NHS Direct

NHS Direct National Health Service Trust Annual Report & Accounts 2010/11

NHS Direct National Health Service Trust
Annual Report & Accounts 2010/11

NHS Direct National Health Service Trust Annual Report & Accounts 2010/11

Presented to Parliament pursuant to Schedule 15 of the National Health Service Act 2006.

Ordered by the House of Commons
to be printed on 12 July 2011.

HC 1114 LONDON: THE STATIONERY OFFICE £20.50

Any enquiries regarding this document should be sent to us at NHS Direct, 2nd Floor, 120 Leman Street, London E1 8EU. Telephone 020 7599 4200.

This publication is also available for download at www.official-documents.gov.uk and www.nhsdirect.nhs.uk.

ISBN: 9780102971613

Printed in the UK by The Stationery Office Limited
on behalf of the Controller of Her Majesty's Stationery Office

ID: 2427153 07/11

Printed on paper containing 75% recycled fibre content minimum.

Contents

We're

here.

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

This makes us unique.

Joanne Shaw Chair's Statement

Remote and virtual heath care has a great deal to offer to patients, the NHS and the wider social care system. We share a vision that patient empowerment supported by self-service and self-care is critical for the future of a sustainable NHS, as well as being what patients themselves want.

Remotely delivered services help manage the pressures on already stretched primary and secondary healthcare, by reducing avoidable demand on face-to-face services and by steering demand to the right setting at the right time. They support patients to take greater control and exercise greater choice over their health and healthcare, and how they access services. They do so in ways which promote patient safety and support the achievement of high quality health outcomes.

In 2010/11 we took significant steps towards the Trust's vision to provide remotely delivered care that is increasingly valued by patients and the wider health and social care system. The Trust aims to be a trusted delivery partner in every local NHS health community. We continued to work in partnership with the East of England Strategic Health Authority (SHA) – which commissions the national 0845 4647 service – and local health commissioners, GPs and other NHS organisations, to increase the value of the service for both patients and the NHS, and to reduce its cost.

During 2010, the Coalition government announced its plans for the national rollout of a new NHS 111 telephone service for patients with non-emergency health needs, which will ultimately replace the 0845 4647 service. We are very pleased to be involved in all of the first four pilots of the new service. The government's broader plans for reform to NHS commissioning, the introduction of greater competition, and the requirement for all NHS trusts to become NHS Foundation Trusts, have profound implications for us. The consequent risks and opportunities have been recognised by the Board, and the whole organisation is now gearing up to the challenges ahead. I was pleased to able to confirm, with the valued support of both the Department of Health and the East of England SHA that the Trust will seek NHS Foundation Trust status from April 2013.

Over the last year, we have taken further steps to strengthen our Board. We appointed Dr Brian Gaffney as Director of Public Health/Acting Medical Director, with a specific brief to ensure the Trust reaches out to the medical profession, both nationally and locally. Ronnette Lucraft was appointed as Chief Operating Officer, and has led the Trust's plans to improve its operational efficiency. We also saw Tricia Hamilton step up as Chief Nurse and Clinical Director, and Alan Bentall join the Board as Chief Information Officer on a permanent basis. Steve Duncan joined the Board as a Non-Executive Director, bringing with him experience from a distinguished career leading consumer-facing healthcare and pharmaceutical businesses. Our non-executive directors with medical backgrounds, Dr Luisa Dillner and Dr Tim Heymann, appointed in late 2009, have been able to provide valuable additional clinical direction to the development of the Trust and its services.

We recognise that we ask a great deal of our staff. They tell us that the degree of change we are facing as an organisation creates considerable uncertainty for them, in addition to what is already a stressful job. We take these concerns extremely seriously. It reinforces our determination to engage staff at every level in shaping our plans for the future and to demonstrate our appreciation for their continuing commitment to patients and the service.

In the coming year, we look forward to playing a leading role in supporting the NHS to exploit the full potential of multi-channel, remotely delivered clinical care. We are excited about our new role in supporting NHS 111 and about creating new remote and digital channels to meet the growing and changing demands for healthcare, helping the NHS to catch up with other sectors of the economy. We look forward to working within the new commissioning and competitive provider regime to clearly demonstrate the value offered by our services, for the mutual benefit of patients, the wider public, and local and national health economies

Joanne Shaw
Chair, NHS Direct National Health Service Trust

Nick Chapman
Chief Executive's Statement

2010/11 was a year of change for the NHS Direct National Health Service Trust, signalling the start of a new direction for the organisation. The catalyst for this change was the Coalition government's announcement of far reaching plans to introduce a new NHS 111 telephone service for non-emergency health care, and plans to phase out the NHS Direct 0845 4647 telephone service when the NHS 111 rollout is complete. We have been working with other NHS organisations to pilot NHS 111 since the spring of 2009, and the work we've undertaken over the last year has helped us to focus our future plans and ambitions. It is our intention to compete for future NHS 111 business, working alongside other NHS providers, and we envisage that we will have a new role as a major provider of the new service.

Although NHS 111 has been a significant area of work in 2010/11, we have not neglected the important job of providing trusted health information and advice to the millions of people who use our existing telephone and online services. Last year, 4.7 million patients used the 0845 4647 telephone line, and a further 5.6 million patients used our range of online health and symptom checkers. We have seen an increase in popularity of our online tools, and the numbers show that more people are initially accessing our services online than over the phone. Over the last year, we have rapidly developed these services and we now have nearly 40 health and symptom checkers available on the web and a mobile app, which allows people to access our services more conveniently wherever they are. The added benefit of our web tools is their link to our telephone service, so our patients know they can speak to one of our nurses should they need additional support. Over 90% of our patients continued to rate our services as good or excellent last year. This lets our staff know that what they do is of huge value and that their efforts do make a difference.

We have played an important role in the wider NHS landscape, by taking pressure off other NHS services and significantly contributing to the £20 billion of efficiency savings the NHS needs to be able to make to keep up with rising demand for healthcare from England's ageing population. We reduced the cost of providing our services to the rest of the NHS by £11.1 million in 2010/11. By the end of 2011/12, we will have reduced the cost of our service to the NHS by £33 million a year.

The services that we provide enable patients to care for themselves, where this is appropriate, and reduce unnecessary A&E attendances and GP surgery appointments. During the year, over half of the patients who contacted our 0845 4647 service were able to care for themselves with the advice given to them by our staff and did not require onward referral to another part of the NHS. Because of this we estimate that in 2010/11 the core service saved 1.6 million unnecessary GP surgery appointments, 1.1 million A&E attendances/999 calls, and 0.5 million other face-to-face appointments.

In 2010/11, we developed 42 local innovation pilots with local health communities to test out the use of remote telehealth monitoring, and online patient decision aids. Our ambition is to develop these pilots to support patients with long-term conditions and provide more patient choice. We hope that these services will make an important contribution to patients and commissioners. The pilots provided a great opportunity to work closely with other NHS organisations and with our commissioners, the East of England SHA, who have supported this programme of work.

As always, our staff have played a vital role in the last year, and will continue to as we move forward. This includes those people working on the front line in our 31 contact centres, those working behind the scenes supporting services, and over 100 home-based nurses who have demonstrated that it is possible to provide a professional, safe and effective service in another setting.

Although the level of recruitment we needed to make over the year fell, the stability of our front line resource was evident, and at the end of the year, almost 90% of our front line staff had been in post for longer than 18 months. Internally, the Trust reduced its management costs by 28% during the year, and improved front line efficiency by 15%. Staff sickness fell by 13% from the levels of the previous year, but reducing staff sickness absence still remains a priority for the Trust.

As ever, I would like to record my personal thanks to staff at every level within the Trust for the commitment and skill that they have shown during the year, to the partnership of many organisations with whom the Trust works closely, and to our members and users of the service who help us to improve through their engagement with us.

Nick Chapman
Chief Executive, NHS Direct National Health Service Trust
27 June 2011

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 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 as a result, 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.

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
- 40 online health and symptom checkers, giving advice on the most appropriate course of action, with the option to request a call back from an NHS Direct nurse advisor if required (www.nhs.uk/nhsdirect)
- an initial assessment symptom checker for web-enabled mobile phones, which uses the same triage process as the telephone helpline (mobile.nhsdirect.nhs.uk)
- assessment of low priority (Cat C) 999 calls for eight ambulance trusts
- provision of a mix of clinical assessment and health information for the NHS 111 pilots in Durham and Darlington, Luton, Nottingham and Lincolnshire. Project management, stakeholder engagement and development of the local Directory of Services is also delivered for one of the pilots
- 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.

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 NHS Direct health advisors.

Supporting patient choice

- 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
- management of The Appointments Line, one of the main ways patients can book their first hospital or clinic appointment using Choose and Book.

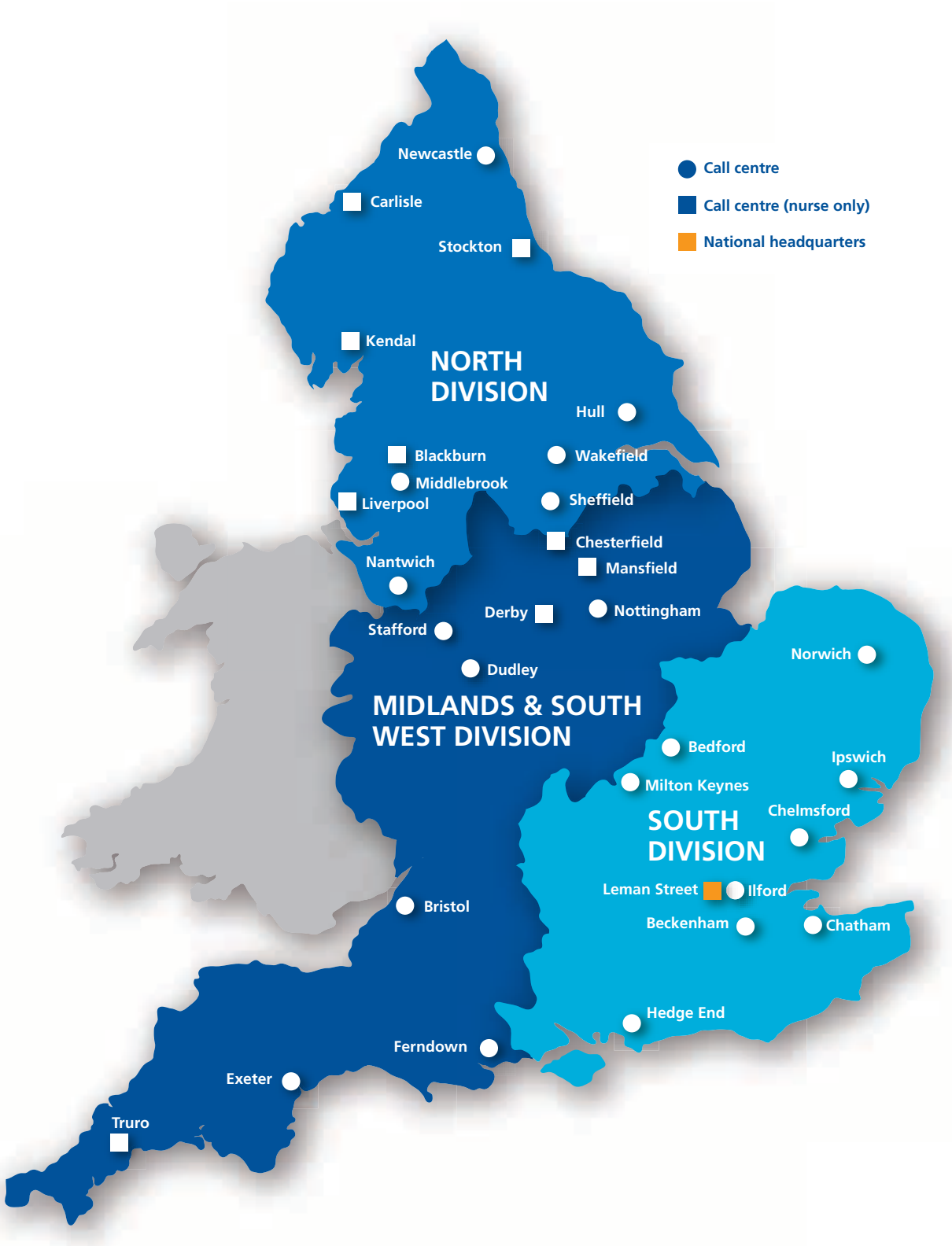
National resilience

- management and operation of the National Pandemic Flu service.

Our national network of contact centres

The NHS Direct National Health Service 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, with every centre able to provide back-up and resilience to the whole network. Our headquarters are at 120 Leman Street, London E1 8EU.

Our national network of contact centres



The external environment

In 2010/11, the Trust continued to keep under review the factors likely to have the greatest impact on future health needs, and considered how the Trust should best respond to these.

2010/11 saw the Coalition government come into office. The new government announced a plan to rollout a new three digit number – NHS 111 – to provide patients with a single integrated telephone service to provide advice and onward referral as needed for patients with non-emergency health care needs. It subsequently confirmed that this new service would eventually replace the 0845 4647 telephone service that the Trust is nationally commissioned to provide. This is a real opportunity for the NHS to increase the number of patients who access advice and guidance about health issues, to be empowered to take better care of themselves and to make the most appropriate use of NHS services.

The UK population is forecast to grow significantly over the next 15 years, with the over 65 age group growing from 10 million to 14 million during this period. One in three people already lives with a long-term condition and this number is expected to increase by a further 20% over the next 25 years. The Trust has long experience of supporting patients with a range of long-term conditions, and will aim to develop these services to help meet the needs of this expanding group of patients.

We are also seeing changes driven by people's higher expectations of health services. Patients want more and better information about their health needs, and a shared approach to making important decisions about their health: "no decision about me without me". With over 53% of people now using the internet every day, and 69% using it every week, health information and services will increasingly be delivered via the web. The Trust can help meet these demands by delivering remote and virtual services which improve the patient experience, help take pressure off traditional face-to-face services and thus reduce costs.

The combination of growing demand for health care and real constraints in the public finances, means that the NHS is planning to create efficiency savings of £20 billion by the end of 2014/15 to re-invest in front line care. In order to contribute to this, the Trust has improved its own internal efficiency. It saved £13.7 million in 2009/10, £11.1 million in 2010/11, and has agreed a further contract reduction of £8.2 million in 2011/12. In total, the Trust will have reduced the cost of its service to the NHS by £33.1 million over three years, which is £71.6 million in cash terms. This has been achieved through reduced management and overhead costs; reduced IT costs; increased use of our web services; improved front line productivity and changes to our operating model.

Our vision and objectives in 2010/11

At the start of 2010/11, the Trust published its high level vision for the organisation.

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

To achieve this vision, we set ourselves six strategic objectives for the next four years (2010/14):

- raise the quality and productivity of our services
- increase the value we create for patients, the public, the NHS and social care
- improve the culture of our organisation through a strong set of values
- 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

Our performance

Our performance against strategic objectives was monitored throughout the year through the publication of the 'Board scorecard' showing the picture of performance for the Trust as a whole.

1. Quality and productivity of our services

The Board set challenging targets for maintaining high levels of patient satisfaction, and continuing to keep the number of patient complaints at a very low level. These were achieved.

The Board set stretching targets in the area of quality and safety. The only area where performance did not reach the stretch target was in the area of expert call review scores. During the year a new and more challenging call review tool was introduced, which systematically audits calls with patients against best practice standards. The target average score for the year of 80% was not achieved. The actual average score was 62%. In 2011/12, improvements will be generated through individual reviews with all front line staff, with individual development plans arising from the call review findings.

The standards set for access and timeliness mirrored those agreed with our main commissioner, the East of England SHA. Whilst the standards for dealing with urgent calls were achieved, less urgent and non-urgent calls were subject to delays at points in the year and overall just failed to meet the standards set. We will continue to work with our staff and clinical decision support systems to reduce the proportion of less urgent calls requiring assessment by a nurse advisor, allowing them to focus on more urgent calls. We have also introduced a longest wait measure, which will ensure that, as well as meeting targets for commencing clinical assessment, we have a maximum time limit for all calls appropriate to their level of urgency. Our rolling recruitment plan, performance improvement plan and improvements to how we schedule staff will also ensure we have the right number of nurse advisors available at the right time to respond to the number of calls requiring clinical assessment.

Substantial progress was made in improving productivity amongst health advisors, and the challenging target to improve productivity was met. Improvements in rostering meant that the time spent by staff waiting for calls was reduced below the 15% target, which reflects industry best practice levels. However, less progress was made in improving productivity amongst nurse advisors and within the health information service.

See Appendix A 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 NHS Direct National Health Service Trust Quality Account for 2010/11 which is available at www.nhsdirect.nhs.uk.

2. Value to patients, the NHS and social care

During the year, the Trust expanded its range of internet-based health and symptom checkers, and over-achieved its own target with more than 5.6 million uses recorded. In contrast, the numbers using the telephone service fell slightly below the number expected.

The Trust regularly surveys patients who contact its core service, through the 0845 4647 telephone service and via the internet, to ask them about their experience of using the service, what they say 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 2010/11 the core service saved 1.6 million unnecessary GP surgery appointments, 1.1 million A&E attendances/999 calls, and 0.5 million other face-to-face appointments. This was achieved because on average 58% of patients using the core telephone service and website did not require onward referral, exceeding the 50% target agreed with commissioners, but just less than the internal stretch target of 60%. In addition, the Trust met the agreed target of 25% or less patients requiring urgent or emergency onward referral.

During the year, the value of locally commissioned services fell. This was largely due to commissioners' responses to a re-alignment of contract prices, necessary to eliminate unwarranted cross-subsidisation. The Trust aims to become a trusted local delivery partner in every local health community. Feedback from local commissioners collated during the year showed that the proportion who rated NHS Direct highly had remained at a high level, but had not made the progress that the Board had set as its aspiration.

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 2010/11, we worked with our staff to start to embed these values in the way we conduct ourselves individually and corporately, through the front line services we provide and in the ways we engage with our patients, the public, our members, our partners and each other. We will continue this work during 2011/12.

4. Great place to work

We want the Trust to be a great place to work. We know it is the quality and commitment of our staff to deliver our objectives that makes the difference for our patients.

In 2010/11, the management of sickness absence was a real priority for the Trust. As a result, overall sickness fell by 13% (from 17.1 days for whole time equivalents to 14.9 days). However, the stretch 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. Reducing sickness absence remains a priority and forms part of our workforce strategy for 2011/12.

Recruitment became less of an active issue for the Trust, as the overall numbers of front line, support or back office staff was planned to fall. This reflected the planned improvement in productivity and reduction in management costs. Overall, front line staffing was stable and the Trust has retained its experienced front line workforce. We completed the year with 89% of the Trust's front line staff having been in post for longer than 12 months. We were also able to meet 97% of our projected requirements for nurse advisors. During the year, 100 front line staff out of a total of 1,967 were recruited but left before completing 12 months service. This shows that more has to be done to ensure that our recruitment procedures really establish which applicants are likely to be suited to providing remotely delivered care.

5. Planning for the future

In 2010/11, the Trust successfully developed 42 local innovation pilots with local health communities to test out the use of remote telehealth monitoring, and the use of internet based patient decision aids. We are grateful to the East of England SHA for the support they showed in backing these innovation schemes.

6. Corporate effectiveness

The Trust set itself an internal target to reduce its management costs substantially, and a recurring reduction of 28% was actually achieved. The Trust also maintained strong control over its financial resources and completed the year in recurring balance.

The Trust completed another successful financial year with a surplus of £2,733,000 compared to £448,000 in 2009/10.

The Trust's financial plans included a £20 million savings target for the year in order to meet contract price reductions and to fund its cost pressure and investment plans. The contract reductions included £11.1 million agreed by the Trust with the East of England SHA, in addition to the £13.7 million reduction in 2009/10. In total, the Trust has agreed reductions of £24.7 million across the last two financial years, some £38.5 million in cash terms, with further significant savings agreed for 2011/12. The savings programmes associated with these reductions have improved the Trust's financial efficiency and enabled the Trust to resource its Strategic Development Programme in order to further improve the effectiveness and efficiency of our patient services.

Income from patient care activities was £145.3 million, with associated operating expenses of £145.8 million. Staffing costs were £94.5 million compared to £104.9 million in 2009/10.

Overall cash and bank balances were £20 million at year-end.

A total of £23.7 million was invested in capital assets including securing a licence in perpetuity for teleguide clinical content, IT infrastructure and systems, premises, equipment and facility improvements for staff and patients. Specific schemes included the development of our web-based health and symptom checkers, air-conditioning facilities to improve the working environment, and furniture and telephony improvements. Further investment is planned for 2011/12 to continue to improve services, infrastructure and facilities.

Alongside this challenging operational agenda, the Trust is facing a number of broader uncertainties affecting the market in which it operates. These uncertainties could give rise to significant financial and organisational risks over the next two years in particular.

The Secretary of State has confirmed that the 0845 4647 service will continue until full national roll-out of NHS 111 services, planned for April 2013, is complete. The Department of Health and NHS Operations Board have agreed to continue to commission the 0845 4647 service under a single national contract for at least 2011/12 and 2012/13. Uncertainty arises from the fact that the precise arrangements for commissioning the residual 0845 4647 service have yet to be finalised.

Similarly, the Trust will need to secure longer term contracts for future delivery of NHS 111 services to maintain its financial viability and to progress its NHS Foundation Trust application. This will depend upon the future commissioning arrangements for NHS 111 services, which have yet to be confirmed.

Clearly these factors represent major challenges and generate possible financial risk from any associated re-organisation, changes in contractual terms or change in Trust status. The Trust will continue to monitor and manage these risks on an ongoing basis, keeping its stakeholders closely informed.

Sustainability

The Trust's delivery model is entirely based around telephone and web-based support for patients, so is intrinsically well placed to deliver sustainable healthcare in the community. Remotely delivered healthcare clearly reduces the environmental impact of car, bus and train travel e.g. to GP surgeries, hospitals and other NHS facilities.

The Trust has also started to pilot home working for some of its nurse advisors. Early indications are that it increases the quality of service we can offer patients, delivering improvements in productivity and value, with the added benefit to the environment from reduced commuter journeys. There are now over 100 NHS Direct nurse advisors working permanently in their own homes, and other staff who do additional hours from home whilst continuing to work their regular hours in a contact centre.

As an organisation with sites across the whole of England, video and telephone conferencing reduces the need for travel to face-to- face meetings. The use of these methods has been encouraged and expanded across the Trust. Reducing unnecessary business travel will remain a real focus for the Trust.

In compliance with the Carbon Reduction Commitment (CRC) Energy Efficiency legislation, the Trust made an information disclosure to the Environment Agency confirming that our qualifying consumption was 4,348MWhr. This falls below the entry level threshold of 6,000MWhr for full participation in the CRC scheme.

Most of the Trust's electricity is purchased from a central supplier which guarantees that a minimum of 25% of the electricity is generated from renewable sources.

In 2010/11, aggregate utility consumption at the Trust's sites was:

- Electricity = 9,399MWhr* equivalent to 4,112 tonnes of CO_2
- Gas = 5,468MWhr* equivalent to 1,013 tonnes of CO_2
- Water = 22,809m^3*

*each measurement includes some estimation due to the dates and accuracy of meter readings, and the apportionment of cost through service charges.

Aggregate business travel in private, leased and hire cars was 1,741,195 miles in 2010/11. Our car hire policy specifies the use of small economical vehicles, and the use of public transport is encouraged. We promote the Cycle to Work scheme which has been used by 33 employees to assist with the purchase of bicycles.

During 2011/12, the Trust intends to develop and embrace a sustainable development management plan in accordance with the recommendations of the NHS Sustainable Business Unit.

Our future plans

Our market assessments and our engagement with stakeholders, members and staff, have confirmed that the vision and strategic objectives we set in 2010/11 remain relevant for 2011/12.

The Trust has written to the Secretary of State for Health to confirm our intention to become an NHS Foundation Trust from April 2013. This follows the government's confirmation that all existing NHS Trusts must either be merged into other organisations or become NHS Foundation Trusts by April 2014 at the latest. Achieving NHS Foundation Trust status will provide us with increased freedoms, opportunities and benefits, including a strengthened membership, a governor structure and increased ability to access and use our capital.

In 2011/12, our service development plans are to:

- focus on delivering the national specification for the new NHS 111 urgent care telephone service, aiming to be a major provider
- 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, patient choice and national resilience
- continue to provide the 0845 4647 telephone helpline 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, such as call handling and nurse assessment for GP and dental out of hours services, The Appointments Line for Choose and Book, telehealth and telecare.

These service developments will be underpinned by an organisational development programme focussing on four key areas:

- operational delivery model - to design, build and deliver an organisation that operates an NHS 111 service which meets the national specification, offers complementary services, and is competitive on price and quality
- marketing and service development - to build our capability, knowledge and experience to ensure we provide commissioners with the support and services they need
- corporate development - to design, build and deliver the appropriate supporting functions and undertake the programme of work required to be successful in an application for NHS Foundation Trust status
- existing services - to ensure we continue to focus on consistently meeting our clinical, corporate and financial standards on all existing contracts, whilst improving efficiencies and supporting the transition.

Our staff

In 2010/11, the NHS Direct National Health Service Trust had on average 3,157 substantive employees (2,329 whole time equivalents). A high proportion of part-time staff gives flexibility to both the Trust and to staff, and means we can offer employment opportunities across a broad demographic range.

98% of the Trust's substantive staff are contracted under the NHS Terms and Conditions of Service, with the remaining 2% made up of Board members and medical consultants.

40% of our staff are registered with the Nursing & Midwifery Council (NMC), 124 employees are registered with the General Dental Council (GDC) and 5 employees are registered with the General Medical Council (GMC).

Developments in 2010/11

In 2010/11, there were significant changes to staffing structures across the Trust, including a streamlining of divisional operational management and related support functions. New line management arrangements were introduced to improve our ability to manage staff across a large geographical area with multiple sites, to achieve cost efficiencies and to reflect greater public demand for online services, and the resulting reduction in call volumes. The number of managers has been reduced as a result, but this was largely achieved through the natural turnover of staff. The process has resulted in a range of development and progression opportunities for staff in new posts and fresh challenges for those in existing roles.

In summer 2010, the Trust launched a new staff rostering system to give front line staff greater certainty about their shift patterns. It has addressed some of the work/life balance issues experienced under previous rostering systems, whilst ensuring we continue to meet patients' needs 24 hours a day, 7 days a week. Further work is required on the new system, but we anticipate it will lead to improvements in the service we are able to offer patients, and in staff sickness and attrition rates.

The Trust also joined the 'Pennies from Heaven' charity scheme whereby staff can opt to round down their monthly salary to the nearest pound, giving up to £0.99 per month to the Trust's chosen charity ' Help for Heroes'.

Equality and diversity

As a public body, the Trust has a statutory duty to actively promote equality in relation to race, disability and gender. We have equality schemes in place to cover all these areas and preparations are underway to ensure compliance with the additional statutory duties which came into force in April 2011 under the Equality Act 2010.

In 2010/11, we successfully retained the Job Centre Plus's 'two ticks' disability symbol signifying excellent practice in employment for people with disabilities and that we guarantee an interview for any disabled applicant who meets the essential criteria for the job.

As of the end of March 2011, 102 members of staff have a disability, which equates to 3.5% of the total staff employed (2,881). This is a small increase on last year's figure of 3.4%.

Staff engagement, consultation and communication

The Trust has a formal trade union recognition agreement with the Royal College of Nursing, the Royal College of Midwives, Unison and Unite, and effective arrangements for consultation and negotiation with staff side representatives. We hold a monthly National Joint Partnership Forum which is informed by local and divisional meetings. There is excellent engagement with the Royal College of Nursing and Unison's designated full-time officers, who have been closely involved in the changes to staff structures at the Trust during the last year.

We are committed to ensuring that all staff are kept informed about Trust performance and developments, and feel supported and listened to. We communicate with staff in a range of ways including face-to-face meetings, teleconferences, videoconferences, web and videocasts, email, blogs, a weekly electronic newsletter and through our staff intranet.

Staff survey

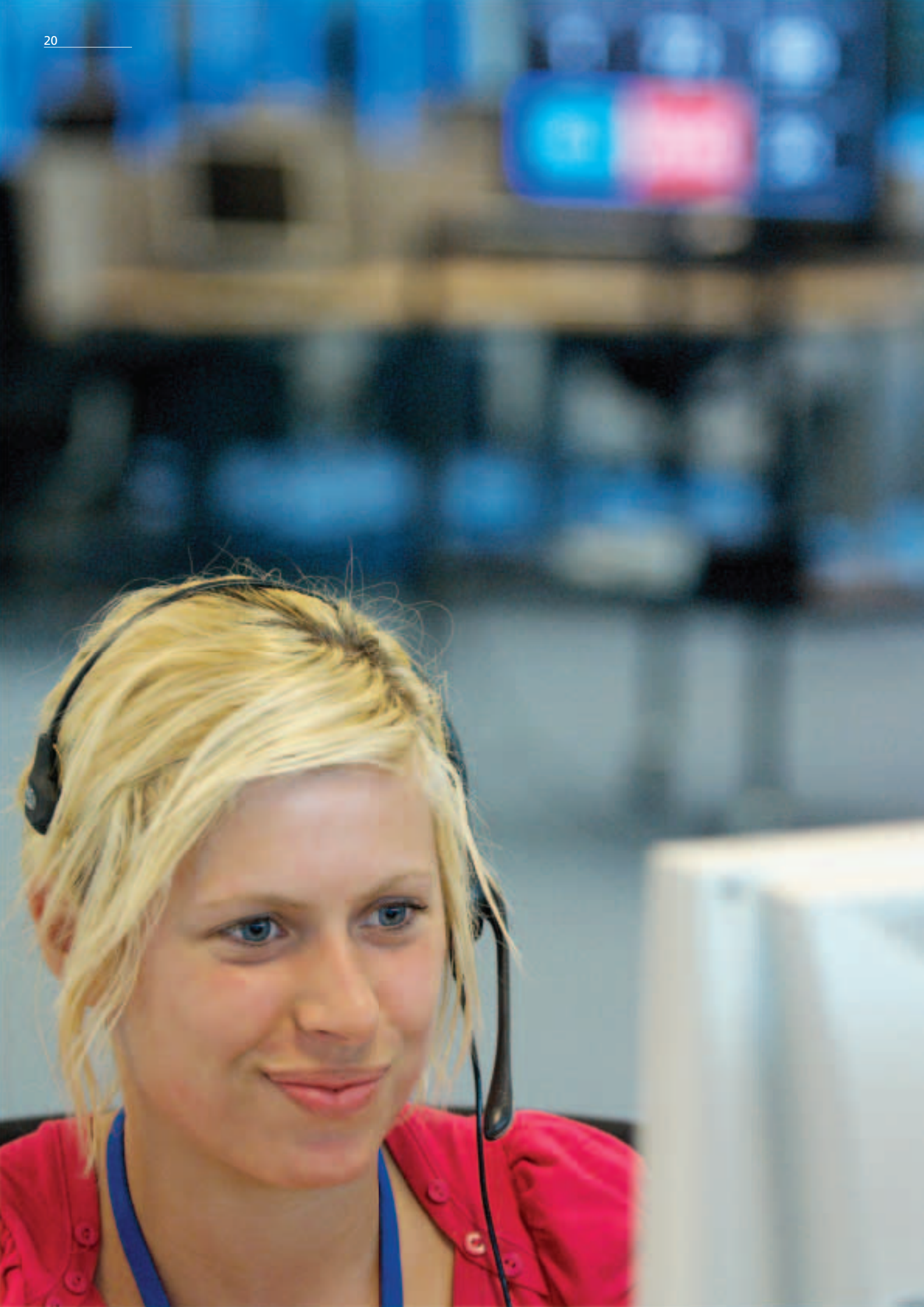
The Trust participated in the NHS staff survey for the first time in 2010. Over half of our employees (56%) took part in the survey, of which 58% were clinically qualified. A large majority felt that their role makes a difference to patients and that they are well trained and competent in their roles. However, survey respondents did not feel they were involved in important decisions made by the Trust or that they were well supported by colleagues. Staff also said they felt stressed at work.

The findings of the staff survey have contributed to the agreement to launch the 'Effective Organisation' programme which will address areas of staff health and well being, recognition, communication, involvement and engagement in 2011/12.

Support for staff

In addition to the NHS national terms and conditions of employment, the Trust continues to offer staff a range of benefits:

- eye care vouchers
- child care vouchers
- a cycle-to-work scheme
- a season ticket loan scheme
- access to a 24/7 employee support line and counselling service.



Health and safety

Generally, the Trust's health and safety record is good, but the NHS staff survey revealed high levels of work-related stress amongst front line staff in our contact centres. During 2011/12, the Trust is launching the 'Effective Organisation' programme, of which health and well being is an important element.

The Chief Operating Officer is the Trust's executive lead for health and safety. Our national health and safety committee provides strategic advice on health and safety issues and is responsible for implementing legislation, commissioning annual audits, developing new policies and quality assuring health and safety training. The national committee is supported by three divisional committees which oversee health and safety at a local level.

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, providing assurance that all standards of health and safety legislation are adhered to and continually monitored.

We are committed to providing our staff with a safe, secure and healthy working environment. Staff receive mandatory health and safety training and our health and safety staff side representatives carry out regular assessments at a local level to ensure we adhere to health and safety legislation.

The Trust's occupational health services are delivered by an external provider.

Counter fraud and corruption

The Trust has a comprehensive counter fraud policy which has been produced in line with NHS Protect guidelines. It is available to staff via the Trust's intranet. The Trust's local counter fraud specialist is responsible for raising staff awareness of the Counter Fraud service and ensuring they know how to report concerns.

In 2010/11, this was achieved through staff inductions, team meetings, via the electronic staff newsletter, leaflets and posters at sites, and by a counter fraud roadshow. The results of the 2010 staff survey showed that 89% of respondents demonstrated that they understood the Trust's procedures for dealing with fraud.

Our stakeholders

In February 2011, the Trust commissioned Jigsaw Research to carry out the third annual research study into regional stakeholders' opinions of the Trust and its services. Telephone interviews were conducted with senior representatives from over 200 organisations including SHAs, PCTs, mental health trusts and ambulance trusts. For the first time, GP pathfinder consortia, local authorities and community service providers formed part of the research sample this year.

The improvement in our overall performance achieved in 2010 was largely maintained in 2011 with 64% of stakeholders rating the Trust and its services as good or better (66% in 2010). 53% of respondents rated the 0845 4647 telephone service as good or better in 2011. Whilst this was slightly down on last year (56% in 2010), 61% rated our online services as good or better in 2011, an increase of 5% on 2010 figures.

This year, the research study also asked stakeholders for their views on our proposed future direction. Respondents were very supportive of our future strategy, and felt that providing a range of telephone and web-based services for patients with long-term conditions was particularly important.

In addition to this annual research study, the Trust communicates with its stakeholders in a wide range of ways including face-to-face meetings, conferences, events and contact centre visits, a monthly electronic news bulletin, access to online PCT performance reports, web streaming of Trust Board meetings and social networking via Facebook and Twitter.

Our patients

The overwhelming majority of our patients say they are very satisfied with the service they receive from us. In 2010/11, we surveyed around 9,000 patients who had used our 0845 4647 telephone service and 93% were satisfied with the way their call was handled.

Our Net Promoter Score, which is based on how likely people would be to recommend us to their family or friends, was 77% which is considered excellent. 76% of patients scored us 10 out of 10 for this measure.

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 2010/11 we received 3,666 items of feedback, which included 274 complaints from patients and service users. This represents only 0.45 complaints for every 10,000 calls handled compared to 797 compliments representing 0.91 for every 10,000 calls we received. 147 of the complaints were upheld where we agreed that they were founded.

During the year, three complaints were referred to the Parliamentary and Health Service Ombudsman for review. The main areas of concern expressed by complainants related to the length of time they had to wait for a nurse call back and to the advice and information they were given during their call. In response to this, we have implemented a performance improvement plan to reduce the length of time callers have to wait for a nurse call back during our busiest periods. Issues relating to the quality of advice and information we provide are always thoroughly investigated. Our information systems are improved and staff are given relevant training and support where appropriate.

Patient and public involvement

In 2010/11, 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
- consultation on the design and development of our online health and symptom checkers and our online patient decision aids
- a review of calls about dental problems to gain insight into patients' experiences
- engagement with patients to improve our services for those with long-term conditions
- consultation with our public members on the Trust's proposed future direction, which generated 955 responses
- involvement of public members in a range of groups and committees, including research and clinical audit.

Our 18,000 public members also receive a quarterly newsletter, either by post or email, updating them on news and developments at the Trust, as well as a copy of our annual review, which provides a summary of the annual report and accounts.

Public information activity

In 2010/11, the Trust worked with a number PCTs across the country, to provide public information aimed at raising awareness and usage of our telephone and web-based services amongst those patient groups which we felt would most benefit from them.

We also carried out a range of national activities to raise awareness of our multi-channel services including:

- promotional leaflets and cards distributed to over 5,000 GP surgeries, 4,000 pharmacies and in 150,000 'Bounty' packs given to new mothers by their midwives
- over 2 million pharmacy bags carrying the 0845 4647 number were distributed through 1,700 pharmacies
- display of posters in over 2,000 working men's clubs
- partnership working with organisations including Citizens Advice Bureau, Job Centre Plus, WRVS, YWCA, Tourist Information Centres, Travelodge, Premier Inn, Days Inn, Welcome Break and Road Chef Motorway services to distribute information about our 0845 4647 telephone and online services.

In addition, nine regional outreach champions, seconded for one day a week away from their usual front line roles, increased awareness and usage of our services by giving talks to local groups, organising events and distributing promotional materials within their local health community.

Public Interest and Governance

Non-Executive Directors' biographies

1. Joanne Shaw, Chair

Joanne has chaired the Board of the NHS Direct National Health Service Trust since August 2008. She is Chairman of Datapharm Communications, a leading provider of digital medicines information to the NHS, the pharmaceutical industry and the general public. She was recently appointed a Director of the British Board of Film Classification.

Until August 2008, Joanne was a Trustee for the Long-term Conditions Alliance, and chaired the not-for-profit company behind the 'Ask About Medicines' campaign. Prior to that, she served on the management board of the Audit Commission, was a Director of Medicines Partnership, a Department of Health initiative to improve the use of medicines in the NHS, and worked internationally with the Boston Consulting Group.

Joanne has a strong interest in the use of new communication channels for health and medicines. She advocates partnership between patients and health professionals and supporting people to make better informed choices about their health.

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 not-for-profit and charitable organisations. He is currently a County Councillor in West Sussex and Cabinet Member for Adults' Services. He is a Fellow of the Faculty of Health at the University of Brighton. He also has number of appointments in the professional regulatory sector, and is an independent healthcare consultant and business advisor to the independent health sector.

3. Luisa Dillner

Dr Luisa Dillner 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 for doctors and consumers. 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.

4. Steve Duncan

Steve Duncan joined the Board on 1 October 2010. A pharmacist by training, he has a track record of leading transformation and driving performance in complex multi-national, multi-site environments. Steve 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 will remain an advisor within Alliance Boots for the next two years.

5. Tim Heymann

Tim Heymann joined the Board on 1 February 2010. He is a consultant physician at Kingston Hospital, specialising in gastroenterology and liver disease. He was responsible for developing Kingston Case Notes, an award-winning electronic patient record pilot and has been clinical lead for major projects which helped redefine the way services are delivered. Tim also works at Imperial College Business School where he 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. Tim has previously been a consultant for McKinsey and Booz Allen.

6. Sue Hunt

Sue joined the Board on 1 April 2007. Sue currently holds an Appointed Trustee position at CfBT Education Trust. She is a chartered accountant who spent 18 years with global accountancy and business advisory firm KPMG, working with a range of clients from the public and private sectors, both in the UK and internationally. Sue was instrumental in establishing a multi-disciplinary healthcare group at KPMG and advised trusts on all aspects of their NHS Foundation Trust applications, either directly or on behalf of the Department of Health NHS Foundation Trust Implementation Unit.

7. 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.

8. Tim Walton

Tim joined the Board on 1 April 2007. He is an independent consultant and Non-Executive Director on the Department for Business, Innovation and Skills' operating committee. He was previously Chief Information Officer for CLM, the Olympic Delivery Authority delivery partner for London 2012. His career has included executive and non-executive roles spanning operational, commercial, financial, e-business and IT assignments in civil and military aerospace, construction and design engineering. Tim is a Fellow of the British Computer Society and a Chartered Engineer.


1.


5.


2.


6.


3.


7.


4.


8.

Executive Directors' biographies

1. Nick Chapman, Chief Executive

Nick has been the Chief Executive of the NHS Direct National Health Service Trust since 1 April 2009. Prior to this, he was on secondment from the NHS to the Department of Health working on reducing cancer waits, and on the implementation of patient choice and booking. He was the Department of Health Director responsible for the 18 week programme. Nick 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 Somerset.

2. Alan Bentall, Chief Information Officer**

Alan was appointed Chief Information Officer (CIO) on 16 April 2010. Prior to this, 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 is a Fellow of the British Computer Society and a Chartered IT professional. He has held leading roles on assignments in many of the major central government departments and a selection of private businesses. 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.

3. Brian Gaffney, Director of Public Health/Acting Medical Director

Brian was appointed Director of Public Health/Acting Medical Director on 1 March 2010 having previously been National Public Health Advisor to the Trust. He has worked in public health and general practice in the NHS since 1988 and was appointed a consultant in public health medicine in 1993. He was previously Chief Executive of the Health Promotion Agency in Northern Ireland and was Director of the World Health Organisation collaborating centre at the agency, leading its contribution to a number of European projects and programmes. Brian works part-time for the Trust so that he can continue to work in General Practice in Northern Ireland.

4. Tricia 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 clinical safety, quality and effectiveness of care delivered by the service. She joined the Trust as a nurse advisor in September 1999 and has since held senior positions at a local and national level within the Trust. Tricia has 27 years of nursing experience covering a variety of disciplines including neuro intensive care, general surgery and remote care delivery.

5. Ronnette Lucraft, Chief Operating Officer

Ronnette joined the Board on 11 April 2007 as Commercial Director before becoming Chief Operating Officer in January 2010. She is responsible for the co-ordination of the Trust's internal management and systems to ensure excellent standards of operational performance and resilience. She pioneered the development of the Trust's digital channels and was also Operations Director of the National Pandemic Flu Service during the 2009 swine flu pandemic. Ronnette has held senior management positions within the communications and new media industries at BT, Telewest and ntl (now Virgin Media). She spent two years with Living Health, which led the way in providing television-based public healthcare services, worked with the NHS University and as an NHS LIFT Chief Executive.

6. Ruth Rankine, Director of Strategy & Planning**

Ruth joined the Trust on 14 October 2007, on secondment from the Department of Health, and was formally appointed to the post in June 2010. She was previously Principal Private Secretary to the NHS Chief Executive and the Permanent Secretary at the Department of Health. Before that, Ruth was Director of Emergency Care for Leeds Teaching Hospitals NHS Trust & Leeds PCTs, Programme Director for the GP contract negotiations whilst working for the NHS Confederation and Programme Director for Primary Care Access and NHS Walk-in Centres at the Department of Health.

7. Roger Rawlinson, Human Resources 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.

8. Trevor Smith, Finance Director

Trevor joined the Trust as Finance Director in January 2009. Prior to that he was Finance Director at Barking, Havering and Redbridge NHS Trust where he led their financial recovery plan. Trevor joined the NHS from local government in 1996 and has also held finance director roles at Basildon and Thurrock University Hospitals NHS Foundation Trust 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.

*Helen Young was Clinical Director/Chief Nurse until December 2010.

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


1.


5.


2.


6.


3.


7.


4.


8.

Directors' declaration of interest during 2010/11

Name	Interest declared
Alan Bentall	None declared
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 and Cabinet Member for Adult Services
Nick Chapman	Spouse – self-employed consultant who does work from time to time with and for NHS bodies.
Luisa Dillner	British Medical Journal Publishing Group Limited - Head of New Product Development
Steve Duncan	Sole director of Aston West Lands Ltd - company providing consultancy in health care Advisor to Alliance Boots
Brian Gaffney	Sessional GP in Northern Ireland
Tricia Hamilton	None declared
Tim Heymann	Medicine Today Limited – directorship and shareholder National Association of Colitis and Crohn's Disease (NACC) – Medical Advisor Imperial College Business School – reader in health management Kingston Hospital NHS Trust – consultant physician
Sue Hunt	CfBT Education Trust – Appointed Trustee
Trevor Jones	Womens' Royal Voluntary Service – Trustee WellChild – Trustee National Patient Safety Agency – Non-Executive Director
Ronnette Lucraft	None declared
Ruth Rankine	Carers First (charitable organisation), Tonbridge - Trustee
Roger Rawlinson	None declared
Joanne Shaw	The Money Advice Service - Director Consumer Financial Education Body (CFEB) – Non-Executive 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 Open Public Services Network Ltd - Director
Trevor Smith	None declared
Tim Walton	Accent Group – Non-Executive Director Timothy Walton and Associates Limited – Director Highways Agency – Non-Executive Director

Information governance

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

Summary of protected personal data related incidents formally reported to the Information Commissioner's office in 2010/11				
Statement on information risk	During 2010/11 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 2009/10 are still effective and to identify and assess any potential new information risks. During 201 1/12 we will continue to appoint and train our information asset owners/ administrators for their role.			
Date of incident (month)	Nature of incident	Nature of data involved	Number of people potentially affected	Notification steps
July 2010	Unauthorised disclosure	Personal Data • name • address • telephone number.	59	Individuals notified by post
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: • appointing and training additional information asset owners/administrators • continue the implementation of our rolling information risk assessment and management strategy plan and programme •conducting privacy impact assessments on relevant projects.			

Summary of other protected personal data related incidents in 2010/11

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

Category	Nature of incident	Total
I	Loss of inadequately protected electronic equipment, devices or paper documents from secured NHS premises	2
II	Loss of inadequately protected electronic equipment, devices or paper documents from outside secured NHS premises	1
III	Insecure disposal of inadequately protected electronic equipment, devices or paper documents	0
IV	Unauthorised disclosure	2
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 v8 in March 2011. 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 2011/12.

Better Payments Practice Code

	2010/11		2009/10	
	Number	£000	Number	£000
Total non-NHS trade invoices paid in the year	24,434	64,720	30,741	95,535
Total non-NHS trade invoices paid within target	23,940	62,225	28,615	85,068
Percentage of non-NHS trade invoices paid within target	98%	96%	93%	89%
Total NHS trade invoices paid in the year	719	4,137	869	4,516
Total NHS trade invoices paid within target	674	3,829	797	3,649
Percentage of NHS trade invoices paid within target	94%	93%	92%	81%

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

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 £90,000. 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.

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 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 2010/11 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 2010/11, 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' contracts and notice periods

Name	Role	Start	Notice	Nature	Continuous Service Date
Nick Chapman	Chief Executive	01/04/09	6 months	Permanent	25/11/79
Alan Bentall	Chief Information Officer	16/04/10	3 Months	Permanent	16/04/10
Brian Gaffney	Director of Public Health/Acting Medical Director	23/11/09	3 months	Permanent	23/11/09
Patricia Hamilton	Clinical Director/ Chief Nurse (Interim from 11/01/11)	01/09/99	3 Months	Interim	01/10/81
Ronnette Lucraft	Chief Operating Officer	11/04/07	3 Months	Permanent	11/04/07
Ruth Rankine	Director of Strategy & Planning	01/06/10	3 Months	Permanent	01/06/10
Roger Rawlinson	HR Director	01/09/07	3 Months	Permanent	01/09/03
Trevor Smith	Finance Director	02/01/09	3 Months	Permanent	22/04/96
Helen Young	Clinical Director/ Chief Nurse (away on secondment from 11/01/11)	01/12/04	6 Months	Permanent	01/09/94

Salaries and allowances

Name & title	2010/11 Salary (bands of £5,000) £000	Salary includes PRP awarded £000	Other remuneration (bands of £5,000) £000	Benefits in kind (rounded to nearest £00) £00	2009/10 Salary (bands of £5,000) £000	Other remuneration (bands of £5,000) £000	Benefits in in kind (rounded to nearest £00) £00
Nick Chapman Chief Executive	150–155	0	0	0	150-155	0	0
Alan Bentall Chief Information Officer from 16/04/10	115–120	0–5	0	0	0	0	0
Brian Gaffney Director of Public Health/Acting Medical Director	20–25	0	0	0	0	0	0
Patricia Hamilton Clinical Director/Chief Nurse from 01/01/11	20–25	0	0	8	0	0	0
Ronnette Lucraft Chief Operating officer	125–130	0–5	0	0	115–120	0	4
Ruth Rankine Director of Strategy & Planning from 01/06/10	90–95	0–5	0	0	0	0	0
Roger Rawlinson HR Director	100–105	0–5	0	3	100–105	0	5
Trevor Smith Finance Director	135–140	0–5	0	5	135–140	0	3
Helen Young Clinical Director/Chief Nurse to 31/12/10	80–85	0	0	7	110–115	0	0
Joanne Shaw (Non-Executive Chair)	35–40	0	0	0	35–40	0	0
Peter Catchpole (Non-Executive)	10–15	0	0	1	10–15	0	0
Luisa Dillner (Non-Executive)	5–10	0	0	0	0–5	0	0
Steve Duncan (Non-Executive) appointed 01/10/10	5–10	0	0	0	0	0	0
Tim Heyman (Non-Executive)	0	0	0	0	0–5	0	0
Sue Hunt (Non-Executive)	5–10	0	0	0	5–10	0	0
Trevor Jones (Non-Executive)	5–10	0	0	0	5–10	0	1
Tim Walton (Non-Executive)	5–10	0	0	0	5–10	0	0

Nick Chapman was awarded a performance related bonus of £3,420, but has declined it. Therefore it is not included in the salary figures above. Ronnette Lucraft was appointed Chief Operating Officer on 17 March 2010 and therefore a full year's salary in this position is reflected for 2010/11.

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	2010/11	2009/10
Alan Bentall, as Interim Chief Information Officer	£10–15K	£280-285K
Ruth Rankine, as Interim Director of Strategy and Planning	£20–25K	£110-115K
Tim Heyman, Non-Executive	£5–10K	0

The payment to the third party organisation for Tim Heyman is to reinburse 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	Real increase in pension lump sum at age 60 31 March 2011 (bands of £5,000) £000	Lump sum at age 60 related to accrued pension at 31 March 2011 (bands of £5,000) £000	Cash Equivalent Transfer Value at 31 March 2011 £000	Cash Equivalent Transfer Value at 31 March 2010 £000	Cash increase in Cash Equivalent Transfer Value £000	Employer's contribution to stakeholder pension £000
Nick Chapman Chief Executive	0-(2.5)	(2.5)-(5)	55-60	175-180	1,108	1,181	-136	0
Alan Bentall Chief Information Officer	0-2.5	0	0-5	0	30	0	28	0
Brian Gaffney Director of Public Health/Acting Medical Director	0	0	0	0	0	0	0	0
Patricia Hamilton Clinical Director/Chief Nurse	0–2.5	0–2.5	20–25	70-75	367	375	-7	0
Ronnette Lucraft Chief Operating Officer	0–2.5	5–7.5	5–10	15-20	78	62	12	0
Ruth Rankine Director of Strategy & Planning	0–2.5	0	0–5	0	12	0	7	0
Roger Rawlinson HR Director	0–2.5	0–2.5	5–10	25-30	188	181	-2	0
Trevor Smith Finance Director	0–2.5	2.5–5	35–40	115-120	511	560	-79	0
Helen Young Clinical Director/Chief Nurse	0-(2.5)	0-(2.5)	30–35	95-100	373	429	-60	0

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

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.

Reporting of other compensation schemes - exit packages

For 2010/11, HM Treasury requires the disclosure of exit package information in the format set out below.

a	b	c	d	e
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 (total cost)	Number of departures included in (b) and (c) where special payments have been made (special payment element (totalled))
<20,001	9	0	9 (110,380)	0
£20,001 - £40,000	3	0	3 (107,139)	0
£40,001 - 100,000	12	1	13 (858,146)	0
£100,001 - £150,000	5	1	6 (690,205)	0
£150,001 - £200,000	1	0	1 (173,270)	0
>200,000	1	0	1 (231,023)	0
Total	31	2	33 (2,170,163)	0

Nick Chapman
Chief Executive

27 June 2011

NHS Direct National Health Service Trust Accounts 2010/11

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

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 judgements and estimates on a reasonable basis
- state whether applicable accounting standards have been followed, and disclose and explain any material departures in the financial statements
- prepare the financial statements on a going concern basis, unless it is inappropriate to presume that NHS Direct 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.

Statement on internal control

1. Scope of responsibility

The Board of NHS Direct National Health Service Trust is accountable for internal control. As Accountable Officer, and Chief Executive of this Board, I have responsibility for maintaining a sound system of internal control that supports the achievement of the organisation's policies, aims and objectives. I also have responsibility for safeguarding the public funds and the organisation's assets for which I am personally responsible as set out in the Accountable Officer Memorandum.

The Trust has a range of mechanisms in place to facilitate effective working with key partners, in particular the East of England Strategic Health Authority, who have been responsible for ensuring that the Trust procedures operate effectively, efficiently and in the interest of the public and the NHS. This requirement is addressed at regular performance review meetings, which cover all aspects of the organisation's current and future business activities. I also provide regular service performance and financial reports to every meeting of the Trust Board, covering patient experience, clinical safety and staffing matters. As Chief Executive, I take responsibility for risk management at Board level.

2. The purpose of the system of internal control

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

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

The system of internal control has been in place in the NHS Direct National Health Service Trust for the year ended 31 March 2011 and up to the date of approval of the annual report and accounts.

3. Capacity to handle risk

The Trust is committed to the effective management of risk throughout the organisation to:

- ensure that risk to the quality and delivery of patient care is minimised
- protect the services, reputation and finances of the organisation
- create a culture where staff acknowledge risk as the responsibility of everyone, but which also supports the provision of realistic resources, training and information
- ensure the organisation meets its statutory requirements.

Alongside myself, the Board has ultimate management responsibility for the management of risk within the Trust. The Board monitors the Trust's approach to the management of risk and its effectiveness which includes the approval of the risk management strategy, policy and risk tolerance criteria for strategic risk. The Board is responsible for overseeing the strategic risks and ensuring these are effectively managed.

The Audit Committee is responsible for providing assurance to the Board on the adequacy of all risk and control assurance disclosure statements. It also reviews the establishment and maintenance of an effective risk management system across the whole of the organisation's activities that support the achievement of the organisation's objectives.

All Executive Directors and managers are responsible for ensuring that the risk management policy is implemented across the organisation and the need for the effective management of risk is embedded within the culture of the organisation. Specifically the Clinical Director/Chief Nurse leads the management of clinical risk within the Trust and the Chief Operating Officer leads the management of operational risk.

Risk management leads have been identified within the organisation. These leads meet together as a forum with the remit of: ensuring risk management is seen as an integral part of the day-to-day running of the organisation; sharing best practice; and providing support and training to the individual directorates.

Staff receive training in the overview of risk management at corporate induction. Further training is provided dependent on staff responsibilities. Line managers receive risk assessment training as part of the health and safety training programme. An e-learning package is currently being developed for this purpose. Members of the Board also recently received risk management training in the form of a Board seminar.

4. The risk and control framework

In the latter part of 2010/11, the organisation reviewed its risk management process and risk management policy following an internal audit recommendation that the previous combined Corporate Risk and Assurance Register should be separated into two reported documents, namely, the Corporate Risk Register and the Board Assurance Framework (BAF). This recommendation was implemented in January 2011. The Corporate Risk Register primarily relates to operational risks and the BAF addresses those risks that affect the organisation's strategic objectives. However, these two documents are closely scrutinised and aligned as some risks on the Corporate Risk Register may be linked to strategic objectives.

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

To ensure that risk is embedded in the activity of the organisation, risks to the delivery of objectives in the business plan have been identified, assessed and controlled as part of the risk management process.

Risk registers are held at departmental, directorate and corporate levels. There is a clear process for risk escalation where it is deemed appropriate that risks should be reflected within higher level risk registers.

The Board Assurance Framework (BAF) identifies the assurance available to the Board in relation to the achievement of the Trust's key priorities and objectives, and the effectiveness of the operation of key control processes. The Board is appraised on a regular basis of the gaps in control and assurance, and the action being taken to address such gaps. The types of gaps in control include training, policies, procedures and systems, while the gaps in assurance include policy direction, monitoring and reporting arrangements. Gaps in control and assurance were particularly identified in relation to the increase in demand for our services in December 2010 and our capacity to meet this. This was due to the unexpected prolonged weather severity. The organisation has since strengthened its forecasting approach and has agreed contingency plans to meet increased demand in the event of such adverse seasonal variations.

During 2010/11 the Senior Information Risk Owner (SIRO) and the Head of Information Security and Risk Management continued to champion information risk throughout the organisation at an operational level, through the implementation of the Information Risk Assessment and Management Strategy Plan and Programme. The SIRO and Head of Information Security and 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 2009/10 are still effective and to identify and assess any potential new information risks. During 2011/12 we will continue to appoint and train our Information Asset Owners / Administrators for their role. We have also initiated an improvement plan for our asset management procedures.

There are number of changes on the horizon for the NHS Direct National Health Service Trust and the wider NHS environment. The most significant will see the Trust converting from being the single national provider of the 0845 4647 service, commissioned on behalf of the NHS by the East of England Strategic Health Authority through a single contract, generating over 80% of its total income, to a position where it will be one of a number of providers competing to provide the new NHS 111 service, procured and contracted by a number of more local commissioners. The market for NHS 111 is at a very early stage of development, with significant uncertainties of how it will evolve, however, a number of organisations are already poised to enter the market in the areas where we are planning to develop our services. The NHS 111 service specification will require a different operational delivery model to that currently in place and we will need to move to this new model whilst continuing to deliver the 0845 4647 service. Given the change in market conditions, the Trust is currently undertaking a comprehensive risk analysis with corresponding risk mitigation plans.

Sickness absence levels remain unacceptably high amongst front line staff, despite some significant progress in the first half of 2010/11. Following an audit on sickness absence reporting which offered only "adequate assurance", a series of measures have been introduced to improve sickness absence management and recording, and a series of activities have been introduced to address the causes of sickness absence, specifically work related stress, which is the most common reason for long-term sickness absence in the organisation.

For risks relating to major system failures, the Trust has business continuity operating procedures for the following systems. ICT, HR, finance, risk management, and operations. Business continuity plans are currently being drawn up for other potential risks related to estates, major site outages and other external influences e.g. weather and fuel shortages.

We engage with patients, carers and the public to manage clinical risk at three significant levels: firstly, we engage at a strategic level annually with our public members to help set the business plan priorities for the coming year; secondly, we work with patients, carers and expert patient groups in the development of new services and improvement of existing services through a range of engagement mechanisms; and thirdly, we provide our services in a way that ensures that individual service users and their carers are actively engaged in the decision-making process regarding their care and the information and advice provided to them.

Control measures are in place to ensure that all the organisation's obligations under equality, diversity and human rights legislation are complied with. Within the organisation, all major policies, strategies, service development and working practices are subject to an Equality Impact Assessment (EIA) and a declaration made that there is no disadvantage on the grounds of equality.

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

In 2011/12, the Trust proposes to undertake a climate change risk assessment and develop an adaptation plan, to support its emergency preparedness and civil contingency requirements, as based on the UK Climate Projections 2009 (UKCP09), to ensure that this organisation's obligations under the Climate Change Act are met. This action will fall within the wider remit of the Trust's requirement

to develop a Sustainable Development Management Action Plan (SDMP). The SDMP will be developed during 2011/12.

The Trust is fully compliant with Care Quality Commission (CQC) essential standards of quality and safety.

5. Review of effectiveness

As Accountable Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review is informed in a number of ways. The Head of Internal Audit provides me with an opinion on the overall arrangements for gaining assurance through the assurance framework and on the controls reviewed as part of Internal Audit's work.

The Head of Internal Audit's opinion for 2010/11 was: "significant assurance can be given that there is a generally sound system of internal control, designed to meet the organisation's objectives, and that controls are generally being applied consistently. However, some weakness in the design and/or inconsistent application of controls put the achievement of particular objectives at risk."

In November 2010, Internal Audit carried out two interim reviews relating to our assurance framework and risk management systems and gave limited assurance for both reviews. Internal Audit has since revised its opinion for both reviews to substantial assurance based upon evidence that the Trust has implemented the majority of the recommendations which address the weaknesses and gaps in controls and this was further evidenced in the BAF dated February 2011.

Internal Audit's review has therefore concluded that for 2010/11, the Trust's assurance framework "provides reasonable assurance that there is an effective system of internal control to manage the principal risks identified by the organisation."

Executive managers within the organisation who have responsibility for the development and maintenance of the system of internal control provide me with assurance. The assurance framework itself provides me with evidence that the effectiveness of controls that manage the risks to the organisation to achieve its principal objectives have been reviewed. My review is also informed by our external auditors, the National Audit Office, internal auditors, Parkhill, and our compliance with CQC essential standards of quality and safety.

The Executive Management Board (EMB) is the key operating management board. Part of EMB's responsibility is to consider and review performance and risk management.

Internal Audit carried out and reported on ten internal audit systems and computer audit reviews during 2010/11. An audit was undertaken to review the controls and procedures in place for the management of mobile devices/equipment and the monitoring of their usage to ensure the contract provided value for money. This was triggered by a local counter fraud specialist (LCFS) investigation into a high mobile invoice charge. The audit opinion was of limited assurance. Since this review the Trust has strengthened its controls and processes and further remedial action is being undertaken.

Excluding the above audits, substantial or adequate assurance opinions were given for the other reviews.

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

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

The Board

The Board reviews the assurance framework and receives regular information from the Audit and Clinical Governance committees, as well as receiving regular monitoring information on the Trust's balanced scorecard in respect of incidents and complaint trends.

The Audit Committee (sub-committee of the Board)

The Audit Committee reviews the adequacy of the underlying assurance processes which indicate the degree of achievement of corporate objectives, the effectiveness of the management of principal risks and the appropriateness of the above disclosure statements. The internal audit plan enables the Board to be reassured that key internal controls and other matters relating to risk are regularly reviewed. It receives internal and external audit reports, and progress reports on risk-related issues, while also providing to the Board an overview of the effectiveness of the assurance arrangements based upon the work of the Clinical Governance Committee.

The Clinical Governance Committee (sub-committee of the Board)

The Clinical Governance Committee is responsible for the oversight of clinical governance within Trust. It provides assurance to the Board that appropriate structures and systems are working effectively to support and deliver clinical governance.

The Finance Committee (sub-committee of the Board)

The Finance Committee is responsible for providing additional assurance to the Board on financial matters and considers investment for recommendation to the Board. It provides effective governance and controls over investment decisions and benefits realisation and oversees financial planning, management, performance and reporting.

Information Governance Steering Group

The Information Governance Steering Group provides a clear strategic steer on information governance to the Executive Management Board, 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 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.

Summary

In 2010/11, the Trust has made significant progress in the following areas of internal control:

- the development of an e-learning package on risk assessment training for line managers to receive as part of the health and safety training programme
- a Board seminar on risk management training for members of the Board
- separation of the Corporate Risk and Assurance Register into the Corporate Risk Register and the Board Assurance Framework following an internal audit of the Trust's risk management process and risk management policy
- strengthening the Trust's forecasting approach and agreeing contingency plans to meet increased demand in the event of adverse seasonal variations following the unexpected prolonged bad weather in December 2010.
- refresher training for the Senior Information Risk Owner and Head of Information Security and Risk Management to ensure their knowledge and skills are kept up to date and in line with current requirements.
- a personal data flow mapping and risk assessment exercise to evaluate if the controls identified during 2009/10 are still effective and to identify and assess any potential new information risks
- a comprehensive risk analysis of the Trust's new commissioning environment with corresponding risk mitigation plans
- an internal audit rating of 'substantial' assurance' following reviews of the Trust's assurance framework and risk management systems and ratings of either 'substantial' or 'adequate' assurance for other reviews on internal audit systems and computer audit reviews.

My review confirms that the NHS Direct National Health Service Trust has a generally sound system of internal control that supports the achievement of its policies, aims and objectives.

Nick Chapman
Chief Executive

27 June 2011

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 National Health Service Trust (NHS Direct) for the year ended 31 March 2011 under the National Health Service Act 2006. These 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, Chief Executive and auditor

As explained more fully in the Statement of the Board's and Chief Executive's Responsibilities, the Chief Executive as Accounting Officer is 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 NHS Direct's circumstances and have been consistently applied and adequately disclosed; the reasonableness of significant accounting estimates made by NHS Direct; 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.

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

Opinion on Regularity

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

Opinion on financial statements

In my opinion:

- the financial statements give a true and fair view of the state of NHS Direct's affairs as at 31 March 2011 and of its net expenditure for the year then ended; and
- the financial statements have been properly prepared in accordance with the NHS National Health Service Act 2006 and directions issued thereunder by the Secretary of State.

Opinion on other matters

In my opinion:

- the part of the Remuneration Report to be audited has been properly prepared in accordance with the Secretary of State's directions issued under the National Health Service Act 2006; and
- the information given in the Chief Executive's statement, the management commentary and public interest and governance section, 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
- the financial statements and the part of the Remuneration Report to be audited are not in agreement with the accounting records or returns; or
- I have not received all of the information and explanations I require for my audit; or
- the Statement on Internal Control 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: 30 June 2011

Annual Accounts 2010/11

Statement of comprehensive income for the year ended 31 March 2011

Revenue	Note	2010/11 £000	2009/10 £000
Revenue from patient care activities	4	145,313	189,056
Other operating revenue	5	4,293	1,980
Operating expenses	7	(145,819)	(190,227)
Operating surplus (deficit)		3,787	809
Finance costs:			
Investment revenue	12	50	69
Other gains and (losses)	13	(545)	0
Finance costs	14	0	0
Surplus/(deficit) for the financial year		3,292	878
Public dividend capital dividends payable		(559)	(430)
Retained surplus/(deficit) for the year		2,733	448
Other comprehensive income			
Impairments and reversals		0	0
(Losses)/gains on revaluations		0	(509)
Receipt of donated/government granted assets		0	0
Net gain/(loss) on other reserves (e.g. defined benefit pension scheme)		0	0
Net gains/(losses) on available for sale financial assets		0	0
Reclassification adjustments:			
Transfers from donated and government grant reserves		0	0
On disposal of available for sale financial assets		0	0
Total comprehensive income for the year		2,733	(61)

Reported NHS financial performance position - adjusted retained surplus/(deficit)

Retained surplus/(deficit) for the year	2,733	448
IFRIC 12 adjustment	0	0
Impairments	0	501
Reported NHS financial performance position [adjusted retained surplus/(deficit)	2,733	949

A Trust's Reported NHS financial performance position is derived from its retained surplus/(Deficit), but adjusted for the following:

a) Impairments to Fixed Assets 2009/10 was the final year for organisations to revalue their assets to a Modern Equivalent Asset (MEA) basis of valuation. An impairment charge is not considered part of the organisation's operating position.

b) The revenue cost of bringing PFI assets onto the balance sheet (due to the introduction of International Financial Reporting Standards (IFRS) accounting in 2009/10) - NHS Trusts' financial performance measurement needs to be aligned with the guidance issued by HM Treasury measuring Departmental expenditure. Therefore, the incremental revenue expenditure resulting from the application of IFRS to PFI, which has no cash impact and is not chargeable for overall budgeting purposes, should be reported as technical. This additional cost is not considered part of the organisation's operating position.

The notes on pages 48 to 76 form part of these accounts.

Statement of financial position as at 31 March 2011

Non-current assets	Note	31 March 2011 £000	31 March 2010 £000
Property, plant and equipment	15	11,110	12,860
Intangible assets	16	23,367	2,810
Trade and other receivables	19	0	0
Total non-current assets		34,477	15,670
Current assets			
Trade and other receivables	19	5,181	18,666
Cash and cash equivalents	20	19,958	14,256
		25,139	32,922
Non-current assets held for sale	21	0	0
Total current assets		25,139	32,922
Total assets		59,616	48,592
Current liabilities			
Trade and other payables	22	(16,963)	(13,797)
Borrowings		0	0
Provisions	23	(1,212)	(2,250)
Net current assets/(liabilities)		6,964	16,875
Total assets less current liabilities		41,441	32,545
Non-current liabilities			
Trade and other payables	22	(6,261)	0
Borrowings		0	0
Provisions	23	(708)	(806)
Total assets employed		34,472	31,739
Financed by taxpayers' equity:			
Public dividend capital		24,511	24,511
Retained earnings		9,500	6,767
Revaluation reserve		461	461
Total taxpayers' equity		34,472	31,739

The financial statements on pages 44 to 76 were approved by the Board on 27 June 2011 and signed on its behalf by:

Signed: Nick Chapman

Chief Executive
27 June 2011

Statement of changes in taxpayers' equity

	Public dividend capital (PDC)	Retained earnings	Revaluation reserve	Total
Balance at 31 March 2009	£000	£000	£000	£000
As previously stated	24,511	6,319	970	31,800
Prior period adjustment	0	0	0	0
Restated balance	**24,511**	**6,319**	**970**	**31,800**
Changes in taxpayers' equity for 2009/10				
Total Comprehensive Income for the year:				
Retained surplus/(deficit) for the year	0	448	0	448
Loss on revaluation of long leasehold land and building	0	0	(509)	(509)
Indexation	0	0	0	0
Balance at 31 March 2010	**24,511**	**6,767**	**461**	**31,739**
Changes in taxpayers' equity for 2010-11				
Total Comprehensive Income for the year				
Retained surplus/(deficit) for the year	0	2,733	0	2,733
Impairments and reversals	0	0	0	0
PDC repaid in year	0	0	0	0
Balance at 31 March 2011	**24,511**	**9,500**	**461**	**34,472**

Statement of cashflows for the year ended 31 March 2011

	Note	2010/11 £000	2009/10 £000
Cash flows from operating activities			
Operating surplus/(deficit)		3,787	809
Depreciation and amortisation		4,305	3,008
Impairments and reversals		0	12
Loss on revaluation of long leasehold land and building		0	501
Interest paid		0	0
Dividends paid		(559)	(430)
(Increase)/decrease in trade and other receivables		13,486	(9,729)
(Increase)/decrease in other current assets		0	0
Increase/(decrease) in trade and other payables		9,428	1,081
Increase/(decrease) in other current liabilities		0	0
Increase/(decrease) in provisions	23	(1,136)	(2,609)
Net cash inflow/(outflow) from operating activities		29,311	(7,357)
Cash flows from investing activities			
Interest received		50	69
(Payments) for property, plant and equipment	15	(1,420)	(1,340)
Proceeds from disposal of plant, property and equipment		0	0
(Payments) for intangible assets	16	(22,239)	(1,895)
Proceeds from disposal of intangible assets		0	0
Net cash inflow/(outflow) from investing activities		(23,609)	(3,166)
Net cash inflow/(outflow) before financing		5,702	(10,523)
Cash flows from financing activities			
Public dividend capital repaid		0	0
Capital element of finance leases and PFI		0	0
Net cash inflow/(outflow) from financing		0	0
Net increase/(decrease) in cash and cash equivalents		5,702	(10,523)
Cash (and) cash equivalents (and bank overdrafts) at the beginning of the financial year		14,256	24,779
Effect of exchange rate changes on the balance of cash held in foreign currencies		0	0
Cash (and) cash equivalents (and bank overdrafts) at the end of the financial year	20	19,958	14,256

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 2010/11 NHS Trusts Manual for Accounts issued by the Department of Health. The accounting policies contained in that manual follow International Financial Reporting Standards 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 also recognises with the major changes taking place within the NHS this period will have to be kept under review.

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, estimates have been used as final figures cannot be arrived at until consultations with staff at risk of redundancy have been concluded. These estimates have been included in the total provision made in these accounts of £653,765.

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, the East of England Strategic Health Authority.

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. This is a change in accounting policy from previous years where all impairments were taken to the revaluation reserve to the extent that a balance was held for that asset and thereafter 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. This is a change in accounting policy from previous years where all impairments were taken to the revaluation reserve to the extent that a balance was held for that asset and thereafter 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 of 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 3 months or less from the date of acquisition and that are readily convertible to known amounts of cash with insignificant risk of change in value.

1.13 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.

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 arsing 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 24.

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 on the balance sheet when the Trust becomes party to the financial instrument contract or, in the case of trade receivables, when the goods or services have been delivered. Financial assets are derecognised when the contractual rights have expired or the asset has been transferred.

Financial assets are initially recognised at fair value.

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

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

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

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

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 balance sheet when the Trust becomes party to the contractual provisions of the financial instrument or, in the case of trade payables, when the goods or services have been received. Financial liabilities are de-recognised when the liability has been discharged, that is, the liability has been paid or has expired.

Financial liabilities are initially recognised at fair value.

Financial liabilities are classified as either financial liabilities 'at fair value through profit and loss' or other financial liabilities. The Trust only has financial liabilities within the other financial liabilities category. The Trust's financial liabilities comprise of creditors for goods and services received in the normal course of business 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. Prior to 2009/10 the PDC dividend was determined using forecast average relevant net assets and a note to the accounts discloses the rate that the dividend represents as a percentage of the actual average carrying amount of assets less liabilities in the year. From 1 April 2009, the dividend payable is based on the actual average relevant net assets for the year instead of forecast amounts.

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).

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.

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

	2010-11 £000	2009-10 £000
Core services	118,258	124,924
Choose & Book Appointments Line	7,406	7,540
Out of hours services	2,346	3,511
Dental services	1,785	1,907
Long-term conditions	4,001	3,453
Single Point of Access to NHS services	5,564	6,329
Pandemic flu & Fluline service	4,861	39,557
Other contestable income	1,092	1,835
	145,313	189,056

During 2010/11 there was a contract variation of £2.7m for non recurrent income to fund strategic changes in the Trust's operations. As the Trust underspent in the relevant areas, £2m of this has been deferred until 2011/12 with the agreement of the commissioner.

In the financial year ended 31 March 2010, there was a contract variation of £2m as a result of an underspend of Strategic Development Investment; this included investment for advertising not required given the wider pandemic flu publicity.

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, the East of England Strategic Health Authority, using service line reporting. Contracts for which income is insufficient to provide a contribution and/or cover full cost, 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. 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 £48m for the system and keeping it in a state of readiness over its expected life of 5 years.

The budget for all activities referred to above was increased by the Department of Health from £48m to £71m to accommodate the additional work.

The charges to the devolved health authorities are subject to separate contracts which were signed during the current financial year.

Income from Department of Health in 2010/11 includes £4,216,213 (2009/10 £36,326,897) for reimbursement of costs incurred on the pandemic flu project, summarised below.

	2010-11 £000	2009-10 £000
Income from Department of Health for system build and maintenance	3,844	32,590
Income from the devolved health authorities for Scotland, Wales and Northern Ireland	645	3,230
Costs		
Directly attributable costs	(57)	(14,919)
System Build costs	(10)	(13,814)
Dormancy Fees	(4,390)	(3,761)
External charges	(6)	(2,867)
Contribution to specified overheads including staff working on the project	26	459
Included within the above, contribution from the devolved health authorities under the contracts referred to above	0	13
Income from Department of Health for delivery of Fluline service	372	3,737
External charges	(118)	(943)
Internal recharges	(208)	(2,266)
Contribution to specified overheads including staff working on the project	46	528

Dental services	2010/11 £000	2009/10 £000
Income	1,785	1,907
Full cost	(2,336)	(3,359)
Surplus/(deficit)	(551)	(1,452)
Contribution	282	(111)

GP out of hours services	2010/11 £000	2009/10 £000
Income	2,346	3,511
Full cost	(2,582)	(4,094)
Surplus/(deficit)	(236)	(583)
Contribution	708	807

Long-term conditions	2010/11 £000	2009/10 £000
Income	4,001	3,453
Full cost	(4,970)	(3,956)
Surplus/(deficit)	(969)	(503)
Contribution	783	886

Single Point of Access to NHS services	2010/11 £000	2009/10 £000
Income	5,564	6,329
Full cost	(7,242)	(8,669)
Surplus/(deficit)	(1,678)	(2,340)
Contribution	(667)	(1,165)

Although the contibution position has improved, this has been insufficient to avoid penalties under the cross subsidisation provisions of the core contract resulting in penalties of £175,000 in 2010/11.

The Appointments Line	2010/11 £000	2009/10 £000
Income	7,406	7,540
Full cost	(7,085)	(7,784)
Surplus/(deficit)	321	(244)
Contribution	2,065	1,668

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:

	2010/11 £000	2009/10 £000
Income	118,258	124,924
Full cost	(112,953)	(121,621)
Surplus/(deficit)	5,305	3,303

4 Revenue from patient care activities

	2010/11 £000	2009/10 £000
Strategic Health Authorities	125,884	132,433
NHS Trusts	165	277
Primary Care Trusts	9,950	12,249
NHS Foundation Trusts	193	232
Local authorities	0	0
Department of Health	4,315	40,082
NHS other	0	1
Non-NHS	4,806	3,782
	145,313	189,056

5 Other operating revenue

	2010/11 £000	2009/10 £000
Education, training and research	489	149
Rental revenue	428	457
Other revenue	3,376	1,374
	4,293	1,980

6 Revenue

Revenue from the sale of goods is immaterial.

7 Operating expenses

	2010/11 £000	2009/10 £000
Chairman and Non Executive Directors	105	88
Directors' costs	1,066	1,357
Staff costs	94,518	104,902
Consultancy services (a)	1,308	4,955
Supplies and services - general	134	170
Establishment expenses	2,979	3,217
Education & training	632	597
Telecommunications	6,007	6,636
Premises	8,388	8,973
Transport	1,704	1,896
Depreciation and amortisation	4,305	3,008
IT contracts (b)	18,459	48,940
Audit fees	90	102
Other audit fees	93	121
Contributions to the NHS Litigation Authority	185	154
Health information services	3,425	3,684
Redundancy costs	1,075	1,460
Early retirement costs	0	(568)
Mutually Agreed Resignation Scheme	73	0
Other (c)	1,273	34
Revaluation of long leasehold land in Nottingham (d)	0	501
	145,819	190,227

(a) Consultancy cost is nil (2009/10 £2,955,957) in respect of work done on the pandemic flu project.

(b) IT contracts costs include £4,390,004 (2009/10 £30,105,998) in respect of pandemic flu and Fluline dormancy fees and in 2009/10 also system development costs charged to the Department of Health per note 3. As a result of acquiring a licence in perpetuity for the clinical content and content engine used in the Trust's activities, the operating contract with CS Solutions reduced, £10,678,025 (2009/10 £16,077,880).

(c) Significant items included in Other costs are: interpreting skills £239,191 (2009/10 £388,419), patient surveys and public participation activities £131,378 (2009/10 £166,401), and website development costs £588,714 (2009/10 £210,068). In 2009/10 the figure for website development costs was changed reflecting the prior year adjustments to capitalisation of intangibles.

(d) The long leasehold land and buildings in Nottingham were revalued at 1 January 2010, resulting in a reduction in value of £1,010,298 of which £501,273 is included in operating expenses in respect of the land and the balance charged to revaluation reserve in 2009/10. Refer to note 15.

8 Operating leases

8.1 As lessee

The Trust has 2 main types of operating leases:
Car leases which are all for a period of 3 years
Rental of premises for operational and administrative purposes

Payments recognised as an expense	2010/11 £000	2009/10 £000
Minimum lease payments	4,217	4,301
Contingent rents	0	0
Sub-lease payments	0	0
	4,217	4,301

Total future minimum lease payments	Buildings £000	Land £000	2010/11 Other £000	Total £000	2009/10 £000
Payable:					
Not later than one year	1,497	0	67	1,564	897
Between one and five years	2,115	0	171	2,286	1,722
After 5 years	533	0	0	533	1,258
Total	4,145	0	238	4,383	3,877

Total future sublease payments expected to be received: £912,889

8.2 As lessor

The Trust sublets 5 of the premises occupied

Rental revenue	2010/11 £000	2009/10 £000
Minimum lease payments	428	457
Contingent rent	0	0
Other	0	0
Total rental revenue	428	457

Total future minimum lease payments	2010/11 £000	2009/10 £000
Receivable:		
Not later than one year	202	113
Between one and five years	0	178
After 5 years	155	0
Total	357	291

9 Employee costs and numbers

9.1 Employee costs

	2010/11 Total £000	2010/11 Permanently employed £000	2010/11 Other £000	2009/10 Total £000	2009/10 Permanently employed £000	2009/10 Other £000
Salaries and wages	81,327	72,966	8,361	90,950	79,069	11,881
Social security costs	5,566	5,566	0	5,925	5,925	0
Employer contributions to NHS Pension scheme	8,744	8,744	0	9,528	9,528	0
Other pension costs	0	0	0	0	0	0
Other post-employment benefits	0	0	0	0	0	0
Termination benefits	1,149	1,149	0	892	892	0
Employee benefits expense	96,786	88,425	8,361	107,295	95,414	11,881

9.2 Average number of people employed

	2010/11 Total number	2010/11 Permanently employed number	2010/11 Other number	2009/10 Total number	2009/10 Permanently employed number	2009/10 Other number
Medical and dental	3	3	0	4	4	0
Administration and estates	1,680	1,449	231	1,881	1,582	299
Nursing, midwifery and health visiting staff	917	900	17	979	902	77
Scientific, therapeutic and technical staff	105	105	0	83	83	0
Other	3	3	0	5	5	0
Total	2,708	2,460	248	2,952	2,576	376
Of the above:						
Number of staff (WTE) engaged on capital projects	2	2	0	3	3	0

9.3 Staff sickness absence

	2010/11 Number	2009/10 Number
Total days lost	34,522	42,482
Total staff years	2,315	2,490
Average working days lost	14.9	17.1
Total staff employed in period (headcount)	3,157	3,447
Total staff employed in period with no absence (headcount)	998	871
Percentage staff with no sick leave	31.6%	25.3%

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.

9.4 Management costs

	2010/11 £000	2009/10 £000
Management costs	22,392	24,496
Income	141,128	150,250
Management Costs as a percentage of income	15.9%	16.3%

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

10 Pension costs

Past and present employees are covered by the provisions of the NHS Pension 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 AVC's run by the scheme's approved providers or by other Free Standing Additional Voluntary Contributions (FSAVC) providers.

11 Better Payment Practice Code

11.1 Better Payment Practice Code - measure of compliance

	Number	2010/11 £000	Number	2009/10 £000
Total non-NHS trade invoices paid in the year	24,434	64,720	30,741	95,535
Total non NHS trade invoices paid within target	23,940	62,225	28,615	85,068
Percentage of non-NHS trade invoices paid within target	98%	96%	93%	89%
Total NHS trade invoices paid in the year	719	4,137	869	4,516
Total NHS trade invoices paid within target	674	3,829	797	3,649
Percentage of NHS trade invoices paid within target	94%	93%	92%	81%

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

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

	2010/11 £000	2009/10 £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
Total	0	0

12 Investment revenue

	2010/11 £000	2009/10 £000
Interest revenue:		
Bank accounts	44	69
Other	6	0
Total	50	69

13 Other gains and losses

	2010/11 £000	2009/10 £000
Gain/(loss) on disposal of property, plant and equipment	(221)	(13)
Gain/(loss) on disposal of intangible assets	(324)	0
Total	(545)	(13)

The loss in the year arose mainly as a result of assets not transferred to the new head office location, as well as historic costs relating to the self assessment tools, which have been replaced by the new health and sympton checkers capitalised in the current year.

14 Finance costs

	2010/11 £000	2009/10 £000
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 Property, plant and equipment

2010/11	Long leasehold land £000	Buildings excluding dwellings £000	Assets under construction £000	Plant and machinery £000	Information technology £000	Furniture & fittings £000	Total £000
Cost or valuation at 1 April 2010	556	11,988	1,002	1,394	6,546	2,030	23,516
Additions purchased	0	262	133	253	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	(952)	41	395	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 gains	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
At 31 March 2011	**556**	**11,570**	**183**	**1,688**	**7,564**	**2,281**	**23,842**
Depreciation at 1 April 2010	6	5,067	0	562	4,095	926	10,656
Reclassifications	0	0	0	0	0	0	0
Reclassified as held for sale	0	0	0	0	0	0	0
Disposals other than by sale	0	(481)	0	0	0	(86)	(567)
Revaluation	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	301	2,643
Depreciation at 31 March 2011	**7**	**5,338**	**0**	**851**	**5,395**	**1,141**	**12,732**
Net book value							
Purchased	549	6,232	183	837	2,169	1,140	11,110
Donated	0	0	0	0	0	0	0
Government granted	0	0	0	0	0	0	0
Total at 31 March 2011	**549**	**6,232**	**183**	**837**	**2,169**	**1,140**	**11,110**
Asset financing							
Owned	549	6,232	183	837	2,169	1,140	11,110
Finance Leased	0	0	0	0	0	0	0
Private finance initiative	0	0	0	0	0	0	0
PFI residual interests	0	0	0	0	0	0	0
Total 31 March 2011	**549**	**6,232**	**183**	**837**	**2,169**	**1,140**	**11,110**

15.1 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 1 April 2010	0	400	25	0	36	461
Movements	0	0	0	0	0	0
At 31 March 2011	**0**	**400**	**25**	**0**	**36**	**461**

15.2 Prior year

2009/10:	Long leasehold land £000	Buildings excluding dwellings £000	Assets under construction £000	Plant and machinery £000	Information technology £000	Furniture & fittings £000	Total £000
Cost or valuation at 1 April 2009	1,162	12,076	872	1,092	6,293	1,713	23,208
Additions purchased	0	55	971	268	40	6	1,340
Reclassifications	0	261	(841)	56	213	311	0
Reclassified as held for sale	0	0	0	0	0	0	0
Disposals other than by sale	0	0	0	(22)	0	0	(22)
Revaluation gains/(losses)	(606)	(404)	0	0	0	0	(1,010)
At 31 March 2010	**556**	**11,988**	**1,002**	**1,394**	**6,546**	**2,030**	**23,516**
Depreciation at 1 April 2009	5	4,338	0	315	2,851	678	8,187
Reclassifications	0	0	0	0	0	0	0
Reclassified as held for sale	0	0	0	0	0	0	0
Disposals other than by sale	0	0	0	(8)	0	0	(8)
Indexation	0	0	0	0	0	0	0
Charged during the year	1	729	0	255	1,244	248	2,477
Depreciation at 31 March 2010	**6**	**5,067**	**0**	**562**	**4,095**	**926**	**10,656**
Net book value							
Purchased	550	6,921	1,002	832	2,451	1,104	12,860
Total at 31 March 2010	**550**	**6,921**	**1,002**	**832**	**2,451**	**1,104**	**12,860**
Total at 31 March 2009	1,157	7,738	872	777	3,442	1,034	15,020
Asset financing							
Owned	550	6,921	1,002	832	2,451	1,104	12,860
Finance leased	0	0	0	0	0	0	0
Total 31 March 2010	**550**	**6,921**	**1,002**	**832**	**2,451**	**1,104**	**12,860**

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 DVS 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	2	10

The gross revalued amount of assets fully depreciated but still in use at 31 March 2011 is £3,390,032 (at 31 March 2010 £2,630,185)

At 2009/10	Min life (years)	Max life (years)
Long leasehold land	990	990
Buildings excluding dwellings - all leasehold	4	71
Plant & machinery	4	9
Information Technology	5	5
Furniture & fittings	4	10

16 Intangible assets

2010/11:	Computer software - purchased £000	Computer software - internally generated £000	Assets under construction £000	Licensed content £000	Development expenditure (internally generated) £000	Total £000
Gross cost at 1 April 2010	1,414	602	1,750	0	196	3,962
Additions purchased	2,037	0	757	19,445	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	1,690	162	(1,547)	0	0	305
Reclassified as held for sale	0	0	0	0	0	0
Disposals other than by sale	0	(764)	0	0	0	(764)
Revaluation	0	0	0	0	0	0
Impairments	0	0	0	0	0	0
Reversals of impairments	0	0	0	0	0	0
Gross cost at 31 March 2011	**5,141**	**0**	**960**	**19,445**	**196**	**25,742**
Amortisation at 1 April 2010	872	199	0	0	81	1,152
Reclassifications	0	0	0	0	0	0
Reclassifications as held for sale	0	0	0	0	0	0
Disposals other than by sale	0	(440)	0	0	0	(440)
Revaluation	0	0	0	0	0	0
Impairments	0	0	0	0	0	0
Reversal of impairments	0	0	0	0	0	0
Charged during the year	453	241	0	903	66	1,663
Amortisation at 31 March 2011	**1,325**	**0**	**0**	**903**	**147**	**2,375**
Net book value						
Purchased	3,816	0	960	18,542	49	23,367
Donated	0	0	0	0	0	0
Government granted	0	0	0	0	0	0
Total at 31 March 2011	**3,816**	**0**	**960**	**18,542**	**49**	**23,367**
Asset financing						
Owned	3,816	0	960	18,542	49	23,367
Finance leased	0	0	0	0	0	0
Private finance initiative	0	0	0	0	0	0
PFI residual interests	0	0	0	0	0	0
Total 31 March 2011	**3,816**	**0**	**960**	**18,542**	**49**	**23,367**

Prior year

2009/10:	Computer software - purchased £000	Computer software - internally generated £000	Assets under construction £000	Development expenditure (internally generated) £000	Total £000
Gross cost at 1 April 2009	1,258	407	206	196	2,067
Additions purchased	125	52	1,718	0	1,895
Additions internally generated	0	0	0	0	0
Additions donated	0	0	0	0	0
Additions government granted	0	0	0	0	0
Reclassifications	31	143	(174)	0	0
Reclassified as held for sale	0	0	0	0	0
Disposals other than by sale	0	0	0	0	0
Revaluation	0	0	0	0	0
Impairments	0	0	0	0	0
Reversals of impairments	0	0	0	0	0
Gross cost at 31 March 2010	**1,414**	**602**	**1,750**	**196**	**3,962**
Amortisation at 1 April 2009	586	19	0	16	621
Reclassifications	0	0	0	0	0
Reclassifications as held for sale	0	0	0	0	0
Disposals other than by sale	0	0	0	0	0
Revaluation	0	0	0	0	0
Impairments	0	0	0	0	0
Reversal of impairments	0	0	0	0	0
Charged during the year	286	180	0	65	531
Amortisation at 31 March 2010	**872**	**199**	**0**	**81**	**1,152**
Net book value					
Purchased	542	403	1,750	115	2,810
Total at 31 March 2010	**542**	**403**	**1,750**	**115**	**2,810**
Total at 31 March 2009	672	388	206	180	1,446

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

	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

At 2009-10	Min life (years)	Max life (years)
Computer software purchased	2	5
Computer software internally generated	3	3
Development expenditure internally generated	3	3

The gross revalued amount of assets fully depreciated but still in use at 31 March 2011 is £156,210 (at 31 March 2010 £nil)

17 Impairments

Following the nature of property, plant and equipment in Note 15 and intangible assets referred to in Note 16, impairments have been considered but not deemed necessary at 31 March 2011.

18 Capital commitments

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

	31 March 2011 £000	31 March 2010 £000
Property, plant and equipment	0	128
Intangible assets	1,050	588
Total	1,050	716

19 Trade and other receivables

19.1 Trade and other receivables

	Current 31 March 2011 £000	Non-current 31 March 2011 £000	Current 31 March 2010 £000	Non-current 31 March 2010 £000
NHS receivables	1,085	0	3,715	0
Other trade receivables	1,307	0	4,382	0
VAT	1,272	0	1,239	0
Accrued income	124	0	4,086	0
Provision for the impairment of receivables	(216)	0	(240)	0
Prepayments other	1,609	0	5,484	0
Total	5,181	0	18,666	0

The great majority of trade is with strategic health and primary care trusts, as commissioners for NHS patient care services. As these trusts 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.

19.2 Receivables past their due date but not impaired

	31 March 2011 £000	31 March 2010 £000
By up to three months	135	2,573
By three to six months	0	28
By more than six months	39	371
Total	174	2,972

19.3 Provision for impairment of receivables

	31 March 2011 £000	31 March 2010 £000
Balance at 1 April	240	292
Amount written off during the year	(53)	(89)
Amount recovered during the year	29	(21)
(Increase)/decrease in receivables impaired	0	58
Balance at 31 March	216	240

The provision relates to salary overpayments to former staff deemed irrecoverable

20 Cash and cash equivalents

	31 March 2011 £000	31 March 2010 £000
Balance at 1 April	14,256	24,779
Net change in year	5,702	(10,523)
Balance at 31 March	19,958	14,256
Made up of:		
Cash with Office of HM Paymaster General	19,958	14,256
Commercial banks and cash in hand	0	0
Current investments	0	0
Cash and cash equivalents as in statement of financial position	19,958	14,256
Bank overdraft - Office of HM Paymaster General	0	0
Bank overdraft - commercial banks	0	0
Cash and cash equivalents as in statement of cash flows	19,958	14,256

21 Non-current assets held for sale

There were no non-current assets held for sale at 31 March 2011.

22 Trade and other payables

	Current 31 March 2011 £000	Non-current 31 March 2011 £000	Current 31 March 2010 £000	Non-current 31 March 2010 £000
Interest payable	0	0	0	0
NHS payables	168	0	657	0
Other trade payables - revenue	3,004	0	2,388	0
Other trade payables - capital	1,498	6,261	0	0
Tax and social security costs	1,726	0	1,785	0
VAT	0	0	0	0
Accruals	7,442	0	7,858	0
Deferred income	3,125	0	1,109	0
Other	0	0	0	0
Total	16,963	6,261	13,797	0

Other payables revenue include:
Outstanding pensions contributions at 31 March 2011 £945,284 (2009/10 £1,138,032).

23 Provisions

	Current 31 March 2011 £000	Non-current 31 March 2011 £000	Current 31 March 2010 £000	Non-current 31 March 2010 £000
Pensions relating to former directors	0	0	0	0
Pensions relating to other staff	34	708	34	806
Legal claims	0	0	0	0
Restructurings	654	0	1,675	0
Other (specify)	524	0	541	0
Total	1,212	708	2,250	806

Other provisions include the VAT due on contracts where the price is VAT inclusive £394,015. (31 March 2010 £394,015).

	Pensions relating to former directors £000	Pensions relating to other staff £000	Legal claims £000	Restructurings £000	Other £000	Total £000
At 1 April 2010	0	840	0	1,675	541	3,056
Arising during the year	0	0	0	654	0	654
Used during the year	0	(29)	0	(1,675)	(17)	(1,721)
Reversed unused	0	(69)	0	0	0	(69)
Unwinding of discount	0	0	0	0	0	0
At 31 March 2011	0	742	0	654	524	1,920
Expected timing of cash flows:						
In the remainder of the spending review						
Period to 31 March 2012	0	34	0	654	524	1,212
Between 1 April 2012 and 31 March 2017	0	154	0	0	0	154
Between 1 April 2017 and 31 March 2022	0	133	0	0	0	133
Thereafter	0	421	0	0	0	421

£5,485,495 is included in the provisions of the NHS Litigation Authority at 31 March 2011 in respect of clinical negligence liabilities of the Trust (31 March 2010, £323,747).

24 Contingent liabilities

	2010/11 £000	2009/10 £000
Equal pay cases	0	0
Other	42	22
Total	42	22

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

25 Financial instruments

Disclosure

IFRS 7 does not require fair value disclosures for financial assets and liabilities where the carrying amount is a reasonable approximation of fair value; this option has been applied to this note.

26 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 2010 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.

27 Events after the reporting period

In Note 1.3.2, the Trust drew attention to the restructurings taking place to improve efficiency and reduce the cost base in recognition of the reduced income available for core activities in 2011/12 from the East of England Strategic Health Authority and beyond, owing to other changes taking place in the NHS. These continue and will result in additional costs not provided for in these accounts, as the processes were not sufficiently advanced at 31 March 2011 to facilitate their inclusion.

28 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.

28.1 Breakeven performance

	2008/09 £000	2009/10 £000	2010/11 £000
Turnover	161,566	191,036	149,606
Retained surplus/(deficit) for the year	467	949	2,733
Break-even cumulative position	5,529	6,478	9,211

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

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

28.2 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 divident 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%.

28.3 External financing

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

	2010/11 £000	2009/10 £000
External financing limit	28,542	6,217
Cash flow financing	5,702	(10,523)
Finance leases taken out in the year	0	0
Other capital receipts	0	0
External financing requirement	0	0
Undershoot/(overshoot)	34,244	(4,306)

28.4 Capital resource limit

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

	2010/11 £000	2009/10 £000
Gross capital expenditure	23,659	3,235
Less: book value of assets disposed of	0	(13)
Charge against the capital resource limit	23,659	3,222
Capital resource limit	28,012	5,891
(Over)/underspend against the capital resource limit	4,353	2,669

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 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 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
- Primary Care Trusts
- NHS Trusts
- NHS Foundation Trusts
- NHS Litigation Authority.

In addition, the Trust has had a number of material transactions with other government departments and other central and local government bodies. Most of these transactions have been with the Central Office of Information.

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

Income in nature	2010/11 £000 Income	Debtor	Creditor	2009/10 £000 Income	Debtor	Creditor
East of England Strategic Health Authority	129,112	0	121	102,386	293	0
Department of Health	4,461	17	0	31,054	5,932	0
Calderdale PCT	5,564	56	0	4,598	0	0
Nottingham City PCT	449	131	0	522	399	0
East Lancashire PCT	507	0	0	376	0	0
Stockport PCT	310	245	19	298	28	0
South East Essex PCT	203	21	0	293	24	0
Hillingdon PCT	121	0	0	273	30	0
Bury PCT	207	3	0	252	56	0
Hounslow PCT	291	0	0	250	28	0

Expenditure in nature	Expenditure	Debtor	Creditor	Expenditure	Debtor	Creditor
Yorkshire Ambulance Service NHS Trust	746	0	2	379	0	0
University Hospitals of Leicester NHS Trust	554	0	0	297	0	0
Nottinghamshire Healthcare NHS Trust	333	0	2	267	0	7
NHS Professionals	0	0	0	244	0	266
Imperial College Healthcare NHS Trust	281	0	37	0	0	0
NHS Litigation Authority	305	0	0	0	0	0

30 Intra-Government and other balances

	Current receivables £000	Non-current receivables £000	Current payables £000	Non-current payables £000
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
Intra Government balances	1,088	0	198	0
Balances with bodies external to Government	4,093	0	16,765	6,261
31 March 2011	5,181	0	16,963	6,261
Balances with other central Government bodies	8,195	0	3,154	0
Balances with local authorities	0	0	0	0
Balances with NHS Trusts and Foundation Trusts	100	0	123	0
Balances with public corporations and trading funds	0	0	0	0
Intra Government balances	8,295	0	3,277	0
Balances with bodies external to Government	10,371	0	10,520	0
At 31 March 2010	18,666	0	13,797	0

31 Losses and special payments

There were 30 cases of losses and special payments (2009/10 16 cases) totalling £55,718 paid during 2010/11 (2009/10 £77,504).

Appendices

Appendix A

Indicators of quality for 2010/11

The table below contains the indicators of quality selected by the Trust Board for the core 0845 4647 telephone service and website and reviewed by it regularly during the year.

Safety domain*	Effectiveness domain	Patient experience domain
% incidents reviewed nationally that were judged as leading to harm to patients	% of calls resulting in onward referral to emergency and urgent health services	Patient satisfaction (%)
% urgent (P1) clinical assessments started in 20 minutes	% of calls that did not require any onward referral	Number of complaints per 10,000 calls
% less urgent clinical assessments (P2) started in 60 minutes	% of health and nurse advisors' time online spent talking with patients	% calls answered within 60 seconds
% non urgent clinical assessments (P3) started in 120 minutes	% call reviews achieving good or excellent	% complaints resolved first time

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

1. Safety

In 2010/11, NHS Direct achieved the following performance in indicators relating to patient safety:

Safety domain*	2010/11 achievement	2010/11 target
% incidents for national review leading to harm**: standard achieved	1%	≤10%
% urgent (P1) clinical assessments started in 20 minutes: standard achieved	95.8%	≥95%
% less urgent clinical assessments (P2) started in 60 minutes: standard not achieved	89.3%	≥95%
% non-urgent clinical assessments (P3) started in 120 minutes: standard not achieved	91.1%	≥95%

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

2. Clinical effectiveness

In 2010/11, the Trust achieved the following performance in indicators relating to clinical effectiveness:

Effectiveness domain*	2010/11 achievement	2010/11 target
% of emergency and urgent referrals: standard achieved	24.9%	≤25%
% of callers with episode completed within NHS Direct: standard achieved	57.6%	≥50%
% of health and nurse advisors' time online spent talking with patients: standard not achieved	43.5%	≥50%
% call reviews achieving good or excellent: standard not achieved	62%	≥80%

3. Patient experience

In 2010/11, the Trust achieved the following level of quality for performance in indicators relating to patient experience:

Patient experience domain*	2010/11 achievement	2010/11 target
Patient satisfaction (%): standard achieved	93%	≥90%
Number of complaints per 10,000 calls: standard achieved	0.5	≤1.0
% calls answered within 60 seconds: standard not achieved	90%	≥95%
% complaints resolved first time: standard achieved	98%	≥95%

Appendix B

Detailed definitions of key performance indicators

KPI name	Purpose	Definition and calculation method	Target	Data source
% calls answered within 60 seconds	Access measure	Calls answered within 60 seconds of being offered ÷ total calls answered.	≥95%	Symposium telephony system
% urgent calls started within 20 minutes	Identifies the speed of response to clinically urgent calls	% of urgent calls (i.e. those with clinical priorities P0, P1, and D1) where triage by a clinician is started within 20 minutes. Calculated using: number of urgent clinical calls (P0, P1 and D1) started within 20 minutes ÷ number of urgent clinical calls (P0, P1 and D1) requiring clinical assessment.	≥95%	Clinical Assessment System (CAS)
% less urgent calls started within 60 minutes	Identifies the speed of response to clinically less urgent calls	% of less urgent calls (i.e. those with clinical priority P2) where triage by a clinician is started within 60 minutes. Calculated using: number of less urgent clinical calls (P2) where triage by a clinician is started within 60 minutes ÷ number of less urgent clinical calls (P2) requiring clinical assessment.	≥95%	Clinical Assessment System (CAS)
% non-urgent calls started within 120 minutes	Identifies the speed of response to clinically non-urgent calls	% of non-urgent calls (i.e. those with clinical priorities P2, P3, D2, D3) where triage by clinician is started within 120 minutes. Calculated using: number of non-urgent clinical calls (P2, P3, D2, D3) started within 120 minutes ÷ number of non-urgent clinical calls (P2, P3, D2, D3) requiring clinical assessment.	≥95%	Clinical Assessment System (CAS)
% of callers with episode completed within NHS Direct	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.	% of calls NHS Direct completes without onward referral. Calculated using the number of dispositions set as self care, pharmacy, primary care service (PCS) routine and health information (HI) with formula: (self care + pharmacy + PCS routine + HI) ÷ number of calls for combined service.	≥50%	Clinical Assessment System (CAS)

KPI name	Purpose	Definition and calculation method	Target	Data source
% of emergency and urgent referrals	Measure value to NHS	Number of symptomatic calls referred to urgent and emergency care disposition (999, A&E and PCS urgent) for core service ÷ number of symptomatic calls for core service.	≤25%	Clinical Assessment System (CAS)
Time spent by staff waiting for calls	Productivity measure	The % of time front line staff (HA, NA, HIA, DN) spend waiting for a call. (Amount of time speaking with patients / paid time - annual leave) x 100.	<50%	Symposium telephony system and CCC.
% of health and nurse advisors' time online spent talking with patients	Productivity measure	Actual staff time (hours speaking with the caller + call wrap + call follow up + call postal work + call research + call child protection + safeguarding adults) with patients compared to the total time employed (IRT logged on hours + total planned absences (CCC) + total changed absences (CCC) minus scheduled breaks (IRT) for NA, HA, DNA and HIA.	≥50%	CCC, Individual Reporting Tool and Symposium telephony system
% call reviews achieving good or excellent	Identifies the overall quality of calls, as per in-house quality assurance tool	Percentage of random supervisory / peer call reviews undertaken for clinical services rating good / excellent.	≥80%	Collated call reviews from front line managers and expert call review team
Patient satisfaction	To measure patients' perception of quality of our services	Patient perception of level of service being provided by NHS Direct. % of respondents satisfied with NHS Direct service provided to them.	≥90%	External monthly satisfaction survey (IFF Research)
Number of complaints per 10,000 calls	Indicates the quality of our service	Number of complaints relating to clinical services per 10,000 calls. Calculated using: number of nationally handled complaints reported (for combined service) relating to clinical services x 10,000 ÷ number of calls answered.	≤1.0	Datix and regional complaints reporting
% complaints resolved first time	To measure the quality of complaints handling process	Percentage of complaints resolved to the satisfaction of the complainant and not appealed or referred to Ombudsman.	≥95%	Datix and regional complaints reporting
Calls answered vs. latest contract target (volume)	Measures performance against contract	Number of calls answered against the number of calls agreed as latest contract targets.	+/- 10%	Symposium telephony system

KPI name	Purpose	Definition and calculation method	Target	Data source
Self assessment tool (SAT) usage	Indicates success of web-based service	Number of SAT visits compared to phased contract plan.	88 users per 10k population for the year	Clinical Assessment System (CAS)
Growth in the volume of non-core services purchased by commissioners	Measure of income from contracts outside the core contract	Income generated by enhanced contracts (all contracts other than core) compared to planned income target. The income generated by enhanced contracts (including flu) compared to planned income target/ planned income target.	£17.6m	Accounts
Stakeholder perception annual survey	Measures key stakeholders' perception of our service	Stakeholder perception of level of service being provided by NHS Direct. % of respondents rating NHS Direct's overall performance as good or excellent.	≥70%	Annual stakeholder perception research carried out by Jigsaw Research
Projected requirements for nurse advisors	Measure of recruitment and retention	(Total number of staff projected taking into account attrition, sickness, staff in training and projected recruitment of staff / Total number of staff as per the capacity plan with SDP savings) x 100.	100%	Deployment tracker with information supplied by HR
Front line staff attrition leaving within one year	Measure of staff turnover	Nurse advisors (NA), health advisors (HA), dental nurse advisors (DNA) and health information advisors (HIA) starters headcount (12 month rolling) who have left within <1 year service ÷ NA, HA, DNA and HIA starters head count (12 month rolling).	<10%	Electronic staff record
Gross number of days per whole time equivalent (WTE) per year lost to sick leave	Measure of staff sickness	For all NHS Direct staff year to date (YTD) actual time spent off sick – WTE days (annualised) ÷ YTD average number of WTE.	<10	Electronic staff record
Monthly recurrent expenditure run-rate	Measure of rate of expenditure	Actual expenditure run-rate (excluding non-recurring items) compared to planned run-rate. (Current actual expenditure run-rate (excluding non-recurring items) – planned run-rate)/Planned run-rate.	-2.5% to +2.5%	Accounts
Department of Health (DH) Financial Health Index	DH measure of financial health	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.	≥2.5	Accounts

If, owing to a special need, you would like this document in another format please call the NHS Direct Communications Department on 020 7599 4200.

NHS Direct

Published by TSO (The Stationery Office) and available from:

Online
www.tsoshop.co.uk

Mail, telephone fax & e-mail

TSO
PO Box 29, Norwich, NR3 1GN
Telephone orders/general enquiries 0870 600 5522
Order through the Parliamentary Hotline Lo-Call 0845 7 023474
Fax orders: 0870 600 5533
E-mail: customer.services@tso.co.uk
Textphone: 0870 240 3701

The Parliamentary Bookshop

12 Bridge Street, Parliament Square,
London SW1A 2JX
Telephone orders/ general enquiries: 020 7219 3890
Fax orders: 020 7219 3866
Email: bookshop@parliament.uk
Internet: http://www.bookshop.parliament.uk

TSO@Blackwell and other Accredited Agents

Customers can also order publications from

TSO Ireland
16 Arthur Street, Belfast BT1 4GD
Telephone orders/general enquiries 028 9023 8451
Fax 028 9023 5401

ISBN 978-0-10-297161-3

9 780102 971613