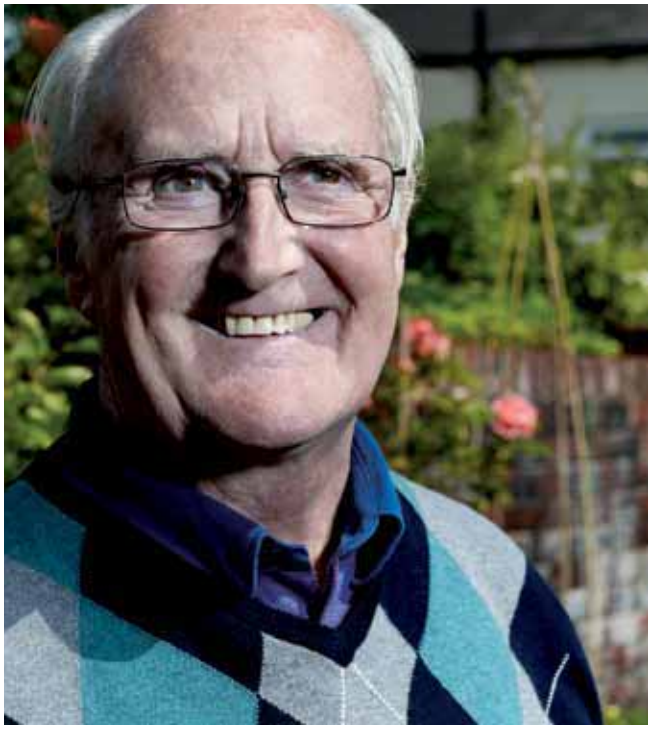
NHS Direct
Annual Report & Accounts 2008/09



NHS Direct
Annual Report & Accounts 2008/09

NHS Direct Annual Report 2008/09

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Contents

We're

here.

To make a difference to the lives of people in England 24 hours a day. We're always here for them whenever they have health worries, and we have the knowledge and experience to give them real help and reassurance.

This makes us unique.

Joanne Shaw
Chair's Statement

NHS Direct – An integral part of the modern National Health Service

Over the last 10 years, NHS Direct has been on a tremendous journey. The service began as a project conceived by the Department of Health, with a radical vision of the telephone and internet as channels through which NHS care could be accessed, and patients and the public could be signposted to the most appropriate face-to-face service to meet their needs.

By April 2004, our service was being delivered by more than 50 call centres hosted by NHS trusts, primary care trusts and ambulance services throughout England. NHS Direct then came of age as an organisation in its own right, becoming a Special Health Authority employing over 3,000 staff with its own Board. It had a mission to exploit the potential of new channels to meet the changing needs and expectations of the public and the NHS.

Since becoming a Trust in April 2007, NHS Direct has overcome initial scepticism and proven itself. Specifically, it has proven its ability to meet stringent performance standards while delivering a remote service which is safe, high quality and valued by patients. We are proud to be the only national provider of NHS services to patients, with the largest number of annual patient contacts of any NHS body as well as 17,000 public members. Our national technological infrastructure is important to the resilience of health services in emergencies, providing a unique platform for the development of cost-effective solutions for the NHS. This simultaneously improves the quality of service to the public and helps the NHS make the best use of its resources.

A joint review with the Department of Health in April 2008 has confirmed that NHS Direct's current operating model, which combines national delivery with effective engagement at a local level, is right for such a crucial national service. As well as contributing to the development of the digital NHS, NHS Direct is uniquely placed to support the delivery of a single three-digit number for access to non-emergency care.

Given the national importance of our current service, and potential requests from the Department of Health to expand our role in the future, it has been agreed that Foundation Trust status is not the most appropriate organisational form for the time being. This decision frees us to concentrate on developing our service based on the needs of our customers and users and the NHS. This coming year, our key commissioning relationship transfers from the Department of Health to the East of England Strategic Health Authority on behalf of the NHS. This is a welcome development which will further strengthen our relationship with, and responsiveness to, the rest of the NHS.

Healthcare is changing rapidly, driven by changing patient expectations and the availability of new technologies. The demands of an ageing population and pressure on public finances mean that the NHS needs to develop new and more efficient ways to provide care. It also needs to support self-care for patients with acute problems and long-term conditions, and to encourage people to take a more active role in managing their own health.

Telephony and the internet are now the preferred means of communication for a large and growing proportion of the population. In response, NHS Direct is developing its services to become the world's best multi-channel provider of health advice and information. This empowers people to make better-informed decisions about their own health and wellbeing, and helps the NHS respond to challenging times ahead.

Joanne Shaw
Chair, NHS Direct


NHS
Direct

Chief Executives' Statements

From Paula Higson
Interim Chief Executive January – March 2009

In the year in which NHS Direct celebrated its 10th anniversary, the organisation and the service enjoyed a series of substantial successes and achievements.

We continue to deliver high quality care for all through a safe and clinically effective operation, delivering a valued service to our users and providing an essential service to the whole of the NHS.

We were awarded a 'Good' performance rating by the Healthcare Commission in our first annual health check, after only four years as a national organisation and one year as an NHS Trust. We have achieved all of our targets as agreed with the Department of Health.

We are reaching more users. Our phone service volumes have increased to achieve our target of 5 million calls, and a range of interactive and online services attract over 31 million contacts.

As a result of the high levels of morbidity associated with colds and flu, the Christmas and New Year period (which is always our busiest and most challenging time) was busier than ever for the whole of the NHS. Between 20 December 2008 and 1 January 2009, we answered 256,000 calls—up 16% on the same period in the previous year. Our telephone number was widely promoted in the media by NHS colleagues, so that their own services could be freed up to meet the most urgent needs. We worked closely with acute services and with ambulance trusts to enable less urgent needs to be met through our telephone service.

Our services are central to the NHS. More than 50% of our calls are handled in their entirety by our operation, thus relieving pressure elsewhere in the system. Three new Category C integrations (non-urgent 999 calls) were established with ambulance trusts which, together with two existing integrations, meant that we took almost 20,000 calls for them between December and March. This reserved valuable 'blue-light' time for the most urgent needs.

We operate services on behalf of the Department of Health. In the event of a flu pandemic, we will operate the National Pandemic Flu Service for all UK countries. Following the swine flu outbreak in April 2009 we developed an interim Flu Service to be available for deployment if needed. We are continuing to work on the full Flu Service solution to be ready from 1 October 2009.

The number of calls to The Appointments Line for 'Choose and Book' grew significantly, and we have been awarded the helpline and signposting service for the Department of Health's National Programme for Improving Access to Psychological Therapies.

From our national infrastructure, we continue to deliver services to meet local needs. We were successful in winning a number of major contracts for commissioned services, including: the 'Access and Assess' element of the new West Yorkshire Urgent Care Service; a three-year expansion of the Birmingham OwnHealth® programme; and a long-term care programme for Nottingham City PCT.

We are also investing in our staff. We are taking a number of actions to respond to suggestions made by our staff on how we can make NHS Direct a 'great place to work'. This includes improving our rostering system so that it is more appropriate to the needs of our staff, and improving the working environment in our contact centres.

We are continuously improving our efficiency and effectiveness. We have worked within our budget and have once again delivered a surplus, which this year amounts to £467,000.

Our business plan for 2008/09 contained 14 corporate objectives agreed in March 2008. During the year, one significant change was the decision, made jointly with the Department of Health, not to pursue Foundation Trust status; rather, we are focusing on defining our longer-term vision for NHS Direct as an NHS Trust. We have achieved the vast majority of our very challenging objectives for 2008/09. Throughout 2009/10 we will be building on this excellent delivery record to achieve an even more ambitious plan.

Quality is at the heart of everything we do in engaging users and commissioners. This has been the first full year in which NHS Direct has had a membership. On 1 April 2008 we had 7,400 public members; this more than doubled in 2008/09 to over 17,000 by 31 March 2009. We have developed a strategy for engaging our members in the development of new services and the improvement of existing services. We invited members to participate in 16 different areas, with very encouraging numbers taking part.

We continue to develop new ways of working in an increasingly multi-channel world. This year we successfully launched our new online colds and flu self-assessment tool, which has received over 147,000 visits. We have also provided services via real-time webchat and through social-networking sites such as Bebo.

In conclusion, we have had a very successful and productive year, celebrating 10 years of high-quality, safe and effective support for millions of callers and internet users. We have made excellent progress in our plans for improvement in our services; in the working lives of our staff; in our engagement with communities and members; in our engagement with NHS commissioners; and in our corporate governance and controls. This has been achieved through the hard work of all of our staff and managers, and with the support of suppliers and others in the NHS and the Department of Health. We know that we still have much to do if we are to continue improving the lives and health of our users, the working lives of our staff, and our role in the NHS. This is our aim in the coming year.

Paula Higson
Interim Chief Executive, NHS Direct

From Nick Chapman
Chief Executive from April 2009

It's great to start my time as the Chief Executive of NHS Direct following a year of solid achievement. Our key targets have been met and we delivered on the vast majority of the objectives set at the beginning of the financial year.

However, I'm keen to build on these achievements. I am therefore committed to:

- Using our national scale to deliver services which are a clear favoured choice for commissioners, based on greater quality and performance and lower operational and overhead costs
- Increasing the time we spend with patients and adding more value to these conversations
- Strengthening our relationships with the NHS so that we deliver services which meet their needs, becoming a trusted and valued part of local health communities
- Agreeing clear strategic priorities for action through our Strategic Development Programme—and implementing them smartly.

I would like to pay tribute to the achievements of NHS Direct staff during 2008/09, under the leadership of Matt Tee and Paula Higson. I have already met many staff as I have been getting to know the organisation, and I have been very impressed by their enthusiasm and commitment to providing our patients with the best possible service. Evidence of their excellent work can be found in our very high levels of caller and patient satisfaction (94%) and in meeting our challenging key performance indicators.

The commissioning arrangements with the East of England Strategic Health Authority also give us a great opportunity to become more closely integrated with our colleagues in the wider NHS. I look forward to working productively and creatively with our new commissioners for the benefit of patients and the rest of the health system.

2009/10 will be a challenging and exciting year for us. Delivering on our business plan and our Strategic Development Programme will put us in the best place to give greater value services to our patients, users and commissioners. I believe this will enable NHS Direct to continue to provide a valued service to patients and commissioners for many years to come.

Nick Chapman
Chief Executive, NHS Direct

We're here for Carol

When I started on the Birmingham OwnHealth® programme my health was of a low standard, I was overweight and had low self esteem due to several strokes. By 2009 I had lost enough weight to have my diabetic medication stopped, I was fitter, breathed easier and had confidence in myself.

The main thing that my care manager did for me was to believe in me. Initially the care manager gave me the support and confidence to be willing to make a change with my life. Support was given through knowledge of my condition and ways to improve my health. Being informed that housework was an acceptable physical activity was a simple boost to my daily activity routine.

It was easier to know I was doing exercise when doing housework rather than having to go to the gym. However, as time elapsed I did end up going to the gym, walking between bus stops and gardening (an activity I really love). I enrolled on a course to begin studying again, such was the confidence that I developed after so many years of it being absent.

Sometimes a very small amount of advice and support can make a vast difference to my life. I hope this service continues for a very long time as I have gained a lot more from this than I ever envisaged.

Birmingham OwnHealth® is a partnership with NHS Birmingham East and North, UK Pfizer Health Solutions and NHS Direct.

Management Commentary

Overview

History and background

Who we are and what we do

NHS Direct is here to make a difference to the lives of people in England: 24 hours a day, 365 days a year. We're here for them whenever they have health worries, and we have the knowledge and experience to give them real help and reassurance. This makes us unique.

Our strategic vision is to be the national healthline, providing expert advice, information and reassurance. Using our world-class telephone service and website, we will be the NHS' provider of choice for telephone and digitally delivered health services.

This vision supports and builds upon the original aim of NHS Direct when it was launched in 1998: 'To provide 24-hour access to health advice and information for non-emergency issues and to help patients navigate their way through the health service'. Ten years on, with the experience we now have, we can do even more to support patients who contact us with health enquiries. We have a greater role to play in helping the NHS to deliver improvements in health and health care.

Core service

NHS Direct is a renowned specialist in delivering multi-channel clinical services 24 hours a day, 365 days a year. We handle a wide range of calls to our helpline (0845 4647), involving:

- Clinical assessments which enable people to care for themselves at home, or to find the right care from within the rest of the NHS
- Information on local health services and support organisations
- Advice on maintaining a healthy lifestyle
- Information about illnesses, conditions, tests, treatments and operations
- Complex enquiries about medication, eg interactions, overdosing, poisoning, etc
- Information in response to national and local health scares, eg swine flu.

Commissioned services

We also offer commissioned services to other parts of the NHS, helping them to meet their patients' needs. In addition to the core service, we provide a range of additional services to primary care trusts and other health providers, helping them deliver on their service objectives.

NHS Direct is also committed to delivering high-quality services which meet the needs of people with long-term conditions. We have developed partnerships with Pfizer Health Solutions and Humana Europe to deliver world-class telephone-based care management services. These will encourage and help people to follow personalised health plans, to look after themselves at home, and to learn how to manage their long-term conditions so that they can enjoy a happier and healthier lifestyle.

The external environment

As part of our preparation for our business plan for 2009/2010 (available via our website), we analysed and assessed the environment within which we will operate next year. This included considering our strengths and weaknesses as well as the opportunities and challenges we face. It also included looking at changes in the users of our service, the markets in which we operate, and our statutory and regulatory environments. All of this will ensure that NHS Direct is in the best possible position for responding to known and anticipated external opportunities and challenges.

In common with the rest of the NHS, the public sector and the wider economy, we are entering a period of unprecedented pressure on public spending. This will become more severe over the coming years; however, we have the potential to help the public make more appropriate use of NHS services. Therefore, we must demonstrate that resources invested in NHS Direct save money for the wider NHS, supporting the whole system in providing patients with a high-quality, safe service while using dramatically fewer resources. At the same time, we must deliver a higher-quality service for less.

Trends and factors which could impact on NHS Direct

Our contract with the East of England Strategic Health Authority provides us with annual funding for our core service. Unlike our competitors, we are the only organisation within the health sector that has a national infrastructure plus experience of providing protocol-based advice and information over the telephone and internet.

Channels for the provision of health and social care services are becoming increasingly diverse. A wide range of public, private, voluntary-sector and social enterprises are now competing to provide NHS-funded services. As a result, services will need to be integrated across organisational boundaries. In addition, the need to deliver an excellent service, representing value for money, has never been greater. These are challenges which NHS Direct will continue to address.

The potential move to a three-digit number for access to non-emergency healthcare, in line with the recommendations of the Next Stage Review, would have significant implications for NHS Direct.

The Non-Executive Directors have been linked to each region as follows:

Derek Newman	North East & Yorkshire & the Humber
Peter Catchpole	East (except Bedford & Stevenage) & South East
Philip Baker	North West
Trevor Jones	South West
Sue Hunt	London & East (Bedford & Stevenage only)
Tim Walton	West Midlands & East Midlands

Overview

We provide a national service from a small head office in London. Our nine-region structure is generally aligned with Strategic Health Authority boundaries.

Estate

Our service delivery is virtual, provided through 35 contact centres. Our headquarters are at Riverside House, 2a Southwark Bridge Road, London SE1 9HA.

Head Office
01 Riverside House

Yorkshire and the Humber
02 Hull
03 Sheffield
04 Wakefield

North East
05 Newcastle
06 Stockton-on-Tees

North West
07 Middlebrook
08 Kendal
09 Nantwich
10 Blackburn
11 Carlisle
12 Liverpool

West Midlands
13 Stafford
14 Dudley

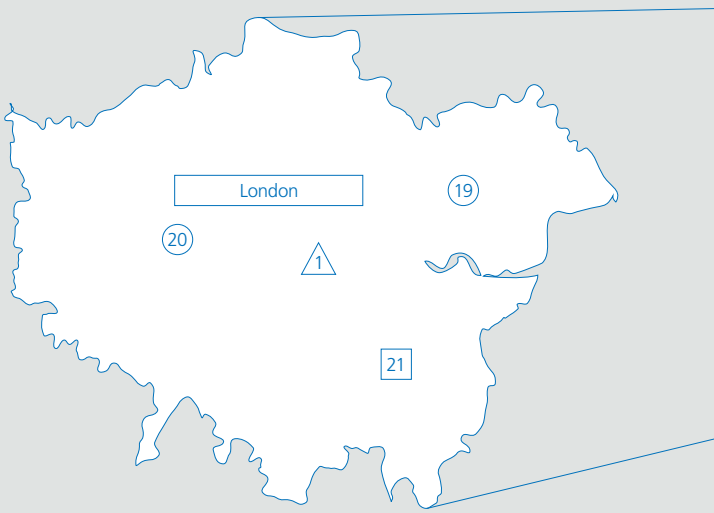
East Midlands
15 Nottingham
16 Derby
17 Chesterfield
18 Mansfield

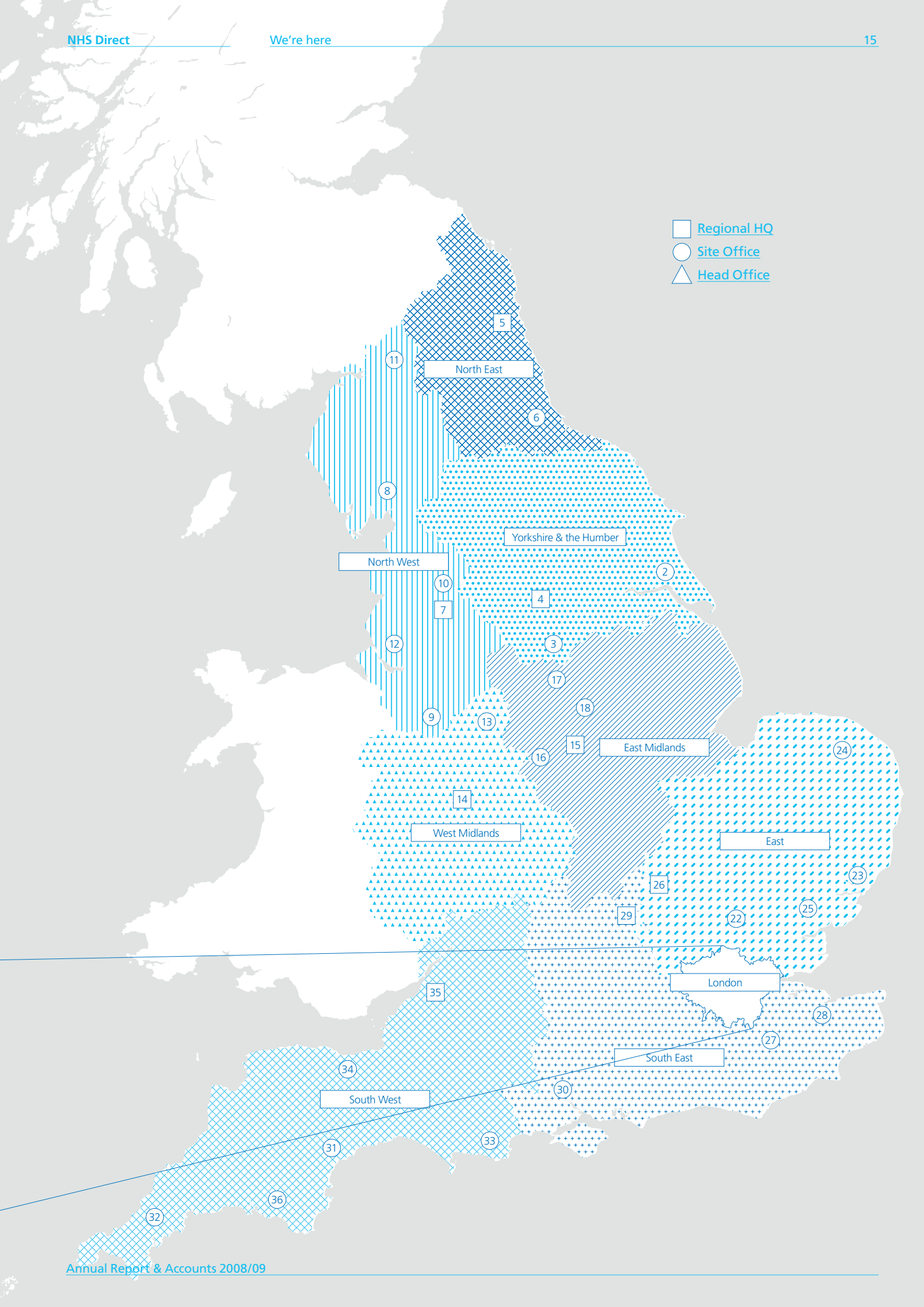
London
19 Illford
20 Southall
21 Beckenham

East
22 Stevenage
23 Ipswich
24 Norwich
25 Chelmsford
26 Bedford

South East
27 Caterham
28 Chatham
29 Milton Keynes
30 Southampton

South West
31 Exeter
32 Truro
33 Ferndown
34 Taunton
35 Bristol
36 Plymouth




Regional HQ
Site Office
Head Office
North East
North West
Yorkshire & the Humber
East Midlands
West Midlands
East
London
South East
South West
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Plans for the future: our corporate goals

NHS Direct is a high-performing organisation which consistently delivers against the targets set for us by the Department of Health and our new lead SHA commissioner. However, we have a compelling sense of how much better we could be and how much more we could be doing.

In everything we do, we will strive to put patients at the centre of our thinking and we will seek to continuously improve the service we provide. We will do this by delivering better care closer to home; prevention and public health education; access to high-quality services; and access to information and support which helps patients to find their way around the health system. Therefore, we are becoming even more patient-focused. We engage with our staff, our patients, the public, our members and the NHS to develop a clear understanding of what they want, and we then adapt our service accordingly.

We want to play a key role in the NHS—delivering high-quality care for all, even within an environment of increasing demands and reducing budgets. We need to become a first-class employer, providing a good working environment as well as key skills which will help to enhance people's careers. We need to be able to demonstrate our worth and to deliver value for money.

To achieve all of this, we have developed a challenging Strategic Development Programme. This will enable us to build on the last 10 years, taking us from a 'Good' to an 'Excellent' rating. The overarching aim of the programme is to maximise our value and to be fit for the future.

Embarking on the Strategic Development Programme over the next 12 to 18 months, will ensure that we:

- Understand the needs of the NHS and the changing behaviour of our patients
- Develop services which precisely meet those needs and behaviours
- Monitor feedback from patients and commissioners, using it as a basis for continual improvement
- Are seen as supporting the NHS in the development of innovative new services and the use of new technologies
- Operate our business in a world-class way, putting our patients and staff at the heart of everything we do.

Our corporate objectives for 2009/10

2009/10 will be the last year in which NHS Direct produces a one-year business plan. During the year, we will deliver a medium-term business plan which sets out how we will achieve our longer-term vision over the next three to five years. As part of the move towards longer-term planning, we will be seeking to agree longer-term arrangements with our commissioner, the East of England Strategic Health Authority. This longer-term approach will help us to be even more ambitious in our plans to deliver a better and more efficient service. It will also enable us to take the hard decisions required to ensure that NHS Direct remains a viable, high-quality service for the future.

For 2009/10 we have defined seven corporate objectives which provide a framework and overall direction for the year ahead. These are aligned with the NHS Leadership Challenge; with what our members have told us they consider to be important; and with our longer-term strategic vision. Each objective is measurable and sets out both our broad ambition and those high-level actions we will be taking in 2009/10 to continuously improve our service.

These seven corporate objectives, are to:

(1) Deliver high-quality care for all, through a safe and clinically effective service

(2) Invest in and value staff

(3) Provide a service that is central to the NHS

(4) Continuously improve our efficiency and effectiveness

(5) Put quality at the heart of everything we do, engaging members, users and commissioners

(6) Deliver services to meet local needs through our national infrastructure

(7) Support the NHS in new ways of working in the multi-channel world.

High-quality care for all through a safe and clinically effective service

Working in a clinically effective way

One of the ways we ensure that we provide a safe and clinically effective service, is by prioritising calls depending on their clinical urgency, ensuring that we deal with the most life-threatening and urgent first. We also have one of the safest services in the NHS, with less than 0.005% of calls resulting in an error which could cause harm to a patient.

Since we complete over 50% of calls within NHS Direct, we help patients care for themselves and therefore we decrease the burden on the NHS. Over half of our callers do not need other NHS services after contacting us. We have developed our decision-support software, and trained our staff, to improve on this further in the coming year. We continually update and improve the algorithms within our clinical assessment system in order to reflect recent research, emerging best practice, and patient and professional feedback.

How we performed

Year-end performance on our key performance indicators (KPIs) is as set out in Table 1, below. (The definitions of the KPIs are set out in an appendix to the report.)

Our business plan for 2008/09 contained 14 corporate objectives agreed in March 2008. During the year, one significant change was our decision (made jointly with the Department of Health) not to pursue Foundation Trust status, but to focus instead on delivering value to patients and the NHS, as an NHS Trust. This had an impact on some of the corporate objectives, and some mid-year amendments were agreed by the Board. These are reflected in the revised objectives in Table 2, overleaf.

We faced a very challenging set of internally agreed corporate objectives for the year 2008/09, but have delivered on almost all of them. We will continue our work towards achieving a number of them in our business plan for 2009/10.

Table 1

Measure	2007-08	2008-09	Target 2008-09
Number of complaints per 10,000 calls	0.99	0.63	< 1
% of incidents for national review leading to harm [1]	5.1%	6.7%	≤ 10%
Abandonment rate	1.6%	1.3%	≤ 5%
% of calls answered within 60 seconds	93%	95%	≥ 95%
% of urgent calls starting clinical assessment within 20 minutes	98%	99%	≥ 95%
% of less-urgent calls starting clinical assessment within 60 minutes	98%	98%	≥ 95%
% of non-urgent calls starting clinical assessment within 120 minutes [2]	N/A [1]	98%	≥ 95%
% of calls resulting in emergency and urgent referral	28%	24%	≤ 25%
% of calls completed within NHS Direct	46%	52%	≥ 50%
Number of 0845 calls answered during the year	4,854,523 [3]	5,059,719	≥ 5 million

Notes

[1] During 2008/09, 75 serious adverse incidents were identified for national review of which 5 were deemed to have led to harm to a patient which equals 6.7% of the total number identified for national review. Our adverse incident rate is 0.13 per 10,000 calls.
[2] The target for the equivalent KPI for 2007-08 was for clinical assessment to start within 240 minutes.
[3] No target was set for 2007-08.

Achievement of our internal corporate objectives in 2008/09

Objective	Description	Year end position
1	To deliver all key performance indicators as agreed with the Department of Health over the plan period. Commentary: We have achieved all of the KPIs we agreed with the Department of Health for 2008/09. See Table 1, on previous page.	Achieved
2	To ensure delivery against the requirements of Standards for Better Health. Commentary: We have declared compliance with all 33 standards which are relevant to us. We had lapses in compliance with standard C7e (Equality and Diversity) and C11a (Training and Development) during the year.	Achieved
3	To reduce the use of messaging to less than 5% of 24/7 operating by 31/03/09. Commentary: At the beginning of the year, we set ourselves a very challenging target of reducing the number of times we play 'busy' messages on the 0845 4647 service. These messages tell callers that the service is experiencing high demand and suggest that those with non-urgent problems either call back at another time or try alternative sources of health advice, such as www.nhs.uk. At the start of 2008/09, we were playing our 'busy' message 37% of the time, and aimed to reduce this to less than 5% by the year-end, in order to provide a better experience for our users. Our performance against this target has improved in 2008/09 when we played the busy message 25% of the time. Analysis during 2008/09 suggests that using the 'busy message' 15% of the time may be a more realistic target. We have plans in place to recruit, retain and manage our staff more effectively during 2009/10 to reduce the need to use the 'busy' message.	Not achieved
4	To agree new KPIs for health information with the Department of Health. Commentary: New KPIs for our health information service have been agreed with the East of England Strategic Health Authority, and will be implemented from 1 April 2009.	Achieved
5	To agree, with the Department of Health, the scope and engagement of the Joint Review of Commissioning. Commentary: The scope of the joint NHS Direct/Department of Health review of our operating and commissioning model was agreed, and the review carried out, between March and May 2008. We agreed with the Department of Health in September 2008 that NHS Direct should continue to be commissioned at a national level, and that the responsibility for commissioning would transfer to the East of England Strategic Health Authority (on behalf of all strategic health authorities).	Achieved
6	To develop the Board and our organisational capability to ensure that NHS Direct is a well-led and high-performing organisation, fit for Foundation Trust status. Commentary: Upon receipt of the outcome of the joint review, Ben Bradshaw, Minister of State for Health, confirmed in writing that "the KPMG review was a clear vote of confidence in NHS Direct as a high-performing organisation, which I support". The Healthcare Commission looked at NHS Direct's governance arrangements as part of its July 2008 inspection, and found that these were fully compliant with the standard for corporate governance.	Achieved and ongoing in 2009/10
7	To operate an effective financial control and performance management environment to ensure delivery of the 08/09 budget. Commentary: We delivered a surplus for the year of £467,000 and ended the year with a bank balance of £24.8m. Almost £3m was invested in capital assets such as IT infrastructure, premises, equipment and facility improvements for staff and patients. The surplus generated was after accounting for the cost of accrued annual leave and reorganisation expenses, net of cost improvement and a funding return of £2.5m to the Department of Health.	Achieved

Objective	Description	Year end position
8	To engage with the tender for NHS Choices to ensure successful delivery of both NHS Direct's and NHS Choices' key requirements. Commentary: In November 2008, the NHS Direct website was relaunched with a fresh, new look reflecting our new brand identity. At the same time, NHS Direct's online health content was successfully migrated to the NHS Choices website, so that patients and the public can now access all NHS online health information via a single website: www.nhs.uk. The NHS Direct website has retained its self-help guide and enquiry service, as well as other new developments such as self-assessment tools and a webchat service.	Achieved
9	To review and implement a channel optimisation strategy which meets user requirements and delivers corporate efficiencies. Commentary: Self-assessment tools were launched in November 2008, and a multi-channel strategy team has been formed to take this work forward in 2009/10.	Achieved and ongoing in 2009/10
10	To review contestable market opportunities and ensure that we capture enough new business to meet our financial targets. Commentary: This year, we consolidated our enhanced services offering and moved closer to achieving the 2008/09 income target of £17.7m. We have achieved £17.1m income on top of our core funding from the Department of Health, both figures include the contract for The Appointments Line.	Substantially Achieved
11	To prepare a brief for the first annual stakeholder audit, deliver the first survey before 31 March 2009, and present the full stakeholder strategy to the Board during the second quarter of 2009/10. Commentary: The stakeholder audit has been completed and the results were reported to the Board in May 2009. A mechanism has been put in place for managing and reporting on contacts with our top 75 external stakeholders, and the strategy is due to be presented to the Board in the second quarter of 2009/10.	Achieved
12	To develop effective home-working pilots in order to evaluate the operational benefits. Commentary: A home-working pilot was carried out in October 2008 and the operational benefits are currently being evaluated.	Achieved
13	To reduce sickness and attrition to agreed levels. Commentary: We achieved our target of reducing sickness by 5%; however, attrition did not reduce to the target figure.	Partially achieved
14	To develop corporate governance, performance and Board reporting in line with Monitor guidance and best practice. Commentary: The Healthcare Commission inspected NHS Direct's governance arrangements as part of its inspection in July 2008 and found them fully compliant with the standard for corporate governance. In September 2008, the Board reviewed its committee structure in line with the Monitor Code of Practice and made changes as appropriate for a non-Foundation Trust. Further improvements have been made in our governance arrangements, including the revision and relaunch of our risk management policy.	Achieved and ongoing in 2009/10

Standards for Better Health

How we continue to meet the Department of Health's Standards for Better Health

Throughout 2008/09, we have worked hard to ensure that we continue to meet Core Standards and to achieve compliance where we fell short in 2007/08. In the summer of 2008, the Healthcare Commission undertook an inspection of NHS Direct in respect of Core Standards and our 2007/08 declaration of compliance. The inspection team was very impressed with the evidence of our work towards compliance. NHS Direct received a glowing report in all five of the areas reviewed, and the Healthcare Commission said that this was indicative of an organisation performing well across all areas of the Core Standards. As a result, no amendments were made to our original Core Standards Declaration.

This was the first year that NHS Direct was assessed by the Healthcare Commission. Based on their assessment for 2007/08, we provided a 'Good' quality of service to patients. We were not able to be assessed on our use of resources, as other NHS Trusts are, because we are audited in that area by the National Audit Office (which uses a different methodology from the Audit Commission, which assesses and audits other NHS Trusts).

Based on our performance against Core Standards, we were awarded a rating of 'Almost Met' for our quality of services—this is the second-highest possible rating. This resulted in our achieving a performance rating of 'Good' in the first annual health check by the Healthcare Commission.

For 2008/09 we have declared compliance with all the Core Standards. We aim to achieve a rating of 'Excellent' for 2008/09 and to maintain that in 2009/10.

Clinical sorting

Achieving Clinical Excellence at NHS Direct

NHS Direct launched the Achieving Clinical Excellence (ACE) project to evaluate the clinical effectiveness of our referrals and the self-care advice we give to patients. It also provides a benchmark of our service against other care providers. The study will enable us to ensure that our systems and referral pathways remain evidence-based and fit for purpose in comparison with other providers.

We also engaged with our members, the voluntary sector and social services as part of this project. We asked them what they liked about our service, and what they felt could be improved.

The first part of the study involved workshops across the country, involving a cross-section of health and social care professionals. Participants reviewed a sample of anonymised case studies featuring patients presenting symptoms based on the 10 most frequent reasons for contacting NHS Direct.

They were asked to recommend the most appropriate outcome for each patient. For each of the case studies reviewed, the workshop outcomes were compared with and measured against NHS Direct's actual outcomes.

In the second part of the study, NHS Direct engaged with a large number of healthcare professionals from a variety of backgrounds (such as emergency practitioners, GPs and nurses) with an online questionnaire presenting a number of symptom-based scenarios. The GPs and nurses undertook these assessments and advised a clinical outcome. This information will be used to inform our clinical outcomes.

In a final stage of the study, focus-group sessions were held with the voluntary and community sector. Invitees included organisations representing black and minority ethnic communities and older people. These workshops were designed to help us understand the perceptions of NHS Direct held by third-sector organisations, and to identify opportunities to engage and work with them.

The study will help to provide improved, faster, more accessible care which is clinically recommended and analysed by a mixture of health and social care professionals. The study may also highlight areas for further staff development when delivering urgent and self-care outcomes.

Our plans for 2009/10

Our first corporate objective for 2009/10 is:

To deliver high-quality care for all through a safe and clinically effective service.

Our success criteria for 2009/10

1.1 Deliver against our KPIs for tracking performance on all key contracts.

1.2 Achieve a 2009/10 rating of 'Excellent' from the Care Quality Commission.

1.3 Achieve Level-2 compliance with all key standards in v6.0 of the Information Governance Toolkit, and deliver our improvement plan.

Our actions to continuously improve our services for the future

1.4 *Identify and implement quick-win changes to our core service.*

1.5 *Identify and build a new operating model which delivers greater value to our patients, users and commissioners.*

1.6 *Establish and embed an organisation-wide process, capability and culture focused on innovation.*

1.7 Promote our service to the public, and increase usage, by ensuring that prompted awareness remains above 80%, as measured in the bi-annual tracking research.

1.8 Embed risk management throughout the organisation, to be evidenced by an audit in the third quarter of 2009/10.

The table above sets out a measurement framework for delivering on this objective, as well as the main actions we will be taking during the year to continuously improve our service. (Actions shown in italics are being delivered through our Strategic Development Programme.)

Investing in and valuing our staff

Creating an environment which improves employee satisfaction and values staff feedback

The last staff survey highlighted the following as areas for improvement: career progression; the management of change; communication and engagement; opportunities to learn and develop; and the rostering system.

This led to a Staff Survey Action Plan, agreed by the Executive Management Team and National Joint Partnership Forum in April 2008, which was pursued throughout the year. Achievements during 2008/09 include:

- The appointment of a Learning & Development lead for each region as well as a National Head of Non-Clinical Learning and Development
- The development, agreement and implementation of a new Management of Change Policy, with guidelines
- The development of a series of projects related to career enhancement, including the introduction of a Band 5 nursing role, a 'home-working' pilot, and a nurse-rotation project
- The development of 'Roster Direct', in partnership between management and employee representatives. This is a tool for understanding the rostering system and using it to its full capacity.

In addition, two in-depth pieces of research were undertaken in the second half of 2008. These were a 'Wellbeing At Work' survey, undertaken in the East and South East regions, and a 'Great Place To Work' research project, undertaken by Capita. The themes which emerged from both pieces of work include those highlighted in the staff survey, but also revealed the need:

- To achieve a better balance between the rostering system and the domestic situation of many of our staff
- For more cohesive team-working
- To generate increased staff pride in NHS Direct as an employer
- To improve the working environment in some of our contact centres.

These findings have been shared with staff and staff-side colleagues, and formed the cornerstone of the 'Great Place to Work' and 'Our Values' workstreams in the Strategic Development Programme.

Strong internal communications

The strengthening of both internal communications and engagement is a key element of our human resources strategy. As a result, NHS Direct's first permanent Internal Communications Manager was appointed in September 2008, and the communications resource has also been strengthened in each of the regions.

Following the setting-up of this infrastructure, 2009/10 will see the launch of the Internal Communications Strategy, which replaces the existing team brief with a quarterly staff magazine, monthly management briefs and weekly e-bulletins, as well as a series of regional initiatives.

A new intranet has been developed during 2008/09. The first phase was launched in April 2009 and will provide a search facility for the first time, as well as the means to present news and messages to all NHS Direct colleagues. Phases two and three are included in the 2009/10 directorate objectives, and include the means to introduce blogging and file sharing, electronic processes in all areas of the organisation, and a one-click performance dashboard. User groups and expert user groups are also being set up.

Staff numbers by grades

Staff structure

Table 1

Banding/Payscale	WTE	HC	HC %
Band 1	0.8	1	0.0%
Band 2	104.3	111	3.4%
Band 3	791.3	924	28.4%
Band 4	354.0	429	13.2%
Band 5	100.9	100	3.1%
Band 6	1158.0	1372	42.2%
Band 7	173.7	170	5.2%
Band 8 - Range A	54.8	46	1.4%
Band 8 - Range B	31.4	27	0.8%
Band 8 - Range C	18.1	15	0.5%
Band 8 - Range D	2.0	2	0.1%
Other	42.7	52	1.6%
Total	2742.0	3249	100.0%

Key:
WTE – whole time equivalent
HC – head count

Table 1 divides NHS Direct into the Agenda for Change bands. The significant groups are the Health Advisors, who are in Band 3; Health Information Advisors and Non-Clinical Team Leaders in Band 4; and Nurse Advisors and Clinical Team Leaders in Band 6.

Sickness absence

Sickness absence is less than that experienced in the typical contact-centre organisation, but is some way above the average for NHS organisations.

Table 2

	Long term sickness		Short term sickness		Total sickness	
Staff Group	WTE	%	WTE	%	WTE	%
Frontline: Overall	86.9	4.3%	77.2	3.8%	164.0	8.0%
Health Advisor	24.8	4.0%	19.6	3.2%	44.3	7.2%
Nurse Advisor	42.8	5.6%	32.3	4.3%	75.1	9.9%
Health Information Advisor	7.0	5.5%	4.9	3.8%	12.0	9.3%
Dental Nurse Advisor	0.6	0.9%	2.3	3.6%	2.8	4.5%
Other Advisor	2.4	1.3%	11.2	6.1%	13.6	7.4%
Team Leader	4.1	3.7%	2.7	2.5%	6.8	6.1%
Clinical Team Leader	4.2	3.0%	2.9	2.1%	7.1	5.1%
Health Information Team Leader			0.8	3.7%	0.8	3.7%
Dental Team Leader			0.0	0.7%	0.0	0.7%
Other Team Leader	1.0	4.7%	0.5	2.1%	1.5	6.9%
Service Delivery Manager	1.0	2.6%			1.0	2.6%
Other	10.7	2.1%	5.2	1.0%	15.9	3.1%
Total	98.6	3.8%	82.4	3.2%	181.0	7.0%

Key: WTE = whole time equivalent

Providing information to and consulting with employees

We have worked in partnership with our three recognised trade unions; UNITE, UNISON and the Royal College of Nursing. Each region has a Regional Joint Partnership Forum which feeds into the National Joint Partnership Forum. There is a staff-side position on the Equality & Diversity Steering Group and the Learning & Development Steering Group, and a strong partnership approach to job evaluation, the Knowledge and Skills Framework and Improving Working Lives. A partnership group has developed 'Roster Direct', a toolkit for understanding and making best use of the rostering system.

Our plans for 2009/10

Our second corporate objective for 2009/10 is:

To invest in and value our staff.

Our success criteria for 2009/10

2.1 *Introduce improvements to rostering, to achieve higher staff satisfaction with the system.*

2.2 90% of personal development plans in place.

2.3 Deliver 90% of statutory and mandatory training.

2.4 Achieve the 'improvement' metrics set out in the 2009/10 Equality and Diversity Plan.

2.5 Reduce staff attrition by 10% by 31 March 2010.

2.6 Reduce sickness levels by 10% by 31 March 2010.

2.7 *20% improvement in staff satisfaction with learning in staff survey.*

2.8 *20% improvement in staff satisfaction relating to internal communications.*

The table above sets out a measurement framework for delivering on this objective, as well as the main actions we will be taking during the year to continuously improve our service. Actions shown in italics are being delivered through our Strategic Development Programme.

Our actions to continuously improve our services for the future

2.9 *Define our organisational values by June 2009, and implement and embed them by March 2010.*

2.10 Establish accreditation schemes for clinical and non-clinical NHS Direct skills and competences by March 2010.

2.11 *Deliver all the principal elements of the 'Great Place to Work' workstream.*

2.12 *Improve the quality of leadership by delivering a development programme to senior managers by March 2010.*

2.13 Improve career progression by introducing Band 5 nurses and rotational opportunities by March 2010.

2.14 Develop a workforce strategy for 2010/12 by March 2010.

A service that is central to the NHS

The Darzi report

In his report 'High Quality Care For All', Lord Darzi identified the challenges for the NHS in the 21st century. He summarised these as: rising expectations; demand driven by demographics; the continuing development of our information society; advances in treatments; the changing nature of disease; and the changing expectations of the health workplace.

As part of the NHS, NHS Direct has a role to play in supporting other NHS colleagues in meeting these challenges, as well as in identifying how they will affect us and how we respond to them. Users can access our service from their own home, 24 hours a day; they can ask for help in understanding their health issues; and they can be guided to care for themselves, when this is safe and appropriate.

We find that for older people, it is often a relative or carer who contacts us on their behalf; we help the carer to look after them. We have developed expertise in supporting long-term conditions; we provide telephone support via care managers who build personal relationships with their users and keep them feeling better at home.

We provide online services including self assessment tools and webchat. In 2008/09, our health information service helped over 339,000 enquirers to keep themselves healthy. Our mental health specialists help our staff to provide support on emotional and mental health issues, identifying such issues even when they are not given as the reason for the call. We are piloting the provision of cognitive behavioural therapy over the phone and internet, and have been awarded the contract by the Department of Health to provide access to psychological therapies.

Our staff and managers were involved in the development of many of the local responses to the vision which Lord Darzi set out. Over the coming year, we will continue to work with local NHS providers to develop patient-centred and clinically driven services which support their work in achieving high-quality care for all. We will work in partnership to prevent ill health by providing care which is personal, effective and safe.

Winter pressures

The demand for NHS Direct's services grew significantly this winter due to increases in morbidity, particularly in relation to colds and flu. Compared with last year, calls about colds and flu began in December rather than in January, and continued over a more prolonged period. During the Christmas week, 13% of all symptomatic calls answered were as a result of colds and flu, and 7% due to diarrhoea and vomiting.

We answered 255,562 telephone calls during the 13-day Christmas holiday period: thus, over a quarter of a million people were helped by NHS Direct during the Christmas and New Year break.

The busiest day for telephone calls was Saturday, 27 December, when we answered 29,179 calls. Boxing Day followed close behind, with 26,130 calls.

The service answered 7.7% more calls this Christmas Day and Boxing Day (41,277 calls) than on the same days last year (38,342 calls).

We also play a key role in supporting other NHS services during very busy times. During this period, NHS Direct handled 2,400 Ambulance Category-C calls (non-urgent calls to 999), helping to ensure that the 999 lines remained available for emergency calls. In addition, doctors' surgeries, A&E departments and the local and national media publicised NHS Direct's number. This helps people to look after themselves and to assess which service is most suited to their needs. In this way, urgent and emergency services are more available for those in greatest need.

Over 147,000 people used NHS Direct's new colds and flu self-assessment tool, launched on our website before Christmas, to help check their symptoms online. This tool supports self-care and also helps people to decide whether professional advice is needed, or if the condition is serious enough to seek urgent medical help. These tools are integrated into our contact centre, allowing webchats and telephone call-backs to take place where appropriate. There were over 400,000 visits to the NHS Direct website during the Christmas period (21 December – 1 January).

Leading the way with the National Pandemic Flu Service

As a key component of the Department of Health Pandemic Flu Strategy, we have been commissioned to design, build and deliver the Flu Line service. This will provide symptomatic patients with rapid access to an initial assessment, advice, triage and, where appropriate, authorisation for antiviral medicine treatment.

In the event of a pandemic, Flu Line will provide a multi-channel response over the web, via automated telephony and call-handlers in contact centres. Flu Line will use a nationally agreed clinical algorithm to assess whether patients require antiviral medicine and whether they need to be referred to a healthcare professional for further assistance and care.

Flu Line builds on our experience of running large-scale health contact centres and of delivering services over multiple channels. In the event of a flu pandemic, the Flu Line service will be central to the protection of public health and also to supporting the rest of the NHS.

During 2008/09, NHS Direct successfully produced an options appraisal for the design of the Flu Line service and secured support from the four UK health departments to proceed.

The Department of Health and HM Treasury undertook a comprehensive review of the Flu Line project and approval was granted on the basis that the requisite design, risk, commercial and legal controls were in place for a project of national significance.

On 1 December 2008, a contract was awarded to BT for the development, testing, dormant management and live launch of the UK-wide Flu Line infrastructure.

In April 2009 the World Health Organisation escalated the global pandemic alert to Level Five. This was then raised to Level Six (confirmed pandemic) on 12 June 2009. On 29 April NHS Direct was commissioned by the Department of Health and the Devolved Administrations to develop an interim Flu Service to be available for urgent deployment. This service was accepted by the Department of Health as being ready for service on 22 May.

NHS Direct and BT have now re-started work on the original Flu Service solution with likely additions to scope to bring together the end to end patient journey and to respond to lessons learnt from the May outbreak. This solution is planned to be available for 1 October 2009.

The Appointment Line

The Appointment Line (TAL) enables patients to book, change or cancel their first outpatient appointments over the telephone. By the end of March 2009, TAL expects to have answered over 3.5m calls across 2008/09. This year, TAL continued to perform very highly against its KPIs.

Our plans for 2009/10

Our third corporate objective for 2009/10 is:

To provide a service that is central to the NHS

Our success criteria for 2009/10

3.1 The National Flu Service to be ready on 31 July 2009, and operated successfully if required.*

3.2 *Participation in more than 50% of all single-point-of-access pilots.*

3.3 Operational integration for Category-C calls in at least six of the 11 ambulance trusts.

3.4 Technological integration for Category-C calls in at least three of the 11 Ambulance Trusts.

3.5 Operational and technological integration established and maintained with over 90% of all out-of-hours providers.

3.6 The stakeholder study (2010) shows a targeted % improvement (to be agreed by the Board) in composite approval score over the baseline measured in April 2009.

The table above sets out a measurement framework for delivering on this objective, as well as the main actions we will be taking during the year to continuously improve our service. Actions shown in italics are being delivered through our Strategic Development Programme.

Our actions to continuously improve our services for the future

3.7 *Understand what our customers and commissioners value.*

3.8 Continue to develop our relationships with Connecting for Health, to identify opportunities for integrating our services operationally and technologically with the National Care Records Service.

3.9 As part of the Strategic Development Programme, develop the business design of our services to take advantage of the opportunities presented through integration with the National Care Records Service.

*This refers to the National Flu Service capability, which will use the internet and telephony to provide a service for the assessment and authorisation of antivirals. The operational readiness date for the original Flu Service was impacted by the swine flu outbreak which started in April 2009. An interim solution was available for deployment from 22 May 2009 and an enhanced solution will be available from 1 October 2009.

Continuously improving our efficiency and effectiveness – our financial performance summary for 2008/09

Delivering value for money to our commissioners

Financial summary 2008/09

The Trust delivered a surplus for the year of £467,000 against an opening planned surplus of £1.1m. The surplus was generated after taking into account the cost of accrued annual leave and reorganisation expenses; it was also net of cost improvements and a funding return of £2.5m to the Department of Health.

Income from activities increased from £143.6m in 2007/08 to £159.8m in 2008/09, with associated operating expenses rising from £141.3m to £161.6m. Staffing costs increased from £87.8m to £97.8m, with £1.4m accounted for as accrued annual leave and with an increase in staff numbers from 2,598 to 2,742. The accounts include the income and expenditure associated with the development of the Flu Service.

Cash and bank balances increased by £5.6m during the year, from £19.2m to £24.8m at the year-end. Debtors decreased from £11.6m to £8.9m. Nearly £3m was invested in capital assets such as IT infrastructure, premises, equipment and facility improvements for staff and patients. Specific schemes included the development of audio and video-conferencing to reduce travel time and costs; air-conditioning facilities to improve the working environment; and furniture and telephony improvements. An element of the cash balance is to be retained and applied to future capital investment, while the majority of the balance has been agreed for a planned return to the Department of Health in 2009/10.

In 2009/10, the emphasis, momentum and drive for substantial efficiency improvements will increase significantly. The Trust must make major improvements in its capability and capacity in order to deliver cost efficiencies and drive down operating costs. Best value, value for money and sound financial management will be essential.

Funding reductions, combined with in-year cost pressures, mean a cost improvement programme of £17m must be achieved in 2009/10. We must rigorously examine our use of resources and explore all possible routes in order to deliver substantial cost and productivity improvements. This must be done whilst not only maintaining, but further improving, the quality of our patient care and user experience.

Business impact on the environment

Caring for the environment

Although NHS Direct's 36 sites have a significant carbon footprint, this is more than offset by the fact that we offer a telephone and internet-based health advice service – thus saving millions of individual car journeys to GP surgeries, health centres and hospitals.

Various energy-saving initiatives are being considered within our buildings, ranging from low-cost 'quick wins' (such as targeted Passive Infrared (PIR) light-switching) through to investment in the wholesale renewal of older air-conditioning systems.

Video-conferencing facilities are installed at all the main NHS Direct sites as well as a number of satellite offices. The system allows multiple sites to connect to the same meeting with conference-calling also possible into the same meeting, thereby reducing the need for extensive travel to a meeting place. Sites with high video conferencing usage will have second systems installed during the first half of 2009.

Other ICT-related energy reduction initiatives include: raising the temperature of the air-conditioning in IT rooms to 21 degrees Celsius to avoid unnecessary cooling; more appropriate specification of systems for the intended tasks; the re-use of older equipment for lower-intensity uses, rather than disposal; and automatic power management on PCs and printers.

The Halfords 'Cycle2Work' scheme, in which bicycles can be purchased at advantageous rates and paid for through tax-efficient salary deductions, has been introduced throughout NHS Direct and, to date, 26 employees have taken it up. The scheme will be promoted again in 2009.

Our plans for 2009/10

Our fourth corporate objective for 2009/10 is:

To continuously improve our efficiency and effectiveness

Our success criteria for 2009/10

4.1 Deliver £1.5m planned surplus for re-investment by the year-end.

4.2 *Full achievement of efficiency (CIP) target of £17m for 2009/10, and delivery of proposals for future years within the business plan for 2010-15.*

4.3 Perform within the Public Sector Payments Policy, achieving 90% compliance (Better Payment Code).

Our actions to continuously improve our services for the future

4.4 *Improve our understanding of key cost drivers, through:*

- *Service-line reporting with effect from Q1*
- *Benchmarking (eg NHS24, NHS Direct Wales, Varney Study)*
- *Estates strategy by December 2009.*

4.5 Renegotiation of Clinical Solutions contract by July 2009.

4.6 Development of an executive information system.

4.7 Deliver a five-year business plan for 2010-2015 which delivers value for money for the start of the financial year 2010/11.

4.8 Continue to develop and improve the Trust's integrated governance arrangements, in accordance with the governance action plan.

The table above sets out a measurement framework for delivering on this objective, as well as the main actions we will be taking during the year to continuously improve our service. Actions shown in italics are being delivered through our Strategic Development Programme.

Quality at the heart of everything we do, engaging members, users and commissioners

How we measure quality

In 2008/09 we worked with our staff and public members to develop meaningful indicators of the quality of our telephone conversations with users across our services. This work is supported by regularly monitoring the quality of calls with individual staff.

During 2009/10 we will report on overall quality, looking at elements of safety as well as identifying levels of empathy shown by our staff. We will use this information, along with other valuable information such as our caller satisfaction survey, to improve our services. During 2009/10, we will also develop new satisfaction measures to support the development of staff, teams and services based on feedback from users.

Delivering an excellent patient experience

We pride ourselves on providing an excellent patient experience, as evidenced by both our own regular monitoring and the independent review of it in May 2008. We are able to provide such a good experience because we listen when patients tell us how to improve, through complaints and other feedback. We also actively ask patients what they think about our services through patient and public involvement.

We also improve what we do on the basis of what we are told by other professionals and managers in the wider NHS, through our Health Professional Feedback mechanisms. In 2008/09, through our Achieving Clinical Excellence Project we actively sought the views of 450 clinicians, 2,500 NHS Direct members and members of the public, and 14 voluntary and community sector organisations from across England.

Feedback

Compliments & complaints

NHS Direct has always believed that feedback from patients and service users is a valuable source of information for helping us drive improvement. It can help us understand where we're doing well and where we could do better. Two obvious sources of information are the compliments and complaints we receive.

We try to ensure not only that we respond to all compliments, but that we also pass them on to the staff concerned.

We investigate all complaints fully, and respond with information about what we found and what we're doing about it, apologising where necessary. We try to respond to the complainant in the way they would like us to. Informal complaints are normally dealt with quickly by telephone, allowing the complainant to be involved in a discussion about the outcome of the investigation. Formal complainants receive a letter from the Chief Executive within 21 working days of making their complaint. (In more than 95% of cases, this exceeds the Department of Health's standard, which requires 95% of all complaints to be answered within 25 working days.)

Our responses to formal complaints also include information about our appeals process. 15 complaints were appealed and answered during this year, with only one complaint going on to the Healthcare Commission (which was not upheld).

	Compliments		Complaints	
	Total compliments received	Compliments per 10,000 calls answered	Total formal complaints received	Formal complaints per 10,000 calls answered
2006/7	938	1.57	981	1.64
2007/8	1,800	2.15	551	0.99
2008/9	1,388	1.49	376	0.63

During this year, NHS Direct achieved a response rate of 93.9% against our 21-day standard, and 99.2% against the Department of Health's 25-day standard.

In 2008/9, the year-on-year trend of fewer complaints continued. Although the number of compliments was slightly less than during 2007/8, it was much higher than in 2006/7.

Dealing with adverse incidents

We have robust systems and processes in place for the very rare occasions when we get things wrong. These involve investigating and learning from adverse incidents, which also contributes to the overall quality of experience and safety for all our patients. In 2008/09, there were 75 serious adverse incidents which were escalated for review by a team of clinicians within NHS Direct. Of these, five led to actual harm to the patient, which is within the 10% indicator agreed with the Department of Health. This is an adverse incident rate of 0.13 per 10,000 calls compared to figures of 0.18 per 10,000 calls in 2007/08 and 0.29 per 10,000 calls in 2006/07.

We take all incidents and near-misses very seriously. That is why we learn as much as we can about each incident, with the goal of improving the safety and quality of what we do. In 2008/09, together with other NHS Trusts, we contributed to the wider learning of the NHS by reporting incidents to the National Patient Safety Agency through the National Reporting and Learning System (information about incidents is anonymised before sharing). When an incident relates to a patient experience with more than one organisation, we contribute to joint reviews with the other agencies involved.

Hearing our stakeholders

NHS Direct interacts with a wide variety of stakeholders locally and nationally. These include professional groups, patient groups, clinicians, health-service providers and commissioners. Hearing our stakeholders is vitally important to NHS Direct, since it helps us to improve the service we offer to patients and also to monitor how well we are performing.

We meet our stakeholders throughout the year at meetings, conferences and events across the country. We have a presence at major health-service events, such as the Royal College of Nursing's annual congress and the NHS Confederation and NHS Alliance annual conferences.

We also host our own events, such as the series of Achieving Clinical Excellence workshops (these, held with clinicians, help to evaluate our most commonly used algorithms). We also held a joint event with the Department of Health, to review how NHS Direct can better support people with diabetes.

This year we commissioned Jigsaw Research to interview over 200 national and regional stakeholders, to help gain an objective picture of how we are viewed within the health community. The research covered many aspects of our core and enhanced services. Just over half (54%) of our stakeholders rated our overall service as 'Good, very good or excellent', with a further 36% rating it as 'Fair'. We aim to repeat the research next year, and will be looking to improve this overall rating.

Growing membership base contributing to our development

We have recruited over 17,000 public members (over half of them joined us during 2008/09). This year, our members told us how we could further develop our online resources to enable members to engage with us and to influence how services are developed in future. Following this, we developed a set of online tools to involve members in prioritising the corporate objectives in our Business Plan.

Our members also helped us to develop the cold and flu self-assessment tool. We involved our members in reviewing to what extent we treat our callers with respect and dignity.

Our members, patients and the public told us they trust us to keep their information safe, and were confident we would ask their permission first if we ever needed to share their details with anyone else. In response to feedback from members, we are reviewing our health information directory and the way in which we ask questions (to ensure that we are clear and can be understood).

We have an active and engaged membership. We continue to be impressed with the high level of responses we receive from our members, whether we engage with them collectively or individually.

PPI strategy

Our Patient and Public Involvement Strategy outlines how we will involve patients and the public. We interview 750 people every month to find out about their experience of calling NHS Direct, and we act on what they tell us. We work closely with the rest of the NHS, social care, voluntary sector and Local Involvement Networks (LiNKs) to improve our services. We report on what people have told us, and also tell people what we have done, following their suggestions, to improve our services.

Our plans for 2009/10

Our fifth corporate objective for 2009/10 is:

To put quality at the heart of everything we do, engaging members, users and commissioners

Our success criteria for 2009/10

5.1 Quality KPIs: Call-review tool scores.

5.2 Complaints under 1 per 10,000 calls.

5.3 Evidence of more than 10 measurable improvements made following input from members, the public, patients, staff and commissioners.

The table above sets out a measurement framework for delivering on this objective, as well as the main actions we will be taking during the year to continuously improve our service. Actions shown in italics are being delivered through our Strategic Development Programme.

Our actions to continuously improve our services for the future

5.4 Deliver Stakeholder Engagement Strategy by June 2009, and implement it during 2009/10.

5.5 Implement our Patient and Public Involvement and Membership Strategies in accordance with the agreed milestones in the Directorate plans.

We're here for David

I phoned for advice because I had a swollen throat and hadn't been able to eat or drink for two days. I had already tried to take paracetamol for the pain but this was too difficult as I was having problems swallowing. When I called NHS Direct the nurse advisor said she thought my condition sounded like dehydration and they called an ambulance for me which arrived promptly. At hospital I was put on a drip for 6 hours and given soluble paracetamol which made me feel much better. I was sent home the next day where my condition improved rapidly.

The benefit of calling NHS Direct was that I felt that people really listened to me. When you live on your own, it's easy to feel vulnerable if you suddenly feel unwell. Knowing NHS Direct is there for me 24/7, 365 days a year has given me a great deal more confidence because I know I can contact them for advice and reassurance whenever I need it.

Delivering services to meet local needs through our national infrastructure

Being local and national

National programmes

In addition to the solutions we deliver regionally and locally, we build and maintain national relationships with the wider NHS and other external organisations. Raising the profile of our services, and gaining engagement with commissioners at a strategic level, ensures that decision-makers are aware of the extent of NHS Direct's capabilities and are confident in our ability to deliver clinically robust, cost-effective and patient-focused services.

In combining a national infrastructure with local delivery, NHS Direct is flexibly able to provide centrally commissioned services which underpin national strategy or link similar locally commissioned projects. This provides high-quality patient outcomes via experienced staff; enables economies of scale by reducing programme duplication; and provides consistent, standardised reporting for project evaluation and assessment. Examples of this national work include the running of The Appointment Line (TAL) for 'Choose and Book', the support line for the Summary National Care Record, and an online support programme for the HPV vaccine campaign.

Developing and delivering enhanced services

We have a lengthy track record in developing and delivering services which support the wider health economy by providing high-quality services to their patients and communities.

We concentrate our efforts in areas where we can add real value. We work in strategic partnerships, helping to develop and deliver innovative new solutions to the challenges facing the health economy at local, regional and national levels.

Long-term conditions

The management of long-term conditions through non-face-to-face contact is an emerging market. NHS Direct has developed strategic partnerships with both Humana Europe and Pfizer Health Solutions to grow our product range specialising in behavioural change programmes.

We are also working in partnership with the Met Office to further extend the 'Weather Watch' service (this supports patients with chronic obstructive pulmonary disease during the winter months).

During 2008/09, we have had the opportunity to work very closely with primary care trusts in developing a new weight-management service. Under this programme, we act as the intelligent front-end offering advice and referral to community services for callers with weight-related issues.

Our intention is to develop our service to support both health services and social services in the wellness agenda.

Urgent care

Urgent (or non-emergency) care forms an important part of our services for those with non-life-threatening issues. Urgent care at NHS Direct includes services such as out-of-hours GP and dental services; support for ambulance service Category-C calls; the development of Single Points of Access (SPA) models; and investigating and piloting approaches which may support the future delivery of a single three-digit number for non-emergency calls.

West Yorkshire Single Point of Access

This year, NHS Direct won a tender to deliver a Single Point of Access for urgent care across the five primary care trusts in the West Yorkshire area: Bradford & Airedale; Calderdale; Kirklees; Leeds; and Wakefield District.

This ground-breaking service provides a Single Point of Access for urgent care to the people of West Yorkshire. It is the first of its kind in the country to span such a large population. The service enables patients to dial a single number to receive an assessment by telephone if they feel they have a problem requiring urgent care. This is as opposed to emergency care, where patients will still call 999.

We are working with the five trusts to ensure that local demands for urgent care are managed effectively: our goal is to provide the right care in the right place and at the right time. We anticipate that our proposed staffing combination, including additional nurse-specialist roles and GPs, combined with excellent local knowledge, will ensure we provide the very best response for local people.

Handling ambulance service Category-C calls

Demand for ambulance services is increasing year-on-year. This places the regional services under increasing pressure, especially during winter. Of all emergency calls made to ambulance trusts, approximately a third continue to be non-urgent 999 calls (often called Category-C calls). Drawing on our previous integrations with some ambulance trusts, we know that 40% of these Category-C calls could have been dealt with by NHS Direct. We already work with a number of trusts on this, and hope to extend it to other trusts as well.

Out-of-hours GP and dental services

We understand the importance of providing services to patients and the public when their usual GP or dental service is closed. We already provide a number of out-of-hours services to local primary care trusts across England, and continually develop our contact-handling and triage services to ensure we offer the best possible products in this area.

Accessing local dental services for patients either in pain or seeking preventative care remains a key commissioning area for primary care trusts, and NHS Direct continues to deliver locally focused solutions across the country. By adopting clinically proven assessment processes, patients can be assured that they will be guided to either an appropriate service or, alternatively, provided with supportive advice. In some areas, we partner strategically to offer both contact centre and face-to-face services.

In both our GP and dental out-of-hours services, patients can be reassured by our approach to safety, governance and delivery against nationally set performance targets. This is uncompromised even during long bank holiday weekends, where services typically receive a far greater number of patient contacts.

Through World Class Commissioning, our commissioners recognise that there is an opportunity to develop patient-focused services which innovate and allow providers' particular strengths to work in the best interests of our patients. We are proud to partner with our commissioners in reaching their service aspirations.

Our plans for 2009/10

Our sixth corporate objective for 2009/10 is:

To deliver services to meet local needs through our national infrastructure

Our success criteria for 2009/10

6.1 *Increase enhanced services turnover to £24.5m or more.*

6.2 Successfully deliver the first year of the contract with West Yorkshire and achieve the milestones set out in the contract.

Our actions to continuously improve our services for the future

6.3 *Agree our target market for enhanced services by June 2009, and develop our service portfolio by August 2009.*

6.4 *Design (by August 2009) and begin the implementation (by November 2009) of an operating model and supporting organisation structure which supports the delivery of our enhanced services.*

6.5 Improve bid/win ratio to 1 in 5 by the year-end (robust measures to be in place by June 2009) and regular win/loss reports to ensure the validity of model.

The table above sets out a measurement framework for delivering on this objective, as well as the main actions we will be taking during the year to continuously improve our service. Actions shown in italics are being delivered through our Strategic Development Programme.

Supporting the NHS in new ways of working in the multi-channel world

Our multi-channel strategy

NHS Direct is more than just a call centre. By providing web-based services such as self-assessment tools and real-time webchat with nurses and health advisors, we are able to offer health advice, information and reassurance to anyone, anywhere, through the contact channel of their choice.

We have identified a number of ways which will enable us to continue providing this unique service. These new methods will support our quest to deliver an interactive digital facility to the nation's health service.

We will introduce a new core digital platform to allow the effective delivery of our services, regardless of channel, to the millions of people who use our service every year. To do this, we will be working with a range of NHS public-sector and third-sector organisations and services to reach those areas where we are most needed.

We will conduct research to better understand our users and what they expect from a digital NHS service. We will continue to use new technologies, such as Facebook and Twitter, to engage with our users. We will also continue to pilot innovative ideas in order to reach more of the nation.

New technologies

Over the last 12 months, NHS Direct has seen a change of direction for its multi-channel services, with the migration of health information and 'local services search' away from the main site to NHS Choices. The move came about as part of the wider decision to join forces with NHS Choices. On 1 April 2009, NHS Direct discontinued its Sky Interactive service (the Freeview service is continuing, but will be hosted by NHS Choices).

Integrating NHS Direct and NHS Choices will ensure that all health information is hosted by one provider, making it more accessible for users. NHS Direct will continue to provide a telephone service on 0845 4647, providing health advice and information around the clock, including weekends.

Following the migration of content to NHS Choices, a new website was launched, with a new house style, in October. As part of this we have begun redeveloping the self-help guide into a new tool called the self-assessment tool. This is intended to maximise the user's ability to self-care, and to ensure that it is easy for users to switch from online help to the telephone service without having to repeat the same information.

In addition, we successfully ran an emergency contraception campaign via the social-networking site Bebo. Over a two-month period, more than 46,000 users engaged in webchats with health information advisors, averaging around 12 minutes each.

Self-assessment tools

The existing online self-help guide has been extremely successful, with approximately 3.5m people using it each year. Due to its success, the multi-channel team is developing a new generation of self-assessment tools which build on what has been learnt by operating the self-help guide so far. We have already successfully launched a number of topics, including colds and flu, contraceptive advice and sexual health.

When fully developed, the self-assessment tools will replace the self-help guide and will allow for integration with other channels (such as telephony, email and webchat). Therefore, journeys started with the self-assessment tool can be continued, if necessary, through other channels such as the telephone.

This self-assessment service is unique in delivering health information to our users, as it is linked directly to our contact centres. These innovative services will be syndicated to partner organisations with experience in similar fields and interactive digital services. This will help to maximise the number of people we reach with our service.

Our plans for 2009/10

Our seventh corporate objective for 2009/10 is:

To support the NHS in new ways of working in the multi-channel world

Our success criteria for 2009/10

7.1 Replace the self-help guide with self-assessment tools.

7.2 Increase customer satisfaction with non-voice channels (a tracking method to be in place by June 2009).

7.3 *Increase the use of non-voice channels as a percentage of overall contact. The baseline to be set as of 1 April 2009.*

Our actions to continuously improve our services for the future

7.4 Deliver improvements to our corporate website.

7.5 Create a plan for the positive strategic use of Web 2.0 technologies, such as social networking, in order to improve engagement and to deliver services.

7.6 *Deliver a blueprint for an integrated service delivery operating model for non-voice channels as an outcome of the Strategic Development Programme.*

The table above sets out a measurement framework for delivering on this objective, as well as the main actions we will be taking during the year to continuously improve our service. Actions shown in italics are being delivered through our Strategic Development Programme.

We're here for Yusra & Anisa

I'd like to tell you about my experience of using NHS Direct because it meant such a lot to me and my family. Anisa fell over and bumped her head in the classroom at school. When she got home she complained of a headache and I was concerned because she does not get headaches very often.

Anisa hadn't told her teacher that she'd had an accident so I was really worried because she must have been in discomfort for some hours. I gave her some painkillers but that didn't seem to help.

My husband wanted to take Anisa to our local GP but I remembered NHS Direct and suggested giving them a call. I was put through to a nurse advisor who advised me to care for Anisa at home but keep a close eye on her. She explained that head injuries can cause symptoms hours or days later, so I needed to pay close attention to her. She advised me to keep Anisa at home the next day to be on the safe side, allow her to get plenty of rest and make sure she avoided any vigorous activity for the next couple of days. Anisa was soon back to her normal self and my husband and I felt really relieved. I realised that it's natural to be worried about a bump to your child's head.

Public Interest and Governance

Statutory background

On 1 April 2007, NHS Direct changed its status from a Special Health Authority to an NHS Trust under the NHS Direct NHS Trust (Establishment) Order 2007 No 478. Its operating framework, including standing orders and standing financial instructions, is set out in its Corporate Governance Manual. A Board was established, comprising a Chair, seven non-executive directors and five executive directors.

The Board and the Chief Executive as Accounting Officer are responsible for preparing the Annual Report, Remuneration Report and the financial statements in accordance with the National Health Service Act 2006 (and directions made there under by the Secretary of State with the approval of HM Treasury). They are also responsible for ensuring the regularity of financial transactions.

Governance framework

The Board manages the Trust through the following committees, with the support of the Executive Management Team.

The Board's membership is:

Joanne Shaw (Chair from August 2008)
Trevor Jones (Vice-Chair from September 2008)
Philip Baker (Non-Executive)
Tim Walton (Non-Executive)
Sue Hunt (Non-Executive)
Peter Catchpole (Non-Executive)
Derek Newman (Non-Executive)

Nick Chapman, Chief Executive
Trevor Smith, Finance Director
Ronnette Lucraft, Commercial Director
Helen Young, Clinical Director/Chief Nurse
Paula Higson, Chief Operating Officer

Alan Bentall, Interim Chief Information Officer and Roger Rawlinson, Human Resources Director are non-voting members of the Trust Board.

David Edmonds was the Chairman of NHS Direct from 1 April 2004 to 31 July 2008.

There has been one vacant non-executive director post since 1 August 2008.

The Board reviewed its Committee structure and agreed a revised structure and changes at its September 2008 Board meeting.

The structure consisted of the following Committees during 2008/09:

- Audit Committee (Risk Committee responsibilities were transferred to the Audit Committee from 16 December 2008, by agreement of the Board)
- Risk Committee (disbanded by the Board on 16 December 2008 with its responsibilities transferred to the Audit Committee)
- Clinical Governance Committee
- Remuneration Committee
- Appointments Committee (established 22 September 2008)
- Investment Committee (established 22 September 2008).

The membership of the Board's Committees is:

Audit Committee:
Peter Catchpole (Chair)
Trevor Jones
Sue Hunt
Derek Newman (from 22 September 2008)
Tim Walton (to 22 September 2008)

Clinical Governance Committee:
Phil Baker (Chair)
Trevor Jones
Derek Newman (from 22 September 2008)
Helen Young, Clinical Director/ Chief Nurse

Remuneration and Terms of Service Committee:
Trevor Jones (Chair)
Phil Baker (from 22 September 2008)
Peter Catchpole (to 22 September 2008)
Tim Walton

Ad Hoc Appointments Committee (from 22 September 2008):
All non-executive directors are eligible

For executive director appointments:
the Chair plus one non-executive director

For the appointment of a Chief Executive:
the Chair plus two non-executive directors

Investment Committee (from 22 September 2008):
Derek Newman (Chair)
Sue Hunt
Tim Walton
Trevor Smith, Finance Director
Ronnette Lucraft, Commercial Director

Risk Committee (to 16 December 2008):
Derek Newman (Chair)
Peter Catchpole
Tim Walton

Non Executive Directors' biographies

1. Joanne Shaw

Joanne joined the Board on 1 April 2004 and took over as Chair of NHS Direct in August 2008. She is Chairman of Datapharm Communications, which provides digital medicines information to the NHS, the pharmaceutical industry and the general public. She was also a Trustee for the Long-term Conditions Alliance until 1 August 2008. She chairs the not-for-profit company behind Ask About Medicines, the independent campaign to increase people's involvement in decisions about their use of medicines. Joanne's principal interests are partnership between patients and health professionals, and the use of new communication channels for health and medicines. After serving on the management board of the Audit Commission, she became Director of Medicines Partnership, a Department of Health initiative to improve the use of medicines within the NHS. She previously worked internationally as a strategy consultant with the Boston Consulting Group.

2. Philip Baker

Philip joined the Board on 1 April 2007. He is Director of the National Institute for Health Research (NIHR) Biomedical Research Centre in Manchester, and was previously Head of Manchester Medical School—one of the largest and most successful medical schools in Europe. He is also a practicing Consultant Obstetrician at St Mary's Hospital, Manchester, and directs a leading pregnancy research group. Under his leadership, the medical school moved out of financial deficit and he led the successful application for a national clinical research facility.

3. Peter Catchpole

Peter joined the Board on 1 April 2004. He has worked as a senior executive in the NHS for 30 years, 20 as a Chief Executive. He has also been a non-executive director for organisations in the not-for-profit and charity sectors. He is currently a County Councillor in West Sussex and a Fellow of the Faculty of Health, and teaches at the University of Brighton Business School and Post-Graduate Medical School. He also holds a number of appointments in the professional regulatory sector, and is an independent healthcare consultant and business advisor to the independent health sector.

4. Sue Hunt

Sue joined the Board on 1 April 2007. She currently holds an Appointed Trustee position at CfBT Education Trust. She is a Chartered Accountant who spent 18 years with global accountancy and business advisory firm KPMG, both as a Consultant and Director. During that time, she worked with a range of clients from the public and private sectors, both in the UK and internationally. Sue was instrumental in setting up a multi-disciplinary healthcare group at KPMG. She advised 16 trusts on all aspects of their Foundation Trust application process, either directly or on behalf of the Department of Health.

5. Trevor Jones

Trevor joined the Board on 1 April 2007 and is an accountant with 29 years' experience in the NHS. He is the former Head of the Scottish Executive Health Department and Chief Executive of NHS Scotland, working with Scottish ministers to establish NHS 24 and to introduce the ban on smoking in public places. More recently he was Chief Executive of a strategic health authority and a member of the NHS Leadership Forum advising the Secretary of State on health policy. He currently holds a number of non-executive director roles in both the public and private sectors.

6. Derek Newman

Derek joined the Board on 1 April 2004. He has more than 20 years' experience as a Chief Information Officer (CIO) in the private sector, and has worked as an independent management consultant. He has held the position of CIO at Northern Foods and Group CIO at Zeneca. Previously, he was European IT Director with ICI, based in Brussels.

7. Tim Walton

Tim joined the Board on 1 April 2007. He is an independent consultant and non-executive director on the Operating Committee of the Department for Business, Enterprise and Regulatory Reform (simply referred to as 'BERR'). His last post was as Chief Information Officer (CIO) for CLM, the Olympic Delivery Authority partner for London 2012. His career has included executive and non-executive roles spanning operational, commercial, financial, e-business and IT assignments in civil and military aerospace, construction and design engineering. A Fellow of the British Computer Society and a Chartered Engineer, Tim has been a member of various steering boards for industry initiatives and is also a guest speaker on Warwick and Oxford MBA Courses.


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Executive Directors' biographies

1. Nick Chapman, Chief Executive

Nick was appointed Chief Executive of NHS Direct from 1 April 2009. He had been the Department of Health's National Director for the 18-week target since 2006. He was also responsible, as SRO within the National Programme for IT, for the Choose and Book and PACS programmes. He joined the Department of Health on secondment from the NHS in 2005 to work on reducing cancer waits, elective waiting times, and the implementation of patient choice and booking. Nick has practical experience in leading and managing NHS organisations and of delivering and sustaining low waiting times. He joined the NHS in 1979 as a national trainee in the South East. After a variety of administrative and managerial posts, he became Unit General Manager for Lewisham Hospital in 1987. He moved to Dorset in 1991 and spent the next 14 years as a Chief Executive for trusts in West Dorset and then Somerset.

2. Paula Higson, Chief Operating Officer

Paula is the Chief Operating Officer of NHS Direct. She joined on 1 May 2008 and is responsible for ensuring the effective and efficient delivery of NHS Direct services. She has 10 years' experience of working at board level in public service organisations. Previously, she was Senior Director for Managed Migration for the UK Border Agency, where she led the programme for the launch of the points-based system and was responsible for improved customer service and a more commercial approach. Prior to UKBA, Paula was Customer Services Director for Three Valleys Water. She has also held senior management positions in the BBC. Paula served as the Interim Chief Executive of NHS Direct from 1 January to 31 March 09.

3. Helen Young, Clinical Director/ Chief Nurse

Helen joined the Board in December 2004 as Executive Director of Nursing. In February 2006 Helen was appointed as the Clinical Director/Chief Nurse of NHS Direct. She is responsible for ensuring safe, effective and evidence-based clinical services for our patients and users, as well as being the clinical professional lead for NHS Direct. Helen has held a number of executive and senior management, lead nurse and midwifery positions in large acute, mental health and community NHS trusts. These include East Kent, Conwy and Denbighshire, Chelsea and Westminster, and Guy's and St Thomas'. Helen has advised the Department of Health on overseas recruitment, 'back to nursing', and educational issues.

4. Roger Rawlinson, Human Resources Director*

Roger joined NHS Direct on 1 September 2007, having worked for 15 years in a variety of human resource positions in clothing manufacturing and retailing. He was appointed Group Human Resources Director of William Baird in 2000. In 2003, he joined Bedfordshire & Hertfordshire Strategic Health Authority as HR Director and Chief Executive of the Workforce Development Confederation. He then worked for the East of England Strategic Health Authority, following the commissioning of a patient-led NHS reconfiguration.

5. Ronnette Lucraft, Commercial Director

Ronnette joined the Board on 11 April 2007, with responsibility for business development, marketing and communications, and multi-channel integration. Ronnette has held senior management positions within the communications and new media industries at BT, Telewest and ntl (now Virgin Media). She has also worked with NHSU and as an NHS LIFT Chief Executive, developing new healthcare facilities for the South West London local health economy. She also spent two years with Living Health, which led the way in providing television-based public healthcare services.

6. Alan Bentall, Chief Information Officer (Interim)*

Alan was seconded to NHS Direct as Chief Information Officer from the professional services firm Deloitte, where he is an Associate Partner in the Technology Integration practice. He has over 25 years' experience in the software and telecommunications sector, more recently focusing on the delivery of major technology-enabled business-change programmes in the public sector. He has held leading roles on assignments in many of the bigger central government departments as well as in a selection of private businesses; these include the Department for Work and Pensions, HMRC, the Ministry of Defence, Connecting for Health and Royal Mail Group. Alan's career has also included roles as Operations Director at Praxis, a software and systems development company specialising in the development of business-critical applications, and as head of ICT in a medical electronics company.

7. Trevor Smith, Finance Director

Trevor joined the Board as Finance Director in January 2009 from Barking, Havering and Redbridge NHS Trust, where he initiated the Turnaround Programme and led the Financial Recovery Plan. His previous Finance Director roles include Basildon and Thurrock University Hospitals NHS Foundation Trust, where he led the successful first-wave FT Financial Application and Assessment process and Billericay, Brentwood and Wickford Primary Care Trust. He joined the NHS in 1996 as a Finance Manager with Barking, Havering and Brentwood Community and Mental Health Trust before going on to become their Acting Director of Finance. Prior to joining the NHS, Trevor trained and qualified with the London Borough of Havering.

* The Chief Information Officer and the Human Resources Director are non-voting members of the Trust Board.


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Directors' declarations of interest during 2008/09

Note: Directors who no longer hold Director posts with NHS Direct are in grey.

All members of the Board have declared any outside interests they hold, as detailed below:

Alan Bentall

Employee of Deloitte MCS Ltd, which has contractual relationships with NHS Direct

Murray Bain
None declared

Philip Baker
Director, National Institute for Health Research Biomedical Research Centre
Practicing Consultant Obstetrician, St Mary's Hospital, Manchester

Peter Catchpole
Board member and Trustee, RETT Syndrome Association UK
Lay member, General Dental Council
Lay member, Nursing and Midwives Conduct and Competence Committee
Associate member, General Medical Council, Fitness to Practice Committee
Lay member, British Association of Psychotherapy and Counselling Conduct Committee
County Councillor, West Sussex County Council

Nick Chapman
Philippa Chapman (wife) is Chair, Sherbourne Youth and Community Centre.

David Edmonds
Chairman, Legal Services Board
Chairman, Wincanton plc
Chairman, NHS Shared Business Services
Director, William Hill plc
Director, Hammerson plc
Trustee, Social Market Foundation

Steve Elvin
None declared

Nigel Gooding
Director Fifth Consultancy Services Ltd

Steve Hopkins
Partner, VERTEX Consultancy LLP
Non-executive director of Stalink Ltd
Contract for Interim Management Services with NHS Direct
Investments:
- Sandpiper Investments Ltd
- VERTEX Consultancy Ltd
- Stalink ltd

Paula Higson
None declared

Sue Hunt
Appointed Trustee, CfBT Education Trust

Trevor Jones
Director, National Patient Safety Agency
Director, Sport England South West – ceased December 2008
Director, Pinnacle Staffing Group plc – ceased September 2008
Trustee, WellChild (a charity)

Ronnette Lucraft
Director, More Than This Ltd

Derek Newman
Trustee on the Board of the Croft House Settlement, Sheffield

Mike Pack
None declared

Roger Rawlinson
None declared

Joanne Shaw
Director, Vanguard Metropolitan Ltd
Chairman, AAMW Ltd
Chairman, Datapharm Communications Ltd
Trustee, Long-Term Conditions Alliance (ceased 1 August 2008)

Trevor Smith
None declared

Matt Tee
53,000 (0.45%) shares in Dr Foster
Relative of contractor supplying professional services to NHS Direct and subsequently a member of staff, Dave Tee

Tim Walton
Non-Executive Director, Accent Group
Non-Executive Director, BERR
Director, Timothy Walton and Associates Limited
Chair, Rural Solutions Limited

Helen Young
Director, Home James of London
Trustee and named individual, Dorothy House (hospice)

Information governance

Incidents, the disclosure of which would in itself create an unacceptable risk of harm, may be excluded in accordance with the exemptions contained in the Freedom of Information Act 2000 or may be subject to the limitations of other UK information legislation.

Table 1: Summary of protected personal-data-related incidents formally reported to the Information Commissioner's Office in 2008/09

Date of incident (month)	Nature of incident	Nature of data involved	Number of people potentially affected	Notification steps
May	Loss of inadequately protected laptop from secured NHS premises	Name, address, reason for absence from work	60	Police notified
October	Loss of inadequately protected laptop from outside secured NHS premises	Name, address, email address.	71	Police notified
October	Unauthorised disclosure	Name, NHS number, date of birth, clinical metrics, address, telephone number.	100	None recorded
Further action on information risk	The Trust will continue to monitor and assess its information risks in light of the events noted above, in order to identify and address any weaknesses and ensure continuous improvement of its systems. Planned steps for the coming year include: • Appointing and training an Information Risk Manager • Implementing an information risk-assessment and management programme • Introducing privacy impact assessments into new projects • Appointing and training Information Asset Owners.			

Table 2: Summary of other protected personal-data-related incidents in 2008-09

Incidents deemed by the Data Controller not to fall within the criteria for report to the Information Commissioner's Office, but recorded centrally within the Department, are set out in the table below. Small, localised incidents are not recorded centrally and are not cited in these figures.

Category	Nature of incident	Total
I	Loss of inadequately protected electronic equipment, devices or paper documents from secured NHS premises	0
II	Loss of inadequately protected electronic equipment, devices or paper documents from outside secured NHS premises	2
III	Insecure disposal of inadequately protected electronic equipment, devices or paper documents	1
IV	Unauthorised disclosure	2
V	Other	0

Equal opportunities

The Trust is committed to a policy of equal opportunity, to ensure that both current employees and applicants for employment are not discriminated against on any grounds.

Policy in relation to disabled employees

Guidance relating to disabled employees appears in a number of human resource policies, including the Equal Opportunities Policy and the Positive Management of Attendance Policy. There is also a series of actions relating to disability in the Trust's Equality & Diversity Strategy, including the development of a Disability Equality Scheme. NHS Direct currently has 83 employees (2.5%) with a declared disability.

Better Payments Practice Code

The Better Payments Practice Code requires the Trust to aim to pay all valid invoices by the due date or within 30 days of receipt of the goods, or a valid invoice date, whichever is the later. Performance in relation to this code is reported in note 7 of the accounts.

Public Sector Information Holders

The Trust has complied with the cost allocation and charging requirements set out in HM Treasury and Office of Public Sector Guidance.

Key stakeholders

During 2008/09, NHS Direct's core service was commissioned by the Department of Health.

Minister of State for Health Services
Ben Bradshaw MP

NHS Chief Executive
David Nicholson

Local commissioners within the primary, acute and social care sectors are also key stakeholders.

NHS Direct has contractual relationships with the following organisations which are essential to the delivery of the NHS Direct service:

- CAS Services Ltd, for application and managed services
- BT, for telephony and network services
- Adastra Software Ltd, for technology solutions for out-of-hours links.

Name of Auditor

These accounts have been audited by the Comptroller and Auditor General in accordance with the National Health Service Act 2006. The external auditor is responsible for reporting whether, in his opinion, the financial statements give a true and fair view of the state of affairs of the Authority's reported financial position and whether the Trust has complied with relevant legislation and other requirements. The Trust incurred audit fees of £107,500 for 2008/09, this includes £7,500 for audit work completed in respect of the implementation of International Financial Reporting Standards in 2009/10. No other audit services were provided during this period.

Pensions

Past and present employees are covered by the provisions of the NHS Pension Scheme. A detailed explanation of how pension liabilities are treated in the accounts of the organisation can be found in Note 1.8 under Accounting Policies in the annual accounts, and also under the Remuneration Report within this annual report.

Disclosure of relevant information

As far as I am aware, there is no relevant information of which the NHS body's auditors are unaware, and I have taken all the steps that I ought to have taken as Accounting Officer in order to make myself aware of any relevant audit information and to establish that the NHS body's auditors are aware of that information.

Remuneration Report

Remuneration Committee

The Remuneration Committee is a sub-committee of the Board, to which it makes recommendations and is accountable. It is chaired by a Non-Executive Director (Trevor Jones) and membership is made up of two further Non-Executive Directors (Tim Walton and Philip Baker (from 22 September 2008; the previous member was Peter Catchpole, Non-Executive Director). The current terms of reference were amended and agreed by the Remuneration Committee in July 2008, and by the Trust Board in September 2008.

Within its terms of reference, the principal duties of the Remuneration Committee relate to the Chief Executive and Executive Directors, and are to determine appropriate remuneration and terms of service; approve annual salary uplifts and recommend bonus payments to the Board, if appropriate; and monitor and review individual and collective performance.

The Chief Executive, HR Director and Head of Governance are invited to attend the committee in an ex-officio capacity to address matters which do not affect them directly.

Remuneration policy and framework

The executive remuneration policy is linked to the Very Senior Manager Pay and Remuneration Framework issued by the Department of Health for strategic health authorities and primary care trusts.

The Remuneration Committee assessed the performance-related pay objectives of the Executive Directors for 2008/09 and made recommendations for payments to the Board. The bonus awards were under the threshold of 5% of the Very Senior Manager pay bill.

In 2008/09, the increase in the annual pay bill for the Executive Directors was contained within an overall uplift of 2.75% (as requested by the Department of Health). This resulted in a 2.2% increase from April 2008.

The following Salaries and Allowances and Pension Benefits tables have been audited.

Contractual notice periods, salaries and potential performance-related pay of Executive Directors

See tables below.

No executive directors received any further allowances or compensation.

Executive Directors' Contracts and Notice Periods

Name	Role	Start	Notice	Nature	Continuous service date
Matt Tee	Chief Executive (to 31/12/08)	01/07/07	6 months	Permanent	01/07/07
Paula Higson	Chief Operating Officer (Interim Chief Executive from 01/01/09 to 31/03/09)	01/05/08	3 months	Permanent	01/05/08
Nigel Gooding	Chief Operating Officer (Interim to 31/03/09)	04/02/09	6 months	Interim	N/A
Murray Bain	ICT Director (to 30/06/08)	01/09/1999	6 months	Permanent	10/03/1970
Alan Bentall	ICT Director (Interim)	11/06/08	N/A	Interim	N/A
Helen Young	Clinical Director/Chief Nurse	01/12/04	6 months	Permanent	11/08/1987
Mike Pack	Finance Director (to 30/06/08)	01/05/07	3 months	Permanent	10/04/07
Steven Hopkins	Finance Director (Interim to 31/12/08)	04/08/08	N/A	Interim	N/A
Trevor Smith	Finance Director	02/01/09	3 months	Permanent	22/04/1996
Ronnette Lucraft	Commercial Director	11/04/07	3 months	Permanent	11/04/07
Roger Rawlinson	HR Director	01/09/07	3 months	Permanent	01/09/03
Steve Elvin	Acting Chief Operating Officer	01/02/08	3 months	Interim	01/04/75

Salaries and Allowances

Name and title	2008-09			2007-08		
Salary and Pension Entitlement of Senior Managers	Salary (bands of £5,000) £000	Other Remuneration (bands of £5,000) £000	Benefits in kind (Rounded to the nearest £00) £00	Salary (bands of £5,000) £000	Other Remuneration (bands of £5,000) £000	Benefits in kind (Rounded to the nearest £00) £00
David Edmonds (Chair to 01.08.08)	10-15	0	0	35-40	0	1
Joanne Shaw (Non Executive: Chair from 01.08.08)	25-30	0	0	5-10	0	0
Peter Catchpole (Non Executive)	10-15	0	0	10-15	0	0
Derek Newman (Non Executive)	5-10	0	0	5-10	0	1
Sue Hunt (Non Executive)	5-10	0	0	5-10	0	1
Philip Baker (Non Executive)	5-10	0	0	5-10	0	0
Trevor Jones (Non Executive)	5-10	0	0	5-10	0	1
Tim Walton (Non Executive)	5-10	0	0	5-10	0	1
Matt Tee, Chief Executive to 31.12.08	115-120	0	0	115-120	0	0
Paula Higson, Chief Operating Officer from 01.05.08 and Interim Chief Executive from 01.01.09 to 31.3.09	130-135	0	0	0	0	0
Murray Bain, Director of ICT to 30.06.08	25-30	0	0	100-105	0	3
Helen Young, Clinical Director/ Chief Nurse	110-115	0	0	115-120	0	0
Mike Pack, Director of Finance to 30.06.08	30-35	0	0	115-120	0	3
Trevor Smith, Director of Finance from 02.01.09	30-35	0	0	0	0	0
Roger Rawlinson, Director of Human Resources	100-105	0	1	55-60	0	0
Ronnette Lucraft, Commercial Director	110-115	0	0	105-110	0	2
Steve Elvin, Acting Chief Operating Officer to 30.04.08	5-10	0	0	5-10	0	0

Amounts paid to third party organisations

The costs shown below for Alan Bentall, Nigel Gooding and Steve Hopkins are the amounts paid by NHS Direct to external organisations for their services.

Name	Total Cost
Alan Bentall – Interim Chief Information Officer from 11.6.08	£140-145k (2007/08 £nil)
Nigel Gooding, Interim Chief Operating Officer from 04.02.09 to 31.03.09	£40-45k (2007/08 £nil)
Steve Hopkins, Interim Director of Finance from 04.08.08 to 31.12.08	£80-85k (2007/08 £nil)

Pension Benefits Table

Name	Real increase in pension at age 60 (bands of £2,500) £000	Real increase in pension lump sum at aged 60 (bands of £2,500) £000	Total accrued pension at age 60 at 31 March 2009 (bands of £5,000) £000	Lump sum at age 60 related to accrued pension at 31 March 2009 (bands of £5,000) £000	Cash Equivalent Transfer Value at 31 March 2009 £000	Cash Equivalent Transfer Value at 31 March 2008 £000	Real increase in Cash Equivalent Transfer Value £000*	Employer's contribution to stakeholder pension £00
Matt Tee – Chief Executive	0-2.5	5-7.5	15-20	45-50	249	170	74	0
Paula Higson – Chief Operating Officer	0-2.5	0-2.5	0-5	0-5	25	0	25	0
Murray Bain – Director of ICT	2.5-5	12.5-15	50-55	160-165	1,314	785	510	0
Helen Young – Clinical Director	0-2.5	2.5-5	25-30	85-90	386	294	84	0
Trevor Smith – Director of Finance	7.5-10	22.5-25	35-40	110-115	529	325	195	0
Mike Pack – Director of Finance	0-2.5	0-2.5	0-5	5-10	46	25	20	0
Roger Rawlinson – Director of Human Resources	0-2.5	2.5-5	5-10	20-25	142	88	51	0
Ronnette Lucraft – Commercial Director	0-2.5	2.5-5	0-5	5-10	39	15	24	0
Steve Elvin, Acting Chief Operating Officer	0-2.5	2.5-5	35-40	105-110	748	547	188	0

As Non-Executive Members do not receive pensionable remuneration, there are no entries in respect of pensions for Non-Executive Members. Interim Directors, employed on agency contracts are not pensionable employees of the Trust.

* The CETV calculation for 31 March 2009 has changed as a result of the Occupation Pension Scheme Regulations 2008. Broadly as a result of these Regulations, the factors applied to calculating the lump sum necessary to provide the accrued pension benefit have changed to reflect a more conservative investment return, resulting in a higher figure than that at 31 March 2008, excluding the effect of inflation.

Pension Benefits

See table left

Cash Equivalent Transfer Value (CETV)

The CETV is a payment made by a pension scheme, or an arrangement to secure pension benefits in another pension scheme, or an arrangement when the member leaves a scheme and chooses to transfer benefits accrued in their former scheme.

The benefits valued are the member's accrued benefits and any contingent spouse's pension payable from the scheme. The pension figures shown relate to the benefits which the individual has accrued as a consequence of their total membership of the pension scheme, not just their service in a senior capacity to which disclosure applies. The CETV figures and other pension details include the value of any pension benefits in another scheme or arrangement which the individual has transferred to the NHS Pension Scheme. They also include any additional pension benefit accrued to the member as a result of 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.

Real Increase in CETV

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

Nick Chapman
Accounting Officer, 30 June 2009

We're here
for Rob, Victoria and Taylor

I called the NHS Direct phone line a few months after we had our son Taylor because my wife Victoria burned herself while ironing. I wasn't sure whether to take her to the accident and emergency department or whether the burn could be dealt with at home so I called NHS Direct for some advice. I was put through to a knowledgeable nurse advisor who recommended I take Victoria to our GP. We drove to our GP that afternoon where Victoria was treated for second degree burns. It was so helpful to be able to talk to someone over the phone because I didn't want a wasted journey to the hospital if that wasn't the best place for us. Victoria made a full recovery and was treated by her GP for the burn and was advised how to care for it to limit the level of scarring.

Since the accident we've used NHS Direct a number of times, mainly for health advice and information for Taylor. When you've got a young family it's reassuring to know that health advice and support is just a phone call away.

NHS Direct
Annual Accounts 2008/09

Annual Accounts
Statement of the Board's and Chief Executive's responsibilities

Under the National Health Service Act 2006 and directions made thereunder by the Secretary of State with the approval of HM Treasury, NHS Direct NHS Trust is required to prepare a statement of accounts for each financial year in the form and on the basis determined by the Secretary of State, with the approval of HM Treasury. The accounts are prepared on an accruals basis, and must give a true and fair view of NHS Direct NHS Trust's state of affairs at the year end, and of the surplus, total recognised gains and losses and cash flows for the financial year.

The Accounting Officer for the Department of Health has appointed the Chief Executive of NHS Direct as the Accounting Officer, with responsibility for preparing the Trust's accounts and for transmitting them to the Comptroller and Auditor General.

In preparing the accounts, the Board and Accounting Officer are required to:

- Observe the accounts direction issued by the Secretary of State, including the relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis
- Make judgements and estimates on a reasonable basis
- State whether applicable accounting standards have been followed, and disclose 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 Direct NHS Trust will continue in operation.

The Chief Executive's relevant responsibilities as Accounting Officer, including responsibility for the propriety and regularity of the public funds and assets vested in NHS Direct NHS Trust, and for the keeping of proper records, are set out in the Accounting Officers' Memorandum issued by the Department of Health.

By order of the Board

Statement on Internal Control 2008/09

1. Scope of responsibility

As Accounting Officer and Chief Executive of NHS Direct, I have responsibility, together with the Board of NHS Direct NHS Trust, for maintaining a sound system of internal control which supports the achievement of the organisation's policies, aims and objectives. I also have responsibility for safeguarding the public funds and the organisation's assets for which I am personally responsible as set out in Managing Public Money.

NHS Direct has a range of mechanisms in place to facilitate effective working with key partners. In particular, from the beginning of the financial year the Senior Departmental Sponsor in the Department of Health, and since September 2008, the East of England Strategic Health Authority, have been responsible for ensuring that NHS Direct procedures operate effectively, efficiently and in the interest of the public and the NHS. This requirement is addressed at regular performance review meetings which cover all aspects of the organisation's current and future business activities. In addition, I provide regular business and financial reports to every meeting of the Trust Board and as Chief Executive take responsibility for risk management at Board level.

2. The purpose of the system of internal control

The system of internal control is designed to manage risk to a reasonable level, rather than to eliminate all risk of failure to achieve policies, aims and objectives. Therefore, it can only provide reasonable, and not absolute, assurance of effectiveness. The system of internal control is based on an ongoing process designed to:

- identify and prioritise the risks to the achievement of the organisation's policies, aims and objectives
- evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically.

The system of internal control has been in place in NHS Direct for the year ended 31 March 2009 and up to the date of approval of the annual report and accounts.

3. Capacity to handle risk

The Trust has continued during the course of the year (its second as an NHS Trust) to enhance its assurance framework and corporate risk register, which are firmly linked to the key objectives of the Trust. These documents identify and prioritise the key risks to the achievement of the objectives in the Trust's approved Business Plan and are subject to regular review and updating at the Board and Senior Management Team, to reflect the changing nature of the risks the organisation faces in delivering its services to patients. Although I have overall responsibility, the management of risk is a key responsibility for all senior management in the organisation.

In 2008/09 the Trust has revised its corporate risk-management policy to ensure that it provides sound guidance and support to staff in developing risk registers at the regional, department and directorate levels. To help embed the process of risk management in the organisation, training has been provided at the Board, directorate, regional and team levels of the organisation. The assurance framework and corporate risk registers are also subject to quarterly review by the Audit Committee, whose minutes are reported to the Board to provide assurance of the process.

4. The risk and control framework

The corporate risk-management policy outlines the process for identifying the risks to achieving objectives and the criteria for assessing these risks in terms of consequence and probability, and provides a risk register template for the recording of risks in a standard format. The process of risk management outlined in the policy includes the requirement for identifying the controls which are in place and any additional actions required to manage these risks.

To ensure that risk management is embedded in the activity of the organisation, risks to the delivery of objectives in the business plan have been identified, assessed and controlled as part of the risk-management process. To help embed the process at all levels of the organisation, a one-page leaflet has been circulated to all staff, outlining the key steps to be taken to identify, assess, manage and record risks.

The assurance framework identifies the assurance available to the Board in relation to the achievement of the Trust's key priorities and objectives and the effectiveness of the operation of the key control processes. The Board is apprised on a regular basis of the gaps in control and assurance and the action being taken to address such gaps. The types of gaps in controls include training, polices, procedures and systems, while the gaps in assurance include policy direction, monitoring and reporting arrangements.

During 2008/09 we appointed our Chief Information Officer as the Senior Information Risk Owner (SIRO) in order to champion information risk throughout the organisation at both a strategic and operational level. This appointment has been endorsed by the Trust Board. Our SIRO, and other ICT staff, have attended a bespoke training course for this role in order to ensure that it can be carried out effectively. The organisation also conducted a personal data-flow mapping and risk-assessment exercise to evaluate whether the controls identified during 2007/08 are still effective, and to identify and assess any potential new risks. During 2009/10 we will appoint and train an Information Risk Manager, and implement an information risk assessment and management programme designed to meet our business needs. We will also seek to train our Information Asset Owners identified from our different business areas.

As an employer with staff entitled to membership of the NHS Pension Scheme, control measures are in place to ensure all employer obligations contained within the Scheme regulations are complied with. This includes ensuring that deductions from salary, employer's contributions and payments into the Scheme are in accordance with the Scheme rules, and that member Pension Scheme records are accurately updated in accordance with the timescales detailed in the Regulations.

Control measures are in place to ensure that all the organisation's obligations under equality, diversity and human rights legislation are complied with.

5. Review of effectiveness

As Accounting Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review is informed in a number of ways. The Head of Internal Audit provides me with an opinion on the overall arrangements for gaining assurance through the Assurance Framework and on the controls reviewed as part of the internal audit work. The Head of Internal Audit's opinion for 2008/09 was that: "Significant assurance can be given that there is a generally sound system of internal control, designed to meet the organisation's objectives, and that controls are being applied consistently. However, some weaknesses, in the design and/or inconsistent application of

controls, put the achievement of particular objectives at risk". Internal Audit's review of the Trust's assurance framework concluded that it: "Provides reasonable assurance that there is an effective system of internal control to manage the principle risks identified by the organisation." We have already started to improve the effectiveness of our assurance framework for 2009/10 by combining it with our risk register and working with a more focused set of corporate objectives.

Executive managers within the organisation, who have responsibility for the development and maintenance of the system of internal control, provide me with assurance. The Assurance Framework itself provides me with evidence that the effectiveness of controls (which manage the risks to the organisation achieving its principal objectives) have been reviewed. My review is also informed by our external auditors, the National Audit Office, internal auditors, Deloittes and our core standards self-assessment declaration for 2008/09.

I have been advised as to the implications of the result of my review of the effectiveness of the system of internal control by the Board, Audit Committee and Clinical Governance Committee. A plan to address weaknesses and ensure continuous improvement of the system is in place.

The one area where management and internal audit identified weaknesses in the design and application of controls relates to payroll. Particular concerns include the occurrence and management of payroll overpayments dating back a number of years, together with payroll-processing issues following the Trust's payroll provider moving part of our payroll service off-shore without prior consultation. This resulted in a significant initial negative impact on the service provided to the Trust and its staff. The Management Team, the Audit Committee and the Trust Board have been fully and regularly informed of this issue since it came to light around November. An action plan (developed by management and the payroll provider) to address the concerns has been agreed and put in place. Progress against the action plan is being monitored by the People and Process Board and reported to the Audit Committee and Trust Board at each meeting. Internal Audit have been supporting this work, and will be working with the Finance and HR Directorates to design and test any amended or additional controls identified as being necessary as a result of these issues.

The following information summarises some of the key activities of the main committees which allow the Board to review the effectiveness of the internal controls:

The Board

The Board reviews the assurance framework and receives regular information from the audit and clinical governance committees, as well as receiving regular monitoring information on the balanced scorecard in respect of incidents and complaint trends.

The Audit Committee

The Audit Committee reviews the adequacy of the underlying assurance processes which indicate the degree of achievement of corporate objectives; the effectiveness of the management of principal risks; and the appropriateness of the above disclosure statements. The internal audit plan enables the Board to be reassured that key internal controls and other matters relating to risk are regularly reviewed. It receives internal and external audit reports and progress reports on risk-related issues, whilst also providing to the Board an overview of the effectiveness of the assurance arrangements based on the work of the Clinical Governance Committee. In December 2008, the Board agreed to dissolve the Risk Committee and transfer its responsibilities to the Audit Committee, on the basis that it was satisfied that our arrangements for risk management had reached such a state of maturity that this change in governance arrangements was appropriate.

Clinical Governance Committee

The Clinical Governance Committee is responsible for the oversight of the clinical governance of the Trust. It oversees the organisation's compliance with Standards for Better Health. A full self-assessment was conducted on 2008/09's compliance with the Core Standards, and we have been able to declare compliance, for the full year, with the standards for corporate and clinical governance. In addition, a Healthcare Commission inspection on Core Standard C7a and c (Corporate and Clinical Governance) for 2007/08 found adequate evidence to demonstrate reasonable assurance of compliance for this standard for the full year.

The Investment Committee

The Investment Committee was established in September 2008 to develop and implement a business case process for making significant investment decisions. It has met twice, in November 2008 and March 2009, and has agreed a business case process which will be implemented from April 2009. This will provide more effective governance and controls over investment decisions and benefits realisation.

Information Governance Steering Group

This Group provides a clear strategic steer on information governance to the Senior Management Team and advises on the development of policy, procedures, guidance and improvement plans to meet information governance requirements, including overseeing the management and reporting against the standards of the NHS Information Governance Toolkit. A full self-assessment against these standards was undertaken during 2007/08. The organisation also successfully completed the NHS Connecting for Health Information Governance Statement of Compliance migration process.

Summary

The organisation has maintained its previous significant progress as an NHS Trust. In particular, it has:

- Taken effective action to address control issues to improve the payroll processes for dealing with overpayments, and to respond to poor service performance by the payroll provider, following their decision to take elements of the service off-shore
- Continued to develop and embed its assurance framework, and worked to embed its principles throughout the organisation
- Reviewed, revised and re-launched its corporate risk management policy throughout the organisation, providing a consistent framework for the management of risk which has been supported by training for all senior managers
- Appointed a Senior Information Risk Owner to provide strong executive leadership of compliance with the Information Governance Toolkit and the organisation's response to information risk
- Reviewed and updated the Trust's major incident plan
- Streamlined its governance structure, including dissolving the Risk Committee and transferring responsibility to the Audit Committee
- Held a risk management workshop for the Trust Board which has provided useful feedback to inform the development of the Trust's risk management strategy
- Through the establishment of a new team (reporting directly to the Chief Executive and responsible for corporate governance), put integrated governance arrangements in place, ensuring that Board and executive activity is focused on the strategic development of the organisation, effectively managing risks and the delivery of NHS Direct's business plan.

Based on my review, I am not aware of any significant internal control problems. During 2009/10, the Trust will continue to strengthen its governance and control arrangements.

Nick Chapman
Accounting Officer, 30 June 2009

The Certificate and Report of the Comptroller and Auditor General to the Houses of Parliament

I certify that I have audited the financial statements of NHS Direct NHS Trust (NHS Direct) for the year ended 31 March 2009 under the National Health Service Act 2006. These comprise the Income and Expenditure Account, the Balance Sheet, the Cash Flow Statement, the Statement of Total Recognised Gains and Losses and the related notes. These financial statements have been prepared under the accounting policies set out within them. I have also audited the information in the Remuneration Report that is described in that report as having been audited.

Respective responsibilities of the Accounting Officer and auditor

The Board and Chief Executive as Accounting Officer are responsible for preparing the Annual Report, which includes the Remuneration Report, and the financial statements in accordance with the National Health Service Act 2006 and directions made thereunder by the Secretary of State with the approval of HM Treasury and for ensuring the regularity of financial transactions. These responsibilities are set out in the Statement of the Board's and Chief Executive's Responsibilities.

My responsibility is to audit the financial statements and the part of the remuneration report to be audited in accordance with relevant legal and regulatory requirements, and with International Standards on Auditing (UK and Ireland).

I report to you my opinion as to whether the financial statements give a true and fair view and whether the financial statements and the part of the Remuneration Report to be audited have been properly prepared in accordance with the National Health Service Act 2006 and directions made thereunder by the Secretary of State. I report to you whether, in my opinion, the information, which comprises the Management Commentary, included in the Annual Report is consistent with the financial statements. I also report whether in all material respects the expenditure and income have been applied to the purposes intended by Parliament and the financial transactions conform to the authorities which govern them.

In addition, I report to you if NHS Direct has not kept proper accounting records, if I have not received all the information and explanations I require for my audit, or if information specified by HM Treasury regarding remuneration and other transactions is not disclosed.

I review whether the Statement on Internal control reflects NHS Direct's compliance with HM Treasury's guidance, and I report if it does not. I am not required to consider whether this statement covers all risks and controls, or form an opinion on the effectiveness of NHS Direct's corporate governance procedures or its risk and control procedures.

I read the other information contained in the Annual Report and consider whether it is consistent with the audited financial statements. This other information comprises the Chair's statement, the Chief Executive's report and the Management Commentary. I consider the implications for my report if I become aware of any apparent misstatements or material inconsistencies with the financial statements. My responsibilities do not extend to any other information.

Basis of audit opinions

I conducted my audit in accordance with International Standards on Auditing (UK and Ireland) issued by the Auditing Practices Board. My audit includes examination, on a test basis, of evidence relevant to the amounts, disclosures and regularity of financial transactions included in the financial statements and the part of the Remuneration Report to be audited. It also includes an assessment of the significant estimates and judgments made by the Accounting Officer in the preparation of the financial statements, and of whether the accounting policies are most appropriate to NHS Direct's circumstances, consistently applied and adequately disclosed.

I planned and performed my audit so as to obtain all the information and explanations which I considered necessary in order to provide me with sufficient evidence to give reasonable assurance that the financial statements and the part of the Remuneration Report to be audited are free from material misstatement, whether caused by fraud or error, and that in all material respects the expenditure and income have been applied to the purposes intended by Parliament and the financial transactions conform to the authorities which govern them. In forming my opinion I also evaluated the overall adequacy of the presentation of information in the financial statements and the part of the Remuneration Report to be audited.

Opinions

In my opinion:

- the financial statements give a true and fair view, in accordance with the National Health Service Act 2006 and directions made thereunder by the Secretary of State with the approval of HM Treasury, of the state of NHS Direct's affairs as at 31 March 2009 and of its surplus, total recognised gains and losses and cash flows for the year then ended;
- the financial statements and the part of the Remuneration Report to be audited have been properly prepared in accordance with the National Health Service Act 2006 and directions made thereunder by the Secretary of State with approval of HM Treasury; and
- information, which comprises the Management Commentary, included within the Annual Report, is consistent with the financial statements.

Opinion on Regularity

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

Report

I have no observations to make on these financial statements.

Amyas C E Morse
Comptroller and Auditor General
National Audit Office
151 Buckingham Palace Road
Victoria
London SWIW 9SS

Date: 3 July 2009

Annual Accounts 2008/09

Income and Expenditure Account for the year ended 31 March 2009

	Note	2008/09 £000	2007/08 £000
Income from activities*	3	159,837	143,619
Other operating income*	4	1,729	762
Operating expenses	5	(161,602)	(141,265)
Operating Surplus		**(36)**	**3,116**
Profit/(loss) on disposal of fixed assets	8	(7)	(3)
Surplus Before Interest		**(43)**	**3,113**
Interest receivable	9	747	2,121
Interest payable	9	(11)	(4)
Surplus For The Financial Year		**693**	**5,230**
Public Dividend Capital dividends payable		(226)	(168)
Retained Surplus For The Year		**467**	**5,062**

The notes on pages 68 to 86 form part of these accounts.
All income and expenditure is derived from continuing operations.
* These amounts have been reanalysed from 2007/08 accounts reflecting revised mapping of the underlying account codes to reflect the nature of activity in 2008/09.

Balance Sheet as at 31 March 2009

	Note	31 March 2009 £000	31 March 2008 £000
Fixed Assets			
Tangible assets	10	**15,677**	14,691
		15,677	14,691
Current Assets			
Debtors	11	**8,938**	11,601
Cash at bank and in hand		**24,778**	19,161
		33,716	30,762
Creditors: Amounts falling due within one year	12	**(12,716)**	(11,646)
Net Current Assets		**21,000**	19,116
Total Assets Less Current Liabilities		**36,677**	33,807
Provisions For Liabilities And Charges	13	**(5,665)**	(3,654)
Total Assets Employed		**31,012**	30,153
Financed By:			
Taxpayers' Equity			
Public dividend capital	19	**24,513**	24,513
Revaluation reserve	14	**970**	578
Income and expenditure reserve	14	**5,529**	5,062
Total Taxpayers' Equity		**31,012**	30,153

The notes on pages 68 to 86 form part of these accounts.
The financial statements on pages 64 to 86 were approved by the Board on 11 June 2009 and signed on its behalf by:

Signed Nick Chapman (Accounting Officer) date 30 June 2009

Statement of Total Recognised Gains and Losses for the year ended 31 March 2009

	2008/09 £000	2007/08 £000
Surplus for the financial year before dividend payments	693	5,230
Unrealised surplus on fixed asset indexation	392	578
Total recognised gains and losses for the financial year	**1,085**	5,808

The notes on pages 68 to 86 form part of these accounts.

Cash Flow Statement for the year ended 31 March 2009

	Note	2008/09 £000	2007/08 £000
Operating Activities			
Net cash inflow/(outflow) from operating activities	15	**8,095**	2,922
Returns On Investments And Servicing Of Finance:			
Interest received	9	**747**	1,962
Interest paid	9	**(11)**	(4)
Net cash inflow/(outflow) from returns on investments and servicing of finance		**736**	1,958
Capital Expenditure			
(Payments) to acquire tangible fixed assets	10	**(2,988)**	(2,564)
Receipts from sale of tangible fixed assets		**0**	0
Net cash inflow/(outflow) from capital expenditure		**(2,988)**	(2,564)
Dividends Paid		**(226)**	**(168)**
Net cash inflow/(outflow) before financing		**5,617**	2,148
Financing			
Public dividend capital received		**0**	902
Capital Funding		**0**	0
Net cash inflow/(outflow) from financing		**0**	902
Increase/(decrease) in cash		**5,617**	3,050

The notes on pages 68 to 86 form part of these accounts.

Notes to the Accounts

1 Accounting Policies

The Secretary of State for Health has directed that the financial statements of NHS Trusts shall meet the accounting requirements of the NHS Trusts Manual for Accounts which shall be agreed with HM Treasury. The accounting policies contained in that manual follow UK generally accepted accounting practice and HM Treasury's Government Financial Reporting Manual to the extent that they are meaningful and appropriate to the NHS. The accounting policies have been applied consistently in dealing with items considered material in relation to the accounts.

1.1 Accounting convention

These accounts have been prepared under the historical cost convention modified to account for the revaluation of fixed assets at their value to the business by reference to their current costs. NHS Trusts are not required to provide a reconciliation between current cost and historical cost surpluses and deficits.

1.2 Acquisitions and discontinued operations

Activities are considered to be 'acquired' only if they are acquired from outside the public sector. Activities are considered to be 'discontinued' only if they cease entirely. They are not considered to be 'discontinued' if they transfer from one public sector body to another.

1.3 Income Recognition

Income is accounted for applying the accruals convention. The main source of income for the Trust is from income from call centres commissioned from the Department of Health and centrally funded through the East of England Strategic Health Authority until 30 September 2008. From 1 October 2008 this changed and East of England Strategic Health Authority became the lead commissioner on behalf of all Strategic Health Authorities. Income is recognised in the period in which services are provided. Where income is received for a specific activity which is to be delivered in the following financial year, that income is deferred.

1.4 Intangible fixed assets

Intangible assets are capitalised when they are capable of being used in a Trust's activities for more than one year; they can be valued; and they have a cost of at least £5,000.

Intangible fixed assets held for operational use are valued at historical cost and are depreciated over the estimated life of the asset on a straight line basis, except capitalised Research and Development which is revalued using an appropriate index figure. The carrying value of intangible assets is reviewed for impairment at the end of the first full year following acquisition and in other periods if events or changes in circumstances indicate the carrying value may not be recoverable.

Purchased computer software licences are capitalised as intangible fixed assets where expenditure of at least £5,000 is incurred. They are amortised over the shorter of the term of the licence and their useful economic lives.

1.5 Tangible fixed assets

Capitalisation

Tangible assets are capitalised if they are capable of being used for a period which exceeds one year and they:

– individually have a cost of at least £5,000; or
– collectively have a cost of at least £5,000 and individually have a cost of more than £250, where 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 setting-up cost of a new building or unit irrespective of their individual or collective cost.

Valuation

Tangible fixed assets are stated at the lower of replacement cost and recoverable amount. On initial recognition they are measured at cost (for leased assets, fair value) including any costs such as installation directly attributable to bringing them into working condition. They are restated to current value each year. The carrying values of tangible fixed assets are reviewed for impairment in periods if events or changes in circumstances indicate the carrying value may not be recoverable.

All land and buildings are restated to current value using professional valuations in accordance with FRS15 every five years and in the intervening years by the use of indices. The buildings index is based on the All in Tender Price Index published by the Building Cost Information Service (BCIS). The land index is based on the residential building land values reported in the Property Market Report published by the Valuation Office.

Professional valuations are carried out by the District Valuers of the Revenue and Customs Government Department. The valuations are carried out in accordance with the Royal Institute of Chartered Surveyors (RICS) Appraisal and Valuation Manual insofar as these terms are consistent with the agreed requirements of the Department of Health and HM Treasury. In accordance with the requirements of the Department of Health, the last asset valuations were undertaken in 2004 as at the prospective valuation date of 1 April 2005 and were applied on 31 March 2005.

The valuations are carried out primarily on the basis of Depreciated Replacement Cost for specialised operational property and Existing Use Value for non-specialised operational property. The value of land for existing use purposes is assessed at Existing Use Value. For non-operational properties including surplus land, the valuations are carried out at Open Market Value.

Additional alternative Open Market Value figures have only been supplied for operational assets scheduled for imminent closure and subsequent disposal.

All adjustments arising from indexation and five-yearly revaluations are taken to the Revaluation Reserve. Falls in value when newly constructed assets are brought into use are also charged there. These falls in value result from the adoption of ideal conditions as the basis for depreciated replacement cost valuations.

Assets in the course of construction are valued at current cost. These assets include any existing land or buildings under the control of a contractor.

Operational equipment other than IT equipment, which is considered to have nil inflation, is valued at net current replacement cost through annual uplift by the change in the value of the GDP deflator. Equipment surplus to requirements is valued at net recoverable amount.

Depreciation, amortisation and impairments

Tangible fixed assets are depreciated at rates calculated to write them down to estimated residual value on a straight-line basis over their estimated useful lives. No depreciation is provided on freehold land and assets surplus to requirements.

Assets in the course of construction and residual interests in off-balance sheet PFI contract assets are not depreciated until the asset is brought into use or reverts to the Trust, respectively.

Buildings, installations and fittings are depreciated on their current value over the estimated remaining life of the asset as advised by the District Valuer. Leaseholds are depreciated over the primary lease term.

Equipment is depreciated on current cost evenly over the estimated life of the asset.

Impairment losses resulting from short-term changes in price that are considered to be recoverable in the longer term are taken in full to the revaluation reserve. These include impairments resulting from the revaluation of fixed assets from their cost to their value in existing use when they become operational. This may lead to a negative revaluation reserve in certain instances.

1.6 Research and development

Expenditure on research is not capitalised. Expenditure on development is capitalised if it meets the following criteria:
– there is a clearly defined project;
– the related expenditure is separately identifiable;
– the outcome of the project has been assessed with reasonable certainty as to:
  – its technical feasibility;
  – its resulting in a product or service which will eventually be brought into use;
– adequate resources exist, or are reasonably expected to be available, to enable the project to be completed and to provide any consequential increases in working.

Expenditure so deferred is limited to the value of future benefits expected and is amortised through the income and expenditure account on a systematic basis over the period expected to benefit from the project. It is revalued on the basis of current cost. The amortisation charge is calculated on the same basis as used for depreciation i.e. on a quarterly basis. Expenditure which does not meet the criteria for capitalisation is treated as an operating cost in the year in which it is incurred. NHS Trusts are unable to disclose the total amount of research and development expenditure charged in the income and expenditure account because some research and development activity cannot be separated from patient care activity.

1.7 Provisions

The Trust provides for legal or constructive obligations that are of uncertain timing or amount at the balance sheet date on the basis of the best estimate of the expenditure required to settle the obligation. Where the effect of the time value of money is material, the estimated risk-adjusted cash flows are discounted using the Treasury's discount rate of 2.2% in real terms.

Clinical negligence costs

The NHS Litigation Authority (NHSLA) operates a risk pooling scheme under which the NHS Trust pays an annual contribution to the NHSLA which in return settles all clinical negligence claims. Although the NHSLA is administratively responsible for all clinical negligence cases the legal liability remains with the Trust. The total value of clinical negligence provisions carried by the NHSLA on behalf of the Trust is disclosed at note 13.

Non-clinical risk pooling

The Trust participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the Trust pays an annual contribution to the NHS Litigation Authority and, in return, receives assistance with the costs of claims arising. The annual membership contributions, and any 'excesses' payable in respect of particular claims are charged to operating expenses as and when they become due.

1.8 Pensions

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

The Scheme is subject to a full actuarial investigation every four years (until 2004, based on a five year valuation cycle), and a FRS accounting valuation every year. An outline of these follows:

a) Full actuarial (funding) valuation

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the scheme (taking into account its recent demographic experience), and to recommend the contribution rates to be paid by employers and scheme members. The last such valuation, which determined current contribution rates was undertaken as at 31 March 2004 and covered the period from 1 April 1999 to that date.

The conclusion from the 2004 valuation was that the Scheme had accumulated a notional deficit of £3.3 billion against the notional assets as at 31 March 2004. However, after taking into account the changes in the benefit and contribution structure effective from 1 April 2008, the Scheme actuary reported that employer contributions could continue at the existing rate of 14% of pensionable pay. On advice from the Scheme actuary, scheme contributions may be varied from time to time to reflect changes in the scheme's liabilities. Up to 31 March 2008, the vast majority of employees paid contributions at the rate of 6% of pensionable pay. From 1 April 2008, employees contributions are on a tiered scale from 5% up to 8.5% of their pensionable pay depending on total earnings.

b) FRS17 Accounting valuation

In accordance with FRS17, a valuation of the Scheme liability is carried out annually by the Scheme Actuary as at the balance sheet date by updating the results of the full actuarial valuation.

Between the full actuarial valuations at a two-year midpoint, a full and detailed member data-set is provided to the Scheme Actuary. At this point the assumptions regarding the composition of the Scheme membership are updated to allow the Scheme liability to be valued.

The valuation of the Scheme liability as at 31 March 2008, is based on detailed membership data as at 31 March 2006 (the latest midpoint) updated to 31 March 2008 with summary global member and accounting data.

The latest assessment of the liabilities of the Scheme is contained in the Scheme Actuary report, which forms part of the annual NHS Pension Scheme (England and Wales) Resource Account, published annually. These accounts can be viewed on the NHS Pensions website. Copies can also be obtained from The Stationery Office.

Scheme provisions as at 31 March 2009

The scheme is a 'final salary' scheme.

For early retirements other than those due to ill health the additional pension liabilities are not funded by the scheme. The full amount of the liability for the additional costs is charged to the income and expenditure account at the time the Trust commits itself to the retirement, regardless of the method of payment.

The Scheme provides the opportunity to members to increase their benefits through money purchase Additional Voluntary Contributions (AVCs) provided by an approved panel of life companies. Under the arrangement the employee/member can make contributions to enhance an employee's pension benefits. The benefits payable relate directly to the value of the investments made. From 1 April 2008 a voluntary additional pension facility becomes available, under which members may purchase up to £5,000 per annum of additional pension at a cost determined by the actuary from time-to-time.

Early payment of a pension is available to members of the Scheme who are permanently incapable of fulfilling their duties effectively through illness or infirmity. A death gratuity of twice final year's pensionable pay for death in service, and five times their annual pension for death after retirement, less pension already paid, subject to a maximum amount equal to twice the member's final year's pensionable pay less their retirement lump sum for those who die after retirement, is payable.

Existing members at 1 April 2008

Annual pensions are normally based on 1/80th of the best of the last 3 years pensionable pay for each year of service. A lump sum normally equivalent to 3 years pension is payable on retirement. From 1 April 2008 there is the opportunity of giving up some of the pension to increase the retirement lump sum. Annual increases are applied to pension payments at rates defined by the Pensions (Increase) Act 1971, and are based on changes in retail prices in the twelve months ending 30 September in the previous calendar year. On death, a pension of 50% of the member's pension is normally payable to the surviving spouse or eligible unmarried partner.

New entrants from 1 April 2008

Annual pensions for new entrants from 1 April 2008 will be based on 1/60th of the best three-year average of pensionable earnings in the ten years before retirement. Members wishing to obtain a retirement lump sum may give up some of this pension to obtain a retirement lump of up to 25% of the total value of their retirement benefits. Survivor pensions will be available to married and unmarried partners and will be equal to 37.5% of the member's pension.

1.9 Value Added Tax

Most of the activities of the Trust are outside the scope of VAT and, in general, output tax does not apply. Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of fixed assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

1.10 Foreign Exchange

Transactions that are denominated in a foreign currency are translated into sterling at the exchange rate ruling on the dates of the transactions. As the value of these transactions is relatively small, the resulting exchange gains and losses are taken to the Income and Expenditure Account as part of the underlying transaction cost.

1.11 Leases

Where substantially all risks and rewards of ownership of a leased asset are borne by the NHS Trust, the asset is recorded as a tangible fixed asset and a debt is recorded to the lessor of the minimum lease payments discounted by the interest rate implicit in the lease. The interest element of the finance lease payment is charged to the Income and Expenditure Account over the period of the lease at a constant rate in relation to the balance outstanding. Other leases are regarded as operating leases and the rentals are charged to the Income and Expenditure Account on a straight-line basis over the term of the lease.

1.12 Public Dividend Capital (PDC) and PDC Dividend

Public Dividend Capital represents the outstanding public debt of an NHS Trust. At any time the Secretary of State can issue new PDC to, and require repayments of PDC from, the NHS Trust.

A charge, reflecting the forecast cost of capital utilised by the NHS Trust, is paid over as Public Dividend Capital dividend. The charge is calculated at the real rate set by HM Treasury (currently 3.5%) on the forecast average carrying amount of all assets less liabilities, except for donated assets and cash with the Office of the Paymaster General. The average carrying amount of assets is calculated as a simple average of opening and closing relevant net assets. A note to the accounts discloses the rate that the dividend represents as a percentage of the actual average carrying amount of assets less liabilities in the year.

1.13 Losses and Special Payments

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

Losses and Special Payments are charged to the relevant functional headings in the Income and Expenditure Account on an accruals basis, including losses which would have been made good through insurance cover had NHS Trusts not been bearing their own risks (with insurance premiums then being included as normal revenue expenditure). Note 24 is compiled directly from the losses and compensations register which is prepared on a cash basis.

1.14 Financial Instruments

Financial assets

Financial assets are recognised on the balance sheet when the Trust 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.

Financial assets are initially recognised at fair value.

Financial assets are classified into the following categories: financial assets 'at fair value through profit and loss'; 'held to maturity investments'; 'available for sale' financial assets, and 'loans and receivables'. The classification depends on the nature and purpose of the financial assets and is determined at the time of initial recognition. The Trust only has financial assets within the loans and receivables category - debtors for staff, goods and services supplied in the normal course of business.

Loans and receivables are non-derivative financial assets with fixed or determinable payments which are not quoted in an active market. After initial recognition, they are shown less any impairment.

At the balance sheet date, the Trust assesses whether any financial assets are impaired. Financial assets are impaired and impairment losses recognised if there is objective evidence of impairment as a result of one or more events which occurred after the initial recognition of the asset and which has an impact on the estimated future cash flows of the asset.

If, in a subsequent period, the amount of the impairment loss decreases and the decrease can be related objectively to an event occurring after the impairment was recognised, the previously recognised impairment loss is reversed through the income statement to the extent that the carrying amount of the receivable at the date of the impairment is reversed does not exceed what the amortised cost would have been had the impairment not been recognised.

Financial liabilities

Financial liabilities are recognised on the balance sheet when the Trust 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 de-recognised when the liability has been discharged, that is, the liability has been paid or has expired.

Financial liabilities are initially recognised at fair value.

Financial liabilities are classified as either financial liabilities 'at fair value through profit and loss' or other financial liabilities. The Trust only has financial liabilities within the other financial liabilities category. The Trust's financial liabilities comprise of creditors for goods and services received in the normal course of business

After initial recognition, other financial liabilities are measured at amortised cost using the effective interest method. The effective interest rate is the rate that exactly discounts estimated future cash payments through the life of the asset, to the net carrying amount of the financial liability. Interest is recognised using the effective interest method.

2 Segmental Analysis

SSAP 25 requires NHS Trusts that have more than one business segment to report the Income, Surplus / Deficit and Net Assets attributable to each segment.

NHS Direct NHS Trust only has one business segment.

3 Income from Activities

	2008/09 £000	2007/08 £000
Core Services	134,838	*126,720
Choose & Book Appointments Line	7,146	6,032
Out of Hours Services	4,555	*5,576
Other Contestable Income	5,367	*3,607
Department of Health	7,931	1,684
	159,837	143,619

* These amounts have changed from 2007/08 accounts reflecting revised mapping of the underlying account codes to reflect the nature of the business activity in 2008/09.

In the financial year ended 31 March 2009, there was a £2.5m in year contract deduction for core services, as part of the change in commisioner, referred to in note 1.3 above. It was also agreed during the year that the Pathways service should transfer to Connecting for Health. This resulted in a reduction in core income of £1,662,000 but the associated costs also transferred to Connecting for Health.

In the financial year ended 31 March 2007 £11 million of income was surrendered as year-end flexibility to the Department of Health in respect of core services. It was agreed that this would be returned in two tranches of £5.5 million in each of the years ending 31st March 2008 and 31st March 2009.

The first tranche of £5.5 million was included in the Trust's 2007/08 contract with East of England Strategic Health Authority in respect of core services. For 2008/09 it has been agreed that the second tranche of £5.5m year-end flexibility will not be returned to the Trust.

Fees & Charges

During 2007/08 the Department of Health initiated the development of a Pandemic Flu advice and antiviral distribution system through NHS Direct. The solution being not only available in England but throughout the UK and funded accordingly by the respective authorities in each country, on the basis of population. The system will be accessible using both web and call centre technology, hence NHS Direct's leading role in defining and supervision of the solution, drawing on expertise within other organisations and consultants. The Department of Health has contracted to reimburse the direct costs involved in this intiative and specific overheads involved in running this major project, with an overall budget of £48m for the system and keeping it in a state of readiness over its expected life of 5 years.

Income from Department of Health in 2008/09 includes £7,445,017 (2007/08 £1,684,395) for reimbursement of costs incurred on the Pandemic Flu project, summarised below.

	2008/09 £000	2007/08 £000
Income from Department of Health	7,445	1,684
Costs		
Directly attributable costs	(590)	(38)
System Build costs	(2,303)	0
External charges	(3,930)	(1,540)
Contribution to specified overheads including staff working on the project	622	106

The project has been developed within budget and on target in accordance with agreed milestones. This information is provided for fees and charges purposes, not for SSAP25 disclosure.

4 Other Operating Income

	2008/09 £000	2007/08 £000
Rental Income from operating leases	387	335
Department of Health	1,180	*79
Other	162	*348
Other Income	1,729	762

* These amounts have changed from 2007/08 accounts reflecting revised mapping of the underlying account codes to reflect the nature of the business activity in 2008/09.

5 Operating Expenses

5.1 Operating expenses comprise:

	2008/09 £000	2007/08 £000
Directors' costs	1,243	1,051
Staff costs	97,804	*87,776
Consultancy services (c)	7,279	3,627
Supplies and services - general	183	107
Establishment expenses	5,812	*3,802
Education & Training	1,090	*805
Telecommunications	8,098	*9,946
Premises	9,308	*9,098
Transport	1,835	*1,555
Depreciation and amortisation	2,386	1,998
IT contracts	20,662	*17,730
Audit fees (b)	108	100
Other audit fees	120	*217
Contributions to the NHS Litigation Authority	215	187
Health Information services	1,244	*753
Redundancy costs	1,890	184
Early retirement costs	855	0
Other (a)	1,470	*2,329
	161,602	141,265

* These amounts have changed from 2007/08 accounts reflecting revised mapping of the underlying account codes to reflect the nature of the business activity in 2008/09

(a) Significant items included in Other Costs are: interpreting skills £192,358 (2007/08 £185,432), personal injury claims £441,077 (2007/08 £101,338) and website development costs £379,485 (2007/08 £22,800).

(b) Audit fees include £7,500 for audit work completed in respect of the implementation of International Financial Reporting Standards in 2009/10.

(c) Consultancy costs include £3,930,371 (2007/08 £1,540,000) in respect of work done on the Pandemic Flu project.

5.2 Operating leases

5.21 Operating expenses include:

	2008/09 £000	2007/08 £000
Hire of plant and machinery	193	148
Other operating lease rentals	4,336	4,102
	4,529	4,250

5.2.2 Annual commitments under non – cancellable operating leases are:

	2008/09 £000	2007/08 £000
Land and buildings		
Operating leases which expire:		
Within 1 year	1,108	1,132
Between 1 and 5 years	1,811	299
After 5 years	1,236	2,671
	4,155	4,102

	2008/09 £000	2007/08 £000
Other leases		
Operating leases which expire:		
Within 1 year	55	24
Between 1 and 5 years	122	124
	177	148

6 Staff costs and numbers

6.1 Staff costs

	2008/09 Total £000	Permanently Employed £000	Other £000	2007/08 £000
Salaries and wages	84,325	76,459	7,866	75,225
Social Security Costs	5,580	5,580	0	5,046
Employer contributions to NHS Pension Scheme	9,249	9,249	0	8,831
	99,154	91,288	7,866	89,102

6.2 Average number of persons employed

	2008/09 Total Number	2008/09 Permanently Employed Number	2008/09 Other Number	2007/08 Number
Medical and dental	4	4	0	5
Administration and estates*	1,677	1,456	221	1,504
Nursing, midwifery and health visiting staff	1,001	1,001	0	1,054
Scientific, therapeutic and technical staff	54	54	0	35
Other	6	6	0	0
Total	2,742	2,521	221	2,598

*Health Care Advisors are included in the Administration and Estates category

6.3 Employee benefits

	2008/09 £000	2007/08 £000
Car lease and fuel	140	108

6.4 Management costs

	2008/09 £000	2007/08 £000
Management costs	25,780	23,852
Income	152,941	144,381
Management costs as a percentage of income	16.9%	16.5%

Management costs are prepared in line with the definitions in the Department of Health's document 'Definition of Management Costs in NHS Trusts 2002/03'. The nature of NHS Direct's service is significantly different from that supplied by other NHS Trust service providers.

6.5 Retirements due to ill-health

During 2008/09 there were 12 (2007/08, 9) early retirements from the NHS Trust on the grounds of ill-health. The estimated additional pension liabilities of these ill-health retirements will be £740,998 (2007/08 £435,631). The cost of these ill-health retirements will be borne by the NHS Business Services Authority – Pensions Division.

7 Better Payment Practice Code

7.1 Better Payment Practice Code – measure of compliance

	2008/09 Number	2008/09 £000
Total Non-NHS trade invoices paid in the year	31,068	70,649
Total Non NHS trade invoices paid within target	28,788	63,100
Percentage of Non-NHS trade invoices paid within target	93%	89%
Total NHS trade invoices paid in the year	1,014	3,557
Total NHS trade invoices paid within target	869	2,686
Percentage of NHS trade invoices paid within target	86%	76%

The Better Payment Practice Code requires the Trust to aim to pay all undisputed invoices by the due date or within 30 days of receipt of goods or a valid invoice, whichever is later.

7.2 The Late Payment of Commercial Debts (Interest) Act 1998

	2008/09 £000	2007/08 £000
Amounts included within Interest Payable (Note 9) arising from claims made under this legislation	0	0
Compensation paid to cover debt recovery costs under this legislation	0	0

8 Profit/(Loss) on Disposal of Fixed Assets

Profit/(loss) on the disposal of fixed assets is made up as follows:

	2008/09 £000	2007/08 £000
(Loss) on disposal of land and buildings	0	0
(Loss) on disposal of plant and equipment	0	0
(Loss) on disposal of fixtures and fittings	(7)	(3)
	(7)	(3)

9 Finance Costs

Payable:

	2008/09 £000	2007/08 £000
Late payment of commercial debt	0	4
Other interest and finance costs	11	0
Total	11	4
Interest Revenue		
Bank accounts	747	2,121
Total	747	2,121

10 Fixed Assets

10.1 Intangible fixed assets

There were no intangible fixed assets at the current year or prior year balance sheet dates.

10.2 Tangible fixed assets at the balance sheet date comprise the following elements:

	Long Leasehold Land £000	Buildings excluding Dwellings £000	Assets under construction £000	Plant and machinery £000	Information technology £000	Furniture & fittings £000	Total £000
Cost or valuation at 1 April 2008	1,114	10,925	488	684	6,635	1,160	21,006
Additions purchased	0	517	872	346	839	413	2,988
Impairments	0	0	0	0	0	0	0
Reclassifications	0	180	(488)	44	146	119	0
Indexation	48	462	0	18	0	30	558
Disposals	0	(7)	0	0	(86)	(10)	(103)
Cost or Valuation at 31 March 2009	**1,162**	**12,077**	**872**	**1,092**	**7,534**	**1,712**	**24,449**
Depreciation at 1 April 2008	0	3,535	0	127	2,148	505	6,315
Charged during the year	5	660	0	185	1,374	162	2,386
Impairments	0	0	0	0	0	0	0
Reversal of Impairments	0	0	0	0	0	0	0
Reclassifications	0	0	0	0	0	0	0
Indexation	0	150	0	3	0	13	166
Disposals	0	(7)	0	0	(86)	(2)	(95)
Depreciation at 31 March 2009	**5**	**4,338**	**0**	**315**	**3,436**	**678**	**8,772**
Net book value – Total at 1 April 2008	1,114	7,390	488	557	4,487	655	14,691
– Total at 31 March 2009	**1,157**	**7,739**	**872**	**777**	**4,098**	**1,034**	**15,677**

The net book value of assets held under finance leases and hire purchase contracts at the balance sheet date are as follows:	
31 March 2008	£0
31 March 2009	**£0**

The total amount of depreciation charged to the income and expenditure in respect of assets held under finance leases and hire purchase contracts:	
31 March 2008	£0
31 March 2009	**£0**

The economic lives of fixed assets range from:	Min Life (years)	Max Life (years)
Long Leasehold Land	990	990
Buildings excluding dwellings - all leasehold	4	71
Plant & Machinery	4	9
Information Technology	3	5
Furniture & Fittings	4	10

10.3 Net book value of land and buildings

The net book value of land and buildings as at the balance sheet date comprises:

	31 March 2009 £000	31 March 2008 £000
Freehold	0	*3,366
Long leasehold	7,399	4,009
Short leasehold	340	16
Long leasehold land	1,157	1,114
Total	**8,896**	**8,505**

* Investigation into the title to this freehold land reveals it is actually a 999 year lease, hence it has been reclassified in 2008/09

11 Debtors

11.1 Amounts falling due within one year

	31 March 2009 £000	31 March 2008 £000
NHS debtors	**829**	1,055
Department of Health	**189**	1,892
Other prepayments and accrued income	**5,663**	5,990
Recoverable VAT	**1,270**	1,699
Other debtors	**987**	965
Total	**8,938**	11,601

11.2 Amounts falling due after more than one year

There were no amounts falling due after more than one year at the current or previous balance sheet date.

11.3 Provision for irrecoverable debts

	31 March 2009 £000	31 March 2008 £000
Balance at 1 April	0	0
Provided in year	292	0
Written off during year	0	0
Recovered during year	0	0
Total	**292**	0

This provision relates to salary overpayments to former staff deemed irrecoverable.

11.4 Debtors passed due date but not impaired

	31 March 2009 £000	31 March 2008 £000
By up to 3 months	143	2,339
By 3 to 6 months	46	63
By more than 6 months	193	276
Total	**382**	2,678

12 Creditors

Creditors at the balance sheet date are made up of:

12.1 Amounts falling due within one year

	31 March 2009 £000	31 March 2008 £000
NHS Creditors	826	*209
NHS Capital Creditors	0	0
Tax	893	958
Social security	802	817
Other Creditors	2,300	1,877
Accruals	7,433	6,619
Deferred Income	462	1,166
	12,716	11,646

* NHS Pension Scheme is now designated as a non NHS creditor

12.2 Amounts falling due after more than one year:

There were no amounts falling due after more than one year at the current or previous balance sheet date.

12.3 Other Creditors include:

£1,086,618 outstanding pensions contributions at 31 March 2009 (31 March 2008 £1,063,275)

13 Provisions for liabilities and charges

	Pensions relating to former staff £000	Restructurings £000	Other £000	Total £000
At 1 April 2008	424		3,230	**3,654**
Arising during the year	441	2,909	240	**3,590**
Utilised during the year	(32)	0	(1,362)	**(1,394)**
Reversed unused	0	0	(220)	**(220)**
Unwinding of discount	0	0	35	**35**
At 31 March 2009	**833**	**2,909**	**1,923**	**5,665**
Expected timing of cashflows:				
Within one year	33	2,909	420	**3,362**
Between one and five years	126	0	516	**642**
After five years	674	0	987	**1,661**

Provisions for restructuring costs relate to closure of the Trust's sites in Southall and Stevenage.

Included in Other Provisions is £1,638,000 (31 March 2008 £1,935,000) provided in respect of an onerous lease at the Trust's former site in Cambridge.

Provision has been made in respect of doubtful debtors as disclosed in note 11.3.

£388,921 is included in the provisions of the NHS Litigation Authority at 31 March 2009 in respect of clinical negligence liabilities of NHS Direct Trust (31 March 2008 £419,067).

14 Movements on Reserves

Movements on reserves in the year comprised the following:

	Revaluation Reserve £000	Income and Expenditure Reserve £000	Total £000
At 1 April 2008	578	5,062	5,640
Transfer from the income and expenditure account	0	467	467
Surplus/(deficit) on other revaluations/indexation of fixed assets	392	0	392
At 31 March 2009	**970**	**5,529**	**6,499**

15 Note to the Cash Flow Statement

Reconciliation of operating surplus to net cash flow from operating activities:

	2008/09 £000	2007/08 £000
Total operating surplus	**(36)**	3,116
Depreciation and amortisation charge	**2,386**	1,998
Fixed asset impairments and reversals	**0**	0
(Increase)/decrease in debtors	**2,664**	3,162
Increase/(decrease) in creditors	**1,070**	(4,564)
Increase/(decrease) in provisions	**2,011**	(790)
Net cash inflow from operating activities	**8,095**	2,922

16 Capital Commitments

There were no commitments under capital expenditure contracts at 31 March 2009 (31 March 2008 £0).

There was no capital expenditure approved but not contracted at the balance sheet date (31 March 2008 £0).

17 Post Balance Sheet Events

In accordance with the requirements of FRS 21 events after the balance sheet date, post balance sheet events are considered up to the date on which the accounts are authorised for issue. This is interpreted as the date of the Certificate and Report of the Comptroller and Auditor General.

18 Contingencies

	2008/09 £000	2007/08 £000
Contingent Liabilities	**23**	26

The above contingent liabilities arise from the NHS Litigation Authority's LTPS scheme.

19 Movements in Public Dividend Capital

	2008/09 £000	2007/08 £000
Public Dividend Capital issued as originating capital on new establishment	0	23,611
Public Dividend Capital brought forward	24,513	
Public Dividend Capital repaid in year	0	0
New Public Dividend Capital received	0	902
Public Dividend Capital repayable (creditor)	0	0
Public Dividend Capital written off	0	0
Other movements in Public Dividend Capital in year	0	0
Public Dividend Capital as at 31 March 2009	**24,513**	24,513

20 Financial Performance Targets

20.1 Breakeven performance

	2008/09 £000	2007/08 £000
Turnover	144,381	161,566
I&E Retained (deficit)/surplus	5,062	467
Cumulative Position	5,062	5,529

20.2 Capital cost absorption rate

The Trust is required to absorb the cost of capital at a rate of 3.5% of average relevant net assets. The rate is calculated as the percentage that dividends paid on Public Dividend Capital, totalling **£226,000**, bears to the average relevant net assets of **£8,626,597**, that is **2.6%.**

The dividend of £226,000 is an agreed amount for the year based on capital charge estimates submitted in December 2007.

The actual dividend payment based on 3.5% of net relevant assets would have been £301,931.

From 2009/10 dividend payments will be based on actuals rather than estimates for all NHS organisations.

20.3 External financing

The Trust is given an external financing limit which it is permitted to undershoot.

	2008/09 £000	2007/08 £000
External financing limit	4,443	902
Cash flow financing	(5,617)	(2,148)
Undershoot	**10,060**	3,050

20.4 Capital Resource Limit

The Trust is given a capital resource limit which it is not permitted to overspend.

	2008/09 £000	2007/08 £000
Gross capital expenditure	2,988	3,210
Less: book value of assets disposed of	(8)	(4)
Charge against the capital resource limit	**2,980**	3,206
Capital resource limit	**4,000**	9,102
Underspend against the capital resource limit	**1,020**	5,896

21 Related Party Transactions

NHS Direct NHS Trust is a body corporate established by order of the Secretary of State for Health.

During the year none of the Board Members or members of the key management staff or parties related to them has undertaken any material transactions with the Trust. Steve Hopkins is a partner in Vertex Consultancy LLP, which invoiced for his services as interim Finance Director as disclosed in the Remuneration Report. This relationship is disclosed in item 11 of the Annual Report – Public Interest and Other Required Information.

The Department of Health is regarded as a related party. During the year the Trust has had a significant number of material transactions with the Department, and with other entities for which the Department is regarded as the parent Department.

The Trust had material transactions with the following organisations exceeding £250,000 in value:

Income in Nature	2008/09 £000	2007/08 £000
East of England Strategic Health Authority	141,919	132,067
Department of Health	9,245	1,892
Kirklees PCT	539	527
Stockport PCT	520	363
East Lancashire PCT	493	481
Nottingham City PCT	448	160
Hillingdon PCT	367	332
South East Essex PCT	354	285
Hounslow PCT	342	335
Bury PCT	323	321
Harrow PCT	309	302
Blackburn with Darwen PCT	307	298
Calderdale PCT	278	268
Expenditure in Nature		
University Hospitals of Leicester NHS Trust	555	535
Yorkshire Ambulance Service NHS Trust	354	606
Nottinghamshire Healthcare NHS Trust	314	278
Department of Health	268	94

22 Financial Instruments

Financial risk management

Financial Reporting Standard 29 requires disclosure of the role that financial instruments have had during the period in creating or changing the risks a body faces in undertaking its activities. Because of the continuing service provider relationship that the Trust has with the Strategic Health Authority and the way both are financed, the Trust is not exposed to the degree of financial risk faced by business entities. Also financial instruments play a much more limited role in creating or changing risk than would be typical of listed companies, to which these standards mainly apply. The Trust has limited powers to borrow or invest surplus funds and financial assets and liabilities are generated by day-to-day operational activities rather than being held to change by the risks facing the Trust in undertaking its activities. The carrying values of financial assets and financial liabilities are disclosed in the Balance Sheet and supporting notes.

In management's view the carrying value of financial assets and financial liabilities carried at amortised cost is deemed to be a reasonable approximation of their fair value.

Currency risk

The Trust is a domestic organisation with the great majority of transactions, assets and liabilities being in the UK and Sterling based. The Trust has no overseas operations. The Trust therefore has low exposure to currency rate fluctuations.

Interest rate risk

The Trust has no borrowings and therefore no exposure to interest rate fluctuations.

Credit risk

Because the majority of the Trust's income comes from contracts with other public sector bodies, the Trust has low exposure to credit risk.

Liquidity risk

The Trust's net operating costs are incurred in accordance with funding agreed with the Strategic Health Authority which is financed from resources voted annually by Parliament. The Trust funds its capital expenditure from internally generated resources. The Trust is not, therefore, exposed to significant liquidity risks.

Disclosure

FRS 29 provides an option to exclude from the interest-rate risk and fair values disclosures financial assets and liabilities which are due within one year and this option has been applied to this note.

23 Intra-Government and Other Balances

	Debtors: amounts falling due within one year £000	Creditors: amounts falling due within one year £000
Balances with other Central Government Bodies	2,183	2,992
Balances with Local Authorities	23	0
Balances with NHS Trusts and Foundation Trusts	105	616
Balances with Public Corporations and Trading Funds	0	0
	2,311	3,608
Balances with bodies external to government	6,627	9,108
At 31 March 2009	**8,938**	**12,716**
Balances with other Central Government Bodies	2,930	1,775
Balances with Local Authorities	120	97
Balances with NHS Trusts and Foundation Trusts	1,128	2,416
Balances with Public Corporations and Trading Funds	591	1,072
	4,769	5,360
Balances with bodies external to government	6,832	6,286
At 31 March 2008	**11,601**	**11,646**

24 Losses and Special Payments

There were 26 cases of Losses and Special Payments (2007/08: 29 cases) totalling £203,932 (2007/08: £347,914) paid during 2008/09.

Of the above payments, two cases totalling £69,530 had been provided for in the 2007/08 accounts. On an accruals basis the charge to Income and Expenditure Account in 2008/09 is £134,402.

Appendix A
Key Performance Indicators – Detailed Disclosure Requirements

Appendix A Key Performance Indicators – Detailed Disclosure Requirements	Definition and calculation method	Target
% of calls answered within 60 seconds	The percentage of calls answered within 60 seconds following the end of any message played and calculated, using: (Number of calls answered within 60 seconds following any message played) ÷ (total number of calls answered)	greater or equal to 95%
% abandonment rate	The percentage of calls abandoned after 30 seconds following any message played and calculated using: (Number of calls abandoned 30 seconds after any message) ÷ (number of calls abandoned 30 seconds after any message) + (number of calls answered)	less than or equal to 5%
% of urgent calls commencing clinical assessment in 20 minutes	The percentage of urgent calls (ie those with clinical priorities P0, P1 and D1) where triage by a clinician is started within 20 minutes. Calculated using: (Number of urgent clinical calls [P0, P1 & D1]) started within 20 minutes) ÷ (number of urgent clinical calls [P0, P1 & D1])	greater than or equal to 95%
% non-urgent (P2) calls commencing clinical assessment in 60 minutes	The percentage of less urgent calls (ie those with clinical priority P2) requiring clinical assessment, where triage is started by a clinician within 60 minutes and calculated using: (Number of non-urgent clinical calls [P2] started within 60 minutes) ÷ (number of non-urgent clinical calls [P2])	greater than or equal to 95%
% non-urgent calls commencing clinical assessment in 120 minutes	The percentage of non-urgent calls (ie those with clinical priorities P2, P3, D2 and D3) requiring clinical assessment, where triage is started by a clinician in 120 minutes. Calculated using: (Number of non-urgent clinical calls [P2, P3, D2 & D3] started within 120 minutes) ÷ (number of non-urgent clinical calls [P2, P3, D2 & D3])	greater than or equal to 50%

Purpose	Data Source	Future Targets	Changes to KPI	Last Years' Benchmark
To confirm that patients are able to access our service within a timely manner. In line with Department of Health (DoH) out-of-hours provider quality standards, the benefit of the measure is to understand the service provided to patients/callers. Cross-referenced to DoH Standards for Better Health: Domain – Accessible and Responsive Care C18 and C19.	Telephony system (BT Symposium)	Will be for core service only next year	NA	93% 2007/08
To identify the proportion of callers/patients who are unable to access our service within a timely manner. In line with DoH out-of-hours provider quality standards, the benefit of the measure is to understand demand for the service. Cross-referenced to DoH Standards for Better Health: Domains – Accessible and responsive Care C18 and C19 and Public Health C24.	Telephony system (BT Symposium)	Will be for core service only next year	NA	2% 2007/08
Identifies the speed of response to clinically urgent calls. The benefit associated with clinical safety/quality and patient access is in line with DoH out-of-hours provider quality standards. Cross-referenced to DoH Standards for Better Health: Domain – Accessible and responsive Care C18 and C19.	CAS (Clinical Assessment System)	Will be for core service only next year	NA	98% 2007/08 .
Identifies the speed of response to clinically less-urgent calls. Benefit associated with clinical safety/quality and patient access. In line with DoH out-of-hours provider quality standards. Cross-referenced to DoH Standards for Better Health: Domain – Accessible and Responsive Care C18 and C19.	CAS (Clinical Assessment System)	Will be for core service only next year	NA	98% 2007/08
Identifies the speed of response to clinically non-urgent calls. Benefit associated with clinical safety/quality and patient access. In line with DoH out-of-hours provider quality standards. Historically, all non-urgent calls had the same target, with no distinction on priority, which is reflected in the inclusion of P2 calls in this measure and also the non-urgent P2 in 60 measure. Cross-referenced to DoH Standards for Better Health: Domain – Accessible and responsive Care C18 and C19.	CAS (Clinical Assessment System)	Will be for core service only next year	Target time period was reduced from 240 minutes to 120 minutes for the last year.	Not available due to change in measure last year.

Appendix A Key Performance Indicators – Detailed Disclosure Requirements continued...	Definition and calculation method	Target
% Completed within NHS Direct	The percentage of calls NHS Direct completes without onward referral. Calculated using the number of dispositions set as self-care, pharmacy, primary care service (PCS) routine and health information with formulae: (Self-care + pharmacy + PCS routine + health information) ÷ (symptomatic calls + health information calls) 'Symptomatic calls' are calls of a symptomatic nature, where a clinical outcome has been advised.	less than or equal to 25%
% of Emergency & Urgent referrals	The percentage of emergency and urgent referrals for GP out-of-hours and 0845 calls only. Calculated using: (Number of calls referred to 999, A&E or PCS urgent) ÷ symptomatic calls	less than or equal to 1%
Number of complaints per 10,000 calls	This measure is for formal complaints (defined as a complaint which is written). The measure is expressed per 10,000 calls. ((The number of reported complaints) ÷ (the number of calls answered)) ÷ 10,000	less than or equal to 10% per annum
% Incident for National Review leading to harm	The measure, '% incident for national review leading to harm or potential harm', has been agreed with the Department of Health to replace the number of serious adverse incidents per 10,000 calls, and is defined as: The proportion of all reported incidents for national review through NHS Direct core or enhanced telephone services (excluding TAL), where an NHS Direct failing had the potential to have led or contributed, or did lead or contribute, to serious harm or death, or serious loss or damage, to patients or staff, contractors or visitors. The number of incidents for national review reported year to date.	less than or equal to 10% per annum
0845 46 47 answered calls per annum	The number of calls to 0845 46 47 which are answered by a person.	greater than or equal to 5 million for the year

Purpose	Data Source	Future Targets	Changes to KPI	Last Years' Benchmark
Identifies the proportion of calls completed within NHS Direct, ie those not requiring referral to any other NHS healthcare provider. This provides a proxy indicator for the impact of NHS Direct on the wider health economy. Cross-referenced to DoH Standards for Better Health: Domains – Public Health C22, C23, and C24 and Accessible and responsive Care C18.	CAS (Clinical Assessment System)	Will be for core service only next year	NA	Not available due to change in measure last year.
Proxy measure for the impact of NHS Direct dispositions on health economy stakeholders. Cross referenced to DoH Standards for Better Health: Domains – Public Health C22 and C24 and Accessible and Responsive Care D11.	CAS (Clinical Assessment System)	NA	NA	28% 2007/08
To monitor complaints and respond to them in line with the NHS Complaints Regulations 2004, and to learn from these complaints, where appropriate. Cross-referenced to DoH Standards for Better Health: Domains – Safety C1 and D1, Patient Focus C14 and D8 and Accessible and Responsive Care C17.	National Risk Database (DATIX)	NA	NA	1% 2007/08
An incident for national review is "any occurrence, or 'near miss, which led to or could have led to unintended or unexpected serious harm or death, or serious loss or damage to patients; or staff, contractors and visitors (whilst on NHS Direct premises); or the organisation (particularly where this would be expected to attract adverse legal or media attention)." It is a requirement in the NHS that these incidents are reported and acted upon. Learning from adverse incidents is also an important part of a learning culture. Cross-referenced to DoH Standards for Better Health: Domains – Safety C1 and D2 and Accessible and Responsive Care C17.	National Risk Database (DATIX)	NA	NA	5% 2007/08
Indicator of the usage of the 0845 46 47 service, linking to patient access and growth of the service. Cross-referenced to DoH Standards for Better Health: Domains – Public Health C22 and C24 and Accessible and Responsive Care C18 and C19.	Telephony system (BT Symposium)	NA	NA	4.9 million calls answered in 2007/2008

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