The Health and Social Care Information Centre Annual Report and Accounts 2009/10

NHS
The Information Centre
for health and social care

2009/10

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“We believe passionately in the value of high quality information, particularly in helping frontline staff deliver better services to patients.”

Tim Straughan
Chief Executive
The NHS Information Centre

Foreword

I am pleased to present the fifth annual report of The NHS Information Centre for health and social care (The NHS IC).

Over the last year, the organisation has enjoyed considerable success in its frontline focussed programmes of work designed to support social care, commissioning, workforce and clinical care.

Our resources have allowed managers, analysts and clinicians within health and social care settings to benchmark and compare their performance against others and commission the right healthcare services.

Key milestones have included the launch of the World Class Commissioning Data Packs, development of the National Adult Social Care Intelligence Service (NASCIS), our published set of clinically assured indicators and metrics and the continued development and refinement of key information reporting systems such as: NHS Comparators, NHS iView, Compendium of Public Health Indicators and the delivery of several national clinical audits including cardiac, cancer, diabetes and renal services.

Accessing information has been made easier with My IC, a new feature on The NHS IC's website which allows users to create a personalised homepage to store all their most used information resources. My IC gives users access to a library of over 250 useful data, statistical resources and tools from The NHS IC and other public sources – allowing users to store all their key information resources in one place, helping them to access the data and information they need more effectively.

Over the past year we have focussed strongly on information governance and quality: building public confidence in the security of our information systems. We have also established the Data Quality Guild, a web based networking site for data quality practitioners to share issues, problems, and, most importantly, solutions. More than 1,000 staff from over 340 health and social care organisations have joined our Data Quality Guild.

We have continued to promote the value of our information resources to health and social care professionals, exhibiting at over 30 targeted events and exhibitions across England. We have provided online demonstrations of our statistical tools, spoken at key fringe sessions and provided the opportunity for our customers to speak to our dedicated team of data experts.

By building on and exploiting data and information services, encouraging innovation and listening to the views of our stakeholders, we believe we can make an even greater contribution to health and social care in the year ahead. We will show this through demonstrable outputs of our programmes, much quicker response to changing demands and far more targeted and customer focused operations.

The next few months is a crucial period for The NHS IC which faces economic pressures, an NHS Spending Review and the outcome of the review of Arms Length Bodies. While I believe we have never been in a better position to improve care through better use of information in decision making, we will undoubtedly need to amend our plans to fit the strategic requirements of the new Government and any revision to our role.

Tim Straughan
Chief Executive
The NHS Information Centre

How we delivered

Over the last year, The NHS IC has provided access to high quality comparative data and information for benchmarking and analysis to help local organisations plan and deliver better care.

1. Improving information quality and data standards

- Developed an Information Governance Framework (IGF) to bring together relevant legislation, regulations, standards and best practice into a single document
- Implemented a Data Quality programme for data quality practitioners to share issues, problems, and, most importantly, solutions to improve data quality across the NHS. More than 1,000 staff from over 340 health and social care organisations have joined The NHS IC's Data Quality web based networking site
- Developed and published 200 clinical assured Indicators for Quality Improvement
- Developed regional learning networks through the PRIMIS+ quality and training systems to enable data quality facilitators to share ideas, knowledge and experience and to discuss best practice
- On target to meet Department of Health (DH)'s policy to reduce the burden of data collection by 30% this year through its Review of Central Returns (ROCR) process
- Established and refined a data linkage process between Patient Reported Outcome Measures (PROMs) and Hospital Episodes Statistics (HES); and the linkage between HES and Office for National Statistics (ONS) mortality has been refined and is now updated monthly. The linked data will be published in 2010/11, enabling new ways of measuring quality of care

2. Improving access to information

- Created **My IC**, a feature that allows users to create their own homepage on our website. This has enabled our customers to access and use health and social care information far more effectively and usefully. My IC gives users access to a library of over 250 useful data, statistical resources and tools from The NHS IC and other public sources – saving users time and effort accessing the information they need
- Enabled patients and the public to exercise choice by supplying indicators and directories of local health services, validating and ensuring value for money for the content for the NHS Choices site
- Led the DH contribution to the Government's "Making Public Data Public" initiative
- Published major informatics supplements in the Health Service Journal (HSJ) on commissioning, social care, and finance and performance information that have highlighted how The NHS IC's information has and can assist in key frontline decision making

120

Number of publications we published, spanning primary, secondary, community and social care, mental health and covering clinical activity, workforce and facilities

3. Providing relevant information services

Clinical

- Established a clinical directorate to lead the engagement with NHS frontline services to establish what information is needed to improve care
- Led the development of a National Diabetes Information Service (NDIS), a collaborative venture with a number of organisations working in partnership with The NHS IC (including NHS Diabetes, Yorkshire and Humber Public Health Observatory, Diabetes UK and Innove) to provide a comprehensive resource of diabetes information to improve care for people with diabetes
- Developed a Health Needs Assessment tool as part of the National Diabetes Information Service (NDIS). The tool allows users to view any PCT's performance in diabetes care against a large number of indicators
- Acted as the primary lead on several of The NHS IC developmental programmes, including General Practice Extraction Service (GPES) and PRIMIS+ training systems
- Delivered clinical audits for a wide range of conditions, including diabetes, kidney care, cancer and heart disease
- Developed a Health Check data set for vascular checks. The eligible cohort is estimated to be in the region of 15 million people in England and, at full roll out, around 3 million people will be invited for their NHS Health Check each year
- Supported Payment by Results (PbR) policy by developing best practice tariffs for stroke, cataracts, fractured neck of femur and cholosystectomy. In addition, we have also developed currencies to support the reimbursement of mental health patient care
- Provided an effective Medical Research Information Service (MRIS) service to over 500 research projects by 'flagging' cohorts of patient records in order to supply researchers with details of life events
- Played a crucial role in delivering Patient Reported Outcomes Measures (PROMS) data. The health status information collected via a questionnaire from patients provides an indication of the outcomes or quality of care delivered to NHS patients

200 **Number of clinically assured Indicators for Quality Improvement we published online**

“The first step towards improving care is to understand what it is really like. Good information including, critically, information from those who use the services is vital to achieve this.”

Richard Hamblin
Director of Intelligence
The Care Quality Commission

How we delivered continued

Public Health

- Produced 120 national statistical reports on alcohol, drugs, smoking, obesity and health inequalities, supporting commissioning decisions and public health and preventive planning
- Supported area based assessments with robust data from a range of sources using Compendium of Public Health Indicators (NCHOD)
- Released the annual National Health Survey for England
- Released the annual Online GP Quality and Outcomes Framework (QOF) database

Finance and performance

- Added 62 new comparators to our NHS Comparators statistical tool including new maternity indicators which now has a user base of 6,000 registered users

  NHS Comparators is a comparative analytical tool that enables commissioners and providers to improve the quality of care delivered by benchmarking and comparing activity and costs on a local, regional and national level
- Launched a World Wide Web version of the NHS Comparators tool
- Supplied quarterly data to the Audit Commission to power around 50 indicators on the award winning PbR Benchmarker tool
- Secondary Uses Service (SUS) Release 4 delivered Referral to Treatment (RTT) reporting products into live pilot
- SUS Release 5 delivered the improved PbR Online service, which gives NHS organisations the ability to run their own data extracts for PbR data covering Admitted Patient Care, Outpatients and Accident and Emergency (A&E)

Commissioning

- Successfully launched the World Class Commissioning Data packs
- Developed three data sets to support the Women, Children's and Young People's National Service Framework namely: the Maternity, Child Health and Child and Adolescent Mental Health Services Data Sets. These data sets will support the ongoing monitoring of quality of care and service provision and will support commissioning

Social care

- Launched National Adult Social Care Intelligence Service to disseminate integrated social care, health and wellbeing data
- Developed Joint Strategic Needs Assessment indicators to support effective commissioning across health and social care

Workforce

- Successfully launched annual and monthly workforce data on NHS iView allowing users to view data, generate charts and make comparisons
- Produced additional statistical workforce publications, including sickness absence
- Implemented a data quality cycle which now feeds back to NHS organisations each month giving comparative information on the quality of workforce information held with ESR (the Electronic Staff Record)

Working with the independent sector

- Held seminars for private sector suppliers into the NHS Information services market and addressed concerns as they have arisen
- Provided advice and support to new entrants to the NHS information services market.

Who we are

The NHS IC is England's central, authoritative source of health and social care information for frontline decision makers.

Our aim is to revolutionise the use of information to improve decision making, deliver better care and realise increased productivity.

What we do

We collect, analyse and present national data and statistical information from across the health and social care information sector and make sense of it so health professionals can make use of it. From tackling health inequalities to commissioning with confidence, our information ensures decision makers from across the sector deliver the very best services and patient care.

Our information is of value to a wide range of health and social care decision makers including commissioners, public health analysts, clinicians and informatics professionals in health and social care, as well as the public via the NHS.

We are uniquely positioned to deliver a wide range of credible information resources to support the transformation in the NHS including, detailed level data on Hospital Episode Statistics (HES), through to community and mental health (MHMDS), primary care (QOF), dental activity, population health, clinical audit and social care information.

The NHS IC produces a wide range of information including:

- Population health analysis and health surveys
- Health screening
- Clinical quality
- Prescribing
- Care activity
- Waiting times and efficiency
- Adult social care
- NHS workforce
- Estates and facilities

Our mission

To drive the use of information to improve the quality and effectiveness of decision making resulting in the delivery of better care

6,000

Number of registered users to NHS Comparators

1,618

Number of registered users to the National Adult Social Care Intelligence Service (NASCIS)

1,000

Number of Parliamentary Questions (PQ's) answered

Our strategic objectives 2010/11

The NHS IC has a pivotal role to play in delivering:

- Trusted information critical to decision making and public accountability
- Standardised measures and national comparisons which are key to improvement
- Savings through the rationalisation of information services from other parts of the system

Objectives

1. High Information Quality and Standards

Ensure the right quality information is provided, using clear governance and standards in data and data collections

2. Better Access

Improve access to and interpretation of information through better presentation and reporting

Ensure fair and equal access to the information

3. Relevant Information Services

Deliver the information frontline services need to meet their priorities

Be the source of data for official statistics published by DH, Care Quality Commission (CQC) and other bodies for the purposes of accountability

Our customers

Our information is of value to a wide range of health and social care decision makers in frontline organisations, including commissioners, public health analysts, clinicians and informatics professionals in health and social care.

We also support policy makers, central government, regulators and the public including patients.

The challenge for The NHS IC is therefore to meet these divergent demands in the most efficient manner, by collating information in a standardised, flexible way and analysing and presenting it appropriately to meet the needs of the particular customer audience.

Our partnerships

We recognise the value of collaborative partnerships with a wide range of information providers and users in the health and social care market and actively engage with and support the private sector information market.

Regular supplier seminars are hosted which allow for an update of key policy drivers, developments and an exchange of views and opinions. The introduction of Re Use of Public Sector Information has led to a notable increase in the number of organisations entering the NHS information market and a step-change in the level of product sophistication available.

The NHS IC joint venture company, Dr Foster Intelligence, continues to influence and shape the health information agenda, helping to create new opportunities by engaging in thought leadership at all levels of the NHS and Government. During 2010/11 The NHS IC will further develop its relationships with the market as a whole, while keeping the existing strategic rationale for the joint venture relationship under review.

How we are supporting quality, efficiency and productivity

The challenge

"The need is to take an evidence based approach to the quality and productivity challenge"
David Nicholson, NHS Chief Executive

Our response

Through the provision of tools and analyses such as the Indicators for Quality Improvement (IQI) and NHS Comparators with costs and benchmarking data, we are enabling organisations to make evidence based decisions on local activity, costs and outcomes, supporting the continued transformational efficiency of local services.

We are also joining up sources of data and syndicating this to provide a more comprehensive picture of health and social care. Our information helps encourage quality, innovation, productivity and prevention.

“By aligning information for clinicians to improve services, and managers to determine priorities around the quality agenda, these two worlds start to overlap much more significantly.”

Dr Mark Davies
Executive Medical Director
The NHS Information Centre

Our strategic priorities 2010–14

The NHS IC plans to continue to provide the NHS and social care frontline services with timely, flexible, good quality benchmarking and comparative data at a local rather than a national level.

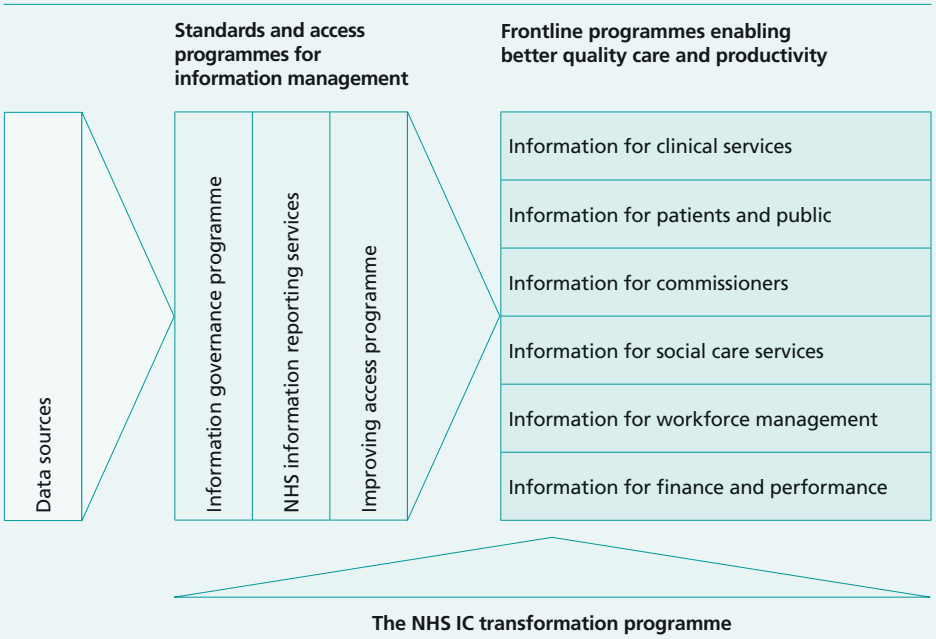
Our data and information will help local organisations plan better local care and help reduce the informatics costs of frontline services.

Priorities

- Increase access to data on primary and acute performance so the public and patients can have access to information to help them choose and manage their care and enable clinicians and managers to improve quality by measuring satisfaction
- Ensure high quality information is provided right across the system; ensuring the right information is provided, using clear governance standards in data and data collections
- Deliver the information frontline services need e.g. Indicators for Quality Improvement, information reporting, workforce data and National Adult Social Care Intelligence Services to improve the needs of those delivering care, allowing them to put information at the heart of their decision making
- Increase our emphasis on linking different types of information, to give managers, commissioners and clinicians insights into complete pathways of care rather than individual elements of individual care providers
- Increase availability of comparative data for benchmarking and analysis so NHS organisations can shape key improvement activities and monitor implementation

Our detailed priorities will be agreed taking direction from the new administration and in consideration of available funding.

Our key programmes of work



Summary of key programmes

Frontline programmes enabling better quality care and productivity

Programme	Aims	How it will be implemented
Information for clinical services	» To meet the information needs of the clinical community in the NHS » To support the new quality framework identified in the Next Stage Review	• Clinical Indicator development • Population health – compendium and publications • Quality and Outcomes Framework • Clinical audit • National Diabetes Information service • Clinical engagement strategy
Information for patients and public	» To drive up quality by publishing comparative performance data » To facilitate the work of government and drive for open and public access to data	• Clinical Indicators to NHS Choices • PROMS provision/syndication • Health and social care response to "Making Public Data Public" • Organise patient consultation groups for general development and also Information Governance
Information for commissioners	» To support world class commissioning so commissioning decisions are based on good analysis and accurate information that can directly lead to cost savings and directly improve patient care	• My IC commissioning tool for analysis of key 'pathways' • NHS Comparators development • Targeted events and communications
Information for social care services	» To provide comparative information and analysis to support the transformation of adult social care services and development of data standards to underpin this	• Maintenance and update of National Adult Social Care Intelligence Service • 5 new collections • 3 new publications • Information to DH for measuring adult social care productivity • Ongoing review of social care collections
Information for workforce management	» To use Electronic Staff Record (ESR) data to provide accurate and timely workforce details of 1.3m employee records on a consistent and comparable basis » Use this data to replace the annual manual census and make accessible to the NHS iView workforce service	• Widen iView access • Enhance GP data • Vacancy surveys • NHS staff numbers • Quarterly / annual publications • Data standards development
Information for finance and performance	» To take an active role in the DH steering group to help develop their agenda for accurate, timely, transparent information to support its use at PCT, SHA and DH when reviewing the performance of NHS providers	• NHS management dashboard • 'Better care, better value' indicators • Wider access of relevant metrics e.g. SHA metrics, mental health prevalence and cost • PBR development and PBR extracts service • Estates, workforce and prescribing information

Standards and access programme for information management

Programme	Aims	How it will be implemented
NHS Information Reporting	» To meet the requirements of 'High Quality Care for All' and the 'NHS Next Stage Review'	• NHS Analysis and Reporting Service • General Practice Extraction Service • Honest Broker Services • Continued SUS delivery • NHS Comparators (new indicators) • New publications (critical care and PROMs)
Information Governance programme	» To improve protection of patient confidential information and access for secondary uses including research. Improved quality of data used in patient treatment resulting in a reduced risk to patient safety » To reduce burden of unnecessary collections	• Feasibility study FIMs / UNIFY transition • Information Governance Compliance Unit • Independent NHS IC advisory function • Procure and implement data quality improvement service for primary and community settings
Improving access to information programme	» To improve the responsiveness of The NHS IC information services to frontline and central customers whilst ensuring the highest standards of information and statistical governance	• New customer request delivery process • Continue to develop web portal and 'My IC' personalised profiles • Data management environment to deliver standardised processes for information analysts in The NHS IC • 'iView' data updates • Master Catalogue of information and services • Data Depot for secure dissemination of data • Document and Records Management systems and processes

19

Number of Hospital Episode Statistics (HES) publications we released

67%

Percentage of haemodialysis patients that took part in our patient transport survey for the National Kidney Care Audit

54%

Increase in publication downloads from our website, with total downloads now at 510,910

Board member profiles

Mike Ramsden
Chairman

Mike was appointed as chairman of The NHS IC in 2005.

He is also director of two companies specialising in consultancy and management services and the founder of Smartrisk Foundation (UK), a charity focussed on preventing injuries, particularly amongst children. Previously he worked within the NHS for 26 years, including chief executive positions with Leeds Health Authority, Leeds Family Health Services Authority and Wakefield Family Health Services Authority.

Mike was appointed part time chief executive of the National Association of Primary Care in October 2007

Tony Allen
Vice Chairman

Tony was appointed as vice chairman of The NHS IC in 2005.

He is chairman of The Chislehurst Society, an independent member of Department of Health Audit Committee and an independent member of the Department for Children, Families and Schools Audit and Risk Committee.

Previously Tony was lead partner at PriceWaterhouseCoopers for services to the NHS and to the Department of Health.

He also led on governance and the effectiveness of boards for the organisation and advised a wide range of public and private corporations.

Tim Straughan
Chief Executive

Tim was appointed chief executive of The NHS IC in 2007. He originally joined as director of finance and corporate services and deputy chief executive six months after its creation in April 2005 and was responsible for the recruitment and migration programme that established the organisation in their Leeds headquarters.

Before that he was acting chief executive of NHS Estates and had a number of years of frontline NHS experience.

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
Executive Director of Business Development and Communications

Phil joined The NHS IC in 2006 from the University for Industry where as group director of marketing, research and policy he played a pivotal role in establishing learndirect as a national brand.

Phil has a strong track record in the commercial sector; successfully developing and marketing products and services for leading blue chip companies such Mars, Del Monte and Pfizer.

Prior to this he worked across numerous sectors with Nielsen Research, the global market research leader.

Trevor Doherty
Executive Director of Finance & Performance

Trevor joined The NHS IC in August 2009.

Previously he was director of health informatics at Tribal Group, working across NHS Connecting For Health and The NHS Information Centre as a Payment by Results lead for the Secondary Uses Service.

He was a member of the Audit Commission Payment by Results External Advisor Group, the Department of Health Payment by Results External Advisory Group and the Department of Health Mental Health Payment by Results Development Board. Earlier, as a director in Tribal's Health Practice, Trevor led on the development of new analytical tools to assist in decision making for projects, training and education in teaching hospitals, healthcare speciality costing and examining future financial stability for foundation trusts.

Before becoming a management consultant, roles within the NHS include director of planning and director of finance in two major teaching hospitals. He was a founder member of NHS Executive Private Finance Unit. An accountant and strategic planner, Trevor is a fellow of the Chartered Institute of Management Accountants (FCMA).

Clare Sanderson
Executive Director of Information Governance

Clare was appointed as executive director of information governance of The NHS IC in 2008.

Previously she worked as an independent information management consultant, providing support to the NHS across all organisation levels.

Clare has worked for a number of respected consultancy firms and also worked in NHS information services for more than 25 years, initially at both a regional and local health authority in the Northwest.

Her expertise in information management and governance has enabled The NHS IC to develop a robust information governance approach to its work programmes.

Clare graduated from Leeds University with an Operational Research and Statistics degree.

Brian Derry
Executive Director of Information Services

Brian joined The NHS IC in 2008.

Prior to this he was on secondment from his role as director of informatics at Leeds Teaching Hospitals NHS Trust, as programme director for implementing the Health Informatics Review at NHS Connecting for Health. Brian has held senior-level informatics posts in a number of Government departments, including the Department of Health, and in the NHS.

He is currently chair of the National Council of The Association for Informatics Professionals in Health and Social Care (ASSIST).

Brian is a chartered statistician, chartered IT professional and is registered with the United Kingdom Council of Health Informatics Professions.

Dr Mark Davies
Executive Medical Director

Mark joined The NHS IC in 2008.

Previously he was national clinical director for NHS Connecting for Health, leading on primary and community care. He also established the clinical contents service, for which he remains senior responsible officer. He has been medical director for the NHS Connecting for Health Choose and Book programme and clinical advisor to the Department of Health. Prior to this he was medical director of one of the largest GP urgent care organisations in the country, and was involved in the reforming emergency care agenda for West Yorkshire.

Mark is a part-time General Practitioner at a practice in Hebden Bridge, West Yorkshire.

Rachael Allsop
Executive Director of Workforce

Rachael joined The NHS IC in 2009.

Previously she was director of human resources at Leeds Teaching Hospitals' NHS Trust.

She has worked at senior level in a variety of human resource functions across all sectors of the NHS, leading teams who have won awards for innovation, recruitment, retention and diversity.

Rachael is a visiting lecturer at Leeds University where her teaching interests include equality and diversity, organisational change, HR strategy and practice and employment law.

She is chair of the Yorkshire branch of the Healthcare People Management Association (HPMA).

Rachael read Economics at University, subsequently specialising in Employment Law at post-graduate level, and is a member of the Chartered Institute of Personnel and Development.

Lucinda Bolton
Non-executive Director

Lucinda was appointed as a non executive director of The NHS IC in 2005.

She is a former executive director of an investment bank and has held a number of public and voluntary sector non-executive directorships.

She was a member of the NHS Pay Review Body until April 2010 when she completed her second term. She is also a retired chair of Hammersmith and Fulham PCT and, before that, of Riverside Community Healthcare NHS Trust. As such she has wide experience of issues affecting the NHS.

She was also a governor of Thames Valley University, and chair of its Audit and Risk Committee until April 2010. Amongst other activities, she is currently an independent member of the Audit Committee of the Commission for Local Administration in England and acts as an Independent Public Appointments Assessor for the Department of Culture Media and Sport.

Roger Clarkson
Non-executive Director

Roger was appointed as a non executive director of The NHS IC in 2005.

He is also a director of 3rd Phase Consulting.

His previous directorships include Lancashire Ambulance Trust and Learning Pool Ltd. Previously Roger was a senior manager with ICL and IBM's government consultancy businesses and led major customer focused change programmes within a wide range of organisations.

He has also been a national advisor to the Office of the Deputy Prime Minister for local government modernisation and had responsibility for the local government online programme.

In 2006 Roger was appointed as a non-executive director of Dr Foster Intelligence (DFI) to represent The NHS IC's shareholding in this joint venture.

Anthony Land
Non-executive Director

Anthony was appointed as a non executive director of The NHS IC in 2005.

During the last decade he has completed a range of interim and advisory board-level assignments at Kensington and Chelsea Primary Care Trust; the General Social Care Council; the Social Care Institute for Excellence; the Commission for Social Care Inspection and the Equal Opportunities Commission.

Anthony's work has included business and corporate planning, the development and review of new risk management systems, financial and IT systems and corporate governance.

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

In 2006 Anthony was appointed as a non-executive director of Dr Foster Intelligence (DFI) to represent The NHS IC's shareholding in this joint venture.

Professor Michael Pearson
Non-executive Director

Michael was appointed as a non executive director of The NHS IC in 2005.

He is professor of clinical evaluation at The University of Liverpool and Hon Consultant Physician at University Hospital Aintree.

Previously Michael 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.

He is trustee director of the Respiratory Education Training Centre and also Lung Health, a company set up to develop patient focussed software for COPD care.

Mike Ramsden
Chairman

Tony Allen
Vice Chairman

Tim Straughan
Chief Executive

Phil Wade
Executive Director of Business Development and Communications

Trevor Doherty
Executive Director of Finance & Performance

Clare Sanderson
Executive Director of Information Governance

Brian Derry
Executive Director of Information Services

Dr Mark Davies
Executive Medical Director

Rachael Allsop
Executive Director of Workforce

Lucinda Bolton
Non-executive Director

Roger Clarkson
Non-executive Director

Anthony Land
Non-executive Director

Professor Michael Pearson
Non-executive Director

Resource Accounts for the year ended 31 March 2010

Management Commentary

The NHS Information Centre for health and social care (The NHS IC) was created in 2005 and is a special health authority of the Department of Health that provides facts and figures to help the NHS and social services in England.

Our data and information helps local organisations provide better local care, national policy development and delivery, and facilitate local and national accountability.

Review of the year

2009/10 has been a year in which a range of key strategic developmental areas for The NHS IC have progressed considerably:

- increasingly focussed on the needs of frontline NHS and social care customers and delivered resources which have allowed managers, analysts and clinicians within health and social care settings to benchmark and compare their performance against others and commission the right healthcare services
- delivered programmes of work and implemented new information services including the:
  - development of a range of indicators for Quality Improvement and for the NHS Choices website, providing assured measures of clinical quality with transparent methodologies
  - creation of a National Adult Social Care Intelligence Service, providing for the first time comparative and other information for adult social care services
  - monthly release of Hospital Episode Statistics
  - major enhancement to NHS Comparators, incorporating new maternity indicators
  - produced workforce information derived from the Electronic Staff Record
- developed an Information Governance Framework (IGF) to bring together relevant legislation, regulations, standards and best practice into a single document
- led the DH contribution to the Government's "Making Public Data Public" initiative

Future Developments

The strategy for The NHS IC in 2010/11 reaffirms the priority to focus on delivering products and services that meet the information needs of local organisations and frontline staff. Our mission is to drive the use of information to improve the effectiveness of decision making resulting in the delivery of better care. In particular, given the increasing cost pressure that the health sector will face, emphasis in the next year will be focused on the requirement to drive improvements in productivity and the quality of patient care under the Quality, Innovation, Productivity & Prevention initiative (QIPP).

Key objectives will be:

1. **High Information Quality and Standards**
   Ensure the right quality information is provided, using clear governance and standards in data and data collections
2. **Better Access**
   Improve access to and interpretation of information through better presentation and reporting

   Ensure fair and equal access to the information
3. **Relevant Information Services**
   Deliver the information frontline services need to meet their local priorities

   Be the source of data for official statistics published by DH, CQC and other bodies for the purposes of accountability

The NHS IC will achieve these objectives through a series of strategic priority programmes. These will largely build on programmes already underway in 2009/10. Some will have an infrastructure or enabling purpose, such as Information Governance and Making Information Accessible, others contain multiple major projects to improve the information available to frontline services.

It is, however, recognised that there are a number of key risks emerging:

— the future of the Arms Length Body sector is currently under review and the outcome is not yet known

— the informatics landscape within the health sector may be subject to change

— significant short term funding will become more difficult to secure within the public sector as a whole

Accounts preparation

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 National Health Service Act 2006 and have been prepared in accordance with the 2009/10 Government Financial Reporting Manual (FReM) issued by HM Treasury. The accounting policies contained in the FReM apply International Financial Reporting Standards (IFRS) as adopted and interpreted for the public sector context.

Financial results

The Department of Health allocated The NHS IC a revenue resource limit for 2009/10 of £43.0 million including £3.5 million to cover depreciation and capital charges. The actual results have generated a small surplus of £0.1 million.

Staff numbers increased by 124 to 632, largely funded by programme work in addition to Grant in Aid.

The capital resource allocation of £8.5 million has been fully spent with The NHS IC investing significant amounts on developing the General Practice Extraction System, improving systems such as NHS Comparators which provides clinical benchmarking data, various web enabling technologies to allow customers better access to our data and a range of software solutions to generate increased efficiency, capacity and governance.

Like many arms length bodies, central funding has been reduced in the year and further efficiencies are expected over the next few years. The NHS IC continues to manage its cost base and generate improved value for money and has developed a programme specifically focused on the QIPP agenda, both externally and within The NHS IC.

The NHS IC continues to seek new funding streams to support its activities in order to reduce its reliance on Grant in Aid and £15.5 million was generated representing a 60 per cent increase over 2008/09.

Outstanding sales ledger balances were £2.8 million, of which £0.1 million was more than 90 days overdue. Debts amounting to £7,565 have been provided for as irrecoverable. Other debtors largely relate to VAT and prepayments on property leases.

Deferred income relates to monies received from the Department of Health and other bodies as a contribution towards survey costs, specific capital projects or other major areas of work in advance of the work being completed. This will be released as expenditure is incurred, or in the case of capital expenditure, as amortisation is charged.

Going concern

It is believed that the Department of Health, as the principal provider of funding, will continue to support The NHS IC for the foreseeable future and thus the Accounts have been prepared as a going concern.

Fixed asset investments

The NHS IC entered into a joint venture partnership arrangement known as Dr Foster Intelligence Limited (DFI) on 17 January 2006. The NHS IC initially 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 further £2.5 million was paid in July 2007. Subsequently, the issue of a share option scheme has reduced The NHS IC share of the company on a fully diluted basis to 47.5 per cent.

DFI has grown considerably with more NHS Trusts using its services for the first time and existing customers using a greater number of products. Turnover has reduced in the 12 months to December 2009 over the previous year as a result of the loss of the NHS Choices website development contract. However, its core business turnover continued to grow enabling an improved operating profit of £1.5 million (2008 – £1.4 million).

In accordance with the provisions of IAS 31 (Joint Ventures) we have treated our investment in the DFI joint venture as a fixed asset investment shown at cost, less any amounts written off. This has been subject to a valuation at the balance sheet date. This valuation carried out by PricewaterhouseCoopers LLP supports the board's opinion that the carrying value of £12 million remains appropriate.

Events after the balance sheet date

On 1 April 2010 The NHS IC received £4 million being its share in a capital reduction of Dr Foster Intelligence Ltd. On the same date, Dr Foster Intelligence Ltd acquired 100% of the capital of Dr Foster Research Limited, a wholly owned subsidiary of Dr Foster LLP, the acquisition price funded by the issue of 13,253 shares in Dr Foster Intelligence Ltd. The NHS IC fully diluted share of the joint venture as a result of this acquisition reduced to 46.4 per cent, although The NHS IC retains 50 per cent of the voting rights.

On 9 July 2010 The NHS IC shareholding in Dr Foster Intelligence Ltd was transferred to the Secretary of State for Health for a consideration of £8 million.

Better payment practice code

	Number	£000
Total non NHS bills paid 2009/10	6,596	34,016
Total non NHS bills paid within target	6,364	29,916
Percentage of non NHS bills paid within target	**96.5%**	**87.9%**
Total NHS bills paid 2009/10	106	1,232
Total NHS bills paid within target	77	1,023
Percentage of NHS bills paid within target	**72.6%**	**83.0%**

Better payments practice code

The NHS IC seeks to comply with the Better Payments Practice Code by paying our suppliers within 30 days of the receipt of goods or services, or within 30 days of receipt of an invoice. The percentage of non NHS invoices paid within this target was 96.5 per cent (2008/09 93.6 per cent).

Refinements to processes have been implemented to comply with the revised guidelines introduced during 2008/09 to pay smaller suppliers within 10 working days.

Political and charitable donations

No political or charitable donations have been made in the year.

Estates strategy

The aim of The NHS IC has been to centralise as much of its activities as possible into its principal leased accommodation in Leeds. This has been largely achieved with a small London presence and a facility in Southport where space is occupied within other public sector buildings. Consequently a formal estates strategy has not been developed.

Auditors

The accounts have been audited by Deloitte LLP on behalf of the Comptroller and Auditor General, who has been appointed under statute and is responsible to Parliament. The cost of the audit was £67,500. The National Audit Office also undertook a review of the work associated with the implementation of IFRS as directed by the Department of Health for which a fee of £10,000 has been charged.

The internal audit service during the financial year was provided by PricewaterhouseCoopers LLP.

The accounting officer has undertaken all steps to ensure he is aware of any relevant audit information and to ensure that The NHS 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 NHS IC's auditors are not aware.

Governance and public interest

Corporate governance

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

The composition, role and main activities of the board and its principal committees during the year under review are outlined below.

Composition	Meetings Attended	Role
Board	**6**	The NHS IC board members have corporate responsibility for: — ensuring that The NHS IC complies with statutory or administrative requirements for the use of public funds — establishing the overall strategic direction of The NHS IC within the policy and resources framework agreed with the DH sponsor — ensuring that the board operates within the limits of its statutory authority and any delegated authority agreed with DH — approving business plans, key financial and performance targets and the annual accounts — approving executive director appointments — approving recommendations of board committees — approving income and expenditure over £0.5m and capital expenditure over £250k Further details including conduct of meetings are contained in The NHS IC Standing Orders and other governance documents Board meetings comprise a public session, where members of the public are able to attend with all minutes and papers made available on The NHS IC website, and a private session where commercial in confidence matters are discussed.
M Ramsden (Chairman)	6	
A Allen	6	
L Bolton	6	
R Clarkson	6	
A Land	6	
M Pearson	6	
Executive directors:		
T Straughan	5	
P Wade	6	
C Sanderson	5	
T Doherty (appointed August 09)	4	
B Derry	6	
M Davies	6	
R Allsop	6	
S Leathley (resigned August 09)	2	
Audit and risk committee	**5**	The audit and risk committee is responsible for reviewing and making recommendations to the board on: — the strategic processes for risk, control and governance and the Statement on Internal Control — the accounting policies, the accounts and the annual report of the organisation — the planned activity and results of both internal and external audit — assurances relating to the corporate governance requirements for the organisation – including annual review of governance documents — proposals for tendering for either internal or external audit services or for purchase of non-audit services from contractors who provide audit services — anti-fraud policies, whistle-blowing processes, and arrangements for special investigations – including appointment of a local counter fraud specialist
A Allen (Chairman)	5	
L Bolton	5	
R Clarkson	4	
M Pearson	1	
A Land (Reserve)	–	
Executive directors:		
T Straughan	3	
S Leathley (resigned August 09)	2	
T Doherty (appointed August 09)	3	
C Sanderson	2	
In addition, both the internal and external auditors attend meetings.		

Composition	Meetings Attended	Role
Information governance committee	**4**	The information governance committee is responsible for:
M Pearson (Chairman)	4	— determining and monitoring information governance strategy and business plans — reviewing and making recommendations on high level significant information governance issues that may impact upon The NHS IC — approving the principles of information governance policies and monitoring their implementation and adoption on an exception basis — probing, testing and monitoring the adequacy of the information governance controls — advising on strategic direction and opportunities for the development of external information governance services and communication strategies for promoting and disseminating this work.
A Land	4	
L Bolton	4	
Executive directors:		
T Straughan	4	
C Sanderson	4	
M Davies	1	
Remuneration committee	**3**	The role of the remuneration committee is to:
M Ramsden (Chairman)	3	— approve the level of the remuneration packages of the chief executive and other executive directors within the provisions of the Pay Framework for Very Senior Managers in the NHS — approve the annual performance objectives and targets of the chief executive and other executive directors — monitor and evaluate the performance of the chief executive and other executive directors and make recommendations to DH (through the Pay and Performance Oversight Committee) on any performance pay awards — approve the level of any annual performance related pay awards to NHS IC staff on ex-civil service terms and conditions
A Allen	3	
L Bolton	3	
Executive directors:		
T Straughan	3	
R Allsop	3	

The board and each of its committees, other than the remuneration committee, undertake an effectiveness review each year. This review consists of a questionnaire which each regular attendee completes, assessing the performance using a scoring mechanism with the opportunity to comment. An anonymised consolidated schedule is then reviewed by the relevant board or committee to which it relates.

Performance management committee

In addition to the above formal board committees, a performance management committee consisting of the executive directors and their direct reports, meets monthly to monitor both financial and operational performance against plan, review key performance indicators and consider significant risks. The minutes from this meeting are presented to the board for information.

Register of interests

The NHS Code of Accountability requires board members to declare any interests that are relevant and material to the NHS body of which they are a member. Board members are expected to declare any changes to their interests at each board meeting and on any particular topic on the agenda prior to discussion commencing.

The board register of declarations of interest is updated on an annual basis. It is kept and maintained by The NHS IC head of the executive office and is available for public inspection.

The register includes the directorships of R Clarkson, A Land and T Straughan in Dr Foster Intelligence Ltd (DFI) as part of the governance structure of the joint venture investment. Tim Straughan resigned from the DFI board on 16th September 2009. He was replaced by Mike Fry, who does not sit on The NHS IC board but has been appointed (via the Appointments Commission as an associate non-executive director of The NHS IC) specifically to represent NHS IC interests on the DFI board.

Risk

The NHS IC board has overall responsibility for risk management and has nominated the Director of Finance and Performance as the director responsible. The audit and risk committee provides assurance that systems are in place to ensure effective risk management. The internal audit function forms part of the review process and oversees assurance on the risk management process, and advises the audit and risk committee accordingly.

Individual directors manage risk at the day-to-day operational and project levels, and maintain departmental risk registers. Key risks from the departmental risk registers are consolidated onto the corporate assurance framework which is reviewed on a regular basis by senior management through the performance management committee.

Information governance

The main purpose of The NHS IC is to collect, analyse and disseminate health related data. Some of this information, notably about patients and NHS employees, is of a personal and sensitive nature and The NHS IC has stringent controls in place to ensure the security of this data.

An information governance committee, chaired by a non-executive director, which reports to the board, specifically oversees the policies and procedures in this area. An information governance toolkit assessment was undertaken in the year, where a high score of 95 per cent was attained. During 2009/10 The NHS IC commenced creating an "honest broker" service and compliance unit which is developing policies on behalf of the wider health service and managing sensitive patient identifiable data within the databases managed by The NHS IC.

In the Cabinet Office's Interim Progress Report on Data Handling Procedures, published on 17 December 2007, Official Report, column 98WS, government made a commitment that its departments will report information risk management in their annual accounts in particular whether there have been any personal data related incidents.

There are no protected personal data incidents to report either in 2009 or 2010 to the date of signing these accounts. This includes those incidents that would need to be formally reported to the Information Commissioners Office (ICO) and those that would be deemed not to require reporting to the ICO.

The NHS IC is subject to the Data Protection Act 1998 and has filed the appropriate notification with the Information Commissioner's Office.

Complaints and adverse incidents

The NHS IC takes all complaints and adverse incidents seriously. The existing processes associated with such incidents have been strengthened during the year to incorporate a new adverse incident reporting system which enables all staff to report an incident in a common format and allow it to be reported upon and its root causes investigated. Regular learning groups review each incident to understand the reasons and put in place measures that will mitigate a future repeat. The level of adverse incidents is a key performance indicator for the organisation and is reviewed regularly by the board.

Freedom of Information Act

As a special health authority The NHS IC is required to comply with the Freedom of Information Act 2000. This means that all requests for information are responded to within the provisions of the act, typically within 20 working days. During 2009/10, 329 Freedom of Information requests were received of which just 3 were not responded to within the 20 working day timeframe.

Public information holder

As a public information holder, The NHS IC has complied with the cost allocation and charging requirements of HM Treasury and Office of Public Sector information guidance.

Sustainable development

The NHS IC acknowledges its roles and responsibilities towards the sustainable development agenda. The working environment in which the organisation operates is predominantly office based and thus opportunities to impact on the environment are relatively limited. However, a number of steps and initiatives have been put in place and these include:

— recycling of office materials has been increased

— using public transport for business travel where ever possible and putting in place a metro scheme

— promoting cycling by providing cycle storage, shower and changing facilities

— disposing of old equipment in a socially and environmentally friendly manner

— use of video conferencing in an effort to reduce the amount of travel

Employee policies

Pension liabilities

The NHS IC participates in both the NHS and the civil service pension schemes and in doing so makes contributions based on the salary of individual members. Both schemes are unfunded multi-employer defined benefit schemes in which the employer is unable to identify its share of underlying assets and liabilities. The schemes are therefore accounted for as if they were defined contribution schemes.

Equality and diversity

The NHS IC is committed to equality of opportunity for all employees and potential employees. It aims to create an environment in which individual differences and the contributions of all employees are recognised and valued and ensure that no eligible job applicant or employee receives less favourable treatment on the grounds of race, colour, nationality or ethnic origin, age, gender, sexual orientation, marital status, disability, religion or religious affiliation, or is disadvantaged by conditions or requirements which cannot be shown as justifiable.

All staff are required to attend an equality and diversity awareness training course and this is also incorporated into the induction process for new employees.

Learning and development

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

Employee consultation

The NHS IC is committed to consulting and communicating with staff and their representatives. A Joint Negotiating and Consultative committee meets bi-monthly to discuss organisation wide issues and local consultation takes place over areas of specific interest.

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

Health and safety

The NHS 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 NHS IC complies with the Health and Safety at Work Act (1974) and all other legislation as appropriate. All staff are required to complete an e-learning package. An on line self assessment tool has been introduced which incorporates a range of health and safety issues

Sickness absence data

During 2009/10 2,416 days (2008/09 2,309 days) were lost due to sickness absence. This represents 4.7 days per employee (2008/09 4.5 days per employee).

Remuneration Report

This report for the year ended 31 March 2010 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 based on the recommendations set by the senior salaries review board 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 relevant Department of Health guidelines.

Remuneration policy

The NHS 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. All relevant posts have been evaluated and pay rates determined by 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 are 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) Regulations (TUPE).

Service contracts

The chief executive and all other permanently employed executive directors are employed under permanent employment contracts with a six month notice period and work for The NHS 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. All of the non-executive directors (other than the chair) were reappointed on 1 April 2009 with further contracts ranging from 3 to 4 years. They are not entitled to compensation for loss of office or early termination of appointment.

Emoluments of board directors

The remuneration relating to all directors in post during 2009/10 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.

	Salary including performance pay (£000) 2009/10	Salary including performance pay (£000) 2008/09	Real increase in pension and related lump sum at age 60 (£000)	Total accrued pension at age 60 at 31/3/10 and related lump sum (£000)	CETV at 31/3/10 (£000)	CETV at 31/3/09 (£000)	Real increase in CETV after adjustment for and changes in market investment factors (£000)
Tim Straughan Chief executive	150–155	145–150	5	30	121	92	19
Phil Wade Director of business development and communications	105–110	100–105	5	20	93	65	19
Trevor Doherty Director of finance and performance (appointed 17th August 2009)	75–80	–	1	1	22	–	10
Brian Derry Director of information services (appointed 1st November 2008)	105–110	40–45	17	184	1067	905	98
Mark Davies* Medical director (appointed 2nd July 2008)	155–160	90–95	7	187	799	711	49
Stephen Leathley Acting director of finance and performance (resigned 17th August 2009)	20–25	70–75	–	–	–	40	–
Clare Sanderson** Director of information governance	150–155	105–110	6	25	237	112	86
Rachael Allsop Director of workforce (appointed 1st January 2008)	115–120	25–30	7	160	726	641	48

Amounts paid to non–executive directors were as follows:

Mike Ramsden (chairman)	65–70	60–65	–	–	–	–	–
Anthony Allen	10–15	10–15	–	–	–	–	–
Lucinda Bolton	5–10	5–10	–	–	–	–	–
Roger Clarkson	5–10	5–10	–	–	–	–	–
Anthony Land	5–10	5–10	–	–	–	–	–
Michael Pearson	5–10	5–10	–	–	–	–	–

Emoluments of executive directors consist of basic pay. No non-cash remuneration or benefits in kind were paid.

* Mark Davies was appointed as a permanent NHS IC employee during the year having formerly been seconded from NHS Connecting for Health. He remains on the NHS Connecting for Health payroll and his costs are recharged to The NHS IC.

** The 2008/09 costs for Clare Sanderson included fees from an external agency until October 2008 and relate to salary from November 2008.

Directors expenses during the year are detailed on The NHS IC website at www.ic.nhs.uk/about-us/our-board

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 them 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 and do not take account of any actual or potential reduction to benefits resulting from Lifetime Allowance Tax which may be due when pension benefits are drawn.

Real increase in CETV

This reflects the increase in the 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
Chief Executive

9 July 2010

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 Treasury, The NHS 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 NHS IC's state of affairs at the year end and of its income and expenditure, recognised gains and losses and cash flows for the financial year.

In preparing the accounts, the board and accounting officer are required to comply with the requirements of the Government Financial Reporting Manual and in particular to:

— observe the accounts direction issued by the Secretary of State, including the relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis

— make judgements and estimates on a reasonable basis

— state whether applicable accounting standards as set out in the Government Financial Reporting Manual have been followed and disclosed and explain any material departures in the financial statements

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

The accounting officer for the Department of Health has appointed the chief executive of The NHS IC as the accounting officer, with responsibility for preparing The NHS IC 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 for which the accounting officer is answerable, for keeping proper records and for safeguarding The NHS IC's assets.

Statement on internal control

Scope of responsibility

As accounting officer, I have responsibility, together with the board of The NHS IC for maintaining a sound system of internal control that supports the achievement of the organisation's policies, aims and objectives whilst safeguarding the public funds and organisation's assets including data and information for which I am personally responsible, in accordance with the responsibilities assigned to me in Managing Public Money.

The senior departmental sponsor for the Department of Health is responsible for ensuring that The NHS IC procedures operate effectively, efficiently and in the interest of the public and the NHS and I have regular dialogue with the Department of Health sponsor in which the key issues affecting The NHS IC are discussed in detail. I provide regular business and financial reports to The NHS 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.

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

Capacity to handle risk

The board and its committees take an active role in risk management and ensure there are effective risk management processes to support the achievement of The NHS IC's policies, aims and objectives. The approach to risk management is continually under review by the board which has resulted in some changes to committee roles during the year. The risk strategy defines the way in which risks are identified, measured and managed.

The NHS IC maintains an assurance framework containing all principal corporate risks and operational teams maintain their own functional risk registers using the enterprise project management system (EPM) introduced during 2009/10.

In particular;

— the executive performance management committee and the audit and risk committee, review the full assurance framework as a standing item including all risks and issues relating to information governance

— the executive directors group review programme risks weekly and strategic and corporate risks monthly

— the board review strategic and high risk areas.

The NHS IC continues to make significant progress in developing its capabilities to manage risk and with all individual risks consolidated through Programme Delivery through EPM. This will introduce a common reporting and escalation methodology within The NHS IC.

Progress continues to be made in strengthening the wider governance arrangements through:

— a rigorous approach to reporting performance which is now well embedded within the organisation

— inclusion of senior managers on the performance management committee which includes the review of governance and risk issues

— the implementation across several key programmes of the IT Information Library (ITIL), a recognised set of standards for service management.

— the development of the programme delivery team to manage the delivery of programmes and project delivery and report on progress and associated risks and issues in a standard manner

— the continuing implementation of the development plan to build on the improvements made to data and information security processes resulting in The NHS IC achieving an improved score of 95% in 2009/10 (2008/09 75%) against the standards set out in the NHS Connecting for Health Information Governance toolkit for the NHS.

The risk and control framework

The board has overall responsibility for risk management and for clear lines of accountability for managing risk throughout the organisation. The audit & risk committee is the board's sub-committee that overviews risk and reports to the board on

— the effectiveness of the system of integrated governance, risk management and internal control including information governance, security and data quality risks

— areas where controls need to be strengthened to ensure that principal risks are being managed effectively

— areas where new assurances are required

Internal control and risk management processes comprise:

— approval of The NHS IC strategy and business plans by both the board and Department of Health

— the implementation and management of agreed internal standards, policies and processes for core business activities

— clearly defined organisation structures and delegated authorities appropriate to The NHS IC's business

— regular management review processes

— a process for identifying, prioritising and managing risks to the achievement of The NHS IC's policies, aims and objectives

The NHS IC's approach to managing risks to an acceptable level on all aspects of its activities is by aligning The NHS IC'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 is informed in a number of ways:

— through submission of the audit & risk committee minutes and its annual report to the board

— the head of internal audit provides 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.

The internal audit assurance statement concluded that:

...taking into account the limited rated reviews [noted below], we can give moderate assurance on the design adequacy and effectiveness of the system of internal control.

Moderate Assurance in our annual opinion is provided whereby we have identified mostly low and medium rated risks during the course of our audit work on business critical systems, but there have been some isolated high risk recommendations and the number of medium rated risks is significant in aggregate. The level of our assurance will therefore be moderated by these risks and we cannot provide a high level of assurance.

During the course of the financial year we have not become aware of any other issues that we believe could, or have had, a significant impact upon the organisation's system of internal control...

The limited rated reviews were; Risk Management and Assurance Gap Analysis, Partnerships and Collaborative working.

— following individual audit reviews, action plans are put in place to address them with progress reviewed by the audit & risk committee on a regular basis

— senior managers within the organisation who have responsibility for the development and maintenance of the system of internal control provide me with assurances

— through clear performance management arrangements in place with executive directors and senior managers

— the assurance framework itself provides evidence on the effectiveness of controls that manage the risks to the organisation have been reviewed

— 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 committee and am accordingly aware of the significant issues that have been raised.

Significant internal control issues

Like any organisation, there are a number of major risks some of which relate to external factors over which control is difficult to exercise.
For instance, the current pressures on public expenditure is likely to have a significant impact upon our funding in future years and may subsequently impact upon our ability to deliver all of our services in the way we do now.

During 2009/10 The NHS IC key risk management priorities included:

— the implementation across The NHS IC of all relevant information governance policies to ensure that processes over information security issues are as strong as possible

— creating an improved management structure with NHS Connecting for Health and the Department of Health, to support a number of wider NHS informatics systems including the Secondary Uses Service (SUS) through the National Informatics Reporting Service board (NIRS)

— ensuring that The NHS IC delivered its high profile projects and programmes

— ensuring the transfer of IT services to an in house management solution was undertaken in an effective manner with minimal disruption to services

— improving communications with the NHS and other stakeholders to ensure they are fully aware of The NHS IC role and service offering.

At the 31 March 2010 two significant control issues arising from reviews undertaken late in the financial year were outstanding. Both of these issues are well advanced in resolution:

Risk Management and Assurance Gap Analysis.

— Internal audit reports identified certain weaknesses in connection with a lack of consistency in the risk and issue management and assurance approach. Our response is that new risk strategy, policy and processes have been developed using Office for Government Commerce 'Management of Risks' best practice and are being rolled out across The NHS IC.

Project Management and Delivery

A review of a number of project out-turns has been initiated by The NHS IC management. Any weaknesses found will be compared to our new Programme Delivery processes and action will be taken to further amend these processes if required

I believe that The NHS IC has continued to develop and employ an appropriate control environment throughout 2009/10 which will continue to be further developed to meet changing priorities or requirements in the years ahead.

Tim Straughan
Chief Executive

9 July 2010

The certificate and report of the Comptroller and Auditor General to the Houses of Parliament

I certify that I have audited the financial statements of the Health and Social Care Information Centre for the year ended 31 March 2010 under the National Health Service Act 2006. These comprise the operating cost statement, the statement of financial position, the statement of cash flows, the statement of changes in taxpayers' equity and the related notes. These financial statements have been prepared under the accounting policies set out within them. I have also audited the information in the remuneration report that is described in that report as having been audited.

Respective responsibilities of the chief executive and auditor

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

Scope of the audit of the financial statements

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

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

Opinion on regularity

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

Opinion on financial statements

In my opinion:

— the financial statements give a true and fair view, of the state of Health and Social Care Information Centre's affairs as at 31 March 2010 and of its net resource outturn, changes in taxpayers' equity and cash flows for the year then ended; and

— the financial statements have been properly prepared in accordance the National Health Services Act 2006 and HM Treasury directions issued thereunder.

Opinion on other matters

In my opinion:

— the part of the remuneration report to be audited has been properly prepared in accordance with HM Treasury directions issued under the National Health Service Act 2006; and

— the information given in management commentary for the financial year for which the financial statements are prepared is consistent with the financial statements.

Matters on which I report by exception

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

— adequate accounting records have not been kept; or

— the financial statements are not in agreement with the accounting records or returns; or

— I have not received all of the information and explanations I require for my audit; or

— the Statement on Internal Control does not reflect compliance with HM Treasury's guidance.

Report

I have no observations to make on these financial statements.

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

15 July 2010

Operating cost statement
For the year ended 31 March 2010

	Notes	2009/10 £000	2008/09 £000
Programme costs			
Staff costs	3.1	29,819	24,390
Programme costs	3.2	28,692	23,294
Income	5	(15,550)	(9,669)
Net operating cost		**42,961**	**38,015**
Net resource outturn		**42,961**	**38,015**

Statement of financial position
as at 31 March 2010

	Notes	31 March 2010 £000	31 March 2009 £000	1 April 2008 £000
Non-current assets				
Property plant and equipment	6.1	6,463	3,018	2,578
Intangible assets	6.2	9,995	7,910	2,713
Financial assets	6.3	12,000	12,000	12,000
Total non-current assets		**28,458**	**22,928**	**17,291**
Current assets				
Trade and other receivables	7	4,598	3,449	4,543
Cash and cash equivalents	8	3,095	5,057	4,279
Total current assets		**7,693**	**8,506**	**8,822**
Current liabilities				
Trade and other payables	9	(3,579)	(4,525)	(4,741)
Other liabilities	9	(9,282)	(9,711)	(7,820)
Total current liabilities		**(12,861)**	**(14,236)**	**(12,561)**
Total assets less current liabilities		**23,290**	**17,198**	**13,552**
Non-current liabilities				
Provisions	10	(1,247)	(1,512)	(1,788)
Assets less liabilities		**22,043**	**15,686**	**11,764**
Taxpayers' equity				
General fund		22,029	15,661	11,735
Revaluation reserve		14	25	29
		22,043	**15,686**	**11,764**

The notes on pages 39 to 56 form part of this account

The financial statements were approved by the Board on 10 June 2010 and signed on its behalf by

T Straughan
Chief Executive

Dated
9 July 2010

Statement of cash flows
For the year ended 31 March 2010

Net cash flow from operating activities	Notes	2009/10 £000	2008/09 £000
Net operating cost		(42,961)	(38,015)
Adjustment for non cash transactions	3.2	3,304	2,311
(Increase) / decrease in trade and other receivables	7	(1,149)	1,094
(Decrease) / increase in trade and other payables	9	(732)	806
Use of provisions	10	(402)	(319)
Net cash outflow from operating activities		**(41,940)**	**(34,123)**
Cash flows from investing activities			
Purchase of property, plant and equipment	6.1	(3,845)	(662)
Purchase of intangible assets	6.2	(4,979)	(6,057)
Net cash outflow from investing activities		**(8,824)**	**(6,719)**
Cash flows from financing activities			
From the consolidated fund supply – current year		48,802	41,620
(Decrease) / increase in cash	8	**(1,962)**	**778**

The notes on pages 39 to 56 form part of this account

Statement of changes in taxpayers equity
For the year ended 31 March 2010

	Notes	General Fund £000	Revaluation Reserve £000
Balance at 31 March 2008		**11,735**	**29**
Changes in taxpayers' equity for 2008/09			
Net operating costs for the year		(38,015)	–
Non cash charges – cost of capital	3.2	317	–
Transfer between reserves		4	(4)
Total recognised income and expense for 2008/09		**(37,694)**	**(4)**
Net Parliamentary Funding – drawn down		41,620	–
Balance at 31 March 2009		**15,661**	**25**
Changes in taxpayers' equity for 2009/10			
Net Operating costs for the year		(42,961)	–
Non cash charges – cost of capital	3.2	516	–
Transfer between reserves		11	(11)
Total recognised income and expense for 2009/10		**(42,434)**	**(11)**
Net Parliamentary Funding – drawn down		48,802	–
Balance at 31 March 2010		**22,029**	**14**

Notes to the accounts

1. Accounting Policies

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

IFRS 1 First time adoption allows entities adopting IFRS for the first time to take certain exemptions from the full requirements of IFRS in the year of transition (ie 2009/10). The NHS IC has not elected to exercise any election.

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 by applying the accruals convention and primarily comprises of fees and charges for services provided on a full cost basis to Department of Health departments, other health related bodies and external customers. Charges comply with HM Treasury and Office of Public Sector Information guidance.

Deferred income refers to:

— income received or credited in the year for which the related costs have not been incurred. The stage of completion of programmes is determined by an estimation of labour and services by 3rd party suppliers and recharges of internal labour costs.

— monies received as a grant or contribution towards capital expenditure which is then written down and released to the operating cost statement in line with the depreciation charged on the assets.

1.3 Administation and programme expenditure

The operating cost statement is analysed between administration and programme income and expenditure. All income and expenditure is considered to be programme expenditure in accordance with the FReM issued by HM Treasury and further guidance from the Department of Health.

1.4 Taxation

The NHS 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.

1.5 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 NHS IC is included within operating costs. The charge is calculated at the real rate set by HM Treasury, currently 3.5% (2008/09 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.

1.6 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.

1.7 Joint venture

The investment in the joint venture is accounted for under the principles of IAS 31 Joint Ventures. The carrying value for the 2009/10 accounts has been reviewed following an independent revaluation of the investment.

In accordance with the provisions of IAS 31 and the provisions in IFRS 1 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. This has been subject to a valuation at the balance sheet date.

1.8 Fixed assets

a. Capitalisation

All assets falling into the following categories are capitalised:

1) Intangible assets, include software development costs and the purchase of 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.

b. Valuation

Expenditure on research activities is recognised as an expense in the period in which it is incurred.

Intangible assets are capitalised when they have a cost of at least £5,000. Intangible assets acquired separately are initially recognised at fair value. Internally-generated assets are recognised if, and only if, all of the following have been demonstrated:

— the technical feasibility of completing the intangible asset so that it will be available for use

— the intention to complete the intangible asset and use it

— the ability to use the intangible asset

— how the intangible asset will generate probable future economic benefits

— the availability of adequate technical, financial and other resources to complete the intangible asset and use it

— the ability to measure reliably the expenditure attributable to the intangible asset during its development

The amount initially recognised for internally-generated intangible assets is the sum of the expenditure incurred from the date when the criteria above are initially met. Where no internally-generated intangible asset can be recognised, the expenditure is charged to the income statement in the period in which it is incurred.

Following initial recognition, intangible assets are carried at fair value by reference to an active market, or, where no active market exists, at amortised replacement cost (modern equivalent assets basis), indexed for relevant price increases, as a proxy for fair value. Internally-developed software is held at historic cost to reflect the opposite effects of development costs and technological advances.

Tangible assets are stated at the lower of replacement cost and recoverable amount.

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

c. Depreciation

Assets under construction are not depreciated until such time that the asset is brought into effective use.

Otherwise, depreciation and amortisation is charged to programme expenditure on a straight line basis to write off the costs or valuation of tangible and intangible non-current assets, less any residual value, over their estimated useful lives as follows:

1) Intangible assets are amortised, on a straight line basis, over the estimated life 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

The estimated useful lives and residual values are reviewed each year end, with the effect of any changes recognised on a prospective basis

1.9 Leases

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

Amounts held under finance leases are initially recognised, at the inception of the lease, at fair value or, if lower, at the present value of the minimum lease payments, with a matching liability for the lease obligation to the lessor. Lease payments are apportioned between finance charges and reduction of the lease obligation so as to achieve a constant rate on interest on the remaining balance of the liability. Finance charges are charged directly to the income statement.

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

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

1.10 Provisions

The NHS 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.

1.11 Accounting for government grants

The development of fixed assets, notably software and IT systems is sometimes made in collaboration with other health sector organisations, for which those other organisations make a contribution towards the cost. In line with IAS 20 Accounting for Government Grants and Disclosure of Government Assistance, the income is credited to the deferred income account and is released against the expected useful life of the related assets.

1.12 Contingent liabilities

In addition to contingent liabilities disclosed in accordance with IAS 37, The NHS IC discloses for parliamentary reporting and accountability purposes certain statutory and non-statutory contingent liabilities where the likelihood of a transfer of economic benefit is remote, but which have been reported to Parliament in accordance with the requirements of Managing Public Money and Government Accounting.

Where the time value of money is material, contingent liabilities which are required to be disclosed under IAS 37 are stated at discounted amounts and the amount reported to parliament separately noted. Contingent liabilities that are not required to be disclosed by IAS 37 are stated at the amounts reported to parliament.

1.13 Pensions

NHS IC employees are covered by the NHS Pension Scheme. The NHS Pension Scheme is a defined benefit scheme and The NHS IC contributions are charged to the operating cost statement as and when they are due so as to spread the cost of pensions over the employee's working life with The NHS IC. Further details of the provision of pensions to staff are given in note 3.1.

1.14 Critical accounting judgements and key sources of estimation uncertainty

In the application of the accounting policies, the directors are required to make judgements, estimates and assumptions about the carrying value of assets and liabilities that are not readily apparent from other sources. The estimates and associated assumptions are based on historical experience and other factors that are considered to be relevant. Actual results may differ from these estimates.

The estimates and underlying assumptions are reviewed on an ongoing basis. Revisions to accounting estimates are recognised in the period in which the estimate is revised if the revision affects only that period, or in the period of the revision and future periods if the revision affects both current and future periods.

The following are the critical judgements and estimations that the directors have made in the process of applying the accounting policies and that have the most significant effect on the amounts recognised in financial statements:

Revenue recognition

The NHS IC receives income from various sources to cover the cost of expenditure on various project related and other activities. Expenditure is regularly incurred over several financial years and income is released to the operating cost statement in order to reflect as closely as possible the phasing of this expenditure incurred.

Joint venture valuation

The NHS IC has a £12m interest in a joint venture arrangement known as Dr Foster Intelligence Limited. In accordance with the provisions of IAS31 (Joint Ventures), the investment is shown at cost less any amounts written off. In order to assess the basis for the value of the investment, a valuation is undertaken by PricewaterhouseCoopers LLP.

Dilapidation Provision

The NHS IC has provided £690k as a provision against dilapidation costs at its leased accommodation in Leeds and London. In order to assess an estimate of the likely liabilities at the end of the leases, management commissioned a report in 2008 from a professional firm of property advisors.

1.15 Business and geographical segments

The NHS IC has adopted IFRS 8 Operating Segments with effect from 1 April 2009. IFRS 8 requires operating segments to be identified on the basis of internal reports about components of the business that are regularly reviewed by the chief executive to allocate resources to the segments and to assess their performance. The NHS IC had not previously produced segmental analysis in the annual report and accounts.

Statement of operating costs by activity
For the year ended 31 March 2010

Aim: To deliver timely, relevant and accurate information for frontline health and social care staff to help improve decision making and thus enable better quality patient care.

2009/10 £000	Information Services	NHS Central Register	Clinical Audit	Business Development and Programmes	Information Governance	Supporting Functions	Total
Core funding	29,058	4,712	–	7,718	1,524	–	43,012
Other Income	6,712	1,229	3,949	2,517	–	1,143	15,550
Staff costs	(11,213)	(3,325)	(2,176)	(5,652)	(770)	(6,683)	(29,819)
Other costs	(16,272)	(1,277)	(877)	(3,484)	(122)	(6,660)	(28,692)
Contribution	**8,285**	**1,339**	**896**	**1,099**	**632**	**(12,200)**	**51**
Reallocation	(7,423)	(1,243)	(825)	(2,468)	(241)	12,200	–
Net Surplus / (Deficit)	**862**	**96**	**71**	**(1,369)**	**391**	**–**	**51**

2008/09 £000	Information Services	NHS Central Register	Clinical Audit	Business Development and Programmes	Information Governance	Supporting Functions	Total
Core funding	27,754	4,587	–	4,357	1,446	–	38,144
Other Income	2,135	1,109	3,116	2,076	–	1,233	9,669
Staff costs	(8,634)	(3,369)	(2,058)	(4,220)	(819)	(5,418)	(24,518)
Other costs	(12,789)	(1,102)	(1,354)	(2,034)	(212)	(5,675)	(23,166)
Contribution	**8,466**	**1,225**	**(296)**	**179**	**415**	**(9,859)**	**129**
Reallocation	(5,773)	(1,205)	(920)	(1,684)	(278)	9,859	–
Net Surplus / (Deficit)	**2,693**	**20**	**(1,216)**	**(1,505)**	**137**	**–**	**129**

The financial position is reported internally as a single segment. Accordingly no segmental analysis is reported.

Information Services
Responsible for nearly all of The NHS IC's core services, publications and other products and services. While a significant element of the work focuses on a range of strategic and developmental areas, the majority of staff remain committed to continuing to produce the core data and information flows on which many of the new indicators, reporting tools, and syndication opportunities rely.

NHS Central Register
To manage and address the data quality issues arising in the NHS Master Patient Index and provide a range of services associated with this index to other health related organisations and research studies.

Clinical Audit
Delivery of informatics aspects of clinical audits, which aim to review patient care and outcomes of specific care pathways, ensuring that what should be done clinically is being done. The NHS IC works in partnership with clinical and patient groups, to deliver contractual requirements set by the national commissioning agency.

Business Development and Programmes
A series of strategic priority programmes to identify and develop more focused and relevant information, by analysing data already collected by the wider system in a more efficient manner but also identifying new data requirements where there are identified gaps.

Information Governance
An approach of continuous improvement in the development and application of information governance policies throughout its business to provide assurance and demonstrate its competency as a trusted custodian of health and social care data.

Supporting functions
Includes IT costs; depreciation and capital charges; accommodation for Trevelyan Square, Leeds; corporate services; marketing; contact centre; central governance etc.

2 First time adoption of IFRS

There have not been any material adjustments to the operating cost statement, statement of cash flows or tax payers equity as a result of the adoption of IFRS.

The disclosure of capitalised software development costs was previously disclosed under tangible assets. In accordance with IAS 38, this is now disclosed within intangible assets. The net book value of assets reclassified at 31 March 2010 is £9,600,000 (31 March 2009 – £7,519,000). The total value for non current assets remains unchanged.

Early adoption of IFRSs, amendments and interpretations

The NHS IC has adopted IFRS 8, operating segments, early. The effective date of the standard was for accounting periods beginning on, or after 1 January 2010. The adoption affects disclosure requirements only. The adoption of this standard has not led to any changes in The NHS IC accounting policies.

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

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

IFRS9 Financial Instruments	A new standard intended to replace IAS39. The effective date is for accounting periods beginning on, or after 1 January 2013.
IFRS1 First-time adoption of IFRS.	Three sets of amendments to the existing standard. The effective date of one set of amendments is for accounting periods beginning on, or after 1 July 2009. The effective date of the second set of amendments is for accounting periods beginning on, or after 1 January 2010. The effective date of the third set of amendments is for accounting periods beginning on, or after 1 July 2010.
IFRS5 Non-current assets held for sale & discontinued operations	Two sets of amendments to the existing standard. The effective date of one set of amendments is for accounting periods beginning on, or after 1 July 2009. The effective date of the second set of amendments is for accounting periods beginning on, or after 1 January 2010.
IAS1 Presentation of financial statements	Amendments to the existing standard. The effective date is for accounting periods beginning on, or after 1 January 2010.
IAS7 Statements of cash flow	Amendments to the existing standard. The effective date is for accounting periods beginning on, or after 1 January 2010.
IAS17 Leases	Amendments to the existing standard. The effective date is for accounting periods beginning on, or after 1 January 2010.
IAS24 Related party disclosures	Amendments to the existing standard. The effective date is for accounting periods beginning on, or after 1 January 2010.
IAS27 Consolidatedinancial statements	Amendments to the existing standard. The effective date is for accounting periods beginning on, or after 1 July 2009.
IAS32 Financial instruments: presentation	Amendments to the existing standard. The effective date is for accounting periods beginning on, or after 1 February 2010.
IAS36 Impairment of assets	Amendments to the existing standard. The effective date is for accounting periods beginning on, or after 1 January 2010.
IAS38 Intangible assets	Amendments to the existing standard. The effective date is for accounting periods beginning on, or after 1 July 2009.
IAS39 Financial Instruments	Two sets of amendments to the existing standard. The effective date of one set of amendments is for accounting periods beginning on, or after 1 July 2009.

Management are to undertake an assessment of the impact that these new accountancy standards will have on the financial statements.

3.1 Staff numbers and related costs

	2009/10 £000	Permanently Employed Staff £000	Temporary and Contract Staff £000	2008/09 £000
Salaries and wages	25,898	17,481	8,417	21,263
Social security costs	1,423	1,423	–	1,089
Employer superannuation contributions – NHSPA	1,848	1,848	–	1,236
Employer superannuation contributions – other	650	650	–	802
	29,819	**21,402**	**8,417**	**24,390**

The average number of whole term equivalent persons employed during the year was:	2009/10 Number	Permanently Employed Staff Number	Temporary and Contract Staff Number	2008/09 Number
Total	**632**	**527**	**105**	**508**

The average number of whole term equivalent persons employed whose time was capitalised was 27 (2008/09 18)

Expenditure on staff benefits

The amount spent on staff benefits during the year totalled £0.00 (2008/09: £0.00)

Retirements due to ill health

During 2009/10 there were no early retirements from The NHS IC on the grounds of ill health (2008/09 NIL).

Principal 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 2007. Details can be found in the resource accounts of the Cabinet Office: (www.civilservice-pensions.gov.uk). For 2009/10, employer's contributions were paid at one of four rates in the range 16.7 per cent to 24.3 per cent. The contribution rates reflect benefits as they accrue, not the costs as they are incurred, and reflect past experience of the scheme.

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. The scheme is not designed to be run in a way that would enable NHS bodies to identify their share in the underlying Scheme assets and liabilities. Therefore the Scheme is accounted for as if it was a defined contribution scheme.

The Scheme is subject to a full actuarial valuation every four years (until 2004, based on a five year valuation cycle), and a IAS 19 Employee Benefits accounting valuation every year.

An outline of these follows:

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

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

b) IAS 19 Accounting valuation
In accordance with IAS 19, a valuation of the Scheme liability is carried out annually by the Scheme Actuary as at the balance sheet date by updating the results of the full actuarial valuation.

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

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

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

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 NHS 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 for 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.

Scheme provisions from 1 April 2008

From 1 April 2008 changes have been made to the NHS Pension Scheme contribution rates and benefits. Further details of these changes can be found on the NHS Pensions website www.pensions.nhsbsa.nhs.uk.

3.2 Programme costs

		2009/10 £000		2008/09 £000
External contractors		19,065		13,213
Training and conferences		629		759
Travel		1,020		1,202
Accommodation costs		2,396		1,970
Personal IT equipment		479		1,049
IT maintenance and support		286		1,342
Office services		597		544
Advertising and publicity		393		512
External audit services		68		70
Other fees to external auditors		10		10
Miscellaneous		445		312
Non cash transactions				
Depreciation and amortisation	2,937		1,812	
Capital Charges	516		317	
Other bodies contribution to amortisation costs	(135)		–	
Provisions	(14)	3,304	182	2,311
		28,692		**23,294**

4.1 Reconciliation of net operating cost to net resource outturn

	2009/10 £000	2008/09 £000
Net resource outturn	42,961	38,015
Revenue resource limit	43,012	38,144
Underspend against revenue resource limit	**51**	**129**

4.2 Reconciliation of grss capital expenditure to capital resource limit

	2009/10 £000	2008/09 £000
Capital expenditure	8,468	7,449
Capital resource limit	8,470	7,832
Underspend against capital resource limit	**2**	**383**

5 Income

	2009/10 £000	2008/09 £000
Income towards clinical audit programme	3,948	3,116
Income towards programme activities	3,969	4,096
Income from data related services	1,514	634
Contributions towards surveys and publications	4,559	1,291
Other income	1,560	532
	15,550	**9,669**

Income towards clinical audit programme relates to funding from the Healthcare Quality Improvement Programme (HQIP) to undertake the collection, analysis and reporting of data across a number of clinical areas such as diabetes, heart and various cancer specialisms.

Income towards programme activities relates to funding for a number of workstreams including input towards the General Practice Extraction Service, NHS Choices data provision, National Diabetes Information Service and Social Care.

6.1 Property, plant and equipment

	Information Technology £000	Fixtures and Fittings £000	Assets in the course of construction £000	Total £000
Cost or Valuation				
At 1 April 2009	2,853	2,171	–	5,024
Additions	522	333	3,372	4,227
Disposals	(362)	–	–	(362)
At 31 March 2010	**3,013**	**2,504**	**3,372**	**8,889**
Depreciation				
At 1 April 2009	1,511	495	–	2,006
Provided during the year	547	235	–	782
Disposals	(362)	–	–	(362)
At 31 March 2010	**1,696**	**730**	**–**	**2,426**
Net book value at 1 April 2009	1,342	1,676	–	3,018
Net book value at 31 March 2010	**1,317**	**1,774**	**3,372**	**6,463**

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.

The gross cost of property, plant and equipment that has been fully depreciated but is still in use is £873,840 (2008/09 £674,697)

	Information Technology £000	Fixtures and Fittings £000	Transport Equipment £000	Total £000
Cost or Valuation				
At 1 April 2008	2,831	1,341	14	4,186
Additions	390	867	–	1,257
Disposals	(368)	(37)	(14)	(419)
At 31 March 2009	**2,853**	**2,171**	**–**	**5,024**
Depreciation				
At 1 April 2008	1,272	327	9	1,608
Provided during the year	607	205	5	817
Disposals	(368)	(37)	(14)	(419)
At 31 March 2009	**1,511**	**495**	**–**	**2,006**
Net book value at 1 April 2008	1,559	1,014	5	2,578
Net book value at 31 March 2009	**1,342**	**1,676**	**–**	**3,018**

The disposal of information technology assets includes certain equipment acquired as part of the transfer of the NHS Central Registry to bring into line with The NHS IC capitalisation policy.

6.2 Intangible fixed assets

	Software Licences £000	Information Technology £000	Websites £000	Total £000
Gross cost at 1 April 2009	522	11,492	227	12,241
Additions – purchased	82	3,088	1,069	4,239
Disposals	–	(2,077)	–	(2,077)
Gross cost at 31 March 2010	**604**	**12,503**	**1,296**	**14,403**
Accumulated amortisation at 1 April 2009	131	4,199	1	4,331
Provided during the year	78	1,987	89	2,154
Disposals	–	(2,077)	–	(2,077)
Accumulated amortisation at 31 March 2010	**209**	**4,109**	**90**	**4,408**
Net book value at 1 April 2009	391	7,293	226	7,910
Net book value at 31 March 2010	**395**	**8,394**	**1,206**	**9,995**

	Software Licences £000	Information Technology £000	Websites £000	Total £000
Gross cost at 1 April 2008	111	6,031	–	6,142
Additions – purchased	411	5,554	227	6,192
Disposals	–	(93)	–	(93)
Gross cost at 31 March 2009	**522**	**11,492**	**227**	**12,241**
Accumulated amortisation at 1 April 2008	81	3,348	–	3,429
Provided during the year	50	944	1	995
Disposals	–	(93)	–	(93)
Accumulated amortisation at 31 March 2009	**131**	**4,199**	**1**	**4,331**
Net book value at 1 April 2008	30	2,683	–	2,713
Net book value at 31 March 2009	**391**	**7,293**	**226**	**7,910**

6.3 Financial assets

	31 March 2010 £000	31 March 2009 £000	1 April 2008 £000
Investment in Joint Venture	12,000	12,000	12,000

On 17 January 2006, The NHS IC entered into a joint venture arrangement known as Dr Foster Intelligence Limited (DFI). The NHS 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 accounting date for Dr Foster Intelligence is 31 December.

An employee share option scheme has been implemented allowing employees a joint share holding to a maximum of 5 per cent of the issued share capital. At 31st December 2009, 98% of the share options have been issued. The NHS IC's proportionate shareholding on a fully diluted basis is 47.5 percent.

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 IAS 31 (Joint Ventures) we have treated our investment in the DFI joint venture as a fixed asset investment shown at cost, less any amounts written off. This has been subject to a valuation at the balance sheet date.

The NHS IC engaged PricewaterhouseCoopers LLP ("PwC") to estimate the value of its investment in DFI as at 31 March 2010. PwC prepared a valuation on the assumption that Dr Foster Holdings LLP, The NHS IC's joint venture partner, would agree to a sale of the whole company's shares and that The NHS IC would receive a 47.5 per cent pro rata share of DFI's current market value.

The NHS IC's share in the accounts of DFI is as follows:

	Year to 31 December 2009 £000	Year to 31 December 2008 £000
Turnover	10,520	19,095
Profit before tax	755	817
Taxation (charge) / credit	(147)	454
Profit after tax	**608**	**1,271**
Fixed Assets	8,897	9,048
Current Assets	8,916	7,905
Liabilities due within one year	(5,690)	(5,582)

7 Trade receivables and other current assets

Amounts falling due within one year	31 March 2010 £000	31 March 2009 £000	1 April 2008 £000
Trade receivables	3,449	1,893	3,516
Value added tax	132	355	385
Prepayments and other receivables	1,017	1,201	642
	4,598	**3,449**	**4,543**

8 Cash and cash equivalents

	£000
Balance at 1 April 2008	4,279
Net changes in cash and cash equivalents	778
Balance at 31 March 2009	**5,057**
Balance at 31 March 2009	5,057
Net changes in cash and cash equivalents	(1,962)
Balance at 31 March 2010	**3,095**

Bank Balances are held with Citibank, Royal Bank of Scotland and Paymaster General Office under the Government Banking Service. As this arrangement includes regular clearing down of balances, the Government Banking Service is deemed to operate as one account for reporting purposes

9 Trade payables and other current liabilities

Amounts payable within 1 year	31 March 2010 £000	31 March 2009 £000	1 April 2008 £000
Trade payables	3,271	4,273	4,687
Other payables	308	252	54
	3,579	**4,525**	**4,741**
Taxation and social security	510	431	283
Deferred income	4,416	3,088	2,586
Accruals	3,923	5,608	4,506
Provisions	433	584	445
	9,282	**9,711**	**7,820**
Total payables and other current liabilities	**12,861**	**14,236**	**12,561**

10 Provisions for liabilities and charges

	Injury Benefit £000	Lease Surrender £000	Dilapidations £000	Staff Termination £000	Total £000
At 31 March 2009	156	116	690	1,134	2,096
Arising during the year	–	–	–	–	–
Utilised during the year	(16)	(36)	–	(350)	(402)
Reversed unutilised	–	–	–	(14)	(14)
At 31 March 2010	**140**	**80**	**690**	**770**	**1,680**
Expected timing of cash flows					
Within 1 year	16	25	100	292	433
1–5 years	66	55	35	478	634
Over 5 years	58	–	555	–	613

	Injury Benefit £000	Lease Surrender £000	Dilapidations £000	Staff Termination £000	Total £000
At 1 April 2008	172	111	640	1,310	2,233
Arising during the year	–	5	50	200	255
Utilised during the year	(16)	–	–	(303)	(319)
Reversed unutilised	–	–	–	(73)	(73)
At 31 March 2009	**156**	**116**	**690**	**1,134**	**2,096**
Expected timing of cash flows					
Within 1 year	16	–	130	438	584
1–5 years	63	116	–	625	804
Over 5 years	77	–	560	71	708

The injury benefit relates to ongoing contributions towards a previous employee who retired from The NHS Information Authority, the predecessor organisation to The NHS IC.

Lease surrender costs relate to the anticipated costs for the vacant property in Exeter.

The Dilapidation provision refers to the anticipated costs for remedial works at the end of the leases for the Leeds and London offices.

Staff termination costs refer to the cost of employee terminations, mainly in 2006, where payments are made monthly to the NHS Pensions Agency.

11 Capital commitments

Capital commitments amount to £179,681 (2008/09 £347,422) and relates to the purchase of IT equipment

12 Commitments under operating leases

The NHS IC is committed to making the following operating lease payments during the next financial year for leases expiring:	31 March 2010 £000	31 March 2009 £000	1 April 2008 £000
Land & Buildings			
Within one year	196	31	–
One to five years	310	889	893
More than five years	785	181	20
	1,291	1,101	913
Office Equipment			
Within one year	4	2	2
One to five years	382	58	31
More than five years	–	–	3
	386	**60**	**36**
Total	**1,677**	**1,161**	**949**

13 Other Commitments

The NHS IC has entered into non-cancellable contracts (which are not operating leases) for the provision of services totalling £NIL as at 31 March 2010 (2008/09 £NIL)

14 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 NHS IC would be obliged to buy out their share of the business, at market value, if no other buyer can be found.

15 Losses, special payments and interest charged under the Late Payment of Commercial Debt Act 1998

There were 6 losses and special payments in 2009/10 amounting to £91,261 (2008/09 £209,187).
Interest totalling £1,343 was paid under the Late Payment of Commercial Debt (Interest) Act 1998 (2008/09 £339)

16 Related parties

The NHS IC is a special health authority established under the National Health Service Act 2006 and directions made thereunder by the Secretary of State for Health. The Department of Health is regarded as a controlling related party.

During the year The NHS 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. In addition, the joint venture partner, Dr Foster Intelligence Limited, is also considered to be a related party. Listed below are those related parties where either the transactions or the balance is in excess of £5,000.

	Amounts payable at 31 March 2010 £000	Amounts receivable at 31 March 2010 £000	Income in 2009/10 £000	Expenditure in 2009/10 £000
Department of Health	–	1,206	7,403	969
Dr Foster Intelligence Limited	–	47	59	2,105
Strategic Health Authorities				
Yorkshire and The Humber Strategic Health Authority	–	–	18	–
East Midlands Strategic Health Authority	–	1	17	–
Special Health Authorities				
National Patient Safety Agency	–	–	37	–
NHS Business Service Authority	14	–	–	60
NHS Institute of Innovation and Improvement	–	–	56	–
NHS Litigation Authority	–	–	–	25
English Primary Care Trusts				
Barnsley PCT	–	9	35	–
Bradford & Airedale PCT	–	–	571	–
Bury PCT	9	–	–	16
Cambridgeshire PCT	–	–	60	–
East Riding Of Yorkshire PCT	13	–	–	27
Hampshire PCT	–	–	24	–
Heart of Birmingham Teaching PCT	–	–	–	160
Milton Keynes PCT	–	–	–	20
NHS Trusts				
Imperial College of Healthcare NHS Trust	–	–	12	1
Leeds Teaching Hospitals NHS Trust	–	–	–	100
North Cumbria Acute Hospitals NHS Trust	–	–	–	32
University Hospital of North Staffordshire NHS Trust	–	–	–	34
University Hospitals of Morecambe Bay NHS Trust	–	–	–	13
NHS Foundation Trusts				
Barnsley Hospital NHS Foundation Trust	–	–	25	14
Bradford Teaching Hospitals NHS Foundation Trust	–	–	–	30
Calderdale & Huddersfield NHS Foundation Trust	–	–	–	7
James Paget University Hospitals NHS Foundation Trust	–	–	–	17
Lancashire Care NHS Foundation Trust	–	–	–	9
Salford Royal NHS Foundation Trust	–	–	–	158
Sheffield Teaching Hospitals NHS Foundation Trust	–	–	–	26
South Tees Hospitals NHS Foundation Trust	–	–	–	31

17 Financial instruments

As the cash requirements of The NHS IC are met through grant-in-aid and programme monies provided by the Department of Health, financial instruments play a more limited role in creating and managing risk than would apply to a non-public sector body. The majority of financial instruments relate to contracts to buy non-financial items in line with The NHS IC's expected purchase and usage requirements and The NHS IC is therefore exposed to little credit, liquidity or market risk.

a) Market risk

The NHS IC was not exposed to currency risk or commodity risk. All material assets and liabilities were denominated in sterling. The NHS IC had no significant interest bearing assets or borrowings subject to variable interest rates, income and cash flows were largely independent of changes in market interest rates.

b) Credit risk

Credit risk arises from cash and cash equivalents, on invoices raised to customers for services provided and for monied received to cover programme activities. Most high value debts relate to balances with the Department of Health and other related bodies against purchase orders and thus do not represent a significant credit risk. The NHS IC had a number of small external debtors and therefore disclosure of the largest individual debt balances was not considered in the evaluation of overall credit risk.

Movement in the allowance for doubtful debts

	2009/10 £000	2008/09 £000
Balance at the beginning of the period	16	10
Amounts written off during the year as uncollectable	(14)	(8)
Impairment losses recognised	8	16
Impairment losses reversed	(2)	(2)
Balance at the end of the period	**8**	**16**

The table below shows the ageing analysis of trade debtors at the balance sheet date:

	Current £000	Less than 30 overdue £000	31-60 days overdue £000	61 and over days overdue £000	Total £000
At 31 March 2010	2,290	589	470	100	3,449
At 31 March 2009	539	1,039	109	206	1,893
At 1 April 2008	2,145	44	244	1,087	3,520

The maximum exposure to credit risk at the reporting date is the fair value of each class of receivables mentioned above. The NHS IC did not hold any collateral as security.

c) Liquidity Risk

Management work with SBS to manage liquidity risk through regular cash flow forecasting.
The Commission had no external borrowings and relies on Grant in Aid from the Department of Health for its cash requirements and was therefore not significantly exposed to liquidity risks.

The table below analyses The NHS IC's financial liabilities which will be settled on a net basis in the period of less than one year. The carrying value of financial liabilities was not considered to differ significantly from the contractual undiscounted cash flows:

	31 March 2010 £000	31 March 2009 £000	1 April 2008 £000
Current Liabilities	12,862	14,236	12,561

18 Intra-government balances

	Amounts receivable Falling due within one year			Amounts payable Falling due within one year		
	31 March 2010 £000	31 March 2009 £000	1 April 2008 £000	31 March 2010 £000	31 March 2009 £000	1 April 2008 £000
Central government bodies	1,206	1,390	2,786	14	357	616
NHS Trusts and PCTs	15	35	786	31	121	58
Other external bodies	3,377	2,024	971	12,817	13,758	11,887
At 31 March	**4,598**	**3,449**	**4,543**	**12,862**	**14,236**	**12,561**

19 Post balance Sheet Events

On 1 April 2010 The NHS IC received £4,000,605 being its share in a capital reduction of the joint venture company Dr Foster Intelligence Ltd. On the same date, Dr Foster Intelligence Ltd acquired 100% of the capital of Dr Foster Research Limited, the acquisition price funded by the issue of 13,253 shares in Dr Foster Intelligence Ltd. The NHS IC share of the joint venture as a result of this acquisition reduced to 46.4%.

On 9 July 2010 The NHS IC shareholding in Dr Foster Intelligence Ltd was transferred to the Secretary of State for Health for a consideration of £8 million.

20 Authorised date for issue

The NHS IC's Annual Report and Accounts are laid before the Houses of Parliament by The NHS IC.
FRS 21 events after the Balance Sheet date requires The NHS IC to disclose the date on which the Annual Report and Accounts are authorised for issue. The authorised date for issue is July 2010

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