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Annual Report and Accounts 2006

NHS DIRECT ANNUAL REPORT AND ACCOUNTS 2005-2006

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Introduction

David Edmonds, Chair of NHS Direct

This is a time of enormous change, both for NHS Direct and the wider NHS as a whole.

As the NHS undergoes a series of far-reaching reforms to provide people with more choice and control over their own healthcare, NHS Direct is responding. Now, more than ever before, patients are involved in making choices about their treatment. Being able to make the right choices is dependent on having access to the best information and advice, and this is where NHS Direct can add real value. Our service is available 24 hours a day every day, providing members of the public with access to safe, good quality health advice from the comfort of their own homes.

NHS Direct is the first truly multimedia health service organisation. We offer our services through three channels: the telephone, digital television and the internet. This year has seen a significant growth of all these channels. Between March 2005 and March 2006, the total number of patient contacts rose from 1.65 million to 2.138 million per month. Planned expansions and improvements to all our channels will see this number rise again during 2006-07. We also plan to develop our role in promoting self care to benefit both patients and the NHS as a whole.

The year ahead will also see us transform from a special health authority to an NHS trust. We will then begin the necessary preparations to achieve NHS foundation trust status. As a foundation trust, we will have increased flexibility and freedom and will also be more accountable to our users, with members of the public and staff forming the majority of the governors. To prepare for these changes and to ensure we meet Healthcare Commission standards, we are working on a national strategy to rationalise and strengthen our existing engagement and consultation work with patients and the public.

NHS Direct has to operate within financial constraints. In 2005-06, we generated a surplus which we will put towards transforming the way services are provided. Increased competition in the health service means it is more important than ever that NHS Direct delivers the highest possible quality of care in the most efficient way. The changes we are introducing to the structure of the organisation will ensure we are fit to succeed in the new NHS.

"Between March 2005 and March 2006, the total number of patient contacts rose from 1.65 million to 2.138 million per month."

Foreword

by Ed Lester, Chief Executive

2005-2006 has been a year of achievement for NHS Direct. We have handled record numbers of patient contacts while delivering some significant improvements in our operational performance. We have also proved ourselves to be an innovative, adaptable and highly effective service, developing new models of care and providing flexible support to other parts of the health service.

Via our telephone, television and online services, NHS Direct has contact with more than two million patients each month, with the website alone attracting a record one million visitors a month. We are now planning to increase the reach of our interactive digital television service, making it available to a further 7.5 million people by the end of 2006. We are also in the process of expanding our interactive television content and making the service more user-friendly.

Underpinning the development of the service has been the implementation of our Virtual Contact Centre. NHS Direct telephone staff now have access to up-to-date details of all local health services, meaning they can offer a consistent, reliable service to callers from anywhere in the country.

As well as improving and fine-tuning our core services, NHS Direct is continually evolving and developing new healthcare solutions. In April 2006, we launched a pilot programme, funded by the North and Eastern Birmingham Primary Care Trusts, to provide help and support for 2,000 people with long-term conditions.

Providing proactive support for people with long-term conditions is just one of the ways that NHS Direct is widening its remit. We are also putting together a business plan to run the Government's new Health Direct service. This new service will provide online information and advice to help people follow more healthy lifestyles.

"By April 2007, NHS Direct will have become an NHS trust and it is our aspiration and that of the Department of Health to achieve foundation trust status as soon as practical thereafter."

By April 2007, NHS Direct will have become an NHS trust and it is our aspiration and that of the Department of Health to achieve foundation trust status as soon as practical thereafter. This will give us greater flexibility and freedom and will also offer patients a greater say in the services we provide. Before we reach that stage, there's an enormous amount of work to do, and we have already begun the process of making the necessary changes.

On 16 May 2006, we began a consultation with staff about restructuring the way the organisation is configured and the way services are provided. However the organisation changes, we will remain committed to providing the services that patients want. This year, we are developing new ways to engage with patients and investing in research to help our health advisors improve the patient experience. As the NHS becomes ever more patient-led, NHS Direct is ideally placed to lead the way.

Management commentary

History and statutory background

On 1 April 2004 NHS Direct was established as a special health authority under the *NHS Direct (Establishment and Constitution) Order 2004,* (Statutory Instrument 569). Its operating framework, including standing financial instructions, is set out in its *Framework Document.* A board was established comprising a chair, five non-executive directors and five executive directors.

NHS Direct Special Health Authority assumed the roles previously undertaken by the Department of Health and 22 host NHS organisations across the country and currently operates from some 50 sites.

Arm's length body review

As a special health authority, NHS Direct is classed as an arm's length body. On 22 July 2004 the Secretary of State for Health announced in a written statement to the House of Commons that the number of NHS bodies that work at 'arm's length' from the Department of Health would be reduced. A report, reconfiguring the Department of Health's arm's length bodies, was published which detailed the bodies that would merge, be abolished or see their functions transferred.

On 30 November 2004, the Secretary of State published *An Implementation Framework for Reconfiguring the Department of Health's Arm's Length Bodies,* setting out the principles, processes and timescales by which the change would be implemented. This initially outlined a plan for NHS Direct to be created as an independent body outside of the arm's length body sector by 1 April 2006. A decision has now been made by the appropriate minister to the effect that NHS Direct will now become an NHS trust with effect from 1 April 2007 and subsequently progress to become an NHS foundation trust.

External environment

NHS Direct operates in a complex environment with a range of stakeholders and audiences and against a background of the wider NHS. As a national service that is delivered and sold locally it requires a strong strategic framework to enable communications and service development to operate effectively locally but within a national strategy and single brand positioning.

Strategic direction

Over the coming years there will be substantial opportunities for NHS Direct to exploit the unprecedented infrastructure and expertise developed by the Government to deliver health services using the telephone and new media.

We know that the public is looking for more information about services, better access to care and improved coordination of services, and these are key themes of the recent *Our health, our care, our say* White Paper. There is also a growing focus on self care, where patients and the NHS work in partnership to empower individuals to take a larger role in their own care.

NHS Direct is also ready to offer a wider range of enhanced services which can help meet local health objectives through deepening relationships with NHS commissioners. In doing so, we recognise that those services must be cost effective, demonstrate clear value and genuinely respond to local need.

As a result the business plan for the next three years reflects the following strategic objectives:

- to improve access to NHS Direct through all channels including the achievement of all national operational performance targets
- to deliver high quality services which are safe, fair, responsive to need and clinically effective
- to develop services in line with the opportunities offered by the *Our health, our care, our say* White Paper for reshaping access to health and social care, including the launch of Health Direct
- to position NHS Direct as THE digital portal for health information
- to increase the contribution made to the delivery of local health and social care objectives through the delivery of a range of enhanced services to support both primary and secondary care
- to ensure effective financial control and balance
- to complete the refresh of NHS Direct's technology platforms to support future developments
- to deliver a national HR strategy that fully supports the operational needs of the service and addresses issues around skill mix
- to deliver an effective organisational change programme which delivers significant improvements in productivity and unit costs and delivers the final recommendations of the review of arm's length bodies.

Operational performance

In 2005-06 NHS Direct has delivered continuous improvement in operational and clinical performance across all its channels, reaching growth targets and interim performance targets agreed with the Department of Health. Performance now stands at its highest level for three years.

NHS Direct tracks its business plan objectives on a monthly basis through key performance indicators reported to the board using a 'balanced scorecard' approach.

The balanced scorecard

This table shows NHS Direct's performance against key performance indicators (KPIs) between March 2005 and March 2006.

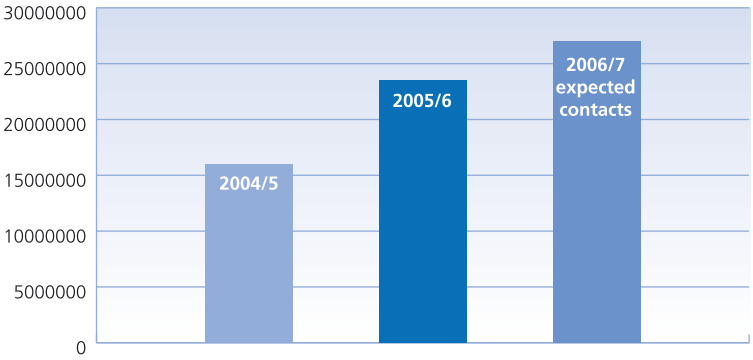
Patient KPIs	Best practice level	Target	Mar 05	Apr 05	May 05	Jun 05	Jul 05	Aug 05	Sep 05	Oct 05	Nov 05	Dec 05	Jan 06	Feb 06	Mar 06
Patients satisfied with service	90%	>= 95%	98%	98%	98%	98%	99%	98%	97%	97%	97%	97%	97%	97%	**97%**
Complaints (per 10,000 calls)	–	<= 1.22 *	0.6	0.6	0.57	1.01	0.84	1.17	1.39	1.32	2.09	1.66	1.4	1.93	**1.49**
Compliments (per 10,000 calls)	–	>= 1.50 *	1.34	2.1	1.95	1.54	1.68	1.95	1.63	1.12	1.17	1.33	1.03	1.11	**1.58**
Complaints responded to within 20 days	–	>= 95%	–	89%	94%	93%	56%	95%	99%	89%	91%	96%	90%	82%	**78%**
Serious adverse incidents (per 10,000 calls)	–	<= 0.28 *	0.29	0.28	0.169	0.34	0.16	0.22	0.27	0.51	0.24	0.39	0.33	0.26	**0.16**
Web visits ('000s)	–	>= 1333.3	1033.9	1062.1	1063.0	1013.0	963.3	1001.9	992.2	1072.2	1073.6	859.7	1459.1	1414.7	**1562.4**
Digital TV visits ('000s)	–	>= 375	–	–	–	–	–	–	–	500	500	500	500	500	**500**
Number of calls answered ('000s)	–	>= 694.7	611.5	558.9	593.4	553.5	570.1	539.7	516.7	569.8	539.4	614.2	629.6	548.8	**576.3**
Abandonment rate	4 – 5%	<= 5%	17%	11%	11%	10%	7%	6%	6%	8%	8%	12%	8%	14%	**16%**
% calls answered within 60 seconds	90% in 10 seconds	>= 95%	57%	68%	68%	71%	76%	79%	79%	73%	74%	69%	72%	60%	**57%**
% urgent calls commencing clinical assessment in 20 minutes	–	>= 95%	96%	97%	97%	97%	97%	97%	97%	96%	97%	96%	96%	95%	**95%**
% non–urgent calls commencing clinical assessment in 60 minutes	–	>= 95%	73%	80%	78%	79%	80%	82%	82%	77%	76%	74%	72%	60%	**60%**
% of health information calls assessed within 3 hours	–	>= 90%	89%	89%	90%	91%	91%	86%	84%	–	–	–	88%	86%	**85%**

* This is a 12 month average

Service demand

NHS Direct's multi-channel service grew by 47 per cent in 2005-06 with more than 23 million patient/customer contacts throughout the year. In April 2006, patient contacts stood at more than two million per month, more than double the level in April 2005.

Patient contacts per year



NHS Direct answered 6.8m telephone calls in 2005-06, three per cent more than the 6.6m calls answered in 2004-05. NHS Direct Online attracted 13.5 million visitors during the year, and NHS Direct Interactive on digital television reached several hundred viewers each month. These channels significantly increased access to health information.

Access performance

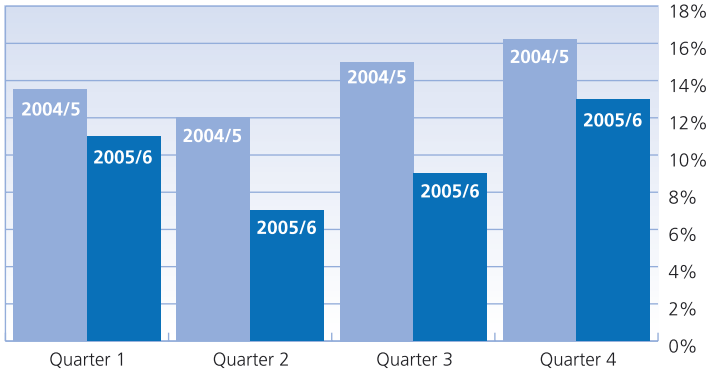
NHS Direct's key performance indicators for access are aligned with the Department of Health's quality standards for out-of-hours unscheduled care. The key indicators are associated with two key stages:

- the initial speed of response to telephone calls, with a target of a five per cent abandonment rate
- the time taken to start a definitive clinical assessment, with a target of 95 per cent of urgent calls to be dealt with in 20 minutes and 95 per cent of non-urgent calls within 60 minutes.

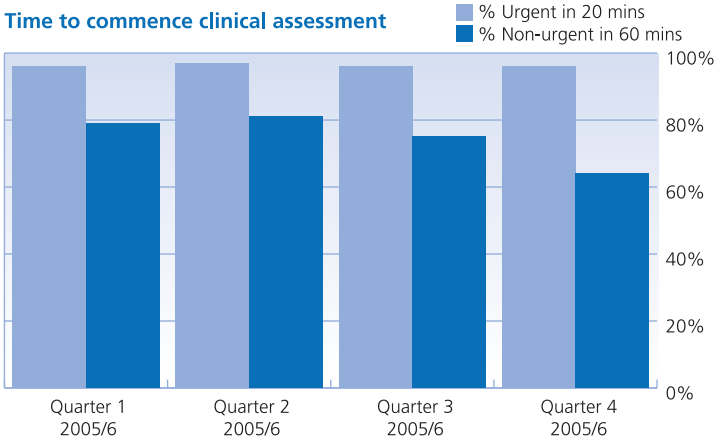
The abandonment rate improved substantially during the first half of the financial year, reducing from 17 per cent in March 2005 to just six per cent in August. With the winter demand increase, there was some deterioration in performance but this still remained better than the same period in 2004-05.

The percentage of urgent calls commencing clinical assessment within 20 minutes has never fallen below the 95 per cent target in any month since measurement began in March 2005. The proportion of non-urgent calls commencing clinical assessment within 60 minutes stood at 75 per cent for the year. This was below the target range, but mostly within the interim targets.

Abandonment rate



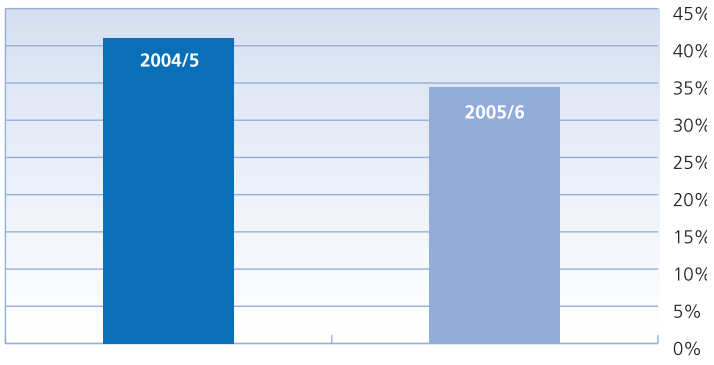
Time to commence clinical assessment



NHS referrals

NHS Direct aims to avoid unnecessary referrals that could lead to duplication of work or put strain on other parts of the health service. We have achieved substantial reductions in the level of urgent referrals to the rest of the NHS and the proportion is now in line with externally validated 'gold standard' benchmarks. Urgent referrals are those callers requiring either an ambulance or attendance at accident & emergency or a GP surgery. The reduction in referrals to urgent care services has been achieved without any adverse impact on patient safety.

% Urgent referrals

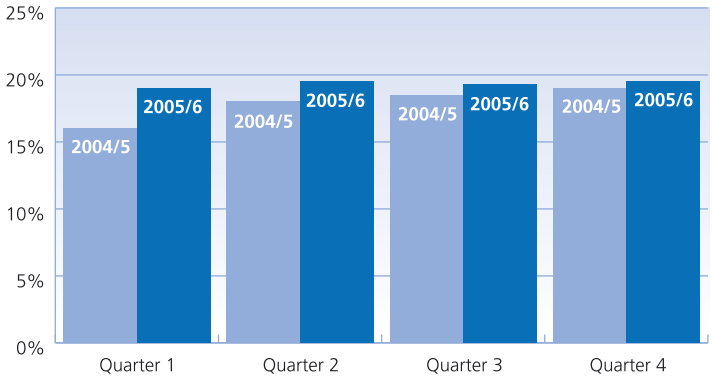


"The nurse advisers were judged to develop 'excellent' relationships with callers, far exceeding national call centre standards."

Improved clinical referrals have been achieved against the backdrop of sustained operational performance. This has been delivered through the management focus which the new organisation has been able to bring, along with the development of our clinical content through NHS Direct's clinical assessment system.

NHS Direct has also contributed to the reduction in referrals by improving the percentage of symptomatic calls which were completed wholly within the service through the provision of self-care advice and information. The graph below shows an upward trend throughout the year.

Home care and pharmacy as % of symptomatic calls



Patient satisfaction

During 2005-06, NHS Direct commissioned a study of the telephone service from the perspective of how it feels to be a patient calling a nurse advisor or health advisor (call handler). Overall, it found that users' experience of NHS Direct was positive, placing the service in the top quartile of contact centres nationally. In particular, the nurse advisors were judged to develop 'excellent' relationships with callers, far exceeding national contact centre standards.

We are now learning from the language and skills deployed by our nurses, and spreading this excellent practice throughout the organisation to further improve the already good performance of health advisors. We are implementing extra training programmes and expanding our induction programme to help health advisors treat each patient as a valued individual. We will then carry out a further assessment of the service in autumn 2006. The results of the study will contribute to the patient experience focus of the clinical governance strategy, which is currently in the early stages of development.

Financial performance

During the first year of operation as a special health authority NHS Direct met its financial targets at the same time as creating a new organisational infrastructure. In the year 2005–06 the authority has generated a surplus of £4.42m. This is detailed in the following table, with the comparative figures from the previous financial year included for reference:

	2005/06	2004/05
	£000	£000
Income	**155,736**	150,180
Expenditure	**(151,316)**	(147,351)
Operating surplus	**4,420**	2,829

The figures for the year 2004–05 have been restated from the published accounts as a result of prior year adjustments agreed with our external auditors in respect of fixed assets and the release of capital grant from reserve. This has had the effect of increasing the operating surplus from £1.011m to £2.829m.

The £4.42m surplus for the year is a result of a transfer of £2.018m from capital reserve to cover the cost of depreciation which was not part of the original financial plan for the year. It is also due to delays in spending on organisational change, on which the authority will be consulting during 2006–07. As a result it has been agreed with the Department of Health that initially £3.8m of the surplus can be carried forward to support the one-off transition cost in 2006–07.

Income and expenditure

Total income of £155.7m was generated during the year. The main components were:

- commissioned services from primary care trusts of £145.5m, of which £126.6m relates to the ring-fenced funding for the telephone, online and digital TV services and the balance of £18.9m to contestable services
- project funding from the Department of Health of £7.3m
- other income of £2.9m.

The total expenditure for the year of £151.3m comprised:

- £106.7m on salary and wages
- £24.5m on telecommunications and technology infrastructure
- £20.1m on organisational overheads.

The authority was required to deliver some £6.6m of savings in 2005–06 as a result of identified financial pressures and adverse expenditure trends in the early months of the financial year. With the exception of some £650,000 these savings were delivered from a variety of recurrent and non-recurrent measures. The savings from the non-recurrent measures are to be made recurrent in 2006–07 and form part of the business plan for the new financial year.

During the course of the year NHS Direct has continued to seek improvements in its overall operational effectiveness by the better use of its technology infrastructure and asset base. Underpinning this programme is a determination to reduce over time the overall cost of the organisation and to reinvest the resources saved into more effective service delivery and other improvements.

Cash flow and balance sheet

There have been a number of changes in the authority's balance sheet and working capital position during the year. The authority ended the year with £20.6m cash in the bank. This was largely due to two factors.

The first was the non-payment of the arrears associated with the implementation of Agenda for Change, which is backdated to 1 October 2004. The new pay arrangements have presented a big challenge to the organisation given that it inherited staff from 22 previous employers who were using some 66 different terms and conditions of employment. Arrears will be paid in the new financial year once the detailed calculations have been finalised.

The second factor was the significant improvement in the flow of funds from primary care trusts which commission services from NHS Direct. The amount owed from NHS organisations decreased from £16.7m in 2004–05 to £6.4m in 2005–06, an improvement of around £10m.

Focus on quality and safety

The clinical integrity of NHS Direct has always been a key strength, ensuring that the organisation remains one of the safest – as well as among the most popular – providers of healthcare within the NHS. In addition to our highly qualified staff and sophisticated decision-support technology, we have a raft of robust quality assurance and improvement systems in place. We continually strive to learn and improve and these systems ensure that clinical quality and patient safety remain at the heart of the service.

During 2005-06, we appointed a new Head of Clinical Governance and the National Clinical Governance Committee continued to meet to ensure that the organisation retains and builds on its clinical strengths and continues to improve performance.

The performance improvements achieved this year (see pages 6 to 8) have been the result of a range of initiatives and changes, detailed below.

Healthcare Commission Standards for Better Health

A key focus of the last year has been ensuring that the service provided by NHS Direct meets the Department of Health's Standards for Better Health. These standards, introduced in 2004, specify the level of quality that all NHS organisations in England are expected to meet in terms of safety, clinical and cost-effectiveness, governance, patient focus, accessible and responsive care, care environment and amenities and public health. They form a key part of the Healthcare Commission's performance assessment of NHS organisations.

In 2005-06, NHS Direct undertook a self assessment of compliance with the standards in advance of its first official assessment. The assessment demonstrated that the service is compliant with all but two of the relevant standards. We are currently working on a national strategy for public and patient involvement (PPI), which will help us to comply with the PPI standard. Due to the unique nature of NHS Direct, there is some uncertainty about the application of one of the public health standards. NHS Direct is currently agreeing with the Healthcare Commission whether this and other standards will be applied.

In April 2007, NHS Direct will conduct another self assessment and formally submit the results to the Healthcare Commission. Based on this statement and other evidence including visits to NHS Direct, the commission will award a performance rating.

Technological changes

Reflecting our first year as a truly national organisation, this year saw the introduction of what is termed the Virtual Contact Centre. This refers to the new technological systems that allow calls from anywhere in the country to be routed to any of our health advisors. It means we can help patients more quickly, cut waiting times, and respond more flexibly to changes in demand.

Another technological improvement involves changes to the algorithms that form the basis of the clinical assessment system used by NHS Direct nurse advisors. During 2005-06, all algorithms were updated to ensure they reflected the latest guidelines from the National Institute for Health and Clinical Evidence and from the Government's National Service Frameworks and other national plans for the treatment of different conditions. The public information provided online and on our digital television service was updated in parallel.

The speed, efficiency and safety of call handling has also been improved by the introduction of new call streaming technology. This new decision-making tool allows health advisors to identify the seriousness of calls and route them accordingly, for example directing urgent calls straight to 999 and sorting other calls into those that must be dealt with immediately and those that can wait a certain number of hours. The technology ensures the best use of resources across the NHS, helps patients reach the appropriate service more quickly, and allows nurse advisors to concentrate on more complex clinical assessments.

New complaints and feedback policy

During 2005-06 NHS Direct has made several changes to improve its systems for recording and handling complaints. Work has progressed throughout the year to ensure that all complaints are correctly identified, recorded and acted upon in all departments and sites. We have developed a new system that brings together all elements of feedback about the service, making it easier to analyse performance, respond to complaints and make necessary service changes.

Complaint response time has also improved throughout the year. In the last three months of the year, approximately 80 per cent of complaints were handled within the 20 day target.

As a result of better systems for capturing complaints and an increase in the number of patient contacts, the number of formal complaints received has increased, rising to 877 this year from 340 in 2004-05. The increase has been steady throughout the year and peaked at around 100 per month.

The majority of complaints relate to communication between staff and patients and the length of time callers wait for a call back from nurses at busy periods. During the year nine complaints were referred to the Healthcare Commission and one to the Ombudsman. The Healthcare Commission has reported on two complaints so far. It is taking no action on one and the other resulted in a request for NHS Direct to provide more information to the complainant about what the service is doing about background noise in the contact centres. The Ombudsman asked NHS Direct to improve the flexibility of health advisors to direct callers to other sources of information when the service is busy and waiting times are long. It also asked the service to look at its internal review of caller/staff interaction.

Dealing with adverse incidents

NHS Direct's adverse incident management policy, introduced in June 2005, sets out the way the service responds to and learns from any adverse incidents that result from NHS Direct advice. Incidents are always thoroughly investigated and are subject to peer review. We also conduct discussions with the patients involved and the staff responsible for the relevant clinical areas.

During 2006-07, we will be introducing a new incident reporting system and database for all incidents, including the less severe ones. This will allow us to collate information nationally, analyse trends and root causes, and share learning nationally.

Mental health and child protection

In 2005-06 NHS Direct introduced mental health and child protection lead posts at regional and site level. These positions are responsible for developing expert practice and providing supervision and support for health advisors and nurses.

The mental health roles were established with funding received from the National Institute for Mental Health for England to ensure that the service deals effectively with mental health issues. Currently, around five per cent of callers to NHS Direct call specifically about a mental health issue, while around 40 per cent of all calls involve some element of mental health.

In addition to the regional child protection roles, a National Adviser for Child and Adolescent Health has been appointed to ensure that NHS Direct provides the best possible service for children. We are also also working with the NSPCC to deliver a joint training programme about children's services for all NHS Direct health advisors and nurses. Currently, around 30 to 40 per cent of our calls are specifically about children's health.

Expanding our service

The public consultation for the *Our health, our care, our say* White Paper identified major gaps between what the NHS is currently providing and what patients want and need. In particular, patients are seeking:

- **better information** to enable them to understand their health and services
- **better access** to services, enabling health, independence and well-being
- **better support**, placing the patient at the centre of health and social care.

In order to meet these needs, NHS Direct is evolving to offer a wide range of new services that also provide support to the wider NHS.

Better information

Health Direct

Over the last year, we have been participating in the development plans for Health Direct, a new information and advice service being designed by the Government to promote and support healthy lifestyles. NHS Direct is now putting together a business case to be involved in the delivery of the service, making use of our existing multi-channel infrastructure. Whereas we have previously focused on helping people with ill health, Health Direct would allow us to use our expertise to support and promote wellness. Such a service could have a huge impact on the rest of the health service by helping people stay healthy and ultimately keeping them out of hospital.

Better access

NHS Direct Choose and Book appointments line

The NHS Direct Choose and Book appointments line service was established in March 2005 as part of the high-profile NHS Choose and Book project. After a patient's GP has referred them to secondary care, they can call the line to book an appointment at a hospital of their choice. Our health advisors can also provide advice about the various options open to the patient.

Call volumes were initially low, but have grown exponentially as more hospitals, clinics and surgeries in the wider NHS have joined the system. There were 44 calls during April 2005, growing to 22,900 in March 2006. The total number of calls during 2005–06 was 70,100. The latest predictions suggest call numbers will grow from 6,000 to around 40,000 calls per week by the end of August 2006.

Dentistry services

To help patients access dental services and to help PCTs meet their obligations under the new dental contract, NHS Direct has developed a range of dental services in a number of areas around the country. The services include handling dental registrations and transfers to local dental services, as well as full assessment and pain management advice by specialist dental nurses. The use of the NHS Direct clinical assessment service supports the delivery of high quality, consistent advice.

Out-of-hours services

Changes to GPs' contracts have placed responsibility for out-of-hours care with PCTs, opening up a new competitive market for provision of out-of-hours services. Throughout the year, NHS Direct has sought to establish its role as a core partner in the urgent and unscheduled care system. Our focus has been on developing flexible models of out-of-hours services that meet local needs and on building partnerships that allow effective integration of clinical services.

Hearing Direct

For 18 months, NHS Direct has worked with the Department of Health, the Royal National Institute for the Deaf and 12 audiology departments to pilot the Hearing Direct service, which provides a telephone-based follow-up service for people with newly fitted hearing aids. Specially trained advisors use an assessment tool to check that patients are comfortable with the aids and that they are benefiting from them. The pilot demonstrated that the service can reduce the need for follow-up hospital appointments by a third, thereby helping to reduce waiting lists.

Better support

Long-term conditions

The growing emphasis on self care and care closer to home, outlined in the *Our health, our care, our say* White Paper, creates new and growing opportunities for NHS Direct to provide support services for people with long-term conditions.

For self care to work effectively, patients need access to the right resources and support. Evidence from the United States indicates that structured programmes of telephone-based support can significantly benefit patients with long-term conditions and help reduce their use of health services, in particular unplanned hospital admissions. During 2005-06, NHS Direct has been trialling such a scheme in Birmingham (see 'Birmingham Own Health' below).

Other services for people with long-term conditions include non-clinical outbound calling programmes such as tele-screening of patients with asthma and Weatherwatch programmes aimed at contacting patients with chronic obstructive pulmonary disease at times when the weather is likely to affect their symptoms.

Birmingham Own Health

The Birmingham Own Health scheme is a partnership between the North and Eastern Birmingham PCTs, UK Pfizer Health Solutions and NHS Direct to deliver telephone-based healthcare support to 2,000 patients with long-term conditions. The programme aims to help patients diagnosed with cardiovascular disease, heart failure or diabetes take a more active and informed role in managing their own health. NHS Direct nurses act as care managers, providing personal support to help patients obtain the best health outcomes from the treatment programmes already agreed between individuals, their GPs and other health professionals. The nurses use disease management software developed by Pfizer to create targeted, customised care plans for individuals in line with national and local clinical protocols. We will be reviewing the pilot scheme after 12 months and hope to offer this type of service more widely in future.

Support for secondary care

NHS Direct has identified a number of ways in which it can work with secondary care providers to help achieve the 18-week referral-to-treatment target. By carrying out some of those services normally provided in an outpatient department, we can bring care closer to patients, reduce the number of hospital visits a patient needs to make, and increase attendance rates for hospital appointments.

We are currently offering two main types of telephone support: pre-operative screening and post-discharge follow up with 'at risk' patients. Since November 2000, we have worked with Bolton Hospitals NHS Trust to provide a telephone-based pre-operative assessment service for patients. This service targets patients waiting for colorectal surgery, an area where operations were often cancelled as patients were not physically prepared for their procedure. NHS Direct now contacts these patients in advance to complete a pre-operative assessment and to ensure they understand the importance of proper preparation. The service contacted 2,000 pre-operative patients in the last year alone.

An organisation fit for the future

Last year, NHS Direct became a truly national organisation for the first time, bringing together services from 22 host NHS organisations. Throughout 2005-06, the board of directors has worked to reconcile the policies of these 22 organisations and to develop single systems for finance, payroll, human resource management and clinical governance.

The organisation is now facing further changes. With the move to trust status and the wider reforms in the NHS, it is under increasing pressure to improve efficiency and deliver more cost-effective solutions. It is against this backdrop that plans for a new organisational design have been taking place.

The original concept of five regional business units, introduced in April 2005, is no longer affordable or responsive enough to the changing environment. Like all parts of the NHS, we must ensure that we deliver a service that offers not just excellent clinical quality but also value for money both for our commissioners and for taxpayers.

To achieve financial balance in 2006-07 and beyond, to remain affordable for commissioners and to match the expected demand for services, we need to improve the efficiency of the way the organisation is run.

Over the year, the board considered five detailed options for organisational change to support NHS Direct through the challenges ahead. Its preferred option of a slimmed down executive team with nine regional operating units and centralised support services provides a good balance between operational stability, affordability and timeliness.

Changes to staffing and to the location of call centres are designed to ensure that users of the service have access to the right staff with the right skills in the right places. Staff members are now being consulted about the proposals, and the agreed changes will be implemented over the next two years.

Listening to users

NHS Direct has always had a strong commitment to involving patients and other interested groups in the design of our services. Listening to and learning from stakeholders is a vital step in ensuring that our services meet patients' needs and deliver value for both users and the wider NHS.

During 2005-06, we consulted more than 2,000 members of the public. Involvement took many forms, including the following:

- a series of discussion groups and a survey of more than 500 people to gain feedback on NHS Direct's multi-channel survey
- discussion groups involving 175 stakeholders, including patients, about the NHS Direct self-help guide
- an online survey to inform our response to the Government's *Our health, our care, our say* consultation
- a consultation on our website development, which led to the introduction of a readership panel made up of members of the public to ensure that our online content is accessible and effective.

We are currently developing a patient and public involvement strategy to ensure a standardised approach to public involvement accross the country. The strategy will be implemented as part of the clinical governance arrangements under the direction of the Director of Nursing.

We are also working to develop and implement an effective engagement strategy with interested parties. This year, we appointed a strategic stakeholder board to advise on priorities for NHS Direct services from a stakeholder viewpoint. In addition, the access issues group, which comprises members of patient groups and other voluntary organisations, continues to meet four times a year. This group provides useful feedback about how well NHS Direct meets the challenge of equitable access to the service.

Looking forward – NHS Direct in 2006-2007

Over the coming year, the wider NHS will undergo a significant level of organisational change. The introduction of the *Commissioning a Patient-Led NHS* reforms, the reconfiguration of ambulance trusts, and the expansion of patient choice will all impact on NHS Direct's services and its relationships with other healthcare organisations.

We are ready to respond to these challenges and the opportunities they present. During 2006-07, we will refocus the role of NHS Direct to offer a wider range of enhanced services, to help meet local health objectives and increase the value the service adds to the healthcare system as a whole.

For example, we are planning to expand our provision of services for people with long-term conditions, with the introduction of non-clinical outbound calling programmes to support both patients and GPs. We will also develop our support of secondary care services by offering NHS trusts the opportunity to use our outbound calling services to help improve the patient experience, improve attendance and reduce overall costs. The development of the Health Direct service (see page 12) will provide another opportunity to diversify our provision.

The core services

2006-07 will also see continued growth and development of our telephone, online and television services, as outlined below.

- During 2006-07 NHS Direct is expecting patient contacts to grow by 15 per cent to 27 million. We expect two per cent growth in the telephony service and 21 per cent growth for the multi-media channels. The success of the NHS Direct digital television channel has enabled us to enter negotiations with cable and Freeview broadcasters to vastly increase access to our TV services.
- We aim to increase the integration of our telephone services with the other NHS Direct media to provide more opportunities for self care and patient empowerment. This will include repositioning the new media over the telephone service and introducing cross-channel messaging to encourage people to use the self-service opportunities.
- We will introduce more advanced technology to support the multi-channel environment and the more sophisticated requirements of the developing organisation. We hope to introduce a new knowledge management and content management solution in March 2007. This will allow all healthcare advisors to access relevant local information from wherever they are based.
- To support the safety and quality of the service, we will introduce a specific performance development plan for each job within NHS Direct. This will allow for better planning and implementation of training and development, ensuring that patients can be assured of the competency of all NHS Direct staff.

Performance targets and measures

NHS Direct is proposing an ambitious set of performance targets to be achieved over the next 15 months. These cover access to the service, the level of clinical referrals and the level of use of online services. The targets include:

- by June 2007, answering 90 per cent of calls in 60 seconds and achieving a maximum five per cent call abandonment rate
- by March 2007, ensuring that all but the least urgent calls are commenced within the standard of one hour
- by March 2007, reducing the level of urgent and emergency referrals by four per cent to 32 per cent, equivalent to 200,000 fewer patients a year being directed to 999, A&E or urgent GP services
- by March 2007, increasing the proportion of calls completed within NHS Direct by four per cent to 38 per cent, equivalent to 300,000 more callers a year
- an increase of more than 35 per cent in the number of visits to NHS Direct's online service, reaching two million per month by March 2007
- maintaining serious adverse incidents at less than 0.24 per 10,000 contacts during 2006
- responding to 95 per cent of complaints within 20 days during 2006-07.

The board and directors

David Edmonds, Chair

David Edmonds has been Chair of NHS Direct since it was set up as a special health authority. Following a career in the senior civil service, he became Chief Executive of the Housing Corporation, before spending seven years in the City, and five years as the UK's telecommunications regulator. He currently sits as a non-executive director on a number of PLC and public sector boards.

Ed Lester, Chief Executive

Ed Lester joined NHS Direct in March 2004 from Motability Finance Ltd, the car scheme for people with disabilities, where he was Chief Executive for nine years. Prior to this, he held a number of senior positions in banking and the oil industry, including Head of Corporate Finance at the HSBC-Forward Trust and Treasurer of Marathon Oil UK Ltd.

Non-executive directors

Peter Catchpole

Peter Catchpole worked as a senior executive in the NHS for 30 years, 20 of these as a Chief Executive. He has also been a non-executive director for organisations in the not-for-profit and charity sectors.

He is currently a county councillor in West Sussex and a fellow of the Faculty of Health at the University of Brighton. He also has a number of appointments in the professional regulatory sector and is an independent healthcare consultant and a business advisor to the independent health sector.

David Evans

David is a Reader in Applied Health Policy Research at the University of the West of England and a trustee of the UKPHA and Lifecycle UK. He was previously Director of Community Development and Public Health at Bristol North Primary Care Trust. He registered as a general nurse in 1986.

John Mallalieu

John is Regional Director of NHS Professionals and has public and private sector operational management experience in financial services and retail. He is a non-executive director for CMI Enterprises Ltd, the trading subsidiary of the Chartered Management Institute, and also has former experience with NHS Direct.

Derek Newman

Derek is currently Chief Information Officer (CIO) for Northern Foods plc. He has more than 20 years' IT management experience, including working as an independent consultant, as Group CIO in Zeneca and as European IT Director with ICI in Brussels.

Joanne Shaw

Joanne has been Chair of Datapharm Communications since April 2006, and is also Vice-Chair of NHS Direct and Chair of Ask About Medicines. Her previous roles include Director of the Task Force on Medicines Partnership, Director of Performance Development at the Audit Commission, and working as a management consultant in the private sector.

Executive directors

Murray Bain, Director of Information and Communications Technology (ICT)

Murray is responsible for the smooth running of NHS Direct's ICT infrastructure. Previous IT roles include Project Manager for St Albans City Council. He joined NHS Direct in 1999 as IT Telecoms Manager at the Bedfordshire and Hertfordshire contact centre before spending two years as national ICT Adviser.

Paul Jenkins, Director of Service Development*

Paul has responsibility for developing existing and new services in addition to relationships with the wider NHS. His remit also includes the NHS Direct New Media Unit. Paul, who has an MBA from the Manchester Business School, was National Director for NHS Direct until March 2004.

Dr Mike Sadler, Chief Operating Officer [from February 2006]

Dr Sadler rejoined NHS Direct in 2004, bringing a wealth of clinical and managerial experience. He worked as the Medical Director until January 2006 and thereafter as the Chief Operating Officer. He is now responsible for ensuring effective and efficient delivery of NHS Direct services.

He began his medical career in general practice, and then moved into public health, eventually working as Deputy Director of Public Health Medicine at Portsmouth and South East Hampshire Health Authority. In 2000, he joined NHS Direct Hampshire & Isle of Wight as local medical director and was also appointed National Medical Adviser to NHS Direct Online. In 2003 he became National Medical Director of Primecare, where he led a programme of clinical improvement before returning to NHS Direct.

Richard Sage, Director of Transformation

Working with executive colleagues and staff from across the organisation Richard is responsible for NHS Direct's Transformation Programme, which has brought NHS Direct together as a national service under a consistent operating model. Prior to joining NHS Direct, he gained extensive experience in management and consultancy in both public and private sectors. He has also worked in operational line management, customer services and IT.

Julie Treanor, Director of Corporate Affairs and Communications [until March 2006]

Stephen White, Chief Operating Officer [until January 2006]

Helen Young, Executive Director for Nursing*

Helen is the professional lead for nursing within NHS Direct. She is responsible for ensuring safe, effective and evidence-based clinical services for patients and users. Helen has worked in a number of large acute trusts holding Sister posts in surgery, critical care and medicine. She has also held senior managerial posts at Chelsea and Westminster and Guy's and St Thomas's, as well as various director of nursing positions. Prior to joining NHS Direct, she was Director of Nursing in North Wales with responsibility for acute nursing, mental health, community and midwifery services. She joined NHS Direct in December 2004 as Executive Director of Nursing and has been Executive Clinical Director since February 2006.

Michael Munt, Director of Finance and Estates*

Michael joined NHS Direct as Director of Finance and Estates in 2004. He began his NHS career as a regional finance trainee and was later appointed Finance Director of Maidstone Health Authority. Following a series of mergers, he became Finance Director and Deputy Chief Executive of the West Kent Health Authority. He moved to the Department of Health in 2001 as a Regional Finance Director and subsequently assumed the national finance role for the implementation of the new General Medical Services contract for GPs.

Alison Rayner, Director of Human Resources (HR)

Alison joined NHS Direct in October 2004 and is responsible for HR for 4,000 staff. Prior to joining the organisation, she was HR Director of a £340 million teaching hospital in Southampton with a staff of 8,500. While there, she led the introduction of the new consultant contract and a review of junior doctors' working patterns. Alison has also spent seven years as a director of HR at a combined community mental health and learning disabilities trust in west London.

* Board members

Public interest

Equal opportunities

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

Policy in relation to disabled employees

Policies relating to disabled employees are incorporated in to mainstream human resources policy guidance relating to issues such as equal opportunities and managing sickness and absence. NHS Direct currently has 57 employees with a declared disability.

Better payments practice code

The better payments code requires the authority to aim to pay all valid invoices by the due date or within 30 days of receipt of the goods, or a valid invoice date, whichever is the later. In 2005–2006 the authority paid (in number) 67 per cent of non-NHS bills and 38 per cent of NHS bills within this timescale.

Name of auditor

The accounts have been audited by the Comptroller and Auditor General in accordance with the *National Health Service Act 1977* as amended by the *Government Resources and Accounts Act 2000 (Audit of Health Service Bodies) Order 2003 No. 1324.* 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 authority has complied with relevant legislation and other requirements. The authority incurred audit fees of £110,000 in relation to the statutory audit for 2005–2006. No other audit services were provided during this period.

Disclosure of relevant information

As far as I am aware there is no relevant audit information of which NHS Direct's external auditors are unaware. I have also taken all appropriate steps to acquaint myself with any information relevant to the audit and to ensure that the auditors have been informed accordingly.

Directorships

All members of the board have declared any outside interests. The declarations made are detailed below.

David Edmonds, Chair	NHS Shared Business Services
	Hammerson Plc
	Wincanton Plc
	William Hill Plc
Joanne Shaw, non-executive	Vanguard Metropolitan Ltd
	AAMW Ltd
	Datapharm Communications Ltd
	(from April 1st, 2006)
Peter Catchpole, non-executive	None declared
David Evans, non-executive	None declared
Derek Newman, non-executive	None declared
John Mallalieu, non-executive	CMI Enterprises Ltd
Ed Lester, Chief Executive	Casa Toscana Ltd
	Placepass Ltd
Mike Sadler, Medical Director	None declared
Michael Munt, Director of Finance	None declared
Paul Jenkins, Director of Service Development	None declared
Helen Young, Director of Nursing	Home James of London
Stephen White (left 27/2/06)	None declared

Pensions

Past and present employees are covered by the provisions of the NHS pension scheme. Further details are provided in the Remuneration Report below (page 20) and note 1.8 to the Annual Accounts (see page 33).

Signed

Ed Lester

Chief Executive

11 July 2006

Remuneration report

Composition and roles of the remuneration committee

During 2005–06 the remuneration committee comprised John Mallalieu, Derek Newman and Peter Catchpole, all of whom are independent non-executive directors. The committee met five times during the year and was chaired by John Mallalieu. Its terms of reference are available on request.

The committee makes recommendations to the authority, within the formal terms of reference, on the policy and framework of executive remuneration and its overall cost to the authority. The committee is also responsible for the implementation of remuneration policy and determination of specific remuneration arrangements for all executive directors and other senior employees. It has access to the advice and views of the Director of Human Resources (Alison Rayner) and the Chief Executive (Ed Lester).

Executive directors remuneration policy and framework

The executive remuneration policy is linked to the guidance issued by the Department of Health in connection with the pay and remuneration for senior managers in the NHS. In addition, the remuneration committee asssessed any incentive payments based on quantifiable performance against agreed objectives. In 2005-06 the increase in the annual pay bill for executive directors was contained within an overall uplift of 3.225% as requested by the Department of Health. In future, the pay policy for very senior managers will be governed by a new pay framework, linked to the implementation of the *Commissioning a Patient-led NHS* strategy. The framework is currently being finalised and is expected to be published later this year.

All executive directors except one are on permanent contracts of employment. The contract of this member of staff ceases at the end of June 2006. The remuneration relating to all directors in post during 2005–06 (together with the comparative information for 2004–05) is detailed in the following tables, which identify the salary, allowance and pension benefits applicable both to executive and non-executive directors of the authority.

Salaries and allowances

	2005-06			2004-05		
Name and title	Salary (bands of £5,000) £000	Other remuneration (bands of £5,000) £000	Benefits in kind (to the nearest £00) £00	Salary (bands of £5,000) £000	Other remuneration (bands of £5,000) £000	Benefits in kind (to the nearest £00) £00
David Edmonds, Chair	20-25	0	0	20-25	0	0
Joanne Shaw, non-executive	5-10	0	0	5-10	0	0
Peter Catchpole, non-executive	5-10	0	0	5-10	0	0
Derek Newman, non-executive	5-10	0	0	5-10	0	0
John Mallalieu, non-executive	5-10	0	0	5-10	0	0
David Evans, non-executive	5-10	0	0	5-10	0	0
Ed Lester, Chief Executive	165-170	0	1	155-160	0	0
Michael Munt, Director of Finance	105-110	0	4	50-55*	0	1
Paul Jenkins, Director of Service Development	105-110	0	0	80-85	0	0
Alison Rayner, Director of Human Resources	95-100	0	0	50-55*	0	0
Mike Sadler, Medical Director	105-110	0	6	40-45*	0	1
Murray Bain, Director of ICT	95-100	0	4	55-60	0	0
Richard Sage, Director of Transformation	125-130	0	5	75-80*	0	1
Helen Young, Director of Nursing	95-100	0	5	30-35*	0	1
Stephen White, Chief Operating Officer (to 27/2/06)	105-110*	0	0	25-30*	0	0
Julie Treanor, Director of Communication and Corporate Affairs (to 3/3/06)	80-85*	0	3	5-10*	0	0

*Part year only

Pension benefits

Name and title	Real increase in pension at age 60 (bands of £2,500) £000	Lump sum at aged 60 related to real increase in pension (bands of £2,500) £000	Total accrued pension at age 60 at 31 March 2006 (bands of £5,000) £000	Lump sum at age 60 related to accrued pension at 31 March 2006 (bands of £5,000) £000	Cash equivalent transfer value at 31 March 2006 £000	Cash equivalent transfer value at 31 March 2005 £000	Real increase in cash equivalent transfer value £000	Employer's contribution to stakeholder pension £00
Ed Lester, Chief Executive	0-2.5	2.5-5	0-5	5-10	49	21	19	0
Michael Munt, Director of Finance	0-2.5	5-7.5	0-5	5-10	33	7	18	0
Paul Jenkins, Director of Service Development	0-2.5	2.5-5	0-5	0-5	15	0	11	0
Alison Rayner, Director of Human Resources	2.5-5	12.5-15	20-25	60-65	236	176	39	0
Mike Sadler, Medical Director	5-7.5	15-17.5	20-25	70-75	309	235	48	0
Murray Bain, Director of ICT	17.5-20	52.5-55	40-45	130-133	677	403	184	0
Richard Sage, Director of Transformation	0-2.5	2.5-5	0-5	5-10	32	10	15	0
Helen Young, Director of Nursing	0-2.5	0-2.5	15-20	55-60	193	184	3	0
Stephen White, Chief Operating Officer (to 27/2/06)	0-2.5	2.5-5	0-5	0-5	16	3	8	0
Julie Treanor, Director of Communication and Corporate Affairs (to 3/3/06)	5-10	15-17.5	5-10	15-20	67	0	43	0

As non-executive members do not receive pensionable remuneration, there are no entries in respect of pensions for non-executive members.

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.

Signed

Ed Lester

Chief Executive

11 July 2006

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

Under the National Health Service Act 1977 and directions made thereunder by the Secretary of State with the approval of Treasury, NHS Direct 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 Treasury. The accounts are prepared on an accruals basis and must give a true and fair view of NHS Direct's state of affairs at the year end and of the surplus, total recognised gains and losses and cash flows for the financial year.

The Accounting Officer for the Department of Health has appointed the Chief Executive of NHS Direct as the Accounting Officer, with responsibility for preparing the 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 will continue in operation.

The Chief Executive's relevant responsibilities as Accounting Officer, including responsibility for the propriety and regularity of the public funds and assets vested in NHS Direct, 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

Signed

Ed Lester

Chief Executive

11 July 2006

Statement on internal controls

Scope of responsibility

As Accounting Officer, I have responsibility, together with the board of NHS Direct special health authority 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 *Accounting Officer Memorandum.*

NHS Direct has a range of mechanisms in place to facilitate effective working with key partners. In particular, the senior departmental sponsor in the Department of Health is responsible for ensuring that NHS Direct procedures operate effectively, efficiently and in the interest of the public and the NHS. This requirement is addressed at the regular monthly performance review meeting with the sponsor branch. This meeting covers all aspects of the organisation's current and future business activities. In addition, I provide regular business and financial reports to the authority's board on a monthly basis.

NHS Direct also has regular meetings with a representative group of our hosts' service commissioners on a quarterly basis.

The purpose of the system of internal control

The system of internal control is designed to manage risk to a reasonable level to achieve policies, aims and objectives, rather than to eliminate all risk of failure. It can therefore provide only 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 not been in place in NHS Direct for the whole of the financial year ended 31 March 2006. It was in place from 31 October 2005 up to the date of approval of the annual report and accounts.

Capacity to handle risk

The authority has, during the course of the financial year, implemented a comprehensive assurance framework that embraces all aspects of risk. This is based on the principal objectives identified in the authority's approved Business Plan and the principal risks that flow from them. I have overall responsibility for risk management although the management of risk is a key goal for all senior managers in the organisation.

The authority continues to learn from good practice through a range of mechanisms including clinical supervision, individual and peer review, performance monitoring and continuing education and development.

The risk and control framework

The risks that threaten the achievement of the authority's key priorities and objectives have been identified, and actions are in place to address identified shortcomings. The authority's assurance framework identifies the assurance available to the board in relation to the achievement of key priorities and objectives, the principal threats to this achievement, and the effectiveness of the operation of key control processes.

The board is regularly informed of any gaps in control and assurance processes and the action being taken to address these issues. Gaps in control may include training, policies, procedures and systems, whilst the gaps in assurance include policy direction, monitoring and reporting arrangements.

Review of effectiveness

As Accounting Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review is informed in a number of ways. The head of internal audit provides me with an opinion on the overall arrangements for gaining assurance through the assurance framework, and on the controls reviewed as part of the internal audit work. Executive managers within the organisation who have responsibility for the development and maintenance of the system of internal control also provide me with assurance. The assurance framework itself provides me with evidence that the effectiveness of risk management controls has been reviewed. My review is also informed by other sources including external audits and surveys of users and staff.

The following information summarises some of the key activities of the main committees that 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, risk and clinical governance committees as well as receiving regular monitoring information from the balanced scorecard in respect of incidents and complaints trends.

The audit committee

The internal audit plan enables the board to be reassured that key internal financial controls and other matters relating to risk are being regularly reviewed. The audit committee reviews internal and external audit reports and progress on risk related issues whilst also providing the board with an overview of the effectiveness of the assurance arrangements based on the work of the risk and clinical governance committees.

Risk committee

This committee is responsible for assessing the risks to the organisation in terms of their likelihood and their impact on achieving strategic, business and operational objectives. It also reviews and assesses the effectiveness of existing and potential control and assurance systems.

Clinical governance committee

This committee has been reviewing the organisation's compliance with the Healthcare Commission's standards for better health. A formal Healthcare Commission review is planned later in the year.

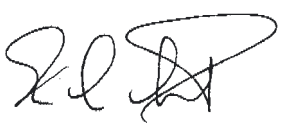
Summary

In conclusion, the authority has and is continuing to address the control weaknesses identified last year. In particular, it has:

- fundamentally reviewed its risk management processes during the year following the absence of an adequate assurance framework in 2004-05
- addressed the central financial control processes relating to the verification of expenditure and collection of income
- progressed action in respect of the information technology control environment
- consolidated its payroll arrangements and introduced standard procedures across the organisation.

It is however acknowledged that work remains to be done in the last two areas of activity, particularly in respect of payroll arrangements. We are continuing to embed an appropriate control environment linked to the application of agreed payroll polices and procedures.

Signed



Ed Lester

Chief Executive

11 July 2006

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 for the year ended 31 March 2006 under the National Health Service Act 1977. These comprise the Income and Expenditure Account, the Balance Sheet, the Cashflow Statement and Statement of Total Recognised Gains and Losses and the related notes. These financial statements have been prepared under the accounting policies set out within them.

Respective responsibilities of the Chief Executive and auditor

The Chief Executive is responsible for preparing the Annual Report, the Remuneration Report and the financial statements in accordance with the National Health Service Act 1977 and directions made thereunder by the Secretary of State with the approval of the Treasury and for ensuring the regularity of financial transactions. These responsibilities are set out in the Statement of Chief Executive's Responsibilities.

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

I report to you my opinion as to whether the financial statements give a true and fair view and whether the financial statements and the part of the Remuneration Report to be audited have been properly prepared in accordance with the National Health Service Act 1977 and directions made thereunder by the Secretary of State with the approval of the Treasury. I also report whether in all material respects the expenditure and income have been applied to the purposes intended by Parliament and the financial transactions conform to the authorities which govern them. I also report to you if, in my opinion, the Annual Report is not consistent with the financial statements, if NHS Direct has not kept proper accounting records, if I have not received all the information and explanations I require for my audit, or if information specified by relevant authorities regarding remuneration and other transactions is not disclosed.

I review whether the statement on page 24 reflects NHS Direct's compliance with HM Treasury's guidance on the Statement on Internal Control, and I report if it does not. I am not required to consider whether the Accounting Officer's statements on internal control cover all risks and controls, or form an opinion on the effectiveness of NHS Direct's corporate governance procedures or its risk and control procedures.

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

Basis of audit opinion

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

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

Opinions

In my opinion:

- the financial statements give a true and fair view, in accordance with the National Health Service Act 1977 and directions made thereunder by the Secretary of State with the approval of the Treasury, of the state of NHS Direct's affairs as at 31 March 2006 and of its surplus, total recognised gains and losses and cashflows for the year then ended;
- the financial statements and the part of the Remuneration Report to be audited have been properly prepared in accordance with the National Health Service Act 1977 and directions made thereunder by the Secretary of State with the approval of the Treasury; and
- 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.

I have no observations to make on these financial statements.

John Bourn
National Audit Office
Comptroller and Auditor General
157-197 Buckingham Palace Road
Victoria
London SW1W 9SP

13 July 2006

Supplementary Statement by the Comptroller and Auditor General

The maintenance and integrity of the NHS Direct special health authority website is the responsibility of the Accounting Officer; my work does not involve consideration of these matters and accordingly I accept no responsibility for any changes that may have occurred to the financial statements of the NHS Direct special health authority since they were initially presented on the web site.

Annual accounts

Income and expenditure account for the year ended 31 March 2006

		2005-06	Restated 2004-05
	Notes	**£000**	£000
Operating income	4	**155,736**	150,180
Expenditure	2.1	**(151,316)**	(147,351)
Retained surplus		**4,420**	2,829

All income and expenditure is derived from continuing operations.

Statement of total recognised gains and losses for the year ended 31 March 2006

		2005-06	Restated 2004-05
	Notes	**£000**	£000
Retained surplus		**4,420**	2,829
Unrealised surplus on the indexation of fixed assets	12.2	**77**	747
Unrealised deficit on the revaluation of fixed assets	12.2	**0**	(182)
Total recognised gains and losses for the financial year		**4,497**	3,394

The notes at pages 31 to 45 form part of these accounts.

Balance sheet as at 31 March 2006

	Notes	31 March 2006 £000	Restated 31 March 2005 £000
Fixed assets			
Tangible assets	5.2	**11,419**	9,217
		11,419	9,217
Current assets			
Debtors	7	**20,798**	30,342
Cash at bank and in hand	8	**20,596**	2,419
		41,394	32,761
Creditors: amounts falling due within one year	9.1	**(21,575)**	(25,850)
Net current assets/(liabilities)		**19,819**	6,911
Total assets less current liabilities		**31,238**	16,128
Provisions for liabilities and charges	10	**(12,254)**	(3,927)
		18,984	12,201
Taxpayers' equity			
Income and Expenditure Reserve	12.1	**7,566**	2,984
Capital Reserve	12.2	**11,418**	9,217
		18,984	12,201

The financial statements on pages 28 to 45 were approved by the Board on 5 July 2006 and signed on its behalf by:

Signed

Date: 11 July 2006

Accounting Officer

Cash flow statement for the year ended 31 March 2006

	Notes	2005-06 £000	Restated 2004-05 £000
Net cash inflow from operating activities	13	**21,898**	3,676
Servicing of finance			
Interest paid		**0**	0
Net cash outflow from servicing finance		**0**	0
Capital expenditure and financial investment:			
Payments to acquire tangible fixed assets		**(4,122)**	(6,077)
Receipts from disposal of tangible fixed assets		**0**	0
Net cash outflow from investing activities		**(4,122)**	(6,077)
Net cash inflow/outflow before financing		**17,776**	(2,401)
Financing:			
Capital Funding		**401**	4,820
Increase in cash in the period	8	**18,177**	2,419

The notes at pages 31 to 45 form part of these accounts.

Notes to the accounts

1 Accounting policies

The financial statements have been prepared in accordance with the Government Financial Reporting Manual issued by HM Treasury. The particular accounting policies adopted by the authority are described below. They have been consistently applied in dealing with items considered material in relation to the accounts.

1.1 Accounting conventions

These accounts are prepared under the historical cost convention, modified to account for the revaluation of tangible fixed assets and stock where material, at their value to the business by reference to current cost. This is in accordance with directions issued by the Secretary of State for Health and approved by HM Treasury.

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

1.2 Income

Operating income is income which relates directly to the operating activities of the authority.

The main source of funding for the authority is income for call centre services provided to NHS primary care trusts. Additional income is derived mainly from development initiatives funded by the Department of Health.

Income is accounted for applying the accruals convention. Where income is derived from a specific activity which is to be delivered in the following financial year, that income is deferred.

1.3 Taxation

The authority is not liable to pay corporation tax. Expenditure is shown net of recoverable VAT. Irrecoverable VAT is charged to the most appropriate expenditure heading or capitalised if it relates to an asset.

1.4 Capital charges

The treatment of fixed assets in the account is in accordance with the principal capital charges objective to ensure that such charges are fully reflected in the cost of capital. The interest rate applied to capital charges in the financial year 2005-06 was 3.5 per cent (2004-05: 3.5 per cent) on all assets less liabilities, except for donated assets and cash balances with the Office of the Paymaster General, where the charge is nil.

1.5 Fixed assets

a] Capitalisation

All assets falling into one of the following categories are capitalised:

i] Intangible assets that are capable of being used for more than one year and have a cost, individually or as a group, equal to or greater than £5,000.

ii] Purchased computer software licences are capitalised as intangible fixed assets where expenditure of at least £5,000 is incurred.

iii] Tangible assets that are capable of being used for more than one year, and that fit one of the following categories:

- individually have a cost equal to or greater than £5,000
- collectively have a cost of at least £5,000, 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
- form part of the initial setting up cost of a new building, irrespective of their individual or collective cost.

iv] Donated fixed assets are capitalised at their current value on receipt, and this value is credited to the donated asset reserve.

b] Valuation

Intangible fixed assets

Intangible fixed assets held for operational use are valued at historical cost, except research and development which is revalued using an appropriate index figure. Surplus intangible assets are valued at the net recoverable amount.

The carrying value of intangible assets is reviewed for impairment at the end of the first full year following acquisition and in other periods if events or changes in circumstances indicate the carrying value may not be recoverable

Tangible fixed assets

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

i] For land and buildings (including dwellings), valuations are carried out by the District Valuer of the Inland Revenue at five-yearly intervals in accordance with FRS 15. Between valuations price indices appropriate to the category of asset are applied to arrive at the current value. The buildings indexation is based on the *All in Tender Price Index* published by the Building Cost Information Service. The land index is based on the residential building land values reported in the *Property Market Report* published by the Valuation Office. The valuations were carried out in accordance with the Royal Institute of Chartered Surveyors (RICS) *Appraisal and Valuation Manual* insofar as these terms are consistent with the agreed requirements of the Department of Health and HM Treasury. In accordance with the requirements of the Department of Health, the asset valuations were undertaken in 2004 as at the prospective valuation date of 1 April 2005.

The valuations have been carried out primarily on the basis of depreciated replacement cost for specialised operational property and existing use value for non-specialised operational property. In respect of non-operational properties, including surplus land, the valuations have been carried out at open market value. The value of land for existing use purposes is assessed to existing use value. The valuations do not include notional directly attributable acquisition costs nor have selling costs been deducted, since they are regarded as not material.

To meet the underlying objectives established by the Department of Health the following accepted variations of the RICS Appraisal and Valuation Manual have been required:

- specialised operational assets have been valued on a replacement rather than modern substitute basis
- no adjustment has been made to the cost figures of operational assets in respect of dilapidations
- additional alternative open market value figures have been supplied only for operational assets scheduled for imminent closure and subsequent disposal.

ii] Operational equipment is valued at net current replacement costs through annual uplift by the change in the value of the GDP deflator. Equipment surplus to requirements is valued at net recoverable amount.

iii] Assets in the course of construction are valued at current cost, using the index as for land and buildings. These assets include any existing land or buildings under the control of a contractor.

iv] Subsequent revaluations to donated fixed assets are taken to the donated asset reserve.

v] All adjustments arising from indexation and five-yearly revaluations are taken to the capital reserve. All impairments resulting from price changes are charged to the statement of recognised gains and losses. Falls in value when newly constructed assets are brought into use are also charged there. These falls in value result from the adoption of ideal conditions as the basis for depreciated replacement cost valuations.

c] Depreciation and amortisation

Depreciation is charged on each individual fixed asset as follows:

- intangible assets are amortised, on a straight line basis, over the estimated lives of the assets
- purchased computer software licences are amortised over the shorter of the term of the licence and their useful economic lives
- land and assets in the course of construction are not depreciated
- buildings are depreciated evenly on their revalued amount over the assessed remaining life of the asset as advised by the District Valuer
- leaseholds are depreciated over the primary lease term
- each equipment asset is depreciated evenly over the expected useful life:

	Years
Plant and machinery	5 to 15
Information communications and technology	5 to 8
Furniture and fittings	10

1.6 Stocks and work in progress

Stocks and work in progress are valued at the lower of their cost and net realisable value. This is considered to be a reasonable approximation to current cost due to the high turnover of stocks. Work in progress comprises goods in intermediate stages of production.

1.7 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. They are divided into different categories which govern the way each individual case is handled.

Losses and special payments are charged to the relevant functional headings, including losses which would have been made good through insurance cover had special health authorities not been bearing their own risks (with insurance premiums then being included as normal revenue expenditure).

1.8 Pension costs

Past and present employees are covered by the provisions of the NHS pension scheme. The scheme is an unfunded, defined benefit scheme that covers NHS employers, general practices and other bodies in England and Wales allowed under the direction of the Secretary of State. As a consequence it is not possible for the authority to identify its share of the underlying scheme liabilities. Therefore, the scheme is accounted for as a defined contribution scheme and the cost of the scheme is equal to the contributions payable to the scheme for the accounting period.

The scheme is subject to a full valuation for FRS 17 purposes every four years. The last valuation on this basis took place as at 31 March 2003. The scheme is also subject to a full valuation by the Government Actuary to assess the scheme's assets and liabilities to allow a review of the employer's contribution rates. This valuation took place as at 31 March 2004 and has yet to be finalised.

The last published valuation on which contributions are based covered the period 1 April 1994 to 31 March 1999. Between valuations the Government Actuary provides an update of the scheme liabilities on an annual basis. The latest assessment of the liabilities of the scheme is contained in the *Scheme Actuary Report*, which forms part of the *NHS Pension Scheme (England and Wales) Resource Account,* published annually. These accounts can be viewed on the NHS Pensions Agency website at www.nhspa.gov.uk. Copies can also be obtained from The Stationery Office.

The conclusion of the 1999 valuation was that the scheme continues to operate on a sound financial basis and the notional surplus of the scheme is £1.1 billion. It was recommended that employers' contributions are set at 14 per cent of pensionable pay from 1 April 2003. On advice from the Actuary the contribution may be varied from time to time to reflect changes in the scheme's liabilities. Employees pay contributions of 6 per cent (manual staff 5 per cent) of their pensionable pay.

NHS bodies are directed by the Secretary of State to charge employers' pension costs contributions to operating expenses as and when they become due.

The scheme is a final salary scheme. Annual pensions are normally based on 1/80th of the best of the last three years' pensionable pay for each year of service. A lump sum normally equivalent to three years' worth of pension is payable on retirement. Annual increases are applied to pension payments at rates defined by the Pensions (Increase) Act 1971, and are based on changes in retail prices in the twelve months ending 30 September in the previous calendar year. On death, a pension of 50 per cent of the member's pension is normally payable to the surviving spouse.

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. Additional pension liabilities arising from early retirement are not funded by the scheme except where the retirement is due to ill health. For early retirements not funded by the scheme, the full amount of the liability for the additional costs is charged to the income and expenditure account at the time the authority commits itself to the retirement, regardless of the method of payment.

A death gratuity of twice the final year's pensionable pay is payable for death in service. The payment for those who die after retirement is up to five times the individual's annual pension less pensions already paid, subject to a maximum amount equal to twice the member's final year's pensionable pay less their retirement lump sum.

The scheme provides the opportunity to members to increase their benefits through money purchase additional voluntary contributions (AVCs) provided by an approved panel of life companies. Under the arrangement the employee can make contributions to enhance their pension benefits. The benefits payable relate directly to the value of the investments made.

1.9 Research and development

Research and development expenditure is charged against income in the year in which it is incurred, except insofar as development expenditure relates to a clearly defined project and the benefits of it can reasonably be regarded as assured. Expenditure so deferred is limited to the value of future benefits expected and is amortised through the income and expenditure account on a systematic basis over the period expected to benefit from the project. It is revalued on the basis of current cost. Amortisation is calculated on the same basis as used for depreciation, ie on a quarterly basis.

1.10 Foreign exchange

Transactions which are denominated in a foreign currency are translated into sterling at the exchange rate ruling on the date of each transaction, except where rates do not fluctuate significantly, in which case an average rate for a period is used.

1.11 Leases

Assets held under finance leases and hire purchase contracts are capitalised in the balance sheet and are depreciated over their useful lives or primary lease term. Rentals under operating leases are charged on a straight line basis over the terms of the lease.

1.12 Provisions

The authority provides for legal or constructive obligations that are of uncertain timing or amount at the balance sheet date on the basis of the best estimate of the expenditure required to settle the obligation. Where the effect of the time value of money is significant, the estimated risk-adjusted cash flows are discounted using the Treasury's discount rate of 2.2 per cent in real terms. This is a change from the rate of 3.5 per cent applied for 2004-05. The effect of the change is to increase the carrying value of the provision. This is shown in note 10 (see page 40).

2 Expenditure

2.1 Authority programme expenditure

		2005-06		Restated 2004-05	
	Notes	£000	£000	£000	£000
Non-executive members' remuneration			53		53
Other salaries and wages	2.2		106,622		93,946
Supplies and services – general			103		88
Establishment expenses			3,069		3,810
Health information services			1,889		1,914
Telecommunications			8,300		9,971
Transport			230		380
Premises and fixed plant			8,422		8,549
IT contracts			16,177		18,389
Service level agreement support provided by previous host trusts [a]			892		2,258
Miscellaneous [b]			3,185		2,354
Depreciation and amortisation	5.1, 5.2	1,963		3,113	
Loss on disposal of fixed assets		55		0	
Capital charges interest		162		155	
Capital charges interest – paid to previous host trusts [c]		0		358	
Impairment of fixed assets		0		1,877	
			2,180		5,503
Other finance costs – unwinding of discount	10	3		7	
– change in discount rate	10	21		(40)	
			24		(33)
Auditor's remuneration: audit fees [d]			110		140
Internal audit fees			60		29
			151,316		147,351

[a] Service level agreement support provided by previous host trusts has included services such as finance, ICT, estates and human resources.

[b] Significant items included in miscellaneous are interpreting services £144,389 (2004-05: £381,000), consultancy £1,386,763 (2004-05: £768,000) and insurance including CNST £93,623 (2004-05: £136,000). Other items include staff training and occupational health.

[c] Reimbursement to previous host trusts of capital charge interest on assets not transferred during the financial year.

[d] The authority did not make any payments to Auditors for non audit work.

Note A: The prior year figures have been restated to eliminate the purchase and associated indexation, revaluation and depreciation of the freehold property used by the authority on the Mayday Healthcare NHS Trust in Croydon, which it has been agreed it is not appropriate to transfer to the ownership of the authority. The associated capital liability, capital grant receipt and capital grant debtor have also been eliminated. The authority's occupation of the property has instead been treated as that of a tenant, with a consequent adjustment to the prior year figures for depreciation, rent paid and capital grant release.

2.2 Staff numbers and related costs

	2005-06 total	2005-06 permanently employed staff	2005-06 other	2004-05 total
	£000	£000	£000	£000
Salaries and wages	**90,778**	87,136	3,627	79,174
Social security costs	**5,971**	5,971	0	5,460
Employer contributions to NHS Pension Agency	**9,873**	9,873	0	9,312
	106,622	102,980	3,627	93,946

	2005-06 total	2005-06 permanently employed staff	2005-06 other	2004-05 total
	Number	Number	Number	Number
Average number of employees during the year	**3,154**	3,042	112	2,931

Expenditure on staff benefits
The amount spent on staff benefits during the year totalled £224,457 (2004-05: £205,080)

Retirements due to ill health
There were four early retirements from the authority on the grounds of ill health in the current year (2004-05: nil), at an additional cost of £404,183.98 (2004-05: £nil). This information has been supplied by NHS Pensions.

2.3 Better payment practice code - measure of compliance

	Number	£000
Total non-NHS bills paid during 2005-06	**22,401**	50,145
Total non-NHS bills paid within target	**14,968**	34,620
Percentage of non-NHS bills paid within target	**66.8%**	69.0%
Total NHS bills paid during 2005-06	**516**	4,030
Total NHS bills paid within target	**195**	1,635
Percentage of NHS bills paid within target	**37.8%**	40.6%

The better payment practice code requires the authority to aim to pay all valid invoices by the due date or within 30 days of receipt of goods or a valid invoice, whichever is later.

No interest was paid under the *Late Payment of Commercial Debts (Interest) Act 1998*.

No compensation was paid to cover debt recovery costs under the *Late Payment of Commercial Debts (Interest) Act 1998*.

3 Reconciliation of gross capital expenditure to capital grant

	2005-06	Restated 2004-05
	£000	£000
Gross capital expenditure	**4,142**	13,642
Capital grant received	**(402)**	(5,352)
Overspend against capital grant received	**3,740**	8,290

£8,290,000 of funding due to be provided in 2005-06 to complete the purchase of fixed assets transferred from previous host trusts was not provided, and as a consequence the completion of the purchase did not occur.

The additional grant required to fund purchases during 2005-06 was paid by the Department of Health after the year end.

See Note A above (page 36).

4 Operating income

Operating income analysed by classification and activity, is as follows:

	2005-06	Restated 2004-05
	£000	£000
Primary care trusts – commissioning	**145,450**	124,201
Department of Health	**7,296**	20,430
Other NHS	**548**	506
Other	**424**	53
Release of government capital grant from capital reserve	**2,018**	4,990
Total	**155,736**	150,180

Note B: The prior year figures have been restated to include the release of £1,877,000 from the capital reserve to match the impairment charge incurred on the authority's property in Nottingham.

See Note A above (page 36).

5 Fixed assets

5.1 Intangible fixed assets

There were no intangible fixed assets at either the current or previous year end.

5.2 Tangible fixed assets

	Land	Non-residential buildings	Plant and machinery	Information technology	Furniture and fittings	Assets under construction	**Restated Total**
	£000	£000	£000	£000	£000	£000	**£000**
Restated cost or valuation at 31 March 2005	1,000	7,853	32	2,549	769	0	**12,203**
Additions	0	115	0	730	0	3,297	**4,142**
Indexation	0	89	1	0	16	0	**106**
Disposals	0	0	(32)	(312)	(34)	0	**(378)**
Gross cost at 31 March 2006	1,000	8,057	1	2,967	751	3,297	**16,073**
Accumulated depreciation at 31 March 2005	0	1,390	26	1,423	147	0	**2,986**
Provided during the year	0	744	2	1,069	148	0	**1,963**
Indexation	0	26	0	0	3	0	**29**
Disposals	0	0	(28)	(285)	(10)	0	**(323)**
Accumulated depreciation at 31 March 2006	0	2,160	0	2,207	288	0	**4,655**
Restated net book value at 31 March 2005	**1,000**	**6,463**	**6**	**1,126**	**622**	**0**	**9,217**
Net book value at 31 March 2006	**1,000**	**5,897**	**1**	**760**	**463**	3,297	**11,419**

See Note A above (page 36).

The net book value of assets held under finance leases and hire purchase contracts at the balance sheet date are as follows:
31 March 2005 £0
31 March 2006 £0

The total amount of depreciation charged in the Income and Expenditure Account in respect of assets held under finance leases and hire purchase contracts:
31 March 2005 £0
31 March 2006 £0

5.3 Net book value of land and buildings

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

	31 March 2006	Restated 31 March 2005
	£000	£000
Freehold buildings	**2,958**	3,000
Improvements to long leasehold buildings	**2,063**	2,506
Improvements to short leasehold buildings	**876**	957
Long leasehold land	**1,000**	1,000
	6,897	7,463

See Note A above (page 36)

6 Stock and work in progress

There was no stock or work in progress at either the current or previous year end.

7 Debtors

7.1 Amounts falling due within one year

	31 March 2006	Restated 31 March 2005
	£000	£000
NHS debtors	**6,379**	16,761
Non-NHS trade debtors	**392**	113
Prepayments	**326**	494
Accrued income	**0**	2,191
NHS capital debtors	**12,563**	8,822
Other debtors	**42**	4
Recoverable VAT	**1,096**	1,957
	20,798	30,342

See Note A above (page 36).

7.2 Amounts falling due after more than one year

There were no amounts falling due after more than one year at the year end.

8 Analysis of changes in cash

	At 31 March 2005	**Change during the year**	At 31 March 2006
	£000	**£000**	£000
Cash at OPG	2,419	**18,177**	20,596
	2,419	**18,177**	20,596

9 Creditors

9.1 Amounts falling due within one year

	31 March 2006	Restated 31 March 2005
	£000	£000
NHS creditors	**4,575**	5,220
Non-NHS trade creditors	**3,102**	8,140
NHS capital creditors	**7,540**	7,540
Capital creditors	**45**	25
Tax and social security	**1,898**	1,496
Other creditors	**15**	15
Accruals	**3,111**	3,147
Deferred income	**1,289**	267
	21,575	25,850

See Note A above (page 36).

9.2 Amounts falling due after more than one year

There were no amounts falling due after more than one year at either the current or previous year end.

10 Provisions for liabilities and charges

	Pensions for former staff	Other	**Total**
	£000	£000	**£000**
At 31 March 2005	113	3,814	**3,927**
Arising during the year	0	8,309	**8,309**
Utilised during the year	(6)	0	**(6)**
Change in discount rate	21	0	**21**
Unwinding of discount	3	0	**3**
At 31 March 2006	**131**	**12,123**	**12,254**
Expected timing of cash flows:			
Within 1 year	6	12,123	**12,129**
1-5 years	21	0	**21**
Over 5 years	**104**	**0**	**104**

Included in the provisions for liabilities and charges is an amount of £12,084,390 (31 March 2005: £3,642,976) to cover the implications of the costs associated with the implementation of Agenda for Change. Amounts owed to staff will be backdated to 1 October 2004 for the assimilation to new salary scales and to 1 December 2004 in respect to changes in contractual hours.

There are no provisions included in the provisions of the NHS Litigation Authority at 31 March 2006 (31 March 2005: £nil) in respect of clinical negligence liabilities relating to the authority.

11 Movements in working capital other than cash

	2005-06	Restated 2004-05
	£000	£000
Increase/(decrease) in debtors	**(13,285)**	21,520
(Increase)/decrease in creditors	**4,295**	(18,285)
	(8,990)	3,235

12 Movements on reserves

12.1 Income and expenditure reserve

	31 March 2006	Restated 31 March 2005
	£000	£000
Balance at 31 March 2005	**2,984**	0
Retained surplus for the year	**4,420**	2,829
Non-cash items:		
Capital charge interest	**162**	155
Balance at 31 March 2006	7,566	2,984

See Note A above (page 36).

12.2 Capital reserve

	31 March 2006	Restated 31 March 2005
	£000	£000
Balance at 31 March 2005	**9,217**	0
Government grant received	**4,142**	13,642
Indexation of fixed assets	**77**	747
Revaluation of fixed assets	**0**	(182)
Transfer of depreciation to income and expenditure account	**(1,963)**	(3,113)
Transfer of loss on disposal to income and expenditure account	**(55)**	0
Transfer of impairment to income and expenditure account	**0**	(1,877)
Balance at 31 March 2006	**11,418**	9,217

See Notes A and B above (pages 36 and 37).

13 Reconciliation of operating surplus to cash flows

	Notes	2005-06	Restated 2004-05
		£000	£000
Net operating surplus (deficit) before interest for the year		**4,420**	2,829
Adjust for non-cash transactions	2.1	**2,179**	5,145
Adjust for movements in working capital other than cash	11	**8,990**	(3,235)
Increase/(decrease) in provisions	10	**8,327**	3,927
Transfer from reserves	12.3	**(2,018)**	(4,990)
Net cash inflow from operating activities		**21,898**	3,676

See Notes A and B above (pages 36 and 37).

14 Contingent liabilities

There were no known contingent liabilities at either the current or previous year end.

15 Capital commitments

Outstanding commitments under capital expenditure contracts at the balance sheet date were £1,956,700 (2004-05: £nil).

Capital expenditure approved but not contracted at the balance sheet date totalled £2,131,800 (2004-05: £nil).

Included in the above totals are £1,430,400 of contractual commitments in respect of the completion of the replacement of the telephony, voice recording and switch equipment and £792,600 of approved but not committed expenditure.

In addition, approval has been given for the development of Choose and Book facilities of which £526,300 was contracted but outstanding and £1,339,200 had not been contractually committed at the balance sheet date.

16 Commitments under operating leases

Expenses of the authority include the following in respect of hire and operating lease rentals:

	2005-06	2004-05
	£000	£000
Hire of plant and machinery	**85**	110
Other operating leases	**4,595**	3,794
	4,680	3,904
Commitments under non-cancellable operating leases:		
Land and buildings		
Operating leases which expire:		
within 1 year	**2,480**	2,172
between 1 and 5 years	**298**	496
after 5 years	**1,817**	1,126
	4,595	3,794
Other leases		
Operating leases which expire:		
within 1 year	**42**	43
between 1 and 5 years	**43**	67
after 5 years	**0**	0
	85	110

17 Other commitments

The Authority had no non-cancellable contracts (which are not operating leases) at either the current or previous year end.

18 Losses and special payments

During the year there were 8 cases (2004-05: NIL) of losses and special payments totalling £4,968.81 (2004-05: £nil).

19 Related parties

The authority is a body corporate established by order of the Secretary of State for Health. The Department of Health is regarded as a controlling related party.

During the year the authority has had a number of material transactions with the Department of Health, and with other entities for which the Department of Health is regarded as the parent department. For example, call handling services to primary care trusts, which were valued at £146m, represented trading with 303 individual organisations.

In particular the Department of Health provided grant-in-aid funding of £6,973,273 during the year.

In addition, the authority had material transactions with several organisations of an income or expenditure nature exceeding £750,000 in value. These organisations are listed overleaf.

	£000
Heart of Birmingham Teaching primary care trust (PCT)	2,613
Ealing PCT	1,251
Northumberland Care Trust	1,160
Nottingham City PCT	1,072
Croydon PCT	1,047
Sutton and Merton PCT	1,008
Brent Teaching PCT	1,000
Burnley, Pendle and Rossendale PCT	947
Shropshire County PCT	942
Central Cheshire PCT	934
Barnet PCT	922
Hillingdon PCT	917
South Birmingham PCT	857
Hounslow PCT	830
Stockport PCT	819
Amber Valley PCT	812
Eastbourne Downs PCT	812
Coventry PCT	803
Bedfordshire Heartlands PCT	798
Southwark PCT	788
Havering PCT	786
Enfield PCT	785
Notrth Somerset PCT	782
Oldham PCT	782
Sheffield West PCT	779
Westminster PCT	776
Walsall Teaching PCT	775
Bromley PCT	770
Morecambe Bay PCT	769
Ashton, Leigh and Wigan PCT	758
Wolverhampton City PCT	755
The NHS Professionals Special Health Authority	765

During the year, none of the authority's members or members of the key management staff or other related parties had undertaken any material transactions with the authority.

20 Post balance sheet events

There are no post balance sheet events that require disclosure.

21 Financial instruments

FRS 13, *Derivatives and Other Financial Instruments,* requires disclosure of the role that financial instruments have had during the period in creating or changing the risks an entity faces in undertaking its activities. Because of the way special health authorities are financed, the authority 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 the listed companies to which FRS 13 mainly applies. The authority 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 authority in undertaking its activities.

As allowed by FRS 13, debtors and creditors that are due to mature or become payable within 12 months from the balance sheet date have been omitted from all disclosures other than the currency profile

Liquidity risk
The authority's net operating costs are financed from resources voted annually by Parliament. The authority largely finances its capital expenditure from funds made available from Government as a capital grant. The authority is not, therefore, exposed to significant liquidity risks.

Interest-rate risk
100 per cent of the authority's financial assets and 100 per cent of its financial liabilities carry nil or fixed rates of interest. The authority is not, therefore, exposed to significant interest-rate risk.

Foreign currency risk
The authority has no foreign currency income or expenditure.

Fair values
Fair values are not significantly different from book values and therefore no additional disclosure is required.

22 Intra-government balances

	Debtors: Amounts falling due within one year	Debtors: Amounts falling due after more than one year	Creditors: Amounts falling due within one year	Creditors: Amounts falling due after more than one year
	£000	£000	£000	£000
Balances with other central government bodies	16,146	0	1,705	0
Balances with local authorities	4	0	95	0
Balances with NHS trusts	3,895	0	13,886	0
Balances with public corporations and trading funds	0	0	0	0
Balances with bodies external to government	753	0	5,889	0
At 31 March 2006	20,798	0	21,575	0
Balances with other central government bodies	Restated 11,958	0	Restated 1,496	0
Balances with local authorities	0	0	134	0
Balances with NHS trusts	18,279	0	13,098	0
Balances with public corporations and trading funds	0	0	0	0
Balances with bodies external to government	105	0	11,122	0
At 31 March 2005	30,342	0	25,850	0

See Note A above (page 36).

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