The Health and Social Care Information Centre Annual Report and Accounts 2010/11

NHS
The Information Centre
for health and social care

2010/11

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Foreword

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

Despite a difficult year, the NHS IC has continued to develop, improve and deliver high quality information for health and social care professionals.

We have dealt with the pressures of in-year budget reductions and recruitment constraints by prioritising work and resources through a transformation programme to manage the delivery of necessary internal changes.

In this year of significant challenge, we have successfully published Patient Reported Outcome Measures (PROMs) data for the first time. We have extended the range of regular statistical releases and services, including new mental health publications and data linkage services. We supported the development and approval of major new data sets, including children's and community services.

As an organisation committed to open access to data, we led on the government's transparency and public data for health and social care initiative, extending the range of NHS information available through www.data.gov.uk to some 1,000 data sets.

As the NHS changes and modernises, everyone working in and around the NHS will be challenged to improve the quality of care for patients while making significant financial savings and efficiencies.

Good quality, timely information will be essential. And that means transforming the way information is collected, analysed and used by the NHS and adult social care services.

Over the next year, the NHS IC will have an essential role to play in collecting, assuring and providing good quality information to our customers. To meet the challenges ahead, we will continue to evolve our plans to fit with our new role and the strategic requirements of the NHS and Department of Health (DH) in the years ahead.

Tim Straughan
Chief Executive
The NHS IC

How we delivered against our objectives 2010/11

High information quality and standards

- Published an extended suite of data quality dashboards to help improve the data received from NHS trusts, particularly useful for national statistics, healthcare planning and payment within the NHS
- Led on the transparency and public data for health and social care initiative and extended the range of NHS information available via www.data.gov.uk to around 1,000 data sets
- Completed a major internal restructure and delivered significant cost savings in preparation for our future role as set out in the Health and Social Care Bill and DH review of Arms Length Bodies.

Better access

- Expanded the range of secondary care (hospital related) data available to customers for analysis and monitoring of patient outcomes
- Published Patient Reported Outcome Measures (PROMs) data for the first time
- Introduced data on the routine monitoring of deaths following hospital care
- Expanded the provider level data freely available for admitted patients (inpatient and day cases), maternity, outpatients and accident and emergency (A&E)
- Published Critical Care Minimum Dataset information for the first time; and linked our A&E and admitted patient data sets
- Improved the timeliness of Hospital Episode Statistics (HES) data extracts to customers
- Improved our IT and information systems infrastructure.

Relevant information services

- Published over 1,000 assured clinical indicators, including Patient Reported Outcome Measures
- Contributed to national reviews on hospital mortality indicators and central data collections
- Developed the National Adult Social Care Intelligence Service, providing comparative information for adult social care services
- Extended the range of Hospital Episode Statistics releases, including new publications on A&E
- Extended the range of prescribing information and indicators to support the Quality, Innovation, Productivity and Prevention (QIPP) initiative
- Supported the development and approval of major new data sets, including children's and community services
- Supported the extension of Payment by Results and major new Secondary Uses Service (SUS) releases
- Extended the range of regular statistical releases and services, including new mental health publications and data linkage services
- Enabled more than a quarter of a million downloads of files from our website, HESonline.

Key highlights

- Published 120 publications
- Produced over 1,000 indicators
- Handled more than 22,000 customer service enquiries
- Received over one million visits to our website
- Delivered almost 500,000 document downloads from our website
- Answered just under 400 Parliamentary Questions

About us

Who we are

The NHS IC is England's national source of health and social care information.

We work with a wide range of health and social care providers nationwide to provide the facts and figures that help the NHS and social services run effectively.

We collect data, analyse it and convert it into useful information which helps providers improve their services and supports academics, researchers, regulators and policy makers in their work.

Our aim is to ensure that the data and information the NHS IC provides is reliable and useful with the purpose of improving patient care and outcomes.

What we do

We collect, process and share information in ways that helps people make decisions about care:

- We collect data from the NHS and other care providers
- We process it safely and securely
- We share it in both free and tailor made formats.

We produce a wide range of statistical publications each year across a number of areas including:

- Primary care
- Health and lifestyles
- Screening
- Hospital care
- Population and geography
- Social care
- Workforce
- Pay statistics.

Our mission

To be the national source for health and social care information – improving patient care and outcomes.

Our responsibility

The NHS IC will have the responsibility to "unlock the potential for making better use of information"[1]. The way we collect data and make it available will be critical in enabling other organisations to make the best use of information for improving care. The effective and efficient use of data depends on an operating principle of "collect once and use many times".

[1] Paragraph 2.30 Liberating the NHS: Legislative Framework and Next Steps

Our strategic objectives 2011/12

Our objectives

1. Produce and publish national and official statistics, indicators and measures to ensure services can be properly measured, audited and held to account for their quality and efficiency.
2. Become England's central, authoritative information source, developing a publicly-accessible national repository of health, public health and social care data as well as a searchable catalogue of nationally available information.
3. Be the leading data source for the national transparency agenda. (www.data.gov.uk)
4. Process and link data from across health, social care and other sources safely and securely to help enrich the range of useful information available nationally.
5. Develop a national framework for assuring data quality which will set out clearly the responsibilities of both local and national organisations.
6. Work collaboratively with commercial, third sector and other information intermediaries to produce a vibrant information environment.

Our customers

1. Health and care professionals – identifying areas for attention and helping them to design programmes to deliver improved outcomes for patients and service users.
2. The service as a whole – to help ensure that services are underpinned by principles of responsiveness, efficiency, and effectiveness.
3. Patients, service users, carers and their families – empowering them to make choices about their health and wellbeing, and the care they require.
4. Regulators - to provide indicators to monitor NHS and care organisations to support and promote better integration of care.
5. Public - providing information directly and indirectly - helping people understand the range of health and social care services available and the factors which are important to them, including accessibility, quality of care and safety.

Our challenges

The Government has set out its vision for an NHS where local commissioning is led by clinicians, informed by evidence and evaluated by its impact on health outcomes and the patient experience.

Information as ever remains fundamental throughout the Government's plan to deliver better choice, care and outcomes for patients and to reduce costs and burden in the system.

Future role for the NHS IC

- **The draft Health and Social Care Bill provides top-level recognition of the importance of information** in improving the quality and efficiency of care services and supporting people to make the best possible choices about their health and care
- **It gives the NHS IC a clearer and strengthened role in unlocking the potential benefits of information** – particularly for developing policy, planning and commissioning better services, and supporting accountability and transparency
- **When passed, it will give us statutory powers to collect process and share health and social care data** on behalf of the Department of Health, the NHS Commissioning Board and regulators.

"The NHS Information Centre will have a statutory role as the single body authorised to conduct national data collections."

Sir David Nicholson
NHS Chief Executive, June 2011

Board member profiles

Mike Ramsden
Chairman

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

He is sole director of MR Management Consultancy Ltd 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 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. He was responsible for the recruitment and migration programme that established the organisation in its 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 and 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 IC 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 has been 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 on secondment from NHS Connecting for Health.

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 has been appointed as a member of the Review Body on Doctors' and Dentists' Remuneration with effect from 1 July 2011. Prior to that she was a member of the NHS Pay Review Body (formerly the Review Body for Nursing and Other Health Professionals between 2004 and 2010). 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 the NHS.

She was also a governor of Thames Valley University (now University of West London) and chair of its Audit and Risk Committee until April 2010. Amongst other activities she is currently Acting Chair of the Audit Committee of the Commission for Local Administration in England and 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.

He resigned from this on 9 July 2010 when the shareholding was transferred to the DH.

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.

He resigned from this on 9 July 2010 when the shareholding was transferred to the DH.

Professor Michael Pearson
Non-executive Director

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

He is an honorary 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 and Performance

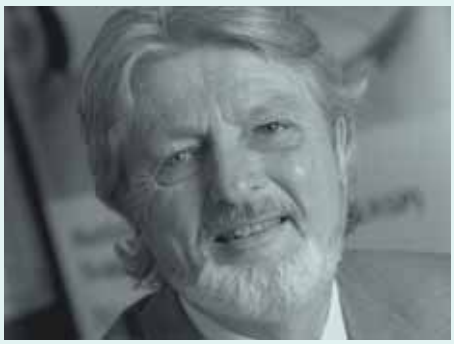
Clare Sanderson
Executive Director of Information Governance

Brian Derry
Executive Director of Information Services

Dr Mark Davies
Executive Medical Director

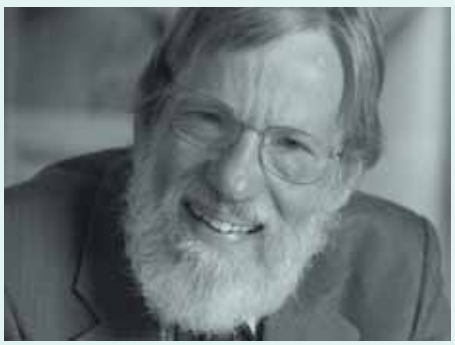
Rachael Allsop
Executive Director of Workforce

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 2011

Management commentary

Management commentary

The NHS IC 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

2010/11 has been a year in which a range of key strategic developmental areas for the NHS IC have progressed considerably:

- delivered key information services including:
  - developing and publishing a wide range of assured clinical indicators, including Patient Reported Outcomes Measures
  - leading contributions to national reviews of hospital mortality indicators and central data collections
  - developing further the National Adult Social Care Intelligence Service, providing comparative and other information for adult social care services, and leading a review of future social care information needs
  - extending the range of Hospital Episode Statistics releases, including new publications on A&E
  - extending the range of prescribing information and indicators to support the Quality, Innovation, Productivity and Prevention (QIPP) programme
  - supporting the development and approval of major new data sets, including children's and community services
  - supporting the extension of Payment by Results and major new Secondary Uses Service (SUS) releases
  - extending the range of regular statistical releases and services, including new mental health publications and data linkage services
  - improving our IT and information systems infrastructure
- playing a leading role on transparency and public data for health and social care, extending the range of NHS information available via www.data.gov.uk to some 1,000 data sets
- completing a major internal restructure delivering significant cost savings, preparing for the future role set out for the NHS IC in the Health and Social Care Bill and DH review of arms length bodies

Future developments

The Department of Health "Report of the arm's-length bodies review, Equity and excellence: Liberating the NHS" released in July 2010 and the subsequent consultation on the information revolution all described a pivotal role for the NHS IC in the collection, assurance and dissemination of information for secondary uses.

This includes other arm's-length bodies transferring their data collection activities to the NHS IC, to reduce duplication and associated costs; and making their information assets available for a national repository, to improve public access. It was decided that in order to carry out these functions the NHS IC needed to be put on a firmer statutory footing, with clearer powers across organisations in the health and care system, and with a functional scope focused on data collection.

The 2011 Health Bill makes provision for this and assuming adopted (subject as currently drafted to further change), the Health and Social Care Information Centre will be established as an executive non-departmental public body during 2012. In essence this means that we will:

- become the focal point for collection, storage and dissemination of national data from health and social care bodies
- collect data that needs to be collected centrally to support the central bodies in discharging their statutory functions
- have power to require a health or social care body to provide the NHS IC with information and to request any other person to provide information
- be able to consider additional requests from other arm's-length bodies, and carry out those data collections if specific criteria are met

— have a duty to seek to reduce the administrative burden of data collections on the NHS with powers to support this

— publish the data that we have collected in a non-identifiable, standard and aggregated format for wider use by a multiplicity of customers

— be required to assess the extent to which information we collect meets standards for processing information published by the Secretary of State or the NHS Commissioning Board and publish a record of results of the assessment if we plan to publish the information

— maintain and publish a register containing descriptions of the information we collect

subject to potential regulations:

— establish and operate a scheme for accreditation of information service providers

— establish, maintain and publish a database of quality indicators in relation to the provision of health services and adult social care in England

— have a role in connection with the verification of the identity of general medical practitioners

— have wider income generation powers

During 2011/12, the NHS IC will continue work towards this proposed revised role by reviewing all data sources and assessing the viability for the NHS IC to undertake them, liaise with other bodies and agree a way forward and also improve internal IT systems to ensure that the transfer and storage of data is undertaken in the most secure and robust manner possible.

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 2010/11 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 2010/11 of £40.4 million including £4.1 million to cover depreciation and £1.9m to cover restructuring costs. The actual results have generated an underspend of £0.6 million.

Staff numbers have reduced by 49 to 583 as a result of the reduced funding and recruitment controls implemented during the year.

The capital resource allocation of £7.2 million has been considerably underspent due to delays in progress on developing the General Practice Extraction System and the NHS Analysis Reporting System following the need to complete and gain approval for all major IT projects and also a reassessment of future requirements following the anticipated changes arising from the Health Bill. Previously capitalised expenditure of £2.5 million on these projects has been written off in the year.

Like many arms length bodies, central funding will continue to be substantially reduced in the next three years and the NHS IC has undertaken a review of its operations and organisational structure in order to meet this challenge. Various voluntary and compulsory exit schemes have been offered to staff with the result that approximately 38 staff will leave the organisation and a provision of £1.5 million has been included in the accounts.

The NHS IC continues to seek new funding streams to support its activities in order to reduce its reliance on grant in aid. In 2010/11£16.9 million was generated from these other funding sources, amounting to £1.1 million higher than 2009/10.

Outstanding sales ledger balances were £3.5 million, of which £0.06 million was more than 60 days overdue. Debts amounting to £110,509 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 to income as expenditure is incurred, or in the case of capital expenditure, as amortisation is charged.

Going concern

The ALB Review in July 2010 set out the future direction for the NHS IC and the draft Health Bill included clauses to set up the NHS IC as a non-departmental public body from 2012. Hence 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. On 1 April 2010, the NHS IC received £4 million being its share in a capital reduction of DFI. On 1 July 2010 the remaining investment was transferred to the Department of Health at the carrying value of £8 million.

Events after the balance sheet date

There are no significant events after the balance sheet date.

	Number	£000
Total non NHS bills paid 2010/11	4,714	30,726
Total non NHS bills paid within target	4,466	30,308
Percentage of non NHS bills paid within target	**94.7%**	**98.6%**
Total NHS bills paid 2010/11	153	2,210
Total NHS bills paid within target	133	1,921
Percentage of NHS bills paid within target	**86.9%**	**86.9%**

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 94.7 per cent (2009/10 96.5 per cent).

Refinements to processes have been implemented to comply with the revised guidelines introduced during 2009/10 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.

The lease on part of the premises in Leeds is due to end on 24 March 2012 and the decision has been made to not seek a new lease. The area has been vacated and the lease costs for 2011/12 have been accrued in 2010/11 as an onerous lease in accordance with IAS 37 Provisions, Contingent Liabilities and Contingent Assets.

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 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 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		The NHS IC board members have corporate responsibility for:
M Ramsden (Chair)	6	— 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
A Allen	5	
L Bolton	6	
R Clarkson	6	
A Land	5	
M Pearson	4	
Executive directors:		
T Straughan	6	
P Wade	6	
C Sanderson	6	
T Doherty	6	
B Derry	5	
M Davies	5	
R Allsop	6	Further details including the 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, in addition to a private session where commercial in confidence matters are discussed.
Audit and risk committee		The committee is charged with providing assurance and making recommendations to the Board on:
A Allen (Chair)	4	— the effectiveness of the system of integrated governance, risk management and internal control including information governance, security and data quality risks — the accounting policies, the accounts and the annual report of the organisation — planned audit activity and results of both internal and external audit reports — proposals for tendering audit services — any required changes to key corporate governance documents (standing orders, standing financial instructions and the scheme of delegation) — anti-fraud policies, whistle-blowing processes and arrangements for special investigations – including appointment of a local counter-fraud specialist.
L Bolton	4	
R Clarkson	3	
M Pearson	4	
A Land	4	
Executive directors - in attendance		
T Straughan	4	
T Doherty	4	
C Sanderson	4	
In addition, representatives of both the internal and external auditors attend meetings.		

Composition	Meetings attended	Role
Information governance committee		The information governance committee was disbanded with effect from 25th November 2010 – in light of the transfer of its functions to the audit and risk committee and the information governance programme board. Responsibilities of the information governance committee included: — 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.
M Pearson (Chair)	2	
A Land	1	
L Bolton	2	
Executive directors – in attendance		
T Straughan	2	
C Sanderson	2	
M Davies	1	
Remuneration committee		The Board has delegated full responsibility to the remuneration committee to: — make recommendations to the Department of Health (through the pay and performance oversight committee) on 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 (VSMs) in the NHS or successor arrangements — approve the level of any annual performance related pay awards to NHS IC staff on ex-civil service terms and conditions — approve the annual performance objectives and targets of executive directors — ensure that pay arrangements are appropriate in terms of equal pay requirements.
M Ramsden (Chair)	2	
A Allen	2	
L Bolton	2	
Executive directors - in attendance		
T Straughan	2	
R Allsop	2	

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 arrangements

The transformation team (comprising executive directors and their direct reports) was established in 2010 to play a leading role in delivering the organisational change programme. This group meets monthly and was intended originally to operate in parallel with the performance management committee (PMC) which up until September 2010 was responsible for reviewing and monitoring the performance of the business and initiating corrective action as required. It was decided, however, to suspend further meetings of the PMC to enable senior managers to focus on delivery of the critical change programme activities.

It has been agreed that a review of performance management information will be added to the agenda for transformation team meetings in future. Performance monitoring activity is also covered through:

- executive directors meetings (EDG) that address strategic and urgent operational issues on a weekly basis and review corporate risks and issues on a monthly basis
- reporting of financial performance against budget to the main NHS IC Board through the monthly management accounts
- quarterly financial forecasting at a cost centre level against business plan
- regular reporting of the key performance indicators (KPIs) that are reviewed by EDG, main NHS IC Board and the audit and risk committee
- a comprehensive programme of internal audit reviews on key areas of the business with reports, recommendations and management responses being reviewed by the audit and risk committee
- quarterly accountability meetings with the DH sponsor team and ALB finance team
- laying of audited annual report and accounts before parliament
- monthly reporting of adverse incidents as a measure included within the KPIs
- a formal staff performance appraisal system, including annual reviews of each individual's performance against their objectives. The chairman conducts an appraisal of the performance of the chief executive
- annual appraisal of all non executive directors by the chairman under arrangements sponsored by the Appointments Commission. Annual appraisal of the chairman by the lead commissioner from the Appointments Commission
- arrangements for reviewing risk on a regular basis through the corporate assurance framework, strategic and operational risk registers
- annual meeting of the audit and risk committee to review the statement of internal control.

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.

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. During 2010, a new risk reporting and management process was implemented and has been embedded into the business. Risks are reviewed monthly at an operational level and consolidated up to a corporate level for reporting and action by senior management through the transformation committee, audit and risk committee and the NHS IC Board.

Information governance

The main purpose of the NHS IC is to collect, analyse and disseminate health and social care 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.

Information governance matters are now managed through the audit and risk committee and the information governance programme board. An information governance toolkit assessment was undertaken in the year, where a high score of 97 per cent was attained.

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 2010 or 2011 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 ICO.

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 2010/11 271 requests were received of which just 1 was 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 the Office of Public Sector Information.

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, the NHS IC will continue to seek ways of reducing carbon emissions by the following measures:

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

— work with the landlords to reduce energy and water consumption in our buildings and purchase utility services from sustainable, environmentally friendly sources

— encourage staff to support the recycling initiative and reduce electrical consumption

— continue to promote the use of public transport for commuting by supporting the metro scheme allowing staff to purchase tickets at a discount and to spread payments

— support cycling, walking and running by providing changing areas, a clothes drying unit and shower facilities and continue with the bike-to-work incentive scheme

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

— improve the monitoring and recording of sustainable activities leading to reductions in carbon emissions

— reduce colour printing volume when the existing contract ends

— promote the concept of a paperless office.

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 are 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 ensuring 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, the chief executive issues an update bulletin on a weekly basis and 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 2010/11 2,421 days (2009/10 2,416 days) were lost due to sickness absence. This represents 4.6 days per employee (2009/10 4.7 days per employee).

Remuneration report

This report for the year ended 31 March 2011 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 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 2010/11 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 2010/11 (£000)	Salary including performance pay 2009/10 (£000)	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 31/3/11 (£000)	CETV at 31/3/10 (£000)	Real increase in CETV after adjustment for and changes in market investment factors (£000)
Tim Straughan Chief executive	140–145	150–155	7	37	129	121	8
Phil Wade Director of business development and communications	100–105	105–110	5	25	105	93	12
Trevor Doherty Director of finance and performance (appointed 17th August 2009)	125–130	75–80	2	3	53	22	31
Brian Derry Director of information services	105–110	105–110	5	189	1036	1067	(31)
Mark Davies* Medical director	155–160	155–160	13	200	756	799	(43)
Clare Sanderson Director of information governance	105–110	105–110	5	56	239	237	2
Rachael Allsop Director of workforce	115–120	115–120	6	166	667	726	(59)
Amounts paid to non–executive directors were as follows:							
Mike Ramsden (chairman)	60–65	65–70	–	–	–	–	–
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 is seconded from NHS Connecting for Health.

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 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
1 July 2011

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 HM 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 2011 and up to the date of approval of the annual report and accounts, and accords with Treasury guidance.

Capacity to handle risk

The NHS IC's risk management policy and procedures set out responsibilities at all levels including senior-level leadership for the risk management process. In addition, risk management is included as part of the performance criteria of all directors and senior staff.

The aim is to ensure that the data and information the NHS IC provides is reliable and useful with the purpose of improving patient care and outcomes. This is achieved through putting in place appropriate quality standards, adequate supervision and training of staff, appropriate delegation, continuous review of processes and a process for managing adverse incidents, with lessons learned being promulgated through the NHS IC's intranet.

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). The assurance framework is contained within the 'performance pack' which is circulated to all senior managers and the Board. In particular;

— the executive directors group, transformation team (senior managers) and the audit and risk committee review the full assurance framework as a standing item including risks and issues relating to information governance

— 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 using the EPM system. This has introduced 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

— senior managers on the transformation team review governance and risk issues

— a programme delivery team managing the delivery of programmes and projects and reporting 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 97% in 2010/11 (95% in 2009/10) 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 approving the NHS IC's risk management strategy and management and for clear lines of accountability for managing risk throughout the organisation. As accounting officer, I have overall responsibility for establishing the organisation's internal controls and I have delegated certain risk management responsibilities to other directors and their senior managers.

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, including review by the NHS IC senior information risk owner and the NHS IC information security officer of the information asset risks

— 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.

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

Control measures are in place to ensure the organisation complies with obligations under equality, diversity and human rights legislation.

During 2010/11 the NHS IC key risk management priorities included:

— ensuring that key data services and publications were completed as required during a period when new recruitment controls restricted the NHS IC's ability to recruit replacement staff, both on a permanent and temporary basis, which made continued delivery a massive challenge. This particularly affected the internal IT team

— dealing with a period of uncertainty about the future existence of the NHS IC during the arms length body review

— the implementation across the NHS IC of all relevant information governance policies to ensure that processes for risk assurance are as strong as possible.

Information Governance

Of particular importance to the NHS IC is to ensure that the organisation has very robust information governance procedures in place. Thus the NHS IC has a clear information governance strategy and framework that sets out the people, resources, culture and processes necessary for managing data and information within the organisation. By ensuring that information is managed securely, effectively and efficiently the NHS IC will secure a standard of excellence in information governance. To achieve this, information records are:

— held securely and confidentially

— obtained fairly and efficiently

— recorded accurately and reliably

— used effectively and ethically

— shared appropriately and lawfully

All information processing is undertaken in accordance with legislation and best practice. The NHS IC has set policies and procedures to ensure that appropriate standards are defined, implemented and maintained. Regular reviews of information governance policies and compliance audits are carried out by our internal auditors.

Information governance is included within the mandatory staff induction day for new appointees. In addition, each year all staff complete information governance training in line with requirements of the Connecting for Health information governance toolkit. More specialist training is undertaken by the senior information risk owner, the information security officer, the Caldicott Guardian, information asset owners and information asset administrators.

At 31 March 2011, all staff have successfully undertaken the appropriate training. The NHS IC completes the Connecting for Health information governance toolkit and achieved a score of 97% in 2010/11, a further improvement over the 95% achieved in 2009/10. The NHS IC completes the secondary uses version of the information governance toolkit which requires evidence that robust information governance controls are in place to protect our information assets and in particular patient confidentiality.

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:

"…We have completed the program of internal audit work for the year ended 31 March 2011 and we can report that our work did not identify any significant control weaknesses that we consider to be pervasive in their effects on the system of internal control.

Consequently, taking into account the high rated and moderate rated reviews 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, however, the likely impact of these weaknesses on the achievement of the key system, function or process objectives is not expected to be significant. Furthermore, these weaknesses are unlikely to impact upon the achievement of organisational objectives…."

- following individual audit reviews, action plans are put in place to address recommendations 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

At the 31 March 2011 there were no significant control issues outstanding arising from reviews undertaken in the financial year that have not been addressed, although three high priority recommendations from the prior year had not been fully implemented. However those not fully implemented were mitigated by other changes to structure and processes.

These were:

- Partnerships and Collaborative Working (where our new income monitoring processes and account management structure mitigates)
- Information Governance Toolkit (where the audit carried out prior to completion raised concerns, but we achieved a score of 97%, higher than last year)
- Key work areas at Southport and MRIS (formal data sharing agreements).

The outstanding control issues included in last years statement of internal control have been resolved as follows:

- a consistent risk strategy, policy and process has been adopted across the NHS IC
- a review of programme delivery function resulted in revised processes and structure.

Overall there has been a strengthening of our internal controls with, for example, the assurance of the financial controls reviewed in the year being reported as 'significant' by our internal auditors.

Like any organisation, there are a number of risks relating to external factors over which control is difficult. The current pressures on public expenditure have had a significant impact upon our funding in 2010/11 and will continue to have in future years.

Key risk management issues for the NHS IC during 2010/11 while maintaining services and meeting its existing statutory functions and responsibilities were:

- the implementation of two budget reductions during 2010/11 (totalling over 10%)
- complying with a total vacancy freeze and the removal of all delegated authority for appointing temporary staff and contractors, requiring a professional services business case to be approved by ministers for each individual temporary staff or contractor
- investing time and expertise of senior staff and directors in responding to the White Paper, the Health Bill, the Informatics Strategy and a large number of new requests for data on many aspects of our staffing, infrastructure and commercial arrangements
- the planning work required to absorb other functions to be transferred from DH and other arms length bodies and deliver the new role and remit for the organisation as a statutory non-departmental public body as originally planned in the Health Bill from April 2012.

We mitigated these risks as far as possible by:

- aggressive prioritisation of work and resources
- establishing a transformation programme in 2010/11 to manage the delivery of internal changes
- ensuring key stakeholders are aware and committed to the implications of the Health Bill. We have agreed new processes to obtain financial support from the DH Director Generals who fund the NHS IC, and if necessary, agreed to postpone deadlines or de-scope deliverables.

The major control issue facing the NHS IC at the 31 March 2011 was facing the continuing challenge of planned budget reductions and the resulting mismatch between the demand for new and existing services and resources; money, people and skills.

Since 31 March 2011, the announcement of the pause in the progress of the Health Bill for a listening exercise has added to the uncertainty of the future landscape.

I believe that the NHS IC has continued to develop and employ an appropriate control environment throughout 2010/11. The control environment will continue to be further developed to meet changing priorities or requirements in the years ahead.

Tim Straughan
Chief Executive
1 July 2011

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 2011 under the National Health Service Act 2006. These comprise the statement of comprehensive net expenditure, 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 Board, chief executive and auditor

As explained more fully in the statement of the Board and chief executive responsibilities, the Board and chief executive are 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, certify and report on the financial statements in accordance with the National Health Service Act 2006. I conducted my audit in accordance with 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 read all the financial and non-financial information in the annual report to identify material inconsistencies with the audited financial statements. If I become aware of any apparent material misstatements or inconsistencies then I consider the implications for my certificate.

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 2011 and of its net operating costs 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 by 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 and the part of the remuneration report to be audited 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

5 July 2011

Statement of comprehensive net expenditure
For the year ended 31 March 2011

	Notes	2010/11 £000	2009/10 £000 (as restated)
Programme costs			
Staff costs	4	28,616	29,933
Programme costs	7	28,103	28,311
Income	6	(16,911)	(15,799)
Net operating cost		**39,808**	**42,445**
Net resource outturn		**39,808**	**42,445**

The notes numbered 1 to 24 on pages 35 to 50 form part of this account

Statement of financial position
as at 31 March 2011

	Notes	31 March 2011 £000	31 March 2010 £000
Non-current assets			
Property plant and equipment	8	5,697	6,463
Intangible assets	9	7,640	9,995
Financial assets	10	–	12,000
Total non-current assets		**13,337**	**28,458**
Current assets			
Trade and other receivables	11	4,681	4,598
Cash and cash equivalents	12	3,757	3,095
Total current assets		**8,438**	**7,693**
Total assets		**21,775**	**36,151**
Current liabilities			
Trade and other payables	13	(2,504)	(3,579)
Other liabilities	13	(8,539)	(9,282)
Total current liabilities		**(11,043)**	**(12,861)**
Non-current assets plus net current assets		**10,732**	**23,290**
Non-current liabilities			
Provisions	14	(997)	(1,247)
Assets less liabilities		**9,735**	**22,043**
Taxpayers' equity			
General fund		9,723	22,029
Revaluation reserve		12	14
Total tax payer's equity		**9,735**	**22,043**

The notes numbered 1 to 24 on pages 35 to 50 form part of this account

The financial statements on pages 33 to 50 were approved by the Board on 9 June 2011 and signed on its behalf by

T Straughan
Chief Executive

Dated
1 July 2011

Statement of cash flows
For the year ended 31 March 2011

	Notes	2010/11 £000	2009/10 £000 (as restated)
Cash flows from operating activities			
Net operating cost		(39,808)	(42,445)
Adjustment for non cash transactions	7	8,207	2,923
Increase in trade and other receivables	11	(83)	(1,149)
Decrease in trade and other payables	13	(4,144)	(867)
Use of provisions	14	(359)	(402)
Net cash outflow from operating activities		**(36,187)**	**(41,940)**
Cash flows from investing activities			
Purchase of property, plant and equipment	8	(1,879)	(4,979)
Purchase of intangible assets	9	(772)	(3,845)
Capital reduction from joint venture	10	4,000	–
Net cash inflow / (outflow) from investing activities		**1,349**	**(8,824)**
Cash flows from financing activities			
From the consolidated fund (supply) – current year		35,500	48,802
Increase / (decrease) in cash	12	**662**	**(1,962)**

The notes numbered 1 to 24 on pages 35 to 50 form part of this account

Statement of changes in taxpayers equity
For the year ended 31 March 2011

	Notes	General Fund £000	Revaluation Reserve £000
Balance at 31 March 2010		**22,029**	**14**
Changes in taxpayers' equity for 2010/11			
Net operating costs for the year		(39,808)	–
Transfer of joint venture	10	(8,000)	–
Transfer between reserves		2	(2)
Total recognised income and expense for 2010/11		**(47,806)**	(2)
Net parliamentary funding – drawn down		35,500	–
Balance at 31 March 2011		**9,723**	**12**

Notes to the accounts

1.1 General information

The Health and Social Care Information Centre (NHS IC) is an arms length body of the Department of Health incorporated in England. The address of its registered office and principle place of business are disclosed in the introduction to the annual report. The principle activities of the NHS IC is the collection, analysis and dissemination of health data for secondary uses purposes.

1.2 Accounting policies

The financial statements have been prepared in accordance with the 2010/11 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.

In accordance with the 2010/11 FReM, capital charges have been excluded from the annual accounts.

Prior year accounts have been restated due to this accounting policy change and the statement of financial position and accompanying notes amended accordingly. A second comparative year has been omitted. This is a departure from the requirements of IAS1. A direction has been issued by HM Treasury permitting non-departmental public bodies and other public bodies to omit a third statement of financial position. A prior period adjustment note is disclosed at note 23.

1.3 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.

1.4 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.

1.5 Administration and programme expenditure

The statement of comprehensive net expenditure 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.

1.6 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.

1.7 Losses and special payments

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

Losses and special payments are charged to the relevant functional headings in the statement of comprehensive net expenditure.

1.8 Employee benefits

Short-term employee benefits

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

Retirement benefit costs

Past and present employees are covered by the provisions of the NHS Pensions Scheme. The scheme is an unfunded, defined benefit scheme that covers NHS employers, general practices and other bodies, allowed under the direction of the Secretary of State, in England and Wales. The scheme is not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, the scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in the scheme is taken as equal to the contributions payable to the scheme for the accounting period. For early retirements other than those due to ill health the additional pension liabilities are not funded by the scheme.

The full amount of the liability for the additional costs is charged to expenditure at the time the organisation commits itself to the retirement, regardless of the method of payment.

1.9 Joint venture

The investment in the joint venture was accounted for under the principles of IAS 31 Joint Ventures. 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 was subject to a valuation at 31 March 2010.

During the year the interest in the joint venture was transferred to the Department of Health.

1.10 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 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 lives of the asset

2) Purchased computer software licences are amortised over the shorter of the term of the licence and their useful economic life

3) Each equipment asset is depreciated on a straight line basis over its expected useful life as follows

— Fixtures and fittings 7 – 13 years

— Office, information technology, short life equipment 3 – 5 years

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

1.11 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.

1.12 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.

1.13 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 to income to offset the amortisation charge over the expected useful life of the related assets.

1.14 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.

1.15 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 statement of net expenditure 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 4.

1.16 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 statement of net expenditure in order to reflect as closely as possible the phasing of this expenditure incurred.

Dilapidation provision

The NHS IC has provided £690,000 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 which is used as the basis of the provision.

Staff termination costs

During the year, the NHS IC has undertaken a restructuring which has resulted in a number of permanent posts being placed at risk. The exact details of the restructure has not been fully finalised and some cost estimates have been made. A costing model has been developed which has proved to be reliable to date and is the basis used for assessing the provision required.

1.17 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.

2 Statement of operating costs by activity

For the year ended 31 March 2011

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.

2010/11 £000	Information services	NHS central register	Clinical audit	Business development and programmes	Information governance	Supporting functions	Total
Core funding	26,793	3,879	–	6,201	1,633	1,900	40,406
Other income	6,799	1,317	3,549	2,815	–	2,431	16,911
Staff costs	(10,615)	(3,133)	(2,066)	(5,866)	(863)	(6,073)	(28,616)
Other costs	(14,033)	(1,156)	(751)	(2,585)	(20)	(9,558)	(28,103)
Contribution	**8,944**	**907**	**732**	**565**	**750**	**(11,300)**	**598**
Central overhead	(6,879)	(943)	(827)	(2,338)	(313)	11,300	–
Net surplus / (deficit)	**2,065**	**(36)**	**(95)**	**(1,773)**	**437**	**–**	**598**

2009/10 £000	Information services	NHS central register	Clinical audit	Business development and programmes (as restated)	Information governance	Supporting functions (as restated)	Total
Core funding	29,058	4,712	–	7,718	1,524	–	43,012
Other income	6,712	1,229	3,949	2,631	–	1,278	15,799
Staff costs	(11,213)	(3,325)	(2,176)	(5,766)	(770)	(6,683)	(29,933)
Other costs	(16,272)	(1,277)	(877)	(2,968)	(122)	(6,795)	(28,311)
Contribution	**8,285**	**1,339**	**896**	**1,615**	**632**	**(12,200)**	**567**
Central overhead	(7,423)	(1,243)	(825)	(2,468)	(241)	12,200	–
Net surplus / (deficit)	**862**	**96**	**71**	**(853)**	**391**	**–**	**567**

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

The segmental analysis represents the key areas of activity for the NHS IC breaking down business into its main core themes.

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 against clinical guidelines, 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 the NHS IC to provide assurance and demonstrate its competency as a trusted custodian of health and social care data.

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

3 New and revised IFRSs applied with no material effect on the consolidated financial statements

The following new and revised IFRSs have not been adopted in these consolidated financial statements. The application of these new and revised IFRSs has not had any material impact on the amounts reported for the current and prior years but may affect the accounting for future transactions or arrangements.

IFRS 9 Financial instruments	Effective for annual periods beginning on or after 1 January 2013. The amendments consolidate disclosure and recognition issues in connection with financial instruments including IAS 32 and IAS 39.
IFRS 10 Consolidation	Effective for annual periods beginning on or after 1 January 2013. To establish principles for the presentation and preparation of consolidated financial statements when an entity controls one or more other entities.
IFRS 11 Joint ventures	Effective for annual periods beginning on or after 1 January 2013. To clarify when a party to a joint arrangement determines the type of joint arrangement in which it is involved by assessing its rights and obligations and accounts for those rights and obligations in accordance with that type of joint arrangement.
IFRS 12 Disclosure on interest in other entities	Effective for annual periods beginning on or after 1 January 2013. To clarify how certain aspects of existing IASB literature are to be applied to service concession arrangements.
IFRS 13 Fair value measurement	Effective for annual periods beginning on or after 1 January 2013. Seeks to increase consistency and comparability in fair value measurements and related disclosures through a 'fair value hierarchy'.
IAS 1 Presentation of comprehensive income	Effective for annual periods beginning on or after 1 January 2011. To prescribe the basis for presentation of general purpose financial statements, to ensure comparability both with the entity's financial statements of previous periods and with the financial statements of other entities.
IAS19 Defined benefit plans	Effective for annual periods beginning on or after 1 January 2011. To prescribe the accounting and disclosure for employee benefits.
IAS 24 (amended) Related party disclosures	"Effective for annual periods beginning on or after 1 January 2011. To ensure that an entity's financial statements contain the disclosures necessary to draw attention to the possibility that its financial position and profit or loss may have been affected by the existence of related parties and by transactions and outstanding balances with such parties.
IAS 27 Separate financial statements	Effective for annual periods beginning on or after 1 January 2013. This has the twin objectives of setting standards to be applied in the preparation and presentation of consolidated financial statements for a group of entities under the control of a parent; and in accounting for investments in subsidiaries, jointly controlled entities, and associates when an entity elects, or is required by local regulations, to present separate (non-consolidated) financial statements.
IAS 28 Associates	Effective for annual periods beginning on or after 1 January 2013. To clarify when an investor has significant influence but not control or joint control except for investments held by a venture capital organisation, mutual fund, unit trust, and similar entity that are designated under IAS 39 to be at fair value with fair value changes recognised in profit or loss.
IAS 32 (amended) Classification of rights issues	Effective for annual periods beginning on or after 1 January 2011. To establish principles for presenting financial instruments as liabilities or equity and for offsetting financial assets and liabilities.
IFRIC 14 Prepayments of a minimum funding requirement	Effective for annual periods beginning on or after 1 January 2011. The amendment is to recognise as an asset some voluntary prepayments for minimum funding contributions.
IFRIC 19 Extinguishing financial liabilities with equity instruments	Effective for annual periods beginning on or after 1 July 2010. Clarifies the accounting of the entity that issues equity instruments in order to settle, in full or in part, a financial liability.

4 Staff numbers and related costs

	2010/11 £000	2009/10 £000 (as restated)
Salaries and wages	19,365	17,637
Social security costs	1,547	1,406
Employer superannuation contributions – NHSPA	2,035	1,826
Employer superannuation contributions – other	619	642
Staff seconded to other organisations	130	262
	23,696	**21,773**
Temporary staff	**470**	1,150
Contractors	**5,212**	9,372
Capitalised staff costs	**(762)**	(2,362)
	28,616	**29,933**

The average number of whole term equivalent persons employed during the year was:	2010/11 Number	2009/10 Number
Permanent staff	530	527
Temporary and contract staff	53	105
Total	**583**	**632**

During the year, the NHS IC engaged temporary staff, contractors and secondees on differing contractual terms and arrangements. Due to the nature of these contracts, it is not possible to precisely quantify the full time equivalent number of persons employed. It is estimated that 9 full time equivalent persons are engaged on these arrangements (2009/10 27).

The analysis for 2009/10 has been adjusted to gross up certain income received for staff seconded to other organisations. Income is shown within fees, charges and other income in note 6.

During the year, provisions for staff termination costs of £1,521,000 have been made.

Expenditure on staff benefits

There were no amounts spent on staff benefits during the year (2009/10: £NIL).

Retirements due to ill health

During 2010/11 there were no early retirements from the NHS IC on the grounds of ill health (2009/10 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 price 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 2010/11, employer's contributions of £618,630 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.

Further details of the benefits payable can be found on the NHS pensions website at: www.pensions.nhsbsa.nhs.uk.

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 2011, is based on detailed membership data as at 31 March 2008 (the latest midpoint) updated to 31 March 2011 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.

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 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.

5.1 Reconciliation of net operating cost to net resource outturn

	2010/11 £000	2009/10 £000 (as restated)
Net resource outturn	39,808	42,445
Revenue resource limit	40,406	43,012
Underspend against revenue resource limit	**598**	**567**

The underspend as disclosed in the 2009/10 financial statements was £51,000. In 2010/11 a prior year adjustment was made to the 2009/10 comparatives for the cost of capital (see note 23).

5.2 Reconciliation of gross capital expenditure to capital resource limit

	2010/11 £000	2009/10 £000
Capital expenditure	3,447	8,468
Capital resource limit	7,184	8,470
Underspend against capital resource limit	**3,737**	**2**

6 Income

Operating income analysed by classification and activity is as follows:	2010/11 £000	2009/10 £000 (as restated)
Income towards programme activities	4,458	3,969
Funding for surveys and publications	3,396	4,559
Fees and charges	7,826	6,437
Other income	1,231	834
	16,911	**15,799**

Included in the above number is income received from the Scottish Parliament £134,841 (2009/10 £12,436), the National Assembly for Wales £367,372 (2009/10 £341,390), and the Northern Ireland Assembly £61,703 (2009/10 £343,694).

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

Other income for 2009/10 has been restated to gross up secondee income from other bodies.

The following information is provided for fees and charges purposes in accordance with the requirements of the FReM

	Clinical Audit Services £000	Data Related Services £000	2010/11 Total £000	2009/10 Total £000
Income	3,549	4,277	7,826	6,437
Less direct costs and overheads	(2,817)	(3,384)	(6,201)	(4,788)
Contribution	732	893	1,625	1,649
Allocation of central overheads	(827)	(572)	(1,399)	(1,293)
Net surplus / (deficit)	(95)	321	226	356

Clinical audit services funding is mainly 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. The financial objective of the clinical audit programme is full cost recovery.

Data related services relates to the provision of health related data in a form the customer requires, data linkage services and extracts for research purposes. The financial objective is to recover full direct cost plus a percentage mark up.

7 Programme costs

	£000	2010/11 £000	£000	2009/10 £000 (as restated)
External contractors		15,081		19,065
Training and conferences		169		629
Travel		572		1,020
Accommodation costs		2,346		2,396
Personal IT equipment		338		479
IT maintenance and support		608		286
Office services		456		597
Advertising and publicity		202		393
External audit services		68		68
Other fees to external auditors		–		10
Miscellaneous		56		445
Non cash transactions				
Depreciation and amortisation	4,103		2,937	
Impairment and loss on sale of assets	2,465		–	
Provisions	1,639	8,207	(14)	2,923
		28,103		**28,311**

8 Non-current assets - 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 2010	3,013	2,504	3,372	8,889
Additions	963	55	491	1,509
Impairments	–	–	(1,904)	(1,904)
Transfers	558	–	–	558
Disposals	(470)	(48)	–	(518)
At 31 March 2011	**4,064**	**2,511**	**1,959**	**8,534**
Depreciation				
At 1 April 2010	1,696	730	–	2,426
Provided during the year	767	245	–	1,012
Transfers	(83)	–	–	(83)
Disposals	(470)	(48)	–	(518)
At 31 March 2011	**1,910**	**927**	**–**	**2,837**
Net book value at 1 April 2010	**1,317**	**1,774**	**3,372**	**6,463**
Net book value at 31 March 2011	**2,154**	**1,584**	**1,959**	**5,697**

Certain development costs were capitalised under assets in the course of construction during 2009/10. Following a review of major capital projects and changed circumstances some of these costs have been impaired during 2010/11 as they no longer are deemed to have an economic value. The impairments have been charged to development programmes in the segmental reporting note.

The transfer relates to assets reclassified from intangible assets following a detailed review of the fixed asset register as part of the impairment review.

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 £603,061 (2009/10 £873,840)

9 Non current assets - intangible fixed assets

Cost or Valuation	Software licences £000	Information technology £000	Websites £000	Total £000
At 1 April 2010	604	12,503	1,296	14,403
Additions	18	1,791	129	1,938
Impairments	(127)	(421)	–	(548)
Transfers	–	(558)	–	(558)
Disposals	(99)	(15)	–	(114)
At 31 March 2011	**396**	**13,300**	**1,425**	**15,121**
Depreciation				
At 1 April 2010	209	4,109	90	4,408
Provided during the year	111	2,707	273	3,091
Transfers	–	83	–	83
Disposals	(99)	(2)	–	(101)
At 31 March 2011	**221**	**6,897**	**363**	**7,481**
Net book value at 1 April 2010	**395**	**8,394**	**1,206**	**9,995**
Net book value at 31 March 2011	**175**	**6,403**	**1,062**	**7,640**

The gross cost of intangible assets that has been fully depreciated but still in use is £2,156,224 (2009/10 £1,059,525).

The transfer relates to assets reclassified to tangible assets following a detailed review of the fixed asset register as part of the impairment review

10 Financial assets

	31 March 2011 £000	31 March 2010 £000
Investment in joint venture	–	12,000

The NHS IC investment in the joint venture arrangement known as Dr Foster Intelligence Limited was disposed of during the year as follows:
— On 1 April 2010 Dr Foster Intelligence Limited undertook a capital reduction for which the NHS IC received £4,000,000
— On 1 July 2010 the whole of the NHS IC shareholding in Dr Foster Intelligence Limited was transferred to the Department of Health at the remaining book value of £8,000,000.

11 Trade receivables and other current assets

Amounts falling due within one year	31 March 2011 £000	31 March 2010 £000
Trade receivables	3,474	3,449
Value added tax	94	132
Prepayments and other receivables	1,113	1,017
	4,681	**4,598**

Intra-government balances

Intra-government balances within trade receivables and other current assets are as follows:	31 March 2011 £000	31 March 2010 £000
Department of Health and other central government bodies	2,629	1,206
NHS Trusts and PCTs	38	15
Other external bodies	2,014	3,377
	4,681	**4,598**

12 Cash and cash equivalents

	31 March 2011 £000	31 March 2010 £000
Balance at 1 April	3,095	5,057
Net changes in cash and cash equivalents	662	1,962
Balance at 31 March	**3,757**	**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

13 Trade payables and other current liabilities

Amounts payable within 1 year	31 March 2011 £000	31 March 2010 £000
Trade payables	1,868	3,271
Other payables	636	308
	2,504	**3,579**
Taxation and social security	499	510
Deferred income	3,102	4,416
Accruals	2,975	3,923
Provisions	1,963	433
	8,539	**9,282**
Total payables and other current liabilities	**11,043**	**12,861**

Intra-government balances

Intra-government balances within trade payables and other current liabilities are as follows:	31 March 2011 £000	31 March 2010 £000
Department of Health and other central government bodies	298	14
NHS Trusts and PCTs	48	31
Other external bodies	10,697	12,816
	11,043	**12,861**

14 Provisions for liabilities and charges

	Injury benefit £000	Lease surrender £000	Dilapidations £000	Staff termination £000	Total £000
At 31 March 2010	140	80	690	770	1,680
Arising during the year	–	155	–	1,521	1,676
Utilised during the year	(16)	(57)	–	(286)	(359)
Reversed unutilised	–	–	–	(37)	(37)
At 31 March 2011	**124**	**178**	**690**	**1,968**	**2,960**
Expected timing of cash flows					
Within 1 year	16	142	180	1,625	1,963
1–5 years	66	36	35	343	480
Over 5 years	42	–	475	–	517

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. The amount due is based on an assessment by the NHS Pensions Agency.

Lease surrender costs relate to the anticipated costs for the vacant property in Exeter and represent costs payable to the end of the lease less the contribution from a subtenant on part of the building.

The dilapidation provision refers to the anticipated costs for remedial works at the end of the leases for the Leeds and London offices and is based on an assessment by a property advisor.

Staff termination costs refer to the cost of employee terminations. Payments are made monthly to the NHS Pensions Agency, directly through the payroll or are provisions for restructuring during the year ended 31 March 2011. The costs arising in the year have been calculated based on actual costs agreed or a detailed internal calculation using relevant guidance and terms and conditions of employment for those posts placed at risk.

Exit packages are detailed as follows

Exit package cost band	Number of compulsory redundancies	Number of other departures agreed	Total number of exit packages by cost band (total cost) 2010/11
<£20,001	*	10	10
£20,000 - £40,000	*	10	10
£40,000 - £100,000	*	10	10
£100,000 - £150,000	*	*	*
£150,000 - £200,000	*	*	*
Total	**11 (£419,206)**	**27 (£779,451)**	**38 (£1,198,657)**

*The number of exit packages have been rounded to the nearest 10 and where below 5 have been asterisked.

There were no exit packages in 2009/10.

15 Capital commitments

Capital commitments amount to £NIL (2009/10 £179,861)

16 Commitments under operating leases

Expenditure includes the following in respect of operating leases:	**2010/11 £000**	**2009/10 £000**
Accommodation	1,423	1,394
Operating leases	248	386
	1,671	**1,780**
At the balance sheet date, the NHS IC is committed to making the following payments under non-cancellable operating leases for:		
Land & buildings		
The next year	1,109	196
Years two through five combined	3,065	310
Beyond five years	944	785
	5,118	**1,291**
Office equipment		
The next year	194	4
Years two through five combined	47	382
	241	**386**
Total	**5,359**	**1,677**

17 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 2011 (31 March 2010 £NIL)

18 Contingent assets and liabilities

There are no contingent assets or liabilities at 31 March 2011 (31 March 2010 - £NIL)

19 Losses and special payments

There were 10 losses and special payments in 2010/11 amounting to £30,428 (2009/10 £91,261). Interest totalling £294 was paid under the Late Payment of Commercial Debt (Interest) Act 1998 (2009/10 £1,343)

20 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 of Health, and with other entities for which the Department of Health 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.

Listed below are those related parties where either the transactions or the balance is in excess of £5,000. The investment in the joint venture with Dr Foster Intelligence Ltd was transferred to the Department of Health on 1 July 2010, but transactions for the full financial year have been disclosed below.

No related party transactions were noted with key management other than remuneration and expenses as disclosed in the remuneration report.

	Amounts payable at 31 March 2011 £000	Amounts receivable at 31 March 2011 £000	Income in 2010/11 £000	Expenditure in 2010/11 £000
Department of Health	284	2,576	11,683	882
Dr Foster Ltd and group companies		12	113	50
Strategic Health Authorities				
Yorkshire and The Humber Strategic Health Authority			10	
Special Health Authorities				
National Patient Safety Agency			93	
NHS Business Services Authority	14			84
NHS Institute of Innovation and Improvement		17	575	
NHS Litigation Authority			30	
Health Protection Agency	13		2	13
With English Primary Care Trusts				
Barnsley PCT			204	
Bradford and Airedale PCT		11	158	
East Riding of Yorkshire PCT				27
Hampshire PCT			12	
South East Essex PCT				8
NHS Trusts				
Bradford District Care NHS Trust				20
East Midlands Ambulance Service NHS Trust			16	
Kent and Medway NHS Trust				5
Leeds Teaching Hospitals NHS Trust	3		1	12
Newham University Hospital NHS Trust			5	
North Cumbria University Hospitals NHS Trust				12
North East Ambulance Service NHS Trust			11	
Southampton University Hospitals Trust				531
University Hospital of North Staffordshire NHS Trust				139
University Hospitals of Leicester NHS Trust				43
West Middlesex University NHS Trust				21
Worcestershire Acute Hospitals NHS Trust				10
NHS Foundation Trusts				
Calderdale and Huddersfield NHS Foundation Trust				5
Cambridge University Hospital NHS Foundation Trust				6
Derby Hospitals NHS Foundation Trust				5
Guys and St Thomas NHS Foundation Trust	11			140
Moorfields Eye Hospital NHS Foundation Trust				54
Sheffield Teaching Hospitals NHS Foundation Trust	7			7
South Tees Hospitals NHS Foundation Trust	12			12
University Hospital Birmingham NHS Foundation Trust			33	

21 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 monies 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

	20010/11 £000	2009/10 £000
Balance at the beginning of the period	8	16
Amounts written off during the year as uncollectable	–	(14)
Impairment losses recognised	103	8
Impairment losses reversed	–	(2)
Balance at the end of the period	**111**	**8**

The allowance for doubful debts is a specific provision determined on an individual debt basis.

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

	Current £000	Less than 30 days overdue £000	31-60 days overdue £000	61 and over days overdue £000	Total £000
At 31 March 2011	2,562	846	4	62	3,474
At 31 March 2010	2,290	589	470	100	3,449

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 manage liquidity risk through regular cash flow forecasting. The NHS IC 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 2011	31 March 2010
Current liabilities	11,043	12,862

22 Post balance sheet events

In accordance with IAS10, events after the reporting period are considered up to the date on which the accounts are authorised for issue.

There are no post statement of financial position events that would require to be reported.

23 Prior period adjustments

Change in accountancy policy

In line with the Treasury Financial Reporting Manual, capital charge interest is no longer applied. Prior year figures have been restated to be compatible to the current year.

The restatement of £516,000 has the following effect on the 2009/10 figures as previously reported:

— a decrease in non-staff programme costs from £28,692,000 to £28,176,000 (SOCNE)

— a decrease in net operating cost from £42,961,000 to £42,445,000 (SOCNE/cashflow)

— a decrease in net resource outturn from £42,961,00 to £42,445,000

— a reduction in other costs from £3,484,000 to £2,968,000 in development programmes on the statement of operating costs by activity

— removal of capital charges in note 7 programme costs reducing the total of non cash transactions from £3,304,000 to £2,788,000.

In addition, certain prior period balances have been reclassified so they are on a comparable basis, grossed up, with the accounting treatment adopted in the current year in line with IAS28:

— gross up secondee income of £114,000 (increase income and staff costs)

— gross up other bodies contribution to amortisation costs of £135,000 (increase income, increase non cash transactions in programme costs and also amend the cash flow by increasing non cash transactions and trade and other payables)

— cash flow comparatives relating to the purchase of property, plant and equipment and intangible fixed assets have been represented to correctly demonstrate the classification between tangible and intangible assets.

24 Authorised date for issue

The NHS IC's Annual Report and Accounts are laid before the Houses of Parliament by the NHS IC. IAS10 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 5 July 2011.

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