The Information Centre

Annual report and accounts 2007/08

The Health and Social Care Information Centre

Annual report and accounts 2007/08

The Health and Social Care Information Centre

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The NHS Information Centre is England's central, authoritative source of health and social care information.

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Foreword

At the leading edge of health and social care information

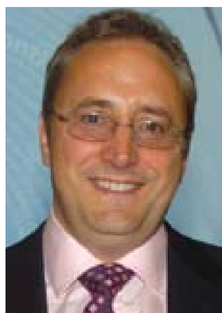
We are pleased to present the third annual report of The NHS Information Centre for health and social care (The NHS IC).

Since it came into being in 2005, the organisation has continued to establish itself as England's central, authoritative source of health and social care information. We deliver a substantial portfolio of products and services for planning and benchmarking, statistical publications on lifestyle issues such as alcohol and obesity as well as a programme of national clinical audits.

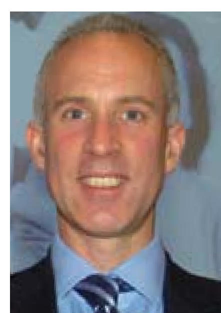
This third report highlights how we have helped support our customers with high quality information. Our dedicated team of statisticians, information specialists and support staff delivered an extensive programme of work to meet our strategic objectives last year. This included the launch of the NHS Comparators website and delivering data directories for the NHS Choices service.

We believe passionately in the value of high quality information in helping local decision makers deliver better services locally. Going forward, our organisation will continue to collect, analyse and distribute data in multiple formats across multiple channels with the overall goal of improving patient care.

In light of the current *Our NHS, Our future* review which sets out a vision of a health service that is 'clinically led, patient centred and locally accountable', The NHS IC will focus more keenly on the information needs of frontline health and social care professionals in the coming year.



Mike Ramsden
Chairman



Tim Straughan
Chief Executive

8 July 2008

Pictures right: The NHS IC executive team

Highlights 2007/08

» Conducted a **wide-scale consultation among 125 local authorities** to learn more about the information needed to support better social care

» Improved the quality of information in the annual NHS Workforce Census by using, for the first time, data from the **Electronic Staff Record**

» Launched **NHS Comparators** service – helping commissioning decisions for over 4,700 users since June 2007

» Delivered and improved over 20 data directories for **NHS Choices** to help the public make better decisions about their care

» Published **120 statistical** reports in health and social care to support public health policy and service planning

» Provided **prescribing information** to support NICE guidelines to manage the drugs bill more effectively

» Developed **HRG4** to support the Department of Health's Payment by Results policy

» Extended information available to the public about GP practices with Quality and Outcomes Framework **(QOF) results**

» Delivered the **National Diabetes Audit** based on more than one million patient records

» Provided material to answer more than 2,000 **parliamentary questions**, ensuring effective government

Who we are

The NHS Information Centre is England's central, authoritative source of health and social care information. Acting as a 'hub' for high quality, national, comparative data for secondary uses, we deliver information for local decision makers to improve the quality and efficiency of frontline care.

Strategic objectives

Focussing on frontline services

We are increasing our range of products and services which help support frontline services to meet government initiatives, by supporting practice based commissioning and progress towards 18 weeks.

Ensuring fair, easy and timely access to our information

Our information is available online and free of charge. We deliver a substantial portfolio of products and services that include core information to underpin planning, benchmarking and improvements right across the healthcare system. We also produce regular statistical publications on subjects ranging from lifestyle issues such as alcohol and obesity to workforce figures and earnings.

Experts in the integrity and quality of information

Local commissioners need reliable, quality information they can trust. The NHS IC is working to ensure providers have clear guidance on implementing new commissioning datasets and minimising the risk of data duplications and rejections of data submissions to the Secondary Uses Service.

Customers

The NHS IC believes its products and services can have a real impact on frontline care and its overriding priority is to support frontline organisations in delivering better care.

NHS and adult social care is entering a new phase with the need for local provision to more accurately reflect local need.

Partnerships

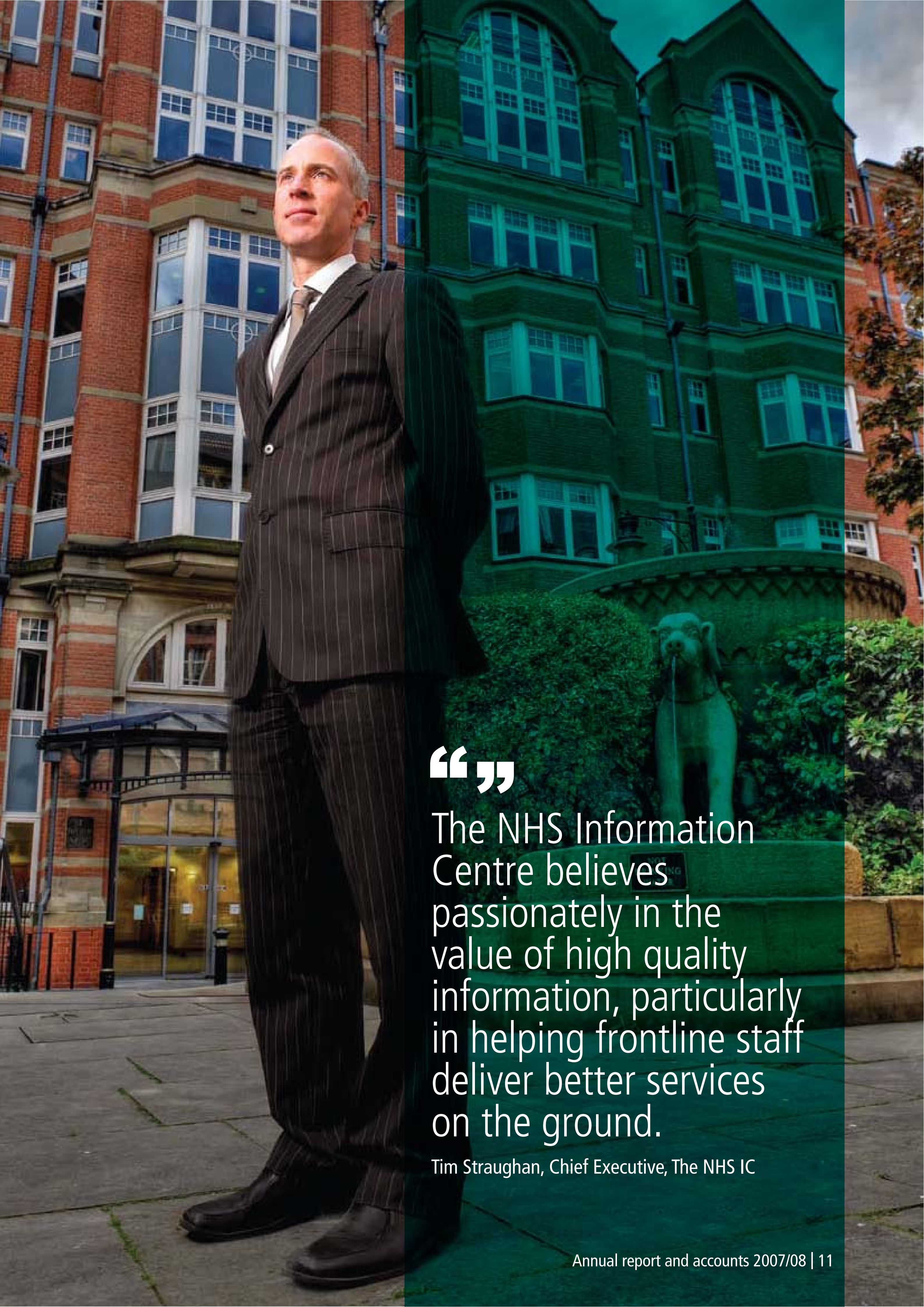
The NHS IC recognises the value of collaborative partnerships with a wide range of information providers and users in the health and social care market.

As a frontline focussed organisation, The NHS IC works in partnership with a range of leading providers including Doctor Foster Intelligence Ltd, Newchurch plc and Alignea, amongst others. It actively encourages new entrants into the market place.

Dr Foster Intelligence Ltd

Dr Foster Intelligence Limited (DFI) is a joint venture company in which The NHS IC has a 50% interest. It has provided the NHS with a wide range of information products, services and tools to improve the quality of patient care and has done so with great success; more than 75% of hospitals in the NHS and 50% of PCTs use its services to monitor their performance.

The Department of Health and The NHS IC will continue to develop the DFI venture in a way that best meets its strategic goals and the public interest of both organisations.



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The NHS Information Centre believes passionately in the value of high quality information, particularly in helping frontline staff deliver better services on the ground.

Tim Straughan, Chief Executive, The NHS IC

Role in the health and social care information market

Quality and standards

Ensuring the right information quality, governance and standards in data and data collections

Delivering solutions

Working collaboratively alongside customers and partners to best utilise our information

Access

Improving access to and interpretation of data through better presentation and reporting

Ensuring fair and equal access to the information

Data and data collection

Products and services

The NHS IC provides a wealth of products and services to help commissioners and providers improve patient and client care within the following areas:

Commissioning

Our information supports local commissioners at every stage of the commissioning cycle including assessment of local health and care needs

Managing finance and performance

- Healthcare Resource Groups to support Payment by Results policy
- Access to NHS practice-level comparators and indicators
- 18 weeks referral to treatment reporting application

Workforce matters

- Statistics on the NHS workforce profile including Electronic Staff Record
- Doctors and dentists statistics and remuneration

Clinical

- Audits in many areas including heart disease, diabetes, cancer and renal
- Secondary Uses Service (SUS) and Hospital Episode Statistics (HES) to inform planning, performance monitoring and research
- Support and advice on managing the primary care drugs bill
- Medical Research Information service to support medical researchers

Social care

- Publications covering many aspects of social care to help decision makers provide the best possible care services
- Statistics on the money spent on social services, direct payments and individual budgets for each local authority
- Developing a new National Adult Social Care Intelligence service to enable benchmarking and analysis of national trends

Public health and key indicators

- National statistics on alcohol, drugs, smoking, obesity and health inequalities
- Area based assessments with robust data from a range of sources using Compendium of Public Health Indicators (NCHOD)
- National Health Survey for England
- Online GP Quality Outcomes Framework (QOF) database
- NHS Central Register of all NHS patient details, from cradle to grave

Picture right: promoting our products and services at NHS Confederation 2008

nhs.uk
'What level of activity do my providers deliver?'
DH Department of Health

Our people

As leaders in the information management community for health and social care, our people are actively involved in shaping the professional development of information staff and sharing best practice in the health service.

Pam Hughes

Customer and Policy Manager

Pam led the pilot health informatics graduate training scheme in 2007, helping improve standards in information management.

The aim of the scheme is to increase the informatics capability and capacity in the NHS to meet current and emerging NHS policy. The trainees started work in NHS organisations in October 2007.

Two of the host trusts – Western Cheshire Primary Care Trust and Heart of England NHS Foundation Trust – are extremely pleased with how the scheme has raised the profile of health informatics as a career pathway both within and outside the NHS.

Evidence from the training scheme is being used in the development of a North West 'intelligence consortium', a co-funded initiative between the NHS North West SHA and the 24 North West PCTs. Further evidence of a raised profile for the scheme will emerge nationally through the NHS Informatics Review.

Virginia Jordan

Programme Head of Standards and Classifications

Virginia has been elected to join the Patient Classifications System International (PCSI) Scientific Committee for a three-year term as one of four representatives of Europe.

The PCSI is the professional body of the international casemix community and brings together 24 countries. The development of HRG4 for casemix is fundamental to Payment by Results.

I regularly present at international casemix conferences, which helps to reinforce the credibility and appropriateness of our work.

By sharing and learning from international experience of casemix developments, this helps to reassure us that others are actively pursuing similar policies and reinforces the general direction of travel in England.

There are also opportunities to review our work in the international arena – for example, I am liaising with European colleagues to assess if it is possible to develop a European benchmarking tool of patient activity care comparisons.

Emma Queenan

Head of Project Office

Emma delivers projects vital for frontline services that are to time, on specification and on budget.

She recently presented the lessons learned from implementing our project office at a major national conference, part of the Association of Project Management (APM). It is the largest independent professional body of its kind in Europe.

As well as raising the profile of The NHS IC to the project management profession, my presentation showed how we have led the development of best practice in this area.

As a result of this, the project office has established contacts with a number of organisations facing similar challenges, helping us to learn from their experiences and share our knowledge and skills as The NHS IC develops.

Supporting the NHS frontline

The NHS Comparators site enabled us to map and plan how we could change from a hospital based to a community based service. Dr Ian Greaves, GP, Staffordshire

A breath of fresh air for community health

Asthma sufferers are breathing easier at Dr Ian Greaves' Staffordshire practice. Instead of many patients having to go to hospital for urgent care, the services are coming to them.

The practice developed a new strategic partnership with their local acute trust after NHS Comparators revealed it referred many more sufferers than average for hospital admittance.

"We felt the high number of admissions could be avoided if urgent care services were better," said Ian.

"So we agreed with the trust to bring those services here to the practice."

From January 2008, junior doctors and doctors of registrar level have been based at the practice 6:30pm-10:30pm every evening, including weekends and bank holidays.

They see urgent cases, including asthmatics, as well as hospital outpatient follow-ups.

Ian said: *"Any new patient we refer will be seen by the doctors that evening so we can therefore easily meet the 18 weeks target."*

"The patient is presented to the consultant by the junior doctor, who gets apprentice type training. We are using the doctors who have failed to get onto specialist training posts and therefore they will have a better CV for when they reapply next year."

Four new nebulisers have also been bought for practice and home use.

The practice and trust are working together to improve patient safety for early discharge from hospital after NHS Comparators highlighted a high number of practice patients being delayed in discharge.

This process also streamlined the practice's aim to deliver a more community driven service. Discussions are in progress to integrate community, intermediate care and hospital nurses which will enable hospital care to be delivered at home.

"The NHS Comparators site enabled us to map and plan how we could change from a hospital based to a community based service," said Ian.

"By involving the hospital we did not undermine them; the site really helped them see what we were about."

Dr Ian Greaves, GP, Staffordshire

Supporting clinicians

I find the audit very helpful as it gives the whole picture rather than just a local one, so I can compare our performance with other areas of the country.

Dr Bob Young, Consultant Diabetologist, Salford

National Diabetes Audit sparks new health campaign in Salford

Type 2 diabetes can be difficult to spot – and the signs may be going unnoticed by future patients in Salford.

Dr Bob Young, consultant diabetologist at the city's Hope Hospital, said the National Diabetes Audit highlighted a much smaller number of people than expected in the area were being diagnosed with type 2 diabetes.

"This could be due to people not knowing about the condition or its symptoms," he said.

"So as a priority, we are working with the local public health organisation to develop an awareness programme for practices and the wider community."

The audit also identified a variation in the standard of support for diabetics among Salford's 60 general practices.

"This was very apparent from the audit and resonated with the views of the Healthcare Commission," said Bob.

"Now we have started a practice development programme, targeting those practices identified as underperforming."

A specialist diabetes team now works with such practices; the ultimate aim being to offer a consistently high standard of care across the city.

"I find the audit very helpful as it gives the whole picture rather than just a local one, so I can compare our performance with other areas of the country," added Bob.

"We will certainly use the next audit to help assess whether these two priority programmes have been successful."

Dr Bob Young, Consultant Diabetologist, Salford

Supporting patients

The NHS IC provided much needed quality assurance to the NHS Choices directories which helped to establish the credibility of the site at launch and continues to do so.

Beverley Bryant, Former Director of Information Services, Department of Health

NHS Choices – building patient trust with quality data

"Information and choice are indispensable if we are to achieve a truly patient-centred NHS in which standards and quality are constantly improved."
Ben Bradshaw, Minister of State for Health Services

This vision puts quality information at the heart of patient choice. The NHS IC's contribution to the successful launch of the NHS Choices website in June 2007 delivered exactly that.

The dedicated team from The NHS IC ensured that only the most up to date information appeared on the website. The team was responsible for collecting, checking and validating data on frontline organisations (including GP practices, dentists, opticians and pharmacies). These service directories are the most visited area of the NHS Choices website.

Building confidence in the integrity of the information available means more patients will access the services they need, when they need them.

The directories provide key service details such as GP surgery opening times and where to find a local pharmacy for over 40,000 organisations. Ensuring the accuracy of this information was a huge undertaking and in a three-month period, the team made over 8,500 calls to healthcare organisations, carried out over 2,000 spot checks on data, ran extensive cross checks and even conducted 'mystery shopping' exercises to identify errors and duplicate entries.

By March 2008 the team had developed over 20 existing and new directories with quality and accuracy improvements, increasing from as low as 60 per cent to 90 per cent.

Beverley Bryant, Department of Health, former director of information services, said:
"The NHS IC provided much needed quality assurance to the NHS Choices directories which helped to establish the credibility of the site at launch and continues to do so."

"This project has demonstrated that The NHS IC can play a dynamic role in programmes of this sort."

Accessing the NHS Choices website

Supporting primary care

The opportunity to access both high quality data and the professional expertise of The NHS IC has been invaluable in producing and assessing the impact of NICE guidance that is related to pharmaceutical products.

Nicola Bent, NICE Associate Director of Implementation Systems

Working together to provide key prescribing guidance

The NHS IC continues to support vital prescribing guidance work by the National Institute for Health and Clinical Excellence (NICE).

Our prescribing support unit produces data that allows NICE to review current patterns of care delivery, estimate the potential cost of recommendations and monitor the implementation of guidance.

In particular, information on prescribing trends in primary and secondary care is used to monitor the uptake of specialist drugs, such as cancer treatments.

Nicola Bent, NICE associate director of implementation systems, said: *"The opportunity to access both high quality data and the professional expertise of The NHS IC has been invaluable in producing and assessing the impact of NICE guidance that is related to pharmaceutical products."*

The NHS IC also provides NICE with sample databases of anonymised general practice records that show first line treatments for conditions, such as hypertension, and the proportion of patients receiving more than one medicine for such conditions.

Aggregate information from the Quality and Outcomes Framework (QOF) is also provided to identify trends, including the prevalence of long-term conditions.

"Analysis into how NICE guidance is being used is critical to developing our implementation strategy," added Nicola.

"The excellent partnership between the two organisations has undoubtedly underpinned this process – ensuring our knowledge and insight into the use of NICE guidance is based upon the most accurate, relevant information possible."

Nicola Bent, NICE Associate Director of Implementation Systems

Supporting the independent sector

The NHS IC will continue to have a significant role in keeping the momentum to improve the quality, quantity and use of independent sector information.

Lorraine Foley, Head of Informatics at the Healthcare Commission

Helping the independent sector deliver the best NHS funded care

Independent providers of NHS care are improving performance after having more comparative information at their fingertips than ever before.

New data quality reports and workshops by The NHS IC show how they compare to others in the independent sector and the NHS.

Not only does the information help identify strengths and weaknesses, it raises awareness of the importance of improving data submissions and helps paint an accurate picture of care across both sectors.

"The data quality reports produced by The NHS IC provide essential evidence that helps us measure and improve data quality," said James Greenman, group IT director of Care UK.

"The process for submission is complex and feedback from the end recipient helps identify and target areas for further improvement. We are fully committed to working with all NHS bodies to improve the quality of our performance related data and welcome the timely collation of further reports."

As a result, submissions have improved – validity of primary diagnosis data has increased in a year by 10 per cent while validity of primary procedure data has increased by 9 per cent.

Lorraine Foley, head of informatics at the Healthcare Commission, said: *"As the chair of the Joint Agency Working Group on independent healthcare information, I am greatly encouraged to see the data quality of independent sector information is being assessed on the same basis as NHS information.*

"This is an important step in progressing the agenda to ultimately align NHS and independent sector information to support the creation of a level playing field across healthcare."

"The NHS IC will continue to have a significant role in keeping the momentum to improve the quality, quantity and use of independent sector information."

Lorraine Foley, Head of Informatics at the Healthcare Commission

Supporting local authorities

If we did not have access to data showing the impact of our grants on our community, a difference would not have been realised.

Mike Marshall, Head of Commissioning for the Council's Community, Adult and Housing Services Directorate

Community spirit blossoms in Dudley with the help of Grant Funded Services

Ann Green* has lived in her Dudley home for 55 years but, like many older people, struggled to cope with the demands of her garden.

An arthritic hip meant it was hard for Ann to maintain the large vegetable and flower beds that her and husband Tom, who has passed away, spent years tending.

However Ann, 85, remains secure in her own four walls and can also enjoy the garden again thanks to a Grant-Funded Gardening service run by Age Concern and funded by Dudley Metropolitan Borough Council.

Along with 160 other homes in the borough, her garden is maintained by gardeners employed by the service which could not run without the help of a £22,753 annual council grant.

Mike Marshall, head of commissioning for the council's community, adult and housing services directorate, said the council's collection of local monitoring data provides information for the The NHS IC's Grant Funded services return and highlights how its funding of independent and voluntary organisations addresses community need.

"The gardening service has undoubtedly helped people to remain independent in their own homes," he said.

"A well-kept garden helps with quality of life and makes people feel safer. An unkempt garden may be a signal to criminals that the homeowner is vulnerable."

The Grant Funded services return collects information on the number of people who are helped to live more independently in their own homes as a result of person-centred services provided by the voluntary and independent sector.

"Age Concern is looking at helping to expand the service because of the difference it makes," added Mike.

"If we did not have access to data showing the impact of our grants on our community, a difference would not have been realised."

Grant Funded Gardening Service, Age Concern

**Name has been changed.*

A customer perspective

Health and social care professionals agree that information is integral to the commissioning of world class services for patients, but how do they think The NHS IC can help them get there?
We spoke to the chief executive of Stockport PCT, Richard Popplewell, to find out.

Statistics can provide great insight, but they can't always be easy to explain. That's how Richard Popplewell, chief executive of Stockport PCT, feels as he mulls over his area's figures for cardiovascular disease. *"We are second or third highest in the country in terms of cardiovascular spend per head of population, but we have relatively poor outcomes,"* he says rather quizzically. *"Is it too much concentration on (expensive) secondary care services? I don't know."*

But importantly, having identified the problem, Richard is now able to do something about it. His organisation is in the middle of redesigning various pathways for cardiovascular patients – just one part of the PCT's impressive-looking implementation plan.

Making comparisons

Having a hypothesis to start from, says Richard, is key to using information to commission services for the 290,000 residents in this large town to the south of Manchester. He does this by comparing the activity and outcomes of his PCT to the national average or various peer groups to see where there are underlying needs that aren't being met.

By identifying areas such as cardiovascular disease and intermediate care (another local priority), Richard can then look at pathway design, and explore better ways of doing things. But it's formulating these early hypotheses that enables the PCT to get full value out of systems like the Secondary Uses Service (SUS), which is delivered by The NHS IC and NHS Connecting for Health. He can then drill down into specific bits of data so that *"it's question and issue-based, rather than saying here's an enormous dataset the size of the Isle of Wight, let's fish in it".*

Putting money in the right places

Knowing what the PCT is paying for treatment is also important to Richard for which he finds SUS and The NHS IC's Healthcare Resource Groups (HRG4) invaluable. *"Chief execs tend to pay attention to finance because if they don't they almost inevitably tend to get caught out at some stage."* Indeed, use of this information has helped the PCT deliver a £1.7 million surplus for the PCT in 2007/08.

To Richard, not to mention the cardiovascular patients of Stockport, it's important that there's an organisation providing him with national, comparable data. *"It's absolutely vital to be able to compare with other PCTs. You can't and aren't complacent that you're doing all you can, and there's always somebody somewhere doing better."*

Meeting national and local targets

Identifying specific local need is one thing, but it's not always easy to focus on providing new services,when there's a wealth of government targets to be met. Richard though, thinks there is a balance

"by trying to make sure you deliver what you think you need locally and what the public want locally, and not being dominated by the national delivery agenda. Nine times out of ten, what you want to do locally to improve services, such as shorten waiting times and improve patient experience, are absolutely the same things as they want to do centrally."

In Stockport, this means the focus is on meeting the government's target that nobody should wait longer than 18 weeks from GP referral to hospital treatment, while innovating locally to install information systems into community services to create a Stockport-wide health record.

Planning ahead

The PCT finds The NHS IC's new NHS Comparators service useful in planning and monitoring services, and Richard pays respect to his team of analysts: *"We tend to draw down a lot of information from the SUS and then analyse and re-interpret it locally. What is particularly interesting is when you have patients flowing across pathways – hospital one to hospital two, particularly in cancer or chronic conditions, SUS is the only way you can do record linkage."*

Trusting data quality

As information is increasingly recognised as the key to delivering good health and social care services, Richard would like to see more timely data. The NHS IC makes sure that all its data complies to rigorous information governance standards, which ensures high data quality but can cause a time lag while it is thoroughly validated. But Richard thinks it's possible to continue to produce accurate and robust data with a quicker turnaround, possibly by being flexible on the completeness of the data, within acceptable limits. *"I think the NHS uses much too little sampling processes and techniques. I come from an operational research and statistics background where it is as important to get some information to the right meeting, rather than 'perfect' information to the wrong meeting."*

Information standards are of great importance to Richard who says he would like to see identical definitions being used by all the various regulatory agencies, such as the Healthcare Commission, Public Health Observatories and The NHS IC itself. As vice-chair of the NHS Information Standards Board he sees that it is necessary for The NHS IC, NHS Connecting for Health and others to work together to achieve this.

All about access

The NHS IC's biggest contribution to improving patient care could be online data systems that allow analysis. Because it collects information from every PCT and local authority in England, he sees the organisation as able to provide each area with national, comparable information that they generally wouldn't be able to access any other way.

He would like to see friendly interfaces, such as dashboards, that are easy to understand at a glance, and also allow the user to drill down into the information for deeper analysis.

The NHS IC has pioneered this approach with services such as the QOF which gives a detailed breakdown and comparisons for every GP practice in England, and NHS Comparators which enables commissioners to investigate aspects of local activity, costs and outcomes.

Over the next year it plans to develop new systems, including a National Adult Social Care Intelligence service. *"The NHS IC ought to be about holding data warehouses and data sets and then giving tools to process and analyse,"* says Richard. *"But not necessarily doing all the analysis for NHS organisations because everybody's got a slightly different question."*

A safe haven

"I'm attracted by the phrase that Tim Straughan (chief executive of The NHS IC) uses, of a safe and secure haven," Richard continues. *"Safe in terms of adequacy and accuracy, secure in terms of reliability and confidentiality of the data. And a haven in the sense that it tries to be neutral with a professionalism that it will have to ensure in the face of political positions at various times."*

It's a vital role at the centre of the complex and increasingly influential information agenda in which The NHS IC looks set to lead the way over the next couple of years. Richard believes that The NHS IC's ability to provide data and knowledge about all aspects of health and social care will have a direct impact on improving patient care. *"It would be about accuracy, reliability and reasonableness of the measures and data systems and services within it. It means you don't have to think, where's the data come from?"*

Knowing that it's from The NHS IC, it seems, will be a sign of reassurance to senior figures across health and social care for some time to come.

Richard Popplewell is a member of the Secondary Uses Service Programme Board.

Our strategic focus

How we will deliver

We understand that NHS and social care professionals need timely, good quality benchmarking and comparative personal data at a local, rather than national, level. The NHS IC will provide data and information to help local organisations plan better local care.

Key programmes of activity for 2008/09

The NHS IC will continue to support frontline services:

- deliver products and services that address key issues and priorities in NHS and social care
- become the recognised source of data for secondary uses in the health and social care system
- lead on the development of data and information standards and ensure data quality is fit for purpose in terms of consistency, relevance, timeliness and accuracy
- establish an 'honest broker' and 'safe haven' capable of managing the authorised disclosure of information to users
- lead the 'information management' community in health and social care.

For more information

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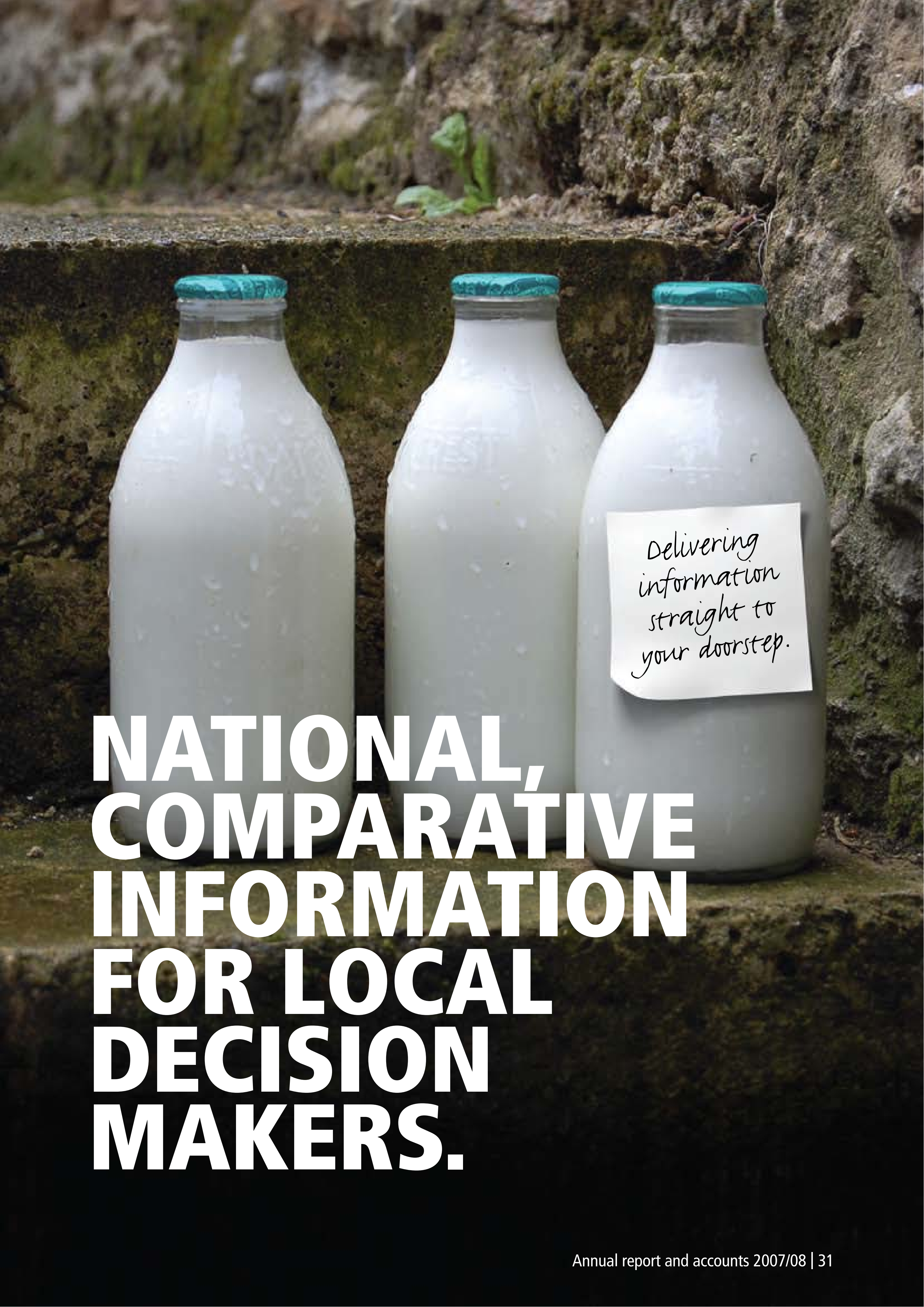
www.ic.nhs.uk



NATIONAL, COMPARATIVE INFORMATION FOR LOCAL DECISION MAKERS.

Board members

Mike Ramsden
Chairman

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

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

Tony Allen
Vice Chairman
Non-executive Director

Tony was a partner at PricewaterhouseCoopers until 30 June 2005, advising a wide range of corporations, both public and private.

From 2001 he was the lead partner for the firm's services to the NHS and to the Department of Health. He also led on governance and the effectiveness of boards. He was appointed as an independent member of the DCSF Audit Committee from 1 July 2005 and the DH Audit Committee from 1 March 2007. He is a trustee of The Wigmore Hall Trust, and Allen's Wholefoods Limited, a family owned health food retail company.

Roger Dewhurst
Operations Director

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

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

Tim Straughan
Chief Executive

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

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

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

Phil Wade
Director of Business Development and Communications

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

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

Stephen Leathley
Acting Director of Finance and Performance

Steve was appointed the acting director of finance and performance on 2 July 2007, having previously headed up the finance team. He joined The NHS IC from the now closed NHS Estates where he was ultimately responsible for closing down the agency's finances.

Steve is a chartered accountant and trained with Ernst and Young. Before joining the public sector, Steve worked within the distribution sector at Graham Builders Merchants Ltd.

Clare Sanderson
Interim Director of Information Governance and Policy

Clare was appointed as interim director of information governance and quality in August 2007. Clare has worked in information services for the NHS for over 25 years, initially at both a regional and local health authority in the Northwest and then as a management consultant providing consultancy support across all organisation levels. Clare worked for a number of respected consultancy firms before establishing herself as an independent consultant which she has done for over 8 years.

Clare's expertise in information management, governance and quality has enabled The NHS IC to develop a robust information governance and quality approach to its work programmes.

Lucinda Bolton
Non-executive Director

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

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

She is currently a member of the NHS Pay Review Body, a Governor of Thames Valley University and an independent assessor at the Department of Culture, Media and Sport. Lucinda has also held several private sector non-executive directorships.

Roger Clarkson
Non-executive Director

Roger was until the end of 2007 a national advisor to the Department of Communities and Local Government on local government modernisation. This followed on from his work as programme director for the Office of the Deputy Prime Minister's local e-government programme.

Prior to that he had been the managing consultant for ICL Fujitsu and then IBM, leading their public sector business consultancies. Between 1990 and 2002 he advised a wide range of organisations, created new models for customer service, and led major change programmes with a wide range of clients.

In addition to his current work on The NHS IC Board, Roger has previous health trust board level experience. He is also proud to be one of the nominated non-executive directors of Dr Foster Intelligence, representing The NHS IC's 50% shareholding on the board of this innovative joint venture, and working actively for its mutual success.

Anthony Land

Non-executive Director

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

Anthony was appointed a non executive director of the NHS IC in April 2005. Since January 2006, Anthony has been a non-executive director of Dr Foster Intelligence (DFI) representing The NHS IC's 50 per cent shareholding in the joint venture. He was chair of the DFI board throughout 2006 and remains a member of its Audit and Remuneration Committees. In April this year he was appointed part-time company secretary of the Commission for Social Care Inspection.

Professor Michael Pearson

Non-executive Director

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

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

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

Management Commentary

For the year ended 31 March 2008

Principal activities

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

The ultimate direction of The NHS IC strategy and business plan for 2007/08 was to gradually shift the focus from providing aggregated data and information for statistical use at a national level towards providing disaggregated person level data and information to assist the more efficient and effective commissioning and delivery of health and social care at a local level. Our data and information will help local organisations plan better local care and our products and services can reduce the burden on NHS and social care frontline staff. The NHS IC will support the frontline by:

- delivering products and services that address key issues and priorities
- becoming the recognised source of data for secondary uses in the health and social care system
- leading on the development of data and information standards and ensuring data quality is fit for purpose in terms of consistency, relevance, timeliness and accuracy
- establishing The NHS IC as an 'honest broker' and a 'safe haven' capable of managing the authorised disclosure of information to users
- leading the information management community

2007/08 has been a year in which information issues have been very much at the centre of attention both at a local level and nationally. The Darzi review highlighted the requirement for good local information whilst the Department of Health initiated a full review of informatics services across the health sector as a whole.

The role of The NHS IC as an information provider is intrinsically linked with these reviews and The NHS IC strategy and business plan for 2008/09 has taken many of these outcomes into account. Work began in 2007/08 and will continue in the future, for The NHS IC to become a key contributor for successful decision making in:

- Commissioning – further develop NHS Comparators and improve availability of HES and SUS data, work with the Department of Health on a Carers survey and an Adult Dental Health survey
- Workforce – fully exploit and improve the quality of information within the electronic staff record including benchmarking with other datasets
- Public Health – extend functionality and use of the Public Health Compendium and manage the National Child Measurement Programme
- Mental Health – develop the mental health minimum datasets through SUS
- Finance and Performance – provide intelligence for the operating framework 'Vital Signs', support, maintain and further develop HRG4 for payments to support Payments by Results and continue the development of performance benchmarking
- Clinical – publish quality and outcome metrics for clinicians use and continue to provide a clinical audit service

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 NHS Act 2006 and have been prepared in accordance with the guidelines set out in the Government Financial Reporting Manual (FReM).

Financial results

The Department of Health allocated The NHS IC a revenue resource limit for 2007/08 of £40.1 million including £2.3 million to cover capital charges. The NHS IC offered £1.9 million back to the Department of Health in year end flexibility, reducing the resource limit it needed to £38.2 million. The NHS IC also achieved a further surplus of £0.8 million against this revised amount, largely as a result of the assignment of a property lease in Exeter which has released provisions for lease surrender and dilapidation costs.

Planned capital investment has been delayed in the year pending the outcome of the informatics review and delays in several associated IT developments. Consequently, expenditure is well below the capital resource allocation of £6.5 million. Of the underspend the Department of Health has agreed that £1.7 million can be carried forward into 2008/09.

Like many arms length bodies, central funding has been reduced and further efficiencies are expected over the next few years. The NHS IC continued to manage its cost base and generate improved value for money by:

- reducing the reliance on external contractors and agency staff from 36 per cent of total pay costs in 2006/07 to 27 per cent in 2007/08 in a year when short term project work was a significant proportion of the spend
- negotiating improved terms with its suppliers, in particular several large and complex Official Journal of European Union (OJEU procurements were completed
- reassigning the lease on unit 3 at Exeter. Spare desk capacity in other offices has also been sublet to other public sector bodies
- delivering efficiencies within the core central service functions that have generated savings when compared to 2006/07
- reviewing all areas of business to ensure that all work is of value and does not duplicate activities carried out elsewhere

The NHS IC initiated a series of high impact projects during the year with the aim of reducing information gaps, improving existing services and meeting the needs of front line information requirements. Most of these projects are nearing completion and running within time and cost.

Outstanding sales ledger balances were £2,452k, of which £1,021k was more than 90 days overdue although the majority relates to transactions with the Department of Health. Debts amounting to £9k have been written off as irrecoverable. Other debtors largely relate to VAT for February and March transactions.

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

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 has 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.

Whilst behind the original business projections, DFI has grown considerably with more NHS Trusts using its services for the first time and existing customers using a greater number of products. Turnover has increased from £9 million at inception to over £25 million in 2007/08. The business made a profit before goodwill amortisation. The NHS IC accounts for the joint venture as a fixed asset investment and therefore does not account for the trading results.

In accordance with the financial reporting standard FRS9 Associates and Joint Ventures, a valuation of DFI has been undertaken to support the value of the investment stated in the balance sheet. This valuation carried out by PricewaterhouseCoopers LLP supports the board's opinion that the carrying value of £12 million remains appropriate.

Post balance sheet event

The NHS Central Records Service (NHSCR) based in Southport was successfully transferred from the Office of National Statistics to The NHS IC on 1 April 2008. The main function of NHSCR is the compilation and maintenance, for the Department of Health, of a computerised central record of those patients who are registered with an NHS General Practitioner in England & Wales, and the Isle of Man. The transfer will deliver a number of strategic benefits to The NHS IC, namely:

- enhance The NHS IC's product and service portfolio
- provide business development opportunities by combining existing dataflows to make more functionally rich information
- focus on data quality and use
- strengthen links with our strategic partner NHS CFH and other NHS bodies

In total 152 staff posts are to be transferred, thus substantially increasing the size of The NHS IC.

Information Governance

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 2007/08 or prior to 2007/08. This includes both 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.

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 allocations to ensure the delivery of The NHS IC's objectives. The board has three committees to assist it, namely the audit and risk committee, the remuneration committee and the information governance and quality committee.

The audit and risk committee

The audit and risk committee comprising of four non-executive directors advises on all matters of audit, corporate governance, risk management and internal control and reports directly to The NHS IC board.

The National Audit Office, internal auditors, chief executive and the director of finance and performance attend by invitation. Meetings are held at least on a quarterly basis.

Employee policies

Equal opportunities – The NHS IC is an equal opportunity employer. It aims to be fair to everybody; to ensure that no eligible job applicant or employee receives less favorable treatment on the grounds of race, colour, nationality or ethnic origin, age, gender, sexual orientation, marital status, disablement, religion or religious affiliation, or is disadvantaged by conditions or requirements which cannot be shown as justifiable.

Learning and development – The 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 informing and consulting with staff. An internal communications manager maintains an intranet site to ensure staff have access to a wide range of information relevant to The NHS IC and the health sector at large. In addition, regular staff briefings are held where senior management update staff 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.

Auditors

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

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

The accounting officer has undertaken all steps to ensure he is aware of any relevant audit information and to ensure that The 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.

Remuneration report

This report for the year ended 31 March 2008 deals with the pay of the chair, chief executive and other members of the board.

Remuneration committee

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

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

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

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

- the need to recruit, maintain and motivate suitably able and qualified people to exercise their responsibilities
- variations in the labour market and their effects on the recruitment and retention of staff
- recommendations of 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 NHS contracted posts have been evaluated under the Agenda for Change (AfC) programme.

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

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

Bonus payments were limited to a non consolidated bonus in line with the civil service scheme for a number of ex-civil service staff by virtue of Transfer of Undertakings Protection of Employment (TUPE).

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

The NHS IC board meetings in 2007/08 – attendance of board members

Name	May-07	June-07	Sep-07	Nov-07	Jan-08	Mar-08
Chair & Non-Execs						
Mike Ramsden	✓	✓	✓	✓	✓	✓
Tony Allen	✗	✓	✓	✓	✓	✓
Lucinda Bolton	✗	✓	✓	✓	✓	✓
Roger Clarkson	✓	✗	✓	✓	✗	✓
Anthony Land	✓	✓	✓	✓	✓	✓
Mike Pearson	✓	✓	✓	✗	✓	✓
Executive Team						
Denise Lievesley	✓	✗				
Tim Straughan	✓	✓	✓	✓	✓	✓
Phil Wade	✓	✓	✓	✓	✓	✓
Roger Dewhurst	✓	✓	✗	✓	✓	✓
Stephen Leathley			✓	✓	✓	✓
Clare Sanderson			✓	✓	✓	✓

Audit & Risk Committee

Name	May-07	June-07	Oct-07	Jan-08
Non-Execs				
Tony Allen	✓	✓	✓	✓
Lucinda Bolton	✓	✓	✓	✓
Roger Clarkson	✓	✓	✓	✓
Mike Pearson	✗	✓	✓	✗
Anthony Land (Reserve)	✓			
Executive Team				
Denise Lievesley	✓	✗		
Tim Straughan	✓	✓	✓	✓
Stephen Leathley			✓	✓

Information Governance & Quality Committee

Name	Oct-07	Dec-07	Jan-08	Feb-08
Non-Execs				
Mike Pearson	✓	✓	✓	✓
Lucinda Bolton	✓	✓	✓	✗
Anthony Land	✓	✓	✓	✗
Executive Team				
Tim Straughan	✓	✓	✓	✓
Clare Sanderson	✓	✓	✓	✓
Phil Wade	✓	✓	✗	✗
Roger Dewhurst	✓	✓	✓	✗
Stephen Leathley	✓	✓	✓	✗

Remuneration Committee

Name	May-07	Sep-07
Chair & Non-Execs		
Mike Ramsden	✓	✓
Tony Allen	✓	✓
Lucinda Bolton	✓	✓
Executive Team		
Denise Lievesley	✓	
Tim Straughan	✗	✓

DFI Board Meetings 2007/08

DFI Board Meetings	May-07	Jun-07	Jul-07	Sep-07	Oct-07	Nov-07	Dec-07
Denise Lievesley	✓	✗					
Roger Clarkson	✓	✓	✓	✓	✓	✓	✓
Anthony Land	✓	✓	✓	✓	✓	✓	✓
Tim Straughan		✓		✓	✓	✓	✓

DFI Board Meetings	Jan-08	Feb-08	Mar-08
Denise Lievesley			
Roger Clarkson	✓	✓	✓
Anthony Land	✗	✓	✓
Tim Straughan	✓	✓	✓

Tim Straughan attended Board meetings in June and September but was not formally appointed as a director of Dr Foster Intelligence Ltd until 4 October 2007.

Emoluments of Board Directors

The remuneration relating to all directors in post during 2007/08 is detailed on the tables below which identifies the salary, other payments, allowances and pension benefits applicable to executives and non executives and are subject to audit.

	Salary including performance pay (£000) 2007/08	Salary including performance pay (£000) 2006/07	Real increase in pension and related lump sum at age 60 (£000)	Total accrued pension at age 60 at 31/3/08 and related lump sum	CETV at 31/3/08 (nearest £000)	CETV at 31/3/07 (nearest £000)	Real increase in CETV after adjustment for and changes in market investment factors (nearest £000)
***Denise Lievesley** Chief executive	100-105	130-135	0-2.5	10-15	51	43	1
***Tim Straughan** Chief executive	130-135	90-95	5-10	10-15	42	21	14
Phil Wade Director of business development and communications	95-100	70-75	5-10	5-10	32	13	13
Roger Dewhurst Director of operations Executive	90-95	55-60	0-2.5	95-100	400	379	10
***Stephen Leathley** Acting director of finance and performance	45-50	-	2.5-5	2.5-5	16	-	8
#Clare Sanderson Interim director of information governance	105-110	-	-	-	-	-	-
Amounts paid to non-executives were as follows:							
Mike Ramsden Chairman	60-65	60-65					
Anthony Allen	10-15	10-15					
Lucinda Bolton	5-10	5-10					
Roger Clarkson	5-10	5-10					
Anthony Land	5-10	5-10					
Michael Pearson	5-10	5-10					

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

* Denise Lievesley resigned on 2 July 2007.

* Tim Straughan was appointed as acting chief executive and accounting officer on the same date and was appointed the substantive chief executive on 7 December 2007.

* Stephen Leathley was appointed acting director of finance and performance with effect from 2 July 2007.

Clare Sanderson was appointed as interim director of information governance on 20 July 2007. The above costs relate to the fees charged by the external agency.

Cash equivalent transfer values

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

The CETV figures, and from 2003/04 the other pension details, include the value of any pension benefit in another scheme or arrangement which the individual transferred to the civil service pension arrangements and for which the civil service vote received a transfer payment commensurate to the additional pension liabilities being assumed. They also include any additional pension benefit accrued to the member as a result of their purchasing additional years of pension service in the scheme at their own cost. CETVs 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 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
8 July 2008

Statement of the board and chief executive's responsibilities

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

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

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

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

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 including quarterly accountability reviews 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 2008 and up to the date of approval of the annual report and accounts, accords with Treasury guidance.

Capacity to handle risk

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

The NHS IC maintains an assurance framework containing all principal risks whilst operational teams maintain their own functional risk registers. In particular;

- both the performance committee and the audit and risk committee review the full assurance framework as a standing item
- the information governance and quality committee review all governance, security and quality risks
- the board review strategic and high risk areas

The NHS IC continues to make progress in developing its capabilities to manage risk. The delivery of all projects and major programme areas

are now assessed and reported on a monthly basis with a traffic lighting system employed to identify the risk of not achieving the relevant aims and objectives. The assurance framework has been further developed in the year to allow management to focus its attention on the risks that threaten the delivery of the principal objectives.

Progress continues to be made in strengthening the wider governance arrangement with the introduction of:

- a balanced scorecard approach to reporting performance. This has been further refined for 2008/09
- the appointment of an information governance and quality director at board level
- a central project office to manage and report in a standard manner on all project activity
- a full review of all data and information security processes including the ratification of several related policies and mandatory training for all staff

The risk and control framework

The audit and risk committee has responsibility for reviewing the establishment and maintenance of an effective system of integrated governance, risk management and internal control across the whole of The NHS IC's activities. It does this by receiving regular reports on the assurances received together with reports from internal audit, external audit and other systems of internal control.

The audit committee reports to the board on

- the effectiveness of the system of integrated governance, risk management and internal control,
- areas where controls need to be strengthened to ensure that principal risks are being managed effectively,
- areas where new assurances are required.

The information governance and quality committee oversee all data governance, security and data quality issues and evaluate and manage all associated risks. It provides the audit and risk committee with a written assurance of controls in place for the year as a whole.

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

Review of effectiveness

As accounting officer, I have responsibility, together with the board, for reviewing the effectiveness of the system of internal control. My review is informed in a number of ways. The head of internal audit provides me with an opinion on the overall arrangements for gaining assurance through the assurance framework and on the controls reviewed as part of the internal audit work.

Executive managers within the organisation who have responsibility for the development and maintenance of the system of internal control provide me with assurances. The assurance framework itself provides me with evidence that the effectiveness of controls that manage the risks to the organisation achieving its principal objectives have been reviewed. My review is also informed by the findings of the National Audit Office as the organisation's external auditors.

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

Significant internal control issues

The NHS IC acknowledged that in 2005/06 there were significant internal control weaknesses. This was due to the fact that The NHS IC was established without the basic infrastructure and senior management team being in place and the concentrated effort of senior managers to finalise the joint venture arrangements and ensure the new organisation was able to function effectively. An action plan was put in place during 2006/07 with the result that these weaknesses have been effectively addressed.

During 2007/08 The NHS IC key risk management priorities included:

- further developing information governance policies to ensure that processes over information security issues are as strong as possible
- reviewing with Connecting for Health the responsibilities for, structure and management of the Secondary Uses Service (SUS) in order to ensure that the service would be fit for purpose in future

- ensuring that all key information issues identified by The NHS IC were fully considered within the informatics review
- ensuring that The NHS IC delivered on a range of high profile projects and programmes
- improving communications with the NHS and other stakeholders many of whom were not fully aware of The NHS IC role and service offering

I believe that The NHS IC has made very substantial strides and employed an appropriate control environment throughout 2007/08 which will be further developed to meet changing priorities or requirements in the years ahead.

Tim Straughan
Chief Executive
8 July 2008

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 2008 under the National Health Service Act 2006. These comprise the Operating Cost Statement, the Statement of Recognised Gains and Losses, the Balance Sheet, the Cash Flow Statement 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 Authority, Chief Executive and auditor

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

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

I report to you my opinion as to whether the financial statements give a true and fair view and whether the financial statements and the part of the Remuneration Report to be audited have been properly prepared in accordance with the National Health Service Act 2006 and directions made by the Secretary of State with the approval of HM Treasury.

I report to you whether, in my opinion, the information, which comprises the Foreword, Highlights, Who we are, Supporting our customers, Our strategic focus, Board members, the Management Commentary and the unaudited part of the Remuneration Report, included in the Annual Report, is consistent with the financial statements. I also report whether in all material respects the expenditure and income have been applied to the purposes intended by Parliament and the financial transactions conform to the authorities which govern them.

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

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

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

Basis of audit opinions

I conducted my audit in accordance with International Standards on Auditing (UK and Ireland) issued by the Auditing Practices Board. My audit includes examination, on a test basis,

of evidence relevant to the amounts, disclosures and regularity of financial transactions included in the financial statements and the part of the Remuneration Report to be audited. It also includes an assessment of the significant estimates and judgements made by the Authority and Accounting Officer in the preparation of the financial statements, and of whether the accounting policies are most appropriate to the Authority's circumstances, consistently applied and adequately disclosed.

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

In forming my opinion I also evaluated the overall adequacy of the presentation of information in the financial statements and the part of the Remuneration Report to be audited.

Opinions

In my opinion:

- the financial statements give a true and fair view, in accordance with the National Health Service Act 2006 and directions made by the Secretary of State with the approval of HM Treasury, of the state of the Authority's affairs as at 31 March 2008 and of its net resource outturn, recognised gains and losses and cash flows for the year then ended;
- the financial statements and the part of the Remuneration Report to be audited have been properly prepared in accordance with the National Health Service Act 2006 and directions made by the Secretary of State with the approval of HM Treasury and;
- information, which comprises the Foreword, Highlights, Who we are, Supporting our customers, Our strategic focus, Board members, the Management Commentary, and the unaudited part of the Remuneration Report, included within the Annual Report, is consistent with the financial statements.

Opinion on Regularity

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

Report

I have no observations to make on these financial statements.

TJ Burr
Comptroller and Auditor General
National Audit Office
151 Buckingham Palace Road
Victoria
London SW1W 9SS
8 July 2008

Accounts 2007/08

Operating cost statement

For the year ended 31 March 2008

	Notes	**2007/08 £000**	2006/07 £000
Operating costs	2.1	**39,538**	38,252
Operating income	5	**(2,124)**	(1,041)
Net operating cost before exceptional items		**37,414**	37,211
Exceptional Items	4	**-**	2,854
Net operating cost		**37,414**	40,065
Net resource outturn		**37,414**	40,065

All income and expenditure is derived from continuing operations

Statement of recognised gains and losses

For the year ended 31 March 2008

	Notes	**2007/08 £000**	2006/07 £000
Unrealised surplus on the indexation of fixed assets	11.2	**-**	25
Recognised gains for the financial year		**-**	25

The notes on pages 53 to 68 form part of this account

NHS

The Information Centre
for health and social care

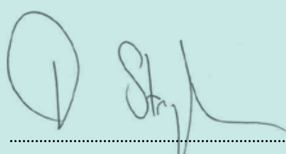
Balance sheet

As at 31 March 2008

	Notes	**2007/08 £000**	2006/07 £000
Fixed assets			
Intangible assets	6.1	**26**	50
Tangible assets	6.2	**5,090**	3,313
Investment	6.3	**12,000**	12,000
		17,116	15,363
Current assets			
Debtors	7	**3,398**	1,671
Cash at bank and in hand	8	**4,279**	5,470
		7,677	7,141
Current Liabilities			
Creditors - amounts falling due within one year	9	**(12,102)**	(8,836)
Net current assets		**(4,425)**	(1,695)
Provisions for liabilities and charges	10	**(2,233)**	(5,053)
Net assets		**10,458**	8,615
Taxpayers' equity			
General fund	11.1	**10,433**	8,590
Revaluation reserve	11.2	**25**	25
		10,458	8,615

The notes on pages 53 to 68 form part of this account

The financial statements on pages 50 to 52 were approved by the board on 25/06/2008 and signed on its behalf by



Dated 8 July 2008

T Straughan
Chief Executive

Cash flow statement

For the year ended 31 March 2008

	Notes	2007/08 £000	2006/07 £000
Net operating cost before interest for the year		**(37,414)**	(37,211)
Depreciation and amortisation	2.1	**1,556**	1,476
Capital charges	2.1	**162**	(25)
Increase in debtors		**(1,727)**	(111)
Increase / (decrease) in creditors		**3,267**	(4,192)
Decrease in provisions		**(2,820)**	(5,476)
Net cash outflow from operating activities		**(36,976)**	(45,539)
Returns on investments and servicing of finance			
Exceptional costs		**-**	(1,454)
Capital expenditure and financial investment			
Payments to acquire intangible fixed assets	6.1	**(20)**	(30)
Payments to acquire tangible fixed assets	6.2	**(3,290)**	(987)
Net cash outflow from investing activities		**(3,310)**	(1,017)
Net cash outflow before financing		**(40,286)**	(48,010)
Financing			
Net parliamentary funding	11.1	**39,095**	40,430
Decrease in cash		**(1,191)**	(7,580)

The notes on pages 53 to 68 form part of this account

Notes to the accounts

1 Accounting policies

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

1.1 Accounting conventions

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

1.2 Income

The main source of funding is a Parliamentary grant from the Department of Health within an approved cash limit, which is credited to the general fund. Parliamentary funding is recognised in the financial period in which it is received.

Operating income is accounted for by applying the accruals convention and primarily comprises of fees and charges for services provided on a full cost basis to external customers and the NHS.

1.3 Taxation

The 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.

1.3 Capital charges

The treatment of fixed assets in the accounts is in accordance with the principal capital charges objective to ensure that such charges are fully reflected in the cost of capital. A charge reflecting the cost of capital utilised by The NHS IC is included within operating costs. The charge is calculated at the real rate set by HM Treasury, currently 3.5% (2006/07 3.5%), on the average carrying value of all assets and liabilities except for cash balances with the Office of the Paymaster General, where the charge is nil.

1.5 Losses and special payments

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

Losses and special payments are charged to the relevant functional headings in the operating cost statement.

1.6 Joint venture

The investment in the joint venture is accounted for under the principles of FRS 9. The carrying value for the 2007/08 accounts has been reviewed following an independent revaluation of the investment.

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

1.7 Fixed assets

a. Capitalisation

All assets falling into the following categories are capitalised:

1) Intangible assets, including 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.

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

b. Valuation

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

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

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

In accordance with Treasury directions, no indexation has been applied in 2007/08.

c. Depreciation

Depreciation is charged on each asset as follows:

1) Intangible assets are amortised, on a straight line basis, over the estimated lives of the asset

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

3) Each equipment asset is depreciated on a straight line basis over its expected useful life as follows
   - Fixtures and fittings 7 - 13 years
   - Office, information technology, short life equipment 3 - 5 years

1.8 Leases

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

1.9 Provisions

The 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.

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

2.1 Operating and programme expenditure

	2007/08 £000	2006/07 £000
Non-executive directors' remuneration	**113**	112
Salaries and wages	**16,644**	15,586
External contractors	**15,182**	14,837
Training and conferences	**674**	359
Travel	**854**	976
Accommodation costs	**1,761**	1,726
Personal IT equipment	**531**	458
IT maintenance and support	**1,096**	1,818
Office services	**421**	469
Advertising and publicity	**377**	196
Loss on disposal of fixed assets	**-**	70
Capital: Depreciation and amortisation	**1,556**	1,406
Capital charges	**162**	(25)
External auditors fees	**70**	70
Miscellaneous	**97**	194
	39,538	38,252

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

2.2 Staff numbers and related costs

	2007/08 £000	**Permanently employed staff £000**	**Temporary and contract staff £000**	2006/07 £000
Salaries and wages	**14,490**	**9,913**	**4,577**	13,512
Social security costs	**825**	**825**	**-**	759
Employer superannuation contributions – NHSPA	**1,001**	**1,001**	**-**	841
Employer superannuation contributions – other	**441**	**441**	**-**	586
Total	**16,757**	**12,180**	**4,577**	15,698

The average number of employees during the year was:

	2007/08 Number	**Permanently employed staff Number**	**Temporary and contract staff Number**	2006/07 Number
Total	**345**	**280**	**65**	351

No staff benefits were paid in the year (2006/07: NIL).

During 2007/08 there were no early retirements from The NHS IC on the grounds of ill health (2006/07 NIL).

Principal Civil Service Pension Scheme (PCSPS)

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

Employee contributions are set at the rate of 1.5per 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 2007/08, employer's contributions of £441,000 were paid at one of four rates in the range 17.1% to 25.5%. The contribution rates reflect benefits as they accrue, not the costs as they are incurred, and reflect past experience of the scheme.

NHS Pension Scheme

Past and present employees are covered by the provisions of the NHS Pension Scheme. Details of the benefits payable under these provisions can be found on the NHS pensions website at www.pensions.nhsbsa.nhs.uk. 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 in the underlying scheme assets and liabilities. Therefore the scheme is accounted for as if it were a defined contribution scheme. The cost to the NHS body of participating in the scheme is taken as equal to the contributions payable to the scheme for the accounting period. The scheme is subject to a full actuarial valuation every four years (until 2004, based on a 5 year valuation cycle) and a FRS17 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% 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% of pensionable pay. From 1 April 2008, employees contributions are on a tiered scale from 5% up to 8.5% of their pensionable pay depending on total earnings.

b) FRS17 Accounting valuation

In accordance with FRS17, 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 2008, is based on detailed membership data as at 31 March 2006 (the latest midpoint) updated to 31 March 2008 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.

Scheme provisions as at 31 March 2008

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

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 the income and expenditure account at the time the Trust commits itself to the retirement, regardless of the method of payment.

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

Scheme provisions from 1 April 2008

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

2.3 Better Payment Practice Code – measure of compliance

	Number	£000
Total non NHS bills paid 2007/08	**5,305**	**26,724**
Total non NHS bills paid within target	**4,918**	**23,489**
Percentage of non NHS bills paid within target	**92.7%**	**87.9%**
Total NHS bills paid 2007/08	**123**	**4,478**
Total NHS bills paid within target	**82**	**2,769**
Percentage of NHS bills paid within target	**66.7%**	**61.8%**

The Better Payment Practice Code requires all valid invoices to be paid by the due date or within 30 days of receipt of goods or a valid invoice, whichever is later.

Interest totalling £100 was paid under the Late Payment of Commercial Debt (Interest) Act 1998. (2006/07 £1,592).

3.1 Reconciliation of net operating cost to net resource outturn

	2007/08 £000	2006/07 £000
Net operating cost	**37,414**	37,211
Exceptional costs	**-**	2,854
Net resource outturn	**37,414**	40,065
Revenue resource limit	**38,173**	41,525
Underspend against revenue resource limit	**759**	1,460

3.2 Reconciliation of gross capital expenditure to capital resource limit

	2007/08 £000	2006/07 £000
Gross capital expenditure	**3,310**	1,017
NBV of assets disposed	**-**	(70)
Net capital resource outturn	**3,310**	947
Capital resource limit	**6,500**	1,444
Underspend against capital resource limit	**3,190**	497

4 Exceptional costs

	2007/08 £000	2006/07 £000
Reorganisation costs	**-**	2,892
Residuary body transactions	**-**	(38)
	-	2,854

Reorganisation costs relate to the costs incurred with the closure of previous NHS Information Authority offices in Birmingham, Exeter and Winchester inorder to centralise all activities into Leeds with a small office in London. Costs include staff redundancies, consultancy fees, loss on sale of fixed assets, lease surrender and dilapidation provisions. The residuary body balances relates to the finalisation of all opening balances inherited from the NHS Information Authority.

5 Operating income

	2007/08 £000	2006/07 £000
Provision of data related services	**2,062**	1,008
Publications and training events	**44**	18
Other	**18**	15
	2,124	1,041

6.1 Intangible fixed assets

	Software Licences £000
Gross cost at 1 April 2007	87
Additions - purchased	20
Gross cost at 31 March 2008	**107**
Accumulated amortisation at 1 April 2007	37
Provided during the year	44
Accumulated amortisation at 31 March 2008	**81**
Net book value at 1 April 2007	50
Net book value at 31 March 2008	**26**

6.2 Tangible fixed assets

Cost or Valuation	Information Technology £000	Software £000	Fixtures & Fittings £000	Total £000
At 1 April 2007	1,694	3,952	657	6,303
Additions	803	2,082	405	3,290
At 31 March 2008	**2,497**	**6,034**	**1,062**	**9,593**
Depreciation				
At 1 April 2007	586	2,330	74	2,990
Provided during the year	388	1,019	106	1,513
At 31 March 2008	**974**	**3,349**	**180**	**4,503**
Net book value at 1 April 2007	1,108	1,622	583	3,313
Net book value at 31 March 2008	**1,523**	**2,685**	**882**	**5,090**

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.

6.3 Fixed assets investments

	31 March 2008 £000	31 March 2007 £000
Investment in joint venture	**12,000**	12,000

On 17 January 2006, The NHS IC entered into a joint venture arrangement known as Dr Foster Intelligence Limited (DFI). The NHS IC acquired 50 per cent of the ordinary share capital and also provided working capital. The remaining share capital is owned by Dr Foster LLP. The accounting date for Dr Foster Intelligence Limited is 31 December.

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

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

The NHS IC engaged PricewaterhouseCoopers LLP ('PwC') to estimate the value of its investment in DFI as at 31 March 2008. PwC prepared a valuation on the assumption that Dr Foster Holdings LLP, The NHS IC's joint venture partner, would agree to a sale of The NHS IC's shares and that The NHS IC would receive a 50% pro rata share of 100% of DFI's current market value.

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

The NHS IC's share in the joint venture accounts are as follows:

	Year to 31 December 2007 £000	Year to 31 December 2006 £000
Turnover	**12,876**	4,676
Loss before tax	**(189)**	(1,400)
Taxation	**(42)**	-
Loss after tax	**(231)**	(1,400)
Fixed assets	**9,605**	10,098
Current assets	**4,857**	4,201
Liabilities due within one year	**(4,093)**	(2,450)
Liabilities due within one year	**-**	(1,250)

7 Debtors

Amounts falling due within one year	**31 March 2008 £000**	31 March 2007 £000
NHS debtors	**2,233**	131
Prepayments	**531**	362
Other debtors	**634**	1,178
	3,398	1,671

8 Analysis of changes in cash

	31 March 2007 £000	Changes during the year £000	**31 March 2008 £000**
Cash at OPG	5,470	(1,191)	**4,279**

9 Creditors

	31 March 2008 £000	31 March 2007 £000
NHS creditors	**41**	1,896
Tax and social security	**283**	274
Other creditors	**4,684**	2,164
Deferred income	**2,586**	-
Accruals	**4,508**	4,502
	12,102	8,836

All creditors are due within one year.

10 Provisions for liabilities and charges

	Injury Benefit £000	Lease Surrender £000	Dilapidations £000	Joint Venture Investment £000	Staff Termination £000	Total £000
At 31 March 2007	187	681	190	2,500	1,495	5,053
Arising during the year	-	-	601	-	165	766
Utilised during the year	(15)	(570)	(151)	(2,500)	(350)	(3,586)
At 31 March 2008	**172**	**111**	**640**	**-**	**1,310**	**2,233**
Expected timing of cash flows						
Within 1 year	15	-	30	-	400	445
1-5 years	60	-	50	-	734	844
Over 5 years	97	111	560	-	176	944

11 Movements on reserves

11.1 General fund

	31 March 2008 £000	31 March 2007 £000
Balance at 1 April 2007	**8,590**	8,319
Net operating costs for the year	**(37,414)**	(40,065)
Net parliamentary funding	**39,095**	40,430
Non cash items		
transfer of software assets	**-**	(69)
capital charges	**162**	(25)
Balance at 31 March 2008	**10,433**	8,590

11.2 Revaluation reserve

	31 March 2008 £000	31 March 2007 £000
Balance at 1 April 2007	**25**	-
Indexation of fixed assets	**-**	25
Balance at 31 March 2008	**25**	25

12 Contingent assets and liabilities

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

13 Capital commitments

There are no capital commitments.

14 Commitments under operating leases

	31 March 2008		31 March 2007	
	Land & Buildings £000	**Office Equipment £000**	Land & Buildings £000	Office Equipment £000
The NHS IC is committed to making the following operating lease payments during the next financial year for leases expiring:				
Within one year	**-**	**2**	572	23
One to five years	**893**	**31**	82	25
More than five years	**20**	**3**	80	-
	913	**36**	734	48

15 Other commitments

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

16 Losses and special payments

There were 44 losses and special payments in 2007/08 amounting to £118,617 (2006/07 £12,190). Of this amount, £106,000 related to staff termination payments.

17 Related parties

The NHS IC is an Arms Length Body established by order of the Secretary of State for Health. The Department of Health is regarded as a controlling related party.

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

Please see table opposite.

17 Related parties *Continued*

	Payments in 2007/08 £000	Receipts in 2007/08 £000	Debtor at 31.03.08 £000	Creditor at 31.03.08 £000
Department of Health	1,543	358	1,405	11
Connecting for Health	154	810	0	(14)
Dr Foster Intelligence Ltd*	2,515	438	63	0
Healthcare Commission	43	25	0	0
NHS Employers	2	0	0	0
National Patient Safety Association	0	69	10	0
Health Protection Agency	58	2	0	0
NHS Business Services Authority	53	0	0	0
NHS Blood and Transplant	15	0	0	0
Milton Keynes PCT	27	0	0	0
London SHA	108	0	0	17
Clatterbridge Centre for Oncology NHS Trust	10	0	0	0
East Midlands Ambulance Service NHS Trust	0	142	61	0
East of England Ambulance Service NHS Trust	0	192	71	0
HM Customs and Revenue	61	0	0	0
HEFCE	25	0	0	0
Imperial College London	80	0	0	20
Great Western Ambulance Service NHS Trust	0	65	30	0
London Ambulance Service NHS Trust	0	174	47	0
Newcastle upon Tyne NHS Trust	0	3	0	0
NHS Confederation	43	0	0	0
NHS Professionals	7	0	0	0
NHS Supply Chain	2	0	0	0
North East Ambulance Service NHS Trust	0	41	30	0
North West Ambulance Service NHS Trust	0	96	144	0
Northampton General Hospital	24	0	0	0
Office For National Statistics	744	0	32	0
Portsmouth Hospitals	32	0	0	0
Royal College of Physicians	8	0	0	41
Royal College of Surgeons of England	255	0	0	0
South Central Ambulance Service NHS Trust	0	111	56	0
South East Coast Ambulance Service NHS Trust	0	135	57	0
South Tees NHS Trust	21	0	0	0
South Western Ambulance Service	0	71	28	0
University College London NHS Trust	36	0	0	0
West Midlands Ambulance Service NHS Trust	0	172	72	0
Yorkshire Ambulance Service NHS Trust	0	214	96	0

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

*The payment to Dr Foster Intelligence Limited includes £2,500,000 in respect of the investment in the joint venture.

18 Post balance sheet events

On 1 April 2008, the NHS Central Records Service based at Southport was transferred from the Office of National Statistics. The main function of the NHSCR is the compilation and maintenance for the Department of Health, of a computerised central record of those patients who are registered with an NHS General Practitioner in England & Wales, and the Isle of Man. The transfer includes 152 staff posts. Fixed assets, outstanding debtors and creditors were also transferred.

The NHS IC's Annual Report and Accounts are laid before the Houses of Parliament by the NHS IC. FRS 21 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 8 July 2008.

19 Financial instruments

FRS13, Derivatives and Other Financial Instruments, requires disclosure of the role that financial instruments have had during the period in creating or changing the risks an entity faces in undertaking its activities. Because of the way Arms Length Bodies are financed, The NHS IC is not exposed to the degree of financial risk faced by business entities. Also financial instruments play a much more limited role in creating or changing risk than would be typical of the listed companies to which FRS13 mainly applies.

The NHS IC has limited powers to borrow or invest surplus funds and financial assets and liabilities are generated by day-to-day operational activities rather than being held to change the risks faced in undertaking its activities. As allowed by FRS13, debtors and creditors that are due to mature or become payable within 12 months from the balance sheet date have been omitted from all disclosures.

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

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

Foreign currency risk
The exposure to foreign currency risk is not material.

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

20 Intra-government balances

	Debtors Amounts falling due within one year		**Creditors Amounts falling due within one year**	
	2007/08	2006/07	**2007/08**	2006/07
	£000	£000	**£000**	£000
Central government bodies	**1,924**	779	**616**	4,129
NHS Trusts & PCT's	**744**	70	**58**	29
Other external bodies	**730**	822	**11,428**	4,678
At 31 March 2008	**3,398**	1,671	**12,102**	8,836

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