NHS Direct

NHS Direct National Health Service Trust
Annual Report & Accounts 2011/12

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Joanne Shaw Chair's Statement

In 2011/12 we made fundamental changes to our operations in preparation for the decommissioning of the national 0845 4647 telephone service (0845 service) and the transition to NHS 111. Our own organisational developments sit against the backdrop of major changes to the wider NHS and the urgent care system, including a new Health Bill and the introduction of Clinical Commissioning Groups to replace Primary Care Trusts and Strategic Health Authorities.

During a year in which the NHS has been focussed on internal organisational change, patients and the public have continued to demonstrate increasing enthusiasm for remote and virtual care, with the NHS Direct National Health Service Trust leading the way in providing useful and valued digital services. Use of our online health and symptom checkers almost doubled from 5.6 to 10.7 million during the year, supported by the introduction of our award-winning mobile app. The app's popularity has exceeded our expectations and it has fast become a trusted resource for patients seeking health advice on the move, with over 1.5 million uses since its launch in May last year, and exceptional patient feedback.

We are pleased to have met our financial duties and to have maintained high levels of patient satisfaction across our 0845 service as well as our online channels. Our net promoter score, an international standard for measuring and improving customer loyalty, was an outstanding 77%, which compares well with leading companies in any sector. We continued to exceed our target of over 90% patient satisfaction.

As in previous years, the Trust has met its financial targets in 2011/12. We continue to make a significant net positive contribution to the whole health economy by providing remote health assessment, reassurance, advice and information, which consistently enables over half of our callers to treat themselves at home, avoiding the need for unnecessary patient journeys and relieving pressure on waiting times and face-to-face care.

Looking ahead, further major changes to the NHS and the urgent care system are on the horizon. Online and mobile, self-serve channels enable patients to look after themselves safely at home where this is appropriate, and are convenient, safe and cost effective approach to healthcare. Expertly supported self-service will inevitably play a critical role in the NHS of the future, building on people's desire to do more for themselves, and safeguarding increasing scarce resources for the people and situations that need them. The immediate future prospect for remote and virtual healthcare is unclear but we know that patients and the public will want and expect NHS 111 to be available via digital channels. We are using our experience to highlight the benefits of digital channels to the Department of Health to consider as part of its digital strategy.

The year ahead will see unprecedented challenges for our organisation and our staff. As far as we know, no patient-facing service of the scale and reach of the national 0845 telephone and web offering, has ever before been de-commissioned. We approach the challenge ahead with determination and focus, in partnership with the Department of Health and our commissioners. We remain committed to providing a safe and effective service for patients, for as long as it is needed, and to our wider goal of ensuring that our expertise and experience in developing and delivering world–class remote and digital services can continue to support commissioners, patients and the wider public.

Joanne Shaw
Chair, NHS Direct National Health Service Trust

Nick Chapman
Chief Executive's Statement

2011/12 saw the NHS Direct National Health Service Trust continue to deliver services which were valued and trusted by patients and the public. Overall, during 2011/12 patient satisfaction and the quality and safety of services remained strong. The number of patients served rose for the third year in a row, with an increasing proportion using our web and mobile health and symptom checkers.

The financial performance of the Trust for 2011/12 – the last year of normal operation of the 0845 service - was sound. We successfully achieved operational cost improvements and efficiencies of over £15.7m. In total, the Trust has released over £30m in recurrent income and expenditure savings since 2009/10, which has made savings of nearly £70m in cash terms available to the NHS over those three years.

Over the past year, our environment has been dominated by the planned replacement of the nationally commissioned 0845 service, by a contested and localised NHS 111 service. The NHS Operating Framework for 2012/13 stated that this change is due to be completed by the end of March 2013. We have been guided in our preparation for the transition to NHS 111 by a set of overarching principles agreed with the Department of Health:

- to safeguard patients at every stage
- to provide continuity of safe and reliable services
- to ensure continuity of employment for staff with an on-going role in NHS 111
- to maintain high standards of governance and accountability
- to protect of the public purse.

The decommissioning of the 0845 service brings with it significant unavoidable costs. The full extent of these costs will depend upon the Trust's and the Department of Health's ability to implement actions to minimise costs, and the extent of services that the Trust continues to operate beyond March 2013. The maximum total liability, estimated at £144m, will be reduced by the application of Cabinet Office Guidelines for the transfer of front line staff to successful bidders of NHS 111 services, and other cost minimisation actions that the Trust and Department of Health can implement. Residual de-commissioning costs will be funded by the Department of Health.

To minimise unnecessary staff redundancies, the Department of Health has agreed to secure the employment for many of our front line staff who have ongoing roles in NHS 111 through the application of Cabinet Office Guidelines where we are not the preferred provider. This important commitment will also preserve the highly-valued skills and experience of our staff, many of whom have 14 years' experience of providing remote healthcare.

In 2012/13 we will continue to focus on the quality and safety of the existing services, as well as implementing the transition from the 0845 service to the new NHS 111 service and continuing to bid for future contracts beyond 2013.

We plan to continue to improve our operational performance and, in line with all other NHS organisations, we also expect to deliver real cash- releasing efficiencies of at least 4%. We will continue to pursue our strategic objectives, which are described in the main body of the report. Given the uncertainty created by the de-commissioning of the 0845 service and the multiple local competitions for the right to provide the new NHS 111 service, the Trust will re-appraise its business plan once the NHS 111 procurements have been decided.

The Trust introduced a new staff rostering approach during 2012. The decision to implement new staff rosters was taken after extensive consultation with staff. This approach has meant disruption for some staff and has placed increased demands upon many in terms of flexibility and working arrangements. The decision to implement new rosters was taken as it is central to the achievement of the service levels and efficiencies required of us. Millions of patients value and depend on the services that we currently offer and we plan to answer more calls and support more contacts via the web and mobile in the coming year.

There is considerable uncertainty surrounding the new NHS 111 service, and this affects the Trust and its staff substantially. Our staff have remained focused, committed and professional in these times of great change, and they are a credit to the organisation and the patients they serve. I would like to record my personal gratitude to all of our staff for the superb work that they do.

Nick Chapman
Chief Executive, NHS Direct National Health Service Trust
11 June 2012

Management commentary

Overview

The NHS Direct National Health Service Trust ("the Trust") provides clinical care and services across a range of channels using its virtual national network of call centres and home workers. We provide a key element of the urgent care pathway, helping patients achieve the best health outcomes, through a number of our services.

We use telephone-based care management, online services and telehealth technology to assess patients' symptoms, provide self-care advice and help them to access appropriate urgent care. The services that we provide enhance patients' ability to care for themselves, reduce demand for face-to-face services, and speed up access to the most appropriate care. We help patients with long-term conditions to manage these better and support them to make choices about their care. We provide the Department of Health and the wider NHS with a source of resilience in the face of national health emergencies.

The 2012/13 NHS Operating Framework set the objective that the Trust's 0845 service be replaced by the NHS 111 service nationally by April 2013. In 2011/12 we led on four NHS 111 pilots, working alongside local commissioners and potential public and private sector partners to enable the new system to be evaluated. In addition, work has been ongoing throughout the year to prepare to bid for contracts in response to tenders.

We also provided telehealth services to enable patients to be remotely monitored through the use of medical devices. We also offered telecoaching and motivational coaching to support patients to make lifestyle changes that can improve health outcomes and prevent the development of long-term conditions, such as heart disease. This approach empowers patients to take greater ownership of their care, and helps reduce pressure on community and hospital based services.

Our services

The Trust provides a wide range of NHS telephone and internet services to people in England:

Urgent care

- a telephone helpline (0845 4647) providing patients with expert health advice and information 24 hours a days, 365 days a year
- over 40 online health and symptom checkers, giving advice on the most appropriate course of action, with the option to request a call back from a nurse advisor if required (www.nhs.uk/nhsdirect)
- a free mobile app for Android and iPhone smartphones providing mobile access to the range of health and symptom checkers
- assessment of low priority (Cat C) 999 calls for six ambulance trusts
- a single point of access for urgent care services across five PCTs in West Yorkshire
- call handling and clinical assessment for out of hours GP and dental services in a number of PCTs
- NHS 111 pilots:
  - providing the full end-to-end service in Lincolnshire, Luton and Nottingham City working closely with GP out of hours services and ambulance service trusts
  - working as part of a consortium with the local GP out of hours service and ambulance trust to deliver the pilot in Lancashire
  - providing health information provision in County Durham and Darlington, Derbyshire, Hillingdon and Croydon.

Management of long-term conditions

- OwnHealth® - telephone based coaching and advice for people with diabetes, cardiovascular disease, heart failure and chronic obstructive pulmonary disease
- NHS Telehealth Direct – monitoring of patients with long-term conditions in their own homes via appliances which transmit daily information about their conditions to the Trust's health advisors
- Healthy Change – providing coaching support and connecting people in Nottingham who have cardiovascular disease risk factors with motivational support on lifestyle choices, including access to locally-delivered lifestyle groups.

Supporting patient choice

- delivering the first phase of online patient decision aids designed to help patients make difficult treatment or screening decisions when there is no clinical evidence that one option is better than another
- managing of The Appointments Line, one of the main ways patients can book their first hospital or clinic appointment using Choose and Book.

National resilience

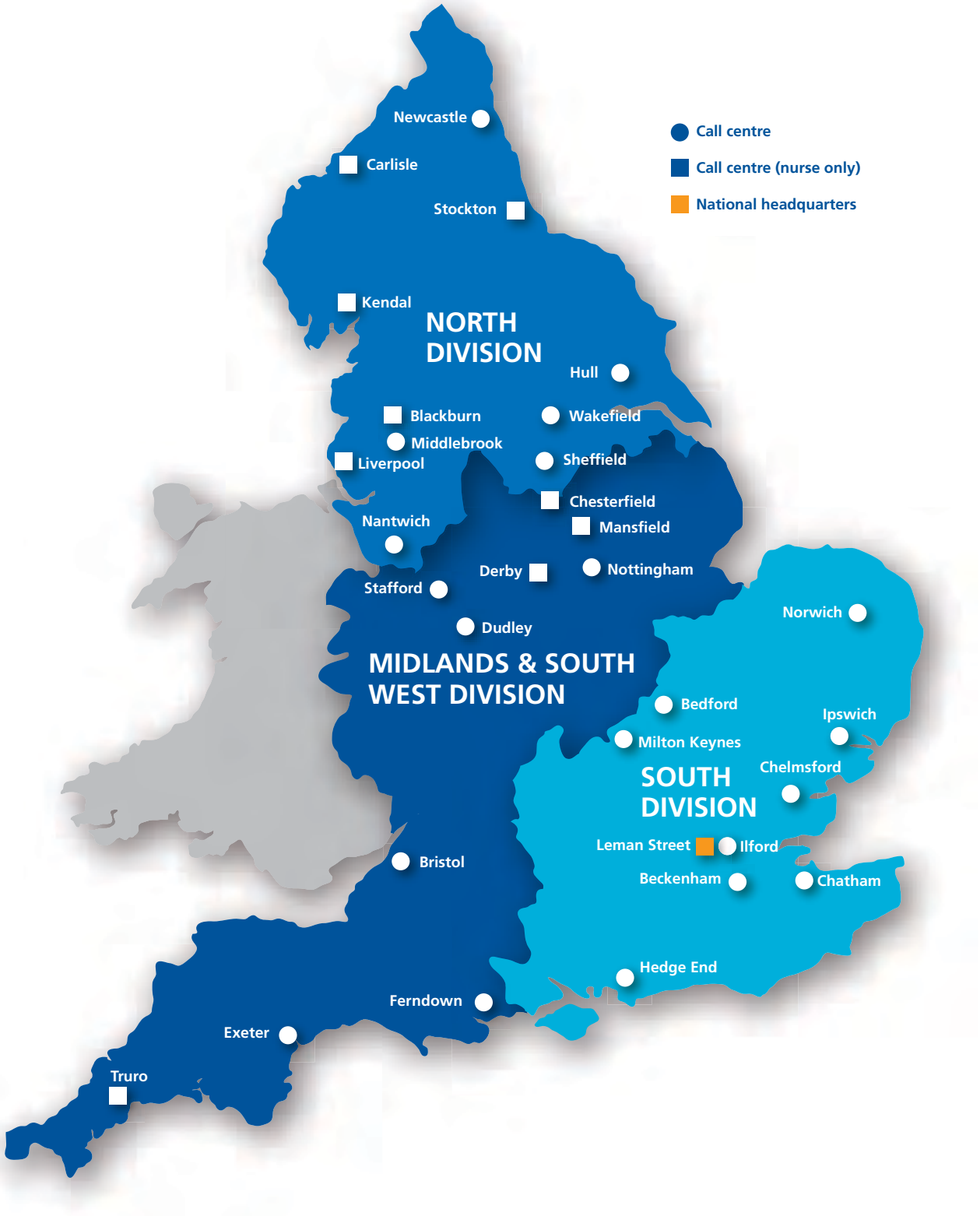
- management and operation of the National Pandemic Flu service.

Our national network of contact centres

The Trust has a local presence through our network of 30 contact centres across England. These are linked together through our electronic network to create a single 'virtual' national contact centre, offering scalability and resilience.

Our headquarters are at 120 Leman Street, London E1 8EU.

Our national network of contact centres



The external environment

The NHS 111 service will be an important part of the urgent care system, and has the potential to reduce demand on other services as well as direct patients to the 'right service first time' without delay. The Department of Health's plan to roll out the service by April 2013, replacing the 0845 service with free telephone access to integrated non-emergency urgent care, will have far reaching implications for our operations and organisation.

We face significant competition to provide NHS 111 services as the Government seeks to create a market for the services that hitherto the Trust has been nationally commissioned to provide. Whilst we have a strong offer to make to commissioners about the quality and effectiveness of the service we can provide for their patients, we face direct competition from local incumbent GP organisations and ambulance trusts able to bid for services on a marginal cost basis.

The regional and sub-regional procurements of the service began formally in 2011/12 and are open to any willing provider who can meet the service specification requirements. The contracts that are being put in place locally are at a significantly lower cost than the pilots being evaluated. Nine pilots have been running during 2011/12 (commencing at various intervals).

At the same time the commissioning regime is changing with the majority of NHS services to be commissioned by Clinical Commissioning Groups (CCGs), which are currently forming and will be fully in place by April 2013. During the year we publicly supported calls from the British Medical Association and other organisations for improved CCG engagement in NHS 111 and to allow greater time for the development of NHS 111 services in the light of the independent evaluation of the four initial pilots.

Patients are increasingly using online services to access healthcare. Over 10 million people a year currently use our online and mobile health and symptom checkers, more than twice the number that call the 0845 telephone number. The Department of Health has committed to providing the NHS 111 service online, alongside the telephone, and we are using our experience of online services to help the Department of Health explore the benefits and capabilities of digital channels.

We recognise that the way in which health and social care services are delivered within the NHS is undergoing considerable change. With the population growing older and living longer, there is a need for innovative ways to reduce the burden of efficiently managing these patients. The aging population is driving growth in the volume of patients with long-term conditions (LTCs) in particular, and the Department of Health estimate that there will be over 18 million sufferers in 2025. Through our development of telehealth and telemonitoring, we are utilising emerging technologies to support the Department of Health's 3 Million Lives campaign, which aims to enhance the lives of three million people over the next five years by accelerating the roll-out of telehealth and telecare in the NHS and social care.

Our vision and objectives in 2011/12

In our business plan for 2011/12 to 2015/16, our market assessments and engagement with stakeholders, members and staff, confirmed that the high level vision set in 2010/11 remained appropriate.

"NHS Direct National Health Service Trust will provide remotely-delivered care that is increasingly valued by patients and the wider health and social care system."

Underpinning this vision, our six strategic objectives are to:

- raise the quality and productivity of our services
- increase the value we create for patients, public, the NHS and social care
- incorporate our values in everything we do
- be a great place to work and an employer of choice
- take advantage of new opportunities and plan effectively for the future
- improve our corporate effectiveness and efficiency.

To achieve our strategy in the context of our market analysis and our strengths, weaknesses, opportunities and threats, we set a series of service development plans:

- focus on delivering the national specification for the NHS 111 urgent care telephone service
- continue to develop clinical services (including a web service) as complementary options to the NHS 111 service, in response to demand from commissioners
- continue to develop clinical services to support patients with long-term conditions; to support patient choice; and to support national resilience
- continue to provide the 0845 service until NHS 111 is nationally available, ensuring it continues to provide a clinically safe and effective service for patients and commissioners
- continue to provide those services commissioned locally and nationally, such as call handling and nurse assessment for GP and dental out of hours services and The Appointments Line.

To deliver these, we set our development plans for our organisation:

- create a delivery model for high quality and cost competitive NHS 111 and other services
- listen carefully to our commissioners and create services that meet their needs, demonstrating our value
- continue to improve staff productivity and availability at the times patients call, and to reduce support and overhead costs
- put in place a project to consider NHS Foundation Trust status from April 2013
- put in place the next stage of our change programme with four workstreams: to create a new operational delivery model to deliver NHS 111; marketing and service development; corporate development; and delivery of existing services
- create a central team to ensure the programme has sufficient management capability and capacity to:
  - provide staff support through the transition and keep them informed
  - manage inter-dependencies
  - oversee programme risks
  - engage with external stakeholders.

Existing services

In 2012/13, we will continue to focus on consistently meeting our standards on all existing contracts, whilst improving efficiencies and supporting the transition to NHS 111. The 0845 service remains a key part of the health service, and we plan to answer more calls in 2012/13 than we did last year whilst maintaining safety and quality standards, meeting patient needs and supporting commissioners and the wider NHS in continuing to help manage demand effectively.

NHS 111

By May 2012 invitations to tender for NHS 111 contracts covering 85% of the population had been issued. By September 2012 we anticipate that the majority of contracts will have been awarded. In early 2012/13 we will continue to engage with local commissioners - including emerging Clinical Commissioning Groups - and work with a variety of potential partners to bid for these contracts.

Long-term conditions

In 2012/13 we will continue to support the Department of Health's 3 Million Lives campaign, working with patients, commissioners, care providers and technology companies.

Patient choice

We will continue to provide The Appointments Line in an extension to our contract as the national provider until late 2013.

In 2011/12 we pioneered the development of some online Patient Decision Aids, supporting patients to make difficult decisions about their treatment options. During 2012/13, we will hand over the ongoing management of this successful project to a new provider to take this project forward to the next stage of its development.

National resilience

The National Pandemic Flu Service is annually tested to ensure it can be quickly activated if required.

Our performance

Our progress towards our strategic objectives and operational performance was monitored by the Board throughout the year.

Overall patient satisfaction and the quality and safety of the service remain strong. The Trust's range of web and mobile health and symptom checkers proved extremely popular in 2011/12 with recorded uses at 10.7m - almost double the 5.5m target set, highlighting patient and public appetite to access health information and advice via digital channels. The numbers of patients using the core telephone service fell slightly below the number expected, to 4.4million calls. We also answered over 325,000 calls to the NHS 111 service in the pilots we were leading on in 2011/12, 3.0m calls to The Appointments Line and over 900,000 calls from locally commissioned services.

The Board reviews performance on a regular monthly cycle, using a Board Scorecard which covers all significant aspects of the Trust's performance, including patient experience, quality and safety, access, productivity, volumes of service, outcomes, staff and finance (see appendix A)

One area where we did not reach our target was staff productivity – 'time with patients'. Whilst overall staff productivity did improve, this metric did not. It particularly measures the effectiveness of ensuring that front line staff are rostered to be with patients on the telephone for an increasing proportion of their time. Two particular factors influence this: arranging for staff to be on duty at times of greatest patient demand, and reducing the amount of "off-line" time for non-patient facing activities. Revised rostering arrangements have now been introduced and further improvements in productivity are now starting to show. However, these improvements did not arise in 2011/12.

The Board set a new, "stretch" target for regular random individual staff "call reviews". All patient calls to the Trust (excluding the Appointments Line) are recorded, and the Trust has a regular process of independently reviewing around 4,000 calls each month. Whilst the clinical safety aspects of call reviews remained satisfactory, non-clinical aspects such as completing documentation pulled the performance level down.

See Appendix B for full details of the indicators of quality selected by the Trust Board for the core service and reviewed by it regularly during the year. These form part of the Trust's Quality Account for 2011/12 which is available at www.nhsdirect.nhs.uk.

We regularly survey patients who contact the core service, through the 0845 service and via the internet, to ask them about their experience of using the service, what they would have done instead if they had not contacted the service, and whether they followed the advice the service gave them. This provides powerful evidence of the value that the core service adds both for patients and for the wider NHS. Patients value the advice they receive, but in addition it saves them the inconvenience of having to attend a face-to-face appointment, and for the wider NHS it reduces demand on hard-pressed GP surgeries and A&E departments.

In agreement with our main commissioner, the Trust estimates that in 2011/12 the core service saved 1.5 million unnecessary GP surgery appointments, 0.7 million A&E attendances/999 calls and 0.6 million other face-to-face appointments. This was achieved because on average, 53% of calls to the core telephone service did not require onward referral. 27% of patients required urgent or emergency care – just above our 25% target.

3. Values

Our values reflect the best of who we are and what we want to be. We want our values to influence our behaviours, both internally and externally. They underpin the delivery of our objectives and the achievement of our vision.

- We're here
- We deliver
- We care
- We empower
- We think ahead
- We listen.

During the year we were fortunate to have 15 staff who volunteered to be values ambassadors. The group worked with the Chief Executive and staff at every level across the organisation to spread the values that we all aspire to in our dealings with patients, other NHS staff and each other. One of their initiatives was the introduction of "values awards" where staff were nominated by their peers under the six value categories. Nominations were judged by a panel of staff members. 17 members of staff won awards for their outstanding work.

4. Great place to work

The Trust aspires to be a great place to work. It is the quality and commitment of our staff to deliver the service that makes the difference for patients.

We now have an "instant recognition" system which staff can access and record their appreciation of their colleagues. This system is well used, and over 200 staff have been recognised by their colleagues for their great contribution.

In 2011/12, reducing sickness absence remained a real priority for the Trust. The Department of Health calendar year figure shows that overall sickness fell for a third year in a row from 14.9 days/wte to

14.6 days. However, the targets set by the Board to reduce overall sickness to 10 days per whole time equivalent, and to reduce the number of staff on long-term sick leave were not achieved. Supporting staff to reduce sickness absence remains a priority for 2012/13.

Overall, front line staffing was stable and the Trust has retained its permanent experienced front line workforce well. We completed the year with 96% of the Trust's permanent front line staff having been in post for longer than 12 months. The Trust was also well supported by its in-source partner Conduit and nursing agencies. These more flexible sources have enabled us to manage peaks in demand more effectively, and will play an increasing role as we approach the end of the 0845 service in March 2013.

5. Corporate effectiveness

The Trust completed another successful financial year with a £0.5m surplus. During the course of the year we delivered further contract cost reductions for our lead commissioner, NHS Midlands and East of £6m and achieved cost improvements and efficiencies of £15.7m.

In total we have now released over £30m in recurrent income and expenditure savings since 2009/10, which has made nearly £70m in cash terms available to the NHS over those three years.

Income from activities totalled £144m, with associated operating expenses of £143m. Staffing costs were £90m, some 65% of our operating costs.

Cash and bank balances remained strong at £22m at year end, increasing from £20m at March 2011.

We invested £2.9m in capital assets including information management, telephony infrastructure, premises, equipment and facility improvements that have benefited staff and patients.

Looking towards 2012/13 we must maintain our momentum and drive for further efficiency and greater levels of productivity. We aim to answer more calls to our 0845 service in 2012/13 and deliver even better levels of performance for patients through our new roster programme; which will ensure our staff are available when our patients need us.

We must do so whilst facing probably our most difficult and challenging year ahead. During the final year of the 0845 service we must continue to serve the millions of patients and users of that service, whilst also bidding for new NHS 111 service contracts and re-designing our operations to deliver the new contracts that we aim to secure through the competitive bidding process. It will be demanding, and it is therefore essential that we maintain our sound systems of financial control with active financial planning and stringent financial management. Our budget holders and financial managers were instrumental in maintaining sound financial control, and this will remain critical in the year ahead.

The cost of change will be significant, in staffing and in financial terms. The outcome will only ultimately be known as NHS 111 procurements conclude during the course of 2012/13. We have therefore noted in the accounts the associated potential contingent liability as at 31 March 2012. The Trust has been in communication with the Department of Health on the significant cost of change and de-commissioning of the 0845 service to ensure they are recognised and funded going forward. We have also worked proactively with commissioners to minimise these liabilities through the application of Cabinet Office Guidelines for the majority of front line staff providing the 0845 service.

Sustainability Report

As a provider of remotely delivered healthcare, the Trust is a sustainable organisation. We offer quality healthcare advice to patients in their own homes without the need for travel; which has a significant impact on energy consumption and CO2e emissions.

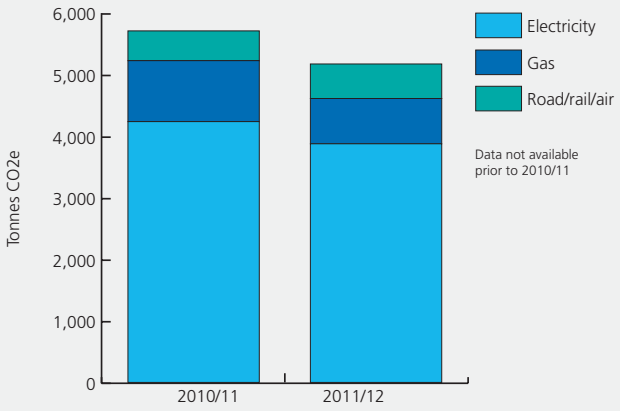
Our organisation has an up to date Sustainable Development Management Plan, although there are areas of work that require further attention.

The Trust complies with all environmental legislation and strives to meet the requirements of other policies and strategies set out by Government, Department of Health and the NHS.

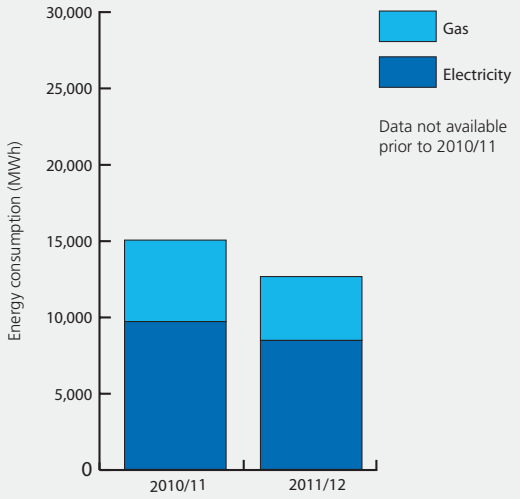
- We are committed to minimising waste by evaluating operations and ensuring that they are as efficient as possible.
- We communicate and promote our sustainability policy, procedures and practices to our staff and others working on our behalf, ensuring that all employees are aware of their responsibilities in sustainability.
- We measure our impact on the environment and set targets for improvement and we will continually improve our performance by setting and reviewing the targets each year.
- We encourage our suppliers to adopt similar attitudes towards improving sustainability and actively promote reuse and recycling amongst our suppliers, and internally to our own staff.
- We are committed to reducing wider environmental and social impacts associated with the procurement of goods and services. This will be set out within our policies on sustainable procurement.
- We have started work on calculating the carbon emissions associated with goods and services we procure.
- A Board Level lead for Sustainability ensures that sustainability issues have visibility and ownership at the highest level of the organisation. Roger Rawlinson, HR & Transition Director is the Board Level Lead for Sustainability.

Sustainability Report

We continue to develop our capture of non-financial data and a summary of the major areas where this has been done are as follows:

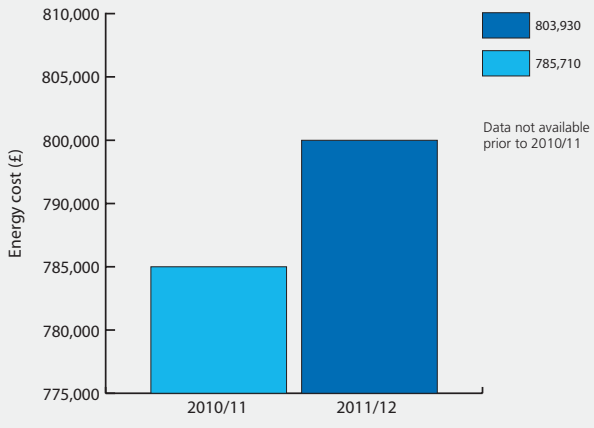


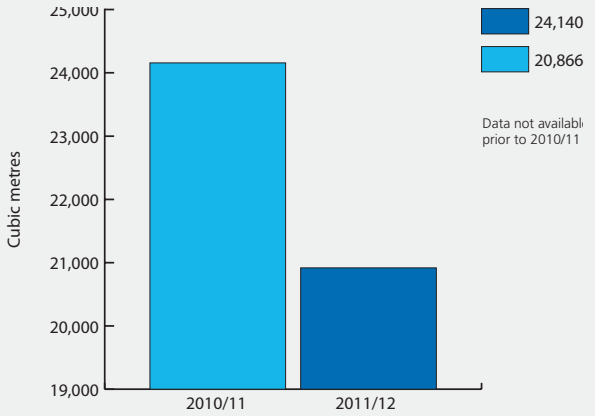
- Our measured greenhouse gas emissions have reduced by 707 tonnes this year. We do not currently collect data on our annual Scope 3 emissions.
- There was a reduction of transport CO2e emissions by 16.2% in 2011/12.
- We have put plans in place to reduce carbon emissions and improve our environmental sustainability. Over the next 10 years we expect to save **£2,500,000** as a result of these measures.
- During 2011/12 our total expenditure on business travel was £1,283,410.



- Our total energy consumption has fallen during the year, from 15,125 to 12,716 MWh.
- Our relative energy consumption has changed during the year from 0.69 to 0.61 MWh/square metre
- Within the NHS Direct estate annual consumption of energy has reduced by 12.8% for electricity, and 21.6% for gas.
- The NHS aims to reduce its carbon footprint by 10% between 2007 and 2015. Reducing the amount of energy used in our organisation contributes to this goal.

Our energy costs have increased by 2% in 2011/12.





- Our water consumption has reduced by 3,274 cubic metres in the recent financial year.
- In 2011/12 we spent £65,000 on water.

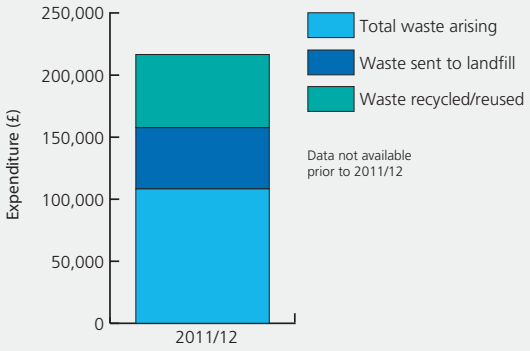
Our future plans

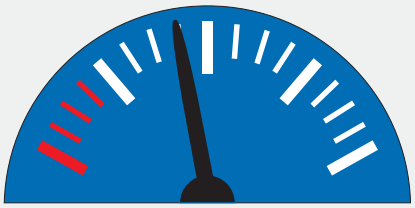
Our Sustainable Development Management Plan highlights objectives for the future.

These include:

- running a general awareness campaign for all staff;
- including sustainability in all frontline job descriptions;
- including and updating sustainability reporting in the corporate risk register;
- putting plans in place to support more effective sustainable travel.

Our expenditure on waste in the last year was incurred as follows:





We recover or recycle **131 tonnes** of waste, which is 34% of the total waste we produce.

Our staff

In 2011/12, on average through the year 2,536 (1,959 Whole Time Equivalents) were contracted to work on a permanent basis for the Trust.

The ability to offer part-time work means that we have both increased flexibility in service delivery but can also offer employment opportunities across a broad demographic range.

99% of our substantive staff are contracted under the NHS Terms and Conditions of Service.

We continue to operate under national terms and conditions of service for substantive staff.

37% of our staff are registered with the Nursing & Midwifery Council (NMC), 87 employees are registered with the General Dental Council (GDC) and 3 employees are registered with the General Medical Council (GMC).

Improvements to rostering – Our Future Workforce

The Trust introduced a new staff rostering approach during 2012. The decision to implement new staff rosters was taken after extensive consultation with staff. This was in response to our staffing patterns needing to be adjusted to provide an increasing proportion of staff to answer calls in the out-of-hours and weekend period. This approach has meant disruption for some staff and has placed increased demands upon many in terms of flexibility and working arrangements.

The changes, which were implemented in late March 2012, will make us more flexible so that we can deal with the changing pattern of call volumes more efficiently. The decision to implement new rosters was taken as it is central to the achievement of the service levels and efficiencies required of us. The rostering system will remain under review to ensure that it continues to meet our needs and pays due regard to our duty under the Equalities Act. Staff will have an opportunity, through their union representatives, to continue to contribute to this.

Nurse Bank

We have expanded our Nurse Bank during the past year to provide staff with a more flexible option for balancing their work with us, with other nursing jobs elsewhere in the NHS and other lifestyle commitments. This gives the Trust greater capacity to meet fluctuations in patient demand. As non- substantive staff, they are under no obligation to accept the shifts offered, but must work a minimum average of 15 hours per month in order to maintain required skill levels. We have also set up a Nurse Bank for the NHS 111 service along similar lines.

Staff redeployment – Birmingham OwnHealth

2011/12 was the final year of the four year Birmingham OwnHealth contract, which was one of our services to support patients with long-term conditions. We continue to operate the OwnHealth Service in Nottingham. Our OwnHealth staff have shown great dedication to the service and its patients over the last four years. We consulted with affected staff about the potential for redeployment within our core service after 31 March 2012 so we did not lose these very valuable and experienced members of staff. We are pleased to have identified suitable alternative posts for those staff who wished to remain with us.

Sickness absence

The management of absence continued to be a priority focus for managers in 2011/12 with the collection of weekly sickness statistics as an aid. After reviewing various options, a decision was made to use the Trust's bespoke sickness management system, Lexicon, which was developed significantly in 2011.

Our Occupational Health service, provided by Imperial Health at Work, has continued to provide important support for us in the management of individual cases of staff sickness in 2011/12. In keeping with our ethos of 'virtuality' we have worked closely with the Occupational Health service to conduct health assessments by telephone wherever possible and trialled a 'fully remote' service from the Imperial hub for three months, which proved very successful.

Equality and Diversity

During the last year the Trust has complied with the specific duties under the Equality Act 2010 to publish equality information with regard to our staff and service provision. We also published four equality objectives which we will take forward in 2012/2013.

Significant progress has been made in ensuring that staff have completed mandatory training on equality and diversity - 75% of staff have completed this training. This has been facilitated by the development of an updated e-learning package.

The Trust has been accredited as a 'Two Ticks Symbol' employer which reflects our compliance with Job Centre Plus standards on the employment of people with disabilities.

As of the end of March 2012, 102 members of staff had a disability, which equates to 4.3% of the total staff employed (2,383). This is a small increase on last year's figure of 3.5%.

Support for staff

In addition to the NHS national terms and conditions of employment we offer our staff a range of benefits:

- Eye-care vouchers
- Child-care vouchers
- Cycle-to-work scheme
- Season-ticket loan scheme
- Access to a 24/7 employee support line and counselling service

In the coming year we will provide staff with professional career support and access to practical advice on potential options such as retirement and redundancy.

Staff survey and resulting action plan

Between October and December 2011 we took part in the national NHS staff survey. This year, 72% of staff took part in the survey, which was carried out online.

There were a broadly equal series of positive and negative movements from the 2010 survey results; however, in the 'key satisfaction areas' there was a deterioration from the 2010 survey when it came to support and communication from senior management and the sense of being valued and recognised.

In these challenging times, we recognise that it is extremely important that our senior managers are given the opportunity and information they need to effectively communicate with their staff, and that our staff feel supported and valued. Areas of focus in the coming year include communications and engagement; recognition; management and career development support and health and wellbeing. The actions resulting from the staff survey will form part of our Staff Support Project through the Our Future programme.

Staff engagement

We are committed to ensuring that our staff have access to information about the Trust, important developments and the information they need to do their job as well as opportunities to ask questions and give feedback where it matters. During the year we have continued to develop our existing communications channels, including a weekly e-bulletin (News Shot), a staff intranet, blogs, face-to-face meetings and open forum teleconferences, videoconferences and emails. The executive and non-executive teams hosted a series of open forums across the contact centres throughout the 'Our Future Workforce' consultation period. We have also doubled our videoconferencing capacity and introduced a formalised cascade system of monthly briefings. These developments will continue into 2012/13 as we ramp-up activity through our change programme.

We recognise four trade unions for the purposes of collective bargaining and partnership working: Royal College of Nursing, Unison, Unite and Royal College of Midwives. Our Recognition Agreement makes clear that staff involvement is central to decision making processes and we hold a monthly national negotiating forum which is informed by local and divisional meetings. The 'Great Place to Work' initiative from 2010/11 successfully ran its course and has now developed into a much more widespread workstream known as 'The Effective Organisation'. This aims to dovetail staff and workforce developments with other initiatives designed to bring improvements to the patient experience.

Health and safety

Roger Rawlinson, Human Resources and Transition Director is the Trust's Executive Lead for Health and Safety.

The National Health and Safety Committee provides strategic health and safety direction to the Trust and is responsible for implementing legislation, commissioning annual audits, quality assuring our health and safety training and new policy development. Supporting the National Committee are three Divisional Health and Safety Committees, which oversee all health and safety matters within a geographical defined area; each Divisional Committee reports into the National Health and Safety Committee.

We continually seek to improve our health and safety processes and procedures, and within the past year have reviewed and rewritten eight health and safety policies to insure compliance to latest legislation and external guidance.

Awareness of health and safety matters has been raised through the efforts and support of site management and staff side representatives who work in partnership to improve the health and safety of our staff and our visitors. Our health and safety staff side representatives make regular assessments proving assurance that all standards of health and safety legislation are adhered to and continually monitored.

Every member of staff receives mandatory training in a number of areas including health and safety and fire safety. We have continued our commitment to provide a tailored health and safety training package for all first and second line managers across the Trust, and 87% of staff have completed health and safety training.

Security management

Trevor Smith, Finance Director is the Trust's Executive Lead for security management.

Over the past twelve months, the Trust's two Local Security Management Specialists (LSMS) have continued to develop our

security management functions and have ensured that reported incidents are investigated and followed through to their appropriate conclusion.

We have also developed an in-house security awareness training package through an e-learning package to raise awareness of the roles of the LSMS and the NHS Counter Fraud and Security Management Service and the responsibilities places upon the Trust and its staff. 95% of staff have completed Information Governance training.

Our Local Security Management Specialists are available to provide advice and support to all staff across the Trust in relation to tackling violence and/or abuse against staff and reducing the impact of crime

Counter fraud arrangements

The Trust is committed to ensuring fraud or corruption does not proliferate within in the organisation. We are fully compliant with the directions issued by the Secretary of State in 1999 and the NHS Counter Fraud and Corruption Manual.

The Trust's Counter Fraud Service is provided by Deloitte & Touche Public Sector Internal Audit Limited. The Local Counter Fraud Specialist (LCFS) reports to the Director of Finance and attends our Audit Committee meetings to report on the work achieved. Our LCFS works to ensure that counter fraud is integrated into all Trust activity in a positive way.

Throughout the past financial year we have continued to embed the counter fraud culture and work is undertaken against each of the areas of action set out in the NHS Counter Fraud and Corruption Manual, namely:

- creating an anti-fraud culture
- deterring, preventing and detecting fraud
- investigations
- sanctions/redress
- mandatory counter fraud arrangements.

Reactive investigations comply with legislative requirements and with the NHS Counter Fraud and Corruption Manual. Our LCFS liaises with other LCFS personnel and relevant external bodies for investigations, as appropriate. The LCFS is available to receive referrals and reports on the results to the Director of Finance and the Audit Committee. All sanctions available to the Trust are considered following a reactive investigation, together with efforts to recover losses incurred.

Our stakeholders

Stakeholder engagement was a significant activity for the Trust in 2011/12. In areas where we are involved in NHS 111 pilots, we have built on our existing relationships working closely with local commissioners (including emerging CCGs) to understand their requirements for the NHS 111 service and to share our experience from the NHS 111 pilots. We have worked closely with GP out of hours services and ambulance trusts to deliver NHS 111 pilots and developed new relationships with potential public and private sector partners.

Stakeholder engagement activity has been led by our Regional Directors and Regional Heads of Service Development, and has included face-to-face briefings, regular meetings, workshops and visits to our contact centres so stakeholders can see first-hand how the NHS 111 service is delivered.

The Medical Director, supported by the senior clinical and regional teams, has met with both national clinical stakeholders and local CCG leads to help develop their understanding of how NHS 111 will work in the wider urgent care landscape and to share our experience of the clinical outputs from the pilots.

The Trust produces a bi-monthly email bulletin for stakeholders to keep them informed about new developments. We also engage with them via social media channels and the web streaming of Trust Board meetings.

The Trust is acknowledged as a research-active NHS Trust. Major achievements in 2011/12 include:

- a 5-year Programme Grant from the National Institute for Health Research. The award is supporting a series of studies to evaluate the role of the Trust in providing telephone and web support to patients with long-term conditions
- recruitment of 2,777 patients for research studies approved by Research Ethics Committees
- continuing to develop strong links with UK universities to enhance and strengthen the Trust's research portfolio.

Our patients

Patient experience

The overwhelming majority of our patients say they are very satisfied with the service they receive from us. In 2011/12, we surveyed around 9,000 patients who had used our 0845 service and 92% were satisfied with the way their call was handled. Our Net Promoter Score - based on the question: "on a scale of 0-10, how likely are you to recommend our service to your family and friends?" - was 77%, which is considered excellent.

Complaints and compliments

The Trust actively encourages patients, carers and health professionals from the wider NHS and social care to provide feedback on our services. In 2011/12 we received 2,667 items of feedback, which included 157 complaints from patients and service users of which 99% were resolved first time with the complainant. This represents only 0.2 complaints for every 10,000 calls handled compared to 472 compliments representing 0.6 for every 10,000 calls we received. Of the complaints we received, 94 were upheld where, following investigation, we agreed that they were founded and appropriate action was taken to make improvements to prevent the issues identified recurring.

The main area of concern expressed by complainants in 2011/12 related to the length of time they had to wait for a nurse call back. In response to this, we have implemented a performance improvement plan; including significant changes to the way our staff are rostered to work, to reduce the length of time callers have to wait for a nurse call back during our busiest periods. We also routinely randomly review over 1% of all calls to our services to ensure that we can identify good practice and any potential areas for development for staff.

During the year, one complaint was investigated by the Parliamentary and Health Service Ombudsman.

Patient and public involvement

In 2011/12, we carried out a programme of activities to engage with our patients, carers, public members and the general public as a whole. This included:

- web streaming of our Trust Board meetings
- engagement with patients and the public in the development of our Medicines Information Service
- involving patients and the public in research, service evaluation and clinical audit projects
- seeking patients' views on the development of new measures of patient reported experience and outcome measures
- involvement of public members in a range of groups and committees, including research and clinical audit.

The Trust has over 18,000 public members that broadly represent the population of England and service-users. Members receive a quarterly newsletter by post or email to keep them informed about new developments. Members are also invited to take part in focus groups and surveys about the Trust's services and strategic direction.

Public Interest and Governance

Non-Executive Directors' biographies

1. Joanne Shaw, Chair

Joanne was formally appointed Chair of the Trust in January 2010, having led the board since 2008. She is Chairman of Datapharm, a leading provider of digital medicines information. She was recently appointed as a Non Executive Governor of Nuffield Health. She sits on the board of the Money Advice Service and she is a director of the British Board of Film Classification. In her professional roles and in her writing for health publications Joanne is known for advocating partnership between patients and health professionals and supporting people to make better informed choices about their health using new communication channels. 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 in the NHS. She previously worked internationally as a strategy consultant with the Boston Consulting Group.

2. Peter Catchpole

Peter joined the Board on 1 April 2004. He has worked as a senior executive in the NHS for 30 years, 20 of them 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 Councilor in West Sussex and Cabinet Member for Health and Adult Services and a Fellow of the Faculty of Health at the University of Brighton. He is a Council Member of the General Dental Council and also has a number of appointments on Fitness to Practice Committees in the professional health regulatory sector. Peter is an independent healthcare consultant and a business advisor to the independent health sector.

3. 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 has a number of Non-Executive Director roles in both the public and private sectors.

4. Sue Hunt

Sue joined the Board on 1 April 2007 and is a chartered accountant who spent circa 20 years with KPMG, a global accountancy and business advisory firm. During that time she gained experience in external and internal audit, mergers and acquisitions and in consultancy. She worked with a wide range of clients across all sectors including technology, property and construction and consumer goods. Latterly, Sue was instrumental in establishing a multi-disciplinary healthcare group at KPMG and led the team contracted by the Department of Health to advise acute and mental health Trusts on all aspects of their Foundation Trust application. She also provided due diligence services to corporate clients, banks and private equity houses on potential investments in the independent healthcare sector. Sue is also an Appointed Trustee and chairs the Audit Committee of CfBT Education Trust, a large charity that operates in the education sector both in the UK and internationally.

5. Tim Walton

Tim joined the Board on 1 April 2007. He is an independent consultant as well as serving as a Non-Executive Director at the Highways Agency and Accent Group, where he chairs the Audit Committee. Formerly he was a Non-Executive Director at BIS serving on the Operating Committee. His executive career included senior roles in e-business, IT, engineering and manufacturing in global aerospace and professional services companies. He is a Chartered Engineer and a Fellow of the British Computer Society.

6. Luisa Dillner

Luisa joined the Board on 1 February 2010. She qualified in medicine from Bristol University and trained in surgery gaining her FRCS in 1991. She is Head of New Product Development at the BMJ Group and has launched some of their most successful online products such as BMJ, Learning and BestHealth, the BMJ Group's online consumer health resource. Most recently she launched doc2doc, an online international global community for doctors and healthcare professionals. Luisa also spent two years as Health Editor at the Guardian and has written three books and numerous health articles for consumer publications.

7. Tim Heymann

Tim joined the Board on 1 February 2010. He is a consultant physician at Kingston Hospital, specialising in gastroenterology and liver disease. He was also responsible for developing Kingston Case Notes, an award-winning electronic patient record pilot. He has also provided the clinical lead for major projects that have helped redefine the way in which services are delivered. Tim has been a consultant for McKinsey and Booz Allen. He also works at Imperial College Business School and is responsible for much of the development and delivery of health management courses for undergraduate medics, post graduates and senior health service managers in the UK and abroad.

8. Steve Duncan

Steve joined the Board on 1 October 2010. A pharmacist by training, Steve has a track record of leading transformation and driving performance in complex multi-national, multi-site environments. He was awarded a place on the prestigious three month Advanced Management Programme at Harvard Business School before going on to hold a number of leadership roles at Moss Pharmacy, Alliance Pharmacy, Alliance UniChem and Alliance Boots. He recently retired as Executive Chairman of Boots. Steve is an advisor with Alliance Boots, alongside his role at the Trust.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Executive Directors' biographies

1. Nick Chapman, Chief Executive

Nick was appointed the Chief executive of NHS Direct National Health Service Trust from 1 April 2009. Before joining the Trust he was the Department of Health's National Director for the 18-week target. He was also responsible within the National Programme for IT as SRO for the Choose and Book and PACS programmes. He joined the DH on secondment from the NHS in 2005 to work on reducing cancer waits, elective waiting times, and in the implementation of patient choice and booking. Nick has practical experience 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 trust Chief executive, first in West Dorset and then in Taunton, Somerset.

2. Keith Gait, Interim Chief Operating Officer*

Keith joined the Trust in August 2011 as Deputy Chief Operating Officer, taking up the role of Chief Operating Officer in December. Keith has 18 years experience in the customer service and contact centre field. He began his career as an advisor and is passionate about operations that recognise their people as well as their customers. Keith was customer service director at Sainsbury's mobile and had a successful career with organisations such as Sitel and Barclaycard. He has completed performance improvement, strategic direction, outsourcing, and transformation programmes for a wide range of clients. Keith is the author of 101 Ways to Improve Customer Service, The Attrition Waterfall, and The Causes of Churn in the Broadband Industry. Keith is also a Judge for the CCF European Call Centre Awards and the Customer Service Training Awards. Keith has recently completed his MBA from Henley Business School.

3. Roger Rawlinson, HR Director

Roger joined the Executive Management Team 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.

4. Alan Bentall, Chief Information Officer

Alan was appointed Chief Information Officer (CIO) in January 2010. Alan was seconded to the Trust as interim CIO in 2008 from the professional services firm Deloitte, where he was an Associate Partner in the Technology Integration Practice. He has held leading roles on assignments in many of the major central government departments and a selection of private businesses, including Department for Work and Pensions (DWP), Her Majesty's Revenue and Customs (HMRC), Ministry of Defence (MoD), Connecting for Health and Royal Mail Group. His 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.

5. Ruth Rankine, Director of Strategy & Planning

Ruth joined the Trust on 14 October 2007, on secondment from the Department of Health. She is responsible for developing the Trust's medium-term strategy and business plan in addition to service development, marketing and communications. Ruth has held senior positions at a national and local level. Her previous post in the Department of Health was Principal Private Secretary to the NHS Chief Executive and the Permanent Secretary. Previous to that she was Director of Emergency Care for Leeds Acute NHS Trust & Leeds PCTs and Programme Director for the GP contract negotiations working for the NHS Confederation.

6. Trevor Smith, Finance Director

Trevor joined the Trust as Finance Director in January 2009 from Barking, Havering and Redbridge NHS Trust where he led the Financial Recovery Plan. His previous Finance Director roles include Basildon and Thurrock University Hospital Foundation Trust, where he led the Financial Application and Assessment process and Billericay, Brentwood and Wickford PCT. He was also the Acting Director of Finance at the Barking, Havering and Brentwood Community and Mental Health Trust where he supported the successful dissolution and disaggregation of the Trust. Trevor joined the NHS in 1996 from local government.

7. Brian Gaffney, Medical Director

Brian has worked in public health and General Practice in the NHS since 1988. Following training posts in public health medicine and time spent as a lecturer in the academic department of epidemiology in Queen's University, Belfast, he was appointed as a Consultant in Public Health Medicine in 1993. In 1996 he joined the Health Promotion Agency in Northern Ireland as Chief Executive with responsibility for all public health and managerial aspects of the Agency's work. Brian was Director of the WHO Collaborating Centre at the Agency and led its contribution to a number of European projects and programmes. Brian joined the Trust as National Public Health Advisor in October 2009 and became Director of Public Health shortly after. He works part-time for the Trust so that he can continue to work in General Practice in Northern Ireland.

8. Patricia Hamilton, Clinical Director/Chief Nurse

Tricia joined the Board in December 2010 as Acting Clinical Director/ Chief Nurse, before being formally appointed to the role in May 2011. She is responsible for the quality, clinical safety, and effectiveness of care delivered by the service. She joined the trust as a nurse advisor in 1999, and has since held senior positions at a local and national level in the trust. Tricia has 27 years of nursing experience covering a variety of disciplines including neuro-intensive care, general surgery and remote care delivery.

*Ronnette Lucraft was Chief Operating Officer until November 2011


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Information Governance, risk and steering group

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.

Summary of protected personal data related incidents formally reported to the Information Commissioner's office in 2011/12				
Statement on information risk	NHS Direct has not formally reported any action on protected personal data related incidents information to the Information Commissioner's Office risk in 2011/12. NHS Direct will continue to monitor and assess its information risks in order to identify and address any weaknesses and ensure continuous improvement of its systems. During 2011/12 the Senior Information Risk Owner (SIRO) and the Head of Information Security & Risk Management continued to champion information risk throughout the organisation at an operational level, through the implementation of the Information Risk Assessment & Management Strategy Plan & Programme. The SIRO and Head of Information Security & Risk Management also undertook refresher training courses for their roles, to help to ensure their responsibilities can be carried out effectively, and so that their knowledge and skills are kept up to date and in line with current requirements. The organisation also conducted a personal data flow mapping and risk assessment exercise to evaluate if the controls identified during 2010/11 are still effective and to identify and assess any potential new information risks. During 2012/13 the Trust will further develop the Risk Assessment & Management Strategy Plan & Programme to ensure the protection of information assets from a wide range of threats.			
Date of incident (month)	Nature of incident	Nature of data involved	Number of people potentially affected	Notification steps
No incidents	N/A	N/A	N/A	N/A
Further action on information risk	The Trust will continue to monitor and assess its information risks, in light of the events noted above, to identify and address any weaknesses and ensure continuous improvement of its systems. Planned steps for the coming year include: • continue the implementation of our rolling information risk assessment and management strategy plan and programme; • appointing and training additional information asset owners/administrators; • conduct privacy impact assessments on relevant projects; • review and revise key information governance, security and confidentiality policies.			

Summary of other protected personal data related incidents in 2011/12

Incidents deemed by the Data Controller not to fall within the criteria for reporting 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	3
II	Loss of inadequately protected electronic equipment, devices or paper documents from outside secured NHS premises	0
III	Insecure disposal of inadequately protected electronic equipment, devices or paper documents	2
IV	Unauthorised disclosure	6
V	Other	1

Internal information governance audit

An information governance audit, utilising the centrally provided audit methodology developed by the Audit Commission, was included in the work plans of our internal auditors, to be carried out following the submission of the Information Governance toolkit v9 in March 2012. The purpose is to provide independent assurance of our returns, and enable the Trust to carry out any necessary remedial action during the course of 2012/13.

Information governance steering group

The information governance steering group provides advice to the executive management team, senior management team, Audit Committee and the Trust Board, advising them on the development of strategy, policy, procedures, guidance and year-on-year improvement plans necessary to meet information governance requirements. The steering group also oversees the management of and reporting against the standards of the NHS Information Governance Toolkit, and ensures the terms and conditions of the Information Governance Assurance Statement are upheld.

Better Payments Practice Code

	2011/12		2010/11	
	Number	£000	Number	£000
Total Non-NHS Trade Invoices Paid in the Year	17,207	67,181	24,434	64,720
Total Non-NHS Trade Invoices Paid Within Target	16,934	66,756	23,940	62,225
Percentage of NHS Trade Invoices Paid Within Target	98.41%	99.37%	97.98%	96.14%
Total NHS Trade Invoices Paid in the Year	330	2,878	719	4,137
Total NHS Trade Invoices Paid Within Target	316	2,850	674	3,829
Percentage of NHS Trade Invoices Paid Within Target	95.76%	99.02%	93.74%	92.55%

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

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 £69,500. No other audit services were provided in this period.

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 to make myself aware of any relevant audit information and to establish that the NHS body's auditors are aware of that information.

Directors' declaration of interest during 2011/12

Name	Interest declared
Joanne Shaw	Nuffield Health – Non- Executive Governor The Money Advice Service – Director Council of Management of the British Board of Film Classification – Member Datapharm Communications Ltd – Chairman Dr Foster Ethics Committee - Member Vanguard Metropolitan Limited – Director
Trevor Jones	Womens' Royal Voluntary Service – Trustee WellChild – Trustee National Patient Safety Agency – Non Executive Director
Tim Walton	Accent Group – Non-Executive Director Timothy Walton and Associates Limited – Director Highways Agency - Non Executive Director
Sue Hunt	CfBT Education Trust – Appointed Trustee
Peter Catchpole	General Dental Council – Lay Member Nursing and Midwives Conduct and Competence Committee – Lay Member General Medical Council Fitness to Practice Committee – Associate Member British Association of Psychotherapy and Counselling Conduct Committee – Lay Member West Sussex County Council – County Councillor Cabinet Member for Health and Adult Services
Luisa Dillner	Head of New Product Development, British Medical Journal Publishing Group Limited
Tim Heymann	Medicine Today Limited– Directorship and Shareholder Imperial College Business School – Reader in Health Management Kingston Hospital NHS Trust – Consultant Physician Collegial relationship with Company Director of New World Value Creation (non-financial interest)
Steve Duncan	Sole Director of Aston West Lands Ltd - company providing consultancy in health care Advisor to Alliance Boots Non Executive Chairman of Funeral Services Partnership
Nick Chapman	Spouse – self-employed consultant who does work from time to time with and for NHS bodies.
Trevor Smith	None declared
Tricia Hamilton	Scholarship with Florence Nightingale Foundation
Keith Gait	Sole Director Orchid Customer Management Limited
Alan Bentall	None declared
Ruth Rankine	Carers First (charitable organisation), Tonbridge - Trustee
Roger Rawlinson	None declared
Brian Gaffney	Sessional GP in Northern Ireland

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 (Peter Catchpole and Tim Walton). The current terms of reference were amended and agreed by the Board on 22 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 Corporate 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 (VSM) Pay and Remuneration Framework issued by the Department of Health for SHAs and PCTs.

The Remuneration Committee assessed the performance-related pay objectives of the executive directors for 2011/12 and made recommendations for payments to the Board. All bonus awards were under the threshold of 5% as required by the VSM pay framework.

In 2011/12, the basic pay of those staff who are subject to the VSM pay framework was not uplifted. It remained frozen at the previous year's level. This decision was in line with a national instruction applying across the NHS.

The following salaries and allowances and pension benefits tables have been audited.

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

Executive Directors' contacts and notice periods

Name	Role	Start	Notice	Nature	Continuous Service Date
Nick Chapman	Chief Executive	01/04/2009	6 months	Permanent	25/11/1979
Alan Bentall	Chief Information Officer	16/04/2010	3 Months	Permanent	16/04/2010
Patricia Hamilton	Clinical Director/ Chief Nurse	01/09/1999	3 Months	Permanent	01/10/1981
Trevor Smith	Finance Director	02/01/2009	3 Months	Permanent	22/04/1996
Roger Rawlinson	HR Director	01/09/2007	3 Months	Permanent	01/09/2003
Ruth Rankine	Director of Strategy & Planning	01/06/2010	3 Months	Permanent	01/06/2010
Keith Gait	Chief Operating Officer	01/08/2011	2 weeks	Temp Agency	N/A

Salaries and allowances

Name & title	2011/12 Salary (bands of £5,000) £000	2011/12 Salary includes PRP awarded £000	2011/12 Other remuneration (bands of £5,000) £000	2011/12 Benefits in kind (rounded to nearest £00) £00	2010/11 Salary (bands of £5,000) £000	2010/11 Salary includes PRP awarded £000	2010/11 Other remuneration (bands of £5,000) £000	2010/11 Benefits in kind (rounded to nearest £00) £00
Nicholas Chapman Chief Executive	150–155	0	0	0	150-155	0	0	0
Trevor Smith Finance Director	135-140	0-5	0	0	135-140	0-5	0	5
Roger Rawlinson Director of Human Resources	100–105	0-5	0	0	100-105	0-5	0	3
Ronnette Lucraft Chief Operating Officer to 16/12/11	90–95	0	0	0	125-130	0-5	0	0
Ruth Rankine Director of Strategy & Planning from 01/06/10	110–115	0-5	0	0	90-95	0-5	0	0
Alan Bentall Chief Information Officer from 16/04/10	120–125	0-5	0	0	115-120	0-5	0	0
Patricia Hamilton Director of Nursing from 01/01/11	95-100	0	0	32	20-25	0	0	8
Brian Gaffney Director of Public Health from 1/11/10	80–85	0	0	0	20-25	0	0	0
Helen Young Director of Nursing to 31/12/10	0	0	0	0	80-85	0	0	7
Joanne Shaw (Non-Executive Chair)	35–40	0	0	3	35-40	0	0	4
Peter Catchpole (Non-Executive)	10–15	0	0	7	10-15	0	0	7
Trevor Jones (Non-Executive)	5–10	0	0	8	5-10	0	0	22
Tim Walton (Non-Executive)	5–10	0	0	26	5-10	0	0	20
Sue Hunt (Non-Executive)	5–10	0	0	11	5-10	0	0	10
Luisa Dillner (Non-Executive)	5–10	0	0	0	5-10	0	0	5
Tim Heymann (Non-Executive)	0	0	0	1	0	0	0	0
Steve Duncan (Non-Executive) appointed 01/10/10	5–10	0	0	5	5-10	0	0	0

Nicholas Chapman was awarded a performance related bonus of £3,350 (£3,420 in 2010/11), but has declined it in both years. Therefore it is not included in the salary figure. Helen Young was seconded to King's College Hospital NHS Foundation Trust on resigning as a Director and left the Trust on 31/12/11. Keith Gait has been fulfilling the role of Chief Operating officer on an interim basis from 28/11/11, following the resignation of Ronnette Lucraft.

Non executive directors are required to attend Board and various committee meetings to fulfil their duties. The travel costs related to attendance is borne by the Trust, but is considered to be home to work by HRMC, and therefore taxable. The amounts shown for benefits in kind reflect this for both years.

Amounts paid to third party organisations

The costs shown are the amounts paid by NHS Direct to external organisations for these individuals' services.

Name and title	2011/12	2010/11
Alan Bentall, as Interim Chief Information Officer	£0K	£10–15K
Ruth Rankine, as Interim Director of Strategy and Planning	£0K	£20–25K
Tim Heymann, Non-Executive	£5–10K	£5–10K
Keith Gait, as Chief Operating Officer	£70-75K	0

The payment to the third party organisation for Tim Heymann is to reimburse them as his employer for time spent on NHS Direct affairs.

Pension benefits

Name	Real increase in pension at age 60 (bands of £2,500) £000	Real increase in pension lump sum at age 60 (bands of £2,500) £000	Total accrued pension at at age 60 at 31 March 2012 (bands of £5,000) £000	Lump sum at age 60 related to accrued pension at 31 March 2012 (bands of £5,000) £000	Cash Equivalent Transfer Value at 31 March 2012 £000	Cash Equivalent Transfer Value at 31 March 2011 £000	Real increase in Cash Equivalent Transfer Value £000
Nicholas Chapman Chief Executive	0-(2.5)	0-(2.5)	60-65	180-185	1,220	1,108	73
Trevor Smith Director of Finance	0–2.5	2.5-5	40–45	125-130	648	511	120
Roger Rawlinson Director of Human Resources	0–2.5	2.5–5	10–15	30-35	232	188	37
Ronnette Lucraft Chief Operating officer to 16/12/11	0–2.5	0–2.5	5–10	20-25	115	78	34
Ruth Rankine Director of Strategy & Planning	0–2.5	0	0–5	0	31	12	18
Alan Bentall Chief Information Officer	0–2.5	0	0-5	0	65	30	35
Patricia Hamilton Director of Nursing	10–12.5	30–32.5	35–40	105-110	610	367	230
Helen Young Director of Nursing left 31/12/10	0	0	0	0	0	373	0

As Non-Executive Directors do not receive pensionable remuneration, there will be no entries in respect of pensions for Non-Executive Directors.

Median salary comparison

Reporting bodies are required to disclose the relationship between the remuneration of the highest-paid director in their organisation. The midpoint of the banded remuneration of the highest paid Director in the Trust for the financial year 2011/12 was £152,500 (£152,500 in 2010/11). This was 5.28 times (5.39 in 2010/11) the median remuneration of the workforce, which was £28,865 (£28,292 in 2010/11).

Total remuneration includes salary, non-consolidated performance-related pay and enhancements for shift working. Bank staff, who are only paid for shifts worked, and other staff employed on a similar basis, are excluded from the employee salary figures. Such staff will frequently have similar arrangements with other employers. It does not include employer national insurance, pension contributions and the cash equivalent transfer value of pensions. Agency workers are not included in the median salary calculation as the invoiced costs include employers oncosts, and is not recorded in a manner which enables the data to be combined with that of permanent staff. Owing to the national pay freeze applied to public sector pay, the ratio of the median salary to that of the highest paid director is similar for both years.

Cash Equivalent Transfer Values

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

11 June 2012

NHS Direct National Health Service Trust Accounts 2011/12

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, the NHS Direct National Health Service 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 the NHS Direct National Health Service 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 the NHS Direct National Health Service Trust as the Accounting Officer, with responsibility for preparing the Authority'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 judgments 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 National Health Service 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 the NHS Direct National Health Service 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.

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 to make myself aware of any relevant audit information and to establish that the NHS body's auditors are aware of that information.

Governance Statement

1. Introduction

1.1 My responsibilities as the Accountable Officer for the Trust are set out in the Accountable Officer Memorandum for Chief Executives of NHS Trusts. I am responsible for maintaining a sound system of internal control to support the achievement of the Trust's policies, aims and objectives as set by the Board, whilst safeguarding the public funds and departmental assets for which I am accountable. I am also responsible for ensuring that the Trust is administered prudently and economically and that resources are applied efficiently and effectively to ensure the quality and safety of the service for patients and the welfare of staff members. I have discharged these responsibilities throughout 2011/12.

1.2 This Annual Governance Statement gives my overview of the governance of the Trust, its performance, management of risk, state of its internal controls, and an assessment of risks in the coming year.

2. Governance structure

2.1 The Trust has a well-functioning and mature system of governance, which sets the overall strategy, policies, aims and objectives of the Trust. It effectively monitors performance, reviews quality and safety of services, maintains a clear overview of stakeholder engagement and staff management, obtains assurances on financial management and the management of risk within the Trust's activities and holds the Chief Executive and Executive Directors to account.

The Board

2.2 The Board is made up of a Non-Executive Chair and seven Non-Executive Directors (NEDs) (one of whom is non-voting), the Chief Executive and seven Executive Directors (three of whom are non-voting). The Board meets in public and its proceedings are also streamed live on the web and posted on YouTube, promoting openness and transparency within the organisation. The Trust has over 18,000 public members that broadly represent the population of England and service users. Members receive a quarterly newsletter by post or email (according to their requirements) to keep them informed about new developments. Members are also invited to take part in focus groups and surveys about the Trust's services and strategic direction. The Board also communicates via Twitter, where we currently have over 15,000 followers and our Facebook page, which is 'liked' by nearly 2,000 people.

2.3 The Board met in regular session 11 times during 2011/12. In addition, the Board was convened for three "Extraordinary meetings" to approve bid submissions for NHS 111 contracts. The Board also met for two events (October 2011 and March 2012) to discuss the Trust's future strategy and to undertake Board development activities. In addition, the Board held five seminars to discuss specific topics of significance. NEDs have each taken a specific interest in a major area of trust activity and have engagement activities with staff and external stakeholders, on which they report to the Board.

2.4 Patient safety and experience form a key part of every Board Agenda. Executive and Non-Executive Board members visit contact centres regularly to experience the service first-hand and to speak to front-line, supervisory and support staff. Executive and Non-Executive Board members also listen to voice recordings of patients' calls to the services we deliver and are invited to observe internal review of our most serious incidents.

2.5 Board membership has remained relatively stable, with the departure of one Executive Director who has been replaced on an interim basis. The Chairs of the Board sub-committees remained unchanged during the year. All Board members have good attendance records at Board and its sub-committees of which they are members.
This is set out in the table below:

Attendance for 2011/12

Board members	Board (14 meetings)	Audit (4 meetings)	Finance (8 meetings)	Remuneration (2 meetings)	Clinical Governance (6 meetings)	Innovation (2 meetings)
Alan Bentall	14 of 14		8 of 8			2 of 2
Brian Gaffney	11 of 14				5 of 6	1 of 2
Joanne Shaw	13 of 14 (C)					2 of 2
Keith Gait	6 of 7				1 of 2	
Luisa Dillner	10 of 14		7 of 8			0 of 2
Nick Chapman	13 of 14	3 of 4	5 of 8		6 of 6	2 of 2
Peter Catchpole	11 of 14	4 of 4 (C)		2 of 2		
Roger Rawlinson	13 of 14					
Ronnette Lucraft*	7 of 7				3 of 4	
Ruth Rankine	12 of 14					1 of 2
Steve Duncan	11 of 14		5 of 8		3 of 5	
Sue Hunt	12 of 14	3 of 4	8 of 8		6 of 6 (C)	
Tim Heymann	11 of 14	2 of 3			5 of 6	
Tim Walton	13 of 14		8 of 8 (C)	2 of 2		2 of 2 (C)
Trevor Jones	10 of 14	4 of 4		2 of 2 (C)	5 of 6	
Trevor Smith	13 of 14	4 of 4	7 of 8			
Tricia Hamilton	14 of 14				6 of 6	

			C	*
Member attendance for total number of meetings	Member attendance for period when active	Non-member in attendance	Chair	No longer active

2.6 The Board of Directors includes a practicing General Practitioner as Executive Medical Director, a Registered Nurse as Chief Nurse/ Clinical Director, and a qualified Finance Director. In addition, the NEDs include two medical practitioners alongside colleagues with experience in the private, not-for-profit and public sectors. The Board maintains an up-to-date register of interests and is in compliance with the UK Corporate Governance Code.

Board Development

2.7 The Board and the executive team have undertaken a programme of individual and team development during the year. This has included individual appraisals and personal development planning, together with 1:1 coaching, Leadership Effectiveness Analysis incorporating 360 degree feedback, Myers Briggs personality profiling, and team development workshops.

2.8 The aim of these activities has been to support and enhance the leadership that we deliver to the organisation by developing a deep understanding of the impact we have in engaging, motivating and inspiring our staff. Having clarity of our own objectives allows us to prioritise areas that would benefit from particular attention, and develop the techniques, skills and practices that get the best from each other and those that work for us.

2.9 An evaluation of each Board meeting is carried out on a rotational basis by Board members and attendees, with focus on quality of inputs, clarity and accountability, Board priorities, Non-Executive challenge, and meeting management.

3. Board sub-committees

Audit Committee

3.1 The Audit Committee reviews the adequacy of the underlying assurance processes, which indicate the degree of achievement of corporate objectives and the effectiveness of the management of principal risks. The Internal Audit Plan, carried out by our Internal Auditors, enables the Board to be assured that key internal controls and other matters relating to risk are regularly reviewed.
The Committee receives internal and external audit reports and progress reports on risk-related issues, whilst also providing the Board with an overview of the effectiveness of the assurance arrangements based on the work of the Clinical Governance Committee.

3.2 The Audit Committee's work is predominantly focused upon the framework of risks, controls and related assurances that underpin the delivery of the Trust's principal objectives. The Committee played a pivotal role in independently monitoring and reviewing the disclosure statements from the organisation's assurance processes. Key activities included:

- reviewing in detail the Annual Accounts 2011/12 for the Trust, including the Audit Completion Report from External Audit
- considering the Audit Planning Report from External Audit
- assessing the Board Assurance Framework and ensuring that any highlighted risk areas were mitigated through reviews or other workstreams
- considering the assurances on risk and control set out in the Internal Audit's annual report and opinion, together with key assurance reported in individual reports.

3.3. During its work activities and areas of review throughout the year, the Committee ensured that any areas of particular concern were brought to the Board's attention.

3.4 The Internal Audit services for the Trust are currently provided by Parkhill. External Audit is currently provided by the National Audit Office (NAO). Both sets of Auditors report independently to the Audit Committee.

Finance Committee

3.5 The Finance Committee is responsible for providing additional assurance to the Board on financial matters. It provides effective governance and controls over spending and investment decisions and benefits realisation; and scrutinises financial planning, management, performance and reporting. It considers investment proposals and responses to invitations to tender from NHS commissioners, and where appropriate makes recommendations for approval to the Board.

Remuneration Committee

3.6 The Remuneration Committee sets the remuneration and terms of service for the Chief Executive and other Executive Directors, including salary uplifts and performance bonus payments where these apply. The Committee maintains an overview of all remuneration matters for staff in the Trust. It reports to the Chair and Non-Executive members of the Board.

Clinical Governance Committee

3.7 The Clinical Governance Committee provides assurance on all aspects of clinical governance including quality, patient safety, experience and effectiveness. The Committee's key activities are:

- ensuring that clinical governance mechanisms are in place and effective in managing clinical risk throughout the Trust
- considering performance against clinical Key Performance Indicators (KPIs) and the results of service quality reviews, training activities, clinical audits, research and evaluation, incident reviews, complaints, litigation, and patient surveys
- reviewing and monitoring executive follow-up actions in respect of clinical governance issues
- reporting the work of the committee to the Board and reporting specifically on clinical risk to the Audit Committee.

Innovation Committee

3.8 The Innovation Committee brings together a wide range of experts and interested parties from the public, private, health and non-health sectors, to review the external environment and innovation in health care delivery, and to consider how the Trust can add value in the provision of remotely-delivered services.

4. Trust Performance

See 'Our Performance' (page 15) and Appendix A for details.

5. Risk management

5.1 The Chief Executive reports to the Trust Board on risks and risk management. The organisation takes an integrated approach to risk management ensuring that clinical and non-clinical risks are considered together. All staff members have responsibility for risk management in the context of their role, and the Trust continues to work to develop a culture where all staff understand their responsibilities and appreciate the important role they play in managing risk to a reasonable level.

5.2 Risks are reported and managed at all levels across the Trust but there are a number of roles with key responsibilities relating to risk management:

- The Chief Executive has ultimate responsibility for risk and implementation of the Board's policy and reporting requirements
- The Executive Directors are responsible for implementing risk policy at Directorate level and developing strategies to manage the risks identified
- The Clinical Director/Chief Nurse leads on the management of clinical risk in the Trust
- The Chief Information Officer is appointed by the Trust Board as the Senior Information Responsible Officer and leads the management of information risk in the Trust through the Information Asset Owners
- The Head of Corporate Governance is responsible for maintaining the Board Assurance Framework (BAF).

5.3 These roles are supported by the Corporate Risk and Resilience Manager (who chairs the Risk Management Forum and is responsible for the Corporate Risk Register), Directorate Risk Leads, and Project Management Officers (responsible for identifying and reporting risks at Directorate or project level).

5.4 The Trust manages the risks to its principal objectives through its BAF. This identifies the assurance available to the Trust Board in relation to the achievement of its key priorities and strategic objectives, and the effectiveness of the operation of key control processes. The Board is appraised on a bi-monthly basis of the gaps in control and assurance, and the action being taken to address such gaps. The Trust's key strategic objectives are:

- raise the quality and productivity of our services
- increase the value we create for patients, the public, the NHS and social care
- incorporate our values in everything we do
- be a great place to work and an employer of choice
- take advantage of new opportunities and plan effectively for the future
- improve our corporate effectiveness and efficiency.

5.5 Incidents are managed using the Datix web-based incident management software. Each incident is risk assessed, investigated (proportionate to the identified risk) and managed to completion. All front-line staff members are trained in identifying and reporting incidents and supervisory and line management staff members are also trained in incident management.

5.6 Front-line staff members are supported by specialist back-office staff, such as clinical governance leads, who have advanced experience and training in investigation management (including Root Cause Analysis), and experience in conducting investigations across multiple partners, collaborating with our commissioners and delivery partners.

6. State of internal controls

6.1 The Trust's internal controls continue to function well in most areas. Overall results, as judged by independent scrutiny and feedback, indicate that risks are being identified and managed effectively. The evidence for 2011/12 is summarised below.

Care Quality Commission inspection

6.2 Following unannounced visits by the Care Quality Commission (CQC) to the Trust's Wakefield and Milton Keynes sites and London head office at the end of last year, the Trust received the highest level of compliance across their range of criteria, with the independent regulator reporting consistently high levels of satisfaction and trust amongst our patients. Their report, published on the CQC website (www.cqc.org.uk) highlights a number of areas where we demonstrated our commitment to providing a safe and effective service for patients and a supportive environment for staff.

Information Governance

6.3 The Trust successfully achieved compliance with the Department of Health's (DHs) Information Governance Standards at level 2. There were no Information Governance Serious Untoward Incidents reportable to the Information Commissioner's Office during 2011/12.

Auditors

6.4 The Internal Auditor carried out a full programme of audits and managed audits of the Trust's governance, key business systems and IT during the year. The Auditor was able to provide the Audit Committee with adequate or substantial assurance in every area. The Auditor was also able to provide the Audit Committee with assurance on the adequacy of management follow-up on actions arising from audits.

The Head of Internal Audit Opinion 2011/12

6.4.1 The purpose of the annual Head of Internal Audit Opinion is to contribute to the assurances available to the Accountable Officer and the Board, which underpin the Board's own assessment of the effectiveness of the Trust's system of internal control.

6.4.2 Significant assurance was given by the Chief Internal Auditor that there is a generally sound system of internal control, designed to meet the organisation's objectives, and that controls are generally being applied consistently.

6.5 External Audit gave the Trust an unqualified opinion without modification on the annual accounts for the financial years 2009/10, 2010/11 and 2011/12.

Clinical audit, evaluation and review

6.6 The Trust completed a full programme of clinical audit and service evaluation and quality reviews during 2011/12. The results of these audits, evaluations and reviews, together with the relevant follow-up management actions, were presented to the Board's Clinical

Governance Committee. The overall results demonstrate that whilst there is the potential for improvement, the services provided by the Trust are safe and continue to operate within established professional and NHS standards.

Patient feedback

6.7 Patient feedback from regular monthly satisfaction surveys demonstrate that the level of satisfaction of patients with the services provided by the Trust is high. Satisfaction rates are consistently above 90% and Net Promoter Scores are extremely high at around 75%.

6.8 Notwithstanding the general overall level of satisfaction, the Trust receives formal complaints at a rate of around 0.2 per 10,000 calls. These complaints are individually investigated and appropriate open and honest responses are given to complainants. In addition, the Trust carries out a national review of incidents judged as having the potential to give rise to serious harm. Each case is carefully scrutinised and where there are lessons to learn and preventative action is required, this is put into effect without delay.

7. Future risks

7.1 The key strategic risks outlined in 2011/12 as part of the Trust's five year plan remain relevant in 2012/13. The Trust has kept these and other emerging risks under close review and developed mitigating actions where possible. These risks, including several significant risks, are summarised below.

7.2 The Trust has kept the DH and its commissioner, NHS Midlands and East Strategic Health Authority (SHA), fully informed of these risks and the potential costs that may arise.

Key risk	Mitigation
That the quality, safety and operational performance of the 0845 service may diminish in the last 12 months of its existence.	The Trust has focused its resources and management on the maintenance of the quality, safety and performance of the service as a priority.
That the policy decision to decommission the 0845 service will give rise to up to £144 million of decommissioning costs.	The Trust identified these costs and formally quantified and reported the risk to the DH and NHS Midlands and East SHA in February 2011. It developed a proposal to reduce the risk of front-line redundancies and associated costs, through adoption of the Cabinet Office Guidelines and this has been accepted and mandated by DH. The Trust is also seeking other means to reduce the other potential costs and associated risks of decommissioning.
That the transition from the 0845 service to the new NHS 111 service will create double running costs and implementation risks.	The Trust has agreed detailed transition plans with the DH to minimise double-running and reduce implementation risks. The DH has instructed SHAs to ensure that the agreed transition plans are adopted by local commissioners and NHS 111 providers.
That the implementation of the new NHS 111 service may impact unfavourably on patient experience and increase demand for face-to-face services thereby affecting the organisation's credibility.	The Trust has led three of the four Phase 1 pilots of the NHS 111 service and has presented comparative data from the pilots, the 0845 service and other similar services it provides, for independent evaluation, and subsequent improvement activity where indicated.
That competition for NHS 111 services will concentrate on the price of the 111 system alone, rather than value for money across the whole urgent care system. For example, the extent to which 111 will promote self care and deflect unnecessary demand on A & E, ambulance and GP services. If this remains the focus it may have an opposing impact on the QIPP agenda.	The Trust has sought to persuade both DH and local commissioners to configure procurements in such a way as to allow providers to demonstrate value for money across the whole urgent care system e.g. ability to manage demand on face-to-face services, and to weight quality appropriately within the evaluation.
That the NHS 111 service will be developed purely as a telephone service, without a multi-channel element such as exists now, and that the Trust's multi-channel expertise will be lost when the 0845 service is decommissioned.	The Trust has championed the case for the inclusion of a multi-channel component to the NHS 111 service and the Secretary of State has committed to an online service for NHS 111. The Trust will continue to explore options for the retention of its accumulated multi-channel expertise.
That the decommissioning of the 0845 service may result in the loss of accumulated expertise and capability to run the National Pandemic Flu Service.	The Trust has raised the issue with the DH, and is seeking an agreed forward plan to safeguard the capability.
That other important accumulated expertise will be lost when the 0845 service is decommissioned, such as the Health Information service, Medicines Enquiry Service, support for patients with long-term conditions, dental assessment, mental health expertise, clinical governance, child and adult protection including the nursing expertise that supports people to self care, development of assessment tools for use in web and telephone applications, and data and voice recordings.	The Trust will continue to work with the DH and other stakeholders to agree forward plans for these capabilities.
Failure of the long-term conditions market to grow as quickly as anticipated.	The Whole Systems Demonstrator evaluation and the DH Innovations report, including the launch of Three Million Lives Campaign, will support the growth of the telehealth market. During 2012/13 we will proactively engage with commissioners to grow our long-term conditions service offering.
Failure to manage external stakeholder relations in order to understand market demands and secure business.	In 2011/12 we enhanced the capability and capacity of our regional teams, and of our bid management team. We continued to engage with locally-based commissioners, national influencers and our partners. In 2012/13, we will explore the potential for increasing income through other service lines.
That the Trust will not fulfil the requirements of DH/Monitor to become an NHS Foundation Trust.	The Trust will continue to consider alternative options for its organisational form should NHS Foundation Trust not be attainable.

Accounting Officer: Nick Chapman

Nick Chapman
Chief Executive

Date: 11 June 2012

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 for the year ended 31 March 2012 under the National Health Service Act 2006. The financial statements comprise: the Statement of Comprehensive Income, the Statement of Financial Position, the Statement of Cash Flows, the Statement of Changes in Taxpayers' Equity; and the related notes. These financial statements have been prepared under the accounting policies set out within them. I have also audited the information in the Remuneration Report that is described in that report as having been audited.

Respective responsibilities of the Board, Accounting Officer and auditor

As explained more fully in the Statement of the Board's and Chief Executive's Responsibilities, the Board and the Accounting Officer are responsible for the preparation of the financial statements and for being satisfied that they give a true and fair view. My responsibility is to audit, certify and report on the financial statements in accordance with the National Health Service Act 2006. I conducted my audit in accordance with International Standards on Auditing (UK and Ireland). Those standards require me and my staff to comply with the Auditing Practices Board's Ethical Standards for Auditors.

Scope of the audit of the financial statements

An audit involves obtaining evidence about the amounts and disclosures in the financial statements sufficient to give reasonable assurance that the financial statements are free from material misstatement, whether caused by fraud or error. This includes an assessment of: whether the accounting policies are appropriate to the NHS Direct NHS Trust's circumstances and have been consistently applied and adequately disclosed; the reasonableness of significant accounting estimates made by NHS Direct NHS Trust; and the overall presentation of the financial statements. In addition I read all the financial and non-financial information in the Annual Report to identify material inconsistencies with the audited financial statements. If I become aware of any apparent material misstatements or inconsistencies I consider the implications for my certificate.

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

Opinion on regularity

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

Opinion on financial statements

In my opinion:

- the financial statements give a true and fair view of the state of NHS Direct NHS Trust's affairs as at 31 March 2012 and of the net expenditure for the year then ended; and
- the financial statements have been properly prepared in accordance with the National Health Service Act 2006 and Secretary of State directions issued thereunder.

Opinion on other matters

In my opinion:

- the part of the Remuneration Report to be audited has been properly prepared in accordance with Secretary of State directions made under the National Health Service Act 2006; and
- the information given in the Chief Executive's report, and the management commentary, included within the Annual Report for the financial year for which the financial statements are prepared is consistent with the financial statements.

Matters on which I report by exception

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

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

Report

I have no observations to make on these financial statements.

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

Date: 25 June 2012

Annual Accounts 2011/12

Statement of comprehensive income for the year ended 31 March 2012

	Note	2011/12 £000	2010/11 £000
Employee benefits	9.1	(91,443)	(96,733)
Other costs	7	(51,438)	(49,087)
Revenue from patient care activities	4	142,504	147,924
Other operating revenue	5	1,297	1,682
Operating surplus/(deficit)		920	3,787
Investment revenue	12	54	50
Other gains and (losses)	13	(3)	(545)
Finance costs	14	0	0
Surplus/(deficit) for the financial year		971	3,292
Public dividend capital dividends payable		(483)	(559)
Retained surplus/(deficit) for the year		488	2,733

Financial performance for the year

Retained surplus/(deficit) for the year	488	
Prior period adjustment to correct errors	0	
IFRIC 12 adjustment	0	
Impairments	0	
Adjusted retained surplus/(deficit)	488	
PDC dividend: balance receivable/(payable) at 31 March 2012	70	

Statement of financial position as at 31 March 2012

Non-current assets	Note	31 March 2012 £000	31 March 2011 £000
Property, plant and equipment	15	9,657	11,110
Intangible assets	16	22,646	23,367
Trade and other receivables	20.1	0	0
Total non-current assets		32,303	34,477
Current assets			
Trade and other receivables	20.1	5,602	5,181
Cash and cash equivalents	21	21,875	19,958
Total current assets		27,477	25,139
Non-current assets held for sale	22	0	0
Total current assets		27,477	25,139
Total assets		59,780	59,616
Current liabilities			
Trade and other payables	23	(15,038)	(16,963)
Provisions	25	(2,038)	(1,212)
Borrowings		0	0
Total current liabilities		(17,076)	(18,175)
Non-current assets plus/less net current assets/liabilities		42,704	41,441
Non-current liabilities			
Trade and other payables	23	(4,468)	(6,261)
Provisions	25	(3,276)	(708)
Borrowings		0	0
Total non-current liabilities		(7,744)	(6,969)
Total assets employed		34,960	34,472
Financed by taxpayers' equity			
Public dividend capital		24,511	24,511
Retained earnings		9,988	9,500
Revaluation reserve		461	461
Total taxpayers' equity:		34,960	34,472

The notes on pages 48-77 form part of this account.
The financial statements on pages 44-47 were approved by the Board on 11 June 2012 and signed on its behalf by

Signed: Nick Chapman Chief Executive
11 June 2012

Statement of changes in taxpayers' equity for the year ended 31 March 2012

	Public dividend capital £000	Retained earnings £000	Revaluation reserve £000	Total reserves £000
Balance at 1 April 2011	24,511	9,500	461	34,472
Opening balance adjustments	0	0	0	0
Restated balance at 1 April 2011	**24,511**	**9,500**	**461**	**34,472**
Changes in taxpayers' equity for 2011/12				
Retained surplus/(deficit) for the year	0	488	0	488
Net gain / (loss) on revaluation of property, plant, equipment	0	0	0	0
Net gain / (loss) on revaluation of intangible assets	0	0	0	0
Impairments and reversals	0	0	0	0
Net recognised revenue/(expense) for the year	0	488	0	488
Balance at 31 March 2012	**24,511**	**9,988**	**461**	**34,960**
Changes in taxpayers' equity for 2010/11				
Balance at 1 April 2010	24,511	6,767	461	31,739
Retained surplus/(deficit) for the year	0	2,733	0	2,733
Net gain / (loss) on revaluation of property, plant, equipment	0	0	0	0
Net gain / (loss) on revaluation of intangible assets	0	0	0	0
Net recognised revenue/(expense) for the year	0	2,733	0	2,733
Balance at 31 March 2011	**24,511**	**9,500**	**461**	**34,472**

Statement of cashflows for the year ended 31 March 2012

	Note	2011/12 £000	2010/11 £000
Cash flows from operating activities			
Operating surplus		920	3,787
Depreciation and amortisation	7	4,880	4,305
Impairments and reversals	7	209	0
Interest paid		0	0
Dividend paid		(472)	(709)
(Increase)/decrease in trade and other receivables		(419)	13,486
(Increase)/decrease in other current assets		0	0
Increase/(decrease) in trade and other payables		(2,067)	1,819
(Increase)/decrease in other current liabilities		0	0
Provisions utilised	25	(510)	(1,722)
Increase/(decrease) in provisions	25	3,903	586
Net cash inflow/(outflow) from operating activities		6,444	21,551
Cash flows from investing activities			
Interest received		54	50
(Payments) for property, plant and equipment	15	(1,170)	(1,420)
(Payments) for intangible assets	16	(1,747)	(14,480)
Net cash inflow/(outflow) from investing activities		(2,863)	(15,849)
Net cash inflow/(outflow) before financing		3,581	5,702
Cash flows from financing activities			
Public dividend capital received		0	0
Public dividend capital repaid		0	0
Other loans repaid		(1,664)	0
Net cash inflow/(outflow) from financing activities		(1,664)	0
Net increase/(decrease) in cash and cash equivalents		1,917	5,702
Cash and cash equivalents (and bank overdraft) at beginning of the period		19,958	14,256
Effect of exchange rate changes in the balance of cash held in foreign currencies		0	0
Cash and cash equivalents (and bank overdraft) at year end		21,875	19,958

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. Consequently, the following financial statements have been prepared in accordance with the 2011/12 NHS Trusts Manual for Accounts issued by the Department of Health. The accounting policies contained in that manual follow International Financial Reporting Standards (IFRS) to the extent that they are meaningful and appropriate to the NHS, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the NHS Trusts Manual for Accounts permits a choice of accounting policy, the accounting policy which is judged to be most appropriate to the particular circumstances of the Trust for the purpose of giving a true and fair view has been selected. The particular policies adopted by the Trust are described below. They 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 property, plant and equipment, intangible assets, inventories and certain financial assets and financial liabilities.

1.2 Acquisitions and discontinued operations

Activities are considered to be 'acquired' only if they are taken on 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 Critical accounting judgements and key sources of estimation uncertainty

In the application of the Trust's accounting policies, management is required to make judgements, estimates and assumptions about the carrying amounts of assets and liabilities that are not readily apparent from other sources. The estimates and associated assumptions are based on historical experience and other factors that are considered to be relevant. Actual results may differ from those estimates and the estimates and underlying assumptions are continually reviewed. Revisions to accounting estimates are recognised in the period in which the estimate is revised if the revision affects only that period or in the period of the revision and future periods if the revision affects both current and future periods.

1.3.1 Critical judgements in applying accounting policies

The Trust is required to disclose the critical judgements, apart from those involving estimations (see below) that management has made in the process of applying the Trust's accounting policies and that have the most significant effect on the amounts recognised in the financial statements. It is not considered the judgements made will have any significant impact under this requirement.

1.3.2 Key sources of estimation uncertainty

The following are the key assumptions concerning the future, and other key sources of estimation uncertainty at the end of the reporting period, that have a significant risk of causing a material adjustment to the carrying amounts of assets and liabilities within the next financial year.

As reported in the 2009/10 accounts, the Trust acquired a licence in perpetuity for the clinical content and content engine used in the Trust's activities on 25 May 2010 for £19,247,000. Although this is licenced in pertuity the Trust has decided to amortise the cost over 15 years and continues to monitor this in the context of the major changes taking place within the NHS. The introduction of the 111 telephony service from 1 April 2013 will have an impact on the Trust's future activities and this licence is still considered necessary to this service and the amortisation period remains appropriate.

The Trust is developing other assets which it considers appropriate to the new 111 service and although not yet operational are included in these accounts at cost of £890,988.

The Trust continues restructuring various support functions and provision has been made for the likely redundancy costs to be incurred when the consultations with staff are concluded. In some cases this can be done with considerable accuracy as the particular staff affected are known. In others the actual staff who will eventually be redundant is less certain and estimates have been made to arrive at the total provision included in these accounts of £544,706.

1.4 Revenue

Revenue in respect of services provided is recognised when, and to the extent that, performance occurs, and is measured at the fair value of the consideration receivable. The main source of revenue for the Trust is from its prime commissioner, NHS Midlands and East Strategic Health Authority (SHA) being an amalgamation of the former East of England SHA and East Midlands SHA.

Where income is received for a specific activity that is to be delivered in the following year, that income is deferred.

1.5 Employee benefits

Short-term employee benefits

Salaries, wages and employment-related payments are recognised in the period in which the service is received from employees, including bonuses earned but not paid and leave earned but not yet taken which are accrued for at the year end.

Retirement benefit costs

Past and present employees are covered by the provisions of the NHS Pensions Scheme. 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.

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 expenditure at the time the Trust commits itself to the retirement, regardless of the method of payment.

1.6 Other expenses

Other operating expenses are recognised when, and to the extent that, the goods or services have been received. They are measured at the fair value of the consideration payable.

1.7 Property, plant and equipment

Recognition

Property, plant and equipment is capitalised if:

- it is held for use in delivering services or for administrative purposes
- it is probable that future economic benefits will flow to, or service potential will be supplied to, the Trust
- it is expected to be used for more than one financial year
- the cost of the item can be measured reliably; and
- the item has cost of at least £5,000; or
- collectively, a number of items 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
- items form part of the initial equipping and setting-up cost of a new building, ward or unit, irrespective of their individual or collective cost.

Where a large asset, for example a building, includes a number of components with significantly different asset lives, the components are treated as separate assets and depreciated over their own useful economic lives.

Valuation

All property, plant and equipment are measured initially at cost, representing the cost directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management. All assets are measured subsequently at fair value.

Land and buildings used for the Trust's services or for administrative purposes are stated in the statement of financial position at their revalued amounts, being the fair value at the date of revaluation less any subsequent accumulated depreciation and impairment losses. Revaluations are performed with sufficient regularity to ensure that carrying amounts are not materially different from those that would be determined at the end of the reporting period. Fair values are determined as market value for existing use.

Until 31 March 2008, fixtures and equipment were carried at replacement cost, as assessed by indexation and depreciation of historic cost. From 1 April 2008 indexation has ceased. The carrying value of existing assets at that date will be written off over their remaining useful lives and new fixtures and equipment are carried at depreciated historic cost as this is not considered to be materially different from fair value.

An increase arising on revaluation is taken to the revaluation reserve except when it reverses an impairment for the same asset previously recognised in expenditure, in which case it is credited to expenditure to the extent of the decrease previously charged there. A revaluation decrease that does not result from a loss of economic value or service potential is recognised as an impairment charged to the revaluation reserve to the extent that there is a balance on the reserve for the asset and, thereafter, to expenditure. Impairment losses that arise from a clear consumption of economic benefit should be taken to expenditure. Gains and losses recognised in the revaluation reserve are reported as other comprehensive income in the Statement of Comprehensive Income.

Subsequent expenditure

Where subsequent expenditure enhances an asset beyond its original specification, the directly attributable cost is capitalised. Where subsequent expenditure restores the asset to its original specification, the expenditure is capitalised and any existing carrying value of the item replaced is written-out and charged to operating expenses.

1.8 Intangible assets

Recognition

Intangible assets are non-monetary assets without physical substance, which are capable of sale separately from the rest of the Trust's business or which arise from contractual or other legal rights. They are recognised only when it is probable that future economic benefits will flow to, or service potential be provided to, the Trust; where the cost of the asset can be measured reliably, and where the cost is at least £5,000.

Intangible assets acquired separately are initially recognised at fair value. Software that is integral to the operating of hardware, for example an operating system, is capitalised as part of the relevant item of property, plant and equipment. Software that is not integral to the operation of hardware, for example application software, is capitalised as an intangible asset. Expenditure on research is not capitalised: it is recognised as an operating expense in the period in which it is incurred. Internally-generated assets are recognised if, and only if, all of the following have been demonstrated:

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

Measurement

The amount initially recognised for internally-generated intangible assets is the sum of the expenditure incurred from the date when the criteria above are initially met. Where no internally-generated intangible asset can be recognised, the expenditure is recognised in the period in which it is incurred.

Following initial recognition, intangible assets are carried at fair value by reference to an active market, or, where no active market exists, at amortised replacement cost (modern equivalent assets basis), as a proxy for fair value. Internally-developed software is held at historic cost to reflect the opposing effects of increases in development costs and technological advances.

1.9 Depreciation, amortisation and impairments

Property, plant and equipment under construction are not depreciated. Intangible assets not completed and available for use in the service are not amortised.

Otherwise, depreciation and amortisation are charged to write off the costs or valuation of property, plant and equipment and intangible non-current assets, less any residual value, over their estimated useful lives, in a manner that reflects the consumption of economic benefits or service potential of the assets. The estimated useful life of an asset is the period over which the Trust expects to obtain economic benefits or service potential from the asset. This is specific to the Trust and may be shorter than the physical life of the asset itself. Estimated useful lives and residual values are reviewed each year end, with the effect of any changes recognised on a prospective basis. Assets held under finance leases are depreciated over their estimated useful lives.

At each reporting period end, the Trust checks whether there is any indication that any of its tangible or intangible non-current assets have suffered an impairment loss. If there is indication of an impairment loss, the recoverable amount of the asset is estimated to determine whether there has been a loss and, if so, its amount. Intangible assets not yet available for use are tested for impairment annually.

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

1.10 Non-current assets held for sale

Non-current assets are classified as held for sale if their carrying amount will be recovered principally through a sale transaction rather than through continuing use. This condition is regarded as met when the sale is highly probable, the asset is available for immediate sale in its present condition and management is committed to the sale, which is expected to qualify for recognition as a completed sale within one year from the date of classification. Non-current assets held for sale are measured at the lower of their previous carrying amount and fair value less costs to sell. Fair value is open market value including alternative uses.

The profit or loss arising on disposal of an asset is the difference between the sale proceeds and the carrying amount and is recognised in the Statement of Comprehensive Income. On disposal, the balance for the asset on the revaluation reserve is transferred to retained earnings.

Property, plant and equipment that is to be scrapped or demolished does not qualify for recognition as held for sale. Instead, it is retained as an operational asset and its economic life is adjusted. The asset is de-recognised when it is scrapped or demolished.

1.11 Leases

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

The Trust as lessee

Property, plant and equipment held under finance leases are initially recognised, at the inception of the lease, at fair value or, if lower, at the present value of the minimum lease payments, with a matching liability for the lease obligation to the lessor. Lease payments are apportioned between finance charges and reduction of the lease obligation so as to achieve a constant rate on interest on the remaining balance of the liability. Finance charges are recognised in calculating the Trust's surplus/deficit.

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

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

Where a lease is for land and buildings, the land and building components are separated and individually assessed as to whether they are operating or finance leases. This is a change in accounting policy from previous years where leased land was always treated as an operating lease but early adoption of the change was permitted and the Trust did this in its 2009/10 accounts, so that the 999 year leasehold land has been treated as a finance lease from then onwards.

The Trust as lessor

Amounts due from lessees under finance leases are recorded as receivables at the amount of the Trust's net investment in the leases. Finance lease income is allocated to accounting periods so as to reflect a constant periodic rate of return on the Trust's net investment outstanding in respect of the leases.

Rental income from operating leases is recognised on a straight-line basis over the term of the lease. Initial direct costs incurred in negotiating and arranging an operating lease are added to the carrying amount of the leased asset and recognised on a straight-line basis over the lease term.

1.12 Cash and cash equivalents

Cash is cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours. Cash equivalents are investments that mature in three months or less from the date of acquisition and that are readily convertible to known amounts of cash with insignificant risk of change in value.

1.13 Provisions

Provisions are recognised when the Trust has a present legal or constructive obligation as a result of a past event, it is probable that the Trust will be required to settle the obligation, and a reliable estimate can be made of the amount of the obligation. The amount recognised as a provision is the best estimate of the expenditure required to settle the obligation at the end of the reporting period, taking into account the risks and uncertainties. Where a provision is measured using the cash flows estimated to settle the obligation, its carrying amount is the present value of those cash flows using HM Treasury's discount rate of 2.2% in real terms (2.8% for employee early departure obligations).

When some or all of the economic benefits required to settle a provision are expected to be recovered from a third party, the receivable is recognised as an asset if it is virtually certain that reimbursements will be received and the amount of the receivable can be measured reliably.

Present obligations arising under onerous contracts are recognised and measured as a provision. An onerous contract is considered to exist where the Trust has a contract under which the unavoidable costs of meeting the obligations under the contract exceed the economic benefits expected to be received under it.

A restructuring provision is recognised when the Trust has developed a detailed formal plan for the restructuring and has raised a valid expectation in those affected that it will carry out the restructuring by starting to implement the plan or announcing its main features to those affected by it. The measurement of a restructuring provision includes only the direct expenditures arising from the restructuring, which are those amounts that are both necessarily entailed by the restructuring and not associated with ongoing activities of the entity.

1.14 Clinical negligence costs

The NHS Litigation Authority (NHSLA) operates a risk pooling scheme under which the Trust pays an annual contribution to the NHSLA which in return settles all clinical negligence claims. The contribution is charged to expenditure. 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 25.

1.15 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.

1.16 Contingencies

A contingent liability is a possible obligation that arises from past events and whose existence will be confirmed only by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the Trust, or a present obligation that is not recognised because it is not probable that a payment will be required to settle the obligation or the amount of the obligation cannot be measured sufficiently reliably. A contingent liability is disclosed unless the possibility of a payment is remote.

A contingent asset is a possible asset that arises from past events and whose existence will be confirmed by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the Trust. A contingent asset is disclosed where an inflow of economic benefits is probable.

Where the time value of money is material, contingencies are disclosed at their present value.

1.17 Financial instruments

Financial assets

Financial assets are recognised 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 end of the reporting period, 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.

For financial assets carried at amortised cost, the amount of the impairment loss is measured as the difference between the asset's carrying amount and the present value of the revised future cash flows discounted at the asset's original effective interest rate. The loss is recognised in expenditure and the carrying amount of the asset is reduced directly for impairment of receivables.

Financial liabilities

Financial liabilities are recognised on the statement of financial position 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 and amounts due under long-term credit arrangements for the acquisition of equipment and intangible assets.

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.

1.18 Value Added Tax

Most of the activities of the Trust are outside the scope of VAT and, in general, output tax does not apply and input tax on purchases is not recoverable. 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.

1.19 Foreign currencies

The Trust's functional currency and presentational currency is sterling. Transactions denominated in a foreign currency are translated into sterling at the exchange rate ruling on the dates of the transactions. At the end of the reporting period, monetary items denominated in foreign currencies are retranslated at the spot exchange rate on 31 March. Resulting exchange gains and losses for either of these are recognised in the Trust's surplus/deficit in the period in which they arise.

1.20 Public Dividend Capital (PDC) and PDC dividend

Public dividend capital represents taxpayers' equity in the NHS Trust. At any time the Secretary of State can issue new PDC to, and require repayments of PDC from, the Trust. PDC is recorded at the value received. As PDC is issued under legislation rather than under contract, it is not treated as an equity financial instrument.

An annual charge, reflecting the cost of capital utilised by the Trust, is payable to the Department of Health as public dividend capital dividend. The charge is calculated at the real rate set by HM Treasury (currently 3.5%) on the average carrying amount of all assets less liabilities, except for donated assets and cash balances 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.

1.21 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 that individual cases are handled.

Losses and special payments are charged to the relevant functional headings in expenditure 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).

1.22 Accounting Standards that have been issued but have not yet been adopted

The Treasury FReM does not require the following Standards and Interpretations to be applied in 2011/12. The application of the Standards as revised would not have a material impact on the accounts for 2011/12, were they applied in that year:

IAS 1	Presentation of financial statements (Other Comprehensive Income) - subject to consultation
IAS 12	Income Taxes (amendment) - subject to consultation
IAS 19	Post-employment benefits (pensions) - subject to consultation
IAS 27	Separate Financial Statements - subject to consultation
IAS 28	Investments in Associates and Joint Ventures - subject to consultation
IFRS 7	Financial Instruments: Disclosures (annual improvements) - effective 2012/13
IFRS 9	Financial Instruments - subject to consultation
IFRS 10	Consolidated Financial Statements - subject to consultation
IFRS 11	Joint Arrangements - subject to consultation
IFRS 12	Disclosure of Interests in Other Entities - subject to consultation
IFRS 13	Fair Value Measurement - subject to consultation
IPSAS 32	Service Concession Arrangement - subject to consultation

2 Operating segments

IFRS 8 requires NHS Trusts that have more than one business segment to report the income, surplus / (deficit) and net assets attributable to each segment.

The NHS Direct National Health Service Trust only has one business segment and none of the customers referred to in note 3 account for more than 10% of income, other than the core service.

Income from the various services provided by the Trust is as follows:

	2011/12 £000	2010/11 £000
Core services	113,428	118,258
Choose & Book Appointments Line	6,388	7,406
Out of hours services	1,275	2,346
Dental services	1,331	1,785
Long-term conditions	3,450	4,001
Single Point of Access to NHS services	5,439	5,564
Pandemic flu & Fluline service	4,387	4,861
Other Contestable income	509	1,092
111 Pilot Income	6,298	2,611
	142,504	147,924

In the financial year 2010/11, £2m of non-recurrent income intended to fund strategic changes in the Trust's operations was deferred until 2011/12 with the agreement of the commissioner. This has now been released and forms part of the income of the year.

In 2010/11, funding received in respect of 111 pilots was included in Other Revenue (Note 5) as the service was in development, but as the pilots extended and provided service to patients, it has now been classified within Note 2 Operating segments.

3 Income generation activities

The Trust undertakes income generation activities with an aim of achieving profit, which is then used in patient care.

The Trust has a substantial investment in the national infrastructure necessary to provide the core service. It has historically undertaken other locally-commissioned services in order to maximise the use of this infrastructure for patient care and to make a contribution towards its cost.

To establish the contribution of each contract, the costs directly incurred in its delivery are charged against the income it generates. In terms of full cost reporting, all overheads incurred in running the Trust's activities are apportioned across all contracts, so that all bear a share of these costs for reporting purposes.

The following provides details of income generation activities whose full cost exceeded £1m or was otherwise material. Contribution by contract service line is subject to quarterly review by the lead commissioner, NHS Midlands and East (formerly East of England) SHA using Service Line Reporting. Contracts for which income is insufficient to provide the agreed contribution level, are subject to review and cost improvement.

Pandemic flu and Fluline service

During 2007/08 the Department of Health initiated the development of a pandemic flu advice and antiviral distribution system through NHS Direct National Health Service Trust. The system was to be available throughout the UK, funded by the Department of Health in England and the Devolved Health Authorities in Scotland, Wales and Northern Ireland. The Department of Health has contracted to reimburse the direct costs involved in this initiative and specific overheads involved in running this major project, with an overall budget of £71m for the system and keeping it in a state of readiness over its expected life of five years.

Income from Department of Health in 2011/12 includes £3,795,260 (2010/11 £4,216,213) for reimbursement of costs incurred on the Pandemic Flu project, summarised below.

	2011/12 £000	2010/11 £000
Income from Department of Health for System Build and Maintenance	3,691	3,844
Income from the Devolved Authorities for Scotland, Wales and Northern Ireland	591	645
Costs	0	0
Directly attributable costs	(5)	(57)
System Build costs	0	(10)
Dormancy Fees	(4,276)	(4,390)
External charges	(1)	(6)
Contribution to specified overheads including staff working on the project	0	26
Included within the above, contribution from the Devolved Health Authorities under the contracts referred to above	0	0
Income from Department of Health for delivery of Fluline service	104	372
External charges	3	(118)
Internal recharges	(83)	(208)
Contribution to specified overheads including staff working on the project	24	46

Dental services	2011/12 £000	2010/11 £000
Income	1,331	1,785
Full cost	(1,361)	(2,336)
Surplus/(deficit)	(30)	(551)
Contribution	433	282

GP out of hours services	2011/12 £000	2010/11 £000
Income	1,275	2,346
Full cost	(1,375)	(2,582)
Surplus/(deficit)	(100)	(236)
Contribution	264	708

Long-term conditions	2011/12 £000	2010/11 £000
Income	3,450	4,001
Full cost	(3,441)	(4,970)
Surplus/(deficit)	9	(969)
Contribution	902	783

Single Point of Access to NHS services	2011/12 £000	2010/11 £000
Income	5,439	5,564
Full cost	(6,671)	(7,242)
Surplus/(deficit)	(1,232)	(1,678)
Contribution	(269)	(667)

Although the contibution position has improved, this has been insufficient to avoid penalties under the cross subsidisation provisions of the core contract. For 2011/12 the penalty is the amount of the loss of £269,000. Penalty in 2010/11 which applied from 1 October 2010 was £175,000.

Choose & Book Appointments Line	2011/12 £000	2010/11 £000
Income	6,388	7,406
Full cost	(6,243)	(7,085)
Surplus/(deficit)	145	321
Contribution	1,741	2,065

111 Pilot Income	2011/12 £000	2010/11 £000
Income	6,298	2,611
Full cost	(8,775)	(4,105)
Surplus/(deficit)	(2,477)	(1,494)
Contribution	1,019	(396)

Core services

As a result of the full cost allocation and apportionment across these services (as previously detailed) the surplus reported for the core service is shown below and the surplus for 2010/11 has been changed to reflect the separation of 111 pilot income.

	2011/12 £000	2010/11 £000
Income	113,428	118,258
Full cost	(109,390)	(111,458)
Surplus/(deficit)	4,038	6,800

4 Revenue from patient care activities

	2011/12 £000	2010/11 £000
Strategic Health Authorities	122,254	128,495
NHS Trusts	11	165
Primary Care Trusts - non-tariff	12,515	9,950
Foundation Trusts	174	193
Department of Health	3,797	4,315
Non-NHS	3,753	4,806
	142,504	147,924

5 Other operating revenue

	2011/12 £000	2010/11 £000
Education, training and research	686	489
Rental revenue from operating leases	166	428
Other revenue	445	765
	1,297	1,682
Total operating revenue	143,801	149,606

The 2010/11 Other revenue figure has been restated to reflect the revised reclassification for 111 pilot income as stated in Note 2.

6 Revenue

	2011/12 £000	2010/11 £000
From rendering of services	143,801	149,606
From sale of goods	0	0

7 Operating expenses (excluding employee benefits)

	2011/12 £000	2010/11 £000
Trust Chair and Non-Executive Directors	102	105
Supplies and services - general	88	134
Consultancy services	2,730	1,308
Establishment	2,178	2,979
Transport	1,407	1,704
Premises	7,998	8,388
Depreciation	2,412	2,642
Amortisation	2,468	1,663
Impairments and reversals of property, plant and equipment	209	0
Audit fees (a)	53	90
Other auditor's remuneration (mainly Internal Audit fees)	109	93
Clinical negligence	185	185
Education and training	134	632
Telecommunications	5,299	6,007
Health information	4,216	3,425
IT contracts (b)	18,200	18,459
Other (c)	3,650	1,273
Operating expenses (excluding employee benefits)	51,438	49,087

(a) Auditors fees for 2011/12 are £69,500 (2010/11 £73,000); although net charge in the accounts is £53,000 due to over-accrual of prior year fees.

(b) IT contracts costs include £4,276,534 (2010/11 £4,390,004) in respect of pandemic flu and Fluline dormancy fees. CS computer contract included is £10,706,381 (2010/11 £10,678,025).

(c) Significant items included in Other costs are: Dilapidations provision £2,588,000 (2010/11: Nil), costs in respect of potential performance fees claimed by our principal IT supplier £554,000 as explained in Note 25 (2010/11 Nil), interpreting skills £136,500 (2010/11 £388,419), patient surveys and public participation activities £138,260 (2010/11 £131,378), and website development costs Nil (2010/11 £588,714).

Employee benefits

Employee benefits excluding Board members	89,011	94,518
Termination Benefits	1,360	1,149
Board members	1,072	1,066
Total employee benefits	91,443	96,732
Total operating expenses	142,881	145,820

8 Operating leases

The Trust has two main types of operating leases:

- Car leases which are all for a period of three years
- Rental of premises for operational and administrative purposes

8.1 Trust as lessee

Payments recognised as an expense	Buildings £000	2011/12 Other £000	Total £000	2010/11 Total £000
Minimum lease payments	0	0	4,094	4,217
Contingent rents	0	0	0	0
Sub-lease payments	0	0	0	0
Total	0	0	4,094	4,217
Payable:				
No later than one year	3,764	224	3,988	4,068
Between one and five years	5,591	169	5,760	6,904
After five years	382	0	382	718
Total	9,737	393	10,130	11,690
Total future sublease payments expected to be received:	0	0	242	926

8.2 Trust as lessor

The Trust sublets four of the premises occupied

Recognised as income	2011/12 £000	2010/11 £000
Rents	166	353
Contingent rent	0	0
Total	166	353
Receivable:		
No later than one year	204	357
Between one and five years	38	569
After five years	0	0
Total	242	926

9 Employee benefits and staff numbers

9.1 Employee benefits

Employee benefits 2011/12 - gross expenditure	Total £000	Permanently employed £000	Other £000
Salaries and wages	77,885	62,538	15,347
Social security costs	4,842	4,841	1
Employer contributions to NHS Pensions scheme	7,481	7,452	29
Termination benefits	1,360	1,360	0
Total employee benefits	91,568	76,191	15,377
Employee costs capitalised	125	125	0
Net employee benefits excluding capitalised costs	91,443	76,066	15,377

Employee benefits 2010/11 - gross expenditure	Total £000	Permanently employed £000	Other £000
Salaries and wages	81,327	72,966	8,361
Social security costs	5,566	5,566	0
Employer contributions to NHS Pensions scheme	8,744	8,744	0
Termination benefits	1,149	1,149	0
Total employee benefits	96,786	88,425	8,361
Employee costs capitalised	53		
Net employee benefits excluding capitalised costs	96,733		

9.2 Staff numbers

Average staff numbers	Total number	2011/12 Permanently employed number	Other number	2010/11 Total number
Medical and dental	2	2	0	3
Ambulance staff	0	0	0	0
Administration and estates	1,383	1,103	280	1,680
Healthcare assistants and other support staff	0	0	0	0
Nursing, midwifery and health visiting staff	685	602	82	917
Nursing, midwifery and health visiting learners	0	0	0	0
Scientific, therapeutic and technical staff	62	62	0	105
Social care staff	0	0	0	0
Other	0	0	0	3
Total	2,132	1,769	362	2,708
Of the above - staff engaged on capital projects	5	5	0	2

9.3 Staff sickness absence and ill health retirements

	2011/12 number	2010/11 number
Total days lost	29,955	34,522
Total staff years	2,045	2,315
Average working days lost	14.65	14.91

The statistics shown above for sickness absence are for the calendar year 1 January to 31 December 2011, rather than the financial year in accordance with instructions issued by the Department of Health.

	2011/12 number	2010/11 number
Number of persons retired early on ill health grounds	9	0
	£000	£000
Total additional pensions liabilities accrued in the year	826	340

9.4 Exit packages agreed in 2011/12

	2011/12			2010/11		
Exit package cost band (including any special payment element)	*Number of compulsory redundancies	*Number of other departures agreed	Total number of exit packages by cost band	*Number of compulsory redundancies	*Number of other departures agreed	Total number of exit packages by cost band
Less than £10,000	8	0	8	2	0	2
£10,001-£25,000	9	0	9	7	0	7
£25,001-£50,000	7	0	7	6	0	6
£50,001-£100,000	6	0	6	9	1	10
£100,001 - £150,000	0	0	0	5	1	6
£150,001 - £200,000	0	0	0	1	0	1
>£200,000	0	0	0	1	0	1
Total number of exit packages by type (total cost)	30	0	30	31	2	33
Total resource cost (£000s)	774	0	774	1,980	190	2,170

Redundancy and other departure costs have been paid in accordance with the Trust's employment contracts. Exit costs in this note are accounted for in full in the year of departure. Where the Trust has agreed early retirements, the additional costs are met by the Trust and not by the NHS pensions scheme. Ill-health retirement costs are met by the NHS pensions scheme and are not included in the table.

This disclosure reports the number and value of exit packages taken by staff leaving in the year.

10 Pension costs

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, GP 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 valuation every four years (until 2004, every five years) and an 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.

In order to defray the costs of benefits, employers pay contributions at 14% of pensionable pay and most employees had up to April 2008 paid 6%, with manual staff paying 5%.

Following the full actuarial review by the Government Actuary undertaken as at 31 March 2004, and after consideration of changes to the NHS Pension Scheme taking effect from 1 April 2008, his valuation report recommended that employer contributions could continue at the existing rate of 14% of pensionable pay, from 1 April 2008, following the introduction of employee contributions on a tiered scale from 5% up to 8.5% of their pensionable pay depending on total earnings.

On advice from the scheme actuary, scheme contributions may be varied from time to time to reflect changes in the scheme's liabilities.

b) Accounting valuation
A valuation of the scheme liability is carried out annually by the scheme actuary as at the end of the reporting period 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 2011, is based on detailed membership data as at 31 March 2008 (the latest midpoint) updated to 31 March 2011 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.

c) Scheme provisions
The NHS Pension Scheme provided defined benefits, which are summarised below. This list is an illustrative guide only, and is not intended to detail all the benefits provided by the Scheme or the specific conditions that must be met before these benefits can be obtained.

The Scheme is a "final salary" scheme. Annual pensions are normally based on 1/80th for the 1995 section and of the best of the last three years pensionable pay for each year of service, and 1/60th for the 2008 section of reckonable pay per year of membership. Members who are practitioners as defined by the Scheme Regulations have their annual pensions based upon total pensionable earnings over the relevant pensionable service.

With effect from 1 April 2008 members can choose to give up some of their annual pension for an additional tax-free lump sum, up to a maximum amount permitted under HMRC rules. This new provision is known as "pension commutation".

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.

Early payment of a pension, with enhancement, 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 is payable.

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 statement of comprehensive income at the time the Trust commits itself to the retirement, regardless of the method of payment.

Members can purchase additional service in the NHS Scheme and contribute to money purchase Additional Voluntary Contributions run by the Scheme's approved providers or by other Free Standing Additional Voluntary Contributions (FSAVC) providers.

11 Better Payment Practice Code

11.1 Measure of compliance

	2011/12 Number	2011/12 £000	2010/11 Number	2010/11 £000
Non-NHS Payables				
Total non-NHS trade invoices paid in the year	17,207	67,181	24,434	64,720
Total non-NHS trade invoices paid within target	16,934	66,756	23,940	62,225
Percentage of NHS trade invoices paid within target	98.41%	99.37%	97.98%	96.14%
NHS Payables				
Total NHS trade invoices paid in the year	330	2,878	719	4,137
Total NHS trade invoices paid within target	316	2,850	674	3,829
Percentage of NHS trade invoices paid within target	95.76%	99.02%	93.74%	92.55%

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

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

	2011/12 £000	2010/11 £000
Amounts included in finance costs from claims made under this legislation	0	0
Compensation paid to cover debt recovery costs under this legislation	0	0

12 Investment income

	2011/12 £000	2010/11 £000
Interest income		
Bank interest	54	44
Other loans and receivables	0	6
Subtotal	54	50
Total investment income	54	50

13 Other gains and losses

	2011/12 £000	2010/11 £000
Gain/(loss) on disposal of property, plant and equipment	(3)	(221)
Gain/(loss) on disposal of intangible assets	0	(324)
Total	(3)	(545)

14 Finance costs

	2011/12 £000	2010/11 £000
Interest		
Interest on loans and overdrafts	0	0
Interest on late payment of commercial debt	0	0
Other interest expense	0	0
Total interest expense	0	0
Other finance costs	0	0
Total	0	0

15.1 Property, plant and equipment

2011/12	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Information Technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000
Cost or valuation							
At 31 March 2011	556	11,570	185	1,687	7,563	2,281	23,842
Additions purchased	0	55	596	232	271	16	1,170
Additions donated	0	0	0	0	0	0	0
Additions Government Granted	0	0	0	0	0	0	0
Reclassifications	0	0	(67)	61	6	0	0
Disposals other than for sale	0	0	0	0	0	(5)	(5)
Upward revaluation/positive indexation	0	0	0	0	0	0	0
Impairments/negative indexation	0	0	0	0	0	0	0
Reversal of impairments	0	0	0	0	0	0	0
Cumulative dep'n adjustment following revaluation	0	0	0	0	0	0	0
At 31 March 2012	556	11,625	714	1,980	7,840	2,292	25,007
Depreciation							
At 31 March 2011	7	5,338	0	851	5,396	1,140	12,732
Prior period adjustments	0	0	0	0	0	0	0
At 1 April 2011 restated	7	5,338	0	851	5,396	1,140	12,732
Reclassifications	0	0	0	0	0	0	0
Disposals other than for sale	0	0	0	0	0	(2)	(2)
Upward revaluation/positive indexation	0	0	0	0	0	0	0
Impairments	0	0	0	0	208	0	208
Reversal of impairments	0	0	0	0	0	0	0
Charged during the year	0	760	0	334	991	327	2,412
Cumulative dep'n adjustment following revaluation	0	0	0	0	0	0	0
At 31 March 2012	7	6,098	0	1,185	6,595	1,465	15,350
Net book value							
Purchased	549	5,527	714	795	1,245	827	9,657
Donated	0	0	0	0	0	0	0
Government Granted	0	0	0	0	0	0	0
Total at 31 March 2012	549	5,527	714	795	1,245	827	9,657
Asset financing							
Owned	549	5,527	714	795	1,245	827	9,657
Held on finance lease	0	0	0	0	0	0	0
Total	549	5,527	714	795	1,245	827	9,657

Revaluation Reserve Balance for property, plant & equipment

	Land £000	Buildings excluding dwellings £000	Plant and machinery £000	Information Technology £000	Furniture & fittings £000	Total £000
At 31 March 2011	0	400	25	0	36	461
Prior period adjustments	0	0	0	0	0	0
Merger adjustments	0	0	0	0	0	0
At 1 April 2011 restated	0	400	25	0	36	461
Movements (specify)	0	0	0	0	0	0
At 31 March 2012	0	400	25	0	36	461

15.2 Property, plant and equipment

2010/11	Land £000	Buildings excluding dwellings £000	Assets under construction £000	Plant & machinery £000	Information Technology £000	Furniture & fittings £000	Total £000
Cost or valuation							
At 1 April 2010	556	11,988	1,002	1,394	6,546	2,030	23,516
Additions purchased	0	262	134	252	623	149	1,420
Additions donated	0	0	0	0	0	0	0
Additions Government granted	0	0	0	0	0	0	0
Reclassifications	0	0	(951)	41	394	211	(305)
Reclassified as held for sale	0	0	0	0	0	0	0
Disposals other than by sale	0	(680)	0	0	0	(109)	(789)
Revaluation & indexation gains	0	0	0	0	0	0	0
Impairments	0	0	0	0	0	0	0
Reversals of impairments	0	0	0	0	0	0	0
At 31 March 2011	556	11,570	185	1,687	7,563	2,281	23,842
Depreciation							
At 1 April 2010	6	5,067	0	562	4,096	926	10,657
Reclassifications	0	0	0	0	0	0	0
Reclassifications as Held for Sale	0	0	0	0	0	0	0
Disposals other than for sale	0	(481)	0	0	0	(86)	(567)
Upward revaluation/positive indexation	0	0	0	0	0	0	0
Impairments	0	0	0	0	0	0	0
Reversal of impairments	0	0	0	0	0	0	0
Charged during the year	1	752	0	289	1,300	300	2,642
At 31 March 2011	7	5,338	0	851	5,396	1,140	12,732

Net book value							
Purchased	549	6,232	185	836	2,167	1,141	11,110
Donated	0	0	0	0	0	0	0
Government granted	0	0	0	0	0	0	0
At 31 March 2011	**549**	**6,232**	**185**	**836**	**2,167**	**1,141**	**11,110**

Asset financing							
Owned	549	6,232	185	836	2,167	1,141	11,110
Held on finance lease	0	0	0	0	0	0	0
Total	**549**	**6,232**	**185**	**836**	**2,167**	**1,141**	**11,110**

The long lease in Nottingham expires on 30 December 2991 and the value of the land is being amortised over this period. The building on that land is being depreciated over 66 years representing an approximation of its useful economic life. The land and building were revalued at 31 March 2010 by District Valuer Services on an existing use basis and this is also deemed its market value.

The economic lives of fixed assets for those still subject to depreciation range from:	Min life (years)	Max life (years)
Long leasehold land	990	990
Buildings excluding dwellings - all leasehold	1	66
Plant & machinery	3	9
Information Technology	1	5
Furniture & fittings	1	10

The gross revalued amount of assets fully depreciated but still in use at 31 March 2012 is £7,393,253 (at 31 March 2011 £3,390,032).

At 2010/11	Min life (years)	Max life (years)
Long leasehold land	990	990
Buildings excluding dwellings - all leasehold	1	66
Plant & machinery	3	9
Information Technology	1	5
Furniture & fittings	2	10

16.1 Intangible non-current assets

2011/12	Software internally generated	Software purchased	Licences & trademarks	Assets under construction	Development expenditure	Total
	£000	£000	£000	£000	£000	£000
Cost or valuation						
At 31 March 2011	0	5,141	19,445	959	196	25,741
Additions purchased	0	577	0	1,165	5	1,747
Additions internally generated	0	0	0	0	0	0
Additions donated	0	0	0	0	0	0
Additions government granted	0	0	0	0	0	0
Reclassifications	0	0	0	(122)	122	0
Reclassified as held for sale	0	0	0	0	0	0
Disposals other than by sale	0	0	0	0	0	0
Revaluation & indexation gains	0	0	0	0	0	0
Impairments charged to reserves	0	0	0	0	0	0
Reversal of impairments charged to reserves	0	0	0	0	0	0
Transfers to Foundation Trusts	0	0	0	0	0	0
Cumulative amortisation adjustment following revaluation	0	0	0	0	0	0
At 31 March 2012	0	5,718	19,445	2,002	323	27,488
Amortisation						
At 31 March 2011	0	1,325	903	0	146	2,374
Prior period adjustments	0	0	0	0	0	0
Merger adjustments	0	0	0	0	0	0
At 1 April 2011	0	1,325	903	0	146	2,374
Reclassifications	0	0	0	0	0	0
Reclassified as held for sale	0	0	0	0	0	0
Disposals other than by sale	0	0	0	0	0	0
Revaluation or indexation gains	0	0	0	0	0	0
Impairments charged to operating expenses	0	0	0	0	0	0
Reversal of impairments charged to operating expenses	0	0	0	0	0	0
Charged during the year	0	1,101	1,302	0	65	2,468
Transfers to Foundation Trusts	0	0	0	0	0	0
Cumulative amortisation adjustment following revaluation	0	0	0	0	0	0
At 31 March 2012	0	2,426	2,205	0	211	4,842
Net book value						
Purchased	0	3,292	17,240	2,002	112	22,646
Donated	0	0	0	0	0	0
Government granted	0	0	0	0	0	0
Total at 31 March 2012	0	3,292	17,240	2,002	112	22,646

16.2 Intangible non-current assets

2010/11	Software internally generated	Software purchased	Licences & trademarks	Assets under construction	Development expenditure	Total
	£000	£000	£000	£000	£000	£000
Cost or valuation						
At 1 April 2010	602	1,414	0	1,749	196	3,961
Additions purchased	0	2,037	19,445	757	0	22,239
Additions internally generated	0	0	0	0	0	0
Additions donated	0	0	0	0	0	0
Additions Government granted	0	0	0	0	0	0
Reclassifications	162	1,690	0	(1,547)	0	305
Reclassified as held for sale	0	0	0	0	0	0
Disposals other than by sale	(764)		0	0	0	(764)
Revaluation & indexation gains	0	0	0	0	0	0
Impairments	0	0	0	0	0	0
Reversal of impairments	0	0	0	0	0	0
Transfers to Foundation Trusts	0	0	0	0	0	0
At 31 March 2011	0	5,141	19,445	959	196	25,741
Amortisation						
At 1 April 2010	199	872	0	0	81	1,152
Reclassifications	0	0	0	0	0	0
Reclassified as held for sale	0	0	0	0	0	0
Disposals other than by sale	(440)		0	0	0	(440)
Revaluation or indexation gains	0	0	0	0	0	0
Impairments charged to operating expenses	0	0	0	0	0	0
Reversal of impairments charged to operating expenses	0	0	0	0	0	0
Charged during the year	241	453	903	0	65	1,662
Transfers to Foundation Trusts	0	0	0	0	0	0
At 31 March 2011	0	1,325	903	0	146	2,374
Net book value						
Purchased	0	3,816	18,542	959	50	23,367
Donated	0	0	0	0	0	0
Government granted	0	0	0	0	0	0
Total at 31 March 2011	0	3,816	18,542	959	50	23,367

16.3 Intangible non-current assets

None of the intangible assets have been revalued as they are software and web products with an economic life limited to the period of the licence purchased and/or subject to upgrading to meet the requirements of the Trust. Consequently they all have finite lives and are depreciated over the following periods:

At 2011/12	Min life (years)	Max life (years)
Computer software purchased	2	5
Computer software internally generated	4	5
Licenced content	15	15
Development expenditure internally generated	4	5

At 2010/11	Min life (years)	Max life (years)
Computer software purchased	3	5
Computer software internally generated	3	3
Licenced content	15	15
Development expenditure internally generated	3	3

The gross revalued amount of assets fully depreciated but still in use at 31 March 2012 is £1,349,680 (at March 2011 £156,210).

17 Analysis of impairments and reversals recognised in 2011/12

	2011/12 Total £000
Property, plant and equipment impairments and reversals taken to SoCI	
Loss or damage resulting from normal operations	209
Over-specification of assets	0
Abandonment of assets in the course of construction	0
Total impairments of property, plant and equipment	209
Total impairments charged to SoCI - DEL	209
Total impairments charged to SoCI - AME	0
Overall total impairments	**209**

The impairment relates to ICT assets caused by changes in technology associated with the telephony upgrade project which results in certain functions within the current system being no longer operational.

18 Capital commitments

Contracted capital commitments at 31 March not otherwise included in these financial statements:

	31 March 2012 £000	31 March 2011 £000
Property, plant and equipment	1,360	0
Intangible assets	132	1,050
Total	1,492	1,050

19 Intra-Government and other balances

	Current receivables £000s	Non-current receivables £000s	Current payables £000s	Non-current payables £000s
Balances with other Central Government Bodies	2,694	0	3,973	0
Balances with Local Authorities	0	0	70	0
Balances with NHS Trusts and Foundation Trusts	59	0	325	0
Balances with Public Corporations and Trading Funds	0	0	0	0
Balances with bodies external to Government	2,849	0	10,670	4,468
At 31 March 2012	5,602	0	15,038	4,468
Prior period				
Balances with other Central Government Bodies	1,007	0	156	0
Balances with Local Authorities	0	0	0	0
Balances with NHS Trusts and Foundation Trusts	81	0	42	0
Balances with Public Corporations and Trading Funds	0	0	0	0
Balances with bodies external to government	4,093	0	16,765	6,261
At 31 March 2011	5,181	0	16,963	6,261

20 Trade and other receivables
20.1 Trade and other receivables

	Current		Non-current	
	31 March 2012	31 March 2011	31 March 2012	31 March 2011
	£000	£000	£000	£000
NHS receivables - revenue	824	1,085	0	0
NHS receivables - capital	0	0	0	0
NHS prepayments and accrued income	661	184	0	0
Non-NHS receivables - revenue	810	1,026	0	0
Non-NHS receivables - capital	0	0	0	0
Non-NHS prepayments and accrued income	2,074	1,545	0	0
Provision for the impairment of receivables	(160)	(216)	0	0
VAT	1,268	1,272	0	0
Other receivables	125	285	0	0
Total	5,602	5,181	0	0
Total current and non current	5,602	5,181	0	0

The great majority of trade is with Strategic Health Authorities and Primary Care Trusts, as commissioners for NHS patient care services. As these are funded by Government to buy NHS patient care services, no credit scoring of them is considered necessary.
Other trade of significance is with big pharmaceutical companies, which have satisfactory credit ratings.

20.2 Receivables past their due date but not impaired

	31 March 2012 £000	31 March 2011 £000
By up to three months	0	135
By three to six months	0	0
By more than six months	0	39
Total	0	174

20.3 Provision for impairment of receivables

	2011/12 £000	2010/11 £000
Balance at 1 April 2011	(216)	(240)
Adjustments	0	0
Restated balance at 1 April 2011	(216)	(240)
Amount written off during the year	56	53
Amount recovered during the year	0	(29)
(Increase)/decrease in receivables impaired	0	0
Balance at 31 March	(160)	216

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

21 Cash and cash equivalents

	31 March 2012 £000	31 March 2011 £000
Opening balance at	19,958	14,256
Net change in year	1,917	5,702
Closing balance	21,875	19,958
Made up of:		
Cash with Government Banking Service	21,875	19,958
Commercial banks	0	0
Cash in hand	0	0
Current investments	0	0
Cash and cash equivalents as in statement of financial position	21,875	19,958
Bank overdraft - Government Banking Service	0	0
Bank overdraft - commercial banks	0	0
Cash and cash equivalents as in statement of cash flows	21,875	19,958

22 Non-current assets held for sale

There were no non-current assets held for sale at 31 March 2012.

23 Trade and other payables

	Current		Non-current	
	31 March 2012	31 March 2011	31 March 2012	31 March 2011
	£000	£000	£000	£000
Interest payable	0	0	0	0
NHS payable - revenue	62	198	0	0
NHS payable - capital	0	0	0	0
NHS accruals and deferred income	1,860	2,356	0	0
Non-NHS payables - revenue	2,323	2,973	0	0
Non-NHS payables - capital	1,627	1,498	4,468	6,261
Non-NHS accruals and deferred income	7,644	8,211	0	0
Social security costs	713	780	0	0
VAT	0	0	0	0
Tax	799	947	0	0
Payments received on account	0	0	0	0
Other	10	0	0	0
Total	15,038	16,963	4,468	6,261
Total payables (current and non-current)	19,506	23,224	0	0
Included above:				
Outstanding Pension Contributions at the year end	864	945	0	0

24 Deferred income

	Current		Non-current	
	31 March 2012	31 March 2011	31 March 2012	31 March 2011
	£000	£000	£000	£000
Opening balance at 1 April 2011	3,125	1,109	0	0
Deferred income addition	337	2,016	0	0
Transfer of deferred income	(2,402)	0	0	0
Current deferred income at 31 March 2012	1,060	3,125	0	0
Total other liabilities (current and non-current)	1,060	3,125	0	0

25 Provisions

	Total £000	Pensions relating to other staff £000	Restructuring £000	Other £000	Redundancy £000
Balance at 1 April 2011	1,920	742	654	524	0
Arising during the year	4,471	48	1,231	3,192	0
Utilised during the year	(510)	(30)	(86)	(394)	0
Reversed unused	(568)	0	(568)	0	0
Unwinding of discount	0	0	0	0	0
Change in discount rate	0	0		0	0
Balance as at 31 March 2012	**5,314**	**761**	**1,231**	**3,322**	**0**
Expected timing of cash flows:					
No later than one year	2,038	35	1,231	772	0
Later than one year and not later than five years	2,366	161	0	2,205	0
Later than five years	910	565	0	345	0

Amount included in the provisions of the NHS Litigation Authority in respect of clinical negligence liabilities:	
As at 31 March 2012	9,941
As at 31 March 2011	5,485

Pensions relating to other staff relates to pensions payable to staff who are in receipt of this through permanent injury on the assumption it would continue to be paid until they are aged 80, discounted at 2.9% in line with Treasury guidance.

Restructuring relates to schemes which have been approved by the Board and advised to staff affected being an estimate of the potential redundancy costs involved on implementation.

Other provisions include dilapidation provision of £2,588,000 which is based on external surveyors assessment of dilapidation payments required on expiry of commercial property leases. It also includes £554,000 in respect of potential performance fees claimed by our principal IT supplier Clinical Solutions, which is the subject of dispute. The remainder of the provision relates to estimated amounts arising under employment tribunal cases and employers liability insurance.

26 Contingencies

Contingent liabilities	31 March 2012 £000
Equal pay	0
Other - employment liability	37
Amounts recoverable against contingent liabilities	0
Net value of contingent liabilities	37

Contingent assets	
Contingent assets	0
Net value of contingent assets/(liabilities)	37

The decommissioning of the 0845 service brings with it significant unavoidable costs. The full extent of these costs will depend upon the Trust's and the Department of Health's ability to implement actions to minimise costs, and the extent of services that NHS Direct continues to operate beyond March 2013.

The maximum total liability, estimated at £144m, will be reduced by the application of Cabinet Office Guidelines for the transfer of front line staff to successful bidders of 111 services, and other cost minimisation actions that the Trust and Department of Health can implement.

Residual decommissioning costs will be funded by the Department of Health.

27 Events after the end of the reporting period

In accordance with the requirements of International Accounting Standard 10, events after the accounting period are considered up to the date the accounts are authorised for issue. This is interpreted as the date of Certificate and Report of the Comptroller and Auditor General.

28 Financial risk management

Financial reporting standard IFRS 7 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 the financial reporting 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 the risks facing the Trust in undertaking its activities.

The Trust's treasury management operations are carried out by the finance department, within parameters defined formally within the Trust's standing financial instructions and policies agreed by the Board of Directors. Trust treasury activity is subject to review by the Trust's internal auditors.

Currency risk

The Trust is principally 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. The maximum exposures as at 31 March 2012 are in receivables from customers, as disclosed in the Trade and other receivables note.

Liquidity risk

The Trust's operating costs are incurred under contracts with the Strategic Health Authority and Primary Care Trusts, which are financed from resources voted annually by Parliament . The Trust funds its capital expenditure from internal resources. The Trust is not, therefore, exposed to significant liquidity risks.

29 Related party transactions

During the year none of the Department of Health Ministers, Trust Board members or members of the key management staff, or parties related to any of them, has undertaken any material transactions with the NHS Direct National Health Service Trust, except as disclosed in the Remuneration Report.

The Department of Health is regarded as a related party. During the year 2011/12, 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. These entities are:

Strategic Health Authorities
NHS Primary Care Trusts
NHS Foundation Trusts
NHS Trusts
NHS Litigation Authority

In addition, the Trust has had a number of immaterial transactions with other Government departments and other central and local government bodies.

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

Income	Income £000	2011/12 Debtor £000	Creditor £000	Income £000	2010/11 Debtor £000	Creditor £000
NHS Midlands and East (formerly East of England) Strategic Health Authority	122,622	0	731	129,112	0	121
Department of Health	4,430	9	517	4,461	17	0
Blackpool PCT	2,063	0	51	6	2	0
Calderdale PCT	5,439	41	0	5,564	56	0
East Lancashire Teaching PCT	338	0	0	507	0	0
Lincolnshire Teaching PCT	1,181	682	0	61	0	0
Luton Teaching PCT	294	175	0	33	0	0
Manchester PCT	263	35	0	212	226	0
Nottingham City PCT	1,177	172	22	449	131	0
Stockport PCT	331	0	0	310	245	19
Hounslow PCT	0	0	0	291	0	0

Expenditure	Expenditure £000	Debtor £000	Creditor £000	Expenditure £000	Debtor £000	Creditor £000
Imperial College Healthcare NHS Trust	327	0	17	281	0	37
NHS Litigation Authority	309	0	0	305	0	0
North West Ambulance Services NHS Trust	492	0	137	0	0	0
University Hospitals of Leicester NHS Trust	385	0	0	554	0	0
Yorkshire Ambulance Service NHS Trust	753	0	76	746	0	2
NHS Pension Scheme	7,481	0	864	8,783	0	979

Nottinghamshire Healthcare NHS Trust	165	0	33	333	0	2

30 Losses and special payments

The total number of losses cases in 2011/12 and their total value was as follows:

	Total value of cases £s	Total number of cases
Losses	0	0
Special payments	38,713	13
Total losses and special payments	38,713	13

The total number of losses cases in 2010/11 and their total value was as follows:

	Total value of cases £s	Total number of cases
Losses	0	0
Special payments	55,718	30
Total losses and special payments	55,718	30

31 Financial performance targets

The figures given for periods prior to 2009/10 are on a UK GAAP basis as that is the basis on which the targets were set for those years.

31.1 Breakeven performance

	2007/08 £000	2008/09 £000	2009/10 £000	2010/11 £000	2011/12 £000
Turnover	144,381	161,566	191,036	149,606	143,801
Retained surplus/(deficit) for the year	5,062	467	949	2,733	488
Break-even cumulative position	5,062	5,529	6,478	9,211	9,699

	2007/08 %	2008/09 %	2009/10 %	2010/11 %	2011/12 %
Materiality test (i.e. is it equal to or less than 0.5%):					
Break-even in-year position as a percentage of turnover	3.5%	0.3%	0.5%	1.8%	0.3%
Break-even cumulative position as a percentage of turnover	3.5%	3.4%	3.4%	6.2%	6.7%

The amounts in the above tables in respect of financial years 2005/06 to 2008/09 inclusive have not been restated to IFRS and remain on a UK GAAP basis.

31.2 Capital cost absorption rate

Until 2008/09 the Trust was required to absorb the cost of capital at a rate of 3.5% of forecast average relevant net assets. The rate is calculated as the percentage that dividends paid on public dividend capital bears to the actual average relevant net assets.

From 2009/10 the dividend payable on public dividend capital is based on the actual (rather than forecast) average relevant net assets and therefore the actual capital cost absorption rate is automatically 3.5%.

31.3 External financing

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

	2011/12 £000	2010/11 £000
External financing limit	9,760	28,542
Cash flow financing	1,917	5,702
Finance leases taken out in the year	0	0
Other capital receipts	0	0
External financing requirement	1,917	5,702
Undershoot/(overshoot)	11,677	34,244

31.4 Capital resource limit

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

	2011/12 £000	2010/11 £000
Gross capital expenditure	2,917	23,659
Less: book value of assets disposed of	(3)	0
Less: capital grants	0	0
Less: donations towards the acquisition of non-current assets	0	0
Charge against the capital resource limit	2,914	23,659
Capital resource limit	9,164	28,012
(Over)/underspend against the capital resource limit	6,250	4,353

Appendices

Appendix A

Indicators of quality for 2011/12

The tables below contain the indicators of quality selected by the Trust Board for the core 0845 service and website. The Trust is reviewed by this criteria regularly during the year.

See Appendix B for a detailed definition of these key performance indicators.

The Trust has unrestricted registration with the Care Quality Commission (CQC). Following a routine unannounced inspection in January 2012, the Trust achieved the highest level of compliance with no improvement actions required.

1. Safety

In 2011/12, NHS Direct National Health Service Trust achieved the following performance in indicators relating to patient safety:

Safety domain	2011/12 achievement	2011/12 target
% of incidents for national review that give rise to harm**: standard achieved Board scorecard rating: green	2%	≤10%
Urgent (P1) clinical assessments started in 20 minutes: standard achieved Board scorecard rating: green	99%	≥95%
Less urgent clinical assessments (P2) started in 60 minutes: standard not achieved Board scorecard rating: amber	87%	≥95%
Non-urgent clinical assessments (P3) started in 120 minutes: standard not achieved Board scorecard rating: amber	91%	≥95%

**This indicator relates to all the Trust's clinical services, not just core national service

2. Clinical effectiveness

In 2011/12, the Trust achieved the following performance in indicators relating to clinical effectiveness:

Effectiveness domain	2011/12 achievement	2011/12 target
Emergency and urgent referrals: standard not achieved Board scorecard rating: amber	27%	≤25%
Telephone contacts not requiring onward referral: standard achieved Board scorecard rating: green	53%	≥50%
Health and nurse advisors' time online spent talking with patients: standard not achieved Board scorecard rating: red	36%	≥50%
Call reviews achieving good or excellent: standard not achieved Board scorecard rating: red	64%	≥80%

3. Patient experience

In 2011/12, the Trust achieved the following level of quality for performance in indicators relating to patient experience:

Patient experience domain	2011/12 achievement	2011/12 target
Patient satisfaction: standard achieved Board scorecard rating: green	93%	≥90%
Number of complaints per 10,000 calls: standard achieved Board scorecard rating: green	0.25	≤1.0
Core calls answered within 60 seconds: standard not achieved Board scorecard rating: amber	91%	≥95%
NHS 111 calls answered within 60 seconds: standard achieved Board scorecard rating: green	96%	≥95%
Abandonment rate: Standard achieved Board scorecard rating: green	2%	≤5%
Waiting for call time: Standard achieved Board scorecard rating: green	9%	≤15%
Actions arising from complaints implemented to deadlines: standard achieved Board scorecard rating: green	97%	≥95%

Appendix B

Detailed definitions of key performance indicators

KPI Name	Target	Purpose	Data Source	Definition	Calculation
Patient satisfaction	≥90%	To measure patients' perception of quality of our services	External monthly satisfaction survey	Patient perception of level of service being provided.	% of respondents satisfied with the service provided to them. Calculated from a range of factors most influential to user experience.
Number of complaints	1 per 10,000 calls	Indicates the quality of our service	Datix and regional complaints reporting	Number of complaints relating to clinical services per 10,000 calls.	Number of nationally handled complaints reported (for combined service relating to clinical services) x 10,000 / number of calls answered
Actions arising from complaints implemented to deadlines	≥95%	To measure the quality of the complaints handling process	Datix and regional complaints reporting	% of actions identified through complaints completed within the timescale set. Timescale is set internally associated with risk and type of action.	(Total number of actions completed to deadline / total number of actions identified) x 100
Expert call review scoring good/excellent	≥80%	Identifies the overall quality of calls, as per in-house quality assurance tool	Collated call reviews from front line managers and expert call review team	% of random supervisory / peer call reviews undertaken for clinical services rating Good / Excellent.	(Total number of expert call reviews rating good or excellent / total number of expert call reviews undertaken) x 100
% of incidents reported to national review that have given rise to harm	≤10%	Patient Safety	DATIX	The proportion of all reported National Incident for Review (NIR) through the core or enhanced telephone services (excluding TAL) where a Trust 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.	Number of National Incidents for Review reported in a month that led to harm / Number of National Incident for Review reported in a month
Core calls answered within 60 seconds	≥95%	Access measure	Symposium telephony system	Number of Combined Calls answered within 60 seconds following the message and 5 second switching delay.	(Calls answered within 60 seconds / total calls answered) x 100

KPI Name	Target	Purpose	Data Source	Definition	Calculation
NHS 111 calls answered in 60 seconds	≥95%	Access measure	Symposium telephony system	Number of 111 Calls answered within 60 seconds following the message and 5 second switching delay.	(111 Calls answered within 60 seconds / total 111 calls answered) x 100
Abandonment rate	≤5%	Access measure	Symposium telephony system	% of Combined calls abandoned after 30 seconds following the message and switching delay.	(Number of calls abandoned after application threshold / (number of calls abandoned after threshold + number of calls answered)) x 100
Urgent (P1) clinical assessment started in 20 minutes	≥95%	Identifies the speed of response to clinically urgent calls	Clinical Assessment System (CAS)	The proportion of urgent [P1 and D1] calls requiring clinical assessment where clinical assessment by a clinician is started within 20 minutes	Number of urgent [P1 & D1] calls starting clinical assessment within 20 minutes / number of urgent [P1 & D1] calls
Less urgent (P2) clinical assessment started in 60 minutes	≥95%	Identifies the speed of response to clinically less urgent calls	Clinical Assessment System (CAS)	Less urgent calls [P2 only] requiring clinical assessment, where clinical assessment is started by a clinician within 60 minutes	Number of less urgent [P2] calls starting clinical assessment within 60 minutes / Number of less urgent clinical [P2] calls
Non-urgent (P3) clinical assessment started in 120 minutes	≥95%	Identifies the speed of response to clinically non urgent calls	Clinical Assessment System (CAS)	Non-urgent [P2, P3, D2, D3] calls requiring clinical assessment, where clinical assessment is started by a clinician within 120 minutes	Number of non-urgent [P2, P3, D2, D3] calls starting clinical assessment within 60 minutes / Number of non-urgent [P2, P3, D2, D3] calls
Health and nurse advisors' time online spent talking with patients	≥50%	Productivity measure	Symposium telephony system & CCC	The % of time front line staff (HA, NA, HIA, DN) spend speaking with patients.	(Amount of time speaking with patients / Paid time - Annual leave) x 100

KPI Name	Target	Purpose	Data Source	Definition	Calculation
Waiting for call time	<15%	Productivity measure	Symposium telephony system & CCC	The % of time front line staff (HA, NA, HIA, DN) spend waiting for a call.	"(Amount of time spent waiting for a call (Idle Time) / Paid Time - Annual Leave) x 100"
NHS 111, 0845 & urgent care	6.2m	Measures performance against contract	Symposium telephony system	Number of calls answered in all services	0845+OOH+Dental+111+WYUC Answered Volumes
Core service contacts	4.7m	Measures performance against contract	Symposium telephony system	Number of calls answered in core service	0845+Cat C+click to call back+online enquiries+web chats+national helplines
Patient choice (TAL)	3.0m	Measures performance against contract	Symposium telephony system	Numbers of calls answered against the number of calls agreed as latest contract target	Number of TAL Calls Answered
Long-term conditions	100,500		Birmingham and Nottingham Ownhealth members		
Number of uses of online health & symptom checkers	5.5m	Indicates success of web-based service	Urchin 7	Number of HaSC successes compared to contract plan	Number of Health and Symptoms Checker uses for the reporting period.
Telephone contacts not requiring onward referral	≥50%	Identifies the proportion of calls completed within NHS Direct i.e. 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	2011/12 EoE Scorecard	Number of Core calls NHS Direct completes without onward referral	((Selfcare + Pharmacy + PCS Routine + HIS) for core service / (Core Service Symptomatic + HIS Calls)) x 100

KPI Name	Target	Purpose	Data Source	Definition	Calculation
Urgent and emergency onward referrals	≤25%	Value to Patients and NHS	2011 12 EoE Scorecard	% of emergency and urgent referrals for Core calls only	(The number of calls referred to 999, A&E or PCS Urgent / Number of calls with clinical dispositions) x 100
Total sickness	10 days per WTE per yr	Great Place to Work	HR Scorecard KPIs -2011 12vs	Gross number of days per WTE per year lost to sick leave	For all NHS Direct staff YTD Actual time spent off sick - WTE days (annualised) /7*5 / YTD Average number of WTE
Number of people on long-term sick leave	Year End Target of 40	Great Place to Work	HR Scorecard KPIs -2011 12vs	Total number of people currently on long term sick leave	Continuous calendar days>28 & absence still open at end of the reporting month
Proportion of staff recruited who complete a year		Great Place to Work	HR Scorecard KPIs -2011 12vs	NA, HA, DNA and HIA (frontline) staff leaving within one year of starting at NHS Direct	(Non-bank NA, HA, DNA and HIA starters HC (12 month rolling) who have left with <1yr service / NA, HA, DNA and HIA starters HC (12 month rolling)) x 100
Recurring financial balance (monthly run-rate)	10%	Corporate Effectiveness & Efficiency	Finance department	Y-T-D recurrent retained surplus variance as a proportion of actual Y-T-D turnover.	Y-T-D recurrent retained surplus variance as a proportion of actual Y-T-D turnover.
Department of Health Financial Health Index	2.5	Corporate Effectiveness & Efficiency	Finance Department	As defined by DH the aggregation of a range of financial measures specified to indicate financial health	Range of performance metrics covering actual financial results and including planning, forecasting, processes and balance sheet efficiency.