Annual Report
and Accounts
2016-17

NHS Digital

Information and technology for better health and care

Health and Social Care Information Centre (HSCIC) Annual Report and Accounts 2016-17.

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Foreword

Over the past year, we have begun to change NHS Digital to underpin the delivery of one of the most significant digital health and care initiatives anywhere in the world.

We have taken steps to align ourselves closely with the NHS England Five Year Forward View and the delivery plans of NHS England, NHS Improvement and the Care Quality Commission.

We have also completed a review of our own capability to help us build the skills and attract the talent we need to continue to be the trusted technology partner of the health and care system and to work with the agility our new role requires of us.

We are reinventing the culture of NHS Digital to become more flexible and responsive to the very dynamic environment in which we operate and to help this organisation meet the high expectations of the professionals and public we serve.

Our job, above all else, is to help our partners use the power of digital technologies to improve the quality, safety, efficiency, reliability and sustainability of all services in a patient-centric NHS and care system.

This report describes real strides on this journey. We are in the early stages of breakthroughs in the way care is delivered to the public and, in 2017 and 2018, we will see the £4.2 billion investment programme in digital transformation begin to deliver major changes and set the groundwork for further improvement.

While laying the foundations of transformation, we have continued to efficiently and securely operate the mission-critical IT infrastructure and the digital services that help frontline staff provide first-rate care across the system.

And we have done all this with a clear understanding that protecting every citizen's data and ensuring the reliability of the NHS's IT infrastructure is fundamental. Recent cyber attacks have brought sharper public focus to our role as the lead national partner for cyber security in the NHS and this report describes our work with local organisations to meet this challenge.

Across our operations, we have looked at what we are doing and challenged ourselves to do better. We have forged new relationships with suppliers, partners and customers and we have kept a steady eye on delivering the tangible improvements for frontline professionals, citizens and system leaders that are the ultimate measure of our success.

I am proud of the contribution our 2,700 staff have made over the past year and excited about the way we are enabling the NHS to deliver sustainability, efficiency and better health and care over the coming year.

Noel Gordon
Chair

We are reinventing the culture of NHS Digital to become more flexible and responsive to the very dynamic environment in which we operate.

Performance report
Chief Executive's introduction

The reason NHS Digital exists is to provide technology that improves people's lives. Our job is supporting better health, better care and a more effective system that makes taxpayers' money go further – not 'computerising' or 'going paperless' for their own sake.

I am pleased to say we have achieved concrete results on all of these fronts in 2016-17.

In September, the e-Referral Service reported it had saved the NHS £10 million in its first year of operation. This is part of a pattern of better, more flexible and more efficient delivery of the core IT infrastructure of the NHS as we have insourced key national services since 2014.

We are saving tens of millions of pounds a year (see page 12) and providing the flexible, robust infrastructure the system needs. In 2016-17, messaging reliability on the NHS Spine was 100 per cent for the entire year despite increasing the volume of messages to nearly 900 million messages a month.

We are also continuously improving the information services that provide the basis for good policy and improved models of care. We published 292 official and national statistical publications and 30 clinical audit reports in the year, including landmark publications like the National Diabetes Audit, the Adult Psychiatric Morbidity Survey and new statistics on the health and care of people with learning disabilities.

We made a fast start on rolling out a unified free Wi-Fi service, with 1,000 GP practices up and running by the end of March, and expect to have coverage across the NHS estate by April 2019.

We delivered new systems for the breast screening programme, developed an NHS Apps Library aimed at helping patients find the digital health tools most appropriate for them and, in August, we completed the transfer of 1.1 million email accounts to the new NHSmail2 programme – the largest single-tenancy email migration in the world.

We have reorganised how we work with local health and care organisations – our vital partners at the frontline of health and care – so that we are linking up much more effectively with NHS England and NHS Improvement's regional teams and providing a more coherent and supportive offering to local organisations.

This is critical because, however excellent our services are, they will only benefit the public if they are implemented on the ground. We saw good progress on implementation in the last year. The number of GP surgeries live on the Electronic Prescription Service rose from 75 per cent to 89 per cent. Ninety-six per cent of the population have a Summary Care Record (SCR) and 18 per cent have an extended SCR with rich clinical functionality. From a standing start 18 months ago, we rolled out access to SCRs to 93 per cent of England's community pharmacies and about 85 per cent of pharmacies now also have NHSmail2 accounts.

The importance of close partnerships with the local NHS is perhaps nowhere so clear as in cyber security. The WannaCry ransomware attack in May fell outside the 2016-17 reporting period, but put fresh focus on this challenge and on our role as the lead national partner for cyber security in the health and care system (see page 18).

Our CareCERT service distributed notifications to 2,095 organisations hit by infections in 2016-17. The service also provided response guidance on specific threats to our network of local partners, including the security patches that were issued at the end of the year that kept thousands of properly updated NHS devices immune from the WannaCry threat.

We significantly expanded our cyber support in the year, offering new assurance tools, training and increased direct support for organisations under attack. To meet the challenges of the cyber security environment, we will need better awareness and skills across the system and, in 2017-18, NHS Digital will continue to work with local and national partners to achieve this.

I took over as NHS Digital's interim Chief Executive from Andy Williams in February. The achievements described in this report are those of the organisation he headed and drove forward since 2014. Over the past year, we have reshaped our Executive Management Team and our Board, recruiting a new Chair and bringing in new skills and perspectives among both our executive and non-executive leadership. We have conducted a capability review to assure our ability to deliver our new commitments and our programmes have been recruiting aggressively to get the skills they need.

In 2016-17, NHS Digital took on a new role in the health and care system and heavy new responsibilities. We face significant challenges, but this report describes an organisation that is fitter than ever to drive the digital revolution the health and care system needs.

Rob Shaw
Interim Chief Executive

The reason NHS Digital exists is to provide technology that improves people's lives.

What we do

Our purpose is to harness the power of information and technology to make health and care better by:

Designing and building new technology and systems

Running live IT services and infrastructure

Collecting and publishing data and information about health and care

Helping partners use information and technology securely and effectively

Our values underpin all of this work. We are:

Professional	Innovative
People focused	Trustworthy

Overview

NHS Digital transformed its role in 2016-17, taking on new responsibilities as the lead national delivery partner for the drive to improve the use of data and digital technologies in the health and care system.

In August, we changed our trading name from the Health and Social Care Information Centre (HSCIC) to NHS Digital to help us better communicate our expanded role. The new name more accurately reflects the extent of our work in designing and building new digital technology, providing data and information and running the live IT services that the health and care system relies on in its day-to-day operations.

By making it easier for the public and our system partners to understand what we do, we can engage more effectively with them and be held more accountable for delivery.

In changing our name, we kept our existing responsibilities as the health and social care system's lead IT and data partner. We were established in April 2013 as an Executive Non-Departmental Public Body (ENDPB) under the Health and Social Care Act 2012 and our name in statute remains the 'Health and Social Care Information Centre'.

We retain statutory duties to manage key services that underpin local health and care provision (eg. the NHS Spine and the e-Referrals service), to collect and present national data and publish national statistical reports, to publish technical standards and guidance in areas such as governance and security, to maintain indicators used to measure the quality of services, to improve data quality and to advise the Secretary of State for Health on ways to reduce the burdens of national data collections on local organisations.

Our new national role

In 2016-17, we worked with national and local partners to define the portfolio, programmes and governance structures to deliver technology and digital services vital to building a smarter health and care system that empowers the public and does more to prevent illness.

In April 2016, the Secretary of State endorsed the National Information Board's plan for 10 domains of delivery for this £4.2 billion digital transformation effort. These domains connect work by all partners to clearly defined system outcomes (see table overleaf).

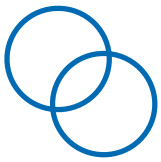
By making it easier for the public to understand what we do, we can be held more accountable for delivery.

Ten domains to support and transform our health and care system

Patient engagement:
Self-care and preservation
Help patients to take control of their own health and care and reduce the pressure on frontline services.

Urgent and emergency care
Improve telephone and online triage and provide better technology to support clinicians so that treatment is better targeted.

Transforming General Practice
Use technology to free general practice from time consuming administrative tasks and provide patients with online services.

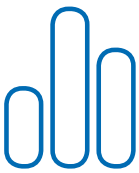


Integrated care and social care
Inform clinical decisions across all health and care settings and improve the experience of service users by enabling and enhancing the flow of patient information.

Digital medicines
Give patients greater choice and added convenience by enabling them to choose where, when and how their medicines are delivered. Improve prescribing accuracy.

Elective care
Improve referral management and provide a better treatment choice for patients by automating referrals across the NHS.

Paper free at the point of care
Equip the NHS with technology that will transform care and ensure the workforce has the skills to get the most out of it.



Data availability for outcomes for research and oversight
Improve the quality, availability and integrity of health data so that frontline staff, researchers and decision makers are better informed.

Infrastructure
Enable information to move securely across all health and care settings by providing and maintaining robust and future-proofed national systems and networks.

Public trust and security
Respect the data sharing preferences of patients and keep their data secure in all settings.

A new way of working

Substantial change will not be achieved without local health and care organisations fully embracing the opportunities offered by new digital technology. Not only will we not deliver our national objectives without local engagement, we know that much of the innovation that will drive the most exciting changes in care will come from frontline organisations and their partners.

In 2015-16, we asked local health and care partners to prepare plans setting out how they would use information and technology to support sustainability and transformation in their areas. These Local Digital Roadmaps were completed by June 2016 and are guiding the way national services are implemented at the local level as well as informing the delivery of our national programmes.

Working in partnership with NHS England and NHS Improvement, we have also launched the Global Digital Exemplar programme, which has identified providers with the potential to act as pathfinders in developing world-class use of digital technology. We continue to work with the NHS England Test Beds, supporting the development of transformative technologies through real-world use in local health economies, and we are supporting the Code4Health and INTEROPen communities' crucial work to build an open and interoperable environment that allows transformative innovations to quickly take root across the system.

Local and national partnership does not mean leaving local organisations to drive change by themselves. One of the clear messages from our consultation on the Personalised Health and Care 2020 technology strategy in 2014 was the important role of the centre in supporting technological innovation. The achievements of our national programmes – whether they be in delivering new digital services, supporting interoperability, improving digital maturity in local organisations or building public trust – will be vital to successful delivery at local level.

NHS Digital's new Implementation and Business Change team, set up in spring 2017, will change the way we work with local health organisations and how we understand their needs.

Traditionally, we have supported service implementation and uptake at the individual programme level. This has sometimes resulted in a lack of clarity about the offering and how services can work together to improve care in a particular locality.

Our new way of working is deploying people into joint regional teams with NHS England and NHS Improvement to work with localities to understand their requirements and explain how the full range of our services can support new models of care. This will enable better feedback and more innovation.

Substantial change will not be achieved without local health and care organisations fully embracing the opportunities offered by new digital technology.

Committed to improvement

NHS Digital is the organisation in England's health and care ecosystem with proven expertise in delivering large-scale digital infrastructure and services that deliver real benefits for patients and frontline professionals. We have a track record of delivering effective and efficient technology programmes. The insourcing of the NHS Spine is saving us £21.2 million a year in annual running costs, comparing 2016-17 with our 2014 baseline. We have also rebuilt the Secondary Uses Service (SUS), the core system used to share information about hospital activity in England. The new service has been delivered on time and for approximately a third of the cost of an annual release of the previous system. Over the next year we will extend SUS to enable more efficient administration of NHS activities. In 2016-17, we also delivered new systems for the National Breast Screening Service and a replacement for the Central Health Record Inquiry Service (CHRIS) demographic system, on time and to budget.

This record of excellence in delivery across our three lines of business – designing and building new technology, providing data and information services and running the live service operations on which the smooth running of the services relies – has made NHS Digital the logical choice as lead national delivery partner for the government's digital transformation programme.

We are committed to improving our leadership, workforce, processes, systems and culture to ensure we are in the best possible shape to lead digital change. Our organisational transformation programme continued to address both structural and cultural enablers of the delivery of our strategy through 2016-17 and we embedded our new operational model over the past year, with our professional groups now up and running and all staff engaging in activity based time recording.

We also conducted an independently assured capability review, tasked specifically with identifying how we can improve our client engagement, delivery models, assurance and workforce to improve our ability to meet our commitments. As a result of the review, we are now taking action to:

- make the changes to our delivery model to improve our performance
- ensure that our current workforce capacity and capabilities are aligned to deliver on the Personalised Health and Care 2020 strategy as well as our existing statutory and corporate commitments
- improve the way we engage with and support our clients and stakeholders
- ensure that the relationships and working arrangements with our national partners (notably the Department of Health and NHS England) are fit to support the delivery of Personalised Health and Care 2020.

A new team has been established to implement this organisational and cultural change alongside the transformation programme.

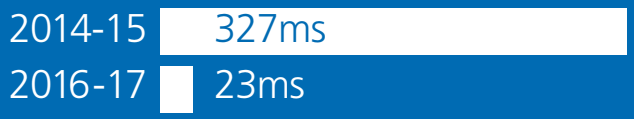
Transforming our infrastructure

In 2014, we insourced the NHS Spine, the core systems that carry information across health and care. It is now operating faster, more efficiently and at less cost.

Speed

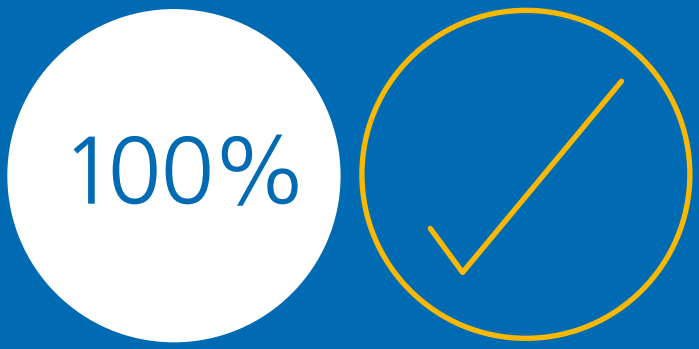
Response times are more than

14x faster



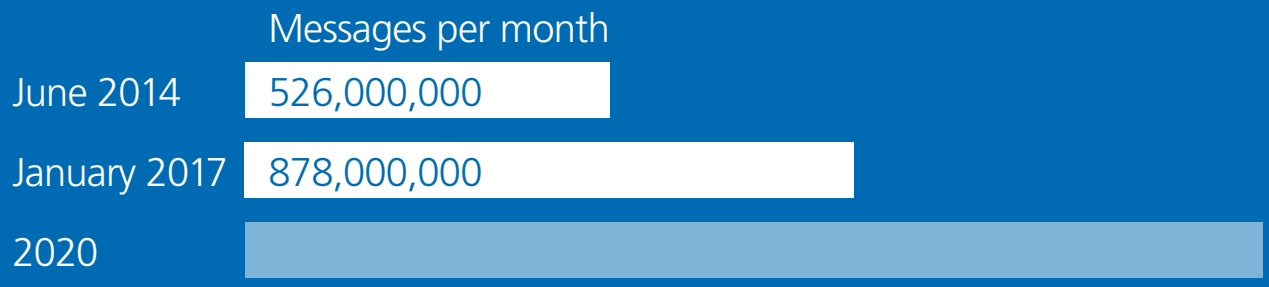
Reliability

Messaging reliability in 2016-17



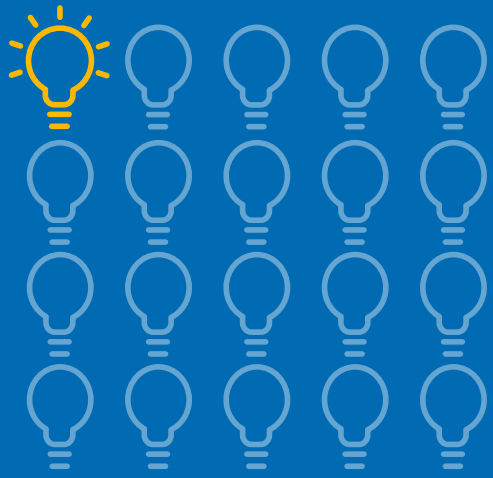
Traffic

The number of messages has increased sharply since 2014. The load on the system is expected to continue to increase.



Environmental impact

Estimated to use 5% of power needed in 2014 for the same services.



Cost

£21.2M cheaper per year

Cost of running spine per year

Delivering for patients

Everything we do at NHS Digital – from building and running digital systems on which doctors, nurses and social workers depend, to collecting and sharing the information needed to drive up the quality of care and make the system more sustainable – is ultimately about improving the health and well-being of the public.

A typical patient will rely on NHS Digital systems from the moment they get in touch with the NHS, be that through a 111 or 999 call, their first steps into their GP surgery or looking for advice on the NHS Choices website. Almost every step of their subsequent journey through care relies on our infrastructure and on professionals who use our systems to do their jobs.

In 2016-17, we worked to improve these crucial services and define and lay the foundations for technologies that will revolutionise how the public interacts with the system.

Improving the citizen experience

Our NHS e-Referral Service is part of the essential fabric of the NHS, combining electronic booking with a choice of place, date and time for first hospital or clinic appointments. A new interface, launched in January, gives patients direct access on their smartphone, tablet or computer to waiting time information when choosing appointments. We have also given clinicians setting up referrals better information on the appropriateness of services for their patients and introduced the first of a series of application programming interfaces (APIs) to enable better integration into other clinical systems – all aimed at reducing unsuitable referrals and wasted time for patients.

In 2017-18, we will deliver new services to allow patients to change or cancel appointments on their smartphones or computers, receive alerts highlighting capacity problems and book follow-up appointments with their clinicians. Patients can expect all first referrals to be on this system by 1 October 2018.

The Electronic Prescription Service (EPS) cuts collection delays, reduces dispensing errors and improves convenience by sending prescriptions electronically from GPs to the pharmacies patients choose.

In the year to February 2017, the proportion of GP surgeries on EPS rose from 75 per cent to 89.3 per cent, with 99.4 per cent of pharmacies now live. The number of patients nominated on the system rose from 17.2 million to 22.7 million people.

Supporting frontline services

Our Systems and Service Delivery team provides the technology that underpins the NHS's screening programmes. For cervical screening alone, more than 5.3 million screening invitations were dispatched and 3.1 million women screened by their GP in 2016-17. In excess of 36,000 severe abnormalities were detected, along with over 149,000 borderline or mild abnormalities. 2.2 million women were screened at local centres for breast cancer in 2015-16 and 18,320 invasive cancers diagnosed. For bowel cancer, 4.8 million test kits were issued to people aged 60-74 in 2016-17 and 57,595 men and women were asked to attend a clinic following an abnormal result. 3,224 cancers were diagnosed.

A new interface gives patients direct access on their smartphone, tablet or computer to waiting time information when choosing appointments.

In July 2016, we delivered a new system for the National Breast Screening Service on time and on budget, replacing a legacy demographic and cohort management system distributed across more than 80 Health Authorities. The new technology centralises information in our secure data centres, creating efficiencies and improved consistency. We worked with Public Health England to provide training in the new systems for staff in screening units across the country and we are on course to meet an autumn 2017 target date for full data migration.

We also began work on replacing the methodology used by the Bowel Cancer Screening test. We are working closely with the supplier of the new FIT (Faecal Immunochemical Test) to ensure we can go live in spring 2018 without disruption to the screening programme. FIT provides a more reliable outcome than the existing test because its result is not affected by individuals' diet and medicines. Doing the self-administered test is also simpler, so we expect to improve uptake and save more lives.

230,000

people will get digital skills training by September 2019

Putting the public in control

About 95 per cent of GPs are now offering patient online services such as online appointment booking, repeat prescription management and access to summary patient records. By March 2017, 9.6 million people, or 16.5 per cent of the population, were using one or more of these services.

We are building on this activity by offering patients and staff much readier access to online services as they move through the system. In 2016-17, we started delivery of a unified, free Wi-Fi system across health and care.

By 31 March 2017, we had established free Wi-Fi in 1,000 general practices providing access for more than 5 million patients. Rollout will continue across the rest of primary care in 2017-18 and will complete across the estate by April 2019.

Universal Wi-Fi is a key first step to unlocking the potential of digital healthcare because it allows patients to take a more active role managing their own health at the point of care. A group of programmes are putting together the building blocks of the rich digital healthcare experience that will form the basis of that engagement.

Our Health Apps Assessment and Uptake programme worked to create the NHS Apps Library launched in April 2017. We also launched a new mobile health space within developer.nhs.uk to allow developers to better understand the NHS's requirements in this area and access the information and tools they need to develop excellent software.

By March 2019, we expect 10 per cent of citizens to be uploading wearable and tele-health information into their health records and to be receiving personalised information based on this data.

NHS 111 Online will allow the public to enter their symptoms online and be connected directly to their local NHS 111 urgent care services when required. Four pilots have been running in locations across the UK and NHS Digital has built a version that is being trialled in Leeds, based on the same triage algorithms as the 111 telephone service. The Leeds pilot will come to a close in June, after which NHS England is expected to announce how the new service will be offered nationally.

Our Citizen ID programme is working with the GOV.UK Verify team and other partners to develop the single, secure identity for members of the public across health and care settings and digital platforms that will tie together these services into a unified and personalised experience.

Building engagement and trust

One in 10 people in England lack the confidence and skills to benefit from digital health technologies and there is a close correlation between digital exclusion and health inequality.

In March 2017, our Widening Digital Participation Programme launched a 3-year effort to work with Clinical Commissioning Groups, local authorities and community groups to help people build the digital health skills they need. It will develop 20 local digital inclusion 'pathfinders,' to be delivered by NHS Digital and the digital and social inclusion charity Good Things Foundation.

Our first two pathfinders are a project with Islington CCG working with young people with mental health problems and learning disabilities and a social prescribing project with Sheffield CCG, supporting older people with one or more long-term conditions.

By 31 March 2017, we had established free Wi-Fi in 1,000 general practices with more than 5 million patients.

We also worked hard to build public trust in digital health and care services. In April 2016, we signed an undertaking with the Information Commissioner's Office (ICO) on type 2 opt outs (requests from patients asking for their personal information not to be shared outside of NHS Digital for purposes other than their direct care). During the year, we processed more than 7.6 billion records and removed 178 million records to support these requests. Our team also improved our communications about how we are handling patient opt outs in line with ICO recommendations.

We adopted the Information Commissioner's Office (ICO) anonymisation code of practice in the handling of patient confidential data and supported the recommendations in the National Data Guardian's review of data security, consent and opt-outs, published in July 2016. We are ready to support the government's response to Dame Fiona Caldicott's findings.

As system leader for cyber security, NHS Digital has developed the Care Computer Emergency Response Team (CareCERT) to act as the central source of cyber security intelligence and incident management for the NHS and other health and care organisations.

The WannaCry ransomware incident in May fell outside of the 2016-17 reporting period but highlighted the vital importance of our cyber security teams to the delivery of NHS and social care services. We provided detailed technical guidance to local IT staff in a series of emergency CareCERT bulletins and direct expert assistance for affected organisations through telephone and on-site support. Our website functioned as an essential source for situation updates and downloadable guidance and, throughout the incident, no central NHS IT services and systems were compromised. No patient data was accessed.

Close partnerships with the National Cyber Security Centre, the Department of Health, NHS England and other key government and law-enforcement agencies underpinned this response and will provide a solid foundation for strengthening the NHS and care system's data security in 2017-18.

CareCERT already provides proactive threat information and remediation advice to 96 per cent of health organisations and local authorities delivering adult social care. In September, we expanded its services, introducing new support to help organisations assess their cyber security measures and identify improvements, as well as a new service for delivering help to organisations responding to specific incidents. We are also developing an e-learning resource to help train NHS and care staff on cyber risks.

One in 10 people in England lack the confidence and skills to benefit from digital health technologies.

Case Study: Speeding up benefits for terminally ill patients

Sharon Longden, a Macmillan Nurse at Airedale Hospital, West Yorkshire, took part in the pilot of a new electronic system to help people with terminal illnesses quickly get the benefits they are entitled to.

"It is very difficult for patients and their families and the last thing they need is concerns over financial issues," she said.

The new system, developed by NHS Digital in partnership with the Department for Work and Pensions (DWP), can be used instead of the paper DS1500 forms that allow clinicians to inform benefits officers that someone is terminally ill. The forms trigger special rules to speed up approval of benefits and ensure allowances are paid at higher rates.

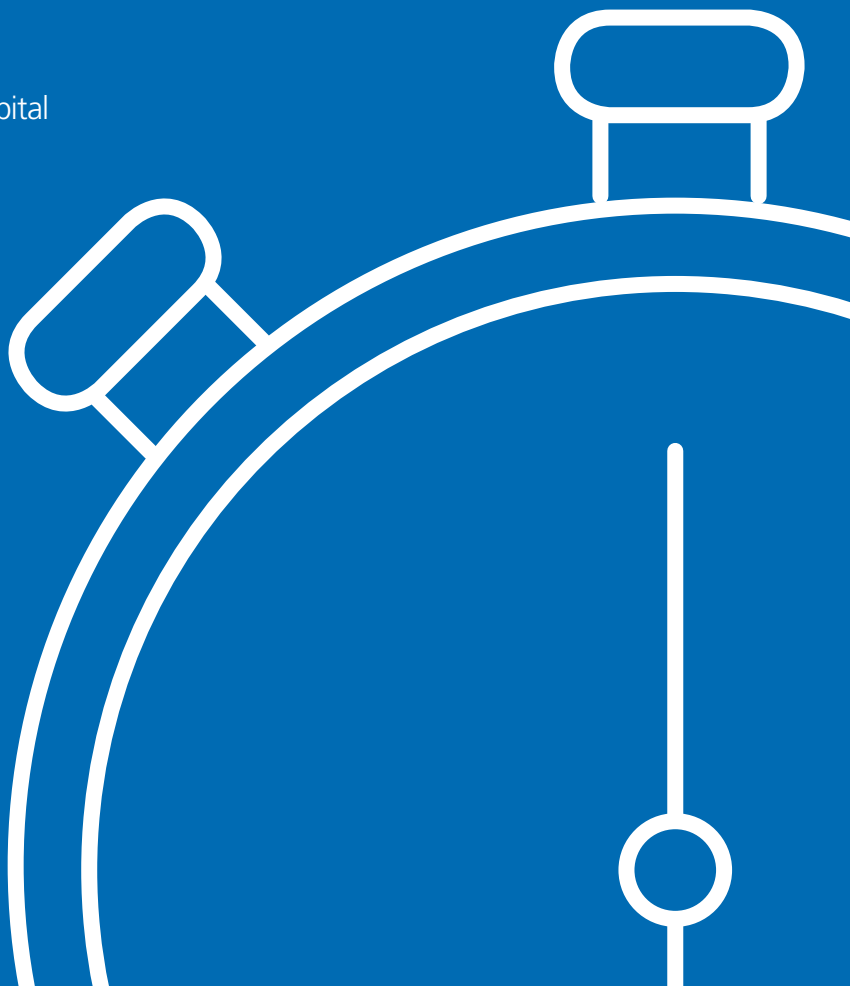
Clinicians can now log in to an electronic version of the form and instantaneously inform benefits officers of their patient's situation. It was successfully piloted in 2016 17 and rolled out across England in April 2017.

Andrew Meyer, Programme Head of NHS Digital's Digital Delivery Centre, said: "The paper form took time to reach the DWP and slowed down the process when it did arrive. By going electronic, the benefits people know that the right clinician has filled in the form and have instant access to the information they need to take action quickly."

Sharon said: "We can quickly fill out the form and send it off securely without having to worry that it is going to get lost in the post."

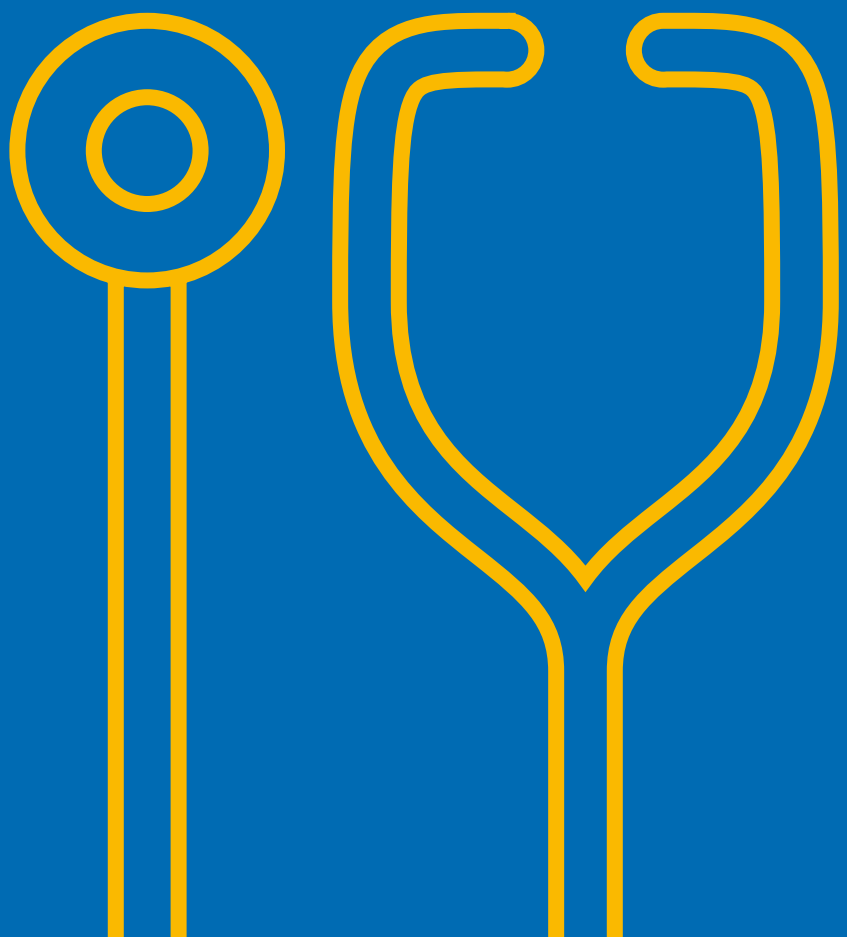
From the patient point of view, it cuts down the time that they are waiting for benefits

Sharon Longden, Macmillan Nurse, Airedale Hospital



Delivering for frontline professionals

Hundreds of thousands of frontline professionals in the NHS and social care rely on NHS Digital systems every day to do their jobs.



We built and maintain the NHS Spine, the basic infrastructure that allows information to be shared quickly and securely across health and care. Our key services are the sinews that pull the system together, allowing doctors, nurses, social workers and other key professionals to do their jobs. The NHS's secure email system, the NHS e-Referral Service, the Electronic Prescription Service, the Summary Care Record system, and the new Messaging Exchange for Social Care and Health (MESH) – which, among many uses, securely carries about 8 million messages a month about pathology results between labs and GPs – are just some of our system-critical services.

Throughout 2016-17, we maintained this vital infrastructure and delivered these services with excellent reliability. We allowed frontline professionals to get on with providing patient care, secure in the knowledge that our systems work.

We also laid the foundations for much greater assistance for care staff through clinical decision support, improved communications, and better information, when and where staff need it.

Improving services

In August, we completed the world's largest ever single-tenancy email migration, transferring more than 1.1 million NHSmail accounts to the new NHSmail2 service and replacing a platform that was reaching the limits of its capacity with the modern email exchange the system needs. NHSmail2 opens the door to new functionality such as instant messaging, teleconferencing enabling peer-to-peer consultations and virtual multi-disciplinary meetings, and a detailed contacts directory to help users navigate the system.

By the end of 2017-18, we expect to have completed NHSmail's rollout to community pharmacies and be delivering the platform to care homes, optometrists and dentists – widening the secure email capability across the health and care system and allowing professionals to securely cooperate to improve care.

We rolled out Summary Care Records (SCRs) to 6,000 community pharmacies in England in 2016-17. By giving pharmacists access to key information from patients' GP records, the service allows them to save time, avoid errors and reduce pressure on other parts of the system by acting as expert points of contact to guide patients to appropriate services.

Summary Care Records are vital to improving the secure sharing of patient information across primary and secondary care.

Access to Summary Care Records allows pharmacists to save time, avoid errors by having them reduce pressure on other parts of the system.

The new Female Genital Mutilation Risk Indication System (FGM RIS), introduced in January, demonstrates how these shared records can help professionals make crucial calls that change people's lives. It allows authorised healthcare staff to add and remove FGM information when they encounter girls at risk– making that crucial information accessible to all healthcare professionals treating the girl throughout her childhood.

The NHS e-Referrals Service achieved a series of major improvements for clinical users. In January, GPs received an improved interface making it easier for them to view service referral criteria and easier to compare referral criteria between services on one screen. The programme also delivered on-screen alerts giving live service information, improved the referrer service search screen to give easier access to information about waiting times and delivered a new application programming interface (API) to facilitate the transfer of clinical documents within hospital clinical systems.

In 2017-18, a new advice and guidance service within the e-referrals system will allow dialogue between referrers and services to reduce the number of inappropriate referrals, deliver shorter waiting times and cut costs.

The Electronic Prescription Service increased its coverage in 2016-17 to about 90 per cent of GPs and nearly all pharmacies. We held roadshows for pharmacy staff through the year to help them get the best out of the system and met our January 2017 target of ensuring all EPS transactions are structured, safe and interoperable with clinical systems. In 2017-18, we will continue to increase the number of live sites and the level of utilisation of both electronic prescriptions and electronic repeat dispensing (eRD). The introduction of controlled drugs (schedules 2 and 3) will bring significant improvement to the service for GPs, pharmacies and patients.

Getting information flowing

An everyday problem for clinicians accessing information on the NHS Spine used to be that protecting confidentiality and security by logging out of the system when leaving their workstation meant they had to start their work from scratch when they returned. In 2016-17, we introduced the new NHS Digital Identity Agent which allows users to resume a Spine session where they left off after logging back in.

By the end of 2017, we are committed to going live with mobile authentication, allowing staff on the move secure access using pooled or personally assigned mobile devices.

A new advice and guidance service will allow dialogue between referrers and services to reduce the number of inappropriate referrals, deliver shorter waiting times and cut costs.

In 2016-17, we completed the replacement of the old Data Transfer Service with the Messaging Exchange for Social Care and Health (MESH) system. MESH is a secure application-to-application and person-to-person messaging service on the NHS Spine and is fundamental to developing more open and interoperable systems across different care settings.

One of the services relying on MESH, for example, is Child Protection – Information Sharing, which connects the IT systems of social care teams with emergency departments, minor injury units, maternity units and other unscheduled care settings. When a young person with a child protection plan or looked-after child status attends one of these settings, a flag appears on their record to alert the healthcare team and provide them with contact details for the relevant social workers (see page 31). At the same time, the social care team is automatically notified that the child has attended and both parties are provided with details of the child's previous 25 presentations for unscheduled care. This means that health and social care staff have easy access to information that can help them identify patterns of attendance, even if across multiple locations.

Over 62,000 children now have this extra level of protection, with the system live in 34 per cent (51) of local authorities and 13 per cent (159) of care settings. Many local authorities with large numbers of children on plans are already live with CP-IS, such as Kent, Lancashire, Leeds and Birmingham and many London boroughs. The programme has momentum and is aiming to have 90 per cent of local authority and 80 per cent of healthcare settings live by March 2019.

We also worked to improve the required sharing of information between acute settings and local authority social care when patients are discharged. We published a national standard and conducted a successful pilot for the secure electronic sharing of this information. A national capability using MESH has been developed and we will be working with system suppliers and local areas in 2017-18 to roll it out.

In 2016-17, we conducted research with the GfK research agency and the Social Care Institute for Excellence to find out how we can support social workers through the use of information technology. We found that many of the issues faced by social workers echoed those in the health sector – suggesting that the Wachter review's call for support for professional, local digital leadership with strong central backing may also be the right model for IT implementation in social care. More than half of social workers said that they experienced difficulties in their jobs because information technology systems are not user friendly and 9 in 10 agreed that easier information sharing between organisations would improve their services.

15 million

messages a month are handled by the Messaging Exchange for Social Care and Health

Building Digital Readiness

In September, Professor Robert Wachter's review of NHS digitisation, 'Making IT work', highlighted the urgent need to improve the digital capability of the health and care workforce and NHS Digital worked with NHS England, Health Education England, the medical royal colleges, professional bodies and other partners in developing the system's response.

The Building a Digital Ready Workforce programme published a comprehensive definition of digital literacy and is committed in 2017-18 to developing an underlying competency framework and targeting support at priority groups. It also helped to establish two new national professional bodies, the Faculty of Clinical Informatics for clinicians and the Federation of Informatics Professionals for non-clinicians, both of which are bringing agencies together to drive informatics professionalism forward.

A key achievement was establishing the requirements for a world-class learning programme for Chief Clinical Information Officers, Chief Information Officers and aspirant leaders. This will be the NHS Digital Academy and the first cohort of students is expected to start in September 2017.

The programme has also completed a national review of the digital knowledge and capabilities of other leaders working in health and care and is now developing plans to support them in using digitisation to improve services.

Professor Robert Wachter highlighted the urgent need to improve the digital capability of the health and care workforce.

Case Study: Supporting ambulance crews with mobile information

Paramedics across south western and south central England now have access to patient information while on the move.

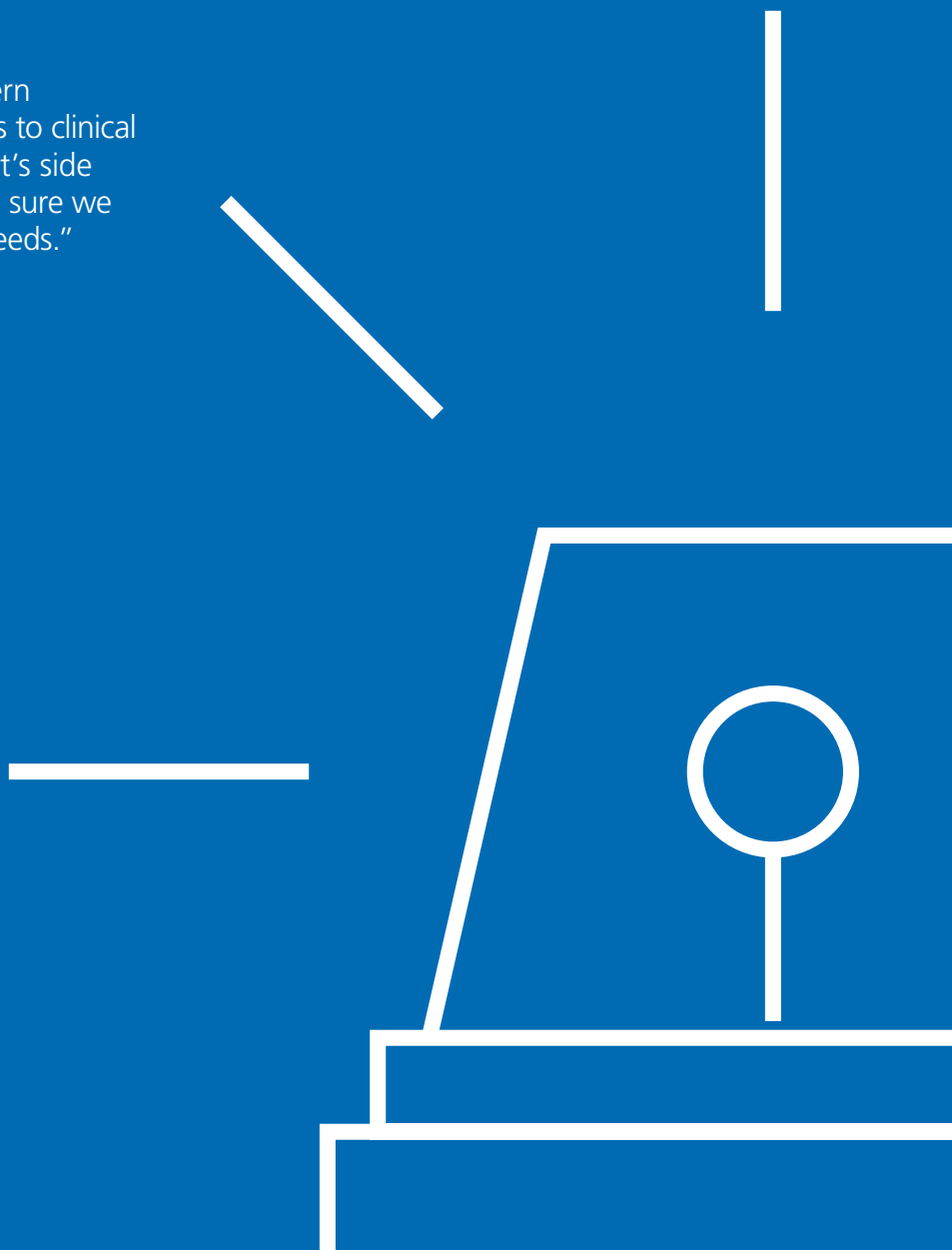
As of January 2017, all paramedics in emergency vehicles across South Western Ambulance Service and South Central Ambulance Services have mobile devices with access to electronic patient records replacing outdated paper records. Paramedics at these trusts now have the information they need at their fingertips to better manage patient care at the scene and to record information for handover to hospital colleagues.

This mobile electronic patient record system, Ortivus Mobimed, can now also securely connect to the patient Summary Care Record. This provides authorised clinicians quick and easy access to additional important patient information such as medications, adverse reactions and known allergies. The work won South Central Ambulance Service the EHI Award for Excellence in Mobile Healthcare in 2016.

Dave Partlow, a paramedic and Clinical Development Manager at South Western Ambulance Service, said: "Having access to clinical information when we are at the patient's side helps us deliver the right care and make sure we understand and meet the individual's needs."

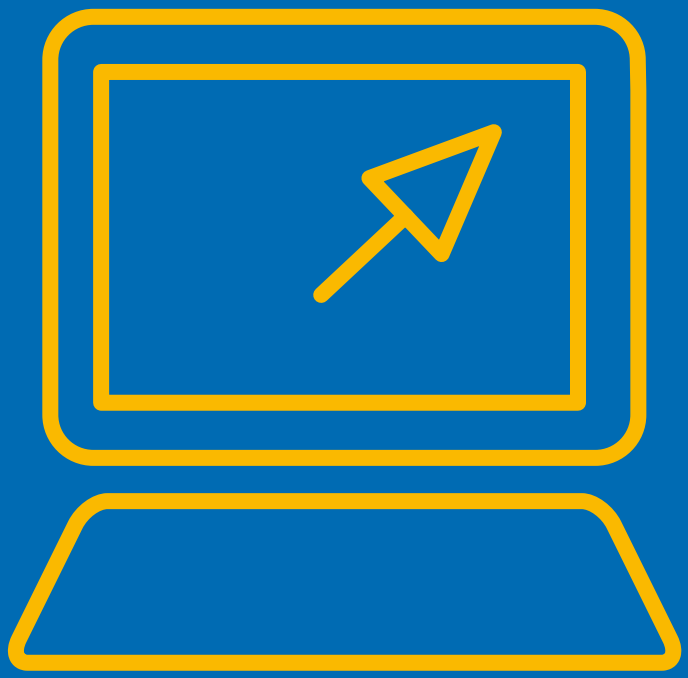
Mobile electronic patient records give paramedics the vital information they need when every minute counts.

Luke Davie, Programme Manager, NHS Digital South Local Clinical Systems



Delivering a smarter system

NHS Digital develops and runs information services that are essential to a more efficient, better connected and smarter health and care system. In 2016-17, we worked to improve the quality, security, accessibility and speed of the information we disseminate and to connect disparate IT systems in primary, secondary and community care to ensure structured information supports better care.



Better data, better decisions

Our new Data and Information Strategy, published in November, commits us to radically improve data content, analysis and access by 2020. We want to get information to the people who need it more quickly and to make it more accessible and usable when they receive it. We are also working to cut duplication between national collections by NHS Digital, NHS Improvement, NHS England, the Care Quality Commission and the Department of Health and 2,000 local data collections, about half of which duplicate national data flows.

In 2016-17, we overhauled the Hospital Episode Statistics (HES) data set – an invaluable national asset recording all admissions, outpatient appointments and A&E attendances at NHS hospitals in England – to speed up delivery.

As a result, data for January 2017 was available in March, a month earlier than in the previous year, and we are continuing to accelerate. This is important because it means data is closer to real time. It reduces the burden on trusts in the submission of aggregate data returns and, by making HES more useful, encourages a greater focus on data quality through the system.

We are rebuilding the Secondary Uses Service (SUS), the core system used to share information about hospital activity in England. The new SUS+ system is scheduled to go live in 2017-18. This will further speed up processing, reduce local burdens, and integrate data flows, allowing us to achieve more useful and closer to real-time system information.

Innovative uses of data

We worked with NHS Improvement to connect HES data to patient-level information and costing systems in six pilot trusts. These systems trace resources used by individual patients and, by linking to HES, we are able to minimise local data collection burdens and build a much better understanding of how costs occur and how efficiencies can be achieved.

Our Data Quality Maturity Index, launched in May 2016, is critical to improving the use of data and information in local organisations, to providing data submitters with transparent information about their data quality and to informing Local Digital Roadmaps. We also developed the Patient Online Management Information (POMI) dataset, which encourages GPs to offer and promote Patient Online services.

Data for January 2017 was available in March, a month earlier than in the previous year, and we are continuing to accelerate.

In total, we developed and assured 86 new information standards, collections and extractions in 2016-17. We published 292 official and national statistical publications and published 30 clinical audit reports, including the National Diabetes Audit, the largest annual clinical audit in the world.

The Adult Psychiatric Morbidity Survey, a census of the nation's mental health, played a key role in informing the continuing national debate about how we respond to mental illness and was the subject of extensive media coverage. We were commissioned by NHS England to produce a one-off Official Statistics publication on GP expenses to support their work to review how General Practice is funded in England. We also worked closely with the British Medical Association, NHS England, Health Education England and the Department of Health to collect the Workforce Minimum Data Set and the National Workforce Dataset, supporting planning for training, recruitment and retention of NHS staff.

We improved the presentation and accessibility of the Summary Hospital-level Mortality Indicator (SHMI) publication and engaged with the UK Statistics Authority assessment team to achieve designated National Statistics status for the SHMI. The statistics are used by the Care Quality Commission to support monitoring of hospitals and by trusts to review performance.

We were commissioned by the Department of Health to develop and publish an experimental statistics report on seven-day services. This examined variations in mortality, length of stays in hospital and emergency readmissions across the week and is being used to support the evaluation of policy in this area. An NHS Digital statistical report in December, the biggest study ever conducted into the health of people with learning disabilities in England, showed that this group has much poorer health and shorter life expectancies than the general population.

We continued to develop the quarterly reports on the female genital mutilation data set, first published as experimental official statistics in September 2015, based on collections from acute trusts, mental health trusts and GP practices. In October, we launched the Breast and Cosmetic Implant Registry, which ensures patients are alerted about faulty implants.

1200

peer reviewed research papers relied on our data in 2015

More accessible information

Data is only valuable if it is accessible and usable. Our Data Access Request Service (DARS) is the mechanism by which approved data customers gain access to the national health and care data we hold. In 2016-17, DARS disseminated more than 10,000 data files under data sharing agreements received and more than 1,000 applications for data.

In 2016, we completely revised the data application process and introduced DARS Online. This provides applicants with a single point of access for data requests and the ability to manage their applications and sign their Data Sharing Agreements online. We also launched a new independent body, the Independent Group Advising on the Release of Data (IGARD), in February 2017 to improve accountability, quality and consistency through robust and independent scrutiny of NHS Digital data disseminations.

In March, we launched a new online interactive reporting tool for the new Child and Adolescent Mental Health Services dataset that allowed users to create their own reports and drill into the detail they were interested in, rather than relying on the predetermined analysis of printed publications. We are rolling out similar interfaces across our publications and developing more accessible analytical tools for data users, while continuing to look to the business intelligence market to provide added value.

Driving interoperability

The NHS and social care system's existing IT landscape is disparate, a product of sometimes siloed national programmes and of tactical solutions to meet local needs. We are using a variety of levers to connect systems and build momentum for interoperability. We terminated the contract for N3, the old centrally managed national broadband network connecting health and care organisations, in March 2017. The replacement, the Health and Social Care Network (HSCN), represents a major stride toward a more connected system. It is creating a standards-based network that will enable multiple suppliers to provide interoperable network services.

In January, we awarded the contract for HSCN's peering exchange, the key system to allow information to flow across the system, and throughout the year we worked with N3 customers to help them plan their move to HSCN services. We have established a three-year transitional arrangement, which started in April 2017, to ensure continued availability and reliability of network services and expect the first customers to start using the new HSCN network by the end of 2017.

HSCN is part of a broader drive to move from siloed, single-supplier contracts to secure, open frameworks. We are working with the local NHS and industry to co-design these new environments through the Code4Health interoperability community and INTEROPen, the supplier supported action group to accelerate the development of open standards. In 2016-17, we managed the transition and closure of the remaining Local Service Provider contracts and worked with partners to develop a new contractual vehicle for the supply and development of GP clinical IT systems for all practices in England, replacing the existing GPSoC framework.

We piloted the new Spine Mini Service Provider (SMSP) in the first quarter of 2017, a new interface to allow read-only connections to information held on the NHS Spine. The SMSP currently makes it much easier for health and care organisations and developers to securely check basic demographic information about patients, ensuring that patients are identified properly across care settings. The project is looking at whether access to other NHS Spine services, such as Summary Care Records or the Electronic Prescription Service, can also be supported.

In general practice, the GP Connect project is launching two pilots in Cornwall and Leeds in 2017-18 using open standards (HL7 FHIR) application programming interfaces (APIs) to share patient records between different provider systems. The next phase of the project, due in 2017-18, will share appointment booking functionality and access to structured clinical data. It will open the door to giving patients much more flexible access to their own clinical information through apps, wearables or interfaces like NHS.UK.

We continued to drive the effort to standardise and structure information shared by health and care professionals. In November 2016, the Standardisation Committee for Care Information (SCCI) published a notice requiring all of general practice to adopt the clinical terminology vocabulary SNOMED CT by April 2018 and all other health providers to adopt it by April 2020.

NHS Digital is supporting the roll-out of SNOMED CT in general practice by assuring the changes to clinical supplier systems, supporting CCGs in providing GP IT Services, and enabling our national systems to transition safely. We are providing a range of materials to support the move, including weekly awareness webinars, training sessions, conversions to SNOMED CT from the current Read codes and other guidance documentation. In 2016-17, we completed work on the professional standard for e-discharge summaries from hospitals based on SNOMED CT.

HSCN is part of a broader drive to move from siloed, single-supplier contracts to secure, open frameworks.

Case Study: Giving clinicians and social workers vital information

One NHS trust using the Child Protection Information Sharing (CP IS) system recently reported how it had improved the information available to staff dealing with a young patient.

She had been brought to an emergency department by ambulance after taking an overdose. When staff entered her details into the system, it alerted them that she was a looked after child, that she was pregnant and that the unborn child was subject to a child protection plan. None of this information had been disclosed by the young woman and would not have been easily accessible to the team previously.

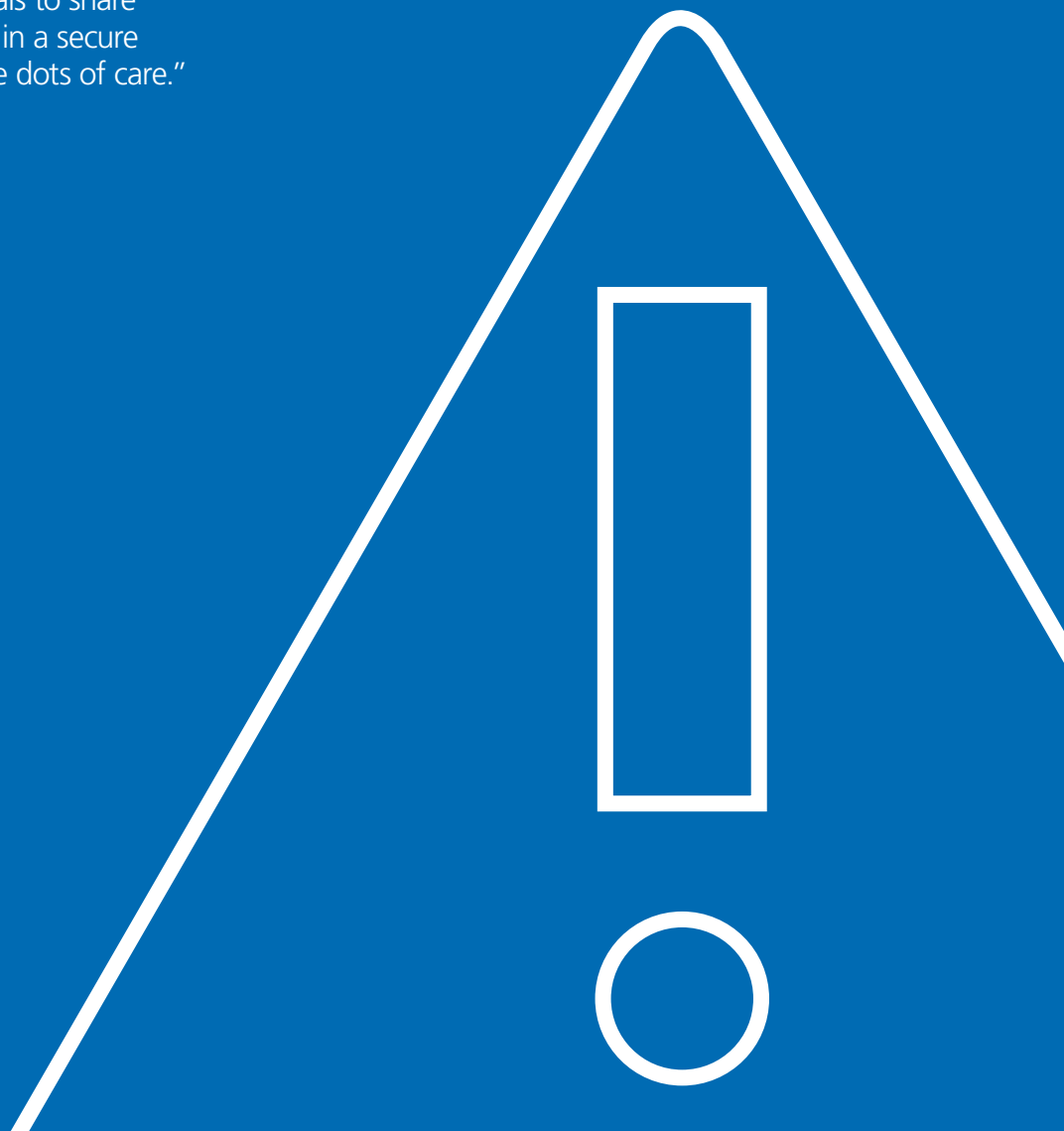
CP IS also provided contact details for her social care team so the triage nurse could quickly make contact and discuss the best multi agency approach.

Nearly 1,000 CP IS notifications are passing between health and social care teams every month, linking up care for vulnerable children.

Penny Coulthard, NHS Digital's CP IS programme head, said: "CP IS provides an extra level of protection for the most vulnerable children. It makes it easier for professionals to share information on a national scale in a secure and timely way and joins up the dots of care."

For organisations who are right at the start of implementing CP-IS, we would really encourage them to look at it as a project that can be delivered, that can be delivered quickly, and that can be delivered at quite a low cost."

Lucinda Cain, Business Partner Manager, Leeds City Council



Performance analysis

Financial results

These accounts have been prepared under a direction issued by the Secretary of State for Health in accordance with the Health and Social Care Act 2012 and the 2016-17 Government Financial Reporting Manual issued by HM Treasury, as interpreted for the health sector by the Department of Health Group Accounting Manual. The accounting policies contained in the Financial Reporting Manual apply the International Financial Reporting Standards (IFRS) as adopted and interpreted for the public sector context. The accounts comprise a statement of financial position, a statement of comprehensive net expenditure, a statement of cash flows and a statement of changes in taxpayers equity, all with related notes.

There have been a number of changes to our role and responsibilities during 2016-17. From 1 December 2016, a number of programmes and services previously owned by the Department of Health but largely managed by NHS Digital were fully transferred. These included NHSmail, the Electronic Referral Service, NHS Spine, Secondary Uses Service, NHS Choices and the N3 service.

Additional Grant in Aid funding has been provided to meet the cost of these services. In addition, non-current assets with a net book value of £49.5 million were transferred, which, following a full review, required some adjustments as described below. Some other services previously managed and paid for by the Department of Health and NHS England were also transferred during the year and are now funded through Grant in Aid.

We have also been tasked with delivering many of the commitments set out in the National Information Board's strategy, Personalised Health and Care 2020 (PHC2020). Our 2017-18 corporate business plan sets out the delivery of this ambitious portfolio of digital technology and data solutions (described on Page 11) which is funded through separate PHC2020 programme funding.

Our increasing responsibilities described above come at a time of ongoing financial pressures across the public sector and the NHS in particular. However, the funding provided to us has been largely agreed based on our three-year business plan submission and whilst it will be challenging, we believe financially manageable. We have therefore prepared the accounts on a going concern basis.

The table below provides a summary of our results split between our ongoing services and those relating to the services transferred:

	Core business £000	DH transfer £000	2016-17 £000	2015-16 £000
Grant in Aid allocation from the Department of Health	204,489	54,011	258,500	179,201
Other income	43,676	662	44,338	61,684
Total income	**248,165**	**54,673**	**302,838**	**240,885**
Operating expenditure	(240,122)	(47,774)	(287,896)	(224,825)
Underspend	**8,043**	**6,899**	**14,942**	**16,060**
Capital expenditure	**17,049**	**4,207**	**21,256**	**14,493**

An analysis of the Grant in Aid funding is as follows:

	2016-17 £000	2015-16 £000
To deliver core services*	168,038	179,201
Transfer of Department of Health national programmes on 1 December 2016	54,011	-
Other services previously invoiced for	18,400	-
PHC2020 funding	18,051	-
Total Grant in Aid	**258,500**	**179,201**

* Our core Grant in Aid supports, among others, the:

- collection, analysis and dissemination of a range of data-related services including the publication of 292 reports of official or national statistics
- operational, commercial and financial support for a number of Department of Health informatics programmes and services (the majority of programmes and services themselves transferred on 1 December 2016)
- development and maintenance of clinical and information standards and terminologies
- support for front line services in a range of informatics-related services and systems
- IT infrastructure, estates and support functions for the organisation.

In addition to Grant in Aid, we generated £44.3 million of other income (2015-16: £61.7 million), the reduction being largely due to a funding transfer into Grant in Aid to support certain services undertaken for the Department of Health and NHS England. Income includes the:

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

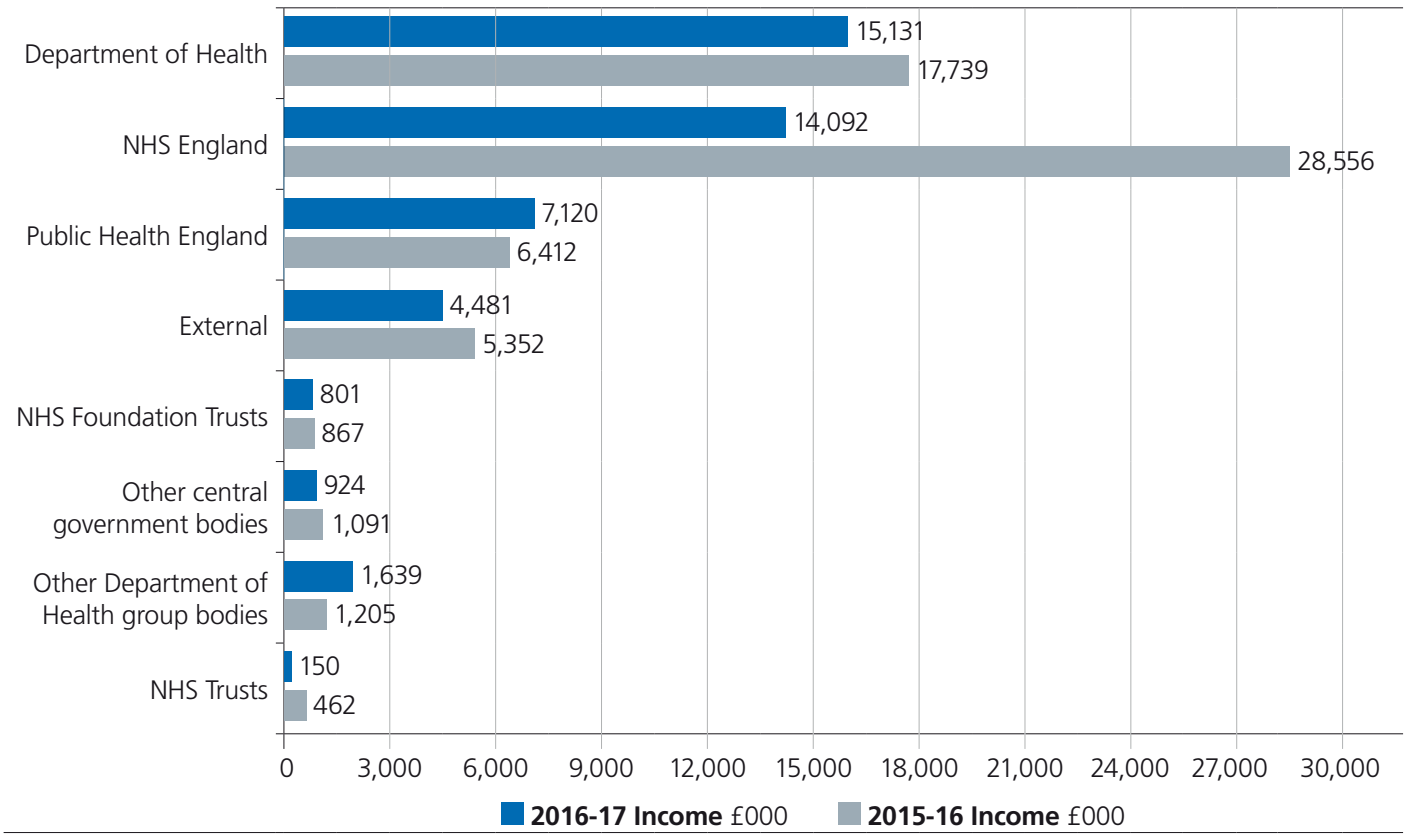
Overall, we have exceeded our financial targets in the year. Operating expenditure was £287.9 million resulting in an underspend of £14.9 million. This underspend is not retained by NHS Digital but is redeployed by the Department of Health for use within the wider health service.

The classification of 'administration' and 'programme' has been reviewed during the year. The provision of data-related services and our corporate support activities are classified as 'administration' with all other activities treated as 'programme'. An underspend has been achieved in both.

Income analysis

The breakdown of income by customer type is as follows:

Income analysis



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

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

Fees and charges (subject to audit)

	Clinical audit services £000	Data related services £000	2016-17 Total £000	2015-16 Total £000
Income	2,095	1,677	3,772	3,541
Expenditure	2,069	1,876	3,945	3,920
Surplus / (deficit)	**26**	**(199)**	**(173)**	**(379)**

The clinical audit programme relates to the collection, analysis and reporting of data across a number of clinical areas such as diabetes, renal health and various cancer specialisms, with the main customer being the Healthcare Quality Improvement Programme (HQIP).

'Data-related services' are the provision of health-related data to customer requirements, data linkage services and data extracts for research purposes.

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

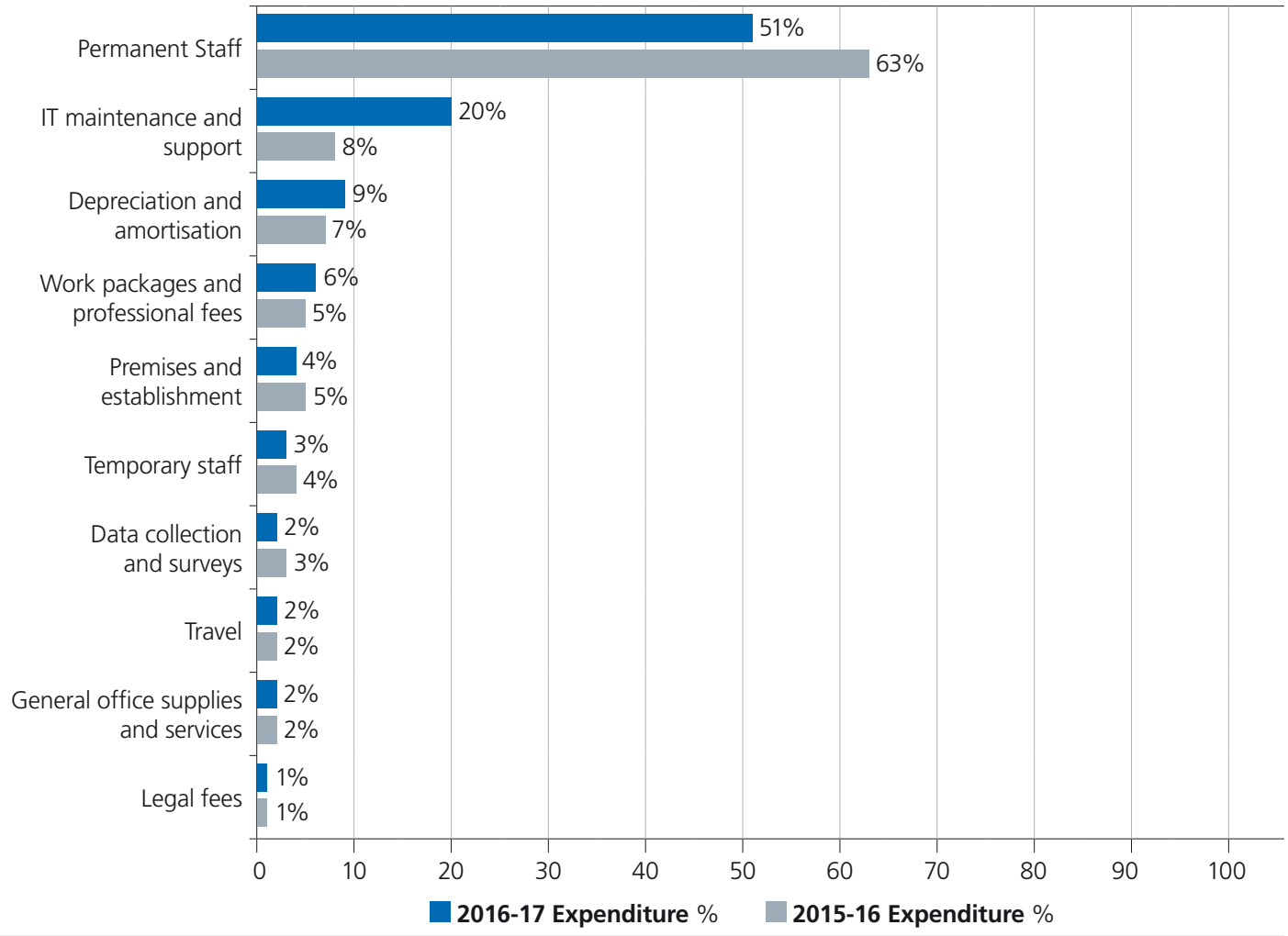
The organisation has invested considerable effort in improving its end-to-end data dissemination processes, including the Data Access Request Service (DARS).

The full cost of this additional governance has not been fully passed on to customers. Efficiencies arising from improved processes, such as the new DARS online service, reduce the ongoing costs of doing business. The charging models were reviewed during 2016-17.

Operating expenditure

The following chart summarises the main categories of operating expenditure:

Operating expenditure



The transfer of the Department of Health programmes on 1 December 2016 has made a considerable difference to the mix of expenditure. Staff costs in totality have hardly been affected by the transfer, as we provided management services for the programmes previously.

However, the impact of the transfer is in relation to non-pay costs, especially IT, work packages and asset depreciation.

Non-current assets

The capital expenditure limit was £26.2 million. The actual expenditure is as follows:

	2016-17 £000	2015-16 £000
Software licences, including desktop and corporate infrastructure licences	1,659	1,283
Internally and externally developed software	9,664	5,620
IT hardware, including desktop and corporate infrastructure	7,051	5,477
Refurbishments and fitting out new office space and new furniture	1,256	2,074
Development expenditure	2,270	404
Net book value of disposals	(644)	(363)
Total	**21,256**	**14,495**

The increase includes £4.2 million of expenditure for the period from 1 December 2016 on the programmes transferred from the Department of Health.

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

- conducted a full due diligence exercise with respect to the assets transferred from the Department of Health. Some adjustments were made to the transfer value to reflect a physical verification exercise, treatment of certain software licences and a restatement to bring the assets in line with NHS Digital accounting policies. In particular, certain assets were transferred with a valuation adjustment using the Retail Price Index, with a net book value of £3 million. This was reversed following an assessment of the total non-current assets held using the NHS Digital methodology, a mixture of Office of National Statistics indices and actual inflation rates, which concluded that the net impact to the historical cost accounting was immaterial.
- undertook a physical check of data centre assets and determined usage of certain software licences using software management tools.
- reviewed all asset lives and adjusted where necessary. For instance, the life of laptops has been reduced from five to four years, in line with the replacement policy. Major programmes such as the General Practice Extraction Service (GPES), NHS Spine, Electronic Referral Service and the Secondary Uses Service have been reviewed in detail.

Internal staff time spent on developing software applications is capitalised. This is captured by either a time recording system or by information technology management tools, with an average rate determined by the employee's grade applied. The rate includes the total direct cost of employment together with an incremental overhead cost comprising mainly estate and IT costs. General overhead is not capitalised. Project management time is only capitalised where time is directly attributable to the development of the asset.

Current assets and liabilities

Outstanding accounts receivable balances amount to £15.8 million (2015-16: £21.8 million). This is a significant reduction and is partly a result of the reduced level of income in 2016-17 and a result of the previous year being unusually high due to a large number of invoices with NHS England issued toward the end of the financial year.

Total prepayments amount to £11.1 million (2015-16: £7.4 million), the increase is largely due to subscription software licences purchased in advance. Accrued income amounts to £4.1 million (2015-16: £3.8 million) representing work completed but not invoiced, mainly with NHS England.

Trade receivables more than 60 days overdue were £0.2 million (2015-16: £0.3 million). Debts amounting to £480 were written off and £1,777 was provided for as irrecoverable. Debts previously provided of £2,535 were released following recoveries of amounts due.

We seek to comply with the Better Payments Practice Code (BPPC) by paying suppliers within 30 days of receipt of an invoice. The percentage of non-NHS invoices paid within this target was 99.3 per cent (2015-16: 97.5 per cent).

Better Payment Practice Code	Number	£000
Total non-NHS bills paid 2016-17	7,359	157,820
Total non-NHS bills paid within target	7,238	156,733
Percentage of non-NHS bills paid within target	**98.4%**	**99.3%**
Total NHS bills paid 2016-17	241	2,960
Total NHS bills paid within target	234	2,924
Percentage of NHS bills paid within target	**97.1%**	**98.8%**
Total value of invoices processed in 2016-17		160,780
Total value of invoices outstanding at 31 March 2017		8,754
Number of days outstanding		19.9

The above calculations use the formula adopted by NHS Shared Business Services (SBS) which stipulates that the days taken to pay is from the date a validly presented invoice is processed on the SBS system to the date a payment is initiated. This can understate the time taken as on average it takes 11 days from the 'invoice' date to processing the invoice on the system. SBS offer a free solution to all suppliers called 'Tradeshift', which allows suppliers to electronically upload invoices to the SBS system in real time. We are actively encouraging all suppliers to use this facility.

Government guidance is to pay 80 per cent of all suppliers' invoices that are not disputed within five working days. This target is particularly challenging for NHS Digital given the complexity of many of our transactions. In 2016-17, we paid 29.7 per cent (2015-16: 21.3 per cent), based on volume, and 50.0 per cent based on value (2015-16: 21.5 per cent) within the five-day target.

We had very limited exposure to financial instruments consisting of cash, trade receivables and payables. Cash flow was managed to meet operational requirements throughout the year by drawing down sufficient cash from the Grant in Aid allocation.

Losses and special payments (subject to audit)

During 2016-17 there were 228 losses and special payments (2015-16: 155) amounting to £40,860 (2015-16: £12,525).

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

Interest paid under the Late Payment of Commercial Debt (Interest) Act 1998 amounted to £nil (2015-16: £nil).

Political and charitable donations

No political or charitable donations were made in the year.

Sustainable development

Information about our environmental impact and sustainability is included in Appendix A on page 94.

Auditors

The accounts have been audited by the Comptroller and Auditor General, who has been appointed under statute and is responsible to Parliament. The audit fee for 2016-17 was £125,000 (2015-16: £95,000), which includes additional audit work in relation to the transfer of programmes from the Department of Health. The audit fee includes only 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. As far as the Accounting Officer is aware, there is no relevant audit information of which NHS Digital's auditors are not aware.

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

Remote contingent liabilities (subject to audit)

Remote contingent liabilities amount to £380,000 (2015-16: £nil) and relate to potential supplier charges.

Key Performance Indicators (KPIs)

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

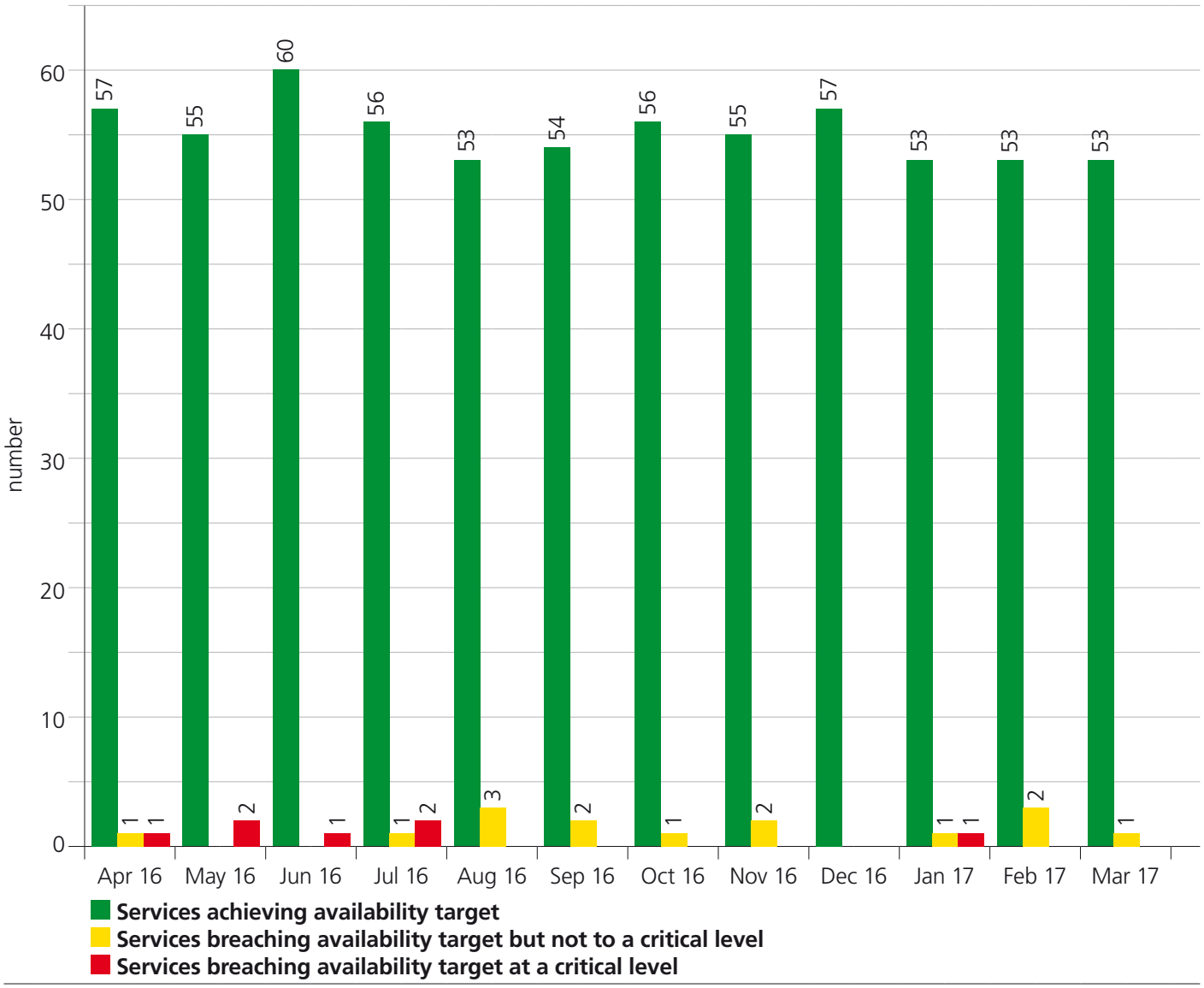
We use financial and non-financial key performance indicators (KPIs) and other management information to continuously monitor performance. Each KPI is assessed on a Red Amber Green (RAG) threshold model, with detailed analysis when performance issues occur. These indicators are integral to the routine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

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

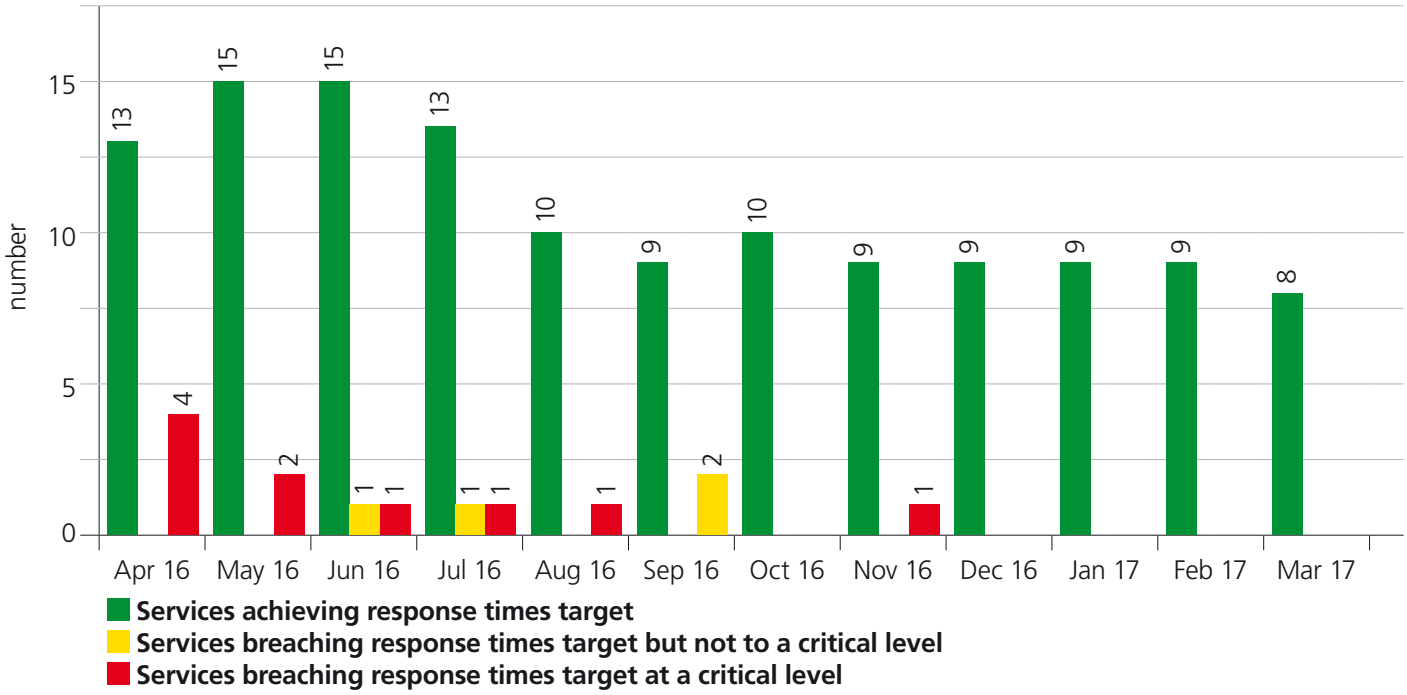
Group	Description	Responsible Director
Programmes' achievement	Provides a consolidated view of the delivery status of our portfolio of programmes, focussing on the overall delivery confidence, and including aggregated findings from gateway reviews.	Director of Programmes
IT service performance	Reports on the performance of information technology services for health and care providers, looking at service availability, incident response times, and high severity service incidents.	Director of Operations and Assurance Services
Organisational health	Includes workforce planning and recruitment, staff turnover, staff engagement, training and development, personal development reviews, and sickness absence rates.	Director of Workforce
Data quality	Looks at the quality of data received by NHS Digital from health and care providers and the effectiveness of our data quality processes.	Director of Information and Analytics
Stakeholder reputation	Gives a composite view of reputation, including outcomes of stakeholder and staff surveys, media coverage, social media sentiment, and complaints handling.	Director of Digital Transformation
Financial management	Covers the management of our organisational finances and other significant funding streams we manage. The performance reports also include the organisation's management accounts.	Director of Finance and Corporate Services
Risk management	Covers management of the organisation's strategic risk themes, providing an assessment of the current risk exposure and the status of mitigation actions for each.	Director of Finance and Corporate Services
Security incidents	Gives a composite view of information security incidents.	Director of Operations and Assurance Services

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

Information Technology service performance: Service availability

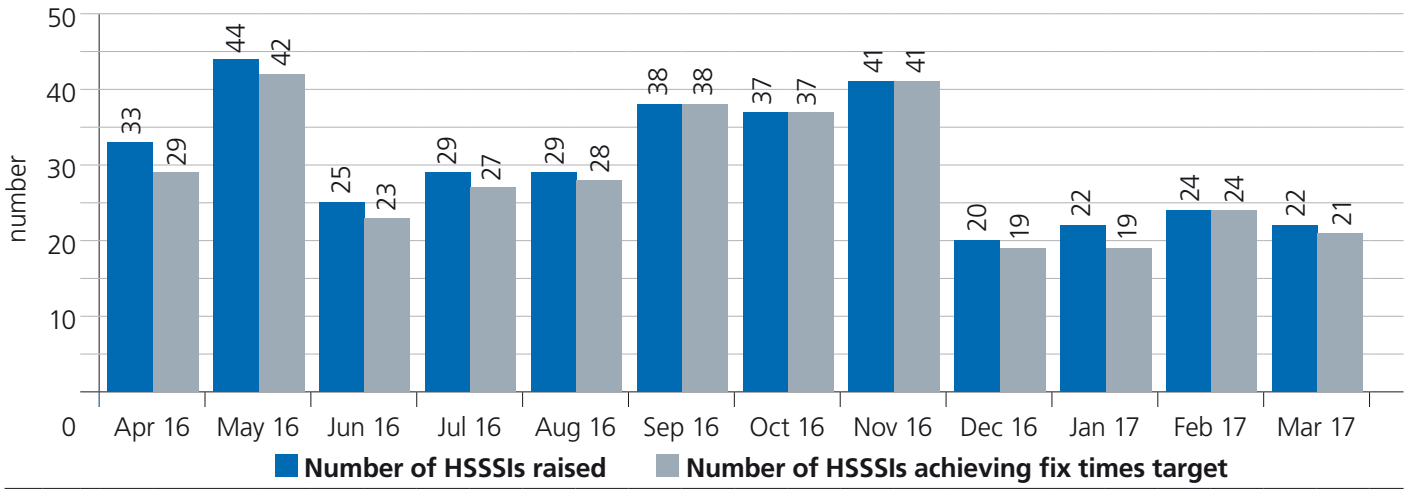


Information Technology service performance: Meeting response time targets

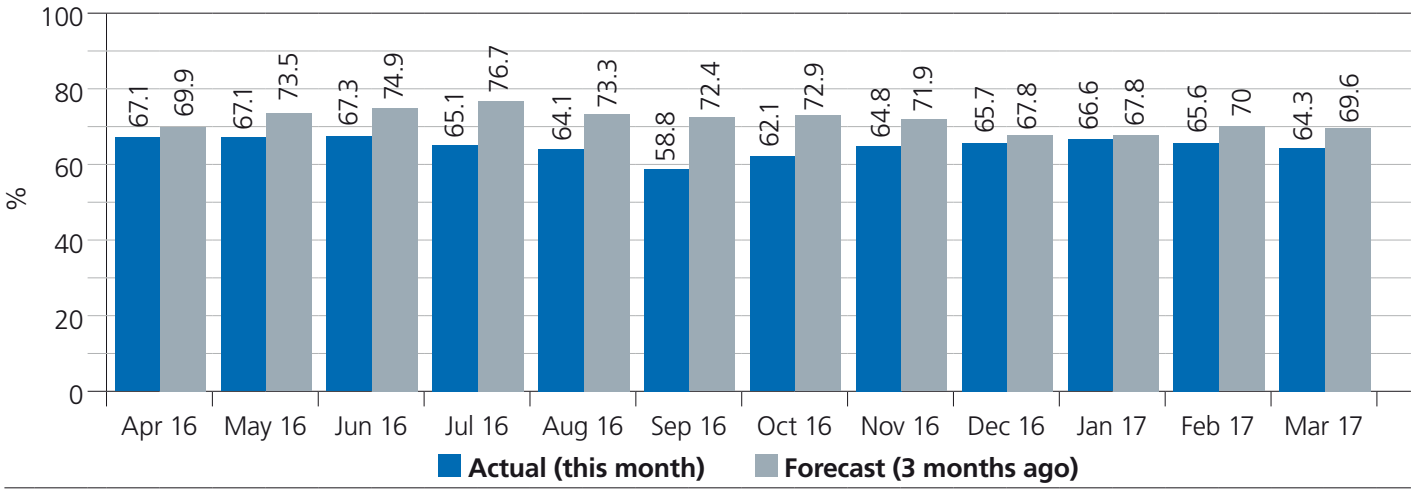


IT service performance: Response to Higher Severity Service Incidents

Higher Severity Service Incidents (HSSI) are incidents managed through our service management desk that cause a serious interruption of business activities. We report on those more serious incidents that have caused a disruption to normal service. The overall number of HSSIs increased in 2016-17 to 364, compared with 292 in 2015-16. This increase is largely due to the growth in services provided. Despite the growth, the number of HSSIs achieving the fixed times target has improved to 95.6% from 91.8% in 2015-16.



Programme achievement: Delivery confidence (%)
In March 2017, delivery confidence across our PHC2020 programmes was 62 per cent (amber-green on the RAG model). Delivery confidence in our non-PHC programmes was 66.7 per cent.



Managing Risk

We have improved the integration of our corporate risk and assurance functions during 2016-17. The use of risk management performance metrics is starting to drive an overall improvement in risk data quality and risk management behaviours, although further action is needed. A fuller explanation of our risk management process is on page 62 of this report.

A significant area of risk for NHS Digital in 2016-17 concerned our ability to deliver our Personalised Health and Care 2020 (PHC2020) commitments on time and to plan. Key risk factors include not understanding the critical dependencies of programmes and not having the technical architecture in place to allow the programmes to integrate with each other.

An independently assured review of our capability was undertaken to assess our ability to meet these commitments, as well as our existing statutory and corporate commitments. It assessed current capacity and capabilities against the emerging requirements for delivery. As a result, we are acting to improve our delivery model, review our workforce capacity and capabilities, improve engagement with clients and stakeholders and change how we work with national partners. We have established a new team to implement the actions emerging from the review and a new structure to improve how we understand the requirements of local health and care organisations and ensure that our programmes meet local needs and are implemented on the ground in local health economies.

Other risk areas included an increasingly difficult cyber security environment, which has informed a significant expansion of our CareCERT programme, and our ongoing responsibility to ensure the continuity of services that are critical to the health and care sector. In November, a serious incident with the NHSmail system disrupted the email of health and care professionals. Immediate remedial action was taken and changes were made to the service to ensure a similar incident would not happen again.

As in 2015-16, there were significant risks around meeting our obligation to uphold patient preferences about the sharing of data. We have removed 178 million records to support type 2 objections and adopted the Information Commissioner's Office (ICO) anonymisation code of practice in the handling of patient confidential data. We worked with the Data Services Commissioners Regional Offices (DSCROs) to improve controls on data releases. In 2017-18, our audit plan will incorporate a review of more DSCRO's in addition to the three undertaken in 2016-17.

The speed of modernisation of our data platforms is to a significant extent dependent upon the scope, affordability, business case approvals and procurement of the National Data Services Programme. We will continue to take action to manage this risk during 2017-18.

During 2016-17, we refined our strategic risk themes, and the corporate risks that align with them, to ensure that they continued to reflect the most significant risks to the delivery of our strategic objectives. The table below sets out risk themes reported to the Executive Management Team and the Assurance and Risk Committee, which represent the most significant operational risks.

	RAG Rating					
Strategic Risk Themes	**Red**	**Amber/ Red**	**Amber**	**Amber/ Green**	**Green**	**Total**
1 – We do not deliver the required levels of clinical quality, safety and utility in its programmes and services	2	1	1	-	-	4
2 – We do not mobilise in a sufficiently timely manner to deliver PHC2020 commitments	5	-	-	-	-	5
3 – We fail to deliver on our statutory, legal and financial obligations	-	6	6	1	-	13
4 – We fail to guard against IT/cyber security threats to protect patient data	-	2	2	-	-	4
5 – We fail to safely collect, analyse and disseminate high quality and timely data/information and maintain public trust	-	2	1	1	1	5
6 – We do not have the ability to support realisation of demonstrable system wide benefits from PHC2020 and other programmes and services	-	1	-	-	-	1
7 – We fail to transform the organisation so that it secures, develops and deploys its workforce effectively and efficiently to deliver its future vision	-	3	2	-	-	5
8 – We fail to deliver operational continuity of the systems and infrastructure it is charged to deliver, to protect patient safety and critical services	-	2	2	-	-	4
9 – We do not secure a positive, responsive and trustworthy reputation and maintain effective relationships with key customers/ stakeholders	-	1	2	-	-	3
10 – We do not design and deliver interoperable systems that work as anticipated to meet user needs	-	3	2	-	-	5
Total	**7**	**21**	**18**	**2**	**1**	**49**

Rob Shaw
Interim Chief Executive
26 June 2017

Remuneration and staff report

This report for the year ended 31 March 2017 deals with the pay of the Chair, Chief Executive and other members of the Board.

Remuneration Committee

The pay of the executive board directors is set by the Remuneration Committee based on the recommendations of the Senior Salaries Review Board and is reviewed on an annual basis.

NHS Digital operates the NHS Executive and Senior Manager (ESM) pay framework with the approval, where necessary, of the Department of Health Remuneration Committee. This includes a job evaluation scheme, administered by the NHS Business Services Authority, and provision for a maximum 5 per cent bonus for not more than the top 25 per cent of performers within the ESM group. Two bonus payments were made in 2016-17 through this mechanism, reflecting performance during 2015-16, details of which are contained in the Remuneration Report. The scheme also provides for an annual performance-based pay award as a flat-rate payment based on 1 per cent of the average ESM salary. The award was made to eight ESMs during 2016-17.

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

Remuneration policy

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.

The AfC pay award for 2016-17, as recommended by the NHS Pay Review Body, comprised a 1 per cent increase to all pay points.

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

Service contracts

All executive directors during 2016-17 were employed on permanent employment contracts with a 6-month notice period and worked for NHS Digital full-time. If contracts are terminated for reasons other than misconduct, they come under the terms of the NHS compensation schemes.

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

	Actual commencement date	Current contract commencement date	End date
Noel Gordon	1 June 2016	1 June 2016	31 May 2020
Sir Ian Andrews	1 April 2013	1 January 2017	31 December 2018
Dr Sarah Blackburn	15 September 2014	15 September 2016	14 September 2018
Dr Marko Balabanovic	1 January 2017	1 January 2017	31 December 2019
Daniel Benton	1 January 2017	1 January 2017	31 December 2020
Professor Soraya Dhillon	1 January 2017	1 January 2017	31 December 2020
Professor Sudhesh Kumar	1 January 2017	1 January 2017	31 December 2019
Rob Tinlin	1 January 2017	1 January 2017	31 December 2019
Sir Nick Partridge	1 April 2013	1 April 2016	31 December 2016
Maria Goddard	1 April 2014	1 April 2014	31 March 2017

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

Emoluments of board directors

The remuneration and pension disclosures relating to all directors in post during 2016-17 and 2015-16 are detailed in the tables below and are subject to audit. Emoluments of executive directors consist of basic pay, performance pay, pension benefits and benefits in kind. Emoluments do not include employer pension contributions or the cash equivalent transfer value of pensions.

	2016-17				
	Salary (bands of £5,000)	**Performance Pay (bands of £5,000)**	***Pension benefits (bands of £2,500)**	**Total emoluments (bands of £5,000)**	**Full year equivalent salary (bands of £5,000)**
Andy Williams[1] Chief Executive to 27 February 2017	185-190	–	–	185-190	185-190
Robert Shaw Interim Chief Executive	145-150	5-10	102.5-105.0	255-260	145-150
Rachael Allsop Director of Workforce	135-140	5-10	150.0-152.5	290-295	135-140
Beverley Bryant Director of Digital Transformation from 1 June 2016	120-125	–	37.5-40.0	160-165	145-150
Carl Vincent[2] Director of Finance and Corporate Services	110-115	–	25.0-27.5	140-145	110-115
^Thomas Denwood Director of Provider Support and Integration	120-125	–	30.0-32.5	150-155	120-125
^James Hawkins Director of Programmes	125-130	–	35.0-37.5	160-165	125-130
^David Hughes Director of Information and Analytics from 22 August 2016	90-95	–	20.0-22.5	110-115	145-150
^Martin Severs[3] Clinical Director and Caldicott Guardian	130-135	-	(45.0-47.5)	85-90	130-135
^Andrew McLaren Director of Information and Analytics between 27 April 2015 and 6 July 2015	–	–	–	–	–
^Peter Counter Chief Technology Officer to 30 April 2016	10-15	–	–	10-15	140-145
Isabel Hunt[4] Director of Customer Relations to 5 June 2016	20-25	–	–	20-25	125-130
Linda Whalley[4] Director of Strategy and Policy between 10 December 2015 and 5 June 2016	20-25	–	–	20-25	90-95

There were no benefits in kind.

* All pension-related benefits are calculated as the real increase in pension multiplied by 20 plus the real increase in any lump sum less the contributions made by the individual. The real increase excludes increases due to inflation or any increases or decreases due to a transfer of pension rights.

^ Until June 2016 attended the Board on a regular basis but are not Board members. From June 2016 attend the Board Development meetings and Executive Management Team meetings

2015-16				
Salary (bands of £5,000)	**Performance Pay (bands of £5,000)**	***Pension benefits (bands of £2,500)**	**Total emoluments (bands of £5,000)**	**Full year equivalent salary (bands of £5,000)**
180-185	5-10	-	190-195	180-185
135-140	5-10	72.5-75.0	215-220	135-140
120-125	–	2.5-5.0	125-130	120-125
–	–	–	–	–
115-120	–	27.5-30.0	145-150	110-115
115-120	–	55.0-57.5	175-180	115-120
120-125	–	47.5-50.0	165-170	120-125
–	–	–	–	–
80-85	–	–	80-85	130-135
25-30	–	–	25-30	145-150
140-145	–	30.0-32.5	175-180	140-145
125-130	–	27.5-30.0	150-155	125-130
85-90	–	7.5-10.0	90-95	85-90

[1] Andy Williams resigned as Chief Executive on 27 February 2017. He subsequently acted as a special advisor to the interim Chief Executive until 31 March 2017. His salary for the full year has been included.

[2] Carl Vincent was seconded from the Department of Health until 31 May 2015 and subsequently transferred to the NHS Digital payroll. His salary includes the full year. Pension details relate to his membership of the NHS Pension scheme from June 2015.

[3] During 2015-16 Martin Severs was seconded part-time from the University of Portsmouth and costs relate to the total value of charges net of irrecoverable VAT. From 11 April 2016 he became an employee of NHS Digital contributing to the NHS Pension Scheme until March 2017 at which point he became in receipt of pension benefits. Consequently, he has no CETV at 31 March 2017. His pensionable pay in 2016-17 is less than that used for the Greenbury data at 31 March 2016 which has resulted in a reduction in pensionable benefits.

[4] Linda Whalley was appointed to the Board on 10 December 2015, but the emoluments in 2015-16 relate to the full financial year as she regularly attended the Executive Management Team prior to that. She resigned from the Board on 5 June 2016. Isabel Hunt also resigned from the Board on 5 June 2016.

	2016-17	2015-16
	Salary (bands of £5,000)	Salary (bands of £5,000)
Noel Gordon Chair from 1 June 2016	50-55	-
Kingsley Manning Chair to 31 May 2016	10-15	60-65
Sir Ian Andrews Non-Executive Director	15-20	10-15
Sir Nick Partridge Non-Executive Director to 31 March 2017	5-10	5-10
Maria Goddard Non-Executive Director to 31 March 2017	5-10	5-10
John Chisholm Non-Executive Director to 31 December 2016	-	-
Sarah Blackburn Non-Executive Director	10-15	10-15
Marko Balabanovic Non-Executive Director from 1 January 2017	0-5	-
Daniel Benton Non-Executive Director from 1 January 2017	0-5	-
Professor Soraya Dhillon Non-Executive Director from 1 January 2017	0-5	-
Professor Sudhesh Kumar[5] Non-Executive Director from 1 January 2017	0-5	-
Rob Tinlin Non-Executive Director from 1 January 2017	0-5	-

[5] Sudhesh Kumar is seconded from the University of Warwick and costs relate to the total value of charges net of irrecoverable VAT.

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

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

Directors' expenses during 2016-17 are detailed on our website at https://www.digital.nhs.uk/board-directors-expenses

Pension benefits

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

Pension benefits (subject to audit)

	Accrued benefits				Cash equivalent transfer values		
	Real increase in pension (bands of £2,500)	Real increase in pension lump sum (bands of £2,500)	Total accrued pension at 31 March 2017 (bands of £5,000)	Lump sum related to accrued pension at 31 March 2017 (bands of £5,000)	CETV at 31 March 2017 £000	CETV at 31 March 2016 £000	Real increase in CETV £000
Andy Williams	–	–	–	–	–	–	–
Robert Shaw	5.0-7.5	7.5-10.0	60-65	165-170	1,064	951	56
Rachael Allsop	5.0-7.5	20.0-22.5	55-60	175-180	1,194	1,014	90
Beverley Bryant	2.5-5.0	–	10-15	–	153	123	15
Carl Vincent	0-2.5	–	0-5	–	44	20	12
Thomas Denwood	0-2.5	0-2.5	15-20	45-50	238	210	14
James Hawkins	2.5-5.0	0-2.5	15-20	40-45	277	241	17
David Hughes	0-2.5	–	50-55	–	665	645	10
Martin Severs	(0-2.5)	(2.5-5.0)	60-65	185-190	–	–	–
Peter Counter	–	–	–	–	–	72	–
Isabel Hunt	–	–	–	–	–	37	–
Linda Whalley	–	–	–	–	–	562	–

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

The CETV figures, and from 2003-04 the other pension details, include the value of any pension benefit in another scheme or arrangement that the individual transferred to the civil service pension arrangements and for which the civil service vote received a transfer payment commensurate to the additional pension liabilities being assumed.

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

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

Staff numbers and related costs

Staff costs comprise:
Subject to audit

	2016-17 £000	2015-16 £000
Permanent staff		
Salaries and wages	120,634	114,979
Social security costs	13,201	10,259
Employer superannuation contributions – NHSPS	15,370	14,704
Employer superannuation contributions – other	354	475
Staff seconded to other organisations	704	901
Termination benefits	111	2,559
	150,374	**143,877**
Other staff		
Temporary staff	1,335	1,243
Contractors	8,873	8,726
Staff seconded from other organisations	700	952
	10,908	**10,921**
Capitalised staff costs	(5,084)	(2,807)
	156,198	**151,991**

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

	2016-17 Number	2015-16 Number
Permanent staff and secondees	2,665	2,591
Temporary and contract staff	100	104
Total	**2,765**	**2,695**
The average number of whole term equivalent persons employed during the year whose time was capitalised	92	51

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

Comparison of the remuneration of the highest paid director and the median remuneration of the workforce is given below (subject to audit):

	Highest paid director £000	Range of staff remuneration £	Median pay of the workforce £	Ratio to the median of the workforce
2016-17 (excluding pension benefit)	185 - 190	13,758 to 195,536	41,373	4.5
2015-16 (excluding pension benefit)	190 - 195	13,216 to 195,536	40,964	4.5

There have been no material changes to the range of staff remuneration or the median pay. The median pay increased in line with the pay award.
Four members of staff received full-time equivalent remuneration in excess of the highest-paid director.
There are 10 posts, as of 31 March 2017, that meet the criteria of board members and/or senior officials with significant financial responsibility.

Pension Information

Most NHS Digital staff are covered by NHS pension schemes (the 1995/2008 scheme and the 2015 scheme), although a number belong to the Principal Civil Service Pension Scheme.

NHS Pension Scheme

Past and present employees are covered by the provisions of the two NHS pension schemes. Details of the benefits payable and rules of the schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. Both are unfunded, defined-benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State in England and Wales. 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 organisation of participating is taken to be equal to the contributions payable to that scheme for the accounting period.

The Government Financial Reporting Manual requires that "the period between formal valuations shall be four years, with approximate assessments in intervening years" 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 following valuations have been conducted:

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 at 31 March 2017 is based on valuation data for 31 March 2016, updated to 31 March 2017 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant Government Financial Reporting Manual interpretations, and the discount rate prescribed by HM Treasury have also been used.

The latest assessment of the liabilities of the scheme is contained in the scheme actuary report, which forms part of the annual NHS Pension Scheme (England and Wales) Pension Accounts. These accounts can be viewed on the NHS Pensions 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 its recent demographic experience) and to recommend contribution rates payable by employees and employers.

The last published actuarial valuation undertaken for the NHS Pension Scheme was completed for the year ending 31 March 2012. The scheme regulations allow contribution rates to be set by the Secretary of State for Health with the consent of HM Treasury and considering the advice of the scheme actuary and appropriate employee and employer representatives, as deemed appropriate.

The next actuarial valuation will be carried out as at 31 March 2016. This will set the employer contribution rate payable from April 2019 and will consider the cost of the scheme relative to the employer cost cap. There are provisions in the Public Service Pension Act 2013 to adjust member benefits or contribution rates if the cost of the scheme changes by more than 2 per cent of pay. Subject to this 'employer cost cap' assessment, any required revisions to member benefits or contribution rates will be determined by the Secretary of State for Health after consultation with the relevant stakeholders.

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

Employees who do not wish to join the NHS Occupational Pension Scheme can opt to join the National Employment Savings Trust (NEST) scheme. This is a stakeholder pension scheme based on defined contributions. The minimum combined contribution is 2 per cent of qualifying earnings, of which the employer must pay 1 per cent, rising to 8 per cent in 2018, of which the employer must pay 3 per cent. Employees can choose to pay more into the fund, subject to a current cap of £4,700 per annum. Five NHS Digital employees were members of the NEST Scheme during 2016-17.

The Principal Civil Service Pension Scheme

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

For 2016-17, employers' contributions of £450,675 were payable to the Principal Civil Service Pension Scheme (2015-16: £477,714) at one of four rates in the range 20.0 per cent to 24.5 per cent of pensionable earnings, based on salary bands. The Scheme Actuary reviews employer contributions, usually every four years following a full scheme valuation. The contribution rates are set to meet the cost of the benefits accruing during 2016-17 to be paid when the member retires and not the benefits paid during this period to existing pensioners.

Employees can opt to open a partnership pension account, a stakeholder pension with an employer contribution. Employer contributions are age-related and range from 8 per cent to 14.75 per cent of pensionable earning. Employers also match employee contributions up to 3 per cent of pensionable earnings.

No NHS Digital employees have opted for the partnership pension account.

Sickness absence data

During 2016, 12,033 working days (2015: 13,101) were lost due to sickness absence. This represented 4.5 working days (2015: 5.2) per employee. The above figures are based on calendar year, not financial year, and were centrally produced from the Electronic Staff Record. Average sickness absence for 2016 was 2 per cent.

Consultancy

The total spend on consultancy, as defined by HM Treasury guidance, was £1,584,760.

Health and safety

We have legal responsibilities in relation to the health, safety and welfare of our employees and for all people using our premises. We comply with the Health and Safety at Work Act (1974) and also operate a Health and Safety Committee under the Safety Representatives and Safety Committee regulations (1977). Training on fire safety is mandatory and there are e-learning packages available for other Health and Safety topics including Manual Handling and work with visual display equipment.

Reporting of Civil Service and other compensation schemes – exit packages

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

2016-17	Number of compulsory redundancies	Number of other departures agreed	Total number of exit packages	Cost of compulsory redundancies £	Cost of other departures agreed £	Total cost of exit packages £
Cost Band						
£25,000 - £50,000	1	-	1	34,242	-	34,242
£50,000 - £100,000	1	-	1	72,049	-	72,049
Total	**2**	**-**	**2**	**106,291**	**-**	**106,291**

2015-16	Number of compulsory redundancies	Number of other departures agreed	Total number of exit packages	Cost of compulsory redundancies £	Cost of other departures agreed £	Total cost of exit packages £
Cost Band						
<£10,000	1	18	19	6,006	123,250	129,256
£10,000 - £25,000	-	33	33	-	549,545	549,545
£25,000 - £50,000	-	32	32	-	1,146,932	1,146,932
£50,000 - £100,000	-	12	12	-	733,606	733,606
Total	**1**	**95**	**96**	**6,006**	**2,553,333**	**2,559,339**

Analysis of other departures 2015-16	Number of departures agreed Number	Total value of departures agreed £
Mutually agreed resignations (MARS) contractual costs	94	2,547,461
Contractual payments in lieu of notice	1	5,872
Total of exit packages	**95**	**2,553,333**

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

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

The following is a breakdown of all off-payroll engagements as of 31 March 2017 that were for more than £220 per day and lasted longer than six months:

	Number
Number of existing engagements as of 31 March 2017	52
Of which, the number that have existed:	
for less than one year at the time of reporting	22
for between one and two years at the time of reporting	23
for between two and three years at the time of reporting	6
for between three and four years at the time of reporting	1
for four or more years at the time of reporting	-

The next table shows all new off-payroll engagements between 1 April 2016 and 31 March 2017 that were for more than £220 per day and lasted more than 6 months

	Number
Number of new engagements, or those that reached six months in duration, between 1 April 2016 and 31 March 2017	31
Number of new engagements that include contractual clauses giving NHS Digital the right to request assurance in relation to income tax and National Insurance obligations	31
Number for whom assurance has been requested	31
Number for whom assurance has been received	27
Number for whom assurance has not been received	4
Engagement terminated as a result of assurance not having been received, or ended before assurance received	-

We have implemented an assurance process in line with guidance issued by the Department of Health. This includes requesting appropriate assurance from contractors as and when it is clear that their engagement is likely to exceed a 6-month period. All contractors have been assessed using the toolkit supplied by HMRC in late February 2017.

Diversity and inclusion

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

Over the next three years, we aim to:

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

During 2016-17, we continued our membership of the NHS Equality and Diversity Council and reaccredited our use of the 'Disability Confident' symbol, which is externally reviewed and advertises our commitment to the employment, retention, training and career development of disabled people.

We signed up to the Mindful Employer Charter and worked toward removing barriers for employees with mental health issues. The NHS Digital Academy provides graduate programmes and apprenticeships to increase opportunities for young people.

The continued development of the annual diversity and inclusion workforce report and gender pay report improved our baseline understanding of the nature of our workforce.

We are now gathering more information on attitudes to diversity and inclusion through regular staff engagement sessions and an all staff 'pulse' survey and supporting improved induction of new recruits by providing a position statement within the new employee handbook incorporating diversity and inclusion questions and incorporating a micro behaviours drama into the induction process. We have included video clips on fair recruitment, understanding bias, and race, gender and age discrimination in our new recruitment toolkit.

We have also rolled out mandatory e-learning on understanding bias for all staff. This was complemented by a pilot of an 'Understanding bias – thinking fast and slow' face-to-face training programme for managers and recruiters.

Our new staff networks, including LGBT & Allies, Embrace (Ethnic Minorities Broadening Racial Awareness and Cultural Exchange), Age Aware, Ability network (Disabilities, long term conditions and carers) and Women's Network are all staff-led, with a core group of members, an executive sponsor and a workforce senior management team sponsor. They are critical to nurturing the culture and structures of mutual support that will help NHS Digital drive continuous improvement in this area.

Supporting diversity and inclusion is not only an internal priority. We are working to ensure it informs all of our activity. For example, in 2016-17 we developed easy-read versions of two key publications, the Learning Disability Services Monthly Statistics and Health and Care of People with Learning Disabilities. These were co-produced by consultants with a learning disability and their carers.

The gender distribution in NHS Digital for each Agenda for Change equivalent grade is given below:

	Agenda for Change equivalent grades	2016-17		2015-16	
		Male	Female	Male	Female
Directors		5.7	3.8	6.0	3.0
Senior Managers	9	37.9	12.9	38.1	12.4
	8d	95.9	35.9	84.6	32.1
Managers	8c	184.4	95.4	190.2	93.5
	8b	314.6	143.8	316.6	144.9
	8a	379.8	240.0	363.4	219.0
Other staff	7	274.2	213.0	262.5	210.8
	6	121.1	170.8	126.2	158.0
	5	97.4	156.6	82.8	144.2
	4	45.9	60.4	58.2	62.5
	3	28.5	31.9	19.4	44.7
	2	3.3	1.1	2.1	2.8
	Secondees	8.6	2.2	13.1	3.9
Total		**1,597.2**	**1,167.8**	**1,563.1**	**1,131.9**

There has been no significant change in the gender or grade split of our workforce. 58 per cent of all employees are male (2015-16: 58 per cent) against a British business average of 53 per cent. Figures from the UK Commission for Employment and Skills show that the number of women in Britain's digital workforce in 2015 was 27 per cent. We are acting to promote digital careers for women, including working with Women in Digital to get more women into digital apprenticeships.

We publish an annual Diversity and Inclusion Workforce Report. The 2015-16 report is available at: https://digital.nhs.uk/media/1153/Diversity-and-inclusion-workforce-report-2015-16-1Mb-/pdf/HSCIC_Diversity_and_Inclusion_Workforce_Report.

The 2016-17 report is scheduled to be published in July 2017.

Community and social responsibility

We have a special leave policy that allows staff paid leave to undertake public duties (for example, magistrate, school governor and reserve forces roles).

We have also developed work experience and placement programmes that will be extended to schools, colleges and universities near our office locations over the next 12 months.

Rob Shaw
Interim Chief Executive
26 June 2017

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

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

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

The Board

We are led by a Board consisting, by the end of 2016-17, of five executive and eight non-executive members including a chair. This is the senior decision making body. A further three senior executives attend the Board as required and there are three 'ex-officio' members. The Board supports the Chief Executive, who is the Accounting Officer and is therefore accountable to both the Secretary of State for Health and to Parliament. Board biographies and the Register of Interests are in Appendix B on page 100.

Board members have a responsibility to ensure that we comply with all statutory and administrative requirements for the use of public funds. Details of the conduct of the Board and the roles and responsibilities of members are set out in our Corporate Governance Manual, which includes our Standing Orders and Standing Financial Instructions. These are reviewed annually.

The powers retained by, and the responsibilities, of the Board include:

- agreeing our vision and values, culture and strategy within the policy and resources framework agreed with the Department of Health sponsor
- agreeing appropriate governance and internal assurance controls
- approving business strategy, business plans, key financial and performance targets and the annual accounts
- ensuring sound financial management and value for money
- ensuring controls are in place to manage financial and performance risks, including ensuring that we have the capability to deliver our strategic objectives
- using information appropriately to drive improvements
- supporting the Executive Management Team and holding it to account
- ensuring that we are able to account to Parliament and the public for how we discharge our functions
- ensuring that we comply with any duties imposed on public bodies by statute, including (without limitation) obligations under health and safety legislation, the Human Rights Act 1998, the Data Protection Act 1998, the Freedom of Information Action 2000, the Equality Act 2010, the Public Bodies Health and Social Care Act 2011, the Health and Social Care Act 2012 and secondary legislation made under relevant acts
- ensuring that we have specific responsibility for sustainable development and operate within the framework of the Department of Health's environmental policies
- approving recommendations of board committees
- approving income and expenditure as defined in our 'Levels of Delegated Authority' document.

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

- a public session that other members of the senior management team and a representative from the Department of Health sponsor team are able to attend. Members of the public can attend and observe. Papers and previous minutes are made available via the NHS Digital website in advance of the meeting
- a private, closed session relating to items of a commercial or confidential nature that cannot be discussed in public.

Business meetings discuss key business areas, progress on major programmes, detailed strategies and plans etc. All agendas and minutes are made available on the NHS Digital website.

During 2016-17, six statutory public meetings were held together with a further six board development days. In addition to standing agenda items on the governance and performance of the organisation, the Board has discussed a range of topics including:

- clinical governance safety
- outcomes and future implementation of the Capability Review
- the consideration and subsequent acceptance of various directions, particularly relating to data collections, issued by the Department of Health and NHS England
- the NHS Digital Strategy
- broad range of performance indicators aligned with our strategy and business plan, including the development of key performance indicators for data quality and reputation
- progress toward a patient centric digital health and care system

Members of the Board use the board development days to give in-depth consideration to strategic issues within the organisation and in the broader digital environment. These meetings include additional senior operational staff. Some key issues discussed during 2016-17 included:

- digital innovation and partnerships
- the Health and Social Care Network
- cyber security

Board Committees

The Board has appointed three committees whose delegated responsibilities are as below. Attendance during 2016-17 is detailed in Appendix C on page 109.

The Assurance and Risk Committee (ARC)

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

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

The key areas reviewed in 2016-17 included:

- oversight of the annual accounts preparation, including the annual governance statement on behalf of the Board
- strategic input into the internal audit strategy and annual plan in the context of the Department of Health shared service agenda
- review of internal audit reports and actions arising from these
- review of the local counter-fraud specialist work plan
- review of the reports from internal assurance providers
- consideration of the external audit strategy
- development, implementation and monitoring of corporate risk and assurance arrangements
- consideration of the Capability Review outputs relating to risk and assurance.

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

The Information Assurance and Cyber Security Committee (IACSC)

The IACSC has representation from across government, including the Department of Health. It is responsible for ensuring that there is an effective information assurance function that meets recognised industry and government standards and provides appropriate independent assurance to the Chief Executive and the Board. It reviews the work and findings of the Cyber Security Programme and considers the implications of management responses to its work. It also monitors other significant assurance functions, both internal and external to the organisation, and looks at the implications for governance of the organisation.

It is authorised to investigate activities within its terms of reference and all employees are directed to cooperate with its requests for information. It can seek legal or independent professional advice at NHS Digital's expense.

The main areas considered in 2016-17 included:

- the IACSC Report 2015-16
- the 'IACSC Terms of Reference annual review'
- National Information Board (NIB) progress on funding the National Cyber Security Programme
- formation of the Information Management Strategy Group
- CQC/NDG Health and Social Care Security Review – update on progress of the implementation of new data security standards
- updates from the Department of Health's Information Security and Risk Board
- Information Governance Toolkit refresh
- Citizen Identity discovery
- NHS Digital's relationship with the National Cyber Security Centre
- NHS Digital Board cyber security training session
- Internet of Things security
- updates on health cyber security attacks
- 'Grab bag' cyber security response plan.

The Remuneration Committee (RC)

The Remuneration Committee approves the annual performance objectives of executive directors, evaluates the performance of senior management and makes recommendations to the Department of Health on any proposed annual performance pay awards to them. Other responsibilities include approving the level of annual performance-related pay awards to NHS Digital staff on ex-civil service terms and conditions and determining pay arrangements for medical and other staff groups who are not subject to Agenda for Change (AfC), the ESM framework or the TUPE protected terms and conditions of employment.

The committee ensures that pay arrangements meet equal pay requirements and considers redundancy payments and other (often TUPE related) exceptional items. It ensures that all matters relating to pay and conditions that require approval from the Department of Health Remuneration Committee or other external authorities are submitted for approval and that the decisions of those bodies are implemented.

During 2016-17, the Remuneration Committee considered senior staff succession planning including the restructuring of the NHS Digital Board and the recruitment of a new Chief Executive.

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

Investment Committee (IC)

From May 2017, a new sub-committee of the Board, known as the Investment Committee (IC), has been created consisting of two non-executive directors and the Director of Finance and Corporate Services. One of the non-executive directors will act as chair.

The purpose of the committee is to ensure that NHS Digital takes on an acceptable level of delivery risk. In addition, the IC will provide assurance to the Digital Delivery Board that NHS Digital is able to meet it delivery commitments. Specifically, the IC will ensure that programmes:

- have appropriate management and resourcing arrangements, including agreed commercial strategy and risk management
- are technically robust and clinically safe
- are affordable
- have robust proposals for cyber security and information security
- have acceptable levels of compliance risk, particularly with respect to information governance, procurement and vires.

Following IC endorsement, business cases will be submitted to the Technology and Data Investment Board.

Operational governance structure

The Board is assisted in carrying out its duties by an operational governance structure comprising of the Executive Management Team, with the Operations Board and the Workforce and Transformation Board reporting to it.

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

The Operations Board is responsible for providing strategic and operational oversight of the portfolio of programmes, projects and services so that executive portfolios achieve their delivery commitments.

The Workforce and Transformation Board is responsible for providing strategic oversight of issues relating to workforce, transformation and resource management.

Data and information governance

A wide-ranging legal, regulatory and compliance framework governs our receipt, processing and dissemination of data and information and our production of statistics. A schedule covering the key areas is included at Appendix D on page 110.

A key element of our responsibilities is to ensure that all data and information is collected, stored and disseminated appropriately. Information and statistical governance are taken extremely seriously and we have further improved controls and protocols this year through the launch of the Data Access Request Service (DARS) Online, which enables data applicants to submit and manage data access requests and sign data sharing agreements through a single, intuitive online portal. This has delivered far greater transparency and a significant reduction in administrative burden. The service is being continuously improved and there has been a programme of engagement across the health and care community.

We have also developed our Data Collections Service, which continues to make significant progress in consolidating data collections and transitioning them onto a unified suite of collection tools. Improvements made in 2016 mean the service can now establish new collections in the Strategic Data Collection System (SDCS) at pace and without the need for additional development. This has increased efficiency and public benefit.

By centralising all data requests and disseminations through DARS and the introduction of new tools and services we will continue to increase efficiency and improve the quality of service for external users. We also provide system-wide advice on operational information governance to the health and social care sectors in England. This is separate from our principal role as guardian of data, set out in the Health and Social Care Act 2012.

Improving governance and assurance processes across the system

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

A more extensive explanation of information governance issues is included in the annual governance statement on page 63.

Annual Governance Statement for the year ended 31 March 2017

Introduction and context

NHS Digital is an executive non-departmental public body (ENPDB) responsible for setting up and operating systems for the collection, analysis, dissemination and publication of information relating to health services and adult social care and for ensuring citizens' health data is protected. We develop and operate information and communications systems for health services and adult social care in England and act as the authority for determining and publishing information standards. We are accountable directly to Parliament for the delivery of the statutory functions described within the Health and Social Care Act 2012.

During the year, we have been working closely with the Department of Health and NHS England to manage responsibilities for the governance of informatics services. We have agreed to act as the technology and data delivery partner for the health and care system, including delivering the commitments set out in the National Information Board's strategy 'Personalised Health and Care 2020'. At the same time, we have new arrangements for governance and assurance as the Department of Health slims down and hands over funding and controls to its arms-length bodies, including NHS Digital and NHS England.

Taken together, this represents a major shift in our delivery responsibility and accountability and in the scale and complexity of our portfolio. Between October 2016 and March 2017, we worked with external advisers to review our capabilities, and identify what steps would be needed to further transform NHS Digital into a modern, agile organisation capable of meeting all of our delivery commitments and maintaining the confidence of key external partners and stakeholders, including HM Treasury.

The review's main objectives were to:

- review our current capacity and capabilities against the emerging requirements for the delivery of the Personalised Health and Care 2020 strategy and our existing statutory and corporate commitments
- identify the future direction for our delivery model and any changes that are required
- consolidate the work that is currently in progress through the Digital Transformation portfolio, to improve the way we engage with and support our clients and stakeholders
- ensure that the relationships and working arrangements with our national partners (notably the Department of Health and NHS England) are fit for the governance and assurance of the delivery of Personalised Health and Care 2020
- agree plans to enhance our new operating model, both tactically, by strengthening our workforce planning capabilities, and strategically, through a new workforce strategy.

The review was intended to inform the next phase of our organisational transformation, which started in 2015-16 with the objective of empowering our people and our organisation to be "more flexible and agile in order to deliver the right things for our customers with greater efficiency and provide better value for money in line with the urgent needs of the health and care system". This transformation has been underpinned by an organisation-wide cultural change programme delivered through a number of interrelated workstreams, including a structural emphasis around the portfolio of programmes and services, the introduction of workforce planning, time recording, an improved approach to promotion, talent management, and a new learning and development strategy. More information about this work is included in Appendix E on page 111.

The review highlighted a number of issues and potential improvements, for which action plans are being developed.

Scope of responsibility

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

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

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

Board developments

A number of changes to the senior management of the organisation have occurred during 2016-17, including the appointment of the:

- new Chair, effective from 1 June 2016
- Chief Operating Officer, effective from 1 April 2016, broadening the role of the previous Director of Operations and Assurance Services
- Director of Workforce, effective from 1 April 2016, broadening the role of the previous Director of Human Resources and Transformation
- Director of Digital Transformation, effective from 1 June 2016

The Chief Executive retired on 31 March 2017, after handing over his chief executive responsibilities with effect from 27 February 2017. The Chief Operating Officer has assumed the responsibilities of Chief Executive and will continue until the newly recruited permanent Chief Executive starts in August 2017.

Corporate governance

NHS digital complies with the best practice described in the corporate governance code for central government departments issued by HM Treasury.

The Board has at least six non-executive directors, including the Chair, and there are fewer executive directors than non-executive directors. The Chair and non-executive directors are appointed by the Secretary of State for Health. Executive members are appointed by the Board. During 2016-17, four non-executive directors retired and six new non-executive directors were appointed.

Details of our constitution, our operational accountability, our Board and its appointed committees are provided on pages 55 to 58. Information about the conduct of the Board and the roles and responsibilities of members are set out in our Standing Orders, Standing Financial Instructions and Code of Practice for board members, which have been reviewed during the course of 2016-17.

NHS Digital remains committed to transparency and regularly holds Board meetings in public. Board papers, and the minutes of those meetings, are published on the NHS Digital website. It is normal to undertake a review of board effectiveness and governance annually, but given the number of changes to the Board composition during the year it was decided to delay this until the new Board has settled down. The review undertaken in 2015-16 did not highlight any significant issues that required immediate action or comment in the Governance Statement.

Corporate governance assurance is provided by means of bi-annual executive director assurance statements, which take account of criteria laid out by the Department of Health and are reported to the Department of Health Sponsor. We have developed a Risk Control and Assurance Framework (RCAF), which supports the Assurance Statements and builds on our previous assurance map. It provides assessments of the assurance on controls in place across the organisation and against the strategic risks, using the 'Three Lines of Defence Model'. The RCAF has also been used in developing the internal audit programme for 2016-17.

Corporate policies are reviewed on a regular basis and will be refined as appropriate as part of our ongoing transformation programme.

Internal Audit

NHS Digital's internal audit service is provided as part of the Department of Health Group Internal Audit Service, which became part of the Government Internal Audit Agency in October 2016. It plays a crucial role in reviewing the effectiveness of management controls, risk management and governance. It focuses audit activity on the key risk areas. This service uses a blend of internal Department of Health staff and professional firms.

The internal audit service operates in accordance with the Public Sector Internal Audit Standards and to an annual internal audit plan approved by the Assurance and Risk Committee (ARC).

Regular reports are submitted on the effectiveness of our systems of internal control and the management of key business risks, together

with recommendations for improvement by management. The status of audit recommendations is reported to each ARC meeting, which has placed strong emphasis on reducing overdue actions to acceptable levels during the past year.

There were 16 separate audits undertaken across a range of business areas, of which five were rated as "limited". Action plans agreed by management arising from internal audits are monitored and reported on regularly to the Executive Management Team and ARC.

The Head of Internal Audit provided a moderate rating for 2016-17.

We recently commissioned PriceWaterhouseCoopers to undertake an ISAE3402 level review of the GP Payments system we manage on behalf of NHS England. This was qualified with a number of recommendations for improvement. We are in the process of assessing and developing action plans to address these recommendations.

We are also conscious that a qualified ISAE3402 report was received covering the external payroll service provided by NHS Shared Business Services. However, following an assessment of the reasons for qualification and an assessment of our internal controls, we do not believe this to be a significant issue for our level of assurance. The equivalent report covering Finance transaction services was satisfactory.

Counter fraud

We are responsible for investigating allegations of fraud related to our functions and work. We have an internally appointed counter-fraud officer who ensures that appropriate anti-fraud arrangements are in place and who does reactive and proactive counter-fraud work.

The internal policy on tackling fraud, bribery and corruption is communicated to all staff and available on our website. We work closely with a number of bodies, including NHS Protect, to establish appropriate and efficient anti-fraud arrangements across the wider commissioning system, and to comply with the standards set out by NHS Protect. We are co-operating fully with the National Fraud Initiative.

Public interest disclosure

NHS Digital was one of the first 100 organisations to sign up to the Public Concern at Work (PCAW) Whistleblowing Commission code of practice. We attend an annual networking event to discuss progress in implementing whistleblowing procedures and will continue to improve our policy and practice through engagement with PCAW. During 2016-17, we revised our whistleblowing communications strategy to promote a culture in which staff feel more empowered to speak up when they have concerns. One referral is currently being investigated as a potential whistleblowing report.

Key relationships

We do not work in isolation. We are part of the health and care information system created by the Health and Social Care Act 2012. The Act places a duty on all national arms-length bodies to work collaboratively in the interests of the system as a whole.

Our role within the informatics arena and the relationships with our key partners has been clearly set out during the year. We are the main informatics delivery organisation and both contribute to, and are held operationally accountable by, the Digital Delivery Board, a cross organisational board responsible for informatics. Our Chief Executive is a member of this Board and a significant number of our executive management team and senior managers are involved in the development of the plans for 2017-18 and beyond.

Performance management

Corporate performance management is integrated with business planning and risk management to provide a joined-up view of what we intend to deliver (business planning), what factors that could prevent successful delivery and how they can be mitigated (risk management) and how well we are delivering (performance management).

We continue to use and develop an organisation-wide performance management framework to help deliver our statutory obligations and our commitments to stakeholders.

It includes the periodic reporting at differing levels of granularity in performance packs to the Digital Delivery Board, our internal Board, the Executive Management Team and business units of:

- Key Performance Indicators which contain financial and non-financial performance information, key risks and issues, and an assessment of delivery against strategic commitments.
- business plan delivery at corporate and directorate levels. Each director had a quarterly performance review with the Chief Executive Officer and the Director of Finance.
- other key work such as delivery of specific programmes and organisational development and transformation.

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

Risk management

We have improved the integration of our corporate risk and assurance functions during 2016-17 and will continue to do so as we implement the recommendations of the Capability Review. Our main focus during 2016-17 was on training and communications to develop management capability and awareness of risk and to improve the reporting of our most significant risks.

We have reviewed the existing risk data repository and are replacing it with a new system. We continue to carry out regular quality assurance checks to ensure that the risk information held is current, accurate and of good quality.

We have refined the Strategic Risk Dashboard to focus on the outcomes of our risk management effort and these are reported to ARC and the Board.

The use of risk management performance metrics is starting to drive an overall improvement in risk data quality and risk management behaviours, although further action is needed.

We have also maintained a risk management forum to act as our risk management community of interest. The forum's main objective is to improve risk management capability, so that risk management becomes embedded throughout our organisation and underpins its sustainability and resilience.

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

During 2016-17, we have:

- refined our strategic risk themes and the corporate risks aligned to each them to ensure that these continue to reflect the most significant risks to the delivery of our strategic objectives
- refined our approach to strategic risk to reflect new and amended strategic risk themes
- continued delivery of our targeted risk management improvement plan. We have focused on risk maturity, capability and awareness, including improved tools, metrics, reporting and collection methods and enhanced visibility of, and confidence in, our risk management capability
- implemented a more integrated approach to risk and assurance activity through the Risk Control and Assurance Framework, which uses a risk-based approach to focus assurance activity on the most significant areas of risk, based on the revised strategic risk themes
- reviewed our governance and accountabilities for managing risks, especially where these cross organisational boundaries
- started implementing a new Corporate Risk Information System
- sought opportunities to leverage the use of risk information in decision-making.

In 2017-18, we will emphasise integrating risk, control and assurance effort and the development of our strategic risk appetite at a more granular delivery level.

Information governance

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

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

Our strategy's work plan is in train and includes:

- training for key information asset owners, who are responsible for assets containing personal confidential data certified by Communications-Electronics Security Group (CESG), the government's national technical authority for information assurance
- the implementation and maintenance of the online access to a personal confidential data tool for staff to replace manual processes
- the publication of a consolidated policy for information governance and security
- the implementation of the Independent Group Advising on the Release of Data, which reviews applications for sensitive NHS Digital data and has expert members and an enhanced transparency remit
- a review of data sharing framework contracts and agreements
- the implementation of enhanced internal physical security measures
- the development of systems including a decision tree to support identification of roles requiring security vetting, a unified register to provide a single view of NHS Digital's data model and a new system to uphold patient objections to the sharing of personal data.

Additional information governance activities for the year included the completion of staff training in line with requirements of the NHS Information Governance Toolkit (IG Toolkit).

Additional specialist training is undertaken by staff responsible for the management and control of data assets and information. Compliance with mandatory training is monitored and failure to comply may result in the revocation of individuals' system access.

We also completed the annual IG Toolkit assessment. We were compliant for 2016-17, exceeding the required 'satisfactory' level with an overall score of 92 per cent.

We logged 14 incidents on the Serious Incident Requiring Investigation (SIRI) reporting tool: 12 near misses and two breaches. We investigated and managed these internally in accordance with the Information Commissioner's Office (ICO) and SIRI reporting guidelines. For the 12 near misses, it was determined that ICO notification was not required. For the breaches, one was reported to the ICO in July 2016, which the ICO decided no further action was required, and the second was reported in November 2016 that the ICO is still investigating.

We filed the appropriate notifications with the ICO in relation to the Data Protection Act 1998. During 2016-17, we received 864 Freedom of Information requests and 114 Subject Access Requests. There was one breach of the timescales for handling a Freedom of Information request but none for Subject Access Requests. There were no complaints made to the ICO by applicants dissatisfied with our responses under the Freedom of Information Act or Data Protection Act.

External information governance

We continue to host the Information Governance Alliance which brings together expertise from across health and social care to act as the primary point of contact for authoritative advice and guidance on information governance to the wider health and social care system. This guidance is published and disseminated through newsletters, conferences, workshops and webinars. We work collaboratively alongside NHS England, Public Health England and the Department of Health to position the Information Governance Alliance as the single source of information governance advice and guidance for the health and care system.

Key areas of focus in 2017-18 will be supporting the implementation of the Government response to the National Data Guardian's review of security, consent and opt-outs; the implementation of the EU directive on data protection; and continuing support for health and care organisations to improve information sharing and integration.

Assurance

We have established arrangements to audit the methodology of third-party organisations' compliance with the data sharing agreements they have with NHS Digital. We carried out 30 audits during 2016-17 and published the audit reports on our website.

We continue to meet our statutory responsibility to advise on the reduction of burden and bureaucracy through our Burden Advice and Assessment Service, which formally submitted advice to the Secretary of State for Health for the first time in 2016.

Our Standardisation Committee for Care Information (SCCI) team provides a holistic assurance and appraisal service for projects, programs and developers of standards, collections and extractions across the health and care system to ensure that standards are robust, represent value and enable the safe transfer of information between care organisations. The service provides expert knowledge and advice, working with business leads to support them in achieving the best outcome for all standards, collections and extractions. A review of the SCCI committee and its functions was completed this year and 2017-18 will see a transformation of the assurance and appraisal services to align with the Digital Delivery Board and its structures and better support the assurance of Personalised Health and Care 2020 programmes.

Data Security

The Data Security Centre (DSC) provides a robust data security model to NHS Digital and the wider health and care system, as well as operating live security services through the CareCERT service providing proactive threat information and remediation advice to more than 10,000 contacts across health and social care.

During 2016-17 the DSC delivered 2,095 notifications to infected sites through regular CareCERT bulletins and reported a reduction in active sites with an infection at any one time from 110 in April 2016 to 42 in March 2017. A Single Incident Reporting Process has been implemented across the organisation; some 263 security incidents were raised with the number unresolved reducing by 48 per cent. We significantly expanded our cyber support, offering new assurance tools, training and increased direct support for organisations under attack. To meet the challenges of the cyber security environment, we will need better awareness and skills across the system and, in 2017-18, we will continue to work with local and national partners to achieve this.

The importance of this work was highlighted by the recent ransomware attack in May. Our CareCERT service had issued security patches that kept thousands of properly updated NHS devices immune from this threat. We subsequently also assisted those affected sites to recover together with providing further direct guidance and support.

The DSC intends to further expand the scope and functionality of its service. We will develop realtime intelligence on technological threats faced by health and care. We will also provide underpinning tools, guidance and education about process and good practice to help system leaders embed better local data security cultures together with continuing to provide free on-site assessments and develop a security 'grab pack' for senior staff to use during an incident.

Data quality assurance

We understand the importance of good quality data and our role in ensuring that the data we collect, process and share is subject to the most rigorous levels of quality assurance.

Given our unique position as a processor, user and sharer of national health and social care data, we also have a duty to promote understanding of the importance of data quality across the health and social care sector.

We continue to seek ways for improving our data quality assurance and during 2016-17 we:

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

Clinical governance

As we move toward providing digital programmes and services that impact more closely on the lives of patients and citizens through the Personalised Health and Care 2020 strategy, there is a requirement to raise the profile of clinical governance at all levels of the organisation. This year, we have approved a clinical governance framework and have appointed two very senior clinicians to non-executive positions and allocated one with special responsibility for this area.

We also appointed nine senior clinicians with strong informatics competencies to lead on our major domains of activity and have for the first time produced annual clinical governance and patient safety reports with associated improvement plans for scrutiny by the ARC. We have also established processes to ensure that all our staff with clinical roles are validated for practice by their regulators.

We re-invigorated our patient safety approach to ensure it keeps pace with new digital technologies and advances in the use of digital technologies. This work is ongoing but includes decision-support algorithms, apps and machine learning.

Clinician time will be allocated according to clinical risk in each programme and, in the next year, the ARC will undertake detailed clinical governance and patient safety 'deep dives' in at least three specific domain areas.

Chief Executive's review of effectiveness

As Accounting Officer, I have responsibility, together with the Board, for reviewing the effectiveness of the system of internal control. The internal audit team has completed an agreed, comprehensive range of assessments and the head of internal audit provided an opinion on the overall arrangements for assurance and on the controls reviewed as part of the internal audit work. The internal audit assurance statement concluded on a moderate rating.

My review of 2016-17 has also been informed by:

- my attendance at the ARC and review of its minutes, papers and annual report to the Board, as well as my attendance at the IACSC
- work undertaken by the National Audit Office. This includes their review of the due diligence exercise undertaken as part of the transfer of assets from the Department of Health
- individual audit reports. Action plans were put in place to address recommendations and progress was reviewed by the ARC on a regular basis
- assurance provided to me by senior NHS Digital manager with responsibility for the development and maintenance of the system of internal control
- clear performance management arrangements for executive directors and senior managers
- the assurance framework itself, which provided evidence on the effectiveness of the controls that manage the risks to the organisation
- by review of and accepting a report from Andy Williams dated 27 February 2017 confirming that appropriate governance was in place until this date.

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

Significant Internal Control Issues

The past year has been challenging, with continued internal transformation activities, additional responsibilities arising from the transfer of functions from the Department of Health and the start of the PHC2020 programmes. Despite this period of change I am confident that the level of governance, assurance and control has improved.

I believe we have made significant progress this year and are now well on the way to achieving the standards of control I expect of the organisation.

Last year, we addressed several specific concerns raised from internal audit reports. I'm pleased to report that follow-up audits on difficult areas including risk management, business continuity and disaster management and financial controls noted significant progress. The Executive Management Team continues to dedicate a monthly meeting to these areas

The major financial issue in previous years has been the identification and recording of non-current assets, which required significant review and reconciliation. We have made considerable progress on this issue although there is still some work required to fully embed an efficient end-to-end control environment. No material concerns have been raised for 2016-17 and we are comfortable with the due diligence undertaken on the assets transferred during the year where a different level of materiality applied.

We have continued to address the concerns raised previously by the National Audit Office regarding the GP Extraction Service (GPES), which was the subject of a Public Accounts Committee hearing. Our action is focusing on the GP Data for Secondary Uses programme, which will deliver a replacement for GPES, and the General Practice Operational Systems and Services programme.

In year, we have successfully managed a major incident regarding the NHS Mail system. This involved significant email queues across the system resulting from a test email being sent to a locally created distribution list by a local administrator in a trust that was inadvertently sent to all users of the network. Immediate remedial action was taken and a series of changes were made to the service to ensure that this could not be repeated.

Clearly, the increasing responsibilities we hold and the development and implementation of new programmes will lead to a step change in our risk profile. We will need to ensure that our control environment continues to improve to reflect this. Hence, in addition to improving controls generally over the course of 2017-18, we will ensure that the recommendations from the Capability Review are fully implemented, particularly:

- System governance and assurance – during 2016-17, we have been working closely with the Department of Health and NHS England to agree the respective organisational responsibilities for all aspects of informatics services. We will continue to liaise with stakeholders to ensure that the appropriate governance put in place is fully complied with.
- Workforce capability and capacity – we will develop a coherent organisation-wide strategy coupled with a stronger ability to forecast demand and source the supply of the skills and capacity we require, at both a strategic and operational level. This includes the creation of a Workforce Planning Centre of Expertise, which will consider all aspects of delivery and capacity.
- Delivery model – we will develop and implement our preferred delivery model across the organisation to ensure that we operate in a consistent and efficient way using the right methods and tools.

In addition, we will also ensure that we continue to apply appropriate internal financial controls on our significantly larger level of responsibilities, including continuing to improve the recording of capital expenditure.

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 embed rigorous and sound assurance as a priority for NHS Digital in 2017-18.

Rob Shaw
Interim Chief Executive
26 June 2017

Statement of the Board and Chief Executive's responsibilities

Under the Health and Social Care Act 2012 and directions made thereunder by the Secretary of State with the approval of 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 cashflows for the financial year.

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

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

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

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

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

I certify that I have audited the financial statements of the Health and Social Care Information Centre for the year ended 31 March 2017 under the Health and Social Care Act 2012. The financial statements comprise: the Statements of Comprehensive Net Expenditure, Financial Position, Cash Flows, Changes in Taxpayers' Equity; and the related notes. These financial statements have been prepared under the accounting policies set out within them. I have also audited the information in the Remuneration and Staff Report and the Parliamentary Accountability Disclosures that is described as having been audited.

Respective responsibilities of the Board, Accounting Officer and auditor

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

Scope of the audit of the financial statements

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

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

Opinion on regularity

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

Opinion on financial statements

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 2017 and of the net expenditure for the year then ended; and
- the financial statements have been properly prepared in accordance with the Health and Social Care Act and Secretary of State directions issued thereunder.

Opinion on other matters

In my opinion:

- the part of the Remuneration and Staff Report and the Parliamentary Accountability disclosures to be audited have been properly prepared in accordance with Secretary of State directions made under the Health and Social Care Act; and
- the information given in the Performance Report and Accountability Report for the financial year for which the financial statements are prepared is consistent with the financial statements.

Matters on which I report by exception

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

- adequate accounting records have not been kept or returns adequate for my audit have not been received from branches not visited by my staff; or
- The financial statements and the part of the Remuneration and Staff Report and Parliamentary Accountability Disclosures to be audited are not in agreement with the accounting records and returns; or
- I have not received all of the information and explanations I require for my audit; or
- the Governance Statement does not reflect compliance with HM Treasury's guidance.

Report

I have no observations to make on these financial statements.

Sir Amyas C E Morse
Comptroller and Auditor General
4 July 2017
National Audit Office
157-197 Buckingham Palace Road
Victoria
London
SW1W 9SP

Statement of comprehensive net expenditure
For the year ended 31 March 2017

	Note	2016-17 £000	2015-16 £000
Expenditure			
Staff costs	3	156,198	151,991
Operating expenditure	5	106,103	57,751
Depreciation and amortisation	5	24,950	14,707
Loss on disposal of non-current assets	5	645	376
Total expenditure		**287,896**	**224,825**
Less income	4	(44,338)	(61,684)
Net operating expenditure for the financial year		**243,558**	**163,141**
Net gain on assets and liabilities transferred under absorption accounting	15	(35,936)	–
Net loss / (gain) on reconciliation of transferred assets	6	218	(1,226)
Net expenditure for the financial year		**207,840**	**161,915**

All income and expenditure derives from continuing operations.

Notes 1 to 23 form part of these financial statements.

Statement of financial position
As at 31 March 2017

	Notes	31 March 2017 £000	31 March 2016 £000 Restated
Non-current assets			
Property plant and equipment	7	22,329	19,052
Intangible assets	8	64,711	25,380
Other non-current receivables	9	4,235	1,509
Total non-current assets		**91,275**	**45,941**
Current assets			
Trade and other receivables	10	33,926	33,322
Cash and cash equivalents	11	15,434	10,152
Total current assets		**49,360**	**43,474**
Total assets		**140,635**	**89,415**
Current liabilities			
Trade and other payables	12	(30,823)	(25,826)
Provisions	13	(39)	(592)
Total current liabilities		**(30,862)**	**(26,418)**
Total assets less current liabilities		**109,773**	**62,997**
Non-current liabilities			
Provisions	13	(2,049)	(1,921)
Total assets less total liabilities		**107,724**	**61,076**
Taxpayers' equity and other reserves			
General reserve		107,724	61,076
Revaluation reserve		–	–
Total taxpayers' equity and other reserves		**107,724**	**61,076**

Notes 1 to 23 form part of these financial statements.

The financial statements on pages 70 to 93 were approved by the Board on 31 May 2017 and signed on its behalf by:

Rob Shaw,
Interim Chief Executive

Dated
26 June 2017

Statement of cash flows
For the year ended 31 March 2017

	Notes	2016-17 £000	2015-16 £000 Restated
Cash flows from operating activities			
Net operating expenditure for the financial year		(243,558)	(163,141)
Adjustment for non-cash transactions:			
– depreciation and amortisation	5	24,950	14,707
– loss on disposal of non-current assets	5	645	376
– provisions arising during the year	13	(5)	611
Increase in non-current receivables	9	(2,726)	(981)
Increase in trade and other receivables	14	(334)	(8,261)
Decrease in trade and other payables	14	(8,851)	(3,776)
Increase in capital accruals		(2,098)	(479)
Provisions utilised	13	(420)	(162)
Net cash outflow from operating activities		**(232,397)**	**(161,106)**
Cash flows from investing activities			
Purchase of property, plant and equipment		(7,003)	(7,835)
Purchase of intangible assets		(12,799)	(6,544)
Net cash outflow from investing activities		**(19,802)**	**(14,379)**
Cash flows from financing activities			
Grant in Aid from the Department of Health: cash drawn down in year		257,481	175,390
Net financing		**257,481**	**175,390**
Net increase / (reduction) in cash in the period	11	**5,282**	**(95)**
Cash and cash equivalents at the beginning of the period	11	10,152	10,247
Cash and cash equivalents at the end of the period	11	15,434	10,152
Net increase / (reduction) in cash in the period	11	**5,282**	**(95)**

All cash flow relates to continuing activities.

Notes 1 to 23 form part of these financial statements.

Statement of changes in taxpayers' equity
For the year ended 31 March 2017

	Notes	General reserve £000	Revaluation reserve £000	Total reserves £000
Balance at 31 March 2015		**47,578**	**23**	**47,601**
Changes in taxpayers' equity				
Net expenditure for the financial year		(161,915)	–	**(161,915)**
Transfers between reserves		23	(23)	**–**
Total recognised income and expense		**(161,892)**	**(23)**	**(161,915)**
Grant in Aid from the Department of Health: cash drawn down in year		175,390	–	**175,390**
Total Grant in Aid funding		**175,390**	**–**	**175,390**
Balance at 31 March 2016		**61,076**	**–**	**61,076**
Balance at 31 March 2016		**61,076**	**–**	**61,076**
Changes in taxpayers' equity				
Net expenditure for the financial year		(207,840)	–	**(207,840)**
Transfers between reserves	8	(2,993)	2,993	**–**
Align transferred assets with NHS Digital policy	8	–	(2,993)	**(2,993)**
Total recognised income and expense		**(210,833)**	**–**	**(210,833)**
Grant in Aid from the Department of Health: cash drawn down in year		257,481	–	**257,481**
Total Grant in Aid funding		**257,481**	**–**	**257,481**
Balance at 31 March 2017		**107,724**	**–**	**107,724**

Notes 1 to 23 form part of these financial statements

Notes to the accounts

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. The address of its registered office and principal place of business are disclosed in the introduction to the annual report. The principal activities of NHS Digital is the collection, analysis and dissemination of health data for secondary uses purposes together with the development and contract management of elements of the NHS IT infrastructure. It is accountable to the Secretary of State for Health for discharging its functions, duties and powers effectively, efficiently and economically. The Department of Health actively undertakes this role on his behalf on a day to day basis.

1.2 Basis of accounting

The financial statements have been prepared in accordance with the 2016-17 Government Financial Reporting Manual (FReM) issued by HM Treasury as interpreted for the health sector in the Department of Health 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 which 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 tangible fixed assets. This is in accordance with directions issued by the Secretary of State for Health and approved by HM Treasury.

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

'Transfers from the Department of Health' relates to the transfer of certain national infrastructure systems from 1 December 2016. The transfer was accounted for using standard absorption accounting in accordance with the FReM. Transfers under standard absorption accounting are recorded against assets or liabilities as appropriate, with the net gain or loss recorded through the statement of comprehensive net expenditure, and is disclosed separately from operating costs. Standard absorption accounting requires that entities account for their transactions in the period in which they took place, with no restatement of performance required when functions transfer within the public sector.

Early adoption of accounting standards amendments and interpretations

No accounting standard changes were adopted early in 2016-17.

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

The FReM does not require the following standards and interpretations to be applied in 2016-17. The application of the standards as revised would not have a material impact on the accounts for 2016-17, were they applied in the year:

- IFRS 9 Financial Instruments – Effective for accounting periods starting on or after 1 January 2018, but not yet adopted by the FReM.
- IFRS 15 Contracts with Customers – Effective for accounting periods starting on or after 1 January 2018, but not yet adopted by the FReM.

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

1.3 Income

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

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

Operating income is accounted for by applying the accruals convention and primarily comprises fees and charges for services provided on a full cost basis to the Department of Health, NHS England, Public Health England, other health related bodies and external customers. Charges comply with HM Treasury and Office of Public Sector Information guidance.

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

1.4 Administration, programme and annually managed expenditure

The analysis of income and expenditure for non-departmental public bodies between administration and programme is only required to be consistent with returns made for the purposes of the Department of Health Group consolidation. The net operating expenditure for the financial year in the consolidation return submitted to the Department of Health was split between net administration expenditure of £112.1 million and net programme expenditure of £131.5 million. The difference between the total of the administration and programme expenditure and the net operating expenditure for the year reported in the Statement of Comprehensive Net Expenditure is attributable to expenditure falling under the Annually Managed Expenditure (AME) heading, which relates to the creation and usage of provisions.

1.5 Taxation

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

1.6 Losses and special payments

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

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

1.7 Employee benefits

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

1.8 Non-current assets

a. Capitalisation

All assets falling into the following categories are capitalised:

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

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

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

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

- individually have a cost equal to or greater than £5,000; or
- collectively have a cost of at least £5,000 and, the assets are functionally interdependent, they had broadly simultaneous purchase dates, are anticipated to have simultaneous disposal dates and are under single managerial control; or
- form part of the initial equipping and set up cost of a new asset irrespective of their individual cost.

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

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

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

b. Carrying gross cost

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

Assets are assessed either using appropriate indices provided by the Office for National Statistics or, in the case of internal software developments, by considering the inflation rates of staff and other resources and potential other efficiency factors. The current value in existing use at March 2017 was not materially different to the original historic cost and thus no adjustment has been incorporated, except for land and buildings which are subject to a professional valuation. The carrying values of all assets are reviewed for impairment if events or changes in circumstances indicate the carrying value may not be appropriate.

c. Depreciation

Development expenditure is not depreciated until such time 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 the estimated life of the asset or 10 years whichever is less. 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 or 5 years whichever is less

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

- buildings 27 years
- fixtures and fittings 1 - 12 years
- office, information technology, short life equipment 1 - 5 years

The estimated useful lives and residual values are reviewed annually.

1.9 Research and development

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

1.10 Leases

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

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

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

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

1.11 Provisions

Provisions are recognised when a present obligation exists as a result of a past event, and it is probable that 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.

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

1.13 Pensions

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

1.14 Critical accounting judgements and key sources of estimation uncertainty

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

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

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

Revenue recognition

NHS Digital receives income from various sources to cover the cost of expenditure on project related and other activities. Expenditure is regularly incurred over several financial years and income is released to the Statement of Comprehensive Net Expenditure in order to reflect as closely as possible the phasing of the expenditure incurred.

Dilapidation provision

NHS Digital has provided £1.9 million as a provision against dilapidation costs of its leased accommodation across its estate where required. In order to assess an estimate of the likely liabilities at the end of the leases, management has used property advisors' reports and also assessments from suitably qualified internal staff.

Developed systems

NHS Digital manage 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 are undertaken in-house and a detailed assessment is required to determine the level of capitalisation of such work. In addition, management undertake an annual review of the likely asset life that these systems should be amortised over. In particular, the asset life of the General Practice Extraction Service has been extended from September 2017 to March 2018 in the year following a review.

Non-current assets

During 2016-17 a substantial number of non-current assets were transferred from the Department of Health. Management have undertaken a physical evidence check on computer hardware and software licences together with a review of developed software assets but have had to accept that accounting decisions in the past were made on a fair and reasonable basis. Management have also reviewed the future asset lives of certain assets to reflect their best view of remaining life, amended the depreciation policy and revaluation approach in line with that of NHS Digitals' standard policies.

Valuation of non-current assets

NHS Digital use a mixture of appropriate Office for National Statistics indices and estimates of other inflation factors to assess the value of non-current assets.

1.15 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.

1.16 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 for its cash requirements. NHS Digital is therefore not exposed to liquidity risks. All cash balances are held within the Government Banking Service and all material assets and liabilities are denominated in sterling, so it is not exposed to interest rate risk or currency risk.

Financial assets are recognised on the Statement of Financial Position when 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 impairment.

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

Confirmation has been received of the main Grant in Aid budget allocation for the 2017-18 financial year in line with the business plan submitted. Consequently, the financial accounts have been prepared on the basis that NHS Digital is a going concern.

2 Statement of operating costs by activity

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

For the year ended 31 March 2017

£000	Health Digital Services	Clinical Services	Digital Transformation	Information & Analytics
Income	(11,797)	(319)	(60)	(10,105)
Staff costs	36,640	6,454	5,409	27,504
Professional fees	2,108	1,334	61	6,669
Information technology	13,293	33	415	1,754
Accommodation	(1)	1	19	8
Travel & subsistence	1,233	204	218	358
Marketing, training & events	252	112	555	51
Office services	96	62	180	20
Other	–	–	–	–
Depreciation / amortisation	5,710	–	–	1,962
Reallocation of central costs	10,855	1,782	1,027	9,303
Non staff costs	**33,546**	**3,528**	**2,475**	**20,125**
Net expenditure	**58,389**	**9,663**	**7,824**	**37,524**

The reallocation of central costs reallocates core overheads to programmes and services. There has been an internal restructure during the year and the figures for 2015-16 are not directly comparable.

For the year ended 31 March 2016

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

The statement of financial position is reported internally as a single segment. Accordingly no segmental analysis of assets and liabilities is reported. There has been an internal restructure during the year and the two years segmental information are not directly comparable.

For the year ended 31 March 2017

£000	Operations & Assurance Services	Provider Support & Integration	Workforce	Finance & Corporate Services	Total
	(15,065)	(5,648)	–	(1,344)	(44,338)
	31,447	28,379	7,571	12,794	156,198
	6,878	6,140	909	850	24,949
	16,577	27,207	12	190	59,514
	260	2	3	10,591	10,883
	596	818	142	1,566	5,135
	434	132	52	1,422	3,010
	443	60	112	932	1,905
	–	–	–	707	707
	16,576	225	12	1,109	25,595
	(3,136)	8,278	708	(28,817)	–
	38,662	**42,862**	**1,950**	**(11,450)**	**131,698**
	55,044	**65,593**	**9,521**	**–**	**243,558**

For the year ended 31 March 2016

£000	Provider Support & Integration	Health Digital Services	Finance & Corporate Services	Clinical Leadership	HR & Transformation	HSCIC Corporate	Total
	(5,253)	(16,276)	(194)	–	–	79	(61,684)
	16,774	23,990	13,353	775	2,563	3,101	151,991
	1,408	202	1,989	–	92	(650)	18,428
	158	4,333	653	–	22	(280)	18,957
	50	957	9,372	–	18	200	11,886
	976	1,399	277	64	38	(112)	5,388
	309	424	68	17	133	(132)	2,347
	13	72	1,453	1	42	(41)	2,693
	1	1	16	–	70	(1,701)	(1,585)
	–	5,672	–	–	–	8,438	14,720
	2,915	**13,060**	**13,828**	**82**	**415**	**5,722**	**72,834**
	14,436	**20,774**	**26,987**	**857**	**2,978**	**8,902**	**163,141**

Health Digital Services	Delivers programmes and services primarily affecting NHS primary care. Community pharmacy and patient-facing services.
Clinical Services	Provide expert clinical input and support to all programmes and services.
Digital Transformation	Leads strategy, innovation and partnerships and coordinates the organisation's external facing activities including client engagement, communication and analysis of requirements for emerging customer needs.
Information & Analytics	Collect and analyses data and provides useful, trusted and accessible information to a wide range of users across NHS and social care services, government, researchers, interest groups, patients and the public, to support scientific investigation, patient choice and public debate.
Operations & Assurance Services	Responsible for ensuring systems and programmes are delivered in a technically and clinically safe and secure manner. Once systems are in the live environment, the directorate is responsible for ensuring they maintain high availability and provide a fully resilient service. Also responsible for the ongoing development of critical national infrastructure components like Spine, E-Referrals, and API development for Interoperability.
Provider Support & Integration	Delivers programme and services primarily affecting NHS providers and local authorities, including driving uptake of clinical systems and integration across healthcare services and between health and social care.
Workforce	Delivers a high performing organisation that is recognised as an outstanding place to work, through the provision of optimal HR services and development of the capability and capacity of the workforce.
Finance & Corporate Services	Provides key corporate services, infrastructure and expertise that secure the probity, financial health and reputation of the organisation, enabling the delivery of high quality information, data and IT systems.

3 Staff costs

Staff costs comprise:	2016-17 £000	2015-16 £000
Permanent staff		
Salaries and wages	120,634	114,979
Social security costs	13,201	10,259
Employer superannuation contributions - NHSPS	15,370	14,704
Employer superannuation contributions - other	354	475
Staff seconded to other organisations	704	901
Termination benefits	111	2,559
	150,374	**143,877**
Other staff		
Temporary staff	1,335	1,243
Contractors	8,873	8,726
Staff seconded from other organisations	700	952
	10,908	**10,921**
Capitalised staff costs	(5,084)	(2,807)
	156,198	**151,991**

4 Income

Income analysed by classification and activity is as follows:	2016-17 £000	2015-16 £000
Income from activities		
Programme and project management	8,676	13,415
Service delivery	28,708	40,298
Surveys and data collection	1,884	1,660
Fees and charges	3,772	3,541
Other income	535	29
	43,575	**58,943**
Other income		
Other non-trading income	763	2,741
	44,338	**61,684**

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

During 2016-17 a number of workstreams with the Department of Health and NHS England that would have formed part of programme and project management and service delivery, have become the responsibility of NHS Digital to deliver and have now been funded through Grant in Aid. Those work programmes which continue to be subject to invoicing arrangements are largely agreed in advance of the financial year commencing and included in the budget planning, thus minimising the in year financial risk to NHS Digital.

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

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

Fees and charges relate to data services and clinical audit activities and are detailed on page 34.

5 Expenditure

	2016-17 £000	2015-16 £000
Workpackages and professional fees	17,758	11,420
Data collection and surveys	5,583	5,657
Legal fees	1,608	1,351
Chair and non-executive emoluments	122	114
Marketing, training & events	2,773	2,347
Travel	5,135	5,388
Premises and establishment	10,883	11,886
IT maintenance and support*	15,496	8,380
IT managed services*	44,018	10,577
General office supplies and services	1,895	2,343
Communications	237	350
Insurance	200	95
External audit fees	125	95
Internal audit fees	259	217
Provision for impairment of receivables	(1)	(5)
Prior years' partial exemption VAT claims	–	(2,461)
Other	12	(3)
Operating expenditure	**106,103**	**57,751**
Depreciation – property, plant & equipment	7,227	5,336
Amortisation – intangible assets	17,723	9,371
Loss on disposal of non-current assets	645	376
Non cash transactions	**25,595**	**15,083**
Total expenditure	**131,698**	**72,834**

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

* In order to be more transparent IT maintenance and support has been disaggregated and been presented as IT maintenance and support and IT managed services. The 2015-16 figures have been represented to reflect this, although there is no change to the total of 2015-16 expenditure.

6 Aligning accounting treatment of transfers

	2016-17 £000	2015-16 £000
Adjustment to asset values following transfer	2,219	(1,226)
Alignment of depreciation and amortisation policies	(2,001)	–
Net loss / (gain)	**218**	**(1,226)**

On 1 December 2016, assets were transferred to NHS Digital from the Department of Health. The value of certain assets have been adjusted in order to align the accounting treatment with NHS Digital policies. In addition some assets, following a physical asset verification exercise, have been disposed of. The adjustments have been presented separately on the statement of comprehensive net expenditure to reflect standard absorption accounting treatment.

The gain in 2015-16 relates to assets transferred in prior years.

7 Non-current assets – property, plant and equipment

2016-17	Land	Buildings	Computer hardware	Fixtures & fittings	Total
	£000	£000	£000	£000	£000
Cost or valuation					
At 1 April 2016	310	1,170	31,829	7,768	41,077
Additions	–	–	7,051	1,256	8,307
Transfers from the Department of Health	–	–	4,223	–	4,223
Reclassifications	–	–	2,128	–	2,128
Accounting policy alignment	–	–	(985)	–	(985)
Disposals	–	–	(5,443)	(241)	(5,684)
At 31 March 2017	**310**	**1,170**	**38,803**	**8,783**	**49,066**
Depreciation					
At 1 April 2016	–	351	17,946	3,728	22,025
Provided during the year	–	42	6,212	973	7,227
Transfers from the Department of Health	–	–	2,206	–	2,206
Reclassifications	–	–	903	–	903
Accounting policy alignment	–	–	(507)	–	(507)
Disposals	–	–	(4,932)	(185)	(5,117)
At 31 March 2017	**–**	**393**	**21,828**	**4,516**	**26,737**
Net book value at 1 April 2016	310	819	13,883	4,040	19,052
Net book value at 31 March 2017	**310**	**777**	**16,975**	**4,267**	**22,329**

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

Transfers from the Department of Health represent the assets transferred on 1 December 2016 being largely hardware assets for the Spine and Secondary Uses programmes. The transfer was accounted for using standard absorption accounting rules in accordance with the Department of Health's accounting policies as set out in the Group Accounting Manual.

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

The gross cost of property, plant and equipment that has been fully depreciated but is still in use is £9,269,860.

The freehold building was valued in March 2014 at existing use by the local Valuation Office. We have consulted with the local Valuation Office who have clarified that the market for this type of property has not materially changed since 2014 and thus we have not commissioned a further valuation report.

All tangible assets are owned by NHS Digital.

2015-16	Land	Buildings	Computer hardware	Fixtures & fittings	Total
	£000	£000	£000	£000	£000
Cost or valuation					
At 1 April 2015	310	1,170	23,673	5,733	30,886
Additions	–	–	5,477	2,074	7,551
Adjustments arising from asset review	–	–	3,294	–	3,294
Disposals	–	–	(615)	(39)	(654)
At 31 March 2016	**310**	**1,170**	**31,829**	**7,768**	**41,077**
Depreciation					
At 1 April 2015	–	309	11,455	3,057	14,821
Provided during the year	–	42	4,617	677	5,336
Adjustments arising from asset review	–	–	2,310	–	2,310
Disposals	–	–	(436)	(6)	(442)
At 31 March 2016	**–**	**351**	**17,946**	**3,728**	**22,025**
Net book value at 1 April 2015	310	861	12,218	2,676	16,065
Net book value at 31 March 2016	**310**	**819**	**13,883**	**4,040**	**19,052**

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

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

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

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

All tangible assets are owned by NHS Digital.

8 Non-current assets – intangible assets

2016-17	Software licences £000	Information technology £000	Development expenditure £000	Websites £000	Total £000
Cost or valuation					
At 1 April 2016	17,717	33,402	60	1,685	52,864
Transfers from the Department of Health	10,666	119,654	–	–	130,320
Reclassification	(2,036)	(984)	892	–	(2,128)
Additions	1,659	9,664	2,270	–	13,593
Reversal of revaluation transferred to reserves	(147)	(5,880)	–	–	(6,027)
Accounting policy alignment	(1,311)	(2,977)	–	–	(4,288)
Disposals	(3,162)	(193)	–	(520)	(3,875)
At 31 March 2017	**23,386**	**152,686**	**3,222**	**1,165**	**180,459**
Amortisation					
At 1 April 2016	10,862	15,019	–	1,603	27,484
Transfers from the Department of Health	7,220	75,603	–	–	82,823
Reclassification	(900)	(3)	–	–	(903)
Provided during the year	3,712	13,929	–	82	17,723
Reversal of revaluation transferred to reserves	(91)	(2,943)	–	–	(3,034)
Accounting policy alignment	(812)	(3,736)	–	–	(4,548)
Disposals	(3,089)	(188)	–	(520)	(3,797)
At 31 March 2017	**16,902**	**97,681**	**-**	**1,165**	**115,748**
Net book value at 1 April 2016	6,855	18,383	60	82	25,380
Net book value at 31 March 2017	**6,484**	**55,005**	**3,222**	**–**	**64,711**

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

Transfers from the Department of Health represent the assets transferred on 1 December 2016 being software licences and software development assets for the Electronic Referral System (e-RS), Spine and Secondary Uses programmes. The transfer was accounted for using standard absorption accounting rules in accordance with the Department of Health's accounting policies as set out in the Group Accounting Manual.

In accordance with standard absorption accounting the revaluation reserve of £3.0 million associated with the transfer of assets from the Department of Health was established. Following a revaluation of all assets using the NHS Digital methodology this was subsequently reversed.

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

The gross cost of intangible assets that were fully depreciated but still in use are £46,799,266. This includes £38,184,219 for the SUS system transferred from the Department of Health during the year. This system is being decommissioned in July 2017.

Included within intangible assets are major programmes including Spine with a net book value of £15.4 million, the electronic referral service (e-RS) with a net book value of £18.1 million and the Secondary Uses Services with a net book value of £5.3 million. These programmes are amortised over the anticipated life of the programme and at 31 March 2017 with Spine and e-RS having approximately five years remaining. The existing Secondary Uses Services is due to end in July 2017 with the replacement "SUS+" due to commence amortisation in April 2017.

The value of own staff capitalised within intangible assets additions amounts to £5,084,248.

All intangible assets are owned by NHS Digital.

2015-16	Software licences £000	Information technology £000	Development expenditure £000	Websites £000	Total £000
Cost or valuation					
At 1 April 2015	18,382	27,130	295	1,820	47,627
Reclassification	–	639	(639)	–	–
Additions	1,283	5,620	404	–	7,307
Adjustments arising from asset review	594	13	–	(135)	472
Disposals	(2,542)	–	–	–	(2,542)
At 31 March 2016	**17,717**	**33,402**	**60**	**1,685**	**52,864**
Amortisation					
At 1 April 2015	9,937	8,792	–	1,532	20,261
Reclassification	–	–	–	–	–
Additions	2,852	6,313	–	206	9,371
Adjustments arising from asset review	451	(86)	–	(135)	230
Disposals	(2,378)	–	–	–	(2,378)
At 31 March 2016	**10,862**	**15,019**	**–**	**1,603**	**27,484**
Net book value at 1 April 2015	8,445	18,338	295	288	27,366
Net book value at 31 March 2016	**6,855**	**18,383**	**60**	**82**	**25,380**

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

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

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

The value of own staff capitalised within intangible assets additions amounts to £2,806,280.

All intangible assets are owned by NHS Digital.

9 Other non-current receivables

	31 March 2017 £000	31 March 2016 £000 restated
Prepayments	**4,235**	**1,509**

Prepayments relate primarily to software licenses purchased on a subscription basis for more than one year. Prior year comparators have been adjusted.

10 Trade receivables and other current assets

Amounts falling due within one year	31 March 2017 £000	31 March 2016 £000 Restated
Trade receivables	15,827	21,773
Value added tax	6,711	1,538
Deposits and advances	443	348
Prepayments and other receivables	6,871	5,906*
Accrued income	4,074	3,757
	33,926	**33,322**

* Prepayments relate primarily to software licenses purchased on a subscription basis within than one year. Prior year comparators have been adjusted and amounts due after more than one year have been separately presented (see note 9).

11 Cash and cash equivalents

	31 March 2017 £000	31 March 2016 £000
Balance at 1 April 2016	10,152	10,247
Net changes in cash and cash equivalents	5,282	(95)
Balance at 31 March 2017	**15,434**	**10,152**

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

12 Trade and other payables

Amounts payable within one year	31 March 2017 £000	31 March 2016 £000
Trade and other payables	8,754	5,057
Income tax, National Insurance and superannuation	6,088	5,504
Deferred income	309	295
Accruals	15,672	14,970
	30,823	**25,826**

13 Provisions for liabilities and charges

	Dilapidations £000	Injury benefit £000	Staff termination £000	Other staff related £000	Total £000
Balance at 1 April 2016	1,969	225	19	300	2,513
Arising during the year	544	–	–	–	544
Utilised during the year	(95)	(26)	(18)	(281)	(420)
Reversed unused	(529)	-	(1)	(19)	(549)
Balance at 31 March 2017	**1,889**	**199**	**–**	**–**	**2,088**
Expected timing of cash flows					
Within one year	37	2	–	–	39
Two to five years	1,852	29	–	–	1,881
Over five years	–	168	–	–	168

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

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

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

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

14 Working capital movements

	2016-17 £000	2015-16 £000
Receivables		
Opening balance	33,322	25,061
Balances transferred from the Department of Health	270	–
Total opening trade receivables and other current assets plus balances transferred in	**33,592**	**25,061**
Closing trade receivables and other current assets	33,926	33,322
Increase in trade receivables and other current assets	**(334)**	**(8,261)**
Payables		
Opening balance	25,826	29,602
Balances transferred from the Department of Health	13,848	–
Total opening trade and other payables plus balances transferred in	39,674	29,602
Closing current trade and other payables	30,823	25,826
Decrease in trade and other payables	**(8,851)**	**(3,776)**

Balances transferred from the Department of Health represent the payables and receivables balances on the programmes and services transferred on 1 December 2016. The transfer was accounted for using standard absorption accounting in accordance with the Department of Health group accounting policies set out in the Group Accounting Manual.

15 Transfers from other bodies

Transfers under absorption accounting taken through the SoCNE	2016-17 £000	2015-16 £000
Property plant and equipment	2,017	–
Intangible assets	47,497	–
Accruals and prepayments	(13,578)	–
Net assets transferred	**35,936**	**–**

16 Capital commitments

Capital commitments amount to £2,533,614 (2015-16 £1,335,548) and relate to ordered IT equipment, software and office furniture.

17 Commitments under operating leases

Expenditure includes the following in respect of operating leases:	2016-17 £000	2015-16 £000
Accommodation	5,503	6,429
Other operating leases	101	124
	5,604	**6,553**

At the reporting date non-cancellable operating lease commitments were:

Land & buildings	31 March 2017 £000	31 March 2016 £000
Not later than one year	5,277	5,171
Between one and five years	10,544	6,259
Later than five years	82	466
	15,903	**11,896**
Other leases		
Not later than one year	84	92
Between one and five years	31	78
Later than five years	–	–
	115	**170**
Total	**16,018**	**12,066**

18 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 2017 (31 March 2016 £nil).

19 Contingent assets and liabilities

Contingent liabilities amount to £1,000,000 (31 March 2016 £nil) and relate to potential supplier charges.

Remote contingent liabilities amount to £380,000 (31 March 2016 £nil) and relate to potential supplier charges.

20 Related parties

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 the Department together with its arms-length bodies are therefore regarded as related parties.

During the year NHS Digital raised invoices to Genomics England Limited totalling £1,666,248 excluding VAT. A non-executive director of NHS Digital is also chair of Genomics England Limited. Genomics England Limited is wholly owned by the Department of Health.

During the year NHS Digital received invoices from Accenture (UK) Limited totalling £5,801,634 excluding VAT. The NHS Digital Chair and another non-executive director hold shares in Accenture (UK) Limited. £5,446,205 of this related to the NHSmail contract, which was novated from the Department of Health to NHS Digital as part of the transfer of informatics programmes on 1 December 2016.

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

21 Financial instruments

As the cash requirements of NHS Digital are met through Grant in Aid by the Department of Health, and invoiced income largely received from the Department of Health, NHS England and Public Health England, financial instruments play a more limited role in creating and managing risk than would apply to a non-public sector body. The majority of financial instruments relate to contracts to buy non-financial items in line with 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, NHS England, Public Health England and other related bodies against purchase orders and thus 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 were not considered in the evaluation of overall credit risk.

Movement in the allowance for doubtful debts

	2016-17 £000	2015-16 £000
Balance at 1 April	3	9
Provided for in year	2	3
Reversed unutilised	(3)	(8)
Amounts written off during the year as uncollectible	–	(1)
Balance at 31 March	**2**	**3**

The provision for doubtful debts is assessed on an individual debt basis. The expense in the year relating to related parties amounted to: £217 (2015-16: £91)

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 2017	**8,819**	**6,771**	**45**	**192**	**15,827**
Balance at 31 March 2016	11,222	9,631	649	271	21,773

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

c. Liquidity risk

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

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

	31 March 2017 £000	31 March 2016 £000
Current liabilities	30,823	25,826

22 Events after the reporting period ended

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

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

23 Authorised date for issue

NHS Digital's Annual Report and Accounts are laid before Parliament by NHS Digital. IAS10 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 July 2017.

Appendix A – Sustainable development

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

We have previously developed a carbon reduction plan that sets out where we will focus our attention and investment. During 2016-17, we commissioned a full review of this plan. The report is currently being considered and action plans are being developed.

Procurement

We procure the majority of our goods and services from nationally agreed frameworks and contracts, which are all fully in line with Government Buying Standards (GBS) and incorporate sustainability considerations by commodity type. All IT hardware procured is in line with the GBS minimum mandatory standards and, in most cases, the best-practice standards. Sustainability considerations are embedded in our procurement activity and, during this year, we have included sustainability more visibly in our proposed commercial policy. Our sustainable procurement lead is working to further develop commercial processes to ensure environmental and sustainability considerations are continually integrated into sourcing and contract-management cycles, to establish appropriate coaching and support and to monitor and report on progress through the following activities:

- ensuring that staff involved in procurement activity receive appropriate training in sustainable procurement
- the introduction of a whole-life costing approach to procurement activity, rather than just the purchase price
- developing the evidence base on sustainable procurement by identifying priority areas with specific targets and through key performance indicators.

Estate

We have a presence in 14 buildings spread across eight dispersed locations. We own Hexagon House, Exeter and have a direct responsibility for reporting business activity in six properties where we are leaseholders. The other buildings we occupy are the responsibility of other public bodies to report. We have included our best assessment of the organisation's overall carbon foot print by reporting on all buildings.

We utilise a number of data centres including three managed by HM Land Registry and one in the Crown facility who provide services to us on a co-location basis. All the data centres house more than 110 racks, each hosting approximately 200 individual services. These include NHS facing services such as cancer waiting times, the Information Governance Toolkit and GP payments, as well as national systems such as the NHS Spine and Secondary Uses Service. As with our non-reported offices, carbon emissions have been identified separately for reporting purposes.

Greenhouse gas emissions

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

Approximately 80 per cent of our direct GHG emissions are from gas and electricity use across the estate and the majority of the remainder from business travel. Such emissions are a result of the occupation of offices and increasingly, the management of an IT infrastructure for both our own use and that for the wider NHS. The increase in funding to support additional informatics requirements will clearly put an upward pressure on energy use as requirements to collect and use data increase. A Corporate Information Systems Strategy for 2017-18 and beyond has just been agreed together with a greening ICT positioning statement, which will move us toward a more financially efficient and environmentally sustainable IT infrastructure. This includes the:

- consolidation of a number of data centres and increasing the use of the Crown facilities
- better use of the core infrastructure across programmes to maximise efficiency
- greater use of cloud services
- use of procurement frameworks that include sustainability and environmental requirements
- disposal of infrastructure to Waste Electrical and Electronic Equipment (WEEE) standards
- increased use of web and video conferencing and other collaboration tools.

The overall position is best summarised by the clear reduction in energy consumption, energy cost and water use by full time equivalent (FTE) employees in the last few years.

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

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

Scope 1
Direct GHG emissions (such as from fossil fuels)

Scope 2
Indirect GHG emissions from consumption of purchased energy

Scope 3
Other indirect emissions, including transport in vehicles not owned or controlled by NHS Digital, and transmission and distribution losses not covered in Scope 2.

GHG emissions – non-financial indicators		2016-17	2015-16	2014-15
Non-financial indicators (000kWh)	**Scope 1**			
	Natural gas (properties – reportable)	1,778	1,697	1,911
	Natural gas (properties – non-reportable)	531	613	601
	Scope 2 & 3			
	Mains electricity (properties – reportable)	3,722	3,935	3,684
	Mains electricity (properties – non-reportable)	692	1,039	1,033
	Mains electricity (data centres – non-reportable)	1,915	1,837	1,446
Non-financial indicators (000km travelled)	Travel – air	999	766	713
	Travel – rail	9,425	8,062	6,816
	Travel – private cars	1,350	1,562	1,512
	Travel – leased vehicles	287	261	179
Non-financial indicators tonnes CO_2 (tCO_2)	**Scope 1**			
	Natural gas (properties – reportable)	327	295	387
	Natural gas (properties – non-reportable)	98	112	111
	Scope 2			
	Mains electricity (properties – reportable)	1,534	1,819	1,782
	Mains electricity (properties – non-reportable)	285	478	508
	Mains electricity (data centres – non-reportable)	789	849	715
	Scope 3			
	Mains electricity (properties – reportable)	139	150	159
	Mains electricity (properties non-reportable)	26	39	44
	Mains electricity (data centres – non-reportable)	71	70	62
	Travel – air (reportable)	118	103	86
	Travel – rail (reportable)	270	363	323
	Travel – private cars (reportable)	252	291	286
	Travel – leased vehicles (reportable)	54	48	34
Total reportable emissions		**2,694**	**3,069**	**3,057**
Total non-reportable emissions		**1,269**	**1,548**	**1,440**
Total emissions		**3,963**	**4,617**	**4,497**
Total tCO_2 per FTE employee		**1.43**	**1.72**	**1.94**

GHG emissions – financial indicators		2016-17	2015-16	2014-15
Financial indicators (£000)	Natural gas (properties – reportable)	50	50	89
	Natural gas (properties – non-reportable)	15	20	21
	Mains electricity (properties – reportable)	366	389	400
	Mains electricity (properties – non-reportable)	65	108	108
	Mains electricity (data centres – non-reportable)	188	176	128
	Travel – air (reportable)	255	192	135
	Travel – rail (reportable)	2,567	2,284	1,863
	Travel – private cars (reportable)	446	516	508
	Travel – leased vehicles (reportable)	24	24	16
Total reportable emissions		**3,708**	**3,455**	**3,011**
Total non-reportable emissions		**268**	**304**	**257**
Total emissions		**3,976**	**3,759**	**3,268**
Total energy cost per FTE employee		**1.44**	**1.37**	**1.38**

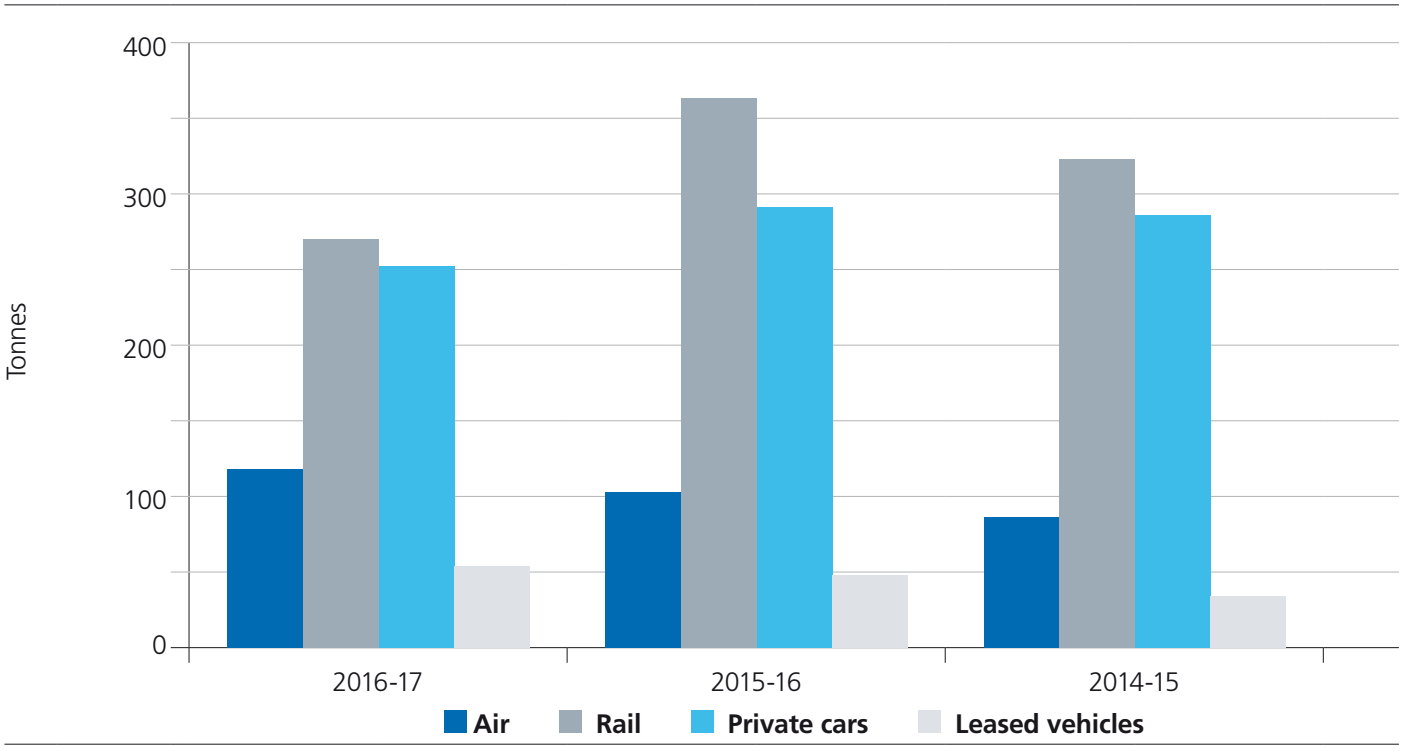
Non-reportable electricity has dropped significantly in the year as we consolidated space requirements in several locations and temporarily sublet space back to the landlord in one building.

Business Travel

Overall, business travel (kilometres) increased by 13 per cent during 2016-17. Specifically, we spent more on rail and air travel. This partly reflected a larger workforce, but also more cross-team working on new projects. The increase in air flights in particular was largely attributable to travel between our offices in Exeter and Southampton and bases in Leeds and Newcastle.

We continue to encourage the use of technology such as video and telephone conferencing as an alternative to travel and to invest in new video conferencing equipment. The Metro Card and Cycle to Work schemes encourage staff to commute using more environment and community-friendly means of transport. Car use for business purposes is restricted to situations in which it is impractical for staff to travel by public transport.

Total carbon emissions in tonnes CO_2 for business travel by category



Water

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

Water Consumption		2016-17	2015-16	2014-15
Non-financial indicators (m^3)	Water from whole estate (reportable)	12,934	10,923	10,387
	Water from estate (non-reportable)*	2,466	2,843	2,776
Financial indicators (£000) (reportable sites only)	Water supply costs**	36	35	33
Total water m^3 per FTE employee		**5.6**	**5.1**	**5.6**

* estimated

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

Water usage in most buildings has remained largely consistent but there has been a marked increase in one Leeds building, partly the result of a significant increase in occupation but also due to it being the most inefficient building from a water usage perspective. We are liaising with the landlords to address this issue. Water use is purely for normal office facilities, including the provision of showers to meet a growing number of staff choosing to cycle to work.

Waste

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

It is estimated that 25 tonnes was sent to landfill, which represents 23 per cent of our total waste. This is similar to 2015-16.

Information Technology waste is predominantly recycled into component materials for manufacturing. Less than 1 per cent is not recyclable and this is used in the energy-from-waste chain, ensuring no IT waste goes to landfill.

Waste – SCOPE 3 (Waste)		2016-17	2015-16	2014-15
Non-financial indicators (tonnes)	Waste recycled externally (non-IT equipment)	66	65	34
	Waste reused externally (non-IT equipment)	–	–	–
	IT Waste recycled externally	13	11	12
	IT Waste reused externally	–	1	3
	Waste incinerated	12	6	0
Total waste sent to landfill		25	25	41
Total waste not sent to landfill		92	83	49
Total waste		**117**	**108**	**90**
Financial indicators (£000)	General Waste including recycling (non-IT equipment)	21	20	Not known
	Confidential paper waste shredding and recycling (non-IT equipment)	5	6	Not known
	IT Waste (reused and recycled)	28	73	Not known
Total costs		**54**	**99**	**Not known**

Paper

The Greening Government Commitments operational target is a 50 per cent reduction in paper consumption by 2019-20, against a 2009-10 baseline.

We do not hold accurate figures from 2009-10. However, our paper consumption has fallen by 30 per cent since 2013-14. Consumption is measured in 'equivalent A4 reams' and our use of paper has reduced from 9,487 reams in 2013-14 to 6,615 reams in 2016-17. Managed print systems, new technologies and the encouragement of the paperless office through cost improvement initiatives have been the primary tools used in reducing paper consumption.

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.

Executive directors

Rob Shaw, Interim Chief Executive (from 27 February 2017) and Chief Operating Officer

Rob became Interim Chief Executive in February. He was appointed as NHS Digital's Chief Operating Officer in April 2016.

Rob previously worked as Director of Operations and Assurance Services and managed the insourcing of major infrastructure services from BT, including the NHS Spine, the Care Identity Service (CIS) and the Secondary Uses Service (SUS). He has been instrumental in setting up a series of programmes and operational services to support better cyber security in health and social care and has worked across agencies and with the National Cyber Security Centre to integrate the sector with other emergency response teams.

He previously worked for the Department of Work and Pensions, where he led intervention teams to assist complex programmes with governance and delivery, and joined the National Programme for IT in late 2005.

Andy Williams, Chief Executive (retired as Chief Executive on 27 February 2017)

Andy retired as Chief Executive on 27 February 2017, after three years leading the organisation, and left the organisation on 31 March. He joined the Health and Social Care Information Centre in April 2014 following a private sector career in information technology and telecommunications that spanned a range of technology service areas including systems integration, outsourcing and consulting.

He previously worked as president of managed services for CSC in Europe, as a member of the management committee and services division president at Alcatel-Lucent and in a wide range of roles with IBM.

Rachael Allsop, Director of Workforce

Rachael joined the NHS Information Centre, a predecessor of NHS Digital, in 2009 and oversaw a successful staffing merger with NHS Connecting for Health. She was appointed to the Board as Director of Human Resources and became Director of Workforce in April 2016. Rachael has announced that she will be leaving NHS Digital in Autumn 2017.

She has occupied board roles in health organisations for the past 25 years and has extensive experience as both a general manager and a human resources practitioner in all aspects of the health service. She worked as the human resources director of Leeds Teaching Hospitals' Trust, then the largest trust in the country.

Beverley Bryant, Director of Digital Transformation

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

Before joining NHS England, Beverley was Managing Director of Health at Capita and has worked in various change, performance improvement and operational roles in 'big-five' consulting companies, as well as leadership roles in the Department of Health and the NHS.

Carl Vincent, Director of Finance and Corporate Services

Carl joined NHS Digital in June 2013 on secondment from the Department of Health and became our permanent Director of Finance and Corporate Services in June 2015.

He initially worked as an economist with the Department of Health from 1996 before qualifying as an accountant. He has worked across a range of financial areas and led in a number of areas as a senior manager. These include NHS financial performance, a Spending Review, and commercial delivery. Carl was also the Senior Responsible Owner for implementing the system-wide financial implications of the Health and Social Care Act 2012.

Professor Martin Severs, Clinical Director and Caldicott Guardian

Martin is the Executive Director for Clinical and Information Governance and Caldicott Guardian. He previously worked as Interim Executive Director for Information and Analytics.

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

Non-executive directors

Noel Gordon, Chair (appointed 1 June 2016)

Formerly an economist and a banker, Noel spent most of his career in consultancy until his retirement in 2012 including, for the last 16 years, with Accenture, where he was global managing director of the Banking Industry Practice. He has extensive practical experience of driving fundamental innovations in transforming industries, and of big data, analytics, mobile and digital technologies.

Noel is Chairman of NHS Digital, Chairman of Healthcare UK Advisory Board, a non-executive director of NHS England and Chair of its Specialised Commissioning Committee. He is a member of the Life Sciences Industrial Strategy Board of the Department of Health, a non-executive director of the Payments Systems Regulator, a member of the Audit and Risk Committee of the University of Warwick , a member of the Development Board of Age UK, and Chairman of the Board of Trustees of UserVoice.org.

Sir Ian Andrews

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

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

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

Dr Sarah Blackburn

Sarah has been the chief executive of the Wayside Network, a group of consultants specialising in governance, since 2002. She previously worked as a director of assurance and risk management in FTSE100 companies. She is a chartered fellow of the Chartered Institute of Internal Auditors and The Institute of Chartered Accountants in England and Wales.

Sarah was a founder member of the Healthcare Commission Board and a member of the editorial board of the first NHS Integrated Governance Handbook. Since 2005, she has been a director of a private company supplying primary care and addiction services to secure environments in the NHS.

Dr Marko Balabanovic (appointed 1 January 2017)

Marko has more than 20 years' experience of innovation in academia, corporations and start-ups and is Chief Technology Officer at Digital Catapult. He has been instrumental in bringing several new technologies to market. Most recently, he worked at the startup State to launch a digital global opinion network. He was previously head of innovation at lastminute.com and did ground-breaking research on artificial intelligence systems at Stanford University.

On the Board of NHS Digital, he leads on innovation, emerging technologies, partnerships and technology transfer.

Non-executive directors

Daniel Benton (appointed 1 January 2017)

Daniel spent most of his career at Accenture, where he was global head of the technology strategy and digital strategy practices. He has extensive experience of setting and implementing the technology agendas for large organisations through periods of transformational change, including the implementation of advanced consumer-facing technologies. He worked on secondment as a Chief Information Officer for an international bank and a large global insurer.

On the Board of NHS Digital, Daniel leads on IT delivery excellence, operational transformation and technology strategy. He is a trustee of The Grange Festival and a member of the fundraising and finance committees of the NSPCC.

Professor Soraya Dhillon (appointed 1 January 2017)

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

She is a non-executive director at The Hillingdon Hospital NHS Foundation Trust and senior independent director of the Improvement Steering Group of the Eastern Academic Health Science Network. She is a fellow of the Royal Pharmaceutical Society (RPS). She was previously chair of Luton and Dunstable Hospital NHS Foundation Trust (1999-2010), a member of the General Pharmaceutical Council and a board director of the Eastern Academic Health Science Network.

On the Board of NHS Digital, Soraya leads on clinical safety and governance, e-channels and diversity and inclusion.

Professor Sudhesh Kumar (appointed 1 January 2017)

Sudhesh is Dean of the Warwick Medical School and Director of the Institute of Digital Healthcare at University of Warwick. He is also a non-executive director of the University Hospital Coventry & Warwickshire NHS Trust.

He is a clinical endocrinologist with 22 years' experience as a consultant physician in the NHS. His research interests include innovation in managing obesity and diabetes and he has published over 240 papers and six books on these subjects.

On the NHS Digital Board, Sudhesh leads on big data, the research sector, clinical informatics and medical technology and life sciences strategy.

Rob Tinlin (appointed 1 January 2017)

Rob has been Chief Executive and Town Clerk in Southend-on-Sea from 2005 until March 2017. In 2012, the authority won LGC Council of the Year for excellence and innovation in its services. He was previously Chief Executive of South Northamptonshire Council.

Rob was a board member of the Department of Health National Information Board (NIB), a board member of the Anglia Ruskin MedTech Campus, and a member of the advisory board for the Queen Mary University of London Business School.

On the Board of NHS Digital, he leads on integrated care, digitising social care, change management and organisational development.

Non-executive directors

Professor Maria Goddard (resigned 31 March 2017)

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

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

Sir John Chisholm (resigned 31 March 2017)

Sir John is the executive chair at Genomics England, which is building a dataset of 100,000 whole genome sequences linked to clinical data.

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

In 1991, he was asked by the UK government to turn its defence research laboratories into a commercial organisation. This floated on the London Stock Exchange as QinetiQ Group plc. He was chair of the Medical Research Council (MRC) from 2006 and guided the innovation charity Nesta out of the public sector as its chair from 2009.

Sir Nick Partridge (resigned 31 December 2016)

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

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

Register of interests

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

The register of declarations of interest is updated on an annual basis. It is kept and maintained by the Secretary to the Board and the Head of Corporate Governance and is available for public inspection. Director's interests declared during 2016-17 that are relevant to their NHS Digital role are as follows:

Noel Gordon: Non-executive director, NHS England. Holds shares in Accenture, a supplier to NHS Digital.

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

Daniel Benton: Holds shares in Accenture, a supplier to NHS Digital.

Sir John Chisholm: Executive Chair, Genomics England Ltd.

Dr Sarah Blackburn: Chief Executive, The Wayside Network Ltd., which has a contract to supply GP and nursing services to an NHS partnership body.

Professor Soraya Dillon: Non-executive director, The Hillingdon Hospital NHS Foundation Trust.

Professor Sudhesh Kumar: Non-executive director, University Hospital of Coventry and Warwickshire (UHCW) NHS Trust.

Appendix C – Attendance at the Board and committees

	Public Board (6 meetings)	Board Development (6 meetings)	ARC (6 meetings)	IACSC (5 meetings)	REMCOM (4 meetings)
Executive directors					
Andy Williams	6	5	5	4	4
Rob Shaw	6	5	5	4	1
Rachael Allsop	2	4	2	3	2
Beverley Bryant	4	5	1	n/a	n/a
Carl Vincent	5	6	6	n/a	1
Non executive directors					
Noel Gordon	5	5	1	n/a	4
Sir Ian Andrews	4	6	6	4	2
Dr Sarah Blackburn	5	4	6	4	1
Sir John Chisholm	4	5	5	n/a	n/a
Prof Maria Goddard	4	4	n/a	n/a	3
Sir Nick Partridge	5	4	4	3	2
Prof Soraya Dhillon	2	1	n/a	n/a	1
Dr Marko Balabanovic	2	1	n/a	1	n/a
Daniel Benton	2	1	1	n/a	n/a
Prof Sudhesh Kumar	2	1	n/a	n/a	1
Rob Tinlin	2	1	0	n/a	n/a
Kingsley Manning	1	1	n/a	n/a	n/a
Other senior officers					
*Tom Denwood	2	5	1	n/a	n/a
*James Hawkins	3	6	n/a	n/a	n/a
*Prof David Hughes	1	3	n/a	n/a	n/a
Prof Martin Severs	5	4	2	4	n/a

Representatives from our main sponsors, Tamara Finkelstein (Director General for Community Care; Chief Clinical Information Officer, Department of Health) and Professor Keith McNeil (Chief Clinical Information Officer, NHS England) attend the Board. They fully contribute to the discussions but have no voting rights. They are not paid by NHS Digital for their attendance.

* Attended the Board until June 2017 but now attend board development days

Appendix D – Our regulatory and compliance framework

Our regulatory and compliance framework includes (but not limited to) the:

- Caldicott Report – Review of Patient-Identifiable Information (1997)
- Caldicott 2 Report – Information: To Share or Not To Share? The Information Governance Review (2013)
- Caldicott 3 Report – Review of Data Security, Consent and Opt-Outs (2016)
- Care Quality Commission – Safe Data, Safe Care: Data Security Review (2016)
- Code of Practice on Confidential Information, NHS Digital
- Common law duty of confidentiality
- Confidentiality: NHS Code of Practice (2003)
- Copyright, Designs and Patents Act (1998)
- Data Protection Act (1998)
- Data Protection (Processing of Sensitive Personal Data) Order (2000)
- Environmental Information Regulations (2004)
- Freedom of Information Act (2000)
- Public Record Act (1958)
- Health and Social Care Act (2001)
- Health and Social Care Act (2012)
- Information Security Management: NHS Code of Practice (2007)
- International Information Security Standard: ISO/IEC 27001:2013 and ISO/IEC 27002:2013
- International Standard on Records Management ISO 15489:2015
- BS 10008 Evidential Weight and Legal Admissibility of Electronic Information
- Human Rights Act (1998) Article 8
- NHS Act (2006)
- NHS Care Record Guarantee for England (2011)
- NHS Constitution
- Records Management Code of Practice for Health and Social Care (2016)
- Re-Use of Public Sector Information Regulations (2005)
- Social Care Record Guarantee for England (2009)
- ICO Code of Practice
- Anonymisation Standard

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

Appendix E – Internal transformation activities

2016-17 has been a year of significant achievement as we have transitioned to the new organisational operating model during the course of the year, but also one of great challenge as we have strived to deliver wholesale organisational change.

There has been strong engagement with the move to a profession-based operating model and commitment to developing supporting architecture (for example, career ladders, competency frameworks and generic job descriptions). The 33 professional groups are at different levels of maturity but all now have the foundations in place to better facilitate the development of professional skill levels within the organisation and the deployment of those skilled resources in line with the organisation's priorities. Our first Workforce Capability Plan provides us with an excellent understanding of the current capability within the professional structure and forms part of our evolutionary journey.

A resource management service has been established and embedded with resources being scheduled and assigned in response to short-term articulated demand. In future, a more sophisticated understanding of skills and capabilities together with appropriate management information and greater clarity about the future demand requirements will enable better alignment between individuals and assignments.

The introduction of career managers as part of the new operating model has generally been welcomed by staff and has encouraged a longer term perspective on the training and development needs of individuals. The development of stretch assignments and better linkage of performance with progression are starting to align employees' contributions with the objectives of the business.

A new talent management strategy was launched and defined the organisation's approach to attracting, nurturing and engaging talent. Within this framework, early achievements have been the design and implementation of a new recruitment system incorporating a behavioural competency approach and the trialling of alternative sourcing channels. A returners' programme and a referral scheme have both been launched. We have continued to develop our entry grade offer and invest in the University Technical College Leeds initiative to develop digital and creative skills in young people.

Our talent tool has been re-designed to facilitate contributions by both assignment and career managers, with further review to streamline the requirements planned following the end of this year's performance round in June. A new approach to promotion has been developed and succession planning has begun for senior and critical roles.

A new Leadership Development Programme was launched very successfully, with the first cohort rating it very highly.

During the year, we undertook both an internal review of the Transformation Programme and, subsequently, an externally assured Capability Review, the recommendations from which will inform the next phase of organisational development activity.

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