hscic Health & Social Care Information Centre

Annual Report and Accounts 2014/15

Health and Social Care Information Centre Annual Report and Accounts 2014/15

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Chief Executive's foreword

Now in our second year, I am pleased to say we are fully formed as a single organisation. Our senior management team is in place following successful external recruitment to bring in new skills and perspectives. Membership of our non-executive board is almost complete and I am grateful for their contribution. Looking to the future, I know if we are going to achieve our ambitious plans it is vital for us to continue to attract the brightest and best talent to work for the HSCIC.

Working closely with the National Information Board (NIB), and following extensive consultation with staff and stakeholders in both national and local health and care organisations, we developed our strategy for 2015-2020 entitled *"Information and technology for better care"*. It sets out our overarching objective of revolutionising the way technology and information are used to transform the delivery of England's health and care services.

Building firm foundations for the future

In the past year we have delivered major new programmes of work and in doing so, demonstrated our commitment to service excellence. The photographs that appear in the 'Management Commentary' section of these accounts feature some of the customers, partners and staff who have been involved with a selection of important projects in 2014/15.

In August we upgraded NHS Spine which provides the essential infrastructure for systems critical to the day to day operations of the NHS. We successfully migrated the Spine from our service providers to systems built and run here at the HSCIC.

I believe this to be a 'watershed' moment for us, given that the Spine holds over 80 million demographic records, manages 1.7 million electronic prescriptions per day and connects over 28,000 systems. Over 1 million clinicians and administrative staff use our new Spine to deliver more than 1,500 messages per second. This project has reduced response times by 89 per cent and operates on less than 5 per cent of the power and one tenth of the infrastructure of the original Spine.

We also successfully transitioned the Care Identity Service (CIS) and Secondary Uses Service (SUS) during February-March this year. Users report that SUS is now running up to 5 times faster.

Delivery of the Spine and other similar transitions will bring significant cost savings, support new systems that will enable health and care staff to provide better services and support the integration of health and social care thereby providing wider access to information for local authorities and social care organisations.

Whilst improving our services, we upheld the high levels of operational integrity that are of critical importance to the health and care system. Major systems and services such as the Electronic Prescription Service, Choose and Book and the Summary Care Record have operated at 99.97 per cent availability to users throughout the year.

This spring, following a highly competitive procurement process, a supplier was chosen to operate the NHSmail service for the next five years. We consulted service users and over 2,000 offered feedback on the proposed solutions.

The new service will continue to be Microsoft Exchange based and offer larger mailboxes, improved archiving, branding for local organisations, mobile device access and an all-round better browsing experience for users.

Working in partnership to provide trusted digital services

Throughout our period of transformation we have continued to work in partnership with, and provide a significant portfolio of digital services for, patients, the NHS and all our customers and stakeholders.

NHS Choices is the UK's biggest patient facing heath website. Last year visitors to the site increased from 42 million to 48 million per month. In the autumn, the Choices team launched the 'My NHS' beta web site, created to provide performance information – for example on consultant outcomes – to patients thus supporting transparency and improving quality. Then in February this year the team worked with Public Health England and the British Heart Foundation to successfully launch the 'Heart Age' tool which helps the public become more aware of their blood pressure and cholesterol numbers and appreciate the importance of these factors to their health.

Our Local Service Provider teams have worked in partnership with local healthcare organisations and private sector system suppliers to support a number of important technical deployments this year. Highlights include the roll-out of the Electronic Patient Record (EPR) system Cerner Millennium at both Imperial College Healthcare NHS Trust and Croydon Health Services NHS Trust. At Croydon, for example, over 2,500 staff use the system each day and it has dramatically reduced data inputting duplication giving staff more time to spend caring for patients. Its value was recognised in October when Croydon received the UK's highest rating for use of IT systems to improve patient care using electronic patient record systems.

We played a major role in supporting the development of the NIB, which in November published its Framework for Action, the blueprint for using information and technology to transform health and care services. In the future, patients, service users and staff will be better placed to take advantage of digital technologies to improve health and wellbeing. We have the lead role to play in seeing these ambitions realised as detailed in our five year strategy *"Information and technology for better care"*.

Our challenges

One of the most significant challenges we face is striking the balance between preserving the confidentiality and security of people's confidential data and maintaining the appropriate flow of data for our customers. In the past year this challenge was intensified by heightened public

scrutiny of the care.data programme and criticism we received about the way we manage data access and disseminate patient and service user data. We have also faced questions about the integrity and robustness of our processes.

In June a report prepared by Sir Nick Partridge made nine recommendations for change. We acknowledged failings where they existed and accepted all nine recommendations. In his subsequent 'Review of Data Releases' published in November 2014 Sir Nick acknowledged our progress but talked of the 'tension between the ambition to improve health and care for all and protecting people's privacy diligently'. This remains our key challenge along with our work to establish clear lines on managing patient consent and objections to data sharing.

One consequence of this review's recommendations was our temporary suspension of all data sharing services. This led to a backlog of customer requests for information – particularly for researchers. Whilst this was necessary, I do apologise to the research community for the difficulties caused. We have been working hard to clear that backlog and to work with that community and others to find better, more efficient ways of working in the future.

Despite all these challenges we were still able to fulfil hundreds of requests for data this year in addition to responding to more than 600 parliamentary questions, 890 Freedom of Information requests and publishing over 260 statistical publications to help inform public debate and provide useful information to aid decision making across the health and care system.

We also have a duty to manage public funds responsibly and to achieve efficiencies where we can. That is why, as part of a move to rationalise our office estate, we have made a number of changes in Leeds, releasing two serviced offices and moving some teams to Bridgewater Place. The new office space allows staff there to work more flexibly together and will also enable us to make savings of £3 million over time. This project received recognition in the Cabinet Office's 'State of the Estate' 2013/14 report.

Looking ahead

There are major challenges ahead for the organisation internally and externally. We are still responding to Sir Nick Partridge's recommendations and acknowledge that we still have progress to make in both gaining public trust and confidence in what we do and in providing a more efficient service to our customers.

In the year ahead, we will work hard to fulfil our commitment to make sure that each person's confidential information is protected. We will also focus on developing IT systems that will support our commitments and enable people to better manage their own health and care.

We will lead a complex programme of work to support the safe, secure exit and transition of organisations from the LSP contracts. The BT LSP contract for London and the South ends in October 2015 and the PACS contract in London ends July 2015. In 2016 the CSC LSP contract and the PACS contract for the North Midlands and East will both come to an end. A controlled exit to these contracts is essential if we are to ensure that organisations have arrangements in place that continue to advance digital maturity.

We will continue to build the firm foundations for an integrated health and social care system with improved benefits for all the projects we deliver as we establish the Health and Social Care Network, transition NHS Mail and deploy the NHS e-Referral Service.

We know that we need to build stronger relationships with our stakeholders, customers, suppliers and partner organisations in the wider health and social care system and also show people who use our services that we are listening and responding to their needs.

We will continue to work in partnership with staff to transform our culture and ensure they remain focused on embodying our values of being people focused, professional, trustworthy and innovative.

I would also like to recognise the dedication shown by our staff day in and day out, and often beyond their regular responsibilities. For example, last summer, an HSCIC staff initiative supported and took part in the 'Etape du Yorkshire' in conjunction with the Cyclists for Cancer charity. Together they raised £75k for Cancer Charities. I was also heartened by launching our graduate training scheme and welcoming our first ten graduates to HSCIC through this route in January.

Over the past year, working through a period of intense transformation and challenge, our staff have demonstrated expertise and capability as well as the commitment to fulfilling the responsibilities we hold as the national provider of data, information and IT services to our customers. I feel confident that we will continue to work together, maintain this commitment and uphold our values as we rise to the challenges of the year ahead.

Andy Williams
Chief Executive

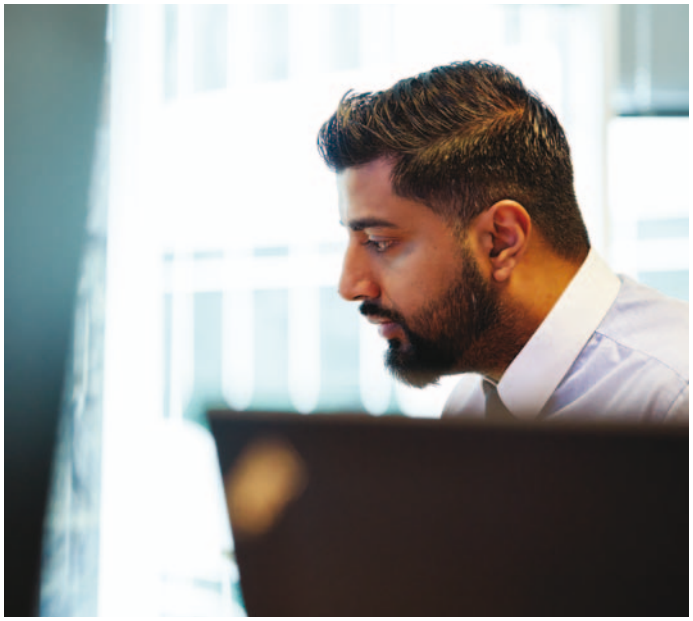
April 2014: Deirdre Lyons (Consultant Obstetrics and Gynaecology), Rosie Burbidge (Nurse Educator), Rufina Cardozo (Healthcare assistant), Grace Osorio (Nurse) and Pearl Bowen-Hall (Nurse) of Imperial College Healthcare NHS Trust

Our Local Service Provider teams help NHS organisations to select IT systems providers and then work with them and their suppliers to successfully implement the solutions. Last year we worked with Imperial College Healthcare NHS Trust and their suppliers BT to implement the Cerner Millennium patient administration system and start the roll-out of electronic health records across their estate. Deirdre and her team were involved in the pilot programme and are now benefitting from the increased access to care information that the system provides.


Cerner@Imperial Champion

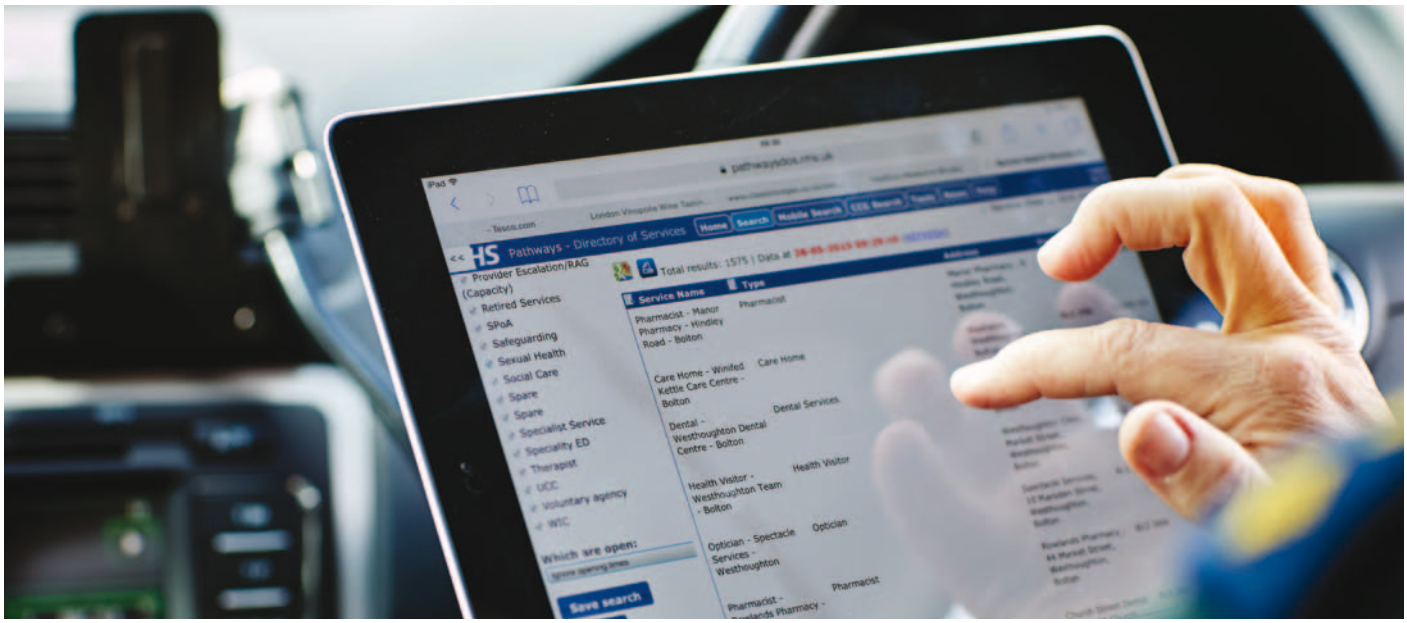
August 2014: Jamie Hurst (Service Manager) and Saqlain Hussain (Service Management Analyst)

Jamie manages the HSCIC Service Bridge which is our command and control centre responsible for dealing with significant incidents affecting any of our managed IT services. The Service Bridge focuses on monitoring for early identification of IT service issues and ensuring the fastest possible restoration of service when issues do occur. The Service Bridge was a part of the wider team that played a critical role in the successful migration of the Spine in 2014. The Spine is a collection of national applications, services and directories that support the NHS in the exchange of information across national and local NHS systems.



September 2014: Carol Robertson (Paramedic, North West Ambulance Service)

NHS Pathways is a suite of clinical assessment content used to triage telephone calls from the public, based on the symptoms they report when they call. It has an integrated Directory of Services which identifies appropriate services for a patient's care if an ambulance is not required. A mobile version of the directory was developed for use by clinicians to direct patients to a service that is most suitable for their needs following a face to face assessment. Carol and her colleagues at the North West Ambulance Service were amongst the first in the country to use the NHS Pathways mobile directory during its pilot last year.

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LIFEPAK
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Management commentary
Strategic report

Background

The Health and Social Care Information Centre (HSCIC) was established as an Executive Non-Departmental Public Body (ENDPB) in April 2013 through the Health and Social Care Act 2012. We are responsible for setting up and operating systems for the collection, analysis, dissemination and publication of information relating to health services and adult social care. We are also the authority for determining and publishing information standards for health and adult social care in England. The HSCIC comprises of functions transferred from:

- The former Information Centre (NHS IC), whose primary purpose was the collection, analysis and dissemination of health related data and information for secondary uses purposes,
- NHS Connecting for Health (NHS CfH), part of the informatics division of the Department of Health (DH) whose primary purpose was the development and management of national health systems and IT infrastructure,
- Former Strategic Health Authorities (SHAs) and a Primary Care Trust (PCTs), where staff provide technical and management expertise to Trusts, with respect to the implementation of National IT systems,
- An external provider, Capita, who undertook the development and management of the NHS Choices website.

We are also the national provider of information, data and IT systems for patients, service users, clinicians, commissioners, analysts, and researchers in health and social care. Our role is to improve health and social care in England by putting technology, data and information to work. We provide national technology and information services and we are the centre of excellence and leadership in the development and use of technology, data and information.

Working with our partners across the health and social care system, particularly within the framework of the National Information Board (NIB), we have the key role in enabling and supporting the whole health and care system to use technology, data and information to transform its services. We have a number of statutory duties funded through Grant in Aid (GIA) which are important for the way the health and care system operates. In summary, we:

- Manage a number of technical services which underpin local health and care organisations – such as the Spine, e-Referrals, NHS Choices, and others,
- Collect, analyse and present national health and social care data, and use the data to publish a series of national statistical reports,
- Publish guidelines and standards that are important for shaping the way services are delivered locally. These include technical standards for data and technology, to support interoperable services. We also publish guidance on information governance and security, including a set of rules on how people's personal confidential information must be looked after,
- Create indicators that can be used to measure the quality of health and care services,
- Help health and care organisations improve the quality of the data they collect and send to us, and
- Advise the Secretary of State for Health on ways of reducing the impact of administrative burden on local health and care organisations caused by national data collections.

Under separate direct commissioning arrangements, we also undertake other related services for a range of customers, notably the Department of Health (DH), NHS England (NHSE) and Public Health England (PHE).

We have developed a detailed strategy for the next five years that sets out our vision and this can be found at: https://www.gov.uk/government/publications/hscic-strategy-2013-15.

"By 2020, all the citizens who want it will have access to national and local data and technology services that enable them to see and manage their own records; undertake a wide range of transactions with care providers; and increasingly manage their own health, care and well-being.

By the same date, care professionals will have timely access to the information, data, analysis and decision-support systems that they need to deliver safe and effective care."

The strategy commits us to:

1. **Ensuring that every citizen's data is protected**
   We will assure the quality, safety and security of data and information flows across the health and social care sector so that citizens will willingly share their data in the knowledge that it will be kept confidential and secure. Citizens will also be confident that their data will only be shared when appropriate, with their consent and for their benefit.
2. **Establishing shared architecture and standards so everyone benefits**
   We will create a new architecture for the sector's technology and data services and extend a framework of standards to encourage interoperability and the development of new, digitally enabled services.
   We will enable safe and secure information sharing so that carers and clinicians have timely and reliable information about those in their care. Citizens will be able to see and contribute to information held about them. We will do this in collaboration with our national partners and with care providers and the software market.
3. **Implementing services that meet national and local needs**
   Where there is a clear advantage in a national, integrated approach, we will continue to build and operate national technology and data services for the benefit of citizens and health and care organisations. Where necessary to fulfil the commitments in the NIB Framework, we will integrate some of these national systems to create a new information and transaction service for citizens, including service users and carers. We will also open up access to our core systems, with appropriate safeguards, so that third parties can develop new and innovative services. Finally, as we all become more dependent on these systems, we will continue to make them secure and resilient.
4. **Supporting health and care organisations to get the best from technology, data and information**
   We will help local health and social care organisations maximise the value of their information technology investments, and when invited, help them decide on future investments and implementations.
   We will encourage local innovation that delivers new forms of health and care services, and take steps to foster their broader adoption.
5. **Making better use of health and care information**
   We will analyse, use, and make available more data, information and insights about the health and social care sector. Where there is a clear benefit to the health and social care of citizens, we will supply sophisticated analytical technology to all-comers. This work will allow citizens to make informed choices about their own care. It will help care professionals make better and safer decisions, support policymakers, and facilitate better commissioning of health and care services. It will also provide research organisations with the data they need.

We need to change the way we work to deliver these objectives. Our sixth strategic objective is to transform the way we engage and work. We will do this through an organisational development focus on our internal systems and processes, service management and delivery models, and engagement with customers and the wider sector, including patients, service users and the public.

We deliver a considerable range of Services and Programmes, a sample of which can be found in the table below:

Services	Description / Purpose
Burden Advice and Assessment Service	Reviews and assesses the impact of national and local data collections on the NHS.
Calculating Quality Reporting Service	Calculates, reports and approves outcome-related achievement and payments to GP practices and NHS England area teams.
Clinical Audit Management Service	Delivers all elements of the clinical audit lifecycle, from the development of the audit's questions and scope, to local and national feedback and reporting.
Data Access Request Service	Handles customer requests to access our wide range of health and social care information, products and services including HES data extract, data linkage and Medical Research Information Services.
Data Services for Commissioners	Infrastructure, systems and services to enable effective data provision to health and care commissioning organisations.
General Practice Extraction Service	Extracts information from general practice IT clinical systems for a range of purposes. It is also part of the process for providing payments to GPs and Clinical Commissioning Groups (CCGs).
Hospital Episode Statistics	A data warehouse containing details of all admissions, outpatient appointments and A&E attendances at NHS hospitals in England. We produce a range of statistical publications using this data.
Indicator Portal	Provides quick and easy access to hundreds of indicators from a range of sources including the outcomes frameworks, social care, GP practice and public health indicators.
Health Surveys Service	Commissions and manages contracts to carry out surveys on all aspects of health and social care.
Maternity and Children's Dataset	Collection and reporting of data concerning maternity, child health and adolescent mental health services.
National Adult Social Care Intelligence Service	A single national resource of social care information for England. The website has a collection of data, tools and resources designed to meet the needs of service planners, managers, researchers and policy makers.
National Casemix Office	Designs and refines the classifications that are used by the NHS in England to describe healthcare activity. These classifications underpin the Payment by Results system from costing through to payment, and support local commissioning and performance management.
NHS Choices	The website for the National Health Service in the UK, providing health and lifestyle advice, information about local services and the latest health news.
NHS iView	An online service that provides aggregated health and social care data to authorised users within the NHS. The service lets users select data, make comparisons and create tables and graphs.
NHS Safety Thermometer	A local improvement tool for measuring, monitoring and analysing patient harms and 'harm free' care.
Statistical Publications	Producing over 260 statistical publications every year on a broad range of topics that include public health reports and lifestyle surveys, hospital care, NHS workforce, social care statistics, mental health and prescribing statistics and clinical audits.
Secondary Uses Service	The single, comprehensive repository of healthcare data for hospital services in England. It enables healthcare activity to be analysed and reported on, locally and nationally.

Programmes	Description / Purpose
care.data	A programme to capture and link data from primary and secondary care to increase transparency and improve patient outcomes.
Child Protection – Information Sharing	Connects local authorities' children's social care IT systems with those used by NHS unscheduled care settings (such as Accident and Emergency) to provide better care and earlier intervention for children who are considered 'vulnerable and at risk'.
Cross Government Programme	Facilitating the provision of care and information sharing across government, and supporting the delivery of Ministerial priorities.
Developing Informatics Skills and Capability	Offers support materials, guidance and tools, as well as general information about health informatics and how it can help make organisations to be more efficient and effective.
Electronic Prescription Service	Enables prescriptions to be sent electronically from a GP surgery to a pharmacy of the patients' choice and then on to NHS Prescription Services for payment.
Female Genital Mutilation Prevention	Information collection and sharing by the NHS on Female Genital Mutilation.
GP2GP	A computerised system to manage the electronic transfer of patient records between GP practices.
General Practice Systems of Choice	Provision and delivery of clinical information technology systems for GP practices.
Local Service Provision	Upgrading information technology in NHS provider organisations so that they can implement the electronic patient record at the point of care.
N3 / Health and Social Care Network	N3 is a national IT network that connects NHS organisations by enabling information to flow efficiently through the system – placing key data at the fingertips of clinicians and patients.
NHS e-Referral Service	A system that combines electronic booking with a choice of place, date and time for hospital or clinic appointments. These can be booked in the GP surgery at the point of referral, or later at home, on the phone or online.
NHS Mail 2	NHS Mail is the secure email service available for use across organisations commissioned to deliver health and social care. NHS Mail 2 will replace the existing NHS email system and transition users and services onto the new solution.
NHS Pathways	A clinical assessment tool used by urgent and emergency care teams for direct patient care. It triages calls from the public made to NHS 111, 999 and GP out-of-hours services.
Spine2	Spine is a collection of national applications, services and directories that support the NHS in the exchange of information across national and local NHS systems.
Summary Care Record	The Summary Care Record is a copy of key information from a patient's GP record. It provides authorised healthcare staff with faster, more secure access to essential patient information.
Systems and Service Delivery	Provides professional software development, support and hosting resources including services for Breast Cancer Screening, contact centre services and IT hosting services.

Regulatory and compliance framework

As an ENDPB, we are accountable to Parliament and are responsible for:

- The collection, storage, analysis and dissemination of health and adult social care data for England and the provision of guidance on any matters relating to these activities,
- The provision of a trusted, safe haven for confidential patient identifiable information,
- The establishment, delivery and operation of systems that deliver better, more effective care for the community and allow patients, service users and carers greater choice while fulfilling statutory duties and functions which underpin the services we provide.

In carrying out these functions we are required to:

- Seek to minimise the burdens we impose on others, and
- Exercise our functions effectively, efficiently and economically.

In practice, we are accountable to the Department of Health which also provides the majority of funding via Grant In Aid (GIA) allocations. A specific sponsor team engage with and oversee our activities and provide a comprehensive support and accountability function. We are fully represented within the main informatics related Boards thus ensuring there is a coordinated and joined up approach to our activities.

We have a responsibility for maintaining a sound system of internal control that supports the achievement of our policies, aims and objectives whilst safeguarding public funds and our assets in accordance with the responsibilities assigned in Managing Public Money. The key governance and accountability policies and processes are now fully embedded.

There is a wide ranging legal, regulatory and compliance framework which governs our receipt, processing and dissemination of data and information and our production of statistics.

Our regulatory and compliance framework includes the:

- Data Protection Act (1998)
- Freedom of Information Act (2000)
- Human Rights Act (1998)
- Environmental Information Regulations (2004)
- Copyright, Designs and Patents Act (1998)
- Data Protection (Processing of Sensitive Personal Data) Order 2000
- Health and Social Care Act (2001)
- NHS Act (2006)
- Health and Social Care Act (2012)
- Re-use of Public Sector Information Regulations (2005)
- NHS Codes of Practice on Information Security (2007)
- Records Management (Part 1 2006 & Part 2 2009) and Confidentiality (2003)
- Common law duty of confidentiality
- Caldicott Report (1997)
- NHS Information Governance Toolkit.

In respect of statistics produced by the HSCIC, the Statistics and Registration Service Act (2007) gave rise to the UK Statistics Authority, whose *Code of Practice for Official Statistics* governs HSCIC statistical work, and who can monitor and comment publically on compliance with the *Code*. The UK Statistics Authority also formally assess statistics for compliance with the Code and can designate or continue to designate them as *National Statistics* if they comply.

Accounts preparation

The Accounts have been prepared under a direction issued by the Secretary of State in accordance with the Health and Social Care Act 2012 and have been prepared in accordance with the 2014/15 Government Financial Reporting Manual (FReM) issued by HM Treasury. The accounting policies contained in the FReM apply International Financial Reporting Standards (IFRS) as adopted and interpreted for the public sector context. The Accounts are comprised of a statement of financial position, statement of comprehensive net expenditure, a statement of cash flows and a statement of changes in taxpayers' equity, all with related notes.

Under the 2013/14 FReM, the transfer of functions into the HSCIC was accounted for using absorption accounting rules with assets and liabilities for NHS Connecting for Health, Strategic Health Authorities and Primary Care Trusts using standard absorption rules and the NHS Information Centre using modified absorption rules (whereby the net value of transfer is accounted for through the general reserve). Similarly the transfer of assets from NHS Direct during 2014/15 was accounted for using standard absorption rules.

Review of the year

This has been an extremely challenging but successful year for us. We have fully completed the integration of the various organisations and our transformation programme, fully supported by management and staff, has made significant progress.

We have made significant progress during the last twelve months against the commitments we made in our business plan for 2014/15. We either completed or made strong progress against 42 of our 56 commitments that were to be delivered during the year. On a further 12 commitments we made good progress, although these require planned work to be carried forward into 2015/16. The two commitments where we have made less progress are the National Tariff Service and the Health and Social Care Network. We are working with our sponsors and partners to accelerate progress on both of these programmes.

In particular we have:

- Completed the insourcing of Spine 2, the Care Identity Service (CIS) and the Secondary User Service (SUS) – parts of the essential national infrastructure that holds demographic information, the summary care record for the majority of the population of England and many data and technology functions for the health sector,
- Improved the way we manage requests for data by implementing the recommendations from Sir Nick Partridge's review of data releases,
- Maintained an average service availability of 99.97 per cent for all the national technology services we provide,
- Published the Code of Practice for managing confidential information across the health and care system,
- Overseen significant increase in traffic to the NHS Choices website, from 42 million to 48 million total visits per month,
- Seen the coverage of the Summary Care Record (SCR) increase to 95 per cent of the population. An SCR is viewed every 15 seconds which equates to over 2.3 million views per year,
- Initiated a national cyber security programme for the health and care system,
- Enhanced the functionality provided by the Child Protection Information Sharing system, which helps to improve the protection of children who have previously been identified by children's social care services as being vulnerable or at-risk. Three NHS organisations and three local authorities have now gone live in the first wave of this project, which will connect social care, emergency departments, out of hours GP services, walk-in centres, paediatric wards, maternity wards, minor injury units and ambulance services with IT systems used in local authorities' child protection systems,
- Published the first ever national report on the prevalence of Female Genital Mutilation, which has received significant media coverage and is already informing national commissioning, policy and prevention work,
- Supported the deployment of electronic patient record systems to Trusts in England (including one which is the largest deployment for over ten years), all of which support these Trusts to deliver better and safer care for patients,
- With the sponsorship of the DH, launched a new social care informatics programme that will:
  - develop standards for adult social care to ensure information flows support integration between health and social care,
  - extend our Social Care Integration 'Adapter' project which saw its first site go live in 2014/15. The project has been developed in London and allows discharge notices to be securely exchanged between a hospital's administration system and a local authority's social care case management system. It also supports automated alerts to signal key events, such as when a vulnerable adult is about to be discharged from hospital, and
  - pilot a secure email project with care homes in Shropshire, aimed at breaking down communication boundaries between health and social care by using NHSMail to replace current processes which are predominantly fax-based.

Financial results

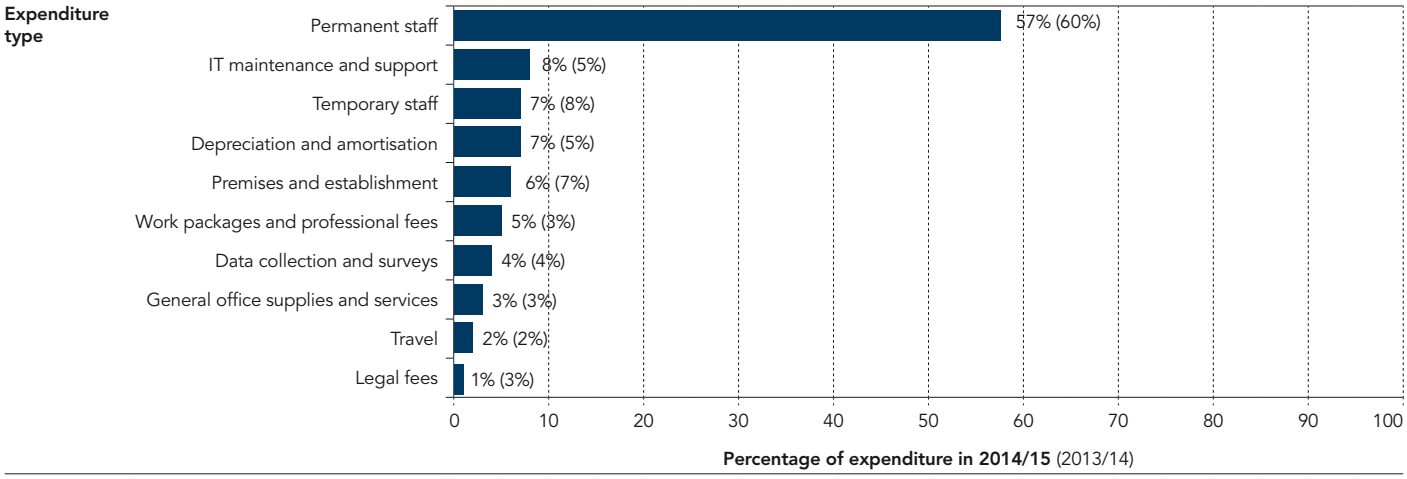
The table below provides a summary of the 2014/15 results:

	2014/15 £000
Grant in Aid allocation from the Department of Health	177,705
Other income	55,670
Total income	**233,375**
Operating expenditure	**(215,109)**
Underspend	**18,266**

We have remained focused on delivering our services within an environment where central funding for public bodies has become increasingly tight with the core GIA funding being approximately £7 million less than that provided the previous year. The net operating expenditure of £159.4 million is £18.3 million less than the GIA allocation provided by the Department of Health for the year. The underspend is not retained by the HSCIC but is redeployed by the Department of Health for use within the wider health service.

The HSCIC receives both administration (to support the core service delivery and support functions) and programme (to support front line activities) funding. An underspend was generated in both.

Analysis of operating expenditure



Operating expenditure

Permanent staff remain the major expenditure representing 57 per cent (2013/14 60 per cent). Staff numbers have increased throughout the year from an average of 1,995 in 2013/14 to 2,332 in 2014/15. This is partially a result of the transfer of functions from NHS Direct, insourcing of systems such as SPINE and filling budgeted vacancies that have existed since our inception.

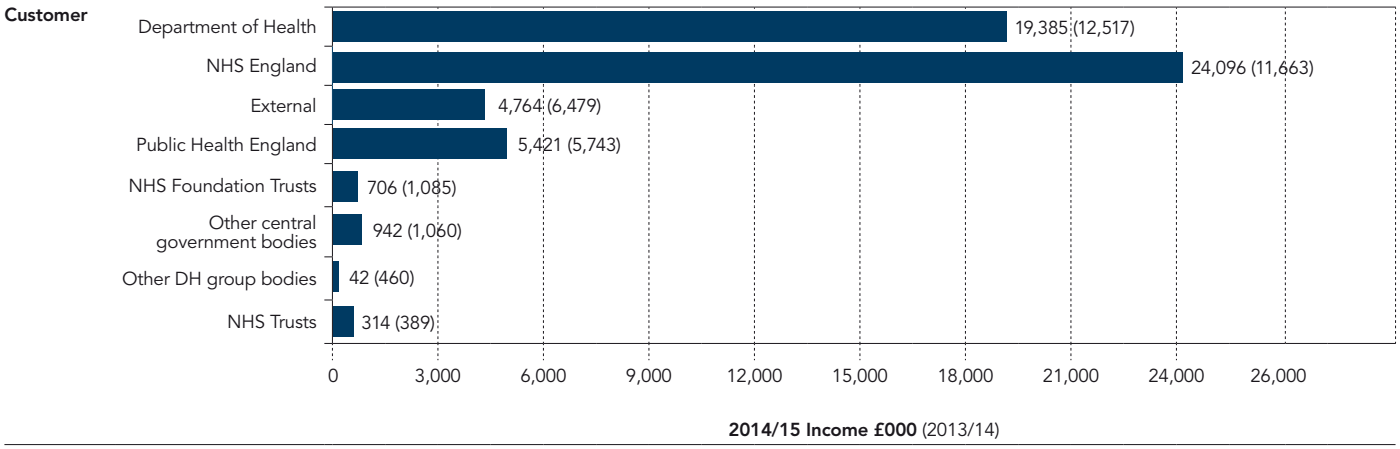
Other major costs include:

- IT expenditure – the increase includes the infrastructure costs of the Telephony Managed Service transferred from NHS Direct and running costs of the General Practice Extraction Service (GPES),
- Premises – this has increased by £1 million largely due to increased recharges from DH for Skipton House. The rationalisation of the Leeds estate where several relatively expensive managed buildings are being vacated and another has been reassigned onto a direct lease arrangement will begin to generate operational savings during 2015/16,
- Work packages and professional fees – includes increased costs for undertaking health surveys and service / programme developments which are largely offset by additional GIA allocations and other income sources.

Other income

In addition to GIA, we generated a further £55.6 million of other income (2013/14 £39.4 million), primarily undertaking programme management, IT services and the delivery of other services for the Department of Health and NHS England. The breakdown of such income by customer type is as follows:

Analysis of income by customer



External income includes the provision of clinical audit services and fees and charges for providing data extracts and tabulations and data linkage services. All such charges are on a full cost recovery basis.

Non-current assets

During the year, a major exercise has been undertaken to verify the non-current asset base. In particular we have undertaken:

- A full IT equipment and software license inventory to verify the existence of all assets and to reconcile to the IT department's asset management system. This has been followed with a cross check against the fixed asset register maintained by Finance. This exercise has resulted in the carrying value of some assets being adjusted and the disposal of other assets with a cost of £7.4 million and a net book value of £0.4 million. A number of other assets were also reclassified, costs previously written to revenue were capitalised and changes made to some asset lives,
- A full internal review of the General Practice Extraction Service (GPES) asset, which having a net book value of £12.9 million, is the organisation's single largest value asset. The service went into live operation in 2014/15 having taken some 6 years to develop. The outcome of the review was to impair £0.8 million of abortive or incompleted software development in respect of the General Practice Extraction Tool - Query (GPET-Q) function and a reduced amortisation period of two years as the functionality, designed a number of years ago, is anticipated to be superceded by 2017.

The capital resource allocation was £14.5 million with an actual spend of £14.2 million. Main expenditure included:

- Completion of the development of GPES,
- Computer equipment, licenses and bought in software, relating to programme or project activities,
- Internally developed software,
- Office decoration and purchase of fittings for the reorganisation of the Leeds property estate.

It should be noted that while we manage a large portfolio of major IT infrastructure programmes on behalf of DH, the associated assets are accounted for within the DH financial statements.

Current assets and liabilities

Outstanding accounts receivable balances amounted to £14.8 million (2013/14 £14.4 million), of which £0.3 million (2013/14 £0.6 million) was more than 60 days overdue. Debts amounting to £45,770 were written off and £3,921 was provided for as irrecoverable. Debts previously provided of £218,728 were released following recoveries of amounts due. Other debtors largely related to prepayments and accrued income.

We sought to comply with the Better Payments Practice Code (BPPC) by paying suppliers within 30 days of receipt of an invoice. The percentage of non NHS invoices paid within this target was 90.7 per cent (2013/14 95.4 per cent).

Better payments practice code	Number	£000
Total non NHS bills paid 2014/15	11,062	86,625
Total non NHS bills paid within target	10,038	79,033
Percentage of non NHS bills paid within target	**90.7%**	**91.2%**
Total NHS bills paid 2014/15	309	3,845
Total NHS bills paid within target	220	2,446
Percentage of NHS bills paid within target	**71.2%**	**63.6%**
Total value of invoices processed in 2014/15		90,455
Total value of invoices outstanding at 31 March 2015		6,738
Average number of days outstanding at 31 March 2015		21

In December 2014, we migrated from release 11 of Oracle to release 12. This necessitated a period of nearly three weeks where no accounting ledgers were available. Whilst we put in place steps to ensure that urgent payments were made during this period, the impact on the processing of transactions and payments to suppliers was significant. Prior to the migration the non-NHS BPPC ratio was just under 97 per cent but this fell cumulatively to under 91per cent for the full year.

Going concern

Confirmation of the main GIA budget allocation for the 2015/16 financial year in line with the business plan submitted to DH has been received. The Accounts have been prepared on the basis that we are a going concern.

Financial instruments

We had only a very limited exposure to financial instruments consisting of cash, trade receivables and payables. Cash flow was managed to meet operational requirements throughout the year by drawing down sufficient cash from the GIA allocation. There are no significant issues with respect to the outstanding balances at the reporting date.

Events after the reporting period ended

There are no significant events after the reporting period ended.

Political and charitable donations

No political or charitable donations were made in the year.

Information Governance

A key element of our responsibilities is to ensure that the collection, storage and dissemination of all data and information is secure and appropriately controlled. Information and statistical governance are taken extremely seriously and we have established very specific controls and protocols. In fact, during 2014/15 we have expanded our governance responsibilities to provide system wide advice on operational information governance across the health and social care sectors in England. This is separate from our principal role of guardian of data as set out in the Health and Social Care Act 2012.

We have created an Information Assurance and Cyber Security Committee (IACSC) to strengthen controls around the security of our IT infrastructure. The committee is chaired by a non-executive director who reports to the main Board. The IACSC has commissioned on-going reviews of information and cyber security across the organisation, which is informing and refining information security assurance activities. A Cyber Security Programme has been initiated to review our internal approach to security as well as to provide innovative cyber security for the wider health and care sector.

In particular:

- We completed the Information Governance Toolkit (IGT) which is the self-assessment process required to assess information governance controls within the health and social care system. We achieved a score of 95 per cent,
- We undertook public consultation in developing a Code of Practice in the handling of confidential information to be followed by the wider health sector,
- There has been one personal data incident in 2014/15 that required reporting to the Information Commissioners Office (ICO),
- In April 2014, as part of the regular review and assurance of data the HSCIC undertakes, it was discovered that a number of NHS organisations that have been submitting data values to the secure Secondary Users Service (SUS) did not conform to NHS Data Dictionary Standards. In accordance with good practice and in relation to issues impacting on the use of patient data, we referred this incident to the ICO. We subsequently reminded data providers of their responsibilities and put in place processes to mitigate this going forward. The risk to patient confidentiality was classified as low by the ICO.

  We have logged and managed a small number of incidents. An assessment against ICO guidelines determined these did not require ICO notification due to the small scale of the incident or because no clinical or sensitive data was involved.

  We are subject to the Data Protection Act 1998 and have filed the appropriate notification with the ICO. During 2014/15, we received 890 Freedom of Information requests and 66 Subject Access requests. There have been 29 breaches of the timescales for handling a Freedom of Information request and 6 breaches for handling a Subject Access request,
- During 2014/15 one incident was logged on the Serious Incident Requiring Investigation (SIRI) reporting tool as a near miss, which we investigated and managed internally in accordance with, and having been assessed against, Information Commissioner's Office (ICO) and SIRI reporting guidelines. These determined that an ICO notification was not required; this is where the incident is a near miss, minor or where no clinical or sensitive data was involved, and
- As a public information holder, we have complied with the cost allocation and charging requirements of HM Treasury and the Office of Public Sector Information. No charges have been made for access to information during 2014/15.

A more extensive explanation of information governance issues is included in the Governance Statement on page 55.

Sustainable Development

We are required to prepare a report in line with the 2014/15 HM Treasury Sustainability guidelines, fully consistent with non-financial information requirements laid down under the Greening Government commitments (including the transparency requirements).

The sustainability aim is to reduce the impact of the business on the environment, especially to reduce carbon dioxide (CO^2) emissions. The key areas of carbon use for the HSCIC are in relation to IT, accommodation and travel.

We take our impact on the environment seriously and endeavour to achieve the requirements as set out in the Greener Government Strategy.

During 2014/15 we have:

- Introduced as part of the Leeds office estate reorganisation the greater use of flexible working arrangements and in particular the implementation of improved desk sharing facilities,
- Consolidated our IT infrastructure which has reduced carbon use from large local servers formerly managed in offices to our more efficient hosted environment,
- Reduced the carbon consumption per employee from 1.4 Tonnes CO^2 (TCO^2) to 1.2TCO^2,
- Invested in more video conferencing and other technologies to minimise the requirements for travel,
- Raised the profile of sustainability when procuring or upgrading services. For instance the redevelopment of the SPINE service has reduced the power consumption by 95 per cent and the infrastructure requirements by 90 per cent,
- Continued to promote greener methods of travel to work, including improving changing facilities, supporting cycle to work and operating Metro card schemes,
- Supported the raising of £75,000 for charities by organising, with Cycling Fighting Cancer, a sportive for 1,500 cyclists following the day one route of the Tour de France. Some 150 staff took part in the ride with many more assisting with the organisation.

We do not own any commercial transport, but do lease a small number of cars for specific staff who require them for business need, all such provision is based on a maximum CO^2 output of 105gm. Where video or audio conferencing cannot be used then travel is primarily by public transport although car travel is necessary between locations where it is difficult or not efficient to use public transport.

The HSCIC property estate currently comprises a number of buildings in twelve locations across England. The number and dispersal is a result of the establishment of the HSCIC in April 2013 which brought together the estates of the predecessor organisations, CfH and NHS IC along with a requirement for local office accommodation for IT delivery staff based in eleven former strategic health authority buildings.

A location and estate strategy has been developed to rationalise these locations over time, and during this financial year one location has closed and three buildings in the North East of England have been co-located with a Department for Work & Pensions building in Washington, Tyne and Wear. The present estate structure follows guidance issued by the Cabinet Office and comprises HQ offices in Leeds supported by five hub offices in Exeter, Southport, Redditch, London and Newcastle alongside four remaining hosted locations, which will be closed during 2015/16. Some staff also work from home.

The key principles of the strategy are to:

- Maintain value for money in the provision of a fit for purpose estate,
- Comply with national property controls and Government Property Unit (Cabinet Office) policy,
- Maximise the utilisation of properties.

These principles will be achieved by completing the reduction of the number of locations in use and the number of buildings at these locations, reappraising the space requirements in both Leeds and London, taking on the initiatives contained in the Government's New Ways of Working guidance and maximising the sharing of suitable space across the government estate.

The present space per workstation across the majority of the estate is 7.9m^2. As new ways of working and the other elements of the strategy are implemented the aim is to stabilise at 8.0m^2 across all of the HSCIC buildings and increase utilisation from an average of 89 per cent to an average of 95 per cent.

The table below provides an overview of each of the three main reporting areas:

Greenhouse gas emissions		2014/15	2013/14 Restated
Non financial indicators (tco^2)	Scope 1 emissions		
	Natural Gas	387	352
	Scope 2 emissions		
	Electricity	1,778	2,001
	Scope 3 emissions		
	Rail	323	284
	Air	86	100
	Electricity	160	162
	Total energy	**2,734**	**2,899**
	Total energy per FTE	**1.2**	**1.4**
Financial indicators (£000)	Scope 1 emissions		
	Natural Gas	89	110
	Scope 2 emissions		
	Electricity	367	417
	Scope 3 emissions		
	Rail	1,863	1,669
	Air	135	125
	Electricity	33	33
	Total energy cost	**2,487**	**2,354**
	Total energy cost per FTE	**1.0**	**1.1**
Water (m^3)		10,387	10,543
Water (£000)		56	57

It has been agreed that the required accommodation reporting for buildings where the landlord is another NHS or government body is undertaken by the other parties, the balance of our properties are reported through the Annual State of the Government Estate and managed via a Department of Health Sustainable Development Action Plan. Such properties disclosed elsewhere include our offices in London (DH) and Southport (Home Office) together with the IT hosting centres (HM Land Registry).

We have provided utilities information where it has been possible to separate it from landlords' service charges. Flights and rail travel has been provided by our travel service provider; we have not provided vehicle travel emissions because the service provider does not track this information.

Water figures include usage for drinking, cleaning, lavatories and showers, the latter of which have seen increased use as 'bike to work' and Government 'get fit' promotions have encouraged cycling to work.

The waste facilities in some locations are shared with other tenants of the buildings occupied and thus it was not possible to accurately identify the volume of waste disposed of. We estimate that 49 tonnes (including 15 tonnes of IT related equipment) was recycled and 41 tonnes was sent to landfill.

Waste is minimised by the provision of managed print services, closed loop paper supplies and recycling along with a range of other recycling services across the estate.

Waste is primarily normal office waste as most business procurement relates to information services rather than products.

The volume of paper amounts to the equivalent of 9,215 (2013/14 9,487) reams of A4 paper, representing 4.0 (2013/14 4.4) reams per FTE.

Sustainable procurement

Most procurements are for services rather than products and are through nationally agreed frameworks where sustainability provisions have been incorporated. Our direct procurement includes specific sustainability provisions and forms part of the tendering process where applicable and suppliers are required to demonstrate a similar commitment through the incorporation of sustainable practices into their provision of goods and services.

Biodiversity

We are an office based organisation and as such have minimal impact on biodiversity issues and do not have a biodiversity action plan.

Andy Williams
3 July 2015

October 2014: Astrid Fairclough (Programme Head – Female Genital Mutilation Prevention, Department of Health)

Astrid and her team are tackling the issue of Female Genital Mutilation (FGM) which was identified as a priority for the Department of Health during the last year. The programme aims to ensure that the NHS knows how to care for survivors, and protect girls from ever having FGM, and ensuring that FGM cases are recorded. Last Autumn, at the request of the Secretary of State, we published the first official figures on the number of patients with FGM seen in hospitals in England. Our work collecting the data and reporting the figures supports Astrid's important programme of work, and was ground breaking in the field, being the first time such information has ever been collected and published at a national scale.

November 2014: Andrew Sofield (Children's Social Care Senior Manager, Lancashire County Council) and Vivien Barnes (Lead Nurse for Safeguarding Children, Lancashire Teaching Hospitals NHS Foundation Trust)

Andrew and Vivien worked with us on the pilot of the Child Protection – Information Sharing (CP-IS) system which then went live in November last year. CP-IS connects local authorities' children's social care IT systems with those used by NHS unscheduled care settings (such as Accident and Emergency) to provide better care and earlier intervention for children who are considered 'vulnerable and at risk'.

Directors' Report
Board Members and Biographies

During 2013/14, we established an interim Board while we appointed to certain key positions. On 1 June 2013, a permanent Chair, Kingsley Manning, and from 1 April 2014, a permanent Chief Executive, Andy Williams, were appointed together with all the non-executive directors. During 2014/15 we have appointed a permanent Board.

Kingsley Manning
Chair

Kingsley was appointed as our Chair in June 2013. He has 30 years' experience in advising health authorities, NHS trusts and major private sector healthcare companies on strategy and policy development. He was founder and Managing Director of Newchurch Limited, a leading firm of health and information consultants, from 1983 until 2009 and other roles have included Executive Chairman of Tribal Group's health business and senior adviser at McKinsey & Company.

Andy Williams
Chief Executive

Andy has spent his career working in a range of progressively more senior roles at large international technology companies. In the last 15 years, he has led very large technology services organisations in companies such as IBM, CSC and Alcatel-Lucent. Much of his work in these roles was in technology-led transformation carried out for other well-known international companies across a wide range of industry sectors including financial services, telecommunications, government and manufacturing. He takes a great interest in how organisations adapt to embrace new technologies and how technology can change the way people buy goods and services and generally interact with organisations.

Sir Nick Partridge
Non-executive Director

Sir Nick joined the Terrence Higgins Trust (THT) as its first member of staff in 1985 and stepped down as its Chief Executive at the end of 2013. During that time, he was a consistent voice in the media coverage of AIDS and sexual health in all its aspects from health promotion, social care and advocacy through to research. The THT grew to become the largest HIV charity in the UK during this period. In 2013, THT directly supported over 100,000 people, employed 350 staff and mobilised more than 15,000 members and volunteers.

In 1987, Sir Nick became the first community advocate to join a Medical Research Council Trails Committee and he was involved with the Concorde, Alpha, Delta, CHER and DART clinical trials.

From 1998 to 2011, he was Chair of INVOLVE, which aims to ensure that patients and the public help to decide what research is important, how it is done and how the results are shared.

In 2013 he was a member of the Information Governance Review led by Dame Fiona Caldicott. He is currently Chair of the Clinical Priorities Advisory Group for NHS England, Deputy Chair of the UK Clinical Research Collaboration and Deputy Chair of the Sexual Health and HIV Forum at the Department of Health.

Sir Ian Andrews
Non-executive Director

Sir Ian was a former Second Permanent Secretary of the Ministry of Defence who retired from the civil service in 2009, and was non-executive Chairman of the UK Serious Organised Crime Agency – now part of the National Crime Agency – from 2009-13. For much of the last twenty years has been closely involved in the management of transformational change in large and complex organisations in the national security field. His appointments have included Managing Director of a major Ministry of Defence Trading Fund (the Defence Evaluation and Research Agency) and Chief Executive of the then Defence Estates Agency. As the second Permanent Secretary he was a member of the Defence Board where his responsibilities included information assurance and security. He continues to pursue a range of wider national security interests, including raising public and private sector awareness of cyber security threats, providing support to Defence Diplomacy and contributing to various public sector and academic leadership initiatives.

Sir John Chisholm
Non-executive Director

Sir John is a Cambridge engineer who started work in the automobile industry but moved into the computer software industry to specialise on complex systems. In 1979 he founded CAP Scientific Ltd, which grew rapidly to become a core part of the CAP Group plc and, following a merger, the Sema Group plc of which he was UK Managing Director. In 1991 he was asked by the UK government to take on the transformation of its defence research laboratories into a commercial organisation. In due course these became an internationally successful technology services company which floated on the London Stock Exchange as QinetiQ Group plc.

In 2006 he was asked to take the Chair of the Medical Research Council and during his tenure oversaw the successful development of new models to translate its world class research for clinical and economic benefit. In 2009 he also took the Chair of Nesta to guide its transition out of the public sector and its re-orientation towards stimulating both social and economic innovation.

In 2013 he took up the Executive Chair of Genomics England Ltd, the company formed to execute the government's strategy to build a critical mass dataset of 100,000 whole genome sequences linked to clinical data for the purpose of projecting the UK into the forefront of genomic medicine.

Professor Maria Goddard
Non-executive Director

Maria is a Professor of Health Economics and the Director of the Centre for Health Economics, a research centre at the University of York. She has previously worked in the NHS and as an Economic Adviser in the NHS Executive (Department of Health). Her current research interests are related to the measurement of performance, commissioning, mental health, the role of incentives and the regulation and financing of health care systems.

She was elected as a Fellow of The Learned Society of Wales in its inaugural election, and is an elected member of the Women's Committee of the Royal Economic Society. She has acted as an adviser and consultant to the Organisation for Economic Co-operation and Development, World Bank, World Health Organisation and the Audit Commission and is an Associate Editor for the Journal of Health Services Research and Policy.

Dr Sarah Blackburn
Non-executive Director

Sarah is Chief Executive of the Wayside Network, a fluid group of consultants specialising in governance, since 2002. Sarah has worked as a director of assurance and risk management in four FTSE companies (Argos, Kingfisher, RAC and Exel) and one public service property company.

Sarah has a particular interest in healthcare: she was a founder member of the Healthcare Commission Board and a member of the editorial board for the first NHS Integrated Governance Handbook. Since 2005 she has been a director of a private company supplying primary care and addiction services to secure environments in the NHS. In 2014 she was appointed a non-executive Partner in The Green Practice, a primary care provider in Bristol.

Sarah's other non-executive director roles have included the Identity and Passport Service, the Open University and the Royal Institution of Chartered Surveyors. Sarah is a Fellow of the Institute of Chartered Accountants in England and Wales, and a past President and Chartered Fellow of the Chartered Institute of Internal Auditors. She led the Institute's campaign in 2008-09 to achieve a Royal Charter. Sarah is currently a Global Board Director of IIA Inc. and serves on its Global Finance Committee, the International Relations Committeeand a task force reviewing International Standards for professional practice.

Carl Vincent
Director of Finance and Corporate Services

Carl joined us in June 2013 on secondment from the DH, where his most recent posts were Director of Group Finance and the Senior Responsible Officer of the Finance work stream within the Transition Programme as part of the implementation of the Health and Social Care Act 2012.

He joined the Department of Health in 1996 as an economist and worked across a number of policy areas, including the private finance initiative and resource allocation. After moving over to finance roles he was the head of NHS Financial Performance team between 2004 and 2006, and led the Comprehensive Spending Review that reported in 2007. Over the last few years he has also spent time on secondment to a large consultancy provider, and has experience of leading commercial teams.

Rachael Allsop
Director of Human Resources and Transformation

Rachael transferred from the NHS Information Centre which she joined in 2009. Previously she was Director of Human Resources at Leeds Teaching Hospitals NHS Trust having worked at a senior level in a variety of human resource functions across all sectors of the NHS, leading teams who have won awards for innovation, recruitment, retention and diversity. Rachael is a visiting lecturer at Leeds University where her teaching interests include equality and diversity, organisational change, HR strategy and practice and employment law. She is chair of the Yorkshire branch of the Healthcare People Management Association.

Robert Shaw
Director of Operations and Assurance Services

Rob joined the National Programme for IT in late 2005 working in the National Integration Centre as Head of Assurance Services. In 2009 he became Director of the then Technical Assurance Group and lead the redesign of Assurance and Accreditation as part of Future State improvements. In 2012 he also took over management of Technical Architecture and Infrastructure following the departure of Paul Jones.

In 2014 Rob successfully delivered three major insourcing programmes for Core Spine, Care Identity Service and the Secondary Uses Service. He was also the NHS cross-government lead for agile delivery. In addition he has now become an accredited Senior Information Risk Owner (SIRO) one of the first in health.

Previously Rob worked for the Department of Work and Pensions where he was involved in the implementation of Disability Living Allowance and computerising the payment of Attendance Allowance. He led a number of DWP high risk reviews; later moving to provide an intervention role for DWP's mission critical portfolio.

Thomas Denwood
Director of National Provider Support

Tom has over ten years' experience in leading major programmes – with the last five years in complex programme turnaround scenarios.

Having started his career at Deloitte Consulting, Tom worked on the Mayor of London's original Congestion Charging Scheme. He then joined NHS Connecting for Health where he worked on a number of initiatives including; Choose and Book, a strategic IT 'Informatics Review' and the turnaround of the Southern Programme for IT. This was followed by a 12-month career break where he led a turnaround team in the Venue Security Programme for the London 2012 Olympic Games.

Tom has a post graduate degree in Major Programme Management from the University Oxford.

James Hawkins
Director of Programmes

James has over twenty years' experience of working in major programme delivery spanning both the public and private sector.

He leads a team of over 500 staff delivering a portfolio of IT change programmes across the health and social care system. Prior to joining the HSCIC, James worked for a number of private sector organisations including British Gas, ntl, and Deloitte. At Deloitte he worked on a number of high profile change programmes such as the introduction of the London Congestion Charging Scheme.

In 2011, James took a year out from health to be a leading member of the turnaround team on the security of the London 2012 Olympics, which ultimately delivered a safe and secure Olympics.

James has a Masters of Engineering from Heriot Watt University and is a graduate of the Government's Major Project Leadership Academy from Said Business School, Oxford University.

Isabel Hunt
Director of Customer Relations

Isabel joined the HSCIC in October 2014, moving from the University of Leeds where she was the Director of Communications and Public Relations.

Before joining the University, Isabel worked at the Home Office and Cabinet Office as a Director in the Strategy and International Affairs team and as Executive Director for Marketing and Business Development at the Identity and Passport Service. She was also a member of the National Identity Service Programme Board. She previously worked for nearly 10 years in senior commercial and marketing roles at Royal Mail, including a spell as Commercial Director on the international board. She is a graduate of Birmingham University, has an MBA from Cranfield University and is a member of the Chartered Institute of Marketing.

Isabel is the HSCIC board representative for equality and diversity, a Trustee of the Thackray Medical Museum in Leeds and a Council member of Leeds Minister.

Professor Martin Severs
Caldicott Guardian and Lead Clinician

Martin joined us on 1 April 2014 on secondment from the University of Portsmouth and Portsmouth Hospitals NHS Trust where he is a consultant geriatrician in active medical practice working in district general and community hospitals. He is an Associate Dean (Clinical Practice) and co-ordinator of the University of Portsmouth Ageing Network. In Health Informatics, he has held a number of national and international roles including Chairman of the Management Board of the International Health Terminology Standards Development Organisation, Chairman of the Information Standards Board and clinical lead for the Caldicott Information Governance Review.

Peter Counter
Chief Technology Officer

Peter joined the HSCIC in June 2014. A highly experienced IT architect he has provided leadership on some of IBM's largest and most complex engagements.

Peter was most recently Director for delivering a major enterprise-wide IT platform for UK pharmaceutical giants AstraZeneca.

Before that he was an IBM Distinguished Engineer and an Executive IT Architect with a career going back over three decades and spanning project and technical management, IT architecture, systems engineering and sales.

Andrew MacLaren
Director of Information and Analytics

Andrew joined the HSCIC in April 2015 and has 20 years of international information management and analytics expertise at executive and delivery management levels.

Previously, Andrew has occupied senior level roles with Accenture, IBM, EMC and other major organisations throughout both North America and Europe.

Andrew's experience has led him to remain actively involved in driving data solutions initiatives within the public sector as well as health sciences, telecommunications, insurance and banking industries. He is also actively involved in several healthcare charities in the UK.

Register of interests

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

The register of declarations of interest is updated on an annual basis. It is kept and maintained by the HSCIC head of the executive office and is available for public inspection. Directors' interests declared during 2014/15 and relevant to their HSCIC role are as follows:

Sir Ian Andrews: Consultancy support through Abis Partnership Ltd/IMA Partners Ltd to DH in connection with governance of NHS Transformation and renegotiation of CSC Connecting for Health contract and oversight of the Fujitsu Arbitration process.

Sir Nick Partridge: Interim Chair, Clinical Priorities Advisory Group, NHS England; Deputy Chair, UK Clinical Research Collaboration.

Sir John Chisholm: Executive Chairman – Genomics England Ltd.

Dr Sarah Blackburn: Chief Executive, The Wayside Network Limited; Non-Executive Partner, The Green Practice, Whitchurch, Bristol – Primary Care.

Kingsley Manning
Chair

Rachael Allsop
Director of Human Resources and Transformation

Andy Williams
Chief Executive

Robert Shaw
Director of Operations and Assurance Services

Sir Nick Partridge
Non-executive Director

Thomas Denwood
Director of National Provider Support

Sir Ian Andrews
Non-executive Director

James Hawkins
Director of Programmes

Sir John Chisholm
Non-executive Director

Isabel Hunt
Director of Customer Relations

Professor Maria Goddard
Non-executive Director

Professor Martin Severs
Caldicott Guardian and Lead Clinician

Sarah Blackburn
Non-executive Director

Peter Counter
Chief Technology Officer

Carl Vincent
Director of Finance and Corporate Services

Andrew MacLaren
Director of Information and Analytics

Review of tax arrangements of public sector appointees – off-payroll engagements

As part of the Review of Tax Arrangements of Public Sector Appointees published by the Chief Secretary to the Treasury on 23 May 2012, we are required to publish information about the number of off-payroll engagements that are in place and where individual costs exceed £58,200 per annum (or £220 per day).

For all off-payroll engagements as of 31 March 2015, for more than £220 per day and that last longer than six months:	Number
Number of existing engagements as of 31 March 2015	65
Of which, the number that have existed:	
for less than one year at the time of reporting	34
for between one and two years at the time of reporting	22
for between 2 and 3 years at the time of reporting	9
for between 3 and 4 years at the time of reporting	–
for 4 or more years at the time of reporting	–

For all new off-payroll engagements as of 1 April 2014 and 31 March 2015, for more than £220 per day and that last longer than six months:	Number
Number of new engagements, or those that reached six months in duration, between 1 April 2014 and 31 March 2015	121
Number of new engagements which include contractual clauses giving the HSCIC the right to request assurance in relation to income tax and National Insurance obligations	116
Number for whom assurance has been requested	121
Number for whom assurance has been received	2
Number for whom assurance has not been received	119
Engagements terminated as a result of assurance not being received	0

We have recently instigated a new process for obtaining assurance for the income tax and National Insurance contributions for off-payroll workers in addition to the assurances received by the agency framework suppliers. This process incorporates the very latest guidance received from DH and covers all identified relevant engagements. The low number of assurance responses to date is because the deadline for the receipt of information has not yet passed.

There are 10 posts, as of 31 March 2015, which meet the criteria of board members and/or senior officials with significant financial responsibility. As disclosed in the Remuneration Report, two of these are secondees from other employers and therefore not technically on the HSCIC payroll and verification of the payment of correct income tax and National Insurance contributions from their employing bodies has been received.

Auditors

The accounts have been audited by the Comptroller and Auditor General, who has been appointed under statute and is responsible to Parliament. The audit fee for 2014/15 was £100,000 (2013/14 £103,245). The audit fee reflected in the accounts for 2014/15 includes £3,250 in respect of an increase in the 2013/14 fee to £103,245, agreed after the accounts were completed to reflect the additional work required to complete the audit. The auditors carried out only standard audit work and received no additional payments.

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

The internal audit service during the financial year was provided by the Health Group Internal Audit Service.

Cost allocation and charges

We provide free of charge on our website (www.hscic.gov.uk) a comprehensive range of aggregate datasets and other related information. However, services are available for customers to request data extracts, tabulations, linkage to other datasets or data presented in a different format, for which we make a charge based on full cost recovery. No charge is made for the actual data itself, we only charge for delivering the requirement including undertaking associated information governance reviews where relevant. We follow Treasury guidance as specified in 'Managing Public Money' for all fees and charges made.

Following the Partridge report into releases of data, the governance arrangements and processes for approving the release of data and information to third parties has been reviewed. This review made a number of recommendations which have been actioned during the year. This resulted in some delays in approving requests and issuing data for some customers and the cost of servicing such requests are now higher than the previous pricing structure provided to customers. Consequently, we have been unable to fully offset our costs in 2014/15. Charges for 2015/16 and beyond are currently being reviewed.

Community and social responsibility

We have started to develop a comprehensive strategy and approach to corporate responsibility that will address green transport, recycling and energy as well as employment issues. A special leave policy operates that allows staff paid leave for public duties such as Justice of the Peace, School Governor and training with Reserve Forces.

We have developed work experience/placement programmes that will be extended to schools, colleges and universities within the catchment areas of our locations over the next twelve months. We offer schemes such as the Metro Card and Cycle to Work to staff to encourage a more environmental and community friendly means of commuting. Car use for business purposes is only allowed where it is impractical for staff to travel by public transport.

Equality and diversity

We continued our commitment to equality and diversity and the delivery of our obligations under the Public Sector Equality Duty. For our staff, we aimed to create an environment in which individual differences and the contributions of all employees were valued. Our recruitment policy and practice seeks to ensure that no eligible job applicant receives less favourable treatment or is disadvantaged by conditions or requirements that could not be shown as justifiable.

Equality and diversity awareness training is available to all staff via civil service learning and we are considering including that in our mandatory training requirements. We established a diversity steering group and a womens' network in the course of 2014/15 and will seek to develop these further in the year ahead.

In terms of our duty toward service users and the wider public, we have actively sought opportunities to address inequalities in the course of delivering our systems, services and publications. For example, during 2014 we commissioned two guides on improving the usability and accessibility of health and social care digital information systems with the charities AbilityNet and the Patients Association.

They are:

- Ensuring Health and Social Care Information is accessible and usable for all – A guide to support the design of accessible health and social care digital information for patients and service users – from AbilityNet focusing on supporting people with disabilities,
- Designing Digital Services FOR Patients WITH Patients – from the Patients Association focusing on improving usability for people from disadvantaged and less digitally literate groups.

We deliver webinars for health and care organisations and professionals, designed to share and embed good practice, that have included a focus on digital accessibility.

Transformation

Following our establishment in 2013 the Transformation Programme has continued to be the primary driver for internal organisational change in order to fulfil our vision of becoming "a high performing organisation with an international reputation, recognised as an outstanding place to work", underpinned by four organisational values; Professional, People focused, Trustworthy and Innovative.

Building on the initial foundations in the first year, the Transformation Programme has continued to focus on fundamental people related priorities so that we are able to prioritise and resource our work more effectively and efficiently.

In taking forward the developments described in the following paragraphs, staff across the organisation have demonstrated a high level of resilience and professionalism, as well as a strong commitment to the values and strategic objectives.

The Transformation Programme will continue into 2015/16 with an extended scope and vision. This will include everything that is required to be done differently across the whole organisation in order to fulfil our vision for 2020 and to deliver a positive change to our culture. This will particularly include a focus on quality and customer service.

In addition to a range of business and performance improvement projects, the Transformation Programme has addressed several workforce related strategic developments, including:

- recruitment
- pay and reward
- staff engagement
- line management development
- flexible deployment models
- professional groups to develop career pathways and to identify and address professional development needs.

A number of these activities have subsequently been assimilated into 'Business as Usual' and good progress has already been made in a number of areas, as described below:

Recruitment

We have introduced a number of initiatives to 'grow our own' staff, including work placements, apprenticeships and a graduate trainee scheme, all of which have received positive feedback from trainees and from managers.

Training programme	Number of roles
Work placements (across the HSCIC)	20
Apprenticeships (IT, Business Administration and Project Management)	5
Graduate Trainee Scheme (IT)	10

These schemes will increasingly underpin our approach to attracting and retaining the expertise and experience that we require. There have also been improvements to our recruitment processes and systems, aimed at reducing the time taken to recruit to posts, and we have developed more strategic responses to historically hard to fill posts.

- **Professional groups**
  Implementation of Professional Groups has progressed significantly in 2014/15 with the aim of building professional communities of practice across the organisation, to share knowledge, develop standard ways of working, provide a clear view of relevant professional training requirements and to support staff in shaping career paths. Professional competencies have been embedded in generic job descriptions to support agile and effective deployment of staff.
- **Flexible deployment models**
  A programme of work is underway to create and embed dynamic resource pools and a central resource function for all Project and Programme Delivery professionals. This will enable the organisation to ensure our workforce is deployed to organisational priorities as well as maximising opportunities for individuals.
- **Performance and talent management**
  A new Performance and Development Review process was introduced from April 2014 which brings together a number of different components including an assessment against our values, professional competencies and the delivery of objectives. In addition, line managers are assessed against our Line Manager Charter.

  The process also signposted the HSCIC's intent to introduce a 'nine box' model to assess potential and performance - a systematic way of identifying and nurturing our talent. This process has now been implemented for our most senior staff within the organisation and will be rolled out more widely in the year ahead.

  In addition, a "virtual" leadership development group is being established, with membership of the group being determined through an assessment of individual performance and potential of staff at band 8d and 9 rather than simply based on organisational hierarchy.
- **Performance measurement and business intelligence**
  We have continued to develop and improve a range of Key Performance Indicators that are reported monthly to the Executive Management Team (EMT) and to the Board. Reports are also produced by directorate to support effective performance management. We are aligning Key Performance Indicators with other governance activity such as risk management and assurance and we are committed to the continuous improvement of our management information linked to our key strategic priorities
- **Staff engagement and communication**
  We have continued to develop and enhance our communication channels with staff and their representatives. Our intranet site ensures staff have access to a wide range of information relevant to the HSCIC and the health and social care sector at large. In addition to the monthly 'Insight' staff magazine, the Chief Executive issues a weekly bulletin and regular staff briefings are held where executive directors and senior managers update staff and receive feedback on key issues.

  We have undertaken comprehensive consultation on our future strategy, engaging staff in a series of workshops, and have commissioned a review of engagement and communication, due to report in the first quarter of 2015/16.

  We undertake formal consultation with our trade unions on a range of policy and employment issues at monthly joint meetings and within sub-groups. We continued to build effective partnership working and joint problem solving during 2014/15.

A comprehensive staff survey was undertaken in March 2014 and repeated in October 2014 to provide an internal benchmark and a comparison with other organisations. The results of the October survey were very positive, with a high response rate and improved scores in almost all categories of questions. Action plans to address key themes highlighted in the survey have been developed and are being implemented.

The 'Champions for Change' forum has considered a range of issues across the business. Forum members are invited to attend EMT meetings on a regular basis and the initiative has proved to be very successful in terms of engagement and generating solutions to matters of common interest.

Staff development

The move to Civil Service Learning has been completed and more than 80 per cent of staff are now registered. A wide range of online and classroom based training is available to address core training needs and specialist training is procured via a national gateway process. This has delivered efficiencies in training and the experience of staff who have undertaken training has been positive.

An improved induction training programme has been implemented, with 100 per cent positive feedback. The assessment of ongoing development needs is undertaken through agreed core values which have now been embedded in a revised Personal Development Review process.

Health and safety

We recognise and accept the legal responsibility in relation to the health, safety and welfare of employees and for all people using our premises. We comply with the Health and Safety at Work Act (1974) and also operate a Health and Safety Committee under the Safety Representatives and Safety Committee regulations (1977). Training on Health and Safety, including fire safety, manual handling and work with visual display equipment, is mandatory and is delivered through an e-learning package.

Sickness absence data

During 2014 10,985 (2013 7,615) days were lost due to sickness absence. This represented 5.1 (2013 4.4) days per employee. The above figures are based on calendar year data, not financial year, and were centrally provided from data contained within the Electronic Staff Record.

Pensions

We offer the NHS Pension Scheme and maintain existing Civil Service Pension Schemes (which are closed to new members) and in doing so made contributions based on the salary of individual members. Both schemes are unfunded multi-employer defined benefit schemes in which the employer was unable to identify its share of underlying assets and liabilities. The schemes are therefore accounted for as if they were defined contribution schemes.

We successfully managed the HSCIC responsibilities in relation to the introduction of the new NHS and Civil Service Pension Schemes for 2015.

Andy Williams
3 July 2015

Remuneration report

This report for the year ended 31 March 2015 deals with the pay of the Chair, Chief Executive and other members of the Board.

Remuneration Committee

The pay of the executive board directors is set by the Remuneration Committee based on the recommendations of the Senior Salaries Review Board and is reviewed on an annual basis. The Remuneration Committee consists of four non-executive directors (including the Board Chair) and all are required to be present. It is chaired by the Board Chair.

We, with the approval of the Department of Health Remuneration Committee operate the NHS Very Senior Manager pay framework (VSM). This includes a job evaluation scheme, administered by the NHS Business Services Authority, and provision for a maximum 5 per cent bonus for not more than the top 25 per cent of performers within the VSM group. One bonus payment was made in 2014/15 through this mechanism, reflecting performance during 2013/14. Another performance related bonus was paid by the individual's host organisation for services undertaken in 2013/14.

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

The work of the committee is supported and administered by the Executive office.

In reaching its recommendations, the Remuneration Committee takes 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, and
- Recommendations in line with relevant Department of Health guidelines.

Remuneration policy

The standard remuneration arrangements for HSCIC are those provided under the national NHS Agenda for Change terms and conditions of employment. This includes a job evaluation that has been tested and demonstrated to be equality proofed.

Staff on NHS terms and conditions are entitled to receive increments within their pay-scale under AfC guidelines, subject to meeting agreed performance standards. The AfC pay award for 2014/15 was described as a minimum 1 per cent increase, either by virtue of incremental progression or as a non-consolidated 1 per cent increase for staff who were already at the top of the pay scale.

Comparable arrangements were implemented for staff who had transferred into the HSCIC with terms and conditions protected under the Transfer of Undertakings (Protection of Employment) legislation (TUPE), except where there was a legal entitlement to a protected award.

There was no pay award for staff engaged under the VSM framework.

Service contracts

Carl Vincent is employed by the Department of Health and Martin Severs is employed by the University of Portsmouth and seconded to the HSCIC throughout the period.

All executive directors are employed under permanent employment contracts with a six month notice period and work for the HSCIC full-time. If their contracts are terminated for reasons other than misconduct, they will come under the terms of the NHS compensation schemes.

The Chair was appointed on a four year contract from 1 June 2013.

From 1 April 2014 all non-executive directors were appointed on either two or three year contracts through the DH Appointments Team and its terms and conditions applied to them. They are not entitled to compensation for loss of office or early termination of appointment.

Emoluments of board directors

The remuneration relating to all directors in post during 2014/15 is detailed in the table below and is subject to audit. Emoluments of executive directors consisted of basic pay, performance pay, pension benefits and benefits in kind. Emoluments do not include employer pension contributions or the cash equivalent transfer value of pensions.

			2014/15			
	Appointment date (Other than 01-Apr-2013)	**Resignation date**	**Salary (bands of £5,000)**	**Performance Pay (bands of £5,000)**	***Pension benefits £000**	**Total emoluments (bands of £5,000)**
Andy Williams Chief Executive	01-Apr-14		180-185	–	–	180-185
Rachael Allsop Executive Director of Transformation and Human Resources			120-125	5-10	56	180-185
^**Thomas Denwood** Director of National Provider Support			110-115	–	32	140-145
^**James Hawkins** Director of Programmes	01-Jun-13		110-115	–	33	145-150
Maxwell Jones[1] Executive Director of Information and Analytics		10-Nov-14	75-80	–	30	105-110
Robert Shaw Executive Director of Operations and Assurance Services	01-Jun-13		130-135	–	206	335-340
Carl Vincent[2] Executive Director of Finance and Corporate Services	29-Aug-13		90-95	5-10	23	120-125
^**Martin Severs**[3] Caldicott Guardian and Lead Clinician	01-Apr-14		70-75	–	–	70-75
^**Peter Counter** Chief Technology Officer	16-Jun-14		110-115	–	22	135-140
^**Isabel Hunt** Director of Customer Relations	06-Oct-14		60-65	–	12	70-75
Alan Perkins[4] Interim Chief Executive		31-Mar-14	–	–	–	–
Mark Davies[5] Executive Director of Clinical and Public Assurance		31-Mar-14	–	–	–	–
Trevor Doherty[5] Executive Director of Finance and Corporate Services		29-Aug-13	–	–	–	–
^**Clare Sanderson**[5] Director of Information Governance		31-Dec-13	–	–	–	–
^**John Varlow** Director of Information Services		12-Jun-13	–	–	–	–
^**Andrew Haw**[6] Director of Data Services		12-Jun-13	–	–	–	–

2013/14					
Salary (bands of £5,000)	Performance Pay (bands of £5,000)	Benefits in kind £	*Pension benefits £000	Total emoluments (bands of £5,000)	Full year equivalent salary (bands of £5,000)
–	–	–	–	–	–
125-130	–	–	26	150-155	125-130
105-110	–	–	21	125-130	105-110
85-90	–	–	7	90-95	100-105
110-115	–	5,900	21	135-140	110-115
100-105	–	–	22	120-125	120-125
50-55	–	–	77	130-135	90-95
–	–	–	–	–	–
–	–	–	–	–	–
–	–	–	–	–	–
145-150	–	–	172	315-320	145-150
155-160	–	–	25	180-185	155-160
50-55	–	–	2	55-60	125-130
80-85	–	–	10	90-95	110-115
15-20	–	–	4	20-25	95-100
25-30	–	–	–	25-30	140-145

Emoluments of board directors

			2014/15			
	Appointment date (Other than 01-Apr-2013)	Resignation date	Salary (bands of £5,000)	Performance Pay (bands of £5,000)	*Pension benefits £000	Total emoluments (bands of £5,000)
Kingsley Manning Chair	01-Jun-13		60-65	–	–	60-65
Sir Ian Andrews Non-Executive Director			10-15	–	–	10-15
Sir Nick Partridge Non-Executive Director			10-15	–	–	10-15
Jan Ormondroyd Non-Executive Director	01-Apr-14	19-Oct-14	0-5	–	–	0-5
Maria Goddard Non-Executive Director	01-Apr-14		5-10	–	–	5-10
John Chisholm Non-Executive Director	01-Apr-14		–	–	–	–
Sarah Blackburn Non-Executive Director	15-Sep-14		5-10	–	–	5-10
Candy Morris Interim Chair		31-May-13	–	–	–	–
Anthony Allen Non-Executive Director		31-Mar-14	–	–	–	–
Lucinda Bolton Non-Executive Director		31-Mar-14	–	–	–	–
Mike Pearson Non-Executive Director		31-Mar-14	–	–	–	–

There were no benefits in kind in 2014/15.

Certain directors were in post only for part of the year. Their full time equivalent salaries were: Maxwell Jones 125-130, Peter Counter 145-150, Isabel Hunt 125-130, Jan Ormondroyd 5-10 and Sarah Blackburn 10-15.

* All benefits in year from participating in pension schemes but excluding employee contributions. These are the aggregate amounts, calculated using the method set out in Section 229 of the Finance Act 2004 (i) and using the indices directed by the Department of Health. (See http://www.nhsbsa.nhs.uk/Documents/Pensions/Disclosure_of_Senior_Managers_Remuneration_Greenbury_2015_v2_10.2014.pdf)

^ attend the Board on a regular basis but do not have voting rights.

1 Maxwell Jones received a termination payment of £103,248.

2 Carl Vincent is seconded from the DH. During 2014/15 he was paid a performance bonus by the DH.

3 Martin Severs is seconded three days per week from the University of Portsmouth and costs relate to the total value of charges net of irrecoverable VAT.

2013/14					
Salary (bands of £5,000)	Performance Pay (bands of £5,000)	Benefits in kind £000	*Pension benefits £000	Total emoluments (bands of £5,000)	Full year equivalent salary (bands of £5,000)
50-55	–	–	–	50-55	60-65
5-10	–	–	–	5-10	5-10
5-10	–	–	–	5-10	5-10
–	–	–	–	–	–
–	–	–	–	–	–
–	–	–	–	–	–
–	–	–	–	–	–
25-30	–	–	–	25-30	105-110
10-15	–	–	–	10-15	10-15
5-10	–	–	–	5-10	5-10
5-10	–	–	–	5-10	5-10

4 Alan Perkins was seconded from the Department of Health for 12 months ending 31 March 2014 having agreed to a temporary secondment as the Chief Executive of the HSCIC during the set up phase of the organisation until a permanent Chief Executive was appointed. He was awarded a bonus of £6,256 during 2013/14 relating to his performance during 2012/13 whilst working for the DH. He also received a termination payment of £306,538 paid and accounted for by DH which was due to DH restructuring leading to termination of employment by them.

5 Mark Davies received a termination payment of £132,708 and Trevor Doherty received £42,500. Clare Sanderson received £99,462 by way of a contribution to her pension scheme.

6 Andrew Haw was seconded from Calderdale and Huddersfield NHS Foundation Trust and costs relate to the value of the secondment charge.

The emoluments of the Chair and the non-executive Directors above do not include employer National Insurance contributions. The total included in note 5 of the accounts do include such contributions.

Reporting bodies are required to disclose the relationship between the remuneration of the highest-paid director in their organisation and the median remuneration of the organisation's workforce.

	Highest paid director	Median pay of the workforce	Ratio to the median of the workforce
2014/15 Excluding pension benefit	£180-£185k	£40,964	4.5
2013/14 Excluding termination payment and pension benefit	£155-£160k	£40,987	3.9

Six members of staff received full time equivalent remuneration in excess of the highest-paid director.

Director's expenses during 2014/15 are detailed on our website at https://www.gov.uk/government/publications/hscic-board-directors-expenses

The total number of staff employed at 31 March 2015 split by gender is as follows:

	2014/15		2013/14	
	Male	Female	Male	Female
Directors	10	4	13	2
Senior Managers	130	42	117	42
Other staff	1,376	1,135	1,184	950
	1,516	**1,181**	**1,314**	**994**

Pension benefits

Pension benefits were provided through the NHS Pension scheme for the executive directors except Carl Vincent whose pension is provided through the Principal Civil Service Pension Scheme (PCSPS). Those directors who received pension scheme benefits are detailed below:

	Accrued benefits				Cash equivalent transfer values		
	Real increase in pension (bands of £2,500)	Real increase in pension lump sum (bands of £2,500)	Total accrued pension at 31 March 2015 (bands of £5,000)	Lump sum related to accrued pension at 31 March 2015 (bands of £5,000)	CETV at 31 March 2015 £000	CETV at 31 March 2014 £000	Real increase in CETV £000
Rachael Allsop	2.5 – 5.0	10 – 12.5	50 – 55	150 – 155	972	873	49
Thomas Denwood	0 – 2.5	5 – 7.5	10 – 15	40 – 45	174	141	16
James Hawkins	0 – 2.5	5 – 7.5	10 – 15	35 – 40	201	160	20
Maxwell Jones	0 – 2.5	5 – 7.5	20 – 25	65 – 70	364	319	22
Robert Shaw	10 – 12.5	30 – 32.5	45 – 50	145 – 150	872	674	97
Carl Vincent	0 – 2.5	2.5 – 5	25 – 30	85 – 90	489	450	20
Peter Counter	0 – 2.5	–	0 – 2.5	–	30	–	15
Isabel Hunt	0 – 2.5	–	0 – 2.5	–	12	–	6

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 with the additional pension liabilities being assumed. They also include any additional pension benefit accrued to the member as a result of them purchasing additional years of pension service in the scheme at their own cost. CETV's are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries and do not take account of any actual or potential reduction to benefits resulting from Lifetime Allowance Tax which may be due when pension benefits are drawn.

The real increase in CETV reflects the increase effectively funded by the employer. It excludes the increase in accrued pension due to inflation and 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.

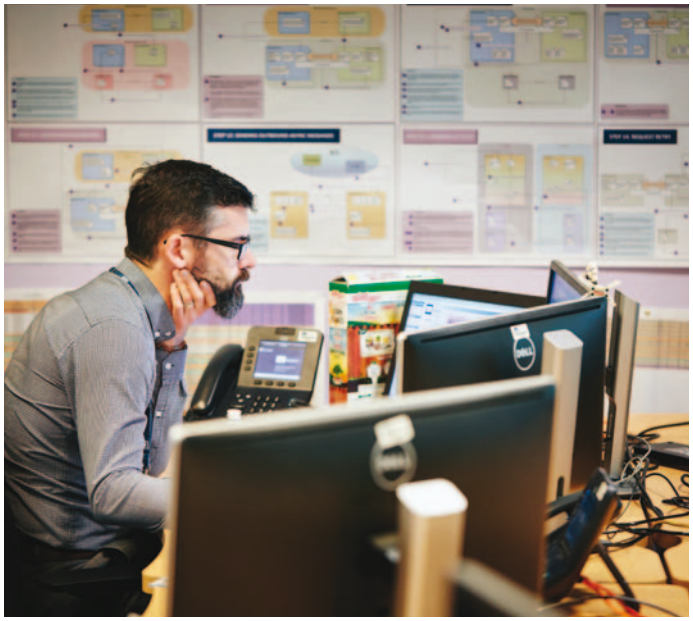
Andy Williams
Chief Executive
3 July 2015

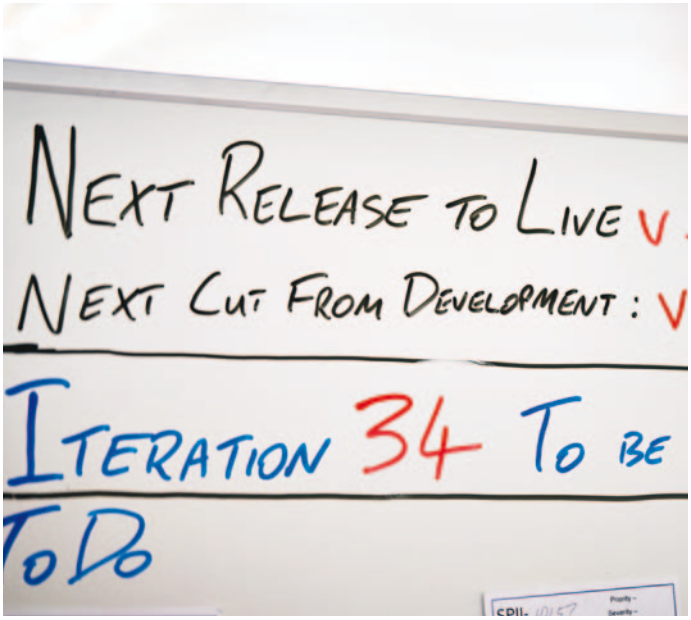
December 2014: Anne Nicholson (Head of Business Services), Chris Wilkinson (ICT Project Manager) in the photo on the left and Liam Keogh (Project Manager) in the photo below.

Anne, Chris and Liam were part of the HSCIC team that worked on our move into Bridgewater Place. The new office space allows staff there to work more flexibly together and will also enable us to make savings of £3 million over time. This project received recognition in the Cabinet Office's 'State of the Estate' 2014/5 Report.

January 2015: Emma Holmes (Graduate ICT Trainee)

Emma is one of the ten trainees we recruited in January as part of our inaugural Graduate Training Scheme. Our trainees undertake a series of four, six month placements during their two years with us. Rotating between roles and teams they will gain valuable experience in agile development and delivery and be exposed to the full scope of roles and services offered within the organisation.





February 2015: Kerry McLeod (Heart Health Multimedia Manager) and Ceri Jones (Head of Programme) of the British Heart Foundation

Kerry and Ceri collaborated with the NHS Choices team and Public Health England to develop, launch and promote the Heart Age tool. Launched on Valentine's Day, the tool appeared on both the NHS Choices and British Heart Foundation websites and was aimed at making any high risk users (over 40 years old) more aware of their blood pressure and cholesterol levels as these are key indicators for heart health. Since the launch over 450,000 visitors to NHS Choices have completed the Heart Age test.

Statement of the Board and Chief Executive's responsibilities

Under the Health and Social Care Act 2012 and directions made thereunder by the Secretary of State with the approval of Treasury, we are 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 our state of affairs at the year end and of its income and expenditure, recognised gains and losses and cash flows for the financial year.

In preparing the Accounts, the Board and Accounting Officer are required to comply with the requirements of the Government Financial Reporting Manual and in particular to:

- Observe the accounts direction issued by the Secretary of State, including the relevant accounting and disclosure requirements and apply suitable accounting policies on a consistent basis,
- Make judgements and estimates on a reasonable basis,
- State whether applicable accounting standards as set out in the Government Financial Reporting Manual have been followed and disclosed and explain any material departures in the financial statements, and
- Prepare the financial statements on a going concern basis, unless it is inappropriate to presume that the HSCIC will continue in operation.

The Accounting Officer for the Department of Health has appointed our Chief Executive Officer, with responsibility for preparing our 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 our assets.

Annual Governance Statement for the year ended 31 March 2015

Introduction and context

The Health and Social Care Information Centre (HSCIC) is an executive non-departmental public body (ENDPB) established in April 2013 by the Health and Social Care Act 2012. We are responsible for setting up and operating systems for the collection, analysis, dissemination and publication of information relating to health services and adult social care. We are also the authority for determining and publishing information standards for health and adult social care in England. We may also be directed by the Secretary of State for Health or NHS England to provide system delivery functions in relation to the development or operation of information or communications systems concerned with the provision of health services or adult social care in England. We are accountable directly to Parliament for the delivery of its statutory functions described within the Health and Social Care Act.

Over the course of the year we have continued to strengthen our governance arrangements. In April 2014, the Health Group Internal Audit Service, a shared services audit function provided through the Department of Health, took over as the internal auditors for the HSCIC and a new Head of Internal Audit appointed. Although internal audit identified areas of good progress they also highlighted areas where greater rigour was required and steps are being taken to address these concerns. Our intention is to continue the progress to date and for our governance and control structures to become more widely embedded across all areas of the HSCIC during 2015/16.

We are still a relatively new organisation and ensuring greater rigour is a key factor in our developing assurance processes. Some examples of the strengthened controls that have already been put in place include:

- The establishment of an Information Assurance and Cyber Security Committee, chaired by a non-executive director and, reporting to the main Board,
- The development of an Assurance Map to support our control over audit provision and risk management,
- Improved reporting of key performance indicators to executive management and the main Board and strengthened risk management, both confirmed by audit, and
- The establishment of a Quality Council to review and monitor the effectiveness of the implementation and maintenance of all accepted standards, such as those of the International Organization for Standardization (ISO).

Despite the positive progress made in many areas and following concerns raised by the Health Select Committee, our Board directed that a review be carried out of all data releases approved, including those authorised by predecessor organisation the NHS Information Centre, to ensure proper governance had been applied in authorising the release of information. Sir Nick Partridge, a non-executive director, oversaw this independent review and reported in June 2014 with nine recommendations for strengthening governance and control in this area.

These recommendations have since been taken forward.

A considerable amount of work has been undertaken to address the concern reported in the 2013/14 Governance Statement over the quality of accounting information on assets transferred from the DH to the HSCIC. However, there are still some areas still to be fully addressed and certain corollary concerns have subsequently arisen. Full details are contained in the Significant Controls Issues section.

Scope of responsibility

We are responsible for maintaining a sound system of internal control that supports the achievement of our policies, aims and objectives whilst safeguarding public funds and the assets for which we are accountable, including data and information, in accordance with the requirements of *Managing Public Money*.

Throughout the year, our Board and Accounting Officer have sought to exercise these responsibilities by establishing visible and effective systems of internal control and governance. The Senior Departmental Sponsor for the DH (DH Sponsor) is responsible for ensuring our procedures operate effectively, efficiently and in the interest of the public and the health sector.

Organisational developments

We were joined by a new Chief Executive and team of non-executive directors on 1 April 2014 and further executive appointments have been made during the year. A Senior Independent Director was appointed in April 2014 and a new non-executive Chair of the Assurance and Risk Committee in September.

As new executive directors have been appointed, responsibilities have changed within the executive team.

The governance framework

Our constitution was established and set out in Schedule 18 of the Health and Social Care Act 2012.

We are led by a Board consisting of non-executive and executive members and this is the senior decision making structure in the organisation. The Board supports the Chief Executive, who is the Accounting Officer and is therefore accountable to both the Secretary of State for Health and to Parliament.

In operational terms, our accountability is to the DH Sponsor. The formal arrangements are set out in the Accounting Officer Memorandum sent to our Chief Executive by the DH Accounting Officer. They are also reflected in a Framework Agreement, which governs the relationship between the DH and our organisation.

Board members have a corporate responsibility for ensuring that we comply with all statutory and administrative requirements for the use of public funds. Details of the conduct of the Board and the roles and responsibilities of members are set out in our Standing Orders, Standing Financial Instructions and Code of Practice for board members, which were reviewed during the course of 2014/15.

Our Board is assisted in carrying out its duties by an operational governance structure comprising the:

- Executive Management Team (EMT): responsible for communicating and delivering our overall strategy and agreeing policy and procedures whilst supporting implementation. EMT is chaired by the Chief Executive and meets weekly with action points and decisions disseminated to all staff via the intranet,
- Programme and Service Delivery Board (PSDB): focussed predominately on the provision of assurance of all programmes, projects, services and corporate and statutory services (the HSCIC Portfolio), ensuring our Portfolio is delivered within agreed tolerances, to associated delegated authorities and to appropriate standards. Where exceptions arise PSDB provides a mechanism for resolution,
- Corporate Assurance Panel: ensures that items requiring approval or endorsement by the Accounting Officer or Board meet the delegated approvals contained in our Standing Financial Instructions and our quality standard expectations,
- Transformation Programme Board: owned the internal organisation development strategy and plan and ensured consistency across directorate transformation projects, until it was absorbed by EMT in June 2014 to ensure full alignment with executive management.

Our Board and Committee structures

The Board has responsibility for determining the strategy for the delivery of our objectives within the available resources. The composition, role and main activities of the Board and its principal committees are detailed in the Annex on page 59.

In addition to standing agenda items on the governance and performance of the organisation, the Board has discussed a range of topics including:

- The development of a strategy and business plan in the context of a rapidly changing health and care system and a tight financial regime,
- Our governance and structure, led by an increasingly integrated internal transformation programme,
- Links and relationships with key stakeholders including NHS England and the DH Sponsor,
- The monitoring of performance indicators throughout the year which are aligned with the approved strategy and business plan. The Board has highlighted where it feels the information provided to it could be developed and improved. This has led to a progressively refreshed and updated board performance pack.

There is a standing item on the Board agenda which enables Chairs of the Assurance and Risk Committee, Information Assurance and Cyber Security Committee and the Remuneration Committees to report to the Board on their discussions after each committee meeting. The minutes of the Board's sub-committees are circulated to Board members once they have been ratified.

In 2014/15, we undertook an internal audit review of Board effectiveness and governance and the findings brought to the attention of the Board. The audit did not highlight any significant issues that required immediate action or impacted on the Governance Statement.

The inaugural meeting of our Information Assurance and Cyber Security Committee (IACSC) was held on 13 May 2014. The IACSC was constituted to ensure that there is an effective information assurance function that provides appropriate independent assurance to our Chief Executive and the Board.

The work of the Assurance and Risk Committee (ARC) has developed over the year. The key areas it addressed include:

- Oversight of the annual accounts preparation and our annual governance statement on behalf of the Board,
- Strategic input to the internal audit strategy and annual plans in the context of the DH shared service agenda,
- Review of internal audit reports,
- Review of the local counter-fraud specialist work-plan,
- Consideration of the external audit strategy,
- Monitoring of the management of the corporate risks and issues, and
- Development and implementation of a corporate assurance map.

We comply with the central government corporate governance code as far as is relevant. No material departures have been identified.

Corporate governance

Corporate governance assurance is provided by means of a quarterly Statement of Internal Control against criteria laid out by DH, which is approved by the Chief Executive and delivered to the DH Sponsor. We have developed an assurance map which provides assessments of the assurance in place across the organisation and against the strategic risks, using the 'Three Lines of Defence Model'. The Map has also been used in developing the internal audit programme for 2015/16.

Corporate policies are reviewed on an annual basis and we have carried out an exercise to ensure staff are aware of our confidentiality policy requirements and that conflicts of interest are declared.

Key relationships

We do not work in isolation. We are part of the health and care information system created by the Health and Social Care Act 2012 and we work in collaboration with national partners. The Act places a duty on all national arms' length body organisations (ALBs) to work collaboratively in the interests of the system as a whole. This includes other national ALBs, commissioners and providers, local NHS organisations and local authorities.

We have established a Customer Relations directorate, under the leadership of a new director, to develop strong relationships with customers and stakeholders that will enable us to better support the delivery of high quality services to patients, service users and the public. We are developing plans to set up revised stakeholder and customer management, including strategic account management for key customers. We are recruiting Strategic Account Managers who will use their insight into their customers' businesses to help shape our plans, products and services and act as our ambassadors and they will focus on:

- National bodies (such as the regulators and Public Health England),
- Research and information markets and
- Social care.

The way we work alongside industry will be critical to our success. Our Industry Liaison manager will manage these relationships alongside the Strategic Account Managers and delivery teams.

We have also assigned executive leads to our important stakeholders. We have maintained existing relationships with Monitor, the Care Quality Commission and the NHS Trust Development Authority and these are being revitalised through strategic executive level discussions between the organisations.

We are a key member of the National Information Board (NIB), which was established by the Department of Health to set the strategy and direction for the health and care system on information technology and information. Our Chief Executive is a member of the NIB's Leadership Group, and all members of our EMT are involved in one or more of the NIB's working groups. We recognise the importance of the NIB and have contributed to its Framework for Action. Many of the commitments in the Framework relate directly to our statutory role, and we have therefore invested significant time and energy in ensuring there is alignment across the NIB Framework and our own strategy.

Performance management

Corporate performance management is integrated with business planning and risk management in order to provide a joined-up view of:

- What we intend to deliver (business planning),
- Factors that could prevent successful delivery and mitigation of these (risk management) and
- How well we are delivering (performance management).

We have designed an organisation-wide performance management framework to help us deliver our statutory obligations and commitments to stakeholders. It includes the following elements:

- Key Performance Indicators (KPIs) reported in performance packs at our Board, EMT and directorate level. These contain a mix of financial and non-financial performance information, key risks and issues, and assessment of delivery against strategic commitments,
- Monitoring of business plan delivery at corporate and directorate levels with reports provided quarterly at Board, EMT and directorate levels,
- Performance reporting of other key work at Board, EMT and directorate level, such as cyber security, organisational development and transformation, innovation and burden reduction.

With the exception of a few business confidential indicators, all of the performance framework is reported to public meetings of our Board and is available on our website. In this respect they support open and transparent governance and constitute an important channel of public accountability. Performance packs and business plan monitoring reports also inform quarterly accountability meetings between the DH and ourselves.

We have established a Performance Management Community to provide an internal professional network and source of expertise. An internal audit review reported good practice in the development of our performance management arrangements. The performance indicators are kept under regular review to ensure they remain meaningful and effective.

Risk management

We have established a single policy, covering strategy, and a framework for risk management. We have also appointed a corporate risk manager. Our main focus during 2014/15 has been on training and communications to develop management capability and awareness of risk.

We have commenced a review of the current risk data repository and carried out a data cleanse and regular quality assurance checks to ensure that the risk information held is current, accurate and of good quality.

We have introduced a corporate risk management KPI and Risk Dashboard to focus on the outcomes of our risk management effort and these are reported to EMT and our Board. The use of risk management performance metrics is starting to drive an overall improvement in risk data quality and risk management behaviours, although further action is needed.

We have established a Risk Management Forum to act as our risk management community of interest, The Forum's main objective is to improve risk management capability, so that risk management becomes embedded throughout our organisation and underpins organisational sustainability and resilience.

Risks are reported regularly and escalated through the internal governance structure with the top corporate risks and issues ultimately being considered by EMT, ARC and our Board.

The most significant risks in 2014/15 were:

- Delivering on the HSCIC statutory and legal obligations,
- Protection of data and cyber security,
- Safe collection, analysis and dissemination of high quality and timely data and information, which meets customer expectations,
- Demonstrating delivery of benefits from the programmes and services,
- Securing an appropriate workforce,
- Maintaining operational continuity of systems and infrastructure,
- Securing a positive, responsive and trustworthy reputation and maintaining effective relationships with stakeholders, and
- Design and delivery of systems that work or deliver as anticipated.

The mitigations were:

- Working with the DH Sponsor team to ensure we are meeting our statutory and legal obligations,
- Establishing industry-recognised practices (such as mandatory staff training, controls around data access, movement and destruction), and establishing a cyber security programme,
- Contributing to, and implementing the recommendations of, the Information Governance Assurance Review and the 'Review of Data Releases' by Sir Nick Partridge,
- Improving planning, forecasting, benefits and performance management capabilities, reporting quality and promoting a culture that encourages openness,
- Implementing a budget based on the zero base review of finances and resource requirements carried out in 2013/14, the continued implementation of a Transformation Programme and targeted recruitment activity to ensure we have the people and skills to meet our commitments,
- Maintaining robust infrastructure (such as high-availability networks, dual-site data centres, a single approach to service management, testing of Business Continuity plans),
- Managing customer and stakeholder relationship activity to ensure we support them in delivering high quality services,
- Developing of technical governance structures and information governance standards.

During 2015/16, risk management will be developed in the following areas. We will:

- Further refine the strategic risk set that was defined in 2014/15,
- Further develop our risk appetite and communicate it throughout the organisation,
- Further refine our risk KPI to focus on the effectiveness of the outcomes of risk management effort,
- Continue to deliver our targeted risk management improvement plan. We will focus on risk maturity, capability and awareness, including improved tools, metrics, reporting and collection methods and enhanced EMT, ARC and Board visibility of, and confidence in, our risk management capability,
- Explore options for a more integrated approach to risk and assurance activity, using a risk based approach to focus assurance activity on the most significant areas of risk,
- Review our governance and accountabilities for managing risks, especially where these cross-organisational boundaries and
- Leverage the use of risk information in decision-making.

Information governance

We fully recognise the importance of robust information governance and have put in place procedures that are consistent across our organisation and support the work we have been commissioned to deliver (the care.data programme, insourcing of SPINE2 etc).

During 2014/15 our governance responsibilities have been expanded to provide system wide advice on operational information governance across the health and social care sectors in England. This is separate from our principal role to be the guardian of data, which is set out in the Health and Social Care Act 2012.

We have published our Code of Practice on handling confidential information in line with the Health and Social Care Act 2012 and we have also published a Guide to Confidentiality, which complements the Code. Both documents apply to the entire health and social care landscape in England.

We host the Information Governance Alliance which brings together expertise from across health and social care to act as the primary point of contact for authoritative advice and guidance on information governance to the wider health and social care system.

As a further example of this system-wide remit we established a Caldicott Implementation Monitoring Team to provide support to Dame Fiona Caldicott's Independent Information Governance Oversight Panel (IIGOP) by monitoring and reporting on implementation of the recommendations of the Information Governance Review. The outputs were reflected in the IIGOP's annual report published in January 2015.

A number of innovative cyber security projects will run alongside our Cyber Security Programme with the objective of benefiting the entire health and social care system. We will:

- Establish an authoritative national focal point and governance model for care system cyber security guidance and incident support (CareCERT),
- Develop a 'scenario assist' package with relevant supporting products made available to all care organisations and business partners to help guide their actions for cyber preparation, assurance and incident response, and
- Establish a strategic cyber risk oversight capability that will provide situational awareness monitoring of active risks such that scale is understood and early mitigations are possible.

We have fully embraced the nine recommendations in Sir Nick Partridge's report, referred to above, and progress has been made on each as follows. We have:

- Undertaken a programme of work to ensure that data has been deleted appropriately where the Data Sharing Agreement has ended,
- Developed one clear, simple, efficient and transparent process for the management of all data releases,
- Implemented a robust audit function, which will enable ongoing scrutiny of how data is being used, stored and deleted by those receiving it,
- Published our policy, process and governance for the release of data,
- Ensured there is clear, transparent and timely decision making, using the appropriate governance for all data releases, and that all decisions are documented and published on our website,
- Implemented a robust record keeping approach and made available the details of all data releases (including the purpose for which they are released) on our website,
- Developed one framework Data Sharing Contract (DSC) and one Data Sharing Agreement (DSA), which is used for all releases of data, and which includes clear sanctions for any breaches,
- Actively pursued and continue to pursue a technical solution to allow access to data, without the need to release data to external organisations, and
- Published a quarterly register of all releases of identifiable or potentially identifiable data.

During 2014/15, work continued to consolidate strategies, frameworks, and procedures in relation to information governance to improve quality and efficiencies and ensure that information records are:

- held securely and confidentially
- obtained fairly and efficiently
- recorded accurately and reliably
- used effectively and ethically, and
- shared appropriately and lawfully.

We have met our statutory responsibility to minimise burden by assessing and challenging the burden of all new and changed data collections and making recommendations to the Standardisation Committee for Care Information. Our Burden Advice and Assessment Service has developed Burden Reduction Plans with DH and each of its Arm's Length Bodies and has also initiated a rolling review of all existing national and local data collections.

With regard to a summary of other activity in relation to information governance for the year:

- We established a three-year cyber security programme. This is designed to instigate a number of projects that will provide an enhanced set of information assurance and cyber security capabilities as befit an organisation responsible for the security and protection of personal and patient identifiable data across the health and social care system in England,
- We are establishing an audit function and the organisation is working towards ISO 27001 (information security standard) conformance,
- We are developing a new IG Assurance Framework, which includes significant changes to the IG Toolkit,

- We complete the IG Toolkit assessment annually. We were compliant for 2014/15 exceeding the required 'satisfactory' level. A particular challenge for us remains ensuring that staff seconded in the Data Sharing for Commissioners Regional Offices understand and adhere to the corporate IG policies and processes and contribute to the response to the IG Toolkit,
- During 2014/15 one incident was logged on the Serious Incident Requiring Investigation (SIRI) incident reporting tool as a near miss. We investigated and managed this internally in accordance with and having been assessed against Information Commissioner's Office (ICO) and SIRI reporting guidelines. These determined that ICO notification was not required; this is where the incident is a near miss, minor or where no clinical or sensitive data was involved,
- We are subject to the Data Protection Act (DPA) 1998 and have filed the appropriate notification with the ICO. During 2014/15, we received 890 Freedom of Information (FoI) requests and 66 Subject Access Requests (SARs). There were 29 breaches of the timescales for handling a FoI request and 6 for handling a SAR,
- One complaint was made to the ICO by an applicant dissatisfied with our response provided to them under the FoI Act. Part of the information requested was exempt and part pending future publication in our annual report. Following a review, the data was released together with links to the published annual report and accounts, and no further action was required. Two complaints were made by applicants dissatisfied with our response under the DPA. In both cases, the ICO was given clarification around the process undertaken, no additional data was released and no further action required,
- As a public information holder, we have complied with the cost allocation and charging requirements of HM Treasury and the Office of Public Sector Information. No charges have been made for access to information during 2014/15,
- We are committed to the regular review and assurance of all data we handle. In the course of discharging this responsibility, we discovered in April 2014 a number of NHS organisations that have been submitting data values to the secure Secondary Uses Service (SUS) which did not conform to NHS Data Dictionary Standards. In accordance with good practice and in relation to issues impacting on the use of patient data, we referred this incident to the Information Commissioner's Office (ICO) and have reminded data providers of their responsibilities. We are working with data recipients to support them to delete the affected data. The risk to patient confidentiality has been classified as low by the ICO.

Statistical governance

We comply with the Code of Practice for Official Statistics as set by the UK Statistics Authority under the guidance of the Head of Profession for Statistics who oversees management of two key risks: of breaches of the Code of Practice for Official Statistics and of errors in published figures, both of which are managed through the standard HSCIC risk management processes and escalation routes.

During 2014/15 there were six breaches of the Code of Practice for Official Statistics. One breach related to release practices where a publication was briefly available on our website eight hours before its official publication time. Another breach occurred when our website experienced major technical difficulties making unavailable the entire publication catalogue. This resulted in the publication's release being delayed by 70 minutes. The other four breaches were due to issues with pre-release access. In three instances, the briefing coordinators in external organisations mishandled pre-release access material, in two cases sending the material to the incorrect contact within their organisation and in the other, issuing a statement containing embargoed HSCIC figures. In the final breach, a draft document was sent in error to the incorrect contact for review. In accordance with our incident management processes, we have implemented more rigorous processes to prevent recurrence.

The production of some statistics relies on the use of complex models which are deemed to be business critical. In line with the requirements of the Macpherson Report 'Review of quality assurance of Government analytical models', the DH framework of quality assurance of business critical models includes two of our statistical models: Summary Hospital-level Mortality Indicator (SHMI) and Better Care, Better Value (BCBV).

Public Interest Disclosure

One member of staff raised a matter as a public interest disclosure (whistleblowing) during 2014/15. This matter has now been investigated by independent auditors. Their report will be passed to our Assurance and Risk Committee in early 2015/16 and we will take appropriate action as a consequence of the investigation. Arrangements are in place to ensure the individual who raised the concern, and who has been afforded appropriate support under the terms of our public interest disclosure policy, is updated.

The National Audit Office reviewed our public interest disclosure policy in 2013/14 and identified no significant issues. Nonetheless, we have engaged with *Public Concern at Work* with a view to improving our policy and practice in this area, and to embedding a culture in which staff are able to raise concerns in the expectation that they are addressed openly, positively and in a timely manner.

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 of 2014/15 has been informed in a number of ways including:

- My attendance at ARC and review of minutes and papers and its annual report to the Board, together with my attendance at IACSC,
- The internal audit plan. Despite a delayed start to the delivery of the year's plan and a number of reviews being deferred or dropped, the internal audit team completed a comprehensive range of assessments and the head of internal audit provided an opinion on the overall arrangements for gaining assurance through the assurance framework and on the controls reviewed as part of the internal audit work. The internal audit assurance statement concluded:

  "For the three areas on which I must report, I have concluded the following:

  In the case of risk management: good progress has been made in implementing the new risk management strategy, and the organisation has made substantial investment in understanding its risks. However, our audit work shows that there remain a number of significant areas for improvement in order to fully embed an effective and value-adding risk management framework and culture.

  In the case of governance: HSCIC has been developing its governance arrangements since the beginning of the year and at the top level has appropriate oversight of corporate activity. HSCIC has developed a scorecard and reporting mechanism that allows a better understanding of accountability, delivery and control both internally and in relation to the Department of Health sponsorship arrangements. Progress in this area will continue to be assessed and assured as part of future audit plans.

  In the case of control: HSCIC is continually developing and improving its control mechanisms in place on the business critical systems. However, our work on key financial controls, business continuity planning and data quality shows that there remains scope for the significant improvement of the control framework in these areas.

  Overall, improvements are being made as the Health and Social Care Information Centre develops its governance, risk and control frameworks. However, due to the weaknesses identified in our audit work, my overall opinion is that I can only give limited assurance to the Accounting Officer that the Health and Social Care Information Centre has had adequate and effective systems of control, governance and risk management in place for the reporting year 2014/15."
- Other work undertaken by the National Audit Office. In particular, a report has been recently issued for GPES, a project run by one of our predecessor organisations. This report highlighted weaknesses in respect of governance, contract management and testing of system functionality. I have fully accepted these findings and will ensure that current arrangements are sufficiently robust to mitigate a similar occurrence in the future. An internal audit of contract management arrangements has already been undertaken with a satisfactory outcome,
- Following individual audit reports, action plans were put in place to address recommendations with progress reviewed by the ARC on a regular basis,
- Senior managers within the organisation who had responsibility for the development and maintenance of the system of internal control provided me with assurances,
- Through clear performance management arrangements in place with executive directors and senior managers,
- The assurance framework itself provided evidence on the effectiveness of controls that managed the risks to the organisation,
- By the findings of the National Audit Office as the organisation's external auditors.

I have been advised on the effectiveness of the system of internal control by the Board, the IACSC and the ARC and am accordingly aware of any significant issues that have been raised.

Significant Internal Control Issues

The past year has been a continuation of the journey we embarked upon in 2013/14 which was to develop and then strengthen and improve the governance arrangements of the HSCIC. I therefore welcome the comment in the internal audit report that progress is apparent but appreciate that we still have significant work to do before we can be fully confident over the effectiveness of our controls. Last year, we were not satisfied with the internal audit arrangements and so we brought in new arrangements and a new head of internal audit. This took until the middle of the financial year to become fully established and be able to make significant progress on the delivery of the audit programme. The work undertaken has provided more rigour and been helpful in demonstrating the gaps that were not previously identified. However, it will take time to achieve the standards of control I expect of the organisation and in the meantime we will work closely with our auditors to address problems as and when they are identified to ensure immediate remedial action is applied.

I have already initiated action to address the specific concerns raised from this year's internal audit reports around risk management, business continuity and disaster management and our financial controls. The issues concerning data quality and systems and service delivery form part of a wider focus on the management of data arising from the Partridge Review. Progress against this action is being monitored by the executive management team and the ARC; a responsible manager for each area has been identified to ensure that all necessary remedial action is applied.

The 2013/14 Governance Statement noted a number of particular concerns regarding certain controls in place during the year. Some have been reviewed and addressed as part of the further internal audit work above but I need to refer specifically to the controls around our non-current assets.

We inherited in April 2013 a very incomplete non-current asset register which required significant review and reconciliation. Enough progress was made to provide adequate assurance in the 2013/14 Accounts whilst recognising we needed to invest further. During 2014/15 we have:

- Undertaken a full inventory of our IT equipment through both actual physical verification and through our various asset tracking software. The Configuration Management Database (CMDB), the asset list maintained by IT has been updated to reflect the physical verification,
- The CMDB and the financial asset register were legacy organisation systems maintained independently with no common fields to link the two. Considerable work has been undertaken during the year to reconcile the two files and create common fields for assets purchased in the last two financial years. Material differences have been investigated and adjusted. Due to the limitations of the respective systems and transaction management processes in place, undertaking a sufficiently robust match was difficult and sometimes difficult to evidence from an audit perspective,
- Reviewed asset lives across all non-current assets,
- Developed revised procedures and clarified capitalisation policies,
- Identified a replacement for the financial asset register system which will be implemented early in 2015/16 which will enable a more rigorous control environment to apply,
- Reviewed in detail the valuation of previously capitalised internally generated software including the General Practice Extraction System (GPES) with a net book value of £12.9 million. Some impairments have been made which are separately disclosed in the accounts.

I recognise this has been a major undertaking and the whole end to end transaction and reconciliation process is still requiring substantial improvement to ensure that capital transaction processing is correct. This will be addressed early in 2015/16 but we have already implemented a revised requisition approval process allowing Finance to check the accounts coding which will reduce the level of such errors on purchase orders raised in the future. However, I feel confident we have made sufficient genuine progress to be able to adopt the updated CMDB records as the basis for our ongoing computer equipment and software licence records.

In addition to addressing the immediate concerns and improving controls generally over the course of the year we will also ensure specific effort in 2015/16 is focussed on strengthening assurance and control through:

- Improving the organisation's understanding of, and compliance with, key financial controls and reporting requirements,
- Further development of a comprehensive internal assurance map to provide the Board and DH with assurance that the risk management of internal systems and procedures is aligned with established and developing assurance controls,
- Continued emphasis on protecting the organisation from cyber and social engineering attacks which has been a significant driver for our overhaul of information and physical security arrangements under the oversight of our Information Assurance and Cyber Security Committee, a sub-committee of the Board,
- Ensuring our governance and controls around the release of data meet with the recommendations of the Partridge Review, are transparent and fair but also provide people with confidence that the personal data of citizens are effectively managed and properly protected.

I accept the observations by both the internal auditors and the NAO which I believe to be a fair and accurate view of the organisation at this point in its development. I acknowledge that there remains much to be done and we will continue to address the development of rigorous and sound assurance as a key priority for the HSCIC in 2015/16.

Andy Williams
Accounting Officer
3 July 2015

Annex

HSCIC Board 2014/15

Membership	Meetings Attended	Role
Board		Board members have corporate responsibility for ensuring that we comply with any statutory or administrative requirements for the use of public funds. The powers retained by and the responsibilities of our Board include: • Agreeing our vision and values, culture and strategy within the policy and resources framework agreed with the Department of Health sponsor, • Agreeing appropriate governance and internal assurance controls, • Approving business strategy, business plans, key financial and performance targets and the annual accounts, • Ensuring sound financial management and good value for money, • Ensuring controls are in place to manage financial and performance risks, including ensuring that we have the capability to deliver our strategic objectives, • Using information appropriately to drive improvements, • Supporting the Executive Management Team and holding it to account, • Ensuring the Board is able to account to Parliament and the public for how it discharges its functions, • Ensuring that we comply with any duties imposed on public bodies by statute, including without limitation obligations under health and safety legislation, the Human Rights Act 1998, the Disability Discrimination Act 2005, the Race Relations (Amendment) Act 2000, the Data Protection Act 1998, the Freedom of Information Act 2000 and the Equality Act 2010, • Ensuring that we have specific responsibility for sustainable development and operate within the framework of the Department of Health's environmental policies, • Approving recommendations of Board committees, • Approving income and expenditure as defined in our Levels of Delegated Authority document. Further details, including the conduct of meetings are contained in our Corporate Governance Manual incorporating the Standing Orders and Standing Financial Instructions, and other governance documents. The statutory Board meetings comprised a public session, where members of the public were able to attend, with all minutes and papers made available on our website. In addition, from time to time, the Board needed to consider commercial or confidential items that could not be discussed in public. In that event a private session was held without any observers.
Non-Executive directors:		
K Manning (Chair)	9	
Sir I Andrews (Senior Independent Director)	9	
Sir N Partridge (Vice Chair)	9	
Sir J Chisholm	8	
Prof. M Goddard	7	
J Ormondroyd (until 19/10/2014)	6	
Dr S Blackburn (from 15/09/2014)	3	
Executive directors:		
A Williams (CEO)	9	
R Allsop	9	
R Shaw (Senior Information Risk Owner [SIRO])	8	
C Vincent	9	
M Jones (until 10/11/2014)	5	
Other directors:		
T Denwood	8	
J Hawkins	7	
P Counter (from 16/06/2014)	5	
I Hunt from (06/10/2014)	3	
Prof. M Severs (Caldicott Guardian and Lead Clinician)	7	

HSCIC Assurance and Risk Committee 2014/15

Membership	Meetings Attended	Role
Non executive directors:		The Board delegated full responsibility to the Assurance and Risk Committee to:
Dr S Blackburn (Chair - from Nov 2014)	3	• Investigate any activity within the terms of reference. The Committee was authorised to seek any information that it requires from any employee and all employees are directed to cooperate with any request made,
Sir I Andrews (interim Chair - until Oct 2014)	8	
Sir N Partridge	7	
Sir J Chisholm	6	• Obtain outside legal or independent professional advice, at our expense, and to secure the attendance of external specialists with relevant experience and expertise if it considers this necessary,
J Ormondroyd (until Oct 2014)	5	
Executive directors – in attendance:		The Committee was charged with providing assurance and making recommendations to the Board on:
A Williams	6	• The operational effectiveness of policies and procedures,
C Vincent	8	
R Shaw	7	• The policies and procedures for all work related to fraud, corruption and whistleblowing, including the appointment of a Local Counter Fraud Specialist and to enable the Local Counter Fraud Specialist to attend Assurance and Risk Committee meetings when required,
R Allsop (from Nov 2014)	3	
Other directors in attendance:		• An effective internal audit function established by management that meets mandatory internal audit standards and provides appropriate independent assurance to our Chief Executive and Board,
J Hawkins (from Nov 2014)	3	
In addition, representatives of both the internal and external auditors attend the meetings.		• The effectiveness of the system of integrated governance, risk, management and internal control including information governance, security and data quality risks,
		• The accounting policies, the accounts and the annual report of the organisation,
		• Planned audit activity and results of both internal and external audit reports,
		• Any required changes to key corporate governance documents (for example the Corporate Governance Manual, standing orders, standing financial instructions and the scheme of delegation).

HSCIC Remuneration Committee 2014/15

Membership	Meetings Attended	Role
Non executive directors:		The Board delegated full responsibility to the Remuneration Committee to:
K Manning (Chair)	3	• Make recommendations to the Department of Health (DH) on the level of the remuneration packages of the CEO and other executive directors within the provisions of the Pay Framework for Very Senior Managers (VSMs) or successor arrangements,
Sir N Partridge	3	
Prof. M Goddard	3	
J Ormondroyd (until Oct 2014)	2	• Determine pay arrangements for medical and other staff groups who are not subject to Agenda for Change (AfC), VSM or the Transfer of Undertakings (Protection of Employment) Regulations 2006 (TUPE) protected terms and conditions of employment,
Executive directors – in attendance:		• Maintain an overview of senior non-medical staff pay (currently defined as over £100,000 per annum, including any award of Performance Related Pay) to ensure that pay remains consistent with public pay policy,
A Williams	3	• Approve the level of any annual performance related pay awards to HSCIC staff on ex-Civil Service terms and conditions,
R Allsop	3	• Approve the annual performance objectives and targets of executive Directors,
		• Monitor and evaluate the performance of VSMs and make recommendations to DH) on any proposed annual performance pay awards within the total of VSM pay bill which may be used for performance related pay (as set annually by DH, taking account of the recommendations of the Senior Salaries Review Body),
		• Ensure that pay arrangements are appropriate in terms of Equal Pay requirements,
		• Consider and approve redundancy payments and other (often TUPE related) exceptional matters,
		• Ensure that all matters relating to pay and conditions that require approval from the Department of Health Remuneration Committee or other external authority are submitted for approval and that the decisions of those bodies are appropriately implemented.

HSCIC Information Assurance and Cyber Security Committee (IACSC) 2014/15

The inaugural meeting of the HSCIC IACSC was held on 13 May 2014.

Membership	Meetings Attended	Role
Non executive directors:		The Board delegated full responsibility to the Information Assurance and Cyber Security Committee to: • Investigate any activity within the terms of reference. It was authorised to seek any information that it requires from any employee and all employees are directed to cooperate with any request made by the Information Assurance and Cyber Security Committee, • Obtain outside legal or independent professional advice, at our expense, and to secure the attendance of outsiders with relevant experience and expertise if it considers this necessary, • Ensure that there is an effective Information Assurance function that meets recognised industry and Government standards and provides appropriate independent assurance to the Chief Executive and Board, • Review the work and findings of the Cyber Security Programme and take account of the implications and management responses to their work, • Review the findings of other significant assurance functions, both internal and external to the organisation, and consider the implications to the governance of the organisation.
Sir I Andrews (Chair)	6	
Sir N Partridge	6	
J Ormondroyd (until Oct 2014)	2	
Prof. M Goddard (from Nov 2014)	1	
Executive directors – in attendance		
A Williams	2	
R Shaw	6	
R Allsop	6	
Other directors in attendance:		
P Counter (from July 2014)	5	
Prof. M Severs	6	
In addition, representatives from DH and cross government organisations attend the meetings.		

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 2015 under the Health and Social Care Act 2012. The financial statements comprise: the Statements of Comprehensive Net Expenditure, Financial Position, Cash Flows, Changes in Taxpayers' Equity; and the related notes. These financial statements have been prepared under the accounting policies set out within them. I have also audited the information in the Remuneration Report that is described in that report as having been audited.

Respective responsibilities of the Board, Accounting Officer and auditor

As explained more fully in the Statement of Accounting Officer's Responsibilities, the Board and the Accounting Officer are responsible for the preparation of the financial statements and for being satisfied that they give a true and fair view. My responsibility is to audit, certify and report on the financial statements in accordance with the Health and Social Care Act 2012. I conducted my audit in accordance with International Standards on Auditing (UK and Ireland). Those standards require me and my staff to comply with the Auditing Practices Board's Ethical Standards for Auditors.

Scope of the audit of the financial statements

An audit involves obtaining evidence about the amounts and disclosures in the financial statements sufficient to give reasonable assurance that the financial statements are free from material misstatement, whether caused by fraud or error. This includes an assessment of: whether the accounting policies are appropriate to the Health and Social Care Information Centre's circumstances and have been consistently applied and adequately disclosed; the reasonableness of significant accounting estimates made by Health and Social Care Information Centre; and the overall presentation of the financial statements. In addition I read all the financial and non-financial information in the Strategic Report, Directors' Report, Remuneration Report and Governance Statement to identify material inconsistencies with the audited financial statements and to identify any information that is apparently materially incorrect based on, or materially inconsistent with, the knowledge acquired by me in the course of performing the audit. If I become aware of any apparent material misstatements or inconsistencies I consider the implications for my certificate.

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

Opinion on regularity

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

Opinion on financial statements

In my opinion the financial statements give a true and fair view of the state of Health and Social Care Information Centre's affairs as at 31 March 2015 and of the net expenditure for the year then ended; and the financial statements have been properly prepared in accordance with the Health and Social Care Act and Secretary of State directions issued thereunder.

Opinion on other matters

In my opinion the part of the Remuneration Report to be audited has been properly prepared in accordance with Secretary of State directions made under the Health and Social Care Act; and the information given in the Strategic Report and Directors' Report for the financial year for which the financial statements are prepared is consistent with the financial statements.

Matters on which I report by exception

I have nothing to report in respect of the following matters which I report to you if, in my opinion: adequate accounting records have not been kept or returns adequate for my audit have not been received from branches not visited by my staff; or the financial statements and the part of the Remuneration Report to be audited are not in agreement with the accounting records and returns; or I have not received all of the information and explanations I require for my audit; or the Governance Statement does not reflect compliance with HM Treasury's guidance.

Report

I have no observations to make on these financial statements.

Sir Amyas C E Morse
7 July 2015

Comptroller and Auditor General
National Audit Office
157-197 Buckingham Palace Road
Victoria
London
SW1W 9SP

Statement of comprehensive net expenditure
For the year ended 31 March 2015

	Note	2014/15 £000	2013/14 £000
Expenditure			
Staff costs	3	136,453	131,732
Other expenditure	5	63,681	51,590
Depreciation and amortisation	5	12,537	8,149
Loss on revaluation of non-current assets	5	–	262
Loss on disposal of non-current assets	5	2,438	733
Total expenditure		**215,109**	**192,466**
Less income	4	(55,670)	(39,396)
Net operating expenditure for the financial year		**159,439**	**153,070**
Net gain on assets and liabilities transferred under absorption accounting	15	(1,246)	(16,427)
Net loss on aligning accounting treatment of transfers from the Department of Health	6	41	705
Net expenditure for the financial year		**158,234**	**137,348**
Other comprehensive expenditure			
Net loss on the revaluation of property, plant and equipment		(42)	35
Net gain on aligning accounting treatment of transfers from legacy bodies	6	–	(1,074)
Total comprehensive expenditure		**158,192**	**136,309**

All income and expenditure derives from continuing operations.

Notes 1 to 24 form part of these financial statements.

Statement of financial position
As at 31 March 2015

	Notes	2014/15 £000	2013/14 £000
Non-current assets			
Property plant and equipment	7	16,065	15,145
Intangible assets	8	27,366	27,865
Other non-current assets	9	528	813
Total non-current assets		**43,959**	**43,823**
Current assets			
Trade and other receivables	10	25,061	25,502
Cash and cash equivalents	11	10,247	22,931
Total current assets		**35,308**	**48,433**
Total assets		**79,267**	**92,256**
Current liabilities			
Trade and other payables	12	(29,602)	(28,955)
Provisions	13	(176)	(561)
Total current liabilities		**(29,778)**	**(29,516)**
Non-current assets plus net current assets		**49,489**	**62,740**
Non-current liabilities			
Provisions	13	(1,888)	(947)
Assets less liabilities		**47,601**	**61,793**
Taxpayers' equity			
General reserve		47,578	61,793
Revaluation reserve		23	–
Total taxpayers' equity		**47,601**	**61,793**

Notes 1 to 24 form part of these financial statements.

The financial statements on pages 64 to 90 were approved by the Board on 10 June and signed on its behalf by:

Andy Williams
Chief Executive

Dated
3 July 2015

Statement of cash flows
For the year ended 31 March 2015

	Notes	2014/15 £000	2013/14 £000
Cash flows from operating activities			
Net operating expenditure for the financial year		(159,439)	(153,070)
Adjustment for non-cash transactions:			
– depreciation and amortisation	5	12,537	8,149
– loss on disposal of non-current assets	5	2,438	733
– loss on revaluation of non-current assets	5	–	262
– provisions arising/reversed during the year	13	637	119
Decrease / (increase) in trade and other receivables	14	726	(14,780)
Increase / (decrease) in trade and other payables	14	1,188	(871)
Provisions utilised	13	(81)	(564)
Net cash outflow from operating activities		**(141,994)**	**(160,022)**
Cash flows from investing activities			
Purchase of property, plant and equipment		(7,620)	(5,692)
Purchase of intangible assets		(7,070)	(8,711)
Net cash outflow from investing activities		**(14,690)**	**(14,403)**
Cash flows from financing activities			
Bank balances transferred from CfH		–	15,724
Bank balances transferred from NHS IC		–	6,632
Grants from the Department of Health: cash drawn down in year		144,000	175,000
Net financing		**144,000**	**197,356**
Net (reduction) / increase in cash in the period	11	**(12,684)**	**22,931**
Cash and cash equivalents at the beginning of the period	11	22,931	
Cash and cash equivalents at the end of the period	11	10,247	22,931
Net (reduction) / increase in cash in the period		**(12,684)**	**22,931**

All cash flow relates to continuing activities.

Notes 1 to 24 form part of these financial statements.

Statement of changes in taxpayers equity
As at 31 March 2015

	Notes	General reserve £000	Revaluation reserve £000	Total reserves £000
Balance at 31 March 2013		**–**	**–**	**–**
Transfer from NHS IC	15	16,497		16,497
Transfer from SHAs/PCTs	15	(2,311)	–	(2,311)
Total transfers from legacy bodies		**14,186**	**–**	**14,186**
Changes in taxpayers' equity				
Net expenditure for the financial year		(137,348)	–	(137,348)
Gain on the revaluation of property, plant and equipment		1,074	–	1,074
Transfer between reserves for property, plant and equipment		(35)	35	–
Loss on revaluation of property, plant and equipment		–	(35)	(35)
Total recognised income and expense		**(136,309)**	**–**	**(136,309)**
Grant in aid from the Department of Health: bank balances transferred from NHS IC		6,632	–	6,632
Grant in aid from the Department of Health: payments made by Department of Health on behalf of HSCIC		2,284	–	2,284
Grant in aid from the Department of Health: cash drawn down in year		175,000	–	175,000
Total grant in aid funding		**183,916**	**–**	**183,916**
Balance at 31 March 2014		**61,793**	**–**	**61,793**
Balance at 31 March 2014		**61,793**	**–**	**61,793**
Changes in taxpayers' equity				
Net expenditure for the financial year		(158,234)	–	(158,234)
Net gain on aligning accounting treatment of transfers from legacy bodies	6	**–**	42	42
Movement between reserves	6	19	(19)	0
Total recognised income and expense		**(158,215)**	**23**	**(158,192)**
Grant in aid from the Department of Health: cash drawn down in year		144,000	–	144,000
Total grant in aid funding		**144,000**	**–**	**144,000**
Balance at 31 March 2015		**47,578**	**23**	**47,601**

Notes 1 to 24 form part of these financial statements.

Transfer from NHS IC represents the assets and liabilities transferred from the Health and Social Care Information Centre Special Health Authority, which was dissolved on 31 March 2013. Transfer from SHAs/PCTs represents the assets and liabilities relating to the informatics functions transferred from Strategic Health Authorities and a Primary Care Trust when these bodies were dissolved on 31 March 2013. These transfers were accounted for using modified absorption accounting rules, in accordance with the Department of Health group accounting policies set out in the NHS Manual for Accounts.

The transfer between reserves for property, plant and equipment represents the re-establishment of the revaluation reserve on assets transferred from Connecting for Health, formerly part of the Department of Health Informatics Directorate, and accounted for as part of the net gain on assets and liabilities transferred under absorption accounting in the statement of comprehensive net expenditure.

Notes to the accounts

1.1 General Information

The Health and Social Care Information Centre (HSCIC) is an executive non-departmental government body established under the Health and Social Care Act 2012. The address of its registered office and principal place of business are disclosed in the introduction to the annual report. The principal activities of the HSCIC is the collection, analysis and dissemination of health data for secondary uses purposes together with the development and contract management of elements of the NHS IT infrastructure on behalf of the Department of Health and NHS England. It is accountable to the Secretary of State for Health for discharging its functions, duties and powers effectively, efficiently and economically.

1.2 Basis of accounting

The financial statements have been prepared in accordance with the 2014/15 Government Financial Reporting Manual (FReM) issued by HM Treasury. The accounting policies contained in the FReM apply International Financial Reporting Standards (IFRS) as adopted and interpreted for the public sector context. Where the FReM permits a choice of accounting policy, the accounting policy which is judged to be most appropriate to the particular circumstances of the HSCIC for the purpose of giving a true and fair view has been selected. The particular policies adopted by the HSCIC are described below. They have been applied consistently in dealing with items that are considered material to the accounts.

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

The presentational currency is pounds sterling and, unless otherwise stated, the accounts have been prepared to the nearest £000.

Transfer from "NHS Direct" represents the assets transferred from NHS Direct which relate to various telephony equipment and systems together with other software applications managed by the HSCIC from 1 April 2014. The transfer was accounted for using standard absorption accounting in accordance with the Department of Health group accounting policies set out in the NHS Manual for Accounts. Transfers under standard absorption accounting are recorded against assets or liabilities as appropriate, with the net gain or loss recorded through the statement of comprehensive net expenditure.

On 1 April 2013 assets were transferred from:

- "CfH" representing the assets transferred from the DH Informatics Directorate which relate to the IT system delivery functions managed by the HSCIC from 1 April 2013. The transfer was accounted for using standard absorption accounting
- "NHS IC" representing the assets transferred from the Health and Social Care Information Centre Special Health Authority, which was dissolved on 31 March 2013. The transfer was accounted for using modified absorption accounting rules in accordance with the Department of Health group accounting policies set out in the NHS Manual for Accounts. Transfers under modified absorption accounting are recorded against assets or liabilities as appropriate, with the net gain or loss recorded against the General Reserve
- "SHAs/PCTs" represents the assets and liabilities transferred from Strategic Health Authorities and a Primary Care Trust relating to the informatics functions that moved to the Health and Social Care Information Centre when these bodies were dissolved on 31 March 2013. These transfers were accounted for using modified absorption accounting rules.

Early adoption of accounting standard amendments and interpretations

No accounting standard changes were adopted early in 2014/15.

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

The Treasury Financial Reporting Manual does not require the following standards and interpretations to be applied in 2014/15. The application of the standards as revised would not have a material impact on the accounts for 2014/15, were they applied in the year:

- IFRS 9 Financial Instruments - published October 2010, expected to be effective from 1 January 2018
- IFRS 13 Fair Value - published May 2011, effective from 1 April 2015
- IFRS 14 Regulatory Deferral Accounts, effective from 1 January 2016
- IFRS 15 Revenue for Contract with Customers, effective from 1 January 2017

The HSCIC does not believe that the application of the above standards would have a material impact to the accounts.

1.3 Income

Income is recognised to the extent that it is probable that the economic benefits will flow to the HSCIC and the income can be reliably measured.

The main source of funding is a parliamentary grant from the DH within an approved cash limit, which is credited to the general reserve. 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 the Department of Health, NHS England, Public Health England, other health related bodies and external customers. Charges comply with HM Treasury and Office of Public Sector Information guidance.

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

1.4 Taxation

The HSCIC 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 a non-current asset.

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 statement of comprehensive net expenditure.

1.6 Employee benefits

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

1.7 Non-current assets

a. Capitalisation

All assets falling into the following categories are capitalised:

1) Intangible assets, include software development expenditure and the purchase of computer software licences, where they are capable of being used for more than one year and:

- Individually with a cost equal to or greater than £5,000; or
- Collectively with a cost of at least £5,000, the assets are functionally interdependent, they had broadly simultaneous purchase dates, are anticipated to have simultaneous disposal dates and are under single managerial control.

Development expenditure is transferred to other categories of non-current assets when the development is sufficiently complete to enable the asset as a whole to be fully deployed and effective for the management's intended purpose.

2) Tangible assets which are capable of being used for more than one year, and:

- Individually have a cost equal to or greater than £5,000 or,
- Collectively have a cost of at least £5,000, 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 set up cost of a new asset irrespective of their individual cost.

Internally-generated assets are recognised if, and only if, all of the following have been demonstrated:

- The technical feasibility of completing the intangible asset so that it will be available for use,
- The intention to complete the intangible asset and use it,
- The ability to use the intangible asset,
- How the intangible asset will generate probable future economic benefits,
- The availability of adequate technical, financial and other resources to complete the intangible asset and use it,
- The ability to measure reliably the expenditure attributable to the intangible asset during its development.

Expenditure on research activities and project management costs are recognised as an expense in the period in which it is incurred.

A capitalisation policy with respect to programme work undertaken for major customers, particularly the DH, has been agreed. Those assets procured or developed which are deemed to form part of the HSCIC statutory functions primarily in relation to the collection, storage, analysis and dissemination of data and information will be capitalised in the HSCIC accounts. Any assets generated that are for the benefit of the wider NHS infrastructure are not deemed to be an HSCIC asset and will be recharged and capitalised in the accounts of the customer commissioning the work.

b. Valuation

Non-current assets are recognised at cost, including expenditure such as installation directly attributable to bringing them into working condition. Revaluations are performed annually in order to assess whether cost is materially different to fair value.

Any revaluation or indexation increase is credited to the revaluation reserve, except to the extent that it reverses a revaluation decrease for the same asset previously recognised as an expense, in which case the increase is credited to the statement of comprehensive net expenditure to the extent of the decrease previously expensed. A decrease in carrying amount arising on the revaluation of the asset is charged as an expense to the extent that it exceeds the balance, if any, held in the revaluation reserve relating to a previous revaluation of that asset.

Assets are revalued either using appropriate indices provided by the Office for National Statistics or, in the case of internal software developments, by considering the inflation rates of staff and other resources and potential other efficiency factors. The revaluation undertaken during 2014/15 was not materially different to the original historic cost and thus no valuation adjustment has been incorporated, except for land and buildings which were subject to a professional valuation in 2013/14.

The carrying values of all assets are reviewed for impairment if events or changes in circumstances indicate the carrying value may not be appropriate.

c. Depreciation

Development expenditure is not depreciated until such time the asset is available for use. Otherwise, depreciation and amortisation is charged on a straight line basis to write off the costs or valuation of tangible and intangible non-current assets, less any residual value, over their estimated useful lives as follows:

1) Intangible software assets are amortised, on a straight line basis, over the estimated life of the asset or 5 years whichever is less
2) Purchased computer software licences are amortised over the shorter of the term of the licence or 5 years whichever is less
3) Property, plant and equipment is depreciated on a straight line basis over its expected useful life as follows:
   - Buildings 40 years
   - Fixtures and fittings 5-10 years
   - Office, information technology, short life equipment 3-5 years

The estimated useful lives and residual values are reviewed annually.

1.8 Research and development

Expenditure incurred on pure and applied research is treated as an operating charge in the year in which it is incurred. Development expenditure is for the development of specific business systems. Expenditure which does not meet the criteria for capitalisation is treated as an operating cost in the year in which it is incurred. Development expenditure meeting the criteria for capitalisation is treated as an intangible non-current asset until such time that the asset is brought into use.

1.9 Leases

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

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

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

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

1.10 Provisions

Provisions are recognised when a present obligation exists as a result of a past event, and it is probable that the HSCIC will be required to settle that obligation. Provisions are measured at the directors' best estimate of the expenditure required to settle the obligation at the reporting date, and are discounted to present value where the effect is material.

1.11 Contingent liabilities

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

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

1.12 Pensions

Past and present employees are covered by both the NHS Pension Scheme (NHSPS) and the Principal Civil Service Pension Scheme (PCSPS). Both schemes are unfunded, defined benefit schemes. The schemes are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme's assets and liabilities. Therefore, the schemes are accounted for as if they were defined contribution schemes with the cost to the NHS body of participating in the scheme taken as equal to the contributions payable to the scheme for the accounting period.

1.13 Critical accounting judgements and key sources of estimation uncertainty

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

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

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

Revenue recognition

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

Dilapidation provision

The HSCIC has provided £1,737,000 as a provision against dilapidation costs of its leased accommodation across its estate where required. In order to assess an estimate of the likely liabilities at the end of the leases, management has used property advisors' reports and also assessments from suitably qualified internal staff.

General Practice Extraction Service (GPES)

The system, having been six years in development, went live during 2014/15. An internal review of the system functionality and expected life has been undertaken during the year with the result that management have amended the assets carrying value as follows:

- An impairment relating to the GPET-Q query execution/data extraction management software of £842,000 with respect to abortive or non functional elements,
- To amortise the remainder of the GPET-Q asset value over a reduced two year life,
- Management have considered valuing GPET-Q on a replacement cost basis but establishing a reliable cost providing similar functionality is not currently feasible.

All other aspects of GPES to remain at cost and a five year life.

Non-current assets

During 2013/14 the HSCIC inherited a substantial number of non-current assets from legacy organisations. The accounting policies adopted for both the capitalisation and amortisation of certain categories of assets were different, and in some instances the accounting records were not sufficiently robust. Management have undertaken a physical verification of computer hardware and software licences together with a reconciliation between the IT asset list and the financial ledgers for all assets purchased in the last two years. The resulting IT asset list has been adopted to represent the assets at 31 March 2015.

1.14 Business and geographical segments

The HSCIC has adopted IFRS 8 Operating Segments. IFRS 8 requires operating segments to be identified on the basis of internal reports about components of the business that are regularly reviewed by the Chief Executive to allocate resources to the segments and to assess their performance. The organisation has had a number of directorate changes within the year and the analysis in Note 2 represents the structure in place at 31 March 2015.

1.15 Financial instruments

The HSCIC is largely in a non-trading environment and the majority of its income is from other government or NHS bodies. Consequently the HSCIC is not exposed to a significant degree of financial risk that is faced by most other business entities. The HSCIC has no borrowings and relies largely on the grants from the Department of Health for its cash requirements. The HSCIC is therefore not exposed to liquidity risks. It has no material deposits and all material assets and liabilities are denominated in sterling so it is not exposed to interest rate risk or currency risk.

Financial assets are recognised on the statement of financial position when the HSCIC becomes party to the financial instrument contract or, in the case of trade receivables, when the goods or services have been delivered. Financial assets are derecognised when the contractual rights have expired or the asset has been transferred. The HSCIC has no financial assets other than trade debtors. Trade debtors do not carry any interest and are stated at their nominal value less any provision for impairment.

Financial liabilities are recognised on the statement of financial position when the HSCIC becomes party to the contractual provisions of the financial instrument or, in the case of trade payables, when the goods or services have been received. Financial liabilities are derecognised when the liability has been discharged, that is, the liability has been paid or has expired. The HSCIC has no financial liabilities other than trade payables. Trade payables are not interest bearing and are stated at their nominal value.

1.16 Going concern

Confirmation of the main grant in aid budget allocation for the 2015/16 financial year in line with the business plan submitted has been received. Consequently, the financial accounts have been prepared on the basis that the HSCIC is a going concern.

2 Statement of operating costs by activity

IFRS 8 requires operating segments to be identified on the basis of internal reports that are regularly reviewed by the Chief Executive. HSCIC's Board monitor the performance and resources of the organisation by directorate.

For the year ended 31 March 2015

£000	Architecture Standards & Innovation	Customer Relations	Information & Analytics	Operations & Assurance Services
Income	(1,143)	(342)	(15,282)	(17,582)
Staff Costs	13,403	3,504	20,597	43,708
Professional Fees	288	61	9,562	4,262
Information Technology	762	78	1,669	11,868
Accommodation	95	39	30	967
Travel & Subsistence	409	79	402	1,283
Marketing, Training & Events	143	260	147	552
Office Services	640	128	93	554
Other	(87)	68	456	(567)
Depreciation / Amortisation	–	–	66	64
Non staff costs	**2,250**	**713**	**12,425**	**18,983**
Net expenditure	**14,510**	**3,875**	**17,740**	**45,109**

For the year ended 31 March 2014 – All restated

£000	Architecture Standards & Innovation	Customer Relations	Information & Analytics	Operations & Assurance Services
Income	(1,174)	(210)	(12,648)	(13,068)
Staff Costs	12,989	2,893	21,633	37,262
Professional Fees	319	(1)	8,994	1,136
Information Technology	446	106	374	8,952
Accommodation	18	164	2,862	(496)
Travel & Subsistence	358	46	340	976
Marketing, Training & Events	31	230	77	259
Office Services	659	129	99	438
Other	(77)	(12)	835	(1,252)
Depreciation / Amortisation	–	–	75	–
Non staff costs	**1,754**	**662**	**13,656**	**10,013**
Net expenditure	**13,569**	**3,345**	**22,641**	**34,207**

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

Provider Support	Programme Delivery	Finance & Corporate Services	HR & Transformation	HSCIC Corporate	Total
(276)	(20,738)	(274)	(100)	67	(55,670)
10,565	25,379	16,269	2,743	285	136,453
40	7,046	1,921	123	(455)	22,848
32	2,248	226	28	223	17,134
29	559	12,443	1	93	14,256
574	1,515	290	64	(134)	4,482
116	204	165	125	(199)	1,513
24	168	1,286	95	17	3,005
(7)	1,039	267	235	(961)	443
–	2,617	–	–	12,228	14,975
808	**15,396**	**16,598**	**671**	**10,812**	**78,656**
11,097	**20,037**	**32,593**	**3,314**	**11,164**	**159,439**

Provider Support	Programme Delivery	Finance & Corporate Services	HR & Transformation	HSCIC Corporate	Total
(1,114)	(9,959)	(1,132)	(65)	(26)	(39,396)
17,094	18,331	14,100	2,785	4,645	131,732
86	961	6,730	224	821	19,270
10	424	115	31	(385)	10,073
26	548	9,539	14	75	12,750
639	969	329	114	314	4,085
33	97	32	473	–	1,232
21	130	841	48	610	2,975
–	2,683	18	347	(1,337)	1,205
–	–	–	–	9,069	9,144
815	**5,812**	**17,604**	**1,251**	**9,167**	**60,734**
16,795	**14,184**	**30,572**	**3,971**	**13,786**	**153,070**

Architecture, Standards & Innovation	To ensure the organisation meets the highest standards in information and statistical governance, and provide guidance to the health sector as a whole, ensuring that health related data is used safely, securely and for the purposes intended.
Customer Relations	The primary purpose of the Customer Relations directorate is to manage our stakeholders and customers' requirements effectively, understand how our services can be best utilised and build our reputation as the information, data and technology partner for the health and social care sectors.
Information & Analytics	To collect and analyse data and provide useful, trusted and accessible information to a wide range of users, including the health service and providers of social care services, Government, researchers, interest groups, patients and the public, to support scientific investigation, patient choice and public debate.
Operations & Assurance Services	The Operations and Assurance Services directorate is responsible for ensuring systems and programmes are delivered in a technically and clinically safe and secure manner. Once systems are in the live environment, the directorate is responsible for ensuring they maintain high availability and provide a fully resilient service. The directorate is also responsible for ensuring that upgrades to the Spine, part of the critical national infrastructure are developed and applied in a safe, secure and cost effective manner.
Provider Support	To deliver systems and services including those supplied by the Local Service Provider and the South Local Clinical Systems programmes to NHS Trusts and other provider organisations on behalf of the Department of Health.
Programme Delivery	The Programmes Directorate delivers IT enabled business change programmes, projects and operational services across the health and social care system including Summary Care Record, e-Referral System, electronic prescription service, GP Systems of Choice, NHS Mail, Health and Social Care Networks and NHS Choices.
Finance & Corporate Services	To provide key central services, estate management, infrastructure and expertise that secure the probity, financial health and reputation of the organisation, enabling the delivery of high quality information, data and IT systems.
HR & Transformation	To deliver a high performing organisation that is recognised as an outstanding place to work, through the provision of optimal HR services and development of the capability and capacity of the workforce.
HSCIC Corporate	Relates to central corporate level activities and expenditure which is not specifically allocated to directorates including depreciation, staff termination costs and other central accounting adjustments.

3 Staff numbers and related costs

3.1 Staff costs comprise:

	2014/15 £000	2013/14 £000
Permanent staff		
Salaries and wages	99,188	90,731
Social security costs	9,276	8,420
Employer superannuation contributions – NHSPS	12,610	11,420
Employer superannuation contributions – other	644	491
Staff seconded to other organisations	1,420	917
Termination benefits	(161)	4,352
	122,977	**116,331**
Other staff		
Temporary staff	1,809	1,544
Contractors	11,839	12,662
Staff seconded from other organisations	1,401	1,602
	15,049	**15,808**
Capitalised staff costs	(1,573)	(407)
	136,453	**131,732**

3.2 The average number of whole term equivalent persons employed during the year was:

	2014/15 Number	2013/14 Number
Permanent staff and secondees	2,232	1,995
Temporary and contract staff	140	135
Total	**2,372**	**2,130**
The average number of whole term equivalent persons employed during the year whose time was capitalised was	18	7

There were no amounts spent on staff benefits during the year and there was one early retirement on the grounds of ill health.

3.3 Total staff termination packages are detailed as follows:

2014/15	Number of compulsory redundancies	Number of other departures agreed	Total number of exit packages	Cost of compulsory redundancies £	Cost of other departures agreed £	Total cost of exit packages £
Cost Band						
£25,000-£50,000	1	1	**2**	41,000	32,457	**73,457**
£50,000-£100,000	3	–	**3**	262,657	–	**262,657**
£100,000-150,000	–	1	**1**	–	103,248	**103,248**
Total	**4**	**2**	**6**	**303,657**	**135,705**	**439,362**

2013/14	Number of compulsory redundancies	Number of other departures agreed	Total number of exit packages	Cost of compulsory redundancies £	Cost of other departures agreed £	Total cost of exit packages £
Cost Band						
<£10,000	4	1	**5**	27,088	6,605	**33,693**
£10,000-£25,000	16	6	**22**	293,069	99,285	**392,354**
£25,000-£50,000	9	5	**14**	337,312	210,570	**547,882**
£50,000-£100,000	9	6	**15**	608,807	405,561	**1,014,368**
£100,000-£150,000	10	4	**14**	1,295,954	517,047	**1,813,001**
£150,000-£200,000	–	2	**2**	–	336,723	**336,723**
>£200,000	1	–	**1**	206,077	–	**206,077**
Total	**49**	**24**	**73**	**2,768,307**	**1,575,791**	**4,344,098**

Most HSCIC staff are covered by the NHS Pensions Scheme, although a number belong to the Principal Civil Service Pension Scheme.

NHS Pension Scheme

Past and present employees are covered by the provisions of the NHS Pensions Scheme. Details of the benefits payable under these provisions can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. The scheme is an unfunded, defined benefit scheme that covers NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State, in England and Wales. The scheme is not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, the scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS Body of participating in the scheme is taken as equal to the contributions payable to the scheme for the accounting period.

In order that the defined benefit obligations recognised in the financial statements do not differ materially from those that would be determined at the reporting date by a formal actuarial valuation, the FReM requires that "the period between formal valuations shall be four years, with approximate assessments in intervening years". An outline of these follows:

a) Accounting valuation

A valuation of the scheme liability is carried out annually by the scheme actuary as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and are accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2015, is based on valuation data as 31 March 2014, updated to 31 March 2015 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used. 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) Pension Accounts, published annually. These accounts can be viewed on the NHS Pensions website. Copies can also be obtained from The Stationery Office.

b) 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.

The last publiched actuarial valuation undertaken for the NHS Pension Scheme was completed for the year ending 31 March 2012.

The scheme regulations allow contribution rates to be set by the Secretary of State for Health, with the consent of HM Treasury, and consideration of the advice of the scheme actuary and appropriate employee and employer representatives as deemed appropriate.

c) Scheme provisions

The NHS Pension Scheme provides defined benefits, which are summarised below. This list is an illustrative guide only, and is not intended to detail all the benefits provided by the scheme or the specific conditions that must be met before these benefits can be obtained:

The scheme is a "final salary" scheme. Annual pensions are normally based on 1/80th for the 1995 section and of the best of the last three years pensionable pay for each year of service, and 1/60th for the 2008 section of reckonable pay per year of membership. Members who are practitioners as defined by the scheme regulations have their annual pensions based upon total pensionable earnings over the relevant pensionable service.

With effect from 1 April 2008 members can choose to give up some of their annual pension for an additional tax free lump sum, up to a maximum amount permitted under HMRC rules. This new provision is known as "pension commutation".

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. From 2011/12 the Consumer Price Index (CPI) has been used and replaced the Retail Prices Index (RPI).

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 year's pensionable pay for death in service, and five times their annual pension for death 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 employer.

Members can purchase additional service in the NHS Pension Scheme and contribute to money purchase additional voluntary contributions run by the scheme's approved providers or by other free standing additional voluntary contributions providers.

Employees who do not wish to join the NHS Occupational Pension Scheme can opt to join the National Employment Savings Trust (NEST) scheme. This is a stakeholder pension scheme based on defined contributions. The minimum combined contribution is current 2 per cent of qualifying earnings, of which the employer must pay 1 per cent, rising to 8 per cent in 2018, of which the employer must pay 3 per cent. Employees can choose to pay more into the fund, subject to a current cap of £4,700 per annum. 6 employees of the HSCIC were members of the NEST Scheme during 2014/15.

The Principal Civil Service Pension Scheme (PCSPS)

The PCSPS is an unfunded multi-employer defined benefit scheme in which the HSCIC 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: (http://www.civilservicepensionscheme.org.uk).

For 2014/15, employer's contributions of £470,374 were paid at one of four rates in the range 16.7 per cent to 24.3 per cent of pensionable pay based on salary bands. The salary bands and contribution rates have remained unchanged in 2014/15. The scheme actuary reviews employer contributions usually every four years following a valuation. The contribution rates reflect benefits as they accrue, not the costs as they are incurred, and reflect past experience of the scheme.

Employees can opt to open a partnership pension account, a stakeholder pension with an employer contribution. Employer contributions are age related and range from 3 per cent to 12.5 per cent of pensionable pay. Employers may also match employee contributions up to 3 per cent of pensionable pay. No employees of the HSCIC have opted for the partnership pension account.

4 Income

Income analysed by classification and activity is as follows:	2014/15 £000	2013/14 £000
Income from activities		
Programme and project management	17,852	17,142
Surveys and data collection	4,952	2,917
Service delivery	28,223	13,135
Fees and charges	2,910	3,487
Other income	(7)	1,225
	53,930	**37,906**
Other income		
Other non trading income	1,740	1,490
	55,670	**39,396**

Income from programme and project management relates to a number of workstreams primarily for the Department of Health and NHS England and include work on NHS Choices, National Child Measurement Programme and the Breast Cancer Screening development together with staff time capitalised on Department of Health national programmes.

Income from surveys and data collection relates to the cost of running health surveys and other national data collection activities.

Income from service delivery covers a range of data management, system support and hosting, training and helpdesk services.

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

	Clinical audit services £000	Data related services £000	2014/15 Total £000	2013/14 Total £000
Income	2,206	704	2,910	3,487
Expenditure	2,092	1,026	3,118	3,557
Surplus / (deficit)	**114**	**(322)**	**(208)**	**(70)**

The clinical audit programme relates to the collection, analysis and reporting of data across a number of clinical areas such as diabetes, renal and various cancer specialisms, with the main customer being the Healthcare Quality Improvement Programme (HQIP). Data related services is the provision of health related data in a form the customer requires, data linkage services and data extracts for research purposes.

The financial objective is to recover full cost plus a return on investment, in accordance with Treasury guidance, in particular Managing Public Money. No charges are made for the actual data, only for the cost of providing the data to the customer in the format and specification required, including a fee for ensuring information governance requirements are met, where relevant.

5 Other expenditure

	2014/15 £000	2013/14 £000
Workpackages and professional fees	11,394	5,959
Data collection and surveys	8,832	6,929
Legal fees	2,622	6,382
Chair and non-executive emoluments	120	133
Marketing, training and events	1,513	1,230
Travel	4,482	4,084
Premises and establishment	14,256	12,750
IT maintenance and support	17,134	10,073
General office supplies and services	2,752	3,088
Communications	253	187
Insurance	257	123
External audit fees	103	100
Internal audit fees	165	241
Provision for impairment of receivables	(215)	186
Other	13	125
	63,681	**51,590**
Non cash transactions		
Depreciation – property, plant & equipment	5,105	4,319
Amortisation – intangible assets	7,432	3,830
Loss on revaluation of property, plant & equipment	–	262
Loss on disposal of non-current assets	2,438	733
	14,975	**9,144**
	78,656	**60,734**

6 Aligning accounting treatment of transfers

	2014/15 £000	From NHS IC 2013/14 £000	From CfH 2013/14 £000
Capitalisation of expenditure previously charged to revenue	–	(949)	–
Creation of holiday pay accrual	–	–	1,241
Creation of dilapidation provision	–	–	735
Adjustment to deposits on property leases	–	–	(234)
Alignment of depreciation and amortisation policies	41	(125)	(1,037)
Net loss / (gain)	**41**	**(1,074)**	**705**

Assets were transferred to the HSCIC on 1 April 2013 from several organisations. The value of certain assets has been adjusted in order to align the accounting treatment onto the HSCIC policies. The adjustments between the bodies have been presented separately on the statement of comprehensive net expenditure to reflect those transfers using standard absorption accounting and those using modified absorption accounting.

7 Non-current assets – property, plant and equipment

	Land	Buildings	Information technology	Fixtures & fittings	Total
	£000	£000	£000	£000	£000
Cost or valuation					
At 1 April 2014	310	1,170	26,847	3,835	32,162
Transfers from NHS Direct	–	–	581	–	581
Reclassification	–	–	(613)	418	(195)
Additions	–	–	6,582	1,521	8,103
Adjustments arising from asset review	–	–	(1,406)	–	(1,406)
Disposals	–	–	(8,318)	(41)	(8,359)
At 31 March 2015	**310**	**1,170**	**23,673**	**5,733**	**30,886**
Depreciation					
At 1 April 2014	–	278	14,414	2,325	17,017
Transfers from NHS Direct	–	–	116	–	116
Reclassification	–	–	(308)	254	(54)
Provided during the year	–	31	4,582	492	5,105
Adjustments arising from asset review	–	–	(350)	–	(350)
Disposals	–	–	(6,999)	(14)	(7,013)
At 31 March 2015	**–**	**309**	**11,455**	**3,057**	**14,821**
Net book value at 1 April 2014	310	892	12,433	1,510	15,145
Net book value at 31 March 2015	**310**	**861**	**12,218**	**2,676**	**16,065**

Transfers from NHS Direct represents the assets transferred from NHS Direct on 1 April 2014 in relation to the telephony infrastructure and associated software that the HSCIC has the responsibility to manage. The transfer was accounted for using standard absorption accounting in accordance with the Department of Health group accounting policies set out in the NHS Manual for Accounts.

Adjustments arising from the asset review refers to the outcome of the full physical asset verification and reconciliation work between the respective asset registers held by Finance and the IT department. These adjustments include a mixture of changes to costs, equipment now capitalised previously not identified and changes to certain asset lives. Disposals include certain assets that were identified on the IT asset register as having been disposed of or decommissioned in previous financial periods or were not found through the physical verification exercise.

The gross cost of property, plant and equipment that has been fully depreciated but is still in use is £5,225,392.

The freehold building was valued in March 2014 at existing use by the local Valuation Office.

The total depreciation charged in the statement of comprehensive net expenditure in respect of assets held under finance leases and hire purchase contracts was £nil.

All tangible assets are owned by the HSCIC.

7 Non-current assets – property, plant and equipment

	Land	Buildings	Information technology	Fixtures & fittings	Total
	£000	£000	£000	£000	£000
Cost or valuation					
At 1 April 2013	–	–	–	–	–
Transfers from NHS IC	–	–	3,647	2,471	6,118
Transfers from CfH	435	1,565	18,443	1,045	21,488
Reclassification	–	(223)	1,001	223	1,001
Additions	–	–	4,947	135	5,082
Disposals	–	–	(2,469)	(39)	(2,508)
Revaluation	(125)	(172)	–	–	(297)
Assets previously disposed of by CfH reinstated	–	–	1,278	–	1,278
At 31 March 2014	**310**	**1,170**	**26,847**	**3,835**	**32,162**
Depreciation					
At 1 April 2013	–	–	–	–	–
Transfers from NHS IC	–	–	2,212	1,180	3,392
Transfers from CfH	–	266	9,720	858	10,844
Reclassification	–	(46)	192	46	192
Provided during the year	–	58	3,933	328	4,319
Disposals	–	–	(2,292)	(20)	(2,312)
Assets previously disposed of by CfH reinstated	–	–	1,278	–	1,278
Accounting policy alignment	–	–	(629)	(67)	(696)
At 31 March 2014	**–**	**278**	**14,414**	**2,325**	**17,017**
Net book value at 1 April 2013	–	–	–	–	–
Net book value at 31 March 2014	**310**	**892**	**12,433**	**1,510**	**15,145**

Assets previously disposed of by CfH reinstated refers to certain fully depreciated assets that were not transferred by CfH as they had been disposed of in their financial records. However these assets are still in use and have been reinstated at cost and the equivalent value of depreciation.

Accounting policy alignment refers to amending the accounting treatment of assets transferred from former bodies to those policies adopted by the HSCIC. This includes certain expenditure that was formerly capitalised now being written to revenue and aligning the depreciation policy.

Following the merger, some of the IT software and systems employed by both organisations has been retired, or significantly upgraded or replaced. In addition, following a review, some of the CfH assets transferred have been disposed of as they were no longer identifiable or had any future economic benefit to the HSCIC. The total loss on disposal amounted to £196,000.

8 Non-current assets – intangible assets

	Software licences £000	Information technology £000	Development expenditure £000	Websites £000	Total £000
Cost or valuation					
At 1 April 2014	10,052	10,361	15,370	1,852	37,635
Transfers from NHS Direct	1,799	127	–	–	1,926
Reclassification	672	16,410	(16,887)	–	195
Additions	2,674	1,561	1,812	–	6,047
Revaluation	42	–	–	–	42
Adjustments arising from asset review	4,906	(28)	–	–	4,878
Disposals	(1,763)	(1,301)	–	(32)	(3,096)
At 31 March 2015	**18,382**	**27,130**	**295**	**1,820**	**47,627**
Amortisation					
At 1 April 2014	4,347	4,095	–	1,328	9,770
Transfers from NHS Direct	1,075	70	–	–	1,145
Reclassification	142	(88)	–	–	54
Provided during the last year	2,112	5,088	–	232	7,432
Adjustments arising from asset review	3,872	(8)	–	–	3,864
Disposals	(1,611)	(365)	–	(28)	(2,004)
At 31 March 2015	**9,937**	**8,792**	**–**	**1,532**	**20,261**
Net book value at 1 April 2014	5,705	6,266	15,370	524	27,865
Net book value at 31 March 2015	**8,445**	**18,338**	**295**	**288**	**27,366**

The gross cost of intangible assets that were fully amortised but still in use was £5,851,393.

Transfers from NHS Direct represents the assets transferred from NHS Direct on 1 April 2014 in relation to the telephony infrastructure and associated software that the HSCIC has the responsibility to manage. The transfer was accounted for using standard absorption accounting in accordance with the Department of Health group accounting policies set out in the NHS Manual for Accounts.

Adjustments arising from the asset review refers to the outcome of the full physical asset verification and reconciliation work between the respective asset registers held by Finance and the IT department. These adjustments include a mixture of changes to costs, software licences now capitalised previously not identified and changes to certain asset lives. Disposals include certain assets that were identified on the IT asset register as having been disposed of or decommissioned in previous financial periods or were not found through the physical verification exercise.

Development expenditure included the investment in the General Practice Extraction Service which collects general practice data for agreed specific purposes. The service commenced during 2014/15 and the asset value has been reclassified. A review was undertaken during the year and an impairment of £842,000 has been made. This impairment is included within disposals.

The value of own staff capitalised within intangible assets additions amounts to £1,573,000.

The total amortisation charged in the statement of comprehensive expenditure in respect of assets held under finance leases and hire purchase agreements was £nil.

All intangible assets are owned by the HSCIC.

8 Non-current assets – intangible assets

	Software licences £000	Information technology £000	Development expenditure £000	Websites £000	Total £000
Cost or valuation					
At 1 April 2013	–	–	–	–	–
Transfers from NHS IC	3,141	16,913	12,688	1,852	34,594
Transfers from CfH	–	3,389	–	–	3,389
Reclassification	2,981	(3,262)	(720)	–	(1,001)
Additions	2,158	3,686	2,453	–	8,297
Disposals	(174)	(9,236)	–	–	(9,410)
Assets previously disposed of by CfH reinstated	2,162	–	–	–	2,162
Accounting policy alignment	(216)	(1,129)	949	–	(396)
At 31 March 2014	**10,052**	**10,361**	**15,370**	**1,852**	**37,635**
Amortisation					
At 1 April 2013	–	–	–	–	–
Transfers from NHS IC	339	9,761	–	1,025	11,125
Transfers from CfH	–	2,185	–	–	2,185
Reclassification	1,263	(1,455)	–	–	(192)
Provided during the last year	780	2,747	–	303	3,830
Disposals	(169)	(8,699)	–	–	(8,868)
Assets previously disposed of by CfH reinstated	2,162	–	–	–	2,162
Accounting policy alignment	(28)	(444)	–	–	(472)
At 31 March 2014	**4,347**	**4,095**	**–**	**1,328**	**9,770**
Net book value at 1 April 2013	–	–	–	–	–
Net book value at 31 March 2014	**5,705**	**6,266**	**15,370**	**524**	**27,865**

Assets previously disposed of by CfH reinstated refers to certain fully amortised assets were not transferred by CfH as they had been disposed of in their financial records. However these assets are still in use and have been reinstated at cost and the equivalent value of amortisation.

Accounting policy alignment refers to amending the accounting treatment of assets transferred from former bodies to those policies adopted by the HSCIC. This includes certain expenditure that was formerly capitalised now being written to revenue and aligning the amortisation policy.

9 Other non-current assets

	31 March 2015 £000	31 March 2014 £000
Non-current deposits and advances	528	813

Non-current deposits and advances comprises deposits paid on rented properties. The deposits are treated in accordance with management expectations as to when the leases will end.

10 Trade receivables and other current assets

Amounts falling due within one year	31 March 2015 £000	31 March 2014 £000
Trade receivables	14,799	14,354
Prepayments and other receivables	3,655	4,415
Accrued income	6,607	6,733
	25,061	**25,502**

Intra-government balances

Intra-government balances within trade receivables and other current assets are as follows:	31 March 2015 £000	31 March 2014 £000
Department of Health and other central government bodies	11,628	11,539
NHS bodies	8,701	8,480
Local authorities	–	1
Other external bodies	4,732	5,482
	25,061	**25,502**

11 Cash and cash equivalents

	£000	£000
Balance at 1 April 2014	22,931	–
Net changes in cash and cash equivalents	(12,684)	22,931
Balance at 31 March 2015	**10,247**	**22,931**

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

12 Trade and other payables

Amounts payable within one year	31 March 2015 £000	31 March 2014 £000
Trade and other payables	5,816	4,518
Value added tax	251	1,324
Income tax, National Insurance and superannuation	4,955	4,546
Deferred income	1,638	959
Accruals	16,942	17,608
	29,602	**28,955**

Intra-government balances

Intra-government balances within trade payables and other current liabilities are as follows:	31 March 2015 £000	31 March 2014 £000
Department of Health and other central government bodies	8,307	6,593
NHS bodies	243	393
Local authorities	1,703	8
Other external bodies	19,349	21,961
	29,602	**28,955**

13 Provisions for liabilities and charges

	Injury Benefit £000	Dilapidations £000	Staff termination £000	Total £000
Balance at 1 April 2014	–	1,392	116	1,508
Arising during the year	255	507	15	777
Utilised during the year	–	(35)	(46)	(81)
Reversed unused	–	(127)	(13)	(140)
Balance at 31 March 2015	**255**	**1,737**	**72**	**2,064**
Expected timing of cash flows				
Within one year	41	78	57	176
Two to five years	34	1,260	15	1,309
Over five years	180	399	–	579

The injury benefit refers to an award where monthly payments are made to the individual via the NHS Pension Scheme.

The dilapidation provision refers to the anticipated costs for remedial works at the end of property leases and is based on an assessment made by an external property advisor and internal assessments using industry standard estimates for other properties.

Staff termination costs refer to the cost of employee voluntary and compulsory redundancies where monthly payments are made to the NHS Pension Scheme to top up future pension commitments.

14 Working capital movements

Receivables	2014/15 £000	2013/14 £000
Opening current trade and receivables	25,502	–
Opening non-current trade receivables	813	–
Opening trade and other receivables	**26,315**	**–**
Balances transferred from NHS IC	–	4,629
Balances transferred from CfH	–	4,420
Balances transferred from SHAs/PCTs	–	984
Balances transferred to HSCIC	**–**	**10,033**
Adjustments to opening non-current trade and other receivables not passing through operating expenditure in the SoCNE, in respect of lease deposits	–	234
Adjustments to opening current trade and other receivables not passing through operating expenditure in the SoCNE, in respect of non-current assets reclassified as revenue expenditure	–	1,344
Adjusted trade and other receivables for working capital movement	**26,315**	**11,611**
Closing current trade and other receivables	25,061	25,502
Closing non-current trade and other receivables	528	813
Closing trade and other receivables	**25,589**	**26,315**
Cash received by the Department of Health on behalf of HSCIC in respect of balances transferred from SHAs/PCTs	–	76
(Decrease)/increase in trade and other receivables	**(726)**	**14,780**

Payables	£000	£000
Opening balance	**28,955**	**–**
Balances transferred from NHS IC	–	13,109
Balances transferred from CfH	–	15,565
Balances transferred from SHAs/PCTs	–	3,295
Total trade and other payables balances transferred to HSCIC	**–**	**31,969**
Adjustments to opening current trade and other payables not passing through operating expenditure in the SoCNE, in respect of creation of opening holiday pay accrual for CfH staff.	–	1,241
Adjusted trade and other payables for working capital movement	**28,955**	**33,210**
Closing current trade and other payables	29,602	28,955
Payments of balances transferred from SHAs/PCTs made on behalf of HSCIC by the Department of Health	–	2,360
Movement in capital payables	541	1,024
	30,143	**32,339**
Increase/(decrease) in trade and other payables	**1,188**	**(871)**

15 Transfers from other bodies

	Transfers under absorption accounting taken through the SoCNE 2014/15	Transfers under absorption accounting taken through the SoCNE 2013/14	Transfers under modified absorption accounting taken through the SoCTE 2013/14	
	From NHS Direct £000	From CfH £000	NHS IC £000	From SHAs/PCTs £000
Property plant and equipment	465	10,644	2,726	–
Intangible assets	781	1,204	23,469	–
Trade and other receivables	–	4,420	4,629	984
Cash and cash equivalents	–	15,724	–	–
Trade and other payables	–	(15,565)	(13,109)	(3,295)
Provisions	–	–	(1,218)	–
Net assets / (liabilities) transferred	**1,246**	**16,427**	**16,497**	**(2,311)**

16 Capital commitments

Capital commitments amount to £676,141 (2013/14 £950,000) and relate to ordered IT equipment, software and office furniture.

17 Commitments under operating leases

Expenditure includes the following in respect of operating leases	2014/15 £000	2013/14 £000
Accommodation	9,292	9,524
Other operating leases	58	78
	9,350	**9,602**
At the balance sheet date non-cancellable operating lease commitments were:		
Land & buildings		
Not later than one year	6,249	8,662
Between one and five years	8,377	4,566
Later than five years	647	–
	15,273	**13,228**
Other leases		
Not later than one year	65	21
Between one and five years	99	11
Later than five years	–	–
	164	**32**
Total	**15,437**	**13,260**

18 Other financial commitments

The HSCIC has not entered into any non-cancellable contracts (which are not operating leases) for the provision of services as at 31 March 2015 (31 March 2014 £NIL).

19 Contingent assets and liabilities

Contingent liabilities amount to £156,435 as at 31 March 2015 (31 March 2014 £NIL) and relate to potential legal claims and supplier charges.

20 Losses and special payments

There were 310 losses and special payments in 2014/15 amounting to £3,248,300 (2013/14 £21,608).

Losses and special payments include:

- an impairment amounting to £842,000 for the GPES asset relating to the external cost of specifying and developing software that was never brought in to live service,
- additional costs incurred to bring GPES into operational readiness of £1,928,316 which includes £500,000 of expenditure that was accrued in 2013/14,
- the write off of expenditure with respect to the abandonment of a project for the development of an indicator portal of £304,095,
- bad debts written off and IT equipment and mobile phones, not identified following full asset stocktake,
- Interest paid under the Late Payment of Commercial Debt (Interest) Act 1998 amounted to £44.

21 Related parties

The HSCIC is an executive non-departmental public body (ENDPB) created by The Health and Social Care Act 2012. It is sponsored by the Department of Health, and the Department is therefore regarded as a related party.

During the year the HSCIC had a number of material transactions with the Department of Health, and with other entities for which the Department of Health is regarded as the parent Department. Transactions with these organisations include the provision of software enhancements, programme management, system maintenance and support, and training courses.

Listed below are the amounts transacted with each type of related party.

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

	Amounts payable at 31 March 2015 £000	Amounts receivable at 31 March 2015 £000	Income in 2014/15 £000	Expenditure in 2014/15 £000
Department of Health	2,289	9,674	19,385	2,312
Public Health England	3	1,720	5,421	24
Health Education England	–	30	30	–
NHS England	300	8,490	24,096	322
Non-Departmental Public Bodies	–	17	14	–
NHS Trusts	51	85	314	151
NHS Foundation Trusts	192	126	706	655
Other DH group bodies	29	–	–	228
Other central government bodies	5,688	187	830	25,050
Local authorities	1,703	–	112	1,685

22 Financial instruments

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

a. Market risk

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

b. Credit risk

Credit risk arises from invoices raised to customers for services provided, or monies received to cover programme activities. Most high value receivables relate to balances with the Department of Health, NHS England and other related bodies against purchase orders and thus do not represent a significant credit risk. HSCIC had a comparatively small value of external receivables and therefore disclosure of the largest individual debt balances were not considered in the evaluation of overall credit risk.

Movement in the allowance for doubtful debts

	2014/15 £000	2013/14 £000
Balance at 1 April	270	–
Transfers from NHS IC	–	16
Transfers from CfH	–	87
Provided for in year	4	186
Reversed unutilised	(219)	–
Amounts written off during the year as uncollectible	(46)	(19)
Balance at 31 March	**9**	**270**

The provision for doubtful debts is assessed on an individual debt basis. The expense in the year relating to related parties amounts to £2,677.

The table below shows the ageing analysis of trade amounts receivable at the reporting date:

	Current £000	Less than 30 days overdue £000	31-60 days overdue £000	61 and over days overdue £000	Total £000
Balance at 31 March 2015	**7,346**	**6,701**	**494**	**258**	**14,799**
Balance at 31 March 2014	10,114	3,558	120	562	14,354

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

c. Liquidity risk

Management manage liquidity risk through regular cash flow forecasting. HSCIC had no external borrowings and relies on grant-in-aid from the Department of Health for its cash requirements and was therefore not significantly exposed to liquidity risks.

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

	31 March 2015 £000	31 March 2014 £000
Current liabilities	29,602	28,955

23 Events after the reporting period ended

In accordance with IAS 10, events after the reporting period are considered up to the date on which the accounts are authorised for issue.

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

24 Authorised date for issue

The HSCIC's Annual Report and Accounts are laid before Parliament by the HSCIC. IAS10 requires the HSCIC to disclose the date on which the Annual Report and Accounts are authorised for issue.

The Accounting Officer authorised these financial statements for issue on 7 July 2015.

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