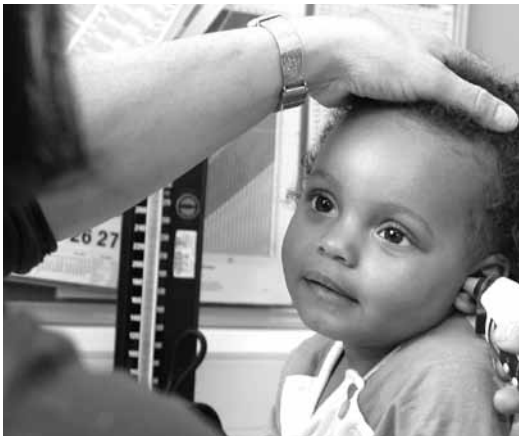
hscic Health & Social Care Information Centre

Annual Report and Accounts 2013/14






Health and Social Care Information Centre Annual Report and Accounts 2013/14

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The Chair and Chief Executive's foreword

The Health and Social Care Information Centre (HSCIC) was established on the 1 April 2013 by the Health and Social Care Act 2012 as an Executive Non-Departmental Public Body (ENDPB).

The HSCIC has three core functions to:-

- operate the key data and information systems in support of the NHS, social care services and the wider health and social care sector
- develop the next generation of national data and information systems
- analyse, publish and disseminate data and information to enable professionals, commissioners, regulators, researchers and especially individual citizens understand the safety and effectiveness of care services and make informed decisions about personal, individual and community-wide health and social care.

We do this whilst ensuring that all of the data and information collected about an individual's health and social care is kept secure and confidential.

The organisation which employs some 2,100 staff and is responsible for the management of approximately £1.2 billion of taxpayer's money, was formed from several predecessor organisations:

- the former Health and Social Care Information Centre (known as The NHS Information Centre), a Special Health Authority, which was abolished in March 2013
- Connecting for Health, primarily responsible for the National Programme for IT, which until April 2013 was part of the Department of Health (DH)
- informatics functions from local Strategic Health Authorities and a Primary Care Trust.

In addition, other functions were transferred into the HSCIC such as NHS Choices, the NHS's digital information system, which until August 2013 was operated by Capita and some supporting functions from NHS Direct transferred in April 2014.

The primary task for the HSCIC in its first year of operation has therefore been to bring these functions and organisations together without having any impact on the services provided to support patient care. This objective has been overwhelmingly achieved.

Secure, safe and accurate data is fundamental to the delivery and development of modern care services and the continued willingness of citizens to share their data with us.

Whilst delivering our services, the HSCIC has been transforming itself as an organisation. A largely new senior management team has been appointed, including five non-executive directors who were appointed on 1 April 2014. A major Transformation Programme has run throughout the year, involving every employee, as we seek to ensure that all our staff understand our goals and ambitions and contribute to their achievement. Above all we want to make sure that the HSCIC becomes an employer-of-choice so that we can recruit and retain the highly-skilled, committed, individuals who we rely on in every aspect of our work.

Data and information is only useful if individuals and professionals can rely on the services that provide it. Availability of the major systems used by the NHS is therefore critical to ensuring the delivery of uninterrupted safe care to patients. During the last financial year all of the major systems operated and managed by the HSCIC were provided to consistent high levels of availability. For example, the 'Spine' is the key information system supporting every intervention with patients. It operated at 99.97% availability, whilst handling over 3.5 million records each day. The National Back Office resolved over 25,000 cases of duplication or confusions in medical records to increase patient safety and NHS Choices dealt with 29 million individual enquires every month. We supported a range of screening services including cervical screening which annually saves approximately 1,300 lives and breast screening which detects more than 13,500 invasive cancers. We also supported the successful implementation of five local hospital systems serving more than 1.8 million patients and have been redeveloping the Spine, using ground-breaking agile development techniques, which will improve overall performance and reduce annual costs.

These systems underpin our role as the national provider of data and statistics about the health and social care system. During the year the HSCIC published 220 statistical reports, many such as the "Focus on accident & emergency" and the "Health survey for England" providing crucial insights for both citizens and policy makers into the performance of the health and social care system. The continued and recognised reliability and independence of the HSCIC statistical services is fundamental to this work.

As the health and social care systems come under greater pressure, data and information technology will become increasingly central to the delivery of safe and effective care. The HSCIC, as the Design and Standards Authority for the health and social care system as a whole, has therefore a crucial role in both the development of the national information systems and local systems to support local providers and commissioners.

We very much welcome the increased public interest in, and debate about, the collection and use of patient records. Secure, safe and accurate data is fundamental to the delivery and development of modern care services and relies on the continued willingness of citizens to share their data with us. During 2013/14 we have no evidence of any significant breach of security which would threaten the security of patients' data. However, we do not believe that the systems and procedures inherited from our predecessor organisations are sufficiently robust in the face of new technologies and heightened public concern.

A key element in sustaining the trust of citizens with respect to their data is transparency. We have therefore published details of the data we have released to support the delivery and improvement of health and social care services for the first time and this will continue on a quarterly basis. We have also published details of our confidentiality and security performance to coincide with every public board meeting.

In June 2014, we published the results of an internal audit and investigation by Sir Nick Partridge into the operations of one of our predecessor organisations, the NHS Information Centre. The report made 9 recommendations designed to further improve confidence in our processes, our transparency and the auditability of our contracts for data releases. The Board and executive management team have accepted these recommendations in full and are totally committed to making sure they are implemented as soon as possible. We also welcome the government's proposals set out in the Care Act 2014 and in particular the intention to establish appropriate oversight of our activities.

The success of the HSCIC in delivering its service over the last twelve months is overwhelmingly down to our staff, who have, worked diligently and enthusiastically to support the development and delivery of safe and effective care during a period of challenging transition. The HSCIC Board is extremely grateful for their efforts and dedication. In particular we would like to thank our interim Chief Executive, Alan Perkins, whose steady hand was crucial in steering the organisation through this transitional period.

Kingsley Manning
Chair

Andy Williams
Chief Executive

The HSCIC was established in April 2013 through the Health and Social Care Act 2012 as a national information and technology delivery organisation for health, public health and social care[1].

2100 staff

19 locations

Annual budget £210m

Oversee £1bn spend

We provide technology and information services to organisations involved in the commissioning and delivery of health and care services. Our technology services are used widely to support the delivery of care, and our information services are available for wider use, supplying data, statistics and indicators to help people make informed decisions, to understand patterns of health need and to monitor improvements in take-up and outcomes. They are used by patients, service users, the public at large and health and care professionals as well as by research, industry and commercial organisations.

The establishment of the HSCIC is a clear signal of the importance of a consolidated, system-wide approach to data and technology. The HSCIC is intended to act as the key delivery partner for the health and care system, and more details of our role and responsibilities are set out below.

Whilst this creates opportunities for us, it also brings challenges, as the history of national investment in data and technology services is fragmented as a result of different policy changes as well as the speed with which technological advances have been made.

Our statutory duties include:

- the collection, storage and analysis of national healthcare, public health and social care data, including personal confidential data
- acting as the custodian of National and Official Statistics for health, public health and social care
- assessing and assuring the quality of the data we collect
- designing, delivering and managing any programme or technical service for the health and care system, as directed by the Secretary of State for Health or NHS England (NHSE)
- establishing and operating systems for the collection or analysis of information as directed by the Secretary of State for Health or NHSE
- publishing a code of practice for the collection, analysis, publication and other dissemination of confidential information concerning, or connected with, the provision of health services or of adult social care in England
- publishing a register of the collections and the contents of each collection that we manage
- establishing and publishing a database of quality indicators in relation to the provision of health services and adult social care in England
- assessing the extent to which information we collect meets the information standards (so far as they are applicable) and publish a record of the results of the assessment
- working with other national bodies to deliver a year on year reduction in administrative burden on the front line.

You will find more information about us in our strategy for 2013/15, which we published in January 2014[2]. It focuses on four themes:

- promoting trust through secure and interoperable services
- delivering the national technology services
- providing information to support better care
- supporting the wider economy.

We do not work in isolation. The Health and Social Care Act 2012 brought about significant structural reform of the health and care system, and we work with all of our national partners on the wider informatics agenda. During 2013/14, the DH commissioned a review of the governance arrangements for national informatics (known as the IGAR review). As a result of the IGAR, a new governance and operating model is being introduced to ensure national organisations responsible for informatics work together under a single unified strategy, which provides a clear and coherent framework for making robust investment decisions that will benefit the health and care system as a whole. The National Information Board (NIB) has been established to co-ordinate the strategic informatics agenda across these organisations.

The HSCIC recognises the importance of the IGAR and the NIB in bringing this clarity. In October 2014 the DH will publish a new strategy which will set out a roadmap for ensuring that all parts of the health and care system fulfil the mission of putting data and technology to work to the best advantage for patients, professionals, citizens and taxpayers.

As the new health and care system starts its second year, it is essential that we develop a collective vision for maximising the use of data and technology across the system. This vision will mark a fundamentally new approach which sees the paradigm shift from a technical perspective to an outcome-based one.

The strategy will require new ways of working across all of the health and care system, particularly as the responsibility for delivering the strategy will be devolved to local organisations. The NIB has an important role to play in achieving this.

[1] See our Business Plan for 2013/14 for more information about how we were established: http://www.hscic.gov.uk/media/11860/HSCIC-business-plan-2013-14/pdf/80305_HSCIC_Business_plan_V1.0.pdf
[2] http://www.hscic.gov.uk/media/13557/A-strategy-for-the-Health-and-Social-Care-Information-Centre-2013-2015/pdf/hscic-strategy-2014.pdf

Key services and systems managed by the HSCIC

NHSmail

NHSmail provides a secure email, calendar, directory and SMS service used by more than 600,000 active registered staff on a daily basis.

GP2GP

GP2GP allows patients' electronic health records to be transferred directly and securely between GP practices. A survey found 89% of clinicians agreed that having access to this record at a first consultation improved the patient experience when they join a new practice.

Spine

The Spine service connects clinicians, patients and local service providers through a collection of national applications, essential services and directories that underpin the NHS in England using some 27,000 connections and containing over 80 million records.

NHS Choices

NHS Choices (www.nhs.uk) is the UK's biggest health website and handles some 29 million enquiries every month.

GP Payments Service

The GP payments service calculates and pays over £7.2 billion in GP payments annually.

Statistical reports

Over 220 statistical reports on a range of health care topics were published this year and we answered over 600 parliamentary questions, supporting public accountability and parliamentary debate.

Choose and Book

This year the milestone has been achieved of 50 million patient referrals booked via Choose and Book – the service managing referrals from GPs for patients needing hospital appointments.

Electronic Prescription Service

Enables prescribers (such as GPs and practice nurses) to send prescriptions electronically to a dispenser of a patient's choice. If adopted by all GP practices it has the potential to save the NHS £179 million per year.

Informing public discussion

In the last twelve months our statistics and data have been featured in over 3,000 media articles to inform public awareness and discussion.

Screening

Supporting a range of screening services including cervical screening which saves annually approximately 1,300 lives and breast screening which detects more than 13,500 invasive cancers.

National Back Office

The National Back Office manages the accuracy of some 6.3 million primary care transactions per year.

Since we were established in April 2013, we have made significant achievements and advances on a number of fronts, but we have also had to address many challenges to our organisation.

Increasingly during 2014, there has been growing interest and public debate in the work of the HSCIC, particularly regarding the publication and sharing of data. The public wants to know what we are doing, and wants to be able to influence our plans. In an age of scrutiny and accountability, our organisation needs to be open and transparent in all that we do, bold in our ambition, and receptive to external influences and challenge.

During 2013/14, we have:

- managed a significant transition programme to establish the new organisation and ensure there are appropriate governance arrangements for the rich legacy of services and programmes that we deliver
- continued to deliver the services we inherited from our predecessor organisations
- successfully migrated new services into the HSCIC, such as NHS Choices and some services from NHS Direct.

Our success over the past twelve months is overwhelmingly due to our staff, working to support the development and delivery of safe and effective care, during a period of challenging transition.

Promoting trust through secure and interoperable services

Review of data sharing processes

Launched a review of all policies, processes and governance for the sharing of data, to ensure that there are appropriate approvals in place for any release of potentially identifiable data.

Gaining public trust through transparency

Published in April 2014 a register detailing data releases by the HSCIC. It lists the organisations receiving the data, the legal basis on which data was released and the purpose to which the data is being put. This report will be updated on a quarterly basis and is intended to encourage transparency and public scrutiny of HSCIC decisions.

Five rule guide to confidential information

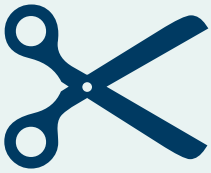
Our guide to confidentiality in health and care services was published. This included a five-rule guide designed to strike the right balance between sharing and protecting personal confidential information.

Support professionals in information standards

A new website www.infostandards.org was launched to support professionals in information standards across health and social care.

Busting bureaucracy

At the request of the Secretary of State, the HSCIC launched a "Busting Bureaucracy" campaign (building on the work of the NHS Confederation) for tackling the administrative burden across the NHS, and an audit of 16 acute trusts identified issues and solutions that could be used on a wider basis.



Reducing the cost of data collections

Introduced concordats with each of our partner organisations aimed at reducing the administrative burden imposed on front line services. The Review of Central Returns (ROCR) team has saved the NHS over £1 million. This is following an exercise to review and create a comprehensive national collection/baseline of data requested from NHS organisations by the DH and its ALBs.

Achieving ISO9001 accreditation

Achieved ISO 9001 accreditation of the clinical classification and pharmacy terminology services that underpin key areas of interoperable care services. Established in partnership with other ALBs and DH, the standardisation committee for care services governs system-wide developments of national standards. We continue to develop and support other key interoperability standards.

Delivering the national technology services

Information services maintained

Maintained operational, technical and information services through the transition, catering for widespread organisational changes across the whole health and care system.

New programmes increase portfolio

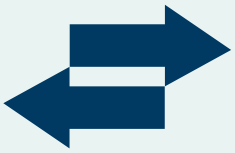
Continued to progress and support a substantial portfolio of programmes and projects with the DH and NHSE including the national Spine service, NHSMail, the Summary Care Record and Choose and Book.

Super-fast broadband for GP surgeries

Nine out of 10 GP surgeries are now connected to the latest super-fast broadband technology to improve access to clinical applications and services. The N3 Programme has progressively upgraded the network technology infrastructure not just for GPs but also for other small health sites, including clinics and ambulance stations.

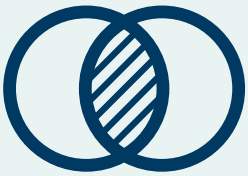
Choose and Book transfer successfully completed

The Choose and Book programme has transferred to the new NHS operating landscape and prepared for an extensive migration of the service into an e-Referrals service.



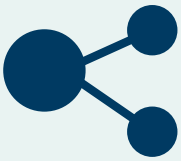
Collaborative working on Spine2

The development of Spine2 with the associated business change required to optimise an in-house solution has been a great example of collaborative working.



Successful deployment of IT systems

A number of major hospitals in London are now using new or upgraded IT systems and functions following a series of deployments under the BT LSP Programme. The most substantial launch was at Croydon Health Services NHS Trust which introduced the Cerner Millennium system for the first time. The system is now in use with nearly 3,000 users across accident & emergency, inpatients, outpatients and community services.



New service launched

The HSCIC Systems & Service Delivery group is now providing a one-stop service, on behalf of NHS England, for the public and NHS from a contact centre in Redditch.

Providing information to support better care

Developing care.data

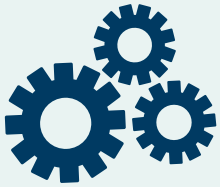
Supported NHS England in the design and development of the proposed care.data service[4].

220 statistical reports published

Published approximately 220 statistical reports on a range of health and care topics, and trailed new approaches to the development of publications, such as our report on the use of accident and emergency services.

Automating data extraction

At the request of the DH Social Care Directorate, undertook a project investigating the feasibility of automating data extracts from adult social care information systems.

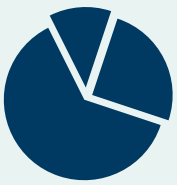


Ground breaking new analysis

Staff working on the National Bowel Cancer Audit published two year survival rates for the first time. Records of more than 50,000 bowel cancer patients were part of the analysis, which found four in five who had major surgery lived beyond two years of diagnosis, in contrast to two in five non-surgery patients.

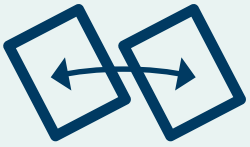
Leading the way in publishing health and care data

Surgeon level data has been published for two specialties following unprecedented work by HSCIC's clinical audit team. Outcomes data for both head and neck and oesophago-gastric cancer surgeons in England have been released via the NHS Choices website. This follows a commitment to present such data for 10 different surgical and clinical specialties, as part of a drive within the NHS to improve the transparency of information available to the public.



Linked data products developed

A range of new data linkage and extract service products have been developed, using data from the Hospital Episode Statistics, the Mental Health Minimum and the Diagnostic Imaging datasets.



Community and Child Health programme approved

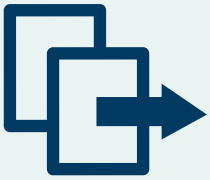
The Southern Community and Child Health programme received final approval of its Full Business Case. A significant milestone for the HSCIC, as the first programme to receive cross-government approval, and move from approval and into delivery, since the new NHS system and HSCIC came into force.

[4] http://www.england.nhs.uk/ourwork/tsd/care-data/

Providing information to support better care

GP Extraction Service

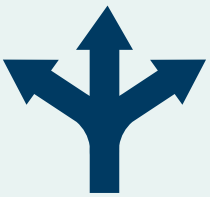
The GP Extraction Service successfully extracted data from GP practices in England to enable the Quality Outcome Framework 2013/14 calculation.



Supporting the wider economy

Supporting the open data agenda

Played a lead role in the publication of health and care data to support the transparency agenda by publishing over 680 individual open datasets, including the publication of consultant-level audit data in September 2013.



Developing the UK informatics skill base

Developed a range of support materials, guidance and toolkits to help individuals and organisations in the NHS, the DH and other health and care organisations to develop their informatics skills and capability in a changing environment.

Our priorities for 2014/15

Our strategy and business plan sets out details of our commitments and priorities for 2014/15. We will progress these in the context of a growing recognition about the power of information and technology to support transformational change across health and care services, and of growing publicity and public debate about the value and use of data, and associated information assurance and security risks. The public understanding of these risks is influenced not only by reports of problems with health data but also by reports about the wider use of data by government and for commercial uses.

We must address these concerns and build trust and confidence in our organisation. This requires us to engage constructively and effectively in the public debate about these issues and to be open and transparent about the processes we use and the decisions we take. In particular we will continue our process of transformation, including improving our governance and controls, particularly relating to asset management and liaising with our key partners to determine the wider operational governance arrangements.

We have ambitious plans for our organisation to fulfil our potential and to help patients and other bodies make the best use of our services and products. We are introducing a new executive team, which will strengthen our focus on:

- engaging with our customers, through a new Director for Customer Relationships
- appointing a Chief Technology Officer to improve our ability to work with industry to capitalise on the potential offered to us through new technological developments
- strengthening our voice with clinicians and care professionals, by strengthening our networks with professional groups and by giving our Caldicott Guardian more influence with our leadership team
- supporting our staff to harness their skills to support our activities, and to make the HSCIC a place where the very best people want to work.

This section sets out some of the priority actions we will be taking during 2014/15. For more information, please refer to our strategy and our business plan.

Improving access to our data and information services

We have a statutory duty to publish a catalogue of the data that we collect and hold. We already publish details of what we collect, and what is available for others to use. Currently, this only includes high level details of our data collections, and people tell us that this is not easy to use - they do not know what data we hold, and so it is impossible to know what, if any data we hold about them.

Therefore, in July 2014, we will publish a full catalogue of the data we collect and make available for secondary uses. The catalogue will explain the legal basis for each collection, describe what we hold, and set out the arrangements for publishing that data. In October 2014, the catalogue will be extended to include the data stored to support direct care.

Reducing the burden on the front line

NHS Trusts and other providers of health and care services want to know how we will fulfil our duty for managing and reducing the administrative burden that national data collections impose on the front line. They provide data to a number of organisations, not just the HSCIC. They are also aware that their local Clinical Commissioning Groups are keen for their data. They want to see a co-ordinated campaign to rationalise this and to reduce the unnecessary bureaucracy this imposes on them[5].

There are three main aspects to our work on reducing burden:

- produce a burden assessment and advisory service, previously known as the Review of Central Returns, that measures the burden that each collection generates, and acts as a gateway for other organisations that wish to collect data from local health and care organisations
- agree concordats[6] with each national ALB, whereby they commit to working collaboratively with the HSCIC and each other to reduce burden
- use local audits to help trusts identify opportunities for improvement and share lessons learned.

We will use our concordats with the other national bodies to accelerate our work on reducing burden on the front line and to agree plans for rationalising the different collections that are handled by other national bodies, with a view to consolidating them through the HSCIC, as required by the Health and Social Care Act 2012.

[5] See NHS Confederation report on Challenging Bureaucracy, published in 2013 http://www.nhsconfed.org/Publications/reports/Pages/challenging-bureaucracy.aspx, and the HSCIC's report on the Busting Bureaucracy audits carried out in 2013 http://www.hscic.gov.uk/media/13996/Busting-Bureaucracy-Report/pdf/HSCIC_Busting_Bureaucracy_0514_singles.pdf

[6] https://www.gov.uk/government/publications/reducing-burden-of-national-requests-for-information-concordat

Robust and transparent processes for handling data

The HSCIC is commissioned to collect, publish and otherwise disseminate data from across the health and care system to support direct care and make it available for wider use in conformance with its statutory obligations.

Our data covers many aspects of health and care services:

- Hospital information
- Adult social care
- Mental health & community
- Prescribing & primary care services
- Clinical audit
- Clinical indicators
- Population health statistics and surveys
- Workforce
- NHS facilities
- Payment by results.

Much of what we collect, process and publish does not contain information that can be used to identify individual people. As such, it is freely available on our website for anybody to use.

It is understandable that people are confused about the processes and governance arrangements relating to our information services. Because of the history of our services, we have a range of inherited practices and processes that are dispersed in different places. Moreover, there are inconsistencies in the way services are managed, which adds to the public's concern about the robustness and transparency of our arrangements.

We are reviewing the way this information is published, with a view to making it easier for people to understand the way we work. In doing this, we will work with other organisations who are also involved in the collection and processing of data, and the public rightly expect there to be consistency across the board.

Code of Practice on handling confidential information

In 2013, we published a guide to Confidentiality in Health and Social Care. We have also issued a draft Code of Practice in June 2014 for consultation with health and care organisations, care professionals and interested stakeholders to ensure it covers all the necessary requirements. We will publish the formal Code of Practice later in the year as required by the Health and Social Care Act 2012.

Governance arrangements for our data dissemination activities

People want reassurance about the way the HSCIC handles requests for data and how we store and process the data. In July 2014, we will introduce a new process for handling all requests for data, so that there is a single, auditable process that is managed consistently across the HSCIC. As part of that process, we will publish the criteria that we apply when we are assessing requests for data.

The HSCIC has already committed to publishing a quarterly register of all data agreements which allow data to be issued, to whom, for what purpose, and under what legal basis. We published this for the first time in April 2014, and will continue to enhance it as we publish future versions, for example by including details of requests that are not approved.

We are also exploring ways of protecting the security of the data we hold through the use of a new service whereby people and organisations can access data for analytical purposes only in a "safe" environment, such as on HSCIC-managed networks and facilities. Requests for access to data would still need to go through the same rigorous and transparent request and approvals processes. Data laboratory tools are widely used in other parts of government and in research.

This would also be consistent with the policy of reducing the number of organisations and locations where identifiable data is stored. The Health and Social Care Act 2012 set the general direction of travel for the establishment of Accredited Safe Havens for the processing of identifiable data, and for the preference for there to be a small number of these, on the basis that helps reduce the risk of security breaches.

Managing identifiable data

People must have confidence in the tools and techniques that are used to protect their data. There is widespread interest in the different ways that data might be protected, and especially in the application of pseudonymisation techniques, which can be used to reduce the risk of re-identification, but do not eradicate that risk altogether.

There are different views as to how and when pseudonymisation should be applied to data which will be used for purposes other than for direct care. It can be done either at source, when the data is collected, or when it is processed by the HSCIC. We have brought together a number of experts in this area, to help us explore the issues involved and to determine whether there is a consensus as to the way forward. This group has already confirmed that people have different views as to what is involved, and therefore there is a need to agree a common understanding of pseudonymisation.

With this expert help, our review will help achieve three things:

- reach a shared view as to what pseudonymisation involves
- consider the relative merits of pseudonymisation at source and at the point of receipt within the HSCIC, and
- assess the implications for future data quality and linkage services.

Security and quality management

We take seriously our obligations for securely holding information and for protecting it from unauthorised access or disclosure. We have established an Information Assurance and Cyber Security Committee to provide Board level oversight on all matters relating to information and cyber security risks and assurance.

We believe that the best way to provide that reassurance is for the HSCIC to adhere to the highest industry standards and to be subject to external assessment against these standards. In the context of data security, this is ISO-27001, and for quality management it is ISO-9001. This is a major commitment requiring sustained effort and time to achieve. It is a necessary step in the process of ensuring that the public has trust in our work, and we will publish in July 2014 full details of how we propose to achieve these standards.

We will review continually the security clearance and training requirements for all our staff, and ensure that enhanced obligatory security training is provided at the right level for all staff, based on their duties and the data to which they have access.

We will also work with our partners to agree what security policies and measures need to be applied consistently across the health and care system, with a view to agreeing the requirements that a "trusted" partner would have to meet to receive data from the HSCIC.

Trust and the benefits of data sharing

This year saw much debate regarding public confidence in the collection, analysis and use of health care data. Whilst sometimes challenging we have welcomed this specifically as the HSCIC was created to be a trusted, safe haven for the individual's most personal data.

Shared data and its analysis is critical to the sustainability of the NHS, allowing evaluation of resources and whether they are efficiently allocated, and to assure patients that the services being provided are appropriate, safe and effective. Data analysis can be used to develop new drugs and treatments or to better allow patients to manage their own chronic long term conditions. But that potential will only be realised if the great majority of the public continues to trust the HSCIC with their data.

The clear benefits to patients of research and analysis of medical outcomes must drive our lawful release of data. and this is why we were created by the Health and Social Care Act 2012.

The HSCIC is committed to improving the transparency of its decision-making and building public trust in both its actions and that the organisation is operating to the highest standards. A comprehensive review is being undertaken for all policies, processes and governance for the sharing of data, which involves ensuring there are appropriate approvals in place for any release of potentially identifiable data. We want all these processes and decisions to be accessible to the public and open to scrutiny. We are also reflecting on the implications of legislation currently going through parliament with the Care Bill, which aims to add further protections for individuals, including their right to object to the indirect use of their data.

On 2 April 2014 we published a report detailing all data released by the HSCIC, including the legal basis on which data was released and the purpose to which the data is being put. This report will be updated on a quarterly basis and is intended to encourage public scrutiny of HSCIC decisions.

This was followed by the publication in June of a review, led by one of our non-executive directors, Sir Nick Partridge, of all the data releases made by the predecessor organisations.

A number of other measures we are committed to undertake were confirmed at this time;

- patients and public representatives will be part of the new membership of the HSCIC's data oversight committee, the Data Access Advisory Group (DAAG)
- all data agreements will be re-issued, to ensure activity is centrally logged, monitored and audited, resulting in a clear and transparent process
- a new, strengthened audit function will monitor adherence to data sharing agreements and halt the flow of data if there are any concerns exposed. This will also monitor that data has been deleted when an agreement comes to the end
- a programme of active communication to the public and patients will help bring greater clarity about an individual's right to object to their data flowing to or from the HSCIC
- a list of all active data sharing agreements will be published in the HSCIC quarterly register
- working with partners through the National Information Board we will begin a public consultation and vision for a new national collection strategy for health, public health and social care data and report by May 2015 on its findings
- the HSCIC will take forward its new responsibility to oversee NHS data security across the health and social care sector, to ensure best practice is followed and the most up-to-date technology is employed to protect patients
- the HSCIC will plan a new 'data laboratory' service which will protect the public's information by allowing access to it in a safe environment with HSCIC managed networks and facilities
- the HSCIC will work towards the externally assessed, highest industry standards of ISO27001 for data security and ISO9001, for data management, as part of its efforts to build public confidence.

The diagram opposite shows how our commitments align with our strategic objectives; and how these objectives in turn align with Government priorities:

Our strategic objectives	Our commitments - how we will deliver our strategic objectives	Government priorities relevant to HSCIC
Providing information to support better care	• Publish accessible information for the public and professionals • Make data more accessible • Provide national, assured indicators • Drive better value through services for clinical audit.	• Improving care for vulnerable older people • Achieving true 'parity of esteem' between mental and physical health • Bowel scope screening • Improving access to psychological therapy • Children and young people's improving access to psychological therapy • Dementia • Nurse technology fund • Strategy for UK life sciences • Reducing costs of ill health to taxpayers • DH and NHS estate • NHS procurement • Improving productivity and long term sustainability and ensuring value for money for the taxpayer • Contributing to economic growth • Implementing social care reform • Developing the resilience of DH and the wider health and care system by: focusing on improved delivery and performance; working together to build a sense of common purpose.
Promoting trust through secure and interoperable services	• Keep data secure • Improve data quality • Improve interoperability • Minimise the burden on the front line.	
Delivering the national technology services	• Address the future requirements for national technology services • Manage the transition of the Local Service Provider contracts • Develop a coherent architecture for the national services • Work with the market.	
Supporting the wider economy	• Develop the information marketplace • Develop a comprehensive service for the life science industry • Develop the informatics skill base • Create partnerships for innovation • Support the local community.	
A high-performing organisation with an international reputation	• Implement the new organisational structure • Transform the organisation • Recruit and retain highly skilled staff • Invest significantly in the professional development of our staff.	

Board members and biographies

The Board members during 2013/14 were, and in place for 2014/15, are:	2013/14	2014/15
Chair	Candy Morris Kingsley Manning	Kingsley Manning
Chief Executive	Alan Perkins	Andy Williams
Non–executive directors	Anthony Allen Lucinda Bolton Michael Pearson Sir Nick Partridge Sir Ian Andrews	Sir Nick Partridge Sir Ian Andrews Sir John Chisholm Professor Maria Goddard Jan Ormondroyd
Executive directors	Rachael Allsop Mark Davies Thomas Denwood Trevor Doherty James Hawkins Maxwell Jones Clare Sanderson Robert Shaw Carl Vincent John Varlow Andrew Haw	Rachael Allsop Peter Counter Thomas Denwood James Hawkins Maxwell Jones Robert Shaw Carl Vincent Professor Martin Severs

Kingsley Manning
Chair

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

Andy Williams
Chief Executive

Andy has extensive experience in overseeing large transformational technology projects in the UK and around the world having led teams in companies such as IBM, Alcatel-Lucent and CSC during the last three decades. He has worked across a variety of industry sectors, usually being involved in programme governance, introducing complex new technology and managing change. He has an international reputation and the companies he has worked with include many well-known names both in the UK and abroad.

Sir Nick Partridge
Non-executive Director

Sir Nick has worked for Terrence Higgins Trust since 1985 and was appointed its Chief Executive in 1991. Over the past 28 years, he has been a consistent voice in the media coverage of AIDS and sexual health in all its aspects from health promotion, social care and advocacy through to research and treatment issues. The Terrence Higgins Trust mobilises over 10,000 members and 280 staff, and provides a wide range of HIV and sexual health services. He is Deputy Chair of the UK Clinical Research Collaboration, which aims to establish the UK as a world leader in clinical research and was Chair of INVOLVE, which promotes patient and public involvement in NHS research for 12 years until June 2011 and a member of the Information Governance Review led by Dame Fiona Caldicott in 2013.

Sir Ian Andrews
Non-executive Director

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

Sir John Chisholm
Non-executive Director

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

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

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

Professor Maria Goddard
Non-executive Director

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

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

Jan Ormondroyd
Non-executive Director

Jan has worked at a senior level in local government for the last 25 years. Most recently she was Chief Executive of Bristol City Council, the 7th largest authority outside London. In 2012 Bristol was named the most successful city outside London.

Before this she worked as Deputy Chief Executive in Hull, Chief Executive of Suffolk Coastal District Council, spent time in the Civil Service as a Director of Local Government Practice in the Office of the Deputy Prime Minister, was a Director in Bradford and spent a short secondment at Cape Town City Council at a time of major change. She has a long history of working in partnership with both the public and private sectors and specialises in managing change and improvement work.

Carl Vincent
Director of Finance and Corporate Services

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

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

Rachael Allsop
Director of Human Resources and Transformation

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

Maxwell Jones
Director of Information and Analytics

Max transferred from NHS Connecting for Health which he joined in 2003 having joined its predecessor the National Programme for IT. Previously he was the Chief International Officer for McKesson and came with extensive senior experience in NHS IT systems development, strategy, information analysis, implementation, customer care and service management.

Max has undertaken senior roles in CfH across the full service lifecycle starting in the Technology Office in 2003 developing messaging architectures and standards. In 2005 he went on to be the Programme Director for picture archiving and communications system taking it from its early days to major rollout across the country before moving in 2007 to manage the national local ownership programme service management functions for the North, Midlands and East SHAs before returning to manage a portfolio of programmes and services in 2009, culminating in the role of Director of Programmes and Operations.

Robert Shaw
Director of Operations and Technical Assurance

Rob joined the National Programme for IT in late 2005 working in the National Integration Centre as Head of Assurance Services. In 2009 he became Director of the then Technical Assurance Group and led the redesign of Assurance and Accreditation as part of Future State improvements. In 2012 he also took over management of Technical Architecture and Infrastructure following the departure of Paul Jones. In 2011 Rob ran the feasibility to deliver a new Spine solution and continues to provide the programme direction for Spine2. He is also the NHS cross-government lead for agile delivery.

Prior to that Rob worked for the Department of Work and Pensions (DWP) where he was involved in the implementation of disability living allowance and computerising the payment of attendance allowance. He led a number of DWP high risk reviews; later moving to provide an intervention role for DWP's mission critical portfolio.

Thomas Denwood
Director of Local Service Provider Delivery

Tom joined what was the National Programme for IT in 2003 from Deloitte Consulting, where he worked on major programmes such as the Mayor of London's Congestion Charging Scheme. Between 2003 and 2007 he worked on the Choose and Book Programme and spent the last 18 months of that time leading the programme. In 2007/08 Tom was Programme Manager for the Informatics Review, working to the DH Director General for Information.

In 2008/09 Tom led the National Programme Office, before moving to lead the Southern Programme for IT until 2011. This involved transferring critical services between data centres and the delivery of new or upgraded patient record and clinical systems to 35 Mental Health, Community and Acute Hospitals.

During 2012 he took a career break to work for The London Organising Committee of the Olympic and Paralympic Games. He now leads the Local Service Provider delivery directorate within the HSCIC.

James Hawkins
Director of Programmes

James joined what was the National Programme for IT in 2003 from Deloitte Consulting. He has over twenty years' experience of working in programme environments spanning both the public and private sector. During that time he has worked on a number of high profile change programmes including the introduction of the Mayor of London's Congestion Charging Scheme and the NHS Summary Care Record. In 2011, James took a year out from the NHS to be Head of the Security Workforce within the London Organising Committee for the Olympic and Paralympic Games. Since June 2013 he has held the position of Director of Programmes within the HSCIC, where his responsibilities include delivering a portfolio of programmes across the health and social care system.

Professor Martin Severs
Caldicott Guardian and Lead Clinician

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

Peter Counter
Chief Technology Officer

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

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

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

Kingsley Manning
Chair

Rachael Allsop
Director of Human Resources and Transformation

Andy Williams
Chief Executive

Maxwell Jones
Director of Information and Analytics

Sir Nick Partridge
Non-executive Director

Robert Shaw
Director of Operations and Technical Assurance

Sir Ian Andrews
Non-executive Director

Thomas Denwood
Director of Local Service Provider Delivery

Sir John Chisholm
Non-executive Director

James Hawkins
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Professor Martin Severs
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Peter Counter
Chief Technology Officer

Carl Vincent
Director of Finance and Corporate Services

Accounts for the year ended 31 March 2014

Management commentary
Strategic report

Background

The Health and Social Care Act 2012 approved by Parliament on 27 March 2012 proposed the dissolution of the Health and Social Care Information Centre as a Special Health Authority (NHS IC), and the creation of a new body – the Health and Social Care Information Centre (HSCIC) as an Executive Non-Departmental Public Body (ENDPB) with effect from 1 April 2013. This change has put the organisation onto a more secure footing. Other functions and assets were also transferred; and the new organisation comprises of informatics and system related functions from:

- the NHS IC, whose primary purpose was the collection, analysis and dissemination of health related data and information for secondary uses purposes
- NHS Connecting for Health (CfH), part of the informatics division of the Department of Health (DH) whose primary purpose was the development and management of national health systems and IT infrastructure
- former Strategic Health Authorities and a Primary Care Trust (SHAs/PCTs)
- an external provider, Capita, who undertook the development and management of the NHS Choices website.

As a result of these changes all employees were given notice of their transfer into the new body under Transfer of Undertakings (Protection of Employment) Regulations with their current responsibilities and terms of service, including their pension arrangements, intact.

As the legal form of the HSCIC is distinct from the NHS IC, the Accounts have been prepared as a completely new body with no prior year comparatives. Under the 2013/14 Government Financial Reporting Manual (FReM), the transfer has been accounted for using absorption accounting rules with assets and liabilities for CfH using standard absorption rules and the NHS IC and SHA/PCTs using modified absorption rules (whereby the net value of transfer is accounted for through the general reserve). All assets and liabilities have been transferred at their carrying value at the date of transfer.

The HSCIC receives the majority of its funding via grant in aid (GIA) allocations managed by the DH. After the creation of the new body a number of key organisational policies and procedures have been developed, including Standing Orders, Standing Financial Instructions and Delegated Authorities, reflecting the new status and internal governance arrangements.

Regulatory and compliance framework

The HSCIC is accountable to Parliament and is responsible for:

- the collection, storage, analysis and dissemination of health and adult social care data for England and the provision of guidance on any matters relating to these activities
- the provision of a trusted safe haven for confidential patient identifiable information
- the establishment, delivery and the operation of technical systems that enable data to be used by the HSCIC to support an individual's care and to deliver better, more effective care for the community as a whole through services which allow patients and carers greater choice
- fulfilling statutory duties and functions which underpin the services provided by the HSCIC.

In carrying out these functions the HSCIC is required to:

- seek to minimise the burdens it imposes on others, and
- exercise its functions effectively, efficiently and economically.

The HSCIC has responsibility for maintaining a sound system of internal control that supports the achievement of the organisation's policies, aims and objectives whilst safeguarding public funds and the organisation's assets including data and information in accordance with the responsibilities assigned in Managing Public Money. There is a wide ranging legal, regulatory and compliance framework which governs the receipt, processing and dissemination of data and information by the HSCIC and its production of statistics.

As a new organisation established in April 2013, the HSCIC is still developing, and this includes its governance arrangements. Although the processes are satisfactory there is further work that needs to be done in 2014/15 to ensure that they become fully embedded and that they meet the needs of the organisation to provide assurance to its stakeholders across health and social care, the government and the public.

Our regulatory and compliance framework included the:

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

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

Review of the year

2013/14 has been an extremely challenging but successful year for the HSCIC. The organisation was created on 1 April 2013 and had to assimilate a number of organisations and functions whilst maintaining the running of all business operations and progress a number of developments. This was also further complicated by the restructuring of our main sponsors and customers, notably the DH and NHS England (NHSE) where governance arrangements between all parties had to be agreed.

A transformation programme fully supported by management was created which has overseen a series of internal workstreams. This is detailed more fully in the Directors' Report.

The new organisation has had to very quickly understand and manage a diverse range of activities and responsibilities that includes:

- the management of nearly £1 billion of DH expenditure, capital and revenue, on behalf of the DH
- the collection, analysis and dissemination of data and information for secondary purposes including publishing over 220 statistical reports on a range of health care topics
- managing the transfer of local service provider (LSP) contracts to the management of the NHS. This will take several years to fully complete but the restructuring to date has resulted in the announcement of the loss of some 60 posts within the HSCIC
- taking on a range of new services and programmes such as NHS Choices, Data Services for Commissioners and from 1 April 2014 elements of former services provided by NHS Direct
- managing a range of services on behalf of NHSE and Public Health England (PHE)
- working closely with NHSE in designing and developing the care.data initiative, particularly in relation to creating the most appropriate means of collecting and storing data in as secure a manner as possible.

At the same time, the HSCIC has had to remain focused on delivering the above within an environment where central funding for public bodies is becoming increasingly tight and the GIA funding being approximately 10% less than that provided to the respective predecessor bodies in 2012/13. This financial target was more than achieved, as the net operating expenditure for 2013/14 resulted in an underspend of £21.5 million. The GIA is to cover both those statutory functions to be delivered by the HSCIC and also the revenue administration costs of delivering the DH portfolio of programmes.

Our priorities for 2014/15

Our priorities for the next twelve months include:

- **promoting trust through secure and interoperable services -** ensure that we sustain the public's trust that their data is being collected, stored and used, safely and appropriately
- **delivering the national technology services -** continue to provide the key technology and information services that support our partners in the delivery, commissioning and regulation of health and social care services
- **providing information to support better care -** help to meet the Secretary of State's ambitious objectives to give citizens the information they need to manage their own health and care and provide care organisations with the information they need to deliver safe, high quality services
- **supporting the wider economy -** contribute to the development of the health and care informatics industry and the wider UK economy
- **becoming a high-performing organisation with an international reputation -** consolidate and develop our own organisation, so that it becomes the world's leading institution for health and care informatics.

In particular, a strategy for the longer term development of our data and information systems is to be developed. This must be for the whole of the health and social care system, including clinical, social, and informal care provided by the NHS, social care services, the voluntary and independent sectors as well by individuals themselves and their carers. In contrast with recent experience, this strategy will not be prescriptive but enabling, recognising that the impact of technology and changing cultural practices is both unpredictable and uncertain. The objective must be to build a data and information eco-system that encourages innovation in service provision, removing and reducing the barriers to service redesign and which places the individual at its centre.

The core GIA funding for 2014/15 has been confirmed as £154.5 million, a reduction of approximately £7.5 million from 2013/14. However, this includes an element of funding for the delivery of several DH programmes where certain services formerly procured externally have been brought in house.

Accounts preparation

The Accounts have been prepared under a direction issued by the Secretary of State in accordance with the Health and Social Care Act 2012 and have been prepared in accordance with the 2013/14 FReM issued by HM Treasury. The accounting policies contained in the FReM apply International Financial Reporting Standards (IFRS) as adopted and interpreted for the public sector context. The Accounts comprise of a statement of financial position, statement of comprehensive net expenditure, a statement of cash flows and a statement of changes in taxpayers equity, all with related notes.

Financial results

The following table provides a summary of the 2013/14 results:

	2013/14 £000
Operating expenditure	192,466
Income	(39,396)
Net expenditure before transfers under absorption accounting	153,070

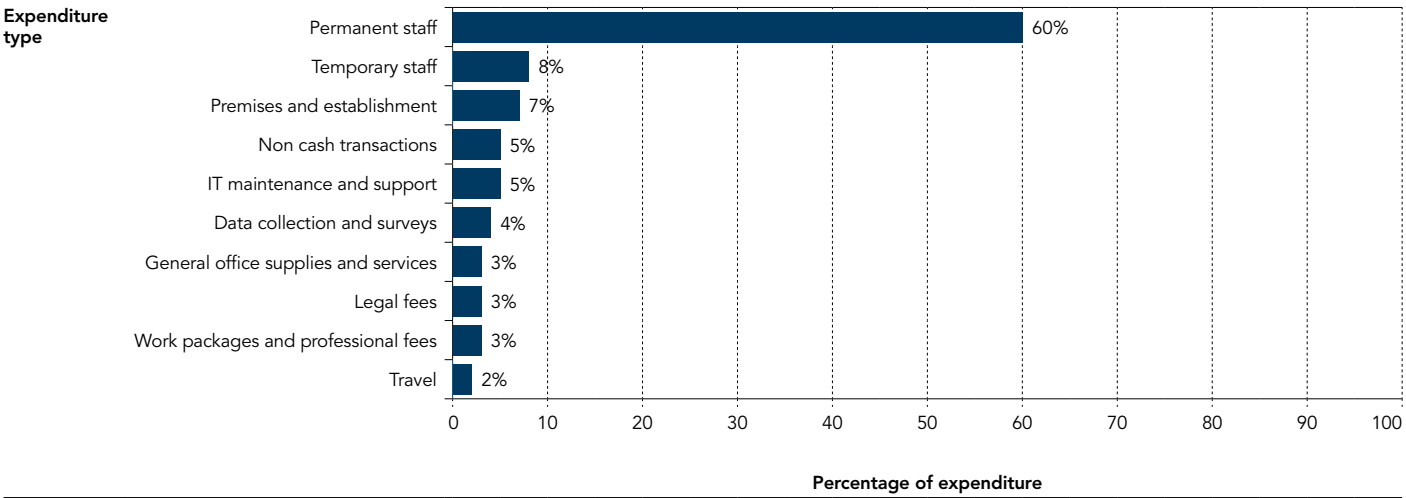
In addition to the above income and expenditure, adjustments have been made to align the accounting policies and restate certain asset values transferred from the transferring organisations. These adjustments resulted in a gain of £1.1 million from those assets transferred from the NHS IC and a loss of £0.7 million from those transferred from CfH. These have been disclosed separately in the statement of comprehensive net expenditure and in note 6 to the accounts.

The largest element of operating expenditure is with staff as the following chart details:

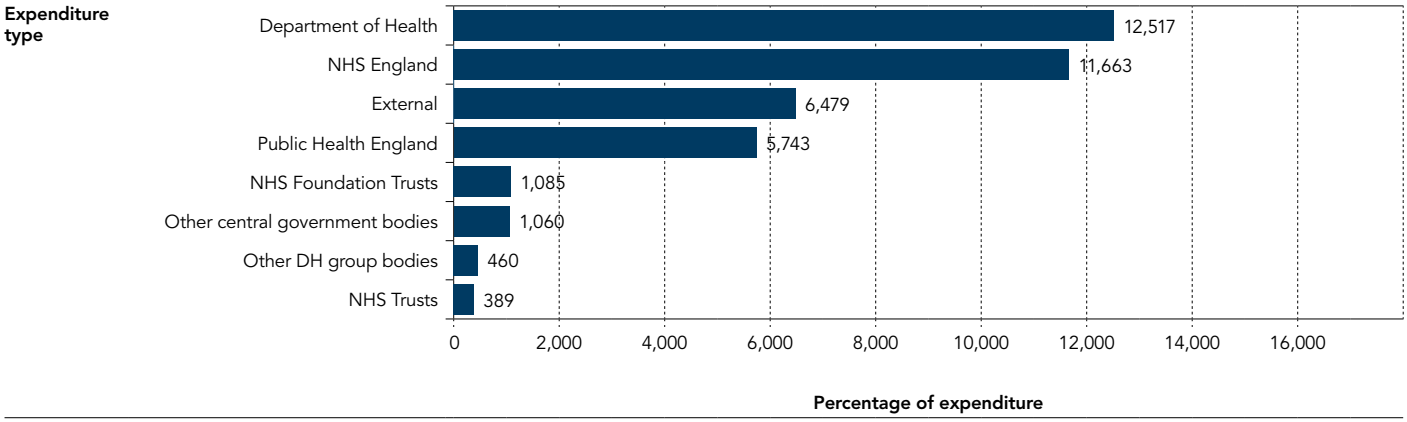
Included within the operating expenditure are the following items:

- termination benefits for staff largely in relation to changes to the LSP contract arrangements
- disposal of assets, mainly relating to a review of assets transferred from predecessor organisations which have now been superceded by replacement systems
- legal fees primarily with respect to ongoing contractual disputes to certain DH programmes which the HSCIC manages on behalf of DH. HSCIC incurred the legal costs but any potential liabilities arising are accounted for within the DH financial statements.

Analysis of operating expenditure



Analysis of income by customer (in £000)



The core operations of the HSCIC are funded by a GIA allocation managed by the DH. The revenue resource limit for 2013/14 amounted to £174.5 million including £11 million to cover depreciation. Net expenditure was less than that allocated resulting in an operational surplus of £21.5 million. The non-recruitment of budgeted vacancies and reductions in certain anticipated activities being the key elements.

In addition to GIA, the HSCIC generated a further £39.4 million of other income, primarily undertaking programme management, IT services and the delivery of other services for the DH and NHSE.

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

Non-current assets

The non-current assets largely consist of transfers on 1 April 2013 from the NHS IC with a net book value of £26.2 million and from CfH of £11.8 million. The verification and disclosure of non-current assets transferred provided the most significant challenge for the audit, particularly in relation to those transferred from CfH. A full review has been undertaken including a cross check with records maintained by the IT team with the outcome that:

- a number of assets have been disposed of, largely through obsolescence as new internal infrastructures have been developed
- certain expenditure previously written to revenue has been reinstated as an asset
- certain IT equipment older than five years which had been previously written off and thus not transferred to the HSCIC, but which was still in use, has been reinstated at the original cost and accumulated depreciation.

It is recognised that there is a lot more work to do in this area during 2014/15 in order to build and embed effective mechanisms of governance and control.

The capital resource allocation of £14.5 million was largely spent. Main expenditure included:

- the development of the General Practice Extraction Service, a means of extracting clinical data in a standard format from the varied general practice systems
- computer equipment, licenses and software, both externally procured and internally developed relating to programme or project activities
- transitional activities to merge and develop a unified internal infrastructure for the organisation.

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

Current assets and liabilities

Outstanding accounts receivable balances amounted to £14.3 million, of which £0.6 million was more than 60 days overdue. Debts amounting to £18,798 were written off and £186,016 was provided for as irrecoverable. Other debtors largely related to prepayments and accrued income. The level of accounts receivable balances outstanding was exceptionally high as many invoices to DH and NHSE in particular, were not issued until near the end of the financial year.

The HSCIC sought to comply with the Better Payments Practice Code by paying suppliers within 30 days of receipt of an invoice. The percentage of non NHS invoices paid within this target was 95.4 per cent.

Better payments practice code	Number	£000
Total non NHS bills paid 2013/14	10,535	87,203
Total non NHS bills paid within target	10,051	81,204
Percentage of non NHS bills paid within target	**95.4%**	**93.1%**
Total NHS bills paid 2013/14	406	4,505
Total NHS bills paid within target	325	3,618
Percentage of NHS bills paid within target	**80.1%**	**80.3%**
Total value of invoices processed in 2013/14		85,156
Total value of invoices outstanding at 31 March 2014		4,819
Number of days outstanding		21

During the merger of the predecessor organisations' accounting systems some delays to payments to suppliers were experienced, the issues lasting for several months. However these were subsequently resolved and as the year progressed the profile improved significantly whereby the latter months of the year the non NHS bills paid (in value) was in excess of 98%.

Going concern

Confirmation of the main GIA budget allocation for the 2014/15 financial year in line with the business plan submitted to DH has been received. In addition, it has been agreed that certain additional activities previously undertaken by other organisations, notably aspects of work from NHS Direct, have been transferred to the HSCIC together with appropriate funding commitments. Consequently, the Accounts have been prepared on the basis that the HSCIC is a going concern.

Financial instruments

The HSCIC had only a very limited exposure to financial instruments consisting of cash, account 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

On 1 April 2014, certain functions previously undertaken by NHS Direct were transferred to the HSCIC. These functions are funded and underwritten by NHSE with the total value of funding anticipated to be £6 million and a net asset transfer of £1.5 million.

Political and charitable donations

No political or charitable donations were made in the year.

Information governance

Ensuring that all data and information collected, stored and disseminated by the HSCIC and the health sector as a whole is a key element of the HSCIC's responsibilities. Information and statistical governance is taken extremely seriously within the organisation and very specific controls and protocols have been established. In particular:

- the HSCIC completed the information governance toolkit, which is the self assessment process required to assess information governance controls within the health and social care system, achieving a score of 93%
- there have been no personal data incidents in 2013/14 which required reporting to the Information Commissioners Office (ICO). A small number of incidents have been logged and managed internally by the HSCIC. An assessment against ICO guidelines determined these did not require ICO notification due to the small scale of the incident or that no clinical or sensitive data was involved
- the HSCIC is subject to the Data Protection Act 1998 and has filed the appropriate notification with the ICO. During 2013/14, 815 Freedom of Information requests and 46 Subject Access requests were received. There have been 4 breaches of the timescales for handling a Freedom of Information request and 1 breach for handling a Subject Access request
- no complaints were made to the ICO by applicants dissatisfied with responses provided to them under the Freedom of Information Act
- as a public information holder, the HSCIC has 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 2013/14.

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

Environment, social and community development

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

A location and estate strategy is being developed to rationalise these locations over time. The present estate structure follows guidance issued by the Cabinet Office and comprises HQ offices in Leeds supported by five hub offices in Exeter, Southport, Redditch, London and Newcastle and hosted locations. Some staff are also geographically based and work from home.

The key principles of the strategy are to:

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

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

The present space per workstation across the majority of the estate is 7.66m^2. As new ways of working and the other elements of the strategy are implemented the aim is to stabilise at 8.0m^2 across all of the HSCIC buildings and increase utilisation from an average of 86% to an average of 95%.

Sustainability

The HSCIC is required to prepare a report in line with the 2013/14 HM Treasury Sustainability guidelines, fully consistent with non-financial information requirements laid down under the Greening Government commitments (including the transparency requirements).

The sustainability aim is to reduce the impact of the business on the environment, especially to reduce carbon dioxide (CO_2) emissions. Managing efficient use of IT, accommodation and travel are the key strands of this work. The HSCIC does not own any commercial transport, but does lease seven cars allocated to certain specific staff who require them for business need. Travel is primarily by public transport although car travel between locations where it is difficult or not efficient to use public transport is necessary.

As a new organisation it is not possible to provide previous year comparison data as the predecessor organisations had access to differing levels of information detail. A report in comparison format will be provided in future years.

Suppliers are required to demonstrate a similar commitment through the incorporation of sustainable practices into their provision of goods and services.

It has been agreed that the required accommodation reporting for buildings where the landlord is another NHS or government body is undertaken by the other parties.

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

Greenhouse gas emissions		**2013/14**
Non financial indicators (tco^2)	Scope 1 emissions	527.1
	Scope 2 emissions	
	Electricity & Gas	2,001.4
	Scope 3 emissions	
	Rail	507.5
	Air	47.5
	Total energy	**3,083.5**
	Total energy per FTE	**1.5**
Financial indicators (£000)	Scope 1 emissions	109.6
	Scope 2 emissions	
	Electricity & Gas	450.0
	Scope 3 emissions	
	Rail	1,668.9
	Air	124.9
	Total energy cost	**2,353.4**
	Total energy cost per FTE	**1.1**
Water (m^3)		10,543.0
Water (£000)		57.4

Utilities information has been provided where it has been possible to separate it from landlords' service charges. Flights and rail travel has been provided by the HSCIC's travel service provider; vehicle travel emissions by car have not been provided as the service provider does not track this information.

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

The waste facilities in some locations are shared with other tenants of the buildings occupied and thus it was not possible to accurately identify the volume of waste disposed of. It is estimated that 39 tonnes (including 4 tonnes of IT related equipment) was recycled and 42 tonnes was sent to landfill.

Waste is minimised by the provision of managed print services, closed loop paper supplies and recycling along with a range of other recycling services across the estate. Waste is primarily normal office waste as most business procurement relates to information services rather than products.

The volume of paper amounts to the equivalent of 9,487 reams of A4 paper, representing 4.4 reams per FTE.

Sustainable procurement

Most procurements are for services rather than products and is through nationally agreed frameworks where sustainability provisions have been incorporated. Direct procurement by the HSCIC includes specific sustainability provisions and forms part of the tendering process where applicable.

Biodiversity

Being purely an office based organisation, the HSCIC has minimal impact on biodiversity issues and does not have a biodiversity action plan.

Andy Williams
2 July 2014

In the run up to the creation of the HSCIC a shadow board was established. The shadow board met three times during the first three months of 2013 and consisted of a mixture of existing NHS IC executive and non-executive directors and representatives from the DH, NHSE and Public Health England. This included Candy Morris and Alan Perkins who were appointed interim Chair and Chief Executive respectively of the HSCIC from April 2013. The governance arrangements for each individual organisation remained up to 31 March 2013 until the new Board became effective.

To facilitate a smoother transition of the two main bodies in the HSCIC, the NHS IC Director of HR, Rachael Allsop, became responsible for both the NHS IC and CfH HR functions during 2012/13.

A new interim Board for the HSCIC was set up on 1 April 2013 to manage the HSCIC as an ENDPB including an interim Chair and Chief Executive together with a number of non-executive directors from the NHS IC Board whose contracts were extended by one year and two new non-executive directors appointed on an initial one year contract.

On 1 June 2013, a permanent Chair, Kingsley Manning, and from 1 April 2014, a permanent Chief Executive, Andy Williams were appointed together with all the non-executive directors. A number of new director posts have been agreed and appointments made.

Register of interests

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

The register of declarations of interest is updated on an annual basis. It is kept and maintained by the HSCIC head of the executive office and is available for public inspection. Directors' interests declared during 2013/14, and relevant to HSCIC role, are as follows:

Lucinda Bolton: member of the Review Body on doctors' and dentists' remuneration.

Michael Pearson: Trustee director of the Respiratory Education Training centre and also Lung Health, a company set up to develop patient focussed software for chronic obstructive pulmonary disease care.

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

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

Auditors

The accounts have been audited by the Comptroller and Auditor General, who has been appointed under statute and is responsible to Parliament. The cost of the audit was £99,995. 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 with the actual audit work undertaken by PricewaterhouseCoopers LLP.

Cost allocation and charges

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

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, the HSCIC is 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).

For all off-payroll engagements as of 31 March 2014, for more than £220 per day and that last longer than six months:	**Number**
Number of existing engagements as of 31 March 2014	79
Of which, the number that have existed:	
for less than one year at the time of reporting	44
for between one and two years at the time of reporting	27
for between 2 and 3 years at the time of reporting	6
for between 3 and 4 years at the time of reporting	1
for 4 or more years at the time of reporting	1

For all new off-payroll engagements between 1 April 2013 and 31 March 2014, 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 2013 and 31 March 2014	52
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	52
Number for whom assurance has been requested	–

All off-payroll contracts for individual engagements are sourced via pan government frameworks. As such, the HSCIC have deemed it not necessary to request any direct assurance from individuals that they are paying the correct rate of tax as this would be a requirement of the framework call off arrangement itself.

Community and social responsibility

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

A work experience/placement programme has been developed that will be extended to schools, colleges and universities within the catchment areas of our locations over the next 12 months. Schemes such as the Metro Card and Cycle to Work schemes were offered to staff to encourage a more environment and community friendly means of commuting. Car use for business purposes was only allowed where it was impractical for staff to travel by public transport.

Equality and diversity

The HSCIC continued its commitment to equality of opportunity for all employees and potential employees and was fully compliant with the Equality Act (2010). It aimed to create an environment in which individual differences and the contributions of all employees were valued ensuring that no eligible job applicant or employee received less favourable treatment on the grounds of diversity or was disadvantaged by conditions or requirements which could not be shown as justifiable.

Equality and diversity awareness training has been embedded into the induction process for new employees and is being made available to all staff via the introduction of civil service learning.

Transformation

As a new statutory body, which was formed from the merger of several organisations, the HSCIC needed a major change programme to assimilate the predecessor bodies. At the same time, the external environment has been very fluid, as many of our partner organisations are also establishing themselves or changing the way they operate. This has led to a year with a high level of organisational change. There was a strong commitment to this work from the Board and the senior management of the organisation, and in particular to drive as much of the work as possible through a 'bottom up' approach with strong engagement with staff and individual teams.

Consequently, a comprehensive transformation programme was established early in the year, designed to progress our vision to be **"a high performing organisation with an international reputation that is recognised as an outstanding place to work".**

In addition to a range of business and performance improvement projects, the transformation programme began to address several workforce related strategic developments, including:

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

Good progress has already been made in a number of areas, as described in the paragraphs below:

- **Operational governance -** the HSCIC had operational governance arrangements in place throughout the year, including a weekly meeting of the executive management team (EMT) that is chaired by the CEO. The procedures operated through these arrangements were communicated to staff extensively from the outset, and over time they became increasingly embedded throughout the organisation
- **Organisation structure -** there has been substantial structural reorganisation in many areas as we have moved to a structure that will deliver the potential synergies from merging the predecessor bodies and for delivering our strategy. An interim structure was established in June 2013, with the final structure agreed in February 2014
- **Performance measurement and management -** the new organisation started the year with no systematic approach to measuring and managing the delivery of its key objectives. A project initiated early in the year has created a KPI based performance pack that provides the basis of performance reporting to the Board and the EMT, and the same approach is used for performance management at directorate level. Further work is needed to refine the performance pack to ensure the management information it contains is focused on our key strategic priorities
- **Operational management -** the organisation commenced the year from a very low base in terms of the development of internal policies, processes and organisational governance. However substantial progress was made during the year. In particular, a Joint Negotiating and Consultative Committee met monthly to discuss organisation wide issues, including the development and implementation of 21 harmonised employment policies from 500 separate policies inherited from the legacy organisations. Local consultation takes place with recognised Trades Unions over areas of specific interest

- **Communicating with staff -** the HSCIC has committed to consult and communicate with staff and their representatives across a range of topics. An intranet site ensures staff had access to a wide range of information relevant to the HSCIC and the health and social care sector at large. In addition, the Chief Executive issues a weekly bulletin and regular staff briefings are held where executives and senior managers update staff and receive feedback on key issues.

  A comprehensive staff survey was undertaken in August 2013, based on the NHS Staff Survey, and repeated in March 2014 in order to provide an internal benchmark and a comparison with relevant NHS organisations. The results of the 2013 Staff Survey were very positive with a response rate that was higher than the NHS average; the responses to most categories of questions also scored higher than the NHS comparator group. Results from the March 2014 survey are still being analysed but the overall results compare well with the previous survey.

  A 'Champions for Change' forum has been established with representation from each directorate to raise and discuss a range of issues across the business. Forum members are invited to attend EMT meetings on a regular basis and the initiative has proved to be very successful in terms of engagement and generating solutions to matters of common interest

- **Staff development -** the HSCIC is committed to providing employees with the right training and development to support the HSCIC's overall objectives. During 2013/14 training was delivered through a number of internal and external means. To ensure that training was cost effective whilst maintaining quality, the organisation had a preferred training provider who was performance managed to deliver the majority of technical and professional requirements. Towards the end of the financial year we concluded arrangements to introduce Civil Service Learning, which will offer further efficiencies in the administration and delivery of training. The assessment of development needs is undertaken through agreed core values which have now been embedded in a revised Personal Development Review process

- **Pensions -** the pension auto-enrolment process was completed to ensure that all staff are enrolled into an appropriate pension scheme.

In taking forward the developments described above, staff across the organisation have demonstrated a high level of resilience and professionalism, as well as a strong commitment to the values and strategic objectives. In an extremely difficult environment, they have delivered a number of major achievements as well as playing the major role in the steps to becoming the high performing organisation to which the HSCIC aspires.

The transformation programme will continue into 2014/15 to embed and further the work undertaken to date.

Health and safety

The HSCIC recognises and accepts its legal responsibilities in relation to the health, safety and welfare of its employees and for all people using its premises. The HSCIC complies with the Health and Safety at Work Act (1974) and also operates a Health and Safety Committee under the Safety Representatives and Safety Committee regulations (1977). All staff were required to complete an e-learning package which includes a self-assessment of their workspace.

Sickness absence data

During 2013/14 7,615 days were lost due to sickness absence. This represented 4.4 days per employee. The above figures are based on calendar year data, not financial year, and were centrally provided from data contained within the Electronic Staff Record.

Pension liabilities

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

Andy Williams
2 July 2014

Remuneration report

This report for the year ended 31 March 2014 deals with the pay of the Chair, Chief Executive and other members of the Board.

Remuneration Committee

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

The HSCIC, with the approval of the DH Remuneration committee operates the NHS Very Senior Manager pay framework (VSM). This includes a provision for a maximum 5% bonus for not more than 25 of the top performers within the VSM group. No bonuses were paid in 2013/14.

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

The work of the committee is supported and administered by the Chief Executive and appropriate staff.

In reaching its recommendations, the Remuneration Committee takes into account:

- the need to recruit, maintain and motivate suitably able and qualified people to exercise their responsibilities
- variations in the labour market and their effects on the recruitment and retention of staff
- recommendations in line with relevant DH guidelines.

Remuneration policy

The HSCIC aims to pay employees on a fair and equitable basis for the role and responsibilities they undertake in line with best practice within the NHS. All posts are evaluated and pay rates determined by the Agenda for Change (AfC) programme.

Staff on civil service terms and conditions are entitled to receive performance related pay (PRP) in line with the DH collective agreements. Staff on NHS terms and conditions are able to receive increments within their pay-scale under AfC guidelines. Both Performance Related Pay and AfC increments are linked to a single individual performance and development review mechanism. A 1% 'cost of living' pay award, recommended by the Pay Review Bodies and agreed by government, was implemented for staff on VSM, AfC and Civil Service terms and conditions of employment on 1 April 2013.

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

Service contracts

During 2013/14, Alan Perkins was employed by the DH and was seconded to the HSCIC for twelve months from 1 April 2013. Mr Carl Vincent is employed by the DH and seconded to the HSCIC from 17 June 2013 until 30 June 2015.

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

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

During 2013/14 the non-executive directors (other than the Chair) were appointed either by 12 month extensions to their previous NHS IC contracts or though interim arrangements. From 1 April 2014 all non-executive directors were appointed on either two or three year contracts through the DH Appointments Team and its terms and conditions applied to them. They are not entitled to compensation for loss of office or early termination of appointment.

Emoluments of board directors

The remuneration relating to all directors in post during 2013/14 is detailed in the table below and are subject to audit. Emoluments of executive directors consisted of basic pay, performance pay, termination payments were relevant and benefits in kind. Emoluments do not include employer pension contributions or the cash equivalent transfer value of pensions.

	Appointment date*	Resignation date	Salary (bands of £5,000)	Benefits in kind £	Pension benefits £000	Total emoluments (bands of £5,000)	Full year equivalent emoluments (bands of £5,000)
Alan Perkins Interim Chief Executive		31-Mar-14	145-150	–	172	315-320	315-320
Rachael Allsop Executive Director of Transformation and Human Resources			125-130	–	26	150-155	150-155
Mark Davies Executive Director of Clinical and Public Assurance		31-Mar-14	155-160	–	25	180-185	180-185
^**Thomas Denwood** National LSP Programme Director			105-110	–	21	125-130	125-130
Trevor Doherty Executive Director of Finance and Corporate Services		29-Aug-13	50-55	–	2	55-60	130-135
^**James Hawkins** Director of Programmes	01-Jun-13		85-90	–	7	90-95	110-115
Maxwell Jones Executive Director of Information and Analytics			110-115	5,900	21	135-140	135-140
^**Clare Sanderson** Director of Information Governance		31-Dec-13	80-85	–	10	90-95	125-130
^**Robert Shaw** Director of Operations and Technical Services	01-Jun-13		100-105	–	22	120-125	145-150
Carl Vincent Executive Director of Finance and Corporate Services	29-Aug-13		50-55	–	77	130-135	165-170
^**John Varlow** Director of Information Services		12-Jun-13	15-20	–	4	20-25	115-120
^**Andrew Haw** Director of Data Services		12-Jun-13	25-30	–	–	25-30	140-145

^attend the Board on a regular basis but do not have voting rights. Robert Shaw was appointed as an executive director from 1 April 2014.
*other than 1 April 2013.

No performance bonuses were paid by the HSCIC in the year.
Mark Davies received a termination payment of £132,708 and Trevor Doherty received £42,500. Clare Sanderson received £99,462 by way of a contribution to her pension scheme.
Alan Perkins was seconded from the DH for 12 months ending 31 March 2014 having agreed to a temporary secondment as the Chief Executive of the HSCIC during the set up phase of the organisation until a permanent Chief Executive was appointed. He was awarded a bonus of £6,256 during the year relating to his performance during 2012/13 whilst working for the DH. He also received a termination payment of £306,538, paid and accounted for by DH, which was due to DH restructuring leading to termination of his employment by them.
Andrew Haw was seconded from Calderdale and Huddersfield NHS Foundation Trust and Carl Vincent from the DH and charges refer to the relevant secondment costs.

	Appointment date*	Resignation date	Salary (bands of £5,000)	Benefits in kind £	Pension benefits £000	Total emoluments (bands of £5,000)	Full year equivalent emoluments (bands of £5,000)
Kingsley Manning Chair	01-Jun-13		50-55	–	–	50-55	60-65
Candy Morris Interim Chair		31-May-13	25-30	–	–	25-30	105-110
Anthony Allen Non-Executive Director		31-Mar-14	10-15	–	–	10-15	10-15
Ian Andrews Interim Non-Executive Director			5-10	–	–	5-10	5-10
Lucinda Bolton Non-Executive Director		31-Mar-14	5-10	–	–	5-10	5-10
Nick Partridge Interim Non-Executive Director			5-10	–	–	5-10	5-10
Mike Pearson Non-Executive Director		31-Mar-14	5-10	–	–	5-10	5-10

*other than 1 April 2013
No performance bonuses were paid in the year.

On 31 March 2014, the interim Chief Executive, Executive Director of Clinical and Public Assurance and three non-executives resigned from the Board. Mr Andy Williams was appointed as Chief Executive and Sir John Chisholm, Professor Maria Goddard, Jan Ormondroyd, Sir Ian Andrews and Sir Nick Partridge were appointed as non-executive directors. Robert Shaw was also appointed as an executive director. Since 1 April 2014, Professor Martin Severs has been appointed as the Caldicott Guardian and Lead Clinician and Peter Counter has been appointed as the Chief Technology Officer.

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

The total number of staff employed at 31 March 2014 split by gender is as follows:

	Male	Female
Directors	13	2
Senior Managers	117	42
Other staff	1,184	950
	1,314	**994**

	Highest paid director	Median pay of the workforce	Ratio to the median of the workforce
Excluding termination payment and pension benefit	£155-£160k	£40,987	3.9
Including termination payment but excluding pension benefit*	£455-£460k	£40,987	11.2

*this includes a bonus and termination payment paid and accounted for by DH.

Nine temporary members of staff received remuneration in excess of the highest-paid director.

Director's expenses during 2013/14 are detailed on the HSCIC website at http://www.hscic.gov.uk/spend

Pension benefits

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

	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 2014 (bands of £5,000)	Lump sum related to accrued pension at 31 March 2014 (bands of £5,000)	CETV at 31 March 2014 £000	CETV at 31 March 2013 £000	Real increase in CETV £000
Alan Perkins	7.5 - 10	25 - 27.5	70 - 75	215 - 220	–	1,480	–
Rachael Allsop	0 - 2-5	5 - 7.5	45 - 50	135 - 140	873	813	24
Mark Davies	0 - 2-5	5 - 7.5	35 - 40	110 - 115	671	617	23
Thomas Denwood	0 - 2-5	2.5 - 5	10 - 15	30 - 35	141	125	7
Trevor Doherty	0 - 2-5	–	5 - 10	–	–	130	–
James Hawkins	0 - 2-5	0 - 2-5	10 - 15	30 - 35	160	150	4
Maxwell Jones	0 - 2-5	2.5 - 5	20 - 25	60 - 65	319	286	14
Clare Sanderson	0 - 2-5	2.5 - 5	15 - 20	50 - 55	–	313	–
Robert Shaw	0 - 2-5	5 - 7.5	35 - 40	115 - 120	674	624	21
Carl Vincent	2.5 - 5	10 - 12.5	25 - 30	80 - 85	450	374	53
John Varlow	0 - 2-5	2.5 - 5	20 - 25	70 - 75	367	336	13

Alan Perkins, Trevor Doherty and Clare Sanderson are in receipt of benefits and hence have no CETV at 31 March 2014.

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

The CETV figures and from 2003/04 the other pension details, include the value of any pension benefit in another scheme or arrangement which the individual transferred to the civil service pension arrangements and for which the civil service vote received a transfer payment commensurate to the additional pension liabilities being assumed. They also include any additional pension benefit accrued to the member as a result of them purchasing additional years of pension service in the scheme at their own cost. CETV's are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries and do not take account of any actual or potential reduction to benefits resulting from Lifetime Allowance Tax which may be due when pension benefits are drawn.

The real increase in CETV reflects the increase effectively funded by the employer. It excludes the increase in accrued pension due to inflation and contributions made by the employee (including the value of any benefits transferred from another pension scheme or arrangements) and uses common market valuation factors for the start and end of the period.

Andy Williams
Chief Executive
2 July 2014

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, the HSCIC is required to prepare a Statement of Accounts for each financial year in the form and on the basis determined by the Secretary of State. The accounts are prepared on an accruals basis and must give a true and fair view of the HSCIC's state of affairs at the year end and of its income and expenditure, recognised gains and losses and cash flows for the financial year.

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

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

The Accounting Officer for the Department of Health has appointed the Chief Executive of the HSCIC as the Accounting Officer, with responsibility for preparing the HSCIC accounts and for transmitting them to the Comptroller and Auditor General. Specific responsibilities include the responsibility for the propriety and regularity of the public finances for which the Accounting Officer is answerable, for keeping proper records and for safeguarding the HSCIC's assets.

Alan Perkins was Accounting Officer for the period until 31 March 2014 and Andy Williams from 1 April 2014. Alan Perkins has provided a letter of assurance confirming that appropriate governance was in place until 31 March 2014.

Annual Governance Statement for the year ended 31 March 2014

Introduction and context

The Health and Social Care Information Centre (HSCIC) was created as an Executive Non-Departmental Public Body (ENDPB) on 1 April 2013. It inherited informatics and systems related functions from:

- the former Health and Social Care Information Centre, a Special Health Authority whose primary purpose was the collection, analysis and dissemination of health related data and information for secondary uses purposes
- NHS Connecting for Health (CfH), part of the informatics division of the Department of Health (DH) whose primary purpose was the development and management of national health systems and IT infrastructure
- former Strategic Health Authorities and a Primary Care Trust (SHAs/PCTs)
- an external provider who undertook the development and management of the NHS Choices website.

A major focus during 2013/14 has been on developing new governance arrangements and the supporting of internal control systems and processes whilst at the same time ensuring adequate control was maintained until these changes were in place. As an ENDPB, the HSCIC is accountable directly to Parliament for the delivery of its statutory functions and use of public resources.

The formation of the HSCIC involved creating a new single governance and accountability framework for the organisation from the merging of established arrangements inherited from its predecessor organisations. Those arrangements were substantially different and did not satisfy the requirements for the new body nor the vision of the DH for the governance of its new arm's length bodies. Bringing these disparate control arrangements together into an effective framework that was fit for purpose has been a major challenge.

Some essential governance and accountability structures were put in place immediately but the broader internal control arrangements were less well developed. They gradually became more so as the year progressed. This journey has been reflected in the quarterly statement of internal control reviews and internal audit reports, and endorsed through the publication of the Framework Agreement between the HSCIC and DH which sets out the overarching accountability and operating relationship between the two organisations.

Further in year changes have added to the challenge of developing effective governance and control arrangements. These included the transfer in of NHS Choices in August 2013, planning for the transfer of elements of the former NHS Direct towards the end of the year, the implications of the decision to insource Spine 2 and the operational complexities of managing the Data Sharing for Commissioners Regional Offices. The commissioning by DH of an Informatics Governance and Assurance Review (IGAR) which reported in January helped to clarify respective responsibilities and accountabilities across the health and social care system. Some aspects of the review were implemented by the year end and the remainder will follow during 2014/15.

A key milestone in setting the governance arrangements was the review of the HSCIC's Standing Orders and Standing Financial Instructions carried out last summer when the opportunity was taken to strengthen the existing control arrangements on delegated financial authority both for funds controlled by the HSCIC and that managed on behalf of the DH and NHS England.

The governance and internal control structures are still in development and much work remains to be done in 2014/15 to ensure that they are fully embedded and that they meet the needs of the organisation to provide assurance to its stakeholders across health and social care, the government and the public.

In addition to the governance structures, the HSCIC was transferred assets and liabilities from the predecessor organisations. The quality of accounting information on assets transferred from DH to HSCIC was a particular cause for concern and remained so at year end.

Scope of responsibility

The HSCIC has responsibility for maintaining a sound system of internal control that supports the achievement of its policies, aims and objectives whilst safeguarding public funds and the assets for which it is accountable, including data and information, in accordance with the requirements of Managing Public Money.

Throughout the year, the Accounting Officer and HSCIC Board have sought to exercise these responsibilities by establishing visible and effective systems of internal control and governance.

The Senior Departmental Sponsor for the DH (Sponsor) is responsible for ensuring that the HSCIC procedures operate effectively, efficiently and in the interest of the public and the health sector.

Transition & transformation

2013/14 was a year of transition and transformation. We began under the transitional leadership of an interim Board and executive team. Over the course of the year, permanent appointments were made, starting with a new Chair in June 2013 who was joined by a new Chief Executive and a new team of non-executive directors on 1 April 2014. Further executive appointments followed after the year end.

New operational management arrangements were set up in April 2013 and have been reviewed in year to take account of the structural changes. As the organisation matured and its role and responsibilities became clearer, an organisational structure more focussed on the future has been established. This will be reviewed on an on-going basis and mechanisms have been put in place to review their effectiveness on a regular basis.

During the summer of 2013 a new strategic vision was developed aimed at informing discussions with national partners about the HSCIC's role. It also informed wider discussions about system-wide issues and priorities for 2014/15. A strategy was published in January 2014 following consultation with stakeholder partner organisations.

Reflecting the growing concerns across government over the importance of sound information governance controls and in the light of the growing cyber security threat, the HSCIC has established, as a Committee of the Board, an Information Assurance and Cyber Security Committee under the chairmanship of a non-executive director to lead on this vital area. As a first step a 'hosting' strategy on how information held electronically has been developed and an implementation plan is underway to ensure all data is kept in secure data centres that meet government security requirements.

The Health and Social Care Act 2012 also sets out wider statutory obligations around the collection, analysis, dissemination and publication of information. Work is presently underway to ensure the HSCIC is fully compliant in these areas. A code of practice for the collection, analysis and dissemination of confidential information describing these arrangements is due to be published by October 2014.

The governance framework

The constitution of the HSCIC is set out in Schedule 18 of the Health and Social Care Act 2012.

The HSCIC is led by a Board consisting of non-executive and executive members and is the senior decision making structure in the organisation. It is accountable to the Secretary of State for Health and to Parliament. The final outstanding appointment to be made later in 2014 is that of another non-executive director to be the permanent chair of the Assurance and Risk Committee (ARC).

The organisation is managed on a day to day basis, by an executive team led by the Chief Executive who is the Accounting Officer and is accountable to the Secretary of State and to Parliament for the performance of all functions and for meeting the organisation's statutory duties.

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

Board members have a corporate responsibility for ensuring that HSCIC complies 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 the HSCIC Standing Orders, Standing Financial Instructions and Code of Practice for board members.

The HSCIC Board is assisted in carrying out its duties through an operational governance structure comprising the:

- **Executive Management Team (EMT):** responsible for communicating and delivering the overall strategy for the HSCIC (as agreed by the Board) and agreeing policy and procedures whilst supporting implementation. The group meets weekly with action points and decisions disseminated to all staff via the corporate intranet
- **Portfolio Board (PB):** an internal HSCIC board focussing predominantly on the management of programmes and projects, allocating resources and ensuring oversight, management of general delivery, risks and issues, and tolerance exceptions. Plans were developed for 2014/15 to cover more fully operational services, and to increase attention on validating new work commissions, prioritisation of resources and ensuring architectural integrity
- **Corporate Assurance Panel (CAP):** ensures that items requiring approval or endorsement by the Accounting Officer receive the appropriate scrutiny and delegated approvals in accordance with the HSCIC Standing Financial Instructions and have met quality standard expectations prior to submission to him
- **Transformation Programme Board:** owns the internal organisation development strategy and plan and ensures consistency across directorate transformation projects.

HSCIC Board and Committee structures

The Board has responsibility for defining strategy and determining resource requirements to ensure the delivery of the HSCIC's objectives. The composition, role and main activities of the Board and its principal committees are detailed in the Annex.

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

- development of a strategy and business plan in the context of a rapidly changing health and care system and a tight financial regime
- governance and structure of the HSCIC, led by the internal Transformation Programme
- links and relationships with key stakeholders including NHS England and the Senior DH Sponsor
- monitoring of a broad range of performance indicators throughout the year which are consistent with the approved strategy and business plan. This included the introduction of a board performance pack.

The Board and the ARC undertook effectiveness reviews. These did not highlight any significant issues or concerns that required immediate action or impact on the content of the Governance Statement. Similar to the organisation as a whole, the work of the ARC has developed over the year. The key areas it addressed in terms of assurance included:

- oversight of the 2012/13 annual accounts preparation for the NHS IC and recommending the approval of the final accounts to the Board
- review of the content of the draft annual governance statement and oversight of the annual accounts preparation process for 2013/14
- strategic steer on and input to the internal audit strategy and annual plans in the context of the DH's shared service agenda
- review of the range of internal audit reports and monitoring of implementation of associated recommendations
- review of the local counter-fraud specialist work-plan
- review of the external audit strategy
- monitoring of the management of corporate risks and issues
- high level oversight of approach to contracts and procurement.

The HSCIC complies with the central government corporate governance code as far as is relevant. No material departures have been identified.

Corporate governance

Corporate governance measures at the start of the year relied heavily on those of the predecessor organisations but rapid progress has been made over the year to bring them together, including:

- the development of a suite of new corporate and human resources policies including a Code of Business Conduct
- ensuring awareness of the HSCIC's confidentiality policy requirements and conducting a conflicts of interest declaration exercise
- development of a range of assurance approaches, which we will develop into a full assurance map during 2014/15
- providing clarity over individual executive director responsibilities for compliance with statutory obligations of the Health and Social Care Act 2012. Work will continue in 2014/15 to ensure full and on-going compliance
- meeting statutory obligations in areas such as health and safety.

Key relationships

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

The HSCIC is an active member of the National Information Board (NIB). The NIB was created following the recommendations of a review of the governance arrangements for national informatics (known as the IGAR review) and replaced the Informatics Services Commissioning Group (ISCG) which played an important role during 2013/14 in bringing together all national bodies to facilitate a more collaborative approach to the commissioning of informatics services. The NIB has taken on the ISCG's responsibilities for the development of the strategy for the health and care information system, as well as the management of commissioning and investment proposals.

It is important to acknowledge the complex framework of interests and stakeholders in which the HSCIC operates and the vital need for clear organisational and individual responsibilities alongside a collaborative approach to decision making. IGAR helped to bring coherence to these relationships and its recommendations will result in a clearer role for the HSCIC, even greater rigour for the way public money is spent and better management of major programmes. The lack of clear governance and accountability across the system was a major risk to the HSCIC, which is why the HSCIC played a key role in developing the IGAR principles and has a critical part to play in ensuring they are implemented effectively. Stakeholder relationships nevertheless remain a major risk and a director has since been appointed to manage them.

Performance Management

At the start of 2013/14 the HSCIC had only limited management information for performance management, but new key performance indicators (KPIs) and performance packs for the HSCIC Board, EMT and directorate senior management teams were developed following best practice principles, with input from non-executive and executive directors and other senior staff. These packs track implementation of the HSCIC's strategic objectives as well as delivery of business plans, and are being reviewed in early 2014/15 in order to improve their utility and the efficiency with which they are produced.

The performance packs contain a mix of performance data for each KPI and other relevant management information needed to take informed decisions. The KPI data is presented in a number of different formats designed to encourage exception reporting and management.

Every KPI has been assigned an owner, whose primary role is to be accountable for the delivery of KPI targets. KPI owners must escalate any serious or recurring problems which require resolution. It is vital that any corrective action taken by the KPI owner as part of the business as usual activities is done in consultation with other KPI owners. There are many dynamic 'cause and effect' relationships between the KPIs and there is a risk that a decision taken to rectify one KPI could have unintended (and potentially adverse) consequences for one or more of the other KPIs.

The content of all performance packs is kept under review to ensure they are providing the information required to support better decision making. The targets for all the KPIs (at both corporate and directorate levels) are shown in the business plans for 2014/15.

Risk assessment and management

For much of 2013/14, the HSCIC continued to operate the processes it inherited from its predecessor organisations. This resulted in inconsistent risk recording and reporting quality, although there was structure and control over how risks were managed and escalated. A single policy and framework for risk management has been approved and the processes and practices needed to fully implement these are being embedded.

A single platform to be the sole risk data repository for the short to medium term has been selected and the process of migrating all users not currently using the tool is underway. A data cleanse exercise has been carried out to ensure that the risk information held is current and accurate.

A corporate risk management KPI has been agreed and is being reported to EMT and the Board. This KPI is underpinned by a set of metrics and indicators that measure performance against data quality, process compliance and effectiveness. The use of risk management performance metrics is starting to drive an overall improvement in risk data quality and risk management behaviours.

Risks are reported monthly and escalated through the internal governance structure with the top corporate risks and issues ultimately being considered at the Board, ARC and by the Sponsor. There has been a significant improvement in risk management within the organisation although it is acknowledged that the new processes need some further time to bed in.

The most significant risks faced by the organisation through the year were:

- a lack of clarity over the role and responsibilities of the HSCIC both internally and across the wider health and care system
- ineffective or flawed governance arrangements between the HSCIC and other organisations, especially DH and NHSE
- delays to major programmes causing costs to be deferred to the following financial year
- the capacity and capability to deliver to our commitments
- a major data loss / breach of data security.

These risks were mitigated by:

- working with our sponsor team to ensure our role and responsibilities are clearly defined in a Memorandum of Understanding with other organisations within the health and care system
- contributing to, and implementing the recommendations of, the IGAR review
- improving planning and forecasting capabilities, reporting quality and promoting a culture that encourages openness
- undertaking a zero base review of finances and resource requirements and the creation of a Transformation Programme to ensure we have the people and skills to meet our commitments
- establishing industry-recognised practices (e.g. mandatory staff training, controls around data access, movement and destruction) backed up by robust infrastructure (e.g. high-availability networks, dual-site data centres).

During 2014/15, risk management will be developed in the following areas:

- the corporate strategic risk set, newly identified in late 2013/14, will be fully articulated, assessed and mitigating actions taken
- the HSCIC risk appetite will be developed and communicated throughout the organisation and individual directorates will develop their local risk management policies and appetites
- the embedding of the performance management approach to risk management, will continue, with improved metrics and collection methods and enhanced EMT, ARC and Board visibility of, and confidence in, the organisation's risk management capability.

Information governance

Within the HSCIC, the importance of having robust information governance procedures in place which are consistent across the organisation is fully recognised by the Board. This is a fundamental consideration for work the HSCIC has been commissioned to deliver such as the care.data programme and the insourcing of Spine 2.

Since the end of the year the governance responsibilities of the HSCIC have been expanded to provide system wide advice on operational information governance across the health and social care sectors. This is separate from its principal role of guardian of data which is set out in the Health and Social Care Act 2012. The HSCIC will host the Information Governance Alliance which will act as the primary point of contact for advice and guidance to the wider system. HSCIC will also deliver a programme of assurance across the health sector as directed by the Secretary of State, to determine where enhancements or additional capabilities at a local, regional and national level can be made.

Following concerns raised by the Health Select Committee, Sir Nick Partridge was asked by the HSCIC Board to undertake a review of all the data releases made by the predecessor organisation, the NHS IC. The review examined the arrangements that were in place for the release of data and provided insight and key observations that will allow the HSCIC to learn from its predecessors' experience and ensure the HSCIC's processes are as robust, open and transparent as possible.

During 2013/14, work continued to consolidate strategies, frameworks, and procedures in relation to information governance to improve quality and efficiencies and ensure that information records are:

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

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

- each year all staff complete information governance training in line with requirements of the NHS information governance toolkit and more specialist training is undertaken by those staff who are responsible for the management and control of data assets and information
- the HSCIC completed the information governance toolkit. A particular challenge for the HSCIC during 2013/14 has been the secondment of staff in the Data Sharing for Commissioners Regional Offices and ensuring they understand and adhere to the corporate HSCIC information governance policies and processes and contribute to the HSCIC submission of the Information Governance Toolkit
- there have been no personal data incidents in 2013/14 which required reporting to the Information Commissioners Office (ICO). A small number of incidents have been logged and managed internally by the HSCIC. Assessment against ICO guidelines determined these did not require ICO notification due to the minor scale of the incident or that no clinical or sensitive data was included
- the HSCIC is subject to the Data Protection Act 1998 and has filed the appropriate notification with the ICO. During 2013/14, 815 Freedom of Information requests and 46 Subject Access requests were received. There have been four breaches of the timescales for handling a Freedom of Information request and one for handling a Subject Access request. No complaints were made to the ICO by applicants dissatisfied with responses provided to them under the Freedom of Information Act
- as a public information holder, the HSCIC has 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 2013/14.
- the HSCIC is committed to the regular review and assurance of all data it handles. In the course of discharging this responsibility, we have discovered in April 2014 a number of NHS organisations that have been submitting data values to the secure Secondary Uses Service (SUS) which do not conform to NHS Data Dictionary Standards. In accordance with good practice and in relation to issues impacting on the use of patient data, we have referred this incident to the Information Commissioner's Office (ICO). We have reminded data providers of their responsibilities and are working with data recipients to support them to delete the affected data. The risk to patient confidentiality has been classified as low by the ICO.

Statistical Governance

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

During 2013/14 there were five breaches of the Code. All concerned release practices. In four cases, release of publications was delayed due to IT problems with a new content management system (CMS). The remaining breach was a planned update to an existing publication and the additional tables went live several hours early due to a problem with the CMS. In accordance with the HSCIC's incident management processes, contingencies have been implemented to protect against IT system error, the CMS has been improved and the processes made more robust.

The production of some statistics relies on the use of complex models which are deemed to be business critical. In line with the requirements of the Macpherson Report "Review of quality assurance of Government analytical models" an appropriate framework of quality assurance of business critical models is in place.

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 2013/14 has been informed in a number of ways:

- through ARC minutes and papers and its annual report to the Board
- the internal audit plan. I acknowledge this was developed at the start of the year before a full risk assessment had been developed for the organisation, but nevertheless the internal audit team completed a comprehensive range of assessments, and the head of internal audit provided an opinion on the overall arrangements for gaining assurance through the assurance framework and on the controls reviewed as part of the internal audit work. While recognising the challenging circumstances within which the HSCIC operated during the year, the internal audit assurance statement concluded that:

  There is a generally sound system of internal control, designed to meet the organisation's objectives, and controls are generally being applied consistently. This is supported by our work on key financial and operational processes, which has identified mostly low and medium risk findings.

However, our work has also identified some high risk findings in areas which are key to HSCIC's organisational objectives and priorities. These include:

- *the physical security of buildings and information (including visitor checks, building access controls and tailgating); and*
- *the in-sourcing of the Spine 2 service (including risks relating to the adequacy of project planning and delays in preparing for data migration), although we have noted that a number of management actions were taken prior to the year end to mitigate these risks.*

Therefore, based on the work we have completed, we believe that there is some risk that objectives in these areas may not be fully achieved. Whilst we are satisfied that these are isolated to specific systems and processes rather than being pervasive to the system of internal control, improvements are required in these areas to enhance the adequacy and / or effectiveness of governance, risk management and control.

The basis for forming the opinion is as follows:

- *we have completed the program of internal audit work for the year ended 2013/14 with the exception of the five reviews to be completed in 2014/15. This program of work identified 15 low, 21 medium and 7 high risk findings; and*
- *during the course of our work, we have also become aware of other issues that we believe could have, or have had an impact upon The Health & Social Care Information Centre's system of internal control. These matters were raised within separate assurance related reviews outside of the agreed programme of internal audit work, both of which identified high risk findings as follows:*
  - *our work on Data Services for Commissioners Regional Offices (DSCROs) identified a range of findings relating to information governance at the DCSROs; and*
  - *our review of BT SUS Security identified a high risk finding relating to the lack of systematic audit logging or monitoring within the SUS environment.*

We also note the following limitation of our opinion:

- *a detailed review of risk management was not performed and was instead deferred into the 2014/15 year at management's request. As a result, our work on risk management was limited to a high level review and commentary on the developing framework only, and we are not able to form a definitive conclusion on the effectiveness of risk management processes during 2013/14; and*
  - *is based solely on the annual internal audit activity of 263 days for 2013/14, and on our assessment of whether the controls in place support the achievement of management's objectives as set out in our Annual Internal Audit Risk Assessment and Plan and individual assignment reports.*

- following individual audit reports, action plans were put in place to address recommendations with progress reviewed by the ARC on a regular basis
- senior managers within the organisation who had responsibility for the development and maintenance of the system of internal control provided the former interim Chief Executive with assurances
- through clear performance management arrangements in place with executive directors and senior managers
- the assurance framework itself provided evidence on the effectiveness of controls that managed the risks to the organisation
- by the findings of the National Audit Office as the organisation's external auditors
- by review of and accepting a report from Alan Perkins (Accounting Officer to 31 March 2014) dated 31 March 2014 confirming that appropriate governance was in place until this date.

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

Significant Internal Control Issues

I recognise that during the year certain control issues have arisen that need addressing as a priority in 2014/15. The key concern was in relation to the accounting for non-current assets an area also raised by the NAO who have rightly drawn them to my attention.

We started the year with a very incomplete non-current asset register and processes that were substantially inadequate for providing an appropriate level of control. Although we have made sufficient progress on our record keeping and processes to give me adequate assurance for our 2013/14 Accounts, we need to invest further to make the necessary improvements in the year ahead.

The starting position was in part due to the granularity of the information provided to the HSCIC when it was formed. We have also had to assimilate IT equipment from other organisations, and consolidate the infrastructure across a number of external data centres partly as a means of increasing efficiency, but also improving the physical security and resilience of the systems and the confidentiality of data contained on them. The particular issues included the following:

- the identification of assets due to transfer to the HSCIC in the DH ledger was incomplete. The HSCIC inherited only a small fraction of the assets formerly held by CfH contained on the DH ledger, and although the HSCIC manages the delivery of the continuing former CfH programmes, we are not involved in their management or record keeping
- the underlying accounting records at the start of the financial year in some important cases fell well short of the standard needed, and although we have made significant improvements to the records we still have more work to do
- the impact of inadequate records was compounded because we found it difficult to prove the existence of some of the assets transferred, particularly physical IT equipment where assets were componentised and located in external data centres
- the "equipment list" maintained by IT for internal asset management purposes was not complete or reconciled to the accounting records and thus was not sufficiently robust for financial reconciliation purposes
- there was an insufficiently robust process for determining the correct accounting treatment for complex software developments and licence arrangements including the classification between non-current asset categories and adherence with the requirements of the relevant accounting standards
- reviewing the assets transferred from the various organisations which employed different capitalisation and depreciation policies.

Most of these issues were highlighted early in the audit planning cycle, and my finance team assigned additional resources to complete remedial work to improve our records and put in place improved control processes. I am satisfied that we now have adequate control, but given the value and the importance of the IT assets generally to the organisation, I am firmly committed to putting our asset management onto a much more robust footing. Our provisional plan of action includes the following:

- undertake a full asset verification exercise in the autumn of 2014
- seek to build a single asset management database that serves a multitude of purposes for the organisation
- undertake a review of our asset life policy
- establish closer working with between the finance, IT and procurement team, to ensure all teams are using an agreed and robust process, transactions are undertaken based on robust technical advice and all staff have clarity over roles and responsibilities.

My finance and IT teams are still working on the details, but I will fully support all and every action they need to take to provide the highest possible assurance that we have a robust and effective approach to managing our non-current assets. I expect this to include the appointment of a dedicated accountant, investment in the development of a database, and substantial work by our finance, IT and procurement teams working collaboratively.

Other concerns include:

- an urgent need for a comprehensive internal assurance map which will provide the Board and DH with systematic assurance that risk management is internal controls are in place across the organisation
- aspects of resilience to social engineering and BT SUS security. These, along with wider Government concerns over cyber security, have been a significant driver for an overhaul of information and physical security arrangements within the HSCIC which will continue under the oversight of the new Information Assurance and Cyber Security sub-Committee of the Board
- the controls surrounding data released by the NHS IC, one of our predecessor organisations. From April 2005 to March 2013, its role had been to collect and manage health records data, including sharing it with third parties under data sharing agreements which restricted its use. The Board commissioned an independent review by PricewaterhouseCoopers which was published in June 2014. PwC identified lapses in the strict arrangements that were supposed to be in place to ensure that people's personal data would never be used improperly, although the failings in terms of the processes, control and overarching governance were not systemic. The HSCIC is committed to implementing all the recommendations arising from the review.

I fully accept and welcome these observations on our controls.

Wherever practical mitigation measures have also been put in place against externally generated risks from across the wider health and social care system over which HSCIC has no direct control and which are for DH to consider. Finally, assurance advice has been sought from internal audit on the information governance processes and framework controls in place at Data Services for Commissioners Regional Offices (DSCROs). Although not conducted as a formal audit their advice through a series of phased reviews has provided a series of recommendations to strengthen the controls which are presently being considered.

I believe that the HSCIC started the year with governance and internal control arrangements which were less than effective but which it has taken significant steps to strengthen. But much remains to be done and this will continue to be addressed as a priority during 2014/15.

Andy Williams
Accounting Officer
2 July 2014

Annex

HSCIC Board 2013/14

Membership	Meetings Attended	Role
Board		Board members have corporate responsibility for ensuring that the HSCIC complies with any statutory or administrative requirements for the use of public funds. Other important responsibilities of Board members include: • agreeing the vision and values, culture and strategy of the HSCIC within the policy and resources framework agreed with the DH sponsor • agreeing appropriate governance and internal controls • approving business strategy, business plans, key financial and performance targets and the annual accounts • ensuring sound financial management and good value for money • ensuring controls are in place to manage financial and performance risks, including ensuring that the HSCIC has the capability to deliver • using information appropriately to drive improvements • supporting the EMT 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 the HSCIC complies with any duties imposed on public bodies by statute • ensuring that the HSCIC meets its obligations for sustainable development and operates within the framework of the DH's environmental policies • approving recommendations of Board committees • approving income and expenditure within the approved schema of delegated authorities. Further details including the conduct of meetings are contained in the HSCIC standing orders and other governance documents. Board meetings comprised a public session, where members of the public were able to attend, with all minutes and papers made available on the HSCIC website. In addition, from time to time, the Board needed to consider commercial or staff in confidence items that could not be discussed in public. In that event a private session was held without any observers.
Non-Executive directors:		
C Morris (Chair) – until June 2013	2	
K Manning (Chair) – from June 2013	8	
A Allen	10	
L Bolton	10	
M Pearson	9	
Sir I Andrews	8	
Sir N Partridge	11	
Executive directors:		
A Perkins	10	
T Doherty – until Aug 2013	4	
M Davies	6	
R Allsop	9	
C Vincent – from Aug 2013	7	
M Jones	11	
Other directors:		
C Sanderson – until Dec 2014	7	
T Denwood	8	
R Shaw – from June 2013	8	
J Hawkins – from June 2013	7	
J Varlow – until May 2013	2	
A Haw – until May 2013	2	

HSCIC Assurance and Risk Committee 2013/14

Membership	Meetings Attended	Role
Non executive directors:		The committee was charged with providing assurance and making recommendations to the Board on:
A Allen (Chair)	7	
L Bolton	6	
Sir I Andrews	5	• the effectiveness of the system of integrated governance, risk management and internal control including information governance, security and data quality risks
Sir N Partridge	4	
Executive directors – in attendance		• the accounting policies, the accounts and the annual report of the organisation
A Perkins	6	
T Doherty – until Sept 2013	4	• planned audit activity and results of both internal and external audit reports
C Vincent – from Aug 2013	4	
R Allsop	1	• proposals for the move to the DH Group Internal Audit service in 2014/15
M Jones	2	
Other directors in attendance:		• any required changes to key corporate governance documents (standing orders, standing financial instructions and the scheme of delegation)
C Sanderson – until Dec 2013	5	
In addition, representatives of both the internal and external auditors attend meetings.		• anti-fraud policies, whistle-blowing processes and arrangements for special investigations – including appointment of a local counter-fraud specialist.

HSCIC Remuneration Committee 2013/14

Membership	Meetings Attended	Role
Remuneration Committee (to 31 March 2014)		The Board delegated full responsibility to the Remuneration Committee to:
Non executive directors:		
C Morris (Chair) – until June 2013	1	• make recommendations to the Department of Health (through the pay and performance oversight committee) on the level of the remuneration packages of the Chief Executive and other executive directors within the provisions of the pay framework for very senior managers (VSMs) in the NHS or successor arrangements. All posts with salaries above £100k must be approved by the Department
K Manning (Chair) – from June 2013	3	
L Bolton – until Nov 2013	2	• approve the level of any annual performance related pay awards to HSCIC staff on ex-civil service terms and conditions
Sir I Andrews	3	
Sir N Partridge	4	• approve the annual performance objectives and targets of executive directors
M Pearson	3	
Executive directors – in attendance:		• monitor and evaluate the performance of VSMs and make recommendations to the Department on any proposed annual performance pay awards, within the total of VSM pay bill which may be used for performance related pay (as set annually by the Department, taking account of the recommendations of the Senior Salaries Review Body)
A Perkins	4	
R Allsop	4	• ensure that pay arrangements are appropriate in terms of equal pay requirements
		• Consider and approve redundancy payments.

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 2014 under the Health and Social Care Act 2012. The financial statements comprise: the Statements of Comprehensive Net Expenditure, Financial Position, Cash Flows, Changes in Taxpayers' Equity; and the related notes. These financial statements have been prepared under the accounting policies set out within them. I have also audited the information in the Remuneration Report that is described in that report as having been audited.

Respective responsibilities of the Board, Accounting Officer and auditor

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

Scope of the audit of the financial statements

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

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

Opinion on regularity

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

Opinion on financial statements

In my opinion, the financial statements give a true and fair view of the state of Health and Social Care Information Centre's affairs as at 31 March 2014 and of the net expenditure for the year then ended; and the financial statements have been properly prepared in accordance with the Health and Social Care Act and Secretary of State directions issued thereunder.

Opinion on other matters

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

Matters on which I report by exception

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

Report

I have no observations to make on these financial statements.

Sir Amyas C E Morse
8 July 2014

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 2014

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

All income and expenditure derives from continuing operations.

Notes 1 to 24 form part of these financial statements.

Statement of financial position
As at 31 March 2014

	Notes	31 March 2014 £000
Non-current assets		
Property plant and equipment	7	15,145
Intangible assets	8	27,865
Other non-current assets	9	813
Total non-current assets		**43,823**
Current assets		
Trade and other receivables	10	25,502
Cash and cash equivalents	11	22,931
Total current assets		**48,433**
Total assets		**92,256**
Current liabilities		
Trade and other payables	12	(28,955)
Provisions	13	(561)
Total current liabilities		**(29,516)**
Non-current assets plus net current assets		**62,740**
Non-current liabilities		
Provisions	13	(947)
Assets less liabilities		**61,793**
Taxpayers' equity		
General reserve		61,793
Revaluation reserve		–
Total taxpayers' equity		**61,793**

Notes 1 to 24 form part of these financial statements.

The financial statements on pages 57 to 80 were approved by the Board on 17 June 2014 and signed on its behalf by:

Andy Williams
Chief Executive

Dated
2 July 2014

Statement of cash flows
For the year ended 31 March 2014

	Notes	2013/14 £000
Cash flows from operating activities		
Net operating expenditure for the financial year		(153,070)
Adjustment for non-cash transactions:		
- depreciation	5	8,149
- loss on disposal of non-current assets	5	733
- loss on revaluation of non-current assets	5	262
- provisions arising during the year	13	119
Increase in trade and other receivables	14	(14,780)
Decrease in trade and other payables	14	(871)
Provisions utilised	13	(564)
Net cash outflow from operating activities		**(160,022)**
Cash flows from investing activities		
Purchase of property, plant and equipment		(5,692)
Purchase of intangible assets		(8,711)
Net cash outflow from investing activities		**(14,403)**
Cash flows from financing activities		
Bank balances transferred from CfH		15,724
Bank balances transferred from NHS IC		6,632
Grants from the Department of Health: cash drawn down in year		175,000
Net financing		**197,356**
Cash and cash equivalents at the end of the period	11	**22,931**

All cash flow relates to continuing activities.

Notes 1 to 24 form part of these financial statements.

Statement of changes in taxpayers equity
As at 31 March 2014

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

Notes 1 to 24 form part of these financial statements.

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

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

1.1 General Information

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

1.2 Basis of accounting

The financial statements have been prepared in accordance with the 2013/14 Government Financial Reporting Manual (FReM) issued by HM Treasury. The accounting policies contained in the FReM apply International Financial Reporting Standards (IFRS) as adopted and interpreted for the public sector context. Where the FReM permits a choice of accounting policy, the accounting policy which is judged to be most appropriate to the particular circumstances of the HSCIC for the purpose of giving a true and fair view has been selected. The particular policies adopted by the HSCIC are described below. They have been applied consistently in dealing with items that are considered material to the accounts.

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

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

Transfers from "NHS IC" represents the assets transferred from the Health and Social Care Information Centre Special Health Authority, which was dissolved on 31 March 2013. The transfer was accounted for using modified absorption accounting rules in accordance with the Department of Health group accounting policies set out in the NHS Manual for Accounts. Transfers under modified absorption accounting are recorded against assets or liabilities as appropriate, with the net gain or loss recorded against the general reserve.

Transfers from"SHAs/PCTs" represent the assets and liabilities transferred from Strategic Health Authorities and a Primary Care Trust relating to the informatics functions that moved to the HSCIC when these bodies were dissolved on 31 March 2013. These transfers were accounted for using modified absorption accounting rules, in accordance with the DH group accounting policies set out in the NHS Manual for Accounts. Transfers under modified absorption accounting are recorded against assets or liabilities as appropriate, with the net gain or loss recorded against the general reserve.

Transfers from "CfH" represents the assets transferred from the DH Informatics Directorate which relate to the IT system delivery functions managed by HSCIC from 1 April 2013. The transfer was accounted for using standard absorption accounting in accordance with the DH group accounting policies set out in the NHS Manual for Accounts. Transfers under standard absorption accounting are recorded against assets or liabilities as appropriate, with the net gain or loss recorded through the statement of comprehensive net expenditure.

Early adoption of accounting standard amendments and interpretations

No accounting standard changes were adopted early in 2013/14.

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

The Treasury Financial Reporting Manual does not require the following standards and interpretations to be applied in 2013/14. The application of the standards as revised would not have a material impact on the accounts for 2013/14, were they applied in the year:

- IAS 27 Separate Financial Statements - published May 2011, expected to be effective in 2014/15
- IAS 28 Investments in Associates and Joint Ventures - published May 2011, expected to be effective in 2014/15
- IPSAS 32 Service Concession Arrangement - subject to consultation
- IFRS 9 Financial Instruments - published October 2010, expected date of adoption uncertain
- IFRS 10 Consolidated Financial Statements - published May 2011, expected to be effective in 2014/15
- IFRS 11 Joint Arrangements - published May 2011, expected to be effective in 2014/15
- IFRS 12 Disclosure of Interests in Other Entities - published May 2011, expected to be effective in 2014/15
- IFRS 13 Fair Value - published May 2011, subject to consultation

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

1.3 Income

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

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

Operating income is accounted for by applying the accruals convention and primarily comprises of fees and charges for services provided on a full cost basis to DH, NHSE, 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 and programme 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 DH group consolidation. The net operating expenditure for the financial year in the consolidation return submitted to the DH was split between net administration expenditure of £153.2 million and a programme surplus of £0.1 million.

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 each individual asset is over £250, the assets are functionally interdependent, they had broadly simultaneous purchase dates, are anticipated to have simultaneous disposal dates and are under single managerial control.

   Development expenditure is transferred to other categories of non-current assets when the development is sufficiently complete to enable the asset as a whole to be fully deployed and effective for the management's intended purpose.
2) Tangible assets which are capable of being used for more than one year, and:
   - individually have a cost equal to or greater than £5,000; or
   - collectively have a cost of at least £5,000 and each individual asset is over £250, the assets are functionally interdependent, they had broadly simultaneous purchase dates, are anticipated to have simultaneous disposal dates and are under single managerial control; or
   - form part of the initial equipping and set up cost of a new asset irrespective of their individual cost.

   Internally-generated assets are recognised if, and only if, all of the following have been demonstrated:
   - the technical feasibility of completing the intangible asset so that it will be available for use
   - the intention to complete the intangible asset and use it
   - the ability to use the intangible asset
   - how the intangible asset will generate probable future economic benefits
   - the availability of adequate technical, financial and other resources to complete the intangible asset and use it
   - the ability to measure reliably the expenditure attributable to the intangible asset during its development.

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

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

b. Valuation

Non-current assets are recognised at cost, including expenditure such as installation directly attributable to bringing them into working condition. Revaluations are performed annually in order to assess whether cost is materially different to fair value. Any revaluation or indexation increase is credited to the revaluation reserve, except to the extent that it reverses a revaluation decrease for the same asset previously recognised as an expense, in which case the increase is credited to the statement of comprehensive net expenditure to the extent of the decrease previously expensed. A decrease in carrying amount arising on the revaluation of the asset is charged as an expense to the extent that it exceeds the balance, if any, held in the revaluation reserve relating to a previous revaluation of that asset.

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

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

1) intangible software assets are amortised, on a straight line basis, over the estimated life of the asset or 5 years whichever is less

2) purchased computer software licences are amortised over the shorter of the term of the licence or 5 years whichever is less

3) property, plant and equipment is depreciated on a straight line basis over its expected useful life as follows:

• buildings	40 years
• fixtures and fittings	5-10 years
• office, information technology, short life equipment	3-5 years

The estimated useful lives and residual values are reviewed annually.

1.9 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 that 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 on interest on the remaining balance of the liability. Finance charges are charged directly to the statement of comprehensive net expenditure.

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

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

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

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

Dilapidation provision

The HSCIC has provided £1,392,000 as a provision against dilapidation costs of its leased accommodation across its estate where required. In order to assess an estimate of the likely liabilities at the end of the leases, management has used property advisors reports and also assessments from suitably qualified internal staff.

General Practice Extraction Service

An investment of over £15 million is currently shown as development expenditure within intangible assets. The system is not fully complete yet although an initial extract of data for Quality Outcomes Framework purposes has been undertaken. Further investment is required and management intend to complete the development during 2014/15 and thus believe the asset is fairly valued.

Non-current assets

The HSCIC has 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 are different and in some instances the accounting records were not sufficiently robust. Management have made some judgements and estimates in order to fairly represent the value of such assets in total.

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

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

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

1.17 Going concern

Confirmation of the main grant in aid budget allocation for the 2014/15 financial year in line with the business plan submitted has been received. In addition, it has been agreed that certain additional activities previously undertaken by other organisations have been transferred to the HSCIC together with appropriate funding arrangements. Consequently, the financial accounts have been prepared on the basis that the HSCIC is a going concern.

2 Statement of operating costs by activity

For the year ended 31 March 2014

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

£000	LSP Delivery	Programme Delivery	Operations and Technical Services	Data and Information Services
Income	(1,114)	(8,063)	(13,622)	(15,615)
Staff Costs	16,763	17,821	35,495	30,901
Professional Fees	53	594	443	11,874
Information Technology	10	423	3,444	102
Travel & Subsistence	633	945	942	581
Accommodation	25	420	306	89
Marketing, Training & Events	33	97	254	104
Office Services	21	128	109	755
Other	–	685	(1,451)	1,027
Depreciation / Amortisation	–	–	–	36
Non staff costs	**775**	**3,292**	**4,047**	**14,568**
Net expenditure	**16,424**	**13,050**	**25,920**	**29,854**

LSP Delivery	To deliver on behalf of the DH critical systems and services to the NHS through service provider contracts across most of England together with the South Local Clinical Systems programmes.
Programme Delivery	To deliver the current and future DH and other programmes to time, cost and quality. These include Summary Care Record, e-referral system, GP Systems of Choice, NHS Mail, Health and Social Care Digital Service and the GP2GP system.
Operations and Technical Services	To provide a world class standards and assurance service for the health sector as a whole, and a technical and service support service to major programmes and critical national infrastructure releases ensuring they are delivered in a safe, cost effective and technically optimal manner.
Data and Information Services	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.

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

Information Assurance	Clinical & Public Assurance	Finance & Corporate Services	HR & Transformation	HSCIC Corporate	Total
(275)	(61)	(617)	(4)	(25)	(39,396)
3,393	1,212	19,905	1,573	4,669	131,732
690	7	5,455	258	(104)	19,270
43	24	5,508	7	512	10,073
83	91	473	23	314	4,085
9	3	–	–	11,898	12,750
9	39	253	443	–	1,232
35	2	1,658	46	221	2,975
103	6	658	300	(123)	1,205
–	–	–	–	9,108	9,144
972	**172**	**14,005**	**1,077**	**21,826**	**60,734**
4,090	**1,323**	**33,293**	**2,646**	**26,470**	**153,070**

Information Assurance	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.
Clinical & Public Assurance	The lead on strategic and policy matters, ensuring that the organisations' services, programmes and products are informed by effective engagement with citizens and service users, and with clinical and healthcare professionals.
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.
HR & Transformation	To deliver a high performing organisation that is recognised as an outstanding place to work, through the provision of optimal HR services and development of the capability and capacity of the workforce.
HSCIC Corporate	Relates to central corporate level activities and expenditure which is not specifically allocated to directorates including accommodation, depreciation, staff termination costs and other central accounting adjustments.

3 Staff numbers and related costs

3.1 Staff costs comprise:

	2013/14 £000
Permanent staff	
Salaries and wages	90,731
Social security costs	8,420
Employer superannuation contributions – NHSPS	11,420
Employer superannuation contributions – other	491
Staff seconded to other organisations	917
Termination benefits	4,352
	116,331
Other staff	
Temporary staff	1,544
Contractors	12,662
Staff seconded from other organisations	1,602
	15,808
Capitalised staff costs	(407)
	131,732

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

	2013/14 Number
Permanent staff and secondees	1,995
Temporary and contract staff	135
Total	**2,130**

The average number of whole term equivalent persons employed during the year whose time was capitalised was 7.

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

3.3 Total staff termination packages are detailed as follows:

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

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

NHS Pension Scheme

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

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

a) Accounting valuation

A valuation of the scheme liability is carried out annually by the scheme actuary as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and are accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2014, is based on valuation data as 31 March 2013, updated to 31 March 2014 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 2004. Consequently, a formal actuarial valuation would have been due for the year ending 31 March 2008. However, formal actuarial valuations for unfunded public service schemes were suspended by HM Treasury on value for money grounds while consideration is given to recent changes to public service pensions, and while future scheme terms are developed as part of the reforms to public service pension provision due in 2015.

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

The next formal valuation to be used for funding purposes will be carried out at as at March 2012 and will be used to inform the contribution rates to be used from 1 April 2015.

c) Scheme provisions

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

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

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

Annual increases are applied to pension payments at rates defined by the Pensions (Increase) Act 1971, and are based on changes in retail prices in the twelve months ending 30 September in the previous calendar year. From 2011/12 the Consumer Price Index (CPI) has been used and replaced the Retail Prices Index (RPI).

Early payment of a pension, with enhancement, is available to members of the scheme who are permanently incapable of fulfilling their duties effectively through illness or infirmity. A death gratuity of twice final year's pensionable pay for death in service, and five times their annual pension for death after retirement is payable.

For early retirements other than those due to ill health the additional pension liabilities are not funded by the scheme. The full amount of the liability for the additional costs is charged to the employer.

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

The Principal Civil Service Pension Scheme (PCSPS)

The PCSPS is an unfunded multi-employer defined benefit scheme in which the HSCIC is unable to identify its share of underlying assets and liabilities. A full actuarial valuation was undertaken on 31 March 2007. Details can be found in the resource accounts of the Cabinet Office: (www.civilservice-pensions.gov.uk).

For 2013/14, employer's contributions of £490,895 were paid at one of four rates in the range 16.7 per cent to 24.3 per cent of pensionable pay based on salary bands. The salary bands and contribution rates have remained unchanged in 2013/14. The scheme actuary reviews employer contributions usually every four years following a valuation. The contribution rates reflect benefits as they accrue, not the costs as they are incurred, and reflect past experience of the scheme.

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

4 Income

Income analysed by classification and activity is as follows:	2013/14 £000
Income from activities	
Programme and project management	17,142
Surveys and data collection	2,917
Service delivery	13,135
Fees and charges	3,487
Other income	1,225
	37,906
Other income	
Other non trading income	1,490
	39,396

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

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

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

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

	Clinical audit services £000	Data related services £000	2013/14 Total £000
Income	2,514	973	3,487
Expenditure	2,572	985	3,557
Deficit	**(58)**	**(12)**	**(70)**

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

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

5 Other expenditure

		2013/14 £000
Workpackages and professional fees		5,959
Data collection and surveys		6,929
Legal fees		6,382
Chair and non-executive emoluments		133
Marketing, training and events		1,230
Travel		4,084
Premises and establishment		12,750
IT maintenance and support		10,073
General office supplies and services		3,088
Communications		187
Insurance		123
External audit fees		100
Internal audit fees		241
Provision for impairment of receivables		186
Other		125
		51,590
Non cash transactions		
Depreciation - property, plant & equipment	4,319	
Amortisation - intangible assets	3,830	
Loss on revaluation of property, plant & equipment	262	
Loss on disposal of non-current assets	733	
		9,144
		60,734

6 Aligning accounting treatment of transfers

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

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

7 Non-current assets - property, plant and equipment

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

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.

The gross cost of property, plant and equipment that has been fully depreciated but is still in use is £5,116,000.

Transfers from the NHS IC represents the assets transferred from the former Health and Social Care Information Centre, which was dissolved on 31 March 2013. The transfer was accounted for using modified absorption accounting rules in accordance with the Department of Health group accounting policies set out in the NHS Manual for Accounts.

Transfers from CfH represents the assets transferred from Connecting for Health, formerly part of the Department of Health Informatics Directorate, which relate to the IT system delivery functions managed by HSCIC from 1 April 2013. The transfer was accounted for using standard absorption accounting in accordance with the Department of Health group accounting policies set out in the NHS Manual for Accounts.

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

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

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

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

All tangible assets are owned by HSCIC.

8 Non-current assets - intangible assets

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

The gross cost of intangible assets that were fully depreciated but still in use was £3,908,000.

Transfers from NHS IC represents the assets transferred from the former Health and Social Care Information Centre, which was dissolved on 31 March 2013. The transfer was accounted for using modified absorption accounting rules in accordance with the Department of Health group accounting policies set out in the NHS Manual for Accounts.

Transfers from CfH represents the assets transferred from Connecting for Health, formerly part of the Department of Health Informatics Directorate, which relate to the IT system delivery functions managed by HSCIC from 1 April 2013. The transfer was accounted for using standard absorption accounting in accordance with the Department of Health group accounting policies set out in the NHS Manual for Accounts.

Certain fully amortised assets were not transferred by CfH as they had been disposed of in their financial records. However these assets are still in use and have been reinstated at cost and the equivalent value of amortisation. Accounting policy alignment refers to amending the accounting treatment of assets transferred from former bodies to those policies adopted by the HSCIC. This includes certain expenditure that was formerly capitalised now being written to revenue and aligning the amortisation policy.

Following the merger, some of the IT software and systems employed by both organisations has been retired, or significantly upgraded or replaced. In addition, following a review some of the CfH assets transferred have been disposed of as they were no longer identifiable or had any future economic benefit to the HSCIC. The total loss on disposal amounted to £542,000.

Development expenditure includes the investment in the General Practice Extraction Service which will collect general practice data for agreed specific purposes. The service is due to commence early in 2014/15.

The value of own staff capitalised within intangible assets additions amounts to £407,000.

All intangible assets are owned by the HSCIC.

9 Other non-current assets

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

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

10 Trade receivables and other current assets

Amounts falling due within one year	31 March 2014 £000
Trade receivables	14,354
Prepayments and other receivables	4,415
Accrued income	6,733
	25,502

Intra-government balances

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

11 Cash and cash equivalents

	£000
Balance at 1 April 2013	–
Net changes in cash and cash equivalents	22,931
Balance at 31 March 2014	**22,931**

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

12 Trade and other payables

Amounts payable within one year	31 March 2014 £000
Trade and other payables	4,518
Value added tax	1,324
Income tax, National Insurance and superannuation	4,546
Deferred income	959
Accruals	17,608
	28,955

Intra-government balances

Intra-government balances within trade payables and other current liabilities are as follows:	31 March 2014 £000
Department of Health and other central government bodies	6,593
NHS bodies	393
Local authorities	8
Other external bodies	21,961
	28,955

13 Provisions for liabilities and charges

	Dilapidations £000	Staff termination £000	Total £000
Balance at 1 April 2013	–	–	–
Transfers from NHS IC	590	628	1,218
Arising during the year	802	52	854
Utilised during the year	–	(564)	(564)
Balance at 31 March 2014	**1,392**	**116**	**1,508**
Expected timing of cash flows			
Within one year	508	53	561
Two to five years	884	63	947
Over five years	–	–	–

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 for the NHS IC properties, and an internal assessment using industry standard estimates for other properties. £735,000 of the provision arising during the year relates to the creation of a dilapidations provision in respect of properties transferred from CfH, where no provision had previously been made; as an adjustment to the opening position, this sum has passed through the statement of comprehensive net expenditure below the operating expenditure line, and the statement of cashflows therefore reflects the lower figure of £119,000 as provisions arising during the financial year.

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

14 Working capital movements

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

Payables	£000
Opening balance 1 April 2013	–
Balances transferred from NHS IC	13,109
Balances transferred from CfH	15,565
Balances transferred from SHAs/PCTs	3,295
Total trade and other payables balances transferred to HSCIC	**31,969**
Adjustments to opening current trade and other payables not passing through operating expenditure in the SoCNE, in respect of creation of opening holiday pay accrual for CfH staff	1,241
Adjusted trade and other payables for working capital movement	**33,210**
Closing current trade and other payables	28,955
Payments of balances transferred from SHAs/PCTs made on behalf of HSCIC by the Department of Health	2,360
Movement in capital payables	1,024
	32,339
Decrease in trade and other payables	**(871)**

Balances transferred from NHS IC represent the payables and receivables balances transferred from the former Health and Social Care Information Centre, which was dissolved on 31 March 2013. The transfer was accounted for using modified absorption accounting rules in accordance with the Department of Health group accounting policies set out in the NHS Manual for Accounts.

Balances transferred from CfH represent the payables and receivables assets transferred from Connecting for Health, formerly part of the Informatics Directorate of the Department of Health, which relate to the IT system delivery functions managed by HSCIC from 1 April 2013. The transfer was accounted for using standard absorption accounting in accordance with the Department of Health group accounting policies set out in the NHS Manual for Accounts.

Balances transferred from SHAs/PCTs represent the payables and receivables balances transferred from Strategic Health Authorities and a Primary Care Trust, which were dissolved on 31 March 2013. The transfer was accounted for using modified absorption accounting rules in accordance with the Department of Health group accounting policies set out in the NHS Manual for Accounts.

15 Transfers from other bodies

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

16 Capital commitments

Capital commitments amount to £950,000 and relate to further development work on the General Practice Extraction Service.

17 Commitments under operating leases

Expenditure includes the following in respect of operating leases	**2013/14 £000**
Accommodation	9,524
Other operating leases	78
	9,602

At the balance sheet date non-cancellable operating lease commitments were:	**2013/14 £000**
Land & buildings	
Not later than one year	8,662
Between one and five years	4,566
Later than five years	–
	13,228
Other leases	
Not later than one year	21
Between one and five years	11
Later than five years	–
	32
Total non-cancellable operating lease commitments	**13,260**

18 Other financial commitments

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

19 Contingent assets and liabilities

There are no contingent assets or liabilities as at 31 March 2014.

20 Losses and special payments

There were 58 losses and special payments in 2013/14 amounting to £21,608.
These included bad debts written off, and losses of minor IT equipment and mobile phones.
There was no interest paid under the Late Payment of Commercial Debt (Interest) Act 1998.

21 Related parties

HSCIC is an Executive Non-Departmental Public Body (ENDPB) created by The Health and Social Care Act 2012.
It is sponsored by the Department of Health, and the Department is therefore regarded as a related party.

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

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

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

	Amounts payable at 31 March 2014 £000	Amounts receivable at 31 March 2014 £000	Income in 2013/14 £000	Expenditure in 2013/14 £000
Department of Health	274	9,215	12,517	1,206
Special Health Authorities	21	16	41	598
Public Health England	35	1,334	5,743	31
Health Education England	–	337	337	–
NHS England	29	7,969	11,663	57
Non-Departmental Public Bodies	–	1	35	(16)
NHS Trusts	39	154	389	323
NHS Foundation Trusts	325	357	1,085	1,513
Other DH group bodies	181	18	47	181
Other central government bodies	6,082	618	1,060	23,486

22 Financial instruments

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

a. Market risk

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

b. Credit risk

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

Movement in the allowance for doubtful debts

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

The provision for doubtful debts is assessed on an individual debt basis. The expense in the year relating to related parties amounts to £171,815.

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

	Current £000	Less than 30 days overdue £000	31-60 days overdue £000	61 and over days overdue £000	Total £000
Balance at 31 March 2014	10,114	3,558	120	562	**14,354**

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

c. Liquidity risk

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

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

	31 March 2014 £000
Current liabilities	28,955

23 Events after the reporting period ended

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

On 1 April 2014, certain functions previously undertaken by NHS Direct were transferred to the HSCIC. These functions are funded and underwritten by NHS England with the total value of funding anticipated to be £6 million and a net asset transfer of £1.5million.

24 Authorised date for issue

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

The authorised date for issue is as shown on the certificate and report of the Comptroller and Auditor General at the front of these financial statements.

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