.

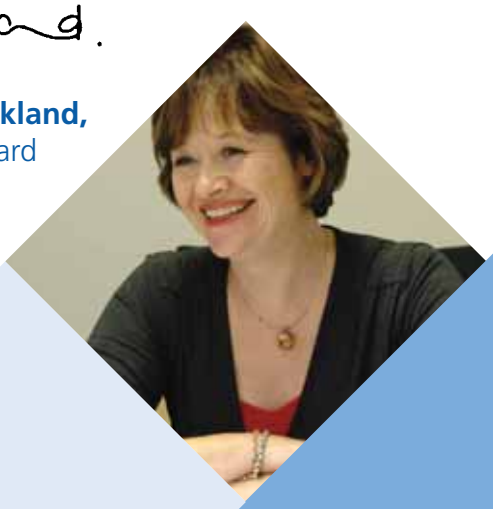
I would like to thank the NHS Institute Board and our Sounding Board for all their wisdom and support through the year and to acknowledge our continuing and very positive relationship with the Department of Health. We have improved our Board governance generally and extended the role of the Board in monitoring customer satisfaction.

As we have become established, it has been a pleasure to host many visitors to the NHS Institute. Highlights of the year have included the visit of the Secretary of State for Health and meetings organised for the Directors of Service Development from Strategic Health Authorities and the Top Leaders event hosted by the Director General of Workforce, Clare Chapman. Throughout the year there has been a stream of visitors attending events and the NHS Institute itself is becoming increasingly recognised as a high-quality venue and resource centre for NHS organisations.

All in all, we can be pleased with our achievements this year and look forward to the challenges of next year, when we can move the NHS Institute even further in terms of impact and value for the NHS.

Yve Buckland.

Dame Yve Buckland,
Chair of the Board



Foreword from the Chief Executive Officer

Welcome to the NHS Institute for Innovation and Improvement's second Annual Report. The NHS Institute supports the NHS to transform healthcare for patients and the public by rapidly developing and spreading new ways of working, new technology and world-class leadership.

We have demonstrated this support in the financial year 2006–07 with an exciting range of products and initiatives which we have developed in partnership with the NHS and others. Highlights include tools for clean, safe care, for delivering quality and value, and for achieving the 18 week patient pathway. We published a guide to lean thinking in the NHS and began to look at different ways of helping the NHS to better productivity.

During the year, we welcomed NHS Live into the NHS Institute and took over responsibility for the Health and Social Care Awards. We also launched The National Innovation Centre in September 2006. The Centre is both working to remove obstacles to outsiders disseminating their healthcare innovations into the NHS, and supporting innovators and inventors from within the NHS to develop ideas and roll them out, while protecting their intellectual property.

Because we are conscious of the imperative to build relationships with those who will use our products, we have put a strong emphasis this year on partnerships. Early in the year we signed a strategic partnership agreement with the US Institute for Healthcare Improvement. We have also developed a number of networks through which we can engage with the NHS. They include networks of leaders across the Strategic Health Authorities, two networks of chief executives from Primary Care and Acute Trusts, and our Practice Partner Network – a network of NHS organisations through which we can pilot and test our products.

These official networks build on the many individual relationships our team members have developed, across the NHS and with the wider world of academia and the private sector.

Our first full year since establishment has continued to be a time of learning and development, and a time when we have been able to begin publicising and distributing our first products. It has also been a time of understanding how our relationships with our partners, particularly our NHS partners, will be key to ensuring that the NHS Institute is in tune with all that is happening in the wider NHS, and able to have a direct and positive input into that environment.

I would like to take this opportunity to thank all my colleagues in the NHS Institute for their hard work this year, achieving so much in so many areas.

For more information about our work, please subscribe to our monthly newsletter at www.institute.nhs.uk.

Bernard Crump
Chief Executive Officer

Management Commentary

The NHS Institute was set up on 1 July 2005 under the NHS Institute for Innovation and Improvement (Establishment and Constitution) Order 2005, which was laid before Parliament on 3 June 2005.

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

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

Corporate overview

The NHS Institute for Innovation and Improvement supports the NHS to transform healthcare for patients and the public by rapidly developing and spreading new ways of working, new technology and world-class leadership. All our activities are dedicated to this end.

Priority Programmes

Our Priority Programmes and work activities for 2006–07, which were agreed with NHS leaders and our sponsors, the Department of Health, were as follows:

- *No Delays* – helping the NHS to deliver the 18 week pathway that ensures no patient waits longer than 18 weeks from referral to treatment.
- *Care Outside Hospital* (formerly Long-term Conditions) – focusing on ways to help the NHS make the shift from secondary to primary care and from primary to home-based care for patients with long-term conditions.
- *Delivering Quality and Value* – working with the NHS towards meeting the challenges of improving clinical and service quality at the same time as controlling costs.
- *Healthcare Associated Infections (HCAIs)*
  – producing tools to help tackle HCAIs in non-acute health settings for use by organisations, teams and individuals (now superseded by the more broadly focused *Safer Care Priority Programme*).
- *Encouraging innovation, building capability and capacity*
  – The National Innovation Centre (NIC) – working to provide guidance and support to innovators from within the NHS and those from outside wishing to work with the NHS, and co-ordinating the activities of the nine NHS Regional Innovation Hubs.
  – Leadership – working to deliver the renowned Graduate Training Scheme for the NHS, the Breaking Through Programme for managers of black and minority ethnic origin, and the Gateway to Leadership Programme, which develops managers from outside the NHS to transfer their skills to the NHS.
  – Learning – working to ensure that best practice is spread and that learning is captured, accessible and practical.
  – Service Transformation – working to develop clinical systems improvement, the Productive series of initiatives and experience-based design.

The Priority Programmes are discussed in detail on pages 10–25.

Building networks and engaging with the Service – getting closer to the NHS

A key focus this year has been the development of networks through which we are able to engage with the NHS. We have built up a very significant number of contacts at every level. NHS staff, particularly those at the front line, are vital stakeholders for the NHS Institute, and for this reason we involve practitioners in the development, testing, launch, adoption and maintenance of the products and strategies we develop for the NHS through our Priority Programmes.

Our networks include:

- *Engagement with the Strategic Health Authorities (SHAs)* – this year we have worked with the newly configured SHAs to share support and learning, to help them improve the NHS locally. Working at a senior level, we are developing robust relationships, enabling effective improvement and a joined-up approach that will impact the NHS across England.
- *Practice Partner Network* – during the year, we have recruited seven organisations to work with us to pilot and test our products. These highly motivated organisations will encourage the update of knowledge, skills and tools and promote faster learning for the NHS.
- *Delivering through Improvement* – this network comprises two groups of chief executives: one from Acute Trusts and the other from Primary Care Trusts. These individuals are committed to delivering health improvement in their localities through the application of improvement science and practice across the services they provide.
- *NHS Live* – a free learning network established to support staff, patients and their communities with improvement activities and projects. This transferred from the Department of Health to the NHS Institute in September 2006.

Working in partnership

The right relationships are crucial to the work we deliver. As well as working across the NHS to build learning and user networks, we continue to develop our relationships with academia (particularly through the NIC), the healthcare industry and other organisations around the world that are working to improve healthcare. This year, for example, we formed an extremely valuable strategic partnership with the United States Institute for Healthcare Improvement (IHI). The IHI is an internationally renowned not-for-profit organisation. It fulfils a similar role to our own within the US healthcare system and also works to bring about improvements in healthcare internationally.

Measuring impact

We have established a regular system of customer satisfaction reporting to the Board. Currently each work area reports qualitative, quantitative and anecdotal information on a monthly rolling basis. We are currently developing a more sophisticated method of reporting, using a 'customer satisfaction dashboard' for the Priority Programmes and monthly progress meetings, with results consolidated at the year end.

Corporate functions and services

We continue to seek ways to formalise and improve vital functions such as Human Resources, finance and IT support as well as marketing and communications, building in a strong customer service focus on these areas and making connections with every area of our business.

We continue to work on policy and strategy development with a view to our long-term impact on the NHS.

The year at a glance

April 2006
We signed up to a three-year strategic partnership with the United States Institute for Healthcare Improvement (IHI). A team of key IHI personnel later came to us for a three-day visit to share learning.

June 2006
The *Essential steps to safe, clean care* framework was produced by the Healthcare Associated Infections (HCAIs) Priority Programme. The framework contains downloadable tools and products for use by organisations, teams and individuals. (For more on the work of the HCAIs Priority Programme, see page 15.)

September 2006
The National Innovation Centre (NIC) showed 300 delegates from across the innovation network that it was open for business with a conference at Imperial College London. (For more on the NIC, see page 18.)

NHS Live moved to the NHS Institute. The NHS Institute and NHS Live are a particularly good fit because our networks help us reach the frontline staff who use NHS Live to support service improvements.

October 2006
The NHS Institute hosted a highly successful event to launch its Joint Improvement Strategy, which aims to foster new ways of working and knowledge-sharing between the NHS, Strategic Health Authorities (SHAs) and the NHS Institute – and crucially between SHAs themselves. The event was attended by SHA Link Directors and their NHS Institute counterparts.

The Delivering Quality and Value (DQV) Priority Programme published initial reports as part of the High-volume Care Project. This marks the first stage of results in an ambitious long-term study in eight different areas of healthcare. (For more on the work of the DQV Priority Programme, see page 13.)

The NHS Institute took part for the first time in the HSJ Management Challenge and came away with two awards.

November 2006
Secretary of State for Health Patricia Hewitt visited the NHS Institute headquarters. Guests included frontline staff and patients from the Maxillofacial Unit at Luton & Dunstable NHS Trust, who took part in a groundbreaking Service Transformation Experience-based Design exercise to improve the quality of patient experience in the unit. (For more about our Service Transformation Team, see page 24.)

"I would like to congratulate you on everything you are doing here at the Institute… What you are doing is critical to the future of the NHS."

Patricia Hewitt, Secretary of State for Health

November 2006 (continued)
No Delays Achiever was launched. This cutting-edge, web-based service improvement tool gives unprecedented access to data designed to help operational managers in Acute Trusts achieve the 18 week patient pathway. (For more on the work of the No Delays Priority Programme, see page 10.)

January 2007
We held an Improvement Metrics summit for over 140 people from the Department of Health, NHS and related organisations. This was also attended by delegates from the IHI.

February 2007
The Service Transformation Team published *Going lean in the NHS*, a short practical guide to applying lean processes. There have been 7,000 copy requests and 3,000 pdf downloads since publication. (For more about the work of our Service Transformation Team, see page 24.)

The Health and Social Care Awards, for which the NHS Institute took over responsibility from the Department of Health earlier in the year, were held in London to 'celebrate the best'.

NHS Live hosted a national event on the theme of 'energising', to celebrate achievements throughout the year and to share knowledge and learning.

Participants included project teams, patient representatives, SHA co-ordinators, NHS Live Wires and corporate partner representatives.

Financial performance

2006–07 Finances at a glance

This report includes the financial information for the year ended 31 March 2007. The NHS Institute was required to achieve a number of key statutory financial targets:

- The NHS Institute was required to maintain its revenue expenditure within a limit of £56,231,000. This was achieved.
- The NHS Institute was required to maintain its capital expenditure within a limit of £1,900,000. This was achieved.
- The NHS Institute was required to maintain its net cash outgoings within a limit of £65,731,000. This was achieved.
- In addition to the key statutory targets, the NHS Institute is expected to undertake its business in accordance with the Better Payment Practice Code. The NHS Institute is required to meet the better payment practice code target of paying all non-NHS trade creditors within 30 days of receipt of goods or a valid invoice (whichever is later) unless other payment terms have been agreed. In this respect, the NHS Institute paid 81.5% (by value) and 83.2% (by number) of its non-NHS trade creditors within 30 days of receipt of goods or valid invoice, whichever was the later.

Director of Finance commentary

The accounts on pages 39 to 72 have been produced in accordance with the direction given by the Secretary of State dated 3 June 2005, 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.

Going concern

The balance sheet at 31 March 2007 shows net liabilities of £4,095,000. This reflects the inclusion of liabilities falling due in the future which, to the extent that they are not to be met from the NHS Institute for Innovation and Improvement's other sources of income, may only be met by future direct funding from the Institute's sponsoring department, the Department of Health. This is because, under the normal conventions applying to parliamentary control over income and expenditure, payments may not be made by the Department of Health in advance of need.

Funding for 2007–08, taking into account the amounts needed to meet the NHS Institute's liabilities falling due in that year, has already been included in the Department of Health's estimates for that year, which have been approved by Parliament. It has accordingly been considered appropriate to adopt a going concern basis for the preparation of the NHS Institute's accounts.

Comparatives

The prior period comparative figures are for the first accounting period of the NHS Institute for the nine months from 1 July 2005 to 31 March 2006. As a result of improvements in the financial reporting systems of the NHS Institute, the 2006–07 disclosures provide a better analysis of the business. Consequently, some comparatives have been re-stated to make them consistent with these disclosures.

The NHS Institute met its key statutory financial targets for 2006–07.

The year has seen us build on our first nine months of operation and meet all our key financial objectives. This is a considerable achievement, particularly at a time when many NHS organisations have found it increasingly challenging to maintain financial balance.

The year has seen a continued focus on developing financial controls, governance and assurance processes that will stand us in good stead for the future.

Throughout this report you will read of the key initiatives and developments that have taken place in 2006–07. Each of these has required financial investment. For example, investment in the No Delays and Delivering Quality and Value Priority Programmes has produced a range of value-added products for the NHS, supporting a strategic direction based on improving health outcomes and operating performance, as well as building capability and change capacity in the Health Service.

Much has been achieved, but there is a lot more to do. The focus on innovation and improvement will continue. The NHS Institute will be developing an Innovation Fund to promote the development and exploitation by the NHS of innovative products and procedures. At the same time the NHS Institute will continue to develop our business model and commercialisation agenda, which is likely to see the creation of a separate commercial trading arm. In short, we have another busy year ahead.

Priority Programmes

"I must congratulate you on the content of the No Delays Achiever and the ease with which the site is navigated. I find it most helpful."

User comment in response to the February 2007 release

No Delays – achieving the 18 week patient pathway

The Department of Health commissioned our No Delays Priority Programme with a broad and simple aim: to develop products to help NHS organisations ensure that, by 2008, patients are waiting no longer than 18 weeks from referral to treatment.

The No Delays Achiever

Our work this year has focused on one key product – a cutting-edge web-based tool designed to support operational managers in Acute Trusts, as they are the group with responsibility for redesigning services to accommodate the 18 week patient pathway.

This tool, called the No Delays Achiever, offers unprecedented access to data that can be sorted, analysed and displayed in response to user needs. For example, if as a user you call up trust-level reports, you are able to separate out and track the data in a variety of ways. You could select a specific pathway – a specialty, for example – then you could select reports on patients with conditions related to that specialty within your trust to see the variations in the pathway they experienced. You could view this data for:

- all patients
- day cases
- elective cases
- non-admitted cases
- patients by cross-provider.

In this way, the people charged with service redesign can get a clear and detailed picture of how their trust is functioning in terms of the patient pathway from referral to point of treatment.

A unique feature of the No Delays Achiever is that it does not just present the data as the user requests it, it also analyses the data and, based on the results, provides a link to the most appropriate tools and resources. Alongside the vast amount of data, the Achiever also includes:

- 120 service improvement tools
- 80 resources, for example journal articles and guides to service improvement
- 20 case studies, which will be added to over time.

If you are not a 'data person' and don't want to deal with numbers, the No Delays Achiever also offers a descriptive, symptom-based way of assessing the level and location of delays, from which it will direct you to the most appropriate service improvement tools and resources.

The No Delays Achiever was launched on 1 November 2006 to great acclaim.

Developing the product

Our initial prototypes were tested within the NHS and were strongly supported by the staff who used them. We had all the data analysis and service improvement expertise we needed within the NHS Institute, but had to procure website designers and programmers to develop the online tool. The commissioning and development phase of the project began in June 2006 and work proceeded extremely rapidly, given the complexity of the project and the vast amounts of data involved.

Continuous improvement

Getting the No Delays Achiever up and running was by no means the end of our work. As well as routine maintenance and updating (the database tracks 45 million patient pathways over three years and is updated monthly), we have a permanent team dedicated to improving the product in response to feedback from users. Their work resulted in the first new release – an improved version of the product that replaced the original version in February 2007.

Feedback from our stakeholders in the NHS was the basis for the changes we made for the February release, most significantly in the presentation and organisation of data as you first enter the No Delays Achiever website, so it is easier to see what is available for your chosen selection.

Six things…

We developed one other key product this year: a booklet for operational managers entitled *Six things to make a big difference to the 18 weeks pathway*.

We know from our work within the NHS that operational managers simply don't have the time to read theoretical literature, even though some of the ideas it contains could be helpful to their work. With this in mind, we have read widely around current management and organisational, lean and queuing theory and distilled the key lessons into six things that can have a real impact on cutting waiting lists, illustrated with real case studies.

What next for the No Delays Priority Programme?

The year ahead holds a fresh set of challenges for the No Delays Priority Programme. In 2007–08 we will:

- focus on developing a spread and adoption strategy to ensure the No Delays Achiever reaches the largest possible user group
- continue to update the No Delays Achiever to take in the latest data and any other changes so that it can maintain its usefulness and, crucially,
- direct our attention towards commissioners in PCTs to work out how we can best support them in commissioning to achieve the 18 week patient pathway.

"The process is really helpful in that it forces making a decision to either proceed, stop or re-scope projects."

PCT Commissioning Adviser, Derbyshire Accelerated Improvement test site

Care Outside Hospital (formerly Long-term Conditions)

Background

Care Outside Hospital is the new name for the Long-term Conditions/Primary Care Priority Programme, which began in December 2005. It was based on the White Paper *Our health, our care, our say* and its original aim was to help improve the management of long-term conditions, particularly through innovations in primary care.

This first phase of the programme culminated in:

- *A suite of high-profile products*
  These included the publications *Making the Shift: Key Success Factors* and *High Impact Changes for Practice Teams.* These products have been well received by the NHS, with thousands of downloads from the NHS Institute's website and through NHS Networks.
- *Stronger and wider partnerships*
  The team developed strong partnerships with a wide range of providers and commissioners within the NHS as well as with other organisations, including the internationally respected Institute for Healthcare Improvement (IHI) in the US. Through these partnerships, the team ensured that its products reflected whole-system needs and also raised awareness of the products. For example, demand for *Making the Shift* continues to increase at local, national and international levels.

Making the Shift

For 2007–08, this Priority Programme has been renamed Care Outside Hospital to reflect a new, broader remit related to making the shift – delivering community care services closer to home.

For the programme as a whole, the key challenge is to implement change in an exemplary manner and at an accelerated pace.

Accelerated Improvement projects

The main focus of the work this year has been on developing and testing a range of approaches to make the shift from delivering care in traditional settings to delivering care in a more responsive way in line with patient needs.

We carried out this work as 14 separate Accelerated Improvement projects focusing on the clinical areas identified in the White Paper. The projects were conducted at five test sites, which ranged from urban (central Manchester) to rural (Dorset) and were mostly PCTs, with one local GP practice. We also commissioned a management consultancy and an academic organisation to support work on the sites.

An additional challenge was presented in the form of wholesale organisational changes to the NHS, several of which had implications for our test sites. Despite this, all 14 projects continued on schedule.

As a result, not only have there been some tangible shifts in service, but valuable insights from these test sites are being built into a comprehensive suite of products. These products will be developed and tested with selected health communities up to October 2007 and then released for use across the NHS for inclusion in the 2007–08 Local Development and Planning round.

These products will include:

- a 'data cube' – an analytical tool which will provide individual PCTs with information to enable them to prioritise areas of local service with the greatest potential to benefit from being delivered outside hospital settings
- a practical step-by-step guide to managing projects designed specifically for care outside hospital.

Delivering Quality and Value (DQV)

Aim

As with so many of the Priority Programmes, the overall aim of Delivering Quality and Value is a simple one: to help the NHS provide consistently high-quality, high-value care to all patients. Its key task is to ensure that all trusts function at the same level, reflecting best practice in terms of providing care that is both clinically and cost effective.

This year, we focused on two complementary projects:

- Better Care, Better Value Indicators
- High-volume Care.

Better Care, Better Value

The Better Care, Better Value Indicators work culminated in the quarterly publication of indicators highlighting variations in practice across the NHS, quantifying opportunities for increased productivity and identifying potential savings of over £2 billion.

This research has had a great deal of coverage in the press, was quoted by the Secretary of State and has been taken up by the Institute for Public Policy Research.

If the Better Care, Better Value Indicators can be seen as a product to 'push' the NHS forward (as they highlight areas for improvement), the published research on High-volume Care is more of a 'pull' – not just telling people what they should be doing but showing them how it is being done in the best-performing healthcare organisations.

High-volume Care

The High-volume Care project is a long-term, large-scale work of research. The first stage culminated in October 2006 with the publication of summary and detailed reports reflecting the work we have done to identify, test and promote a comprehensive and detailed range of specific or system improvements along the entire patient pathway, from primary care through referral and treatment to discharge and rehabilitation for the following eight areas of high-volume care:

- cholecystectomy
- urinary tract infection (as a tracker for complex elderly health problems)
- acute admissions in mental health
- fractured neck of femur
- primary hip and knee replacement
- acute stroke
- caesarean section
- short-stay emergency care (of two days or less).

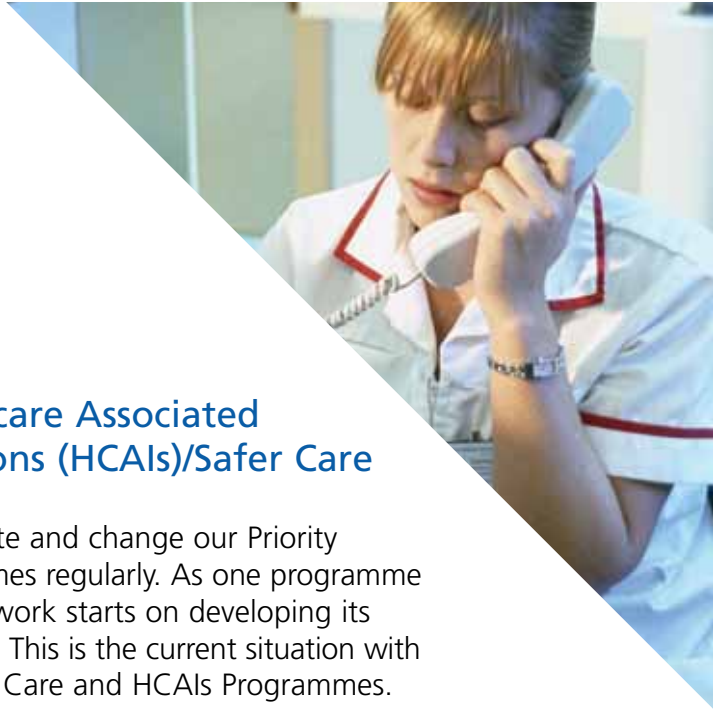
The first stages of the High-volume Care project were primarily research based. We explored current thinking about efficient healthcare organisations and compared it with our own detailed observations of a range of over 40 organisations working in the areas of care listed above. Our findings illustrated a strong correlation between best-quality and best-value care, indicating that the best outcomes are not directly related to resource availability but rather to the efficiency of the organisation. The focus of our work subsequently moved on to discovering what it is that the most efficient organisations do that has an impact on outcomes and efficiency.

The overarching aim of the High-volume Care project is to capture how the top-performing organisations deliver the highest quality care with the best resource utilisation and to make their ways of working accessible across the NHS. This research will also form the basis of a whole tranche of new supporting products.

Directory of Emergency Ambulatory Care

The first of these additional High-volume Care products, the Directory of Emergency Ambulatory Care for Adults, was launched in March 2007. The Directory, which grew out of the short-stay emergency care work, is based on the practices of those hospitals that managed successfully to treat the largest number of people without admitting them to a hospital bed – allowing the patients to benefit from care delivered closer to home and freeing up more acute hospital beds for the patients in greatest need.

The Directory is intended as a reference tool to share this knowledge. As such, it will be of use to frontline staff in both primary and secondary care organisations.



Engaging with the NHS

All the High-volume Care work was 'co-produced' with a large number of NHS staff from a wide range of organisations. As with almost all our work, the NHS Institute did not just go in and study the NHS; NHS staff also worked with us at the NHS Institute, playing a key role in thinking through and synthesising the results in order to make end products that are, above all, useful.

Although we are about to move on and focus on a new set of areas for the ongoing High-volume Care project, the original eight areas are still active as we continue to help the spread and adoption of best practice care across the NHS.

"It's great to be able to give feedback on prototypes."

Member of staff at York Hospitals NHS Trust

Healthcare Associated Infections (HCAIs)/Safer Care

We update and change our Priority Programmes regularly. As one programme finishes, work starts on developing its successor. This is the current situation with the Safer Care and HCAIs Programmes.

Completed programme: Addressing HCAIs

The Addressing HCAIs Priority Programme comprised a set of specific activities that formed one strand of the Department of Health's 'Saving Lives' project to tackle HCAIs and MRSA. The Department has involved a range of healthcare agencies in this project, which aims to halve MRSA rates by 2008. Our activities under the Addressing HCAIs Programme were successfully completed over the summer.

Our work on this programme resulted in a range of products, tools and resources to support local healthcare organisations in the fight against HCAIs and MRSA. These were subsequently handed over to the Department of Health's Cleaner Hospitals Team.

Products and toolkits produced for the Addressing HCAIs Priority Programme include:

- *Essential steps to safe, clean care*
  A framework of self-assessment tools and products to help staff reduce HCAIs in various 'non-acute' healthcare settings, including Mental Health Trusts, Primary Care Trusts, independent healthcare, care homes, hospices, GP practices and ambulance services.

- *Three key recommendations*
  These recommendations and the associated support tools were developed after in-depth investigation into public perceptions of MRSA and HCAIs. Their aim is to give the public confidence that they are being treated in safe and reliable organisations.
- *Alison and Sue*
  We commissioned a 10-minute film telling the story of a patient and her daughter who were seriously affected by MRSA and *Clostridium difficile*.

We also developed the following resources:

- *Dr Foster report*
  This report provides the results of the staff segmentation project we commissioned from Dr Foster Intelligence. It concludes with recommendations and suggestions for further research.
- *Healthcare Commission and NHS Institute HCAIs collaborative workshops, conducted by Opinion Leader Research*
  Report of two workshops carried out with patients and the public, healthcare professionals and special interest groups. The report includes action plans for changing behaviours towards HCAIs.
- *Report on Peer Assist Workshop*
  We held a peer assist workshop as part of the project's detailed observation and reframing phase to understand how public perception had been managed in other high-profile situations. The report includes details of the peer assist approach and a summary of how this workshop has informed our work.
- *Confidence Matters report*
  Report of a 10-month study on public perceptions of health services with recommendations for ways of improving public confidence.
- *Newsletters*
  Five key briefing newsletters on different areas of work.

Programme in development: Safer Care

Recommendation 11
The NHS Institute for Innovation and Improvement should be asked to work with the medical Royal Colleges and other educational providers to ensure that advances are made in education and training to support patient safety.

Rationale
The mission of the NHS Institute for Innovation and Improvement is 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 capacity at the front line. Building on its existing work and relationships, patient safety is an area that fits well within the goal of building improved capacity and capability within the NHS, and is indeed already incorporated in existing streams of work. The organisation is, therefore, in an excellent position to facilitate the development of education and training in a short timescale.

It is important that a patient safety curriculum is developed and widely implemented in undergraduate, postgraduate and continuing education, in order to promote the knowledge, skills, attitudes and behaviours required of clinical and non-clinical staff to provide the safest possible care to patients.

(*Safety First*, Department of Health, December 2006)

The Safer Care Priority Programme is being established in response to the Department of Health's 2006 report *Safety First*, and in particular Recommendation 11 (see opposite). The Programme is due to become fully operational by mid-2007, but existing leads are working with the Department of Health and the Chief Medical Officer to define and develop the NHS Institute's role.

The main emphasis will be on education and training, and the learning will focus on changing practice. The main challenge is to ensure that evidence-based good practice becomes embedded within organisational culture.

This process will involve staff at all levels and may well necessitate reducing the complexities of existing systems. The work the NHS Institute has already done on the Productive Ward and the pilot for embedding improvement in undergraduate training will form useful starting points.

The NHS Institute has many existing workstreams that it can bring together from across the organisation in order to work effectively in the extremely broad area of patient safety. The Learning, Leadership and Service Transformation teams will all contribute.

Our proposals for the initial pilot phase include the following opportunities to deliver education and training:

- undergraduate training
- management training
- board development
- clinical leadership
- NHS Institute fellowship
- Clinical Systems Improvement (CSI) capability
- Productive Wards
- NHS Live
- CHAINs (Contact, Help, Advice and Information Networks) and other networks.

"[The NHS Institute is] in an excellent position to facilitate the development of education and training in a short timescale."

Safety First, *Department of Health, December 2006*

Encouraging innovation, building capability and capacity

The National Innovation Centre (NIC)

The National Innovation Centre was first conceived following the Wanless report of 2003, *Securing Good Health for the Whole Population*, in which the NHS was identified as 'a slow adopter' of healthcare technology. A government report later that year recognised the potential for innovation within the NHS and the contribution this could make to UK productivity. It recommended the establishment of a national centre that would work in collaboration with local networks both within and outside the Health Service.

This plan was developed further in the 2004 Health Industry Task Force report *Better Health through Partnership: a programme for action*. It emphasised a major need to accelerate the uptake of new technology to improve the outcome for patients and to position the UK as a healthcare technology research destination of choice.

The NIC was set up within the NHS Institute in 2005 to form partnerships between the healthcare industry, academia and the NHS, with the aim of co-developing technologies that are based on clear needs and have the potential to yield significant results.

The National Innovation Centre has a unique structure and position. It sits at the heart of a complex innovations network that includes a range of government organisations, such as the Department of Health and the Department of Trade and Industry, the NHS, academia, the healthcare industry and other organisations focused on technology development in the UK. Its structure, with nine regional innovation hubs and two further hubs for training and adoption, is a reflection of this.

Doing the groundwork

Although the idea of an NIC had been in existence for some time, a great deal of preparation and development was needed to get the organisation up and running. A key strand of this preparation involved building strong relationships with stakeholders to ensure good connectivity across the network. To this end, a series of interactive workshops was held with the innovation hubs, industry partners, the Department of Trade and Industry, HM Treasury and the Department of Health.

By the end of summer 2006, the NIC was fully staffed, with a live website (www.nic.nhs.uk) and the first phase of its operational strategy agreed. In September 2006, a conference at Imperial College London for 300 delegates from across the innovation network marked the fact that the NIC was open for business.

In its first full financial year of operation, the NIC's focus was on two key areas:

- establishing the partnerships and channels of communication between the organisations within the healthcare innovations network
- developing ideas and managing intellectual property emanating from the NHS via the nine regional hubs.

Developing network partnerships

The NIC has worked to develop partnerships by:

- acting as a focal point for partner networks, signposting innovators to the most appropriate NHS organisations and acting as a broker for technology innovation into the NHS. The NIC has done this through its website tools and through the added value advice that its staff provide for innovators
- developing two new hubs: one in London focused on advanced training tools for new technological innovations and one in Manchester focused on accelerating NHS adoption of innovations
- working with the NHS to co-develop technologies to meet recognised needs in priority areas – proactive work on this is now under way in 11 trusts
- establishing an innovation fund to support the commercial development of innovations within the healthcare system.

Using the website to develop ideas

The 'Assess your idea' and 'Innovation know-how' sections of the NIC website are the first ports of call for anyone who has an innovative idea related to healthcare.

The 'Assess your idea' pages include a free interactive innovation assessment tool, designed to highlight those ideas with development potential and particularly those that correspond to current NHS priority areas.

If an innovation meets the appropriate criteria, the NIC can offer guidance on development and help the originator source financial support. Ideas from within the NHS are referred to the appropriate regional hub for advice on further development.

'Innovation know-how' includes:

- a development framework explaining how a healthcare product is developed from conception to launch
- a series of 'how to' guides covering everything from patent protection to finding development partners
- a range of case studies
- links to other organisations such as the Association of British Healthcare Industries, the Health Technologies Knowledge Transfer Network, the National Institute for Health and Clinical Excellence, and so on.

In the website's first six months of operation there were:

- 18,000 site visits
- 152 registrations with the innovation assessment tool
- 53 unique ideas submitted to the NIC for professional review.

Innovation hubs

The NIC co-ordinates the activities of nine regional innovation hubs. The hubs provide commercial and legal advice to member trusts on how to identify, protect and develop any intellectual property that originates from within the NHS.

In addition, the NIC holds an annual innovation competition, in which it selects overall national winners from the hubs' regional competition winners. Winning innovators announced in August 2006 included Dr Michael Ford, NHS Innovations North, with his MRSA diagnostic test, which identifies antibiotic-resistant strains of MRSA in 24 hours, cutting the previous diagnosis time in half.

Training and adoption hubs

The Training Hub for Operative Technologies in Healthcare (THOTH), based at Chelsea and Westminster Hospital, became fully operational in summer 2005. THOTH is chaired by Professor Sir Ara Darzi and works alongside universities and industry to identify and develop advanced training tools for advanced technology. This year, THOTH has finalised its governance and operational structure and released its first two products – a medical device training guide and a patient safety video for use by inpatients.

The Adoption Hub is based at Central Manchester and Manchester Children's University Hospital. It will identify the elements that need to be in place to allow for the successful dissemination of new technology in the NHS.

Leadership

Our core functions

The Leadership Centre within the NHS Institute focuses on building capacity and capability across the NHS. We do this through a variety of means that include:

- *Graduate training schemes*
  These are widely acknowledged as some of the very best in the UK, allowing us to attract high-calibre graduates. In 2006–07 we redesigned the schemes to reflect the NHS's broad agenda of reform. In September 2006, 220 graduates started training with us – a 15% increase on last year.
- *Gateway to Leadership Programme*
  We recruit around 40 leaders a year from outside the NHS for management positions within the organisation, where they can make a positive impact. A structured induction and development programme forms a bridge into the NHS. To date, over 160 participants have secured management jobs, with some moving into director-level positions.
- *The Breaking Through Programme*
  This offers accelerated development opportunities and mentoring support to give leaders from black and minority ethnic backgrounds the confidence and skills to progress their careers into higher-level NHS management. This year, 70 people were recruited onto the scheme.
- *A portfolio of development opportunities*
  We provide development opportunities for around 3,000 board-level leaders across the NHS, targeted at both individuals and whole boards.
- *A range of diagnostic tools to underpin board-level development*
  These include the Leadership Qualities Framework (LQF), outlining the core competencies required of NHS leaders, and an associated 360-degree feedback instrument.

In addition, we are working with the Academy of Medical Royal Colleges on a long-term project to develop a training programme to ensure doctors acquire management and leadership skills at key stages in their careers. This underpins a broader Department of Health strategy to increase medical engagement in the planning, delivery and transformation of services.

Meeting the needs of the NHS

Everything we do is closely linked to the needs of the NHS, as evidenced by our engagement with NHS colleagues and informed by their input into the planning and development stages.

For example, when planning a portfolio of programmes to help Primary Care Trusts (PCTs) develop their commissioning abilities, we carried out a needs analysis with NHS colleagues to ensure that our provision was relevant, focused on the key issues and accessible both to individual leaders and whole boards. We also refined our plans in the light of the findings of a national reference group comprising colleagues from across the NHS.

When the NHS Institute proposed a redesign of graduate schemes, we consulted a national advisory group with representation from across the NHS. The group was involved at every stage, including the selection of third-party education providers and the assessment and selection of graduates to join the scheme.

Development for senior NHS staff

We have built on an already strong programme of training and development for chairs, chief executives and directors this year by:

- developing a comprehensive training support package for board-level leaders focusing on commissioning-related skills. This package, which can be used by individuals, leadership teams or whole organisations, underpins the Department of Health policy Commissioning a Patient-led NHS
- incorporating a 360-degree feedback tool into the PCT Fitness for Purpose process. This tool forms the basis for whole-board performance review and development planning
- supporting Strategic Health Authorities (SHAs) in developing strategies for identifying and developing a pool of candidates as potential successors to chief executive positions. This has been identified as a key leadership development priority by David Nicholson, NHS Chief Executive
- piloting a strategic finance leadership programme in conjunction with MONITOR, for a target audience of around 700 NHS Finance Directors. This will be delivered by Cass Business School, with full rollout in 2007
- significantly increasing one-to-one coaching for senior leaders in the NHS, using the NHS Institute's national faculty of accredited coaches. We are also supporting SHAs in building coaching capability into their organisations via an accredited coaching scheme with the School of Coaching and Strathclyde University.

The changing NHS

This year has been particularly challenging because of the organisational and structural changes the NHS has undergone, particularly at the level of SHAs, resulting in significant changes for individuals, boards and whole organisations.

We are well aware of both the opportunities and the uncertainties that such change can bring, and have been working closely with colleagues in the NHS and the Department of Health to define and deliver the type of leadership support required and to target our efforts to where they are most needed. A key concern, for example, has been to protect the long-term investment in the graduate training schemes and to secure roles in the NHS for those completing the schemes in 2006.

This year we have been awarded:

- the Number One Graduate Training Scheme in Britain award for our Human Resources and Graduate Management Training Schemes (*The Times*)
- gold award for innovative work across the public sector in association with our partner Hay Consultants (*Management Today*).

In addition, the NHS was voted sixth-best organisation in Britain to work for (up from seventh place the previous year).

Learning

The scope of the Learning Team

The Learning Team has a broad role: to take lessons from world-class best practice in innovation and improvement and to apply what they learn in order to build capability across the NHS.

The breadth of this role is reflected in a diverse range of projects and products, all of which aim to change both attitudes and practices within the NHS. They do this by:

- increasing awareness of and willingness to engage with innovation and improvement across the NHS
- developing skills within the NHS (and offering support and direction in applying these skills) to manage change and bring about service improvements.

This year the team has focused on three major projects:

- the Practice Partner Network
- the NHS Institute Fellowship Programme
- improvement modules.

The Practice Partner Network

During 2006 the Learning Team piloted a new concept – the Practice Partner Network. The key objectives of the Practice Partner Network are to:

- build a 'special relationship' with a small network of receptive and highly motivated organisations which can rapidly pilot new knowledge, processes, skills and tools
- create a powerful niche role for the Practice Partner Network within the NHS Institute's development and dissemination process, to enable better, quicker learning for the NHS
- act as eyes and ears for the NHS Institute within the wider health and social care system and help build the evidence base of the Institute.

Seven NHS organisations from across England agreed to act as pilot sites and undertook an intensive period of collaboration with the NHS Institute. The aim was to establish a network of NHS organisations that will become our first port of call for testing concepts, tools, ideas or products that will ultimately improve the service provided by the wider NHS.

The pilot phase was positively received and has generated enormous interest from NHS organisations across the country. Membership has already increased, and the Learning Team aim to have 35 practice partners in the network by July 2007.

The NHS Institute Fellowship Programme

The programme became active this year with the recruitment from within the NHS of the first four NHS Institute Fellows. The four Fellows are Mark Lambert, Simon Watson, Mark Batt and Martin Wale. Their fellowships will last for a year, during which time they will work on specific, high-impact projects within the NHS Institute with the aim of developing high-level healthcare improvement skills. Their fellowship also includes visits to appropriate improvement organisations.

At the end of their year at the NHS Institute, the Fellows will return to their organisations ready to take on leadership roles in innovation and improvement.

Improvement Modules

This is an ongoing project to build improvement into the pre-registration training of clinicians. The long-term aim of the modules is to create an openness to improvement and commitment to patient safety that is embedded in the culture of the NHS.

This is particularly important as it forms part of pre-registration training for healthcare students, as opposed to those already at work in the NHS. Providing training in improvement at this early stage will help to ensure that students enter healthcare organisations willing to challenge and be challenged, and able to look at the patient journey and experience in a questioning way, rather than simply accepting the status quo.

This year has seen the completion of the first phase with four universities (the University of Teesside; the Universities of Warwick and Coventry in association with the West Midlands Postgraduate Deanery; and York St John University College with York Hospitals NHS Trust) working with the NHS Institute to develop three similar but different modules. All have a strong service-user perspective and comprise a core day on improvement and supplementary days for more in-depth training. The first student groups at all four universities have received improvement training this year.

On 8 March 2007, the NHS Institute and the universities that developed the modules held an event to share their learning and experiences with other universities, professional bodies and those with an interest in workforce development. Based on the success of phase one, phase two is being planned with six additional universities as partners to test the implementation of the improvement modules.

Work within and outside the NHS Institute

Other outward-facing projects on which the Learning Team has made significant progress this year include:

- *Improvement Leaders' Guides*
  We brought out two new additions to this highly successful range of small texts on improvement tools and techniques: one on technology; the other on sustainability.
- *Action Learning Sets*
  These are designed for senior service improvement leaders, to help them learn from each other and think their way through the complex challenges they face.
- *Patient and Public Involvement Project*
  We have made a commitment to working with patients, staff and the public to transform good ideas into workable solutions.

- *NHS Centre for Involvement*
  We performance manage this centre, which supports organisations to involve people more effectively.

Within the NHS Institute, the Learning Team supports various activities of the Priority Programmes by lending expertise and support. We also focus on learning within the NHS Institute, helping to ensure an environment of continuous development for staff through a combination of live events and the use of new technology to capture learning and training elements for personal use.

Service Transformation

Overview

The Service Transformation Team's aim is to help the NHS at every level to become more confident, ambitious and radical in its approach to change, so that the experience and outcomes for patients are significantly improved and NHS organisations and staff are adaptable and prepared for change.

The team frequently works with and across the Priority Programmes and its knowledge and products are picked up across the NHS Institute.

During 2006–07 the team focused intensively on developing new products, many of which NHS staff will have access to in 2007–08. These new products include:

- the NHS Sustainability Model and Guide
- expert training sessions on various aspects of Clinical Systems Improvement (CSI) and other CSI-related products including a suite of Reducing Mortality guides and guides to lean Sigma for the NHS (a concept that can significantly improve productivity, reduce waste and lower NHS costs)
- additions to the Productive series
- published papers and guidance on experience-based design
- the Vision to Delivery Accelerator (V2DA)
- Delivering for Improvement guidance material focused on Primary Care Trust (PCT) commissioning
- a practitioners' guide on Social Movements.

The NHS Sustainability Model and Guide

NHS staff have told us in a formal evaluation process that the NHS Sustainability Model and Guide have helped them pinpoint areas that need attention in order to increase the sustainability of their improvement work.

Clinical Systems Improvement (CSI) and related products

CSI is a body of knowledge adapted from systems engineering, psychology and other disciplines to improve the clinical processes at the heart of service delivery.

The Service Transformation Team has already introduced CSI training throughout the NHS, but in 2006–07 we have been working with the Leadership Team to develop CSI training modules specifically aimed at senior leaders. Because these leaders set the tone for their organisations, by targeting them in this way we are working to make the overall environment in the NHS more receptive to change.

The team is also working on a suite of CSI-related products, including guides for reducing mortality, a guide to lean Sigma and a practical guide to lean processes.

This last publication, entitled *Going lean in the NHS*, has been particularly popular, with over 7,000 copy requests and 3,000 downloads of the PDF since its launch in February 2007.

The Productive series

This currently comprises three main workstreams:

- *The Productive Ward*
  Launching in April 2007, this identifies the factors that impact on ward staff's ability to deliver safe, reliable and efficient care, helping staff redesign systems to increase the time they have for direct patient care.
- *The Productive Community Hospital*
  This will support leaders of community services in the implementation of best practice tools and techniques identified through the field test projects (launching in September 2007).
- *Peak Personal Productivity*
  April 2007 marks the end of the initial scoping phase for a campaign to improve 'personal productivity' across the NHS. The campaign launch is scheduled for February 2008.

The series will also pull together existing knowledge from the application of lean principles in pathology and imaging departments.

Experience-based design

This programme is based on the recognised need to promote innovation in enabling patients and carers to co-design health services in order to achieve the improvements necessary to provide the best possible service for themselves and future patients.

So far, over 40 changes have been made to improve the patient experience and we are now starting work on a guide and web resource for NHS staff, which will be launched in June 2007.

The Vision to Delivery Accelerator (V2DA)

The V2DA will be both a facility and process that NHS teams (including NHS Institute teams) can use to help them better understand a current challenge, see the possibilities for significantly improved services provision in the future (the Vision) and help them create those future services (the Delivery) in a far shorter timescale than normal (the Accelerator).

Work is currently at the testing stage, and we are working closely with three NHS organisations.

Delivering for Improvement

We have been working with a network of 20 PCT chief executives to identify the practical characteristics of the high-performing commissioning organisation. The results of this work so far include a list of characteristics and methods for achieving them, as well as an established cadre of PCT chief executives focused on improving performance.

Social Movements

The development of a practitioner guide for Social Movements will result in a practical, evidence-based resource of strategies, tools and techniques that will enable NHS leaders at all levels to create and mobilise organisational energy for widespread, transformational change.

Governance structure

In *NHS Institute for Innovation and Improvement – Directions* 2005 the Secretary of State set out the functions the NHS Institute was to undertake. *NHS Institute for Innovation and Improvement – Regulations* 2005 dealt with the membership and procedures of the organisation.

The NHS Institute's role is '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 NHS Institute has drawn on the work of the NHS Modernisation Agency, the NHS Leadership Centre and NHSU, and incorporates the new National Innovation Centre. It is based at the University of Warwick:

NHS Institute for Innovation
and Improvement
Coventry House
University of Warwick Campus
Gibbet Hill Road
Coventry CV4 7AL

The Board of the NHS Institute is the body responsible for making the organisation's key decisions. It is made up of a Chair and a combination of Executive Directors and Non-Executive Directors appointed by the Secretary of State. The Chief Executive Officer is appointed by the Chair and the Non-Executive Directors; together they appoint the members who are officers of the NHS Institute.

The Board's current composition is as follows:

Dame Yve Buckland
Chair

Mike Collier CBE
Vice-Chair

Professor Dame Carol Black
Non-Executive Director

David Bower
Non-Executive Director

Professor Tony Butterworth CBE
Non-Executive Director

Mike Deegan CBE
Non-Executive Director

Andrew Smith
Non-Executive Director

Professor Bernard Crump
Chief Executive Officer

Simone Jordan
Executive Director
(Director of Learning and Deputy Chief Executive)

Paul Allen
Executive Director
(Director of Leadership Development)

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

Michael Cawley
Executive Director
(Director of Finance and Business Services)

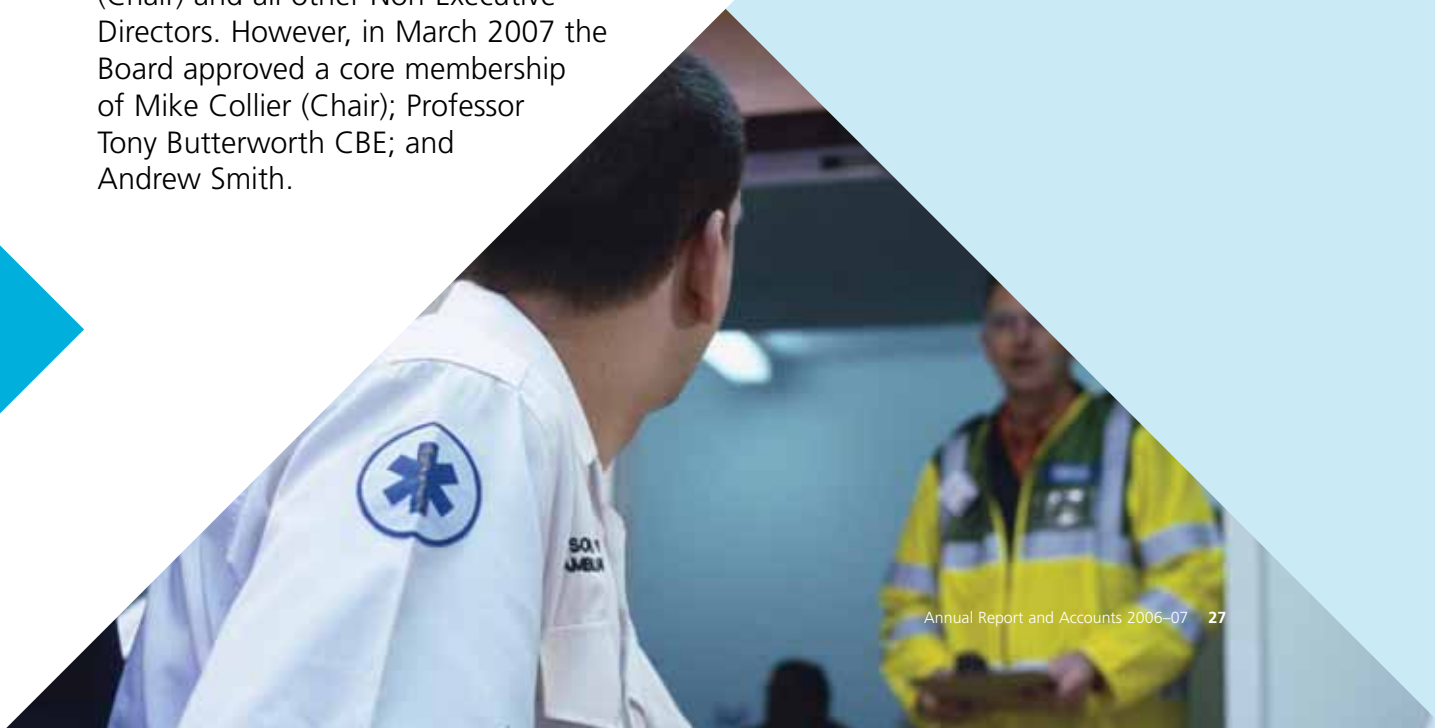
Dr Maire Smith
Executive Director
(Director of Technology and Product Innovation)

Dennis Sherwood was a Non-Executive Director for part of the year before tendering his resignation. Andrew Smith was appointed to fill the vacancy in March 2007.

Mike Collier, Non-Executive Director, was appointed to the post of Vice-Chair on 23 November 2006.

A number of committees support the NHS Institute Board. These include:

- The Audit and Risk Management Committee, responsible to the Board for developing and overseeing effective arrangements for all aspects of internal control and financial reporting within the NHS Institute. As part of this remit it is also responsible for maintaining an appropriate relationship with external and internal auditors. As such, the Committee is the principal body, below the Board, for carrying out scrutiny of policy and processes within the NHS Institute. It is this remit which distinguishes the work of the Audit and Risk Management Committee from the other groups advising the Board. Members are: Mike Collier (Chair) and all other Non-Executive Directors. However, in March 2007 the Board approved a core membership of Mike Collier (Chair); Professor Tony Butterworth CBE; and Andrew Smith.
- The Remuneration and Terms of Service Committee, details of which are contained within the Remuneration Report on pages 29–37.



Board members' Declarations 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 and are attached to the public record of Board meetings in cases where a Declaration of Interest form has been completed. A register of Declarations of Interest is kept and maintained by the Board Secretary, and is open to public inspection.

In accordance with Standing Orders, this register is kept up to date by means of an annual review in which any changes of interest declared during the preceding 12 months are incorporated.

'Declarations of Interest' is included as an item on all Board meeting agendas. 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 (as required by Standing Order paragraph 6.6).

For details of the Declarations of Interest, please refer to the register of interests and to the minutes of the Board.

Remuneration Report

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

The NHS Institute has a Remuneration Committee consisting of all Non-Executive Directors, the Chief Executive, the Deputy Chief Executive and Director of Learning and the Company Secretary. The Committee meets three times a year, supported by the Human Resources Department, and:

1. Establishes procedures for developing policy on Executive Director and senior staff remuneration
2. Recommends to the Board terms of service and remuneration for the Chief Executive, Executive Directors and senior staff
3. Ensures that appropriate systems are in place on job evaluation, individual performance appraisal and processes for contractual arrangements for senior staff.

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

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.

There is national work currently being undertaken by the Department of Health to determine remuneration levels for Chairs and Non-Executive Directors and Very Senior Managers. The NHS Institute obtains its guidance and advice from the Department of Health. This national work aims to build on the work already completed as part of Agenda for Change taking into account the context of organisational changes arising from Commissioning a Patient Led NHS.

Performance conditions

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

The Executive Directors take the lead on this process within their individual areas. Their pay is not specifically performance-related, but performance is regularly monitored.

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 Institute or the health service that they should continue to hold office.
- If the Chair or non-executive member does not attend a meeting of the Special Health Authority for a period of three months.
- If the Chair or non-executive member does not properly comply with the requirements of the regulations with regard to pecuniary interests in matters under discussion at meetings of the Special Health Authority (e.g. a failure to disclose such an interest).

The following list provides examples of matters which may indicate to the Commission that it is no longer in the interests of the health service that an appointee continues in office. The list is not intended to be exhaustive or definitive; the Commission will consider

each case on its merits, taking account of all relevant factors.

a) If an annual appraisal or sequence of appraisals is unsatisfactory
b) If the appointee no longer enjoys the confidence of the board
c) If the appointee loses the confidence of the public
d) If a chair appointee fails to ensure that the board monitors the performance of the special health authority in an effective way
e) If the appointee fails to deliver work against pre-agreed targets incorporated within their annual objectives
f) If there is a terminal breakdown in essential relationships, e.g. between a chair and a chief executive or between an appointee and the rest of the board
g) When a new chair is appointed to a board he/she will be expected to review the objectives of all board members and may, at the time of their next appraisal, make recommendation to the Commission regarding their continued appointment
h) There is no provision in the NHS Institute's Annual Accounts for the early termination of any non-executive's appointment.

5. Remuneration – The Chair and non-executive members are entitled under the Act to be remunerated by the Special Health Authority for so long as they continue to hold office as chair or non-executive member. They are entitled to receive remuneration only in relation to the period for which they hold office. There is no entitlement to compensation for loss of office.

6. Current rate for chair and non-executives – The current rate of remuneration payable to the Chair of the NHS Institute for Innovation and Improvement is £60,000 pa for up to three days a week. The current rate of remuneration payable to members is £7,500 pa for approximately two days per month with an additional £5,000 pa for the Chair of the Risk and Audit 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.

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

For Executive Directors of the NHS Institute for Innovation and Improvement

TERMS AND CONDITIONS

1. Basis for appointment – All of the Executive Directors have been appointed on a permanent basis under a contract of service at an agreed annual salary, an entitlement to a lease car and eligibility to claim allowances for travel and subsistence costs, at rates set by the NHS Institute for expenses incurred necessarily on its behalf.

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.

Notice of termination of contract of service to the NHS Institute by an Executive Director is three months.

There were no payments made to Executive Directors for early termination during the 2006–07 financial year.

There is no provision for compensation included in the NHS Institute's Annual Accounts for the early termination of any Executive Director.

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

Name	Title	Start date	Review date
Yve Buckland	Chair	1 July 2005	30 June 2009
Mike Collier	Vice-Chair and Chair of Audit Committee	1 October 2005	30 September 2009
Carol Black	Non-Executive Director	15 February 2006	14 February 2010
David Bower	Non-Executive Director	1 July 2005	30 June 2008
Tony Butterworth	Non-Executive Director	1 July 2005	30 June 2008
Michael Deegan	Non-Executive Director	1 July 2005	30 June 2009
Andrew Smith	Non-Executive Director	15 February 2007	14 February 2011
Bernard Crump	Chief Executive	1 July 2005	Not applicable
Simone Jordan	Deputy Chief Executive and Director of Learning	1 October 2005	Not applicable
Paul Allen	Director of Leadership	1 September 2005	Not applicable
Helen Bevan	Director of Service Transformation	1 July 2005	Not applicable
Michael Cawley	Director of Finance and Business Services	1 October 2005	Not applicable
Maire Smith	Director of Technology and Product Innovation	1 September 2005	Not applicable
Dennis Sherwood	Non-Executive Director	1 July 2005	Resigned his position October 2006

Salaries and allowances 2006–07

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

	Salary (bands of £5,000)	**Other remuneration** (bands of £5,000)	**Benefits in kind** (rounded to the nearest £100)
Name and Title	**£000**	**£000**	**£00**
Bernard Crump (Chief Executive)	155–160	0	49–50
Simone Jordan (Deputy Chief Executive and Director of Learning)	120–125	0	39–40
Helen Bevan (Director of Service Transformation)	120–125	0	0
Maire Smith (Director of Technology and Product Innovation)	115–120	0	0
Michael Cawley (Director of Finance and Business Services)	110–115	0	43–44
Paul Allen (Director of Leadership)	110–115	0	0
Yve Buckland (Chair)	60–65	0	0
David Bower (Non-Executive Director)	5–10	0	0
Tony Butterworth (Non-Executive Director)	5–10	0	0
Mike Collier (Vice-Chair and Chair of Audit Committee)	10–15	0	0
Michael Deegan (Non-Executive Director)	5–10	0	0
Dennis Sherwood (Non-Executive Director)	0–5 See note 1	0	0
Carol Black (Non-Executive Director)	5–10	0	0
Andrew Smith (Non-Executive Director)	0 See note 2	0	0

Notes:
1. Dennis Sherwood resigned from his post on 31 October 2006.
2. There were no payments made to Andrew Smith in the financial year 2006–07.

Salaries and allowances 2005–06

Name and Title	**Salary** (bands of £5,000) £000	**Other remuneration** (bands of £5,000) £000	**Benefits in kind** (rounded to the nearest £100) £00
Bernard Crump (Chief Executive)	100–105	0	29–30
Simone Jordan (Deputy Chief Executive and Director of Learning)	60–65	0	28–29
Helen Bevan (Director of Service Transformation)	120–125	0	0
Maire Smith (Director of Technology and Product Innovation)	65–70	0	0
Michael Cawley (Director of Finance and Business Services)	55–60	0	16–17
Paul Allen (Director of Leadership)	60–65	0	0
Yve Buckland (Chair)	45–50	0	0
David Bower (Non-Executive Director)	0–5	0	0
Tony Butterworth (Non-Executive Director)	0–5	0	0
Mike Collier (Non-Executive Director and Chair of Audit Committee)	0–5	0	0
Michael Deegan (Non-Executive Director)	0–5	0	0
Dennis Sherwood (Non-Executive Director)	0–5	0	0
Carol Black (Non-Executive Director)	0 See note 3	0	0
Andrew Smith (Non-Executive Director)	0	0	0

Notes:
3. There were no payments made to Carol Black in the financial year 2005–06.

NB: The comparative figures for 2005–06 are for nine months only as the NHS Institute was established as a Special Health Authority on 1 July 2005.

Pension benefits

Name and Title	Real increase in pension at age 60 (bands of £2,500) £000	Real increase in pension lump sum at aged 60 (bands of £2,500) £000	Total accrued pension at age 60 at 31 March 2007 (bands of £5,000) £000	Lump sum at age 60 related to accrued pension at 31 March 2007 (bands of £5,000) £000	Cash Equivalent Transfer Value at 31 March 2007 £000	Cash Equivalent Transfer Value at 31 March 2006 £000	Real increase in Cash Equivalent Transfer Value £000	Employer's contribution to stakeholder pension £000
Bernard Crump (Chief Executive) See note 1	10–12.5	30–32.5	50–55	155–160	815	615	185	0
Simone Jordan (Deputy Chief Executive and Director of Learning)	0–2.5	2.5–5	20–25	60–65	287	251	30	0
Helen Bevan (Director of Service Transformation)	0–2.5	2.5–5	30–35	95–100	460	412	37	0
Maire Smith (Director of Technology and Product Innovation)	0–2.5	2.5–5	0–5	5–10	39	13	25	0
Michael Cawley (Director of Finance and Business Services)	2.5–5	5–7.5	15–20	50–55	213	172	37	0
Paul Allen (Director of Leadership)	0–2.5	2.5–5	0–5	5–10	32	11	21	0

1. An earnings cap was incorrectly applied in 2005–06 resulting in pensionable pay being understated for that period.

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

Disclosure of relevant audit information

As Accounting Officer I confirm that:

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

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

Dated: 12 July 2007


RECEPTION

Accounts

Statement of the Board's and Chief Executive's responsibilities

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

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

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

Statement of Internal Control for the year ended 31 March 2007

1. SCOPE OF RESPONSIBILITY

As Accounting Officer and Chief Executive of this Board, I have responsibility for maintaining a sound system of internal control that supports the achievement of the organisation's policies, aims and objectives. I also have responsibility for safeguarding the public funds and the organisation's assets for which I am personally responsible as set out 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 the organisation's policies, aims and objectives

- evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically.

The system of internal control has not been in place in the NHS Institute for Innovation and Improvement for the whole of the financial year ended 31 March 2007. Instead, elements were in place up to 30 September 2006. From 1 October 2006, the system of internal control was fully in place up to the date of approval of the Annual Report and Accounts.

3. CAPACITY TO HANDLE RISK

My opinion on the existence of a system of internal control is based on evidence primarily provided to me from oversight by the Audit and Risk Management Committee, which itself is informed by the work of External and Internal Audit together with the work that the Board has undertaken in developing the Assurance Framework for the NHS Institute and monitoring key risks within that Framework.

Where weaknesses have been identified then action has been taken to implement corrective measures, for instance a financial control project was initiated to address process and control issues identified by Internal Audit. This project was supported by a formal Project Board with Executive and Non-Executive representation.

The results of work undertaken by Internal Audit have been reported to the Audit and Risk Management Committee throughout the year and have shown an improving system of internal control as the year has progressed. Improvements include the system

identifying that the NHS Institute's Directions be amended by the Department of Health. This has taken place and is disclosed in Note 2.1 of the Annual Account. Responsibility for overall oversight of the work, on behalf of the Board, remains with the Audit and Risk Management Committee.

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

- the identification of key risks through the business planning process
- risk assessment workshops involving the Executive Team
- regular Audit and Risk Management Committee and Board consideration of key strategic risks
- the recruitment of staff to ensure the NHS Institute is able to manage the risks it faces in its first years of operation
- a programme of control and process work that supports and develops the NHS Institute's existing business model. This includes the creation of a framework to underpin sound accounting and financial management at the NHS Institute covering budgeting, forecasting and month end processes.

4. THE RISK AND CONTROL FRAMEWORK

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

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

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

The updated Assurance Framework, together with the associated strategic and high-level risk registers, were formally adopted by the Board in September 2006. These map the key objectives of the NHS Institute and identify the risks to the achievement of these and also identify the internal control mechanisms to manage the risks. They identify and examine the review and assurance mechanisms, and identify where gaps in control and/or assurance exist.

The framework and supporting risk registers have identified some areas where controls and assurance mechanisms need to be strengthened and remedial action has been taken to address these.

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.

5. 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. Whilst the overall opinion for 2006–07 was of limited assurance, it was acknowledged, together with the work of External Audit, that controls had improved significantly in the second half of the year.

Executive managers within the organisation who have responsibility for the development and maintenance of the system of internal control provide me with assurance. The Assurance Framework itself provides me with evidence that the effectiveness of controls that manage the risks to the organisation achieving its principal objectives have been reviewed.

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

These reviews highlight the need to assess controls in the light of any changes to the NHS Institute's business model; in particular, to ensure that the NHS Institute's control mechanisms are reviewed and updated to address any risks that arise from any such changes. Work is currently under way to understand and assess the impact of any changes. In addition, reviews are currently under way to ensure a focus on whole systems improvement, in the context of continually improving the governance and control framework. Responsibility for oversight of this work, on behalf of the Board, remains with the Audit and Risk Management Committee.

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

Dated: 12 July 2007

The 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 period ended 31 March 2007 under the National Health Service Act 2006. These comprise the Operating Cost Statement, the Balance Sheet, the Cash Flow Statement and Statement of Recognised Gains and Losses and the related notes. These financial statements have been prepared under the accounting policies set out within them. I have also audited the information in the Remuneration Report which is described in that report as having been audited.

Respective responsibilities of the Chief Executive and Auditor

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

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

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

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

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

I read the other information contained in the Annual Report and consider whether it is consistent with the audited financial statements. I consider the implications for my report if I become aware of any apparent misstatements or material inconsistencies with the financial statements. My responsibilities do not extend to any other information.

Basis of audit opinion

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

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

Opinions

Audit opinion
In my opinion:

- the financial statements give a true and fair view, in accordance with the National Health Service Act 2006 and directions made thereunder by the Secretary of State with the approval of HM Treasury, of the state of the NHS Institute for Innovation and Improvement's affairs as at 31 March 2007 and of its net resource outturn, recognised gains and losses and cashflows for the year then ended;
- the financial statements and the part of the Remuneration Report to be audited have been properly prepared in accordance with the National Health Service Act 2006 and directions made thereunder by the Secretary of State with the approval of HM Treasury; and
- information given within the Annual Report, which includes the Management Commentary, Priority Programmes and Governance Structures, is consistent with the financial statements.

Audit 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 that govern them.

Report
I have no observations to make on these financial statements.

John Bourn
Comptroller and Auditor General

July 2007

National Audit Office
157–197 Buckingham Palace Road,
Victoria, London SW1W 9SP

Annual Account of the NHS Institute for Innovation and Improvement for the year ended 31 March 2007

Operating Cost Statement for the year ended 31 March 2007

	Notes	2006–07 £000	2005–06 £000
Programme costs	2.1	56,025	42,450
Operating income	4	(3,011)	(44)
Net operating cost before interest		53,014	42,406
Interest payable		0	0
Net operating cost		53,014	42,406
Net resource outturn	3.1	53,014	42,406

All income and expenditure is derived from continuing operations

Statement of Recognised Gains and Losses for the year ended 31 March 2007

	Note	2006–07 £000	2005–06 £000
Unrealised surplus/(deficit) on the indexation of fixed assets	11.2	(155)	0
Recognised gains and (losses) for the financial year		(155)	0

The notes at pages 49 to 72 form part of these accounts.

Annual Account of the NHS Institute for Innovation and Improvement for the year ended 31 March 2007

Balance Sheet as at 31 March 2007

	Notes	31 March 2007 £000	31 March 2006 £000
Fixed assets:			
Intangible assets	5.1	**250**	227
Tangible assets	5.2	**3,611**	2,050
		3,861	2,277
Current assets:			
Debtors	6	**1,990**	1,426
Cash at bank and in hand	7	**1,803**	2
		3,793	1,428
Creditors: amounts falling due within one year	8	**(9,767)**	(8,995)
Net current assets/(liabilities)		**(5,974)**	(7,567)
Total assets less current liabilities		**(2,113)**	(5,290)
Provisions for liabilities and charges	9	**(1,982)**	(5,455)
		(4,095)	(10,745)
Taxpayers' equity:			
General fund	11.1	**4,233**	10,745
Revaluation reserve	11.2	**(138)**	0
		4,095	10,745

The financial statements on pages 46 to 48 were considered by the Board on 21 June 2007.

Bernard Crump
Chief Executive and Accounting Officer
Dated: 12 July 2007

Annual Account of the NHS Institute for Innovation and Improvement for the year ended 31 March 2007

Cash Flow Statement for the year ended 31 March 2007

	Notes	2006–07 £000	2005–06 £000
Net cash (outflow) from operating activities	12	**(56,170)**	(35,531)
Servicing of finance			
Interest paid		**0**	0
Net cash (outflow) from servicing finance		**0**	0
Capital expenditure and financial investment:			
(Payments) to acquire intangible fixed assets		**(73)**	(227)
(Payments) to acquire tangible fixed assets		**(1,756)**	(2,210)
Net cash inflow/(outflow) from investing activities		**(1,829)**	(2,437)
Net cash (outflow) before financing		**(57,999)**	(37,968)
Financing			
Net parliamentary funding	11.1	**59,800**	37,970
Increase/(decrease) in cash in the period	7	**1,801**	2

The notes at pages 49 to 72 form part of these accounts.

Notes to the Accounts

1 Accounting policies

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

1.1 Accounting conventions

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

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

1.2 Income

Income is accounted for applying the accruals convention. The main source of funding for the NHS Institute is a parliamentary grant from the Department of Health from Request for Resources 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.

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. It includes both income appropriated-in-aid and income to the consolidated fund which HM Treasury has agreed should be treated as operating income. Where income is received for a specific activity which is to be delivered in the following financial year, that income is deferred.

1.3 Taxation

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

1.4 Capital charges

The treatment of fixed assets in the account is in accordance with the principal capital charges objective to ensure that such charges are fully reflected in the cost of capital. The interest rate applied to capital charges in the financial year 2006–07 was 3.5% (2005–06 3.5%) on all assets less liabilities, except for donated assets and cash balances with the Office of the Paymaster General, where the charge is nil.

1 Accounting policies (continued)

1.5 Fixed assets

a. Capitalisation

All assets falling into the following categories are capitalised:

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

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

iii Tangible assets where they are capable of being used for more than one year, and they:

- individually have a cost equal to or greater than £5,000;
- collectively have a cost of at least £5,000 and an individual cost of more than £250, where the assets are functionally interdependent, they had broadly simultaneous purchase dates, are anticipated to have simultaneous disposal dates and are under single managerial control; or
- form part of the initial equipping and setting-up cost of a new or leasehold building, irrespective of their individual or collective cost.

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

b. Valuation

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

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

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

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

1 Accounting policies (continued)

i Land and buildings (including dwellings) valuations are carried out by the District Valuer of HM Revenue and Customs government department at five yearly intervals in accordance with Financial Reporting Standard (FRS) 15. Between valuations, price indices, appropriate to the category of asset, are applied to arrive at the current value. The buildings indexation is based on the All-in Tender Price Index published by the Building Cost Information Service (BCIS). The land index is based on the residential building land values reported in the Property Market Report published by the Valuation Office. The valuations were carried out in accordance with the Royal Institution of Chartered Surveyors (RICS) Appraisal and Valuation Manual insofar as these terms are consistent with the agreed requirements of the Department of Health and HM Treasury.

The valuations have been carried out primarily on the basis of depreciated replacement cost for specialised operational property and existing use value for non-specialised operational property. In respect of non-operational properties, including surplus land, the valuations have been carried out at open market value. The value of land for existing use purposes is assessed to existing use value. The valuations do not include notional directly attributable acquisition costs nor have selling costs been deducted, since they are regarded as not material.

To meet the underlying objectives established by the Department of Health, the following accepted variations of the RICS Appraisal and Valuation Manual have been required:

– specialised operational assets have been valued on a replacement rather than a modern substitute basis;

– no adjustment has been made to the cost figures of operational assets in respect of dilapidations; and

– additional alternative open market value figures have been supplied only for operational assets scheduled for imminent closure and subsequent disposal.

ii Operational equipment is valued at net current replacement cost through annual uplift by the change in the value of the GDP deflator. Equipment surplus to requirements is valued at the net recoverable amount.

iii Assets in the course of construction are valued at current cost, using the index as for land and buildings. These assets include any existing land or buildings under the control of a contractor.

iv Subsequent revaluations to donated fixed assets are taken to the donated asset reserve.

v All adjustments arising from indexation and five yearly revaluations are taken to the revaluation reserve. All impairments resulting from price changes are charged to the Statement of Recognised Gains and Losses. Falls in value when newly constructed

1 Accounting policies (continued)

assets are brought into use are also charged there. These falls in value result from the adoption of ideal conditions as the basis for depreciated replacement cost valuations.

c. Depreciation and amortisation

Depreciation is charged on each individual fixed asset as follows:

i Intangible assets are amortised, on a straight line basis, over the estimated lives of the assets.

ii Purchased computer software licences are amortised over the shorter of the term of the licence and their useful economic lives.

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

iv Buildings are depreciated evenly on their revalued amount over the assessed remaining life of the asset as advised by the District Valuer. Leaseholds and leasehold improvements are depreciated over the primary lease term.

v Each equipment asset is depreciated evenly over the expected useful life from the start of the quarter following the quarter in which the asset was acquired:

	Years
Furniture and fittings	7–10
Transport equipment	7
Information technology	5

1.6 Donated fixed assets

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

1.7 Stocks and work in progress

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

1 Accounting policies (continued)

1.8 Losses and special payments

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

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

1.9 Pension costs

Past and present employees are covered by the provisions of the NHS Pension Scheme. 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. As a consequence it is not possible for the NHS Institute to identify its share of the underlying scheme liabilities. Therefore, the scheme is accounted for as a defined contribution scheme and the cost of the scheme is equal to the contributions payable to the scheme for the accounting period.

The scheme is subject to a full valuation for FRS 17 purposes every four years. The last valuation on this basis took place as at 31 March 2003. The scheme is also subject to a full valuation by the Government Actuary to assess the scheme's assets and liabilities to allow a review of the employers' contribution rates; this valuation took place as at 31 March 2004 and has yet to be finalised. The last published valuation on which contributions were based covered the period 1 April 1994 to 31 March 1999. Between valuations the Government Actuary provides an update of the scheme liabilities on an annual basis. The latest assessment of the liabilities of the scheme is contained in the Scheme Actuary report, which forms part of the NHS Pension Scheme (England and Wales) Resource Account, published annually. These accounts can be viewed on the Business Service Authority – Pensions Division website at www.nhspa.gov.uk. Copies can also be obtained from The Stationery Office.

The conclusion of the 1999 valuation was that the scheme continues to operate on a sound financial basis and the notional surplus of the scheme is £1.1 billion. It was recommended that employers' contributions are set at 14% of pensionable pay with effect from 1 April 2003. On advice from the actuary, the contribution may be varied from time to time to reflect changes in the scheme's liabilities. Employees pay contributions of 6% (manual staff 5%) of their pensionable pay.

1 Accounting policies (continued)

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

Early payment of a pension, with enhancement, is available to members of the scheme who are permanently incapable of fulfilling their duties effectively through illness or infirmity. Additional pension liabilities arising from early retirement are not funded by the scheme except where the retirement is due to ill-health. For early retirements not funded by the scheme, the full amount of the liability for the additional costs is charged to the Operating Cost Statement at the time the NHS Institute commits itself to the retirement, regardless of the method of payment.

A death gratuity of twice final years' pensionable pay for death in service, and up to five times the annual pension for death after retirement, less pensions already paid, subject to a maximum amount equal to twice the member's final years' pensionable pay less their retirement lump sum for those who die after retirement is payable.

The scheme provides the opportunity to members to increase their benefits through money purchase additional voluntary contributions (AVCs) provided by an approved panel of life companies. Under the arrangement the employee can make contributions to enhance their pension benefits. The benefits payable relate directly to the value of the investments made.

1.10 Research and development

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

1.11 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 Accounting policies (continued)

1.12 Leases

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

1.13 Provisions

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

2.1 Programme costs

	Notes	2006–07 £000	2006–07 £000	Re-stated 2005–06 £000
Non-executive members' remuneration			115	70
Other salaries and wages	2.2		9,297	8,553
Supplies and services – general			54	6
Establishment expenses			4,138	5,881
Transport and moveable plant			0	11
Premises and fixed plant			1,312	1,733
External contractors			1,233	1,489
Capital: Depreciation and amortisation	5.1, 5.2	400		160
Capital charges interest		(291)		(188)
			109	(28)
Auditors' remuneration:				
External audit fees			43	48
Internal audit fees			41	46
Miscellaneous:				
Redundancy and early retirement costs		392		725
Residual NHSU activities transferred		2,055		3,469
National Management Development Initiative transferred		0		2,122
Other		11		3,148
			2,458	9,464
Commissioning expenditure[1]	2.3		37,225	15,177
			56,025	42,450

Commissioning expenditure

[1] During 2006–07 the NHS Institute made ten 'funding transfer' payments totalling £2,994,000 (2005–06 ten payments totalling £3,024,000). These transfers were made in the furtherance of the NHS Institute's mission and objectives. The nature of these transfers is to support improvement and innovation initiatives for the benefit of the wider NHS. The NHS Institute does not expect to directly benefit (for example through the receipt of goods or services) by making such payments. Instead, the NHS Institute accrues a benefit to the wider NHS and is able to demonstrate it has achieved the objectives that have been given to it from the Department of Health.

The Secretary of State for Health, in exercise of the powers conferred on her by Sections 16D, 17 and 126(4) and Schedule 5, Part III of the National Health Service Act 1977, issued Directions for the NHS Institute which came into force on 1 July 2005. On 26 April 2007, the Directions were amended, under Sections 7(1), 272(7) and 273(1) and (4) of the National Health Service Act 2006 by the Department of Health. The amendments were made to ensure explicit reference is made to these types of transactions.

During the period in which the 2006 Directions were being drafted, a payment of £407,000 which would have been included in these accounts, was made by the Department rather than the NHS Institute and the NHS Institute's estimates were amended accordingly.

2.2 Staff numbers and related costs

	2006–07 Total £000	Permanently employed staff £000	Other £000	Re-stated 2005–06 £000
Salaries and wages – staff on the NHS Institute payroll	5,300	5,300	0	3,405
Seconded, contract and agency staff	684	0	684	2,389
Salaries and wages – recharges to other NHS organisations	(415)	(415)	0	(140)
Social security costs	1,260	1,260	0	716
Employer contributions to NHS Pension Scheme	2,067	2,067	0	955
NHS Institute employees	8,896	8,212	684	7,325
NHSU residual employees	401[2]	401	0	1,228[1]
Total salaries and wages	9,297	8,613	684	8,553

	Total average WTE	staff average WTE	Other average WTE	Total average WTE
Salaries and wages – staff on the NHS Institute payroll	121	121	0	98
Seconded, contract and agency staff	17	0	17	61
Salaries and wages – recharges to other NHS organisations	(11)	(11)	0	(8)
NHS Institute employees	127	110	17	151
NHSU residual employees	6[2]	6	0	101[1]
Total average whole time equivalent (WTE)	133	116	17	252

NHSU residual employees

[1] Pay costs were incurred until 30 September 2005 in respect of NHSU staff engaged on closure activities. However, these costs were not accrued in the NHSU closure accounts.

[2] These costs relate to former NHSU staff transferred to the NHS Institute but placed on secondment with other NHS organisations.

(continued overleaf)

2.2 Staff numbers and related costs (continued)

Expenditure on staff benefits
The amount spent on staff benefits during the year totalled £nil (2005–06 £nil).

Retirements due to ill-health
During 2006–07 there were no early retirements from the NHS Institute on the grounds of ill-health.

Early retirements and redundancies
During 2006–07 provision was made for seven early retirements or redundancies from the NHS Institute totalling £787,137. Of these, two cases totalling £154,111 were in respect of the closure of the Bristol office. The remaining five cases totalling £533,667 were in respect of staff transferred from the NHSU to the former South Yorkshire Strategic Health Authority. In addition, an existing provision for an early retirement or redundancy was increased by £99,359. Further information in respect of provisions is included in note 9.

2.3 Commissioning expenditure

	2006–07 £000	£000
Building leadership capability		2,845
Building leadership capacity – pay	10,713	
Building leadership capacity – non-pay	6,728	17,441
Clinical Systems Improvement		1,076
Delivering for Improvement		1,022
Care Outside of Hospital (formerly Long-term Conditions)		1,276
Healthcare Associated Infections[1]		282
No Delays		682
Delivering Quality and Value		2,421
PCT development		860
Joint working with Strategic Health Authorities		1,127
National Innovation Centre		3,746
Other (46 projects)		4,447
		37,225

	Re-stated 2005–06 £000
Building leadership capability	1,747
Building leadership capacity – pay	8,399
Building leadership capacity – non-pay	3,073
Service Transformation	52
Technology and Product Innovation	96
Long-term Conditions	85
Healthcare Associated Infections	679
No Delays	140
Delivering Quality and Value	156
PCT fitness for purpose	750
	15,177

[1] The priority programme Healthcare Associated Infections ended during 2006–07.

2.4 Better payment practice code – measure of compliance

	Number	£000
Total non-NHS bills paid 2006–07	9,140	29,159
Total non-NHS bills paid within target	7,604	23,778
Percentage of non-NHS bills paid within target	83.2%	81.5%

	Number	£000
Total NHS bills paid 2006–07	483	15,317
Total NHS bills paid within target	290	7,612
Percentage of NHS bills paid within target	60.0%	49.7%

The Late Payment of Commercial Debts (Interest) Act 1998
No interest was paid under this legislation or no compensation payments made.

3.1 Reconciliation of net operating cost to net resource outturn

	2006–07 £000	2005–06 £000
Net operating cost for the financial year	**53,014**	42,406
Net resource outturn	**53,014**	42,406
Revenue resource limit	**56,231**	61,912
(Over)/under spend against revenue resource limit	**3,217**	19,506

3.2 Reconciliation of gross capital expenditure to capital resource limit

	2006–07 £000	2005–06 £000
Gross capital expenditure	**1,829**	2,437
Net book value of assets disposed	**0**	0
Capital grants	**0**	0
Net capital resource outturn	**1,829**	2,437
Capital resource limit	**1,900**	2,480
(Over)/under spend against capital resource limit	**71**	43

4 Operating income

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

	2006–07 £000	2005–06 £000
Programme income:		
Fees and charges to external customers	2,921	44
Income received from:		
Scottish Parliament	55	0
National Assembly for Wales	31	0
Northern Ireland Assembly	4	0
Total	3,011	44

5 Fixed Assets

5.1 Intangible fixed assets

	Software licences £000	Total £000
Gross cost at 31 March 2006	227	227
Additions – purchased	73	73
Gross cost at 31 March 2007	300	300
Accumulated amortisation at 31 March 2006	0	0
Charged during the year	50	50
Accumulated amortisation at 31 March 2007	50	50
Net book value:		
Total at 31 March 2007	250	250
Net book value:		
Total at 31 March 2006	227	227

5.2 Tangible fixed assets

	Information technology			Leasehold improve-	
	Websites £000	Web-based tools £000	Hardware £000	ments £000	Total £000
Cost or valuation at 31 March 2006	0	0	135	2,075	**2,210**
Additions – purchased	**365**	**846**	**576**	**(31)**[1]	**1,756**
Indexation	**0**	**0**	**0**	**168**	**168**
Gross cost at 31 March 2007	**365**	**846**	**711**	**2,212**	**4,134**
Accumulated depreciation at 31 March 2006	0	0	0	160	160
Charged during the year	**6**	**86**	**33**	**225**	**350**
Indexation	**0**	**0**	**0**	**13**	**13**
Accumulated depreciation at 31 March 2007	**6**	**86**	**33**	**398**	**523**
Net book value:					
Total at 31 March 2007	**359**	**760**	**678**	**1,814**	**3,611**
Net book value:					
Total at 31 March 2006	0	0	135	1,915	2,050

[1] The negative addition is a result of an over accrual made in 2005–06 in respect of the retention held for leasehold improvements.

6 Debtors

6.1 Amounts falling due within one year

	2006–07 £000	2005–06 £000
NHS debtors	507	271
Trade debtors – non-NHS	74	9
Prepayments	569	104
VAT amount due	502	781
Accrued income	143	0
Other debtors	5	261
	1,800	1,426

6.2 Amounts falling due after more than one year

	2006–07 £000	2005–06 £000
Prepayments	190	0
	190	0
Total debtors	1,990	1,426

7 Analysis of changes in cash

	At 31 March 2006 £000	Change during the year £000	At 31 March 2007 £000
Cash at the Office of the Paymaster General	2	1,801	1,803
	2	1,801	1,803

8 Creditors: amounts falling due within one year

	2006–07 £000	Re-stated 2005–06 £000
NHS creditors	**330**	48
Trade creditors – non-NHS	**1,557**	559
Capital creditors	**458**	221
Other creditors	**18**	120
Accruals	**7,404**	8,047
	9,767	8,995

9 Provisions for liabilities and charges

	Pensions for former staff £000	Legal claims £000	Restructuring £000	Other £000	Total £000
At 31 March 2006	5,395	60	0	0	5,455
Arising during the year	**633**[1]	**0**	**154**	**563**[2]	**1,350**
Utilised during the year	**(4,375)**	**0**	**0**	**0**	**(4,375)**
Reversed unused	**(388)**	**(60)**	**0**	**0**	**(448)**
At 31 March 2007	**1,265**	**0**	**154**	**563**	**1,982**
Expected timing of cash flows:					
Within 1 year	1,265	0	154	563	**1,982**

Arising during the year

[1] The NHS Institute has accepted staff related liabilities in relation to the transfer of programmes to the former South Yorkshire Strategic Health Authority. In the event that a significant proportion of these programmes have to be discontinued, there will be a requirement to make associated transferred staff redundant.

[2] The NHS Institute has defined its process for dealing with indirect workers and as a consequence has identified the need for a tax provision of £300,000 relating to their employment status.

The NHS Institute has identified payments of £263,000 which should be charged to expenditure, but are pending clearance by the Institute's financial services provider.

10 Movements in working capital other than cash

	2006–07 £000	2005–06 £000
Increase/(decrease) in debtors	564	1,426
(Increase)/decrease in creditors	(772)	(8,995)
	(208)	(7,569)

11 Movements on reserves

11.1 General fund

	2006–07 £000	2005–06 £000
Balance at 31 March 2006	10,745	0
Net operating costs for the year	53,014	42,406
Net parliamentary funding	(59,800)	(37,970)
Net liabilities transferred from NHSU	0	6,121
Revaluation transfer	(17)	0
Non-cash items: Capital charge interest	291	188
Balance at 31 March 2007	4,233	10,745

11.2 Revaluation reserve

	£000	£000
Balance at 31 March 2006	0	0
Indexation of fixed assets	(155)	0
Transfer to general fund of realised elements of revaluation reserve	17	0
Balance at 31 March 2007	(138)	0

12 Reconciliation of operating costs to operating cash flows

	2006–07 £000	2005–06 £000
Net operating cost before interest for the year	**53,014**	42,406
Adjust for non cash transactions	**(109)**	28
Adjust for movements in working capital other than cash	**(208)**	(7,569)
(Increase)/decrease in provisions	**3,473**	(5,455)
Net liabilities transferred from NHSU	**0**	6,121
Net cash outflow from operating activities	**56,170**	35,531

13 Contingent liabilities

At 31 March 2007 there were no known contingent liabilities (2005–06 £nil).

14 Capital commitments

At 31 March 2007 the value of contracted capital commitments was £143,154 (2005–06 £nil).

15 Commitments under operating leases

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

	2006–07 £000	2005–06 £000
Hire of plant and machinery	**35**	4
Property rental – including headquarters and other properties	**678**	635
Other operating leases	**47**	1
	760	640

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.

		2006–07 £000	2005–06 £000
Land and buildings			
Operating leases which expire:	within 1 year	**100**	55
	between 1 and 5 years	**163**	141
	after 5 years	**415**	415
		678	611
Other leases			
Operating leases which expire:	within 1 year	**29**	0
	between 1 and 5 years	**53**	24
		82	24

16 Other commitments

The NHS Institute has not entered into any additional non cancellable contracts which are not operating leases (2005–06 £nil).

17 Losses and special payments

There were 24 cases of losses and special payments (2005–06 no cases) totalling £53,342 (2005–06 £nil) approved during 2006–07.

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 2006–07 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 total transactions have exceeded £50,000 are disclosed.

	Income £000	Expenditure £000
Department of Health	2,684	304
NHS Connecting for Health		1,000
Derby Hospitals NHS Foundation Trust		54
Homerton University Hospital NHS Foundation Trust		54
Salisbury Healthcare NHS Trust		359
Manchester PCT		95
North Manchester PCT		140
Salford PCT		236
Warrington PCT		54
West Essex PCT		55
NHS Business Services Authority		295
East of England SHA		126
North West SHA		217
Shropshire and Staffordshire SHA		72
South East Coast SHA		177
South Yorkshire SHA		2,055
West Midlands SHA		136
Central Manchester and Manchester Children's University Hospitals NHS Trust		543
Chelsea and Westminster Healthcare NHS Trust		302
East Kent Hospitals NHS Trust		63
George Eliot Hospital NHS Trust		51
King's College Hospital NHS Trust		99
North Bristol NHS Trust		75
Nottingham University Hospitals NHS Trust		372
West Middlesex University Hospital NHS Trust		291

19 Post balance sheet events

There are no material post balance sheet events. This Annual Report and Accounts has been authorised for issue on 16 July 2007 by the NHS Institute Chief Executive and Accounting Officer.

20 Financial instruments

FRS 13, Derivatives and Other Financial Instruments, requires disclosure of the role that financial instruments have had during the period in creating or changing the risks an entity faces in undertaking its activities. Because of the way special health authorities are financed, the NHS Institute is not exposed to the degree of financial risk faced by business entities. Also, financial instruments play a much more limited role in creating or changing risk than would be typical of the listed companies to which FRS 13 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.

As allowed by FRS 13, debtors and creditors that are due to mature or become payable within 12 months from the balance sheet date have been omitted from all disclosures other than from the currency profile.

Liquidity risk
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.

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.

Fair values

A comparison, by category, of book values and fair values of the NHS Institute's financial assets and liabilities as at 31 March 2007 is as follows:

	Book value £000	Fair value £000
Financial assets:		
Cash	1,803	1,803
Debtors over 1 year	190	190
Total	1,993	1,993
Financial liabilities:		
Total	0	0

21 Intra-government balances

	Debtors: amounts falling due within one year £000	Debtors: amounts falling due after more than one year £000	Creditors: amounts falling due within one year £000
Balances with other central government bodies	845	0	1,420
Balances with local authorities	0	0	0
Balances with NHS Trusts	307	0	177
Balances with public corporations and trading funds	0	0	0
Balances with bodies external to government	648	190	8,170
At 31 March 2007	1,800	190	9,767
Balances with other central government bodies	1,017	0	2,366
Balances with local authorities	0	0	0
Balances with NHS Trusts	35	0	364
Balances with public corporations and trading funds	0	0	0
Balances with bodies external to government	374	0	6,265
At 31 March 2006	1,426	0	8,995

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