NHS Digital

Annual Report and Accounts 2021–22

For the period ended 31 March 2022

HC 795

Health and Social Care Information Centre (HSCIC) Annual Report and Accounts 2021-22

The Health and Social Care Information Centre is an executive non-departmental public body created by statute, also known as NHS Digital.

Presented to Parliament pursuant to Schedule 18, paragraph 12(2)(a) of the Health and Social Care Act 2012.

Ordered by the House of Commons to be printed on 8 November 2022.

HC 795

This publication is available at
www.gov.uk/official-documents

Any enquiries regarding this publication should be sent to us at enquiries@nhsdigital.nhs.uk

ISBN 978-1-5286-3692-6
E02793656 11/22

Printed on paper containing 40% recycled fibre content minimum.

Printed in the UK by HH Associates Ltd on behalf of the Controller of His Majesty's Stationery Office.

Contact us:

NHS Digital
7 and 8 Wellington Place
Leeds
West Yorkshire
LS1 4AP

Telephone: 0300 303 5678

www.digital.nhs.uk

Contents

Performance report

Introduction from our Chief Executive and Chair

We've come a long way in 10 years. At the start of January, NHS Digital will join the new unified central body for the NHS in England, exactly a decade after we were set up as a non-departmental public body.

A lot has changed in that period. The reach and scope of our technologies is now, in many areas, starting to fulfil – even surpass – what we hoped we could achieve in 2013.

The NHS App wasn't even a gleam in the NHS's eye 10 years ago. Now, we have more than 26 million verified users and more than 41 million confirmed NHS login accounts, offering a single point of access to an ecosystem of digital health and care services. In 2021-22, there were more than 1.2 billion visits to the NHS website, the largest source of health information in Europe. For tens of millions of people, digital services are now the standard way to access National Health Service advice and treatment.

10 years ago, we envisaged linking up the NHS's unrivalled datasets and building public trust in using these resources. Today, we are developing new Secure Data Environments that will provide researchers with the data they need, while increasing protection of patients' personal information (see page 24). We are committed to developing these new ways of sharing data safely.

We've long held the aim of supporting the life-sciences sector more effectively. This year, we helped support the fastest ever recruitment to a large-scale randomised trial, using routine NHS data to help the NHS-Galleri team recruit 140,000 volunteers between January and August from a standing start.

New data flows are transforming the quality and reach of services. During the pandemic, we were able to identify those most at risk after a COVID-19 infection on a national scale and target them with therapeutics and monitoring in their homes. Live data dashboards, offering open data to the public and secure patient-level insights for authorised health and care staff, are now a standard part of our support to the system.

The sheer scale of our operations would have been hard to anticipate a decade ago. The NHS Spine, the infrastructure that allows information to be shared securely between clinicians, handled 1.4 billion transactions a month last year, about 3 times the traffic in 2014. In 2021-22, health and care staff sent 299 million chat messages, made 31.7 million video calls and scheduled 66 million Microsoft Teams meetings.

There is still much to do.

We are still coming to terms with the enormous impact of COVID-19 on communities, families and individuals. The health and care system itself is facing unprecedented challenges in its wake – treatment backlogs, staff shortages and the realities of dealing with persistent health inequalities in an ageing population. But there is no doubt that the pandemic was a critical opportunity for digital transformation. Our health and care system responded to the biggest health crisis it has ever faced with a concentrated burst of innovation. We rapidly developed digital infrastructure, data flows, point-of-care systems, advanced data analytics and connectivity that made it possible to keep health and care services running effectively, to test and vaccinate an entire population and to develop our understanding of and, eventually, control the virus's effects.

The pandemic pushed people online, transformed patient expectations of what was possible digitally and changed clinicians' ways of working. We've seen mass adoption of digital services by the public and by the health and care workforce. It significantly advanced our agenda, but we must now deliver the functionality – the personalisation, usefulness and responsiveness – that people already expect from digital services in other areas of their lives. Frontline staff simply do not have the time to deal with systems that are not fully joined up or don't fully meet their needs. If we are unable to justify our place on people's smart screens or in the workflows of desperately busy health and care professionals, we will lose it.

That means a renewed commitment to putting data, digital and tech at the heart of transforming the NHS. While we have made progress in some areas, we are still working on issues we had targeted in 2013 in others. We knew 10 years ago that social and community care needed better digital technology and better integration with national services. That is still a problem. We knew in 2013 that we needed to build public trust in the use of data, and particularly the use of patients' GP data. Our public engagement around the GP Data for Planning and Research programme continues the effort to build the understanding and trust required to use that data more effectively. We have been talking for many years about giving clinicians and carers access to secure, shared patient records. While we have made big strides (our Access Record HTML product now covers 98% of GP practices, for example) there is still much to do. We are still trying to implement functional electronic patient record systems, the basic prerequisite for a digital NHS, in some trusts.

Last year, the Wade-Gery review outlined the new operating model and cultures that will support digital transformation through the next, crucial period. By bringing NHS Digital, NHSX and NHS England and Improvement's programmes together in the new Transformation Directorate in NHS England, we are putting digital transformation at the heart of the NHS.

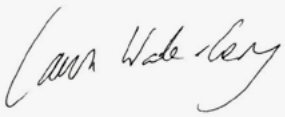
We are taking digital out of its silo and ensuring that the goal of delivering a digital data and technology-driven NHS, orientated around the citizen, is central to all NHS strategy, prioritisation and resource allocation.

As the Secretary of State's plan for digital health and social care made clear this June, that necessitates the improvement of digital skills, leadership and culture across all levels of the health and care system. At the centre, it requires agile, multidisciplinary teams focussed on patient and user needs. We must continue the sort of flexible, productive joint working between national, regional and commercial partners that was so effective in response to the pandemic. And we must work closely with integrated care systems to understand what infrastructure, standards and unified services are required to support their priorities – and what space they need to innovate themselves.

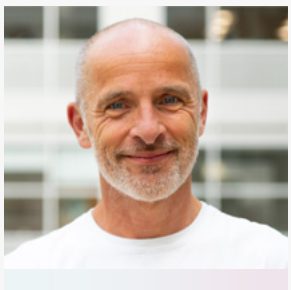
If we can get this right, we will start to see the virtuous cycles of use and continuous improvement that drive the most transformative digital change. We are already seeing this in some areas. For example, the massively increased use of the NHS login service in 2021-22 (1.1 billion logins), led to 8.5 million people updating their contact information. That feeds through to our Personal Demographics Service, ensuring professionals have better information and making digital (and non-digital) services more useful for the patient.

When we look back on 2021-22 in 10 years' time, we may well see it as a turning point. We've been talking about 'digital transformation' in the NHS for a long time. Last year, we began to see transformative change, both in NHS structures and in the use of digital services, that, at last, seem to justify that billing.

None of this would have been possible without the expertise, dedication and teamwork of everybody at NHS Digital and in our partner organisations. We want to thank our teams not only for the achievements outlined in this annual report, but also for the significant contribution they made to this country's response to the pandemic and for the strides we have taken in the NHS's use of digital technology over our 10 years of existence. As we approach the merger with NHS England, we're acutely aware that some of our staff are uncertain about how the new organisation will operate. But it is clear that data and digital technology is central to the future of the NHS and that our teams will continue to be central to delivering that future. We're looking forward to the next 10 years.



Laura Wade-Gery
Chair



Simon Bolton
Interim Chief Executive

Our role

NHS Digital is the national digital, data and technology delivery partner for the NHS and social care system, providing expertise in the design, development and operation of complex IT and data systems.

We collaborate with partners across the NHS, social care, the health tech sector, and life sciences research to support better health and patient outcomes, better experiences, and better value for money.

We:

- build the core IT and data infrastructure, platforms and live services on which the NHS and social care system relies and we run this infrastructure to the highest standards of reliability and security
- design and develop digital products that help NHS and care staff do their work and that put people in control of their health and care
- provide a centre of excellence in cyber security, offering deep technical expertise and national services that help organisations across the NHS defend their systems from digital threats
- offer data services that transform care and support ground-breaking life sciences research. We collect, connect and disseminate some of the world's most valuable health datasets and, as the primary provider of official statistics and analysis to the system, play an important role in improving the efficiency and quality of frontline services
- protect people's private information, acting as the data custodian for England's health and care system and insisting on the highest standards of privacy, transparency and information governance across our services

Our organisation

During 2021-22, our programmes, services and corporate functions were organised into 8 directorates. There were 5 core delivery directorates: Product Delivery, Data Services, IT Operations, Platforms, and Cyber Operations. These directorates were all closely supported by our Privacy, Transparency, Ethics and Legal function, which sits in our Strategy, Policy and Governance directorate. The performance report on pages 6 to 40 is structured around the objectives and achievements of each of these delivery directorates in 2021-22. The performance analysis section and the governance statement set out our purpose, operating environment and the issues and risks affecting delivery over the past year.

NHSX, our key partner in the digital transformation of health and social care, integrated with the Transformation Directorate at NHS England in early 2022.

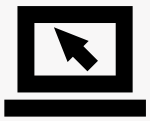
What we did in 2021-22

Product Delivery

We create products and services that put people in control of their own care and help frontline professionals to deliver better services. In 2021-22, we continued to lead on the delivery of COVID-19-related digital systems, while maintaining and developing other key services on which health and care professionals and the public rely.

The impact of this work has been significant:

- 150 million vaccination events were processed by the National Booking Service
- there are now more than 26 million people signed up to the NHS App
- users have securely logged into digital health and care services using NHS login 1.1 billion times in 2021-22



More than 1.2 billion

visits to the NHS website in 2021-22

Our **National Booking Service** supported the biggest vaccination programme in the NHS's history, allowing people to book appointments through the NHS website and helping staff at vaccination sites to manage and check in people for appointments. By March 2022, more than 68.9 million vaccination bookings had been made on the platform. In 2021-22, evolving policy throughout the year meant that we continuously adapted the service to enable different cohorts to access it in line with government advice. When jabs became available to 25 to 29 year-olds, more than 1 million vaccination bookings were made in 24 hours. In December 2021, we opened the service to over 18s as part of the accelerated booster programme in response to the Omicron variant.

We are also the technology delivery lead for the **National Coronavirus Testing System**. In 2021-22, the platform processed more than 350 million test results and we continued to release improvements throughout the year. There were more than 1,000 software releases in response to changing policy.

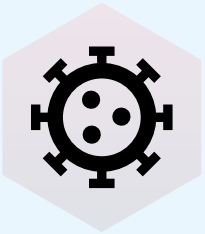
In June 2021, as lockdown restrictions eased, we launched the **NHS COVID Pass**, allowing people to securely demonstrate their COVID-19 vaccination status using the NHS App. In September 2021, we further developed the COVID Pass for international and domestic use, which enabled people to travel and access venues and events. And in October 2021, the medical exemptions service went live. This allows individuals who, for medical reasons, are unable to be vaccinated or tested for COVID-19 to prove their exemption through the COVID Pass. It was followed by extensive volume and performance scaling work in December 2021 to support the government's implementation of 'Plan B', which made the NHS COVID Pass mandatory in some settings. More than 300 million COVID passes have been generated since its launch.

The end of 2021 marked 3 years since the launch of the **NHS App**. There was a sharp increase in the number of people signed up to the app in the past year, partly because of the integration of the COVID Pass. There are now more than 26 million registered users, compared to 2 million at the start of 2020. The app provides quick and secure access to a range of personalised digital health services. It gives people more control of their own care, allowing them to book GP appointments, order repeat prescriptions and register organ donation decisions. 22 million users have now chosen the high-level verification service, which gives access to the app's full features.

NHS login offers patients a single, trusted login account to access health and care websites, apps and services. Over the past year, we have developed its capabilities and now have 56 integrated partners and services. In 2021-22, users securely logged in to digital health and care services using NHS login 1.1 billion times. One feature of the service is the ability for users to update their contact information on the Personal Demographics Service. 7.8 million contact details were updated by patients in 2021-22, ensuring health and care professionals have up-to-date information to support the delivery of services.

In 2021-22, there were more than 1.2 billion visits to the **NHS website**. As well as providing the public with reliable and accessible health information, including COVID-19 guidance, the NHS website also hosts digital tools and services to help connect patients with the treatment they need. In June 2021, the 'Get your NHS COVID Pass letter' service went live, allowing people to request a printed, audio, large print or braille NHS COVID Pass letter for travel as an alternative to the electronic confirmation already available via the NHS App. To date, more than 7.3 million letters have been requested and sent out.

Our **Urgent and Emergency Care services**, such as NHS Pathways and NHS 111 online, help manage the demand on NHS services. NHS Pathways is the national clinical tool used to remotely assess and triage NHS 111 and 999 calls. It handled nearly 20 million calls in the year and we continued to develop the system with 5 major releases. These included clinical updates on a range of topics such as mental health, improving chest pain triage and COVID-19. Acting as an audit for the NHS 111 service, our Repeat Caller Service monitors users who have been processed through the service 3 times or more in a 96-hour period. In September 2021, we upgraded the service to a more modern platform.



350 million test results

processed by our National Coronavirus Testing System

Our **Direct Care APIs** team has worked with GP clinical system suppliers to develop new application programming interfaces (APIs). APIs make data from clinical systems available in a standard form so that authorised clinicians can access it when and where they need it. Our Access Record HTML product gives clinicians a read-only view of a patient's record, regardless of their practice's clinical system. That means the record can be viewed within another GP practice, an urgent care call centre, or an acute care organisation via an accredited system or application. Our Appointment Management product allows GP appointments to be shared across primary care networks so that organisations can manage appointments and support joined-up patient care. In 2021-22, there were more than 36 million interactions with patient records via Access Record (HTML), with 99% of GP practices in England enabled to share records. More than 1.7 million appointments were booked for patients using Appointment Management.

More than 300 million

COVID passes have been generated since its launch

The **GP Data for Planning and Research** programme launched in May 2021. In the months that followed, concerns were raised by patients, professionals and the public about the proposed security and controls on access to data. The then Parliamentary Under Secretary of State for Primary Care and Health Promotion wrote to GPs offering reassurance that a series of commitments would be met before any data was collected. The programme was redesigned to meet the ministerial commitments and realise our ambitions to unlock the benefits of GP data to improve the planning of services, support the treatment and care of patients, and enable research which could unlock new treatments and cures. With a firm commitment to ongoing openness and transparency, our work includes developing a trusted research environment for approved researchers to access limited GP data within a secure NHS environment, and clear and effective communications and engagement to ensure both professionals and the public are involved and informed throughout.

The **Interoperable Medicines programme** is providing high-quality data to improve our understanding of the use, cost, safety and effectiveness of medicines. Fast Healthcare Interoperability Resources (FHIR) is the global industry standard for passing healthcare data between systems. A set of interoperable medicines FHIR standards and implementation guidance has been co-created by suppliers and the NHS. This will allow the seamless transfer of medicines information across all health and care services, supporting safer, more joined-up patient care and reducing the burden on clinicians, who will be able to access accurate patient medication data at the point of care. In October 2021, we published an Information Standard Notice outlining new common standards for the transfer of medicines information, with the aim of these standards being adopted across the NHS by March 2023.

We also develop, run and maintain **national screening programmes** that are inclusive, safe and easy to use. Our teams provide the software to manage the call and recall of women across the UK who are eligible for breast screening. In the past year, we successfully migrated the Breast Screening Information System and Breast Screening Select (which flags those who may be at higher risk of breast cancer) to a cloud-hosted environment, which is more cost-effective, adaptable and secure.

We also run separate systems in England and the Isle of Man to identify those eligible for bowel cancer screening. Both systems send invitations to eligible people, manage appointments and record test results. Over the next 4 years, the screening age for bowel cancer in England will fall from 60 to 50 years-old and we are supporting that transition.

In parallel, we are developing a new NHS Cervical Screening Management System to replace the current call and recall system. This sits on the National Health Application and Infrastructure Services platform, and we are working with NHS England and Cervical Screening Administration Service colleagues to plan next steps.

36 million interactions

with patient records via our Access Record HTML

Case Study

NHS App

Alexis Farrow, Programme Director at Digital Notts, tells us how the NHS App has helped Nottingham and Nottinghamshire to improve its digital health and care services.

Digital Notts is the digital transformation delivery programme across Nottingham and Nottinghamshire integrated care service (ICS) that is helping to transform local health and care services through digital solutions. Programme Director Alexis Farrow has seen first-hand how the NHS App has helped drive opportunities and support change for healthcare professionals and patients.

"People wanted a single, secure place to access their health records, GP services and up-to-date information. After understanding what mattered to our population, the NHS App was the perfect 'front door' for public-facing digital services," she says.

"It provided patients with the ability to access their records, make GP appointments and order repeat prescriptions. On top of this, the NHS App made it easier and quicker for people to securely connect to digital health services through online identity verification."

One local practice decided to encourage patients to register for the NHS App as an alternative to their prescription phone line that was inundated each week. As a result, Derby Road Health Centre has seen its prescription requests via the NHS App double since January 2021, freeing up staff's time to carry out other responsibilities within the practice.

"NHS App has been pivotal in enabling Nottingham and Nottinghamshire ICS to deliver digitally enabled health and care services through a single point of access, which has helped hundreds of thousands of patients access health and care services in an accessible and convenient way – it has also helped reduce the demand and recovery for our operational services."

Data Services

We provide a range of data services for health and social care providers, national bodies, researchers, charities and the public. This enables the health and social care system to make the best use of its data to improve health care outcomes, the efficiency of services and the impact of research. As the independent safe haven for health and social care data, we provide a secure data environment, protected through legal, technical and process controls, where data is processed, linked and stored.

Throughout 2021-22, we continued to deliver data services that changed lives:

- NHS DigiTrials has helped the NHS-Galleri trial recruit 140,000 participants to trial a new blood test that can detect more than 50 types of cancer before symptoms appear
- our vaccine dashboard has helped GP practices and Primary Care Networks increase vaccination uptake across their local communities. Users accessing the dashboard cover 80% of GP practices
- our Data Access Request Service (DARS) supported 939 requests to use health and social care data and approved 846 data sharing agreements

We are directed to securely collect data from across health and care, with approximately 240 collections from more than 10,000 providers including primary, secondary, community, maternity, mental health and adult social care. The raw data is transformed and standardised, making it more usable and valuable. This includes coded mapping, improving data quality via validation and exclusion checks, linking datasets and the creation of derived values and dataset products. We make that data available in national datasets as well as more bespoke analyses, statistical publications, clinical indicators and audits. A large number of stakeholders use it: there are 950 live data sharing agreements with a variety of organisations including 350 research and academic bodies, 41 public bodies, 56 NHS trusts, 400 clinical commissioning groups and local authorities across the country.
In 2021-22, we focused on driving up data quality and improving access, while always protecting the privacy of the people whose data we hold.

80 statistical series

and approximately 270 individual publications were published in 2021-22

Our **statistical publications** offer crucial insights into the health and wellbeing of the public and support research, policy development and operational planning. We produced 80 statistical series in 2021-22 and approximately 270 individual publications.

In November 2021, we published the statistics from the National Child Measurement Programme as part of a long-running series that tracks childhood weight categories. This year's publication revealed a significant increase in obesity rates among primary school-aged children, with a rise of around 4.5 percentage points between 2019-20 and 2020-21. We are supporting a request for in-year monitoring to help understand the trend as children returned to school following the relaxing of COVID-19 restrictions.

In September 2021, we published the results of the Mental Health of Children and Young People in England report. This long-standing survey has been run more frequently to follow the mental health of children and young people during the coronavirus pandemic. It showed the incidence of mental disorders among children remained stable in 2021 after a previous rise. The survey found that 1 in 6 children in England had a probable mental disorder in 2021 – a similar rate to 2020, but an increase from 1 in 9 in 2017.

950 live data sharing agreements

with a range of NHS trusts and research bodies across the country

We are also commissioned to run **clinical audits and registries** for the health and care system in England. Clinical audit is a way to find out if healthcare is being provided in line with standards and allows care providers, commissioners and patients to know where their service is doing well and where it can improve. Working collaboratively with clinical specialists, patient representatives and universities, our Clinical Audits and Registries Management Service supported 8 audits and registries over the past year. In 2021-22, this included the wide-ranging National Diabetes Audit programme, which has been used extensively as part of the national COVID-19 recovery plan, and the establishment of the new National Obesity Audit, which provides data to help commissioners improve prevention and care for people who are overweight or obese.

Our **Data Access Request Service** (DARS) gives access to health and social care data for authorised, non-direct care uses. Its online service now gives customers the ability to apply for access to more than 50 different data sets and, during the last year, we made 21 new data sets available, including Mental Health of Children and Young People, Improving Access to Psychological Therapies and access to more current hospital data through the Uncurated Low Latency Hospital Data Sets for Admitted Patient Care, Outpatient and Critical Care. DARS supported 939 requests to use health and social care data and approved 846 data sharing agreements. These included 186 requests for COVID-19 purposes.

Our new Population Health platform identified

more than 170,000 patients

who could benefit from COVID-19 therapeutic treatments and helped get treatments to

45,000 patients

In line with the direction set out in the Department of Health and Social Care's 'Data Saves Lives' strategy, our **Trusted Research Environment (TRE)** service provides authorised users with remote access to linked, de-identified health data without data ever leaving our secure data environment. More than 20 linkable data sets are now available and 20-30 projects are at various stages of completion. Researchers from across the NHS, government, academia and industry are currently using the TRE to investigate the impact of COVID-19 from a range of perspectives, including effects on cardiovascular disease and cancer. While the TRE service was initially focused on supporting COVID-19 research, we are now developing it to provide a more flexible and scalable solution to support a wide range of studies. This will become the default route for accessing data held by NHS Digital, providing greater transparency and control over how patient data is used and allowing us to support research while reducing risks to privacy.

In 2021-22, we continued to play a key role in supporting the national response to COVID-19. We ensured that information about vaccinations flowed seamlessly into GP records and provided data to identify people who could benefit from COVID-19 therapeutic treatments, supporting event-driven email and SMS messaging to contact them. Our new Population Health platform identified more than 170,000 eligible patients and helped get treatments to 45,000 patients. The platform is also supporting GP referral to the PANORAMIC national study, which aims to find out if new antiviral treatments for COVID-19 in the community reduce the need for hospital admission. GPs can use the Population Health platform to view a list of patients who have tested positive and may be eligible to take part – nearly 23,000 patients had been recruited at the end of March 2022. We also continued to support the Oximetry@home programme with data collection and programme evaluation, supplying the data needed to find patients who would benefit from self-monitoring at home with a pulse oximeter. As of May 2022, more than 160,000 people had been monitored.

Our **Terminology and Classifications service** defines and supports clinical coding best practice. In 2021-22, we published 52 NHS Business Services Authority Dictionary of Medicines and Devices (dm+d) weekly releases, 13 SNOMED CT UK Drug Extension releases, and worked to accommodate important COVID-19-related content such as vaccines given overseas. We also authored and published 5 SNOMED CT UK Clinical Edition releases.

As part of the government's strategy to transform the public health system in England, the management of the National Disease Registration Service (NDRS) transferred from Public Health England to NHS Digital on 1 October 2021. The service collects data on patients with cancer, congenital anomalies and rare diseases and is made up of 2 disease registers: the National Cancer Registration and Analysis Service and the National Congenital Anomaly and Rare Disease Registration Service. In 2021-22, NDRS created a new rapid cancer registration dataset and launched COVID-19 cancer dashboards showing changes in cancer incidence and treatments during the pandemic. The publication of the RECORDER study showed that people with rare autoimmune rheumatic diseases were 1.5 times more likely to have a positive COVID-19 PCR test in the first wave of the pandemic compared to the general population and were 2.4 times more likely to die of COVID-19 complications. In 2021, the NDRS genomics team published the first Lynch syndrome dashboard, showing rates of germline genetic testing in colorectal and endometrial cancer. These dashboards help with the prevention and early detection of cancer.

The **NHS DigiTrials** service is helping clinical trials to use NHS Digital data much more efficiently, reducing the time, effort and cost of developing new drugs, treatments and services. During the past year, we have supported the NHS-Galleri trial, the world's largest trial of a new blood test that can detect more than 50 types of cancer before symptoms appear. It is run by the Cancer Research UK and King's College London Cancer Prevention Trials Unit, in partnership with the NHS and healthcare company GRAIL, and is using NHS DigiTrials to support recruitment, recalls for follow up and the tracking of patient outcomes using NHS Digital data, including data from NDRS. By using routinely collected, national NHS data sets to identify the right people, the burden on frontline staff is reduced. The NHS DigiTrials service helped to recruit a representative population into the trial (for example, by giving access to good distribution across all socioeconomic groups) to ensure the test works for everyone. 140,000 people from across the UK were recruited for the trial, making it the fastest ever recruiting large-scale randomised trial.

In April 2021, the Pelvic Floor Registry began collecting device and outcome-based data from all health care organisations undertaking pelvic floor procedures. This supported the government's response to the report of the Independent Medicines and Medical Devices Safety Review, 'First Do No Harm'. In parallel, the Surgical Devices and Implants Information System began to collect core device data from all health care organisations across all specialties in England to address requirements raised by the report. An Information Standards Notice was published in February 2022 specifying the surgical device and implants data that must be routinely captured in theatre systems.

The Medicines Information System project launched a Medicines in Pregnancy dashboard building on the analytics and reporting published in 2020-21 around the use of valproate and other anti-epileptics prescribed during pregnancy. The interactive dashboard provides better insight to support regulatory and clinical decisions.

In 2021-22, we continued to build our open data offering. We provided a secure, scalable mechanism for giving access to aggregated data for a variety of public and private uses through our visualisation and dashboard capabilities. Our public dashboard hub has served millions of users and our private dashboards have supported hundreds of health and policy professionals. In summer 2021, we created a secure environment to provide a patient-level GP COVID-19 vaccine dashboard to help GP practices and primary care networks increase vaccination uptake across their local communities. Users accessing the dashboard cover 80% of GP practices. In autumn 2021, we launched our GP Appointments Data dashboard, providing information about scheduled activity and GP appointments down to the practice level. This highlights data quality issues and gives local providers vital management information about their own activity.

80% of GP practices

have accessed our vaccine dashboard, helping increase vaccination uptake across local communities

Case Study

Trusted Research Environment service

Professor Angela Wood tells us how access to population-wide healthcare data via our Trusted Research Environment (TRE) service is enhancing COVID-19-related research.

Our TRE service provides approved researchers timely and secure access to health and care data, allowing them to collaborate, link data and share code and results, all within the same research project. Researchers from across the NHS, government, academia and industry are currently using the TRE service to investigate the impact of COVID-19 from a range of perspectives.

Angela Wood, Professor of Health Data Science at the University of Cambridge, has been collaborating with the British Heart Foundation Data Science Centre (hosted by Health Data Research UK) through the CVD-COVID-UK consortium to investigate the relationship between COVID-19 and cardiovascular disease.

"Access to linked population-wide structured healthcare data within NHS Digital's TRE service, including data from hospitalisations, primary care, death registrations, prescriptions and COVID-19 testing and vaccination, has been key for COVID-19-related research," she says.

"Using information from 46 million adults, we have been able to study the rare but serious clotting events after the COVID-19 vaccination. However, we've shown these side effects are outweighed by the vaccination benefits of reducing coronavirus morbidity and deaths. We are also studying the long-term effects of COVID-19 on people's vascular health to pinpoint if or when they return to their pre-COVID-19 risk level.

"If we did not have access to this data resource for research, we wouldn't be able to tackle these important public health and policy-related questions."

"I would certainly advise other researchers to consider how this population-wide data resource would help them address their future health-related research priorities."

IT Operations

We manage and support a range of vital systems and services for the health and care system. It is our job to ensure they perform effectively and are reliable and secure. In 2021-22, we responded rapidly to changing service demands while improving cloud and private hosting arrangements, network connectivity and workplace collaboration tools.

We had a significant impact:

- a Summary Care Record was viewed every 2.2 seconds in October 2021
- outbound telephony for general practices was introduced in December 2021, enabling surgeries to make anonymised outbound-only calls to patients through Microsoft Teams. Between December 2021 and March 2022, 300,000 calls were connected – an additional 1.39 million minutes of outbound call time
- we supported the COVID-19 vaccination programme by rapidly connecting 150 vaccination sites

Throughout the year, we supported the COVID-19 response, maintaining high availability across all services. Our average availability for the last 6 months of 2021 was 96%, which increased to 98% in the first quarter of 2022. We also delivered more than 30 new transformed services.

In September 2021, our Customer Service Function, which includes the Contact Centre (NHS Digital Enquiries), National Service Desk, Exeter Helpdesk, Information Standards Desk and the NHS UK Helpline, won the Contact Centre of the Year in the medium category at the UK National Contact Centre Awards, the longest-running awards programme in the UK call centre industry. The function, which provides support to internal and external customers including NHS staff, health sector service providers and the public, experienced an increased workload in the year, partly because of greater use of services such as the NHS App, NHS login and NHS COVID Pass. In a normal year, we handle around 900,000 requests, enquiries, incident contacts and transactions. In 2021-22, we had passed that number by September. Between May and September 2021, the team worked with the GP Data for Planning and Research programme to manage an extraordinary spike of activity. More than 87,000 contacts were logged across this period for this service alone, with contact peaking at 6,000 calls in a single day.

Summary Care Record (SCR) views reached a record-high of more than 290,000 views per week in early 2022. SCRs are created from GP medical records and give authorised clinicians outside a GP practice access to key information about their patients. As of October 2021, an SCR was viewed every 2.2 seconds.

In 2021-22, we laid the groundwork and made significant progress in moving to **ServiceNow** as a single IT service management software solution. Our current 4 systems are being replaced in a phased approach by the single system, which will enable real-time insight into our services and streamline the rolling out of improvements and new services. Release 1 has gone live and production running is stable. We are seeing a range of immediate improvements in IT Operations Centre capability, commercial process and delivery, HR tooling, workforce management and customer service management.

Our **Cloud Centre of Excellence (CCoE)** aims to support the successful adoption of cloud services and optimise the way we consume and operate them, while reducing infrastructure costs and our carbon footprint. So far, our CCoE foundation services have delivered £14 million of savings through more efficient cloud consumption and have dramatically improved cloud security and best practice compliance. In 2021-22, our CCoE team also trialled a 'community cloud' concept.

More than 87,000 contacts

logged by our Customer Service Function between May and September 2021, with contact peaking at

6,000 calls

in a single day

Working with the Royal College of Obstetricians and Gynaecologists and the pregnancy charity Tommy's, we established high-quality cloud hosting arrangements for a new pregnancy app that uses clinically validated algorithms to accurately assess risk and personalise care for pregnant women – improving pregnancy outcomes for thousands of women each year. We built a cloud landing zone within our Azure subscription, which means the app is scalable and benefits from both our preferential pricing plans with Azure and the OneGov Cloud arrangements, as well as a number of security features.

We successfully managed the timely migration of 120 services and 875 servers from HM Land Registry data centres to new cloud and Crown Hosting environments with no service disruption. As well as meeting the challenge of exiting the data centres before their planned closure, this work has helped to rationalise the on-premises infrastructure estate, bringing technical and sustainability benefits.

In 2021-22, we continued to support the NHS's growing demand for connectivity. We upgraded nearly 900 NHS sites that had been using slow and unreliable copper-based connections and supported the COVID-19 vaccination programme by rapidly connecting 150 vaccination sites. We have begun work to ensure the NHS has access to gigabit-capable connectivity and that care homes are supported to access high-speed connectivity services.

During the year, we began a series of **wireless connectivity trials**, demonstrating how wireless technologies can support service transformation and improve health outcomes. As part of our Future Wireless Project Trials, a Find and Treat mobile health unit is using roaming 4G, 5G and satellite connectivity to offer onboard screening, testing and treatment for vulnerable and homeless people to tackle diseases such as tuberculosis, HIV and hepatitis B and C. Deployed from University College London Hospitals, our technology has transformed the unit's connectivity while on the streets, helping some of society's most vulnerable people get the care they need.

In 2020, we completed the transition to the Health and Social Care Network (HSCN) and in 2021-22 we laid the groundwork and completed the procurement exercise to replace a central piece of HSCN's underlying infrastructure, known as the Peering Exchange Service, by January 2023. The HSCN Peering Exchange Service ensures the 950 NHS, social care, private sector and local authority organisations connected to the network can pick from a marketplace of 21 different suppliers providing standardised network services.

NHSmail users

299 million

chat messages

31.7 million

calls

66 million

meetings scheduled on Microsoft Teams

The **NHSmail** service provides Exchange Online and Office 365 applications and resources to NHS staff. In 2021-22, NHSmail users sent 299 million chat messages, made 31.7 million calls and scheduled 66 million meetings through Microsoft Teams. Based on research by Imperial College Healthcare Trust, these meetings and calls may have saved the equivalent of 6 million hours of staff time. In June 2021, we introduced the Teams Cloud Video Interoperability service for NHSmail, enabling users to join Microsoft Teams calls from video teleconferencing devices by dialling the address included in a meeting invite from an organiser with access to the service.

We introduced outbound telephony for general practices in December 2021 to ease pressure on phone capacity at GP surgeries. Participating general practices are able to use Microsoft Teams to make anonymised outbound-only calls to their patients, independent of their existing telephone solutions, freeing up their current lines for incoming calls. This cloud-based functionality does not require the installation of additional physical equipment and has increased telephone capacity at no extra cost to practices. Between December 2021 and March 2022, 300,000 calls were connected.

We also support NHS Digital staff to work efficiently and effectively by providing internal technical services. We supported NHS Digital's move to the Leeds Hub, providing network connectivity, IT equipment across all desks, a new booking system for rooms, desks and car parking, and a new TechHub. In autumn 2021, we onboarded National Disease Registration Service staff moving from Public Health England to NHS Digital, providing devices and user accounts for more than 300 members of staff and setting up TechHub sessions to ensure a smooth transition for each staff member.

The IT Operations Directorate ensures new and evolving services receive the necessary technical assurance. During August 2021, we fully assured all point of care suppliers for flu and COVID-19 vaccines, as well as testing and assuring the changes required to inbound and outbound data flows. We worked closely with the Clinical Safety Group to ensure they had sufficient time to complete their work.

Case Study

Find and Treat mobile health unit

Outreach worker **Adrian Noctor** tells us how the Find and Treat mobile health clinic is helping some of the most vulnerable in our society get the care they need.

As part of our Future Wireless Project Trials, the Find and Treat mobile health unit aims to tackle a wide range of infectious and chronic diseases by screening, diagnosing and treating vulnerable, homeless and high-risk people. The service, which is deployed from University College London Hospitals, has been fitted with a range of high-tech tools and software to enable real-time remote diagnosis and referrals without having to visit a hospital.

"The new technology allows a crew – normally 3 or 4 people on the mobile x-ray unit and 2 or 3 on the smaller blood-borne virus van – to reach more people," says Adrian.

"There's always someone like me knocking on doors and getting people to come out to the van. We will visit homeless hostels, soup kitchens, day centres and immigration assessment locations. We look for anyone classed as a vulnerable adult."

"The 2 vans work together as often as possible. If you want to get someone out of their room and you've got 5 checks on offer, they might think I'll do one, but once you've got them downstairs, they'll probably do 2 or 3."

"By actively finding people and bringing a vehicle like this to them, it shows that their health is important and that we care."


NHS
NHS
NHS
NHS

Platforms

We provide the core platforms that connect digital services across the health and care system. We build interoperable platforms, develop open standards and application programming interfaces (APIs), and support cloud-based technologies. In 2021-22, we built on the work we did in the first year of the COVID-19 pandemic and delivered products and services to allow local organisations and system suppliers to meet the needs of the NHS and innovate for the future.

We worked rapidly and at an unprecedented scale:

- views of the Summary Care Record increased by 26% to 290,000 per week
- our digital cohort system helped identify and recruit nearly 23,000 patients to the national PANORAMIC study
- our National Event Management Service (NEMS) now covers 80% of child health information services and health visiting services, handling around 85,000 messages per day

We developed an **online GP registration** service for patients, shifting the process of GP registration from paper to digital for the first time. Initially launched across 34 practices, it has proved extremely popular with both patients and practices, who benefit from a quicker process with more accurate information. This helped reduce practice administration time by at least 15 minutes per registration and, with 6 million registrations annually, this promises significant time savings across primary care. We will be expanding from 50 to 500 practices and integrating with GP systems in the coming year.

We also made changes to support the **COVID-19 vaccination programme** as the pandemic evolved. This included supporting the accelerated booster rollout for the various cohorts and the logging of vaccines administered outside the NHS. We introduced the national COVID-19 vaccination invitation preference service, which allows people to choose how they want to be contacted by the NHS to book a COVID-19 vaccination. The service has enabled people to opt out of certain communications, allowing the NHS to target its resources more effectively.

In addition, we improved the quality and timeliness of mortality reporting, using data from the General Register Office, Office for National Statistics and our **Personal Demographics Service** (PDS). Through this work, we reduced the average time to record a death in PDS from 20 days to 9 days and reduced the need for manual resolution from 10% of registered deaths to 0.1%.

The **NHS Spine** responds to service demands across all platforms, allowing secure information sharing in the health and care system. It supports the transfer of vital vaccine information, pathology results, referrals and prescriptions. In December 2021, the Spine reached a record high of 1.8 billion transactions, with a 40% increase in transactions year-on-year. This was handled through proactive hardware scaling and by upgrading the datastore to achieve increased performance and reliability. A significant percentage of the traffic increase has been through the internet, reaching a peak of 14% of total transactions. This growth has been driven by increased use of PDS and the Message Exchange for Social Care and Health (MESH), the secure large file transfer service used across health and social care organisations. These services were used to support the COVID-19 vaccination programme, Test and Trace, and the National Booking Service. Release 1 of our MESH to Cloud service is now complete, meaning files over 2GB are held on Amazon Web Services. This increases our ability to handle large files and reduces risk to the service.

We are continuing to make integration easier and have expanded our **application programming interface (API) platform**, with more than 50 APIs now live on the portal. We have 33 point-of-care and patient-facing applications using these APIs and have processed more than 1.4 billion transactions since January 2021– around half of which were in support of the response to COVID-19. Our new digital onboarding service went live in January 2022 and is making it quicker and easier for applications to get connected to our production environment. We have introduced API lifecycle management, with obsolete APIs being deprecated and eventually retired.

In December 2021, the NHS Spine reached a record high of

1.8 billion transactions

Our APIs use the global standard for health care data exchange, **Fast Healthcare Interoperability Resources** (FHIR). This year, new demographic services based on the latest FHIR 4 standard were used. Population of key fields such as email address and mobile number has improved from 36.2% to 47.9% and 84.9% to 88.3%, respectively, supporting digital communications from local and national programmes.

In 2021-22 we established a UK FHIR governance structure. This will enable the development of common standards that can be agreed by the 4 nations, supporting interoperability across the UK.

To support the fight against COVID-19, our Risk Stratification team built a platform that allows high-risk, non-hospitalised patients with COVID-19 to have access to therapeutics. The digital pathway provides a route for COVID Medicine Delivery Units (CMDUs) to reach out to patients who are vulnerable, testing positive, and digitally identifiable. These patients are clinically triaged and, if eligible, given treatment, reducing their risk of severe outcomes from the virus. To reduce the burden on patients, all patients identified in this way have been provided with priority PCR and lateral flow tests ready for use. These patients are also contacted by text message and email on testing positive to ensure they are aware of the pathway. The platform has identified more than 170,000 eligible patients for clinical triage.

We also supported the national **PANORAMIC Trial**, which investigated whether new antiviral treatments for COVID-19 in the community reduced the need for hospital admission and helped people get better sooner. Our Risk Stratification team built a digital cohort system that gives GPs access to a list of their patients who have tested positive for COVID-19 and might be eligible for the study. GPs use this information to contact patients and offer information about taking part. The trial has exceeded expectations: due to effective patient identification, nearly 23,000 patients have been recruited, compared to the original target of 10,000. Since automated SMS enablement in February 2022, participation rates have doubled, significantly improving the rate of clinical evidence collection from the trial. This work will provide the clinical basis for offering these therapeutics to the wider population.

The COVID-19 pandemic highlighted the need for better information sharing between care settings and localities, as well as between professionals and patients. We have continued to build on the success of the **Summary Care Record application** (SCRa), which gives authorised clinicians access to key information from a patient's GP record. With information on around 52 million people, it is a vital national resource. 50% of ambulance trusts are now accessing the new version of SCRa in order to provide better care to patients and reduce unnecessary hospital admissions. In addition, more than 4,500 paramedics are accessing SCRa using fingerprint verification, speeding up access to vital information. Pilots are also taking place in NHS trusts, care homes and pharmacies. Use of the Summary Care Record (SCR) has increased by 26%, with 290,000 views per week.

50% of ambulance trusts are now accessing the new version of Summary Care Record application (SCRa), with more than 4,500 paramedics using fingerprint verification

The **National Record Locator** (NRL) helps clinicians find patient information held in other parts of the NHS, alerting users when records exist and pointing to where they are held. In 2021-22, the number of pointers on the NRL's index has increased 10-fold, from 40,000 in March 2021 to 400,000 in March 2022. More than 13,000 healthcare professionals can now access 5 different types of records from other care settings, including mental health crisis plans, end-of-life plans and urgent care plans.

We have also expanded the use of the **National Event Management Service** (NEMS), which improves the sharing of information about children's contacts with healthcare. It now covers 80% of child health information services and health visiting services and handles about 85,000 messages per day.

The **Electronic Prescription Service** (EPS) offers a safe and secure way to digitally prescribe, dispense, track and sign for prescriptions from any care setting. Digital prescribing rates rose to 90% in 2021-22. During the year, we piloted support for digital prescribing in secondary care settings.

Case Study

Summary Care Record application

Nigel Wong,

Business Support Manager to the Chief Clinical Information Officer at London Ambulance Service NHS Trust

"The mobile Summary Care Record application has transformed how we access clinical information to help with decision making on-scene. Developed over time to meet our needs, it now also gives us access to the Child Protection – Information Sharing service and a growing number of care plans via the National Record Locator. Having such timely access to clear and relevant information is helping us to deliver better patient-centred care across the city."

Cyber Operations

We provide trusted operational cyber capability across the health and social care system, helping to protect the systems, data and critical assets that the NHS relies on and supporting national and local organisations with specialist security and advisory services.

We protected the health and care system:

- NHS Secure Boundary provided monitoring of 3 billion firewall transactions per day
- more than 41,000 organisations published Data Security and Protection Toolkit returns, assessing their cyber security resilience against national standards
- in December 2021, we supported organisations through one of the world's largest and most critical vulnerabilities

The **Data Security Centre** continued to ensure that patient data and information was stored in safe and secure systems by providing a comprehensive range of security services, expert guidance and support to help health and care organisations build cyber security resilience, address vulnerabilities and prepare for and recover from incidents. We provided security assurance on the technical infrastructure that supported the national rollout of vaccinations, as well as securing critical services such as the NHS Spine and NHS.UK. Our partnership with the UK Health Security Agency on protective monitoring and incident management has helped to manage the risk to COVID-19 data and services.

By giving real-time visibility of cyber threats and issuing **high-severity alerts**, we keep organisations across health and care abreast of new vulnerabilities. We issued 13 high-severity alerts in 2021-22 and, in December, we supported organisations through one of the world's largest and most critical vulnerabilities called Log4Shell (or Log4j), which impacted Java applications worldwide. We worked in partnership with the National Cyber Security Centre, NHS England Transformation Directorate and organisations across health and care, to rapidly communicate the importance of managing the vulnerability. We shared information about how it worked to help the wider security community respond.

In 2021-22, we issued

13 high-severity cyber alerts

We continued to enhance the protective monitoring and threat intelligence capabilities of our **Cyber Security Operations Centre**, improving the tools and technologies that help us identify malicious content and respond quickly and at scale to emerging risks. This allowed us to provide protective monitoring to 3 billion firewall transactions per day through the **NHS Secure Boundary** service – a free-to-use perimeter security solution that blocks threats as internet traffic moves into or out of networks. It protects 1.6 million devices.

We are also helping organisations to follow the National Cyber Security Centre guidance on dealing with periods of heightened cyber threat. We provide guidance, assessments and training to the system to help the NHS prepare for cyber incidents and improve its resilience, security culture and improve staff awareness of cyber threats and frauds.

In October 2021, we launched the latest phase of our security awareness campaign called **Keep I.T. Confidential**. This online cyber security toolkit is designed to help NHS trusts and other healthcare organisations learn about good security practice and the impact it can have on patient safety. The materials have been designed to help NHS organisations run their own cyber security awareness campaigns at a time and in a way that suits them – and keep a focus on practical steps such as setting secure passwords, keeping devices locked when they are not in use, and being aware of phishing and email scams.

The **Data Security and Protection Toolkit** provides health and care organisations with a way to assess their cyber security resilience against national standards. All organisations that have access to NHS patient data and systems must use the toolkit to provide assurance that they are practising good data security and that personal information is handled correctly. In 2021-22, more than 41,000 organisations published Data Security and Protection Toolkit returns.

Developing strong relationships with suppliers and customers has been critical throughout 2021-22. Our **Cyber Associates Network (CAN)**, managed in partnership with NHS England's Transformation Directorate, now has more than 2,000 members providing peer-to-peer support. In March 2022, we held the first CAN awards event, showcasing the important work being done to manage and improve cyber security across the NHS. We held 20 webinars to share learning and development across the network and hosted the annual CAN event in October 2021.

We also supported outreach work through CyberFirst, P-TECH, and schools programmes to help inspire the cyber teams of the future. We held our first International Women's Day event with a panel discussion, bringing together cyber specialists at the start of their careers and more experienced colleagues, and are establishing a Cyber Women's Network.

More than 2,000 members

in our Cyber Associates Network

Case Study

Cyber Security

Orlagh Zielinski,

Trainee Cyber Security Advisor,
NHS Digital

"It was daunting starting work straight out of school at only 18, but the Cyber team at NHS Digital have been incredibly supportive and friendly. It's rewarding to work in cyber, knowing that I am helping protect society from ever-evolving threats in technology."

Privacy, Transparency, Ethics and Legal

The role of the Privacy, Transparency, Ethics and Legal function is to help NHS Digital drive innovation and improve lives through the use of data and technology, while respecting confidentiality, minimising privacy risks and ensuring we explain to the public in a clear and understandable way how we use their data safely and appropriately.

The team supports and influences the development of national policy on data, information governance and legislative matters, working in close collaboration with stakeholders at a national level. As active participants in the cross-sector Health and Care Information Governance Panel and its working group, we ensure the standardisation and provision of consistent guidance to support health and care organisations in meeting information governance best practice.

In October 2021, the Commercial Legal team moved into the directorate, working closely with the Information Law team to deliver co-ordinated legal advice to programmes and directorates. During 2022, the NHS Digital COVID-19 Public Inquiry Response team was established as part of the sub-directorate and is working to ensure NHS Digital prepares appropriately for the COVID-19 Inquiry.

The function supported and advised on all of the programmes that NHS Digital delivered to support the COVID-19 response and recovery. We also worked with, and supported, other organisations involved in the system-wide response, including NHS England on the vaccination programme and the UK Health Security Agency in relation to COVID-19 testing. We have also continued to proactively engage with the National Data Guardian and the Information Commissioner's Office on key projects.

Other significant delivery achievements included supporting:

- the safe transfer of the National Disease Registration Service from Public Health England to NHS Digital
- the introduction and delivery of the COVID-19 Medications Service to provide antiviral treatment to the most vulnerable people who tested positive for COVID-19
- the continued delivery of the Shielded Patient List, including the management of the ending of the shielding policy
- the introduction and development of the COVID Pass through the NHS App
- the development and implementation of a range of new directions and statutory requests for the collection and analysis of data to support ambulance services, online and video consultations, the Pelvic Floor Registry and bookings and referrals
- the development and implementation of directions to support the Pilot NHS DigiTrials Recruitment Support Services
- the improvement of information governance templates and tools including developing a new Data Protection Impact Assessment template to improve privacy risk assessments in the development of our products and services
- the NHS App team and Patient Knows Best (PKB), a health record provider, on the data protection aspects of onboarding PKB services onto the NHS App
- the development of a global data transfer assessment procedure for NHS Digital to use in relation to assessing the risks of processing personal data which takes place outside of the UK
- the development of the NHS Digital COVID-19 Trusted Research Environment

Performance analysis

These accounts have been prepared under a direction issued by the Secretary of State for Health and Social Care in accordance with the Health and Social Care Act 2012 and the 2021-22 Government Financial Reporting Manual issued by HM Treasury, as interpreted for the health sector by the Department of Health and Social Care (DHSC) Group Accounting Manual.

The accounting policies contained in the Financial Reporting Manual apply International Financial Reporting Standards (IFRS) as adopted and interpreted for the public sector context. The accounts comprise a statement of comprehensive net expenditure, a statement of financial position, a statement of cash flows and a statement of changes in taxpayers' equity, all with related notes.

The accounts have been prepared on a going concern basis. Funding for 2022-23 is in place, and the continuation of provision of services is demonstrated through the plans agreed with our delivery partners. Although the merger of NHS Digital with NHS England has been announced, with the merger being effective in early January 2023, our functions will continue, and therefore in accordance with the DHSC Group Accounting Manual the going concern basis for preparing the financial statements remains appropriate.

2021-22 performance analysis

NHS Digital is a non-departmental public body and the majority of our funding is grant-in-aid from the Department of Health and Social Care.

Our outturn for the year against our key financial controls was as follows:

Revenue expenditure

	2021-22 £000	2020-21 £000
Grant-in-aid from the Department of Health and Social Care[1]	612,574	483,554
Invoiced income	44,863	45,298
Funding and income	**657,437**	**528,852**
Staff costs	(263,142)	(207,651)
Operating expenditure	(380,765)	(296,045)
Loss on disposal of non-current assets	(2,330)	(2,759)
Movement in provisions	(377)	2,065
Expenditure	**(646,614)**	**(504,390)**
Underspend	**10,823**	**24,462**

Table shows outturn against the non-ring fenced revenue expenditure limit. As such, the figures exclude depreciation, amortisation, impairments and absorption transfers of functions between group bodies.

[1] The grant-in-aid is the revenue expenditure limit agreed with the Department of Health and Social Care. The amount shown in the statement of changes to taxpayers' equity on page 113 is the cash drawn down in the year, which also includes that used for capital expenditure and working capital requirements.

Capital expenditure

	2021-22 £000	2020-21 £000
Grant-in-aid from the Department of Health and Social Care[1]	177,237	140,642
Funding	**177,237**	**140,642**
Capital expenditure	(171,798)	(140,556)
Loss on disposal of non-current assets	2,330	2,759
Expenditure	**(169,468)**	**(137,797)**
Underspend	**7,769**	**2,845**

Table shows outturn against the capital expenditure limit.

[1] The grant-in-aid is the capital expenditure limit agreed with the Department of Health and Social Care. The amount shown in the statement of changes to taxpayers' equity on page 113 is the cash drawn down in the year, which also includes that used for revenue expenditure and working capital requirements.

A significant proportion of our delivery is project-based, such as the development of new or enhanced national systems, or relates to the response to the COVID-19 pandemic. As such, requirements, timescales and volumes of transactions can vary quickly, and we work closely with the Department of Health and Social Care, NHS England and the UK Health Security Agency to ensure early identification of changing demands, and enable the reallocation of funding within the Technology Transformation Portfolio at the earliest opportunity.

2021-22 saw further increases in the scope of delivery and workload across all areas. Additionally, on 1 October 2021 the National Disease Registration Service transferred to NHS Digital from Public Health England, together with 329 staff and £11.1m of funding. Our delivery is described in detail in the Performance Report (see pages 6 to 40).

Our performance against our programmes was regularly reviewed by our Board, with risks managed accordingly and measured against key performance indicators as noted on pages 49 to 53. During the year, changes in our delivery focus were closely monitored and indicators were updated to ensure an accurate reflection of our performance.

Income

In addition to our grant-in-aid funding, we also received income from a range of activities and services including:

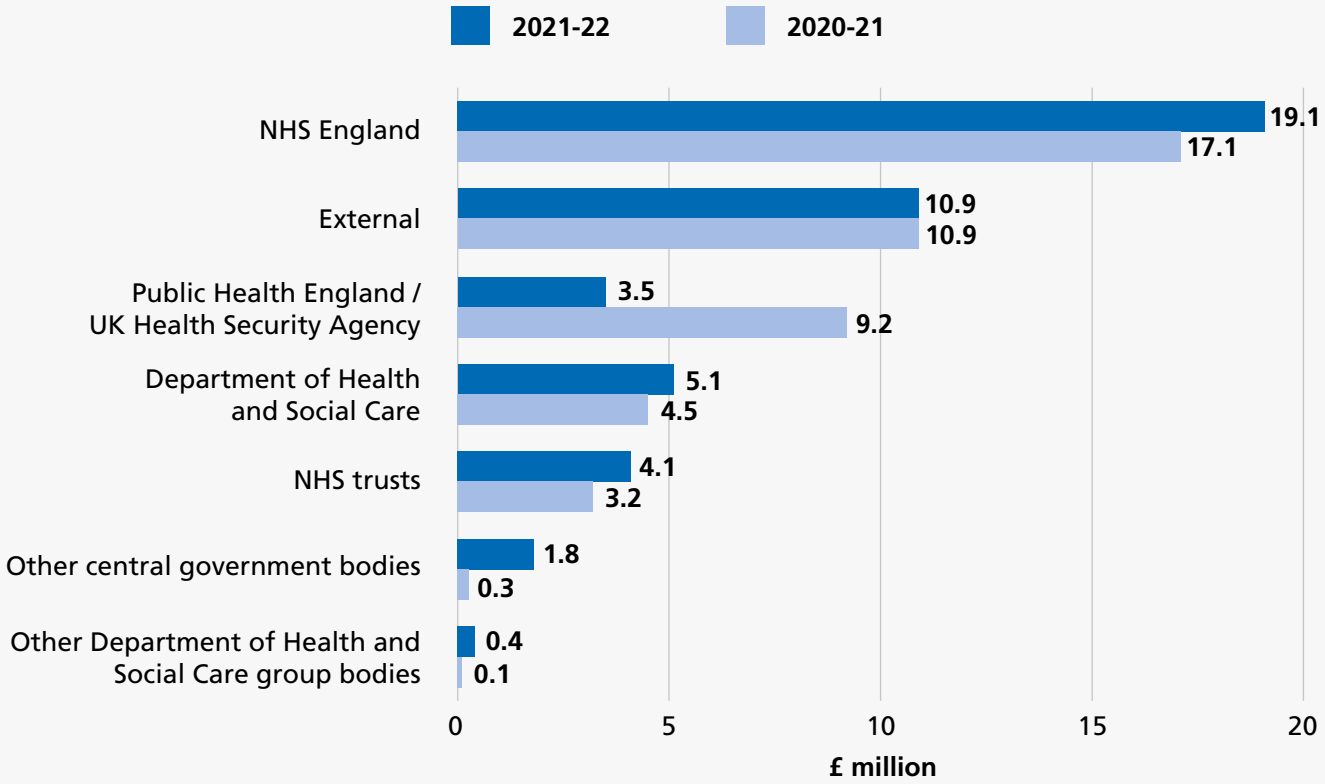
- the development of informatics-related systems
- the design and management of clinical audits
- the hosting, management and development of IT systems for the NHS
- providing contact centre services
- extracting data and disseminating it to customers, inside and outside the NHS
- providing training

Income from these activities and services in 2021-22 was £44.9 million, a small decrease on the £45.3 million generated in 2020-21. Most of our significant invoiced income is supported by agreed work packages and is on a time and materials basis. At the end of 2020-21, £1.8 million of income had not been recognised, since signed agreements were not yet in place. This income was subsequently recognised in 2021-22. All contract income for 2021-22 was supported by signed agreements, and was therefore recognised in the year.

We have a charging policy and a rate card for staff time, with the aim of charging all customers based on full cost recovery.

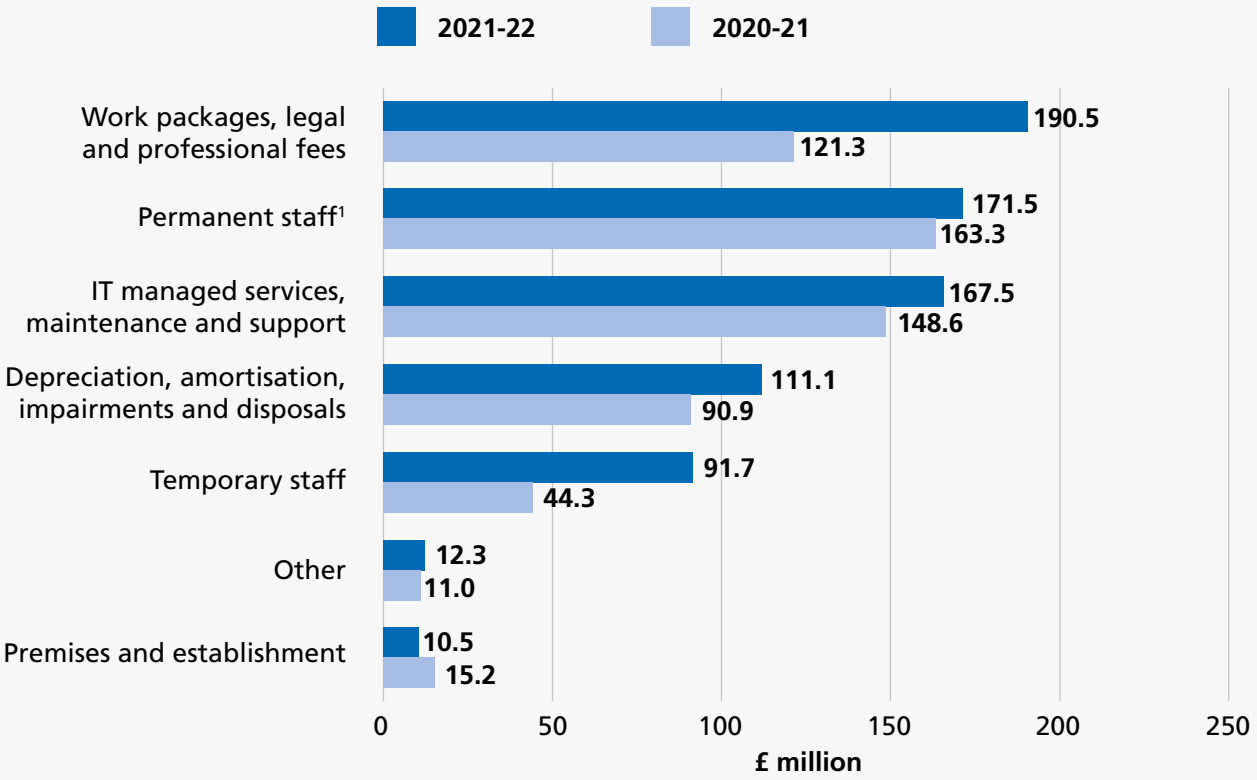
Our major customers are NHS England and the Department of Health and Social Care (DHSC). As part of the cessation of Public Health England and the creation of the UK Health Security Agency, some of the work we deliver that was previously commissioned by Public Health England is now commissioned by NHS England.

Breakdown of income by customer type:



Revenue expenditure

The following chart summarises the main categories of revenue expenditure:



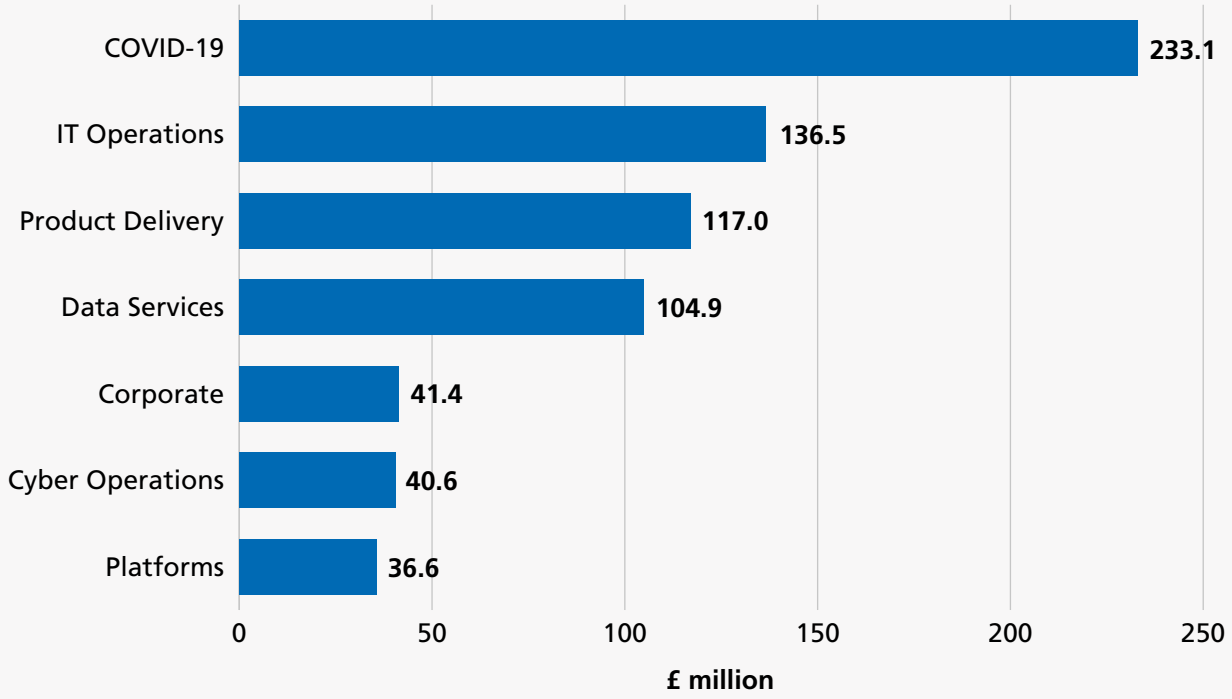
[1] Includes termination benefits

Total permanent and temporary staff costs increased to £263.1 million (2020-21: £207.7 million), with salary costs increasing primarily due to an increase in the number of staff, and contingent labour and secondees rising to £91.7 million (2020-21: £44.3 million). The significant increase in temporary staff was mainly due to the continued expanded scope of delivery started in the previous year related to the COVID-19 response.

Operating expenditure increased significantly to £380.8 million (2020-21: £296.0 million), driven by the increased use of work packages to provide short-term specialist input and software development skills on key projects, and increased use of outsourced managed services to provide support and maintenance for existing services, and capacity and functions such as call centres to enable increased public take-up of services such as the NHS App.

Depreciation, amortisation, impairments and disposals rose to £111.1 million (2020-21: £90.9 million) of which net impairment of assets comprised £40.2 million (2020-21: £17.4 million) as a result of the accounting and audit requirement for the external professional valuation and impairment of the National Coronavirus Testing System arising from the exceptional pandemic circumstances in which it was developed.

2021-22 Net revenue expenditure by delivery directorate (£ million)



More information relating to net revenue expenditure can be found in Note 2 on pages 124 to 129. The 'Corporate' segment in the chart includes Corporate Services, Assurance and Risk Management, Strategy, Policy and Governance and Central net expenditure.

Capital expenditure

	2021-22 £000	2020-21 £000
Internally and externally developed software	147,503	99,266
Development expenditure	13,499	21,031
IT hardware, including desktop and corporate infrastructure	6,221	5,730
Software licences, including desktop and corporate infrastructure licences	3,688	3,805
Refurbishments, fitting out new office space and furniture	887	10,724
Net book value of disposals	(2,330)	(2,759)
Total	**169,468**	**137,797**

Developed software and development expenditure utilised a mix of supplier and internal resources, with the value of internal time capitalised amounting to £16.3 million (2020-21: £12.5 million).

A significant part of our capital expenditure during the year was the continued development of the National Coronavirus Testing System. This supports the end-to-end testing journey, from booking a test at a test centre, or ordering test kits for home delivery, to the operation of test centres, and the dissemination of results both to the individual and for data analysis and reporting. During the year we added additional functionality to cater for international arrivals, data feeds to the NHS App for the Covid Pass, a digital reader to support the upload of lateral flow test results and changes to support the response to the Omicron variant. We also increased the capabilities for the bulk registration of tests, increased the speed of data flows, improved the monitoring for variants of concern, and continued to cater for the specific requirements of each of the Devolved Administrations. The National Coronavirus Testing System accounted for £70m (2020-21: £47.1m) of our capital expenditure during the year.

We also continued to develop our other national systems, in response to both the pandemic and ongoing healthcare needs.

We have applied indexation to non-current assets in existence at 1 April 2021, using a mix of Office for National Statistics indices, actual pay awards and assessments of other supplier cost increases. The indexation impact was an increase in net book value of £1.4 million. The exception was software licences, where indexation has not been applied from 1 April 2019 onwards. From this date, software licences have been held at depreciated historical cost, on the basis that they are short-life assets and, as such, depreciated historical cost is considered a suitable proxy for current value in existing use.

Other non-current receivables include software licences where the subscription period is greater than a year. These have not been revalued.

Current assets and liabilities

Contract receivable balances amount to £9.7 million (31 March 2021: £12.7 million). The decrease in contract receivables was more than offset by the increase in contract receivables not yet invoiced to £7.1 million (31 March 2021: £2.0 million) which represents work completed but not yet invoiced. The increase in contract receivables not yet invoiced was due to a number of income agreements being signed towards the end of the year; this income has been invoiced to customers early in the 2022-23 financial year.

Prepayments under 1 year amount to £19.0 million (31 March 2021: £14.0 million), the increase being primarily due to software licence subscriptions.

We seek to comply with the Better Payments Practice Code (BPPC) by paying suppliers within 30 days of receipt of valid invoice. The percentage of non-NHS invoices paid within this target was 99.1% (31 March 2021: 99.5%). Creditor days outstanding at 31 March 2022 reduced to 14.1 days from 31.4 days at 31 March 2021, which is reflective of the exceptionally high level of payments to suppliers achieved during March.

Auditors

These accounts have been audited by the Comptroller and Auditor General, who has been appointed under statute and is responsible to Parliament. The audit fee for 2021-22 was £166,500 (2020-21: £150,000). The audit fee only includes audit work. No additional payments were made.

The Accounting Officer has taken all steps to ensure he is aware of any relevant audit information and to ensure that NHS Digital's auditors are aware of that information. To the best of the Accounting Officer's knowledge, there is no relevant audit information of which our auditors are unaware.

The internal audit service during the financial year was provided by the Government Internal Audit Agency.

Sustainability

Information about our environmental impact and sustainability is included in Appendix A on pages 151 to 154.

Managing performance and risk

Effective performance management across our organisation ensures we meet our statutory obligations and commitments to stakeholders. It facilitates the delivery of our strategic and operational goals and minimises risk for both NHS Digital and its stakeholders.

We continue to make improvements to the performance management process to ensure rigorous monitoring and the reporting of key management information across the organisation. Financial and non-financial key performance indicators (KPIs) and other management information are primary tools used to continuously monitor and report on performance.

These indicators are integral to NHS Digital's routine business, and support the decision-making processes of the Board and our Executive Management Team (EMT). Performance reporting is undertaken monthly to our EMT and 6 times a year to the Board, with our performance reports published regularly on our website as part of the board papers.

Significant changes and improvements to performance reporting were made in 2021-22 to ensure that KPIs were in line with industry standards and aligned with NHS Digital's strategic objectives. Each KPI, reviewed in detail by the Board in February 2022, has a clear definition and target that is tied to a set of objectives or key priority areas. Our performance reporting provides an enriched narrative that focuses on key achievements and outcomes, supporting better understanding, transparency and appropriate scrutiny of issues and challenges faced by the organisation.

Each KPI is assessed based on the red, amber, green (RAG) model, with detailed analysis where performance issues are identified. To ensure that KPIs were aligned with NHS Digital's objectives, they were categorised under 5 main priority areas for the organisation:

- running NHS Digital well
- operating safe, reliable, and cyber-secure live services
- delivering products and platforms that meet user needs
- maximising the quality and utility of NHS data
- making NHS Digital a fantastic place to work

For 2021-22, KPIs were organised as follows:

Priority area category	KPI area	Description	Responsible director
Running NHS Digital well	Clinical governance	This is the overarching control against causing harm to patients, directly or indirectly, as a result of the clinical aspects of NHS Digital's products and services.	Chief Medical Officer
	Commercial	Reporting on performance relating to supplier contracts and value for money delivered for the organisation.	Chief Commercial Officer
	Financial performance	Covers the management of NHS Digital's finances, including the organisation's funding, budgeting, forecasting, and management and statutory accounts.	Chief Financial Officer
Operating safe, reliable and cyber-secure live services	Live Services, IT service performance	Performance reporting on availability of IT services, number of incidents per day, Customer Service Function (CSF) and Live IT Services Continuity Management (ITSCM).	Associate Director, Live Services
	Data Security Centre, Cyber Security Operations Centre and live service performance	Provides a composite view of internal and external information security incidents and related cyber issues.	Chief Information Security Officer
Delivering products and platforms that meet user needs	Platforms	Provides reporting on operation and performance of the core platforms that connect digital services across the health and care system, including integrated and interoperable platforms, leveraging open standards and application programming interfaces (APIs).	Executive Director of Platforms
	Product Delivery	Provides a consolidated view of the delivery status of our product and programme portfolio, focussing on the overall delivery confidence, including aggregated findings from gateway reviews.	Executive Director, Product Delivery
Maximising the quality and utility of NHS Digital data	Privacy, Transparency, Ethics and Legal	Reporting on compliance with statutory requirements relating to data and information governance.	Executive Director of Privacy, Transparency, Ethics and Legal
	Data Services	Reports on performance relating to the timely publication of national and official statistics and clinical indicators; time required and/or taken to approve applications to enable rapid data sharing; and meeting target delivery dates for data releases.	Executive Director, Data Services
Making NHS Digital a fantastic place to work	Workforce	This covers the performance of the organisation's capacity and capability based on the target staffing model, the efficiency of the recruitment processes, diversity representation and inclusion within the organisation, and compliance with the organisation's mandatory training.	Chief People Officer
	Mandatory training	Reporting on the completion rate of the organisation's mandatory training courses, e.g., Data Security Awareness, Health and Safety Awareness and Clinical Informatics Professional Group.	Chief People Officer

Rolling 12-month performance tracker (as at the end of March 2022)

KPI area	KPI	April 21	May 21	June 21	July 21	August 21	September 21	October 21	November 21	December 21	January 22	February 22	March 22
Programme delivery	Product Delivery		A	A	A	A	A	A	A	A	A	A	A
	Data Services					A/G	A/G	A	A/G	A/G	A/G	A/G	A/G
	Platforms					A	A	A/G	A/G	A	A/G	A/G	A/G
	IT Operations					A/G	G	G	A/G	A/G	A/G	A	A/G
	Cyber Operations					G	G	G	A	A	A	A	A
Data Services	Publications	A/G	A/G	A/G	A/G	A	A	A	A	G	R	G	A/G
	Data Access	G	G	G	A	A							
	Approval Stages - Agreement approved Under Precedent	A	A	A			G	R	R	R	R		
	File Release						R	R	R	R	A		
	Direct Data Access via Data Access Request Service											R	G
IT service performance	Availability Performance	G	R	A	R	R		G	G	R	A	G	G
	Higher Severity Service Incident Volumes Performance	A	R	R	A	G							
	Higher Severity Service Incident Rate							R	R	R	A	G	G
	Customer Service Function Performance - Service Level Attainment					A		G	G	G	G	G	A
Privacy Transparency Ethics and Legal	Freedom of Information Act Requests received, closed and compliance with statutory timetables	G	G	G	G	G	G	G	G	G	G	G	G
	Data Subject Access Requests received, closed and compliance with statutory timetables	G	G	G	G	G	G	G	G	G	G	G	G
Workforce	Organisation Capacity and Capability				A	A	A	A	A	A	A	R	R
	Time to Offer	A	A	A	A	A	A	A	A	A	A	A	A
	Diversity and Inclusion				G	A	G	G	A	A	A	A	R
Mandatory training	Data Security Awareness	R	R	A	R	A	G	G	R	A	A	A	
	Health and Safety Awareness		R	R	R	R	A	A	A	A	A	A	
	Clinical Informatics Professional Group	G	G	G	G	A	G	G	G	G	G	G	
Financial performance	Revenue	A	A	A	A	A	A	A	A	A	A	A	
	Expenditure Analysis	G	A	A	A	A	A						
	Capital	A	A	A	A	A	A	A	A	A	A	A	
Clinical governance	Risk and Issue Trend	G	A	A	A	A	G	A	G	A	A	A	A
	Clinical Risks Reviewed				G	G	G	G	A	G	A	G	G
	Preventing Future Deaths				G	G	G	G	G	G	A	G	G

Programme delivery

Overall, performance for Product Delivery remained stable at an amber rating throughout 2021-22, reflecting the complexity of the Technology Transformation Portfolio. Overall, Data Services, Platforms, IT Operations and Cyber Operations averaged a rating of amber/green throughout 2021-22, indicating they met many of their key programme outcomes. The following programmes were reported with either a red or amber/red rating, continuing to present delivery challenges throughout 2021-22:

- GP Data for Planning and Research
- GP Appointment Data
- Direct Care APIs
- Digital Transformation of Screening
- Primary Care Registration Management

NHS Digital has worked with NHS England and other partners to prioritise the transformation portfolio through 2021-22 and develop delivery plans for the financial year 2022-23.

Data Services

Performance reporting for Data Services underwent reviews throughout the year, resulting in changes to KPIs reported to ensure that reporting was directly linked to the objectives of the organisation and directorate. By the end of the year, reporting was based on 2 key focus areas: 'Publications' and 'Direct Data Access'. Overall, the Publications KPI was rated amber/green, with the majority of publications released on or before the target publication date. A red rating was reported in January 2022 due to resourcing and operational issues that were outside of NHS Digital's control.

The 'Direct Data Access via the Data Access Request Service' KPI was introduced in February 2022, with a green rating reported in March 2022 – a clear improvement from the red rating reported the previous month. The average number of days an application remained in the assurance and approval stage reduced from 41 in February 2022 to 31 in March 2022, a 24.3% improvement.

IT service performance

Reporting on IT service performance was mainly against 3 KPIs:

- Availability Performance (reported throughout the year)
- High Severity Service Incident (HSSI) rate (reported since October 2021)
- Customer Service Function (CSF) Performance – Service Level Attainment KPI (reported since August 2021)

Overall, 'Availability Performance' improved in the second half of 2021-22 with a reported green rating for 3 out of 6 months, compared to a red rating reported for 3 out of 5 months in the first half of the year. This indicates improved service availability, with an average availability of 99.9% across all reported services at the end of the year.

The 'Higher Severity Service Incident Rate' KPI improved significantly in the last 3 months of the year, reporting a green rating over this time period, primarily due to focused service improvement plans that were put in place, as well as a reduction in volume of some key services, such as the National Coronavirus Testing System, as a result of the 'Living with COVID-19' strategy.

A green rating was generally reported for the 'Customer Service Function Performance - Service Level Attainment' KPI, achieving the target in 5 out of the 7 months of reporting, with volumes and service level attainment remaining steady and consistent.

Privacy, Transparency, Ethics and Legal

The 2 KPIs, 'Freedom of Information Act Requests received, closed and compliance with statutory timetables' and 'Data Subject Access Requests received, closed and compliance with statutory timetables', had a green rating reported month on month throughout 2021-22, indicating that we have achieved our statutory timelines all year.

Workforce

The 3 KPIs on which workforce performance reporting was based were 'Organisation Capacity and Capability', 'Time to Offer' and 'Diversity and Inclusion'. The 'Capacity and Capability' KPI remained below the monthly target full-time equivalent staff (FTE) throughout the year, reporting mainly an amber rating, and red ratings for February and March 2022. As of the end of March 2022, 86% of the target staffing model had been filled in terms of FTEs. Appointments into 311 roles were made in the last 3 months of the year, 193 external roles and 118 internal roles, with another 245 start dates confirmed or verbal offers accepted.

An amber rating was reported for the 'Time to Offer' KPI throughout the year, with the time to offer for external roles averaging 6.3 weeks and internal roles averaging 5.59 weeks (the target is 5 weeks). Time to offer is calculated from the start of advertising to the successful candidate's verbal offer date. Considering the large volume of recruitment activity across the organisation, the performance of the Time to Offer KPI is not unexpected. We are focusing on progressing candidates through the recruitment journey as quickly as possible to achieve the 5-week target. Internally, we provide a breakdown of time taken for each step of the process to enable individual directorates to identify and focus on areas of improvement.

On average, the 'Diversity and Inclusion' KPI reported an amber rating through most of 2021-22, although we reported 3 periods where we met our stated targets. There remains an increased focus and work to improve diversity and inclusion across our workforce. Through our outreach engagement events, we are inviting communities from underrepresented groups to come and learn more about us as an employer and we are continuing to encourage applications from a diverse range of candidates.

Mandatory training

Performance reporting for mandatory training is based on a selection of our mandatory training courses, outlined in the KPIs below:

- Data Security Awareness
- Health and Safety Awareness
- Clinical Informatics Professional Group

Data Security Awareness reported an overall amber rating, with an average of 94% of all staff (permanent and non-permanent staff, including contractors) completing the annual training. An overall amber rating was reported for Health and Safety Awareness in 2021-22, with an average of 92% of all staff completing the training. All statistics above are as at February 2022. Work to drive improvement continues to form a key part of the directorates' conversations, with a stated target of at least 95% completion. Finally, the Clinical Informatics Professional Group KPI reported a green rating across the year with one exception of an amber rating.

Financial performance

Overall, an amber rating was reported for financial performance based on 2 KPIs:

- revenue
- capital

The amber ratings for both KPIs were due the challenges of balancing the changing demands of the ongoing pandemic response with both funding and delivery capacity and, towards the end of the financial year, the uncertainty created by the announcement of the 'Living with Covid-19' strategy, and it's potential impact on the future usage and longevity of non-current assets that directly support the pandemic response, and the National Coronavirus Testing System in particular.

Clinical governance

Our clinical governance reporting was based on the following KPIs:

- Risk and Issue Trend
- Clinical Risks Reviewed
- Preventing Future Deaths

Overall, our clinical governance remains generally strong as evidenced by our KPI performance in this area. The 'Risk and Issue Trend' KPI was rated amber overall, with a green rating reported for 3 months of the year. The rating is a composite score based on risks in 'live' services. It considers absolute numbers and levels of risk as well as the numbers of risks de-escalated, or closed, month-on-month. Overall risk levels remained relatively stable throughout the year. Increases in the number of risks were related to operational processes and resourcing, as well as the significant number of change initiatives supported by the organisation during the year. This reflects the organisational desire to streamline processes and ensure ongoing safe, efficient working as we support the wider healthcare sector.

The 'Clinical Risks Reviewed' KPI was reported from July 2021 with an overall green rating, indicating that at least 90% of all red risks were reviewed at the Critical Risk Incident Safety Panel. The 'Preventing Future Deaths' KPI was also reported from July 2021, with an overall green rating. NHS Digital's clinical safety processes reasonably reduced the likelihood of harm or death to patients, with no Regulation 28 Preventing Future Deaths Reports issued by coroners which named NHS Digital. There continues to be good engagement with clinical risk management activities. Strategic deployment of clinical support to maintain risk management and oversight is planned, following recruitment activities undertaken during 2021-22.

Simon Bolton
Interim Chief Executive
2 November 2022

Accountability report

Corporate governance report

This section explains the external framework and internal systems of monitoring and control that help us define our objectives and ensure we achieve them.

Our constitution is set out in Schedule 18 of the Health and Social Care Act 2012. An Accounting Officer Memorandum sent by the Department of Health and Social Care Principal Accounting Officer to our Chief Executive describes the formal arrangements that underpin our existence.

Our governance

NHS Digital is led by a board and 4 board committees. All of these committees are chaired by non-executive directors.

The Board is supported operationally by the Executive Management Team (EMT). The EMT is responsible for communicating and delivering the strategy agreed by the Board.

The Board consisted, at 31 March 2022, of 3 executives, 9 non-executives, including the Chair and 1 ex-officio member who is the department sponsor. These arrangements comply with the requirements of the Health and Social Care Act 2012, which stipulates that the Board should have at least 6 non-executive directors and not more than 5 executive members.

The Board

The Board supports the Chief Executive, who is the Accounting Officer and is accountable to both the Secretary of State for Health and Social Care and to Parliament for the performance of the organisation. The Chief Executive is also responsible for maintaining high standards of probity in the management of public funds. Collectively, the Board is responsible for ensuring that NHS Digital complies with all statutory and administrative requirements, and for the appropriate use of public funds allocated to it.

Details of the conduct of the Board, and the roles and responsibilities of its members, are set out in the Board Terms of Reference, which are derived from our Corporate Governance Manual. These include our standing orders, standing financial instructions and scheme of delegation. All of these documents are reviewed annually and are available to the public.

The powers retained and exercised by the Board include:

- agreeing our vision, values, culture and strategy within the policy and resources framework agreed with the Department of Health and Social Care
- agreeing appropriate governance and internal assurance controls, especially in relation to financial and performance risks
- approving business strategy, business plans, key financial and performance targets, and the annual accounts
- ensuring sound financial management and value for money
- supporting the EMT and holding it to account
- ensuring that we comply with any duties imposed on public bodies by statute

A register of interests, drawing together declarations of interest made by all members of the Board, is open to public scrutiny and is published with every set of board papers, copies of which can be found on the 'Our organisation' section of the NHS Digital website. Details of related-party transactions are set out in Note 18 of the Accounts on page 147 of this report. Biographies of the Board are in appendix B on pages 155 to 165.

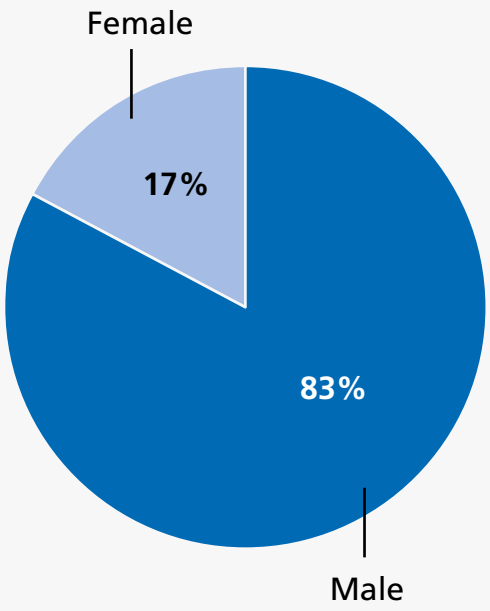
The Chair and non-executive directors are appointed by the Secretary of State for Health and Social Care. The Chief Executive is appointed by the Board, and other executive officers are appointed by the Chief Executive. Executive membership is agreed by the Board.

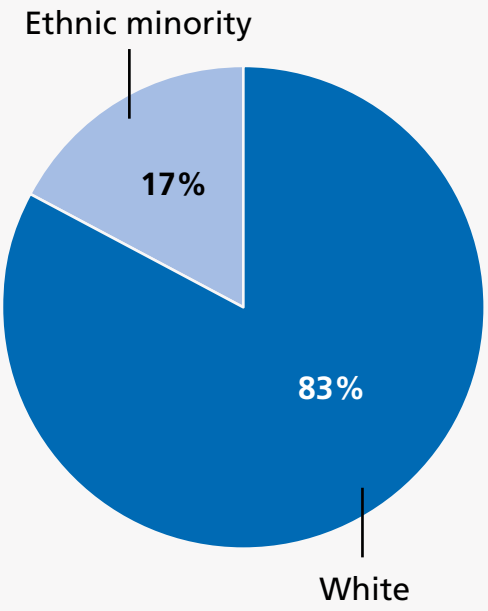
Changes to the Board's membership during the year were:

- Ben Goldacre, Steven Woodford and Patrick Eldridge were appointed on 1 April 2021
- Sarah Wilkinson left her post as Chief Executive Officer and was replaced by Simon Bolton as Interim Chief Executive Officer, with the handover of Accounting Officer responsibilities effective from 4 June 2021
- Pete Rose died in service in August 2021
- Soraya Dhillon and Marko Balabanovic completed their terms of office as non-executive directors on 31 December 2021
- Daniel Benton and Sudesh Kumar's terms of office were extended for another year
- Daniel Benton was also appointed as Senior Independent Director

On 31 March 2022, the Board included 3 executive directors who were men and no executive directors who were women. 7 of our non-executives were men and 2 were women.

The charts below show the composition of our Board members by gender and ethnicity.





Each non-executive director's term of office is as follows:

Name	Appointed	End date
Laura Wade-Gery[1]	1 September 2020	31 March 2023
Soraya Dhillon[2]	1 January 2017	31 December 2021
Marko Balabanovic[2]	1 January 2017	31 December 2021
Daniel Benton[3]	1 January 2017	31 March 2023
Sudhesh Kumar[3]	1 January 2017	31 March 2023
Deborah Oakley	1 July 2018	30 June 2024
John Noble	1 July 2018	30 June 2024
Balram Veliath	1 July 2018	30 June 2024
Ben Goldacre	1 April 2021	31 March 2024
Steven Woodford	1 April 2021	31 March 2024
Patrick Eltridge[4]	1 April 2021	31 March 2024

[1] The Department of Health and Social Care confirmed the extension of Laura Wade-Gery's term of office as Chair of NHS Digital by 12 months to 31 March 2023
[2] Soroya Dhillon and Marko Balabanovic ended their term of service and retired from the Board on 31 December 2021
[3] Daniel Benton and Sudhesh Kumar have had their terms of office extended until the merger between NHS Digital and NHS England takes place
[4] Patrick Eltridge ended his term of service and retired from the Board in September 2022

During 2021-22, the planned programme of board meetings continued to be impacted by the pandemic, resulting in board meetings being held virtually. Over the year, 5 formal meetings of the Board were convened, and these sessions were open to members of the public to attend and observe. The sessions held in private considered items of a commercial or confidential nature that could not be discussed in public.

Papers and previous minutes are made available on the 'Our organisation' section of the NHS Digital website (https://digital.nhs.uk/about-nhs-digital/our-organisation) in advance of the meetings.

As well as standing agenda items on the governance and performance of our organisation, the statutory meetings discussed a range of topics including, exceptionally:

- COVID-19 – NHS Digital's support for the national response to the pandemic
- employee welfare and support arrangements
- equality, diversity and inclusion, including ambitions and targets
- health and safety
- sustainability
- in-depth reviews of live services, infrastructure and collaboration technologies
- NHSmail and Health and Social Care Network deployment
- GP Data for Planning and Research
- NHS App & COVID-19 vaccination certifications

Members of the Board also allocate time alongside the formal meetings for board development and to consider strategic issues within the organisation and in the broader digital environment. These in-depth meetings include additional senior operational staff.

Some key issues discussed during 2021-22 included:

- the publication of the Wade-Gery review commissioned by the Secretary of State, titled 'Putting data, digital and tech at the heart of transforming the NHS', and the recommendations including the future direction of NHS Digital, Health Education England and NHS England
- the future approach to product management and service design
- consideration of accrued technical debt
- race awareness
- aligning systems architecture across the health service
- cloud services strategy and system-wide sustainability
- Health & Care Bill and what it means to the NHS
- Information and data governance and framework

Board Effectiveness

In the 2019-20 Annual Report, the former Chair confirmed that an independent external review of the Board's effectiveness had been undertaken and that the main themes emerging from the review were:

1. Board leadership: non-executive directors, with executive directors, should continue engaging actively with partners and providers to extend NHS Digital's insight and influence on technical and data strategy across the system.
2. The Board's effectiveness as a team: the Board should optimise its value-add overall in the context of NHS Digital's remit for 2021-22.
3. Ensuring a healthy culture: the Board should continue its work to ensure a healthy culture and high levels of staff engagement to support the delivery of NHS Digital's strategic objectives.

The COVID-19 pandemic and subsequent national lockdowns had an impact on the progress of all aspects of the review; however, the Board has used multiple opportunities to progress with these themes. For example, the move to video communications and webinars for 'All Hands' staff meetings has enabled non-executive directors to operate in fuller knowledge of team morale, while the introduction of wellness pulse check-ins for all staff has strengthened organisation engagement.

At the beginning of 2021-22 the Board appointed 3 new non-executive directors which, coupled with the new interim CEO, strengthened the Board and allowed it to refocus on NHS Digital's role within the health system and how best to leverage its expertise to drive wider system transformation for the future. Our new non-executive directors bring highly relevant backgrounds to our role in the provision of data and technology solutions to the health and care system and have added to the Board's value.

In 2021-22, the Board committed to reviewing its progress against the 2019-20 recommendations and its overall effectiveness using an internal review process. This internal review was completed in the final quarter of 2021-22 and will formally report its findings to the Board in early 2022-23. However, the key observations are:

- good progress has been made and continues to be made against the 3 key 2019-20 board effectiveness themes, with the review noting improvements in the Board's level of engagement with key stakeholders, its support for the development of NHS Digital's culture, and having increased its support for and engagement with the Executive Management Team

The 2021-22 review also sought views on what the future Board (after the merger of NHS Digital with NHS England) might need to know. The key observation being:

- respondents identified that there has been significant added value from establishing non-executive led assurance committees such as those for cyber, information and data

The Board committees

The Board has established 4 committees with responsibility for providing an independent view to the Chief Executive and the Board on:

- audit and risk
- information assurance and cyber security
- people and transition
- investment assurance

Day-to-day operational matters are managed through the Executive Management Team.

A standing item on the Board's agenda allows the chairs of committees to report on their deliberations. The minutes of the Board's committees (other than those of the People and Transition Committee) are circulated to board members after they are ratified.

The delegated responsibilities of each committee are described as follows.

Audit and Risk Committee (ARC) – Chair: Deborah Oakley

The committee provides an independent view to the Chief Executive and the Board of the organisation's internal controls, operational effectiveness, governance and risk management. This includes an overview of internal and external audit services, risk management and counter-fraud activities.

The committee is authorised to investigate any activity within its terms of reference and to seek any information that it requires from any employee. It is able to seek legal or independent professional advice and secure the attendance of external specialists.

The key areas of activity in 2021-22 included:

- continued review of the Risk Radar and progress towards the agreement of key risk indicators
- several strategic risk 'deep dives' including clinical risk and vaccinations, medical devices, National Disease Registration Service transfer, transition governance and an overview of key risks outside NHS Digital's risk appetite
- several directorate assurance 'deep dives' including HR, Data Services and Platforms
- continued review of risks with respect to the COVID-19 pandemic and the impact on NHS Digital's overall risk profile
- received assurance of NHS Digital's internal controls through a robust internal audit plan and regular reporting on whistleblowing and counter fraud
- careful consideration of the valuation methodology and approach for NHS Digital's intangible assets
- beginning to consider NHS Digital's transitional risk into the new organisation

Information Assurance and Cyber Security Committee (IACSC) – Chair: John Noble

The committee has representation from across government and beyond, including the Cabinet Office, the National Cyber Security Centre (NCSC), and UK Health Security Agency. It is responsible for ensuring that there is an effective cyber security and information assurance function that meets recognised government standards and provides appropriate independent assurance to the Chief Executive and the Board.

The IACSC reviews the cyber security work of the Data Security Centre (DSC), the IT Operations directorate, and the Privacy, Transparency, Ethics and Legal (PTEL) directorate and considers the implications of management responses to its work. It monitors other significant internal and external cyber assurance functions. It is authorised to investigate activities within its terms of reference, and all employees are directed to co-operate with its requests for information. It can seek legal or independent professional advice at NHS Digital's expense.

The main areas considered in 2021-22 included:

- assuring cyber security work undertaken by NHS Digital with the NCSC and NHSX to provide enhanced protection for health and social care organisations during the COVID-19 pandemic
- considering the wider cyber security threat context on a global scale that the NHS operates within, thanks to regular advice and guidance from the NCSC
- assurance that NHS Digital has been working towards achieving Cyber Essentials Plus (CE+) certification
- regular updates from the DSC with regards to the challenges in recruiting to the required staffing levels, and the work of the Cyber Security Operations Centre to support NHS Test and Trace and the vaccines and booster roll-out
- reviewing the decisions made by the DSC's Specialist Security Services team during the pandemic and the impact of those decisions on security and technical debt
- development of improved key performance indicators to measure organisational and system-wide cyber security readiness
- understanding and measuring third-party risk, including looking at the cyber readiness of NHS Digital corporate systems provided by third parties
- a 'deep dive' examination of the security of NHS Digital's own systems using the NCSC's 'Questions for Boards to Ask about Cyber Security'
- developing the remit of IACSC to better incorporate information governance assurance from the PTEL directorate, and undertaking reviews of current data sharing arrangements

People and Transition Committee (PTC) – Chair: Laura Wade-Gery

Previously called the Talent, Remuneration and Management Committee, the People and Transition Committee's role, among a range of staff-related matters, is to:

- make recommendations to the Department of Health and Social Care on the level of the remuneration packages of the Chief Executive and other executive directors within the provisions of the pay framework for executive and senior managers or successor arrangements
- review and assure the annual performance objectives and targets of executive directors and pay arrangements for other senior managers
- ensure that all matters relating to pay and conditions that require approval from the Department of Health and Social Care Remuneration Committee, or other external authority, are submitted for approval and that the decisions of those bodies are appropriately implemented
- review and assure workforce and senior management restructuring proposals arising from annual productivity assessments, specific cost reduction plans or capability prioritisation proposals
- review and make recommendations on the size, composition and structure of the Board, including assessing and making recommendations to the Department of Health and Social Care about the skills, knowledge and experience required from board appointees

Investment Committee (IC) – Chair: Daniel Benton

The committee assures delivery commitments made by NHS Digital in response to commissions and approves financial commitments whose value exceeds the delegated authority of the Chief Executive, to ensure that NHS Digital assumes an acceptable level of delivery risk. It consists of 3 non-executive directors and the Chief Financial Officer, the Chief Commercial Officer, and Executive Director of Product Delivery. Other members of the Executive Management Team attend as required by the agenda.

Specifically, the committee ensures that programmes have shown that they:

- provide solutions that meet the requirements of the Delivery Oversight and Assurance Board (DOAB) and the senior responsible owner which do not exceed the required scope, and which provide value for money
- have appropriate management and resourcing arrangements, including agreed commercial strategies and risk management
- are technically robust and clinically safe
- are affordable
- have robust proposals for cyber and information security
- have acceptable levels of compliance risk, particularly with respect to information governance and procurement

The IC has recently considered:

- how to regularise commercial commitments that were put in place rapidly to enable us to respond to the urgent needs of the pandemic, developing transition plans that balance the need to manage operational risk and the need to move to more sustainable commercial arrangements
- investment cases for programmes of work, including an interim cervical call/recall solution, Interoperable Medicines, GP IT Futures, e-Referral Service transformation and optimisation, national digital channels and Digital Transformation of Screening.

Following IC endorsement, business cases are submitted to the DOAB hosted by NHS England Transformation Directorate.

Executive Management Team (EMT)

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

Directors' attendance at the Board and its committees was as follows:

	Public Board	Board Development	Audit and Risk Committee	Information Assurance and Cyber Security Committee	People and Transition Committee[1]	Investment Committee
Number of meetings	5	3	6	4	6	9
Executive directors						
Sarah Wilkinson[2]	1 / 1	-	1 / 1	-	1 / 1	-
Simon Bolton	5 / 5	3 / 3	6 / 6	-	5 / 6	3 / 5[3]
Peter Rose[4]	1 / 2	1 / 2	-	0 / 1	-	-
Carl Vincent	5 / 5	3 / 3	6 / 6	-	-	8 / 9
Jonathan Benger	5 / 5	3 / 3	1 / 1[5]	-	1 / 1[5]	-
Non-executive directors						
Laura Wade-Gery	4 / 5	2 / 3	-	-	5 / 6	-
Marko Balabanovic[6]	4 / 5	3 / 3	-	3 / 3	-	5 / 6
Soraya Dhillon[6]	4 / 5	3 / 3	-	-	4 / 5	6 / 6
Daniel Benton[7]	5 / 5	3 / 3	6 / 6	-	1 / 1	9 / 9
Sudhesh Kumar[8]	5 / 5	3 / 3	6 / 6	-	1 / 1	-
John Noble[7]	4 / 5	3 / 3	6 / 6	4 / 4	1 / 1	-
Deborah Oakley	5 / 5	3 / 3	6 / 6	4 / 4	-	-
Balram Veliath	4 / 5	3 / 3	6 / 6	-	6 / 6	-
Ben Goldacre	4 / 5	3 / 3	-	-	-	-
Steven Woodford	4 / 5	3 / 3	-	-	-	2 / 3
Patrick Eltridge	5 / 5	2 / 3	-	-	1 / 1	9 / 9

[1] The Talent, Remuneration and Management Committee changed its name to the People and Transition Committee in February 2022
[2] Sarah Wilkinson stepped down as Chief Executive in June 2021
[3] From October 2021 as an attendee, not a member of the committee
[4] Pete Rose died in August 2021
[5] As an attendee, not a member of the committee
[6] The term of office for Marko Balabanovic and Soraya Dhillon ended on 31 December 2021
[7] Daniel Benton and John Noble joined the People and Transition Committee during 2021-22
[8] Sudhesh Kumar attended 1 People and Transition Committee meeting as Chair

Remuneration and staff report

The staff costs below, and the average number of whole-time equivalent persons on the following page, are subject to audit.

	2021-22 £000	2020-21 £000
Permanent staff		
Salaries and wages	138,036	131,428
Social security costs	15,375	14,284
Apprenticeship levy	678	628
Employer superannuation contributions – NHS Pension Scheme	26,100	23,877
Employer superannuation contributions – other	487	404
Staff seconded to other organisations	798	1,049
Capitalised employed staff costs	(10,125)	(9,011)
	171,349	**162,659**
Other staff		
Temporary staff	23,177	13,834
Contractors	73,329	32,872
Staff seconded from other organisations	1,388	1,028
Capitalised other staff costs	(6,214)	(3,402)
	91,680	**44,332**
Total staff costs	**263,029**	**206,991**
Termination benefits	114	660
Total staff costs including termination benefits	**263,143**	**207,651**

The average number of whole-time equivalent persons employed during the year was:

	2021-22	2020-21
Permanent staff and secondees	2,661	2,480
Temporary staff and contractors	841	452
Total	**3,502**	**2,932**
The average number of whole-time equivalent persons employed during the years whose time was capitalised	182	150

Nothing was spent on staff benefits during the year and there were 2 early retirements on the grounds of ill health; the accrued pension benefit was £80,837. In 2020-21, there were 2 (re-stated) early retirements on the grounds of ill health; the accrued pension benefit for these people was £49,894. Of the 7 originally disclosed in 2020-21, 5 were of pensionable age.

Exit packages

Total staff termination packages were as follows and are subject to audit.

	2021-22		2020-21	
	Number of compulsory redundancies	Cost of compulsory redundancies £	Number of compulsory redundancies	Cost of compulsory redundancies £
<£10,000	1	7,033	3	11,419
£10,000 - £25,000	2	40,148	1	20,526
£25,000 - £50,000	-	-	-	-
£50,000 - £100,000	-	-	2	141,969
£100,000 - £150,000	1	123,995	1	140,437
£150,000 - £200,000	1	183,739	1	166,962
>£200,000	-	-	-	-
Total number of exit packages	**5**	**354,915**	**8**	**481,313**

There were no voluntary or other redundancies.

All redundancies for 2021-22 reported above were concluded in the year, and there were no accrued costs as at 31 March 2022.

Pension information

Most NHS Digital staff are covered by the NHS Pension Scheme (the 1995/2008 scheme and the 2015 scheme).

NHS Pension Scheme

Past and present employees are covered by the provisions of the 2 NHS pension schemes. Details of the benefits payable and rules of the schemes can be found on the NHS Pension Scheme website at www.nhsbsa.nhs.uk/pensions. Both are unfunded, defined benefit schemes that cover NHS employers, GP practices and other bodies in England and Wales allowed under the direction of the Secretary of State for Health and Social Care. They are 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, each scheme is accounted for as if it were a defined contribution scheme whereby the cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to that scheme for the accounting period.

So 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 Financial Reporting Manual (FReM) requires that "the period between formal valuations shall be 4 years, with approximate assessments in intervening years." An outline of these follows:

a) Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability, as at 31 March 2022, is based on valuation data for 31 March 2021, updated to 31 March 2022, 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's actuary report, which forms part of the annual NHS Pension Scheme pension accounts. These accounts can be viewed on the NHS Pension Scheme website and are published annually. 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 schemes (taking into account recent demographic experience) and to recommend contribution rates payable by employees and employers.

The latest actuarial valuation undertaken for the NHS Pension Scheme was completed as at 31 March 2016. The results of this valuation set the employer contribution rate payable from April 2019 to 20.6% of pensionable pay.

The 2016 funding valuation also tested the cost of the scheme relative to the employer cost cap that was set following the 2012 valuation. There was initially a pause in 2019 to the cost control element of the 2016 valuations, due to the uncertainty around member benefits caused by the discrimination ruling relating to the McCloud case. In July 2020, the government announced that the pause had been lifted, and so the cost control element of the 2016 valuations could be completed.

HM Treasury published valuation directions dated 7 October 2021[1] that set out the technical detail of how the costs of remedy are included in the 2016 valuation process. Following these directions, the scheme actuary has completed the cost control element of the 2016 valuation for the NHS Pension Scheme, which concludes no changes to benefits or member contributions are required. The 2016 valuation reports can be found on the NHS pension scheme website at https://www.nhsbsa.nhs.uk/nhs-pension-scheme-accounts-and-valuation-reports.

National Employment Savings Trust

Employees who do not wish to join the NHS Pension Scheme can opt to join the National Employment Savings Trust (NEST) scheme. This is a stakeholder pension scheme based on defined contributions. The minimum combined contribution is currently 8% of qualifying earnings, of which the employer must pay 3%. Employees can choose to pay more into the fund, subject to a current cap of £4,700 per annum. 10 NHS Digital employees were members of the NEST Scheme during 2021-22.

The Principal Civil Service Pension Scheme

The Principal Civil Service Pension Scheme (PCSPS) and the Civil Servant and other Pension Scheme, known as 'alpha', are unfunded multi-employer defined benefit schemes. NHS Digital is unable to identify its share of the underlying assets and liabilities. The scheme actuary valued the scheme as at 31 March 2016.

Details can be found in the resource accounts of the Cabinet Office at www.civilservicepensionscheme.org.uk

For 2021-22, employer's contributions of £487,372 were payable to the PCSPS (2020-21: £409,319) at 1 of 4 rates in the range 26.6% to 30.3% of pensionable earnings, based on salary bands. The scheme actuary reviews employer contributions, usually every 4 years following a full scheme valuation. The contribution rates are set to meet the cost of the benefits accruing during 2021-22 to be paid when the member retires and not the benefits paid during this period to existing pensioners.

Employees can opt to open a Partnership Pension Account, which is a stakeholder pension with an employer contribution. Employer contributions are age-related and range from 8% to 14.75% of pensionable earnings. Employers also match employee contributions up to 3% of pensionable earnings. No employees have opted for the Partnership Pension Account.

[1] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1023845/The_Public_Service_Pensions__Valuations_and_Employer_Cost_Cap___Amendment__Directions_2021.pdf

Off-payroll engagements

As part of the 'Review of tax arrangements of public sector appointees', published by the Chief Secretary to the Treasury on 23 May 2012, we are required to publish information about the number of off-payroll engagements that are in place where individual costs exceed £245 per day.

For all off-payroll engagements as at 31 March 2022, for more than £245 per day:	Number
Number of existing engagements as at 31 March 2022	332
Of which, the number that have existed:	
for less than 1 year at the time of reporting	146
for between 1 and 2 years at the time of reporting	129
for between 2 and 3 years at the time of reporting	36
for between 3 and 4 years at the time of reporting	9
for 4 or more years at the time of reporting	12

For all off-payroll engagements between 1 April 2021 and 31 March 2022, for more than £245 per day:	Number
Number of temporary off-payroll workers engaged between 1 April 2021 and 31 March 2022	758
Of which, the number:	
not subject to off-payroll legislation	-
subject to off-payroll legislation and determined as in-scope of IR35	758
subject to off-payroll legislation and determined as out of scope of IR35	-
Number of engagements reassessed for compliance or assurance purposes during the year	-
Of which, the number of engagements that saw a change to IR35 status following the review	-

For all off-payroll engagements of board members and/or senior officials with significant financial responsibility between 1 April 2021 and 31 March 2022:	Number
Number of off-payroll engagements of board members and/or senior officials with significant financial responsibility during the financial year	4
Total number of individuals on-payroll and off-payroll that have been deemed 'board members and/or senior officials with significant financial responsibility' during the financial year.	19

We are committed to maintaining in-house capacity, but it is recognised that, with a significant element of our activity being project-based and with peaks and troughs in requirements, making the best use of the temporary labour market is essential. Many of our programmes require specialist input on a temporary basis and it is not always cost-effective to permanently recruit such skills.

The total cost of temporary labour increased in the year to £96.5 million, compared to £46.7 million in 2020-21, as we brought in significant additional specialist resources to address the continued development and delivery of critical programmes relating to COVID-19, while still progressing with key projects as part of our digital transformation programme.

Equality, diversity and inclusion

Our 3 key strategic priorities for equality, diversity and inclusion guide our action plans and day-to-day interactions with our employees and have executive director-level accountability across the business.

These are to:

1. deliver appropriate learning and development to ensure that all NHS Digital staff develop a good level of equality and diversity awareness
2. work towards having no difference in the employment outcomes for NHS Digital staff or potential recruits because of protected characteristics
3. develop best practice in workforce equality and diversity by creating internal and external networks and supporting positive action initiatives

We are striving to create a working environment that values difference and fosters an inclusive workplace culture. We want to build a culture in which employees from all backgrounds can give their best, are treated fairly, are valued for their contributions, and can progress in their careers. We regularly review our people management policies to reflect changes and support all colleagues to develop. We make sure that policies are inclusive for people with different protected equality characteristics, and we consult widely, including with the unions and the equality and diversity networks. Our recruitment policies can be found at https://digital.nhs.uk/careers/recruitment-your-journey-to-a-career-with-us

The gender distribution in NHS Digital for each Agenda for Change (AfC) equivalent grade is provided below[1]:

		2021-22		2020-21	
AfC equivalent grades		**Male**	**Female**	**Male**	**Female**
Directors		6.0	3.0	8.6	3.0
Senior managers	9	61.5	26.5	59.4	23.2
	8d	83.4	46.8	79.7	45.5
Managers	8c	200.4	138.6	181.2	115.0
	8b	334.4	184.3	304.8	157.7
	8a	465.7	333.4	383.6	261.2
Other staff	7	425.3	306.0	351.4	258.0
	6	220.5	209.8	172.0	153.9
	5	159.8	247.9	148.8	176.9
	4	142.1	211.5	127.1	164.2
	3	9.0	17.6	7.0	1.0
	2	1.0	2.0	0.5	-
	Net secondees	(0.4)	8.9	-	-
Total (full-time equivalent)		**2,108.7**	**1,736.3**	**1,824.1**	**1,359.6**

[1] We recognise that gender is complex and that not everyone identifies as either male or female. However, our Electronic Staff Record does not yet facilitate the collation of gender identity data and so we are currently unable to report on it.

There has been no significant change in the gender or grade split of our workforce in the year. 55% of staff are male (2020-21: 57%). The figures in the table above include both directly employed staff and contingent labour.

Fair Pay

The fair pay tables are subject to audit.

Percentage change in total salary and bonuses for the highest paid director and the staff average as at 31 March 2022:

	2021-22		2020-21	
	Total salary and allowances	Bonus payments	Total salary and allowances	Bonus payments
Staff average	2.8%	-91.8%	6.4%	519.6%
Highest paid director	-7.6%	0.0%	20.7%	0.0%

During 2020-21, we settled 2 years' bonuses for staff employed under TUPE terms and conditions, and additionally we paid a bonus to staff supporting the frontline COVID-19 response in respect of their significant contribution above and beyond normal responsibilities. In 2021-22, there were no bonuses paid for COVID-19-related work, and the bonus for staff employed under TUPE terms and conditions reduced considerably as many had moved on to Agenda for Change terms and conditions or had left the organisation.

The highest paid director was a work package contractor, with his costs representing the day rate charged less non-recoverable VAT. During 2021-22, he worked fewer days than the previous year, which resulted in a fall in the equivalent annualised salary.

Ratio between the highest paid directors' total remuneration and the lower, median and upper quartile for staff pay as at 31 March 2022:

	Lower quartile	Median	Upper quartile
2021-22	7.4 : 1	5.1 : 1	3.7 : 1
2020-21	7.8 : 1	5.7 : 1	4.1 : 1

The table shows the relationship between the remuneration of the highest paid director, and the lower, median and upper quartiles of the organisation's workforce.

The banded remuneration of the highest paid director in 2021-22 was £242,500 (2020-21: £262,500). This was 5.1 times (2020-21: 5.7) the median remuneration of the workforce, which was £47,439 (2020-21: £46,351). The highest paid director was a work package contractor, with their costs representing the day rate charged less non-recoverable VAT; during 2021-22 they worked fewer days than the previous year, which resulted in a fall in the equivalent annualised salary. As a result of this decrease, and the 3% pay award for all Agenda for Change staff during 2021-22, the pay ratios between the highest paid director and the lower quartile, median and upper quartile for staff pay have all decreased in 2021-22.

Lower quartile, median and upper quartile for staff pay for salaries and total pay and benefits as at 31 March 2022:

	Lower quartile		Median		Upper quartile	
	2021-22	2020-21	2021-22	2020-21	2021-22	2020-21
Salary	32,306	33,176	47,126	45,753	63,862	62,001
Total pay and benefits	**32,821**	**33,656**	**47,439**	**46,351**	**65,977**	**64,072**

In 2021-22, 1 (2020-21: 0) employee received remuneration in excess of the highest paid director. Remuneration for the workforce ranged from £15,000-£20,000 (2020-21: £10,000-£15,000) to £245,000-£250,000 (2020-21: £260,000-£265,000).

Total remuneration includes salary and non-consolidated performance-related pay; there were no benefits-in-kind. It does not include severance payments, employer pension contributions and the cash equivalent transfer value of pensions.

Our gender pay gap for the reporting period to March 2022 was:

Mean gender pay (hourly rate)	2022	2021
Women	£29.06	£28.08
Men	£35.98	£33.83
Gap between the mean salaries of women and men	**19.2%**	**17.0%**

Median gender pay (hourly rate)	2022	2021
Women	£26.44	£26.49
Men	£32.40	£30.75
Gap between the median salaries of women and men	**18.4%**	**13.9%**

The data in the table above includes staff employed directly by NHS Digital on its payroll, as well as temporary staff and contractors. We continue to have a significant gender pay gap, slightly above the public sector median of 18.0% (based on Office for National Statistics provisional data for November 2021). The main factor contributing to this pay gap is men occupying more senior pay bands than women.

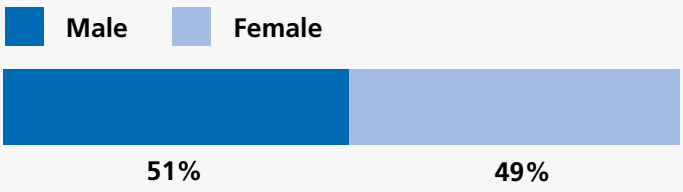
Workforce data

Our latest detailed workforce data for staff directly employed by NHS Digital as at 31 March 2021 was published in our 2021-22 Annual Inclusion Report earlier this year, and is available at: https://digital.nhs.uk/about-nhs-digital/corporate-information-and-documents/how-we-support-diversity-and-inclusion/annual-inclusion-report-2021-22. The report also shows how our workforce demographics have changed over time. Our 2022-23 report is scheduled for publication in spring 2023.

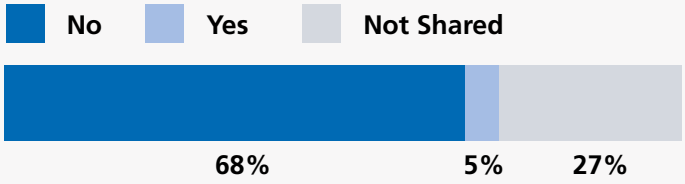
We understand that diversity and inclusion are vital to the continued success and growth of the capabilities and outcomes that NHS Digital delivers. Valuing diversity and creating an inclusive environment allows us to build a workforce that better represents health and care staff and the communities we serve, which will enable us to develop and deliver better products and services, and ultimately enable improved healthcare outcomes.

As at 31 March 2022, we had a directly employed workforce of 3,026 people. Below are graphs showing the split of declared characteristics.

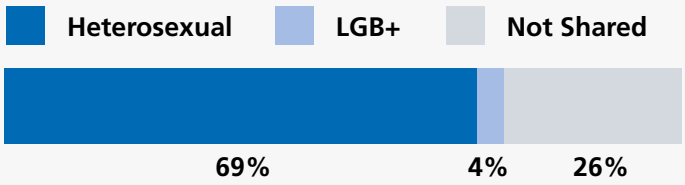
Sex



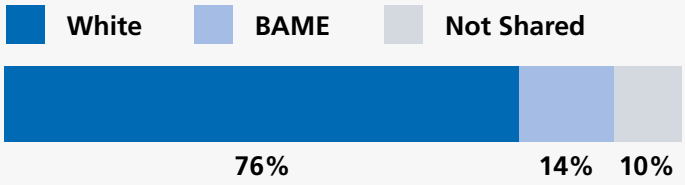
Disability



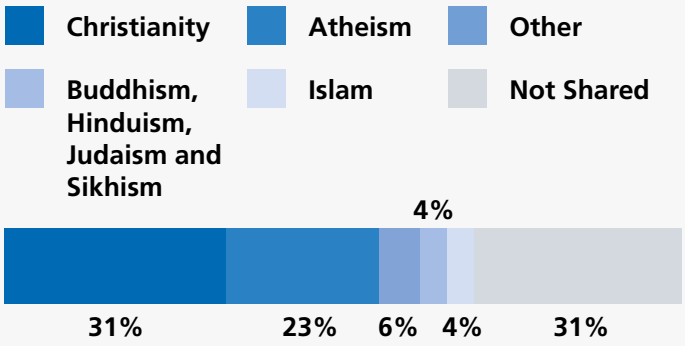
Sexual orientation



Ethnic origin



Religion



The graphs reflect the continued improvement in the diversity of the organisation, with 5.4% of our workforce identifying as having a disability (2021: 4.8%), 13.7% identifying as BAME (2021: 13.3%), and that gender composition was 51.6% male and 48.4% female (2021: male 55.3%; female 44.7%). Colleagues identifying as LGB+ represented 4.4% (2021: 3.9%) of our directly employed staff, and our colleagues have a wide range of religious beliefs.

Where 'not shared' appears in the above graphs, this includes unspecified, undecided and prefer not to answer.

Our networks

NHS Digital has 7 networks for our colleagues to join. We continue to listen, learn and understand perspectives from all of our colleagues, with the help of our staff networks, to ensure that we are improving equality, diversity and inclusion across the organisation and that colleagues feel supported and able to thrive.

2 years on from the peak of the Black Live Matter protests, which brought race inequality into sharp focus across the globe, our EMBRACE (Ethnic Minorities Broadening Racial Awareness and Cultural Exchange) network continued to play an important role in our inclusion journey by raising the agenda of race and equality at NHS Digital. Working closely with HR and inclusion partners Pearn Kandola, the network showed colleagues how to be active bystanders and constructively challenge racist and non-inclusive behaviours. The network also supported colleagues from Black, Asian and minority ethnic backgrounds to progress their careers, fostering a relationship with Fujitsu to run peer-coaching sessions and launching their own Exchange Mentoring Scheme.

The Women's Network has highlighted some key issues during the year. From sharing stories during Baby Loss Awareness Week, to introducing a 'Menopause Café' for people wanting to know more about the symptoms of peri-menopause, the network is encouraging an increased awareness among allies, men and leaders of the issues that can disproportionately impact women.

The LGBTQ+ and Allies Network also led a range of initiatives during the year. These included sharing the LGB Health Report from the Health Survey for England through NHS Virtual Pride; hosting a series of guest speaker events, including the National Advisor for LGBT Health at NHS England for Zero Discrimination Day; successfully supporting user research activities in the Cancer Screening Programme; and providing trans awareness training for colleagues, which led to working with the NHS Login delivery team to inform initial improvements to the user journey for trans people.

The Ability Network regularly provides advice on adjustments in the workplace. Simple yet effective measures they have encouraged during the year include the use of cameras being on during meetings for those hard of hearing to lip read, or to follow up meetings with a written summary.

Our merger with NHS England presents an exciting opportunity to share best practice, innovate together and push boundaries further to reach our shared inclusion goals. We know that, moving forward, our aims and actions will need to align and complement those of our new NHS England family, and we very much look forward to that collaboration. In doing so, we will not lose sight of the commitments we have made to make our organisation more inclusive and diverse.

Trade Union facility time

We work in partnership with trade union representatives on all matters affecting our employees to ensure an effective and successful organisation. Joint Negotiation and Consultation Committee meetings are held regularly to allow discussion, consultation and negotiation on employment-related matters.

Staff members are permitted time to engage in appropriate trade union activities. Details are below:

Union officials	
Number of employees who were relevant union officials during the relevant period	17
Full-time equivalent (FTE) employee number	2,661

Percentage of time spent on facility time	**Number of employees**
0%	-
1% - 50%	17
51% - 99%	-
100%	-

Percentage of pay bill spent on facility time	
Total cost of facility time	£56,635
Total pay bill (excluding termination costs)	£181,473,000
Percentage of the total pay bill spent on facility time	0.03%

Paid trade union activities	
Time spent on paid trade union activities as a percentage of total paid facility time hours	3.8%

Consultancy

The total spend on consultancy, as defined by HM Treasury guidance, was £311,427.

Staff Turnover

Our staff turnover rate for 2021-22 was 10.29%, and an increase from 8.2% the previous year. As we work towards the merger of NHS Digital with NHS England in early January 2023, there continues to be significant management focus on regular and open communication with staff, maintaining morale and ensuring staff retention during the transition period.

Sickness absence

During 2021, 10,980 (2020: 10,843) working days were lost due to sickness absence. This represented 4.3 (2020: 4.3) working days per employee. These figures are based on calendar years, not financial years, and were centrally produced from the Electronic Staff Record. Average sickness absence for 2021 was 1.9% (2020: 1.9%).

Sickness absence data can be found on our website at: https://digital.nhs.uk/data-and-information/publications/statistical/nhs-sickness-absence-rates

Community and social responsibility

We have a special leave policy that allows staff to take paid leave for public duties (for example, magistrate, school governor and reserve forces roles). We have also developed work experience and placement programmes for schools, colleges and universities near our offices.

We support the government's objective of eradicating modern slavery and human trafficking and our statement is published on our website at https://digital.nhs.uk/about-nhs-digital/corporate-information-and-documents/nhs-digital-slavery-and-human-trafficking-statement

Health, safety and wellbeing

2021-22 has been another outstanding year in our health and safety journey, as we have continued to focus on our colleagues' needs. While we continued to respond effectively to COVID-19, we also delivered an ambitious work plan, building upon the foundations delivered in the previous year. Some of the key improvements this year include:

- risk management: we focused heavily on assessing work-related risks across the organisation, in particular the activities and roles of colleagues within their directorates
- building compliance and safety: to support building compliance and increase ownership at a facilities manager level, we implemented a building health and safety file for each of our premises, which enables all health and safety documentation to be held in one place and managed correctly
- hybrid working: we developed hybrid working guidance and tools, including Health and Safety Awareness for hybrid working, the first in a series of health and safety e-learning training modules
- health and safety induction: we built and implemented a health and safety induction package for new starters. This helped to support our National Disease Registration Service colleagues, who transferred into the organisation during the year from Public Health England, and who gave positive feedback on their health and safety experience
- training: we purchased a creative platform tool that enables us to produce internal training and presentations. This resource helps us to bring our health and safety risks and training to life and deliver a superior level of training that focuses on the user experience. So far, we have used this to build bespoke bitesize electronic learning courses, which have received positive feedback from our colleagues and our staff networks
- COVID-19: we have continued to respond to the COVID-19 pandemic by supporting colleagues wherever they work, ensuring our offices remain a safe environment
- fire management: to support our new ways of working we have begun to roll out the TagEvac emergency evacuation system across our sites. The TagEvac system, alongside an updated approach to fire wardens, is recognised as good practice in fire evacuation. A new bitesize fire essentials training course was developed and rolled out across the organisation in March 2022
- equality, diversity and inclusion: to help us deliver a fair and equal health and safety provision, equality, diversity, and inclusion are now permanent elements of our risk assessment template.

Salaries and pensions of senior management

The remuneration and pension disclosures relating to board members and the Executive Management Team in post during 2021-22 and 2020-21 are detailed in the tables below and are subject to audit. The figures provided consist of basic pay, performance pay and pension benefits; there were no benefits in kind. They do not include employer pension contributions or the cash equivalent transfer value of pensions.

				2021-22					2020-21				
		Appointment date	Until date	Salary (Bands of £5,000)	Performance Pay (bands of £5,000)	Pension benefits[1] (bands of £2,500)	Total (bands of £5,000)	Full-year equivalents salary (bands of £5,000)	Salary (bands of £5,000)	Performance pay (bands of £5,000)	Pension benefits (bands of £2,500)	Total (bands of £5,000)	Full-year equivalent salary (bands £5,000)
Board directors													
Sarah Wilkinson	Chief Executive Officer		18 Jun 21	45-50	-	12.5-15	60-65	190-195	195-200	5-10	45-47.5	250-255	195-200
Simon Bolton	Interim Chief Executive Officer	10 May 21		175-180	-	40-42.5	215-220	195-200	-	-	-	-	-
Peter Rose[2]	Deputy Chief Executive Officer, Managing Director	04 May 20	01 Aug 21	60-65	-	-	60-65	170-175	155-160	-	35-37.5	190-195	170-175
Carl Vincent	Chief Financial Officer			140-145	-	35-37.5	175-180	140-145	140-145	-	35-37.5	175-180	140-145
Jonathan Benger[3]	Chief Medical Officer			95-100	-	67.5-70	160-165	160-165	105-110	-	60-62.5	165-170	195-200
Senior managers													
Ben Davison[4]	Executive Director, Product Delivery	20 Jan 20	31 Aug 21	95-100	-	-	95-100	240-245	260-265	-	-	260-265	260-265
Nic Fox	Chief Commercial Officer			130-135	5-10	35-37.5	175-180	130-135	130-135	5-10	72.5-75	215-220	130-135
Jackie Gray	Executive Director, Privacy, Transparency, Ethics and Legal			155-160	0-5	35-37.5	195-200	155-160	150-155	5-10	32.2-35	195-200	150-155
James Hawkins	Executive Director, Product Delivery			130-135	5-10	37.5-40	175-180	130-135	125-130	-	37.5-40	165-170	125-130
Julie Pinder	Chief People Officer			125-130	0-5	27.5-30	155-160	125-130	125-130	-	27.5-30	155-160	125-130
Jeremy Rashbass	Executive Director, Data Services		30 Jun 21	60-65	-	-	60-65	180-185	180-185	0-5	-	185-190	180-185
Mark Reynolds[5]	Chief Technology Officer	26 Oct 20		175-180	-	-	175-180	200-205	90-95	-	-	90-95	210-215
Stephen Koch[6]	Executive Director, Platforms	18 Jan 21		210-215	-	-	210-215	210-215	45-50	-	-	45-50	200-205
Fran Woodard[7]	Executive Director, Data Services	6 May 21		130-135	0-5	117.5-120	250-255	145-150	-	-	-	-	-
John Quinn	Executive Director, IT Operations	1 Feb 22		20-25	-	5-7.5	25-30	145-150	-	-	-	-	-
Matt Bacon	Director of Communications	26 Aug 21		60-65	0-5	15-17.5	80-85	105-110	-	-	-	-	-
Leila Shepherd	Director of Strategy	26 Aug 21		75-80	5-10	2.5-5	85-90	130-135	-	-	-	-	-
Neil Bennett	Chief Information Security Officer	2 Sep 21	16 Jan 22	40-45	0-5	17.5-20	60-65	110-115	-	-	-	-	-
Mark Logsdon[8]	Chief Information Security Officer	4 Jan 22		40-45	-	-	40-45	215-220	-	-	-	-	-
Thomas Denwood	Executive Director, Data Services		18 Oct 20	-	-				70-75	-	12.5-15	85-90	130-135

[1] All benefits in year from participating in pension schemes but excluding employee contributions. These are the aggregate amounts, calculated using the method set out in Section 229 of the Finance Act 2004 (i) and using the indices directed by the Department of Health. See: https://www.nhsbsa.nhs.uk/disclosure-senior-managers-remuneration-greenbury-2022

[2] Pete Rose died on 1 August 2021. Any accrued pension benefit was paid as a lump sum to his estate after his death.

[3] Jonathan Benger is seconded from University Hospitals Bristol and Weston NHS Foundation Trust. The costs relate to charges net of employer national insurance and pension charges.

[4] Ben Davison was a work package contractor with his costs representing the day rate charged less non-recoverable VAT. He was paid for the number of actual days worked and did not receive any payments in respect of pension contributions or annual leave.

[5] Mark Reynolds was a contractor and his salary was calculated based on the day rate he received from the recruitment agency less non-recoverable VAT.

[6] Stephen Koch was a contractor from 1 April 2021 to 28 February 2022, when his contract changed to on-payroll. His full-year salary has been calculated based on the day rate he received from the recruitment agency less non-recoverable VAT for 11 months, plus the on-payroll salary for March 2022. His FTE salary as an employee only is £160-165k.

[7] Fran Woodard was promoted to EMT during the reporting year. She has worked within the NHS for many years as both a clinician and as a senior manager in numerous roles, before moving to NHS Digital to influence the use and power of health and social care data.

[8] Mark Logsdon was a contractor and his salary was calculated based on the day rate he received from the recruitment agency less non-recoverable VAT.

The remuneration information includes both those executive officers who are NHS Digital board members, and those who are members of the Executive Management Team.

Non-executive director remuneration

				2021-22			2020-21		
		Appointment date	Until date	Salary (bands of £5,000)	Total emoluments (bands of £5,000)	Full-year equivalent salary (bands of £5,000)	Salary (bands of £5,000)	Total emoluments (bands of £5,000)	Full-year equivalent salary (bands of £5,000)
Non-executive directors									
Laura Wade-Gery	Chair	1 Sep 20		60-65	60-65	60-65	35-40	35-40	60-65
Daniel Benton	Non-executive director			5-10	5-10	5-10	5-10	5-10	5-10
Marko Balabanovic	Non-executive director		31 Dec 21	5-10	5-10	5-10	5-10	5-10	5-10
Soroya Dhillon	Non-executive director		31 Dec 21	5-10	5-10	5-10	5-10	5-10	5-10
Sudhesh Kumar	Non-executive director			5-10	5-10	5-10	5-10	5-10	5-10
John Noble	Non-executive director			10-15	10-15	10-15	10-15	10-15	10-15
Deborah Oakley	Non-executive director			10-15	10-15	10-15	10-15	10-15	10-15
Balram Veliath	Non-executive director			5-10	5-10	5-10	5-10	5-10	5-10
Steven Woodford	Non-executive director	1 Apr 21		5-10	5-10	5-10	-	-	-
Ben Goldacre	Non-executive director	1 Apr 21		5-10	5-10	5-10	-	-	-
Patrick Eltridge	Non-executive director	1 Apr 21		5-10	5-10	5-10	-	-	-
Noel Gordon	Chair		31 Aug 20	-	-	-	25-30	25-30	60-65
Rob Tinlin	Non-executive director		31 Dec 20	-	-	-	5-10	5-10	5-10

No performance pay, benefits in kind or pension-related benefits were paid.

The emoluments of the Chair and the non-executive directors do not include employer national insurance contributions. The total included in note 5 of the accounts does include such contributions.

Remuneration policy

The pay of the executive board directors is set by the People and Transition Committee based on the recommendations of the Senior Salaries Review Board and is reviewed annually. NHS Digital operates the NHS Executive and Senior Manager (ESM) pay framework with the approval, where necessary, of the Department of Health and Social Care Remuneration Committee. This includes a job evaluation scheme, administered by the NHS Business Services Authority, and provision for a maximum 5% bonus for the top performers within the ESM group. The scheme also provides an annual pay award as a flat-rate payment based on 1% of the average ESM salary and an additional discretionary ring-fenced 1% pot to address any significant pay progression issues or anomalies.

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

Executive directors were normally employed on permanent employment contracts with a 6-month notice period and work for NHS Digital full-time. However, Leila Shepherd was part-time, and Professor Jonathan Benger is seconded from University Hospitals Bristol NHS Foundation Trust on a part-time basis. If contracts are terminated for reasons other than misconduct, they come under the terms of the NHS compensation schemes.

Pension benefits

Pension benefits were provided through the NHS Pension Scheme.

	Accrued benefits				Cash equivalent transfer values (CETV)		
	Real increase in pension (bands of £2,500)	Real increase in pension lump sum (bands of £2,500)	Total accrued pension at 31 March 2022 (bands of £5,000)	Lump sum related to accrued pension at 31 March 2022 (bands of £5,000)	CETV at 31 March 2022 (£000)	CETV at 31 March 2021 (£000)	Real increase in CETV (£000)
Sarah Wilkinson[1]	0-2.5	-	15-20	-	230	168	55
Simon Bolton[1]	2.5-5	-	0-5	-	45	-	19
Pete Rose[2]	-	-	-	-	-	39	-
Carl Vincent[1]	2.5-5	-	15-20	-	253	209	24
Jonathan Benger	2.5-5	5-7.5	85-90	185-190	1,561	1,568	-
Nic Fox	2.5-5	0-2.5	35-40	65-70	560	514	24
Jackie Gray[1]	2.5-5	-	5-10	-	111	74	14
James Hawkins	2.5-5	0-2.5	30-35	45-50	552	498	31
Julie Pinder[1]	0-2.5	-	5-10	-	100	69	13
Fran Woodard	5-7.5	10-12.5	65-70	145-150	1,327	1,163	124
John Quinn[1]	0-2.5	-	0-5	-	6	-	2
Matt Bacon[1]	0-2.5	-	5-10	-	73	44	9
Leila Shepherd[1]	0-2.5	-	0-5	-	34	2	8
Neil Bennett[1]	0-2.5	-	30-35	40-45	451	402	11

[1] No lump sum is disclosed as there is no set minimum lump sum within the 2008 or 2015 sections of the NHS Pension Scheme.
[2] Pete Rose died on 1 August 2021. His pension paid out a lump sum to his estate following his death in service.

A 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 figure and other pension details include the value of any pension benefit in another scheme or arrangement that the individual transferred to the NHS Pension scheme. 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. CETVs are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries.

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.

Annual governance statement

NHS Digital is accountable directly to Parliament for the delivery of the statutory functions described within the Health and Social Care Act 2012 and the Care Act 2014. For more information about our responsibilities and areas of work, see page 10 and our Performance report (pages 6 to 40).

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

Governance framework

Details of our constitution, our operational accountability, our Board and its appointed committees are provided in the Corporate Governance Report on pages 85 to 94. Information about the conduct of the Board and the roles and responsibilities of members are set out in our Corporate Governance Manual, which incorporates the Standing Orders, Standing Financial Instructions, Scheme of Delegation, and Committee Terms of Reference. The Corporate Governance Manual is reviewed and updated annually. We comply with the best practice described in the corporate governance code for central government departments issued by HM Treasury. Corporate policies are regularly reviewed and, where it is appropriate to do so, compliance and awareness levels are monitored.

Governance and assurance across the health and social care sector

We all have an interest in good governance, both within NHS Digital and with other bodies, including NHS England, as part of the system-wide oversight of national informatics expenditure.

We are the main informatics delivery organisation for the national informatics portfolio and contribute to, and are held operationally accountable by, the Delivery Oversight and Assurance Board (DOAB). Our Chief Financial Officer is a member of the DOAB and our Director of Assurance and Risk Management attends regularly, along with other members of our Executive Management Team (EMT) where required to discuss specific areas of delivery. A significant number of our EMT and senior managers work closely with colleagues from NHS England and other bodies to develop future plans.

In 2020-21, additional governance arrangements were put in place to oversee delivery as part of the government's response to the COVID-19 pandemic, both within NHS Digital and across the wider system. These arrangements continued in 2021-22 to manage the ongoing uncertainty and changing requirements, as well as the need to mobilise and co-ordinate delivery at pace.

Merger with NHS England

On 22 November 2021, the Wade-Gery review entitled 'Putting data, digital and tech at the heart of transforming the NHS' was published, and recommended the merger of NHS Digital and NHS England. Since the announcement, while progressing work to deliver the merger of our organisation, we have been working on risk management, as well as assurance and governance, to ensure that the merger does not impact on the services that we provide to patients and the NHS.

Risk and assurance framework

We have reviewed our corporate risk management framework and methodology during 2021-22 to improve risk data quality and risk management behaviours. Key actions during the year were:

- refreshing our risk management policy
- redefining the significant operational risks and issues
- reviewing our short- and long-term risk environment, and evaluating our overall level of risk relative to our risk appetite
- updating our risk-management training approach and supporting materials
- implementing directorate level and other operational risk dashboards to improve the quality, reliability and accessibility of risk information
- developing the integration between risk management and our assurance frameworks

Risks and assurance items are reported regularly and escalated through our internal governance structure. The significant operational risks and issues, and details of mitigation plans, are reviewed monthly by the EMT, reported to the Audit and Risk Committee (ARC), as well as to the Board at each meeting. Following the announcement of the merger of NHS Digital, Health Education England and NHSE to create a new NHS England, we have begun to evaluate the risks associated with the transition to the new organisation. We are tracking both the risks associated with the delivery of our objectives and the risks associated with the merger.

As part of the COVID-19 ongoing response, we accepted that our overall risk position increased during 2020-21 as a result of the operational necessities of the crisis. The management of COVID-19 response is now regularised as part of our wider risk management approach, and overall, during 2021-22 our risk position has improved, as we have seen a reduction in the level of risk we are carrying.

During 2021-22, we further embedded the directorate assurance frameworks across NHS Digital and put in place a 6-monthly review process. All directorates completed a 2021-22 year-end review and an assurance statement. Actions to raise levels of assurance were captured and monitored with progress reports shared with the EMT and the ARC.

In 2021-2022, we also developed a Corporate Assurance Framework (CAF). This document maps the assurance in place for 11 of NHS Digital's highest scoring, long-term risks. All risks on the CAF have been assessed to have high levels of overall assurance and therefore sufficient assurance is in place.

Our assurance work has allowed us to strengthen the view of our key controls and existing sources of assurance on key processes, programmes and risks. The directorate assurance frameworks and the CAF are updated and refreshed at least every 6 months.

Performance management

Our performance management framework links closely to risk management. It includes periodic reporting at differing levels of granularity in performance packs to the DOAB, the Board, the EMT and other internal business units.

This performance reporting covers:

- financial and non-financial information, key risks and issues, and an assessment of delivery against strategic commitments
- business plan delivery at corporate level
- other work, such as delivery of specific programmes and organisational development and transformation

Our performance framework and individual performance indicators are kept under regular review to ensure they remain meaningful and effective and support open and transparent governance. With the exception of a limited number of confidential indicators, all elements of the performance framework are reported to public meetings of the Board and most of the information is available on our website (https://digital.nhs.uk/about-nhs-digital/our-organisation/nhs-digital-board/board-minutes-and-papers). Our performance measures are consistently reviewed to ensure they remain relevant and clearly illustrate how we are performing against our goals and objectives.

Internal audit and other third-party assurance

Our internal audit service is provided by the Government Internal Audit Agency (GIAA). Acting independently, it focuses audit activity on key risk areas and chooses additional areas based on interviews with the EMT and its knowledge and experience of our business. The internal audit service operates in accordance with the Public Sector Internal Audit Standards and to an annual internal audit plan approved by the ARC.

Regular reports are submitted to the ARC on the effectiveness of our systems of internal control and the management of key business risks, with recommendations for improvement.

During 2021-22, our internal audit plan originally included 16 internal audits. This was reduced to 15 due to the deferment of the Temporary Staff Controls audit which is due to be undertaken later in 2022-23.

2 internal audits produced a 'substantial' assurance rating, 7 produced a 'moderate' assurance rating, and 3 produced a 'limited' rating. The remaining 3 are at draft report stage. The 'limited' audits are outlined below:

1. **Whistleblowing arrangements**: NHS Digital's whistleblowing policy was reviewed and assessed against the National Audit Office criteria and it was discovered that the policy was poor for addressing concerns and providing feedback. Although there was no definitive evidence that concerns were not being reported, the lack of detail within the current policy and the absence of supporting guidance could adversely affect employees' understanding of the whistleblowing processes. The policy was overhauled during the year to address these concerns and ensure a more robust process.
2. **Commissioning process**: A lack of compliance was identified with the centralised process that governs how commissions are managed, along with the lack of a single 'front door'. This meant that there was inadequate visibility of the new works and commissions received by NHS Digital, leading to a potential misunderstanding of the availability and capacity of resources. There was no regular review of the whole book of work by a clearly defined governance committee with the responsibility of making decisions on the sequencing or decommissioning of programmes. This raised the risk that the lack of capacity and/or capability and insufficient detail in the commission was not identified in a timely manner.

3. **Legacy systems (technical debt)**: The review identified that, despite the progress the current actions had led to, there was still no defined approach to how the framework should be operating and consistently delivered. This left the framework vulnerable to priority changes in the future should business objectives and risk appetite change. An action plan was agreed and all 3 recommendations were completed by March 2022.

The Head of Internal Audit gave an overall assurance rating of moderate and noted that this reflected the fact that, despite the inevitable impact of the pandemic on NHS Digital's staff working arrangements and key deliverables, alongside the merger announcement in November 2021, the organisation had continued to operate in a relatively stable and controlled environment.

In addition to our internal audit service, we receive other third-party assurances, including:

- ISAE 3402 assurance reports covering our out-sourced payroll and financial services provided by NHS Shared Business Services (SBS)

  The report for financial services was qualified due to the control on the annual inspection of fire alert and water detection systems and the testing of the generator. SBS advised the fire and water detection system was properly booked and scheduled but cancelled due to the engineer contracting COVID-19, with a re-scheduled date outside of the control window. The generator was scheduled for testing in quarter 4, having been tested on a quarterly basis. However, due to the pandemic and resourcing issues, the test was postponed until a date outside of the control window. Both areas were deemed to be low risk to client data and systems.

  The report for payroll services was qualified due to several incidents. Reasons for areas receiving a qualified rating included failing to provide evidence of checks, them being made after the event, or not undertaken in a timely manner. This includes where additional reviews were required on differences or tolerances being breached. Some of the issues arose following a recent recruitment drive and during the busy time of applying the national pay award to all staff across their client base. No financial losses were incurred. SBS is improving its education processes and looking to increase the automation of some additional checks for improved assurance.

- we provide annual assurance on our GP Payments system to our stakeholders. The ISAE 3000 report gave a qualified assurance due to an instance where 2 leavers did not have their access removed in a timely manner from the GP Data Collection (GPDC) application. This has since been actioned and access has been removed. It was also considered there was not appropriate segregation of duties between the production and the development environments of the GPDC application. Subsequently, a control to monitor the audit log is being established.

External audit

We have worked closely with the National Audit Office, which attends and contributes to all the ARC meetings. The external audit work sits outside of our normal governance arrangements but informs the development of our governance and risk processes as well as our financial and other controls. The work of external audit is monitored by the ARC through regular progress reports. During 2021-22, we engaged early with the National Audit Office on key issues, particularly in relation to the accounting treatment of the major systems delivered in response to COVID-19 and their continued improvements during the reporting year.

Preventing fraud, bribery and corruption

Public bodies and the NHS continue to be major targets for fraud. The pandemic has accelerated the digitisation of data and technology services, which have been key targets for fraudsters using traditional and cyber-enabled methods as well as exploiting business logic to commit cyber crimes.

In 2021-22, there was a rise in NHS branded scams and spoof websites to steal user credentials. We are working with the Data Security Centre and public sector partners, such as the NHS Counter Fraud Authority and the National Cyber Security Centre, to identify and mitigate cyber-enabled fraud risks for NHS Digital and the wider health and care system.

There were also increased instances of 'dual-working', where staff and contractors may have held fulltime contracts with 2 employers at the same time. This was exacerbated by the pandemic and the move to homeworking, as there was reduced direct management oversight, which could be exploited by opportunistic fraudsters. To mitigate this, we reviewed and strengthened controls with key stakeholders and suppliers. In addition, we shared the mitigation steps taken at NHS Digital with government partners and worked collaboratively to implement controls and raise awareness across the public sector.

In order to mitigate the risk of fraud, bribery and corruption to NHS Digital we have the following control measures in place:

- a counter fraud, bribery and corruption strategy aligned to the government functional standard for counter fraud to continuously improve our approach in identifying and preventing the risk of fraud
- a counter fraud, bribery and corruption policy that is required to be read and accepted by all staff. The policy and our management statement on fraud, bribery and corruption are available on our website at: https://digital.nhs.uk/about-nhs-digital/corporate-information-and-documents/anti-fraud-bribery-and-corruption
- a fraud risk framework, and working with internal and external stakeholders to mitigate risks and implement robust controls
- a quarterly working group, chaired by the Finance Director, with both internal and external stakeholders
- proactive exercises using data analytics to detect and prevent fraud, including participation in national exercises, such as the biennial National Fraud Initiative
- an internal counter fraud team to investigate allegations of fraud and to always seek the appropriate disciplinary, regulatory, civil and criminal sanctions against fraudsters and, where possible, recover our losses
- collaborative working with external stakeholders including the Department of Health and Social Care Anti-Fraud Unit, the NHS Counter Fraud Authority, and the Cabinet Office to share intelligence, insight and best practice

Whistleblowing

We continue to work with Protect, the UK's leading whistleblowing charity, to enhance our ability to support staff through improved guidance, policy and awareness training. We encourage staff to openly raise concerns through a number of channels. Following the limited assurance received from the internal audit, our policy was overhauled and made more robust.

There were 8 whistleblowing cases during 2021-22 which were all subsequently resolved.

Freedom to Speak Up

In 2021-22 we appointed 5 Freedom to Speak Up guardians and established an independent and confidential reporting service as part of our 'Safe to Challenge' initiative. The guardian role is one of independence, impartiality and objectivity, contributing to the Freedom to Speak Up network to comply with National Guardian's Office guidance, and providing peer-to-peer support and learning.

Whistleblowing and Freedom to Speak Up both have nominated board-level officers to assure these arrangements.

Impact of COVID-19

We continued to deliver on all commitments, including those developed to respond to the COVID-19 pandemic which changed rapidly during the year – with national lockdown restrictions still in place at the start of the reporting year alongside the national COVID-19 vaccination programme, lockdown easing over the summer, the surge of the Omicron variant in winter, and the 'Living with COVID-19' strategy announced in February 2022.

The risks in ensuring capacity within the National Coronavirus Testing System during the Omicron surge were managed with the dedication of our colleagues. They worked diligently to mitigate the risks of the high volume of lateral flow test results that needed processing, enabling many people to safely spend time with their families over the Christmas period.

Wellbeing check-ins with colleagues continued during the year, and our offices continued to be 'COVID-19 secure' and available for those that needed them.

We also worked to ensure that colleagues received help with working safely and effectively during the pandemic, including support on working safely and effectively from home. These initiatives were delivered through the Organisational Wellbeing workstream, which was jointly led by the Chief Commercial Officer and Chief People Officer.

Data and cyber security

Cyber security is a significant and ongoing risk to operations, patient care and patient safety. With increasing use and reliance on digital data and technology, our Data Security Centre continued to work rapidly to support organisations to reduce their risk and increase their protection against cyber risks in close partnership with the National Chief Information Security Officer, NHS England Transformation Directorate and the National Cyber Security Centre. As a result, health and care organisations are better protected, including through effective use of threat intelligence, continuous scanning and monitoring of the NHS estate in England, and additional cyber support across the health sector.

We continued to deliver technical remediation for the most vulnerable trusts, and were able to offer a range of security services, such as vulnerability scanning, immediate fixes for major cyber security flaws and additional integration of data and threat feeds into the National Cyber Security Centre to counter increased ransomware and COVID-19 phishing efforts.

Alongside our health and care system-wide responsibility and growing range of managed cyber security services, we provided consultancy and assurance for a number of Department of Health and Social Care Group Critical National Infrastructure (CNI) systems, and protective monitoring for NHS Digital CNI systems. We have also strengthened our internal security approach and culture to support this.

The risks to the health and care system from cyber attacks continue to grow and evolve. We will continue to respond to these risks by providing guidance, assessments and support to help organisations understand and manage their cyber risks. We are also currently scoping new programmes of work, aligned to the National Government Cyber Strategy, which are expected to deliver further enhancements to cyber defences across NHS Digital and the wider health and care sector in the future.

Data governance

A wide-ranging legal, regulatory and compliance framework governs our receipt, processing and dissemination of data and information and our production of statistics. We are responsible for ensuring that health and social care data and information is collected, stored and disseminated appropriately.

We continued to improve controls and protocols for secondary uses of NHS data through the Data Access Request Service (DARS) in consultation with the Independent Group Advising on the Release of Data (IGARD). For General Practice Extraction Service (GPES) data requests for pandemic planning and research, we ensured an additional layer of clinical scrutiny by representatives of the British Medical Association and the Royal College of General Practitioners through the Profession Advisory Group.

On 1 October 2021, responsibility for the National Disease Registration Service (NDRS) transferred from Public Health England (PHE) to NHS Digital. Following the transfer, requests for access to data held by the NDRS continued to be assessed on a case-by-case basis by the Office for Data Release (ODR), which until 30 September 2021 had been part of PHE, and from 1 October 2021 became part of the UK Health Security Agency.

Before any data is shared, we ensure that:

- a legal basis for accessing the data exists
- the customer has an appropriate level of security to safeguard the data
- the customer passes our assessment process
- dissemination is covered by a signed data-sharing agreement and a data-sharing framework contract

Particularly sensitive releases follow a full governance and approval process, and we seek independent advice from IGARD when appropriate.

We publish details of our data sharing agreements through our Data Uses Register (https://digital.nhs.uk/services/data-access-request-service-dars/data-uses-register). We improved this in 2021-22 by providing a new interactive tool that makes it easier to see which organisations access data, the purposes for which they are permitted to use it, and the expected benefits.

To ensure that organisations meet the terms of their data sharing agreement and framework contract, we undertake data sharing audits. During 2021-22, we conducted audits of 19 organisations and recorded observations about their processes, procedures and nonconformities with NHS Digital requirements. The outcome of audits and post-audit reviews are published on our website (https://digital.nhs.uk/services/data-access-request-service-dars/data-sharing-audits).

Privacy, transparency, ethics and legal

The Privacy, Transparency, Ethics and Legal directorate is comprised of the Data Protection Officer team, the Information Governance Delivery team, the Information Law team, the Commercial Legal team and the COVID-19 Public Inquiry Response team.

Personal data breaches and audits

The Data Protection Officer (DPO) and their team provide oversight of NHS Digital's compliance with data protection law, advise on data protection matters and personal data breaches, and have a central role in setting the overall strategy for data protection compliance.

There were 52 personal data breaches, as defined in the UK General Data Protection Regulation (UK GDPR), reported to the DPO in 2021-22. There were 8 personal data breaches reported to the Information Commissioner's Office.

The DPO audit function carried out 9 audits in the year as part of the DPO's statutory role in monitoring compliance with UK GDPR, the Data Protection Act 2018, and our own data protection policies. Where improvements were needed, they were captured as audit actions, with progress and completion monitored and reported on through corporate risk and assurance processes.

NHS Digital's Data Security and Protection Toolkit (DSPT) 2020-21 assessment was successfully submitted as 'standard met' by the end of June 2021 deadline, achieving 88 mandatory and 20 non-mandatory requirements. The Government Internal Audit Agency assessed NHS Digital against a mandatory assessment framework and tested the approach used to ensure a robust self-assessment is undertaken. The outcome was a 'substantial' (green) rating, finding the framework of governance, risk management and control adequate and effective.

The GIAA also undertook an audit of the NHS Digital DPO function in 2021-22 which also received a 'substantial' (green) rating, indicating that the framework of governance, risk management and control around the DPO function was adequate and effective.

The records management function undertook an ISO 9001:2015 Quality Management System routine external audit in August 2021 and was successful in maintaining certification for this period.

Freedom of information requests

The Information Governance Delivery team provides information governance services across NHS Digital, including information governance advice and support on the operation of national data and IT products, services and programmes, strategic records management advice, secretariat support for the Independent Group Advising on Release of Data (IGARD), an internal information governance helpline service and a freedom of information (FOI) and data subject access request (DSAR) response team.

1,867 FOI requests were received in 2021-22 – a 0.8% increase on the previous financial year. In recent years, we have started to receive an increasing volume of FOI requests for information held on the 1939 register from commercial genealogists. The 1939 register holds a snapshot of information on the population of England and Wales from just before the Second World War. A digital version of the register is available through National Archive partner organisations, but the original manual register records are still held by NHS Digital.

In 2021, the number of requests from some of these organisations for information held in these manual records became exceptionally high, creating a disproportionate and excessive burden on the National Back Office and FOI teams. A number of these requests were therefore refused under the terms of the Freedom of Information Act 2000. We provided advice and assistance to the relevant requesters about how to reduce the breadth and volume of their requests to reduce the burden on resources, and have seen a significant drop in the number of such requests since. We continue to assess the need for NHS Digital to retain the 1939 register manual records.

The average annual rate of compliance with the statutory timescales for responding to FOI requests remains high at 99.2%. 22 internal reviews were carried out and 4 complaints were made to the Information Commissioner's Office (ICO), 2 of which remain open. The closed cases were resolved informally with no action required by NHS Digital.

Data subject access requests under UK GDPR

804 data subject access requests (DSARs) for access to personal data under UK GDPR were received. 99.6% of DSARs were responded to within the statutory timescales for compliance. 1 internal review was carried out during the year and no complaints were made to the ICO.

10 audits were commissioned internally by the Data Protection Officer as part of their statutory role in monitoring our compliance with GDPR.

COVID-19 Public Inquiry preparations

NHS Digital has been taking steps to prepare for the COVID-19 Public Inquiry through the establishment of a COVID-19 Public Inquiry Response team. The team is responsible for ensuring NHS Digital prepares appropriately, identifies and retains relevant records, and manages and responds to requests from the inquiry for information and evidence to support its work.

The Government Internal Audit Agency (GIAA) undertook an advisory review of our preparations in February 2022 as part of high-level assurance for the Department of Health and Social Care of initial preparations for the inquiry by all its arm's-length-bodies. GIAA concluded that we had made reasonable progress in preparing for the commencement of the inquiry. The review made a number of suggestions to help further shape our preparations. To address these suggestions, our COVID-19 Public Inquiry Response team formulated an action plan which will be subject to a progress review and further recommendations by an internal team of auditors.

Business continuity

NHS Digital manages a range of essential IT systems on behalf of the NHS. It is critical that these systems operate in an efficient manner and that we can support the NHS in the event of threats to them. We maintain a business continuity management system that is aligned to the requirements of ISO 22301 and related standards. This provides:

- a corporate incident management framework and supporting processes
- business continuity plans covering all NHS Digital activities
- a range of IT service continuity and disaster recovery plans for services managed in-house or by external suppliers
- arrangements to support the management of NHS Digital facility-related health and safety incidents
- supply chain continuity management. We confirm that critical suppliers and other delivery partners have suitable business continuity arrangements in place to protect delivery of services to NHS Digital and its customers

Our staff provide subject matter expertise in line with relevant industry standards and best practice across government. During 2021-22, NHS Digital showed its organisational resilience and its ability to continue to deliver, despite the challenges of the pandemic.

Clinical governance

Our digital programmes, services and data are central to the health and care of patients and citizens. Our clinicians remain absolutely integral to the development and delivery of the digital services that have supported the country's ongoing response to COVID-19, ensuring they are clinically safe, and that all associated clinical risks are understood and managed appropriately. We have also contributed clinical informatics expertise to the development and delivery of a wide range of products and services that underpin the day-to-day work of the health and care system, alongside new programmes of recovery and transformation.

Having an effective clinical governance framework is key to this assurance, since it provides clear oversight and accountability alongside a system of learning, professional development and continuous quality improvement in our programmes and services. This was independently assessed by the Government Internal Audit Agency this year, receiving a rarely awarded 'substantial' (green) rating. We have also expanded and developed the clinical team to enhance its profile, effectiveness and impact across the organisation.

Chief Executive's review of effectiveness

As Accounting Officer, I have responsibility for the system of internal controls supporting and enabling the achievement of NHS Digital's aims and objectives, while safeguarding the public funds and assets for which I am personally responsible in accordance with 'Managing Public Money' and as set out in my Accounting Officer appointment letter. In particular, I am responsible for ensuring that expenditure does not exceed the annual budget allocated. I have undertaken this responsibility by seeking a range of assurances.

In 2021-22, I was primarily informed by:

- a full Governance review briefing document from my predecessor, with the handover being effective from 4 June 2021
- my attendance at NHS Digital's Audit and Risk Committee, its minutes, papers and annual report to the Board
- the work of the National Audit Office
- the work of internal audit, which has completed an agreed, comprehensive range of assessments. The head of internal audit gave 'moderate' ratings to the overall arrangements for assurance and to the controls reviewed
- monitoring regularly reviewed audit actions
- the assurance framework, which outlines key processes, risks and programmes and the controls and assurance mechanisms administered by the organisation. This is mapped to the three-line model and has been used to drive management action
- clear performance management arrangements for executive directors and senior managers
- the system of internal control provided by the Board, Information Assurance and Cyber Security Committee and Audit and Risk Committee

I am accordingly aware of any significant issues that have been raised.

Significant challenges

As with the previous year, 2021-22 has been dominated by COVID-19. The scale and volume of delivery and the amount of change required to support the health and social care sector during this period continued to be unprecedented. In February 2022, the Prime Minister announced to Parliament the 'Living with COVID-19' strategy, which has led to its own set of challenges. Additionally, on 22 November 2021, it was announced that NHS Digital would merge with NHS England as part of the Wade-Gery review. We met these challenges, and I am confident that we maintained good standards of governance, assurance and control.

Significant challenges we have dealt with in the year include:

1. Merger with NHS England

In November 2021, the Secretary of State for Health and Social Care announced plans to merge NHS Digital (and NHSX and Health Education England) with NHS England, following the recommendations of Laura Wade-Gery, non-executive director at NHS England and Chair of NHS Digital, in the independent report 'Putting data, digital and tech at the heart of transforming the NHS'.

Since the announcement, NHS Digital has been planning for the merger, working closely with the NHS England Transformation Directorate on both in-year delivery priorities and designing the future operating model for digital, data and technology. Significant management focus has been on staff morale and retention during the transition period.

Following the passage of the Health and Care Bill into law in April 2022, secondary legislation can now be developed to enable the legal merger of NHS Digital with NHS England, planned for early January 2023. This will need to consider how all of the functions performed by NHS Digital will transfer to NHS England, including those in relation to data safe haven provisions.

2. Turnover in senior leadership

The last year has been challenging for NHS Digital as there has been a disproportionately high number of changes in the Executive Management Team (EMT), including changes in post, retirement and death in service.

In order to address these challenges, we considered the make-up and experience across the team, invited existing colleagues to the EMT for their wisdom and counsel where knowledge gaps were identified, promoted internally to replace a retiree, and back-filled until permanent on-payroll replacements could be found in order to maintain leadership and stability.

Further information relating to changes in the EMT can be located in the Remuneration Report on pages 78 to 79.

3. Ongoing COVID-19 response

3.a Scaling up COVID-19 testing and vaccination services

As new variants of COVID-19 emerged, our teams and resources were reprioritised to deal with new demands, while maintaining existing essential services.

By March 2022, over 68.9 million bookings had been made on the National Booking Service for COVID-19 vaccinations and over 150 million vaccination events were processed. The service has adapted continuously to evolving policy throughout the year, allowing different cohorts to access vaccinations in line with government advice. Notably, it supported the accelerated COVID-19 booster vaccinations programme in December 2021 to deal with the impact of the Omicron variant.

NHS Digital continued to be the technology delivery lead for the UK Health Security Agency for COVID-19 testing services for the public. The demands of the Omicron variant meant that we needed to scale the National Coronavirus Testing System throughout the year, with more than 350 million test results processed on the platform during the year.

Our Corporate Services such as Commercial, Finance and Human Resources also worked hard to support our COVID-19 response. The Gold-Silver-Bronze command structure established in March 2020 remained in place throughout the year. Risk identification and reporting continued to remain strengthened.

3.b Preparations to respond to the COVID-19 Public Inquiry

In May 2021, the Prime Minister announced a Public Inquiry into the UK's response to the COVID-19 pandemic. As a key provider of national health technology and data services used throughout the pandemic, NHS Digital started preparations to respond to the Public Inquiry. Colleagues were informed that all COVID-19-related records and information had to be retained. As of July 2021, a legal hold notice was applied to corporate record-holding systems, including email, so that any records would be secured and accessible. All relevant services, programmes and teams identified and recorded their information repositories, staff and suppliers. The COVID-19 Public Inquiry Response team was set up to ensure adequate preparation, governance and controls. The team has established protocols and procedures, and defined a request management tool. We are recruiting in the Public Inquiry Response team and engaging with our legal and counsel representation as part of the preparations.

4. Managing the financial position and preventing fraud

During the year we worked closely with finance colleagues at the Department of Health and Social Care, NHS England, UK Health Security Agency and NHSX (now the NHS England Transformation Directorate) to ensure funding was provided for our expenditure for ongoing COVID-19 delivery commissions, and to adjust to changing requirements following the government's 'Living with Covid' announcement in February 2022.

The demands of the COVID-19 response continued to impact our non-COVID-19 delivery, constraining our ability to secure sufficient capacity and capability to deliver the full scope of the Technology Transformation Portfolio work that had been originally planned for the year. We worked closely with delivery teams across NHS Digital, the Department of Health and Social Care, and NHS England to identify potential underspends in non-COVID-19 activities and enable the early return of funding to the portfolio to be utilised for other health pressures.

The persistent very unusual circumstances of the pandemic continued to create a highly challenging delivery environment, including for the ongoing development of the National Coronavirus Testing System. The requirements had to be met extremely urgently, with more than 1,000 software releases during the year in response to changing policy. Despite the fact that the system has continued to be effective and reliable, the exceptional circumstances under which the system was built meant that accounting standards required us to produce a valuation for the balance sheet based on the cost of replacing the asset in an artificial optimal environment as at 31 March 2022. As with the valuation at the end of the previous financial year, the assumptions used to produce the replacement valuation include perfect hindsight in terms of lessons learned in initially building the asset. The value on 31 March 2022 is also reduced to reflect the fact that it has been used over the previous 2 years. To ensure independence we were again required to commission an external expert valuation, and using this valuation of a hypothetical replacement, adjusted for the use of the asset up to 31 March 2022, we have impaired the asset by £40.2 million.

Due to its exceptionally rapid development, the National Coronavirus Testing System was originally built as a single system, which grew exponentially as use cases, testing volumes and requirements for data increased in line with the requirements for responding to the pandemic. During 2021-22, work was undertaken to separate the system into modules that reflected individual parts of the overall service. Breaking the system down into modules enabled a phased reprocurement to be undertaken, whilst ensuring service continuity throughout the process.

During the year we received 15 referrals to our counter fraud service relating to contractors potentially working full-time for NHS Digital and also having full-time temporary contracts with other organisations. This was due to the recruitment agency allowing individuals multiple contracts to cater for part-time working, and was exacerbated by remote working arrangements. The recruitment agency identified the issue through their own internal audit, and brought this to our attention. We worked with the agency to establish additional controls to prevent reoccurrence. Although the individuals involved were working more than one job, our investigations did not find evidence of fraud, and therefore there was no loss to the organisation. The individuals are no longer engaged by NHS Digital.

5. Public Health England and the National Disease Registration Service transition

Public Health England (PHE) closed on 30 September 2021, with its functions being transferred into 4 receiving organisations as part of plans to reform the public health system in England. PHE's National Disease Registration Service (NDRS) transferred into NHS Digital's Data Services directorate on 1 October 2021.

NHS Digital was confirmed as a receiving organisation for NDRS on 1 April 2021, leaving 6 months to plan, resource, implement and deliver the work, which involved the novation of over 700 contracts and data sharing agreements and transferring 329 staff records and payroll details.

Work on the transition project was undertaken alongside the normal duties of staff, who were already handling increased workloads from supporting the response to the pandemic, adding further pressure to an already challenging timeline of 6 months.

Despite the pressure and challenges, strong leadership and project management, combined with regular and ongoing communication throughout the transition process, meant that the service delivery was maintained and that data flows were uninterrupted.

6. Pause on the GPDPR programme to 'listen'

When the GP Data for Planning and Research (GPDPR) programme launched in May 2021, it was met with concern from professionals, and the public about the potential uses, and controls on access to data. As a result, the programme was paused to listen to feedback, which then prompted a programme redesign to address the issues raised and to meet a series of ministerial commitments.

It has taken some time for us to work through the practicalities of meeting these commitments. Reflecting on the feedback and strengthening our governance and decision-making processes, we have organised our work around 3 key areas:

- communications: to ensure that we learn from feedback and continue to have focused and ongoing conversations with stakeholders and the public about patient data
- data management, access and governance: to work on the trusted research environment and other aspects of the programme that focus on how data is processed, accessed and kept secure
- opt-outs: the programme must meet the commitment to reduce the burden of opt-outs on GPs and practice staff, while providing a positive experience for anyone who chooses to opt out of their GP practice sharing their data

We published further information about this work on NHS Digital's Data Points blog: https://digital.nhs.uk/blog/data-points-blog/2022/your-nhs-data-makes-a-difference

7. Russia-Ukraine conflict

In line with government policy and the Cabinet Office Procurement Note 01/22, we have identified a means of assessing Russian ownership of organisations using credit referencing organisations, and proposed this to the Department of Health and Social Care as a centrally led solution. This allowed us to review all of our contracts and confirm that we have no direct contracts with Russian (or Belarusian) suppliers. While we do not have an obligation to monitor sub-contractors of prime suppliers providing goods or services to us, we will however take the appropriate action when we become aware of any such instances.

Given our nature as a technology solutions organisation, we have verified that specific Russian-linked cloud software solution providers are not promoted as strategic products.

We have reviewed our financial risks profile to determine the impact of the conflict. While there is no immediate direct impact on our financial position, there is an impact on the UK and world economy, with the conflict being only one factor impacting the economic environment. We are tracking our prices, including labour costs, and closely monitoring the impact of inflation on the cost of delivery.

The National Cyber Security Centre has assessed that we are in a heightened period of cyber threat, but with no specific new threats to the UK. The situation does not change the likely impact of a successful cyber-attack against NHS Digital, nor the improvements we recommend. Their advice during such periods aligns with our own cyber improvement priorities, which we continue to monitor.

Significant control issues

There was 1 significant control issue during the year:

As we reported in last year's annual report, we received retrospective approval from HM Treasury for the retention of 3 members of the Executive Management Team (EMT) on an off-payroll basis beyond the usual 6-month limit. We are reporting this again this year because the excess period for 2 of the individuals was in the 2021-22 financial year.

All 3 individuals played a pivotal role in leading the delivery of new critical services in response to the pandemic, and their appointment was extended beyond the usual 6 months to ensure delivery, continuity and stability at a senior level. During the course of the reporting year, the longest serving of the 3 members ceased to be a member of the EMT and was replaced in post by an on-payroll post holder in summer 2021. HM Treasury approval was granted on the proviso that: there was a lessons learned exercise, the remaining 2 post holders were on payroll by February 2022, and the funding provided to NHS Digital was reduced by £645,000 for 2021-22 as a penalty for not seeking approval from HM Treasury in advance. All HM Treasury requirements have been complied with.

There have been no other control issues.

I accept the observations by both the internal auditors and the National Audit Office, and I believe them to be a fair and accurate view of the organisation. We will continue to ensure rigorous and sound assurance is a priority for NHS Digital in 2022-23.

Statement of Accounting Officer's responsibilities

Under the Health and Social Care Act 2012 and directions made thereunder by the Secretary of State with the approval of HM Treasury, we are required to prepare a statement of accounts for each financial year in the form and on the basis determined by the Secretary of State. The accounts are prepared on an accruals basis and must give a true and fair view of our state of affairs and of our net resource outturn, application of resources, changes in taxpayers' equity and cash flows for the financial year.

In preparing the accounts, the Accounting Officer is 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 for Health and Social Care, 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 NHS Digital will continue in operation

The Accounting Officer for the Department of Health and Social Care has appointed me as the Accounting Officer who has responsibility for preparing our accounts and transmitting them to the Comptroller and Auditor General. Specific responsibilities include the propriety and regularity of the public finances for which the Accounting Officer is answerable, for keeping proper records and for safeguarding our assets, as set out in 'Managing Public Money' published by HM Treasury. As Accounting Officer, I am able to confirm that:

- as far as I am aware, there is no relevant audit information of which the auditors are unaware
- I have made myself aware of any relevant audit information and established that the entity's auditors are aware of that information
- the Annual Report and Accounts as a whole are fair, balanced, and understandable
- I take personal responsibility for the Annual Report and Accounts and the judgement required for determining that they are fair, balanced, and understandable

Parliamentary accountability and audit report

The purpose of the Parliamentary Accountability and Audit Report is to summarise the key parliamentary accountability documents within the Annual Report and Accounts, including the certificate and report of the Comptroller and Auditor General to the Houses of Parliament. All elements of this report are subject to audit.

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.

During 2021-22, there were 124 (2020-21: 1,266) losses and special payments amounting to £181,321 (2020-21: £1,221,422). There were no individual losses over £300,000 requiring separate disclosure.

No interest was paid under the Late Payments of Commercial Debts (Interest) Act 1998 (2020-21: nil).

Remote contingent liabilities

We have not identified any significant remote contingent liabilities. These are liabilities for which the likelihood of a transfer of economic benefit in settlement is too remote to meet the definition of contingent liability within the meaning of IAS 3.

Fees and charges

Fees and charges are for 'data-related services'. These are the provision of health-related data to customer requirements, data linkage services and data extracts for research purposes. No charges are made for the actual data, only for the cost of providing the data to the customer in the format and to the specification required, including a fee for compliance with information governance requirements.

No charges are made for data supplied to the NHS or local authorities when the data is required to support the planning and commissioning of healthcare. A charge is made if the data is required for other purposes. The following table shows the income received, less the costs for the full service, including the costs of providing data for the planning and commissioning of healthcare.

During 2021-22 we began a full review of our charging policy, which we expect to conclude during 2022-23. The review is being carried out in consultation with NHS England's Centre for Improving Data Collaboration, and will also consider the outcome and recommendations of the Goldacre Review and the Health and Social Care Data Strategy.

The fees and charges note below is subject to audit:

	2021-22 £000	2020-21 £000
Income	2,857	3,489
Expenditure	(6,493)	(6,807)
(Deficit)/Surplus	(3,636)	**(3,318)**

Simon Bolton
Interim Chief Executive
2 November 2022

The certificate and report of the Comptroller and Auditor General to the Houses of Parliament

Opinion on financial statements

I certify that I have audited the financial statements of the Health and Social Care Information Centre for the year ended 31 March 2022 under the Health and Social Care Act 2012.

The financial statements comprise the Health and Social Care Information Centre's:

- Statement of Financial Position as at 31 March 2022;
- Statement of Comprehensive Net Expenditure, Statement of Cash Flows and Statement of Changes in Taxpayers' Equity for the year then ended; and
- the related notes including the significant accounting policies.

The financial reporting framework that has been applied in the preparation of the financial statements is applicable law and UK adopted International Accounting Standards.

In my opinion, the financial statements:

- give a true and fair view of the state of the Health and Social Care Information Centre's affairs as at 31 March 2022 and its net expenditure for the year then ended; and
- have been properly prepared in accordance with the Health and Social Care Act 2012 and Secretary of State directions issued thereunder.

Opinion on regularity

In my opinion, in all material respects, the income and expenditure 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.

Basis for opinions

I conducted my audit in accordance with International Standards on Auditing (UK) (ISAs UK), applicable law and Practice Note 10 'Audit of Financial Statements of Public Sector Entities in the United Kingdom'. My responsibilities under those standards are further described in the 'Auditor's responsibilities for the audit of the financial statements' section of my certificate.

Those standards require me and my staff to comply with the Financial Reporting Council's 'Revised Ethical Standard 2019'. I have also elected to apply the ethical standards relevant to listed entities. I am independent of the Health and Social Care Information Centre in accordance with the ethical requirements that are relevant to my audit of the financial statements in the UK. My staff and I have fulfilled our other ethical responsibilities in accordance with these requirements.

I believe that the audit evidence I have obtained is sufficient and appropriate to provide a basis for my opinion.

Conclusions relating to going concern

In auditing the financial statements, I have concluded that the Health and Social Care Information Centre's use of the going concern basis of accounting in the preparation of the financial statements is appropriate.

Based on the work I have performed, I have not identified any material uncertainties relating to events or conditions that, individually or collectively, may cast significant doubt on the Health and Social Care Information Centre's ability to continue as a going concern for a period of at least twelve months from when the financial statements are authorised for issue.

My responsibilities and the responsibilities of the Accounting Officer with respect to going concern are described in the relevant sections of this certificate.

The going concern basis of accounting for the Health and Social Care Information Centre is adopted in consideration of the requirements set out in HM Treasury's Government Financial Reporting Manual, which require entities to adopt the going concern basis of accounting in the preparation of the financial statements where it anticipated that the services which they provide will continue into the future.

Other Information

The other information comprises information included in the Annual Report, but does not include the financial statements nor my auditor's certificate. The Accounting Officer is responsible for the other information.

My opinion on the financial statements does not cover the other information and, except to the extent otherwise explicitly stated in my certificate, I do not express any form of assurance conclusion thereon.

In connection with my audit of the financial statements, my responsibility is to read the other information and, in doing so, consider whether the other information is materially inconsistent with the financial statements or my knowledge obtained in the audit or otherwise appears to be materially misstated.

If I identify such material inconsistencies or apparent material misstatements, I am required to determine whether this gives rise to a material misstatement in the financial statements themselves. If, based on the work I have performed, I conclude that there is a material misstatement of this other information, I am required to report that fact.

I have nothing to report in this regard.

Opinion on other matters

In my opinion, the part of the Remuneration and Staff Report to be audited has been properly prepared in accordance with Secretary of State directions issued under the Health and Social Care Act 2012.

In my opinion, based on the work undertaken in the course of the audit:

- the parts of the Accountability Report subject to audit have been properly prepared in accordance with Secretary of State directions made under the Health and Social Care Act 2012; and
- the information given in the Performance and Accountability Reports for the financial year for which the financial statements are prepared is consistent with the financial statements and is in accordance with the applicable legal requirements.

Matters on which I report by exception

In the light of the knowledge and understanding of the Health and Social Care Information Centre and its environment obtained in the course of the audit, I have not identified material misstatements in the Performance and Accountability Report.

I have nothing to report in respect of the following matters which I report to you if, in my opinion:

- I have not received all of the information and explanations I require for my audit; or
- adequate accounting records have not been kept by the Health and Social Care Information Centre or returns adequate for my audit have not been received from branches not visited by my staff; or
- the financial statements and the parts of the Accountability Report subject to audit are not in agreement with the accounting records and returns; or
- certain disclosures of remuneration specified by HM Treasury's Government Financial Reporting Manual have not been made or parts of the Remuneration and Staff Report to be audited is not in agreement with the accounting records and returns; or
- the Governance Statement does not reflect compliance with HM Treasury's guidance.

Responsibilities of the Accounting Officer for the financial statements

As explained more fully in the Statement of Accounting Officer's Responsibilities, the Accounting Officer is responsible for:

- maintaining proper accounting records;
- the preparation of the financial statements and Annual Report in accordance with the applicable financial reporting framework and for being satisfied that they give a true and fair view;
- ensuring that the Annual Report and accounts as a whole is fair, balanced and understandable;
- internal controls as the Accounting Officer determines is necessary to enable the preparation of financial statement to be free from material misstatement, whether due to fraud or error; and
- assessing the Health and Social Care Information Centre's ability to continue as a going concern, disclosing, as applicable, matters related to going concern and using the going concern basis of accounting unless the Accounting Officer anticipates that the services provided by the Health and Social Care Information Centre will not continue to be provided in the future.

Auditor's responsibilities for the audit of the financial statements

My responsibility is to audit, certify and report on the financial statements in accordance with the Health and Social Care Act 2012.

My objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue a certificate that includes my opinion. Reasonable assurance is a high level of assurance but is not a guarantee that an audit conducted in accordance with ISAs (UK) will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in the aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of these financial statements.

Extent to which the audit was considered capable of detecting non-compliance with laws and regulations including fraud

I design procedures in line with my responsibilities, outlined above, to detect material misstatements in respect of non-compliance with laws and regulations, including fraud. The extent to which my procedures are capable of detecting non-compliance with laws and regulations, including fraud, is detailed below.

Identifying and assessing potential risks related to non-compliance with laws and regulations, including fraud

In identifying and assessing risks of material misstatement in respect of non-compliance with laws and regulations, including fraud, we considered the following:

- the nature of the sector, control environment and operational performance including the design of the Health and Social Care Information Centre's accounting policies, and key performance indicators.
- inquiring of management, the Health and Social Care Information Centre's head of internal audit and those charged with governance, including obtaining and reviewing supporting documentation relating to the Health and Social Care Information Centre's policies and procedures relating to:
  - identifying, evaluating and complying with laws and regulations and whether they were aware of any instances of non-compliance;
  - detecting and responding to the risks of fraud and whether they have knowledge of any actual, suspected or alleged fraud; and
  - the internal controls established to mitigate risks related to fraud or non-compliance with laws and regulations including the Health and Social Care Information Centre's controls relating to the Health and Social Care Information Centre's compliance with the Health and Social Care Act 2012, and Managing Public Money.
- discussing among the engagement team and involving relevant internal and external specialists, including valuation expertise regarding how and where fraud might occur in the financial statements and any potential indicators of fraud.

As a result of these procedures, I considered the opportunities and incentives that may exist within the Health and Social Care Information Centre for fraud and identified the greatest potential for fraud in the following areas: revenue recognition, posting of unusual journals, complex transactions, and bias in management estimates. In common with all audits under ISAs (UK), I am also required to perform specific procedures to respond to the risk of management override of controls.

I also obtained an understanding of the Health and Social Care Information Centre's framework of authority as well as other legal and regulatory frameworks in which the Health and Social Care Information Centre operates, focusing on those laws and regulations that had a direct effect on material amounts and disclosures in the financial statements or that had a fundamental effect on the operations of the Health and Social Care Information Centre. The key laws and regulations I considered in this context included the Health and Social Care Act 2012, Managing Public Money, employment law and tax Legislation.

Audit response to identified risk

As a result of performing the above, the procedures I implemented to respond to identified risks included the following:

- reviewing the financial statement disclosures and testing to supporting documentation to assess compliance with provisions of relevant laws and regulations described above as having direct effect on the financial statements;
- inquiring of management, the Audit and Risk Committee and in-house legal counsel concerning actual and potential litigation and claims;
- reading and reviewing minutes of meetings of those charged with governance and the Board and internal audit reports; and
- in addressing the risk of fraud through management override of controls, testing the appropriateness of journal entries and other adjustments; assessing whether the judgements made in making accounting estimates are indicative of a potential bias; and evaluating the business rationale of any significant transactions that are unusual or outside the normal course of business.

I also communicated relevant identified laws and regulations and potential fraud risks to all engagement team members including internal specialists and remained alert to any indications of fraud or non-compliance with laws and regulations throughout the audit.

A further description of my responsibilities for the audit of the financial statements is located on the Financial Reporting Council's website at: www.frc.org.uk/auditorsresponsibilities. This description forms part of my certificate.

Other auditor's responsibilities

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

I communicate with those charged with governance regarding, among other matters, the planned scope and timing of the audit and significant audit findings, including any significant deficiencies in internal control that I identify during my audit.

Report

I have no observations to make on these financial statements.

Gareth Davies

Comptroller and Auditor General
4 November 2022

National Audit Office
157-197 Buckingham Palace Road
Victoria
London
SW1W 9SP

2021-22 Accounts

Statement of comprehensive net expenditure for the year ended 31 March 2022

	Note	2021-22 £000	2020-21 £000
Expenditure			
Staff costs	3	263,029	206,991
Termination benefits	3	114	660
Operating expenditure	5	380,765	296,045
Depreciation and amortisation	5	68,415	70,725
Net impairments of non-current assets	5	40,349	17,447
Loss on disposal of non-current assets	5	2,330	2,759
Total expenditure		**755,002**	**594,627**
Less income	4	(44,863)	(45,298)
Net operating expenditure for the financial year		**710,139**	**549,329**
Net expenditure for the financial year		**710,139**	**549,329**
Other comprehensive net expenditure			
Items not included in net operating costs:			
Net (gain) / loss on revaluation of property plant and equipment	6	(94)	68
Net gain on revaluation of intangible assets	7	(1,263)	(5,109)
Net gain in non-current tangible assets transferred in under absorption accounting	6	(101)	-
Net gain on non-current intangible assets transferred in under absorption accounting	7	(930)	(5,723)
Net gain on current assets and liabilities transferred in under absorption accounting		(79)	-
Net loss on assets transferred out as a capital grant-in-kind	6	-	1,775
Comprehensive net expenditure for the year		**707,672**	**540,340**

All income and expenditure derive from continuing operations.

Notes 1 to 21 form part of these financial statements.

Statement of financial position at 31 March 2022

	Note	31 March 2022 £000	31 March 2021 £000
Non-current assets			
Property plant and equipment	6	34,436	33,531
Intangible assets	7	302,880	240,690
Other non-current receivables	8	4,672	6,344
Total non-current assets		**341,988**	**280,565**
Current assets			
Trade and other receivables	9	51,697	47,336
Cash and cash equivalents	10	19,430	22,641
Total current assets		**71,127**	**69,977**
Total assets		**413,115**	**350,542**
Current liabilities			
Trade and other payables	11	(100,239)	(100,361)
Provisions	12	(29)	(1,864)
Lease incentives	17	(658)	(638)
Total current liabilities		**(100,926)**	**(102,863)**
Total assets less current liabilities		**312,189**	**247,679**
Non-current liabilities			
Provisions	12	(6,001)	(4,543)
Lease incentives	17	(10,761)	(11,037)
Total assets less total liabilities		**295,427**	**232,099**
Taxpayers' equity and other reserves			
General reserve		290,257	224,561
Revaluation reserve		5,170	7,538
Total taxpayers' equity and other reserves		**295,427**	**232,099**

Notes 1 to 21 form part of these financial statements.

The financial statements on pages 110 to 149 were approved by the Board on 12 October 2022 and signed on its behalf by:

Simon Bolton
Interim Chief Executive
2 November 2022

Statement of cash flows for the year ended 31 March 2022

	Note	2021-22 £000	Re-presented 2020-21* £000
Cash flows from operating activities			
Net operating expenditure for the financial year		(710,139)	(549,329)
Adjustment for non-cash transactions:			
• depreciation and amortisation	5	68,415	70,725
• impairments / (reversal of impairments) or property, plant and equipment	5	157	(85)
• impairments of intangible assets	5	40,192	17,532
• loss on disposal of non-current assets	5	2,330	2,759
• provisions arising during the year	12	1,488	4,146
• provisions reversed unused	12	(1,256)	(735)
• lease incentive received	17	413	11,985
Decrease in non-current receivables	8	1,672	4,952
(Increase) / decrease in trade and other receivables	9	(4,361)	(14,660)
Increase / (decrease) in trade and other payables	11	(122)	33,728
Release of lease incentive		(669)	(310)
Adjustment for working capital movements arising from net absorption transfers in		79	-
(Increase) / decrease in capital payables and accruals		7,111	(5,155)
Provisions utilised	12	(609)	(1,346)
Net cash outflow from operating activities		**(595,299)**	**(425,793)**
Cash flows from investing activities			
Purchase of property, plant and equipment		(16,912)	(14,263)
Purchase of intangible assets		(162,000)	(121,140)
Net cash outflow from investing activities		**(178,912)**	**(135,403)**
Cash flows from financing activities			
Grant-in-aid from the Department of Health and Social Care: cash drawn down in the year		771,000	564,000
Net financing		**771,000**	**564,000**
Net increase / (decrease) in cash in the period	10	**(3,211)**	**2,804**
Cash and cash equivalents at the beginning of the period	10	22,641	19,837
Cash and cash equivalents at the end of the period	10	19,430	22,641
Net increase / (decrease) in cash in the period	10	**(3,211)**	**2,804**

All cash flows relate to continuing activities. Notes 1 to 21 form part of these financial statements.

* See footnote on Note 17.

Statement of changes in taxpayers' equity for the year ended 31 March 2022

	General reserve £000	Revaluation reserve £000	Total reserves £000
Balance at 31 March 2020	**201,520**	**6,919**	**208,439**
Changes in taxpayers' equity			
Net expenditure in the financial year	(549,329)		**(549,329)**
Loss on the revaluation of property, plant and equipment	-	(68)	**(68)**
Gain on the revaluation of intangible assets	-	5,109	**5,109**
Net gain on assets transferred in under absorption accounting	5,723	-	**5,723**
Net loss on assets transferred out as capital grant in kind	(1,775)	-	**(1,775)**
Movement between reserves	4,422	(4,422)	**-**
Total recognised income and expense	**(540,959)**	**619**	**(540,340)**
Grant-in-aid from the Department of Health and Social Care: Cash draw down during the year	564,000	-	**564,000**
Total grant-in-aid funding	**564,000**	**-**	**564,000**
Balance at 31 March 2021	**224,561**	**7,538**	**232,099**

Balance at 31 March 2021	**224,561**	**7,538**	**232,099**
Changes in taxpayers' equity			
Net expenditure in the financial year	(710,139)	-	**(710,139)**
Gain on the revaluation of property plant and equipment	-	94	**94**
Gain on the revaluation of intangible assets	-	1,263	**1,263**
Net gain on assets transferred in under absorption accounting	1,110	-	**1,110**
Movement between reserves	3,725	(3,725)	**-**
Total recognised income and expense	(705,304)	(2,368)	**(707,672)**
Grant-in-aid from the Department of Health and Social Care: Cash draw down during the year	771,000	-	**771,000**
Total grant-in-aid funding	**771,000**	**-**	**771,000**
Balance at 31 March 2022	**290,257**	**5,170**	**295,427**

Notes 1 to 21 form part of these financial statements.

Notes to the accounts

Note 1

1.1 General information

The Health and Social Care Information Centre (NHS Digital) is an executive non-departmental government body established under the Health and Social Care Act 2012. Further information about our remit, structure and work can be found on page 10 and in the Performance Report (see pages 6 to 40). The address of our registered office and principal place of business is provided on page 4. We are accountable to the Secretary of State for Health and Social Care for discharging our functions, duties and powers effectively, efficiently and economically. The Department of Health and Social Care undertakes this role on the Secretary of State's behalf on a day-to-day basis.

1.2 Basis of accounting

The financial statements have been prepared in accordance with the 2021-22 Government Financial Reporting Manual (FReM) and amendments to it issued by HM Treasury, as interpreted for the health sector in the Department of Health and Social Care Group Accounting Manual (GAM). The accounting policies contained in the FReM apply International Financial Reporting Standards (IFRS) as adopted and interpreted for the public sector context. Where the FReM permits a choice of accounting policy, the accounting policy that is judged to be most appropriate to the particular circumstances for the purpose of giving a true and fair view has been selected. The particular policies adopted by NHS Digital 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 non-current assets. This is in accordance with directions issued by the Secretary of State for Health and Social Care and approved by HM Treasury.

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

No accounting standard changes were adopted early in 2021-22.

The FReM does not require the following standards and interpretations to be applied in 2021-22:

- **IFRS 14 Regulatory Deferral Accounts**

  This applies to first-time adopters of International Financial Reporting Standards after 1 January 2016, and is therefore not applicable to Department of Health and Social Care group bodies.

- **IFRS 16 Leases**

  Implementation for those entities that follow the FReM has been deferred until 2022-23. NHS Digital has undertaken a detailed review of its existing leases in preparation for the implementation of the standard from 1 April 2022. A comparison of the expected transactions and balances arising in 2022-23 from the adoption of IFRS 16 compared to the previous IAS 17 lease standard is set out on the below:

2022-23	IAS 17 (old standard)				
2022-23	Statement of comprehensive net expenditure		Statement of financial position		
	Income £000	Expenditure £000	Asset £000	Cash £000	Liability £000
Balance at 1 April					**(11,419)**
Transactions in the year:					
Rent		6,198		(6,198)	
Release of lease incentive		(658)			658
Balance at 31 March					**(10,761)**

2022-23	IFRS 16 (new standard)				
	Statement of comprehensive net expenditure		Statement of financial position		
	Income £000	Expenditure £000	Asset £000	Cash £000	Liability £000
Balance at 1 April			**71,034**		**(82,453)**
Transactions in the year:					
Depreciation charge		5,135	(5,135)		
Interest on lease liability		760			(760)
Lease payments				(6,198)	6,198
Balance at 31 March			**65,899**		**(77,015)**

The FReM mandates the application of the practical expedient outlined in paragraph C3 of the standard in which IFRS 16 is applied to contracts that fell within the scope of IAS 17 and IFRIC 4 and not applied to those identified as not containing a lease under the previous standards.

- **IFRS 17 Insurance Contracts**
  This is effective for accounting periods beginning on or after 1 January 2021, but has not yet been adopted by the 2021-22 FReM. The application of IFRS 17 would not have a material impact on the accounts for 2021-22, had it been applied in the year.

1.3 Income

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

The main source of funding is a parliamentary grant from the Department of Health and Social Care, known as 'grant in aid', within an approved cash limit, which is credited to the general reserve. The grant in aid is recognised in the financial period in which it is received.

In line with IFRS 15, contract income is not recognised until a signed agreement is in place, or a purchase order is received from the customer.

Income is recognised in proportion to the fulfilment of the performance obligations set out in the agreement. Some performance obligations may be fulfilled by third parties under contract. Performance obligations are satisfied as data, reports and analyses are supplied, or by the passage of time as the service is delivered, or as time and material costs are incurred, or by the fulfilment of specific milestones. Where recognition is based on time and materials incurred or achievement of milestones, income is recognised as progress and/or costs incurred are agreed with the customer, either by correspondence or at project and programme boards.

The practical expedient in IFRS 15.121 has not been applied. All consideration for contracts is received in the form of cash. Warranties are not offered in relation to services provided, and hence refunds and returns do not apply. There are no assets recognised from the costs incurred to obtain or fulfil a contract with a customer.

Non-contract income is recognised when it has been invoiced, or for non-invoiced income when payment is received, and relates to smaller income streams.

All prices are based on full cost recovery.

Contract liabilities refer to income received or credited in the year for which the related costs have not yet been incurred.

1.4 Taxation

NHS Digital is not liable to pay corporation tax. Income is shown net of VAT, and expenditure is shown net of recoverable VAT. Irrecoverable VAT is charged to the most appropriate expenditure heading or capitalised if it relates to a non-current asset.

1.5 Transfer of functions

As public sector bodies within a departmental boundary are deemed to operate under common control, business reconfigurations are outside the scope of IFRS 3 Business Combinations. When functions transfer between 2 public sector bodies the FReM requires the application of 'absorption accounting'. Absorption accounting requires that entities account for their transactions in the period in which those transactions took place. Where assets and liabilities transfer, the gain or loss resulting is recognised in the Statement of Comprehensive Net Expenditure, and is disclosed separately from operating costs.

On 1 October 2021, the National Disease Registration Service (NDRS) transferred from Public Health England to NHS Digital (see: https://digital.nhs.uk/services/national-disease-registration-service). 329 staff transferred to NHS Digital, together with net assets of £1,110,000. Revenue expenditure for NDRS from the date of transfer to the end of the financial year was £9,278,000, and capital expenditure was £358,000.

1.6 Employee benefits

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

1.7 Non-current assets

a. Capitalisation

All assets falling into the following categories are capitalised:

1) Intangible assets include software development expenditure and the purchase of computer software licences, where they are capable of being used for more than 1 year and:
   - individually have a cost equal to or greater than £5,000; or
   - collectively have a cost of at least £5,000 and the assets are functionally interdependent, have 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 1 year, and:
   - individually have a cost equal to or greater than £5,000; or
   - collectively have a cost of at least £5,000 and, the assets are functionally interdependent, have 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
   - an intention to complete the intangible asset and use it
   - an 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 they are incurred.

b. Carrying gross cost

Non-current assets are initially recognised at cost, including expenditure such as installation directly attributable to bringing them into working condition. Subsequently non-current assets are held at current value in existing use. Any increase in value is credited to the revaluation reserve, except to the extent that it reverses a revaluation decrease for the same asset previously recognised as an expense. In that case, the increase is credited to the statement of comprehensive net expenditure to the extent of the decrease previously expensed. A decrease in carrying amount arising on the restatement in value of the asset is charged as an expense to the extent that it exceeds the balance, if any, held in the revaluation reserve relating to a previous revaluation of that asset.

Assets are assessed 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 efficiency factors or, where the asset is material and non-standard circumstances apply, by an external professional valuation. All assets have been revalued in the year, except software licences. Indexation had previously been applied to software licences up to 31 March 2019. Indexation has not been applied to software licences from 1 April 2019. After that date, software licences have been held at depreciated historical cost, on the basis that they are short-life assets and, as such, depreciated historical cost is considered a suitable proxy for current value in existing use. 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 the asset is available for use. Otherwise, depreciation and amortisation are charged on a straight-line basis to write off the costs or valuation of tangible and intangible non-current assets, less any residual value, over their estimated useful lives as follows:

1. Intangible software development assets are amortised, on a straight-line basis, over 5 years or the estimated life of the asset where this is known to be different. The asset lives are reviewed on an annual basis considering the degree of evolution of the asset and what plans, if any, are being made for its replacement.
2. Purchased computer software licences are amortised over the term of the licence.
3. Property, plant and equipment is depreciated on a straight-line basis over its expected useful life as follows:
   - fixtures and fittings: 1-18 years
   - office equipment and information technology: 1-10 years

The estimated useful lives and residual values are reviewed annually.

d. Depreciated replacement cost

Assets that are held for their service potential, and are in use, are held at their current value in existing use. For non-specialised assets, this is interpreted as market value in existing use, defined in the Royal Institution of Chartered Surveyors (RICS) Red Book as Existing Use Value (EUV). For specialised assets, this is interpreted as depreciated replacement cost on a modern equivalent asset basis.

e. Impairment

A revaluation decrease that does not result from a loss of economic value or service potential is recognised as an impairment charged to the revaluation reserve to the extent that there is a balance on the reserve for the asset being impaired and, thereafter, to expenditure. Impairment losses that arise from a clear consumption of economic benefit are taken to expenditure. Where an impairment loss subsequently reverses, the carrying amount of the asset is increased to the revised estimate of the recoverable amount but capped at the amount that would have been determined had there been no initial impairment loss. The reversal of the impairment loss is credited to expenditure to the extent of the decrease previously charged there, and thereafter to the revaluation reserve.

1.8 Research and development

Expenditure incurred on pure and applied research is treated as an operating expense in the year in which it is incurred. Development expenditure is for the development of specific business systems. Expenditure that does not meet the criteria for capitalisation is treated as an operating expense in the year in which it is incurred. Development expenditure meeting the criteria for capitalisation is treated as an intangible asset under construction until the asset is brought into use.

1.9 Leases

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

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

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

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

1.10 Provisions

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

1.11 Contingent liabilities

In addition to contingent liabilities disclosed in accordance with IAS 37, NHS Digital 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 the Department of Health and Social Care Group Accounting Manual. Where the time value of money is material, contingent liabilities that are required to be disclosed under IAS 37 are stated at discounted amounts and the amount reported to Parliament separately noted. Contingent liabilities that are not required to be disclosed by IAS 37 are stated at the amounts reported to Parliament.

1.12 Pensions

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

Early retirements, other than those due to ill health, are not funded by the schemes. The full amount of the liability for the additional costs is charged to expenditure at the time the retirement agreement is committed, regardless of the method of payment.

1.13 Critical accounting judgements and key sources of estimation uncertainty

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

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

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

Dilapidations provision

NHS Digital has provided £5.4 million in respect of anticipated dilapidation costs of its leased accommodation across its estate where required. Management has used either external property advisors or information provided by the Department of Health and Social Care property directorate to assess likely liabilities at the end of the leases.

Employment taxes

An accrual of £0.6m for penalties in respect of IR35 has been included in the year-end position, to cover the period from April 2017 to the end of March 2022. At the end of June 2022 HMRC concluded its IR35 investigation, with no further IR35 liabilities arising. Penalties were suspended for 3 months, conditional on upskilling hiring managers, a 100% double-check of any out-of-scope determinations, and on-time filing of all tax-related returns.

Developed systems

NHS Digital manages a suite of national infrastructure systems, as well as a number of large internal data collection systems and databases. Much of the development of such systems is undertaken in-house and a detailed assessment is required to determine the level of capitalisation of such work, including the percentage used to determine the ratio of capital work for each individual. In addition, management undertake an annual review to identify any impairments or disposals required, and to confirm the likely asset life over which these systems should be amortised.

Our most material asset remains the National Coronavirus Testing System. This supports the end-to-end testing journey, from booking a test at a test centre, or ordering test kits for home delivery, to the operation of test centres, and the dissemination of results both to the individual and for data analysis and reporting. During the year we added additional functionality to cater for international arrivals, data feeds to the NHS App for the COVID Pass, a digital reader to support the upload of lateral flow test results and changes to support the response to the Omicron variant. We also increased the capabilities for the bulk registration of tests, increased the speed of data flows, improved the monitoring for variants of concern, and continued to cater for the specific requirements of each of the Devolved Administrations. The system continued to be developed as requirements evolved in response to the pandemic, and the very unusual and challenging circumstances affected the way the National Coronavirus Testing System was built. The requirements had to be met extremely urgently, with more than 1,000 software releases during the year in response to changing policy. The system has continued to be effective and reliable.

Accounting standards required us to produce a valuation for the balance sheet based on the cost of replacing the asset as at 31 March 2022. The assumptions used to produce the replacement valuation include perfect hindsight about lessons learned in initially building the asset. Also, the value at 31 March 2022 was reduced to reflect the fact that it had been used over the preceding 2 years. To ensure independence, we were required to commission an external expert valuation. As is common with reports of this nature, the valuation of the system was expressed as being within a range. We assessed this range, using our experience of the software development market, and determined that the higher end of the range best represented the public sector position on both risk and retaining skilled roles within the United Kingdom, with lower levels of offshoring of development work than might be seen in the private sector.

Using the higher end of the range, adjusted for the use of the asset up to 31 March 2022, we estimate that, as at 31 March 2022, the value would have been £40.2 million lower than the value of the asset held on our balance sheet, and, as required by accounting standards, we have impaired the asset by this amount.

1.14 Business and geographical segments

NHS Digital 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.

1.15 Cash and cash equivalents

Cash is cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours.

Cash equivalents are investments that mature in 3 months or less from the date of acquisition and that are readily convertible to known amounts of cash with insignificant risk of change in value.

1.16 Financial instruments

NHS Digital operates largely in a non-trading environment and the majority of its income is from other government or NHS bodies. Consequently, NHS Digital is not exposed to the significant degree of financial risk that is faced by most other business entities.

NHS Digital has no borrowings and relies largely on grant-in-aid from the Department of Health and Social Care for its cash requirements. NHS Digital is therefore not exposed to interest rate or liquidity risks.

All cash balances are held within the Government Banking Service and all material assets and liabilities are denominated in sterling, so it is not exposed to material currency risks.

Financial assets are recognised on the statement of financial position when NHS Digital 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. NHS Digital has no financial assets other than trade receivables. Trade receivables do not carry any interest and are stated at their nominal value, less any provision for expected credit losses.

Financial liabilities are recognised on the statement of financial position when NHS Digital 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. NHS Digital 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

The financial statements have been prepared on a going concern basis. Funding for 2022-23 is in place, and the continuation of the provision of services is demonstrated through the plans agreed with our delivery partners.

On 22 November 2021 the Secretary of State for Health and Social Care announced that NHS Digital would be merged into NHS England (see: https://www.gov.uk/government/news/major-reforms-to-nhs-workforce-planning-and-tech-agenda). The functions carried out by NHS Digital will transfer in their entirety to NHS England, and will continue to be delivered, and therefore, in accordance with the Department of Health and Social Care Group Accounting Manual, the going concern basis for preparing the financial statements remains appropriate.

Note 2

Statement of operating costs by activity

IFRS 8 requires operating segments to be identified on the basis of internal reports that are regularly reviewed by the Chief Executive. The NHS Digital Executive Management Team monitors the performance and resources of the organisation by directorate. The statement of financial position is reported internally as a single segment. Accordingly, no segmental analysis of assets and liabilities is reported.

The majority of income is derived from other bodies within the Department of Health and Social Care group, and more than 10% of total income is received from the following customers: NHS England (£19.1 million), and the Department of Health and Social Care (£5.1 million). The income derived from outside the UK is immaterial.

For the year ended 31 March 2022

£000	Assurance and Risk Management	Corporate Services	Data Services	IT Operations	Platforms	Cyber Operations	Product Development	Strategy, Policy and Governance	COVID-19 delivery	Central (not allocated to a segment)	Total
Income	**-**	**(209)**	**(24,870)**	**(676)**	**(299)**	**-**	**(14,655)**	**(818)**	**(1,150)**	**(2,186)**	**(44,863)**
Staff costs	**3,604**	**19,369**	**66,023**	**44,434**	**7,478**	**9,636**	**69,409**	**19,661**	**24,174**	**(645)**	**263,143**
Professional fees	939	7,111	33,059	13,472	30,111	11,847	25,033	2,230	73,045	(723)	196,124
Information technology	69	1,161	7,649	63,388	5,649	11,303	12,227	703	65,387	(17)	167,519
Accommodation	-	10,023	11	25	3	2	8	2	(1)	(40)	10,033
Travel and subsistence	2	435	32	50	4	18	84	26	9	1	661
Marketing, training, events and communications	20	2,235	549	14	56	344	74	138	67	(7)	3,490
Office services	1	1,333	266	303	20	75	69	163	14	2	2,246
Other	-	482	(2)	175	1	-	-	1	(2)	37	692
Loss on disposal of non-current assets	-	827	286	376	3	1	179	-	715	(57)	2,330
Depreciation and amortisation	-	1,541	10,481	10,703	285	6,585	14,973	569	23,385	(107)	68,415
Impairment – property plant and equipment	-	3	-	127	24	2	-	-	-	1	157
Impairment of intangible assets	-	-	-	-	-	-	11	-	40,181	-	40,192
Reallocation of central costs	290	(28,010)	11,430	4,137	(6,776)	754	9,625	1,274	7,276	-	-
Non-staff costs	**1,321**	**(2,859)**	**63,761**	**92,770**	**29,380**	**30,931**	**62,283**	**5,106**	**210,076**	**(910)**	**491,859**
Net expenditure	**4,925**	**16,301**	**104,914**	**136,528**	**36,559**	**40,567**	**117,037**	**23,949**	**233,100**	**(3,741)**	**710,139**

The reallocation of central costs attributes central overheads to programme and services.

Assurance and Risk Management

Provides independent assurance that strategic and delivery risks are being managed appropriately and in line with our approach to risk across live services, change programmes and corporate functions. Provides oversight to ensure compliance with standards and accurate and timely information, intelligence, analysis, and insight to enable robust decision-making.

Corporate Services

The centre of expertise and management for financial, commercial, people and workforce functions.

Data Services

As the data custodian for the health and care system, has primary responsibility for improving data quality and our ability to link data, transforming our data architecture and platforms and providing independent and reliable statistics to guide policy and research. All work is guided by an absolute respect for data privacy and a commitment to empowering healthcare research and the UK life sciences sector.

IT Operations

Responsible for the reliable, performant and secure operation of all live systems and services that we operate for the health and care system.

Cyber Operations

Provides trusted operational capability, ensuring that the health and social care system is resilient to cyber attacks, protecting individuals and technological advances in care.

Platforms

Provides the core infrastructure and platforms that connect digital service providers across the health and care system and delivers platforms to support NHS Digital's data services and product development.

Product Delivery

Designs and delivers new applications and services commissioned by NHS England, NHS Improvement, Public Health England and other arm's-length bodies to help citizens, patients and clinicians across primary, secondary and social care. Works with the external healthcare market and fosters digital knowledge and capabilities across the system.

Strategy, Policy and Governance

Defines our strategic direction based on the needs of our clients and evolving political, technical, government and market environments. Liaises with the Department of Health and Social Care, third parties and internal teams to ensure coherent and clear policies and governance. Provides clinical and information governance guidance and oversight.

COVID-19 delivery

Spend relates to delivery during the pandemic.

For the year ended March 2021

£000	Assurance and Risk Management	Corporate Services	Data Services	IT Operations	Platforms and Infrastructure	Product Development	Strategy, Policy and Governance	COVID-19 delivery	Central (not allocated to a segment)	Total
Income	**-**	**(299)**	**(20,328)**	**(638)**	**(824)**	**(19,182)**	**(914)**	**(2,952)**	**(161)**	**(45,298)**
Staff costs	**2,928**	**18,010**	**36,921**	**30,573**	**20,219**	**52,337**	**12,777**	**33,881**	**5**	**207,651**
Professional fees	1,049	3,255	18,554	14,786	24,183	11,883	2,340	49,195	(558)	**124,687**
Information technology	8	1,020	5,742	11,273	84,635	13,611	683	31,503	83	**148,558**
Accommodation	-	12,771	1	1	(43)	2	2	37	1,827	**14,598**
Travel and subsistence	1	63	6	5	7	15	4	218	-	**319**
Marketing, training, events and communications	15	1,872	91	144	14	48	101	128	(54)	**2,359**
Office services	-	1,514	25	30	146	128	141	79	1	**2,064**
Other	-	683	4	-	100	-	-	2,528	145	**3,460**
Loss on disposal of non-current assets	-	565	1,015	-	934	60	26	-	159	**2,759**
Depreciation and amortisation	402	1,956	9,935	7,147	19,542	25,240	828	5,504	171	**70,725**
Reversal of impairment – property plant and equipment	-	-	-	-	-	-	-	-	(85)	**(85)**
Impairment of intangible assets	-	-	-	-	-	-	-	17,532	-	**17,532**
Reallocation of central costs	287	(15,700)	7,227	3,218	(4,431)	8,183	1,216	-	-	**-**
Non-staff costs	**1,762**	**7,999**	**42,600**	**36,604**	**125,087**	**59,170**	**5,341**	**106,724**	**1,689**	**386,976**
Net expenditure	**4,690**	**25,710**	**59,193**	**66,539**	**144,482**	**92,325**	**17,204**	**137,653**	**1,533**	**549,329**

Note 3

Staff costs

	2021-22 £000	2020-21 £000
Permanent Staff		
Salaries and wages	**138,036**	131,428
Social security costs	**15,375**	14,284
Apprenticeship levy	**678**	628
Employer superannuation contributions – NHPCS	**26,100**	23,877
Employer superannuation contributions – other	**487**	404
Staff seconded to other organisations	**798**	1,049
Capitalised employed staff costs	**(10,125)**	(9,011)
	171,349	**162,659**
Other staff		
Temporary staff	**23,177**	**13,834**
Contractors	**73,329**	**32,872**
Staff seconded from other organisations	**1,388**	**1,028**
Capitalised other staff costs	**(6,214)**	**(3,402)**
	91,680	**44,332**
Staff costs	**263,029**	**206,991**
Termination benefits	**114**	660
Total staff costs including termination benefits	**263,143**	**207,651**

There were no amounts spent on staff benefits during the year and there were 2 (2020-21: 7) early retirements on the grounds of ill health. The costs of ill-health retirements are met by the NHS Pension Scheme.

Note 4

Income

Income analysed by classification and activity is as follows:

	2021-22 £000	2020-21 £000
Contract income		
Programme and service delivery	**36,920**	35,203
Surveys and data collection	**2,495**	1,208
Grant income	**1,302**	1,679
Fees and charges	**2,857**	3,489
Total contract income	**43,574**	**41,579**
Non-contract income		
Programme and service delivery	**234**	293
Sale of goods	**-**	2,175
Non-trading income	**866**	1,087
Apprenticeship levy utilisation	**189**	164
Total non-contract income	**1,289**	**3,719**
Total income	**44,863**	**45,298**

Income from programme and service delivery covers programme, project and service management, system support, hosting, training and helpdesk services.

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

Income from surveys and data collection refers to undertaking health surveys and other data collection activities.

'Sale of goods' relates to the purchase and resale of IT hardware at cost to other NHS bodies as part of the COVID-19 response.

Grant income received in year related to the National Core Study aimed at accelerating research on COVID-19, a digital innovation hub focussing on supporting the improved planning and delivery of clinical trials in the UK, and the ECHILD project, which is studying how disruptions to services during the national lockdowns affected children's health and education.

Fees and charges relate to data services and are detailed on pages 102 to 103.

£1,368,036 of income was included in contract liabilities at 31 March 2021 and £956,176 of this has been recognised in 2021-22, and £21,408 has been credited. The balance relates to future periods.

Payment terms are 30 days, except for purchases made online via our e-Store, where payment is due at the time of ordering.

Contract income expected to be recognised in future periods related to contract performance obligations not yet completed at the reporting date:

2021-22	Contract income not yet invoiced £000	Contract income invoiced and deferred £000	Total £000
Not later than 1 year	725	766	**1,491**
Between 1 and 5 years	462	190	**652**
Later than 5 years	-	-	**-**
	1,187	**956**	**2,143**

2020-21	Contract income not yet invoiced £000	Contract income invoiced and deferred £000	Total £000
Not later than 1 year	519	977	**1,496**
Between 1 and 5 years	223	391	**614**
Later than 5 years	-	-	**-**
	742	**1,368**	**2,110**

Note 5

Non-staff expenditure

	2021-22 £000	2020-21 £000
Expenditure		
Work packages and professional fees	**188,280**	118,922
Data collection and surveys	**5,157**	2,969
Legal fees	**2,230**	2,373
Chair's and non-executive directors' emoluments	**158**	144
Marketing, training and events	**2,598**	1,932
Travel	**661**	319
Premises and establishment	**10,516**	15,220
IT maintenance and support	**36,028**	29,953
IT managed services	**131,490**	118,605
General office supplies and services	**1,991**	2,168
Communications	**703**	263
Insurance	**150**	196
External audit fees	**167**	150
Internal audit fees	**290**	274
Apprenticeship levy training	**189**	164
Cost of goods sold	**-**	2,175
(Reversal of) / Expected credit loss on non-contract receivables	**-**	(24)
Other	**157**	242
Operating expenditure	**380,765**	**296,045**
Depreciation – property, plant and equipment	**4,927**	9,385
Amortisation – intangible assets	**63,488**	61,340
Impairments / (Reversals of) – property, plant and equipment	**157**	(85)
Impairments – intangible assets	**40,192**	17,532
Loss on disposal – non-current assets	**2,330**	2,759
Non-cash transactions	**111,094**	**90,931**
Total non-staff expenditure	**491,859**	**386,976**

Note 6

Non-current assets: property, plant and equipment

2021-22	Assets under construction £000	Computer hardware £000	Fixtures and fittings £000	Total £000
Cost or valuation				
At 1 April 2021	16,357	52,476	7,368	**76,201**
Additions	-	6,221	887	**7,108**
Reclassification	(16,357)	(168)	16,357	**(168)**
Transfer under absorption accounting	-	195	-	**195**
Disposals	-	(21,051)	(5,355)	**(26,406)**
Impairments and reversals to other operating expenditure	-	(303)	-	**(303)**
Revaluation and indexation to revaluation reserve	-	(196)	191	**(5)**
At 31 March 2022	**-**	**37,174**	**19,448**	**56,622**
Depreciation				
At 1 April 2021	-	37,789	4,881	**42,670**
Provided during the year	-	3,503	1,424	**4,927**
Transfer under absorption accounting	-	94	-	**94**
Disposals	-	(20,730)	(4,529)	**(25,259)**
Impairments and reversals to other operating expenditure	-	(147)	-	**(147)**
Revaluation and indexation to revaluation reserve	-	(125)	26	**(99)**
At 31 March 2022	**-**	**20,384**	**1,802**	**22,186**
Net book value at 1 April 2021	16,357	14,687	2,487	33,531
Net book value at 31 March 2022	**-**	**16,790**	**17,646**	**34,436**

The total depreciation charged in the statement of comprehensive net expenditure in respect of assets held under finance leases and hire purchase contracts was £1,277,346. All tangible assets are owned by NHS Digital, except computer hardware with a net book value of £1,123,808, accounted for as a finance lease in accordance with IFRIC 4 and paid in full at the outset.

The gross cost of property, plant and equipment that has been fully depreciated but is still in use reduced from £26,667,123 at 31 March 2021 to £6,116,113 at 31 March 2022 due to a detailed review of asset lives.

Transfers in under absorption accounting were in respect of the National Disease Registration Service, which transferred to NHS Digital from Public Health England on 1 October 2021.

Movement in the revaluation reserve property plant and equipment

	2021-22 £000	2020-21 £000
Balance at 1 April	183	852
Net gain / (loss) on revaluation of property, plant and equipment	94	(68)
Transfer to the general reserve	(109)	(601)
Balance at 31 March	**168**	**183**

2020-21	Land £000	Buildings £000	Assets under construction £000	Computer hardware £000	Fixtures and fittings £000	Total £000
Cost or valuation						
At 1 April 2020	310	2,158	5,857	50,737	12.252	**71,314**
Additions	-	-	10,499	5,730	225	**16,454**
Reclassification	-	-	-	1,679	-	**1,679**
Disposals	-	-	-	(5,670)	(4,789)	**(10,459)**
Transfer out as capital grant in kind	(533)	(1,777)	-	-	(373)	**(2,683)**
Impairments and reversals to other operating expenditure	125	(8)	-	-	(59)	**58**
Revaluation and indexation to revaluation reserve	98	(373)	1	-	112	**(162)**
At 31 March 2021	**-**	**-**	**16,357**	**52,476**	**7,368**	**76,201**
Depreciation						
At 1 April 2020	-	893	-	35,814	7,303	**44,010**
Provided during the year	-	32	-	7,444	1,906	**9,382**
Disposals	-	-	-	(5,469)	(4,224)	**(9,693)**
Transfer out as capital grant in kind		(760)	-	-	(148)	**(908)**
Impairments and reversals to other operating expenditure	-	-	-	-	(27)	**(27)**
Revaluation and indexation to revaluation reserve	-	(165)	-	-	71	**(94)**
At 31 March 2021	**-**	**-**	**-**	**37,789**	**4,881**	**42,670**
Net book value at 1 April 2020	310	1,265	5,857	14,923	4,949	27,304
Net book value at 31 March 2021	**-**	**-**	**16,357**	**14,687**	**2,487**	**33,531**

The total depreciation charges in the statement of comprehensive net expenditure in respect of assets held under finance leases and hire purchase contracts was £766,181. All tangible assets are owned by NHS Digital, except computer hardware with a net book value of £2,096,807 held under a finance lease. There were no finance lease liabilities outstanding at 31 March 2021

The gross cost of property, plant and equipment that has been fully depreciated but is still in use is £26,667,123.

The freehold building was independently valued in March 2021 by the Government Property Agency immediately prior to transfer.

Note 7

Non-current assets: Intangible assets

2021-22	Software licences £000	Information technology £000	Development expenditure £000	Websites £000	Total £000
Cost or valuation					
At 1 April 2021	33,457	359,754	27,313	3,720	**424,244**
Additions	3,688	147,503	13,151	348	**164,690**
Reclassification	168	17,795	(17,795)	-	**168**
Transfers in under absorption accounting	-	1,444	-	-	**1,444**
Impairments and reversals to other operating expenditure	-	(53,107)	-	-	**(53,107)**
Revaluation and indexation to revaluation reserve	-	2,065	228	24	**2,317**
Disposals	(458)	(8,074)	-	117	**(8,415)**
At 31 March 2022	**36,855**	**467,380**	**22,897**	**4,209**	**531,341**
Depreciation					
At 1 April 2021	16,966	164,483	-	2,105	**183,554**
Provided during the year	10,240	52,845	-	402	**63,487**
Transfers in under absorption accounting	-	514	-	-	**514**
Impairments and reversals to other operating expenditure	-	(12,916)	-	-	**(12,916)**
Revaluation and indexation to revaluation reserve	-	1,042	-	12	**1,054**
Disposals	(447)	(6,902)	-	117	**(7,232)**
At 31 March 2022	**26,759**	**199,066**	**-**	**2,636**	**228,461**
Net book value at 1 April 2021	16,491	195,271	27,313	1,615	240,690
Net book value at 31 March 2022	**10,096**	**268,314**	**22,897**	**1,573**	**302,880**

The total amortisation charged on the statement of comprehensive net expenditure in respect of assets held under finance leases and hire purchase agreements was £nil. All intangible assets are owned by NHS Digital.

The gross cost of intangible assets that were fully amortised but still in use is £18,029,717.

Information technology, development expenditure and websites are internally generated assets, created using a mix of staff and supplier resources. The value of own staff capitalised within intangible asset additions amounts to £16,339,501.

Research and development expenditure associated with intangible asset development has been recognised as an expense in note 3 and note 5 and is categorised by the nature of the spend incurred.

Transfers in under absorption accounting were in respect of the National Disease Registration Service, which transferred to NHS Digital from Public Health England on 1 October 2021.

Carrying value of material intangible assets

	2021-22			2020-21		
	Gross Book Value £000	Net Book Value £000	Remaining life months	Gross Book Value £000	Net Book Value £000	Remaining life months
NHS e-Referral Service	65,228	38,333	60	58,546	22,704	60
National Coronavirus Testing System	47,392	35,874	36	32,270	27,593	24
Spine 2	66,054	31,767	36	48,898	13,012	60
NHS App	34,238	19,786	60	27,702	19,189	60
NHS login	25,011	14,955	60	19,393	13,717	60
Cervical screening replatform	14,797	14,797	n/a	5,612	5,612	n/a
Data processing service	25,061	12,756	60	20,346	12,960	60
Interoperability and architecture	13,766	10,967	48	13,083	13,082	60
NHS.UK	18,973	8,297	60	15,813	8,592	60
Primary Care Registration Management	8,637	7,656	60	3,902	3,701	60

n/a indicates asset is still under construction.

Material intangible assets, ranked by current year net book value. The descriptions of 2 of the assets have been updated since the previous year to better describe their function. ‘NHS Online’ now appears in the table as ‘NHS App’ and ‘Citizen Identity’ now appears as ‘NHS login’.

Movement in the revaluation reserve: intangible assets

	2021-22 £000	2020-21 £000
Balance at 1 April	7,355	6,067
Net gain on revaluation of intangible assets	1,263	5,109
Transfer to general reserve	(3,616)	(3,821)
Balance at 31 March	**5,002**	**7,355**

2020-21	Software licences £000	Information technology £000	Development expenditure £000	Websites £000	Total £000
Cost or valuation					
At 1 April 2020	32,696	260,866	22,769	3,418	**319,749**
Additions	3,805	99,318	20,805	174	**124,102**
Reclassification	-	15,123	(16,802)	-	**(1,679)**
Net transfers in under absorption accounting	-	5,723	-	-	**5,723**
Impairments and reversals to other operating expenditure	-	(20,504)	-	-	**(20,504)**
Revaluation and indexation to revaluation reserve	-	8,024	541	128	**8,693**
Disposals	(3,044)	(8,796)	-	-	**(11,840)**
At 31 March 2021	**33,457**	**359,754**	**27,313**	**3,720**	**424,244**
Depreciation					
At 1 April 2020	10,921	119,100	-	1,427	**131,448**
Provided during the year	9,081	51,626	-	634	**61,341**
Impairments and reversals to other operating expenditure	-	(2,972)	-	-	**(2,972)**
Revaluation and indexation to revaluation reserve	-	3,540	-	44	**3,584**
Disposals	(3,036)	(6,811)	-	-	**(9,847)**
At 31 March 2021	**16,966**	**164,483**	**-**	**2,105**	**183,554**
Net book value at 1 April 2020	21,775	141,766	22,769	1,991	188,301
Net book value at 31 March 2021	**16,491**	**195,271**	**27,313**	**1,615**	**240,690**

The total amortisation charged on the statement of comprehensive net expenditure in respect of assets held under finance leases and hire purchase agreements was £nil. All intangible assets are owned by NHS Digital.

The gross cost of intangible assets that were fully amortised but still in use is £16,560,106.

Information technology, development expenditure and websites are internally generated assets, created using a mix of staff and supplier resources. The value of own staff capitalised within intangible asset additions amounts to £12,413,000.

Research and development expenditure associated with intangible asset development has been recognised as an expense in note 3 and note 5 and is categorised by the nature of the spend incurred.

Assets with a value of £7,304,528 were transferred in from the Department of Health and Social Care (DHSC) in July 2020, and assets with a value of £1,581,70 were transferred back to DHSC in September 2020.

Note 8

Other non-current receivables

	31 March 2022 £000	31 March 2021 £000
Prepayments	4,672	6,344

Non-current prepayments relate to software licences and support extended hardware warranties.

Note 9

Trade receivables and other current assets

Amounts falling due within 1 year	31 March 2022 £000	31 March 2021 £000
Contract receivables invoiced	9,672	12,706
Other receivables	182	271
Value Added Tax	15,710	18,324
Prepayments and other receivables	19,061	14,006
Contract receivables not yet invoices	7,069	2,016
Other accrued income	3	13
Total trade receivables and other current assets	**51,697**	**47,336**

Note 10

Cash and cash equivalents

	31 March 2022 £000	31 March 2021 £000
Balance at 1 April 2021	22,641	19,837
Net changes in cash and cash equivalents	(3,211)	2,804
Balance at 31 March 2022	**19,430**	**22,641**

Bank balances were held during the year with NatWest under the Government Banking Service.

Note 11

Trade and other payables

Amounts payable within 1 year	31 March 2022 £000	31 March 2021 £000
Trade and other payables	24,543	42,235
Income tax, national insurance and superannuation	7,368	6,453
Contract liabilities	956	1,368
Accruals	67,372	50,305
Total trade and other payables	**100,239**	**100,361**

Note 12

Provisions for liabilities and charges

	Dilapidations £000	Injury benefit £000	Termination benefits £000	Total £000
Balance at 1 April 2021	5,466	633	308	**6,407**
Arising during the year	1,485	3	-	**1,488**
Utilised during the year	(272)	(29)	(308)	**(609)**
Reversed unused during the year	(1,256)	-		**(1,256)**
Balance at 31 March 2022	**5,423**	**607**	**-**	**6,030**

Expected timing of cash flows				
Within 1 year	-	29	-	**29**
1 to 5 years	118	116	-	**234**
Over 5 years	5,304	463	-	**5,767**

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

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

Termination benefits relate to the anticipated cost of redundancies where specific employees have been notified as ‘at risk’, but formal notice has not been provided.

Note 13

Capital commitments

Capital commitments amount to £587,717 (31 March 2021: £512,551). Of this £390,069 relates to ordered IT equipment and £197,648 relates to software licences and development work.

Note 14

Other financial commitments

NHS Digital has not entered into any non-cancellable contracts (which are not operating leases) for the provision of services as at 31 March 2022 (31 March 2021: £nil).

Note 15

Contingent assets and liabilities

Contingent liabilities amount to £57,000 (31 March 2021: £175,000) and relates to estimated potential employment-related claims.

Note 16

Commitments under operating leases

Expenditure includes the following in respect of operating leases:	2021-22 £000	2020-21 £000
Accommodation	5,720	6,264
Other operating leases	(4)	45
	5,716	**6,309**

At the reporting date non-cancellable operating lease commitments were:	31 March 2022 £000	31 March 2021 £000
Land and buildings		
Not later than 1 year	**6,198**	**5,259**
Between 1 and 5 years	**24,030**	**18,467**
Later than 5 years	**58,516**	**57,263**
Total land and buildings	**88,744**	**80,989**
Other leases		
Not later than 1 year	**-**	**2**
Between 1 and 5 years	**-**	**-**
Later than 5 years	**-**	**-**
Total other leases	**-**	**2**
Total	**88,744**	**80,991**

In 2020-21, the Leeds Government Hub commitments were calculated based on an end date of 4 October 2040. However, the final signed Memorandum of Terms of Occupation (MOTO) confirmed the first break option is 4 August 2039. This has led to a reduction in the total lease liability over the contract term of £4,604k. Therefore the lease liability later than 5 years should have been £52,659k.

Note 17

Lease Incentives

	2021-22 £000	Re-presented 2020-21 £000
Balance at 1 April	11,675	-
Received during the year	413	11,985
Released during the year	(669)	(310)
Balance at 31 March	**11,419**	**11,675**
Lease incentive - current	658	638
Lease incentive - not current	10,761	11,037
	11,419	**11,675**

The numbers for 2020-21 have been represented to add clarity and transparency for reporting. Whilst the ending balance is unchanged the lease incentive received and utilisation of the lease incentive have been presented as individual components in both the above table and in the Statement of Cash Flows.

Note 18

Related Parties

The Health and Social Care Information Centre, also known as NHS Digital, is an executive non-departmental public body created by the Health and Social Care Act 2012. It is sponsored by the Department of Health and Social Care (DHSC), and DHSC, together with its associated bodies, are therefore regarded as related parties. During the year, NHS Digital had the following transactions with DHSC group bodies: income £32.1 million (2020-21: £35.9 million) and expenditure of £4.6 million (2020-21: £9.3 million), and, at 31 March 2022, had the following balances with DHSC group bodies: £12.2 million receivables (2020-21: £11.3 million) and £3.4 million payables (2020-21: £1.1 million). The major customers within the group were the DHSC, NHS England and Public Health England (latterly, known as the UK Heath Security Agency). The majority of expenditure related to transactions with the Department of Health and Social Care.

In addition, NHS Digital has had a number of transactions with other government departments and other central and local government bodies. In order to reduce the volume of detailed disclosures, IAS 24 does not require the disclosure of transactions between bodies under the control of the same government.

No special terms and conditions were applicable to transactions with related parties. No guarantees or security were accepted or given. All transactions were or will be settled in cash. No provisions were made for doubtful debts in respect of these transactions. The bad debt expense in the year relating to related parties amounted to: £nil (2020-21: £nil).

	Related to roles within NHS Digital	Amounts payable at 31 March 2022 £000	Amounts receivable at 31 March 2022 £000	Income in 2021-22 £000	Expenditure in 2021-22 £000
Accenture (UK) Ltd	Non-executive directors	2,623	-	-	51,445
King's College London	Chief Executive	-	-	2	-
McKinsey & Company	Non-executive director	-	-	9	345
University College London	Non-executive director	-	43	182	31
University Of Oxford	Chief Executive and non-executive director	-	16	399	207
		2,623	**59**	**592**	**52,028**

In addition, at 31 March 2022, there were capital commitments of £nil (2020-21: £47,722) with Accenture (UK) Ltd.

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

Note 19

Financial instruments

As the cash requirements of NHS Digital are met through grant-in-aid by the Department of Health and Social Care, and invoiced income largely received from the Department of Health and Social Care and its related bodies, 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 NHS Digital's expected purchase and usage requirements and NHS Digital is therefore exposed to little credit, liquidity or market risk.

a) Market risk

NHS Digital was not exposed to material currency risk or commodity risk. All material assets and liabilities were denominated in sterling. NHS Digital 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. Most high-value receivables relate to balances with the Department of Health and Social Care and its related bodies against purchase orders and therefore do not represent a significant credit risk. NHS Digital had a comparatively small value of external receivables and therefore disclosure of the largest individual debt balances was not considered in the evaluation of overall credit risk.

Movement in the provision for expected credit losses	2021-22 £000	2020-21 £000
Balance at 1 April	8	32
Provided for in the year	2	8
Reversed unutilised	(2)	(32)
Amounts written off in the year as uncollectible	-	-
Balance at 31 March	**8**	**8**

The provision for expected credit losses is assessed on an individual debt basis.

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

	Current £000	<30 days overdue £000	31-60 days overdue £000	>61 days overdue £000	Total £000
Balance at 31 March 2022	**9,343**	**209**	**145**	**157**	**9,854**
Balance at 31 March 2021	10,085	32	1,298	1,562	12,977

NHS Digital's standard payment terms are 30 days from date of invoice. The maximum exposure to credit risk at the reporting date is the fair value of each class of receivables mentioned above. NHS Digital did not hold any collateral as security.

c) Liquidity risk

Liquidity risk is managed through regular cash flow forecasting. NHS Digital had no external borrowings and relies on grant-in-aid from the Department of Health and Social Care for its cash requirements and was therefore not significantly exposed to liquidity risks. The table below analyses NHS Digital's financial liabilities that will be settled on a net basis in the period of less than 1 year. The carrying value of financial liabilities was not considered to differ significantly from the contractual undiscounted cash flows:

	31 March 2022 £000	31 March 2021 £000
Current liabilities	100,239	100,361

Note 20

Events after the reporting period

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

Since the reporting year end, it has been announced that the effective date of the merger with NHS England, will be effective from early January 2023.

There are no other events on which to report.

Note 21

Authorised date for issue

NHS Digital's Annual Report and Accounts are laid before Parliament. IAS 10 requires NHS Digital to disclose the date on which the Annual Report and Accounts are authorised for issue.

The Accounting Officer authorised these financial statements for issue on 4 November 2022.

Appendices

Appendix A – Embedding sustainability across our organisation

Our goal is for sustainability thinking to be embedded in everything we do. To achieve this, we need to inform and motivate our staff. In 2021-22, our Corporate Sustainability Programme improved access to sustainability data, increased transparency of our environmental impact and raised awareness of the sustainability agenda. All areas of our organisation, from corporate functions like Human Resources, Estates and Commercial, to ICT and Live Services, as well as individual employees have been actively involved in delivering sustainability improvements.

During 2021-22, we:

- recorded a good set of results across the Greening Government Commitments (GGC) against our baseline of 2013-14. The results for 2021-22 are affected by COVID-19 impacts in a similar way to 2020-21
- supported and complied with Procurement Policy Note PPN 06/20 ('Social Value weighting to the Award of Central Government Contracts'). Our Commercial team applied a 10% social value weighting to 86% of its new procurements. We are also now tracking the application of social value themes as part of the Commercial senior management team's regular reporting
- continued to make significant progress in moving services from on-premise data centres to the public cloud in response to The Technology Code of Practice (TCOP) Sustainability Principle. As of March 2022, 56% of NHS Digital applications are now hosted on the cloud
- migrated all services hosted in the HM Land Registry data centres to more sustainable Crown hosting and public cloud arrangements
- improved the transparency of our cloud hosting reporting
- reduced the impact of the applications used by our staff, by finding different ways to address the requirements of those applications that were particularly resource-hungry. This resulted in reduced downtime and increased productivity across end-user devices, for instance by cutting the level of server and computer resources required to host archives for our end users
- continued to improve our buildings, estates and ICT waste management
- reduced the level of infrastructure and network WEEE (Waste Electrical and Electronic Equipment) waste going to landfill to less than 0.1%
- of the total support assets disposed in the year, 75% were resold for reuse, the remaining 25% were recycled with the following results:

  2,644,055kg Co_2 saved through reuse, 9,385kg Co_2 saved through recycling, 1,421,833,333 litres of water saved, 10,576,219 tonnes of earth not mined, and 13,424kg of ICT equipment not destined for landfill

- donated 95 Surface Pro 4 devices, which were at the end of their normal useful life, to 2 schools and 2 hospitals
- left our Trevelyan Square office in quarter 1 2021-22 with 0% waste going to landfill
- set out our sustainability pledges in support of the Greener NHS programme. We asked employees about sustainability in our Pulse Survey to find out what mattered to them, and then responded by offering a range of sustainability-themed opportunities, including a virtual masterclass by a sustainability expert in January 2022, an employee Home Energy Guide to support our move to hybrid working, and providing regular sustainability 'top tips' in our weekly all-hands newsletter

We recognise our responsibility to drive and support change that can deliver a positive contribution to the UK Greening Government Commitments and the global climate change challenge.

We are planning multiple initiatives in 2022-23, building on the progress we have made, including:

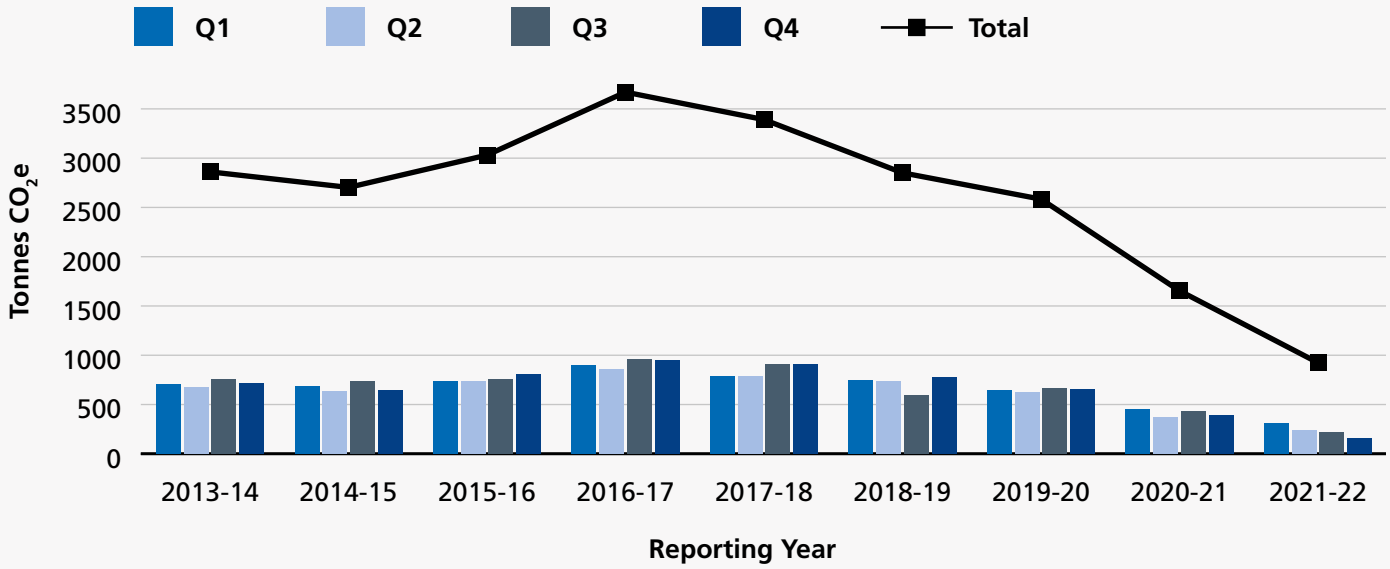
- increasing the adoption and optimisation of cloud services both within NHS Digital and across the wider NHS
- continuing to improve the transparency and accuracy of our carbon footprint data, including focusing on the impact of our hybrid working policy. We will reflect this in our organisational reporting
- developing guidance and tooling to allow programmes to estimate the net impacts of their digital services
- improving engagement with, and assessment of, our supply chain, in particular our suppliers' sustainability plans and impacts
- continuing our engagement with our employees on sustainability

Our carbon footprint

NHS Digital was established in 2013. Data from our predecessor organisations was incomplete and our adopted baseline of 2013-14 reflects this.

Sustainability performance 2021-22 compared with 2013-14

The data in this section for both 2021-22 and 2013-14 is based on NHS Digital's reporting within the scope of the Greening Government Commitments (GGC).



The Greening Government Commitments (GGC) set out the actions UK government departments and their agencies will take to reduce their impacts on the environment. We submit quarterly and annual GGC reporting for our estate to DHSC. To prevent duplication of data across the full government estate, GGC reporting requires that departments and their agencies do not include cost or usage data associated with any government buildings within their estate where they are not the landlord.

GGC requires individual departments to publish their own sustainability reports, either as part of their annual report, or as separate reports. Our Sustainability Annual Report for 2020-21 was published on 9 December 2021, and is available here: https://digital.nhs.uk/about-nhs-digital/corporate-information-and-documents/sustainability-reports/sustainability-annual-report-2020---2021. Our report for 2021-22 will be published later in 2022, and will be made available on our website.

Appendices

Element	% Change from baseline year	Observations
Total GGC scope (tonnes CO_2e)	68% reduction[1]	
Electricity consumption (tonnes CO_2e)	62% reduction[1]	Reduction resulting from installation of solar panels at Exeter in 2019-20.
Gas use (tonnes CO_2e)	88% reduction[1]	
Water use [m^3]	78% reduction[1]	
Waste diverted from landfill [tonnes]	93% increase	
Waste diversion rate	32% increase	
Paper procurement [reams]	97% reduction[1]	
Travel carbon footprint (tonnes CO_2e)	93% reduction[1]	2021-22 data includes 2 additional metrics (taxi journeys and car travel) which weren't available at the time of the 2013-14 baseline data set.

[1] The results for 2021-22 are affected by COVID-19 impacts in a similar way to results for 2020-21.

Appendix B – Board members' biographies and register of interests

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

The register of interests of board directors is included within the board papers for each public meeting: https://digital.nhs.uk/about-nhs-digital/our-organisation/nhs-digital-board/board-minutes-and-papers

The summary of directors' expenses can be viewed at https://digital.nhs.uk/about-nhs-digital/our-organisation/nhs-digital-board/board-members/nhs-digital-board-directors-expenses

Managing directors

Simon Bolton
Interim Chief Executive

Simon joined NHS Digital in June 2021. He is also the Interim Chief Information Officer (CIO) for NHS England, which falls under the newly formed Transformation Directorate.

Prior to joining NHS Digital, Simon was the CIO at NHS Test & Trace and has held a number of executive technology leadership roles including CIO of Jaguar Land Rover and CIO of Rolls-Royce's Land and Sea Division.

Simon was appointed as an Independent Member of Governing Council for The University of Derby in April 2019 and is also on the Board of Tech Partnership Degrees, an employer-led and not-for-profit organisation that unites employers and universities to improve the flow of talent into the digital workforce. Simon is also a Member of the Board of Advisors for Armis, a computer and network security company based in California.

Pete Rose
Deputy Chief Executive and Chief Information Security Officer

Pete Rose joined NHS Digital in May 2020 as Deputy Chief Executive. He died in August 2021.

Pete was an outstanding public servant with a long track record of delivering digital and technology services to the British public. He made a significant contribution to our response to the pandemic, leading our service operations, infrastructure, collaboration services and cyber security functions during one of the most intense and challenging periods in our history.

Before joining NHS Digital, he was Deputy Chief Digital, Data and Technology Officer for the Home Office. He had previously served in the Cabinet Office and had held senior roles in the private sector.

Sarah Wilkinson
Chief Executive
(until June 2021)

Sarah joined NHS Digital in August 2017. She was previously CIO at the Home Office and, prior to that, worked in financial services, where she held CIO roles at Credit Suisse, UBS, Deutsche Bank and Lehman Brothers.

Sarah is also a non-executive director of NatWest Markets, the investment banking arm of The NatWest Group, and a member of the Audit, Risk and Compliance Committee of King's College London.

Executive directors

Carl Vincent
Chief Financial Officer
(until October 2022)

Carl joined NHS Digital in June 2013 on secondment from the Department of Health and Social Care (DHSC) and became permanent 2 years later. As well as leading the finance and estates functions, he has also provided temporary leadership to a number of corporate and delivery functions.

Carl has an MSc in Health Economics and joined the DHSC as an economist in 1996, where he worked in a range of roles in analytical services, commercial and finance. He also spent a year on secondment at Ernst & Young.

Pete Thomas
Interim Chief Financial Officer
(from October 2022)

Pete joined NHS Digital in January 2016 as Commercial Director and became Finance Director the following year.

He has extensive experience working within the health sector. Between January 2013 and January 2016, Pete was Commercial Director at NHS Yorkshire and Humber Commissioning Support Unit (CSU) and was previously on secondment as Interim Chief Financial Officer at NHS West Yorkshire CSU. Pete has held senior roles within professional services, where he focused on financial management and corporate finance, working for organisations such as KPMG and Deloitte and advising public and private organisations including DHSC and the NHS.

Pete is a qualified accountant and trustee of Cardiomyopathy UK.

Non-executive directors

Professor Jonathan Benger CBE
Chief Medical Officer

Jonathan joined NHS Digital in October 2019. He is Professor of Emergency Care at the University of the West of England and an NHS consultant in emergency medicine and pre-hospital care. He works as a clinician at the Bristol Royal Infirmary and with the Great Western Air Ambulance, which he established as its first medical advisor between 2007 and 2011.

Between May 2013 and July 2019, Jonathan was the National Clinical Director for Urgent Care at NHS England and led reform of the ambulance services and wider emergency care system. This included the implementation of the NHS England review of Urgent and Emergency Care, the development of the NHS Long Term Plan, and the Emergency Care Data Set. Before 2013, Jonathan chaired the Clinical Effectiveness Committee of the Royal College of Emergency Medicine and served on the college's council and executive board.

Laura Wade-Gery
Chair

Laura is Chair of the NHS Digital Board, as well as Chair of the People and Transition Committee.

Laura is also a non-executive director of NHS England.

Laura has over 20 years' business experience having worked for several large businesses, including Marks & Spencer Group and Tesco. She joined Marks & Spencer Group in 2011 and was Executive Director, Multi-Channel, responsible for stores and online until 2016. She was CEO of Tesco.com from 2003 to 2011, and previously held several senior roles at Tesco, having joined them in 1997.

Laura is currently a non-executive director of British Land PLC (and Chair of its Remuneration Committee) and of Legal and General Group. She is a trustee of Britten Pears Arts. She was an advisor to the Government Digital Service from 2012 to 2016 and a non-executive director of the John Lewis Partnership from 2017 to April 2021.

Appointed to the Board: 1 September 2020

Professor Sudhesh Kumar OBE

Sudhesh is Vice Chair of the NHS Digital Board.

He is Dean of the Warwick Medical School at University of Warwick, a non-executive director on the University Hospitals Coventry & Warwickshire NHS Trust Board, and a member of the External Advisory Board at Brunel Medical School.

Sudhesh is a clinical endocrinologist by background with 24 years' experience as a consultant physician in the NHS. His research interests include developing novel approaches, including medical technology, to managing obesity and diabetes that have helped to transform and improve patient care and treatment. He has published over 240 papers and 6 books on these subjects.

Appointed to the Board: 1 January 2017

Daniel Benton

Daniel is Senior Independent Director of the NHS Digital Board.

He spent most of his career at Accenture, where he was global head of the Technology Strategy and Digital Strategy practices. He has extensive experience both of setting and implementing the technology agendas for large organisations through periods of transformational change, including the implementation of advanced consumer-facing technologies. He led much of Accenture's thinking around the impact of technology on business and on transforming IT organisations. He was also seconded twice as CIO to an international bank and a large global insurer.

Daniel is a trustee of The Grange Festival.

Appointed to the Board: 1 January 2017

Deborah Oakley

Deborah is Chair of the Audit and Risk Committee (ARC).

She has a long-standing passion and commitment to the NHS which stretches back to 2000 when she started as a volunteer at University College Hospitals. She was formerly a non-executive director and chair of the audit and risk committee of the Medicines and Healthcare Products Regulatory Agency (MHRA), chair of the audit committee at the Royal Free London NHS Foundation Trust, chair of the Health Protection Agency's Biological Medicines Technical Committee and chair of the Audit Committee at NHS Camden.

Deborah's executive career is in financial services. She worked at Newton Investment Management for 20 years and became a director of the company. Since 2010 she has worked at Veritas Investment Partners (UK) Limited where she is an Investment Partner managing portfolios for private clients, trusts and charities.

Deborah is involved in several charitable projects including a winter homeless night shelter, a food bank and a welfare scheme in Camden.

Appointed to the Board: 1 July 2018

Balram Veliath

Balram is currently the Director of Quality, Risk and Assurance at the BBC where his responsibilities include internal audit, risk management, safety and security, and assurance of critical projects. Previously, he has worked in senior executive roles with Royal Bank of Scotland and ABN Amro covering internal audit and risk management across operations and technology. Prior to this he worked at KPMG for 12 years, including as Partner with responsibility for financial audits across a range of sectors.

Balram qualified as a chartered accountant in 1988 and has over 25 years' experience of risk governance including developing and implementing risk management systems, assisting organisations to assess their capacity to handle risk, and supporting boards with monitoring and assessing culture, diversity and inclusion. He is also on the College Council of Royal Holloway, University of London and is the Chair of the Audit Risk and Compliance Committee.

Appointed to the Board: 1 July 2018

John Noble CBE

John is Chair of the Information and Cyber Security Committee.

Formerly, he was Director of Incident Management at the National Cyber Security Centre, where he led on nearly 800 major cyber incidents. Prior to that, John spent 4 years at the British Embassy in Washington DC.

During his 40 years of government service, John has specialised in operational delivery and strategic business change. He was awarded a CBE in 2012 for his work in creating effective partnerships in the run up to the London 2012 Summer Olympics.

Appointed to the Board: 1 July 2018

Ben Goldacre

Ben joined the Board of NHS Digital as a non-executive director on 1 April 2021.

He is a professor at the University of Oxford, where he is also Director of the Bennett Institute for Applied Data Science, building tools and research outputs from large health datasets and advising government on better uses of data and technology.

He leads various open-source technology projects at the University of Oxford including OpenSAFELY.org, a new model of secure analytics platform that runs across unprecedented volumes of linked primary and secondary care electronic health record data; OpenPrescribing.net, an open data explorer for NHS primary care prescribing with over 130,000 users a year; and TrialsTracker.net, a tool that monitors clinical trial reporting performance.

His books, including 'Bad Science', have sold over 700,000 copies in more than 30 countries. His online lectures have over 5 million views.

Appointed to the Board: 1 April 2021

Steven Woodford

Steve is a member of the Information Assurance and Cyber Security Committee and the Investment Committee.

Until May 2022, he was CIO at BGL Group, home of comparethemarket.com and provider of motor, home and life insurance products from several of the best-known brands in UK financial services including Budget Insurance, Dial Direct and Beagle Street.

Steve's responsibilities include all aspects of technology, business continuity, information security, data platforms and AI / machine learning.

Steve has a strong track record of leading bold technology-enabled business transformation for global organisations in fast-moving, highly regulated sectors. He has developed over 25 years' experience through directorship positions with PwC, BGL Group and tech start-ups, working with organisations as varied as Pfizer, Nestle, GlaxoSmithKline, SBO Bet, Microgaming, Microsoft, BBC and Zurich Insurance. He is a trustee for the UK charity Dr Frost Maths, which provides free online maths learning resources for children across the world.

Appointed to the Board: 1 April 2021

Patrick Eltridge
(until September 2022)

Patrick was a member of the Investment Committee and the People and Transition Committee.

He is currently the Chief Operating Officer at Nationwide Building Society where he leads on technology, digital, operations, data, security, payments, risk and controls, supply chain and property.

In roles prior to Nationwide, Patrick was Group CIO at Royal Bank of Scotland (now NatWest) and Group CIO for Telstra, Australia's largest telecommunications business.

Patrick has a career spanning over 30 years with experience including financial services, telecommunications, consulting and technology start-ups.

Appointed to the Board: 1 April 2021

Dr Marko Balabanovic

Marko has over 25 years' experience developing innovations in academia, corporations and start-ups in both the UK and US. As Technology Director at Our Future Health (previously Early Disease Detection Research Project UK), his role is to develop the technology platforms to underpin one of the world's foremost health research programmes. Previously, as Head of Innovation and Artificial Intelligence at Huma, he was creating market-leading digital health technologies. Prior to that, he was Chief Technology Officer at Digital Catapult, working across emerging technologies including machine learning, 5G, the Internet of Things, virtual and augmented reality and blockchain.

Marko has been instrumental in bringing several new technologies to market. At a start-up called State he helped to launch a digital global opinion network. Formerly, Marko was Head of Innovation at lastminute.com, where his team launched an array of award-winning mobile apps. Marko studied Computer Science at Cambridge University and has a PhD in Computer Science (Artificial Intelligence) from Stanford, where he led foundational work on recommender systems.

Term expired: 31 December 2021

Professor Soraya Dhillon MBE

On the NHS Digital Board, Soraya has a non-executive director oversight role for raising concerns and whistleblowing.

Soraya has over 35 years' experience in academia and clinical practice. She retired as Dean of School of Life and Medical Sciences at the University of Hertfordshire in November 2016 and is Emeritus Professor in Clinical Pharmacology.

Soraya has held several senior non-executive posts in the NHS since 1991. She was chair of Luton and Dunstable University Hospital NHS Foundation Trust (1999-2010), non-executive director and vice chairman at The Hillingdon Hospitals NHS Foundation Trust (2014-2020), a member of the General Pharmaceutical Council and a board director for the Eastern Academic Health Science Network.

Soraya is a non-executive director at Health Education England. She is a fellow of the Royal Pharmaceutical Society, holds the Charter Gold Medal for Science and Practice and was awarded an MBE for her contribution to Health Services in Bedfordshire.

Term expired: 31 December 2021

Ex-officio Board members

Simon Madden
(from 9 May 2022)

Simon is Joint Head of the NHS Transformation Digital Policy Unit and Director of Data Policy in the Department of Health and Social Care.

He is a career civil servant with experience in frontline operations, policy development, project delivery, strategy, planning and performance. His previous posts have included Director of Places for Growth in the Cabinet Office, leading a cross-government programme delivering a commitment to move public bodies and civil service roles out of London into the regions and nations of the United Kingdom; and Deputy Director of the Prime Minister's Implementation Unit where he led on government planning and performance strategy.

Matthew Gould
(until 5 May 2022)

Matthew was the CEO of NHSX, prior to the organisation integrating with the Transformation Directorate at NHS England in early 2022.

Before joining NHSX, he was the government's Director-General for Digital and Media Policy for 3 years. Before that, he was British Ambassador to Israel, where he set up the UK-Israel Tech Hub, and the UK government's Director of Cyber Security. He also served in Tehran, Islamabad, Washington and Manila.

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Contact us:
0300 303 5678
enquiries@nhsdigital.nhs.uk
www.digital.nhs.uk

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978-1-5286-3692-6