Better information, better decisions, better care

The Health and Social Care Information Centre
annual report 2006/07

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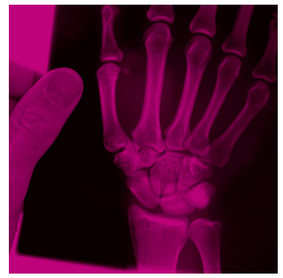

FOR HEALTH AND SOCIAL CARE NHS

Better information,
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Quality and Outcomes Framework (QOF) tool

QOF is an annual review of the quality of care provided by GP practices. As well as publishing practices' QOF results, we also offer an online service where patients can access the QOF results of their local GP practice. www.qof.ic.nhs.uk

Data mapping

This service gives more than 400 NHS organisations access to digital mapping data. They can use this data to identify health inequalities, record changes to patient catchment areas, carry out epidemiological analysis and target services to clinical hotspots.

Health Poverty Index (HPI)

The HPI helps tackle inequalities by illustrating measures of health poverty for areas in England. By looking at geographical, social, health, economic and cultural factors, the HPI can help organisations understand and tackle the causes of health inequalities. www.hpi.org.uk

Review of Central Returns (ROCR)

ROCR is a service run by The IC to streamline requests made to the NHS for data. ROCR ensures that central data collections are only carried out if they are of value and relevance to the people delivering frontline care.

Strategic Information Group for Adult Social Care (SIGASC)

Previously known as the Technical Working Group, SIGASC ensures any new data collections from council social services departments are relevant, useful and do not duplicate information already collected. It also assesses the feasibility of developing new collections.

Clinical and Health Outcomes Knowledge Base

The IC commissions the National Centre for Health Outcomes Development to deliver a range of web-based health outcomes indicators and products - including the Compendium of Clinical and Health Indicators (a database of health outcomes data at various geographies and with interactive graphs and maps), a Directory of Clinical Databases (DoCDat) and a bibliographic database of patient-reported health status and quality of life instruments. The knowledge base can be accessed at www.nchod.nhs.uk

Prescription cost analysis

The IC manages the database which holds details of all prescriptions dispensed in the community in England and publishes two national statistics publications each year summarising trends in prescribing and listing drugs dispensed in the previous year.

The Information Catalogue

The Information Catalogue is a searchable catalogue giving information about current, proposed and past national data collections relating to health and social care. Use of the catalogue has consistently increased during 2006/07, and a significant programme of development is planned for 2007/08. www.ic.nhs.uk/infocat

Performance Assessment Framework (PAF)

We collect the information for, and calculate, the PAF indicators which are a detailed analysis of every council's social services. This contributes towards the evidence used by the Commission for Social Care Inspection to award star ratings.

Primary care resources

The IC produces reports relating to a wide range of resourcing issues in primary care. These include a series of reports relating to the new dental contract. The IC also works with various organisations to produce impartial reports on issues relating to remuneration. These include reports on the income and expenses levels for GPs and dentists.

Omnibus Survey

This is a flexible online tool to help NHS and social care organisation submit vital data to The IC with minimum burden on themselves. The survey has already been responsible for many high-profile data collections, including ambulance performance, mental health, emergency preparation data and NHS contraceptive services. www.omnibus.nhs.uk

Further information on all our products and work areas can be found on The IC website at www.ic.nhs.uk

The Health and Social Care Information Centre
Annual report and accounts 2006/07

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Ordered by the House of Commons to be printed on 17 July 2007

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www.ic.nhs.uk

Annex A
Summary of our products and services

Our wide range of products and services include:

Secondary Uses Service (SUS)

SUS is a component of the National Programme for IT and is being developed by NHS Connecting for Health and The IC in partnership. It is a single, secure data environment which maintains patient-based data for use in healthcare planning, commissioning, public health, clinical audit and governance, benchmarking, performance improvement, medical research and national policy development. SUS ensures the confidentiality of this information while enabling linkage of data and the consistent construction of indicators. SUS comprises a core data warehouse and related applications that use data from this warehouse.

Hospital Episode Statistics (HES)

HES is a statistical service that contains information about hospital admissions and outpatient appointments in England derived from the core SUS warehouse. It is used by the NHS, government, patient organisations and others to carry out healthcare analysis. HES provides information to monitor activity, improve performance and plan future services. www.hesonline.nhs.uk

Commissioning Datasets (CDS)

CDS are mandated data collected by healthcare providers to cover areas such as inpatient, outpatient and accident and emergency activity. They generate data which, through SUS, contributes to HES.

Healthcare Resource Grouper 4 (HRG4)

The new classification system that enables services to be commissioned, costed and paid for under Payment by Results.

National clinical audits

These focus on heart disease, cancer, diabetes and other specialist areas. They look at the care patients are receiving and give clinicians reliable, valid information to help them review their own performance and identify any areas for improvement. The audits help healthcare organisations ensure clinical standards are being met, compare their performance and identify and share good practice.

NHS Workforce Census

The census collects information on the 1.3 million employees who work for the NHS, including their clinical areas; age; gender and location. As the NHS develops new and better ways of working, the census is a valuable tool for national and local organisations alike, helping them ensure sufficient people with the appropriate skills are employed in the right areas of healthcare.

The Health Survey for England

The Health Survey for England is a series of annual surveys of the general population designed to monitor trends in the nation's health and monitor progress towards selected health targets. The survey collects data on subjects such as smoking, drinking, consumption of fruit and vegetables, general health, cardio-vascular disease, diabetes and physical activity and takes measurements of blood pressure, height and weight, obesity.

Contents

The Information Centre is England's independent, authoritative source of health and social care information. Information is our business. When used effectively, information improves people's health and well-being and has a lasting impact on all of our lives.

www.ic.nhs.uk

18 Post balance sheet events

This annual report and accounts has been authorised for issue on 13 July 2007 by The IC's acting chief executive and accounting officer. Denise Lievesley resigned as chief executive and accounting officer on 2 July 2007. Tim Straughan was appointed as acting chief executive and accounting officer on the same date.

19 Financial instruments

FRS13, 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 arms length bodies are financed, The IC 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 FRS13 mainly applies. The IC has limited powers to borrow or invest surplus funds and financial assets and liabilities are generated by day-to-day operational activities rather than being held to change the risks faced in undertaking its activities.

As allowed by FRS13, 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.

Liquidity risk

The net operating assets are financed from resources voted annually by Parliament. The IC finances its capital expenditure from funds made available from Government under an agreed borrowing limit. The IC is therefore not exposed to significant liquidity risks.

Interest rate risk

All of the financial assets and liabilities carry nil or fixed rates of interest. The IC is therefore not exposed to significant interest rate risk.

Foreign currency risk

The exposure to foreign currency risk is not material.

Fair values

Fair values are not significantly different from book values and therefore no additional disclosure is required.

20 Intra-government balances

	Debtors Amounts falling due within one year		Creditors Amounts falling due within one year	
	2006/07 £000	2005/06 £000	**2006/07 £000**	2005/06 £000
Central government bodies	**779**	165	**4,129**	4,318
NHS trusts and PCT's	**70**	3	**29**	154
Other external bodies	**822**	1,392	**4,678**	8,556
At 31 March 2007	**1,671**	1,560	**8,836**	13,028

Related parties cont.	Payments in 2006/07 £000	Receipts in 2006/07 £000	Debtor at 31 March 07 £000	Creditor at 31 March 07 £000
Department of Health	2,209	49	51	1,365
NHS Connecting for Health	1,285		10	1,908
London SHA	30			
Healthcare Commission	130			39
NHS Employers	10	100		
Merseyside Regional Ambulance Service		25		
National Patient Safety Association		57		
Health Protection Agency	55			
NHS Business Services Authority	94			20
NHS Blood & Transplant Services				15
Medicines and Healthcare Products Regulatory Agency	125			
Dr Foster Intelligence	85	98	353	
Dacorum PCT	3			
Milton Keynes PCT				19
Liverpool PCT	20	9		
Clatterbridge Centre for Oncology NHS Trust	15			
Devon Partnership NHS Trust	7			
East Midlands Ambulance Service NHS Trust		44		
East of England Ambulance Service NHS Trust		35	25	
Great Western Ambulance Service NHS Trust		24		
Humber Mental Health Teaching NHS Trust	53			
Leeds Teaching Hospitals NHS Trust	17			
London Ambulance Service NHS Trust			40	
Newcastle upon Tyne NHS Trust			3	
Northampton Acute NHS Trust	92			
North East Ambulance Service NHS Trust		25		
North West Ambulance Service NHS Trust		92		
Nottingham NHS Trust	10			
Papworth NHS Trust	51			5
Portsmouth Hospitals	54			
Robert Jones & Agnes Hunt NHS Trust	8			
Royal Liverpool Childrens Hospital NHS Trust	10			
Somerset Partnership NHS Trust	7			
South Central Ambulance Service NHS Trust		51		
South East Coast Ambulance Service NHS Trust		35		
South Tees NHS Trust	28			
South Western Ambulance Service		24		
Staffordshire Ambulance Service NHS Trust		13		
Surrey Ambulance Service NHS Trust		13		
Surrey & Borders NHS Trust	7			
Swindon and Marlborough NHS Trust	26			
The Royal Marsden NHS Trust	5			
The Royal Wolverhampton Hospitals NHS Trust	9			
University College London NHS Trust	71			5
University Hospitals of Leicester NHS Trust	13			
West Midlands Ambulance Service NHS Trust		48		
Yorkshire Ambulance Service NHS Trust		81		

During the year none of The IC's directors or key management staff has undertaken any material transactions with The IC.

Foreword by Mike Ramsden

I am extremely proud and excited to be presenting the second annual report of The Information Centre for health and social care (The IC).

The IC is a young organisation that prides itself on being vibrant, adaptable and, most importantly, pro-active and responsive. Over the past two years, we have become England's authoritative and independent source of health and social care information. We have shown we can respond quickly to emerging needs by developing new data collections, software and analytical tools as soon as they are wanted.

For us that's meant two years of full-on effort, but also two years of amazing achievement. We are driven by the knowledge that the information we provide to ministers and frontline professionals is at the centre of high-quality care.

In 2006/07 alone, The IC delivered a substantial portfolio of products and services that included:

- core information to underpin planning, benchmarking and improvements right across the healthcare system
- 120 statistical publications covering subjects ranging from lifestyle issues – such as drugs and alcohol misuse, smoking, exercise, nutrition and obesity – to health and social care services, workforce and earnings
- improved quality of information in the annual NHS Workforce Census by using data from the Electronic Staff Record for the first time.

Our work has provided the mechanisms and measures needed to implement pivotal system reforms such as Payment by Results and Practice Based Commissioning. These reforms share two important attributes:

- They are about delivering the government's vision of giving people quality services close to where they live and real choice over their care.
- They each rely on good information to deliver real benefits for patients and staff.

And The IC's work is already having a powerful impact.

The **public** can assess the performance of health and social care services through trustworthy data published by The IC; **GP practices** can find out how their referral patterns compare to others locally and nationally; **clinicians** have access to more reliable and useful clinical audit data; **social care** organisations are being consulted about the best way to develop information for them in the future.

Amid all of this, we never lose sight of the pressures on frontline staff and, as a result, The IC streamlined requests for data from the NHS, saving it the equivalent in time of 120 full-time posts during the year.

As an organisation, we are open and enthusiastic about the new partnerships we have developed to help us improve the range and relevance of information services and to deliver data quickly.

Our joint venture with Dr Foster Ltd has resulted in a new information business, Dr Foster Intelligence, and demonstrates our commitment to work collaboratively to have a real impact on care.

There is more about all this work and our other key achievements during 2006/07 later in the document.

But this second annual report is about more than cataloguing our successes. It's about demonstrating to everyone the crucial importance of good information and the clear relevance of our products. It's also about acknowledging the areas where we have a lot more to do and explaining how we plan to move forward to help bring about greater improvements to care services.

In particular, this report looks at how we are contributing to four key activities that, together, will turn promises of better services into reality:

- reforming the system
- focusing on the biggest clinical priorities
- using information to improve local decision-making
- reducing the burden on staff.

Finally, while this document is mainly intended to give our external partners and audiences a clear understanding of our work to create a healthier nation, I cannot lose the opportunity to say a word of genuine thanks to our outgoing chief executive Denise Lievesley, our management team, our board and particularly our staff. They should read this report and feel as confident and excited about our role as I do.

Whatever their individual jobs and skills, our team of statisticians, information specialists and support staff are the reason I am able to report on such an extensive programme of work. Our staff are also the reason this report is able to set out our ambitious plans to make an even bigger impact in the future and why I, personally, am looking forward so enthusiastically to the year ahead.

Mike Ramsden,
Chairman of The Information Centre.

14 Commitments under operating leases

	31 March 2007		31 March 2006	
	Land and buildings £000	**Office equipment £000**	Land and buildings £000	Office equipment £000
The IC is committed to making the following operating lease payments during the next financial year for leases expiring:				
Within one year	**572**	**23**	1,148	18
One to five years	**82**	**25**	-	31
More than five years	**80**	**-**	80	3
	734	**48**	1,228	52

15 Other commitments

The IC has no non-cancellable contracts at 31 March 2007.

16 Losses and special payments

There were five losses and special payments in 2006/07 amounting to £12,190 (2005/06 £32,383).

17 Related parties

The IC is an arms length body established by order of the secretary of state for health. The Department of Health is regarded as a controlling related party.

During the year The IC has had a number of material transactions with the department, and with other entities for which the department is regarded as the parent department. Transactions with these organisations include the provision of software enhancements, maintenance and support, seconded staff, training courses and conferences.

Please see table overleaf.

11 Movements on reserves

11.1 General fund

		31 March 2007 £000	31 March 2006 £000
Balance at 1 April 2006		**8,319**	(16,493)
Net operating costs for the year		**(40,065)**	(52,996)
Net parliamentary funding		**40,430**	55,383
Funding provided to settle opening residuary balances		**-**	20,886
Transfer of realised profits from revaluation reserve		**-**	44
Non cash items	transfer of software assets	**(69)**	1,798
	capital charges	**(25)**	(303)
Balance at 31 March 2007		**8,590**	8,319

11.2 Revaluation reserve

	31 March 2007 £000	31 March 2006 £000
Balance at 1 April 2006	**-**	33
Indexation of fixed assets	**25**	11
Transfer to General Fund: realised revaluation	**-**	(44)
Balance at 31 March 2007	**25**	-

12 Contingent assets and liabilities

The joint venture contract includes a put option whereby if, anytime from 1 January 2009 to 31 December 2013, Dr Foster LLP shareholders wish to sell their share in the investment, The IC would be obliged to buy out their share of the business, at market value, if no other buyer can be found.

13 Capital commitments

On 11 May 2007, The IC agreed to take out a further lease on the 4th floor of Trevelyan Square, Leeds expiring in 2017, offices previously occupied by DWP. The capital expenditure required to refurbish and improve the accommodation is £280k. Once complete the offices in Lisbon House, Leeds will be vacated.

Our key achievements 2006/07

At The IC, we are not complacent about the scale of the challenges ahead or the work yet to be done to ensure our information is used effectively to underpin better services.

Nevertheless we are proud of our achievements so far and here's a brief summary…

During 2006/07, we:

- **delivered the data** and the associated classification system, Healthcare Resource Groups Version 4, essential for the implementation of Payment by Results
- **supported GP practices** by providing greater comparative information from the Secondary Uses Service to help them in Practice Based Commissioning, in partnership with NHS Connecting for Health
- **extended the information** available to the public about GP practices' Quality and Outcomes Framework results
- **supported the development and implementation** of changes in NHS data flows to enable trusts to monitor their progress towards the 18-week maximum waiting time from referral to the start of treatment
- **conducted a wide-scale consultation** among local authorities to learn more about the information needed to support better social care
- **carried out 18 clinical audits** – making us the largest single provider of clinical audits to the NHS
- **delivered the National Diabetes Audit** – considered the biggest annual clinical audit in the world – as well as audits on heart disease and cancer
- **improved the quality of information** in the annual NHS Workforce Census by using, for the first time, data from the Electronic Staff Record
- **published 120 statistical reports** to support public health policy and service planning
- **purchased data mapping services** on behalf of the NHS – helping local organisations identify health inequalities and target services to clinical hotspots
- **invested in Dr Foster Intelligence** which has generated four new analytical tools and seen its products used by 385 organisations
- **saved the NHS** the equivalent in time of 120 full-time posts by streamlining requests for data to local organisations
- **provided material to answer more than 2,000 parliamentary questions** – around one in four of all questions sent to the Department of Health – and answered more than 11,600 email enquiries and 9,600 telephone enquiries
- **played a significant role in developing NHS Choices** – the website to provide the public and health professionals with a wide range of information about health and healthcare provision – by collecting the information needed for the directories of GPs and other primary care providers
- **provided the majority of data** on adults for the Performance Assessment Framework which enables the Commission for Social Care Inspection to give star ratings to all council social services departments.

Chapter 1
Who we are and what we do

‘despite our role at the heart of health and social care, many customers are still more familiar with our services than they are with our name’

Some facts about us

The IC is England’s authoritative and independent source of health and social care information. We are a special health authority and our role is to support better health and social care by providing trusted, high-quality information that helps national and local organisations make the best decisions to improve people’s care and well-being.

Working with more than 300 health and social care providers, we collect data, analyse it and convert it into useful information for clinicians, managers, policy-makers, patients, service users, members of the public, regulators, academics and researchers.

We aim only to collect data that has a positive effect on health and social care and the quality and timeliness of our information is key. It is independent and trustworthy. We make sure it is collected only once and improvements to our collection systems mean it is now quicker and easier for frontline staff to provide it.

How does information make a difference?

High-quality information is absolutely fundamental to high-quality health and social care. Used properly in health and social care, we believe that good information can have a lasting impact on all of our lives.

Of course, that’s easy to say. So how do we know it’s true, especially in an NHS which is changing at such a fast rate? How do we know that our work genuinely influences the life of a person with heart disease in Luton, for example, or an older person with a history of falls and reduced mobility in Salford?

The fact is that trustworthy, relevant and timely information enables the NHS and social care to run effectively, keep to budget and to develop services that best meet the needs and preferences of local communities.

Clear information that is easy to access and understand helps people make important choices about their own health and care too.

If you were a patient with heart disease in Luton, the information and products delivered by The IC over the last two years mean:

- you have easy access to new web-based information, giving you reliable facts and figures about national survival rates at heart centres - helping you make the right choice of hospital if you need an operation
- your wait for surgery will be shorter because The IC is publishing the first ever national, patient-level data on outpatient appointments and this will be developed to help organisations track and speed up their progress towards the 18-week target
- your chances of surviving surgery will be better because clinical teams across the country now have access to up-to-date information on treatments and outcomes provided by our clinical audits
- you might have to visit hospital less and get more of your longer-term care closer to where you live, because The IC is giving GPs better information to help them commission high-quality follow-up care in convenient community settings.

8 Analysis of changes in cash

	31 March 2006	Changes during the year	**31 March 2007**
	£000	£000	**£000**
Cash at OPG	12,459	(6,989)	**5,470**
Cash with BSA	591	(591)	**-**
	13,050	(7,580)	**5,470**

The Business Services Authority (BSA), formerly The Prescription Pricing Agency, undertook accounting services for The IC during 2005/06 and funds were provided in order to meet The IC debts as they became due. All monies have now been repaid.

9 Creditors

	31 March 2007 £000	31 March 2006 £000
NHS creditors	**1,896**	4,469
Tax and social security	**274**	48
Other creditors	**2,164**	142
Accruals	**4,502**	8,369
	8,836	13,028

All creditors are due within one year.

10 Provisions for liabilities and charges

	Injury benefit £000	**Lease surrender £000**	**Dilapidations £000**	**Joint venture investment £000**	**Staff termination £000**	**Total £000**
At 31 March 2006	198	740	180	2,500	5,511	9,129
Arising during the year	-	528	10	-	862	1,400
Utilised during the year	(11)	(587)	-	-	(4,878)	(5,476)
At 31 March 2007	**187**	**681**	**190**	**2,500**	**1,495**	**5,053**
Expected timing of cash flows						
Within 1 year	12	85	35	2,500	489	3,121
1-5 years	60	425	-	-	876	1,361
Over 5 years	115	171	155	-	130	571

6.3 Fixed asset investments

	31 March 2007 £000	31 March 2006 £000
Investment in joint venture	**12,000**	12,000

On 17 January 2006, The IC entered into a joint venture arrangement known as Dr Foster Intelligence (DFI). The IC acquired 50 per cent of the ordinary share capital and also provided working capital. The remaining share capital is owned by Dr Foster LLP. The investment was satisfied by a £9,500,000 cash payment and a further £2,500,000 promissory note due in July 2007.

The accounting date for DFI is 31 December.

The purpose of DFI is to transform the quality and efficiency of the health and social care informatics market by providing authoritative, timely and comparable information presented and marketed in a way that engages managers, clinicians, patients and citizens.

In accordance with the provisions of FRS 9 (Associates and Joint Ventures) and the FREM we have treated the investment in DFI as a fixed asset investment shown at cost, less any amounts written off. At this time the directors of The IC do not believe it is appropriate to write off any amount from The IC's original £12m investment in DFI.

The IC engaged PricewaterhouseCoopers LLP (PwC) to estimate the value of its investment in DFI as at 31 March 2007. PwC prepared a valuation on the assumption that Dr Foster Holdings LLP, The IC's joint venture partner, would agree to a sale of The IC's shares and that The IC would receive a 50% pro rata share of 100% of DFI's current market value.

The original cost of The IC's investment in DFI of £12m falls within the valuation range estimated by PwC based on the above assumptions, which has provided the directors of The IC with further comfort that treating The IC's investment in DFI as a fixed asset investment shown at cost appropriately reflects the requirements of FRS 9.

The IC's share in the accounts of DFI to 31 December 2006 are as follows:

	Year to 31 Dec 2006 £000
Turnover	4,676
Loss before tax	(1,400)
Taxation	-
Loss after tax	(1,400)
Fixed Assets	10,098
Current Assets	4,201
Liabilities due within one year	(2,450)
Liabilities due after one year or more	(1,250)

The loss before tax includes goodwill amortisation of £0.5m.

7 Debtors

Amounts falling due within one year	31 March 2007 £000	31 March 2006 £000
NHS debtors	**131**	168
Prepayments	**362**	333
Other debtors	**1,178**	1,059
	1,671	1,560

Best known for our products...

Yet, despite our role at the heart of health and social care, many customers are still more familiar with our services than they are with our name.

For instance, many people working in a hospital or PCT will know about Hospital Episode Statistics (HES), but it's less likely they'll know it is The IC that produces them.

Of course it's important to us that our customers become increasingly familiar with who we are and what we do. But it is even more important that they continue to trust in the quality and usefulness of our information and products.

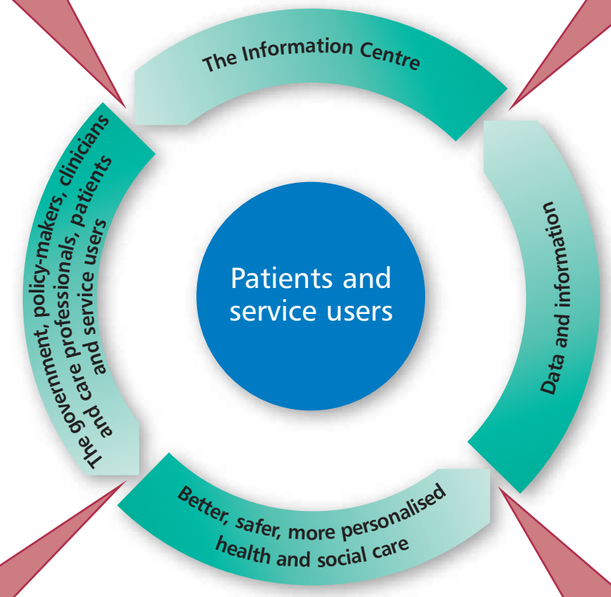
We have an extremely strong track record on which to build – as the following sections of this report demonstrate.

What The IC is doing

We work quickly and collaboratively to get the best information to the people and places where it can have the biggest impact on better care.

What The IC is doing

We are translating data into high-quality, reliable and up-to-date information.



What The IC is doing

We are providing information in formats that frontline professionals can understand and use.

What The IC is doing

We are making it easier for health and social care organisations to return data to us.

We avoid duplications and make sure we only ask them for information that we know will help us produce the best information and tools.

"The importance of information in the healthcare sector cannot be stressed enough. Only by creating processes for reliable data transfer and systems for analysis can we accurately ascertain the effectiveness and efficiency for each specialty. Data reliability can only be increased through rigorous use and examination. This should bring about positive changes, not only making it easier to identify areas of excellence, but also making us faster in identifying areas that need improvement."

Professor Sir Ara Darzi, chair of surgery, Imperial College London and recently appointed health minister

6.2 Tangible fixed assets

	Information technology £000	Software £000	Fixtures and fittings £000	Total £000
Cost or valuation				
At 1 April 2006	1,306	3,621	551	5,478
Additions	388	522	77	987
Transfers	-	(121)	-	(121)
Indexation	-	-	29	29
Disposals	-	(70)	-	(70)
At 31 March 2007	**1,694**	**3,952**	**657**	**6,303**
Depreciation				
At 1 April 2006	19	1,645	4	1,668
Provided during the year	567	737	67	1,370
Transfers	-	(52)	-	(52)
Indexation	-	-	3	3
At 31 March 2007	**586**	**2,330**	**74**	**2,990**
Net book value at 1 April 2006	**1,287**	**1,976**	**547**	**3,810**
Net book value at 31 March 2007	**1,108**	**1,622**	**583**	**3,313**

The total amount of depreciation charged in the operating cost statement in respect of assets held under finance leases and hire purchase contracts was £nil.

5 Operating income

	2006/07 £000	2005/06 £000
Provision of data related services	**1,008**	809
Publications and training events	**18**	44
Other	**15**	129
	1,041	982

6.1 Intangible fixed assets

	Software licences £000
Gross cost at 1 April 2006	57
Additions - purchased	30
Gross cost at 31 March 2007	**87**
Accumulated amortisation at 1 April 2006	1
Provided during the year	36
Accumulated amortisation at 31 March 2007	**37**
Net Book value at 1 April 2006	56
Net Book value at 31 March 2007	**50**

Chapter 2

We're helping make national reforms work

'The vision is clear enough – but making it work depends on having in place the right mechanisms, measures and data'

The government's vision is to give people convenient access to good quality NHS services and social care in the community where they live. Increasingly, NHS services will need to respond to people's individual needs; give them choices about where and when they are treated; and help them keep as fit as possible by promoting healthy lifestyles.

The vision is clear enough – but making it work depends on having in place the right mechanisms, measures and data. This is why system reform was such a priority for The IC during 2006/07.

Payment by Results

Payment by Results (PbR) is designed to provide a transparent, rules-based system for paying trusts for the activities they actually carry out. Its aim is to reward efficiency, support patient choice, encourage a wider range of providers and, through all this, reduce waiting times.

Secondary Uses Service

The Secondary Uses Service (SUS) is being jointly developed by The IC and NHS Connecting for Health to ensure the data collected for direct patient care can also be used for healthcare planning, commissioning, public health, clinical audit, governance, benchmarking, performance improvement and policy development.

The initial focus of SUS has been to provide a consistent system for processing the data flows necessary for delivering PbR.

Supporting more efficient care at University College London Hospitals

The introduction of the Secondary Uses Service (SUS) is helping to improve the efficiency of patient care at University College London Hospitals NHS Foundation Trust.

Before, the trust devoted considerable time and resources to resolving technical disagreements with PCTs over the cost of patient care.

However, the introduction of the SUS software system has meant there are now far fewer disputes over cost.

Instead, PCTs who commission services from the hospital are now able to focus on the efficiency of care - something which usually leads to a better patient experience.

"Before SUS, there were a lot of disputes around the cost of each attendance and the bigger picture tended to get overlooked," said Kathy Hadley, the trust's finance and commissioning information manager.

"Because SUS has resolved many of the minor disputes, PCTs are now able to look more closely at the way care is delivered and see if it is as efficient and cost-effective as possible. For example, a PCT will want to know why a patient had five, rather than one, outpatient appointments before they were put on an elective waiting list because that costs extra money.

"The introduction of SUS has undoubtedly freed up both ourselves and PCTs so we can now focus far more on improving the efficiency of care which makes for happier patients."

NEW FOCUS: Kathy Hadley, finance and commissioning information manager

3.1 Reconciliation of net operating cost to net resource outturn

	2006/07 £000	2005/06 £000
Net operating cost	**37,211**	43,941
Exceptional costs	**2,854**	9,055
Net resource outturn	**40,065**	52,996
Revenue resource limit	**41,525**	53,133
Underspend against revenue resource limit	**1,460**	137

3.2 Reconciliation of gross capital expenditure to capital resource limit

	2006/07 £000	2005/06 £000
Gross capital expenditure	**1,017**	14,238
NBV of assets disposed	**(70)**	-
Net capital resource outturn	**947**	14,238
Capital resource limit	**1,444**	14,250
Underspend against capital resource limit	**497**	137

4 Exceptional costs

	2006/07 £000	2005/06 £000
Reorganisation costs	**2,892**	7,930
Loss on transfer of software assets	**-**	1,802
Residuary body transactions	**(38)**	(677)
	2,854	9,055

Reorganisation costs relate to the costs incurred with the closure of previous NHS Information Authority offices in Birmingham, Exeter and Winchester. Costs include staff redundancies, consultancy fees, loss on sale of fixed assets, lease surrender and dilapidation provisions. The Department of Health agreed to contribute towards these costs by an increased resource limit allocation.

In 2005/06 certain software assets that are an integral part of the functions transferred to the joint venture operation, DFI, were transferred for nil consideration.

The residuary body transactions relate to the finalisation of all opening balances inherited from the NHS Information Authority.

NHS Pension Scheme

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 for England and Wales. As a consequence it is not possible for the employer to identify its share of the underlying scheme liabilities. The total employer contributions payable in 2006/07 was £841,000.

The scheme is subject to a full valuation by the government actuary every four years which is followed by a review of the employer contribution rates. The last valuation took place as at 31 March 2003 and has yet to be finalised. The last published valuation 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 NHS Pensions Agency website at www.nhspa.gov.uk. Copies can also be obtained from The Stationery Office.

NHS bodies are directed by the secretary of state to charge employers pension costs contributions to operating expenses as and when they become due. Employer contribution rates are reviewed every four years following a scheme valuation carried out by the government actuary. On advice from the actuary the contribution may be varied from time to time to reflect changes in the scheme's liabilities. At the last valuation on which contribution rates were based (31 March 1999) employer contribution rates for 2006/07 were set at 14% of pensionable pay (14% for 2005/06).

The scheme is a 'final salary' scheme. Annual pensions are normally based on 1/80th of the best of the last 3 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 twelve months ending 30 September in the previous calendar year. On death, a pension of 50 per cent 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 IC 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 their 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.

2.3 Better payment practice code - measure of compliance

	Number	£000
Total non NHS bills paid 2006/07	**6,847**	**30,175**
Total non NHS bills paid within target	**6,234**	**25,132**
Percentage of non NHS bills paid within target	**91.0%**	**83.3%**
Total NHS bills paid 2006/07	**176**	**6,804**
Total NHS bills paid within target	**105**	**4,198**
Percentage of NHS bills paid within target	**59.7%**	**61.7%**

The better payment practice code requires all valid invoices to be paid by the due date or within 30 days of receipt of goods or a valid invoice, whichever is later.

Interest totalling £1,592 was paid under the Late Payment of Commercial Debt (Interest) Act 1998 (2005/06 £nil).

Highlights:

- SUS provides a single, secure data environment which will make it possible to manage and link data from different sources relating to the same person, and carry out detailed analyses while ensuring complete patient confidentiality.
- The IC's chief executive became senior responsible officer for SUS during the year.

New classifications

The development of Healthcare Resource Groups version 4 (HRG4) was also completed during 2006/07. HRG4 is an updated classification system which provides a key component of the framework within which services can be commissioned, costed and paid for under PbR.

We worked closely with the PbR policy team at the Department of Health and colleagues in NHS Connecting for Health to design, commission and test HRG4, as well as to develop support and training to help frontline staff use it.

We held 11 roadshows around the country to launch HRG4 to the NHS. We also produced online support materials, including a business simulation game called 'Group It', to demonstrate the importance of accurate and complete data in NHS information flows.

Highlights:

- HRG4 takes account of advances in clinical practice and is more accurate in representing the resources used in patient care than previous classifications.
- It increases coverage by extending HRGs to new clinical areas, such as specialist palliative care, chemotherapy, radiotherapy, diagnostic imaging and critical care.
- It supports better identification and classification of procedures using updated OPCS[1] codes.
- It makes possible a more accurate analysis of healthcare needs within the service.

[1] Office of Population, Censuses and Surveys - Classification of Surgical Operations and Procedures

Practice Based Commissioning

Practice Based Commissioning (PBC) gives the clinicians nearest to patients the resources and support they need to become more involved in commissioning services.

Helping GPs to commission services more effectively

GP Shane Gordon is analysing his practice's care for ears, nose and throat (ENT) patients after a new tool, developed by The IC and NHS Connecting for Health, showed it was referring higher than average numbers for outpatient appointments.

NHS Comparators website - https://nww.nhscomparators.nhs.uk - is designed to support Practice Based Commissioning (PBS) by enabling GPs and PCTs to see how practices refer patients, comparing practices locally and nationally with each other.

"There's a real hunger for comparative information and this is the only free access to national comparators of this type," said Shane, a GP at Tiptree Medical Centre in Colchester and chief executive of the Colchester PBC cluster, which covers 23 practices and 170,000 patients and is the largest cluster in Essex.

"For me, it's the best bit of software to come out of the centre for a long time. It's simply laid out, easy to use and does what it says on the tin."

For the Tiptree Medical Centre, the site showed referrals for some types of outpatient appointments are significantly higher than average whilst other areas of care, such as emergency admissions, are below average. This is helping Shane to focus his efforts on examining outpatient referrals at his practice in more detail.

"I'm currently analysing which specialties are showing the higher referral rates," said Shane.

"So far, we're looking at ENT. We'll be looking at our case-mix and referrals in detail and see if we can deliver ENT services more effectively, either by making changes within the practice or working with other practices to commission new types of services."

BETTER REFERRING: GP Shane Gordon

However, in order to make sound commissioning decisions, GPs and practices need better access to relevant local and comparative national data.

NHS Comparators

As part of the SUS programme, NHS Connecting for Health and The IC developed a web-based resource - NHS Comparators. This provides general practices, primary care trusts and strategic health authorities with comparative measures of the use of secondary care services by local populations.

Highlights:

- NHS Comparators - https://nww.nhscomparators.nhs.uk - allows practices to compare their referral patterns with other practices and against national and regional averages.
- It is intended to help practices identify if and where they can commission and provide alternative services to improve patient care and efficiency.

Choice

A central theme of the government's vision for better local services is to give patients greater choice over where and when they are treated. But for this choice to mean anything, patients need facts and figures about services so they can decide which care is best for them.

The IC was involved in a number of projects during 2006/07 designed to give people better access to information.

NHS Choices

The website NHS Choices - www.nhs.uk - was launched in June 2007 to give patients, the public and health professionals a wide range of information about health and healthcare provision.

Highlights:

- As part of our role in developing NHS Choices, The IC created a web tool which allows primary care providers - such as GP practices, pharmacies, opticians and dentists - to maintain their own contact and service details on the site.

Access to practice results

The IC developed and launched a new website to give patients, the public and healthcare professionals easy access to the results from the Quality and Outcomes Framework for every practice in England. www.qof.ic.nhs.uk

Giving patients information to help them choose a GP practice

New graduate Ygraine Cadlock is determined to find the right GP practice to meet her needs when she moves to London next month.

After living in both Brighton and Oxford since graduating from Exeter University, Ygraine has been registered with three practices in the past year.

Now, as she prepares to take up a new job in the capital, she plans to use a website launched by The IC to find a GP.

The site – www.qof.ic.nhs.uk - highlights the Quality and Outcomes Framework (QOF) results of every practice in England, enabling users to compare services.

"The site is great at showing all the practices in the area so you know what options are available to you," said Ygraine.

"There's also a lot of information about practices' QOF results to help you make comparisons. My only difficulty has been that all practices score highly so it's hard to work out which is best.

"For me, the site is a good starting point and helped me select the practices I wanted to find out more about, such as their range of services and waiting times."

CHOOSING CARE: New graduate Ygraine Cadlock

Highlights:

- The site makes it possible for practices to compare their performance against that of other practices, both locally and nationally.
- It gives patients important information that may influence their choice of practice.
- The website attracted 21,000 visits in the first three months of operation.

2.2 Staff numbers and related costs

	2006/07	Permanently employed staff	Temporary and contract staff	2005/06
	£000	£000	£000	£000
Salaries and wages	**13,512**	**7,855**	**5,657**	18,819
Social security costs	**759**	**759**		796
Employer superannuation contributions - NHSPA	**841**	**841**		858
Employer superannuation contributions - other	**586**	**586**		512
	15,698	**10,041**	**5,657**	20,985

The average number of employees during the year was:

	2006/07	Permanently employed staff	Temporary and contract staff	2005/06
	Number	Number	Number	Number
	351	**267**	**84**	358

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 IC on the grounds of ill health (2005/06 £76,114).

Principle Civil Service Pension Scheme (PCSPS)

From 1 October 2002, civil servants may be in one of three statutory based 'final salary' defined benefit schemes (classic, premium and classic plus). The schemes are unfunded, with the costs of benefit met by monies voted by Parliament each year. Pensions payable under classic, premium and classic plus are increased annually in line with changes in the retail prices index. New entrants after 1 October 2002 may choose between membership of premium or joining a good quality 'money purchase' stakeholder arrangement with a significant employer contribution (partnership pension account).

Employee contributions are set at the rate of 1.5 per cent of pensionable earnings for classic and 3.5 per cent for premium and classic plus. Benefits in classic accrue at the rate of 1/80th of pensionable salary for each year of service. In addition, a lump sum equivalent to three years' pension is payable on retirement. For premium, benefits accrue at the rate of 1/60th of final pensionable earnings for each year of service. Unlike classic, there is no automatic lump sum but members may give up (commute) some of their pension to provide a lump sum. Classic plus is essentially a variation of premium, but with the benefits in respect of service before 1 October 2002 calculated broadly as per classic.

The partnership pension account is a stakeholder pension arrangement. The employer makes a basic contribution of between 3 per cent and 12.5 per cent (depending on the age of the member) into a stakeholder pension product chosen by the employee. The employee does not have to contribute but where they do make contributions, the employer will match these up to a limit of 3 per cent of pensionable salary (in addition to the employer's basic contribution). The employer also contributes a further 0.8 per cent of pensionable salary to cover the cost of centrally-provided risk benefit cover (death in service and ill health retirement).

The PCSPS scheme is an unfunded multi-employer defined benefit scheme in which the employer is unable to identify its share of underlying assets and liabilities. A full actuarial valuation was undertaken on 31 March 2003. Details can be found in the resource accounts of the Cabinet Office: (www.civilservice-pensions.gov.uk). For 2006/07, employer's contributions of £586,000 were paid at one of four rates in the range 17.1% to 25.5%. The contribution rates reflect benefits as they accrue, not the costs as they are incurred, and reflect past experience of the scheme.

c. Depreciation

Depreciation is charged on each asset as follows:

1) Intangible assets are amortised, on a straight line basis, over the estimated lives of the asset
2) Purchased computer software licences are amortised over the shorter of the term of the licence and their useful economic life
3) Each equipment asset is depreciated on a straight line basis over its expected useful life as follows

- Fixtures and fittings	7 - 13 years
- Office, information technology, short life equipment	3 - 5 years

1.8 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.

1.9 Provisions

The IC 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.

2.1 Operating and programme expenditure

		2006/07 £000	2005/06 £000
Non-executive directors' remuneration		**112**	94
Salaries and wages		**15,586**	20,891
External contractors		**14,837**	13,699
Training and conferences		**359**	394
Travel		**976**	1,290
Accommodation costs		**1,726**	2,632
Personal IT equipment		**458**	443
IT maintenance and support		**1,818**	3,757
Office services		**469**	366
Advertising and publicity		**196**	373
Loss on disposal of fixed assets		**70**	-
Capital:	Depreciation and amortisation	**1,406**	910
	Capital charges	**(25)**	(303)
External auditors fees		**70**	70
Miscellaneous		**194**	307
		38,252	44,923

No payments were made to the external auditors for non-audit work.

18-week target

By the end of 2008, the Government has pledged that no patient should wait longer than 18 weeks from the time they are referred by their GP to the start of their treatment.

One of the roles of SUS is to manage the new data flows needed to track progress towards the 18-week target.

Commissioning datasets

Version 6 of the Commissioning Datasets (CDS) was developed by NHS Connecting for Health with support from The IC to help provide a more complete picture of patient care.

CDS are mandated data collected by healthcare providers to cover areas such as inpatient, outpatient and accident and emergency activity.

Under Version 6, the datasets have been expanded and now cover activity such as non-consultant outpatient appointments and diagnostics – vital elements when calculating the overall patient journey.

Highlights:

- By providing greater detail about the patient care pathway, CDS should enable PCTs to accurately monitor their progress towards the 18-week target.
- They should give trusts an early indication of any problems which may stop them achieving the target by the December 2008 deadline.
- They should also support PBC and PbR.
- Version 6 CDS gained full approval in May 2007 and will become mandatory from December 2007.

Supporting people to live independently

The Government has a public service agreement (PSA) target to ensure more older people get the support they need to continue living independently in their own home.

The IC is helping it deliver this target and improve care for vulnerable people in a number of ways, including by expanding the range of information available about social care services.

Public service agreement targets

In its report *Summary of the public service agreement target on home care 2005/06,* The IC assessed councils' performance in delivering intensive home care to enable more older people to continue living at home.

Highlights:

- The report enabled the Department of Health to monitor progress towards the PSA target.
- It also helped the department target support and resources to local authorities providing least home care.

Consulting on social care information

Developing social care information was a priority for the IC during the year. We carried out a wide-scale consultation with local authorities responsible for social care to find out how information on social care can be developed in the future. More than two-thirds of local authorities responsible for social services attended our consultation workshops.

The next step will be for The IC to develop a strategy for improving social care data, including developing national data standards and reviewing how information can be used to support integrated services for older people.

The grant-funded sector

The grant-funded sector plays a big role in delivering social care and during the year The IC worked with local authorities to collect, for the first time, information about the services people receive beyond a formal care package. The results of this exercise will be published later in 2007/08 and we have agreed to carry out the collection for a second year.

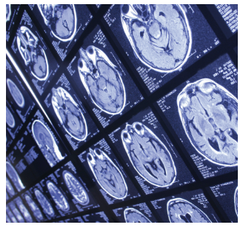
The Adult Care Information Network

The IC launched the Adult Care Information Network in March 2006 to bring together information specialists and policy-makers on adult social care across England, Wales, Scotland and Northern Ireland. Its first full year was 2006/07.

The network means information initiatives taking place in different countries within the UK can be aligned and information specialists can consider similarities between datasets.

Chapter 3

We're targeting the priority clinical areas



'This crucial part of our work allows clinicians and trusts to compare their performance and outcomes against best practice'

Whether it is indicators of clinical outcomes or measures of length of stay or re-admissions, information underpins improvements both to care and people's experience of that care.

Ranging from our programme of clinical audits to the managerial information contained in our Hospital Episodes Statistics, The IC provides the facts and figures which can be used by both frontline clinicians and managers to scrutinise ways of working, benchmark against others and devise new and improved ways of delivering services in the future.

Clinical audits

The IC is the single biggest provider of clinical audits to the NHS carrying out 18 audits each year in the areas of heart disease, cancer and diabetes. Most of these are funded by the Healthcare Commission.

This crucial part of our work allows clinicians and trusts to compare their performance and outcomes against best practice and assess themselves against national guidelines and agreed clinical standards.

For patients, the audits provide vital reassurance about the quality of care they receive.

During 2006/07, The IC increased average participation across all of its audits by more than 30 per cent, making the data more representative, reliable and useful. As clinicians take part in the audits voluntarily, this extended participation was a considerable achievement for The IC. It also demonstrates the importance clinicians attach to these audits and their own commitment to transparency and openness.

Supporting care for diabetics in North Tyneside

The National Diabetes Audit is helping clinicians in North Tyneside review the way services are developed for people with diabetes in the area.

The local diabetes service had been concerned about poor Quality and Outcomes Framework results for foot screening.

However, the audit shows rates of foot amputations for patients from the area are lower than the national average.

"The statistics have reassured us that our model of care, which involves targeting foot care at the most high risk patients, is effective," said consultant diabetologist Simon Eaton.

"Previously this information was not available as patients may go to a range of hospitals, including some outside our area, for procedures such as amputations. The audit helped us by providing data for our patients wherever they go for treatment and gives us a much richer picture of care for people with diabetes locally.

"The combined information has helped us review our services and think through how we need to develop in the future. For example, we are currently focusing on supporting an increase in foot screening rates by giving training to GPs locally."

SERVICE REVIEW: Diabetologist Simon Eaton

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 IC are described below. They have been consistently applied in dealing with items considered material in relation to the accounts.

1.1 Accounting conventions

These accounts have been prepared under the historical cost convention, modified to account for the revaluation of tangible fixed assets and fixed asset investments. This is in accordance with directions issued by the secretary of state for health and approved by HM Treasury.

1.2 Income

The main source of funding is a parliamentary grant from the Department of Health 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 is accounted for applying the accruals convention and primarily comprises of fees and charges for services provided on a full cost basis to external customers and the NHS.

1.3 Taxation

The IC 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. A charge reflecting the cost of capital utilised by The IC is included within operating costs. The charge is calculated at the real rate set by HM Treasury, currently 3.5% (2005/06 3.5%), on the average carrying value of all assets and liabilities except for cash balances with the Office of the Paymaster General, where the charge is nil.

1.5 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.

1.6 Joint venture

The investment in the joint venture is accounted for under the principles of FRS 9. The carrying value for the 2006/07 accounts has been reviewed following an independent revaluation of the investment.

In accordance with the provisions of FRS 9 (Associates and Joint Ventures) and the FREM we have treated the investment in the Dr Foster Intelligence (DFI) joint venture as a fixed asset investment shown at cost, less any amounts written off. At this time the directors of The IC do not believe it is appropriate to write off any amount from The IC's original £12m investment in DFI.

1.7 Fixed assets

a. Capitalisation

All assets falling into the following categories are capitalised:

1) Intangible assets, including purchase computer software licences, 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

2) Tangible assets which 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, 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 building irrespective of their individual cost.

Personal IT equipment such as desk top computers, laptops and local printers are treated as revenue items.

b. Valuation

Intangible fixed assets are valued at historical cost. 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 are stated at the lower of replacement cost and recoverable amount. They are restated to current value each year.

On initial recognition, assets are measured at cost, including any costs such as installation directly attributable to bringing them into working condition.

Cash flow statement

For the year ended 31 March 2007

	Notes	2006/07 £000	2005/06 £000
Net operating cost before interest for the year		**(37,211)**	(43,941)
Depreciation and amortisation	2.1	**1,476**	910
Capital charges	2.1	**(25)**	(303)
(Increase) / decrease in debtors		**(111)**	5,812
Decrease in creditors		**(4,192)**	(13,019)
Decrease in provisions		**(5,476)**	(516)
Net cash outflow from operating activities		**(45,539)**	(51,058)
Returns on investments and servicing of finance			
Exceptional costs		**(1,454)**	(923)
Capital expenditure and financial investment			
Payments to acquire intangible fixed assets	6.1	**(30)**	(57)
Payments to acquire tangible fixed assets	6.2	**(987)**	(1,680)
Fixed asset investment		**-**	(9,500)
Net cash outflow from investing activities		**(1,017)**	(11,237)
Net cash outflow before financing		**(48,010)**	(63,218)
Financing			
Total resource limit	11.1	**40,430**	55,383
Funding for residuary body opening balances	11.1	**-**	20,200
Other funding	11.1	**-**	685
		40,430	76,268
Increase in cash		**(7,580)**	13,050

The notes on pages 51 to 63 form part of this account

Diabetes

The National Diabetes Audit carried out by The IC is considered the biggest annual clinical audit in the world - gathering information from primary care, secondary care and specialist paediatric units.

Highlights:

- In 2006/07, the audit team collected information about 656,000 people with diabetes (around a third more than the previous year) involving 131 PCTs, 2,416 GP practices, 46 hospital trusts and 102 specialist paediatric units.
- In paediatrics, the audit was based on the records of 13,000 patients - over a third more than the previous year. This represented 50 per cent of all children and young people with diabetes in England and Wales.
- We trained clinicians and NHS commissioners on how to use the audit.

Cancer

The IC's cancer audits provide information on the extent to which trusts are implementing national clinical guidelines for lung, head and neck and bowel cancer.

New cancer audits

During the year, The IC was commissioned to carry out two new audits; one for oesophago-gastric cancer and the other for mastectomy and breast reconstruction.

Every year, 12,000 patients are diagnosed with oesophago-gastric cancer. Around 34,000 patients are diagnosed with breast cancer and over 16,000 mastectomies are carried out, with 4,000 cases being followed by reconstructive surgery.

Highlights:

- The National Mastectomy and Breast Reconstruction Audit will look at national data on the types of patients who are offered the procedure – exploring factors such as their age, presenting symptoms, location, length of time waiting for the operation and outcome.
- The National Oesophago-gastric Cancer Audit will evaluate the standard of care given to oesophago-gastric cancer patients and examine national variation in process and outcome.

Heart disease

Heart disease is the most common cause of death, killing around one in five men and one in six women in the UK.

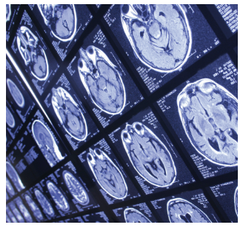
The IC has been commissioned to carry out the National Heart Disease Audit - a collection of nine audits, each focusing on a specific aspect of heart condition care.

Our Central Cardiac Audit Database (CCAD) is used to collect the information for these audits, as well as for a range of other services.

Data from CCAD provides an important mechanism to help ensure patients are getting safe care by highlighting variations in survival rates across heart units. See Monitoring heart surgery at Oxford John Radcliffe Hospital *(page 20)*.

Highlights:

- During the year, The IC supplied data to the Healthcare Commission to help them develop the first ever guide to heart surgery, detailing survival rates for operations at heart units across England and Wales.
- The online guide attracted more than 15,000 visits in its first month and has been warmly welcomed by patients and patient groups. http://heartsurgery.healthcarecommission.org.uk
- The IC also developed a major new website to give the parents of children with congenital heart disease detailed information about survival rates at every specialist heart centre in the UK. www.ccad.org.uk/congenital
- Under the National Infarct Angioplasty Project we have also worked with the Department of Health and the British Cardiovascular Society to explore the case for expanding primary angioplasty – when angioplasty rather than thrombolysis is used as the first treatment for patients following a heart attack. The project is due to publish its findings in summer 2007.



Monitoring heart surgery at Oxford John Radcliffe Hospital

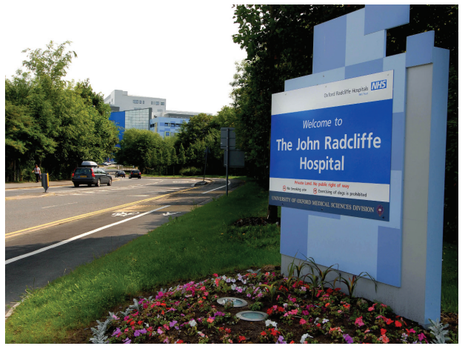
When doubts were raised about the safety of patients undergoing heart surgery at Oxford John Radcliffe Hospital, The IC was called on to provide data to the investigation team.

Using data from The IC's Central Cardiac Audit Database, the Healthcare Commission was able to undertake detailed analyses which showed that, once risk factors such as age or ill-health were taken into account, mortality rates for routine bypass surgery were within acceptable statistical limits.

These findings formed an important basis for the commission's report into the hospital's heart unit which was published in March 2007.

"Our investigation was able to use data from The IC to carry out a number of detailed analyses to show that, when adjusted for risk, mortality rates at the hospital were within predicted limits," said Paula Mansell, investigation manager at the commission.

"Our analyses showed that high rates of mortality at Oxford could not be attributed to any single surgeon or period of time. We were also able to show that the surgeons at Oxford operated on higher risk patients than many other cardiac units."



REPORT FINDINGS: Oxford John Radcliffe Hospital

National service frameworks

National service frameworks (NSFs) are long-term strategies for improving the standards of care in specific clinical areas. The IC supports them by developing national datasets to ensure the right information is collected for the NHS to measure how well it is meeting NSF standards of care.

Highlights:

- The IC carried out a thorough review of the national cancer and diabetes datasets to confirm they will support the new reform strategies over the next five years.
- As part of the review, we consulted widely with the royal colleges, consultants, trusts and strategic health authorities, as well as with our own expert reference panels. We now have a programme of work that identifies how these datasets will be developed during 2007/08.
- During 2006/07, we consulted widely on a new national renal dataset. Now the largest clinical dataset to be approved by the NHS Information Standards Board, it is due to be operationally tested and implemented in five renal units before becoming fully mandatory for the whole NHS from 2008.

Balance sheet

As at 31 March 2007

	Notes	2006/07 £000	2005/06 £000
Fixed assets			
Intangible assets	6.1	**50**	56
Tangible assets	6.2	**3,313**	3,810
Investment	6.3	**12,000**	12,000
		15,363	15,866
Current assets			
Debtors	7	**1,671**	1,560
Cash at bank and in hand	8	**5,470**	13,050
		7,141	14,610
Current liabilities			
Creditors - amounts falling due within one year	9	**(8,836)**	(13,028)
Net current assets		**(1,695)**	1,582
Provisions for liabilities and charges	10	**(5,053)**	(9,129)
Net assets		**8,615**	8,319
Taxpayers' equity			
General fund	11.1	**8,590**	8,319
Revaluation reserve	11.2	**25**	-
		8,615	8,319

The notes on pages 51 to 63 form part of this account

The financial statements on pages 48 to 50 were approved by the board on 28 June 2007 and signed on its behalf by

Dated **12 July 2007**

Tim Straughan
Acting chief executive
The Information Centre

Chapter 14
Accounts 2006/07

Operating cost statement

For the year ended 31 March 2007

	Notes	2006/07 £000	2005/06 £000
Operating cost	2.1	**38,252**	44,923
Operating income	5	**(1,041)**	(982)
Net operating cost before interest and exceptional items		**37,211**	43,941
Exceptional items	4	**2,854**	9,055
Net operating cost		**40,065**	52,996
Net resource outturn		**40,065**	52,996

All income and expenditure is derived from continuing operations

Statement of recognised gains and losses

For the year ended 31 March 2007

	Notes	2006/07 £000	2005/06 £000
Unrealised surplus on the indexation of fixed assets	11.2	**25**	11
Recognised gains for the financial year		**25**	11

The notes on pages 51 to 63 form part of this account

Chapter 4
We're helping organisations plan better local care

Highlights:

- We introduced a new quarterly report on NHS dentistry that reflects changes in the way NHS dental care is delivered following the roll-out of the new dental contract in April 2006.
- The IC works with a range of stakeholders to produce impartial information on pay and earnings in primary care. In 2006/07, we published reports on GP and dental pay for the first time.
- Our annual report on the social care workforce showed how many and what types of people were employed in different aspects of social care.

'organisations sometimes struggle to extract what is relevant from the vast banks of information available to them'

Information is the bedrock of effective service planning and resource allocation. Information pinpoints trends in the nation's health and helps steer public health initiatives and campaigns. Data about the workforce informs recruitment and training strategies at national and local level.

While high-quality data should be at the heart of effective decision-making, organisations sometimes struggle to extract what is relevant from the vast banks of information available to them.

The IC provides a range of support and analytical tools to help clinicians, managers and policy-makers use information to improve services. Many of the tools are developed in partnership with academic or commercial organisations.

Developing a strong workforce

Some 65 per cent of the NHS's budget goes on staff pay, so it is vital that managers and policy-makers have the best possible information about the NHS workforce.

Workforce reports

During 2006/07, The IC published 13 reports on the NHS and social care workforce, covering areas such as staff and vacancy numbers, pay, activity and sick leave.

Workforce Census

For the first time, The IC incorporated information from the Electronic Staff Record (ESR) into our largest staff survey - the annual NHS Workforce Census. ESR is the first standardised payroll and human resources system for the NHS.

Highlights:

- 200 NHS organisations are currently live on the ESR system and marked improvements in data quality are now emerging.
- All NHS organisations will be using the system by April 2008, which should make the annual census easier, improve data quality and open up the possibility of a much wider range of useful figures being available in the future.

Better service planning

In 2006/07, The IC published 120 statistical reports. The topics we covered ranged from lifestyle issues - such as drugs and alcohol misuse, smoking, exercise, nutrition and obesity - to reports on health and social care services, workforce and earnings.

In addition to these, we published our 2005 Health Survey for England which focused on the health of older people and highlighted levels of blood pressure among this group of people.

Highlights:

- By showing trends in people's behaviour and level of health, our reports helped organisations prioritise where to allocate resources and alerted them to issues for which they may have to plan in the future.
- Our reports supported the wider health sector, including charities. DrugScope used The IC's surveys on drugs misuse to answer enquiries about the number of young people using drugs and recent patterns in usage. Similarly, Alcohol Concern used our reports on alcohol usage as evidence of consumption trends.

Driving improvements in social care

Throughout the year, The IC collected a wide range of detailed information about social care services. Seven different social care reports provided a comprehensive picture of how care is delivered and helped councils responsible for social services to plan, monitor and deliver better care. This information was also used to provide performance assessment framework indicators for councils responsible for social care.

Highlights:

- Our information underpinned the Performance Assessment Framework used by the Commission for Social Care Inspection to give star ratings to councils.
- Information collected by The IC contributed to the Audit Commission's Corporate Performance Assessment of local authorities. This important annual assessment is a major driver for councils to improve and develop social care services for their local populations.

Making information a tool for better care

During the year, The IC gave priority to developing analytical tools and services to help frontline staff turn information into better services - as quickly and effectively as possible.

Improving MMR uptake in Luton

Luton PCT has achieved a massive turnaround in MMR uptake after conducting a project which used data mapping services provided under The IC's Pilot NHS (England) Agreement.

Once among the worst performing PCTs for MMR immunisation, Luton is now among the elite with uptake rates of 92 per cent. Child immunisation rates overall have increased to 98 per cent in the area after a campaign led by assistant director of public health Kelly O'Neill.

To improve MMR uptake, public health information analyst Louise Choo used maps to highlight areas where uptake was highest and lowest.

"With this information, we were able to decide where best to target health resources and plan future activities," said Louise.

"In the future, we will look to cross-reference areas of low uptake with the location of GP practices and children's centres to further focus resources where they are most needed."

TARGETING CARE: Louise Choo

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 Information Centre's circumstances, consistently applied and adequately disclosed.

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

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 by the secretary of state with the approval of HM Treasury, of the state of The Information Centre's affairs as at 31 March 2007 and of its net resource outturn, recognised gains and losses, balance sheet 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 by the secretary of state with the approval of HM Treasury.
- Information given within the annual report, which includes the key achievements in 2006/07, supporting patients and staff and management reports 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 which govern them.

Report

I have no observations to make on these financial statements.

John Bourn
Comptroller and
auditor general

16 July 2007

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

Data mapping

The IC's Pilot NHS (England) Agreement enabled more than 400 NHS organisations to access digital map information. This service helped them improve services by allowing them to present information in mapped forms to identify health inequalities, target communications and services to clinical hotspots, identify specific demographic groups, record changes to patient catchment areas and carry out epidemiological analyses. This service is currently being competitively re-tendered on behalf of the NHS.

Highlights:

- The number of organisations using the pilot service increased from 33 per cent in March 2006 to 64 per cent by March 2007.
- Organisations used it to improve services, for example Nottingham City PCT used the service to target smokers in deprived areas, while South Birmingham PCT used it to develop strategies for tackling coronary heart disease in particular local communities.

Tackling health inequalities

In March 2007, The IC published an updated version of its Health Poverty Index (HPI), expanded to include data by ethnicity.

By presenting geographical, social, health and economic factors as well as cultural factors, the HPI tool can be used to support and guide local action aimed at addressing health inequalities and their causes. Users can compare data from one area with another, or against national data. www.hpi.org.uk

Expanding Hospital Episodes Statistics

During the year, we expanded Hospital Episodes Statistics (HES) to include national data on outpatient appointments - providing comprehensive data on outpatient activity for all areas for the first time.

We also made more of our HES data available online by developing the self-service portal so that people can now see hospital admissions based on both procedure/diagnosis and local area at the same time. www.hesonline.nhs.uk

Encouraging services from the commercial sector

The IC has a remit to help the health and social information services market to expand. The aim is to create a market that is capable of supporting the business needs of all forms of care organisations, including care providers, regulators and policy-makers.

Reducing mortality rates from gastrointestinal surgery in Essex

Medical director Dr Marion Woods took immediate action when she received a red alert to say mortality rates for lower gastrointestinal surgery at Essex Rivers Healthcare NHS Trust were higher than expected.

The alert came via Dr Foster Intelligence's Real Time Monitoring tool which analyses data from the Secondary Uses Service.

By studying the information, she noticed that death rates were higher when the most experienced surgeons were not working. As a result, she worked with the clinical team to ensure experienced surgeons were always available to operate on the most severe cases.

"Data clearly showed that most deaths happened when senior surgeons were not available due to routine clinical commitments," said surgeon Tan Arulampalan.

"Since changing our rotas, death rates have gone down and the less experienced surgeons now feel more supported."

PATIENT SAFETY: Surgeon Tan Arulampalan

Keeping people with long-term conditions out of hospital

Ashfield and Mansfield PCT recruited 11 community matrons to cut the number of people with long-term conditions being admitted as emergency cases to hospital.

But covering an area of more than 70 square miles and population of 200,000, the matrons initially found it difficult to identify the patients most in need of their help.

By using a Dr Foster Intelligence tracking system which uses The IC's Hospital Episodes Statistics, the matrons are now able to prioritise their caseload.

The system 'risk profiles' patients according to their past history and flags up those most at risk of being admitted unnecessarily as emergency cases to hospital.

"There are many patients with chronic conditions who've had the same treatment for years," said Nottinghamshire community matron Michelle Wilson.

"Some are not as well controlled as they could be because their condition has worsened. But in the past it was luck as to whether I came across them."

Her patient Ronald Sheppard said: "I used to get up in the morning and it was panic stations – I couldn't breath and I had to call an ambulance. But now Michelle has taught me to control my panicking, steady my breathing and use my inhaler properly."

HELPING HAND: community matron Michelle Wilson and patient

During the year, The IC entered into a number of partnership arrangements with commercial information providers with the aim of making as many analytical tools available to the NHS as quickly as possible.

The most significant partnership in 2006 was our joint venture with Dr Foster Limited to create Dr Foster Intelligence (DFI). DFI uses national data but presents it in a variety of new ways and with significant added value, including on-the-ground support and expertise.

A public accounts committee report into the joint venture is due to be published shortly.

Highlights:

- During its first full year, DFI delivered four new tools:
  - Hospital Marketing Manager – to help trusts develop and market themselves by giving them a better understanding of their referral and admission patterns and those of their neighbouring trusts.
  - NHS Indicator Explorer - to enable users to see where their organisations are performing well or poorly.
  - Patient Experience Tracker – to give trusts a better understanding of their patients' experience by allowing them to collect a large number of patient responses via data capture units.
  - High-impact User Manager – to enable PCTs, community matrons and GPs to generate lists of patients who are, or are likely to become, high impact users of secondary care services.
- Some 385 organisations use DFI products.

Chapter 13
The certificate of the comptroller and auditor general to the Houses of Parliament

I certify that I have audited the financial statements of The Information Centre for the year ended 31 March 2007 under the National Health Service Act 2006. These comprise the operating cost statement, the balance sheet, the cashflow statement and statement of recognised gains and losses and the related notes. These financial statements have been prepared under the accounting policies set out within them. I have also audited the information in the remuneration report that is described in that report as having been audited.

Respective responsibilities of the 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 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 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, including the key achievements in 2006/07, supporting patients and staff and management reports is consistent with the financial statements. I also report whether in all material respects the expenditure and income have been applied to the purposes intended by Parliament and the financial transactions conform to the authorities which govern them.

In addition, I report to you if The Information Centre 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 Information Centre'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 Information Centre'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

The IC is committed to managing risks to an acceptable level on all aspects of the business activity with a clear intention to align the organisation's governance framework with its business plan.

Review of effectiveness

As accounting officer, I have responsibility, together with the board, for reviewing the effectiveness of the system of internal control. My review in a normal year 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. Executive managers within the organisation who have responsibility for the development and maintenance of the system of internal control provide me with assurances. 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. My review is also informed by the findings of the National Audit Office as the organisation's external auditors.

I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the board and the audit and risk management committee and am accordingly aware of the significant issues that have been raised. A plan to address these weaknesses and ensure continuous improvement of the system has been formulated and is progressively being implemented.

Significant internal control issues

In 2006/07 the internal control issues were identified as:

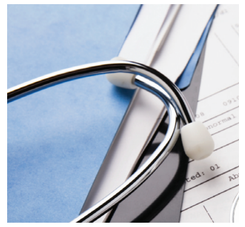
- the change in outsourced supplier for finance processes and the development of an internal HR service
- ongoing management of the joint venture arrangement
- merger of staff from both the NHS and Department of Health with different approaches, terms of employment and method of working
- major changes in the IT infrastructure for the NHS and the means of collecting and assimilating data.

The IC acknowledged that in 2005/06 there were significant internal control weaknesses. This was due to the fact that The IC was established without the basic infrastructure and senior management team being in place and the concentrated effort of senior managers to finalise the joint venture arrangements. These weaknesses have now been largely overcome and a determined effort has been made to establish much tighter internal controls during 2006/07.

A detailed action plan has been implemented including detailed controls and assurance for risks at both a strategic and operational level. The key corporate strategic risks are reviewed in detail by the audit and risk management committee which has been charged by the board to oversee and report on assurance arrangements for the whole organisation.

Tim Straughan
Acting chief executive
12 July 2007

Chapter 5
We're reducing the burden on the frontline staff



'during 2006/07, ROCR saved the NHS in total the equivalent in time of 120 full-time posts'

The IC made significant achievements during the year in streamlining requests for data made to frontline staff. Our aim is to ensure that the data we ask staff to provide will produce valuable and relevant information that is not already available somewhere else.

Review of Central Returns

Our Review of Central Returns (ROCR) is the process by which we consider applications from the Department of Health and other central bodies to carry out new or updated data collections within the NHS. It also reviews current data collections to ensure they are still valuable and efficiently carried out.

Highlights:

- Last year, ROCR reduced by 11 per cent the burden placed on NHS staff by central data collections – stopping 11 collections entirely.
- Of 120 applications for new or adjusted collections, 13 (11 per cent) were changed as a result of ROCR to save the NHS the equivalent of 69 full-time posts.
- This meant, during 2006/07, ROCR saved the NHS in total the equivalent in time of 120 full-time posts.
- It also processed applications more quickly, with average turnaround times cut from 39 to 33 days.

Co-ordinating the regulators

The IC introduced new processes during the year to ensure that healthcare regulators co-ordinate the information they gather from the NHS.

To achieve this, we carried out an audit of all the information collected by the 20 members of the Healthcare Concordat – which includes regulatory bodies such as the Healthcare Commission, National Audit Office, Audit Commission, NHS Litigation Authority and the Commission for Social Care Inspection.

The results were included in an expanded version of The Information Catalogue – an online tool produced by The IC giving users access to a list of every collection carried out by the Department of Health and, now, Healthcare Concordat members. www.ic.nhs.uk/infocat

Highlights:

- Through the audit, The IC identified that the NHS Litigation Authority (NHSLA) was collecting data already available elsewhere and was able to discontinue the collection, saving the NHS the equivalent in time of six full-time posts as well as saving considerable time for the NHSLA.

ROCR-Lite

The IC introduced ROCR-Lite as a voluntary process which regulators go through before carrying out any new data collections from the NHS.

Highlights:

- Through ROCR-Lite, we identified that the NHS Counter Fraud and Security Management Service was applying to carry out an annual survey about assaults on staff – similar to part of an existing survey already conducted each year by the Healthcare Commission.
- The IC was able to broker an agreement between the two bodies who decided to carry out a single collection, which met both their needs and did not require additional input from NHS staff.

Strategic Information Group for Adult Social Care

Previously known as the Technical Working Group, The IC's Strategic Information Group for Adult Social Care ensures any new data collections from council social services departments are relevant, useful and do not duplicate information already collected. It also assesses the feasibility of developing new collections.

During the year, the group gave councils a bigger say in how social care collections are developed by working in partnership with the Association of Directors of Adult Social Services.

Highlights:

- We surveyed councils on how equipment such as handrails and stairlifts helped their clients to live at home. This is being developed into a comprehensive survey of users of community equipment and will be carried out this year.
- We surveyed councils on how the abuse of vulnerable adults is reported in their area. We are using this information to develop a new data collection on this increasingly significant area.

Chapter 12
Statement of internal control

Scope of responsibility

As accounting officer, I have responsibility, together with the board of The IC, 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 officers' memorandum issued by the Department of Health.

I assumed the responsibility of accounting officer on 2 July 2007 following the resignation of the previous accounting officer. However, having reviewed the relevant documentation, had discussions with management, internal and external auditors and also taken into account my knowledge and experience of The IC, I am able to accept responsibility for the conclusions of this statement.

On 1 April 2005 The IC was formed as a special health authority. The senior departmental sponsor in the Department of Health is responsible for ensuring that The IC procedures operate effectively, efficiently and in the interest of the public and the NHS. I provide regular business and financial reports to The IC board.

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.

Significant progress has been made to strengthen the internal control procedures during the year and resolve the weaknesses identified in 2005/06. In particular, the financial environment has strengthened with a refining of processes and the change in the outsourced supplier to Shared Business Services.

The risk and control framework

Corporate risks are aligned to The IC's aims and objectives and the issues affecting their achievement. Functional risks relate to the operations of The IC. These risks are monitored and controlled using an agreed process. Evaluation of risks is carried out using a standard methodology, whereby a range of financial or impact values are defined and applied to each identified risk.

The risk management process was established to address the immediate operational and strategic business risks. This was the subject of executive overview and scrutiny by the audit and risk committee and board.

During 2006/07, The IC concentrated on the following key risk management priorities:

- finance, to effectively manage the financial position and ensure system controls following the change in the outsourced supplier
- monitoring of its joint venture arrangement
- operational processes, to maintain service continuity and capacity
- organisational change, to manage the closure and relocation of various offices and re-establish the various functions in Leeds
- communications, both internal and external
- human resources function transferred from outsourced supplier to an internal arrangement.

Chapter 11
Statement of the board and chief executive's responsibilities

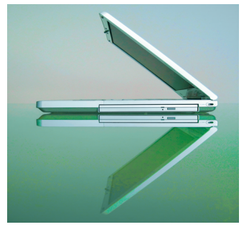
Under the National Health Service Act 2006 and directions made thereunder by the secretary of state with the approval of the Treasury, The IC is required to prepare a statement of accounts for each financial year in the form and on the basis determined by the secretary of state. The accounts are prepared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

The accounting officer for the Department of Health has appointed the acting chief executive of The IC as the accounting officer, with responsibility for preparing The IC's accounts and for transmitting them to the comptroller and auditor general. Specific responsibilities include the responsibility for the propriety and regularity of the public finances and the keeping of proper records.

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, and
- prepare the financial statements on a going concern basis, unless it is inappropriate to presume that The IC will continue in operation.

Chapter 6
Where are we going next?



In March 2007, The IC published its business plan outlining our strategic objectives for 2007/08.

They are to:

- take on wider responsibility for information within the health and social care sector
- continue to raise awareness and understanding of The IC and help customers realise the benefits of our products and services
- conduct a rolling review of our existing data collections and services
- strengthen our role in information governance, quality and independence.

Central to our aims is the future development of the Secondary Uses Service, in partnership with NHS Connecting for Health. Through the service, we want to provide a single, secure data management environment that delivers:

- the ability to construct consistent comparators and indicators, and
- the opportunity to reduce the 'transaction costs' of implementing system reforms.

Our objectives for the year also include eight key projects that focus on meeting specific customer need:

1. To support effective use of the NHS's drugs budget

Under this project, The IC will develop information showing the extent to which GPs follow National Institute of Clinical Excellence guidelines when prescribing drugs, and the extent to which patients 'cash in' prescriptions they have been given. We will also study the feasibility of developing information that shows whether patients are taking their medications as instructed.

2. To support patient choice

The IC will continue to build and improve the data it supplies to NHS Choices – a new website designed to help patients decide where to go for treatment.

3. To integrate NHS and independent sector information

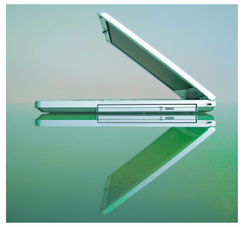
With the independent sector providing an increasing proportion of NHS care, The IC aims to ensure high quality data for all NHS-funded care by including independent sector providers within its stakeholder and reference groups. We will also extend our support and guidance to independent sector providers and produce data quality assessments for the sector. In addition, we will work with key agencies, the Healthcare Commission, Department of Health, NHS Connecting for Health and the independent sector to agree and implement a strategy for aligning information across the NHS and independent sector in order to enable comparable assessments to be carried out.

4. To help improve the financial health of the NHS

The IC will develop key indicators to reflect the financial 'well-being' of NHS organisations using the Electronic Staff Record (ESR) and other comparative data. We will explore the feasibility of applying these indicators nationally through a pilot project with Yorkshire and Humber Strategic Health Authority.

5. To support the development of the ESR

The IC will work with the contractors developing the ESR to ensure its data can be used to its full potential to support The IC's growing range of workforce-related publications.



6. To integrate health and social care information about older people

The IC will produce a publication providing an integrated picture of health and social care services for older people in England. Our aim is to encourage and support care organisations to better co-ordinate the way they plan and deliver services to this group.

7. To support PCTs and practices in their efforts to commission services more effectively

The IC will develop resources and training packages to help PCTs and practices understand and use information to improve the way they commission local services.

8. To encourage clinicians to use data

The IC will work with clinicians to raise awareness about the range of available information that is relevant to their clinical practice. In particular we, together with an academic institution and South East Coast Strategic Health Authority, are working with clinicians to find ways of extracting clinically meaningful analyses from existing data flows. The aim is to encourage improvements in data quality and support better care for patients.

Amounts paid to non-executive directors were as follows:

	Salary including performance pay (£000) 2006/07	Salary including performance pay (£000) 2005/06	Real increase in pension and related lump sum at age 60 (£000)	Total accrued pension at age 60 at 31/3/07 and related lump sum (£000)	CETV at 31/3/07 (£000)	CETV at 31/3/06 (£000)	Real increase in CETV after adjustment for and changes in market investment factors (£000)
Mike Ramsden Chairman	65-70	60-65	-	-	-	-	-
Anthony Allen	10-15	5-10	-	-	-	-	-
Lucinda Bolton	5-10	5-10	-	-	-	-	-
Roger Clarkson	5-10	0-5	-	-	-	-	-
Anthony Land	5-10	5-10	-	-	-	-	-
Michael Pearson	5-10	5-10	-	-	-	-	-

Cash equivalent transfer values

A cash equivalent transfer value (CETV) is the actuarially assessed capitalised value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member's 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 benefits accrued in their former pension 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 disclosure applies.

The CETV figures, and from 2003/04 the other pension details, include the value of any pension benefit in another scheme or arrangement which the individual transferred to the civil service pension arrangements and for which the civil service vote received a transfer payment commensurate to the additional pension liabilities being assumed. 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. CETV's are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries.

Real increase in CETV

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

Tim Straughan
Acting chief executive
12 July 2007

Emoluments of board directors

The remuneration relating to all directors in post during 2006/07 is detailed on the tables below which identifies the salary, other payments, allowances and pension benefits applicable to executives and non-executives and are subject to audit. Emoluments of executive directors consist of basic pay. No non cash remuneration or benefits in kind were paid.

	Salary including performance pay (£000) 2006/07	Salary including performance pay (£000) 2005/06	Real increase in pension and related lump sum at age 60 (£000)	Total accrued pension at age 60 at 31/3/07 and related lump sum (£000)	CETV at 31/3/07 (£000)	CETV at 31/3/06 (£000)	Real increase in CETV after adjustment for and changes in market investment factors (£000)
***Denise Lievesley** Chief executive	160-165	95-100	7.5-10	5-10	43	-	30
***Tim Straughan** Director of finance and corporate services	115-120	45-50	2.5-5.0	5-10	21	7	10
Phil Wade Director of business development and communications (appointed 5 June 2006)	90-95	-	2.5-5.0	0-5.0	13	-	7
Roger Dewhurst Director of operations (appointed 7 August 2006)	70-75	-	0-2.5	95-100	379	360	4
John Fox Executive director of statistics (resigned 30 June 2006)	50-55	100-105	(2.5)-0	45-50 plus 140-145 lump sum	1,093	1,162	(15)

* Salaries in 2005/06 were for a part year only.
* Denise Lievesley resigned as chief executive on 2 July 2007. Tim Straughan was appointed as acting chief executive and accounting officer on the same date.

Chapter 7
Our board members

Mike Ramsden
chairman

Mike began his career in the NHS in 1977 and went on to become chief executive of Wakefield Family Health Services Authority in 1989, chief executive of Leeds Family Health Services Authority in 1992 and chief executive of Leeds Health Authority in 1999.

In 2002, he left the NHS to become a director of two companies specialising in consultancy and management services. At the same time he established Smartrisk Foundation (UK), a charity dedicated to preventing injuries, particularly among children.

Professor Denise Lievesley
chief executive (resigned 2 July 2007)

Denise joined The IC in July 2005 from the United Nations Educational, Scientific and Cultural Organization (UNESCO) where, as director of statistics, she established a new Institute for Statistics.

Prior to joining UNESCO, she was director of the UK Data Archive and Professor of Research Methods in the mathematics department at Essex University.

Although based in Paris and Montreal while at UNESCO, Denise retained her academic links with the UK, as an honorary professor at the University of Durham and a visiting professor at City University London where she received an honorary doctorate.

Denise is due to take up her role as president of the International Statistical Institute in the summer of 2007.

She is a fellow of University College London, a former president of the Royal Statistical Society and the International Association for Official Statistics and is currently the international member of the Board of the American Statistical Association.

On 17 January 2006 Denise was appointed as a non-executive director of Dr Foster Intelligence (DFI) to represent The IC's 50 per cent shareholding in the company. She resigned as chief executive of The IC and as a non-executive director of DFI on 2 July 2007.

Tim Straughan
deputy chief executive (acting chief executive from 2 July 2007)

Tim Straughan was appointed director of finance and corporate services and deputy chief executive on 1 October 2005. He become acting chief executive of The IC on 2 July 2007.

Tim joined The IC from NHS Estates where he was acting chief executive and before that finance director.

Tim is a chartered accountant and trained with KPMG. He is also a qualified dentist with experience of working in general practice, hospital and community facilities.

Phil Wade
director of business development and communications

Phil joined The IC in June 2006 from the University for Industry where, as group director of marketing, research and policy, he played a pivotal role in establishing learndirect, the government's flagship adult learning initiative, as a national brand.

He has developed and marketed products and services for leading blue chip companies such as Mars, Del Monte and Pfizer. He has also worked for the global market research leader, Nielsen Research.

Roger Dewhurst
operations director

Roger joined The IC in August 2006 from Greater Manchester Strategic Health Authority, where he was chief information officer.

He has extensive experience of ICT and information management gained from the private sector (including Secta, CSL and CACI) and has worked in senior positions in both the NHS and local government where he has managed a number of large, cross-agency projects.

Tony Allen vice chairman non-executive director

Tony was a partner at PricewaterhouseCoopers until 2005, advising a wide range of corporations, both public and private.

From 2001, he was the lead partner for the firm's services to the NHS and to the Department of Health. He also led on governance and the effectiveness of boards.

He was appointed as an independent member of the Department for Education and Skills' audit committee in 2005 and the Department of Health's audit committee in 2007. He is a trustee of The Wigmore Hall Trust and a director of informatics company Datamonitor plc and family-owned health food retail company, Allen's Wholefoods Limited.

Lucinda Bolton
non-executive director

Lucinda is a former executive director of an investment bank and has held a number of public and voluntary sector appointments.

These include the chair of Hammersmith and Fulham PCT (2002/03), chair and non-executive director of Riverside Community Healthcare NHS Trust (1998/02), a board member of Tower Hamlets Housing Action Trust (1996/04) and director of Old Ford Housing Association (1998/01).

She is a member of the Review Body for Nursing and Other Health Professions, a governor of Thames Valley University and an independent assessor at the Department of Culture, Media and Sport.

Lucinda has also held several private sector non-executive directorships.

Information and statistical governance meetings in 2006/07 – attendance of committee members

Name	Apr-06	Jul-06	Oct-06	Feb-07
Executive team				
Denise Lievesley	✓	✓	✓	✓
Non-execs				
Lucinda Bolton	✓	✓	✓	✓
Anthony Land	×	✓	✓	×
Mike Pearson	✓	✓	✓	✓

Remuneration committee meetings in 2006/07 – attendance of committee members

Name	May-06	Jun-06	Dec-06
Mike Ramsden	✓	✓	✓
Tony Allen	✓	✓	✓
Lucinda Bolton	✓	✓	✓

DFI board meetings in 2006/07 – attendance of The IC's representatives

DFI board meetings	Apr-06	May-06	Jun-06	Jul-06	Sep-06	Oct-06	Nov-06	Dec-06
Denise Lievesley	✓	✓	✓	✓	✓	✓	✓	✓
Roger Clarkson	✓	✓	✓	✓	✓	✓	✓	✓
Anthony Land	✓	✓	✓	✓	✓	✓	✓	✓

DFI board meetings	Jan-07	Feb-07	Mar-07
Denise Lievesley	✓	✓	✓
Roger Clarkson	×	✓	✓
Anthony Land	✓	✓	✓

The IC board meetings in 2006/07 – attendance of board members

Name	May-06	Jun-06	Sep-06	Oct-06	Dec-06	Jan-07	Mar-07
Executive team							
Denise Lievesley	✓	✓	✓	✓	✓	✓	✓
Tim Straughan	✓	✓	✓	✓	✓	✓	✓
Phil Wade	AJ06	✓	✓	✓	✓	✓	✓
Roger Dewhurst	AA06	AA06	✓	✓	✓	✓	✓
John Fox	✓	✓	RJ06	RJ06	RJ06	RJ06	RJ06
Chair and non-execs							
Mike Ramsden	✓	✓	✓	✓	✓	✓	✓
Tony Allen	✓	✓	✓	✓	✓	✓	✓
Lucinda Bolton	✓	✓	✓	✓	✓	✓	✓
Roger Clarkson	✓	✓	✓	×	✓	✓	✓
Anthony Land	✓	✓	✓	✓	✓	×	✓
Mike Pearson	✓	✓	✓	✓	✓	✓	✓

Key: AJ06 = appointed 5 June 2006, AA06 = appointed 7 August 2006, RJ06 = retired 30 June 06

Audit and risk committee meetings in 2006/07 – attendance of committee members

Name	May-06	Jun-06	Sep-06	Oct-06	Dec-06	Jan-07	Mar-07
Tony Allen	✓	✓	✓	✓	✓	✓	✓
Lucinda Bolton	✓	✓	✓	✓	✓	✓	✓
Roger Clarkson	×	✓	✓	×	✓	✓	✓
Mike Pearson	×	✓	×	✓	✓	✓	✓

Anthony Land
non-executive director

Since he retired in 2000, Anthony has completed a range of advisory assignments for the board and chief executive of the Kensington and Chelsea Primary Care Trust in London, the General Social Care Council, the Social Care Institute for Excellence and the Equal Opportunities Commission.

He has been a non-executive director of the Book Trust, the European Office of Consumer Organisations in Brussels and the Kensington Society.

Since January 2006, Anthony has been non-executive director of Dr Foster Intelligence representing The IC's 50 per cent shareholding in this joint venture. He was chair of the DFI board throughout 2006 and remains a member of its audit and remuneration committees.

Professor Michael Pearson
non-executive director

Michael has been a consultant physician at University Hospital Aintree since 1984. He was director of the clinical effectiveness and evaluation unit at the Royal College of Physicians (RCP) between 1997 and 2006 and director of clinical standards for the RCP between 2005 and 2006. His role at the RCP included leading the development of national clinical guidelines on behalf of the National Institute for Health and Clinical Excellence and establishing national comparative audits linked to the Healthcare Commission.

In 2006, he stepped down from the RCP and took up a new chair in clinical effectiveness at the University of Liverpool where he continues to develop national projects to evaluate clinical outcomes.

He has previously served on the national clinical advisory board of the National Programme for IT and on the interim executive of the NHS Care Records Development Board.

Roger Clarkson
non-executive director

Roger is a national advisor to the Department of Communities and Local Government working in e-government and local government modernisation.

With a career working almost equally in the public and private sectors, he was most recently in senior management roles in a global consultancy firm, working with public sector clients. He has led major customer-focused change programmes within a wide range of organisations.

Roger is a non-executive director of Dr Foster Intelligence to represent The IC's 50 per cent shareholding in the company.

Management reports

Chapter 10
Remuneration report

This report for the year ended 31 March 2007 deals with the pay of the chair, chief executive and other members of the board.

Remuneration committee

The pay of the executive board directors is set by the remuneration committee and is reviewed on an annual basis. The remuneration committee consists of three non-executive directors (including the chairman) and all are required to be present. It is chaired by the board chairman Mike Ramsden.

The chief executive and other executive directors are not present for discussions about their own remuneration and terms of service, but may attend meetings of the committee at the chairman's invitation to discuss other employees' terms.

The work of the committee is supported and administered by the chief executive and appropriate staff.

In reaching its recommendations, the remuneration committee took into account:

- the need to recruit, maintain and motivate suitably able and qualified people to exercise their responsibilities
- variations in the labour market and their effects on the recruitment and retention of staff
- recommendations of the Senior Salaries Review Body, Pay Negotiating Council and other Department of Health guidelines.

Remuneration policy

The IC aims to pay employees on a fair and equitable basis for the role and responsibilities they undertake in line with best practice within the NHS. Each employee's job has been evaluated under the Agenda for Change (AfC) programme.

Staff who continue on civil service terms and conditions will continue to receive performance related pay (PRP) in line with the Department of Health collective agreements. Staff on NHS terms and conditions may receive increments within their pay-scale under AfC guidelines. This will either be the annual increment or the gateway review depending on an individual's service and their point within the band.

Both PRP and AfC increments will be linked to a single individual performance and development review mechanism.

Bonus payments were limited to:

- a non-consolidated bonus in line with the civil service scheme for a number of ex-civil service staff by virtue of Transfer of Undertakings Protection of Employment (TUPE).
- outstanding payment of bonus payment made by West Yorkshire Strategic Health Authority for a number of NHS staff TUPE'd from this organisation.

The remuneration committee is currently considering the introduction of a bonus scheme for senior managers but will keep a watching brief on any further guidance released by the Department of Health.

Service contracts

The chief executive and all other members of the senior management team are employed under permanent employment contracts with a six month notice period and work for The IC full-time. If their contracts are terminated for reasons other than misconduct, they will come under the terms of the NHS compensation schemes.

Non-executive directors are appointed through the NHS Appointments Commission and its terms and conditions apply to them. Each non-executive director is appointed for four years from the date of their appointment. They are not entitled to compensation for loss of office or the early termination of appointment.

Fixed asset investments

The IC entered into a partnership arrangement with Dr Foster Ltd to create the business known as Dr Foster Intelligence (DFI). This was announced by ministers on 17 January 2006 and formally launched on 13 February 2006. This arrangement aims to provide significant opportunities to best utilise private sector expertise and skills to generate improved value-added information tools for use across the health and social care sector.

The IC invested £12 million to purchase a 50 per cent stake in DFI and provide initial working capital of which £9.5 million was paid immediately and a promissory note for a further £2.5 million is to be settled in July 2007. In addition, some staff have been seconded and certain software products transferred to DFI.

The first full year of the joint venture generated a loss of £2.8 million. This result is affected by a one-off change in the accounting policy with respect to the treatment of income from the sale of licences of £1 million, together with a goodwill write-off of £1 million. It is expected that a surplus will be achieved in 2007/08 and beyond. The IC has accounted for the joint venture as a fixed asset investment and therefore does not account for the trading loss in 2006/07.

In accordance with the financial reporting standard, FRS6 Accounting for Acquisitions and Mergers, a valuation of DFI has been undertaken to support the value of the investment stated in the balance sheet. This valuation carried out by PricewaterhouseCooper (PwC) supports the board's view that the valuation of the current investment is fair.

Residuary body

Following the dissolution of the NHS Information Authority, The IC became responsible for collecting outstanding debts and paying outstanding creditors. Most material balances were resolved during 2005/06. A net credit of £38k in 2006/07 largely relates to Inland Revenue refunds arising from earlier years.

Chapter 8
Introduction

On 22 July 2004 the secretary of state for health announced plans to cut the number of bodies working at 'arms length' from the Department of Health. This was followed by the publication of *An Implementation Framework for Reconfiguring the Department of Health's Arm's Length Bodies* (22 July 2004) which said that the NHS Information Authority would be dissolved, with certain functions transferring to two successor organisations: NHS Connecting for Health and the Health and Social Care Information Centre - now The Information Centre for health and social care (The IC) - with effect from 1 April 2005.

The IC was created on 1 April 2005 as a special health authority under the Health and Social Care Information Centre (Establishment and Constitution) Order 2005. The IC inherited various information-related functions from the NHS Information Authority, the Department of Health, West Yorkshire Strategic Health Authority and NHS Estates.

The accounts have been prepared under a direction issued by the secretary of state in accordance with section 232 (schedule 15, paragraph 3) of the NHS Act (2006) and have been prepared in accordance with the guidelines set out in the Government Financial Reporting Manual (FREM).

Principal activities

The principal activities of The IC are to co-ordinate and undertake the capture, production and dissemination of unbiased, credible and comparable information relating to health and social care. In addition, The IC aims to lead information policy development and contribute to wider policy development and research, ensuring information is at the heart of decision-making.

The IC provides a diverse range of services including:

- NHS clinical datasets service
- national clinical audit services and support for conditions including heart disease, diabetes and cancer
- casemix services, including the development of healthcare resource groups to support Payment by Results
- NHS care record Secondary Uses Services
- population and geography data services, and
- production and publication of a diverse range of statistics on topics such as birth and contraception, sickness and health, work and pay, prevention and cure, lifestyle and inequalities and prescriptions.

Corporate governance

The IC is committed to ensuring a high standard of corporate governance. Its board has responsibility for defining strategy and determining resource allocations to ensure the delivery of The IC's objectives. The board has three committees to assist it - the audit and risk committee, the remuneration committee and the information and statistical governance committee.

The audit and risk committee

The audit and risk committee advises on all matters of audit, corporate governance, risk management and internal control and reports directly to The IC board. It comprises of four non-executive directors. The National Audit Office, internal auditors, chief executive and the director of finance and corporate services attend by invitation. Meetings are held at least on a quarterly basis.

Employee policies

Equal opportunities

The IC is an equal opportunity employer. It aims to be fair to everybody and to ensure that no eligible job applicant or employee receives less favourable treatment because of their race, colour, nationality or ethnic origin, age, gender, sexual orientation, marital status, disablement, religion or religious affiliation, or is disadvantaged by conditions or requirements which cannot be shown as justifiable.

Learning and development

The IC is committed to providing employees with proper training and development to enhance their professionalism in supporting The IC's overall objectives. A comprehensive training programme has been developed and implemented.

Employee consultation

The IC is committed to informing and consulting with staff. An internal communications manager maintains an intranet site to ensure staff have access to a wide range of information relevant to The IC and the health sector at large. In addition, regular staff briefings and away days are held where senior management update staff on key issues.

Health and safety

The IC recognises and accepts its legal responsibilities in relation to the health, safety and welfare of its employees and for all people using its premises. The IC complies with the Health and Safety at Work Act (1974) and all other legislation as appropriate.

Auditors

The accounts have been audited by the comptroller and auditor general, who has been appointed under statute and is responsible to Parliament. The cost of the audit was £70,000.

The internal audit service during the year was provided by Bentley Jennison Risk Management Ltd.

The accounting officer has undertaken all steps to ensure he is aware of any relevant audit information and to ensure that The IC's auditors are aware of that information. As far as the accounting officer is aware, there is no relevant audit information of which The IC's auditors are not aware.

Chapter 9
Management commentary

The year 2006/07 saw The IC lay the foundations for its future direction. It began an ongoing process of reviewing all areas of the business in order to provide information and services that are relevant to the NHS and other users of health-related information. A strategy document has been shared and approved with all key stakeholders setting out the vision and targets for the future.

Financial results

The Department of Health allocated The IC a revenue resource limit for 2006/07 of £44.5 million including £2.5 million to cover capital charges and £2.0 million for transition costs. Due to ongoing restructure and delays in certain programme areas, The IC offered £3 million back to the Department of Health in year-end flexibility, reducing the resource limit it needed to £41.5 million. The IC also achieved a further surplus of £1.5m against this revised amount.

Like many arms length bodies, central funding is being reduced over the next few years and The IC took considerable action in the year to reduce its future cost base and generate improved value for money by:

- reducing its reliance on external contractors and agency staff from 48 per cent of total pay costs to 36 per cent in 2006/07 and negotiating improved terms with its suppliers. It plans to reduce its use of external staff still further in 2007/08.
- closing offices in Exeter, Winchester and Birmingham and relocating its London office to smaller, less expensive premises. The IC has exited from all its surplus leases except Exeter, which is being actively marketed.
- implementing an IT strategy that will significantly improve efficiency and future ways of working.
- delivering efficiencies within the core central service functions that have generated savings when compared to 2005/06.
- reviewing all areas of business to ensure that all work is of value and does not duplicate activity carried out elsewhere.

The charge for exceptional items includes:

- the costs of centralising functions to Leeds and London including all costs associated with this restructure, staff relocation expenses, redundancy, office closures, consultancy advice etc
- an increase in the lease surrender provision for the surplus properties at Exeter
- all credits and additional costs associated with the residuary body.

Capital expenditure in the year primarily relates to the relocation of the London office together with the development costs of the IT (ICIS) infrastructure and implementing the IT strategy.

Outstanding sales ledger balances were £577k, of which £289k was more than 60 days overdue although the majority relates to transactions with related parties. A bad debt provision of £6k has been made. Other debtors largely relate to the VAT recovery for February and March.

The principal financial systems were transferred from the Prescription Pricing Authority, now part of the NHS Business Services Authority (BSA), to Shared Business Services (SBS) on 1 April 2006. The provision of payroll services and payment of staff expenses remains with the BSA for the foreseeable future.