

450

National Cancer Registry

Annual report and accounts for year ending 31 December 201%

350

300

250

200

150

100

3 yr

4 yr

5 yr



National
Cancer
Registry
Ireland

National Cancer Registry

Annual financial report and accounts

For the year ending 31st December 2011



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DIRECTOR'S STATEMENT

It is now 20 years since the National Cancer Registry Board was established. As described in more detail on page 22, its future has been for some time in doubt. It was originally planned that the Registry would form part of the Health Information and Quality Authority on the establishment of this body, and that the Registry Board would cease. However it was then decided that the National Cancer Control Programme would be a more appropriate home for the Registry, and plans were made to incorporate the Registry into the HSE. The legal issues related to data protection and the Health (Provision of Information) Act 1997 were found, however, to be an impediment to this merger and it was the opinion of the Department of Health and Children (as it was) that a merger would be possible only if specific provision were made for the continuing collection of data in the Health Information Bill.

Government policy at the end of 2011 was that the Registry would merge into the HSE following the passing into law of the Health Information Bill, but the timing of this remains uncertain. Long-term strategic planning by the Registry Board has been affected by this uncertainty, and by the relatively short terms of office of most recent Boards.

Operationally, the Registry continues to increase the annual volume of cases and treatments registered, within the context of the general restrictions on budget and staff throughout the public sector. Our ability to move to a greater use of electronic data, as has been happening elsewhere in Europe, is hampered by the diversity of IT and data policies within hospitals and the continuing lack of standards in areas such as patient administration systems and histopathology laboratory systems. The Northern Ireland Cancer Registry, which was established at the same time as the National Cancer Registry has been able to carry out full registration using available sources of electronic data since 1993. The two primary sources for cancer registration—histopathology data and identifiable patient discharge data (HIPE)—are still difficult to access in Ireland, the former because of a lack of compatible laboratory IT systems and the latter because of data anonymisation. Planning and evaluation of cancer services require data which is not only accurate and comprehensive but also timely; manual data extraction from paper records will not deliver the last of these.



Harry Comber

REPORT OF THE BOARD ON CORPORATE GOVERNANCE 2011

Report of the Chairperson, National Cancer Registry Board for year ending 31/12/2011

1. Commercially significant developments affecting the body
No commercially significant developments occurred during 2011.
2. Procedures for financial reporting, internal audit, travel, procurement and asset disposals:
These are all being carried out according to official policies and guidelines.
3. System of internal financial control
 - a) The Board is responsible for the body's system of internal financial control.
 - b) Such a system can provide only reasonable, and not absolute, assurance against material error.
 - c) Key procedures which have been put in place by the Board to provide effective internal financial control include:
 - (i) A clearly defined management structure with proper segregation of duties throughout the organisation.
 - (ii) A risk register was compiled in 2010 and was updated throughout 2011.
 - (iii) A procedures document setting out instructions for all areas of financial activity was in place for 2011. This outlined the procedures for the administration of salaries, invoices and expense claims, use of the credit card and petty cash transactions as well as procedures for procurement and for the disposal of assets. The payroll and some invoice processing functions were carried out by University College Cork in 2011. There were regular reconciliations carried out between National Cancer Registry Board records and those maintained by University College Cork.
 - (iv) An Audit Committee had been appointed at the Board Meeting held on 19th January 2010 and as a new Board was appointed in 2011, a new Audit Committee was appointed at its first meeting on 30th November 2011. This committee oversees the work of the Internal Auditors.
 - (v) An ITT for Internal Audit Services was undertaken in March 2010 and a full three-year cycle of internal audits covering core financial, organisational and operational areas have been agreed by the Audit Committee and the Board. Formal internal audits were carried out in 2011 in the areas of Tendering & Procurement, Corporate Governance & Risk Management, ICT and Hardcopy – Information Security and Registration – process controls. Reports on these were considered by the Board's Audit Committee at its meeting in June 2011.
 - (vi) An overall annual budget for the National Cancer Registry was agreed which incorporated a separate budget for IT. A report is prepared on a monthly basis to compare actual with budget figures and overall annual expected figures are updated throughout the year.
 - (vii) Review by the Board at each of its meetings of periodic and annual financial reports.
 - d) The Board carried out a review of the effectiveness of internal financial controls for 2011 at its meeting in February 2012.
4. Codes of business conduct for directors and employees have been put in place and are being adhered to.
5. Government policy on the pay of the Director and all State body employees is being complied with.

6. Compliance with Government guidelines on the payment of directors' fees is not relevant as there are no directors' fees paid at the National Cancer Registry.
7. The Guidelines for the Appraisal and Management of Capital Expenditure Proposals in the public sector are being complied with.
8. Government travel policy requirements are being complied with in all respects.
9. The Code of Practice for the Governance of State Bodies (2009) has been adopted by the Board and is being fully complied with.
10. The National Cancer Registry Board complied with all aspects of contractual agreements that could have a material effect on the financial statements in the event of non-compliance. There have been no communications concerning non-compliance with requirements of regulatory or tax authorities with respect to any matter. The National Cancer Registry Board is not aware of any actual or possible non-compliance with laws or regulations that could impact on the financial statements.



Mr Tony O'Brien
Chairperson, National Cancer Registry Board

6 May 2011

BACKGROUND

Establishment

The National Cancer Registry Board was established by Statutory Order 19 of 1991, “*The National Cancer Registry Board (Establishment) Order*” under the Health (Corporate Bodies) Act, 1961. The Board discharges all its statutory responsibilities through the National Cancer Registry. The Order was amended twice; in 1996 by S.I. No. 293/1996 (*The National Cancer Registry Board (Establishment) Order, 1991 (Amendment) Order*) and in 2009 by the Health (Miscellaneous Provisions) Act 2009.

The Minister for Health and Children, Mary Harney, T.D. on 15th October 2008 announced that the National Cancer Registry would be integrated into the Health Service Executive in 2010. This was confirmed by the Minister for Finance in his 2009 Budget speech.

The National Cancer Registry Board

The Board of the Registry was appointed on 6 August, 2009 by the Minister for Health, for a maximum period of two years. The Board members were:

Mr Tony O’Brien (Chair)

Dr John Devlin

Dr Patricia Fitzpatrick

Dr Anna Gavin

Professor Donal Hollywood

Mr John McCormack

Dr Deirdre Murray

In 2011, the Minister re-appointed the Board, for a further year, with the replacement of Dr John Devlin by Ms Mary Jackson and of Dr Patricia Fitzpatrick by Professor Paul Redmond. The term of this Board was from August 6th, 2011 to August 5th, 2012.

Statutory functions

The statutory functions of the National Cancer Registry Board, as set out in Statutory Order 19 of 1991 are:

- to identify, collect, classify, record, store and analyse information relating to the incidence and prevalence of cancer and related tumours in Ireland;
- to collect, classify, record and store information in relation to each newly diagnosed individual cancer patient and in relation to each tumour which occurs;
- to promote and facilitate the use of the data thus collected in approved research projects and in the planning and management of services;
- to publish an annual report based on the activities of the Registry;
- to furnish advice, information and assistance in relation to any aspect of such service to the Minister.

Aims

- To collect accurate, timely and comprehensive data through cancer registration and related research activities.
- To disseminate data and the results of analysis in a relevant and comprehensive manner.

STAFF

The permanent staff complement was 38.3 FTE, compared to 38.0 at the end of 2010. In addition, 12.8 FTE researchers were funded from external sources (Health Research Board or EU) compared to 10.8 FTE at the end of 2010. Staffing at 31/12/2011 is shown below.

Department of Health Funded staff

Department	Grade	FTE
Director	Principal Officer Higher	1
		1
Administration		
Administrator	Clerical VI	1
Communications & HR Officer	Clerical V	1
Executive Assistant	Clerical IV	1
Clerical Assistant	Clerical III	1
		4
Information Technology		
Information Technology Specialist	Clerical VII	0.5
IT Administrator	Clerical V	0.6
Infrastructure Development Officer	Clerical V	1
Analyst Programmer	Clerical V	1
		3.1
Data Management		
Data Manager/TRO Supervisor	CNM2	0.6
Project Leader – Data Integration Project	Clerical VII	1
Data Manager	Clerical VI	1
Geo-coding Researcher	Clerical IV	1
Data Quality Officer	Clerical IV	2
Data Matching Analyst	Clerical IV	1
		6.6
Research		
Epidemiologist	Senior Lecturer	2
Data Analyst	Clerical VI	1
Researcher/Statistical Analyst	Clerical V	1
Analyst Researcher	Clerical V	1
Statistician	Clerical V	1
		6
Tumour Registration Officers		
Tumour Registration Officer	Senior Staff Nurse D/Qual	6.3
Tumour Registration Officer	Senior Staff Nurse	4.7
Tumour Registration Officer	Staff Nurse	6.6
		17.6
Total (Dept of Health funded)		38.3

Externally Funded staff

Data Management	Grade	FTE	Source
Data Manager/Eurocourse Project	Clerical V	1	EUROCOURSE
		1	
Research			
Project Manager - PSA Costs	Clerical VI	0.8	HRB
Study Co-ordinator - SuN Study	Clerical VI	1	HRB
Researcher - (Economic Impact)	Clerical V	1	HRB
Research Co-ordinator - Cervical	Clerical V	1	HRB/Coombe
Research Co-ordinator – Eurocourse /Cerviva	Clerical V	1	HRB/Coombe EUROCOURSE
Trial Co-ordinator – Cervical RCT	Clerical V	1	HRB/Coombe
Project Co-ordinator – Employ Outcomes	Clerical V	1	HRB
Health Economist/Project Co-ordinator	Clerical V	1	HRB
Epidemiologist/Data Analyst	Clerical VI	1	Sanofi Aventis
Study Interviewer – Employment Outcomes	Clerical IV	1	HRB
Statistician	Clerical V	1	HRB
		10.8	
Administration			
Clerical Assistant	Clerical III	1	HRB
		1	
Total (Externally funded)		12.8	
Total (Dept of Health funded)		38.3	
All Staff		51.1	

ACTIVITIES

The Registry's activities fall into three main categories—data collection, reporting and research.

Data collection

1. Registration activity

Table 1. Number of registrations by year (January 2011).

Year of incidence	open	closed	% closed	all	% expected
2002	40	24,254	100%	24,294	100%
2003	35	25,305	100%	25,340	100%
2004	32	26,700	100%	26,732	102%
2005	59	26,687	100%	26,746	98%
2006	207	28,025	99%	28,232	100%
2007	287	30,278	99%	30,565	105%
2008	2473	28,878	92%	31,351	105%
2009	11586	21,614	65%	33,200	107%
2010	16679	9,275	36%	25,954	81%

Table 2. Number of registrations by year (January 2012)

Year of incidence	open	closed	% closed	all	% expected
2003	35	24,791	100%	24,826	102%
2004	24	26,194	100%	26,218	104%
2005	58	26,142	100%	26,200	101%
2006	171	27,478	99%	27,649	103%
2007	152	30,504	99%	30,655	112%
2008	261	31,450	99%	31,711	111%
2009	1,513	32,302	96%	33,815	106%
2010	10,913	23,874	69%	34,787	109%
2011	17,504	10,278	37%	27,782	87%

Registrations of new cancer cases now come to over 34,000 annually, compared to 19,000 in 1994. 35,523 new cases have been created and 36,251 closed since the start of the year. Overall levels of ascertainment and case closure have improved slightly compared to the same time last year. The Registry database now has over 460,000 registrations of new cancer cases.

2. Completeness of registration

A recent review of registration completeness showed that overall completeness of registration was around 96% at three years and 97% at five years after the date of incidence. This varied with the cancer site (Table 3). Independent verification of cases against the breast screening database gave a level of completeness of 99.3%.

Table 3. Completeness of registration of 2007 cases (%)

	time from registration		
	one year	two years	three years
all invasive cancers (excl NMSC)	87.8	94.2	96.4 [95.7, 97.1]
colorectal	92.4	96.6	97.9 [96.5, 98.9]
lung	92.9	97.8	98.0 [96.1, 99.2]
breast	92.1	96.1	97.0 [94.5, 98.8]
prostate	77.3	88	92.4 [87.9, 95.9]

3. Timeliness

Although the percentage of cases first registered within twelve months of the date of incidence continues to increase, only about 40% are closed within a year and, even at two years after the date of registration, 15% of cases remain open (Table 4). There have been small improvements in these figures since 2006, but complete closure of cases within 18 months remains unattainable.

Table 4. Timeliness of registration (January 2012).

year	number of cases	interval from date of incidence to date of registration			interval from date of incidence to date of closure		
		<3 months	<6 months	<12 months	<6 months	<12 months	<24 months
2003	25344	40%	61%	80%	19%	38%	66%
2004	26744	42%	63%	85%	22%	40%	73%
2005	26783	48%	70%	85%	21%	37%	75%
2006	28249	48%	70%	86%	20%	35%	81%
2007	30662	48%	69%	88%	23%	41%	81%
2008	31707	49%	69%	88%	22%	38%	83%
2009	33852	52%	76%	91%	25%	41%	86%
2010	34452	65%	83%	96%	30%	43%	61%
2011	23377	82%	94%	100%	32%	36%	36%

4. Treatments

The Registry records all treatments given during the first year after diagnosis, their type (surgery, chemotherapy, radiotherapy, hormone therapy), date and the hospital of treatment.

The number of treatment episodes registered has increased from 31,492 annually in 1994 to 81,004 in 2009, the most recent complete year (Table 5). As with case completion, completeness of treatment registration lags behind case generation.

Table 5. Number of treatments by year (January 2012).

year	by year of incidence	by year of treatment
2003	56,959	56,101
2004	60,136	59,383
2005	60,973	61,696
2006	64,726	67,261
2007	69,661	72,618
2008	72,825	77,916
2009	73,707	81,004
2010	60,208	72,131
2011	26,282	32,509

5. Electronic data capture

Collection of data directly from electronic patient records, histopathology reports and similar sources is a more efficient and less error-prone method of registration than transcription from paper records, which remains the predominant source of data for the Registry. Few reliable sources of electronic data exist within the Irish cancer services, although the number is increasing. A joint working group has been established between the National Cancer Registry and HSE (National Cancer Control Programme, National Cancer Screening Service and ICT Directorate) to develop a plan for routine access to complete electronic histopathology data by the National Cancer Registry and CervicalCheck. The initial proposal has been approved by the Departments of Health and Finance.

Death certificates

Death certificates have been received electronically by the Registry since 2005, from both the Central Statistics Office and from the Death Events Publishing Service (DEPS) of the Department of Social Protection. At the end of 2011 cancer death certificates up to the end of March 2011 had been matched to registrations. Queries to GP on death certificates up to the end of 2010 have been sent out and registrations have been updated with the GP response. Non-cancer death certificates have been matched to the end of 2010. DEPS data is processed by the Registry once a week and date of death is now being added to registrations within 4 to 8 weeks of occurrence.

Pathology data

The full histopathology data for St. Vincent's University Hospital laboratory is now being downloaded from the Healthlink site and new registrations are being created from this data. Summary reports for the Mater Private Hospital, Our Lady of Lourdes (Drogheda) and AMNCH (Tallaght) have also been matched to registrations.

Radiotherapy data

2010 Data from UCHG and St. Luke's has been added to registrations.

National HIPE

2010 national HIPE was received in early January 2011 and is now linked to registrations. Matching for 2010 HIPE has been done for most hospitals and the results are being followed up at the hospitals. Three cancer centres are outstanding; Beaumont, St. James's, and UCHG. January to June 2010 has been matched and returned to the Mater and Limerick Regional for follow up. Three acute hospitals are outstanding; Merlin Park (WHB), and St. Colmcille's and St. Michael's in Dublin Mid Leinster.

6. Geocoding

It is estimated that geocoding of 2009 cases is 98% complete, 2010 is 75% complete and 2011 is 28% complete.

Reporting

The Registry provides access to data through routine reports, targeted reports, a data query service and data downloads; we provide additional information through our research programme.

2011 reports

The annual statistical report was published in June 2011, with a more detailed report on breast cancer. In December 2011 the Registry, working with the NI Cancer Registry, published the first all-Ireland cancer atlas.

Reports published in 2011 included:

- Cancer in Ireland 2011 (June 2011)
- All Ireland Cancer Atlas 1995-2007 (December 2011)
- Data Quality and Completeness at the Irish National Cancer Registry
- Breast Cancer Incidence, Mortality, Treatment and Survival in Ireland: 1994-2009
- Cancer Trends
 - Cancers of the kidney, ureter and bladder (November 2011)
 - Cancers of the head and neck (July 2011)
 - Cancers of the colon and rectum (May 2011)
 - Cancers of the oesophagus and stomach (March 2011)
 - Melanoma (January 2011)

Peer-reviewed publications in 2011

Peer-revised publications by registry staff in 2011 were:

1. Ali RA, Dooley C, Comber H, Newell J, Egan LJ. Clinical features, treatment, and survival of patients with colorectal cancer with or without inflammatory bowel disease. *Clin Gastroenterol Hepatol.* 2011 J; 9: 584-9
2. Barron I, Connolly RM, Sharp L, Bennett K, Visvanathan K. Beta-blockers and breast cancer mortality: a population-based study. *J Clin Oncol* 2011; 29: 2635-44.
3. Boyle E, Timmons A, Al-Akash M, Kennedy AM, O'Grady H, Hill AD, Comber H, Keane FB. The management of rectal cancer in Ireland in 2007- room for improvement? *Surgeon* 2011; 8: 179-86.
4. Carsin A-E, Sharp L, Comber H. Geographical, urban-rural and socio-economic variations in non-melanoma skin cancer incidence: a population-based study in Ireland. *Br J Dermatol* 2011; 164: 822-9.
5. Comber H, Deady S, Montgomery E, Gavin A. Drinking water fluoridation and osteosarcoma incidence on the island of Ireland. *Cancer Causes Control* 2011; 22: 919-24.
6. Cotton S*, Sharp L*, Cochran C, Gray N, Cruickshank ME, Smart L, Thornton A, Little J on behalf of the TOMBOLA Group. After-effects reported by women having follow-up cervical cytology tests in primary care: a cohort study within the TOMBOLA trial. *Br J Gen Pract* 2011; 61: 333-9. (* joint principal authors)

7. Johnson CY, Sharp L, Cotton SC, Harris CA, Gray NM, Little J, on behalf of the TOMBOLA Group. Human papillomavirus infection and anxiety: analyses in women with low-grade cervical cytological abnormalities unaware of their infection status. PLOS One 2011; 6: e21046.
8. O Céilleachair A, Finn C, Deady S, Carsin AE, Sharp L. Have developments in palliative care services impacted on place of death of colorectal cancer patients in Ireland? A population-based study. Ir J Med Sci 2011; 180: 91-6.
9. Sharp L, Cotton S, Gray N, Avis M, Russell I, Walker L, Waugh N, Whyne D, Woolley C, Thornton A, Smart L, Cruickshank M, Little J, on behalf of the TOMBOLA Group. <http://www.ncbi.nlm.nih.gov/pubmed/21179033> Long-term psychosocial impact of alternative management policies in women with low-grade abnormal cervical cytology referred for colposcopy: a randomised controlled trial. Br J Cancer 2011;104: 255-64.
10. Sharp L, Timmons A. Social welfare and legal constraints associated with work among breast and prostate cancer survivors: experiences from Ireland. J Cancer Surviv 2011; 5(4): 382-94.
11. Walsh PM, Byrne J, Capra M, Comber H. Childhood cancer survival in Ireland: temporal, regional and deprivation-related patterns. Eur J Cancer 2011; 47: 1852-62.

Data query service

The Registry provides information in response to a large number of queries, from members of the public, Dáil questions, researchers and health service staff. We aim to respond to all but the most complex questions within a working week. Approximately 30 formal queries a month are answered, in addition to many informal telephone enquiries.

Online statistics and data downloads

Pre-calculated case numbers and rates by cancer type, year and geographic area are available through an interactive interface on our website. A subset of the Registry dataset is also available for download from the website. This has been modified to exclude all information which is potentially identifiable, and is updated at least annually.

Research programme

Our current research programme covers a wide range of topics in cancer aetiology, diagnosis, screening, treatment and outcome. We have a particular interest in survivorship and economic aspects of cancer.

Current research activity at the Registry includes a range of descriptive studies of cancer incidence, trends, treatment and survival as well as analytical studies. The list of papers on pages 14-15 illustrates the range of work being undertaken. Current active projects include the following:

- 1 Estimation of cancer risk for renal transplant patients.
- 2 Impact of socio-economic factors on survival from childhood cancer.
- 3 Long-term sequelae of childhood cancer.
- 4 The role of HPV testing in the control of cervical cancer.
- 5 Economic costs of cancer.
- 6 Employment impact of cancer.
- 7 Factors determining treatment of older patients with cancer.
- 8 Measurement of co-morbidity in cancer patients.
- 9 Factors determining length of stay in cancer patients.

Successful funding bids in 2011

The registry research programme is largely dependent on successful applications for competitive grants, mainly from the HRB and the Irish Cancer Society. In 2011, the following applications were successful:

- 1 Sharp L, Clarke N. Investigating factors associated with compliance in the national population-based colorectal cancer screening programme, with particular emphasis on men. Irish Cancer Society PhD Research Scholarship. €120,000. 2011-2014 (student: N Clarke)
- 2 O'Leary J (lead PI), Martin C*, Sharp L*, Normand C*, Flannelly G*, Turner M*. (*co-PIs) CERVIVA 2: building capacity and advancing research and patient care in cervical screening in Ireland. Health Research Board. Interdisciplinary Capacity Enhancement (ICE) Awards. €620,000. 2011-2014
- 3 Bennett K (lead PI), Sharp L*, Barry M*, Walsh C*, Visvanathan K* (*co-PIs). Novel approaches to cancer prevention, treatment and cost using pharmacoepidemiology and pharmacoconomics. Health Research Board. Interdisciplinary Capacity Enhancement (ICE) Awards. €650,000. 2011-2014
- 4 Sharp L, Drummond F, Comber H. Men's experiences of, and satisfaction with, prostate cancer care in Ireland. Irish Cancer Society. €75,000. 2011-2012.

STATEMENT OF STRATEGY 2011

The Board has adopted the following strategic plan.

Aims

- To collect accurate, timely and comprehensive data through cancer registration and related research activities.
- To disseminate data and the results of analysis in a relevant and comprehensive manner.

Objectives

Data collection

- To address problems of timeliness through review of TRO workloads and work practices.
- To explore methods of routinely quality assuring registration data for accuracy and completeness.
- To seek synergies in data collection with HSE-NCCP and with HSE and hospital management generally.
- To explore alternatives to manual extraction of medical records as sources of data.
- To increase efficiency of data processing by update of the registration software.

Research

- To continue to seek external support for research projects.
- To build critical mass within the Registry, and productive collaborations outside.

Dissemination

- To establish a system of timely and comprehensive reporting of registration data.
- To collaborate in international registry reports which raise the profile of the Registry.
- To maintain a high level of output of peer-reviewed papers from both research and analysis.
- Provide an appropriate service to all users and potential users of Registry information.

PERFORMANCE INDICATORS

A set of performance indicators was agreed by the Board in 2010 to evaluate the success of the registry in attaining the objectives set out in the strategic plan. The targets were chosen to be slightly better than current performance in most areas. Performance on these indicators is shown below for the most recent year. Indicators which did not reach the agreed target are shown in red.

	performance	year
1. Registration		
a. Timeliness		
1. 50% of invasive cancers, excluding non-melanoma skin, should be registered within 3 months of the date of incidence.	47.6% 50.4%	2008 2009
2. 90% of invasive cancers, excluding non-melanoma skin, should be registered within 12 months of the date of incidence.	91.0% 92.7%	2008 2009
3. 90% of invasive cancers, excluding non-melanoma skin, should be closed within 24 months of the date of incidence.	89.3% 94.9%	2008 2009
b. Accuracy		
Death certificate only cases should be <1% of the total of all invasive cancers, excluding non- melanoma skin.	1.2% 0.5%	2008 2009
90% of all invasive cancers, excluding non-melanoma skin, should be microscopically verified, if the case is closed.	90.8% 92.4%	2008 2009
Cancers of ill-defined sites should be less than 3% of all invasive cancers, excluding non-melanoma skin.	2.8% 2.6%	2008 2009
c. Completeness		
Registration completeness, as assessed by the flow method, for all invasive cancers excluding non- melanoma skin cancer, should be		
• 90% at one year,	88.1%	2008
• 96% at two years	96.1%	2008
• 98% at five years from the end of the year of registration	96.9%	2006
2. Research and dissemination		
a. Provide data for CI5, EURO CIM, EURO CARE and similar projects on time and as requested	Done, on time	
b. Publish peer-reviewed papers in high impact journals		
1. Submit at least 12 papers for publication in peer-reviewed journals.	submitted 24; published 9	2011
2. Make at least 24 oral and poster presentations at national and international conferences.	oral 13, posters 28	2011
c. Lead, or collaborate in, the submission of at least 4 grant/funding applications.	awarded 4, under review 3	2011
d. Complete 80% of queries within 2 weeks of receipt.	84.6%	2011
e. Produce reports based on registry data and from research studies, including:		
(a) four short reports on cancer trends;	6	2011
(b) one site-specific report;	2	2011
(c) the registry annual report;	1	2011
(d) two reports on original research.	2	2011
3. Administration		
a. The annual accounts and report of the Board to be produced by June 30 th	Yes	
b. Service plan to be delivered to the Department of Health and Children within 4 weeks of letter of allocation	Yes	2012
c. Registry expenditure to remain within assigned annual budget	Yes	2011
d. Deliver on all recommendations in internal audit reports within timeframe agreed.	42/60	2011

OVERVIEW OF ENERGY USAGE IN 2011

The main energy users at the National Cancer Registry are space heating air conditioning and heating. Other uses include lighting, office equipment and catering. All of these are powered by electricity and there is no consumption of gas or fossil fuels for any purpose. It is not possible to apportion electricity consumption between these various uses, as they come off the same supply.

In 2011, the National Cancer Registry consumed 83.631 MWh of energy, all electrical.

Actions Undertaken in 2011

In 2011 the Registry undertook a range of initiatives to improve our energy performance, including:

- Decreased use of heating and air-conditioning by judicious use of natural heating and cooling;
- Powering down of all non-essential IT equipment when not in use.

However, due to adverse weather conditions throughout the year, no significant decrease in energy use was recorded. These measures will be continued in 2012.

ADDITIONAL FINANCIAL STATEMENTS

The National Cancer Registry was fully compliant with its obligations under tax law in 2011.

The National Cancer Registry is fully adherent to Government procurement policy.

Attendance at Board meetings, and aggregate expenses paid to Board members, in 2011 were as follows:

	01/02/2011	02/06/2011	30/11/2011	Expenses claimed
Location	NCRI Cork	NCCP Dublin	NCCP Dublin	
Appointed/reappointed for all of 2011:				
Mr Tony O'Brien	✓	✓	✓	
Dr Anna Gavin		✓	✓	
Professor Donal Hollywood				
Mr John McCormack	✓	✓	✓	
Dr Deirdre Murray	✓	✓	✓	
Term finished on 05/08/11:				
Dr John Devlin				
Dr Patricia Fitzpatrick	✓	✓		€148
Appointed 06/08/11				
Ms Mary Jackson			✓	
Professor Paul Redmond				
Total				€148

PLANS FOR 2012

As part of the Public Sector Reform Plan it was announced in 2011 that the Registry will become part of the HSE in 2012. Strategic planning has been difficult for some years, due to uncertainty regarding the future of the Registry. The 2003 report *“Audit of Structures and Functions in the Health System”* carried out by Prospectus for the Department of Health and Children recommended that the Registry be merged with HIQA. The Statutory Instrument establishing the interim HIQA Board in 2005 (S.I. No. 132 of 2005) described one of its functions as “the integration of the functions of the National Cancer Registry and the Irish Health Services Accreditation Board within the functions of the Authority”. A series of discussions was held over the following two years between HIQA and National Cancer Registry management on the transition process, with a view to merging the two bodies in February 2007. However in December 2006, with the establishment of the National Cancer Control Programme, it was announced by the Minister for Health and Children that it would be more appropriate for the Registry to form part of the NCCP. However, as the provisions of the Health (Information) Act 1997, which allow the Registry to collect data without patient consent, would not apply once the National Cancer Registry Board had been abolished, it was recognized that this transition into the NCCP could not occur until legislation was passed to protect the functions of the Registry. This legislation, the Health Information Bill, is awaited.

A major programme of agency rationalisation within the health sector was announced by the Minister for Health on 15th October, 2008, including the National Cancer Registry Board which was to be dissolved and subsumed into the HSE at end of 2012 (provisionally), following enactment of the Health Information Bill. The Public Reform Plan (November 2011) repeats this intention to merge the National Cancer Registry Board with the HSE. However, the Minister for Health has announced his commitment to *“a radical reform of the health services which will see the introduction of Universal Health Care for our citizens. That major change will include the replacement of the HSE with structures more suited to the delivery of health care under that system.”* In this context, it is unclear how the National Cancer Registry Board will fit into the structures intended to replace the HSE.

This prolonged period of uncertainty, with a series of relatively brief tenures for our Board, has not been the ideal environment for dealing with the challenges which have arisen in the last few years. The Registry, as is the case for many cancer registries in Europe, is dealing with a major transition in the requirements for, and uses of, cancer information. Concomitantly, there has been a change in the role of registries, and in many countries cancer information or cancer intelligence systems have been developed around the cancer registration process.

On the supply side, much larger volumes of data are now available in “real time” and in electronic format. Almost all of this data has been generated in the course of administrative and clinical activity and needs processing to make it suitable for linkage and analysis. Broadband network access and greatly increased computing power now make the sharing and linkage of very large volumes of data from many sources a practical possibility.

On the demand side, the development of comprehensive, evidence-based cancer control programmes has highlighted the unique position of cancer registration in being able to supply complete and accurate data on cancer burden and cancer control activities, but has also produced an increasing demand for data which is more detailed, more timely and more accessible.

All of these developments have made the traditional model of the cancer registry, as an isolated “epidemiological” body with little contact with the clinical community or with health service providers, obsolete. Registries have had to display flexibility and responsiveness to changes in the sources and targets for data. “A Strategy for Cancer Control in Ireland” recognized these changes in recommending the development of “a cancer surveillance system that will build on the existing system of cancer registration”, and which would be responsible for:

- monitoring trends in cancer incidence, prevalence and survival over time and between different geographic areas, social groups, and other defined populations
- evaluating the effectiveness of cancer prevention and screening
- evaluating the quality and outcomes of cancer care
- evaluating the impact of environmental and social factors on cancer risk
- supporting investigations into the causes of cancer
- providing information in support of cancer genetic counselling services for individuals and families at higher risk of developing cancer.

Little progress has been made in Ireland in meeting these objectives, by comparison with most other western European countries. The Netherlands, the separate UK National Health services and most Scandinavian countries all have comprehensive cancer information networks, built on linkages between cancer registration, clinical databases and administrative data. These networks are being built all across Europe. A cancer information network for Ireland must take into account the requirements of Ireland's mixed public/private health system, and the Registry, with its population-based, rather than service-based, remit, is in an ideal position to take this development forward. We look forward to further strategic development of the registration function within the framework of an overarching national cancer information policy.

An analysis was carried out in 2011 of possible alternative arrangements for the National Cancer Registry. There are a number of possible options for the National Cancer Registry. Structures for cancer registration in other countries include:

1. A free-standing state or regional agency;
2. Part of a Department/Ministry of Health;
3. Part of a health agency or agencies outside the Department/Ministry of Health;
4. Part of, or associated with a public health agency, either autonomous or part of the health service;
5. Association with a university;
6. Association with a cancer research centre;
7. Association with a clinical cancer centre.

These options offer three basic alternatives: autonomous existence; merging with a health body; or association with an academic/clinical centre. Option (a) would not rule out an association with an academic or clinical centre which would preserve the essential autonomy of the Registry/Board. We therefore examined two major options: (1) continued existence of the Registry as a statutory body or (2) its amalgamation or merger with another, presumably larger, health body. Taking the current situation as the base case, we set out below the case for and against retaining this configuration.

Benefits

a. Reduction in operating costs

The initial impetus for amalgamation of agencies, and the continuing requirement for this under the Public Reform Plan, is an expected reduction in costs through consolidation and reduction in duplication of efforts. The costs incurred in having a separate agency are:

- i. Abolition of the Board and associated expenses

Members of the National Cancer Registry Board are not paid fees so the costs associated with the existence of the Board are only those of travel and subsistence. In 2011 these amounted to €148.

ii. Reduction in office space

The Registry has 38 staff in a 600 m² office in Cork. Some savings would be expected in sharing office space with another body. For data security and confidentiality reasons, however, the Registry and its IT network would need to be physically separate from that of the other agency. Currently, there is no suitable available accommodation of this size in any health agency in the area and re-location of the entire office staff to another city would be impractical.

iii. Reduction in staff

All but 5 of the Registry's 51 FTE are specialists with access to confidential patient information, and their functions could not be outsourced or distributed within a larger organization. The remaining staff are administrative, consisting of a director, administrator, two clerical staff and a human resources officer who also has responsibility for communications, public relations and freedom of information. Payroll is outsourced to University College, Cork. Other functions—procurement, payments to suppliers, travel and expenses, office administration etc—are performed by clerical/administrative staff. Some cost savings could be made by the merging of these functions with a larger body, but only on the basis of co-location. Previous experience with University College, Cork, who performed many of the listed functions during the early years of the Registry, indicated that the time saved in outsourcing these activities was largely balanced by the time taken in communicating with relevant departments in UCC and checking the work done.

iv. Reduction in overheads

Major overheads, other than those listed above, are:

- Software licences

Most software costs are currently covered by our association with University College, Cork with a saving of about €80,000 annually. This benefit would be lost in a merger with another body.

- Audit fees

Audit fees are currently paid annually to the Comptroller and Auditor General (€9,024) and to contracted internal auditors (€11,316). The former costs would be abolished and the latter greatly reduced in any merger with a larger body.

- Insurance

Insurance is currently arranged through UCC, at a reduced cost, to the Registry. This benefit would be lost in a merger with another body.

b. Better access to data

The Registry has recurring problems in gaining access to working space, medical records, electronic data and other essentials in Irish hospitals. Being a more integral part of the cancer or general health services should allow the Registry staff easier access to these facilities, provided the merger was with a health service provider.

c. More engagement with stakeholders

As an autonomous agency, the Registry has always been somewhat outside the health service, both in terms of acceptability and also the integration of its data in the service planning and monitoring process. Closer integration would be of benefit in this regard.

Risks and costs

a. Loss of key staff

In merging with any larger agency, particularly in times of staff shortage, the Registry would be in danger of having key staff with specialist skills transferred to priority areas within the larger agency. Cancer registration does not pose the same issues of urgency as patient services and could be a low priority.

b. Loss of funding

Currently, Registry funding is allocated by the Department of Health on a largely historical basis. In a larger agency, particularly one which was demand-driven, the Registry would find it difficult to retain its appropriate budget share.

c. Loss of reputation

The Registry has built a reputation for independence in both data collection and reporting. Our standards of data security and confidentiality can assure hospitals and health care professionals that their data will not be shared without their consent. Independence from health boards, HSE and Department of Health has been important in getting full cooperation from the private health care sector. Closer integration with the public health service might endanger this.

The independence of the Registry in publishing data and comparing Ireland's cancer services with those of other countries and over time has been valued as an objective assessment of the national cancer strategies. This independence might be lost to corporate policy in a larger organization. It is also useful, when investigating cancer clusters, in being seen as an independent third party and not part of any official "cover-up".

d. Reduced staff morale

One of the advantages of a small autonomous agency is the identification of staff with the reputation and future of the agency. Registry staff, many of whom have been with the Registry since 1993, support its aims and values, particularly in the areas of data quality and confidentiality, and this constitutes one of their primary motivations. Staff retention and supervision has consequently never been a problem. This may not survive a merger with another body.

e. Operating difficulties

Larger bodies, by their nature, tend to be less flexible and responsive, to have more paperwork and formality associated with most activities and to require more middle management and meetings to deal with a much wider range of policies, procedures and objectives. A smaller agency can manage more informally, with less administrative and managerial overhead.

Evaluation

On balance the cost savings associated with the abolition of the National Cancer Registry Board, while preserving its functions, are minimal, and loss of the link with University College, Cork, could result in a substantial increase in costs. The risks of loss of identity, on the other hand, are significant. A loose association with a larger body, which could provide support and stability, while allowing the autonomy of the Registry to continue, would seem to be the most favourable solution. This body could be a cancer centre (research or clinical), a university or a public health agency. Few suitable candidates currently exist.

OTHER PLANNED DEVELOPMENTS IN 2012

Changes to registration system

As described in the 2011 service plan we will be replacing the existing registry software with a programme which will allow “live” online data entry over the internet. This will largely eliminate the data security issues which exist at present through holding multiple copies of the registry database on the laptops of our hospital-based staff around the country. A full specification for the system is in the final stages of preparation.

Redeployment of staff

Redeployment of a tumour registration officer from St Luke’s to the other radiation oncology centres will take place this year.

Data acquisition

The joint HSE/NCCP/ NCSS/National Cancer Registry electronic histopathology project has begun in 2011, but it is probable that data from this project will not be available in 2012.

Client Identity Services at the Department of Social Protection has agreed to carry out active follow-up on a random sample of living registered cases from 1994-2005. After 2005, dates of birth were available on death certificates but before this, matching of registrations to death certificates was not 100% reliable. We suspect that up to 5% of patients registered as alive have died. This artificially increases survival rates, especially for older patients. Based on the results of this random sample, we may carry out a more thorough matching of “living” cases. However, there are over 100,000 of these.

We have agreement from the Primary Care Reimbursement Service to access chemotherapy data on cancer registrations.

Publications planned for 2012

Colorectal cancer incidence, treatment and survival

This is the third of a planned series of detailed site-specific reports.

Cancer trends

This two-monthly short report is emailed to 400 subscribers in Ireland and is available on our website. Six issues will be produced in 2012, beginning with “Cancers of uterus” in January and “Cancer of pancreas” in March.

Annual report

The usual annual statistical report on cancer incidence, treatment, survival and mortality will be published in June.

National Cancer Registry Board

NATIONAL CANCER REGISTRY BOARD

ACCOUNTS

FOR THE YEAR ENDED 31ST DECEMBER 2011

National Cancer Registry Board

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National Cancer Registry Board

Information

Board Members	Mr Tony O'Brien (Chairperson) Dr Anna Gavin Prof Donal Hollywood Ms Mary Jackson Mr John McCormack Dr Deirdre Murray Prof Paul Redmond
Director	Dr Harry Comber
Business Address	Building 6800, Cork Airport Business Park, Kinsale Road, Cork.
Auditor	Comptroller and Auditor General, Dublin Castle, Dublin 2.
Bankers	Allied Irish Banks plc, 66 South Mall, Cork.

Statement of Board Members' Responsibilities

National Cancer Registry Board

The members of the Board are required by the National Cancer Registry Board (Establishment) Order 1991, to prepare financial statements for each financial year which give a true and fair view of the state of affairs of the Board and of its Income and Expenditure for that period. In preparing those financial statements the Board is required to:

- select suitable accounting policies and then apply them consistently;
- make judgements and estimates that are reasonable and prudent;
- comply with applicable Accounting Standards, subject to any material departures disclosed and explained in the financial statements;
- prepare the financial statements on the going concern basis unless it is appropriate to presume that the Board will not continue in operation.

The Board is responsible for keeping proper accounting records which disclose with reasonable accuracy at any time the financial position of the National Cancer Registry Board and to enable it to ensure that the financial statements comply with the Order. It is also responsible for safeguarding the assets of the National Cancer Registry Board and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities.

On behalf of the Board



.....
Board Member



.....
Board Member

National Cancer Registry Board

Statement on Internal Financial Control for the year ended 31st December 2011

Responsibilities

On behalf of the Board of the National Cancer Registry, I acknowledge our responsibility for ensuring that an effective system of internal financial control is maintained and operated.

The system can only provide reasonable and not absolute assurance that assets are safeguarded, transactions authorised and properly recorded, and that material errors or irregularities are either prevented or would be detected in a timely period.

Key Control Procedures

The key control procedures put in place designed to provide effective financial control are:

- A clearly defined management structure with proper segregation of duties throughout the organisation.
- A risk register was compiled in 2010 and was updated throughout 2011.
- A procedures document setting out instructions for all areas of financial activity was in place for 2011. This outlined the procedures for the administration of salaries, invoices and expense claims, use of the credit card and petty cash transactions as well as procedures for procurement and for the disposal of assets. The payroll and some invoice processing functions were carried out by University College Cork in 2011. There were regular reconciliations carried out between National Cancer Registry Board records and those maintained by University College Cork.
- An Audit Committee had been appointed at the Board Meeting held on 19th January 2010 and as a new Board was appointed in 2011, a new Audit Committee was appointed at its first meeting on 30th November 2011. This committee oversees the work of the Internal Auditors.
- An ITT for Internal Audit Services was undertaken in March 2010 and a full three-year cycle of internal audits covering core financial, organisational and operational areas have been agreed by the Audit Committee and the Board. Formal internal audits were carried out in 2011 in the areas of Tendering & Procurement, Corporate Governance & Risk Management, ICT and Hardcopy – Information Security and Registration – process controls. Reports on these were considered by the Board's Audit Committee at its meeting in June 2011.
- An overall annual budget for the National Cancer Registry was agreed which incorporated a separate budget for IT. A report is prepared on a monthly basis to compare actual with budget figures and overall annual expected figures are updated throughout the year.
- Review by the Board at each of its meetings of periodic and annual financial reports.

Review of Internal Controls

I confirm that the Board carried out a review of the effectiveness of internal financial controls for 2011 at its meeting in February 2012.

Signed on behalf of the Board of the National Cancer Registry



Date: 04/10/2012

Mr Tony O'Brien
Chairperson

National Cancer Registry Board

Report of the Comptroller & Auditor General

National Cancer Registry Board

National Cancer Registry Board

Statement of Accounting Policies for the year ended 31st December 2011

Accounting convention

The financial statements have been prepared under the historical cost convention and comply with the Accounting Standards issued by the Minister for Health.

Tangible fixed assets and depreciation

Fixed Assets are stated at cost less depreciation.

Depreciation is provided at rates calculated to write off the cost or valuation less residual value of each asset over its expected useful life, as follows:

Fixtures and Fittings	20% Straight Line
Office Equipment	20% Straight Line
Computer Hardware	25% Straight Line
Computer Software	33% Straight Line

Certain computer hardware and software is written off in the year of acquisition.

Grants

Revenue grants from the Department of Health are the amounts received for the year. Grants used for capital purposes are deferred and amortised over the same period as the related fixed assets are depreciated.

Pensions

By direction of the Minister for Health no provision has been made in respect of accrued benefits payable in future years under the Nominated Health Agencies Superannuation Scheme and its Spouses and Children Scheme.

Contributions from employees who are members of the scheme are credited to the Income and Expenditure account when received. Pension payments are charged to the Income and Expenditure account when paid.

Research Grants

Research grants are recognised in the period in which the corresponding expenditure is incurred and are accounted for as Other Income.

National Cancer Registry Board

Income and Expenditure Account for the year ended 31st December 2011

	2010		2011	
Notes	€	€		
Income				
Department of Health		1	2,530,000	2,358,306
Superannuation contributions			117,748	113,000
Other Income		2	701,977	590,105
Total Income			3,349,725	3,061,411
Expenditure				
Staff costs		3	2,814,615	2,511,947
Administration costs		4	514,003	518,880
Travel and subsistence			49,375	90,003
Total Expenditure			3,377,993	3,120,830
Surplus/(Deficit) for year			(28,268)	(59,419)
Balance Brought Forward 1 st January			99,384	158,803
Balance Carried Forward 31 st December			71,116	99,384

All gains and losses for the year have been recognised in arriving at the Surplus of Income over Expenditure.

On behalf of the Board:



.....
Board Member

Date:04/10/2012



.....
Board Member

Date:01/10/2012

The accounting policies on page 6 and notes on pages 9-15 form part of these financial statements

National Cancer Registry Board

Balance Sheet as at 31st December 2011

2011		2010			
Notes	€	€	€	€	
Fixed Assets		5		98,340	170,565
Current Assets					
Debtors and Prepayments		6		158,967	113,381
Cash at bank and in hand				578,107	635,112
				<u>737,074</u>	<u>748,493</u>
Current Liabilities					
Amounts due to U.C.C.				212,064	204,588
Other creditors				21,967	34,514
Accruals				36,823	54,642
Grants received in advance		7		395,104	355,365
				<u>665,958</u>	<u>649,109</u>
Net Current Assets				<u>71,116</u>	<u>99,384</u>
Total Assets Less Current Liabilities				<u>169,456</u>	<u>269,949</u>
Financed by:					
Capital Grants		8		98,340	170,565
Income and Expenditure Account				71,116	99,384
				<u>169,456</u>	<u>269,949</u>

On behalf of the Board:



.....
Board Member

Date 04/10/2012



.....
Board Member

Date: 01/10/2012

The accounting policies on page 6 and notes on pages 9-15 form part of these financial statements

National Cancer Registry Board

Notes to the Accounts for the year ended 31st December 2011

1. Department of Health 2011

	2010	
	€	€
Revenue Grant - Applied towards recurrent expenditure	2,530,000	2,358,306
Total Revenue Grant	<u>2,530,000</u>	<u>2,367,000</u>
Capital Grant (Note 8)	22,084	25,530

2. Other Income

	2011	
	2010	2010
	€	€
Prostate Cancer Grant	588	0
Economic Impact of Cancer Grant	183,643	161,502
PSA Grant	55,067	8,344
Cervical Cancer Grant	40,532	104,491
Pancreatic Cancer Grant	30,574	21,609
Finbarr	5,967	0
Cancer in Older Women Grant	1,765	49,898
Health Technology Assessment Grant	4,613	17,477
Employment Outcomes Grant	106,461	39,228
Eurocourse	73,535	92,286
Head & Neck Cancer Grant	64,222	62,083
Cerviva RCT Grant	39,156	0
Sanofi Grant	42,593	0
Hormonal Therapies Grant	5,666	0
Prostate Charity	14,533	0
Miscellaneous	33,062	33,187
	<u>701,977</u>	<u>590,105</u>

National Cancer Registry Board

**Notes to the Accounts
for the year ended 31st December 2011**

3. Information on Employees and Remuneration

	2011 Number	2010 Number
The average numbers of employees during the year was:		
Director	1	1
Administration	36	32
Tumour Registration Officers	<u>20</u>	<u>22</u>
	<u>57</u>	<u>55</u>
Employment Costs	2011	2010
€	€	
Wages and salaries	2,487,681	2,254,326
Social Insurance Costs	258,932	212,442
Pensions	68,002	45,179
	<hr/>	<hr/>
	€	€
Director's Remuneration	174,163	105,429

Sanction was received in June 2011 from the Department of Health, to correct an underpayment to the Director with effect from 1st April 1997. A backpayment was processed in the August 2011 salary payments.

The Director is a member of the Nominated Health Agencies Superannuation Scheme.

The Director did not receive any Performance Related Award in 2011.

	2011 €	2010 €
Travel & Subsistence to attend Board Meetings	148	716

Board members do not receive fees.

National Cancer Registry Board

Notes to the Accounts for the year ended 31st December 2011

4. Administration Expenses	2011	2010
	€	€
Office Consumables	14,333	9,582
Courier and delivery charges	2,627	1,765
Books and periodicals	987	2,110
C&AG Audit fee	9,024	9,024
Other Audit fees	10,193	10,185
Recruitment and training	45,555	39,029
Conference fees	18,912	22,979
Rent, rates & service charges	192,333	175,124
Insurance	13,827	12,416
New Premises fit out & moving	0	387
Light and heat	15,504	13,001
Cleaning	0	5
Repairs, Maintenance, Warranties and Support	23,161	17,087
Printing, postage and stationery	36,761	52,220
Telephone, fax and Internet	38,734	34,698
Corporate Hospitality	0	329
Legal and professional fees	0	8,927
Bank Charges	449	553
Sundry expenses	28,763	54,821
Licences & Subscriptions	56,622	45,756
Information Technology Consumables	6,218	9,131
Amortisation of grants	(95,204)	(104,103)
Depreciation on computer equipment	35,759	46,978
Depreciation on fixtures and fittings	57,976	55,971
Depreciation on office equipment	1,469	1,155
Loss/(Profit) on disposal of fixed assets	0	(250)
Total Administrative Expenses	<u>514,003</u>	<u>518,880</u>

National Cancer Registry Board

Notes to the Accounts for the year ended 31st December 2011

5. Fixed Assets

	Computer Equipment	Fixtures & Fittings	Office Equipment	Total
	€	€	€	€
Cost				
At 1 st January 2011	417,100	291,689	18,346	727,135
Additions	11,377	10,029	1,573	22,979
Disposals	(14,093)	0	0	(14,093)
At 31st December 2011	414,384	301,718	19,919	736,021
Depreciation				
At 1 st January 2011	362,064	178,319	16,187	556,570
On disposals	(14,093)	0	0	(14,093)
Charge for the year	35,759	57,976	1,469	95,204
At 31st December 2011	383,730	236,295	17,656	637,681

Net book Values

At 31 st December 2011	<u>30,654</u>	<u>65,423</u>	<u>2,263</u>	<u>98,340</u>
At 31 st December 2010	<u>55,036</u>	<u>113,370</u>	<u>2,159</u>	<u>170,565</u>

6. Debtors

Debtors		129,502	73,262
Prepayments		29,465	40,119
		<u>158,967</u>	<u>113,381</u>

National Cancer Registry Board

Notes to the Accounts for the year ended 31st December 2011

7. Grants Received in Advance

	2011 €	2010 €
Prostate Cancer Grant	856	1,444
Economic Impact of Cancer Grant	129,697	101,227
Pancreatic Cancer Grant	2,539	22,425
Rarecare Grant	80	80
Employment Outcomes Grant	116,577	141,827
Health Technology Assessment	61	4,673
Finbarr 0	5,967	
Eurocourse	0	26,595
Cancer in Older Women	1,572	3,337
Sanofi 54,401	0	
PSA 27,174	0	
Head and Neck Cancer Grant	49,981	27,940
National Cancer Screening	0	15,000
Cervical Grant	0	1,269
Hormonal Therapies	8,585	0
Eurochip Funding	3,581	3,581
	395,104	355,365

8. Capital Grants

	2011 Total €	2010 Total €
Balance at 1 st January 2011	170,565	240,633
Revenue Grants Received	0	8,694
Capital Grants Received from Department of Health	22,084	25,530
Capital Expenditure funded by HRB Grant	895	0
Amortisation released on disposals	0	(189)
Amortisation in line with depreciation	(95,204)	(104,103)
Balance at 31 st December 2011	98,340	170,565

National Cancer Registry Board

Notes to the Accounts for the year ended 31st December 2011

9. Research Accounts

In addition to its principal function, the Board separately administers research activities which are independently funded by the Health Research Board, the Department of Health and the Northern Ireland Cancer Registry. The funds for these projects are specifically designated and the National Cancer Registry Board has no discretion as to their expenditure. These funds which are not reflected in the Income and Expenditure Account and Balance Sheet of the Board are held by University College Cork.

	Project 4	Project 6	Total €
Funds			
At the 01/01/11	12,308	1,947	14,255
Funds advanced	0	0	0
Funds returned	0	0	0
Fee Income	0	0	0
Transfers	0	0	0
	12,308	1,947	14,255
Research Costs			
Salaries	0	0	0
Recruitment Costs	0	0	0
Insurance	0	0	0
Printing & Design	0	0	0
Travel & Subsistence	0	0	0
Equipment Costs	0	0	0
Advertising	0	0	0
Conference Costs	0	0	0
Course Fees	0	0	0
Miscellaneous	0	0	0
	0	0	0
Funds at 31/12/11	12,308	1,947	14,255

Project 4: NCR General Research Account - this is an aggregate of various research grants which have been closed and these remaining funds are used for research support purposes.

Project 6: Second All-Ireland Cancer Incidence Report - remaining funds re report dissemination costs.

National Cancer Registry Board

Notes to the Accounts for the year ended 31st December 2011

10. Operating Lease Rentals

The Board carried out its business from a premises at Cork Airport Business Park, which it holds under a 5 year lease due to expire on 30th November 2012.

Lease Rentals Charged to Income & Expenditure Account (inc VAT)	156,772	148,767
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The Board has the following annual commitments under operating leases which expire:

Within one year (ex VAT)	121,292	129,563
Within one year (inc VAT 23% & 21%)	149,190	156,772
In the second to fifth years inclusive (ex VAT)	0	121,292
In the second to fifth years inclusive (inc VAT)	0	149,190

11. Going Concern

In October 2008, the Minister for Finance announced that the National Cancer Registry Board would merge into the Health Service Executive. The merger cannot take place until the Health Information Bill has been passed. It is currently the opinion of the Department of Health that this will happen in 2013. In the mean time, the Board does not consider that any material adjustment to the financial statements is needed to take account of the above and, therefore, the financial statements continue to be prepared on a going concern basis.

12. Pension Related Deduction

In accordance with the Financial Emergency Measures in the Public Interest Act 2009, a pension related deduction for public servants became effective from 1 March 2009. The deduction was collected and remitted on a monthly basis through the payroll system at University College Cork. The total of the monthly payments remitted to the Department of Health for the period from January to December 2011 was €143,577. This excluded a shortfall in the June 2011 payment of €1,617, which is to be corrected in 2012.

13. Approval of Financial Statements

The Board approved the financial statements on 18 May 2012.



National
Cancer
Registry
Ireland

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