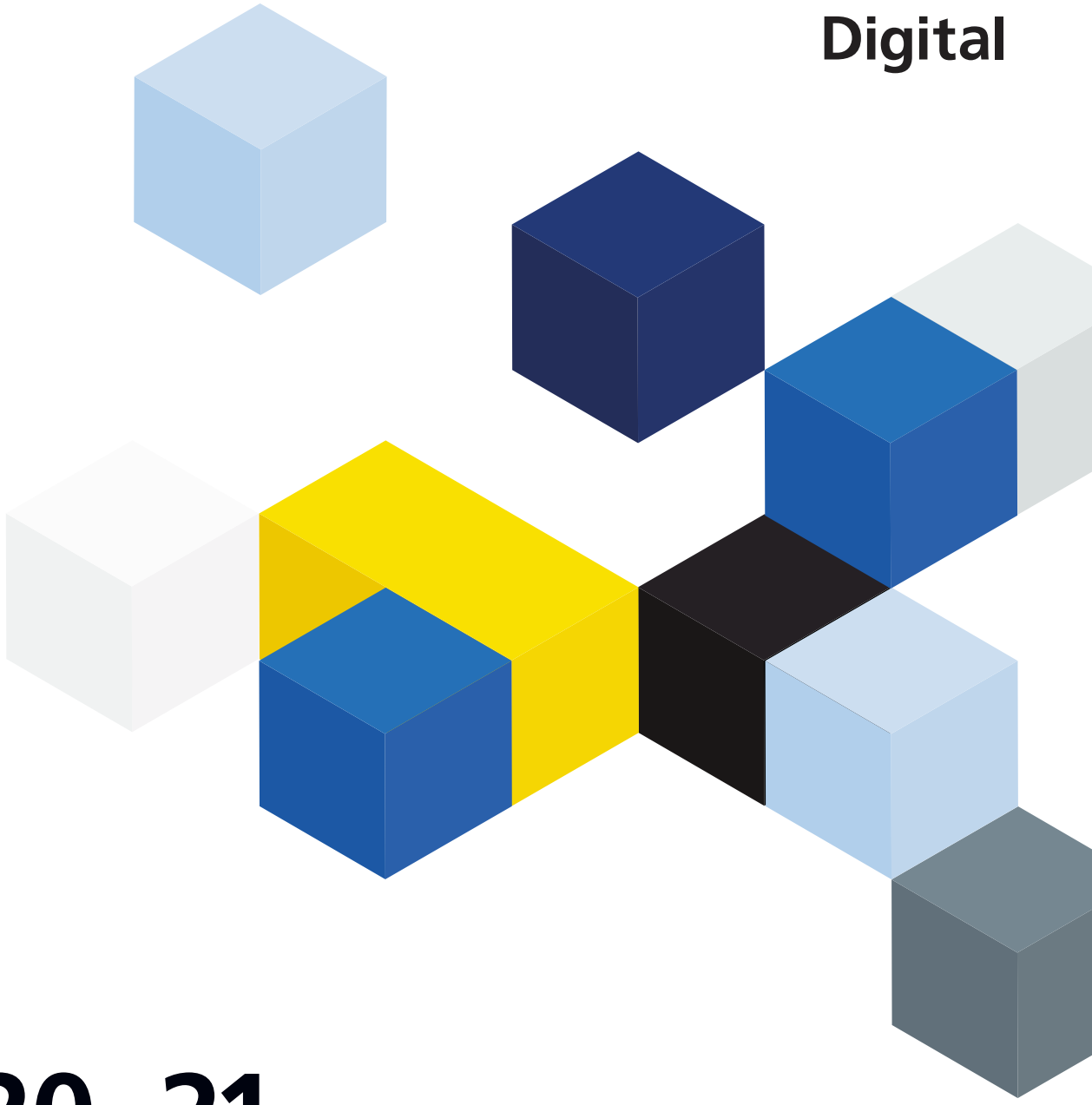
NHS Digital



2020–21 Annual Report and Accounts

Improving lives with data and technology

HC 1028

Health and Social Care Information Centre (HSCIC) Annual Report and Accounts 2020-21

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Introduction from our Chief Executive and Chair

In 2020-21, the National Health Service responded to the most serious crisis it had ever faced. The dedication and bravery of the frontline health and care workforce was witnessed by us all, as was the national effort to protect the NHS. People have stayed home, worn their masks and struggled with their livelihoods to help get the virus under control.

This Annual Report describes an aspect of the NHS's response to COVID-19 that is important for the health and care system to understand. From the beginning of the crisis, digital and data services played a central role in protecting the most vulnerable, helping clinicians care for people, building information about the virus, and developing the treatments, testing infrastructure and vaccines we needed.

We saw digital and data services delivered with a speed and with a unity of purpose that were unprecedented. These technologies played a more central part in core operational work than we have seen before.

The delivery of the vaccination and testing programmes was a huge cross-system effort. We worked with our partners to build the digital infrastructure, data flows, point of care systems, connectivity and cyber protection that underpinned the swift, nationwide rollouts. It's a lesson in what can be achieved when we work together at a national scale.

NHS Digital's patient-facing services – the NHS website, the NHS App, NHS 111 online and NHS Pathways – were crucial to protecting frontline services and ensured millions of people got the information and guidance they needed.

The statistics show the extent of the load and the contribution: 1 billion visits to the NHS website to find out about COVID-19; 4.3 million downloads of the NHS App; a daily average of 19,000 people using NHS 111 online throughout 2020-21.

We built systems to allow appointment booking into emergency care settings, created infrastructure to support remote consultations, and provided physical connectivity across new locations, including the testing sites, vaccination centres and the Nightingale hospitals. Our live services and cyber security teams kept the systems on which the NHS relies operating effectively, despite significant pressures. We also put digital services into care homes, supported the Oximetry @home programme, and helped give hundreds of thousands of NHS staff videoconferencing and other digital tools that were needed for remote collaboration.

We used NHS data in new ways to help protect and support individuals. The Shielded Patient List, our risk stratification tools and the identification of the vaccine cohorts helped people directly. Additional information in the Summary Care Record application helped clinicians dealing with COVID-19 cases, and we saw our data dashboards being used to drive local action. For example, NHS Digital data dashboards powered analysis of ward-level variations in vaccine take-up, supporting efforts to address hesitancy.

And our data services had global impact. The NHS DigiTrials service, jointly created by NHS Digital, the University of Oxford, IBM and Microsoft, helped a series of world-leading COVID-19 trials quickly find the participants they needed and accelerated the delivery of their results. The RECOVERY trial at Oxford, for example, has helped identify 3 COVID-19 treatments, which are estimated to have saved more than a million lives across the world.

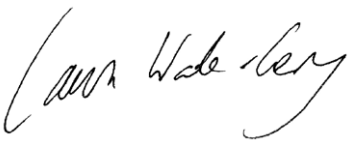
New capabilities, such as our Trusted Research Environments and the COVID-19 Vaccine Registry, supported researchers while ensuring patient data was protected and used appropriately. As we look forward from the pandemic, we will continue to improve these services. Our nation's health records have immense potential to improve outcomes and address health inequalities. We'll continue to work with our life sciences partners to find better ways to use this information, while ensuring that we properly address privacy concerns.

The NHS had to use data and digital technologies differently because of COVID-19 and, in doing so, we saw their potential. To make the most of these possibilities, we must work together. When the pressure of the pandemic was at its height, one of the shared experiences of staff at the heart of the action was that organisational boundaries tended to melt away. Projects involving complex groups of national, local and commercial partners became single teams focused on providing solutions. We want to keep that spirit as we build back after COVID-19. Looking forward, NHS Digital and NHSX will form part of NHS England and Improvement, bringing the key digital bodies of the NHS under one roof for the first time. Working together as one organisation, we will be able to step up the digitally enabled transformation of the NHS and focus our effort on what the system needs most.

We are still dealing with COVID-19, and new pressures are emerging in the virus's wake – profound stresses in primary, emergency and elective care, for example – that mean the pace is not going to let up. We need to keep the rate of delivery, agility and confidence in digital solutions that we saw at the height of the crisis. We have been recruiting in areas where we need new and extra resource to meet our commitments and we will continue to transform our capabilities, build our resilience, and develop our culture so that we can be a great place to work and the system's best possible technology partner.

It is difficult to pick out individuals from 2020-21 because so many people made a difference, but it would be wrong not to mention Pete Rose, our Deputy Chief Executive, who sadly passed away in August 2021. Pete made an important contribution to our response to COVID-19, and we will miss his calm and powerful leadership.

We also want to thank Sarah Wilkinson, who was NHS Digital's Chief Executive throughout the year, for her tremendous contribution to building our organisation's professional and organisational competence over the past 4 years. That transformative work meant we were fighting fit when the system needed us most – and Sarah led our response brilliantly. Most importantly, we want to thank everybody at NHS Digital and in our partner organisations for the commitment, flexibility and sheer amount of work done by our teams in 2020-21. It was an intense, phenomenally productive period. We are confident that we will keep the momentum we have gained over the coming year and continue to demonstrate that better use of data and technology is critical to the future of the NHS.



Laura Wade-Gery
Chair
NHS Digital

Simon Bolton
Interim Chief Executive
NHS Digital

Our role

NHS Digital is the national digital, data and technology delivery partner for the NHS and social care system, with expertise in the design, development and operation of complex IT and data systems. We were established under the Health and Social Care Act 2012 as an executive non-departmental government body and the majority of our funding comes from the Department of Health and Social Care (DHSC).

We work closely with NHSX, the joint unit of NHS England and DHSC responsible for setting the strategy for digital transformation and shaping the delivery of that agenda, to ensure what we are doing is supporting the priorities of the health and care system, and we collaborate with partners across the NHS, social care, the health tech sector, and life sciences research to support better health and patient outcomes, better experiences, and better value for money.

We:

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

Our organisation

During 2020-21, our programmes, services and corporate functions were organised into 7 directorates (see below and page 104). There were 4 core delivery directorates: Product Development, Data Services, IT Operations, and Platforms and Infrastructure, which were all closely supported by our Privacy, Transparency and Ethics function, which sits in our Strategy, Policy and Governance directorate (see page 32). The performance report on pages 9 to 35 is structured around the objectives and achievements of each of these delivery directorates in 2020-21.

The performance analysis section (pages 36 to 42) and the governance statement (pages 43 to 51) set out our purpose, operating environment and the issues and risks affecting delivery over the past year.

What we did in 2020-21

Product Development

Our Product Development directorate played a significant and critical role in the NHS's response to COVID-19, leading on the delivery of new COVID-19 related digital services and rapidly enhancing existing services to ensure people got the right treatment, to enable effective remote working by health and care staff, and to alleviate the extreme pressure on frontline services during the pandemic.

There were nearly 1 billion visits to the NHS website by people seeking information about COVID-19 during 2020-21. NHS.UK's social media channels saw a 979% increase in impressions, with over 700 million in total over the course of the year, and we had 5.33 million page views of information about mental health support.

In addition to supporting citizens with timely, clear and relevant guidance, the NHS website also delivered a number of new digital services during the year. These included a facility, delivered in partnership with the National Institute for Health Research (NIHR), that allowed 350,000 citizens to enrol in COVID-19 vaccine research and a service to allow citizens to look up their NHS number ahead of booking their coronavirus vaccination. By March 2021, over 1 million citizens had successfully retrieved their NHS number using the service.

There were 4.3 million downloads of the NHS App last year, increasing total downloads by 233%. The app has been used by many as a key source of information during the pandemic and the increase has also been driven by new services, including secure messaging between practices and patients, the ability for citizens to view and manage their GP-to-consultant referrals, and allowing citizens to change their nominated pharmacy for prescriptions.

NHS login provides a single login allowing patients to access multiple digital health and social care services including the NHS App. 34 services were integrated with NHS login by the end of 2020-21, up from 13 at the start of the year. 40 more services were in the accreditation process. NHS login also allowed users of the National Coronavirus Testing System to securely register their personal details and store responses to key questions, making the whole process easier for people taking repeated tests and also improving data quality.

Since going live at the end of November 2020, this capability was used nearly 17 million times by about 4 million people. Overall, 9.4 million people had an NHS login by the end of the year, an increase of 107% over 2019-20, with 2.7 million having verified their identity to the highest level of assurance.

In April 2020, NHS Digital was asked by the Department of Health and Social Care (DHSC) to support the design, delivery and operation of the digital services underpinning COVID-19 testing: the Pillar 2 National Coronavirus Testing System. We helped DHSC establish the research, design and delivery assurance of the testing services provided by the digital test suppliers. This work initially focused on helping hospital staff and key workers to get tested, either through test centre or home testing channels.

By the end of April 2020, a platform to allow key workers to order and take polymerase chain reaction (PCR) tests and to then track the samples and disseminate the results was in place. These systems were then integrated with NHS 111 online, allowing members of the public with symptoms to start to book tests.

In May 2020, bookings were available at drive-through and walk-through centres, mobile units or using home swabs. The system was supporting batch orders of tests for care home staff and residents. The following month, results were automatically being sent to GPs' systems.

In June 2020, NHS Digital was asked to take on lead responsibility and ownership of the commercial arrangements of the Test Digital sub-contractors and the digital test assets. We integrated an antibody testing service in September and also connected the NHS COVID-19 app with the testing system, allowing a secure and anonymous flow of test results into the app that meant that people could be notified when they had come into contact with someone who had tested positive.

By early 2021, population-wide testing was starting to become a reality. By March, members of the public were able to order NHS Test and Trace lateral flow tests for home use. Bulk ordering of tests and registering of results by universities, schools and other key settings was fully supported and a new system integrated with third-party hotel booking systems was supporting mandatory testing of international arrivals.

Over the year, we delivered 400 material software releases, rapidly expanding the system's capability and coverage, and by March 2021 the platform had processed more than 110 million test results. Daily load was regularly reaching 1.5 million tests.

Following the successful delivery of the COVID-19 testing digital services, NHS Digital was commissioned by NHS England to lead the delivery of the digital services for COVID-19 vaccinations. This included the design and development of the patient-facing booking portal and integrating and managing services provided by third parties that allow NHS staff to call and recall people for vaccinations and record vaccinations when they have happened. NHS Digital also ensures that individuals' vaccination information flows into their GP records and provides support to identify and address issues with data quality at vaccination sites. NHS Digital worked closely with NHSX to define the architecture before going live in early December 2020. The service had processed over 30 million vaccinations by the end of 2020-21.

NHS 111 online has become a digital 'front door' to the NHS for millions of people, allowing users to check symptoms, determine whether they need in-person care and, through integration with NHS 111 telephony, receive clinical call-backs when required. In April 2020, traffic to 111.nhs.uk stabilised after peaking in early 2020 at nearly 95 times previous highs. Between April 2020 and March 2021, the service saw over 12 million completed sessions, with an average of 19,000 people using the service every day. NHS 111 online is now the single largest consumer of NHS Pathways content and 30% of all triages across NHS 111 are on the online platform.

In July 2020, NHSX and the National Director for Urgent and Elective Care in NHS England worked with NHS Digital to design and deliver digital services that would allow NHS 111 call centres and patients using NHS 111 online to book appointments in emergency departments when required. The web-based platform for 111 to Emergency Department Booking (Emergency Department Digital Integrator or EDDI) was in pilot by November 2020 and had been rolled out nationally by December. The new service not only gets members of the public the right treatment but also helps manage emergency department capacity. Appointments for low-risk patients can be scheduled at less busy times and unnecessary visits are avoided.

In March 2021, 144 out of 178 emergency departments had gone live with appointment booking from NHS 111 using EDDI and more than 100,000 bookings had been made. In parallel, interoperability standards were established to enable direct booking between NHS 111 and emergency department systems. By the end of March, all 4 NHS 111 telephony systems providers and NHS 111 online were complying with the interoperability standards and 5 out of the 22 emergency department systems were on track.

In 2020-21, NHS Pathways, the national clinical triage system supporting the remote assessment of callers to urgent and emergency services, triaged nearly 19 million calls to NHS 111 and 999 services. At the start of the pandemic and in the early months of 2020-21, NHS Pathways issued guidance documents to all NHS 111 and 999 services on how to manage COVID-related calls and make safe clinical assessments. The COVID-19 case definition was changing rapidly, reflecting new assessment guidance and changing information about symptoms and affected countries. NHS Pathways distributed more than 30 clinical triage updates in this period.

In addition to providing critical support for the national pandemic response, the NHS Pathways team developed a number of products to support the safe and effective assessment of callers to urgent or emergency care lines. These included a stand-alone injury assessment product and a Pathways Clinical Consultation Support (PaCCS) product for senior clinicians to support remote consultations. NHS Pathways and NHS 111 online also worked together to develop ED Streaming, a new product to help assess patients presenting in emergency departments and, depending on the triage outcome, direct them to the right part of the department or to other clinical services. Beta testing of this new product started in 2 emergency departments in January 2021 and we plan to roll it out nationally in 2021-22.

The number of referrals made on the NHS e-Referral Service (e-RS) dropped from 18 million to 12 million because of reduced referral activity during the pandemic. The programme improved digital access for patients through integration with the NHS App, which now allows patients to view and manage their GP-to-consultant referrals.

Working closely with NHSX, we also improved support for GPs asking for advice from hospital consultants through e-RS, making it easier to turn an advice request into a referral when needed. In 2020-21, more than 1 million requests for advice and guidance were made through e-RS, an increase of 60% compared with the previous year, and the service is helping both GPs and consultants. Dr Roberto Tamsanguan, a GP at the Bromley by Bow Health Centre and e-RS Clinical Advisor for NHSX, said: "The new functionality is making a huge difference to the patient pathway in a number of specialities, getting patients to the right clinic at the right time [and] reducing avoidable outpatient consultations."

Our GP Connect product, which is being developed in partnership with NHSX and is now called the Direct Care API, continues to evolve to provide approved systems with secure, structured read and write access to clinical records. Following a policy decision by NHSX early in the pandemic, the Direct Care API was rolled out nationally and has played a vital role during the pandemic. The HTML patient record was accessed about 25 million times during 2020-21 and there were 1.3 million bookings at general practices through the Direct Care API. In early summer, we delivered appointment booking and patient record updates from the NHS 111 COVID-19 Clinical Assessment Service (CCAS) to allow clinicians to seamlessly refer patients to their GP for further care and preventing unnecessary attendance at emergency departments. The Direct Care API was also rolled out across social care to provide appropriate access to patient records in support of care.

> **"In the early days of the pandemic, we were constantly updating the NHS website to reflect new knowledge about the virus. People needed that information. It was a pretty intense period.**
>
> Dr Nam Nguyen, clinical lead for the NHS website and GP

We've improved information sharing between community pharmacies and GP practices. In April 2020, in response to COVID-19, NHSX accelerated our existing work to notify GP practices electronically when community pharmacies provide emergency supplies of medicine. Electronic notifications to GP practices of flu vaccinations by community pharmacies were also prioritised, given their importance during the pandemic. The work on medicines was completed in August and the work on flu vaccines finished in November. Both notifications are working on Sonar and Pinnacle systems in pharmacy and TPP and EMIS systems in general practice, meaning the large majority of both sectors are now covered.

The GP clinical record has been critical to many aspects of the COVID-19 response and our Primary Care IT team has worked closely with GP IT suppliers to ensure clinicians have the best possible support. The GP Extraction Service (GPES) and the GP Data for Pandemic Planning service have taken pressure off primary care by centralising the collection and sharing of GP data for coronavirus research. This ensured that key initiatives such as the Shielded Patient List, work on risk stratification for COVID-19 patients and the vaccinations programme had the data they required. We are now moving to replace GPES, which has been collecting data from GP systems for more than 10 years to support planning and research. Its replacement, the GP Data for Planning and Research collection, has been developed in consultation with the British Medical Association (BMA), the Royal College of General Practitioners (RCGP), and the National Data Guardian, and is expected to be deployed in 2021-22.

Despite the pressures of the pandemic, we've continued adding assured solutions to the GP IT Futures framework, which is being developed in partnership with NHSX and provides practices and system suppliers with an assured environment for procuring safe, resilient and functionally rich clinical GP systems that will be interoperable with systems across the NHS and ensure the flow of real-time data across primary care. During 2020-21, 42 solutions were added, taking the total number of systems available on the framework to 62.

The Primary Care team has worked with 5 new GP clinical system suppliers and developed a series of National Integration Adaptors and APIs to simplify integration with national infrastructure. We are replacing brittle legacy integrations with modern extensible standards presented through NHS Digital's API management layer. More directly, we also supported the introduction of online and video consultancy products to support GPs. We distributed laptops and smartcard devices to practices to help clinicians operate remotely during the first lockdown.

Significant steps have also been made towards the decommissioning and replacement of ageing technology. The 35-year-old National Health Application and Infrastructure Service (NHAIS) processes patient GP registrations and GP payments and is a source of demographic data for many other national systems, including screening and immunisation systems. This year, 88 demographic data feeds were migrated from NHAIS to the NHS Spine. We are developing a replacement Primary Care Registration Management system ahead of NHAIS's planned retirement in 2022.

The Interoperable Medicines – Standards and Data Programme is working to improve the flow of information about medicines prescriptions and supply. During 2020-21, we established a regular flow of data from the NHS Business Services Authority on medicines dispensed in community pharmacy. This played a notable role in the COVID-19 response as part of the development and maintenance of the Shielded Patient List and is a significant step for future research and analysis of medication safety. The programme also accelerated work to secure medicines data from secondary care. A dataset has now been delivered that represents around 9% of hospital prescribing, which is available for COVID-19 related research.

We also completed our Adult Social Care Programme in 2020-21. Its objective was to achieve a step change in the digital maturity of the sector and its work will deliver about £100m of benefits for the £25m investment over 5 years. It supported a range of products, services and standards to improve information sharing in key areas such as hospital discharges, assessments and urgent care episodes.

Data Services

We collect data from almost every provider of health and care in the country and process these into more than 200 national datasets and 300 open-data and statistical publications a year. These play a crucial role in shaping debate and forming policy and practice in our healthcare system. The need for accurate, robust and timely health and care data has never been clearer than it was in 2020-21.

Our Data Services directorate also played an important role in the system's response to COVID-19 by collecting new datasets and sharing data to support planning, operations and research. This was enabled by new legislation: the introduction of the COVID-19 Public Health Directions 2020 provided NHS Digital with the legal powers to bring in new datasets to assist in the pandemic response, while the notice issued by the Secretary of State under the Control of Patient Information (COPI) Regulations required NHS Digital to share confidential patient information with organisations entitled to process this under COPI for COVID-19 purposes. This allowed us to contribute to the UK response to the virus, supporting the development of vaccines, public health responses, the assessment of existing drugs and, research into the wider impacts of the pandemic, including on people's general health and care.

10 new datasets were collected to support the pandemic response and made available via NHS Digital's Data Access Request Service (DARS), including data on hospitalisations in England, antigen and antibody test results, vaccination status and adverse reactions, electronic prescribing for COVID-19 in secondary care, GP data for pandemic planning and research, COVID-19 ethnic category data and a COVID-19-specific subset of the Sentinel Stroke National Audit Programme. From the start of the pandemic, requests for COVID-19 data were prioritised by DARS and the service managed a 23% increase in applications for data compared with 2019-20. The service worked with the Independent Group Advising on the Release of Data, which provides independent scrutiny of NHS Digital's data dissemination, to set up fast-track response processes and increase the frequency of independent reviews. We also delivered tactical, COVID-19 data collections to support NHS England and Improvement's operational planning.

In parallel, we significantly developed our data visualisation and dashboard capabilities, providing a secure, scalable mechanism for providing access to aggregated data for a variety of public and private uses. Over the course of the year, our public dashboard hub served millions of unique users and our private dashboards supported hundreds of health and policy professionals. Examples include public-facing dashboards showing the geographic distribution of people on the Shielded Patient List, the private dashboard that enables universities and the Department for Education and Skills to track trends in the COVID-19 test results of returning students and a dashboard to show the number of people who registered an interest in volunteering for vaccine trials. Our Business Intelligence and Data Visualisation function continues to develop existing dashboards and build new products in areas such as vaccination uptake and appointments in primary care. Where appropriate, we also continue to publish aggregated, anonymous open datasets along with these dashboards in line with our commitment to transparency.

We provided approved researchers with secure access to essential linked, de-identified health data in trusted research environments (TREs) to quickly answer COVID-19 related research questions. TREs provide a secure data platform with analytical and statistical tools to support researchers in conducting their work, while minimising external data sharing. They are being used by the British Heart Foundation to investigate the impacts of COVID-19 on diagnosis, management and patient outcomes of cardiovascular disease and by DATA-CAN, the UK's health data research hub for cancer, to investigate rates of cancer referrals, diagnoses and treatment. We are continuing to expand and improve our TRE service for both COVID-19 and non-COVID-19 research questions. We have also partnered with the Office for National Statistics to deliver the COVID-19 Public Health Research Database, which provides linked census, mortality and health data to facilitate investigation of coronavirus risk factors.

Our NHS DigiTrials service is supporting clinical trials at key points where routinely collected patient data can make a real difference – supporting feasibility assessment, trial planning, recruitment, communications with participants and tracking of outcomes. In 2020-21, our major focus was on supporting COVID-19 clinical trials. We built close working relationships with trials to facilitate fast access to vital data about the virus, including many completely new datasets collected to support the response. This included the RECOVERY Trial, the world's largest trial of COVID-19 treatments. Our service helped speed up this research and cut the data collection burdens of an overstretched NHS frontline. To date, the trial has identified 3 treatments (dexamethasone, tocilizumab and Regeneron's monoclonal antibody combination), which are estimated to have saved more than a million lives around the world.

We also supported recruitment into another important COVID-19 clinical trial, the PRINCIPLE trial, which aims to find COVID-19 treatments that can be taken at home and that avoid hospitalisation. Although the study had been running since April 2020, the participant numbers over the first 6 months were low because it was hard to find and engage with patients in the community when they were feeling unwell. The window for recruiting relevant participants following a positive COVID-19 test was 7 to 10 days. By providing the PRINCIPLE team with a daily flow of COVID-19 test data, we helped them to identify suitable trial participants and send out invitations quickly. Recruitment doubled to 200 per week.

Our Terminology and Classifications services responded to the national need to quickly define and disseminate consistent medical terms for COVID-19 diagnoses, tests and test results with a 5-fold increase in the frequency of releases of SNOMED CT clinical codes to the NHS. This allowed Public Health England, the government and researchers to quickly create crucial regional and national statistics. We provided consistent instructions for these codes to the NHS by establishing collaborations with clinical professional groups, agreeing the definition of the COVID-19 terms, and then making guidance on their use available to practitioners in different clinical settings.

We worked with national health agencies and vaccine manufacturers to make sure that all vaccine codes and associated specifications (such as dosages, packaging, ingredients and bar-coded information) were defined and able to flow through all IT systems at the start of the national vaccination campaign. We also provided specialist guidance on the set of diagnoses, medications and medical procedure codes to be used to identify the population cohort that became the Shielded Patient List, which helped protect millions of vulnerable people.

We continued to deliver our core statistical services throughout the pandemic. These publications provide crucial insights into the health and wellbeing of the population, and inform research, policy development and operational planning. In September 2020, the Childhood Vaccination Coverage Statistics showed that during 2019-20 there was an increase in most routine vaccinations. MMR1 vaccine coverage at 24 months increased for the first time in 6 years, from 90.3% in 2018-19 to 90.6% in 2019-20. In October 2020, we published the Mental Health Act Statistics 2019-20, revealing that the rate of detentions under the Mental Health Act in England was more than 4 times higher for Black people than for white people.

In October 2020, we published the Mental Health of Children and Young People in England report. The survey, conducted in July 2020, found that the proportion of children aged 5-16 years experiencing a probable mental disorder increased over the past 3 years, from 1 in 9 in 2017 to 1 in 6 in 2020. It also found that in 2020, 36.7% of parents thought that their children were worried about friends and family catching COVID-19 and 28.5% of children and young people (aged 5-22 years) had experienced sleep problems in the 7 days before they were surveyed.

Alongside this, we continued to run strategic COVID-19 programmes. NHS Digital was responsible for publishing the Shielded Patient List, a list of clinically extremely vulnerable patients considered to be at high risk of complications from COVID-19. The list enabled partner organisations across government to provide support, advice and guidance for those who needed to shield. We updated the list weekly and developed it to ensure all clinically extremely vulnerable people were covered. We also provided services that helped people on the list get evidence of their need to shield for their employer or the Department of Work and Pensions and allowed them to request free vitamin D supplements over winter 2020-21. At the end of September 2021, the Shielded Patient List included about 3.8 million people. We're also delivering digital and data services for COVID-19 Oximetry @home, an NHS England-led service that monitors patients with COVID-19 symptoms in their own homes or care homes. We supply data to providers daily to help them identify patients to onboard and we have collected data for about 50,000 patients that benefitted from home monitoring.

> **"The results that we have seen in the RECOVERY trial have been phenomenal and have shown the value that NHS DigiTrials can have on the world's largest clinical trial on COVID-19 treatments.**
>
> Dr Marion Mafham, consultant kidney specialist and clinical researcher at the University of Oxford

IT Operations and Cyber Security

The IT Operations and Cyber Security directorate manages and supports the large range of live services that we operate for the health and care system, as well as ensuring their cyber security against threats and potential vulnerabilities. From the beginning of the pandemic, additional services have been introduced at an unprecedented pace while we have continued to manage all of our live services to excellent levels of availability, performance and security.

Throughout a turbulent year, we provided safe, fast and reliable access that health and care staff and members of the public could rely on. The average availability of the IT Operations portfolio was 99.96%, and 93.92% of High Severity Service Incidents were dealt with within our target fix times.

IT Operations' customer service centre experienced a 12% increase in calls. The pace of change during the year and the complexity of some incidents resulted in 50% more High Severity Service Incident interventions compared with 2019-20. A new IT Operations Centre (ITOC) was established to manage services more proactively. Launched in September 2020, it supported the National Coronavirus Testing System and has since expanded to support the COVID-19 vaccination service and other responses. The ITOC provides critical real-time information and workflows to guide preventative action and keep services and data available.

The National Coronavirus Testing System was regularly processing more than 1.5 million polymerase chain reaction (PCR) test and lateral flow test (LFT) results a day. The increase of asymptomatic community testing, particularly in education settings, increased the load from LFTs at the end of 2020-21.

The NHS e-Referral Service (e-RS) created an average of more than 1 million monthly referrals. This resulted in a monthly bookings average of approximately 670,000 bookings (including re-bookings). Within e-RS there are 70,923 services available and a further 6,794 with 2-week wait time targets (cancer care). These are offered across a total of 1,547 organisations.

The COVID-19 vaccination service – IT Ops team supported a complex, multi-organisational rollout across England from December 2020. By the end of March, 29.9 million COVID-19 vaccinations had been digitally recorded in a point of care tool in one of 3 delivery settings across thousands of vaccination sites. NHS Digital processed these daily and fed the data into the GP Patient Record and the Summary Care Record application, which allows clinicians to see information about patients. Just over half the adult population of England had at least one COVID-19 vaccination jab during this period.

The Data Processing Service (DPS) is a mix of technologies and processes enabling live services to collect and process data needed to run the health service. These secure technologies and processes enable us to collect, process and access data in a smarter, more efficient way and provide fast access to better quality data for all users.

In 2020-21, the DPS Core processed over 85,500 data submissions, comprising a total of over 128,000 million records and provided 114,000 data extracts. This is 9 times as many data submissions and 5 times as many data extracts compared with 2019-20.

NHS Digital's Data Security Centre (DSC) ensures that our systems, patient data and information are safely and securely managed and protected from cyber security threats and vulnerabilities. We provided a range of security services, expert guidance and support to help organisations build cyber resilience, address vulnerabilities, and prepare for and recover from incidents. Developing strong relationships with suppliers and customers has been critical and our Cyber Associates Network, managed in partnership with NHSX, now has over 1,400 members providing peer-to-peer support.

We dealt with evolving threats from malicious cyber activities, which increased because of the disruption caused by COVID-19. Working in partnership with the National Cyber Security Centre (NCSC), NHSX and organisations across health and care, we obtained intelligence on threats and identified and blocked an average of 21 million malicious attempts every month across the NHS.

We enhanced the protective monitoring and threat intelligence capabilities of our Cyber Security Operations Centre (CSOC) by improving the tools and technologies that help us identify malicious content and respond quickly and at scale to emerging risks. We also launched a vulnerability monitoring service (VMS) to enable organisations to detect weaknesses in their systems.

NHS Secure Boundary is a centrally funded, free-to-use perimeter security solution that blocks threats as internet traffic moves into or out of networks. We continued to expand its coverage in 2020-21, with more than 65% of NHS Trusts now signed up. It protected over 18.5 billion internet transactions in the year.

Through our work with the NCSC, we made the Protective Domain Name Service (PDNS) available to the NHS. PDNS was built to hamper the use of DNS for malware distribution and operation. We have also provided 1.5 million centrally funded Microsoft Defender Advanced Threat Protection (ATP) licenses, which improve visibility and help organisations monitor and identify emerging threats at a local and national level.

Working alongside NHSX, we launched a new high-severity cyber alert system based on the 'Respond to an NHS Cyber Alert' portal. This allows us to quickly inform and support relevant NHS organisations of necessary remediation actions. Affected organisations are required to acknowledge receipt of the alert within 48 hours and complete mitigation action within 14 days. Uptake of the portal has been strong, allowing our Cyber Security Operations Centre, working with NHSX, to clearly and rapidly capture 'estate-wide' exposure to vulnerabilities. We also increased our on-site Cyber Incident Response (CIR) capacity, spending more than 1,000 hours in organisations providing immediate and direct support during cyber incidents and related IT failures. This additional activity was funded from the COVID-19 Action Plan, which was developed jointly by NHS Digital, NHSX and the NCSC.


NHS
COVID-19
nation Centre
Polly

We've worked with NHSmail to strengthen security by aligning password policy to National Cyber Security Centre standards, and we've reduced the number of passwords people have to remember by automatically synchronising the NHS directory and local directories. New functionality will automatically update NHSmail systems when people join or leave the NHS or move jobs within the system, reducing the burden on local teams but also ensuring that only the right people have password access. We are blocking about 96,000 compromised or insecure passwords a month.

The Data Security and Protection Toolkit (DSPT) provides health and care organisations with a way to assess their cyber security resilience against national standards. During 2020-21, more than 37,000 organisations published DSPT returns. We also strengthened NHS Digital's own security through our Corporate Security Transformation Programme, which is improving our processes and behaviours to guard against threats to physical locations, assets and personnel.

Throughout 2020-21, our cyber teams responded to rapidly changing requirements and challenges arising from the COVID-19 response. We established the Cyber Defence Operations Centre (CDOC), a sister unit working alongside our Cyber Security Operations Centre (CSOC). This provides protective monitoring and incident management coverage to the more than 50 services that make up the COVID-19 Test and Trace capability. The CDOC went from concept to initial delivery in 4 weeks and, at its peak, required an additional 40 technical cyber analysts. Our teams helped the Nightingale hospitals secure their operations, provided rapid cyber assurance for the vaccination programme and published guidance for staff across health and care on secure remote working and cyber awareness.

Platforms and Infrastructure

The Platforms and Infrastructure directorate provides the core platforms that connect digital services across the health and care system. We build integrated and interoperable platforms, leveraging open standards and application programming interfaces (APIs) to stimulate market competition and support innovation.

We completed the Health and Social Care Network (HSCN) programme ahead of time, under budget and in a way that has delivered more benefit than expected. A vibrant marketplace of 21 suppliers has been established, which is providing connectivity that costs, on average, 70% less than previous, equivalent services. The value provided by the new HSCN marketplace has enabled health and care organisations to upgrade to far faster, more reliable connections that are better able to support their digital ambitions. This was important as organisations responded to the COVID-19 pandemic. In total, 178 separate procurements for HSCN connectivity services have been completed, covering more than 12,000 premises belonging to 950 health and care organisations.

In addition, we supported connectivity upgrades for 350 NHS premises that needed more capacity to support their COVID-19 response. We delivered connectivity services to 150 vaccination sites.

We have also established improved central capabilities including a cloud-based Domain Name Service (DNS), which is also integrated with the National Cyber Security Centre's Protective DNS (see page 22).

We have continued to improve our system hosting by migrating services from legacy on-premise data centres to more efficient cloud and Crown Hosting environments. We have now migrated 67% of the legacy HM Land Registry data centre estate and aim to complete this in 2021-22.

By more accurately forecasting capacity, implementing new savings plans with Amazon Web Services (AWS) and Microsoft Azure, and joining the 'One Government' AWS and Azure terms, we estimate savings of £7 million over the next 3 years. We are leading wider adoption of cloud services across the NHS in 2021-22, which will help to spread the operational, cost and sustainability benefits associated with cloud adoption across the system.

Our Access Logistics Hub was established to help organisations rapidly access services and products to support their COVID-19 response. During the first wave of the pandemic, the hub supported the roll-out of Microsoft Teams to 1.25 million new users and 25,000 NHSmail accounts to over 9,000 sites. This helped NHS staff to communicate effectively during the pandemic. We deployed 60,000 physical smartcards, 20,000 smartcard readers, more than 2,100 Remote Access Solutions and introduced a virtual smartcard solution to enable secure access to key digital services for the disrupted and expanded health and care workforce. We accelerated the migration of 1,000 premises to higher-bandwidth connections and supported the rapid deployment of network connectivity to several Nightingale hospitals.

The NHS Spine, the core infrastructure allowing secure information sharing across the health and care system, responded to increasing service demands across all platforms, consistently handling 1 billion transactions per month, with a record high of 1.3 billion in February 2021. There was a 30% increase in transactions year-on-year. The COVID-19 response was a significant factor in this increase, with several major citizen-facing services needing to connect to the NHS Spine's demographic, clinical and messaging platforms. Our Personal Demographics Service (PDS), the national electronic database of NHS patient details and NHS numbers, has been critical to the national vaccination programme. It also supported the right for people from the EU to access free healthcare in the UK in line with the government's Brexit commitments, and enabled the widening of the flu vaccination programme during the COVID-19 crisis.

The Electronic Prescription Service (EPS) was changed in response to coronavirus conditions. New functionality allowed locum pharmacists to work with EPS at new locations and we have provided a remote-signing service that allows prescriptions to be authenticated and signed without relying on the Health and Social Care Network and a smartcard. Prescriptions can also now be retrieved if a patient's nominated pharmacy is closed.

As part of the response to the COVID-19 pandemic and in line with COPI legislation and policy instruction from NHSX, we've expanded the use of patients' Summary Care Records (SCRs). SCRs are created from GP medical records and give authorised clinicians outside a GP practice access to key information about the patient. By default, unless a patient has asked for information sharing to be limited, we've made additional information available on 52 million patients' SCRs. Important information from the whole GP record is now being shared, including more detailed medical history, suspected or confirmed COVID-19 status, COVID-19 vaccination information and care plans. The likelihood of a clinician getting access to this additional information when dealing with a patient has increased from around 5% to more than 92%. Use of SCRs by clinicians has increased rapidly to about 240,000 views per week.

> **"We provided more than 7,000 video consultations and sent 38,000 SMS messages in the first months of the crisis – all relying on the new Health and Social Care Network infrastructure.**
>
> Dr Avinash Pillai, North Lincolnshire Clinical Commissioning Group IT lead and GP

A shielded patient flag has been added to the SCR application (SCRa) – the application used to view the SCR and other shared information – to alert clinicians to the patients who are most vulnerable to COVID-19. A reasonable adjustment flag has been added to improve the quality of care for patients with disabilities.

The National Record Locator via SCRa has been rolled out to over 3,500 registered users in the London Ambulance Service, providing paramedics and ambulance crews with instant access to critical clinical information. The number of records available via the National Record Locator is increasing rapidly, with over 80,000 mental health crisis plans and end of life care plans now accessible at the point of need. The roll-out of the National Event Management Service (NEMS), which improves the sharing of information about children's contacts with healthcare, is continuing across child health organisations, and we have linked it up with child health information systems from various suppliers. Deployments have been completed successfully in the Greater Manchester area and Lancashire. NEMS currently covers 72 of CCGs in England (53%).

The Staff Identity and Access Management Service provides a secure digital identity service for health and care staff. In 2020-21, we delivered more than 229 million authentications through the Care Identity Service during the year, providing more than 900,000 staff access to important national health records. We've integrated with Windows Hello for Business on Microsoft Windows devices to allow users to use facial biometrics to access internet-facing services. We also created emergency guidance to support remote working, allowing the use of video meetings to complete registration processes.

Our application processing interface (API) platform provides an easier way for us to build new APIs and for third parties to consume them. We use the latest open standards, including release 4 of the Fast Healthcare Interoperability Resources (FHIR) specification. We provide a developer-focused service through our developer hub, including an API catalogue, specifications, and a portal to allow users to onboard and manage their security credentials.

"The new Health and Social Care Network marketplace has enabled health and care organisations to upgrade to far faster, more reliable connections.

Our APIs were used to support the COVID-19 vaccination programme, Test and Trace, the National Booking Service and the Find My NHS Number service. The first Personal Demographic Service (PDS) API to allow gender-free search was introduced, enabling patients to book a coronavirus vaccination without having to specify their gender and improving our service for trans and non-binary people. We are developing a FHIR API to integrate and share information between clinical systems such as local healthcare records (LHCR), GP systems and the NHS Spine. An ambulance analytics API has been approved, which will improve links between ambulance services and urgent and emergency care systems. This will give frontline professionals better information and improve the planning of services.

During 2020-21, we moved NHSmail to Exchange Online. More than 2 million mailboxes were transferred safely onto the new service, the largest migration of its type in the world. We also gave all NHS organisations improved rates on Microsoft licences through the N365 deal. Microsoft Virtual Visits, Multi Factor Authentication, Portal Licence Management, Power Apps and improved security are among the products now supported by our partnership with Accenture and Microsoft.

Privacy, Transparency and Ethics

Our Information Governance function was renamed Privacy, Transparency and Ethics during 2020 to better reflect its work and to help send a clearer message about the good information governance principles NHS Digital strives to implement.

The COVID-19 crisis underlined the importance of patient rights, transparency and the ethical use of data as well as the fundamental role data protection must play in designing and operating digital services and in ensuring we use data in a safe and appropriate way. The value and benefit of data-driven decisions and technology is clearer than ever, and the importance of retaining the trust of the public is greater than ever.

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

The function supported and advised on all of the programmes of work that NHS Digital delivered in the response to COVID-19. We also worked with and supported other organisations involved in the system-wide response, including NHS England and NHS Test and Trace. We have also proactively engaged with the National Data Guardian and the Information Commissioner's Office on key projects.

We provided complex data protection advice, carried out data protection impact assessments, drafted privacy notices and established proportionate and appropriate data release arrangements quickly to enable new data flows, citizen-facing services, dashboards and data sharing arrangements. Significant delivery achievements included:

- the creation and operation of the Shielded Patient List, which identified people who were clinically extremely vulnerable to coronavirus. We worked closely with Government Digital Services and the Ministry of Housing Communities and Local Government on data sharing to support the delivery of shielding services
- the inclusion of additional information by default in the Summary Care Record and the implementation of national GP Connect functionality to provide healthcare professionals with access to consenting patients' medical records in different care settings
- the digital services and data flows required to support new COVID-19 testing services, including collaboration with the devolved nations to allow cross-border test result data flows
- the creation of the COVID-19 Vaccine Registry, which requires the design, development and operation of a UK-wide online permission-to-contact service. This allowed more than 800,000 volunteers to sign up to take part in vital COVID-19 vaccine trials. The work was done quickly with support from the Information Commissioner's Office (ICO) through the ICO Regulatory Sandbox and built on early work the team had done with the ICO before the pandemic

- advising on a large number of data sharing arrangements to enable COVID-19 surveillance and research
- advising on the establishment and operation of new General Practice Extraction Service (GPES) data collections to support the creation and maintenance of the Shielded Patient List and pandemic planning and research
- advising on the establishment of a new COVID-19 Public Health Research Database in collaboration with the Office of National Statistics and Health Data Research UK. The database, accessible though the ONS Secure Data Store, provides safe and secure access to linked census, mortality and health data to support COVID-19 studies
- the creation of private dashboards to support secure sharing of infection data with local public health teams as well as a range of public dashboards
- advising on data flows to support the flu vaccination programme and on the data flows and design, development and maintenance of the National Booking Service for the COVID-19 vaccination programme
- supporting the design and development of the COVID-19 Clinical Risk Assessment Tool, which helped clinicians to identify clinically vulnerable patients, and the COVID-19 Population Risk Assessment Service, which identified 1.5 million additional clinically vulnerable patients in February 2021

While COVID-19 dominated the year, the Privacy, Transparency and Ethics function also advised on a wide range of non-COVID-19 work, including the Cervical Screening Interim Programme, assurance of new suppliers in the GP IT Futures programme, the Digital Red Book, the National Event Management Service, the National Record Locator, NHSmail and the national Microsoft Teams roll-out. The team also provided advice and support to NHS Digital's Data Access Request Service on complex data access applications.

> **"The COVID-19 Vaccine Registry made it simple and easy for me to volunteer for vaccine trials – and I know how important that is for research teams.**
>
> Suzanne Hartley, Head of Trial Management – Complex Interventions, University of Leeds and a vaccine trial volunteer

Performance analysis

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 2020-21 Government Financial Reporting Manual issued by HM Treasury, as interpreted for the health sector by the Department of Health and Social Care Group Accounting Manual.

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

The financial statements have been prepared on a going concern basis. Funding for 2021-22 is in place, and the continuation of the provision of services is demonstrated through the plans agreed with our delivery partners. We work closely with NHSX, the Department of Health and Social Care (DHSC), NHS England and the UK Health Security Agency to ensure early identification of changing requirements. Although the merger of NHS Digital with NHS England has been announced, our functions will continue, and therefore in accordance with the DHSC Group Accounting Manual the going concern basis for preparing the financial statements remains appropriate.

2020-21 delivery performance

NHS Digital is a non-departmental public body and the majority of our income is grant-in-aid funding from the Department of Health and Social Care. From our total funding of £695 million, £364 million was allocated to running and maintaining existing critical services for the health and care system, £146 million related to new and improved services, and £145 million was allocated to our coronavirus-related delivery. Over the past year, we continued to provide high-quality services with excellent levels of availability, while supporting digital transformation at unprecedented pace as part of the response to the COVID-19 pandemic. Our delivery is described in detail in the Performance Report (see pages 9 to 35). There are five major areas of work:

- providing network and infrastructure services used by health and social care organisations
- providing digital applications that help members of the public, clinicians and health and social care organisations
- the collection, analysis and dissemination of data and the provision of a range of data-related services to the system
- providing a Cyber Security Operations Centre for the health and care system
- the development and implementation of new national systems and the adaptation and enhancement of existing systems as part of the COVID-19 response

2020-21 saw a significant increase in workload across all of these areas. Our performance against our programme was regularly reviewed by our Board, at monthly executive management team meetings and by our Gold-Silver-Bronze command structure implemented to response to COVID-19 as noted on page 72. This oversight was supported by a monthly performance report, which includes key performance indicators covering all aspects of service and programme delivery. During the year, changes in our delivery focus were closely monitored and indicators were updated to ensure an accurate reflection of our performance.

NHS Digital demonstrated consistently high levels of performance despite the rapid deployment of programmes and services required to support the government's response to COVID-19.

Specifically:

- alongside our existing work programmes, and the work on the Technology Transformation Portfolio (TTP), we played, and continue to play, a central role in delivering digital infrastructure, particularly regarding COVID-19. We quickly delivered a portfolio of COVID-19 programmes including the vaccinations booking system, the testing system, risk stratification support, 111 First, the COVID-19 status checker and Oximetry @Home
- our data services continued to increase the range, completeness and accuracy of collections while increasing the production of key information artefacts to the general public through our dashboards. Our dashboard views increased significantly (with one of our dashboards, the Neighbourhood View Dashboard, amassing around 3.5 million total page views by the end of March). Our data access processes improved the flow of data while maintaining close oversight of the use and protection of data

- our live services achieved an average availability of 99.95%, with 94% of our 'fix time' targets met over the year
- the Cyber Security Operations Centre met service targets, improved support for the health and care system and ensured robust internal cyber and information security systems and controls

Funding and income

The grant-in-aid allocated in the year amounted to £695 million (2019-20: £531 million). We also receive income from a range of activities and services including:

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

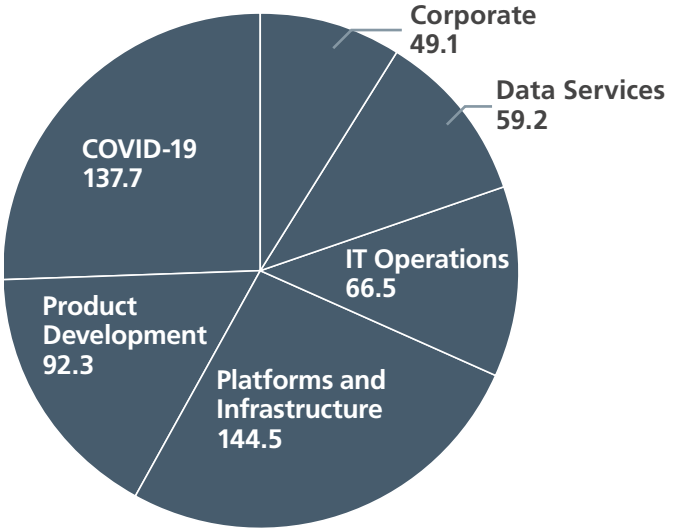
Income from these activities and services in 2020-21 was £45.3 million, a small increase on the £43.5 million generated in 2019-20. Most of our significant invoiced income is supported by agreed work packages and is on a time and materials basis. In accordance with IFRS 15, some £1.8 million (2019-20: £0.8 million) of income was not recognised in the year but will be recognised in 2021-22 when signed agreements are in place. Our major customers are NHS England, the Department of Health and Social Care and Public Health England.

Expenditure

Staff costs increased to £207.0 million (2019-20: £179.8 million), with salary costs remaining broadly similar to the previous year at £171.7 million (2019-20: £169.9 million). Contingent labour and secondees rose to £47.7 million (2019-20: £23.1 million) as additional temporary resources were brought in to assist with the expanded scope of delivery due to COVID-19. Capitalisation of staff time remained at a similar level to the previous year at £12.4 million (2019-20: £13.2 million).

Operating expenditure increased significantly to £296.0 million (2019-20: £224.0 million), driven by greater use of suppliers to support the increased scope of delivery. Some of this expenditure supported programme delivery. We also incurred significant transactional charges to pay for text messages to individuals about COVID-19 tests and for matching lab results to individuals' records. Depreciation and amortisation rose to £70.7 million (2019-20: £52.4 million) as a result of the continuing high levels of investment in non-current assets, particularly developed software.

2020-21 Net revenue expenditure by delivery directorate £m



More information relating to net revenue expenditure by Directorate can be found in Note 2 on pages 102 to 103. Corporate in the chart includes Corporate Services, Assurance and Risk Management, Strategy, Policy and Governance and Central net expenditure.

A summary of capital expenditure is as follows:

	2020-21 £000	2019-20 £000
Internally and externally developed software	99,266	52,011
Development expenditure	21,031	14,175
IT hardware, including desktop and corporate infrastructure	5,730	6,036
Software licences, including desktop and corporate infrastructure licences	3,805	21,603
Refurbishments, fitting out new office space and furniture	10,724	6,932
Net book value of disposals	(2,759)	(1,846)
Total	**137,797**	**98,911**

Developed software and development expenditure paid for a mix of supplier and internal resources. Our most material development during the year was the National Coronavirus Testing System. This supports the end-to-end testing journey, from booking a test at a test centre, or ordering test kits for home delivery, to the operation of test centres, and the dissemination of results both to the individual and for data analysis and reporting. This accounted for £47.1 million of the additions in the year. There were also other smaller coronavirus-related developments, and extensive related work on our existing systems, enhancing and updating existing functionality and scaling up capacity. During the year, we also completed the fit-out of our new Leeds home in the Government Hub building, which was available from 6 April 2021 to staff who needed to work in the office.

We have applied a revaluation to non-current assets in existence at 1 April 2020, using a mix of Office for National Statistics indices, actual pay awards and assessments of other supplier cost increases. The revaluation impact was an increase in net book value of £5.0 million. The exception is software licences, where indexation has not been applied to software licences from 1 April 2019 onwards. From this date software licences have been held at depreciated historical cost, on the basis that they are short-life assets and as such depreciated historical cost is considered a suitable proxy for current value in existing use.

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

Our freehold property, Hexagon House in Exeter, was transferred to the Government Property Agency (GPA) on 31 March 2021. Before the transfer, the land, building and associated fittings were revalued in accordance with a professional valuation undertaken on behalf of the GPA. We continue to occupy the building, with the GPA acting as landlord.

The very unusual circumstances of the last year meant that the National Coronavirus Testing System was built in extremely challenging conditions. The requirements had to be met very urgently, and the rapidly changing environment necessitated regular updates to the specification as new use cases and enhancements were added to support the evolving pandemic response. New releases of the software were rolled out several times each week throughout the year. Despite the fact that the system has proved to be effective and reliable, the exceptional circumstances under which the system was built meant that accounting standards required us to produce a valuation for the balance sheet based on the cost of replacing the asset in an artificial optimal environment as at 31 March 2021. The assumptions used to produce the replacement valuation include perfect hindsight in terms of lessons learned in initially building the asset, and that the value on 31 March 2021 is reduced to reflect the fact that it has been used over the preceding period. To ensure independence we were required to commission an external expert valuation, and using this valuation of a hypothetical replacement, adjusted for the use of the asset up to 31 March 2021, we have impaired the asset by £17.5m.

Current assets and liabilities

Contract receivable balances amount to £12.7 million (31 March 2020: £13.7 million). This is a small decrease despite the overall increase in income. Invoicing of income generally occurs towards the end of the financial year as programmes complete their work.

Prepayments under 1 year amount to £13.6 million (31 March 2020: £12.4 million), while 'contract receivables not yet invoiced' amount to £2.0 million (31 March 2020: £1.6 million), which represents work completed but not yet invoiced.

We seek to comply with the Better Payment Practice Code (BPPC) by paying suppliers within 30 days of receipt of a valid invoice. The percentage of non-NHS invoices paid within this target was 99.5% (31 March 2020: 99.1%). The days outstanding at 31 March 2021 rose to 31.4 days from 9.2 days at 31 March 2020. Volumes of supplier invoices received in March rose by 50% from normal levels, with an exceptionally high value of invoices arriving in the last week of the month.

Auditors

These accounts have been audited by the Comptroller and Auditor General, who has been appointed under statute and is responsible to Parliament. The audit fee for 2020-21 was £150,000 (2019-20: £115,000). The audit fee includes only audit work. No additional payments were made for non-audit services.

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

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

Sustainability

Sustainability is a priority for NHS Digital: both decarbonising the health sector and building climate resilience. Our digital transformation work underpins the Greener NHS Net Zero plan and has accelerated significantly since the start of the pandemic.

Our close involvement with the government's Sustainable Technology Network (STAR) helps ensure we are both shaping and delivering best practice in sustainable and resilient digital services. Our products and services improve interoperability, reduce unnecessary staff and patient travel, and cut printing.

The pandemic has significantly increased digital collaboration through Microsoft Teams across healthcare. We are also seeing greater use of online services such as NHS 111 online and the NHS App. Over the 12 months to December 2020, use of the app increased by more than 900%.

Early indications from an ongoing study commissioned by NHS Digital show an opportunity to reduce the carbon footprint of data centres across the NHS by as much as 80% through a large-scale move to cloud hosting. In 2021, we have established a cloud centre of excellence, with the vision of running an orchestrated, co-ordinated, standardised and optimal approach to cloud adoption throughout the NHS. Our internal cloud migration continues and is expected to contribute significantly to our journey to net-zero.

Our move from 4 offices across Leeds to the Government Hub building, which has a 'BREEAM Excellent' rating, and smarter working by our staff will deliver significant efficiency improvements. We expect reductions in gas, electricity and water use and less business travel.

During the year, we focused on process-based innovation, such as embedding sustainability into our digital design and architecture principles, and on realising the aims of the Public Services (Social Value) Act 2012 within commercial and procurement decisions. By framing sustainability as a risk rather than an opportunity, we have put climate resilience thinking and sustainability on the organisation's risk radar.

To support our Sustainability Strategy for 2021-25, we are expanding our core sustainability team and will deliver sustainable and resilient digital services by embedding sustainability in all key organisational functions and governance gateways. This work demands hearts as well as minds, so sustainability will take a more explicit role within our People Plan and human resources (HR) functions.

Detailed information for 2020-21 is included on the NHS Digital website at https://digital.nhs.uk/about-nhs-digital/corporate-information-and-documents/sustainability-reports/sustainability-annual-report-2020---2021/

End of the European Union exit transition period

NHS Digital carried out a significant amount of work to prepare for the end of the transition period on 31 December 2020. This included ensuring that NHS Digital was prepared for all eventualities and that we understood the potential impact on our own operations, in particular on our supply chain and data flows. We collaborated closely with other health and social care bodies in this planning. No issues were encountered as the transition period ended. The discussions between the UK and EU on data adequacy arrangements have now concluded, and the EU formally adopted adequacy decisions for the UK – one under the General Data Protection Regulation (GDPR) and the other under the Law Enforcement Directive (LED). The decisions came into effect on 28 June 2021 and allow personal data to continue to flow freely from the EU/EEA to the UK.

Simon Bolton
Interim Chief Executive
20 January 2022

Accountabilty report

Corporate governance report

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

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

Our governance

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

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

The Board consisted, at 31 March 2021, of 4 executives, 8 non-executives (including the Chair) and 1 'ex officio' member. These arrangements comply with the requirements of the Health and Social Care Act 2012, which stipulates that the Board should have at least 6 non-executive directors and not more than 5 executive members.

The Board

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

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

The powers retained and exercised by the Board include:

- agreeing our vision, values, culture and strategy within a policy and resources framework agreed with the Department of Health and Social Care
- agreeing appropriate governance and internal assurance controls, especially in relation to financial and performance risks
- approving business strategy, business plans, key financial and performance targets and the annual accounts

- ensuring sound financial management and value for money
- supporting the EMT and holding it to account
- ensuring that we comply with any duties imposed on public bodies by statute

A register of members' interests, drawing together declarations of interest made by all Board members, is open to public scrutiny and is published with every set of Board papers, copies of which can be found on the 'Our Leadership and Governance' section of the NHS Digital website. Details of related-party transactions are set out in Note 18 of the Accounts on page 120 of this report. Biographies of the Board are on page 123.

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

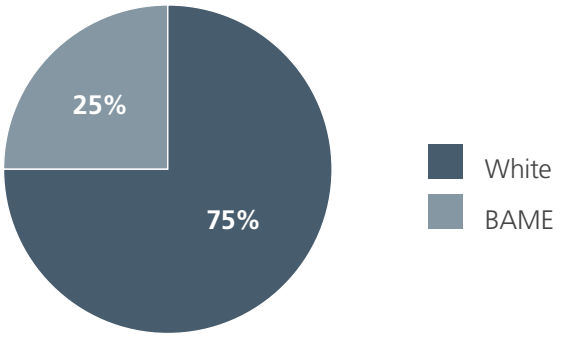
Changes to the Board's membership during the year were:

- Pete Rose was appointed as the Deputy Chief Executive Officer and Chief Information Security Officer on 4 May 2020. Pete died in August 2021
- Noel Gordon completed his term of office as Chair of NHS Digital on 31 August 2020
- Laura Wade-Gery was appointed as Chair of NHS Digital, effective from 1 September 2020
- Robert Tinlin completed his term of office as Non-Executive Director on 31 December 2020

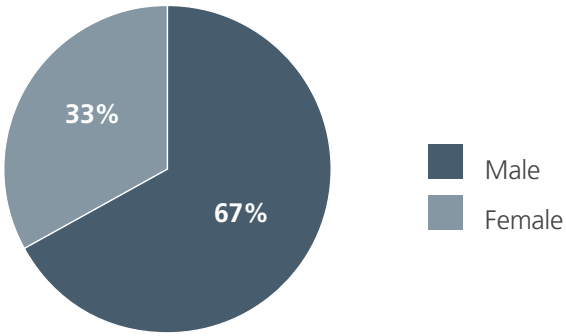
On 31 March 2021, the Board included 3 executive directors who were men and 1 woman. 3 of our non-executives were women and 5 were men.

The charts below show gender and ethnic background of members of the Board.

Ethnicity



Gender



Each non-executive director supports a particular aspect of the organisation's work. Their responsibilities and terms of office are as follows:

	Start date	End date	
Laura Wade-Gery[1]	1 September 2020	31 March 2022	Chair of the Board and the Talent, Remuneration and Management Committee
Noel Gordon[2]	1 June 2016	31 August 2020	Chair of the Board and the Talent, Remuneration and Management Committee and Investment Committee
Marko Balabanovic	1 January 2017	31 December 2021	Leads on innovation, emerging technologies, partnerships and technology transfer
Daniel Benton[3]	1 January 2017	31 December 2022	Chair of the Investment Committee. Leads on IT delivery excellence, operational transformation and technology strategy
Soraya Dhillon	1 January 2017	31 December 2021	Leads on clinical safety and governance, e-channels and diversity and inclusion
Sudhesh Kumar[3]	1 January 2017	31 December 2022	Leads on big data, the research sector, clinical informatics, medtech and life sciences
John Noble[4]	1 July 2018	30 June 2024	Leads on information and cyber security and chairs the Information and Cyber Security Committee
Deborah Oakley[4]	1 July 2018	30 June 2024	Leads on assurance and risk and chairs the Audit and Risk Committee
Rob Tinlin	1 January 2017	31 December 2020	Leads on integrated care, digitising social care, change management and organisational development
Balram Veliath[4]	1 July 2018	30 June 2024	Leads on culture, values and stakeholder relations

[1] The Department of Health and Social Care has confirmed the extension of the appointment of Laura Wade-Gery as Chair of NHS Digital for 12 months with effect from 1 April 2021 to 31 March 2022.

[2] Noel Gordon's original term ended on 31 May 2020 with a 3-month extension granted by the Secretary of State until 31 August 2020.

[3] The contracts for Daniel Benton and Sudhesh Kumar have all been subject to an additional 1-year extension from their revised end date of 31 December 2021.

[4] The contracts for Deborah Oakly, John Noble and Balram Veliath were granted a 3-year extension by the Secretary of State from 30 June 2021 until 30 June 2024.

Patrick Eltridge, Ben Goldacre and Steve Woodford have been appointed as non-executive directors of NHS Digital for 3 years from 1 April 2021.

The planned programme of Board meetings was impacted by the pandemic, resulting in meetings of the Board being held virtually. Over the year, 6 formal meetings of the Board were held and 5 of these sessions were open to members of the public to attend and observe. The sessions held in private considered items of a commercial or confidential nature that could not be discussed in public.

Papers and previous minutes are made available on the NHS Digital website (www.digital.nhs.uk/about-nhs-digital) in advance of the meetings.

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

- COVID-19 – NHS Digital's support for the national response to the pandemic
- employee welfare and support arrangements
- equality, diversity and inclusion
- health and safety
- sustainability
- in-depth reviews of Live Services, Infrastructure and Collaboration Technologies
- NHSmail and Health and Social Care Network deployment

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

Some key issues discussed during 2020-21 included:

- the future approach to product management and service design
- consideration of accrued technical debt
- race awareness

Board effectiveness

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

1. Board leadership: non-executive directors, with executive directors, should continue engaging actively with partners and providers to extend NHS Digital's insight and influence on technical and data strategy across the system.
2. The Board's effectiveness as a team: the Board should optimise its value-add overall in the context of NHS Digital's remit for 2020-21.
3. Ensuring a healthy culture: the Board should continue its work to ensure a healthy culture and high levels of staff engagement to support the delivery of NHS Digital's strategic objectives.

Progress on the actions associated with some of these themes has been impacted by the pandemic, with the Board focusing the majority of its effort on support for the national response to COVID-19.

Nonetheless, during 2020-21, the Board has:

- through the auspices of the new Chair, developed much closer and more direct relationships with our arm's-length body partners, NHS stakeholders and NHS clients, supporting NHS Digital in delivering at pace and at volumes previously thought unachievable
- encouraged the non-executive directors to work closely and engage more regularly with the Chief Executive and members of the executive team, enabling them to contribute their expertise and unique perspectives in response to COVID-19, new business demands, and unexpected risks and issues
- been proactive in supporting management's implementation of the People Plan, responding to Black Lives Matter, and working closely with the Chief Executive and Chief People Officer to support our people in response to the organisational impacts arising from COVID-19

In 2021-22 the Board has committed to review the key recommendations on board effectiveness to ensure we progress against all aspects of the 2019-20 review.

The Board committees

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

- audit and risk
- information assurance and cyber security
- talent, remuneration and management
- investment assurance

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

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

The delegated responsibilities of each committee are described below.

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

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

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

The key areas of activity in 2020-21 included:

- the introduction and regular review of the Risk Radar and progress towards the agreement of key risk indicators
- several strategic risk 'deep dives' including NHS Pathways and clinical risk, technology debt, COVID-19 system resilience, and an overview of key risks outside NHS Digital's risk appetite
- several directorate assurance 'deep dives' including Product Development, Finance and Estates, and Commercial
- continued review of risks in respect to the COVID-19 pandemic and the impact on NHS Digital's overall risk profile
- clarification of NHS Digital's remit
- oversight of the response to the issues identified in the 2019-20 review of payroll controls
- the accounting treatment and the impact on NHS Digital's financial statements of the transfer of assets and activities from other governmental bodies
- NHS Digital's preparedness for the UK's exit from the European Union

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

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

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

The main areas considered in 2020-21 included:

- assuring cyber security work undertaken by NHS Digital with the NCSC and NHSX to provide enhanced protection for health and social care organisations during the COVID-19 pandemic
- regular updates on the work underway in the DSC to create a Cyber Defence Operations Centre (CDOC) to support NHS Test and Trace and the vaccines roll-out
- reviewing the decisions made by the DSC's Specialist Security Services team during the pandemic and the impact of those decisions on security and technical debt
- the development of improved key performance indicators to measure organisational and system-wide cyber security readiness
- a review of the 'Strategic Threat and Risk Assessment' report, commissioned to build a holistic understanding of the physical and personnel security threat and risk landscape
- understanding and measuring third-party risk, including looking at the cyber readiness of NHS Digital corporate systems provided by third parties
- an update in November 2020 to NHS Digital's previous response to the NCSC's Cyber Security Toolkit
- a 'deep dive' examination of the security of NHS Digital's own systems using the NCSC's 'Questions for Boards to Ask about Cyber Security'
- developing the remit of IACSC to better incorporate information governance assurance and undertaking reviews of current data sharing arrangements

Talent, Remuneration and Management Committee (TRaMCo) – Chair: Laura Wade-Gery

The role of this committee, among a range of staff-related matters, is to:

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

- review and make recommendations on the size, composition and structure of the Board, including assessing and making recommendations to the Department of Health and Social Care about the skills, knowledge and experience required from Board appointees

Investment Committee (IC) – Chair: Daniel Benton

The committee assures investment and financial proposals whose value exceeds the delegated authority of the Chief Executive, to ensure that NHS Digital assumes an acceptable level of delivery risk. It consists of 3 non-executive directors and the Chief Financial Officer. The Chief Commercial Officer and other members of the Executive Management Team attend as required by the agenda.

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

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

The IC has recently considered:

- commercial arrangements that were put in place rapidly during the pandemic in a sub-optimal environment. The IC worked closely with the delivery areas and Commercial to develop transition plans that balanced the need to manage operational risk and the need to move to more sustainable commercial arrangements.
- investment cases for programmes of work including the digital transformation of screening, an interim cervical call/recall solution, cyber security and the Data Security Centre

Following IC endorsement, business cases are submitted to the Delivery Oversight and Assurance Board hosted by NHSX.

Executive Management Team (EMT)

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

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

	Public Board	Board Development	Audit and Risk Committee	Information Assurance and Cyber Security Committee	Talent, Remuneration and Management Committee	Investment Committee
Number of meetings	5	3	6	5	5	8
Executive directors						
Sarah Wilkinson	5/5	3/3	6/6	-	5/5	-
Pete Rose	5/5	1/3	-	3/5	-	-
Carl Vincent	5/5	3/3	6/6	-	-	6/8
Jonathan Benger[1]	4/5	2/3	3/3	-	1/1	-
Non-executive directors						
Laura Wade-Gery[2]	3/3	3/3	1/1	1/1	4/4	-
Noel Gordon[3]	-	-	-	1/1	1/1	1/1
Marko Balabanovic	5/5	3/3	-	5/5	-	8/8
Daniel Benton	5/5	3/3	6/6	-	-	8/8
Soraya Dhillon[4]	5/5	3/3	-	-	5/5	2/2
Sudhesh Kumar	5/5	3/3	6/6	-	-	-
Rob Tinlin[3]	3/3	2/3	-	-	3/3	-
John Noble	5/5	3/3	6/6	5/5	-	-
Deborah Oakley	5/5	3/3	6/6	5/5	-	-
Balram Veliath[5]	3/5	3/3	6/6	-	1/1	-

[1] Jonathan Benger attended the Audit and Risk Committee by invitation and not as a member.
[2] Laura Wade-Gery atended the Audit and Risk Committee and the Information Assurance and Cyber Security Committee by invitation and not as a member of the committees.
[3] Noel Gordon and Rob Tinlin left NHS Digital during the year.
[4] Soraya Dhillon joined the Investment Committee as a member from February 2021.
[5] Balram Veliath joined the Talent, Remuneration and Management Committee from March 2021.

Remuneration and staff report

The staff costs and the average number of whole-time equivalent staff are subject to audit:

	2020-21 £000	2019-20 £000
Permanent staff		
Salaries and wages	131,428	129,541
Social security costs	14,284	14,473
Apprenticeship levy	628	633
Employer superannuation contributions - NHS Pension Scheme	23,877	24,025
Employer superannuation contributions - other	404	545
Staff seconded to other organisations	1,049	684
Capitalised employed staff costs	(9,011)	(11,951)
	162,659	**157,950**
Other staff		
Temporary staff	13,834	7,688
Contractors	32,872	14,407
Staff seconded from other organisations	1,028	1,063
Capitalised other staff costs	(3,402)	(1,267)
	44,332	**21,891**
Total staff costs	**206,991**	**179,841**
Termination benefits	660	8,359
Total staff costs including termination benefits	**207,651**	**188,200**

The average number of whole-term equivalent persons employed during the year was:	**2020-21**	**2019-20**
Permanent staff and secondees	2,480	2,617
Temporary staff and contractors	452	271
Total	**2,932**	**2,888**
The average number of whole-term equivalent persons employed during the year whose time was capitalised	150	191

Nothing was spent on staff benefits during the year and there were 7 early retirements on the grounds of ill health. At the time of preparing the accounts, the accrued pension benefit information for the individuals retired on the grounds of ill health was not available – this will be disclosed in the accounts prepared for the next reporting period. The accrued pension benefit for the 1 retirement on the grounds of ill health that occurred during 2019-20 was not available as the person was over the age of 60 and of pensionable age.

Exit packages

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

	2020-21		2019-20	
	Number of compulsory redundancies	Cost of compulsory redundancies £	Number of compulsory redundancies	Cost of compulsory redundancies £
<£10,000	3	11,419	3	16,893
£10,000 - £25,000	1	20,526	31	523,046
£25,000 - £50,000	-	-	52	1,940,159
£50,000 - £100,000	2	141,969	42	3,128,859
£100,000 - £150,000	1	140,437	21	2,380,502
£150,000 - £200,000	1	166,962	6	985,081
>£200,000	-	-	3	677,788
Total number of exit packages	**8**	**481,302**	**158**	**9,652,328**

There were no voluntary or other redundancies.

Exit Packages in 2019-20 related to the first 2 waves of the organisation's internal restructuring programme, known as Org2. A third wave was planned to occur during 2020-21, with a contingent liability reported at 31 March 2020 of £15,500,000 and with undetermined timing. However, this was delayed while the organisation focussed on the COVID-19 response, and the programme was subsequently ceased towards the end of 2020-21. All redundancies for 2020-21 reported above were concluded during the year, and there were no accrued costs as at 31 March 2021. Figures for 2019-20 include employer's National Insurance contributions amounting to £323,971 on those redundancies that had not been paid by 31 March 2020.

Pension information

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

NHS Pension Scheme

Past and present employees are covered by the provisions of the 2 NHS pension schemes. Details of the benefits payable and rules of the schemes can be found on the NHS pension scheme website at www.nhsbsa.nhs.uk/nhs-pensions. Both are unfunded, defined benefit schemes that cover NHS employers, GP practices and other bodies in England and Wales allowed under the direction of the Secretary of State. 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 NHS Digital of participating in the scheme is taken as equal to the contributions payable to that scheme for the accounting period.

So that the defined benefit obligations recognised in the financial statements do not differ materially from those that would be determined at the reporting date by a formal actuarial valuation, the Financial Reporting Manual (FReM) requires that "the period between formal valuations shall be 4 years, with approximate assessments in intervening years". An outline of these follows:

a) Accounting valuation
A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period, in conjunction with updated membership and financial data for the current reporting period and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability, as at 31 March 2021, is based on valuation data for 31 March 2020, updated to 31 March 2021, with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury (HMT) have also been used.

The latest assessment of the liabilities of the scheme is contained in the scheme's actuary report, which forms part of the annual NHS Pension Scheme (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 recent demographic experience) and to recommend contribution rates payable by employees and employers.

The latest actuarial valuation undertaken for the NHS Pension Scheme was completed as at 31 March 2016. The results of this valuation set the employer contribution rate payable from April 2020 at 20.6%. The 2016 funding valuation was also expected to test the cost of the scheme relative to the employer cost cap that was set following the 2012 valuation. In January 2019, the government announced a pause to the cost control element of the 2016 valuations, due to the uncertainty around member benefits caused by the discrimination ruling relating to the McCloud case.

The government subsequently announced in July 2020 that the pause had been lifted, and so the cost control element of the 2016 valuations could be completed. The government said that the costs of remedying the discrimination will be included in this process. HMT valuation directions will set out the detail of how the costs of remedy will be included in the valuation process. The Government Actuary has reviewed the cost control mechanism (this was originally announced in 2018). The review assessed whether the cost control mechanism is working in line with original government objectives and reported to government in April 2021. The findings of this review will not impact the 2016 valuations. The objective is for any changes to the cost-cap mechanism to be made in time for the completion of the 2020 actuarial valuations.

National Employment Savings Trust

Employees who do not wish to join the NHS Pension Scheme can opt to join the National Employment Savings Trust (NEST) scheme. This is a stakeholder pension scheme based on defined contributions. The minimum combined contribution is currently 8% of qualifying earnings, of which the employer must pay 3%. Employees can choose to pay more into the fund, subject to a current cap of £4,700 per annum. There were 11 NHS Digital employees who were members of the NEST scheme during 2020-21.

The Principal Civil Service Pension Scheme

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

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

For 2020-21, employer's contributions of £409,319 were payable to the PCSPS (2019-20: £498,510) at 1 of 4 rates in the range 26.6% to 30.3% of pensionable earnings, based on salary bands. The scheme actuary reviews employer contributions, usually every 4 years following a full scheme valuation. The contribution rates are set to meet the cost of the benefits accruing during 2020-21 to be paid when the member retires and not the benefits paid during this period to existing pensioners.

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

Off-payroll engagements

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

For all off-payroll engagements as of 31 March 2021, for more than £245 per day:	Number
Number of existing engagements as of 31 March 2021	261
Of which, the number that have existed:	
for less than 1 year at the time of reporting	185
for between 1 and 2 years at the time of reporting	54
for between 2 and 3 years at the time of reporting	9
for between 3 and 4 years at the time of reporting	8
for 4 or more years at the time of reporting	5

For all off-payroll engagements between 1 April 2020 and 31 March 2021, for more than £245 per day:	Number
Number of off-payroll workers engaged between 1 April 2020 and 31 March 2021	391
Of which, the number:	
not subject to off-payroll legislation	-
subject to off-payroll legislation and determined as in-scope of IR35	391
subject to off-payroll legislation and determined as out of scope of IR35	-

Number of engagements reassessed for compliance or assurance purposes during the year	3
Of which, the number of engagements that saw a change to IR35 status following the review	3

Off-payroll engagements of Board members or senior officials with significant financial responsibility between 1 April 2020 and 31 March 2021

	Number
Number of off-payroll engagements of Board member or senior officials with significant financial responsibility during the financial year	4
Total number of individuals on-payroll and off-payroll that have been deemed 'board members and/or senior officials with significant financial responsibility' during the financial year	13

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

The total cost of temporary labour increased in the year to £47.7 million, compared with £23.1 million in 2019-20, as we brought in significant specialist resources to address the urgent development and delivery of critical programmes relating to COVID-19, while still progressing with projects that were already underway as part of our digital transformation programme.

Diversity, equality and inclusion

We aim to create and maintain a diverse and representative workforce at NHS Digital. Equality, diversity and inclusion are strategic priorities and have executive director-level accountability across the organisation.

We are striving to create a working environment that values difference and fosters an inclusive workplace culture. We want to build a culture in which employees from all backgrounds can give their best, are treated fairly, are valued for their contributions, and can progress in their careers. We regularly review our people-management policies to reflect changes and help all colleagues develop. We make sure that policies are inclusive for people with different protected equality characteristics, and we consult widely, including with the unions and the equality and diversity networks.

The gender distribution in NHS Digital for each Agenda for Change (AfC) equivalent grade, as at 31 March, was*:

		2020-21		Restated 2019-20	
AfC equivalent grades		**Male**	**Female**	**Male**	**Female**
Directors		8.6	3.0	7.0	3.0
Senior managers	9	59.4	23.2	59.8	19.9
	8d	79.7	45.5	82.7	37.4
Managers	8c	181.2	115.0	185.3	111.2
	8b	304.8	157.7	299.9	156.7
	8a	383.6	261.2	357.1	230.6
Other staff	7	351.4	258.0	273.3	250.3
	6	172.0	153.9	136.0	171.9
	5	148.8	176.9	159.7	165.2
	4	127.1	164.2	90.2	104.1
	3	7.0	1.0	6.0	-
	2	0.5	-	2.0	4.5
	Net secondees	-	-	6.3	1.0
Total (full-time equivalent)		**1,824.1**	**1,359.6**	**1,665.3**	**1,255.8**

*Some people do not identify as either male or female. Given the small number of people in this group, splitting them out in the table would not provide a robust basis for comparison with the larger groups. This information has therefore not been included. We are not seeking to invalidate these people's gender identity by not including the data.

The figures in the above table are as at 31 March. The figures reported in the 2019-20 Annual Report and Accounts were averaged over the year and have been restated as at 31 March.

There has been no change in the gender or grade split of our workforce in the year. 57% of staff are male (2019-20: 57%).

Our most recent Annual Inclusion Report described the make-up of our organisation at 31 March 2020. It reported that 38.0% of people joining NHS Digital were women and that 46.5% of internal promotions were earned by women.

Our gender pay gap for the reporting period to 31 March 2021 was:

Mean gender pay (hourly rate)	2021	Restated 2020
Women	£28.08	£26.83
Men	£33.83	£32.26
Gap between the mean salaries of women and men	**17.0%**	**16.8%**

Median gender pay (hourly rate)	2021	Restated 2020
Women	£26.49	£24.51
Men	£30.75	£28.85
Gap between the median salaries of women and men	**13.9%**	**15.1%**

NHS Digital has a significant gender pay gap among full-time staff. This is slightly below the public sector median of 15.5% (based on Office for National Statistics provisional data for November 2020).

The main factor contributing to this pay gap is men occupying more senior pay bands than women. Men are also more likely to receive the recruitment and retention premiums attached to certain roles and premiums for on-call work.

About 13.4% of our on-payroll employees in March 2021 said they were from Black, Asian and minority ethnic (BAME) backgrounds, broadly the same as in 2019-20 (12.7%). 39.3% of our job applicants were from BAME backgrounds, compared to 38% the previous year, and 9.8% of new hires were BAME candidates (2019-20: 25%). 27% of new hires during 2020-21 have chosen not to share information about their ethnicity. People from BAME backgrounds make up about 12.3% of the UK's working population.

The percentage of on-payroll employees declaring a disability was 5.1%, marginally lower than last year's figure of 5.2%. About 18% of the UK's working-age population and 9.2% of people in employment have a disability.

About 4.0% of our on-payroll employees describe their sexual orientation as LGBT+ while 70.9% say they are heterosexual. 25.1% of staff chose not to share this information.

43.2% of our on-payroll employees are aged between 46 and 65. This proportion has grown slightly since our first report in 2016 and there has been a decrease in the number of staff aged 26-35.

About 31% of our on-payroll employees have not shared details about their religious beliefs but, from the information available, there has been little change in the composition of our workforce on this measure in recent years. About 34% are Christian, 14% follow other religions, and 21% describe themselves as being atheist.

The 2019-20 Annual Inclusion Report report is available at: digital.nhs.uk/about-nhs-digital/corporate-information-and-documents/how-we-support-diversity-and-inclusion. It includes details of our gender pay gap for that period. Our 2020-21 report is scheduled for publication in spring 2022.

The Black Lives Matter movement led to our BAME colleagues challenging us on the racism they have been facing and raised many race and inequality issues. We tried to ensure that these voices were heard by the whole organisation. We are working closely with our EMBRACE staff network to develop our understanding and improve our personal and organisational defences against racial bias, and also encouraging and supporting greater diversity and inclusion. Although some of our work will take time, we continue on a journey with our staff networks to create an inclusive culture for all.

Trade union facility time

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

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

Union officials	
Number of employees who were recognised union officials during 2020-21	18
Full-time equivalent (FTE) employee number	2,480

Percentage of time spent on facility time:	Number of employees
0%	-
1% - 50%	18
51% - 99%	-
100%	-

Percentage of pay bill spent on facility time	
Total cost of facility time	£53,593
Total pay bill (excluding termination costs)	£171,670,000
Percentage of the total pay bill spent on facility time	0.03%

Paid trade union activities	
Time spent on paid trade union activities as a percentage of total paid facility time hours	3.6%

Consultancy

The total spend on consultancy, as defined by HM Treasury guidance, was £926,724.

Sickness absence

During 2020, 10,843 (2019: 13,512) working days were lost due to sickness absence. This represented 4.3 (2019: 5.0) working days per employee. These figures are based on calendar years, not financial years, and were centrally produced from the Electronic Staff Record. Average sickness absence for 2020 was 1.9% (2019: 2.2%).

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

Community and social responsibility

We have a special leave policy that allows staff to take paid leave for public duties (for example, magistrate, school governor, and reserve forces roles). We extended these provisions to support colleagues with caring responsibilities during the pandemic, while also increasing and extending flexible working arrangements. We have developed work experience and placement programmes for schools, colleges and universities near our offices.

Health, safety and wellbeing

In response to COVID-19, we continue to follow government guidance and regularly risk-assess and audit our buildings to ensure we are providing a safe working environment for staff unable to work from home. COVID-19-secure measures are in place and include capacity management via a desk-booking system, a programme of enhanced cleaning, social distancing, and the provision of personal protective products such as face coverings and sanitisers. We have put robust working-from-home arrangements in place. These include wellbeing support, guidance on how to work safely from home, advice on setting up a workstation and the provision of necessary equipment.

The Health and Safety Policy has been reviewed and will now be supported by an online staff Health and Safety Handbook and leadership pledge. The Steering Group Committee continues to be proactive, with leadership from the Chair and Chief Financial Officer, and collaboration from our trade union colleagues and managers. In 2021-22, we will focus on greater equality in our safety provision, the creation of directorate risk assessments, building and office health and safety, improved training and the management of occupational stress.

Salaries and pensions of senior management

The remuneration and pension disclosures relating to board members and the core Executive Management Team in post during 2020-21 and 2019-20 are detailed in the tables below and are subject to audit. The figures provided consist of basic pay, performance pay, pension benefits and benefits in kind. They do not include employer pension contributions or the cash equivalent transfer value of pensions.

		Appointment date	Until date	Salary (bands of £5,000)
Board directors				
Sarah Wilkinson	Chief Executive Officer			195-200
Pete Rose[1]	Deputy Chief Executive Officer	04-May-20		155-160
Carl Vincent	Chief Financial Officer			140-145
Jonathan Benger[2]	Chief Medical Officer	18-Nov-19		105-110
Amir Mehrkar[3]	Senior Clinical Lead	01-Apr-19	30-Sep-19	-
Robert Shaw	Deputy Chief Executive and Senior Information Risk Owner		31-Dec-19	-
Senior managers				
Ben Davison[4]	Executive Director, Product Development	20-Jan-20		260-265
Thomas Denwood	Executive Director, Data Services		18-Oct-20	70-75
Nic Fox	Chief Commercial Officer	15-Nov-19		130-135
Jackie Gray	Executive Director, Privacy, Transparency and Ethics			150-155
James Hawkins	Director, Assurance and Risk Management	01-Dec-19		125-130
Julie Pinder	Chief People Officer			125-130
Jeremy Rashbass	Executive Director, Data Services	01-Nov-19		180-185
Mark Reynolds[5]	Chief Technology Officer	26-Oct-20		90-95
Stephen Koch[6]	Director, Head of Platforms	18-Jan-21		45-50
Wendy Clark	Executive Director, Product Development		29-Nov-19	-
Michael Kay[7]	Chief Commercial Officer		15-Nov-19	-
Mark Stock[8]	Executive Director, Assurance and Risk Management		28-Nov-19	-

[1] Following the end of the reporting year, Peter Rose died on 1 August 2021.
[2] Jonathan Benger is seconded from University Hospitals Bristol NHS Foundation Trust. The costs relate to charges net of employer national insurance and pension charges.
[3] Amir Mehrkar left NHS Digital in December 2019 as part of the Org2 restructure and received a termination payment of £75,625.
[4] Ben Davison is a workpackage contractor, with his costs representing the day rate charged less non-recoverable VAT.
[5] Mark Reynolds is a contractor, and his salary was calculated based on the day rate he received from the recruitment agency less non-recoverable VAT.
[6.] Stephen Koch is a contractor, and his salary was calculated based on the day rate he received from the recruitment agency less non-recoverable VAT.
[7] Michael Kay was a contractor, and his salary was calculated based on the day rate he received from the recruitment agency less non-recoverable VAT.
[8] Mark Stock was seconded from PwC with the costs being that charged less non-recoverable VAT.

2020-21				2019-20				
Performance pay (bands of £5,000)	*Pension benefits (bands of £2,500)	Total (bands of £5,000)	Full-year equivalent salary (bands of £5,000)	Salary (bands of £5,000)	Performance pay (bands of £5,000)	Pension benefits (bands of £2,500)	Total (bands of £5,000)	Full-year equivalent salary (bands of £5,000)
5-10	45-47.5	250-255	195-200	190-195	5-10	45-47.5	245-250	190-195
-	35-37.5	190-195	170-175	-	-	-	-	-
-	35-37.5	175-180	140-145	135-140	5-10	32.5-35	180-185	135-140
-	60-62.5	165-170	195-200	40-45	-	22.5-25	65-70	105-110
-	-	-	-	45-50	-	10-12.5	55-60	90-95
-	-	-	-	135-140	5-10	25-27.5	170-175	165-170
-	-	260-265	260-265	50-55	-	-	50-55	215-220
-	12.5-15	85-90	130-135	130-135	5-10	27.5-30	165-170	130-135
5-10	72.5-75	215-220	130-135	45-50	-	22.5-25	70-75	125-130
5-10	32.5-35	195-200	150-155	145-150	-	32.5-35	180-185	145-150
-	37.5-40	165-170	125-130	40-45	5-10	7.5-10	55-60	125-130
-	27.5-30	155-160	125-130	125-130	0-5	27.5-30	155-160	125-130
0-5	-	185-190	180-185	75-80	-	57.5-60	130-135	180-185
-	-	90-95	210-215	-	-	-	-	-
-	-	45-50	200-205	-	-	-	-	-
-	-	-	-	95-100	-	20-22.5	115-120	145-150
-	-	-	-	140-145	-	-	140-145	215-220
-	-	-	-	80-85	-	-	80-85	105-110

There were no benefits in kind in 2020-21. The above remuneration for executive officers includes those who are NHS Digital Board members and who attend the core Executive Management Team. Following the year end date, Jeremy Rashbass, Executive Director, Data Services, announced that he would retire in the summer of 2021.

* All benefits in year from participating in pension schemes but excluding employee contributions. These are the aggregate amounts, calculated using the method set out in Section 229 of the Finance Act 2004 (i) and using the indices directed by the Department of Health and Social Care. See: www.nhsbsa.nhs.uk/disclosure-senior-managers-remuneration-greenbury-2021

Non-executive director remuneration

				2020-21			2019-20		
		Appointment date	Until date	Salary (bands of £5,000)	Total emoluments (bands of £5,000)	Full-year equivalent salary (bands of £5,000)	Salary (bands of £5,000)	Total emoluments (bands of £5,000)	Full-year equivalent salary (bands of £5,000)
Non-executive directors									
Laura Wade-Gery	Chair	1-Sep-20		35-40	35-40	60-65	-	-	-
Noel Gordon	Chair		31-Aug-20	25-30	25-30	60-65	60-65	60-65	60-65
Daniel Benton	Non-executive director			5-10	5-10	5-10	5-10	5-10	5-10
Marko Balabanovic	Non-executive director			5-10	5-10	5-10	5-10	5-10	5-10
Soraya Dhillon	Non-executive director			5-10	5-10	5-10	5-10	5-10	5-10
Sudhesh Kumar	Non-executive director			5-10	5-10	5-10	5-10	5-10	5-10
John Noble	Non-executive director			10-15	10-15	10-15	10-15	10-15	10-15
Deborah Oakley	Non-executive director			10-15	10-15	10-15	10-15	10-15	10-15
Balram Veliath	Non-executive director			5-10	5-10	5-10	5-10	5-10	5-10
Rob Tinlin	Non-executive director		31-Dec-20	5-10	5-10	5-10	5-10	5-10	5-10

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

The emoluments of the Chair and the non-executive directors do not include employer National Insurance contributions.

The total included in note 5 of the accounts does include such contributions.

Remuneration policy

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

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

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

Pension benefits

Pension benefits were provided through the NHS Pension Scheme.

	Accrued benefits				Cash equivalent transfer values (CETV)		
	Real increase in pension (bands of £2,500)	Real increase in pension lump sum (bands of £2,500)	Total accrued pension at 31 March 2021 (bands of £5,000)	Lump sum related to accrued pension at 31 March 2021 (bands of £5,000)	CETV at 31 March 2021 (£000)	CETV at 31 March 2020 (£000)	Real increase in CETV (£000)
Sarah Wilkinson[1]	2.5-5	-	10-15	-	168	117	20
Pete Rose[1]	2.5-5	-	0-5	-	39	-	16
Carl Vincent[1]	2.5-5	-	15-20	-	209	164	21
Jonathan Benger	2.5-5	2.5-5	75-80	175-180	1,568	1,411	64
Thomas Denwood	0-2.5	(0-2.5)	30-35	45-50	454	415	7
Nic Fox	2.5-5	5-7.5	30-35	60-65	514	436	50
Jackie Gray[1]	2.5-5	-	5-10	-	74	39	13
James Hawkins	2.5-5	0-2.5	30-35	45-50	498	443	29
Julie Pinder[1]	0-2.5	-	5-10	-	69	38	11
Jeremy Rashbass[2]	-	-	65-70	200-205	1,655	1,762	-

[1] No lump sum is disclosed as there is no set minimum lump sum within the 2008 or 2015 sections of the NHS Pension Scheme.

[2] Jeremy Rashbass had no real change in his pension during the reporting year as neither he nor NHS Digital contributed into his pension scheme during 2020-21. Since the end of the reporting year, he reached pensionable age in summer of 2021. The combination of these circumstances led to a small final CETV downwards revaluation at the year end.

A CETV is the actuarially assessed capitalised value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member's accrued benefits and any contingent spouse's pension payable from the scheme. A CETV is a payment made by a pension scheme or arrangement to secure pension benefits in another pension scheme or arrangement when the member leaves a scheme and chooses to transfer the benefits accrued in their former pension scheme.

The pension figures shown relate to the benefits that the individual has accrued as a consequence of their total membership of the pension scheme, not just their service in a senior capacity to which disclosure applies.

The CETV figure and other pension details include the value of any pension benefit in another scheme or arrangement that the individual transferred to the NHS Pension Scheme. They also include any additional pension benefit accrued to the member as a result of them purchasing additional years of pension service in the scheme at their own cost. CETVs are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries.

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

Remuneration of highest paid director compared with the workforce median

The relationship between the remuneration of the highest paid director and the median remuneration of the workforce is subject to audit and is as follows:

	Band of highest paid director's total remuneration £000	Band of lowest paid employee £000	Median pay of the workforce £	Ratio to the median of the workforce
2020-21 excluding pension contributions	260-265	10-15	45,753	5.7
2019-20 excluding pension contributions	215-220	15-20	44,606	4.9

Figures in the above table are as at 31 March each year, and include both permanent and non-permanent staff. The disclosures above are based on employees' salaries and do not take into account any bonuses or other allowances.

Remuneration for non-permanent staff on PAYE contracts has been calculated using the agency day rate less a deemed employer national insurance and pension contribution, annualised based on 261 working days. Remuneration for non-permanent staff on non-PAYE contracts has been calculated using the agency day rate annualised based on 219 working days.

The increase in the median pay reflects the 2020-21 average NHS Agenda for Change pay award. The highest paid director was a workpackage contractor, and the annual remuneration reflects the number of days worked during the year at the applicable rate which has contributed to the increase in ratio from 2019-20 to 2020-21.

The figures in the table above for 2019-20 highest paid director, range of staff pay and ratio to median of the workforce, have been restated to correct the highest paid director.

Annual governance statement

NHS Digital is accountable directly to Parliament for the delivery of the statutory functions described within the Health and Social Care Act 2012 and the Care Act 2014. For more information about our responsibilities and areas of work, see page 8 and our Performance Report (pages 9 to 35).

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

Governance framework

Details of our constitution, our operational accountability, our Board and its appointed committees are provided in the Corporate Governance Report on pages 43 to 51. Information about the conduct of the Board and the roles and responsibilities of members are set out in our Corporate Governance Manual, which incorporates the Standing Orders, Standing Financial Instructions, Scheme of Delegation, Financial Delegations and Committee Terms of Reference. The Corporate Governance Manual is reviewed and updated annually. We comply with the best practice described in the corporate governance code for central government departments issued by HM Treasury. Corporate policies are regularly reviewed and, where it is appropriate to do so, compliance and awareness levels are monitored.

Governance and assurance across the health and social care sector

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

We are the main informatics delivery organisation and contribute to, and are held operationally accountable by, the Delivery Oversight and Assurance Board (DOAB). Our Chief Executive and Chief Financial Officer are members of the DOAB and our Deputy Chief Executive and Director of Assurance and Risk Management attend. A significant number of our Executive Management Team (EMT) and senior managers are involved in the development of future plans.

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

Risk and assurance framework

We have reviewed our corporate risk management framework and methodology during 2020-21 to improve risk data quality and risk management behaviours. Key actions during the year were:

- refreshing our risk-management policy
- redefining our strategic risks and risk-appetite model
- redefining the significant operational risks and issues
- reviewing our short- and long-term risk environment, and evaluating our overall level of risk relative to our risk appetite
- updating our risk-management training approach and supporting materials, including introducing risk master-classes for senior leaders
- implementing directorate level and other operational risk dashboards to improve the quality, reliability and accessibility of risk information
- progressing actions arising from the internal audit on risk management

Risks and assurance items are reported regularly and escalated through our internal governance structure. The significant operational risks and issues and details of mitigation plans are reviewed monthly by the EMT, reported to the Audit and Risk Committee (ARC) as well as to the Board.

During 2020-21, we started the redevelopment of our assurance framework. This has allowed us to strengthen the view of our key controls and existing sources of assurance on key processes.

As part of the COVID-19 response, we accepted certain additional risks because of the operational necessities of the crisis, including risks relating to the management of funding and the transfer of the National Coronavirus Testing System, which we inherited from the Department of Health and Social Care. We inherited the suppliers and their associated commercial arrangements when we took over the testing programme. The Chief Executive's Review of Effectiveness (see pages 76 to 79) discusses these risks and their management.

Performance management

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

This performance reporting covers:

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

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

Internal audit and other third-party assurance

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

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

During 2020-21, our internal audit plan included 12 internal audits and 2 advisory reviews (a 'COVID-19 Record Keeping and Stakeholder Feedback' review and a 'Key Controls' review). The COVID-19 advisory review concluded that NHS Digital established a clear and proportionate governance framework for its COVID-19 response, supported by an appropriate range of products and systems. The key controls advisory review supported the development of our assurance framework and found there was good engagement with the directorates in the design and build of this framework. We are sample-testing the adequacy of controls in 2021-22.

3 internal audits produced a 'substantial' assurance rating, 8 produced a 'moderate' assurance rating, and 1 produced a 'limited' rating. The 'limited' audit is outlined below. The Head of Internal Audit gave an overall assurance rating of 'moderate' and noted that there had been no relaxing of controls during the crisis. In addition to these audits, a detailed follow-up review on our payroll arrangements was also completed to ensure that substantial control concerns identified in 2019-20 had been addressed. The follow-up concluded that significant progress had been made on reviewing and implementing key controls to ensure a robust and sustainable process.

The internal audit of our corporate performance reporting produced a 'limited' assurance rating. A key factor was a delayed mandate letter from NHSX, which has since been received. Recommendations included: progressing a corporate strategy, business plan and a set of corresponding key performance indicators to underpin our corporate objectives. Work is underway to develop our performance reporting infrastructure, increase data automation and improve the visual presentation of our performance reports.

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

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

  The report for financial services was qualified due to a human error in a verification process, which was addressed with additional training. A further control in the process is being considered. No loss was incurred.

  The report for payroll services was qualified due to several minor incidents. Reasons for areas receiving a qualified rating included failing to provide evidence that control checks had taken place or checks being made after the event. The transactions were subsequently verified as being correct or within variance tolerances at the time. These issues arose against a backdrop of staff redeployment to less familiar areas to address staff shortages during the COVID-19 pandemic response.

- We provide annual assurance on our GP Payments system to our stakeholders. The ISAE 3000 gave a qualified assurance due to minor instances where 4 leavers did not have their access removed in a timely manner. This has since been actioned and access has been removed for the leavers.

- Independent testing of the accuracy and appropriateness of the Global Sum (GSUM) algorithm for GP payment processes. While a formal opinion was not required, results were positive, showing the NHS Digital GSUM algorithm performs in line with the original specification, with some minor, justifiable exceptions.

- The National Cyber Security Centre completed a review of the Cyber Security Operations Centre (CSOC). The review focussed on the scope, capabilities, and resources of the CSOC. Recommendations included closer working with NHSX to determine security monitoring responsibilities between CSOC and local NHS operations and increasing the number of analysts. All the recommended actions have since been completed with continued closer collaboration with NHSX.

External audit

We have worked closely with the National Audit Office, which attends and contributes to all ARC meetings. The external audit work sits outside of our normal governance arrangements but informs the development of our governance and risk processes as well as our financial and other controls. The work of external audit is monitored by the ARC through regular progress reports. During 2020-21, we engaged early with the National Audit Office on key issues, particularly in relation to the accounting treatment of major new systems delivered in response to COVID-19.

During the year end audit, the NAO reviewed the Fees and Charges disclosure (which can be found on page 83) in detail, and in particular the basis for providing data for healthcare planning without charge to other NHS bodies and local authorities. As these datasets are for a specific purpose they are different to those provided in response to other requests, although they are provided through the same data access request process. We are funded to provide this data and inherited the original basis for our charging arrangements from a predecessor organisation, but we have agreed with the NAO that we will review which data specifically falls within scope of Fees and Charges, and agree the basis for charging (or not charging), with the Department for Health and Social Care and HM Treasury.

Preventing fraud, bribery and corruption

Public bodies and the NHS continue to be major targets for fraud by a range of actors, and this has been exacerbated by the COVID-19 pandemic. In order to mitigate the risk to NHS Digital we have the following control measures in place:

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

Whistleblowing

We were among the first 100 organisations to sign up to Protect's 'Whistleblowing Commission Code of Practice'. We have continued to improve our policy with Protect's support and are delivering awareness training to staff. We encourage staff to openly raise concerns through a number of channels, with a nominated officer at board level to oversee whistleblowing arrangements.

There were no open whistleblowing cases at the beginning of 2020-21 and only 1 referral in-year, which was subsequently resolved.

However, we recognise that our whistleblowing needs further strengthening, so we are updating our whistleblowing policy, improving training and guidance, strengthening the governance arrangements and enhancing the processes.

Impact of COVID-19

We established specific governance for our initiatives early in the response, consisting of a Gold-Silver-Bronze command structure supported by a COVID-19 Programme Management Office (PMO), and this additional level of oversight has been maintained. This has allowed NHS Digital to deliver on critical commitments in areas including testing, vaccinations and the Shielded Patient List.

We have strengthened our risk identification and risk reporting to help mitigate the varied impact of COVID-19 on the organisation's risk situation. The Government Internal Audit Agency (GIAA) reviewed our COVID-19 control framework, focusing on information governance, financial controls, commercial controls and the COVID-19 Programme Management Office, and confirmed that it remained robust throughout the pandemic response. In addition to assuring delivery on our COVID-19 commitments, we also worked to ensure that colleagues got help with working safely and effectively during the pandemic. This included support on working safely and effectively from home, a focus on wellbeing (including wellbeing check-ins and additional support for people having issues), easements of some HR policies, and work to ensure our offices were 'COVID-19-secure' and available for those that needed them. These initiatives were delivered through the Organisational Wellbeing workstream, which is jointly led by the Chief Commercial Officer and Chief People Officer.

Data and cyber security

Cyber security is an operational, patient care and patient safety issue. From the beginning of the pandemic, digital and data technologies have played an important role in understanding the virus and its impact, protecting members of the public and helping clinical staff. To support the COVID-19 response, our Data Security Centre, working in partnership with NHSX and the National Cyber Security Centre, rapidly increased protection against cyber threats for health and care organisations through the delivery of focused additional support. This included technical remediation in which the most vulnerable trusts were offered a range of security services, such as vulnerability scanning, immediate fixes for major cyber security flaws and additional integration of data and threat feeds into the national Cyber Security Operations Centre to counter increased ransomware and COVID-19 phishing efforts. Alongside our system-wide responsibility and growing range of managed cyber security services, we provide protective monitoring, consultancy and assurance for our critical national infrastructure services and have strengthened our internal security approach and culture to support this.

The risks to the health and social care system from cyber attacks are growing, and will increase significantly with the adoption of new technologies and services. We will continue to provide guidance, assessments and support to help organisations manage risk effectively and to prepare properly.

Data governance

A wide-ranging legal, regulatory and compliance framework governs our receipt, processing and dissemination of data and information and our production of statistics.

We are responsible for ensuring that all NHS data and information is collected, stored and disseminated appropriately and continue to improve controls and protocols through the Data Access Request Service (DARS) in consultation with the Independent Group Advising on the Release of Data (IGARD).

We have ensured that requests for General Practice Extraction Service (GPES) data for pandemic planning and research have received an additional layer of clinical scrutiny. All applications are reviewed by the British Medical Association and the Royal College of General Practitioners, and a GP representative is part of the IGARD panel that looks at these applications.

By centralising all data requests and disseminations through DARS and by introducing new tools and services, we were able to increase efficiency and improve the quality of service for external users. We also provided system-wide advice on operational information governance to the health and social care sectors in England.

DARS handles all requests for personal data that is identifiable or potentially identifiable. Before any data is shared, we ensure that:

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

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

We ensure that the governance around the dissemination of such data is of the highest priority. This includes undertaking data-sharing audits to ensure that organisations meet the terms of their data-sharing agreement and framework contract. During 2020-21, we conducted audits of 8 organisations and recorded observations about their processes, procedures and non-conformities with NHS Digital requirements. The outcome of audits and post-audit reviews are published on our website (digital.nhs.uk/services/data-access-request-service-dars).

Privacy, transparency and ethics

During 2020-21 the Privacy, Transparency and Ethics (PTE) team undertook a large amount of work to support the COVID-19 pandemic response, providing privacy by design, data protection and confidentiality advice to the many COVID-19 programme workstreams. This includes advice to enable a range of new citizen services, complex data flows, and advising the DARS and DigiTrials Service on research and clinical trials data-sharing requests to support COVID-19 scientific and clinical research, including the national core studies. For more information, see pages 32 to 35.

The PTE team worked with the Department of Health and Social Care and NHS England in March 2020 to produce new framework legal directions under the Health and Social Care Act 2012 (2012 Act). These have enabled us to respond rapidly to commissioner requests to collect, analyse, publish and share data for a range of COVID-19 purposes, and to design, develop and operate new systems and services to support the COVID-19 response. In April 2020, framework requests under Section 255 of the 2012 Act were put in place with the devolved nations, enabling the provision of COVID-19 testing services and sharing of test result data across borders.

NHS Digital also worked with the Department of Health and Social Care to draft the first notice issued under Regulation 3(4) of the NHS (Control of Patient Information Regulations) 2002 (COPI) to NHS Digital, which provided additional powers for us to share data for COVID-19 purposes.

To support the new COVID-19 directions and requests, the PTE team established a COVID-19 fast-track approvals process, providing oversight and assurance of data collections, analysis and sharing of data outside the DARS process. This involved PTE, our Data Services directorate, the Caldicott Guardian and the Senior Information Risk Officer. The details of all data releases made through this process are published on the NHS Digital data release register webpages.

Given that a range of new systems, services and complex data-sharing arrangements were put in place to support COVID-19, a new COVID-19 privacy notice was published, and additional project and service-specific privacy notices were also published on the COVID-19 Information Governance Hub webpages (digital.nhs.uk/coronavirus/coronavirus-covid-19-response-information-governance-hub). This provides transparency about our COVID-19 work, allowing the public to easily find out how NHS Digital has used and shared patient data as part of the pandemic response.

There were 35 personal data breaches, as defined in the UK General Data Protection Regulation (GDPR), reported to the Data Protection Officer (DPO) in 2020-21, a 10% reduction against the previous financial year. Of these, 10 related to employee data, 24 related to patient data and 1 related to supplier data. There was 1 personal data breach reported to the Information Commissioner's Office (ICO). 7 audits were carried out by the Data Protection Officer as part of the DPO's statutory role in monitoring our compliance with GDPR.

1,731 freedom of information (FOI) requests were received in 2020-21 – a 5% increase on the previous financial year, with 99.9% of responses within the statutory timescales. 11 internal reviews were carried out. 1 complaint was made to the Information Commissioner's Office (ICO), which resulted in a notice in January 2021 that required NHS Digital to provide additional advice and assistance to help a requester narrow down their inquiry. The original refusal of the request on cost grounds was considered appropriate.

In the same period, 900 data subject access requests (DSARs) for access to personal data under GDPR were received, a decrease of 8% against the previous financial year. Of those, 107 required clinical review, as required by GPDR. 99.9% of DSARs were responded to within the statutory timescales. There were 11 internal reviews carried out and no complaints made to the ICO.

Business continuity

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

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

Our staff provide subject matter expertise in line with relevant industry standards and best practice across government.

During 2019-20, NHS Digital completed a comprehensive round of annual exercises of all of its business continuity plans and of its crisis response mechanism. This included simulating a responses to various threats, including a pandemic. Throughout 2020-21, NHS Digital has shown its organisational resilience and its ability to continue to deliver, despite the challenges of the pandemic.

Clinical governance

Our digital programmes and services are vital to the health and care of patients and citizens. This has never been more apparent than during the past year, when digital services have been developed to support the country's response to COVID-19. Our clinicians have been integral to the development and delivery of these services, ensuring they are clinically safe and that all associated clinical risks are understood and managed appropriately. Having an effective clinical governance framework in place is key to this assurance. Throughout the year, we successfully implemented an enhanced framework that incorporates an improved system of learning, professional development and continuous quality improvement in NHS Digital's programmes and services.

At the same time, we completed a clinical workforce transformation that implemented the recommendations of the review of the organisation's clinical function conducted in 2019. This transformation has ensured greater oversight, accountability, flexibility and cohesion in the Clinical Informatics Team.

Chief Executive's review of effectiveness

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

In 2020-21, my predecessor was primarily informed by:

- her attendance at NHS Digital's Audit and Risk Committee, its minutes, papers and annual report to the Board
- the work of the National Audit Office
- the work of internal audit, which has completed an agreed, comprehensive range of assessments. The head of internal audit gave 'moderate' ratings to the overall arrangements for assurance and to the controls reviewed
- monitoring regularly reviewed audit actions
- the assurance framework, which outlines key processes, controls and assurance mechanisms administered by the organisation and is mapped to the 3-lines model. This has been used to drive management action
- clear performance management arrangements for executive directors and senior managers
- the system of internal control provided by the Board, Information Assurance and Cyber Security Committee and Audit and Risk Committee

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

Significant challenges

The past year was dominated by COVID-19. The scale and volume of delivery and the amount of change required to support the health and social care sector during this period was unprecedented. NHS Digital's organisation and staff were impacted and our suppliers also faced serious challenges. We met these challenges, and I am confident that we maintained good standards of governance, assurance and control.

Significant challenges in the year included:

1. **Co-ordinating the COVID-19 response across the organisation:** As new requirements arose rapidly, resources were reprioritised and increased, and existing essential services were maintained. Back-office services such as commercial, finance and human resources worked hard to support these changes. The Gold-Silver-Bronze command structure established in March 2020 was in place throughout the year. It was supported by a dedicated programme management office, had representation from across the organisation and was the key framework for prioritisation, coordination, and ensuring clear communication across functions. Risk identification and reporting were strengthened. An internal audit review of our COVID-19 control framework confirmed that programme management, information governance and commercial and financial controls were robust.
2. **Staff wellbeing:** The wellbeing of staff working from home was a key concern, and we describe the support we put in place on page 61. Staff lost regular in-person contact with colleagues, and the pandemic impacted their personal lives. Meanwhile, we were asking them to deliver new services to challenging timescales. The Organisational Wellbeing workstream was established, with executive-level leadership, to support our staff in this difficult situation.

A range of measures were implemented and updated through the year to provide additional support, including: policy easements, access to resources and advice around mental and physical health, greater flexibility of working patterns to cater for caring responsibilities, and health and safety advice on working from home. We reimbursed staff for certain equipment for use at home and made appropriate equipment available in line with Display Screen Equipment regulations. Our COVID-19-secure offices remained open across the country for those unable to work from home.

3. **Data services:** The pandemic response brought significant additional demands on our data services. We collected data from new sources, supported research to answer national priority COVID-19 research questions and took a leading role in supporting clinical trials for COVID-19 treatments and vaccines. We collected and analysed data from GP systems as part of the pandemic response and we provided data, analysis and dashboards to help build understanding of the prevalence and spread of infection. We also provided public-facing dashboards to inform individual decision-making and keep people informed. We provided assurance on the completeness and quality of vaccination data, including data quality dashboards to identify issues with data flow and the timeliness, accuracy and completeness of data entry.

4. **Live services:** During the year, a significant number of new systems and live services were developed. The functionality of many existing products and services was extended. Much of this work was done under considerable time pressure and some projects were delivered with less assurance than we would consider appropriate in normal times. We were often dealing with complex interdependencies between multiple suppliers and, in some cases, we were taking over projects and systems from other organisations in the middle of the crisis.

   We took ownership of an early version of the live National Coronavirus Testing System from the Department of Health and Social Care (DHSC) in summer 2020. We developed the system to a rapidly changing specification. Enhancements and updates were added as the response to the pandemic evolved. The transfer from the DHSC meant that we inherited the suppliers, the operational management of the system and the commercial arrangements from the department, which added to the necessary operational risks associated with responding to COVID-19. These risks were appropriately mitigated.

   Use of our services increased significantly during the pandemic and services including NHS 111 online, the NHS website, and NHS login experienced historic levels of demand. Forecasting was difficult and there were unexpected spikes in use in response to events throughout the year. Our decision-making balanced the pressing need to respond quickly to this demand and the need to ensure the resilience of services. We continued to carefully monitor service volumes and performance and rapidly enhanced the capabilities of our products and services to meet the needs of users.

5. **Demand and delivery:** At the start of the pandemic, NHS Digital faced a significant number of high-profile and immediate requests to support the health and care response. Requests were made which impacted all aspects of NHS Digital's operations, including increased demand on platforms and services, changes to existing systems, new data collections and disseminations, and new cyber and information governance challenges. We brought in contingent labour and outsourced work to ensure we met these demands. The testing and vaccination programmes were significant in their size and complexity and timescales were very tight.

Throughout the year, we prioritised the delivery requests we faced, redeployed staff and resources to the highest priority areas and onboarded, at short notice, additional capacity where this was required. Strong oversight was provided by our Gold-Silver-Bronze command.

6. **Supplier and contract management:**
The pandemic required swift actions to ensure continuity of service from suppliers, fast responses to emerging requirements and the continued best possible value for money. The context required that some commercial approaches had to adapt, but our controls remained effective in ensuring the best possible outcomes and value given the external environment. Challenges faced, and successfully managed, included:

   - confirming continuity of service with key suppliers and understanding changes required to ways of working due to pandemic restrictions. We identified and assessed suppliers that might be at risk of financial distress or failure due to the pandemic
   - inheriting delivery and commercial arrangements that were established very rapidly in response to the pandemic, such as the National Coronavirus Testing System that was transferred to us from the DHSC. In this case we took action to ensure service continuity, and started the process of planning for a transition to a more sustainable delivery and commercial model
   - working with suppliers to identify capability and capacity to rapidly address emerging requirements, especially the ability to stand up teams with the required skills
   - ensuring that, where service requirements had reduced because of the changing focus of the NHS, capacity and capability were flexibly available to respond when restrictions eased and services resumed
   - providing continued contract performance management despite rapidly changing delivery requirements
   - as delivery responsibilities were clarified across the health sector, ensuring that contracts initiated by other organisations, and subsequently inherited by NHS Digital, were renegotiated and standardised, with longer-term plans formed for full retendering, while ensuring continuity of service

7. **Management of the financial position:**
We had to reappraise funding throughout the year as the COVID-19 response developed. Some costs were particularly hard to forecast. Volume-related costs for text message notifications to members of the public and for matching of lab results to patient records were driven by virus spread, developing government policies and the public's reactions to those policies.

   The very unusual and challenging circumstances affected, in particular, the way the National Coronavirus Testing System was built. The requirements had to be met extremely urgently, and there were very frequent and rapid changes. Despite the fact that the system has proved to be effective and reliable, the exceptional circumstances under which the system was built meant that accounting standards required us to produce a valuation for the balance sheet based on the cost of replacing the asset in an artificial optimal environment as at 31 March 2021. The assumptions used to produce the replacement valuation include perfect hindsight in terms of lessons learned in initially building the asset, and that the value on 31 March 2021 is reduced to reflect the fact that it has been used over the preceding period. To ensure independence we were required to commission an external expert valuation, and using this valuation of a hypothetical replacement, adjusted for the use of the asset up to 31 March 2021, we have impaired the asset by £17.5m.

   We worked closely with finance colleagues at the Department of Health and Social Care and NHSX to ensure adequate funding was available to cover expected requirements and to allow the early return of funding when reduced requirements were identified.

At the beginning of the reporting year, when national lockdown was being implemented, a payment was made to one of our suppliers under a contract variation note under the provisions of the Cabinet Office Procurement Policy Note 02/20 relating to COVID-19. This was an essential intervention needed to maintain the capacity of an existing critical service to ensure that it could return to the pre-pandemic levels required by NHS organisations, at short notice, as they emerged from the first wave of the pandemic.

In March 2020, prior to the national lockdown, we purchased some software licences to be used from April. Implementation was delayed as we focused on the national response to COVID-19. These losses are reported in the 'Losses and Special Payments' note but we do not consider them to be control failings. They were a necessary part our response to COVID-19.

8. **Ensuring that NHS Digital was adequately prepared to manage the impacts of the end of the European Union exit transition period:**
Mitigation actions taken during the year included:

- re-establishing an executive-level lead and supporting working group
- revisiting previous plans, ensuring proposed mitigations remained valid and business continuity plans were up-to-date
- reviewing major contracts and identifying and mitigating any risks relating to the flow of data or service delivery
- closely liaising with the Department of Health and Social Care and its arm's-length bodies

No issues were encountered as the transition period ended on 31 December. Work concluded in this area in summer this year and the decisions came into effect on 28 June 2021 and allow personal data to continue to flow freely from the EU/EEA to the UK.

Significant control issues

There were 3 significant control issues during the year:

Retrospective approval was sought from HM Treasury for the retention of a member of the core Executive Management Team (EMT) on an off-payroll basis beyond the usual 6 months limit. The individual played a pivotal role in leading the delivery of new critical services in response to the pandemic, and their appointment was extended beyond the usual 6 months to ensure delivery continuity and stability at a senior level. Since the end of the financial year the individual has been replaced in this post by an on-payroll employee of NHS Digital. HM Treasury granted retrospective approval for this individual, and additionally for two other senior officials similarly engaged on an off-payroll basis that were in post at the year end and went beyond the usual 6-month limit during the following financial year, with the proviso that there is a lessons-learned exercise, and that the post holders are on-payroll by February 2022. Additionally, funding provided to NHS Digital is to be reduced by £645,000 for 2021-22 as a penalty for not seeking approval from HM Treasury in advance.

The internal audit on corporate performance reporting delivered a "limited" rating. The discussion of this audit on page 70 makes clear that a delayed mandate letter from NHSX was a key factor behind the issues in this area. Other weaknesses identified have been addressed since the audit.

Work on developing a solution using machine learning to support ventilator and intensive care capacity planning during the pandemic stopped after 2 weeks of work by the supplier. Although half of the work undertaken provided learning that could be reused, a loss in respect of the other half resulted, and has been recorded in a note on page 82.

There have been no other control issues.

I accept the observations by both the internal auditors and the National Audit Office, and I believe them to be a fair and accurate view of the organisation. We will continue to ensure rigorous and sound assurance is a priority for NHS Digital in 2021-22.

Statement of Accounting Officer's responsibilities

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

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

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

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

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

Parliamentary accountability and audit report

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

Losses and special payments

Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature, they are items that ideally should not arise. They are, therefore, subject to special control procedures.

During 2020-21 there were 1,266 losses (2019-20: 92), amounting to £1,221,422 (2019-20: £367,832).

There were two losses of more than £300,000 during the year. One loss related to software licences purchased in March 2020, but where implementation was delayed because of the unexpected and rapid change of priorities necessitated by the national response to COVID-19 (see page 79). The other related to a payment made via a contract variation note under the provisions of Cabinet Office Procurement Policy Note 02/20 relating to COVID-19, which was an essential intervention needed to maintain the capacity of an existing critical service to ensure that it could return at short notice to the levels required by NHS organisations as they emerged from the first wave of the pandemic (see page 79).

The large increase in the number of separate losses reflects losses of small items of IT equipment and mobile phones following a detailed and comprehensive stocktake. Other losses included supplier relief payments made under COVID-19 provisions; COVID-19 related development work that did not progress to completion, as noted under 'Significant Control Issues' on page 79; a variance in the value on settlement of IR35 liabilities; cancellation fees for hotels, meeting rooms and train tickets due to COVID-19; and an irrecoverable salary overpayment.

No interest was paid under the Late Payment of Commercial Debts (Interest) Act 1998 (2019-20: nil).

Political and charitable donations

No political donations were made in the year. During the year, 191 Microsoft Surface tablets at the end of their normal useful life were donated to 7 schools and 2 hospitals. The assets had a nil net book value.

Gifts

No gifts were made or received that meet the disclosure requirements. Staff are required to declare gifts in accordance with our Hospitality and Receipt of Gifts Policy.

Remote contingent liabilities

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

Fees and charges

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

Currently no charges are made for data supplied to the NHS or local authorities when the data is required to support the planning and commissioning of healthcare. A charge is made if the data is required for other purposes. The following table shows the income received, less the costs for the full service including the costs of providing data for the planning and commissioning of healthcare. We will be working with the Department of Health and Social Care during 2021-22 to review our charging policy. Figures for 2019-20 have been restated to show the expenditure covered by income, and the expenditure not covered by income.

The fees and charges note below is subject to audit:

	2021 £000	Restated 2020 £000
Income	3,489	2,385
Expenditure	(6,807)	(6,894)
(Deficit) / surplus	**(3,318)**	**(4,509)**

Simon Bolton
Interim Chief Executive
20 January 2022

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

Opinion on financial statements

I certify that I have audited the financial statements of the Health and Social Care Information Centre for the year ended 31 March 2021 under the Health and Social Care Act 2012. The financial statements comprise: Statement of Comprehensive Net Expenditure, Statement of Financial Position, Statement of Cash Flows, Statement of Changes in Taxpayers' Equity; and the related notes, including the significant accounting policies. These financial statements have been prepared under the accounting policies set out within them. The financial reporting framework that has been applied in their preparation is applicable law and the Department of Health and Social Care Group Accounting Manual.

I have also audited the information in the Accountability Report that is described in that report as having been audited.

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 2021 and of the Health and Social Care Information Centre's net expenditure for the year then ended;
- have been properly prepared in accordance with the Health and Social Care Act 2012 and Secretary of State directions issued thereunder.

Opinion on regularity

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

Basis for opinions

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

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

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

Conclusions relating to going concern

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

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

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

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

Other Information

The other information comprises information included in the annual report, but does not include the parts of the Accountability Report described in that report as having been audited, the financial statements and my auditor's certificate thereon. The Accounting Officer is responsible for the other information. My opinion on the financial statements does not cover the other information and except to the extent otherwise explicitly stated in my certificate, I do not express any form of assurance conclusion thereon. In connection with my audit of the financial statements, my responsibility is to read the other information and, in doing so, consider whether the other information is materially inconsistent with the financial statements or my knowledge obtained in the audit or otherwise appears to be materially misstated. If I identify such material inconsistencies or apparent material misstatements, I am required to determine whether this gives rise to a material misstatement in the financial statements themselves. If, based on the work I have performed, I conclude that there is a material misstatement of this other information, I am required to report that fact.

I have nothing to report in this regard.

Opinion on other matters

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

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

Matters on which I report by exception

In the light of the knowledge and understanding of the Health and Social Care Information Centre and its environment obtained in the course of the audit, I have not identified material misstatements in the Performance and Accountability report. I have nothing to report in respect of the following matters which I report to you if, in my opinion:

- 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 parts of the Accountability Report to be audited are not in agreement with the accounting records and returns; or
- certain disclosures of remuneration specified by HM Treasury's Government Financial Reporting Manual are not made; 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.

Responsibilities of the Accounting Officer for the financial statements

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

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

Auditor's responsibilities for the audit of the financial statements

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

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

I design procedures in line with my responsibilities, outlined above, to detect material misstatements in respect of non-compliance with laws and regulation, including fraud.

My procedures included the following:

- Inquiring of management, the audited entity's head of internal audit and those charged with governance, including obtaining and reviewing supporting documentation relating to the Health and Social Care Information Centre's policies and procedures relating to:
  - identifying, evaluating and complying with laws and regulations and whether they were aware of any instances of non-compliance;
  - detecting and responding to the risks of fraud and whether they have knowledge of any actual, suspected or alleged fraud; and
  - the internal controls established to mitigate risks related to fraud or non-compliance with laws and regulations including the Health and Social Care Information Centre's controls relating to the Health and Social Care Act 2012 and Managing Public Money.
- discussing among the engagement team, regarding how and where fraud might occur in the financial statements and any potential indicators of fraud. As part of this discussion, I identified potential for fraud in the following areas: posting of unusual journals.
- obtaining an understanding of the Health and Social Care Information Centre's framework of authority as well as other legal and regulatory frameworks that the Health and Social Care Information Centre operates in, focusing on those laws and regulations that had a direct effect on the financial statements or that had a fundamental effect on the operations of the Health and Social Care Information Centre. The key laws and regulations I considered in this context included the Health and Social Care Act 2012, Managing Public Money, Employment Law and tax Legislation.

In addition to the above, my procedures to respond to identified risks included the following:

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

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

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

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

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

Report

I have no observations to make on these financial statements.

Gareth Davies
Comptroller and Auditor General
24 January 2022

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

2020-21 Accounts

Statement of comprehensive net expenditure for the year ended 31 March 2021

	Note	2020-21 £000	2019-20 £000
Expenditure			
Staff costs	3	206,991	179,841
Termination benefits	3	660	8,359
Operating expenditure	5	296,045	223,988
Depreciation and amortisation	5	70,725	52,355
Net impairments of non-current assets	5	17,447	729
Loss on disposal of non-current assets	5	2,759	1,846
Total expenditure		**594,627**	**467,118**
Less income	4	(45,298)	(43,519)
Net operating expenditure for the financial year		**549,329**	**423,599**
Net expenditure for the financial year		**549,329**	**423,599**
Other comprehensive net expenditure			
Items not included in net operating costs:			
Net loss / (gain) on revaluation of property, plant and equipment	6	68	(1,210)
Net gain on revaluation of intangible assets	7	(5,109)	(8,327)
Net gain on transfers by absorption	7	(5,723)	-
Net loss on assets transferred out as capital grant in kind	6	1,775	-
Comprehensive net expenditure for the year		**540,340**	**414,062**

All income and expenditure derives from continuing operations.

Notes 1 to 21 form part of these financial statements.

Statement of financial position at 31 March 2021

	Note	31 March 2021 £000	31 March 2020 £000
Non-current assets			
Property, plant and equipment	6	33,531	27,304
Intangible assets	7	240,690	188,301
Other non-current receivables	8	6,344	11,296
Total non-current assets		**280,565**	**226,901**
Current assets			
Trade and other receivables	9	47,336	32,676
Cash and cash equivalents	10	22,641	19,837
Total current assets		**69,977**	**52,513**
Total assets		**350,542**	**279,414**
Current liabilities			
Trade and other payables	11	(100,361)	(66,633)
Provisions	12	(1,864)	(91)
Lease incentives	17	(638)	-
Total current liabilities		**(102,863)**	**(66,724)**
Total assets less current liabilities		**247,679**	**212,690**
Non-current liabilities			
Provisions	12	(4,543)	(4,251)
Lease incentives	17	(11,037)	-
Total assets less total liabilities		**232,099**	**208,439**
Taxpayers' equity and other reserves			
General reserve		224,561	201,520
Revaluation reserve		7,538	6,919
Total taxpayers' equity and other reserves		**232,099**	**208,439**

Notes 1 to 21 form part of these financial statements.

The financial statements on pages 90 to 122 were approved by the Board on 19 January 2022 and signed on its behalf by:

Simon Bolton
Interim Chief Executive
20 January 2022

Statement of cash flows for the year ended 31 March 2021

	Note	2020-21 £000	2019-20 £000
Cash flows from operating activities			
Net operating expenditure for the financial year		(549,329)	(423,599)
Adjustment for non-cash transactions:			
- depreciation and amortisation	5	70,725	52,355
- reversals of impairments of property, plant and equipment	5	(85)	(132)
- impairments of intangible assets	5	17,532	861
- loss on disposal of non-current assets	5	2,759	1,846
- provisions arising during the year	12	4,146	677
- provisions reversed unused	12	(735)	(698)
- lease incentive received	17	11,675	-
Decrease / (increase) in non-current receivables	8	4,952	(5,193)
Increase in trade and other receivables	9	(14,660)	(7,580)
Increase in trade and other payables	11	33,728	4,699
Increase in capital accruals		(5,155)	(8,681)
Provisions utilised	12	(1,346)	(846)
Net cash outflow from operating activities		**(425,793)**	**(386,291)**
Cash flows from investing activities			
Purchase of property, plant and equipment		(14,263)	(6,666)
Purchase of intangible assets		(121,140)	(85,410)
Net cash outflow from investing activities		**(135,403)**	**(92,076)**
Cash flows from financing activities			
Grant-in-aid from the Department of Health and Social Care: cash drawn down in year		564,000	477,000
Net financing		**564,000**	**477,000**
Net increase / (decrease) in cash in the period	10	**2,804**	**(1,367)**
Cash and cash equivalents at the beginning of the period	10	19,837	21,204
Cash and cash equivalents at the end of the period	10	22,641	19,837
Net increase / (decrease) in cash in the period	10	**2,804**	**(1,367)**

All cash flows relate to continuing activities.

Statement of changes in taxpayers' equity for the year ended 31 March 2021

	General reserve £000	Revaluation reserve £000	Total reserve £000
Balance at 31 March 2019	**145,501**	**-**	**145,501**
Changes in taxpayers' equity			
Net expenditure for the financial year	(423,599)	-	**(423,599)**
Gain on the revaluation of property, plant and equipment	-	1,210	**1,210**
Gain on the revaluation of intangible assets	-	8,327	**8,327**
Movement between reserves	2,618	(2,618)	**-**
Total recognised income and expense	**(420,981)**	**6,919**	**(414,062)**
Grant-in-aid from the Department of Health and Social Care: cash drawn down in year	477,000	-	**477,000**
Total grant-in-aid funding	**477,000**	**-**	**477,000**
Balance at 31 March 2020	**201,520**	**6,919**	**208,439**

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

Notes to the accounts

Note 1

1.1 General information

The Health and Social Care Information Centre (NHS Digital) is an executive non-departmental government body established under the Health and Social Care Act 2012. Further information about our remit, structure and work can be found on page 8 and in the Performance Report (see pages 9 to 35). The address of our registered office and principal place of business is provided on page 4. We are accountable to the Secretary of State for Health and Social Care for discharging our functions, duties and powers effectively, efficiently and economically. The Department of Health and Social Care undertakes this role on the Secretary of State's behalf on a day-to-day basis.

1.2 Basis of accounting

The financial statements have been prepared in accordance with the 2020-21 Government Financial Reporting Manual (FReM) and amendments to it issued by HM Treasury, as interpreted for the health sector in the Department of Health and Social Care Group Accounting Manual (GAM). The accounting policies contained in the FReM apply International Financial Reporting Standards (IFRS) as adopted and interpreted for the public sector context. Where the FReM permits a choice of accounting policy, the accounting policy that is judged to be most appropriate to the particular circumstances for the purpose of giving a true and fair view has been selected. The particular policies adopted by NHS Digital are described below. They have been applied consistently in dealing with items that are considered material to the accounts.

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

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

No accounting standard changes were adopted early in 2020-21.

The FReM does not require the following standards and interpretations to be applied in 2020-21:

- **IFRS 14 Regulatory Deferral Accounts**
  This applies to first-time adopters of International Financial Reporting Standards after 1 January 2016, and is therefore not applicable to DHSC group bodies.

- **IFRS 16 Leases**
  Implementation for those entities that follow the FReM has been deferred for a further year until 2022-23. NHS Digital currently has total future commitments under operating leases of £81 million, which IFRS 16 would require to be recognised on the statement of financial position as right of use assets with a value of £69 million. This would be the remaining value of the leases less the associated lease incentives, with corresponding lease liabilities. As at 2020-21, NHS Digital has not identified any further right-of-use assets other than those currently held under operating leases.

- **IFRS 17 Insurance Contracts**
  This is effective for accounting periods beginning on or after 1 January 2021, but has not yet adopted by the 2020-21 FReM. The application of IFRS17 would not have a material impact on the accounts for 2020-21, had it been applied in the year.

1.3 Income

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

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

In line with IFRS 15, contract income is not recognised until a signed agreement is in place.

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

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

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

All prices are based on full cost recovery.

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

1.4 Taxation

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

1.5 Transfer of function

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

1.6 Employee benefits

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

1.7 Non-current assets

a. Capitalisation

All assets falling into the following categories are capitalised:

1) Intangible assets include software development expenditure and the purchase of computer software licences, where they are capable of being used for more than 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, have broadly simultaneous purchase dates, are anticipated to have simultaneous disposal dates and are under single managerial control.

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

2) Tangible assets which are capable of being used for more than 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
- an intention to complete the intangible asset and use it
- an ability to use the intangible asset
- how the intangible asset will generate probable future economic benefits
- the availability of adequate technical, financial and other resources to complete the intangible asset and use it
- the ability to measure reliably the expenditure attributable to the intangible asset during its development

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

b. Carrying gross cost

Non-current assets are initially recognised at cost, including expenditure such as installation directly attributable to bringing them into working condition. Subsequently non-current assets are held at current value in existing use. Any increase in value is credited to the revaluation reserve, except to the extent that it reverses a revaluation decrease for the same asset previously recognised as an expense, in 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.

Freehold land and buildings are externally revalued every three years, and are held at this amount until the next revaluation.

Other assets are assessed using appropriate indices provided by the Office for National Statistics, or in the case of internal software developments by considering the inflation rates of staff and other resources and potential efficiency factors, or where the asset is material and non-standard circumstances apply by an external professional valuation. All assets have been revalued in the year, except software licences. Indexation had previously been applied to software licences up to 31 March 2019. Indexation has not been applied to software licences from 1 April 2019 onwards. From this date software licences have been held at depreciated historical cost, on the basis that they are short-life assets and as such depreciated historical cost is considered a suitable proxy for current value in existing use. The carrying values of all assets are reviewed for impairment if events or changes in circumstances indicate the carrying value may not be appropriate.

c. Depreciation

Development expenditure is not depreciated until the asset is available for use. Otherwise, depreciation and amortisation is charged on a straight line basis to write off the costs or valuation of tangible and intangible non-current assets, less any residual value, over their estimated useful lives as follows:

1. Intangible software 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.

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

   - buildings 40 years
   - fixtures and fittings 1 - 14 years
   - office, information technology, short life equipment 1 - 5 years

   The estimated useful lives and residual values are reviewed annually.

d. Depreciated replacement cost

Assets which are held for their service potential and are in use are held at their current value in existing use. For non-specialised assets, this is interpreted as market value in existing use, defined in the Royal Institution of Chartered Surveyors (RICS) Red Book as Existing Use Value (EUV). For specialised assets, this is interpreted as depreciated replacement cost on a modern equivalent asset basis. Where this applies, underlying bodies may perform a valuation based on an alternative site if this is consistent with the body's requirements to serve the local population.

e. Impairment

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

1.8 Research and development

Expenditure incurred on pure and applied research is treated as an operating 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 asset under construction until such time the asset is brought into use.

1.9 Leases

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

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

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

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

1.10 Provisions

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

1.11 Contingent liabilities

In addition to contingent liabilities disclosed in accordance with IAS 37, NHS Digital discloses for parliamentary reporting and accountability purposes certain statutory and non-statutory contingent liabilities where the likelihood of a transfer of economic benefit is remote, but which have been reported to Parliament in accordance with the requirements of the GAM. 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.

1.12 Pensions

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

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

1.13 Critical accounting judgements and key sources of estimation uncertainty

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

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

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

Dilapidations provision
NHS Digital has provided £5.5 million in respect of anticipated dilapidation costs of its leased accommodation across its estate where required. Management has used external property advisors to assess likely liabilities at the end of the leases.

Employment taxes
An estimate of £0.6m for outstanding potential liabilities in respect of IR35 has been included in the year end position. These have yet to be agreed with HM Revenue and Customs.

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

Additionally, a material new national system was developed and implemented during the year as part of the response to the COVID-19 pandemic. This supports the booking of tests, the test process within testing centres, the dissemination of results to individuals, and the provision of data for further analysis and reporting. The system was developed as requirements evolved in response to the pandemic, and the very unusual and challenging circumstances affected the way the National Coronavirus Testing System was built. The requirements had to be met extremely urgently, and there were very frequent and rapid changes. Despite the fact that the system has proved to be effective and reliable, the exceptional circumstances under which the system was built meant that accounting standards required us to produce a valuation for the balance sheet based on the cost of replacing the asset in an artificial optimal environment as at 31 March 2021. The assumptions used to produce the replacement valuation include perfect hindsight in terms of lessons learned in initially building the asset, and that the value on 31 March 2021 is reduced to reflect the fact that it has been used over the preceding period. To ensure independence we were required to commission an external expert valuation. As is common with reports of this nature, the valuation of the system was expressed as being within a range. We assessed this range, using our experience of the software development market, and determined that the higher end of the range best represented the public sector position on both risk and retaining skilled roles within the United Kingdom, with lower levels of offshoring of development work than might be seen in the private sector.

Using the higher end of the range, adjusted for the use of the asset up to 31 March 2021, we estimate that as at 31 March 2021 the value would have been £17.5m lower than the value of the asset held on our balance sheet, and as required by accounting standards, we have impaired the asset by this amount.

1.14 Business and geographical segments

NHS Digital has adopted IFRS 8 Operating Segments. IFRS 8 requires operating segments to be identified on the basis of internal reports about components of the business that are regularly reviewed by the Chief Executive to allocate resources to the segments and to assess their performance.

1.15 Cash and cash equivalents

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

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

1.16 Financial instruments

NHS Digital operates largely in a non-trading environment and the majority of its income is from other government or NHS bodies. Consequently NHS Digital is not exposed to the significant degree of financial risk that is faced by most other business entities. NHS Digital has no borrowings and relies largely on grant-in-aid from the Department of Health and Social Care for its cash requirements. NHS Digital is therefore not exposed to 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 or material currency risks.

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

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

1.17 Going concern

The financial statements have been prepared on a going concern basis. Funding for 2021-22 is in place, and the continuation of the provision of services is demonstrated through the plans agreed with our delivery partners. Although the merger of NHS Digital with NHS England has been announced, our functions will continue, and therefore in accordance with the DHSC Group Accounting Manual the going concern basis for preparing the financial statements remains appropriate.

Note 2

Statement of operating costs by activity

IFRS 8 requires operating segments to be identified on the basis of internal reports that are regularly reviewed by the Chief Executive. The NHS Digital Executive Management Team monitors the performance and resources of the organisation by directorate. The statement of financial position is reported internally as a single segment. Accordingly, no segmental analysis of assets and liabilities is reported. The majority of income is derived from other bodies within the Department of Health and Social Care group, and more than 10% of total income is received from the following customers: NHS England (£17.7 million), Public Health England (£9.4 million) and the Department of Health and Social Care (£4.6 million).

For the year ended 31 March 2021

£000	Assurance and Risk Management	Corporate Services	Data Services
Income	**-**	**(299)**	**(20,328)**
Staff Costs	**2,928**	**18,010**	**36,921**
Professional fees	1,049	3,255	18,554
Information technology	8	1,020	5,742
Accommodation	-	12,771	1
Travel and subsistence	1	63	6
Marketing, training, events and communications	15	1,872	91
Office services	-	1,514	25
Other	-	683	4
Loss on disposal of non-current assets	-	565	1,015
Depreciation and amortisation	402	1,956	9,935
Reversal of impairments of property, plant and equipment	-	-	-
Impairments of intangible assets	-	-	-
Reallocation of central costs	287	(15,700)	7,227
Non-staff costs	**1,762**	**7,999**	**42,600**
Net expenditure	**4,690**	**25,710**	**59,193**

The reallocation of central costs attributes central overheads to programmes and services. The composition of directorates has changed during the year, and the figures for 2019-20 are not directly comparable.

IT Operations	Platforms and Infrastructure	Product Development	Strategy, Policy and Governance	COVID-19 Delivery	Central (not allocated to a segment)	Total
(638)	**(824)**	**(19,182)**	**(914)**	**(2,952)**	**(161)**	**(45,298)**
30,573	**20,219**	**52,337**	**12,777**	**33,881**	**5**	**207,651**
14,786	24,183	11,883	2,340	49,195	(558)	**124,687**
11,273	84,635	13,611	683	31,503	83	**148,558**
1	(43)	2	2	37	1,827	**14,598**
5	7	15	4	218	-	**319**
144	14	48	101	128	(54)	**2,359**
30	146	128	141	79	1	**2,064**
-	100	-	-	2,528	145	**3,460**
-	934	60	26	-	159	**2,759**
7,147	19,542	25,240	828	5,504	171	**70,725**
-	-	-	-	-	(85)	**(85)**
-	-	-	-	17,532	-	**17,532**
3,218	(4,431)	8,183	1,216	-	-	**-**
36,604	**125,087**	**59,170**	**5,341**	**106,724**	**1,689**	**386,976**
66,539	**144,482**	**92,325**	**17,204**	**137,653**	**1,533**	**549,329**

Assurance and Risk Management
Provides independent audit and assurance, ensuring strategic and delivery risks are appropriately managed across the organisation. Also responsible for portfolio and performance management to provide information, intelligence, analysis, insight and standards enabling decision-making and compliance.

Corporate Services
The centre of expertise and management for financial, commercial, and people functions. In addition, we will deliver iterative change to reshape the way we organise ourselves to deliver work, the way we develop our capabilities and our internal operational tooling.

Data Services
As the data custodian for the health and care system, has primary responsibility for driving data quality, linking data across the system and providing reliable statistics and insights. Guided by an absolute respect for data privacy and a commitment to empowering healthcare research and the UK life sciences sector.

IT Operations
Responsible for the reliable, performant and secure operation of all live systems and services that we operate for the health and care system. Provides cyber security, solution assurance and live service support to an increasingly complex, demanding and digitised health and care system.

For the year ended 31 March 2020

£000	Assurance and Risk Management	Corporate Services	Data Services
Income	**(37)**	**(300)**	**(15,354)**
Staff Costs	**3,306**	**21,186**	**38,390**
Professional fees	390	3,054	5,108
Information technology	1	1,179	4,375
Accommodation	15	10,428	31
Travel and subsistence	37	1,144	429
Marketing, training, events and communications	18	3,867	153
Office services	-	1,623	24
Other	-	389	18
Loss on disposal of non-current assets	-	24	177
Depreciation and amortisation	151	2,504	6,409
Reversal of impairments of property, plant and equipment	-	-	-
Impairments of intangible assets	-	-	-
Reallocation of central costs	636	(45,098)	14,449
Non-staff costs	**1,248**	**(20,886)**	**31,173**
Net expenditure	**4,517**	**-**	**54,209**

Platforms and Infrastructure
Provides the core platforms that connect the vast number of digital service providers across the health and care system and delivers an increasing number of platforms to support NHS Digital's data management and product development activities (for example, identity and access management). Provides local and cloud hosting arrangements, workplace collaboration tools as well as the underlying data network arrangements needed to support an increasingly digitised health and care system.

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

Strategy, Policy and Governance
Defines our strategic agenda based on the needs of our clients and evolving political, technical, government and market environments. Liaises with the Department of Health and Social Care, third parties and internal teams to ensure policy and governance coherence and clarity. Provides clinical and information governance, guidance and oversight.

Live Services and Cyber Security	Platforms and Infrastructure	Product Development	Strategy, Policy and Governance	Central (not allocated to a segment)	Total
(623)	**(1,604)**	**(21,439)**	**(915)**	**(3,247)**	**(43,519)**
30,073	**28,872**	**57,674**	**8,696**	**3**	**188,200**
14,391	26,080	11,618	3,431	(299)	**63,773**
43,350	73,047	14,651	129	(648)	**136,084**
51	7	111	88	220	**10,951**
372	379	1,585	191	(2)	**4,135**
1,522	46	221	391	1	**6,219**
22	254	60	199	18	**2,200**
2	3	2	-	212	**626**
-	269	1,376	-	-	**1,846**
2,205	21,219	19,851	18	(2)	**52,355**
-	-	-	-	(132)	**(132)**
-	5	-	-	856	**861**
10,425	(3,637)	21,046	2,179	-	**-**
72,340	**117,672**	**70,521**	**6,626**	**224**	**278,918**
101,790	**144,940**	**106,756**	**14,407**	**(3,020)**	**423,599**

Note 3

Staff costs

	2020-21 £000	2019-20 £000
Permanent staff		
Salaries and wages	131,428	129,541
Social security costs	14,284	14,473
Apprenticeship levy	628	633
Employer superannuation contributions - NHSPS	23,877	24,025
Employer superannuation contributions - other	404	545
Staff seconded to other organisations	1,049	684
Capitalised employed staff costs	(9,011)	(11,951)
	162,659	**157,950**
Other staff		
Temporary staff	13,834	7,688
Contractors	32,872	14,407
Staff seconded from other organisations	1,028	1,063
Capitalised other staff costs	(3,402)	(1,267)
	44,332	**21,891**
Staff Costs	**206,991**	**179,841**
Termination benefits	660	8,359
Total staff costs including termination benefits	**207,651**	**188,200**

There were no amounts spent on staff benefits during the year and there were 7 early retirements on the grounds of ill health.

Note 4

Income

Income analysed by classification and activity is as follows:

	2020-21 £000	2019-20 £000
Contract income		
Programme and project management	4,438	5,727
Service delivery	30,765	33,012
Surveys and data collection	1,208	1,165
Grant income	1,679	-
Fees and charges	3,489	2,385
Total contract income	**41,579**	**42,289**
Non-contract income		
Programme and project management	84	-
Service delivery	209	256
Sale of goods	2,175	-
Non-trading income	1,087	845
Apprenticeship levy utilisation	164	129
Total non-contract income	**3,719**	**1,230**
Total income	**45,298**	**43,519**

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

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

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

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

Grant income received in year related to a digital innovation hub focusing on supporting the improved planning and delivery of clinical trials in the UK, and COVID-19 National Core Study aimed at supporting and accelerating research on COVID-19.

Fees and charges relate to data services and are detailed on page 83.

£1,325,101 of income was included in contract liabilities at 31 March 2020 and £1,126,525 of this has been recognised in 2020-21. The balance relates to future periods.

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

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

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

2019-20	Contract income not yet invoiced £000	Contract income invoiced and deferred £000	Total £000
Not later than 1 year	2,017	1,127	**3,144**
Between 1 and 5 years	588	168	**756**
Later than 5 years	-	30	**30**
	2,605	**1,325**	**3,930**

Note 5

Non-staff expenditure

	2020-21 £000	2019-20 £000
Expenditure		
Work packages and professional fees	118,922	57,598
Data collection and surveys	2,969	4,122
Legal fees	2,373	1,694
Chair's and non-executive directors' emoluments	144	124
Marketing, training and events	1,932	5,744
Travel	319	4,135
Premises and establishment	15,220	10,958
IT maintenance and support	29,953	23,991
IT managed services	118,605	112,093
General office supplies and services	2,168	2,302
Communications	263	346
Insurance	196	189
External audit fees	150	115
Internal audit fees	274	244
Apprenticeship levy training	164	129
Cost of Goods Sold	2,175	-
Reversal of expected credit loss on contract receivables	-	(2)
(Reversal of expected credit loss) / expected credit loss on non-contract receivables	(24)	27
Other	242	179
Operating expenditure	**296,045**	**223,988**
Depreciation of property, plant and equipment	9,385	10,971
Amortisation of intangible assets	61,340	41,384
Reversals of impairments of property, plant and equipment	(85)	(132)
Impairments of intangible assets	17,532	861
Loss on disposal of non-current assets	2,759	1,846
Non-cash transactions	**90,931**	**54,930**
Total non-staff expenditure	**386,976**	**278,918**

Note 6

Non-current assets: property, plant and equipment

2020-21	Land £000	Buildings £000	Assets under construction £000	Computer hardware £000	Fixtures and fittings £000	Total £000
Cost or valuation						
At 1 April 2020	310	2,158	5,857	50,737	12,252	**71,314**
Additions	-	-	10,499	5,730	225	**16,454**
Reclassification	-	-	-	1,679	-	**1,679**
Disposals	-	-	-	(5,670)	(4,789)	**(10,459)**
Transfer out as capital grant in kind	(533)	(1,777)	-	-	(373)	**(2,683)**
Impairments and reversals to other operating expenditure	125	(8)	-	-	(59)	**58**
Revaluation and indexation to revaluation reserve	98	(373)	1	-	112	**(162)**
At 31 March 2021	**-**	**-**	**16,357**	**52,476**	**7,368**	**76,201**
Depreciation						
At 1 April 2020	-	893	-	35,814	7,303	**44,010**
Provided during the year	-	32	-	7,444	1,906	**9,382**
Disposals	-	-	-	(5,469)	(4,224)	**(9,693)**
Transfer out as capital grant in kind	-	(760)	-	-	(148)	**(908)**
Impairments and reversals to other operating expenditure	-	-	-	-	(27)	**(27)**
Revaluation and indexation to revaluation reserve	-	(165)	-	-	71	**(94)**
At 31 March 2021	**-**	**-**	**-**	**37,789**	**4,881**	**42,670**
Net book value at 1 April 2020	310	1,265	5,857	14,923	4,949	27,304
Net book value at 31 March 2021	**-**	**-**	**16,357**	**14,687**	**2,487**	**33,531**

The total depreciation charged in the statement of comprehensive net expenditure in respect of assets held under finance leases and hire purchase contracts was £766,181.

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

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

All tangible assets are owned by NHS Digital, except computer hardware with a net book value of £2,096,817 held under a finance lease. There were no finance lease liabilities outstanding at 31 March 2021.

Movement in the revaluation reserve: property, plant and equipment

	2020-21 £000	2019-20 £000
Balance at 1 April	852	-
Net (loss) / gain on revaluation of property, plant and equipment	(68)	1,210
Transfer to the general reserve	(601)	(358)
Balance at 31 March	**183**	**852**

2019-20	Land £000	Buildings £000	Assets under construction £000	Computer hardware £000	Fixtures and fittings £000	Total £000
Cost or valuation						
At 1 April 2019	310	1,170	-	46,233	10,644	**58,357**
Additions	-	45	5,838	6,036	1,049	**12,968**
Reclassification	-	-	18	(48)	30	**-**
Disposals	-	-	-	(3,739)	(219)	**(3,958)**
Impairments and reversals to other operating expenditure	-	164	-	-	-	**164**
Revaluation and indexation to revaluation reserve	-	779	1	2,255	748	**3,783**
At 31 March 2020	**310**	**2,158**	**5,857**	**50,737**	**12,252**	**71,314**
Depreciation						
At 1 April 2019	-	477	-	29,256	4,523	**34,256**
Provided during the year	-	32	-	8,450	2,489	**10,971**
Disposals	-	-	-	(3,627)	(195)	**(3,822)**
Impairments and reversals to other operating expenditure	-	32	-	-	-	**32**
Revaluation and indexation to revaluation reserve	-	352	-	1,735	486	**2,573**
At 31 March 2020	**-**	**893**	**-**	**35,814**	**7,303**	**44,010**
Net book value at 1 April 2019	310	693	-	16,977	6,121	24,101
Net book value at 31 March 2020	**310**	**1,265**	**5,857**	**14,923**	**4,949**	**27,304**

The total depreciation charged in the statement of comprehensive net expenditure in respect of assets held under finance leases and hire purchase contracts was £236,842.

The gross cost of property, plant and equipment that has been fully depreciated but is still in use is £19,388,635.

The freehold building was independently valued in March 2019 at existing use by the local District Valuation Office, and the difference in valuation has been reflected in 2019-20 above.

All tangible assets are owned by NHS Digital, except computer hardware with a net book value of £3,147,208 (restated) held under a finance lease. There were no finance lease liabilities outstanding at 31 March 2020.

Note 7

Non-current assets: intangible assets

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

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

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

Information technology, development expenditure and websites are internally generated assets, created using a mix of staff and supplier resource. The value of own staff capitalised within intangible assets amounts to £12,413,030.

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

Assets with a value of £7,304,528 were transferred in from the Department of Health and Social Care (DHSC) in July 2020, and assets with a value of £1,581,790 were transferred back to DHSC in September 2020.

Carrying value of material intangible assets

	2020-21		Re-presented 2019-20	
	Gross Book Value £000	Net Book Value £000	Gross Book Value £000	Net Book Value £000
National Coronavirus Testing System	**32,270**	**27,593**	-	-
NHS e-referrals service	**58,546**	**22,704**	52,343	25,381
NHS online	**27,702**	**19,189**	20,250	16,833
Citizen identity	**19,393**	**13,717**	13,961	11,702
Interoperability and architecture	**13,083**	**13,082**	12,186	12,186
Spine 2	**48,898**	**13,012**	42,550	13,195
Data processing service	**20,346**	**12,960**	11,477	7,748
NHS.UK	**15,813**	**8,592**	13,161	9,105
Corporate cloud management software	**10,729**	**6,259**	10,729	9,835

Material intangible assets, ranked by current year net book value. Prior year figures have been re-presented: digital referral service and e-RS live service were presented separately in 2019-20 but have been combined in the above table as NHS e-referrals service, to better reflect that they represented parts of the same system.

Movement in the revaluation reserve: intangible assets

	2020-21 £000	2019-20 £000
Balance at 1 April	6,067	-
Net gain on revaluation of intangible assets	5,109	8,327
Transfer to the general reserve	(3,821)	(2,260)
Balance at 31 March	**7,355**	**6,067**

2019-20	Software licences £000	Information technology £000	Development expenditure £000	Websites £000	Total £000
Cost or valuation					
At 1 April 2019	16,013	191,438	18,372	3,011	**228,834**
Additions	21,603	51,601	14,175	410	**87,789**
Reclassification	-	9,592	(9,762)	170	**-**
Impairments and reversals to other operating expenditure	(2,595)	(16)	-	-	**(2,611)**
Revaluation and indexation to revaluation reserve	(1,427)	12,986	904	152	**12,615**
Disposals	(898)	(4,735)	(920)	(325)	**(6,878)**
At 31 March 2020	**32,696**	**260,866**	**22,769**	**3,418**	**319,749**
Amortisation					
At 1 April 2019	10,484	80,757	-	1,453	**92,694**
Provided during the year	4,498	36,439	-	447	**41,384**
Reclassification	-	182	-	(182)	**-**
Impairments and reversals to other operating expenditure	(1,738)	(12)	-	-	**(1,750)**
Revaluation and indexation to revaluation reserve	(1,427)	5,681	-	34	**4,288**
Disposals	(896)	(3,947)	-	(325)	**(5,168)**
At 31 March 2020	**10,921**	**119,100**	**-**	**1,427**	**131,448**
Net book value at 1 April 2019	5,529	110,681	18,372	1,558	136,140
Net book value at 31 March 2020	**21,775**	**141,766**	**22,769**	**1,991**	**188,301**

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.

The gross cost of intangible assets that were fully amortised but still in use is £29,146,844.

Information technology, development expenditure and websites are internally generated assets, created using a mix of staff and supplier resource.

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

The value of own staff capitalised within intangible assets additions amounts to £13,217,413.

All intangible assets are owned by NHS Digital.

Note 8

Other non-current receivables

	31 March 2021 £000	31 March 2020 £000
Prepayments	6,344	11,296

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

Note 9

Trade receivables and other current assets

	31 March 2021 £000	31 March 2020 £000
Amounts falling due within one year		
Contract receivables invoiced	12,706	13,734
Other receivables	271	340
Value added tax	18,324	4,630
Prepayments and other receivables	14,006	12,374
Contract receivables not yet invoiced	2,016	1,575
Other accrued income	13	23
Total trade receivables and other current assets	**47,336**	**32,676**

Note 10

Cash and cash equivalents

	31 March 2021 £000	31 March 2020 £000
Balance at 1 April 2020	19,837	21,204
Net changes in cash and cash equivalents	2,804	(1,367)
Balance at 31 March 2021	**22,641**	**19,837**

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

Note 11

Trade and other payables

	31 March 2021 £000	31 March 2020 £000
Amounts payable within one year		
Trade and other payables	42,235	8,930
Income tax, National Insurance and superannuation	6,453	6,388
Contract liabilities	1,368	1,325
Accruals	50,305	49,990
Total trade and other payables	**100,361**	**66,633**

Note 12

Provisions for liabilities and charges

	Dilapidations £000	Injury benefit £000	Termination benefits £000	Total £000
Balance at 1 April 2020	3,636	643	63	**4,342**
Arising during the year	3,820	18	308	**4,146**
Utilised during the year	(1,255)	(28)	(63)	**(1,346)**
Reversed unused	(735)	-	-	**(735)**
Balance at 31 March 2021	**5,466**	**633**	**308**	**6,407**
Expected timing of cash flows				
Within 1 year	1,528	28	308	**1,864**
Between 1 to 5 years	118	112	-	**230**
Over 5 years	3,820	493	-	**4,313**

The dilapidations 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 quarterly payments are made to the NHS Pension Scheme.

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

Note 13

Capital commitments

Capital commitments amount to £512,551 (31 March 2020: £25,507,865). Of this, £248,209 relates to ordered IT equipment and £264,342 relates to software development work.

Note 14

Other Financial Commitments

NHS Digital has not entered into any non-cancellable contracts (that are not operating leases) for the provision of services as at 31 March 2021 (31 March 2020: £nil).

Note 15

Contingent assets and liabilities

Contingent liabilities amount to £175,000 (31 March 2020: £16,564,000) and relate to estimated potential employment-related claims.

Note 16

Commitments under operating leases

Expenditure includes the following in respect of operating leases:

	2020-21 £000	2019-20 £000
Accommodation	6,264	4,804
Other operating leases	45	53
	6,309	**4,857**

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

	31 March 2021 £000	31 March 2020 £000
Land and buildings		
Not later than 1 year	5,259	6,915
Between 1 and 5 years	18,467	19,067
Later than 5 years	57,263	82,784
	80,989	**108,766**
Other leases		
Not later than 1 year	2	26
Between 1 and 5 years	-	3
Later than 5 years	-	-
	2	**29**
Total	**80,991**	**108,795**

Note 17

Lease Incentives

	2020-21 £000	2019-20 £000
Lease incentive – current	638	-
Lease incentive – non-current	11,037	-
	11,675	**-**

Note 18

Related parties

The Health and Social Care Information Centre, also known as NHS Digital, is an executive non-departmental public body created by the Health and Social Care Act 2012. It is sponsored by the Department of Health and Social Care (DHSC), and DHSC together with its associated bodies are therefore regarded as related parties. During the year, NHS Digital had the following transactions with DHSC group bodies: income £35.9 million (2019-20: £38.6 million) and expenditure £9.3 million (2019-20: £11.2 million) and, at 31 March 2021, had the following balances with DHSC group bodies: £11.3 million receivables (2019-20: £12.0 million) and £1.1 million payables (2019-20: £2.7 million). The major customers within the group were the Department of Health and Social Care, NHS England and Public Health England. The majority of expenditure was in respect of transactions with the Department of Health and Social Care.

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

No special terms and conditions were applicable to transactions with related parties, no guarantees or security were accepted or given, all transactions were or will be settled in cash, and no provisions were made for doubtful debts in respect of these transactions. The bad debt expense in the year relating to related parties amounted to: £nil (2019-20: £nil).

The 'Register of Interests of Board Directors' is included within the board papers for each public board meeting: https://digital.nhs.uk/about-nhs-digital/our-organisation/nhs-digital-board/board-minutes-and-papers. Board members' biographies and their register of interests can be found on pages 123 -133.

	Related to roles within NHS Digital	Amounts payable at 31 March 2021 £000	Amounts receivable at 31 March 2021 £000	Income in 2020-21 £000	Expenditure in 2020-21 £000
Accenture (UK) Ltd	Non-executive directors	3,093	-	-	43,764
Imperial College London	Chief Executive	-	2	43	8
King's College London	Chief Executive	-	6	132	-
McKinsey & Company	Non-executive director	-	-	7	642
University of Oxford	Chief Executive	-	48	751	144
University of Warwick	Former Chair (to Aug-20)	-	-	4	108
		3,093	**56**	**937**	**44,666**

In addition, at 31 March 2021, there were capital commitments of £47,722 with Accenture (UK) Ltd.

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

Note 19

Financial instruments

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

a. Market risk

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

b. Credit risk

Credit risk arises from invoices raised to customers for services provided. Most high-value receivables relate to balances with the Department of Health and Social Care and its related bodies against purchase orders and therefore do not represent a significant credit risk. NHS Digital had a comparatively small value of external receivables and therefore disclosure of the largest individual debt balances was not considered in the evaluation of overall credit risk.

Movement in the provision for expected credit losses

	2020-21 £000	2019-20 £000
Balance at 1 April	32	6
Provided for in year	8	32
Reversed unutilised	(32)	(6)
Amounts written off during the year as uncollectible	-	-
Balance at 31 March	**8**	**32**

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

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

	Current £000	< 30 days overdue £000	31-60 days overdue £000	> 61 days overdue £000	Total £000
Balance at 31 March 2021	**10,085**	**32**	**1,298**	**1,562**	**12,977**
Balance at 31 March 2020	10,788	2,402	225	659	14,074

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

c. Liquidity risk

Liquidity risk is managed through regular cash flow forecasting. NHS Digital had no external borrowings and relies on grant-in-aid from the Department of Health and Social Care for its cash requirements and was therefore not significantly exposed to liquidity risks.

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

	31 March 2021 £000	31 March 2020 £000
Current liabilities	100,361	66,633

Note 20

Events after the reporting period ended

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

On 1 October 2021, as part of the replacement of Public Health England (PHE) by the UK Health Security Agency and Office for Health Improvement and Disparities, the National Diseases Registration Services moved from PHE into NHS Digital.

On 22 November 2021 it was announced that NHS Digital would be merged into NHS England and NHS Improvement following the recommendations in the independent review undertaken by Laura Wade-Gery entitled "Putting data, digital and tech at the heart of transforming the NHS".

Both events are non-adjusting events under the requirements of IAS 10 and the Department of Health and Social Care Group Accounting Manual (GAM). Although the future dissolution of NHS Digital has been announced its functions will continue, and therefore in accordance with the guidance in the GAM the going concern concept remains appropriate for the 2020-21 financial statements.

Note 21

Authorised date for issue

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

The Accounting Officer authorised these financial statements for issue on 24 January 2022.

Board members' biographies and register of interests

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

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

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

Managing directors

Sarah Wilkinson
Chief Executive
(until June 2021)

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

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

Simon Bolton
Interim Chief Executive
(from June 2021)

Simon joined NHS Digital in June 2021. Previously, he was the CIO at NHS Test and Trace and has held a number of executive technology leadership roles at companies, including CIO of Jaguar Land Rover and CIO of Rolls-Royce's Land and Sea Division.

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

Pete Rose
Deputy Chief Executive and Chief Information Security Officer
(until August 2021)

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

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

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

Executive directors

Carl Vincent
Chief Financial Officer

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

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

Professor Jonathan Benger CBE
Chief Medical Officer

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

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

Non-executive directors

Laura Wade-Gery
Chair

Laura is Chair of the NHS Digital Board, as well as Chair of the Talent, Remuneration and Management Committee.

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

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

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

Appointed to the Board: 1 September 2020

Noel Gordon
Chair

Noel was chair of the NHS Digital Board until September 2020, when he retired at the end of his 4-year appointment.

Noel was also a non-executive director of NHS England, and the chair of its Specialised Services Commissioning Committee; chair of the Healthcare UK Advisory Board and a non-executive director of the Payments Services Regulator. Additionally, he was formerly a member of the Life Sciences Industrial Strategy Board and the Accelerated Access Review.

Previously an economist and a banker, Noel spent most of his career in consultancy, where he was a Global Managing Director of the banking industry practice at Accenture from 1996 until his retirement in 2012. Prior to that, he was a partner in Booz Allen Hamilton based in both London and New York. He has extensive practical experience in restructuring complex organisations across technology and business cycles and driving fundamental innovations in transforming industries through big data, analytics and digital technologies.

Appointed to the Board: 1 June 2016

Term expired: 31 August 2020

Professor Sudhesh Kumar OBE

On the NHS Digital Board, Sudhesh is the Vice Chair and leads on big data, the research sector, clinical informatics/medtech and life sciences strategy.

Sudhesh is Dean of the Warwick Medical School at University of Warwick. He is also a non-executive director on the University Hospitals Coventry and Warwickshire NHS Trust Board.

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

Appointed to the Board: 1 January 2017

Dr Marko Balabanovic

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

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

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

Appointed to the Board: 1 January 2017

Term expired: 31 December 2021

Professor Soraya Dhillon MBE

On the NHS Digital Board, Soraya is the Senior Independent Director. She leads on clinical safety and governance, e-channels and diversity and inclusion. Soraya also has a NED oversight role for raising concerns and whistleblowing.

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

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

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

Appointed to the Board: 1 January 2017

Term expired: 31 December 2021

Daniel Benton

On the NHS Digital Board, Daniel leads on IT delivery excellence, operational transformation and technology strategy.

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 both of setting and implementing the technology agendas for large organisations through periods of transformational change, including the implementation of advanced consumer-facing technologies. He led much of Accenture's thinking around the impact of technology on business and on transforming IT organisations. He was also seconded twice as CIO, both for an international bank and a large global insurer.

Daniel is a trustee of The Grange Festival.

Appointed to the Board: 1 January 2017

Deborah Oakley

On the NHS Digital Board, Deborah leads on assurance and risk and chairs the Audit and Risk Committee (ARC).

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

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

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

Appointed to the Board: 1 July 2018

Balram Veliath

On the NHS Digital Board, Balram leads on culture, values and stakeholder relations.

Balram qualified as a chartered accountant in 1988 and has over 25 years' experience of risk governance including developing and implementing risk management systems, assisting organisations to assess their capacity to handle risk and supporting boards with monitoring and assessing culture, diversity and inclusion.

He is currently the Director of Quality, Risk and Assurance at the BBC where his responsibilities include internal audit, risk management, safety and security, and assurance of critical projects. He recently joined the College Council of Royal Holloway, University of London and is the Chair of the Audit Risk and Compliance Committee.

Previously, he worked in senior executive roles with Royal Bank of Scotland and ABN Amro covering internal audit and risk management across operations and technology. Prior to this he worked in KPMG for 12 years, including as Partner with responsibility for financial audits across a range of sectors.

Appointed to the Board: 1 July 2018

John Noble CBE

On the NHS Digital Board, John leads on Information and Cyber Security and chairs the Information and Cyber Security Committee (IACSC).

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

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

Appointed to the Board: 1 July 2018

Ben Goldacre

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

Ben is a doctor, researcher and author. He runs the DataLab at the University of Oxford, building tools and services from large health datasets, and advises government on better uses of data and technology.

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

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

Appointed to the Board: 1 April 2021

Steven Woodford

On the NHS Digital Board, Steve is a member of the Information Assurance and Cyber Security Committee.

He is currently Chief Technology Officer at BGL Group, home of comparethemarket.com and provider of motor, home and life insurance products from several of the best-known brands in UK financial services including Budget Insurance, Dial Direct and Beagle Street.

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

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

Appointed to the Board: 1 April 2021

Patrick Eltridge

On the NHS Digital Board, Patrick is a member of the Investment Committee.

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

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

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

Appointed to the Board: 1 April 2021

Ex-officio Board member

Matthew Gould

Matthew is the CEO for NHSX, a body set up to ensure that staff and patients have the technology they need. He has said his priorities are to reduce the burden on clinicians, to put services and information into the hands of citizens, and to ensure that clinicians can safely access patient data from wherever they are in the system.

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

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