Health and Social Care Information Centre Annual Report and Accounts 2015/16

Presented to Parliament pursuant to Paragraphs 12 (2) (a) of the Health and Social Care Act 2012.

Ordered by the House of Commons to be printed on 21 July 2016.

HC392

This publication is available at
https://www.gov.uk/government/publications

Print ISBN 9781474134477

Web ISBN 9781474134484

ID 2905369 07/16

Printed on paper containing 75% recycled fibre content minimum

Printed in the UK by the Williams Lea Group on behalf of the Controller of Her Majesty's Stationery Office

Front cover photographs

Top left: Dr Bernhard Usselmann, Consultant Gastroenterologist at the South Warwickshire NHS Foundation Trust

Top right: Dina Ibrahim Abdelmottaleb, Research visitor (left) and Marilena Elpidorou, PhD student at the University of Leeds, St. James's University Hospital, LIBACS

Bottom left: Michala Liavaag (IT Security Manager) of the Sussex Partnership NHS Foundation Trust

Bottom right: John Parish, Pharmacist Manager (left) and Mandy Roy, Dispensing Technician (right) at Lo's Pharmacy, Chapeltown, Sheffield

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Foreword from the Chief Executive

At the HSCIC, our vision is to harness the power of information and technology to make health and care better.

Everything we do – from maintaining the essential information and technology infrastructure upon which health and care professionals depend, to gathering and disseminating the information needed to improve care quality and find new ways to prevent and treat disease – is about improving the health and well-being of citizens.

I'm pleased to report that 2015/16 was a year of successful delivery for the HSCIC:

We demonstrated, by completing the insourcing of NHS Spine services, that we can efficiently and reliably maintain the safe exchange of health and care information through core IT infrastructure. This delivered a £20.5 million saving in annual running costs for the health service in 2015/16, with 100 per cent service availability.

The insourcing of the Secondary Uses Service not only produced a £6.8 million saving in running costs in 2015/16 but a much better service. Where the old contract had only provided annual tariff releases – the lifeblood of financial tracking and planning in the NHS – we published two releases in 2015/16, a new portal and a tariff projection. This will assist with better financial planning across the sector.

We also launched the NHS e-Referral Service as a replacement for the 'Choose and Book' system, offering patients an improved platform for choosing the date, time and venue for their first outpatient appointments. After initial disruption during transition, the service has stabilised and is handing about 40,000 patient referrals a day. This is improving care and reducing waste – evidence shows that patients are more likely to attend appointments when they have booked electronically.

We increased the coverage of Summary Care Records to over 96 per cent of citizens, so that patients can be treated quickly and efficiently across all health and care settings, and extended the Electronic Prescription Service to 75 per cent of GP practices, giving patients the power to choose when and where they collect their medicines.

Where we saw the opportunity to add value, we acted to improve services. Our improved prescription tracker, for example, allows GPs and pharmacists using the Electronic Prescription Service to find prescriptions, providing a quicker and safer service for patients. Our pilot of ambulance access to the Summary Care Record with South Central Ambulance Service put vital information at the fingertips of paramedics in emergency situations. We will be rolling out the service to more trusts this year.

We introduced enhanced and robust datasets on important and controversial issues such as female genital mutilation, dementia diagnoses in GP practices, maternity and children's care, adult and childhood mental health and new indicators on seven-day services – all published as part of our catalogue of more than 290 reports of official and national statistics.

Our vision is to harness the power of information and technology to make health and care better

We demonstrated, too, that we act decisively when we need to do better. We responded to the challenges identified in Sir Nick Partridge's 2014 Review of Data Releases to ensure that we protect the information we gather, and we worked hard over the last year to get this vital information flowing. In the second half of 2015/16, we saw a near doubling in the throughput of successful applications to our Data Access Review Service. Our protections of personal data are now more rigorous, but researchers requesting information have more support in getting legitimate applications approved and getting the data moving quickly.

Our new DARS online portal will enable our users to view and review existing applications transparently; track the status of applications; and sign data sharing agreements online – removing the need for extensive paper trails and providing improved auditing and governance.

As we move into 2016/17, we do so with a renewed purpose. We have worked with our national partners at the Department of Health and NHS England to translate the National Information Board strategy into the concrete delivery priorities that will drive the health, care and efficiency improvements that are at the heart of the Paperless 2020 agenda. In the past year, we moved from planning this revolution to making it happen, and we are in good shape to continue the momentum.

In 2016/17, we will complete our organisational transformation; one undertaken to make the HSCIC more customer-focused, to create a skilled, agile and flexible workforce and to deliver greater value for money for taxpayers.

We will do so with a new name – NHS Digital – and a new strapline: 'Information and technology for better health and care'. The NHS name is recognised and trusted by the public, clinicians and system leaders and will help us make the case for, and describe the health and social care benefits of, digital transformation. Although we will use the NHS name, we are committed to extending the remit of our technology services to include local health economies so that we can provide genuinely integrated care models. And we will do so under a new chairman, Noel Gordon, who takes on the role filled so ably by Kingsley Manning for the past three years.

I'm confident that our team has the clarity of purpose, capability and commitment to help bring about a revolution in the provision of health and social care information and technology. Our goal is to help clinicians spend more time with patients, help commissioners direct resources to the places they are needed most and help citizens take more control of their own health and well-being.

I'm truly proud of what the HSCIC achieved in 2015/16 and I want to congratulate and thank our staff for their efforts during the past year. I'm looking forward to an even better 2016/17 as NHS Digital.

Andy Williams
Chief Executive

Who we are

The Health and Social Care Information Centre (HSCIC) is the national information, data and IT system provider to the health and care system. We employ more than 2,700 people and provide services to the value of £225million. Our role is to improve health and social care in England by putting technology and information to work in the interests of citizens.

We build and manage the technology infrastructure, digital systems, services and standards that health and care professionals depend on to deliver good care. We gather and disseminate data that is used by researchers to discover new treatments and we generate information that helps providers and commissioners improve care quality.

We have a statutory duty to ensure that the information we hold in trust for the public is always kept safe, secure and private.

Our vision

We aim to bring about a digital revolution in health and care. The exploitation of 21st century technology, the use of increasing quantities of data and the impact of richer information flows has the potential to fundamentally change how citizens look after themselves and how health and social care professionals do their work. We are working with our partners to transform the quality of services and help secure a financially sustainable future for the universal system of health and care.

Our statutory duties

Manage the collection, storage, processing and publication of national health and care information, as directed by the Secretary of State and NHS England.

Deliver the national technology and infrastructure services that underpin the delivery of care services.

Manage the development and delivery of information standards products and services needed to support the health and care services, and the commitments of the National Information Board.

Fulfil our data quality assurance responsibilities by expanding the services we provide to support improvements in data quality and publishing our annual data quality report.

Act as the national source of indicators used to measure the quality of health and care services.

Provide advice and support to health and care organisations on information and cyber security, burden management, standards, technology adoption and information governance.

Develop the Information Governance Toolkit to support greater self-assessment for integrated services.

Strengthen our efforts on the system-wide management of administrative burden and provide the Secretary of State with our assessment of the opportunities for reducing its impact on the front line.

A strategy to transform the health and care system

By 2020, all citizens who want it will have access to national and local data and technology services that will enable them to manage their own records, undertake a wide range of transactions with care providers, and play a transformed role in looking after their own health, care and well-being. At the same time, the health and social care system faces major challenges, with constraints on resources, rising expectations and escalating demand for services all placing strain on current models of care. Our strategy, published in 2015, sets out our view on how the better use of technology, data and information can greatly increase efficiency while helping the system deliver better care and a better patient experience.

We have five strategic objectives. In 2015/16, we made significant progress on all of these and have set out commitments for 2016/17 to continue the momentum.

Our objectives

Ensuring that every citizen's data is protected

Establishing shared architecture and standards so everyone benefits

Implementing national services to meet national and local needs

Supporting health and care organisations to get the best out of technology, data and information

Making better use of health and care information

Ensuring that every citizen's data is protected

The protection of personal data is critical to building and sustaining public trust in the innovative use of data in health and social care.

The HSCIC is committed to ensuring that citizens can have complete confidence that all data in the health and social care system is kept securely and shared only when appropriate and for their benefit. Citizens must be able to state their preferences about the sharing of their personal data for purposes other than their direct care and see that those preferences are implemented.

The Care Identity Service (CIS)

125,000 logins are processed by CIS between 8am and 9am every weekday morning

The CIS ensures only authenticated healthcare staff with a legitimate reason can access systems and patient information held on the NHS Spine. A smartcard and passcode give a worker access to the network at the level necessary to perform their role.

What we did in 2015/16:

- Strengthened oversight of the dissemination of personal data in line with the recommendations of Sir Nick Partridge's Review of Data Releases in 2014. We integrated and expanded the capacity of our scrutiny process so that all applications for data are promptly and rigorously examined.
- Audited 25 organisations' compliance with the terms of their data sharing agreements with the HSCIC. The organisations had to demonstrate that data is stored securely, is only used for the purpose set out in their agreement, and is then destroyed. We also checked that staff understood information governance rules.
- Supported the Care Quality Commission's (CQC) review of current approaches to data security in the NHS and National Data Guardian Dame Fiona Caldicott's work to develop new data security standards, a method of compliance against these and a new model of consent and opt-outs.
- Accepted the Secretary of State for Health's request to take a lead role on cyber security for the health and care system. We established the Care Computer Emergency Response Team (CareCERT) to act as the central source of cyber security intelligence and incident management for the NHS and other health and care organisations. The team identifies new threats, issues national-level alerts and guidance, and acts as a trusted source of advice and best practice for the sector. During 2015/16, HSCIC teams also supported local organisations' response to specific cyber security threats.
- Began work with NHS England and other government partners to develop the secure identity verification systems that will allow all citizens to access electronic patient records and interact with care services online by 2020.

Our commitments for 2016/17:

- Implement a national service that allows citizens to state their preferences about the sharing of their personal data for purposes other than their direct care and that ensures those preferences are implemented. This work will respond to, and be shaped by, the recommendations of National Data Guardian Dame Fiona Caldicott's work on the new model of consent and opt-outs.
- Strengthen leadership on information governance across the health and care sector through the Information Governance Alliance, which brings together the HSCIC, the Department of Health, NHS England and Public Health England.
- Upgrade the Information Governance Toolkit to reflect new requirements from the National Data Guardian and CQC reviews on data security, consent and opt-outs. The toolkit gives health and social care organisations a 'one-stop shop' for all of the information governance requirements they must meet. We will also develop the Information Governance Training Tool to reflect the outcome of the reviews and help health and care staff understand their roles.
- Establish a new group to scrutinise data dissemination applications – the Independent Group Advising on the Release of Data (IGARD) – which will increase transparency under an independent chair, in line with the recommendations of a public consultation held in 2015.

Ensuring that every citizen's data is protected

Michala Liavaag (IT Security Manager) of the Sussex Partnership NHS Foundation Trust

Michala attended the HSCIC's pilot cyber security training programme in December and earned the (ISC)2 Health Care Information Security and Privacy Practitioner (HCISPP) accreditation. The programme is aimed at developing 'cyber champions' in local health and care organisations to ensure patient data is kept secure.

'I am already a qualified information security manager, but the training not only focuses you on the particular challenges for healthcare but brings together professionals working in this area from across the sector. It gives you a much stronger network of peer support,' says Michala.

She has also been using the HSCIC's CareCERT service since early 2016 to help in the daunting task of monitoring and prioritising security threats.

'There are a huge number of sources of information on threats and vulnerabilities which may represent a risk to patient information and you have limited resources to digest, prioritise and remediate these', Michala says. 'CareCERT does a significant amount of that work for you, not only providing risk-assessed alerts on urgent threats but also giving us a central source of guidance.'

Establishing shared architecture and standards so everyone benefits

We need a common information and technology architecture built on shared standards across health and social care. This will allow data to flow efficiently and securely between settings and is vital to unlocking the enormous potential of integrated, digitally-enabled services. It will ensure that clinicians and carers have the information they need, when they need it and in the right formats. It is necessary to meeting our commitment to enabling citizens to see their records and take part in the management of their own care.

The HSCIC has a key role in developing and using shared standards, and we are committed to promoting their adoption across health and care.

Child Protection – Information Sharing (CP-IS)

28,054 vulnerable and 'at risk' children are already flagged via the system.

CP-IS is national service that securely shares a restricted set of child protection information between children's social care and NHS settings where patients make unplanned visits (eg. urgent GP appointments).

What we did in 2015/16:

- Supported the adoption of SNOMED CT, a terminology for recording medical terms that will remove the obstacles to information flow created by different settings using different terms and codes. The HSCIC announced the withdrawal of two legacy terminology products in April 2016 in line with a National Information Board (NIB) commitment to drive the adoption of SNOMED CT across the sector by 2020. We are supporting suppliers and end users in this change.
- Supported shared standards for the transfer of care across care settings and organisations. As the NHS moved to an all-electronic hospital discharge system from October 2015, we worked with the Academy of Royal Medical Colleges' Professional Record Standards Body (PRSB) to create standards specifications for discharge summaries (the records sent to GPs when patients are discharged from hospital) that standardise content and structure and allow coded information to be sent directly to GP systems.
- Developed and assured 78 new information standards, collections and extractions. Following the transfer of the Standardisation Committee for Care Information (SCCI) secretariat to HSCIC from NHS England in April 2015, we have introduced a new process that allows experts to collaborate on the design and development of new standards and ensures all new information standards are dealt with consistently.
- Implemented the standards and technical enablers to support NHS England's roll out of Child Protection-Information Sharing (CP-IS) to local authorities. The system alerts social workers to emergency department visits by children on child protection plans and informs hospital staff when they are dealing with these vulnerable children.
- Worked through the Information Governance Alliance to help local initiatives, such as the Integration Pioneer and Vanguard programmes, develop effective information governance solutions to ensure secure data sharing.
- Hosted the World Health Organisation – Family of International Classifications (WHO-FIC) Network Annual Meeting 2015 in October, which attracted 295 experts in health classifications and coding development from more than 25 countries, including Australia, China, Germany, the United States and Brazil. The HSCIC is the UK WHO-FIC Collaborating Centre.

Our commitments for 2016/17:

- Continue the roll out of SNOMED CT into primary care to ensure that all primary care systems fully adopt it as the main clinical terminology by the end of March 2018.
- Pilot and prepare UK field trials of the next revision of the WHO International Classification of Diseases (ICD-11) to reflect progress in health science and medical practice. ICD-11 will be an international classification for use across electronic health applications and information systems.
- Continue the delivery of the Health and Social Care Network (HSCN) and work toward the closure of the existing N3 national broadband network for NHS organisations. The HSCN network will include both health and social care, support the data flows required by new models of care and provide secure mobile access capabilities.
- Support care providers to make wireless access (WiFi) available to service users and staff. The NHS WiFi programme will, subject to investment approval, work collaboratively with care providers and industry to agree standards and provide practical support to organisations implementing WiFi.
- Improve structured information exchange between health and social care systems following the successful London Adapter pilot, through the development of nationally available services and products that can be customised to local needs.
- Evaluate alternative systems for collecting information from GP clinical systems in England to replace the existing General Practice Extraction Service (GPES).

Establishing shared architecture and standards so everyone benefits

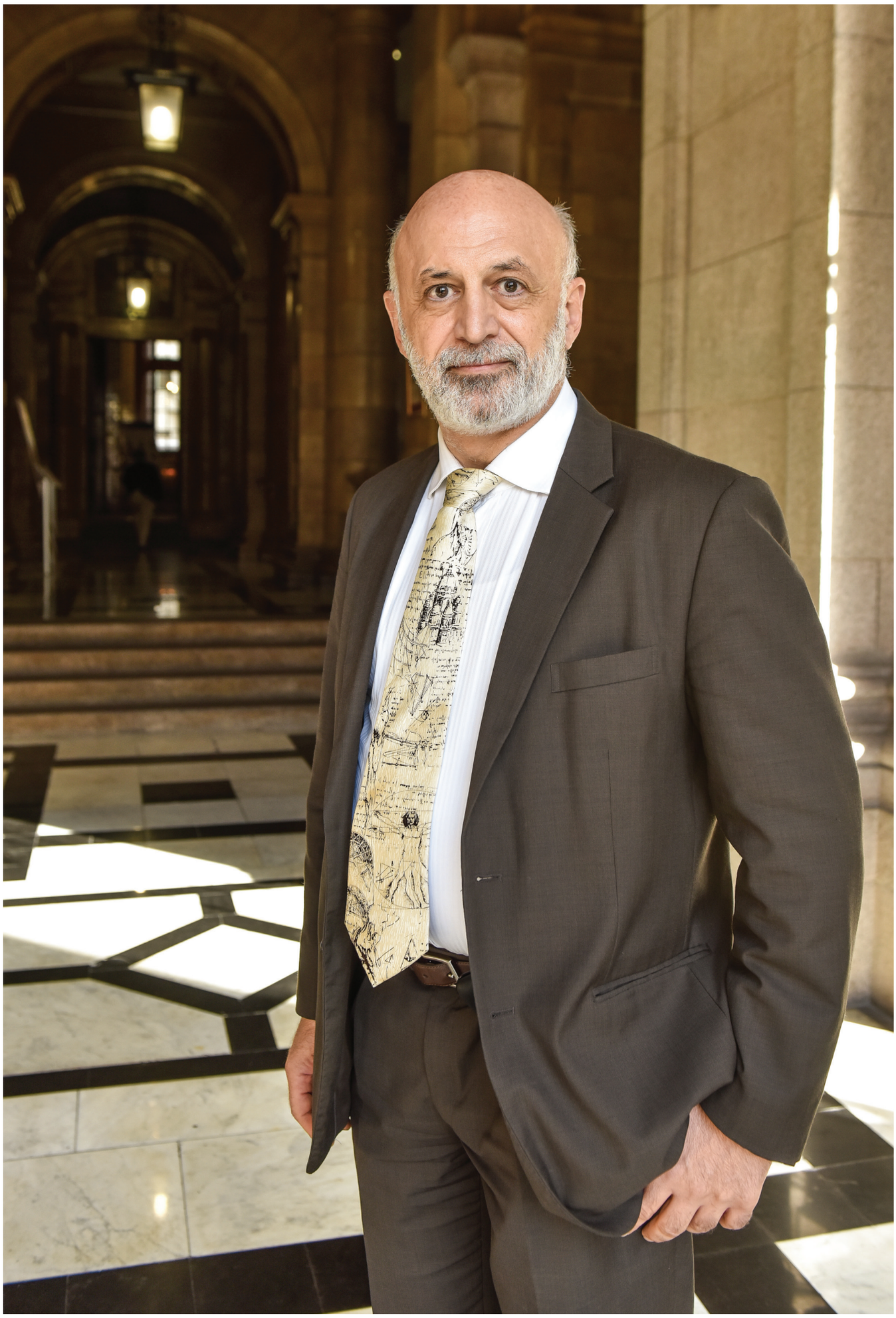
The World Health Organisation – Family of International Classifications (WHO-FIC) Network Annual Meeting, October 2015

Experts in health classifications and coding from 25 countries attended the conference hosted by the HSCIC in October.

WHO-FIC is driving the international standardisation of health classifications – a crucial step in pulling together useful healthcare information across linguistic, political and organisational boundaries.

The HSCIC is the UK's WHO-FIC Collaborating Centre, leading the development and implementation of WHO-FIC classifications and working with users in the UK to improve them.

Dr Bedirhan Üstün, (pictured opposite) Coordinator of Classifications, Terminologies and Standards at the WHO, said: 'I have been doing these meetings since 1998 and this was the best local team I ever worked with. We are extremely pleased that the UK now has a collaborating centre and feel that it is very important for the WHO network. The HSCIC's experience and expertise in technology and digitisation of healthcare will be invaluable to us.'



Implementing national services to meet national and local needs

We deliver a wide variety of technologies that are critical to the day-to-day operation of the NHS, ranging from the NHSmail secure email platform to the systems that underpin electronic patient record access, appointments and prescriptions. We power vital services such as the NHS Choices website and the 111 non-emergency inquiry line. Running 24/7, these programmes handle millions of interactions every day for patients and clinicians across the NHS.

We are working to integrate the health and social care sector's systems into a single, seamless service that will give patients full access to their own records and professionals the information they need to improve care.

Secondary Uses Service

SUS enables the payment of £30 billion worth of NHS services every year, with £217 billion processed to date.

The Secondary Uses Service (SUS) is the single, comprehensive repository of healthcare data for hospital services in England. It collects healthcare activity locally and nationally and provides clinicians, researchers and commissioners with one of the world's richest sources of health and care data.

What we did in 2015/16:

- Saved £20.5 million in annual operational costs and achieved 100 per cent service availability in the first year since the insourcing of the core NHS Spine services. In February 2016, the Data Transfer Service (DTS), a messaging service used throughout the NHS to send and receive secure electronic communication, became the final service under the old BT Spine contract to be successfully transitioned. The new Messaging Exchange for Social Care and Health (MESH) has now taken on DTS's functions and handles 18 million messages a month for more than 8,000 organisations.
- Improved the Secondary Uses Service (SUS), the comprehensive repository for healthcare data in England, after it was insourced in February 2015. Under the previous external contract, the SUS tariff releases that form the basis of financial tracking and planning within the NHS were updated annually. In 2015/16, we delivered two tariff updates, a tariff projection to help NHS users plan for future changes, and a new portal for SUS users. Running costs fell by £6.8 million from the previous year.
- Replaced the Central Health Register Inquiry System (CHRIS), the system used to send registration information between GP practices when patients move areas. The new Spine-based service is considerably faster and reduces management, support and maintenance costs.
- Created the new National Pandemic Flu Service, a cloud-hosted online application for use in a flu pandemic, in partnership with Public Health England and the Department of Health. The portal would allow citizens to get access to appropriate treatment if an outbreak strained the capacity of primary care services.
- Improved Spine-hosted patient records to support the Department of Health's initiative to recover costs from visitors and migrants using NHS services.
- Extended the coverage of Summary Care Records (SCRs) to more than 96 per cent of the population and began the rollout of the programme among community pharmacies.
- Launched the NHS e-Referral system (NHS e-RS), a secure and reliable method of booking a first outpatient appointment that allows patients to choose the date and time of their visit. The service replaced the 'Choose and Book' process in June 2015 and provides a much improved platform for integration with other services and new technologies. It now handles more than 40,000 GP referrals per day.
- Exceeded the target for the number of prescriptions by the Electronic Prescription Service (EPS), with more than 500 million items dispensed electronically so far. Extended the coverage of the service to 75 per cent of all GP practices.
- Completed procurement of a clinical IT system for the new Health and Justice Information Service (HJIS), which is supporting NHS England to deliver integrated information and technology systems for primary care in prisons, young offender institutes, secure training centres, secure children's homes and immigration removal centres. The HSCIC also led the extension of the existing Offender Health IT service into a wider range of settings.
- Achieved ISO 27001 and ISO 20000 international certification for our Systems and Service Delivery (SSD) group, which provides end-to-end service delivery for about 50 nationally deployed services. The accreditations demonstrate international best practice in IT service and security management. Our Customer Service Contact Centre also earned the Cabinet Office's Customer Service Excellence accreditation (see p 31).

Our commitments for 2016/17:

- Continue to extend access to the Summary Care Record to community pharmacies in England and establish pilots in new settings such as scheduled care and care homes.
- Extend the use of the Electronic Prescription Service across general practice and community pharmacies.
- Upgrade NHSmail, the secure email service used across health and care, to offer greater flexibility and improved collaboration tools.
- Deliver the replacement breast screening cohort service to the National Cancer Screening Programme.
- Deliver a replacement Directory of Services (DoS) database in support of the NHS Pathways service and NHS 111 Programme.
- Provide support to NHS England to deliver the necessary data and user migration to support the Primary Care Services programme.
- Begin work on behalf of the National Cancer Screening Programme to integrate the new Faecal Immunochemical Test (FiT) for colorectal cancer in the existing Bowel Cancer Screening Service.

Implementing national services to meet national and local needs

Mandy Roy, Dispensing Technician (below), and John Parish, Pharmacist Manager (right) at Lo's Pharmacy, Chapeltown, Sheffield

John was one of the first community pharmacists to get access to our Summary Care Record (SCR) service, which gives authorised healthcare staff secure access to key information from a patient's GP record. In 2016/17, the service will be rolled out to pharmacies across the country.

'It saves a lot of time. Previously, I would have to call a GP surgery to check a patient's medication and that could take up to 20 minutes. Viewing SCRs is instant and shows the exact medications that a patient is taking and the exact dosages,' he says.

'For instance, I recently had a customer who was on holiday and needed an emergency supply of his medication. By viewing his SCR, I could instantly see what he needed. Another elderly customer couldn't remember which of two different inhalers he needed. I could quickly see one had been discontinued and got him the right one.'

John started using SCRs in early February 2016, after completing e-learning and face-to-face training.

'Using SCRs is quick, removes potential errors in prescribing incorrect dosages and customers like it because it cuts waiting times,' he says.


PHARMACY MANAGER
Summary Care Record
Tips on finding a patient using Basic search
Need more help?
Help with this screen
Tell me more about se
More about privacy alerts

Supporting health and care organisations to get the best out of technology, data and information

The HSCIC works with health and care organisations to make sure they get the most out of their existing technology and information services. We also play a key role in identifying the new technologies that can transform the way organisations work and in joining up local systems to maximise efficiency and impact.

We are committed to supporting a vibrant and diverse supplier market for software and technology and to building the information and technology skills in the sector necessary to make the most of new possibilities.

National Provider Support programmes

In London the HSCIC has stored and migrated the largest volume of patient data in Europe, approximately 1.3 Petabytes (that is 2.4 billion X-rays/scans)

The HSCIC manages the delivery and support of electronic patient record systems and services to GPs, hospitals and other NHS care providers in England through our Local Service Provider programmes.

What we did in 2015/16:

- Completed the transition of 56 trusts in London and the South from the BT Local Service Provider (BT LSP) contract to locally contracted service providers. Our teams worked closely with trusts and suppliers to complete a safe and secure transition by November 2015. We also maximised benefits from the CSC contract, including successfully deploying electronic patient record systems into four new trusts.
- Developed proposals to support the implementation of Lord Carter's recommendations on efficiency in hospitals and worked with NHS England and NHS Improvement to take them forward.
- Improved links with local Chief Information Officers, Chief Clinical Information Officers and suppliers through our sponsorship of the Digital Leaders' Programme. We used events, webinars and online networks to explain HSCIC programmes and discuss their future development with these key stakeholders. This culminated in an open day in Leeds in February 2016 that was attended by more than 150 digital leaders from local organisations. This was followed by a Digital Leadership Summit later in the month.
- Piloted a new 'proof of concept' iPad app called Oxygen (see p 25), which gives authorised clinicians secure mobile access to key patient data held on the NHS Spine. We will look to make the underlying technology available to the wider supplier market, so they can utilise it in their own products.
- Enabled third party suppliers to securely connect to GP clinical IT systems, as part of the GP Systems of Choice (GPSoC) framework, and delivered the functionality to allow patients online access to their detailed clinical records.

Our commitments for 2016/17:

- Manage the transition and closure of the remaining Local Service Provider contracts.
- Work with partners to develop a new contractual vehicle for the supply and development of GP clinical IT systems for all practices in England, to replace the existing GPSoC framework.
- Continue to strengthen support from all of the HSCIC's portfolios for local authorities and social care services, including signing collaboration agreements with a small number of the most advanced local authorities.
- Continue to support the network of Chief Information Officers and Chief Clinical Information Officers and engage with these key partners on the development and delivery of the National Information Board programmes of work.
- Work with NHS Improvement and NHS England to deliver an expert support service to drive implementation of the Local Digital Roadmaps, which complement Sustainability and Transformation Plans by setting out how local health and care systems plan to achieve paperless services at the point of care by 2020.
- Drive improvements in data through further development of the Data Quality Maturity Index, which provides data submitters with timely and transparent information about their data quality.

Supporting health and care organisations to get the best out of technology, data and information

Open Day with the HSCIC, 2 February 2016

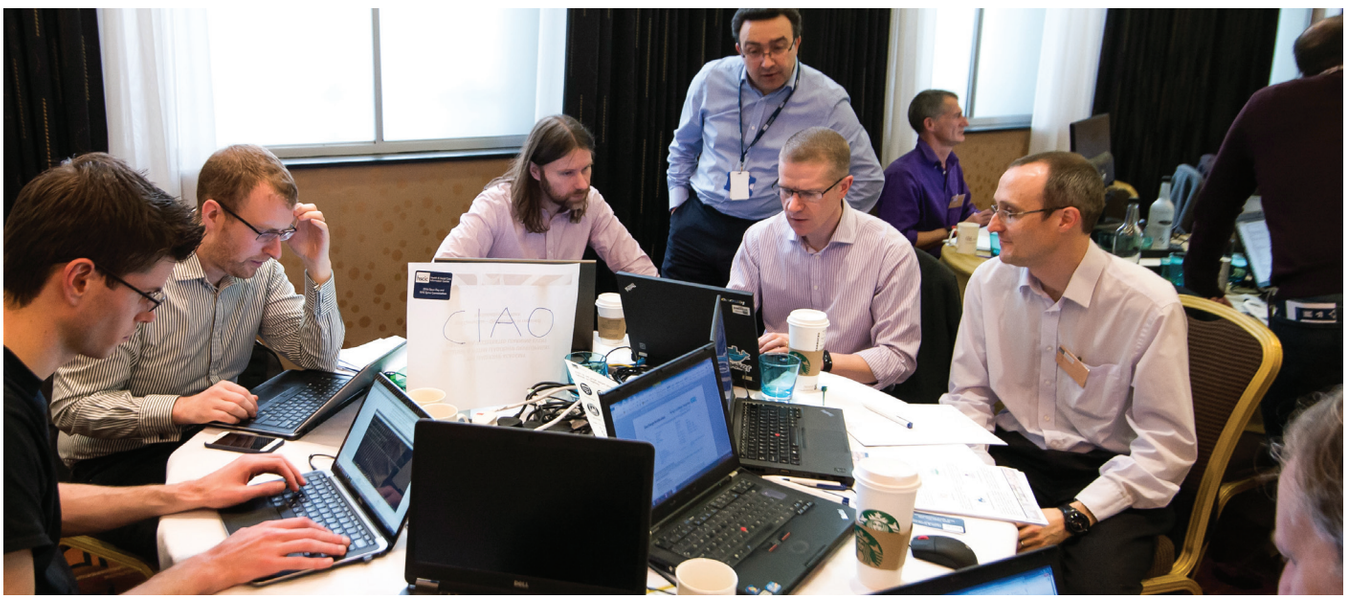
Digital leaders from across the country gathered in Leeds for our first ever open day.

The event was the culmination of the HSCIC's Digital Leaders Programme, which used online communities and webinars to develop stronger links with Chief Clinical Information Officers (CCIOs) and Chief Information Officers (CIOs).

More than 150 CCIOs and CIOs attending the open day had a choice of 20 breakout sessions, a 'market place' of stands about HSCIC programmes and two question and answer sessions with invited panellists and HSCIC leaders.

A 'connectathon' gave developers the chance to work with the HSCIC Spine Team and a demonstration version of the NHS Spine to test new applications.

GP and healthcare IT adviser Dr Marcus Baw (pictured below left), who supervised the connectathon, said: 'An event like this is a great way of saying "come and talk to us". We've got something we've never had before – an opportunity for the heads of programmes to talk directly to the CCIO at every acute trust in the country.'



Dr Bernhard Usselmann (Consultant Gastroenterologist) at the South Warwickshire NHS Foundation Trust

Dr Usselmann was one of 50 clinicians across England who took part in the pilot of our proof-of-concept iPad app Oxygen, which gave authorised clinicians secure mobile access to key data held on the NHS Spine.

'In my role, I am frequently seeing patients in different locations around the hospital. The ability to access Summary Care Records from my mobile device, without the use of a smartcard, did save me time. It allowed me to review medication at the patient's bedside, and to cross-check this information with the patient face-to-face, leading to more appropriate prescriptions and better patient understanding of their treatment,' he says.

The HSCIC is now working to make the underlying technology developed in Oxygen available to the wider supplier market so it can be included in new products.

Making better use of health and care information

The HSCIC manages many of the nation's most important health and care data assets – information that is critical to developing new treatments, monitoring the safety and effectiveness of care providers, and commissioning better services.

We are committed to developing data sets that deepen our understanding of health and care, and to making information available in new ways that can inform changes in treatment, management and individual behaviour –w while always ensuring that citizens' data is kept safe, secure and private.

NHS Choices

69 per cent of traffic on NHS Choices comes from mobile devices

NHS Choices is the online 'front door' to the NHS, providing health advice, information about local services and the latest health news.

What we did in 2015/16:

- Improved our system for handling applications to access data. Following difficulties in our data dissemination process in the wake of Sir Nick Partridge's review in 2014, we have transformed our Data Access Release Service (DARS). The turnaround time for dealing with data requests has reduced, we are engaging more directly with our customers, and our customer feedback from researchers is improving.
- Introduced a new online data dissemination request and triage service – DARS Online – in March 2016, which is designed to enhance and streamline the application process.
- Published more than 290 reports of official or national statistics.
- Introduced an enhanced data set for female genital mutilation and published the first report as experimental statistics in September 2015.
- Created a suite of indicators on seven-day services, which provides information on the days patients are discharged and on emergency readmissions. The indicators were published as experimental statistics in September 2015.
- Improved the data collected from GP practices about dementia diagnoses. New information about the age and gender of patients paints a more accurate picture of variations in dementia diagnoses across England. Publications are now more timely, reflecting data extracted two weeks before.
- Began collecting new, consolidated maternity and children's data sets to support service improvements for pregnant women, new-borns and young children. The first maternity report was published as experimental statistics in November 2015.
- Improved information on mental health through the new Mental Health Services Data Set (MHSDS) and published the first report in January 2016. This includes data on people using learning disability services and children and young people using mental health services.
- Collaborated with the Chief Medical Officer to support studies on resistance to antibiotics. We are active on the English Surveillance Programme for Antimicrobial Utilisation and Resistance and contributed to its report, which was published in November 2015.
- Improved the resilience and performance of the technical platform that supports the Hospital Episode Statistics (HES) service. HES captures more than 180 million records from local hospitals about activity relating to admitted patient, outpatient and accident and emergency attendances.
- Improved the public's access to health information. We built traffic on the NHS Choices website to 49 million visits per month, an increase of 12 per cent on 2014/15, and continued to develop the MyNHS pages, which publish key local and national data on the performance of services across health and care. NHS Choices delivered 50 public-facing campaigns in 2015/16, with partners including Public Health England and a wide range of government and health organisations, as well as local authorities and private sector companies. Major campaigns to which we contributed included Stoptober, Sugar SMart, 10 Minute Shake Up, Be Clear on Cancer, One You, How are you?, Stay Well This Winter and Dry January.

Our commitments for 2016/17:

- Introduce the new National Data Services Development programme, focusing initially in 2016/17 on services for commissioners and on securing and streamlining data collections.
- Improve the usefulness of our publications. A consultation on the whole range of our publications was launched in April 2016 to improve our understanding of customers' and partners' requirements.
- Extend our engagement in collaborative projects to support research and innovation. These include working with the Ministerial Industry Strategy Group, the Accelerated Access Review and the newly established Research Advisory Group. We are making progress with our partners to introduce a single 'front door' to streamline the processes for accessing research data.
- Work with our partners and stakeholders to develop a new strategy for data that recognises the multiplicity of data sources – including data created and curated by citizens themselves – and supports new and emerging policy regarding new care models, capitation-based resource allocation and new pricing and tariff strategies for health and care services. The strategy will also support emerging priorities in data science, Big Data and genomics.

Making better use of health and care information

Professor Dame Valerie Beral (Professor of Epidemiology at the University of Oxford and principal investigator of the Million Women Study)

Dame Valerie's group applied for updated data from the Hospital Episodes Statistics (HES) in 2015/16 to support the Million Women Study, which analyses the data of about one in four women in the UK born between 1930 and 1950 and has produced a string of breakthroughs about cancers and other conditions in the group.

'There is almost nowhere else with data to rival that held by the HSCIC. The quality of the HES data sets are excellent – we have tested them extensively. They are the envy of the world,' says Dame Valerie.

After experiencing problems with the HSCIC's data dissemination service in 2014/15, Dame Valerie says there had been a marked improvement in service quality of the service in the past year.

'Communications, in particular, are much better. People are nominated to be in charge of your case and they ensure that your queries are dealt with promptly. There is an obvious commitment now among the data access team to help the research community,' she says.

Professor Sir Alex Markham (Professor of Medicine at the University of Leeds and Director of the Leeds MRC Medical Bioinformatics Centre)

Sir Alex's team worked with our Data Access Request Service (DARS) in 2015/16 to authorise the use of patient data to investigate possible links between colorectal cancer and certain types of surgery.

'In the past six months, we have seen a complete sea change in the way the HSCIC does its business with the research community. A year ago, some of us were struggling to get access to the data we needed for important programmes of research because of tighter procedures protecting patient data. Since then, we have seen much better support for researchers and a much quicker and more efficient DARS service,' he says.

'Complaints from colleagues about delays in DARS have gone from being a daily occurrence to being very infrequent. We have seen the HSCIC take the lead in building a data dissemination service that both resolutely protects patient data, but also gives the research community the information it needs to improve treatments and drive up standards in the system.'

Changing the way we work

Our ability to deliver our strategy depends on listening to the needs of our service users and meeting their requests by changing the way we work. During the past year, we radically overhauled our structures and processes to ensure that customer focus is our guiding principle at all times.

We have organised our workforce into professional groups, with leaders who are responsible for improving the skills and capabilities of our team based on the needs of our customers. We continue to drive cultural and organisational change across the organisation. For information about our transformation programme, see p 68.

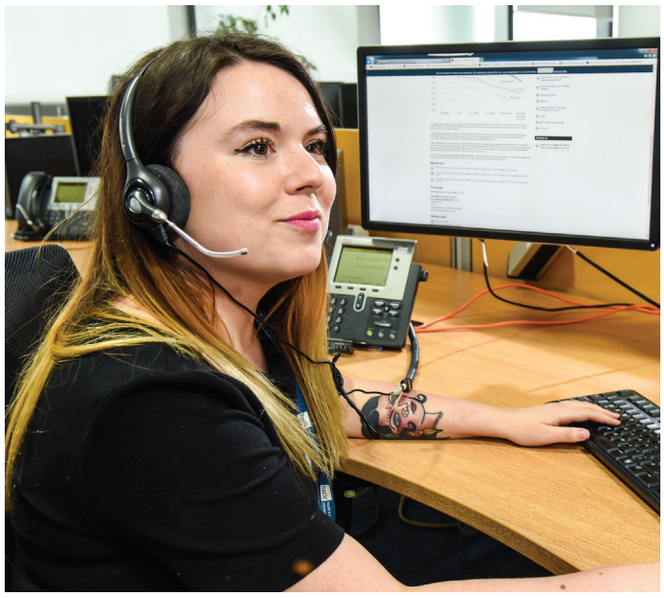
HSCIC's Customer Service Contact Centre: Jane Moore (Head of Customer Service and Support), Helen Rattray (Contact Centre Coordinator) and Jean Penrose (Customer Service Desk Team Manager) in the top photo below. Rose McMahon (Senior Contact Centre Adviser) in the bottom left photo. Martin Seward Douglas and Danielle Barratt (Senior Contact Centre Advisers) in the bottom right photo.

Our Leeds-based Customer Service Contact Centre team dealt with over 125,000 enquiries during 2015/16 and earned the Cabinet Office's Customer Service Excellence (CSE) accreditation. The staff were praised by the inspection team for their professionalism, attitude and interaction with customers.

'We are the front door for a complex organisation and our work is critical to ensuring the HSCIC is accessible and responsive to its customers. We pride ourselves on getting the information or help people need, when they need it,' says Jane.

The Contact Centre handles inbound and outbound telephone and written communications with a wide range of stakeholders, including NHS colleagues, commercial partners, researchers, members of the public and patients.

'We require team members to have a broad knowledge of all our products and services and aim to resolve more than 70 per cent of all enquires received at the first point of contact. For the more complex enquiries, we work closely with colleagues across the HSCIC to ensure that they quickly get to the people who can help,' says Jane.



Managing risk

Risks impacting on the delivery of our strategic objectives are mitigated within our risk management framework. More detail on the framework can be found on page 76 of this report.

There were major risks for the HSCIC in 2015/16 around meeting our obligation to uphold patient preferences about the sharing of personal data. Managing this risk was critical to meeting our twin commitments to protect citizens' data and enable the effective use of health and care information. We built and tested a robust information technology system to manage patient opt-outs; worked with the Department of Health on a direction from the Secretary of State for Health; and agreed an undertaking with the Information Commissioner's Office (ICO) on opt-outs.

Also during 2015/16, our organisational transformation programme continued to address both organisational and cultural barriers to the delivery of our strategy. We mitigated risks by implementing a new operating model, introducing staff resource pools to provide more flexible resourcing and investing in ongoing staff engagement activity to support organisational changes.

We reduced the impact of funding cuts and uncertainties in 2015/16 by advancing our 2016/17 planning process and setting clear cost centre reduction targets through until 2018/19. We worked closely with the Department of Health and NHS England to agree funding for new National Information Board programmes and implemented a prioritisation model to respond to possible funding shortfalls.

On an ongoing basis, we ensure the continuity of services that are critical to the health and care sector by using robust infrastructure, such as high-availability networks and dual-site data centres. We are also implementing a single approach to service management and improving business continuity management frameworks, capability and practice.

As system leaders for cyber security, we have responded to growing cyber security and data risks by implementing a new information governance strategy, mandatory staff training and better controls on data access, data movement, data destruction and system design. We also encourage an environment of continuous learning, where near-miss and mistake reporting are encouraged and avoidable incidents are managed out of the system.

We will continue to take action to manage these and other emerging risks during 2016/17.

Preparation of the accounts

Our commitments will be delivered during a period of financial restraint across the public sector. The Comprehensive Spending Review (CSR) carried out by the Government during 2015 sets out a challenging settlement for health and care services for 2016 to 2021. The HSCIC and partner organisations will have to manage reductions in funding while continuing to invest in programmes and services. We will continue to work closely with our partners in the planning and costing of new work so that sustainable funding plans are agreed.

The CSR has allocated funding to support the delivery of the National Information Board (NIB) objectives. The actual investment decisions are still to be made, and we expect that a significant amount of the NIB funding will be invested in services and programmes to be delivered by the HSCIC. Consequently, there are some significant uncertainties that we will need to manage in this planning round. However, a detailed business plan and 3-year budget has been developed, centred on the indicative Grant in Aid (GIA) funding already provided. This indicates that these funding pressures are financially manageable. It is proposed that the accounts can be prepared on a going concern basis.

Key performance indicators (KPIs)

Effective performance management across our operations ensures we meet our statutory obligations and commitments to stakeholders. It facilitates the delivery of our strategic and operational goals and minimises risk for the HSCIC and our stakeholders.

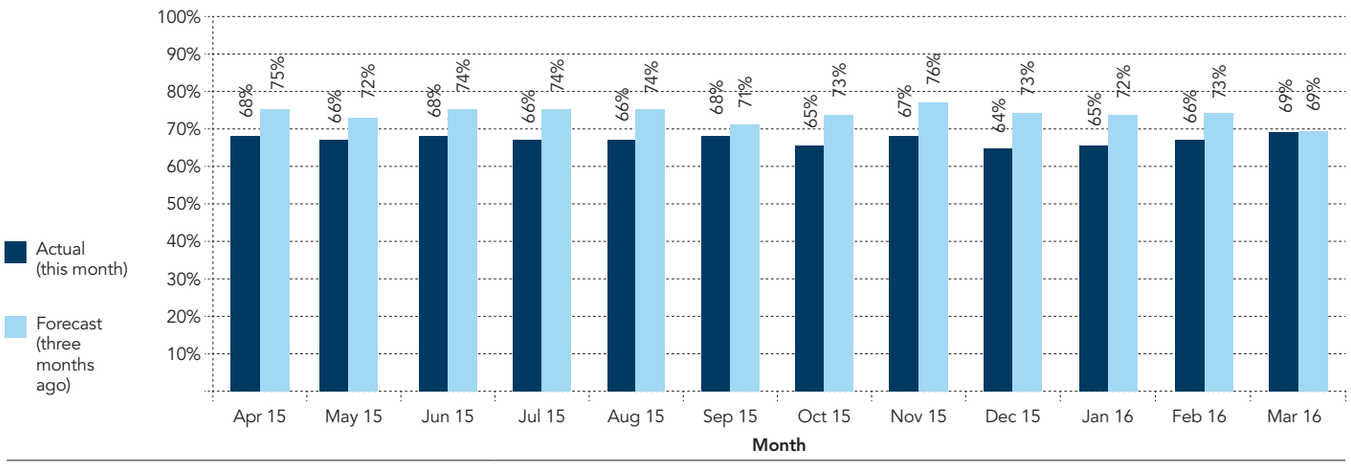
We use financial and non-financial KPIs and other management information to monitor performance. Each KPI is assessed on a Red Amber Green (RAG) threshold model, with detailed analysis when performance issues occur. These indicators are integral to the routine business of our Board and our Executive Management Team and are published monthly on our website as part of the Board papers.

The Board-level KPIs are organised into the following groups:

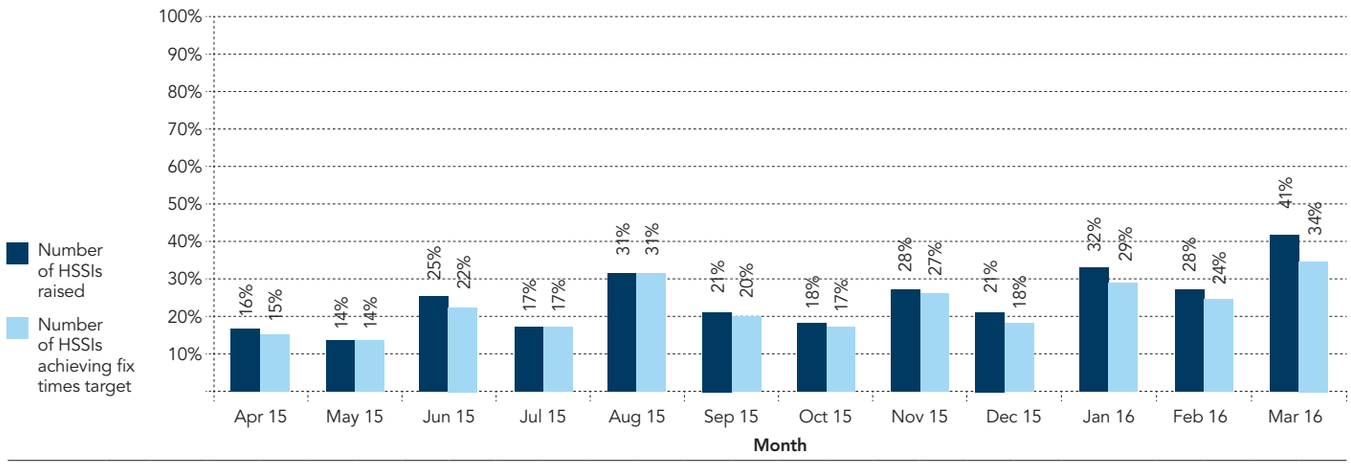
Services	Description / Purpose
Programme achievement	Provides a consolidated view of the status of the HSCIC's portfolio focusing on the performance of major projects and programmes, including aggregated findings from gateway reviews.
IT service performance	Reports on the performance of information technology services for health and care providers, including service availability against targets, incident response times and the number of high-severity service incidents.
Organisational health	Includes workforce planning and recruitment, staff turnover, staff engagement, training and development, personal development reviews and sickness absence rates.
Data quality	Looks at the quality of data received by the HSCIC from health and care providers and the effectiveness of the HSCIC's data quality processes.
Reputation	Includes stakeholder and staff surveys, media coverage, social media sentiment and the handling of complaints.
Financial management	Covers HSCIC finances and the management of Department of Health revenue and capital streams. The indicator reports on in-year spend against budgets and forecast year-end outturn.
Risk management	Monitors management of the current risk exposure and mitigation actions for each of the HSCIC's strategic risk areas.
Information governance incidents	Monitors information governance incidents reported to the HSCIC. These include incidents where the HSCIC is the data controller, incidents arising from supplier compliance issues, and incidents within the health and care system outside the HSCIC.

Some examples of KPIs included in the Board papers are shown overleaf.

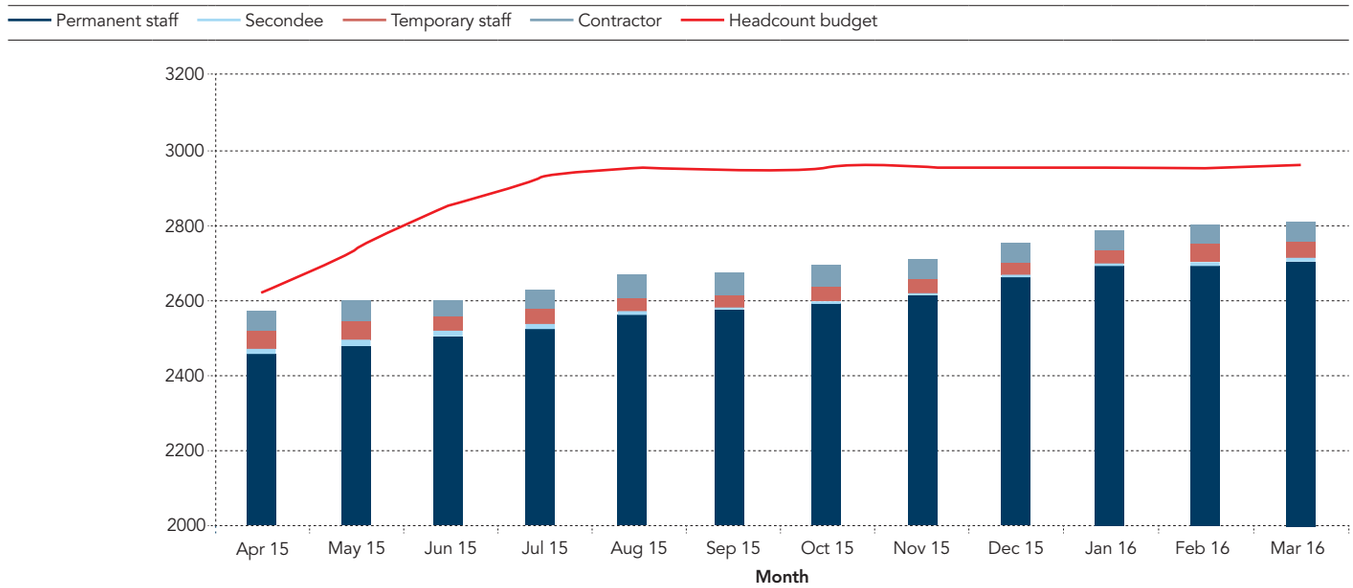
Programme achievement:
Delivery confidence (%)



IT service performance:
Higher severity service incidents (HSSIs)



Financial management:
Workforce budget vs actual (whole time equivalent employees)



Financial Results

These accounts have been prepared under a direction issued by the Secretary of State for Health in accordance with the Health and Social Care Act 2012 and in accordance with the 2015/16 Government Financial Reporting Manual (FReM) issued by HM Treasury. The accounting policies contained in the FReM apply the International Financial Reporting Standards (IFRS) as adopted and interpreted for the public sector context. The accounts comprise a statement of financial position, a statement of comprehensive net expenditure, a statement of cash flows and a statement of changes in taxpayers equity, all with related notes.

In 2015/16, we remained focused on delivering our services as central funding for public bodies has tightened. Core Grant In Aid (GIA) funding from the Department of Health was approximately £7million less than that allocated the previous year, although this has been offset by additional ring-fenced GIA allocated to deliver a number of additional programmes.

Operating expenditure for 2015/16 was £224.8million, resulting in an underspend of £16.1million. This 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 administration funding (to support the core service delivery and support functions) and programme funding (to support front line activities). An underspend was generated in both.

The table below provides a summary of our results:

	2015/16 £000	2014/15 £000
Grant in Aid allocation from the Department of Health	179,201	177,705
Other income	61,684	55,670
Total income	**240,885**	**233,375**
Operating expenditure	**(224,825)**	**(215,109)**
Underspend	**16,060**	**18,266**
Capital expenditure	**14,495**	**14,150**

The Grant in Aid allocation from the Department of Health is the total budgeted to be provided and does not necessarily equate to that used or drawn down.

Funding and other income

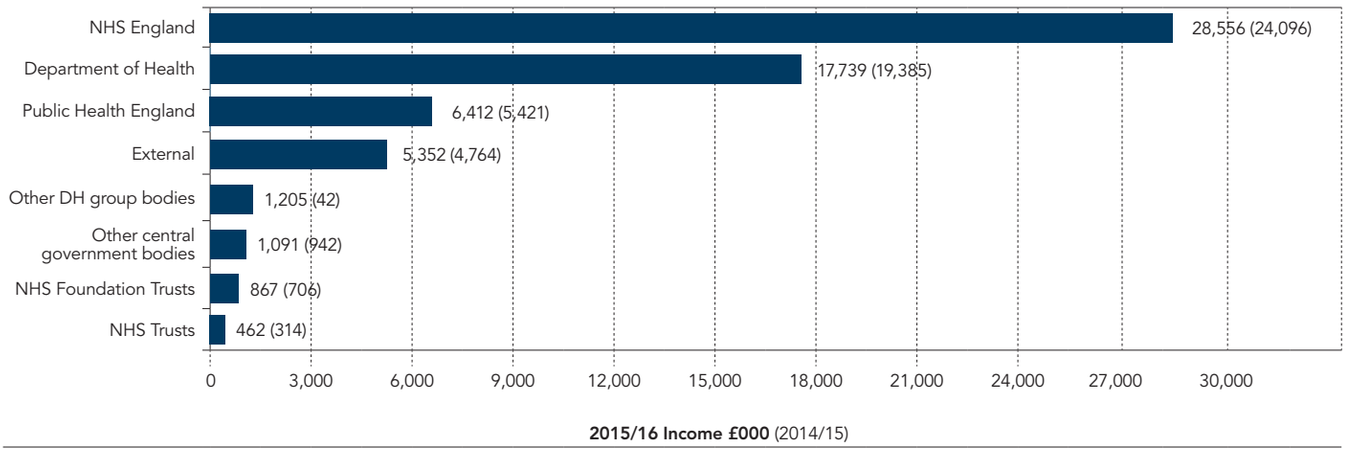
The core GIA allocation supports delivery of our statutory functions as well as the revenue administration costs of delivering the Department of Health's portfolio of programmes and the HSCIC's supporting infrastructure. In particular, it supports:

- the collection, analysis and dissemination of a range of data-related services including the publication of 290 reports of official or national statistics
- operational, commercial and financial services for a number of Department of Health informatics programmes and services
- development and maintenance of clinical and information standards and terminologies
- front line services with a range of information services and systems
- IT infrastructure, estates and support functions for the organisation.

In addition to GIA, we generated £61.7million of other income (2014/15 £55.7million). This activity included the:

- development of information systems on behalf of the Department of Health and NHS England
- design and management of clinical audits
- hosting, management and development of a range of key IT systems on behalf of the NHS
- provision of contact centre services
- extraction of data and information and its dissemination to customers inside and outside the NHS.

Analysis of income by customer



We have developed a charging policy and a standard cost model for staff time, with the aim of charging all customers based on full cost recovery. This is now widely used across the business and also forms a basis for all business cases.

External income includes: the provision of clinical audit services; fees and charges for providing data extracts and tabulations; as well as data linkage services. The fees and charges note below is subject to audit:

	Clinical audit services £000	Data-related services £000	2015/16 Total £000	2014/15 Total £000
Income	2,282	1,259	3,541	2,910
Expenditure	2,231	1,689	3,920	3,118
Surplus / (deficit)	**51**	**(430)**	**(379)**	**(208)**

The clinical audit services analyse and report data across a number of clinical specialisms such as diabetes, renal care and oncology. The main customer is the Healthcare Quality Improvement Partnership (HQIP). Data-related services provide health data for customers, data linkage services and data extracts for research purposes.

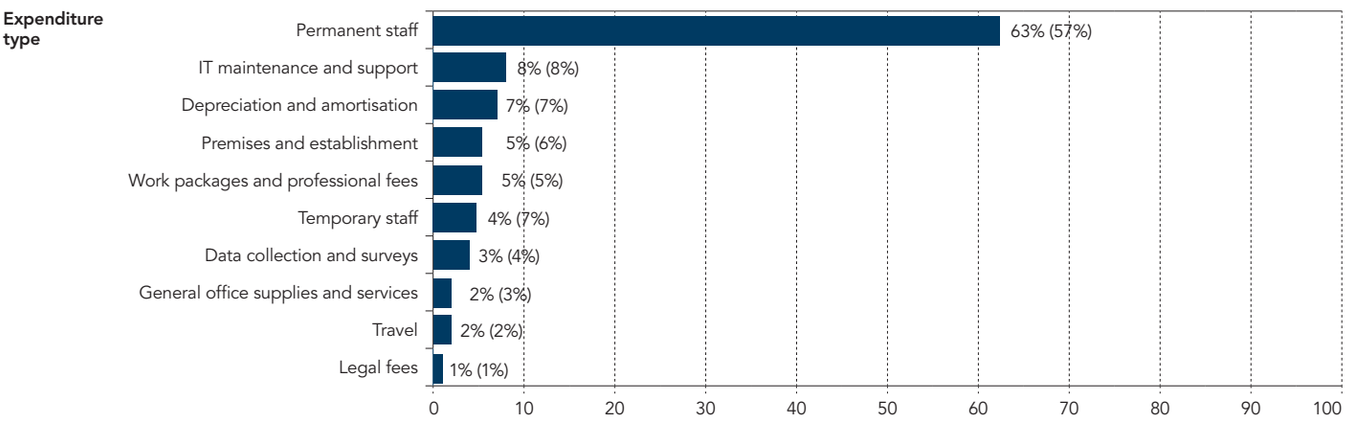
The financial objective is to recover full cost plus a return on investment, in accordance with the HM Treasury guidance Managing Public Money. No charges are made for the actual data. However, we do cover the costs of providing the data to the customer in the format and specification required and of meeting information governance requirements.

The organisation has invested considerable effort in improving its end-to-end data dissemination processes, including the Data Access Request Service (DARS). In the short term, the cost of this additional governance has not been passed on to customers, while improvements in processes such as the new DARS Online service will make the processes more efficient and, ultimately, reduce ongoing costs. The charging models will be reviewed during 2016/17.

Operating expenditure

The following chart summarises the main categories of operating expenditure:

Analysis of operating expenditure



Permanent staff remained the major expenditure, increasing to 63 per cent (2014/15 57 per cent). Average staff numbers increased in the year to 2,591 from 2,232 in 2014/15. This was partly a result of the filling of budgeted vacancies which reduced our reliance on temporary staff and the insourcing of systems such as the NHS Spine.

Other major costs include:

- IT expenditure – £19.0million (2014/15 £17.1million). Meeting the growth in staff numbers and investment in software licensing and systems contributed to the increase.
- Premises – £11.9million (2014/15 £14.3million). The ongoing reorganisation of our estate produced savings, with most of the managed buildings vacated or terms renegotiated and the consolidation of our space in Skipton House, London. This process is ongoing with the lease at Tavistock House in London ending in April 2016 and the occupation of Whitehall 1 in Leeds due to end in November 2016.
- Work packages and professional fees – £11.4million (2014/15 £11.4million). Costs are largely similar to 2014/15 and relate to external support for delivering major programmes and IT projects.
- Surveys and data collections – £5.7million (2014/15 £8.8million). The reduction reflects a fall in survey income following the completion of two major periodic surveys: the Adult Psychiatric Morbidity Survey and the Children and Younger People Mental Health Survey.

Non-current assets

The capital expenditure limit was £14.5million, which was fully utilised as follows:

	£000
Software licences including desktop and corporate infrastructure licences	1,283
Internally and externally developed software	5,620
ICT hardware including desktop and corporate infrastructure	5,477
Refurbishments to the property estate including the fit out of new office space in Trevelyan Square, Leeds together with new furniture	2,074
Development expenditure	404
Net book value of disposals	(363)
Total	**14,495**

Internal staff time spent on developing software applications is capitalised. This is captured by a time recording system to which an average rate determined by the employees' grade is applied. The rate includes the total direct cost of employment together with an incremental overhead cost comprising mainly estate and IT costs. Project management time is only capitalised when it can be directly connected to the development of the asset.

During the year, the management and recording of non-current assets were reviewed. In particular, we:

- undertook a full IT equipment inventory to verify the existence of all assets and to reconcile to the IT department's asset management system, the Configuration Management Database (CMDB)
- undertook a furniture inventory. This exercise verified that the costs of the individual assets in use was largely comparable to the total cost held in the asset register.
- implemented a new financial fixed asset register, which has been reconciled to the CMDB and the nominal ledger. This resulted in an increase in the carrying value of some assets. A number of other assets were also reclassified.
- reviewed the valuation of the General Practice Extraction Service (GPES). This has a net book value of £8.7million and is the organisation's most material single asset. The service went live in 2014/15 after six years of development. A review in 2014/15 resulted in the impairment of £0.8million of abortive or incomplete software development in respect of the GPET-Q tool and a reduced amortisation period of two years as the tool was intended to be superceded by October 2017. A further review in 2015/16 has recommended that the whole GPES infrastructure should be replaced by March 2018. Consequently, the GPET-Q tool has had its life extended while the remainder of the GPES asset is unchanged, already having a life to March 2018.

We manage a large portfolio of major IT infrastructure programmes on behalf of the Department of Health. The associated assets are accounted for within the Department of Health's financial statements.

Current assets and liabilities

Outstanding accounts receivable balances amount to £21.8million (2014/15 £14.8million). The increase is largely due to invoices to NHS England, which were issued toward the end of the financial year. The amount more than 60 days overdue was £0.3million (2014/15 £0.3million). Debts amounting to £744 were written off and £3,443 were provided for as irrecoverable. Debts previously provided of £8,446 were released following recoveries of amounts due. Other debtors largely related to prepayments and accrued income.

We seek 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 97.5 per cent (2014/15 90.7 per cent).

The below calculations use the formula agreed by users of NHS Shared Business Services (SBS), which stipulates that the number of days outstanding is calculated from the date a validly presented invoice is processed on the SBS system to the date a payment is initiated. We are conscious that this calculation can understate the time taken because it takes at least 11 days on average from the invoice date to processing the invoice on the system. SBS offer a free solution to all suppliers called Tradeshift, which allows suppliers to upload invoices to the SBS system in real time. We are encouraging all suppliers to use this facility and to follow the SBS good invoicing guide to improve the process.

Our performance in 2014/15 was affected by the migration of our accounting systems to Release 12 of Oracle, which resulted in ledgers being unavailable for nearly three weeks. During 2015/16, our performance improved, with more than 95 per cent of non-NHS invoices paid within target. The number of invoices fell by approximately 25 per cent, as some of our larger suppliers by transaction volume agreed to issue consolidated invoices. We believe this change reduced the percentage of invoices paid within target because many of these invoices were routine in nature and would previously have been paid within the 30-day period.

Government guidance is to pay 80 per cent of all suppliers' undisputed invoices within five working days. This target is particularly challenging for the HSCIC given the complexity of many of our transactions. In 2015/16, we paid 21.3 per cent based on volume and 21.5 per cent based on value within the five day target. The ratio we use is from the date the invoice is processed on the SBS system to the date the invoice is initiated for payment.

Financial instruments

We had very limited exposure to financial instruments with transactions 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

Following the end of the reporting period, Kingsley Manning resigned as Chair and has been replaced by Noel Gordon with effect from 1 June 2016. In addition, Beverley Bryant has joined as Director of Digital Transformation from the same date having transferred from NHS England. A number of functions are also expected to transfer.

The HSCIC is to operate under the trading name of 'NHS Digital' with effect from Summer 2016.

Political and charitable donations

No political or charitable donations were made in the year.

Better Payment Practice code	Number	£000
Total non-NHS bills paid 2015/16	9,111	95,401
Total non-NHS bills paid within target	8,704	93,018
Percentage of non-NHS bills paid within target	95.5%	97.5%
Total NHS bills paid 2015/16	266	4,501
Total NHS bills paid within target	214	3,467
Percentage of NHS bills paid within target	80.4%	77.0%
Total value of invoices processed in 2015/16		91,980
Total value of invoices outstanding at 31 March 2016		6,834
Number of days outstanding		27.1

Sustainable development

We are committed to sustainable development in all of our activities. Our aim is to deliver sustainable operations and services that help our stakeholder organisations meet their business objectives, contribute to a low carbon economy and support the goals of the sustainable development strategy for the NHS and the social care system. Our intention is to embed sustainability within the core business thinking of the organisation and, in doing so, actively contribute to the government's proposed Greening Government Commitments.

We have developed a carbon reduction plan that sets out where we will focus our attention and investment. This includes our best assessment of the organisation's overall carbon footprint by reporting on all buildings where we have a presence and not just those where we are the major occupier (as required by HM Treasury guidance). The 2015/16 annual report is the first year we will provide this additional detail; it is still work in progress and we hope to continue to improve the analysis in future reports.

We have a presence in 13 buildings spread across 8 dispersed geographic locations. We own Hexagon House, Exeter and have a direct responsibility for reporting business activity in 6 properties where we are leaseholders.

We also share office space in other government owned or leased buildings where reporting of emission data is the responsibility of the major occupier.

We have three data centres that are managed by HM Land Registry that are provided to us on a co-location basis. The data centres house over 110 racks hosting approximately 200 individual services. Along with other bodies such as the Office for National Statistics and the Home Office, we help reduce the HM Land Registry's footprint within their own data centres. They are externally managed on our behalf and are effectively unmanned for HSCIC operational purposes. Electricity consumption is sub-metered and included in the table below. As with our non-reported offices, carbon emissions have been identified separately for reporting purposes.

Greenhouse gas emissions

The proposed new Greening Government Commitments for the period 2016 to 2020 include a reduced greenhouse gas (GHG) emissions target of at least 31 per cent from the whole estate and business travel from a 2009/10 baseline.

Approximately 75 per cent of our direct GHG emissions arise from gas and electricity use across the estate and the majority of the remainder from business travel. Overall, the emissions from HSCIC business activity have remained broadly constant but this does not reflect the true achievement as it has been achieved in the context of:

- a 40 per cent growth in staff numbers since 2013
- the transfer of the management of major NHS-wide IT systems from 3rd party suppliers to an in-house solution. More than 3,000 servers have been replaced by a significantly more efficient infrastructure with fewer than 300 servers resulting in an estimated 90 per cent energy saving. Unfortunately, we do not have the prior year data from the 3rd party supplier to enable us to accurately reflect the impact of these savings on the whole of our operation.

Our GHG emissions management has benefited from a number of initiatives including making better use of office space, consolidating our IT infrastructure, and using technology to reduce travel requirements. We are nearing the end of a major exercise to transform our way of working and a programme of capital projects to improve energy efficiency, with increased use of sub-metering to allow better control and reporting.

The overall position is best summarised by the clear reduction in energy consumption, energy cost and water use by whole-time equivalent (WTE) staff over the last year.

In order to provide a comprehensive carbon footprint report, we have separately reported buildings where we have direct responsibility (reportable sites) and made a best estimate of GHG emissions for those buildings where we are not the major tenant (non-reportable sites).

Energy and travel data is grouped into the following GHG categories:

Scope 1

All direct GHG emissions such as from fossil fuels.

Scope 2

Indirect GHG emissions from consumption of purchased electricity, heat or steam.

Scope 3

Other indirect emissions including travel.

GHG emissions		2015/16	2014/15
Non financial indicators CO^2 emissions (tonnes)	**Scope 1**		
	Natural gas (properties reportable)	295	387
	Natural gas (properties non-reportable)	112	111
	Scope 2		
	Mains electricity (properties reportable)	1,819	1,782
	Mains electricity (properties non-reportable)	478	508
	Mains electricity (data centres non-reportable)	849	715
	Scope 3		
	Mains electricity (properties reportable)	150	159
	Mains electricity (properties non-reportable)	39	44
	Mains electricity (data centres non-reportable)	70	62
	Travel – air (reportable)	103	86
	Travel – rail (reportable)	363	323
	Travel – private cars (reportable)	291	286
	Travel – leased vehicles (reportable)	48	34
Total reportable emissions		**3,069**	**3,057**
Total non-reportable emissions		**1,548**	**1,440**
Total emissions		**4,617**	**4,497**
Total energy cost per WTE employee		**1.72**	**1.94**

GHG emissions		2015/16	2014/15
Financial indicators (£000)	Natural gas (properties reportable)	50	89
	Natural gas (properties non-reportable)	20	21
	Mains electricity (properties reportable)	389	400
	Mains electricity (properties non-reportable)	108	108
	Mains electricity (data centres non-reportable)	176	128
	Travel – air (reportable)	192	135
	Travel – rail (reportable)	2,284	1,863
	Travel – private cars (reportable)	516	508
	Travel – leased vehicles (reportable)	24	16
Total reportable emissions		**3,455**	**3,011**
Total non-reportable emissions		**304**	**257**
Total emissions		**3,759**	**3,268**
Total energy cost per WTE employee		**1.37**	**1.38**

Water

Water consumed in offices where we are not the major tenant (non-reportable accommodation) has been estimated using a recognised benchmarking algorithm.

Overall, water usage for the estate has remained broadly the same, which is to be expected of a largely office-based workforce. Washroom facilities at Trevelyan Square, Leeds are currently being refurbished which will result in more economic water usage. The provision of shower rooms in several buildings to meet the growing numbers of people choosing to cycle to work will have increased consumption. Over time, we should expect to see the effects of flexible working reduce water consumption as people choose to work from locations other than our offices.

Water consumption		**2015/16**	**2014/15**
Non-financial indicators (m³)	Water from estate (reportable)	10,923	10,387
	Water from estate (non-reportable)*	2,843	2,776
Financial indicators (£000)	Water supply costs**	35	33
Total water m³ per WTE employee		5.12	5.65

*estimated
** water costs from major occupier sites (water that was directly supplied to those sites that are within the reportable criteria)

Waste

Waste figures are estimates as waste facilities in many locations are shared with other tenants. It is not possible to accurately identify the volumes by tenant or what is sent to landfill as opposed to recycled. This is an area that will be addressed as waste disposal contracts come up for renewal and we strive to meet the government's target of less than 10 per cent of waste going to landfill by 2020.

It is estimated that 25 tonnes was sent to landfill, which represents 23 per cent of our total waste arising. This is a 49 per cent reduction on 2014/15 and continues the downward trend for non-IT related waste.

Approximately 10 per cent of IT waste was reused externally and the remainder was recycled into component materials for manufacturing. Less than 1 per cent is not recyclable and this is used in the energy from waste chain, ensuring virtually no IT waste goes to landfill.

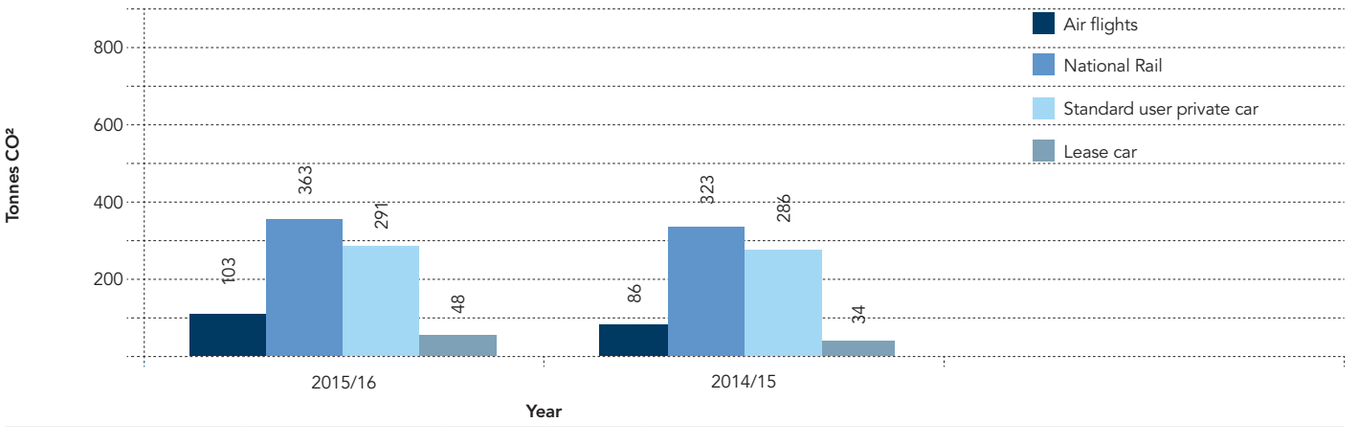
Waste **Scope 3 (Waste)**		**2015/16**	**2014/15**
Non-financial indicators (tonnes)	Waste recycled externally (non-IT equipment)	65	34
	IT waste recycled externally	11	12
	IT waste reused externally	1	3
	Waste incinerated	6	–
	Total waste sent to landfill	25	41
Total waste		**108**	**90**

Financial indicators (£000)	General waste including recycling (non-IT equipment)	20	Not known
	Confidential paper waste shredding and recycling (non-IT equipment)	6	Not known
	IT waste (reused and recycled)	73	Not known
Total costs		**99**	**Not known**

Business travel

Business travel increased by 10 per cent during 2015/16 as staff numbers increased by 16 per cent.

Total carbon emissions in tonnes CO^2 for business travel by category



We continue to encourage use of technology (e.g., video and telephone conferencing) as an alternative to travel and have put significant investment into new video conference equipment during the course of 2015/16. We also recognise that less business travel will benefit health by reducing air pollution and support our aims to reduce carbon emissions and save money. We have implemented a further operational target of reducing the number of domestic business flights by 30 per cent and have introduced a stricter policy in this area.

Paper

The Greening Government Commitments operational target is a 50 per cent reduction in paper consumption by 2019/20 compared to a 2009/10 baseline.

We do not hold accurate figures from 2009/10. However, our paper consumption has fallen by 12 per cent since 2013. Consumption is measured in 'equivalent A4 reams' and our use of paper has reduced from 9,487 reams in 2013/14 to 8,340 reams in 2015/16. Managed print systems, new technologies and the encouragement of the paperless office through cost improvement initiatives have been the primary tools used in reducing paper consumption.

Sustainable procurement

We procure the majority of our goods and services from nationally agreed frameworks. All contracts are fully in line with Government Buying Standards (GBS), which incorporate sustainability considerations by commodity type. All IT hardware procured is in line with the GBS minimum mandatory standards and, in most cases, the best practice standards. Sustainability considerations are embedded into other procurement activity where it is deemed appropriate.

In order to further develop and embed sustainability, we have established a sustainable procurement lead. During 2016/17 this role will further develop policies and processes to ensure sustainability considerations are integrated into the sourcing and contract management cycles, to establish appropriate coaching and support and to monitor and report on progress.

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
27 June 2016

Accountability Report

Corporate governance report

Our constitution was established and set out by Schedule 18 of the Health and Social Care Act 2012. The formal arrangements are set out in the Accounting Officer Memorandum sent to our Chief Executive by the Department of Health Accounting Officer. They are also reflected in a Framework Agreement, which governs the relationship between the Department of Health and our organisation. A specific Department of Health sponsor team engages with and oversees our activities, providing a comprehensive support and accountability function.

We are responsible for maintaining a sound system of internal control that supports the achievement of our policies and objectives, while safeguarding our assets (including data and information assets) and public funds. We work in accordance with the responsibilities assigned in the HM Treasury guidance, Managing Public Money and have fully embedded the key governance and accountability processes in our operations.

We are represented on the main system-wide informatics boards, ensuring there is a coordinated and joined-up approach to our activities.

Corporate governance

We are led by a board consisting in 2015/16 of four executive and six non-executive members including a chair. This is the senior decision making body. A further six senior executives attended the Board on a regular basis and contributed to the discussion. 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.

Board members have a corporate responsibility to ensure 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 Corporate Governance Manual, which includes our Standing Orders and Standing Financial Instructions. These are reviewed annually.

The powers and responsibilities retained by the 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 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 Data Protection Act 1998, the Freedom of Information Action 2000, the Equality Act 2010, the Public Bodies Health and Social Care Act 2011, the Health and Social Care Act 2012 and by secondary legislation made under relevant acts
- 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.

Board meetings are held monthly with public board meetings alternating with business meetings. Public meetings consist of:

- a public session that other members of the senior management team and a representative from the Department of Health sponsor team are able to attend. Members of the public are also welcome to attend and observe. Papers and previous minutes are made available via the HSCIC website in advance of the meeting.
- a private session relating to items of a commercial or confidential nature that could not be discussed in public. Observers are not allowed to attend these sessions.

Business meetings consist of discussions on key business areas, progress on major programmes, strategy and planning. All agendas and minutes are made available on the HSCIC website.

During 2015/16, six public meetings were held at a variety of locations to enable key customers and stakeholders to participate. On three occasions, additional stakeholder engagement sessions were held before or after the Board.

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

- a review of the 2015 HSCIC staff survey results
- the HSCIC transformation programme approach and the implementation of transformation activities in 2016/17 and beyond
- the government comprehensive spending review and business and budgeting planning for 2016/17 to 2018/19
- the consideration of a collaboration agreement proposal to formalise the relationship between Monitor (now called NHS Improvement) and HSCIC
- an initial look at six equality and diversity objectives that will be published in 2016/17 in support of staff diversity and inclusion within the organisation
- the consideration of a proposal to commence operational management of a selection of services to provide informatics support to Genomic's England 100,000 Genomes (research) project
- a review of the HSCIC scheme of delegated financial authorities for 2016/17
- the consideration and subsequent acceptance of directions on data collections issued to the HSCIC by the Department of Health and NHS England
- monitoring a broad range of performance indicators throughout the year, which are aligned with the approved strategy and business plan, including the development of key performance indicators for data quality and reputation
- progress on the patient objections management system.

An internal review of Board effectiveness and governance was undertaken in 2015/16 and the findings were considered by the Board. While there were a number of recommendations, which are in the process of being addressed, the review did not highlight any significant issues.

Board and Executive Management Team

Kingsley Manning
Chair (to 31 May 2016)

Kingsley was appointed in June 2013. He has 30 years' experience in advising health authorities, NHS trusts and major healthcare companies on strategy and policy development.

He was founder and managing director of Newchurch Ltd., a leading firm of health and information consultants, from 1983 to 2009. Other roles have included working as the executive chairman of Tribal Group's health business and a senior adviser at McKinsey & Company.

Noel Gordon
Chair (from 1 June 2016)

Noel is a non-executive director of NHS England, Chair of the Specialised Commissioning Committee of NHS England, a member of the advisory committee of the Department of Health's Accelerated Access Review, a non-executive director of the Payments Systems Regulator, a member of the Audit and Risk Committee of the University of Warwick, a member of the Development Board of Age UK and chair of the board of trustees of UserVoice.org.

He has extensive experience of innovation and industry transformation and with big data, analytics, mobile and digital technologies.

After training as an economist, Noel spent most of his career in consultancy until his retirement in 2012. He was the global managing director of Accenture's banking industry practice from 1996 to 2012.

Andy Williams
Chief Executive

Andy joined us in April 2014 after a private sector career in information technology and telecommunications. He has worked with a variety of global technology companies and, for the past 15 years, has been responsible for organisations offering a broad range of technology services, including consulting, systems integration and outsourcing, to public and private sector clients.

Andy was president of managed services for CSC in Europe, where he led a team of around 15,000 professionals. Previously, he was a member of the management committee and president of the services division at Alcatel-Lucent and worked in a number of roles with IBM.

Andy was an evangelist for the use of the internet in financial services in the late 1990s and is interested in how technology can transform organisations and industries.

Sir Nick Partridge
Non-executive Director

Sir Nick is deputy chair of the UK Clinical Research Collaboration, which aims to make the UK a world leader in clinical research. He worked for the Terrence Higgins Trust since 1985 and was its chief executive between 1991 and 2013. He has been a prominent public voice on AIDS and sexual health over the past three decades.

Sir Nick was chair of INVOLVE, which promotes patient and public involvement in NHS research, between 1999 and 2011, and a member of the Information Governance Review led by Dame Fiona Caldicott in 2013. He also led the independent review of data releases by the NHS Information Centre, one of the HSCIC's predecessor organisations, in 2014.

Board and Executive Management Team

Sir Ian Andrews
Non-executive Director

Sir Ian is a former second permanent secretary at the Ministry of Defence. He retired from the civil service in 2009 and was the non-executive chairman of the UK Serious Organised Crime Agency (SOCA) from 2009 to 2013.

Sir Ian has been managing director of the Defence Research and Evaluation Agency (DERA), chief executive of the Defence Estates Agency and a member of the Defence Board, where his responsibilities included information assurance and security.

He is interested in raising public and private sector awareness of cyber security threats and contributing to public sector and academic leadership programmes.

Dr Sarah Blackburn
Non-executive Director

Dr Sarah Blackburn has been the chief executive of the Wayside Network, a group of consultants specialising in governance, since 2002. She has worked as a director of assurance and risk management for Argos, Kingfisher, RAC and Exel and for a public service property company.

Sarah was a founder member of the Healthcare Commission Board and a member of the editorial board of 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 became 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. She 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 serves on the board of the Institute of Internal Auditors Global (IIA Global).

Sir John Chisholm
Non-executive Director

Sir John is the executive chair at Genomics England, which is building a dataset of 100,000 whole genome sequences linked to clinical data. The project will put the UK at the forefront of genomic medicine.

He is a Cambridge University-educated engineer and started his career in the automobile industry, before moving into the computer software industry to specialise in complex systems. In 1979, he founded CAP Scientific Ltd., which grew rapidly to become a core part of the CAP Group plc. After CAP became part of Sema Group plc, Sir John served as Sema's UK managing director.

In 1991, he was asked by the UK government to turn its defence research laboratories into a commercial organisation. These became an internationally successful technology services company, which floated on the London Stock Exchange as QinetiQ Group plc.

He became chair of the Medical Research Council (MRC) in 2006 and oversaw the development of new models to deliver increased clinical and economic benefits from MRC-funded research. He guided the innovation charity Nesta out of the public sector after taking over as its chair in 2009.

Professor Maria Goddard
Non-executive Director

Maria is Professor of Health Economics at the University of York and director of its Centre for Health Economics. She has previously worked in the NHS and was an economic adviser in the NHS Executive (Department of Health). Her current research interests are performance measurement, incentives, commissioning and mental health, and the regulation and financing of health care systems.

She was elected as a fellow of The Learned Society of Wales and is a member of the Women's Committee of the Royal Economic Society. She has acted as an adviser and consultant to the OECD, World Bank, World Health Organisation and Audit Commission and is an associate editor for the Journal of Health Services Research and Policy and BMC Health Services Research.

Board and Executive Management Team

Carl Vincent
Director of Finance and Corporate Services

Carl joined us in June 2013 on secondment from the Department of Health and was appointed on a permanent basis in June 2015.

He worked as an economist with the Department of Health from 1996 and worked across a number of policy areas, including long term health funding, Payment by Results, and the Public Finance Initiative. After moving over to finance roles, he was head of the NHS Financial Performance team between 2004 and 2006 and led the Comprehensive Spending Review that reported in 2007. He has worked on secondment with a large consultancy provider and has experience of leading commercial teams.

Robert Shaw
Chief Operating Officer

Rob was appointed as Director of Operations and Assurance Services in April 2014. He managed the insourcing of major infrastructure services from BT, including the core NHS Spine, the Care Identity Service (CIS) and the Secondary Uses Service (SUS). In this role, Rob was also responsible for overseeing the provision of more than 60 essential live services to NHS and social care organisations.

He was appointed as the HSCIC's Chief Operating Officer in April 2016 and is also the Senior Responsible Officer for the Cyber Security Programme.

Earlier in his career, Rob worked for the Department of Work and Pensions, where , latterly, he led intervention teams to assist complex programmes with governance and delivery. He 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 in 2012 he also took over management of Technical Architecture and Infrastructure.

Rachael Allsop
Director of Workforce

Rachael joined the NHS Information Centre, a predecessor of the HSCIC, in 2009 and oversaw a successful staffing merger with NHS Connecting for Health. She was appointed to the HSCIC Board as Director of Human Resources and has recently been promoted to become Director of Workforce.

She has occupied board roles in health organisations for the past 25 years and has extensive experience as both a general manager and a human resource practitioner in all aspects of the health service. She worked as the human resources director of Leeds Teaching Hospitals' Trust, then the largest trust in the country. Rachael is a member of the Chartered Institute of Personnel and Development and has a master's degree in employment law. She is a past president of the Yorkshire Healthcare People Management Association and has been a visiting lecturer at Leeds and Keele universities.

Beverley Bryant
Director of Digital Transformation (from 1 June 2016)

Beverley was Director of Digital Technology at NHS England before joining the HSCIC in 2016. She was responsible for setting the national direction for NHS technology and informatics and stimulating technology leadership and innovation across the NHS in England. She also led the delivery of a number of NHS England commitments including Integrated Digital Care Records, NHS E-referrals, Patient Online and Electronic Prescriptions.

Before joining NHS England, Beverley was Managing Director of Health at Capita. She has undertaken various change, performance improvement and operational roles in 'big-five' consulting companies, as well as leadership roles in the Department of Health and the NHS.
A graduate of the University of Sheffield with a degree in Japanese, Beverley's expertise includes over 15 years of IT-enabled change in roles that include business and systems analysis and technical design authority.

Board and Executive Management Team

Isabel Hunt
Director of Customer Relations

Isabel joined the HSCIC in October 2014. She has worked for over 25 years in marketing, communications and business development roles, with nearly 15 years at executive and Board level. She worked as a senior civil servant in strategy and policy roles at the Home Office and Cabinet Office, was a member of the National Identity Service Programme Board and a graduate of the Senior Civil Service top management programme.

She has particular experience of leading through transformational change and building strong teams and has won national awards for business innovation. She is a graduate of the University of Birmingham, 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 member of the NHS Equality and Diversity Council and a trustee of the Thackray Medical Museum in Leeds.

Thomas Denwood
National Provider Support and Integration Director

Tom has extensive experience in leading major programmes. He passionately believes that putting people in control of their care through the use of technology will enhance their lives and that of their families and carers.

He began his career at Deloitte and worked on the Mayor of London's Congestion Charging Scheme. He joined NHS Connecting for Health in 2003 and worked on or led programmes including 'Choose and Book', Matthew Swindells' review of NHS Informatics and the turnaround of the NHS Southern Programme for IT. This was followed by a career break during which he led a turnaround team in the venue security programme of the London 2012 Summer Olympics.

In his current role, Tom leads a team delivering Government Major Project Portfolio programmes that digitise and connect the health and care system. This includes the Health and Social Care Network, CSC Local Service Provider, NHS England Technology Funds, and health and care integration.

Tom has a graduate degree in biology from the University of Birmingham, a post graduate degree in major programme management from the University of Oxford, and is a graduate of HM Government's Major Project Leadership Academy. He is a fellow of the British Computer Society.

James Hawkins
Director of Programmes

James has over 20 years' experience of leading large scale digital transformation programmes in the public and private sectors.

From introducing the London Congestion Charging Scheme during his time with Deloitte, to his central role in the security turnaround team for the 2012 London Olympics, he has a track record of delivering the successful digital transformation of high-profile public services.

As executive director of the Health Digital Services portfolio at the HSCIC, he is responsible for driving the essential health and care information and technology system change required to improve care and make it more efficient. His team is charged with building a user-led digital culture in health and care and is delivering benefits to the public through a wide range of programmes, from empowering patients with the self-care and prevention tools they need to take control of their own health to improving prescribing by giving pharmacists better access to patient information.

Before joining the HSCIC, James worked for private-sector organisations including British Gas, ntl, and Deloitte.

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

Professor Martin Severs
Interim Director of Information and Analytics, Medical Director and Caldicott Guardian

Martin is Executive Director for Clinical and Information Governance and Interim Executive Director for Information and Analytics.

He was a consultant geriatrician for 30 years, a professor of health care for older people at the University of Portsmouth for 25 years and has extensive experience of management at service, medical director, and non-executive board roles in health and research.

Martin has had a number of national and international roles in health informatics, 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.

Board and Executive Management Team

Peter Counter
Chief Technology Officer (to 30 April 2016)

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

Before joining HSCIC, he was the director responsible for delivering enterprise-wide IT for AstraZeneca. He was an IBM Distinguished Engineer and an executive IT architect, with experience spanning project and technical management, IT architecture, systems engineering and sales. He has worked across a number of industry sectors such as banking, defence, government, travel and tourism, oil and gas, pharmaceuticals, and health care.

Peter has been responsible for large-scale technical solutions and is an authority on technical governance. He has provided leadership across a range of disciplines, including project leadership and management, architecture and strategy, governance, contract negotiation, financial management and top-level enterprise resource planning.

Linda Whalley
Director of Strategy and Policy (from 10 December 2015)

Linda joined the former NHS Information Centre in 2007, where she had a business development role working across the organisation. Since the HSCIC was formed in 2013, she has worked on a range of strategy and policy issues, often involving close liaison with our national partners, and has led on our corporate strategy. She was appointed as Director of Strategy and Policy in December 2015.

Linda's career has spanned front line services, as well as corporate policy and senior leadership roles, in the NHS and local government. The use of data and technology to drive improvements in local services has been a key theme of her work. She has managed large-scale information management technology implementations as well as smaller technology change programmes. She was involved in the early wave of primary care commissioning, leading an inner city primary care group to trust status in 2000. She has been involved in numerous collaborative projects at national and local level, working across organisational boundaries and fostering effective partnerships.

All directors have confirmed that they know of no relevant audit information of which the auditors are unaware. They have also confirmed that they have taken all the steps that they should have taken as directors to find out relevant information and to establish that the auditors are aware of it.

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 Secretary to the Board and the Head of Corporate Governance and is available for public inspection. Directors' interests declared during 2015/16 and relevant to their HSCIC role are as follows:

Sir Ian Andrews: Consultancy advice to the Department of Health on aspects of the governance of NHS Transformation, the renegotiation of contracts with CSC, and oversight of the Fujitsu arbitration process.

Sir Nick Partridge: Chair, Clinical Priorities Advisory Group, NHS England; Deputy Chair, UK Clinical Research Collaboration; Deputy Chair, Sexual Health Forum, Department of Health.

Sir John Chisholm: Executive Chair – Genomics England Ltd.

Dr Sarah Blackburn: Chief Executive, The Wayside Network Ltd. which has a contract to supply GP and nursing services to an NHS Partnership body; Non-Executive Partner, The Green Practice, Whitchurch, Bristol.

Board committees

The Board has appointed three committees whose delegated responsibilities are as follows:

The Assurance and Risk Committee (ARC)

The ARC oversees the operational effectiveness of HSCIC policies and procedures; provides assurance and recommendations to the Board on fraud, corruption and whistleblowing; and ensures the provision of an effective internal audit function that meets mandatory internal audit standards and provides appropriate independent assurance to the Chief Executive and the Board. It appoints a local counter-fraud specialist, who attends ARC meetings when required.

The committee is authorised to investigate any activity within its terms of reference and to seek any information that it requires from any employee. All employees are directed to cooperate with its requests. It is able to seek outside legal or independent professional advice at the HSCIC's expense and secure the attendance at its meetings of external specialists with relevant experience and expertise.

The key areas addressed by ARC in 2015/16 included:

- oversight, on behalf of the Board, of the preparation of the annual accounts and our annual governance statement
- reviews of internal audit reports and progress against recommendations and agreed actions
- review of the local counter-fraud specialist work plan, which is now undertaken in-house
- consideration of the external audit strategy
- monitoring of the management of corporate risks and issues
- development and implementation of a corporate assurance map.

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

The Information Assurance and Cyber Security Committee (IACSC)

The IACSC has representation from across government, including the Department of Health. It is responsible for ensuring 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 the Board. It reviews the work and findings of the Cyber Security Programme and considers the implications of management responses to its work. It also monitors other significant assurance functions, both internal and external to the organisation, and looks at the implications for governance of the organisation.

Like the ARC, it is authorised to investigate activities within its terms of reference and all employees are directed to cooperate with its requests for information. It can seek outside legal or independent professional advice at the HSCIC's expense.

The main areas the IACSC considered in 2015/16 included:

- updates from the Department of Health's Information Security and Risk Board
- a commission to support and assist with the Care Quality Commission (CQC) and National Data Guardian Health and Social Care Security Review
- progress on the HSCIC's Cyber Security Programme
- the development and implementation of the Care Computer Emergency Response Team (CareCERT) to offer cyber security advice and guidance to the health and social care sectors
- reports from the HSCIC's internal organisational security programme.

The Remuneration Committee (RC)

The RC approves the annual performance objectives of executive directors, monitors and evaluates the performance of senior management and makes recommendations to the Department of Health on any proposed annual performance pay awards to them. Other responsibilities include approving the level of annual performance related pay awards to HSCIC staff on ex-civil service terms and conditions and determining pay arrangements for medical and other staff groups who are not subject to Agenda for Change (AfC), the Very Senior Managers (VSM) framework or the Transfer of Undertakings (Protection of Employment) Regulations 2006 (TUPE) protected terms and conditions of employment. The committee ensures that HSCIC's pay arrangements meet equal pay requirements and considers redundancy payments and other (often TUPE related) exceptional matters. It ensures that all matters relating to pay and conditions that require approval from the Department of Health Remuneration Committee or other external authorities are submitted for approval and that the decisions of those bodies are appropriately implemented.

Attendance at the Board and committees is as follows:

	Board (12 meetings)	ARC (6 meetings)	IACSC (4 meetings)	RC (2 meetings)
Kingsley Manning (Chair – Board & RC)	11	n/a	n/a	2
Sir Ian Andrews (Chair IASCS)	11	6	4	n/a
Sir Nick Partridge	11	3	3	2
Maria Goddard	11	2*	2*	2
Sir John Chisholm	10	5	n/a	2
Sarah Blackburn (Chair ARC)	8	6	3	n/a
Andy Williams	11	5	2	2
Rachael Allsop	11	6	4	2
Robert Shaw	10	5	4	n/a
Carl Vincent	11	6	n/a	n/a
Peter Counter	11*	1*	2	n/a
Thomas Denwood	10*	n/a	n/a	n/a
James Hawkins	11*	3	n/a	n/a
Isabel Hunt	10*	1*	n/a	n/a
Martin Severs	8*	2*	3	n/a
Linda Whalley	10*	n/a	n/a	n/a

*In attendance

A standing item on the Board's agenda allows chairs of committees to report on their deliberations. The minutes of the Board's sub-committees are circulated to Board members after they are ratified.

Operational governance structure

The Board is assisted in carrying out its duties by an operational governance structure comprising of the Executive Management Team (EMT), Corporate Approvals Board and the Transformation Programme.

The EMT is responsible for communicating and delivering the strategy agreed by the Board. It agrees policy and procedures and supports implementation. The EMT is chaired by the Chief Executive and meets weekly. Action points and decisions are disseminated to all staff through the corporate intranet.

The Corporate Approvals Board is responsible for ensuring that investment decisions are rigorously reviewed and challenged at key stages in the work cycle. It reviews the priority of investments relative to other work in the portfolio, resourcing for successful delivery and alignment with Department of Health and HSCIC strategy. These reviews provide assurance to the Chief Executive and directors to enable them to make endorsements and approvals confidently in line with Standing Financial Instructions. The Board is chaired by the Director of Finance and Corporate Services.

Our transformation programme was revitalised and realigned by the EMT in 2015/16. The EMT directs the organisation's development strategy and plan.

Data and information governance

There is a wide-ranging legal, regulatory and compliance framework governing 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.

The UK Statistics Authority, established under the Statistics and Registration Service Act (2007), guides our statistical work through its Code of Practice for Official Statistics. The authority monitors and can comment publicly on compliance with the code. It also formally assesses compliant statistics for designation as National Statistics.

A key element of our responsibilities is to ensure that all data and information is collected, stored and disseminated appropriately. Information and statistical governance are taken extremely seriously and our controls and protocols have been strengthened following Sir Nick Partridge's Review of Data Releases in 2014.

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 as the guardian of data as set out in the Health and Social Care Act 2012.

The IACSC has been established to strengthen controls around the security of the IT infrastructure, on which all our data sits.

The governance and assurance processes across the system

We all have an interest in good governance – in getting the right decision for the health and care system made by the right people at the right time and for the right reasons. That is why we work closely with our national partners – in particular the Department of Health, NHS England, NHS Improvement and Public Health England – to bring more clarity to the 'client' and 'delivery' roles within the health and care system. This is particularly important in situations where organisations such as the Department of Health or NHS England are fulfilling a number of roles, such as paymaster, budget holder, sponsor, service user, Senior Responsible Owner for a programme and the body holding the HSCIC to account as a public service arms-length body.

It is important that there is even more collaboration across the 'client' organisations, building on the work that the National Information Board (NIB) has already started. We expect that the governance and approvals arrangements can be streamlined considerably as a direct result of such collaboration.

A more extensive explanation of information governance issues is included in the governance statement on p 76.

Remuneration and staff report

This report for the year ended 31 March 2016 deals with the pay of the Chair, Chief Executive and other members of the Board.

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 HSCIC operates the NHS Very Senior Manager (VSM) pay framework with the approval of the Department of Health Remuneration Committee. 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. Two bonus payments were made in 2015/16 through this mechanism, reflecting performance during 2014/15, details of which are contained in the Remuneration Report.

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, retain 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
- relevant Department of Health guidelines.

Remuneration policy

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

The AfC pay award for 2015/16 comprised a 1 per cent increase to pay points 1 to 42, with some additional adjustments for the lowest paid on points 1 to 8. There was no increase to pay points 43 to 54 and the non-consolidated award of 1 per cent to those at the top of their pay band in 2014/15 ceased. Progression on the incremental pay scales was frozen for staff in pay points 34 to 54.

Comparable arrangements were implemented for staff who had transferred into the HSCIC with terms and conditions protected under the TUPE, except where there was a legal entitlement to a protected pay award.

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

Service contracts

Carl Vincent was employed by the Department of Health and seconded to the HSCIC until 31 May 2015. He subsequently transferred to the HSCIC payroll.

Professor Martin Severs was employed by the University of Portsmouth and seconded to the HSCIC until 11th April 2016. He subsequently transferred to the HSCIC payroll.

All executive directors are employed under permanent employment contracts with a 6-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, Kingsley Manning, resigned with effect from 31 May 2016. The new Chair, Noel Gordon was appointed on a 4-year contract from 1 June 2016.

From 1 April 2014, all non-executive directors' contracts in place at that time were reviewed through the Department of Health Appointments Team and its terms and conditions applied to them. Individual contract periods are as follows:

	Actual commencement date	Current contract commencement date	End date
Noel Gordon	1 June 2016	1 June 2016	31 May 2020
Kingsley Manning	3 June 2013	1 April 2014	2 June 2017 Resigned 31 May 2016
Sir Ian Andrews	1 April 2013	1 April 2016	31 December 2016
Sir Nick Partridge	1 April 2013	1 April 2016	31 December 2016
Maria Goddard	1 April 2014	1 April 2014	31 March 2017
Sir John Chisholm	1 April 2014	1 April 2014	31 March 2017
Sarah Blackburn	15 September 2014	15 September 2014	14 September 2016

Non-executive directors are not entitled to compensation for loss of office or early termination of appointment.

Emoluments of Board members and other executive directors

The remuneration and pension disclosures relating to all directors in post during 2015/16 and 2014/15 are detailed in the tables below and are subject to audit. Emoluments of executive directors consist 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.

			2015/16			
	Appointment date	**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			180-185	5-10	-	190-195
Rachael Allsop Director of Workforce			120-125	-	2.5-5.0	125-130
^Thomas Denwood National Provider Support and Integration Director			115-120	-	55.0-57.5	175-180
^James Hawkins Director of Programmes			120-125	-	47.5-50.0	165-170
Robert Shaw Chief Operating Officer			135-140	5-10	72.5-75	215-220
Carl Vincent[1] Executive Director of Finance and Corporate Services			115-120	-	27.5-30.0	145-150
^Andrew MacLaren Director of Information and Analytics	27-Apr-15	06-Jul-15	25-30	-	-	25-30
^Martin Severs[2] Interim Director of Information and Analytics and Lead Clinician			80-85	-	-	80-85
^Peter Counter Chief Technology Officer	16-May-14	30-Apr-16	140-145	-	30.0-32.5	175-180
^Isabel Hunt Director of Customer Relations	06-Oct-14		125-130	-	27.5-30.0	150-155
^Linda Whalley[3] Director of Strategy and Policy	10-Dec-15		85-90	-	7.5-10.0	90-95
Maxwell Jones[4] Executive Director of Information and Analytics		10-Nov-14	-	-	-	-

2014/15				
Salary (bands of £5,000)	Performance Pay (bands of £5,000)	*Pension benefits £000	Total emoluments (bands of £5,000)	Full year equivalent salary (bands of £5,000)
180-185	-	-	180-185	180-185
120-125	5-10	55.0-57.5	180-185	120-125
110-115	-	30.0-32.5	140-145	110-115
110-115	-	32.5-35.0	145-150	110-115
130-135	-	205.0-207.5	335-340	130-135
90-95	5-10	22.5-25.0	120-125	90-95
-	-	-	-	-
70-75	-	-	70-75	70-75
110-115	-	22.5-25.0	135-140	145-150
60-65	-	10.0-12.5	70-75	125-130
-	-	-	-	-
75-80	-	27.5-30.0	105-110	125-130

			2015/16	2014/15
	Appointment date	Resignation date	Salary (bands of £5,000)	Salary (bands of £5,000)
Kingsley Manning Chair		31-May-16	60-65	60-65
Sir Ian Andrews Non-Executive Director			10-15	10-15
Sir Nick Partridge Non-Executive Director			5-10	10-15
Jan Ormondroyd Non-Executive Director		19-Oct-14	-	0-5
Maria Goddard Non-Executive Director			5-10	5-10
Sir John Chisholm Non-Executive Director			-	-
Sarah Blackburn Non-Executive Director	15-Sep-14		10-15	5-10

There were no benefits in kind. Salaries for all directors in 2015/16 are for a full year except for Andrew MacLaren whose full year equivalent is in the band £145,000 - £150,000.

* 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_Snr_Man_Rem_(Greenbury)_2016_(V2)_03.2016.pdf)

^ attend the Board on a regular basis but are not Board members as described in the Health and Social Care Act 2012.

[1] Carl Vincent was seconded from the Department of Health until 31 May 2015 and subsequently transferred to the HSCIC payroll. Remuneration and pensions information for April 2015 and May 2015 has been included. During 2014/15 he was paid a performance bonus by the Department of Health.

[2] Martin Severs is seconded part-time from the University of Portsmouth and costs relate to the total value of charges net of irrecoverable VAT. From 11th April 2016 he became an employee of the HSCIC.

[3] Linda Whalley was appointed to the Board on 10 December 2015, but the emoluments relate to the full financial year.

[4] Maxwell Jones received a termination payment of £103,248 in 2014/15.

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.

Directors expenses during 2015/16 are detailed on our website at https://www.gov.uk/government/publications/hscic-board-directors-expenses

The non-executive directors do not receive any performance pay or pension benefits.

Pension benefits

Pension benefits for the executive directors were provided through the NHS Pension Scheme.

	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 2016 (bands of £5,000)	Lump sum related to accrued pension at 31 March 2016 (bands of £5,000)	CETV at 31 March 2016 £000	CETV at 31 March 2015 £000	Real increase in CETV £000
Andy Williams	-	-	-	-	-	-	-
Rachael Allsop	0-2.5	2.5-5.0	50-55	150-155	1,014	972	15
Thomas Denwood	2.5-5.0	2.5-5.0	15-20	40-45	210	174	17
James Hawkins	2.5-5.0	2.5-5.0	15-20	40-45	241	201	19
Robert Shaw	2.5-5.0	5.0-7.5	50-55	155-160	951	872	34
Carl Vincent	0-2.5	0-2.5	30-35	85-90	523	489	20
Peter Counter	2.5-5.0	-	0-5	-	72	30	20
Isabel Hunt	0-2.5	-	0-5	-	37	12	12
Linda Whalley	0-2.5	2.5-5.0	25-30	85-90	562	523	18

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

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.

Staff numbers and related costs

An analysis of staff costs, the average number of staff employed and the distribution of pay and grades in the organisation is detailed below:

Staff costs comprise:
Subject to audit

	2015/16 £000	2014/15 £000
Permanent staff		
Salaries and wages	114,979	99,188
Social security costs	10,259	9,276
Employer superannuation contributions – NHSPS	14,704	12,610
Employer superannuation contributions – other	475	644
Staff seconded to other organisations	901	1,420
Termination benefits	2,559	(161)
	143,877	**122,977**
Other staff		
Temporary staff	1,243	1,809
Contractors	8,726	11,839
Staff seconded from other organisations	952	1,401
	10,921	**15,049**
Capitalised staff costs	(2,807)	(1,573)
	151,991	**136,453**

The average number of whole term equivalent persons employed during the year was:
Subject to audit

	2015/16 Number	2014/15 Number
Permanent staff and secondees	2,591	2,232
Temporary and contract staff	104	140
Total	**2,695**	**2,372**
The average number of whole term equivalent persons employed during the year whose time was capitalised	51	28

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

	Highest paid director	Range of staff remuneration	Median pay of the workforce	Ratio to the median of the workforce
2015/16 Excluding pension benefit	£190k - £195k	£13,216 to £195,536	£40,964	4.7
2014/15 Excluding termination payment and pension benefit	£180k - £185k	£13,216 to £195,536	£40,964	4.5

There have been no changes to the range of staff remuneration or the median pay.

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

Pension information

Most HSCIC staff are covered by the NHS Pension 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 Pension 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. The scheme is therefore accounted for as if it were a defined contribution scheme, whereby the cost to the organisation 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 Government Financial Reporting Manual (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 is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2016, is based on valuation data as at 31 March 2014, updated to 31 March 2016 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 published 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 considering the advice of the scheme actuary and appropriate employee and employer representatives.

On 16 March 2016, the Chancellor of the Exchequer announced a change in the Superannuation Contributions Adjusted for Past Experience (SCAPE) discount rate from 3.0 per cent to 2.8 per cent. This rate affects the calculation of CETV figures in this report. Due to the lead time required to perform calculations and prepare annual reports, the CETV figures quoted in this report for members of the NHS Pension scheme are based on the previous discount rate and have not been recalculated.

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 for these benefits to 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 HM Revenue and Customs 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 12 months ending 30 September in the previous calendar year. From 2011/12, the Consumer Price Index (CPI) has been used, replacing 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 currently 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. Four employees of the HSCIC were members of the NEST Scheme during 2015/16.

The Principal Civil Service Pension Scheme (PCSPS)

The Principal Civil Service Pension Scheme (PCSPS) and the Civil Servant and Other Pension Scheme (CSOPS) – known as Alpha – are unfunded multi-employer defined benefit schemes but the HSCIC is unable to identify its share of the underlying assets and liabilities. The scheme actuary valued the scheme as at 31 March 2012. Details can be found in the resource accounts of the Cabinet Office at www.civilservice-pensions.gov.uk.

For 2015/16, employers' contributions of £477,714 were payable to the PCSPS (2014/15 £470,374) at one of four rates in the range 20.0 per cent to 24.5 per cent of pensionable earnings, based on salary bands. The Scheme Actuary reviews employer contributions usually every four years following a full scheme valuation. The contribution rates are set to meet the cost of the benefits accruing during 2015/16 to be paid when the member retires and not the benefits paid during this period to existing pensioners.

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 earnings up to 30 September 2015 and from 8 per cent to 14.75 per cent of pensionable earning from 1 October 2015. Employers also match employee contributions up to 3 per cent of pensionable earnings.

No employees of the HSCIC have opted for the partnership pension account.

Reporting of Civil Service and other compensation schemes – exit packages

Total staff termination packages are detailed as follows and are subject to audit:

2015/16	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	1	18	19	6,006	123,250	**129,256**
£10,000 - £25,000	-	33	33	-	549,545	**549,545**
£25,000 - £50,000	-	32	32	-	1,146,932	**1,146,932**
£50,000 - £100,000	-	12	12	-	733,606	**733,606**
Total	**1**	**95**	**96**	**6,006**	**2,553,333**	**2,559,339**

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**

Analysis of other departures	Number of departures agreed	Total value of departures agreed
	Number	**£s**
Mutually agreed resignations (MARS) contractual costs	94	2,547,462
Contractual payments in lieu of notice	1	5,871
Total of exit packages	**95**	**2,553,333**

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 (via the Department of Health) 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).

The following is a breakdown of all off-payroll engagements as of 31 March 2016 that were for more than £220 per day and lasted longer than six months:

For all off-payroll engagements as of 31 March 2016, for more than £220 per day and that last longer than six months:	Number
Number of existing engagements as of 31 March 2016	52
Of which, the number that have existed:	
for less than one year at the time of reporting	32
for between one and two years at the time of reporting	11
for between 2 and 3 years at the time of reporting	6
for between 3 and 4 years at the time of reporting	3
for 4 or more years at the time of reporting	–

For all new off-payroll engagements between 1 April 2015 and 31 March 2016, 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 2015 and 31 March 2016	30
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	30
Number for whom assurance has been requested	19
Number for whom assurance has been received	15
Number for whom assurance has not been received	4
Engagements terminated as a result of assurance not being received or ended before assurance received	–

We have implemented an assurance process in line with guidance issued by the Department of Health. This includes requesting appropriate assurance from contractors as and when it is clear that their engagement is likely to exceed a 6-month period.

There are 11 posts, as of 31 March 2016, that meet the criteria of board members and/or senior officials with significant financial responsibility. As disclosed in the Remuneration Report, one of these was a secondee from another employer and therefore not technically on the HSCIC payroll. Verification of the payment of correct income tax and National Insurance contributions from their employing bodies has been received.

Transformation

Our transformation programme has continued to be the primary driver for organisational change, aimed at fulfilling our vision of becoming a high performing organisation with a reputation as an outstanding place to work. We are continuing to work in partnership with staff to transform our culture and ensure we remain focused on embodying our values of being professional, people focused, trustworthy and innovative. In 2015/16, we built the foundations of a new operating model for the organisation that will form the basis of a more customer and service-focused operational model and there was significant investment in engaging staff in the process.

We introduced professional groups across all work areas in 2015/16, with career ladders built around generic job descriptions. This will support a broader base of knowledge and skills, reduce the risk of single points of failure and target resources effectively at key priorities. In addition to a range of business and performance improvement projects, the transformation programme has addressed several workforce-related strategic developments, including:

a) Recruitment

We have successfully implemented our recruitment strategy, developing our employer brand and building on initiatives to develop staff in house, including work placements, apprenticeships and a graduate trainee scheme. These schemes have received positive feedback from trainees and from managers. Of 18 interns last year, 7 have secured permanent jobs and 2 have applied for the graduate scheme.

These schemes are being brought under the umbrella of the HSCIC Academy, which will underpin our approach to attracting and retaining the expertise and experience we require. We have improved our use of labour market analysis to identify new routes to market and this has resulted in a more strategic response to hard-to-fill posts.

b) Professional groups

We ended 2015/16 with the vast majority of our staff allocated to professional groups and generic job descriptions. This is beginning to deliver professional communities of practice across the organisation and a more coherent approach to identifying and addressing training and development needs. The professional groups will also support more agile and effective deployment of staff, managed by a smaller cadre of managers with the right skills and values.

Training programme	Number of roles
Work placements (across the HSCIC)	18
Apprenticeships	7
Graduate Trainee Scheme	9

c) Flexible deployment models

The professional groups form the 'supply side' of the organisation. Staff are assigned to key activities that align with their knowledge, skills, experience and – as far as possible – the individuals' circumstances and aspirations. This is combined with better forecasting and management of the 'demand' side of the organisation, to ensure that our staff are deployed to organisational priorities and have opportunities to develop their careers.

d) Performance and talent management

Our appraisal and performance development review processes have been improved, with a continuing focus on values, competencies and the delivery of objectives.

The 'nine box' talent management model, used to assess potential and performance, has been rolled out more widely and to good effect. It is starting to inform better decisions around staff development, promotion, succession planning and performance management. As a moderated process, it also brings more fairness and consistency.

e) Performance measurement and business intelligence

We have made good progress in the development and improvement of a range of key performance indicators (KPIs) and other management information, which are reported monthly to the Executive Management Team (EMT) and to the Board. Reports were also produced to support effective performance management at directorate level. These will be built around professional groups in the new operating model. KPIs are aligned with other governance activity, such as risk management and assurance, and we are committed to the continuous improvement of business intelligence linked to our key strategic priorities.

f) Staff engagement and communication

We have taken feedback about communication and engagement to inform improvements to our communication channels with staff and their representatives. A wide range of information is available on our intranet site, through the bi-monthly Insight staff magazine, a weekly bulletin and regular staff briefings. We have also introduced a regular conference call to offer all staff the opportunity to hear about important developments directly from the Chief Executive, and to have their questions answered.

Extensive consultation and engagement has supported the development of the transformation programme and our strategy. Formal consultation takes place with our trade unions on a range of policy and employment issues at monthly meetings and within sub-groups. We continue to build effective partnership working and joint problem solving, which has contributed to the delivery of the first phase of transformation.

A comprehensive staff survey was conducted in October 2015. The results were positive, with a significantly higher response rate and improved scores across all of the staff engagement questions. Action plans to address key themes coming out of the survey are being taken forward within the professional groups.

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 generated solutions to matters of common interest and improved engagement.

g) Staff development

More than 80 per cent of staff are now registered with Civil Service Learning and a wide range of online and classroom-based training is available to address core training needs. Specialist training is procured via a national gateway process. This has delivered efficiencies in training and the experience of staff taking part has been positive. Our spending on training increased, according to plan, compared with 2014/15.

Further improvements have been made to the induction training programme, including information and cyber security training. The programme continues to receive positive feedback. We have begun measuring and reporting on mandatory compliance to ensure it is completed by all staff.

Staff have demonstrated a high level of resilience and professionalism in adapting to the challenges posed by our transformation programme and a strong commitment to our values and strategic objectives. Transformation will be established as 'business as usual' during 2016/17, driving cultural change and new ways of working in order to fulfil our vision for 2020. This will include a particular focus on innovation, quality, customer service and performance.

Community and social responsibility

We are developing a comprehensive approach to corporate responsibility that will address green transport, recycling, energy and employment issues. We have a special leave policy that allows staff paid leave to undertake public duties (e.g., magistrate, school governor and reserve forces roles).

We have also developed work experience and placement programmes that will be extended to schools, colleges and universities within the catchment areas of our locations over the next 12 months. The MetroCard and Cycle to Work schemes encourage staff to commute using more environment and community friendly means of transport. Car use for business purposes is restricted to situations in which it is impractical for staff to travel by public transport.

Diversity and inclusion

The HSCIC continued to promote inclusive practices in our day-to-day interactions with our employees, with executive director-level accountability for driving diversity and inclusion across the business.

During 2015/16, we achieved the following:

- development of a new diversity and inclusion working group guided by the Director of Customer Relations to encourage and support activity across the organisation
- membership of the NHS Equality and Diversity Council
- external review and re-accreditation of the JobCentre Plus 'Two Ticks' symbol, illustrating our commitment to the employment, retention, training and career development of disabled employees
- signing up to the Mindful Employer Charter and working towards removing barriers for employees with mental health issues
- introduction of the HSCIC Academy, which provides graduate programmes and apprenticeships to increase opportunities for young people
- development of the annual diversity and inclusion workforce report and gender pay report, which provides a baseline understanding of the workforce, analysis of diversity data and remedial actions
- continued work on the introduction of diversity awareness training for employees, with plans to mandate this during 2016/17.

The following diversity objectives have been agreed for the period 2016 to 2020:

- We will deliver appropriate learning and development to ensure that all HSCIC staff develop a good level of equality and diversity awareness.
- We will work towards having no difference in the employment outcomes for HSCIC staff or potential recruits because of protected characteristics.
- We will develop best practice in workforce equality and diversity by creating internal and external networks and supporting positive action initiatives.
- Guided by industry best practice, we will seek to deliver clearer, more representative, and more accessible information and guidance when we communicate with the public and service users.
- We will establish a network of staff who will investigate the ways in which we can ensure that our products, policies and behaviours reflect the communities we serve and do not disadvantage or otherwise negatively impact users of our services and the public.
- As the trusted national provider of high-quality information and data about health and social care, we will improve our focus on protected characteristics in the information that we collect and share. By doing so, we will improve knowledge about the health of, and care experienced by, those with protected characteristics.

The average number of staff employed, split by gender and grades, is as follows:

	AfC equivalent grades	2015/16		2014/15	
		Male	Female	Male	Female
Directors	Very senior pay	6.0	3.0	6.4	1.5
Senior Managers	Grade 9	38.1	12.4	32.1	13.9
	Grade 8d	84.6	32.1	90.7	26.6
Managers	Grade 8c	190.2	93.5	163.1	81.4
	Grade 8b	316.6	144.9	278.9	128.3
	Grade 8a	363.4	219.0	280.9	174.9
Other Staff	Grade 7	262.5	210.8	219.3	187.1
	Grade 6	126.2	158.0	112.1	132.6
	Grade 5	82.8	144.2	83.7	139.9
	Grade 4	58.2	62.5	55.1	76.3
	Grade 3	19.4	44.7	19.8	46.8
	Grade 2	2.1	2.8	1.3	1.2
	Secondees	13.0	4.0	8.8	9.3
Total		**1,563.1**	**1,131.9**	**1,352.2**	**1,019.8**

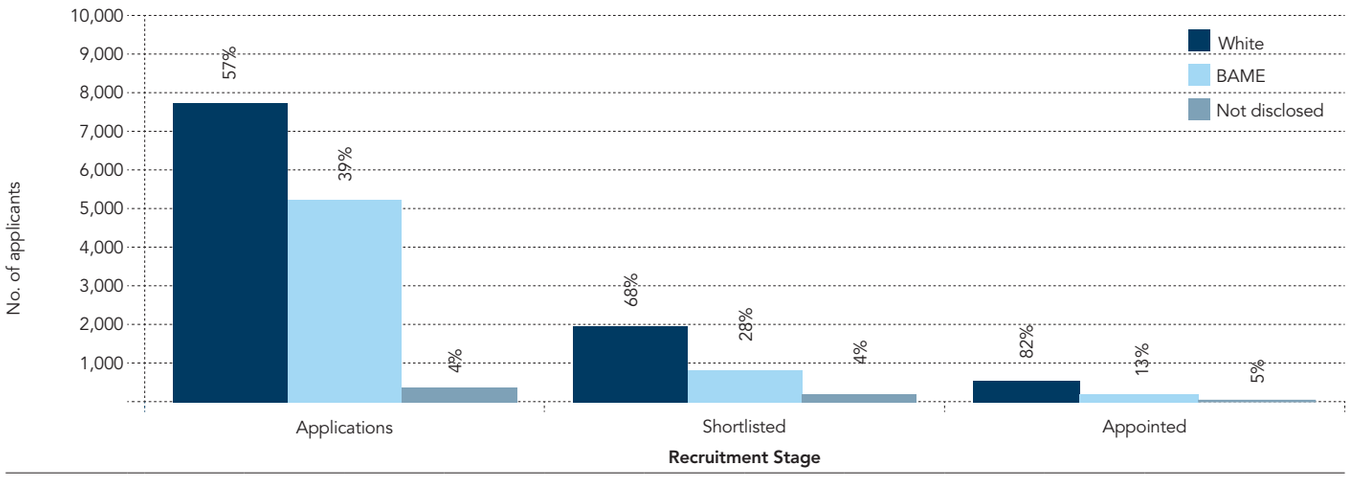
We manage complex and high-profile national systems and services that require many technical experts such as system engineers, software developers, technical architects, programme directors and commercial managers. Many are employed at grades that may be more closely aligned with management grades in other organisations but they do not, in many cases, have specific responsibility for managing staff or significant parts of the organisation. In our new operating model from April 2016, for example, some 250 staff at a range of grades will have ongoing staff management responsibilities, supported by assignment managers who will oversee the day-to-day contribution of staff working within services, projects and programmes.

Fifty-eight per cent of all employees are male (2014/15 57 per cent), compared with the British business average of 53 per cent. The latest figures from the UK Commission for Employment and Skills show that the number of women in the British 'digital workforce' in 2015 was 27 per cent. We are engaging in a number of activities to promote digital careers for women, including work with 'Women in Digital', which is focused on getting more women into digital apprenticeships.

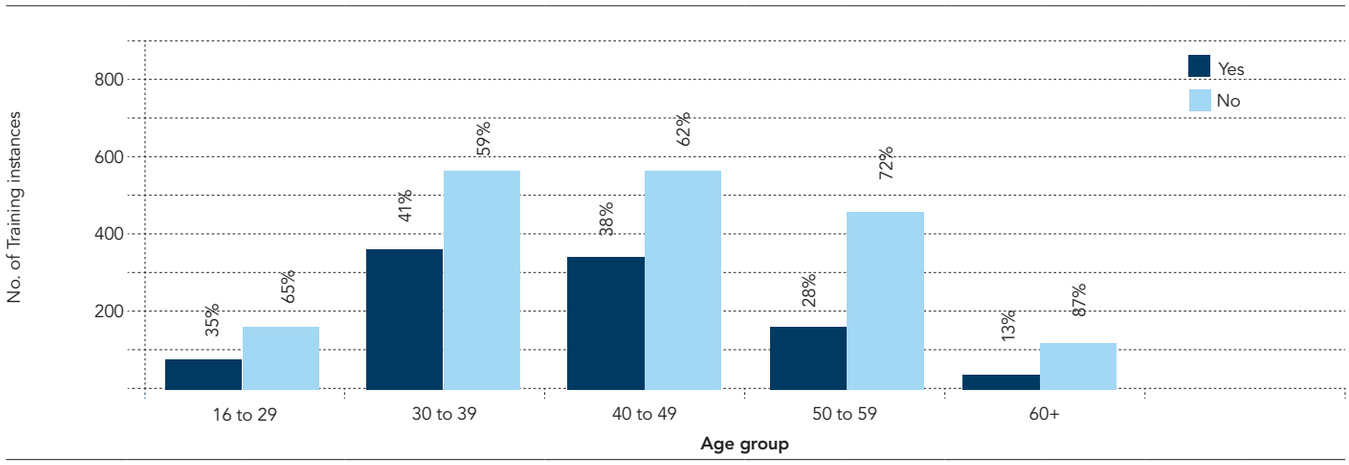
Some examples of the data we are now able to report are reproduced in the bullet points and charts below. These are based on staff directly employed on our payroll on 31 March 2016.

- The proportion of applications received from Black, Asian and Minority Ethnic (BAME) candidates during 2015/16, at 39 per cent, is almost three times higher than the BAME population's representation in the general population of England and Wales (2011 Census: 14 per cent). BAME applicants accounted for 13 per cent of all appointments made during 2015/16, which is closer to the census figure and indicates a rising trend from the 11 percent of the current HSCIC workforce from BAME backgrounds. In 2016/17, we will be exploring why more applications did not result in appointments.
- The conversion rate from application to appointment for males and females was approximately the same.
- Seven per cent of all applicants declared a disability; this converted to the same proportion at shortlisting stage and reduced slightly to 5 per cent at appointment stage.

Recruitment activity by ethnic group



Training received by age group



- Employees aged 60+ were less likely to access training than other age groups.
- There was no difference in the level of training provided to employees with and without a disability.
- Employees from BAME groups were more likely to access training (42 per cent) than white employees (35 per cent).
- Women were slightly more likely to access training (38 per cent) compared with men (33 per cent).
- Employees describing their sexual orientation as LGBT were more likely to access training (48 per cent) than heterosexual employees (36 per cent).

The 2015 staff survey results showed that:

- younger employees (16-30) were more likely to recommend the HSCIC as a place to work
- the staff engagement score was equal for both genders and scores against all questions were very similar
- responses to most of the staff engagement questions were generally slightly more positive from BAME groups when compared to white groups. However, staff from all ethnic backgrounds had a positive (green) staff engagement score. There was also a green rating from all staff groups for support from managers.

Health and safety

We have legal responsibilities for the health, safety and welfare of our 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 2015, 13,101 (2014 10,985) working days were lost due to sickness absence. This represented 5.2 (2014 5.1) working days per employee. The above figures are based on calendar year, not financial year, data and were centrally produced from the Electronic Staff Record. Average sickness absence for 2015 was 2.33 per cent.

Consultancy

The total spend on consultancy, as defined by HM Treasury guidance, amounted to £99,878.

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 2015/16 was £95,000 (2014/15 £100,000). 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 Department of Health audit framework.

Losses and special payments Subject to audit

There were 155 losses and special payments in 2015/16 (2014/15 310) amounting to £12,525 (2014/15 £3,248,300).

Losses and special payments include debts written off, losses of minor IT equipment and mobile phones and the reimbursement of debt collect costs to suppliers.

The losses and special payments in 2014/15 also included:

- 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 £1,428,316
- the write off of expenditure with respect to the abandonment of a project for the development of an indicator portal of £304,095.

Interest paid under the Late Payment of Commercial Debt (Interest) Act 1998 amounted to £nil (2014/15 £44).

Remote contingent liabilities

In addition to contingent liabilities reported within the meaning of IAS 37, we also detail below those liabilities for which the likelihood of a transfer of economic benefit in settlement is too remote to meet the definition of contingent liability.

We have not identified any significant remote contingent liabilities.

Annual governance statement

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 and for ensuring citizens' health data is protected. 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 the statutory functions described within the Health and Social Care Act.

Over the course of the year, we have continued to strengthen our governance arrangements and to embed these more widely across all areas of the HSCIC. Although internal audit identified areas of good progress, it also highlighted areas where greater rigour was required. Steps are being taken to address these concerns. Some examples of the strengthened controls that have already been put in place include:

- the development of a Risk Control and Assurance Framework to build on our assurance map and support our control over assurance provision and risk management by adopting an integrated and risk-based approach to control and assurance
- improved reporting of key performance indicators to executive management and the Board and strengthened risk management
- improved management of and processes covering data releases following the review by Sir Nick Partridge in June 2014. All nine recommendations for strengthening governance and control in this area have been adopted.

Scope of responsibility

Our Board and accounting officer are responsible for maintaining a sound system of internal control that supports the achievement of our policies, aims and objectives while 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 sought to exercise these responsibilities by establishing visible and effective systems of internal control and governance.

The Senior Departmental Sponsor for the Department of Health is responsible for assuring that our procedures operate effectively, efficiently and in the interest of the public and the health sector.

Organisational developments

Following the recruitment of the senior management structure during 2014/15, the new team consolidated and matured with the only change being the appointment of a Policy and Strategy director from December 2015. Following the end of the 2015/16 financial year, a number of changes have occurred, including the appointment of:

- a new chair, effective from 1 June 2016
- a chief operating officer, effective from 1 April 2016, broadening the role of the previous Director of Operations and Assurance Services
- a director of workforce effective from 1 April 2016, broadening the role of the previous Director of Human Resources and Transformation
- a director of digital transformation, effective from 1 June 2016
- the chief technology officer left the organisation as of 30 April 2016.

During the year, the Executive Management Team (EMT) agreed a new transformation vision to 'empower our people and our organisation to be more flexible and agile in order to deliver the right things for our customers with greater efficiency and provide better value for money in line with the urgent needs of the health and care system'. It is anticipated that the transformation and revised operating model will facilitate a more customer-focused approach and increase transparency. This will be underpinned by an organisation-wide cultural change programme. The transformation programme is being delivered through five workstreams over two phases: Phase 1 (to April 2016), focusing on putting in place the key building blocks to deliver this vision; and Phase 2 (April 2016 and beyond), focusing on cultural change, promotion standards, talent management, and a new learning and development strategy. Phase 1 has been successfully implemented with all staff allocated to professional pools, the internal structures addressed and time recording and resource planning functionality commencing.

The governance framework

Details of our constitution, our operational accountability, our Board and its appointed committees are given on pages 44 to 57. Information about 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 have been reviewed during the course of 2015/16. We have also undertaken a review of Board effectiveness and governance and the findings were brought to the attention of the Board. The review did not highlight any significant issues that required immediate action or that impacted on the governance statement.

The quality of the information and papers provided to the Board and its committees is considered to be sufficient. Improvements have been made during the year to develop KPIs, reporting against the key deliverables, risk issues and in the quality of monthly financial data. Improvements are to be undertaken during 2016/17 with respect to the accuracy of financial forecasting, fully absorbed costings of major programmes and services and data quality KPIs.

Corporate governance

Corporate governance assurance is provided through a quarterly Statement of Internal Control against criteria laid out by the Department of Health. This is approved by the Chief Executive and delivered to the Department of Health sponsor. We have developed an assurance map that provides assessments of the assurance in place across the organisation against strategic risks using the 'three lines of defence model'. The map has also been used in developing the internal audit programme for 2015/16. We are building on the assurance map to develop an integrated Risk, Control and Assurance Framework.

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.

We will further develop our corporate arrangements as we define and implement a new operating model as part of our transformation programme.

Statutory obligations

A review of the level of compliance with our statutory obligations, which are contained within the Health and Social Care Act 2012, was carried out. This resulted in changes to strengthen the assurance arrangements and make them more evidenced based. These changes have been reviewed by internal audit and further refinements are being made.

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. The act places a duty on all national arms length bodies (ALBs) to work collaboratively in the interests of the system as a whole.

The National Information Board (NIB) is the key strategic co-ordinating body in health and care data, information and technology. Our Chief Executive is a member of the NIB's Leadership Group and a significant number of our EMT and senior managers are involved in the development of the plans for delivering the NIB commitments during 2016/17. We expect that the HSCIC will have a significant role to play in delivering these commitments and we are therefore planning to ensure that we are ready to act effectively once the necessary investment decisions and approvals are in place.

We have worked to improve relationships with all our customers. The Customer Relations directorate created three new teams:

- Strategic Account Management, whose purpose is to develop relationships with key sectors (national health agencies, social care, research and life sciences, business intelligence and industry liaison)
- External Relations, responsible for managing our relationships with other key stakeholders and influencers, including Parliament, government, think tanks and the Royal Colleges,
- Insight and Research, to ensure effective understanding of, marketing and communication to, and engagement with all of our audience and customer groups. We will work collaboratively with the Government Communications Service Insight Group to ensure common best practice and to share insight and research when appropriate.

Members of the EMT have also been assigned one-to-one relationships with key stakeholders.

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), what factors that could prevent successful delivery and how they can be mitigated (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 our commitments to stakeholders. It includes the following elements:

- KPIs at differing levels of granularity reported in performance packs to the Board, EMT and business units. These KPIs are at a mix of maturity and contain financial and non-financial performance information, key risks and issues, and an assessment of delivery against strategic commitments
- monitoring of business plan delivery with reports provided to the Board and EMT. Each director had a quarterly performance review with the Chief Executive Officer and the Director of Finance
- performance reporting of other key work, such as delivery of specific programmes and organisational development and transformation.

The performance framework and individual performance indicators are kept under regular review to ensure they remain meaningful and effective. With the exception of a few confidential indicators, all elements of the performance framework are reported to public meetings of our Board and most of the information is available on our website. Our performance reporting supports open and transparent governance and constitutes an important channel of public accountability. Performance packs and business plan monitoring reports also inform quarterly accountability meetings between ourselves and the Department of Health.

We have established a performance management community to provide an internal professional network and source of expertise. The most recent internal audit review of corporate performance management arrangements found many instances of good practice.

Risk management

Toward the end of 2015/16, we consolidated our corporate risk and assurance functions and plan to further integrate these during 2016/17. Our main focus during 2015/16 has been on training and communications to develop management capability and awareness of risk and to improve the reporting of our most significant risks.

We started a review of the current risk data repository and continue to carry out regular quality assurance checks to ensure that the risk information held is current, accurate and of good quality.

We have refined the corporate risk management KPI and Strategic 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 maintained 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 its 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, the Assurance and Risk committee (ARC) and our Board.

During 2015/16, we have:

- refined our risk KPIs to focus on the effectiveness of the outcomes of risk management effort
- continued delivery of our targeted risk management improvement plan. We have focused 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
- explored 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
- reviewed our governance and accountabilities for managing risks, especially where these cross organisational boundaries
- sought opportunities to leverage the use of risk information in decision-making.

We will continue these activities during 2016/17, with an emphasis on continuing to integrate risk, control and assurance effort.

Information governance

We are committed to robust information governance and have put in place consistent procedures across our organisation that support the work we have been commissioned to deliver.

During 2015/16, we have continued to meet our governance responsibilities to provide system-wide advice on operational information governance across the health and social care sectors. This is separate from our principal role as the guardian of data, which is set out in the Health and Social Care Act 2012.

We have developed an information governance strategy led by executive directors. Our aim is to earn the public's trust by ensuring that all our staff are committed to the safe and efficient handling of information.

We have committed to:

- clearly communicate what we do with information and how we keep it safe
- continuously improve our information services for the benefit of health and care
- foster an environment of continuous learning
- shape the highest standards of behaviour and integrity
- proactively seek oversight.

Our information governance strategy was approved by the HSCIC Board in September 2015 and is accompanied by a work plan with executive director ownership of actions. We have started to implement key parts of the work plan including:

- training for key information asset owners certified by CESG, the government's national technical authority for information assurance
- implementation of the online Access to Personal Confidential Data Tool for staff to replace manual processes
- development of a consolidated policy for information governance and security
- reconstitution of the information governance working group to focus on the assessment of implementation of good practice throughout the organisation
- consolidation of web pages to inform the public about how we handle their data.

We believe that any data loss or breach is significant and we have a robust process for responding to incidents and managing controls as well as risks.

We continue to host the Information Governance Alliance (IGA) 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. Guidance continues to be published and networks are being engaged. HSCIC works collaboratively alongside NHS England, Public Health England and the Department of Health to position the IGA as the single source of information governance advice and guidance for the health and care system.

As a further example of this system-wide remit we have made several improvements to the IG Toolkit, including making it more accessible to smaller organisations. We also established a Caldicott Implementation Monitoring Report to provide support to Dame Fiona Caldicott's National Data Guardian Panel.

We have also implemented a process for governing and assuring the use of HSCIC's power to request information under the Health & Social Care Act 2012, section 259.

A number of innovative cyber security projects funded by the Cabinet Office's National Cyber Security Programme (NCSP) are being run with the objective of benefiting the entire health and social care system. In particular, we have:

- established an authoritative national focal point and governance model for sector-wide cyber security guidance and incident support, the Care Computer Emergency Response Team (CareCERT), which broadcasts advisory information across the sector and receives threat information from trusted parties to inform the knowledge base
- developed a 'scenario assist' package, with relevant supporting products made available to all health and care organisations and business partners to help guide cyber preparation, assurance and incident response
- established a strategic cyber risk oversight capability that will provide situational awareness monitoring of active risks so that scale is understood and early mitigations are possible
- piloted the Health Care Information Security and Privacy Practitioner (HCISPP) training for 100 security-minded professionals
- introduced cyber training for use by all staff across the health and social care system, which is to be made compulsory within the HSCIC but does not yet have a mandate across the wider system
- worked with the Department of Health, NHS England and NHS Improvement to establish a Cyber Executive Group, jointly chaired by NHS Engand's and HSCIC's senior information risk officers (SIROs), to support the Department of Health's Information Security and Risk Board.

Further bids are also being made to the programme, including:

- CareCERTified, which will build on the existing CareCERT brand to provide an on-site assurance scheme designed to assess cyber security readiness against an agreed set of criteria
- Information Management & Security (IM&S) Training, which will provide enhanced training facilities to fulfil the requirements of National Data Guardian (NDG) Review.

We have established a three-year cyber security programme (CSP) to enhance the HSCIC's information assurance and cyber security and will work to extend the scope of the programme to benefit the wider health and social care system.

Other activity to improve information governance during the year included:

- We provided expertise and project management support to the National Data Guardian's review of data security standards and consent.
- Working closely with the Department of Health and after engagement with the National Data Guardian (NDG), NHS England and the Information Commissioner's Office, the HSCIC has developed a system to allow us to uphold the type-2 opt-outs patients have registered with their GP. A direction[1] from the Secretary of State sets out the Department of Health policy as to how type-2 opt-outs must be applied and instructed the HSCIC to apply type-2 opt-outs from 29 April 2016. Further information is available at www.hscic.gov.uk/yourinfo. The system was successfully implemented in late April 2016.
- All of our staff complete training in line with requirements of the NHS Information Governance Toolkit (IG Toolkit). More specialist training is undertaken by staff responsible for the management and control of data assets and information. Compliance with mandatory training is monitored and staff lose system access if they do not complete the training annually.
- We complete the IG Toolkit assessment annually. We were compliant for 2015/16, exceeding the required 'satisfactory' level with an overall score of 91 per cent.
- During 2015/16, two incidents were logged on the Serious Incident Requiring Investigation (SIRI) incident reporting tool - one near miss and one breach. We investigated and managed these internally in accordance with and having been assessed against Information Commissioner's Office (ICO) and SIRI reporting guidelines. For the near miss, it was determined that ICO notification was not required. For the breach, this was reported to the ICO in March 2016. The incident has been resolved but the ICO investigation is currently ongoing.
- We are subject to the Data Protection Act (DPA) 1998 and have filed the appropriate notification with the ICO. During 2015/16, we received 916 Freedom of Information (FOI) requests and 67 Subject Access Requests (SARs). There were five breaches of the timescales for handling a FOI request and none for handling a SAR.
- Three complaints were made to the ICO by applicants dissatisfied with our response provided to them under the FOI Act. One complaint was made by an applicant dissatisfied with our response under the DPA. In all cases, the ICO was given clarification around the process undertaken, no additional data was released and no further action was 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 2015/16.
- We have established arrangements to audit the methodology of third party organisations in complying with the data sharing agreements they have with the HSCIC. We have carried out 25 audits during 2015/16 and publish the audit reports on our website. This is an important aspect of our assurance of the operation of our data sharing contracts, aimed at increasing public trust and confidence.
- We continue to meet our statutory responsibility to advise on the reduction of burden and bureaucracy through our Burden Advice and Assessment Service (BAAS), which will formally submit advice to the Secretary of State for the first time in 2016. The service assesses and challenges the burden of all new and changed national data collections and makes recommendations to the Standardisation Committee for Care Information (SCCI) and collection owners. It develops and reviews burden reduction plans (BRPs) with the Department of Health and each of its arm's-length bodies and carries out a rolling review of all existing data collections through engagement with health and social care data providers, clinical commissioning groups (CCGs) and collection owners. It continues to support system-wide work such as the government's Cutting Red Tape agenda and has worked with NHS England on minimising burden by strengthening the NHS Standard Contract. Through the BAAS Knowledge Hub, published in November 2015, we share products and tools, good practice and guidance that help the health and social care system in minimising the burden of data collections at a local level, including the burden self-assessment toolkit, pilot burden impact assessment protocol and a central register of assured national data collections.

Statistical governance

We comply with the Code of Practice for Official Statistics as set out by the UK Statistics Authority. The Head of Profession for Statistics oversees management of two key risks:

- breaches of the Code of Practice for Official Statistics, including the risk of publishing disclosive data
- errors in published figures.

Risks around disclosure are overseen by a Disclosure Control Panel, and all risks are managed through our standard risk management processes and escalation routes.

During 2015/16, there were ten breaches of the Code of Practice for Official Statistics. Five breaches related to release practices where publications were not available on our website at the official publication time for technical (memory limitations of the system, or not yet discerned) or manual (fields not being input, approvals not made) reasons. One breach related to release practices where a publication was briefly available on our website 5-10 minutes before its official publication time. The other four breaches were due to issues with pre-release access. In three instances, the briefing co-ordinators or other authorised recipients in external organisations mishandled pre-release access material, sending the material to the incorrect contact within their organisation. In the fourth, a draft press document was sent in error to an incorrect contact for review.

In line with the requirements of the Macpherson Report 'Review of quality assurance of Government analytical models', the Department of Health framework of quality assurance of business critical models includes two of our statistical models: Summary Hospital-level Mortality Indicator and Better Care, Better Value.

Data quality assurance

We understand the importance of good quality data and our role in ensuring that the data we collect, process and share is subject to the most rigorous levels of quality assurance. Given our unique position as a processor, user and sharer of national health and social care data, we also have a duty to promote understanding of the importance of data quality across the health and social care sector. A 2014/15 internal audit of our data quality assurance processes recommended improvements and we have completed the agreed actions, including:

- developing a five-year data quality assurance 'strategy on a page'
- publishing our policy for the quality assurance of secondary uses data
- investigating methods for assessing the accuracy of data
- developing a robust data quality assurance assessment process for use in the development of data collections and extractions.

We are drawing up proposals for improving our data quality assurance during 2016/17 by:

- developing policies for the quality assurance of non-secondary uses data
- monitoring the implementation of our secondary uses data quality assurance policy
- working collaboratively with our partners to develop requirements-based data quality assurance products, processes and tools
- ensuring new and existing data collections and extractions go through the data quality assurance assessment process.

Public interest disclosure

The HSCIC was one of the first 100 organisations to sign up to the Public Concern at Work (PCAW) Whistleblowing Commission code of practice. We attended an annual networking event to discuss progress in implementing whistleblowing procedures. We will continue to improve our policy and practice through engagement with PCAW to ensure we are compliant with the updated code. Policy responsibility in this area now falls under the remit of our finance and corporate services and, specifically, with the newly established role of counter-fraud specialist.

There is one live whistleblowing report that is currently being investigated internally by Human Resources.

In 2016/17, we will revise our whistleblowing communications strategy in line with the new recommendations to promote a culture in which staff feel empowered to speak up when they have concerns.

Chief Executive's 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 2015/16 has been informed in a number of ways. The internal audit team completed an agreed comprehensive range of assessments and the head of internal audit provided an opinion on the overall arrangements for implementing the assurance framework and on the controls reviewed as part of the internal audit work. The internal audit assurance statement concluded:

"*Overall, improvements are being made as the Health and Social Care Information Centre develops its governance, risk and control frameworks. Sound progress is apparent, but there is more to be done. My overall opinion is that I can give reasonable 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 2015/16.*"

My review of 2015/16 has also been informed by:

- my attendance at the ARC and my review of its minutes, papers and annual report to the Board, as well as my attendance at the Information Assurance and Cyber Security Committee (IACSC).
- work undertaken by the National Audit Office as the HSCIC's external auditors. This included a specific report on the governance of the General Practice Extraction Service (GPES), a project developed by one of our predecessor organisations. This report highlighted weaknesses in governance, contract management and testing of system functionality and was subject to a Public Accounts Committee review. I fully accepted these findings and I am working to ensure that current arrangements are sufficiently robust to avoid similar issues in the future. We are looking at the future of GPES and will develop a strategic plan to replace and enhance this service by March 2018.
- individual audit reports. Action plans were put in place to address recommendations and progress was reviewed by the ARC on a regular basis
- assurances from senior HSCIC managers with responsibility for the development and maintenance of the system of internal control
- clear performance management arrangements for executive directors and senior managers
- the assurance framework itself, which provided evidence on the effectiveness of the controls that manage the risks to the organisation.

I have been advised on the effectiveness of the system of internal control by the Board, the IACSC and ARC and, accordingly, I am 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 two years ago to develop, strengthen and improve our governance arrangements.

We acknowledged last year that there was still a significant amount of work to do, especially in addressing a number of historic gaps in our internal controls. This has underlined the need for cultural change. One of the main aims of the transformation programme we have established is to introduce better incentives and management information to help achieve this.

We have also put governance, assurance and control matters at the heart of the EMT agenda. We have a monthly meeting dedicated exclusively to this, where we discuss KPIs and risk and make a detailed review of internal audit reports and recommendations.

I believe we have made significant progress this year and are now well on the way to achieving the standards of control I expect of the organisation. We have worked closely with our auditors to address the problems identified and ensure immediate remedial action has been applied.

Last year, I initiated actions to address the specific concerns raised from internal audit reports around risk management, business continuity, disaster management and our financial controls. I'm pleased to report that follow-up audits have noted significant progress.

The issues concerning data quality and systems and service delivery form part of a wider focus on the management of data arising from Sir Nick Partridge's 2014 Review of Data Releases. Progress against this action is being monitored by the EMT and the ARC. A responsible manager for each area has been identified to ensure that all necessary remedial action is applied.

The major financial issue in previous years has been the identification and recording of non-current assets, which required significant review and reconciliation. Enough progress was made to provide adequate assurance for the 2013/14 and 2014/15 accounts, although we recognised that we needed to invest further. During 2015/16, we have:

- agreed to undertake full inventories of our asset base on a continuing basis. All IT equipment has been verified by physical checks or evidenced through our asset tracking software. Operating system software has been similarly verified and, for the first time, we have checked all of the estate's furniture assets.
- implemented a new financial fixed asset system to replace the former spreadsheet-based register. This has simplified accounting and provided improved reporting and resilience. It has been reconciled to the Configuration Management Database (CMDB), which is used by the IT team for management purposes. An end-to-end transaction process has been implemented to ensure that both registers are routinely aligned.
- developed detailed guidance notes around capital expenditure and implemented new purchase ordering processes, which have resulted in a significant improvement to the coding of transactions including the identification and recording of capital expenditure.
- contributed to a regular capital accounting forum with the Department of Health and NHS England finance teams to discuss funding and ownership issues of new projects, including producing an accounting policy around developments to the NHS Spine.

In addition to addressing emerging concerns and improving controls over the course of the year, we will also ensure specific effort in 2016/17 is focussed on strengthening assurance and control by:

- improving the organisation's understanding of, and compliance with, key financial controls and reporting requirements
- further developing the comprehensive internal assurance map to provide the Board and the Department of Health with assurance that the risk management of internal systems and procedures is aligned with established and developing assurance controls
- continuing our emphasis on protecting the organisation from cyber and social engineering attacks. This has been a major reason for our overhaul of information and physical security arrangements under the oversight of our Board sub-committee IACSC. These arrangements include ensuring that staff who have access to patient identifiable data have appropriate security clearance.
- ensuring our governance and controls around the release of data are consistent with Sir Nick Partridge's recommendations and are transparent and fair.

I accept the observations by both the internal auditors and the National Audit Office and I believe them to be a fair and accurate view of the organisation at this point in its development. Much remains to be done. We will continue to embed the development of rigorous and sound assurance as one of the key priorities in 2016/17.

Andy Williams
Chief Executive
27 June 2016

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 and of our net resource outturn, application of resources, changes in taxpayers' equity and cash flows for the financial year.

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

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

The Accounting Officer for the Department of Health has appointed our chief executive as the Accounting Officer who has 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. The Accounting Officer is also able to confirm that:

- as far as he is aware, there is no relevant audit information of which the auditors are unaware
- he has made himself aware of any relevant audit information and has established that the entity's auditors are aware of that information
- the Annual Report and Accounts as a whole our fair, balanced and understandable
- he takes personal responsibility for the Annual Report and Accounts and the judgements required to determine that they are fair, balanced and understandable.

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 2016 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 and Staff Report and the parliamentary disclosures that are 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 Annual Report and Accounts 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
- 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 2016 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 parts of the Remuneration and Staff Report and the parliamentary accountability disclosures to be audited have been properly prepared in accordance with the Secretary of State's directions made under the Health and Social Care Act
- the information given in the Performance Report and Accountability 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 and Staff 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.

Amyas C E Morse
29 June 2016

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 2016

	Note	2015/16 £000	2014/15 £000
Expenditure			
Staff costs	3	151,991	136,453
Other expenditure	5	57,751	63,681
Depreciation and amortisation	5	14,707	12,537
Loss on disposal of non-current assets	5	376	2,438
Total expenditure		**224,825**	**215,109**
Less income	4	(61,684)	(55,670)
Net operating expenditure for the financial year		**163,141**	**159,439**
Net gain on assets and liabilities transferred under absorption accounting	14	–	(1,246)
Net (gain) / loss on reconciliation of transferred assets	6	(1,226)	41
Net expenditure for the financial year		**161,915**	**158,234**
Other comprehensive expenditure			
Net gain on the revaluation of property, plant and equipment		–	(42)
Total comprehensive expenditure		**161,915**	**158,192**

All income and expenditure derives from continuing operations.

Notes 1 to 22 form part of these financial statements.

Statement of financial position
As at 31 March 2016

	Notes	31 March 2016 £000	31 March 2015 £000
Non-current assets			
Property plant and equipment	7	19,052	16,065
Intangible assets	8	25,380	27,366
Other non-current receivables	9	-	528
Total non-current assets		**44,432**	**43,959**
Current assets			
Trade and other receivables	10	34,831	25,061
Cash and cash equivalents	11	10,152	10,247
Total current assets		**44,983**	**35,308**
Total assets		**89,415**	**79,267**
Current liabilities			
Trade and other payables	12	(25,826)	(29,602)
Provisions	13	(592)	(176)
Total current liabilities		**(26,418)**	**(29,778)**
Non-current assets plus net current assets		**62,997**	**49,489**
Non-current liabilities			
Provisions	13	(1,921)	(1,888)
Assets less liabilities		**61,076**	**47,601**
Taxpayers' equity			
General reserve		61,076	47,578
Revaluation reserve		-	23
Total taxpayers' equity		**61,076**	**47,601**

Notes 1 to 22 form part of these financial statements.

The financial statements on pages 84 to 105 were approved by the Board on 8 June and signed on its behalf by:

Andy Williams
Chief Executive

Dated
27 June 2016

Statement of cash flows
For the year ended 31 March 2016

	Notes	2015/16 £000	2014/15 £000
Cash flows from operating activities			
Net operating expenditure for the financial year		(163,141)	(159,439)
Adjustment for non-cash transactions:			
– depreciation and amortisation	5	14,707	12,537
– loss on disposal of non-current assets	5	376	2,438
– provisions arising during the year	13	611	637
Decrease in non-current receivables	9	528	285
(Increase) / decrease in trade and other receivables	10	(9,770)	441
(Decrease) / increase in trade and other payables	12	(3,776)	647
(Increase) / decrease in capital accruals		(479)	541
Provisions utilised	13	(162)	(81)
Net cash outflow from operating activities		**(161,106)**	**(141,994)**
Cash flows from investing activities			
Purchase of property, plant and equipment		(7,835)	(7,620)
Purchase of intangible assets		(6,544)	(7,070)
Net cash outflow from investing activities		**(14,379)**	**(14,690)**
Cash flows from financing activities			
Grants from the Department of Health: cash drawn down in year		175,390	144,000
Net financing		**175,390**	**144,000**
Net reduction in cash in the period	11	**(95)**	**(12,684)**
Cash and cash equivalents at the beginning of the period	11	10,247	22,931
Cash and cash equivalents at the end of the period	11	10,152	10,247
Net reduction in cash in the period	11	**(95)**	**(12,684)**

All cash flow relates to continuing activities.

Notes 1 to 22 form part of these financial statements.

Statement of changes in taxpayers' equity
As at 31 March 2016

	General reserve £000	Revaluation reserve £000	Total reserves £000
Balance at 31 March 2014	**61,793**	**–**	**61,793**
Changes in taxpayers' equity			
Net expenditure for the financial year	(158,234)	–	**(158,234)**
Gain on the revaluation of property, plant and equipment	–	42	**42**
Movement between reserves	19	(19)	**–**
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**
Balance at 31 March 2015	**47,578**	**23**	**47,601**
Changes in taxpayers' equity			
Net expenditure for the financial year	(161,915)	–	**(161,915)**
Movement between reserves	23	(23)	**–**
Total recognised income and expense	**(161,892)**	**(23)**	**(161,915)**
Grant in Aid from the Department of Health: cash drawn down in year	175,390	–	**175,390**
Total Grant in Aid funding	**175,390**	**–**	**175,390**
Balance at 31 March 2016	**61,076**	**–**	**61,076**

Notes 1 to 22 form part of these financial statements

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 are 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 2015/16 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 that 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.

'Transfers 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 Department of Health Group 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.

Early adoption of accounting standards amendments and interpretations

No accounting standard changes were adopted early in 2015/16.

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

The FReM does not require the following standards and interpretations to be applied in 2015/16. The application of the standards as revised would not have a material impact on the accounts for 2015/16, were they applied in the year:

- IFRS 9 Financial Instruments – effective for accounting periods starting on or after 1 January 2018, but not yet adopted by the FReM.
- IFRS 14 Regulatory Deferral Accounts – not yet endorsed by European Union, not applicable to Department of Health Group bodies.
- IFRS 15 Revenue for Contract with Customers – effective for accounting periods starting on or after 1 January 2017, but not yet adopted by the FReM.

  The HSCIC does not believe that the application of the above standards would have a material impact to the accounts.
- IFRS 16 Leases – effective for accounting periods beginning on or after 1 January 2019, but not yet adopted by the FReM. The HSCIC recognises that the application of this standard is likely to have a material impact to the accounts, but with most material leases, currently expiring prior, or in close proximity to, this date its impact cannot currently be accurately assessed.

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 Department of Health within an approved cash limit, which is credited to the general reserve. The grant 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 Administration, programme and annually managed expenditure

The analysis of income and expenditure for non-departmental public bodies between administration and programme is only required to be consistent with returns made for the purposes of the Department of Health Group consolidation. The net operating expenditure for the financial year in the consolidation return submitted to the Department of Health was split between net administration expenditure of £149.1million and net programme expenditure of £13.6million.

The difference between the total of the administration and programme expenditure and the net operating expenditure for the year reported in the Statement of Comprehensive Net Expenditure is attributable to expenditure falling under the Annually Managed Expenditure (AME) heading, which relates to the creation and usage of provisions.

1.5 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.

1.6 Losses and special payments

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

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

1.7 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.

1.8 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 have a cost equal to or greater than £5,000; or
   - collectively have a cost of at least £5,000 and, 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 that 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 and, 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 Department of Health, has been agreed. Those assets procured or developed that are deemed to form part of the HSCIC's statutory functions primarily in relation to the collection, storage, analysis and dissemination of data and information are capitalised in the HSCIC's 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. Carrying gross cost

Non-current assets are initially recognised at cost, including expenditure such as installation directly attributable to bringing them into working condition. Subsequently, non-current assets are held at current value in existing use. Any increase in value 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 restatement in value 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 assessed 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 current value in existing use at March 2016 was not materially different to the original historic cost and thus no adjustment has been incorporated, except for land and buildings that 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 are 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 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 1–12 years
   - office, information technology, short life equipment 1–5 years

The estimated useful lives and residual values are reviewed annually.

1.9 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 the asset is brought into use.

1.10 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 of 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.

1.11 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.

1.12 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.

1.13 Pensions

Past and present employees are covered by the NHS Pension scheme (NHSPS), the Principal Civil Service Pension scheme (PCSPS) and the Civil Servant and Other Pension scheme (CSOPS). These 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 body participating in the scheme taken as equal to the contributions payable to the scheme for the accounting period.

1.14 Critical accounting judgements and key sources of estimation uncertainty

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

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

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

Revenue recognition

The 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 comprehensive net expenditure in order to reflect as closely as possible the phasing of the expenditure incurred.

Dilapidation provision

The HSCIC has provided £2million 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 was undertaken in 2014/15 with the result that management amended the assets carrying value for the GPET-Q element to amortise the remainder of the GPET-Q asset value over a reduced two year life. During 2015/16, a reappraisal of the anticipated life of all aspects of the GPES asset has been undertaken resulting in a re-life to March 2018 when a new data extraction system is expected to be implemented. The impact was a reduction in the 2015/16 amortisation charge of £1.3m, an expected reduction in 2016/17 of £0.7m and an increase in 2017/18 of £2.0million.

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 undertook a physical evidence check on computer hardware and software licences together with a reconciliation between the IT asset list and the financial ledgers and adopted the resulting IT asset list to represent the assets at 31 March 2015. Additional work was undertaken during 2015/16, identifying some further adjustments to the asset carrying values.

1.15 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.

1.16 Financial instruments

The HSCIC operates 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 the significant degree of financial risk that is faced by most other business entities. The HSCIC has no borrowings and relies largely on Grant in Aid from the Department of Health for its cash requirements. The HSCIC is therefore not exposed to liquidity risks. All cash balances are held within the Government Banking Service 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 receivables. Trade receivables 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.

1.17 Going concern

Confirmation has been received of the main Grant In Aid budget allocation for the 2016/17 financial year in line with the business plan submitted. Consequently, the financial accounts have been prepared on the basis that the HSCIC is a going concern.

2 Statement of operating costs by activity

IFRS8 requires operating segments to be identified on the basis of internal reports that are regularly reviewed by the Chief Executive. The HSCIC's Board monitors the performance and resources of the organisation by directorate.

For the period ended 31 March 2016

£000	Architecture Standards & Innovation	Customer Relations	Information & Analytics	Operations & Assurance Services
Income	(7,098)	(163)	(11,269)	(21,510)
Staff costs	17,361	3,852	24,403	45,819
Professional fees	731	220	6,109	8,327
Information technology	1,166	53	1,187	11,665
Accommodation	107	27	30	1,125
Travel & subsistence	529	100	462	1,655
Marketing, training & events	214	260	187	867
Office services	275	156	115	607
Other	11	(1)	(4)	22
Depreciation / amortisation	-	-	308	302
Non staff costs	**3,033**	**815**	**8,394**	**24,570**
Net expenditure	**13,296**	**4,504**	**21,528**	**48,879**

For the period 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**

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

Provider Support & Integration	Health Digital Services	Finance & Corporate Services	Clinical Leadership	HR & Transformation	HSCIC Corporate	Total
(5,253)	(16,276)	(194)	-	-	79	(61,684)
16,774	23,990	13,353	775	2,563	3,101	151,991
1,408	202	1,989	-	92	(650)	18,428
158	4,333	653	-	22	(280)	18,957
50	957	9,372	-	18	200	11,886
976	1,399	277	64	38	(112)	5,388
309	424	68	17	133	(132)	2,347
13	72	1,453	1	42	(41)	2,693
1	1	16	-	70	(1,701)	(1,585)
-	5,672	-	-	-	8,438	14,720
2,915	**13,060**	**13,828**	**82**	**415**	**5,722**	**72,834**
14,436	**20,774**	**26,987**	**857**	**2,978**	**8,902**	**163,141**

Provider Support & Integration	Health Digital Services	Finance & Corporate Services	Clinical Leadership	HR & Transformation	HSCIC Corporate	Total
(276)	(20,738)	(274)	(44)	(56)	67	(55,670)
10,565	25,379	16,269	511	2,232	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	25	39	(134)	4,482
116	204	165	5	120	(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**	**30**	**641**	**10,812**	**78,656**
11,097	**20,037**	**32,593**	**497**	**2,817**	**11,164**	**159,439**

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 & Integration	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.
Health Digital Services	Health Digital Services delivers IT-enabled business change programmes, projects and operational services across the health and social care system including the 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 corporate services, 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.
Clinical Leadership	To provide clinical input and support to all programmes and services.
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 that are not specifically allocated to directorates, including depreciation, staff termination costs and other central accounting adjustments.

3 Staff costs

Staff costs comprise:	2015/16 £000	2014/15 £000
Permanent staff		
Salaries and wages	114,979	99,188
Social security costs	10,259	9,276
Employer superannuation contributions - NHSPS	14,704	12,610
Employer superannuation contributions - other	475	644
Staff seconded to other organisations	901	1,420
Termination benefits	2,559	(161)
	143,877	**122,977**
Other staff		
Temporary staff	1,243	1,809
Contractors	8,726	11,839
Staff seconded from other organisations	952	1,401
	10,921	**15,049**
Capitalised staff costs	(2,807)	(1,573)
	151,991	**136,453**

4 Income

Income analysed by classification and activity is as follows:	2015/16 £000	2014/15 £000
Income from activities		
Programme and project management	13,415	17,852
Surveys and data collection	1,660	4,952
Service delivery	40,298	28,223
Fees and charges	3,541	2,910
Other income	29	(7)
	58,943	**53,930**
Other income		
Other non trading income	2,741	1,740
	61,684	**55,670**

Income from programme and project management relates to workstreams primarily for the Department of Health and NHS England, together with staff time recharged to Department of Health national programmes.

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

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

5 Other expenditure

	2015/16 £000	2014/15 £000
Operating expenditure		
Workpackages and professional fees	11,420	11,394
Data collection and surveys	5,657	8,832
Legal fees	1,351	2,622
Chair and non-executive emoluments	114	120
Marketing, training & events	2,347	1,513
Travel	5,388	4,482
Premises and establishment	11,886	14,256
IT maintenance and support	18,957	17,134
General office supplies and services	2,343	2,752
Communications	350	253
Insurance	95	257
External audit fees	95	103
Internal audit fees	217	165
Provision for impairment of receivables	(5)	(215)
Other	(3)	13
	60,212	**63,681**
Other Items		
Prior years' partial exemption VAT claims	(2,461)	–
	57,751	**63,681**
Non-cash transactions		
Depreciation – property, plant & equipment	5,336	5,105
Amortisation – intangible assets	9,371	7,432
Loss on disposal of non-current assets	376	2,438
	15,083	**14,975**
	72,834	**78,656**

During 2015/16, partial exemption VAT claims have been undertaken for three financial years. The impact of the 2015/16 claim has been incorporated into the various cost headings above as appropriate, but the claims relating to the two prior years have been shown as a separate line so as not to distort the analysis. The claims for 2013/14 and 2014/15 have been treated as in-year transactions, rather than prior-year adjustments, since agreement for the claims was only reached with HM Revenue and Customs during the 2015/16 financial year.

6 Net (gain) / loss on reconciliation of transferred assets

	2015/16 £000	2014/15 £000
Adjustment to asset values following transfer	(1,226)	–
Alignment of depreciation and amortisation policies	–	41
Net (gain) / loss	**(1,226)**	**41**

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 2015	310	1,170	23,673	5,733	30,886
Additions	-	-	5,477	2,074	7,551
Adjustments arising from asset review	-	-	3,294	-	3,294
Disposals	-	-	(615)	(39)	(654)
At 31 March 2016	**310**	**1,170**	**31,829**	**7,768**	**41,077**
Depreciation					
At 1 April 2015	-	309	11,455	3,057	14,821
Provided during the year	-	42	4,617	677	5,336
Adjustments arising from asset review	-	-	2,310	-	2,310
Disposals	-	-	(436)	(6)	(442)
At 31 March 2016	**-**	**351**	**17,946**	**3,728**	**22,025**
Net book value at 1 April 2015	310	861	12,218	2,676	16,065
Net book value at 31 March 2016	**310**	**819**	**13,883**	**4,040**	**19,052**

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.

Adjustments arising from the asset review refers to the outcome of ongoing work to align the respective asset registers held by the Finance and IT department. This includes correcting costs and also the identification of assets previously written off.

The gross cost of property, plant and equipment that has been fully depreciated but is still in use is £10,277,228.

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

All tangible assets are owned by the HSCIC.

	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**

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.

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.

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 Department of Health Group Manual for Accounts.

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.

All tangible 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 2015	18,382	27,130	295	1,820	47,627
Reclassification	-	639	(639)	-	-
Additions	1,283	5,620	404	-	7,307
Adjustments arising from asset review	594	13	-	(135)	472
Disposals	(2,542)	-	-	-	(2,542)
At 31 March 2016	**17,717**	**33,402**	**60**	**1,685**	**52,864**
Amortisation					
At 1 April 2015	9,937	8,792	-	1,532	20,261
Provided during the last year	2,852	6,313	-	206	9,371
Adjustments arising from asset review	451	(86)	-	(135)	230
Disposals	(2,378)	-	-	-	(2,378)
At 31 March 2016	**10,862**	**15,019**	**-**	**1,603**	**27,484**
Net book value at 1 April 2015	8,445	18,338	295	288	27,366
Net book value at 31 March 2016	**6,855**	**18,383**	**60**	**82**	**25,380**

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

Adjustments arising from the asset review refers to the outcome of ongoing work to align the respective asset registers held by Finance and the IT department. This includes correcting costs and also the identification of assets previously written off.

The gross cost of intangible assets that were fully depreciated but still in use are £8,337,448.

The value of own staff capitalised within intangible assets additions amounts to £2,806,580.

All intangible assets are owned by the HSCIC.

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

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.

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 Department of Health Group Manual for Accounts.

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 gross cost of intangible assets that were fully depreciated but still in use are £5,851,393.

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

All intangible assets are owned by the HSCIC.

9 Other non-current assets

	31 March 2016 £000	31 March 2015 £000
Non-current deposits and advances	–	528

Non-current deposits and advances comprises deposits paid on rented properties. The deposits are accounted for in accordance with management expectations as to when the leases will end. During 2015/16 the one remaining rent deposit has been reclassified to trade receivables and other current assets falling due within one year.

10 Trade receivables and other current assets

Amounts falling due within one year	31 March 2016 £000	31 March 2015 £000
Trade receivables	21,773	14,799
Value added tax	1,538	-
Deposits and advances	348	-
Prepayments and other receivables	7,415	3,655
Accrued income	3,757	6,607
	34,831	**25,061**

11 Cash and cash equivalents

	31 March 2016 £000	31 March 2015 £000
Balance at 1 April 2015	10,247	22,931
Net changes in cash and cash equivalents	(95)	(12,684)
Balance at 31 March 2016	**10,152**	**10,247**

Bank balances were held during the year 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. The HSCIC transitioned to the new Government Banking Service contract during early 2016, under which arrangements the Citibank account closed, and the account with Royal Bank of Scotland was retained.

12 Trade and other payables

Amounts payable within one year	31 March 2016 £000	31 March 2015 £000
Trade and other payables	5,057	5,816
Value added tax	-	251
Income tax, National Insurance and superannuation	5,504	4,955
Deferred income	295	1,638
Accruals	14,970	16,942
	25,826	**29,602**

13 Provisions for liabilities and charges

	Dilapidations £000	Injury Benefit £000	Staff termination £000	Other staff related £000	Total £000
Balance at 1 April 2015	1,737	255	72	-	2,064
Arising during the year	292	25	-	300	617
Utilised during the year	(54)	(55)	(53)	-	(162)
Reversed unused	(6)	-	-	-	(6)
Balance at 31 March 2016	**1,969**	**225**	**19**	**300**	**2,513**
Expected timing of cash flows					
Within one year	246	27	19	300	592
Two to five years	1,723	23	-	-	1,746
Over five years	-	175	-	-	175

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, or an internal assessment using industry standard estimates.

The injury benefit costs refer to an award where monthly payments are made to the NHS Pension Scheme.

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.

'Other staff related' represents a provision for the payment of a bonus to staff entitled under TUPE transfer rights.

14 Transfers from other bodies

	2015/16 Transfers under absorption accounting taken through the SoCNE £000	2014/15 Transfers under absorption accounting taken through the SoCNE £000
Property plant and equipment	–	465
Intangible assets	–	781
Net assets transferred	**–**	**1,246**

Net assets transferred in 2014/15 were received from NHS Direct

15 Capital commitments

Capital commitments amount to £1,335,548 (2014/15 £676,141) and relate to ordered IT equipment, software and office furniture.

16 Commitments under operating leases

Expenditure includes the following in respect of operating leases:	2015/16 £000	2014/15 £000
Accommodation	6,429	9,292
Other operating leases	124	58
	6,553	**9,350**

At the balance sheet date non-cancellable operating lease commitments were:

Land & buildings		
Not later than one year	5,171	6,249
Between one and five years	6,259	8,377
Later than five years	466	647
	11,896	**15,273**
Other leases		
Not later than one year	92	65
Between one and five years	78	99
Later than five years	-	-
	170	**164**
Total	**12,066**	**15,437**

17 Other financial commitments

The HSCIC has not entered into any non-cancellable contracts (that are not operating leases) for the provision of services as at 31 March 2016 (31 March 2015 £nil).

18 Contingent assets and liabilities

There are no contingent liabilities as at 31 March 2016 (31 March 2015 £156,435).

19 Related parties

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

During the year the HSCIC raised invoices to Genomics England Ltd. totalling £639,969 excluding VAT.

A non-executive director of HSCIC is also Chair of Genomics England Ltd.

Genomics England Ltd. is wholly owned by the Department of Health.

20 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

The HSCIC was not exposed to material currency risk or commodity risk. All material assets and liabilities were denominated in sterling. The 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. The 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

	2015/16 £000	2014/15 £000
Balance at 1 April	9	270
Provided for in year	3	4
Reversed unutilised	(8)	(219)
Amounts written off during the year as uncollectible	(1)	(46)
Balance at 31 March	**3**	**9**

The provision for doubtful debts is assessed on an individual debt basis. The expense in the year relating to related parties amounted to: £91 (2014/15: £2,677)

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

	Current £000	< 30 days overdue £000	31-60 days overdue £000	> 61 days overdue £000	Total £000
Balance at 31 March 2016	**11,222**	**9,631**	**649**	**271**	**21,773**
Balance at 31 March 2015	7,346	6,701	494	258	14,799

The HSCIC's standard payment terms are 14 days from date of invoice. The maximum exposure to credit risk at the reporting date is the fair value of each class of receivables mentioned above. HSCIC did not hold any collateral as security.

c. Liquidity risk

We 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 2016 £000	31 March 2015 £000
Current liabilities	25,826	29,602

21 Events after the reporting period ended

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

Certain existing informatics services functions undertaken by NHS England are to transfer to the HSCIC during 2016/17. These functions consist of up to 55 posts, which with other non-pay expenditure have an annualised cost of up to £4million. Exact arrangements, including the associated assets and liabilities to be transferred, are still to be determined. The transfer will be accounted for using 'absorption accounting' as set out in note 1.2.

22 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 29 June 2016.

Notes

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