NHS Direct

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National Health Service Trust
Annual Report & Accounts
2009/10

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Contents

We're

here.

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

This makes us unique.

Joanne Shaw
Chair's Statement

NHS Direct supports patients and the NHS by providing remote and digital health advice and information. Over the past ten years, we have earned the respect and affection of the public, with consistently high levels of awareness and patient satisfaction. During 2009/10, we have concentrated on developing our relationships with our NHS partners so that we can play a more central role within the wider NHS. We have built a deeper understanding of how our services can enable the health service to make better use of its own resources. To achieve this, we have undertaken significant research to analyse how NHS Direct adds value for different kinds of patients and for the local NHS. We are using the outcome of this work as the basis of discussions with professional bodies and our NHS partners about how we can work together more effectively to help meet local needs in urgent care, acute care, long-term conditions and public health.

Over the past year, we have invested in improving the efficiency and effectiveness of our own operations so that we can do more for less. This has involved working closely with front line staff, managers and representative bodies to bring the performance of our contact centres up to the highest standards within the industry, and introducing new practices including homeworking for our nurses.

Our experience — particularly with the National Pandemic Flu Service — and that of other industries, has demonstrated that the NHS could use widely available technologies to put patients in control and provide better healthcare for more people, for less money. NHS Direct's web-first strategy is enabling us to take the first steps towards this. Our web-based self-assessment tools, integrated with telephone-based nurse advice, provide a better and more convenient experience for patients at a dramatically lower cost. These techniques point the way towards a virtual self-service NHS, built around the traditional system. This could meet the needs of the growing proportion of people who choose to conduct important aspects of their lives online, and enable traditional face-to-face services to focus on hands-on care and the needs of people who prefer to deal with the NHS in person. Integrated with our web-based service, we will continue to provide our telephone helplines, which receive over nine million calls each year.

During 2009/10, we have taken steps to bring our own governance and decision-making processes closer to the NHS, and to make our Board more accessible to the general public. We have recruited two new non-executive members of the Board, both of whom are doctors. We are experimenting with streaming our public board meetings over the internet so that a larger number of people can experience how they work first-hand.

In the coming year, we are looking forward to further improving the efficiency of our operations, and supporting the wider NHS to deploy remote and digital technologies to empower patients and make better use of increasingly pressured resources. We look forward to working closely with our partners to meet this goal.

Joanne Shaw
Chair, NHS Direct

Nick Chapman
Chief Executive's Statement

NHS Direct continues to provide people in England with expert health advice, information and reassurance using world-class telephone and web services. We support patients, their carers, and the rest of the NHS by providing advice and information, including how and when to self care. Nine out of ten patients rate highly the service they are given by NHS Direct.

Patients value the convenience of being able to access information and advice when on the move or without having to leave their home. We know that the information and advice we give helps to reduce the demand for face-to-face care. Across all services, nine million people contacted us by telephone and a further five million made use of our online symptom checkers through the NHS Choices and NHS Direct websites, and other websites where our content is syndicated. We estimate that our core services saved 2.4 million unnecessary appointments with GPs and other primary care services. They also saved 1.2 million unnecessary ambulance journeys and visits to accident and emergency departments.

Public awareness of the service remains high with 87% of people being aware of NHS Direct. However, we know there are still groups of patients who use us less than others and who would benefit from our services. We are working with the NHS, locally and nationally, and third sector organisations to try and reach these groups. We have, for the second year, successfully supported the Department of Health's national roll-out of the HPV vaccination campaign. Support includes a telephone helpline, webchat service and web seminars.

We have worked closely with many other NHS organisations to further integrate our services. For example, we received approximately 128,000 calls transferred to us for further clinical assessment from ambulance services across England (Category C calls). We provide over 70 locally commissioned services for NHS organisations, including providing GP and dental out of hours telephone assessment services. In April 2009, we commenced the telephone assessment service for West Yorkshire Urgent Care on behalf of five Primary Care Trusts. This was a big undertaking and, after a period of settling in, the service is now performing well.

During the year, we were part of the national response to the swine flu pandemic and also delivered the specially commissioned National Pandemic Flu Service. The service was mobilised on 23 July 2009 in England and was available as a contingency for Scotland, Northern Ireland and Wales. There were 2.7 million people who used it to gain advice through the web and over the telephone without needing to leave home. Of these, 1.8 million patients obtained authorisation for access to antiviral treatment without the need to visit their GP.

When the swine flu outbreak started, and before the National Pandemic Flu Service went live, we saw a surge of calls about swine flu to our core service (0845 4647) and a similar increase in the volume of visits to our online colds and flu symptom checker. During this time, despite enormous efforts and our staff working extra hours, access to our telephone service was not as good as we would have liked. Our patient feedback and performance statistics in this report reflect this.

We know that many people want to access our service on the web as well as the phone. We are developing our web applications and will make these as widely available as possible. The new applications, which include a much wider range of online health and symptom checkers based on the service patients are given over the telephone, will be launched in the first half of 2010/11.

The year also saw the start of our Strategic Development Programme – a detailed review of our purpose, capabilities and direction, and subsequent action to respond to the needs identified. This has resulted in some significant projects that now form the bedrock of our business plan for 2010/11 and beyond. The Board has approved the Trust's Business Plan for 2010/11, which is now being implemented. The plan includes making significant improvements in the quality of the service, reducing operating and management costs, and tackling staffing issues. These include substantial reductions to staff sickness, and a new approach to rostering for staff which will give staff better control over their working hours and shift patterns, and enable staff numbers to be matched more closely to variations in call volumes. There were many other projects that started during the year, which will bear fruit in 2010, including:

- homeworking pilots
- new band 5 nurse roles
- increases in the number of dental nurses
- tackling staff attrition
- managing teams and performance better
- improving our liaison with other NHS organisations
- working in partnerships with the private sector.

2009/10 also saw the Trust reduce its costs in real terms, thereby releasing funds back to be invested in the rest of the NHS.

I am pleased to include in this report our first Quality Account which details our priorities for improvement for 2009/10 in relation to the quality and safety of our services. This took into account comments and feedback provided from our commissioners and patient groups.

Finally, it is my privilege to pay tribute to the staff of NHS Direct — both those who work on the front line speaking with patients, and those who support the front line. 2009/10 was a tough year for staff as swine flu dominated much of what we did. However, our staff responded magnificently and always strived to do their best. Thank you.

Nick Chapman
Chief Executive, NHS Direct

Management Commentary

Overview

History and background

Who we are and what we do

NHS Direct provides people in England with expert health advice, information and reassurance so that they can care for themselves at home or access appropriate healthcare. Our core service is available 24 hours a day, 365 days a year, by telephone and on the web. We answer around five million calls each year and around five million patients use our online health and symptom checkers. We also offer a range of other nationally and locally commissioned services. We employ over 3,400 staff, including 1,400 trained nurses. Our core service is commissioned by the East of England Strategic Health Authority (SHA), acting as lead commissioner on behalf of the ten SHAs in England.

Core service

We handle a wide range of calls to our helpline (0845 4647) and visits to our website (nhsdirect.nhs.uk) involving:

- clinical assessment to enable people to care for themselves at home or to find the right care from the rest of the NHS
- information on local health services and support organisations
- advice on maintaining a healthy lifestyle
- information about illnesses, conditions, tests, treatments and operations
- complex enquiries about medication e.g. interactions, overdosing and poisoning
- information in response to national and local health scares e.g. swine flu.

Commissioned services

We provide locally commissioned services to other parts of the NHS to help them meet their patients' needs, ranging from telephone triage for out of hours dental and GP services to supporting patients with long-term conditions.

We have developed partnerships with a range of organisations to deliver world-class telephone-based care management services which:

- help and encourage people to follow personalised health plans
- allow people to look after themselves at home
- help people learn how to manage their long-term conditions so they can enjoy a happier and healthier lifestyle.

We also provide services that are nationally commissioned by the Department of Health and others. One example of this is the NHS Stressline, which gives practical and emotional support to people who are worried about debt, housing and unemployment.

The external environment and significant trends

In developing our strategic vision and objectives for the next four years, and our detailed business plan for 2010/11, we have reviewed our external environment, and the current and anticipated factors that we believe will have the most significant impact on people's health needs and on our contribution to meeting those needs.

Pressure on health systems is continuing to grow worldwide. In England, our ageing population will place greater demands on health services, exacerbated by a rise in the already significant numbers of people in the population living with long-term conditions. Demand is likely to become more complex, reflecting both the cultural and socio-economic diversity of our population and the increasing variety of ways in which people want to access information and services. This growth and diversification in demand will take place against a background of significant pressures on public sector expenditure.

NHS Direct can help the NHS meet these challenges. We are building our multi-channel capacity, providing services more cost-effectively and in the ways people want. We are developing our intelligence on where we add most value and how different patient groups access our services, so that we can target services more effectively to benefit patients and the wider NHS. We will not develop, or compete to provide, services unless we are clear about the need for those services and that we are best placed to deliver them. We will collaborate with NHS and other partners to drive innovation in service provision. We will strive for increased efficiencies in our operations while maintaining safety and improving the quality of our services.

Overview

We provide a national service from a small head office in London. We are in the process of moving from nine regions to three operational divisions.

Estate

We provide services from 32 contact centres. The contact centres are connected by a virtual network which means that calls taken in one part of the country can be answered in any one of the centres. Our headquarters are at Riverside House, 2a Southwark Bridge Road, London, SE1 9HA.

Key

Head Office
1 Riverside House

North
2 Newcastle
3 Stockton
4 Wakefield
5 Hull
6 Sheffield
7 Carlisle
8 Kendal
9 Blackburn
10 Middlebrook
11 Liverpool
12 Nantwich

Midlands and South West
13 Chesterfield
14 Mansfield
15 Nottingham
16 Derby
17 Dudley
18 Stafford
19 Bristol
20 Ferndown
21 Taunton
22 Exeter
23 Truro

South
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25 Southampton
26 Caterham
27 Chatham
28 Bedford
29 Chelmsford
30 Ipswich
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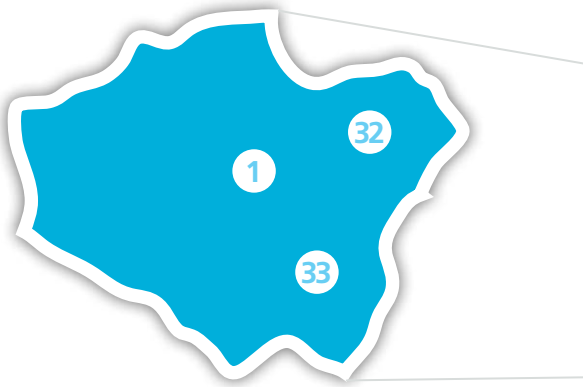
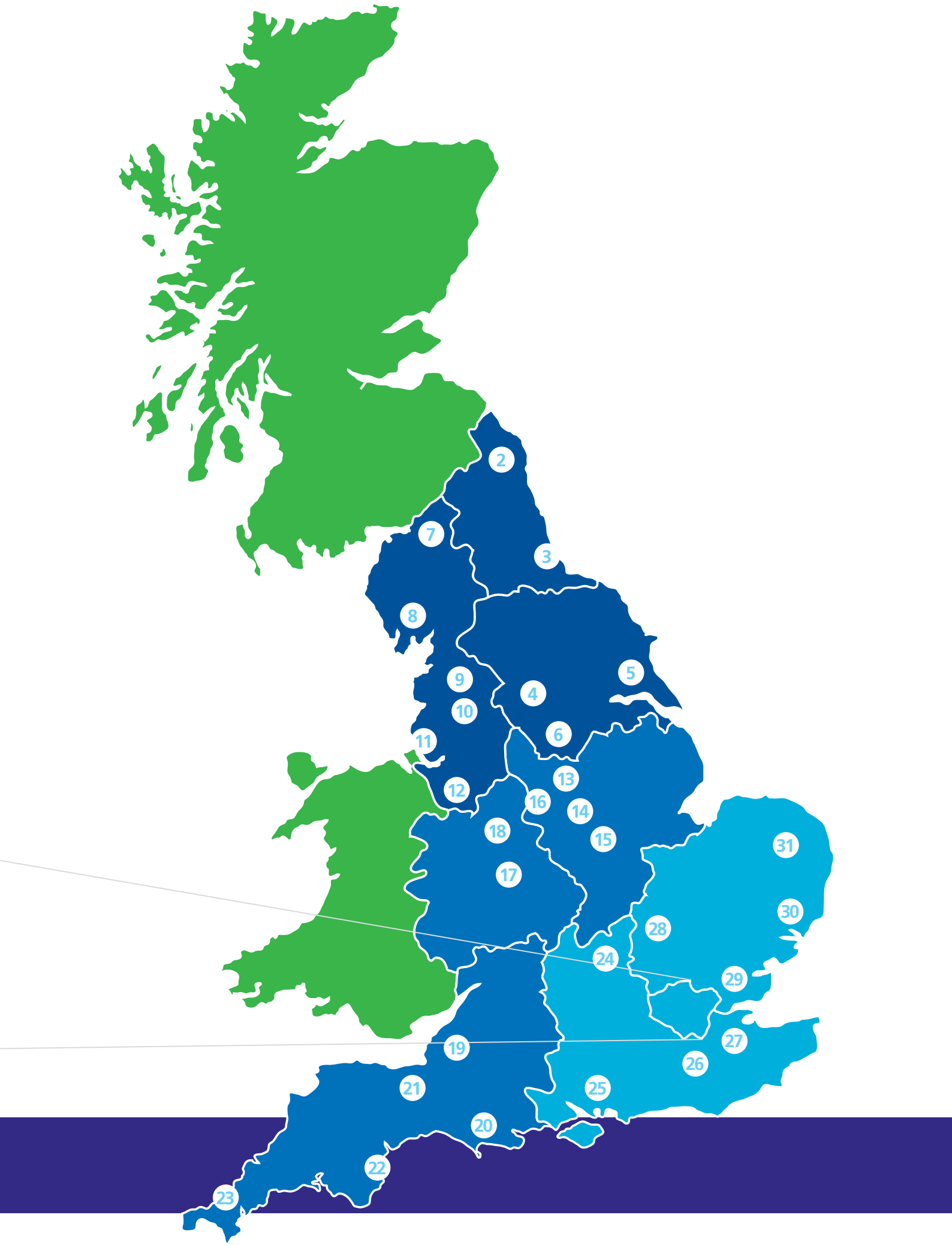
32 Ilford
33 Beckenham



NHS Direct **site locations**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Business impact on the environment

Caring for the environment

NHS Direct has 33 sites and we are currently concentrating on energy and water efficiency issues at these properties. Energy audits have been undertaken at our 16 largest call centres and Display Energy Certificates (DECs) have been published for properties with over 1,000m^2 in floor area.

Other initiatives have also been undertaken to reduce the amount of travelling to and between sites. Video conferencing facilities have now been installed in our main sites and in a number of satellite offices. Telephone conferencing is also frequently used. These mean that we are able to hold multi-site meetings without the time, expense and carbon footprint of unnecessary travel.

A series of successful homeworking pilots were run in 2009/10 which have led to our first teams in Plymouth formally moving from being based at an office location, which we have now closed, to being based at home, which means they no longer have to travel to work. The Halford's "Cycle2Work" scheme, whereby bikes can be purchased at advantageous rates and be paid for through tax efficient salary deductions, has also been introduced throughout NHS Direct.

A carbon reduction strategy will be developed in 2010/11.

Plans for the future

Our corporate objectives

Our 2009/10 business planning process reviewed the demographic and cultural developments that are likely to have an impact on health needs, and how they will be met. We have considered national policy initiatives that are directly focused on shaping the future of NHS provision, such as the NHS Constitution; the NHS Operating Framework; the Quality, Innovation, Productivity and Prevention (QIPP) agenda; the regional Darzi reports; and the national Darzi review: "High Quality Care for All". We have also taken account of the medium-term commissioning strategy of our commissioner, the East of England SHA, which acts on behalf of the ten England SHAs.

Five broad, related themes have emerged, encapsulating the most important challenges for health provision over the next three to four years. They are:

- enabling and supporting people to do more for themselves
- understanding the health needs and behaviours of individuals, and providing high quality services, in flexible ways, to respond to those needs
- developing more efficient and innovative ways of delivering services, to address the twin challenges of increasing demand and economic constraints
- collaborative working among health service providers, both across and outside the NHS, to share expertise and avoid duplication
- challenging, empowering and supporting staff to deliver safe and valued healthcare services.

NHS Direct has a key role in supporting the rest of the NHS to understand the opportunities that remotely delivered care provides, both in terms of patient choice and delivering savings. Our new vision reflects this:

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

In order to achieve this, we have developed six strategic objectives to:

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

We expect these objectives to remain our focus for the next three years, though we will review them regularly with those who commission and use our services, our members and our stakeholders to test their continuing relevance and importance. Each year, we will develop a detailed business plan, setting out what we want to achieve in the following 12 months and the specific activities we will undertake to meet our strategic objectives. This plan also sets out our resource allocation for the year and how we will measure our performance. You can view a copy of our Strategic Framework 2010-2014, which includes our 2010/11 business plan, on our website.

Achievement of our internal corporate objectives in 2009/10

For 2009/10, we defined seven corporate objectives which provided overall direction for the year. Each objective was measurable and set out both our broad ambition and the actions we took to continuously improve our service. They were:

- to deliver high quality care for all through a safe and clinically effective service
- to put quality at the heart of everything we do, engaging members, users and commissioners
- to provide a service that is central to the NHS
- to support the NHS in new ways of working in the multi-channel world
- to deliver services to meet local needs through our national infrastructure
- to invest in and value our staff
- to continuously improve our efficiency and effectiveness.

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

How we performed

The table below sets out how we performed against our objectives. The key performance indicators that we used to measure our performance are defined in the appendix to this report.

Objective	Description	Year end position
1	**To deliver high quality care for all through a safe and clinically effective service.**	
	To achieve 95% patient satisfaction with the service from NHS Direct. Commentary: 91% satisfaction was achieved in the context of a year in which NHS Direct experienced exceptionally high and sustained call volumes due to sickness and public anxiety caused by the swine flu outbreak.	Partially achieved
	To achieve an "excellent" or "good rating" for compliance with the Standards for Better Health. Commentary: NHS Direct received an "excellent" rating which is the top rating available to an NHS Trust.	Achieved
2	**To put quality at the heart of everything we do, engaging members, users and commissioners.**	
	To receive no more than one complaint per 10,000 calls, and less than 10% of incidents identified by clinicians as potentially giving rise to harm being found to have done so. Commentary: Less than one complaint was received per 10,000 calls and only one incident was deemed to have given rise to harm (1.4%).	Achieved
	To achieve the standards for handling high, medium and routine priority calls, as agreed with NHS Direct's commissioners, for 95% of calls. Commentary: 97% of urgent calls requiring a call from a nurse within 20 minutes were achieved within target. The targets for lower priority calls were up to 6% below target. We have implemented a plan to rectify this.	Partially achieved
3	**To provide a service that is central to the NHS.**	
	To receive no more than 5% financial penalties against those indicators which involve contractual performance indicators. Commentary: Four out of ten deductible measures for the core contract were not met across the year. This resulted in penalties of £737,000 (or 29% of the maximum penalty). Staff vacancies, sickness levels and swine flu were major contributors to the loss of performance. We have since implemented a performance improvement plan.	Not achieved
	To achieve the target of four million people using our online health and symptom checker and web chats. Commentary: Online activity consistently exceeded our target throughout the year. This was partly due to people checking for swine flu symptoms, but the sustained nature of our overachievement of the target may be due to heightened public awareness of NHS Direct's services created by the significant publicity we received as a result of the flu pandemic.	Achieved
	To answer the agreed number of calls. Commentary: The required five million calls were answered (5,000,697 calls were answered in 2009/10).	Achieved
	To ensure that no more than 50% of calls require onward referral to other services. Commentary: This target was exceeded with just 42% of calls requiring onward referral.	Achieved

Objective	Description	Year end position
4	To support the NHS in new ways of working in the multi-channel world. To achieve the planned level of growth of non-core services purchased by commissioners. Commentary: This target was exceeded by more than 50%, with NHS Direct providing more than 70 locally commissioned services for NHS organisations including GP and dental out of hours telephone assessment services.	Achieved
5	To deliver services to meet local needs through our national infrastructure. The successful build, mobilisation and operation of the National Pandemic Flu Service (NPFS). Commentary: The NPFS was successfully launched on 23 July 2009. It subsequently supported the assessment of 2.7 million people and enabled 1.8 million patients to receive authorisation for an antiviral without the need to visit their GP.	Achieved
	NHS organisations rating NHS Direct's overall contribution as "good", "very good" or "excellent". Commentary: NHS Direct received a satisfaction rating of 66%, which exceeded the target by 6%. This was partly due to the organisation's successful management of the National Pandemic Flu Service, which alleviated pressure on the rest of the NHS.	Achieved
6	To invest in and value our staff. To reduce the proportion of staff who join then leave within one year to less than 5%. Commentary: The year-end turnover rate for staff is 33%. This is partly being tackled through the implementation of a new rostering system, which will improve the ability of staff to influence the hours that they are scheduled to work. As NHS Direct is a 24-hour service, this action is likely to significantly improve staff satisfaction and retention.	Not achieved
	To reduce staff sickness to an average of ten days per person per year and 75% of staff taking less than five days sickness absence. Commentary: Sickness absence has increased since last year due to the pressure on front line staff caused by high call demand during the swine flu pandemic. NHS Direct's sickness is higher than the NHS average. Robust measures to specifically tackle the causes and management of short-term and long-term sickness have been put in place, with the target of halving sickness absence by the end of 2010/11.	Not achieved
	To achieve 70% staff satisfaction. Commentary: The annual staff survey was not conducted this year due to the pressures arising from the swine flu pandemic.	N/A
	Front line staff spending 60% of their paid time on direct patient care/contact activities. Commentary: The initiatives to improve the amount of paid time available for patients were delayed from the start of the year until winter due to the swine flu outbreak. These initiatives included changes in rostering arrangements to better match call demand, and building team performance and leadership capabilities. Also, more detailed analysis of the data indicates that a 60% target is unachievable within current Agenda for Change frameworks.	Not achieved
7	To continuously improve our efficiency and effectiveness. Monthly recurrent run-rate falling within 1% overspend. Commentary: The Trust failed to fully identify its cost improvement plans on a recurrent basis although they were met through non-recurrent measures in its Financial Recovery Plan. These shortfalls have programmes attached for 2010/11.	Not achieved
	To achieve satisfactory financial health status as judged by Department of Health's Financial Health Index. Commentary: The target status score is 2.5 and NHS Direct achieved a score of 2.8.	Achieved

The swine flu pandemic posed significant challenges for NHS Direct in 2009/10. Our overall performance suffered as a result of unprecedented levels of demand. Extraordinary efforts from all staff enabled us to sustain our core telephone service while we worked with the Department of Health and the rest of the NHS to manage demand across all services.

The implementation of the National Pandemic Flu Service (NPFS) gradually enabled us to recover our delivery standards for our core service, using a range of innovative approaches including:

- implementing a web-first strategy to encourage more people to use online services than the phone
- balancing calls according to the volumes coming through for each service (sometimes referred to as dynamic prioritisation of activity) to achieve the best possible performance for each service under the circumstances
- refining our initial assessment tool to give home care advice to a higher proportion of callers at the first stage of the process, freeing up nurses for more urgent calls
- piloting homeworking, distributing dedicated laptops to nurses enabling them to work more flexibly
- piloting in-sourcing of staff, using agencies to provide temporary health advisors and nurses to expand our capacity at relatively short notice as necessary.

During the year, we have also continued to implement a wide range of challenging efficiency and cost-saving measures, which we previously identified in our Strategic Development Programme.

Standards for Better Health

Throughout 2009/10, we have continued to meet Core Standards as we did in 2008/09. This was the first year that NHS Direct has been regulated by the Care Quality Commission, the new regulator for health and social care. We have worked with them to help them understand NHS Direct and the services that we offer, in order to produce a suitable set of amended standards for us for 2009/10.

The Care Quality Commission gave us an overall rating of 'excellent' based on their assessment for 2009/10. This is an improvement on the previous year when we were rated as 'good'. We could not be assessed on our use of resources, as other NHS Trusts are, because we are audited in that area by the National Audit Office (it uses a different methodology from the Audit Commission, which audits other NHS Trusts).

For 2009/10, we declared compliance with all the Core Standards and we aim to maintain our rating of 'excellent'. The Care Quality Commission is changing its method of rating NHS Direct for 2010/11, which will allow us to be assessed, along with other NHS Trusts, on compliance with national and local priorities.

In January 2010, we submitted an application to the Care Quality Commission for registration of the services we provide that are governed by the Health and Social Care Act 2008 (Regulated Activities) Regulations 2009. The Care Quality Commission approved the application in March 2010.

Achieving Clinical Excellence

It is important that our advice is in line with the rest of the NHS so that patients receive similar advice wherever it comes from. The Achieving Clinical Excellence (ACE) study was designed to compare our advice to that of external clinicians, using face-to-face workshops and online surveys. This study started in 2008/2009 and reported in April 2009.

We asked 80 healthcare, social and allied professionals, 100 GPs, 50 emergency medicine specialists and 200 nurses to review either anonymised transcripts or scenarios of real NHS Direct calls, and select the 'endpoint' they thought most appropriate.

This study shows that in cases where we advised the patient to seek urgent assistance, external clinicians agreed with us. However, where patients' symptoms were less urgent, there was less agreement among the clinicians.

The study is part of a process of continuous learning and improvement. Since the study we have asked a network of external clinicians to input into the development of our clinical sorting and new algorithms. We have also developed key messages to improve external clinicians' understanding of our definitions of 'endpoints' (e.g. the timing associated with 'GP Urgent').

A service that is central to the NHS

QIPP challenges and the role of NHS Direct

To inform our understanding of how we could support the QIPP agenda (which focuses the NHS on quality, innovation, productivity and prevention), we spoke to over 70 NHS organisations. We then reviewed the services we offered and identified ways in which we could most effectively support the NHS, by:

- improving usage of the core service – by developing our understanding of how we create value, and how different groups of patients access and use our services, we can target our services more effectively
- extending the use of online services and developing new channels
- reviewing and rationalising our other commissioned services as they do not always represent the most efficient use of our resources.

These developments will be key priorities for the future.

Our delivery of the NHS Stressline

On 15 July 2009, with the Department of Health, we launched the NHS Stressline, which gives practical and emotional support to people who are worried about debt, housing and unemployment. Debt can be a cause and a consequence of mental health problems, such as stress, anxiety and depression, but often people do not know where to seek help.

The Stressline was set up to respond to increasing anxieties about the credit crunch that can cause feelings of distress and helplessness. NHS Stressline callers receive practical information and advice from our health advisors. If they are suffering from stress, anxiety or depression, they are directed to a wider package of financial and mental health support. The NHS Stressline is available on 0300 123 2000

A caller from Surrey called NHS Stressline in August 2009:

"I rang the NHS Stressline after having gone into work one morning only to be told that the company I worked for had gone into administration. Even my work van keys were taken off me and I had to make my own way home to break the news to my wife and child. I felt sick and couldn't sleep for worrying about how I was going to pay the mortgage or where to go for help. A family member told me about the Stressline and I am so glad that I called.

"The sympathetic advisor listened to my worries and gave me advice on what to do and where to go for help, as well as how to manage my sleeping difficulties. Thankfully, I have been able to find another job since then but the help the Stressline gave me was invaluable at the time. Until something like this happens to you, you just don't know what to do or where to go for help."

The Appointments Line

NHS Direct provides The Appointments Line (TAL) service as part of the government's Choose and Book system. Choose and Book is the electronic hospital appointments booking system. It allows people to make their first outpatient appointment online, at their GP practice, or by calling TAL. Patients can choose the place, date and time of the appointment to suit them.

Patients who need to use TAL are given a password and booking reference number by their GP practice to quote when calling the service. The patient's GP will help them make the right choice from the appointment options available, and their appointment request letter will show the hospitals and clinics available to choose from. TAL can also provide additional information at www.nhs.uk.

TAL employs over 200 front line staff based at NHS Direct sites in Milton Keynes, Chatham and Hedge End. TAL took more than 3.8 million calls in 2009/10.

111 Service

On 18 December 2009, the Department of Health announced that Ofcom, the telecoms regulator, had given the go ahead for a new free three-digit telephone number, 111, to be used for non-emergency healthcare. Three Strategic Health Authorities will be running pilot schemes using the new number to provide a 'single point of access' for urgent care.

The three SHA regions taking part are County Durham and Darlington in the North East, Nottingham City and Lincolnshire in East Midlands and Luton in the East of England. Each region will operate a slightly different service as part of a one-year pilot. They will be evaluated by the Department of Health before any decision is taken to roll out the service nationally.

While the detailed operational models for the pilots are still being finalised, NHS Direct has worked with each pilot to help plan for their delivery.

NHS Direct is a member of the National Three-Digit Number Programme Board and Stakeholder Group, and has contributed to the service specification and technology group.

Social care partnerships

Since March 2009, we have been working with Birmingham City Council Adult and Community Services, West Midlands Fire Service and Tunstall Telecom to provide Telecare Direct, a remote monitoring service to improve older people's safety in their own homes.

Telecare Direct offers a range of non-intrusive telecare equipment that helps manage the risks to a person's health and home environment. Once the equipment is installed, calls and alerts are answered and responded to, 24 hours a day, 365 days a year, by NHS Direct health advisors, who give professional medical support and information.

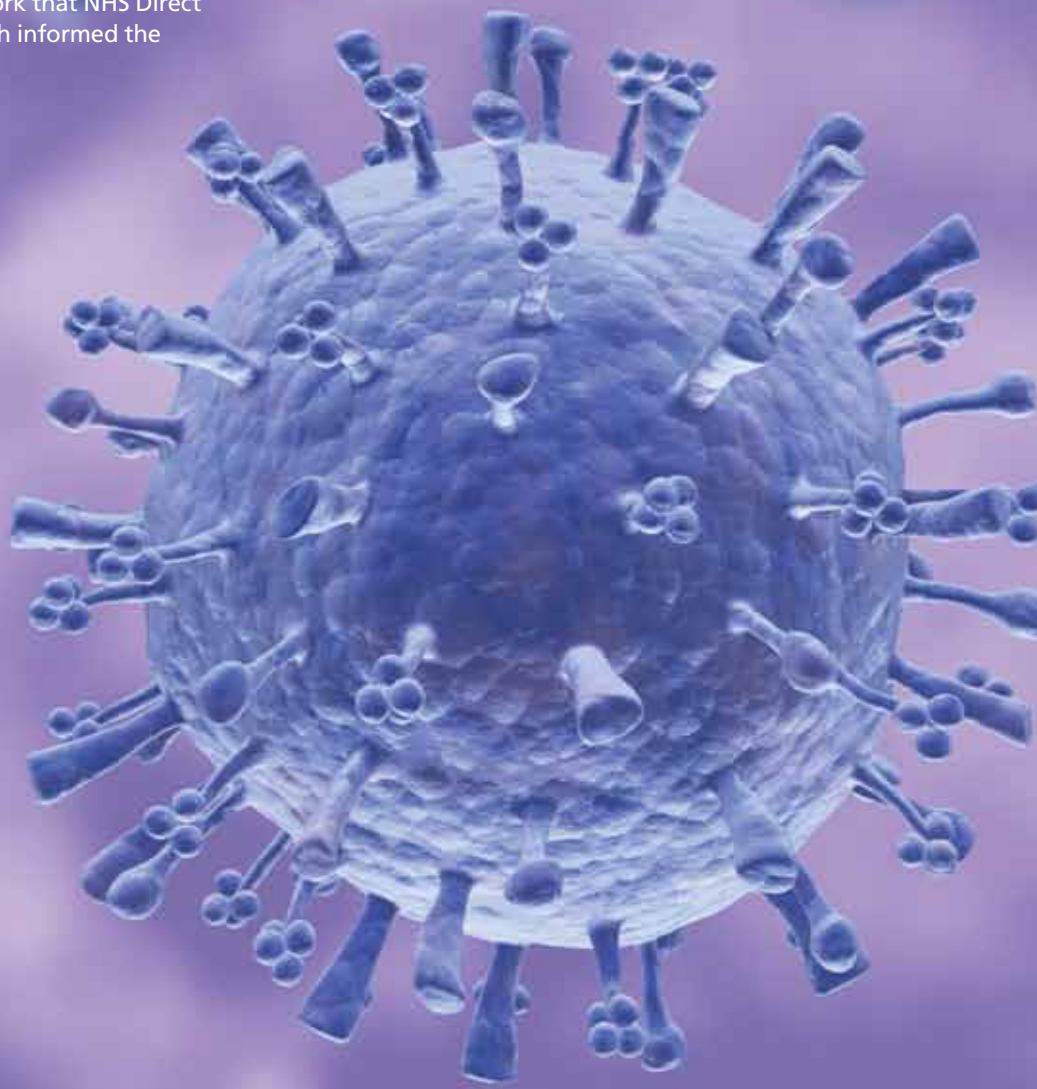
There are over 1,000 devices currently being monitored. These include room temperature devices, which alert NHS Direct when a property becomes dangerously cold, epilepsy sensors, which provide warning of an epileptic seizure while in bed, and a reminder device to ensure that medication is taken regularly and correctly.

Our response to the swine flu pandemic

NHS Direct had three distinct areas of operation related to swine flu. Firstly, we continued to provide our core telephone and web services. In the early days of the pandemic, NHS Direct was widely promoted in the media and by NHS organisations as a source of information, advice and support. This resulted in sharp increases in demand.

Secondly, we were responsible for the day-to-day operation of the National Pandemic Flu Service (NPFS), which enabled patients with flu-like symptoms to assess, via the telephone or the internet, whether they would benefit from antiviral medication and to be authorised to obtain antivirals from local collection points.

Thirdly, we worked with the Health Protection Agency to help them understand the spread of the virus. The HPA ran a surveillance scheme that we supported by sampling callers who presented flu-like symptoms but did not fit the criteria for swine flu. Callers were asked for consent by nurse advisors for us to pass on their details to the HPA who then sent a self-test swab kit to a sample of these patients. This scheme contributed to the wider surveillance work that NHS Direct and GP practices did with the HPA, which informed the Government response to the pandemic.



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

Our web-first strategy

Our strategy is to think 'web first'. By providing services such as the online assessment and real-time web chat with nurses and health advisors, we are able to offer our services to a wider audience.

In the last year, we have developed new self-assessment tools covering colds and flu, contraceptive health, male and female health, and mental health. To reach more people, these services will be syndicated to NHS and third sector organisations. We conducted detailed user research to build our services around what patients want and need. We also continued to make use of social media to engage with our users.

In 2009/10, we began the process of buying a new digital platform to improve the delivery of our online services. It will be in use by autumn 2010. This will help us deliver a clinically sound, digital 'self-service' alternative to the telephone service.

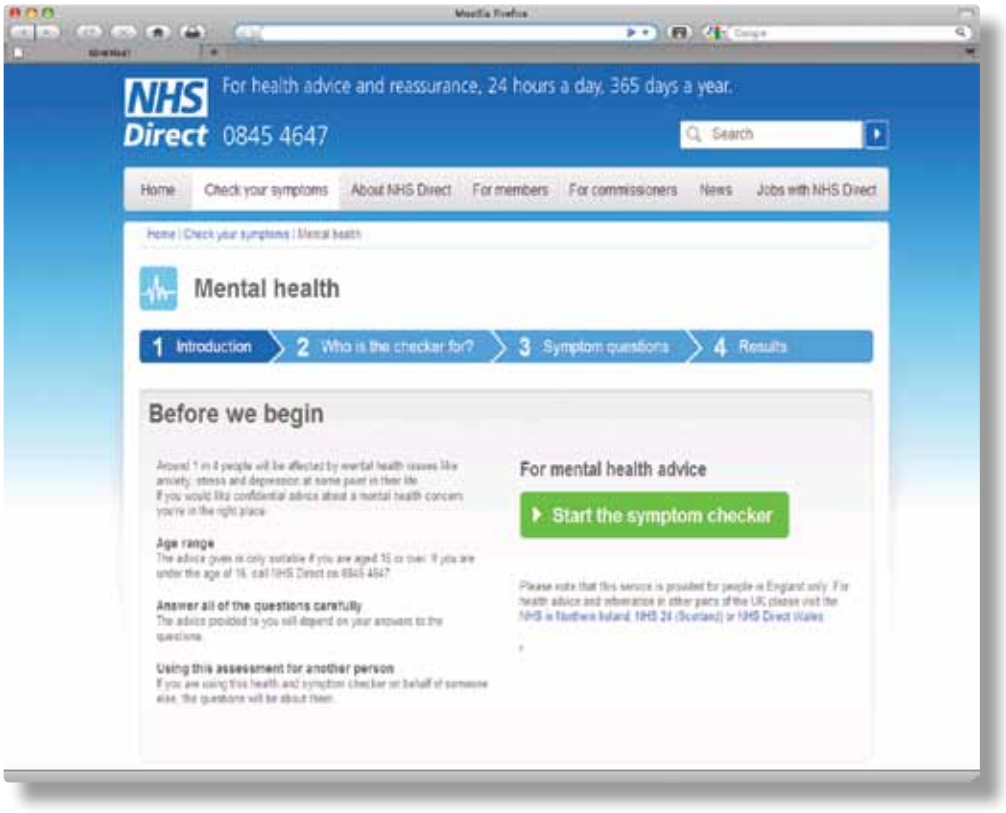
Mental health self-assessment tool

On World Mental Health Day (10 October 2009), we launched a new online self-assessment tool to provide help and advice for people concerned about their mental health or wellbeing.

The tool is available via both nhsdirect.nhs.uk and nhs.uk, and is designed to help people who need mental health support but who can care for themselves. By providing the service as an online resource, we aim to help break the stigma often associated with mental illness.

The self-assessment tool can help people with low impact, long-term issues or people suffering from first time symptoms of stress, anxiety or depression. It asks the user a series of questions and, depending on the information provided, suggests different options. These include a visit to a GP (either routinely or urgently), contacting an appropriate mental health organisation (internal or external to the NHS), or self care advice. The tool is integrated with our contact centres so users can also request a call-back from a trained nurse who can offer further support or advice. As a precaution, the tool provides a rapid assessment tool for people who may be feeling suicidal.

So far over 220,000 people have used the tool.



Investing in and valuing our staff

Working with our staff

We rely on the quality and commitment of our staff to deliver our objectives. The government's vision for the NHS and the NHS Operating Framework identifies the importance of a valued, empowered and appropriately skilled workforce to deliver the improvements sought from the NHS. At NHS Direct, we know there is also clear evidence that high levels of staff satisfaction lead to high levels of patient satisfaction.

As part of the Strategic Development Programme, we took a close look at how we manage our operation and how staff feel about working for NHS Direct. We worked with staff to develop a set of values that reflect the best of who we are and what we want to be. We want our values to influence our behaviours, both internally and externally. Our values are:

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

We will work with our staff to embed these values in the way we conduct ourselves individually and corporately, through the services we provide and in the way we engage with our patients, the public, our members and our partners. The values will underpin the delivery of our objectives and the achievement of our vision.

A great place to work

We want NHS Direct to be a great place to work and the Strategic Development Programme has helped us find new ways to improve employee satisfaction and deliver a great service for our patients. We will develop a more flexible workforce model to help us manage the peaks and troughs of demand for our services more effectively. This will also be more responsive to the needs of existing and potential employees to achieve a good work-life balance (this will include implementing options for partial or permanent homeworking).

In August 2009, we started work on a new approach to rostering. The system we currently use to roster does not adequately serve the needs of our patients or our staff. At present, we are often overstaffed at our quietest times but don't have enough staff available during the busiest times. 60% of our staff currently work within some restriction because of their differing needs. This has meant that the remaining fully flexible 40% of our staff have erratic and greatly varying shift patterns, causing them frustration and difficulty in organising their personal lives. We have consulted front line staff on the new system of working patterns and changes will be made depending on the outcome of the consultation.

We are committed to developing all our staff to ensure they can fulfil their roles effectively and competently. During 2009/10, we implemented a number of National Vocational Qualifications (NVQs). We have introduced a modular approach to training for front line staff to make it easier for them to complete during operational hours. This will help ensure there are increased opportunities for continuing professional development.

In 2009, we launched a new role for less experienced nurses as the first stage in developing a career pathway for staff. The role is on Band 5 of the NHS salary scale and is particularly designed for nurses with one year's post-qualification experience. To trial the concept, we have employed nine whole-time-equivalent staff in the role since October 2009 and are hoping to recruit a further 40 to 50 in early 2010/11.

Alongside the Band 5 nurse project, we have been working with Southampton University Hospitals NHS Trust to pilot a rotational nurse role. This requires the nurse to move between NHS Direct and the Acute Trust every six months in order to develop the full range of skills required for a modern nursing career.

Equality and diversity in our workforce

All our staff undertake an online equality and diversity awareness training course and there is also a managing diversity course for managers. This training was rolled out across the Trust during 2009/10. And as part of their induction, all new staff are made aware of the importance of equal opportunities, and of recognising and valuing diversity.

Equality Impact Assessment (EIA) training was delivered to managers and relevant senior staff between January and March 2010. We have conducted a number of EIAs on our internal functions, mostly related to structural change. We will be in a position to conduct and publish full impact assessments on both our core and enhanced services from April 2010.

We hold the Jobcentre Plus' 'two ticks' disability symbol signifying excellent practice in employment for people with disabilities. We guarantee an interview for any disabled applicant who meets the essential criteria for the job.

Of our 3,400 staff, 115 have a disability, which equates to 3.4% of total staff employed. This is a slight increase from last year's 3%.

Support for staff

As well as the NHS national terms and conditions of employment, we offer our staff a range of benefits including eye-care vouchers, child-care vouchers, a cycle-to-work scheme, a season ticket loan scheme and access to a 24/7 employee support line and counselling service.

Staff numbers by grades

Staff structure

Table 1

Banding/Payscale	WTE	HC	HC %
Band 1	0.8	1	0.0%
Band 2	174.7	198	5.8%
Band 3	656.1	904	26.2%
Band 4	396.3	496	14.4%
Band 5	114.0	126	3.7%
Band 6	889.2	1262	36.6%
Band 7	176.0	205	6.0%
Band 8 - Range A	44.3	45	1.3%
Band 8 - Range B	27.4	28	0.8%
Band 8 - Range C	14.0	14	0.4%
Band 8 - Range D	11.8	12	0.3%
Other	71.3	154	4.5%
Total	2576.0	3447	100.0%

Key:
WTE – whole time equivalent
HC – head count

This table shows NHS Direct staff in the Agenda for Change pay bands. The significant groups are the health advisors, who are in Band 3, health information advisors and non-clinical team leaders in Band 4 and nurse advisors and clinical team leaders in Band 6.

Sickness absence

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

At 8.1%, sickness absence has increased since last year. The Trust has put measures in place to reduce this, including performance management sickness targets, additional training on management of attendance and staff dedicated to addressing long-term sickness issues. The Trust's forthcoming new rostering system, which has been developed in consultation with the recognised trade unions, has also been designed to have a positive impact on staff attendance.

Continuously improving our efficiency and effectiveness

Our financial summary 2009/10

Delivering value for money to our commissioners

The Trust completed a challenging financial year with a surplus of £448,000 compared to £2,529,000 in 2008/09. The Trust had set itself an ambitious £17 million savings target for the year in order to meet contract price reductions and to fund its cost pressure and investment plans. The Trust achieved this surplus after returning further funds in-year to the Strategic Health Authority. This was made possible by the reduced promotional requirements and activities due to the national flu pandemic.

The Trust has also accounted for £1.6 million of re-organisation costs associated with its Strategic Development Programme in order to improve the effectiveness and efficiency of its patient services.

Income from activities increased from £159.8 million in 2008/09 to £189 million in 2009/10, with associated operating expenses rising from £159.5 million to £190.2 million. Staffing costs increased from £99.1 million to £106.4 million with an increase in staff numbers from 2,742 to 2,952. The most significant factor behind these increases is the Trust's income and expenditure in developing and providing the National Pandemic Flu Service.

While overall cash and bank balances decreased by £10.5 million during the year, from £24.8 million to £14.3 million, this was predominantly driven by timing differences between invoicing and income receipt on flu activities. Debtors therefore increased from £8.9 million to £18.7 million at year-end. Over £3 million was invested in capital assets such as IT infrastructure, premises, equipment and facility improvements for staff and patients. Specific schemes included the development of our web-based, patient self-assessment tools, air-conditioning facilities to improve the working environment, and furniture and telephony improvements. Further investment is planned for 2010/11 in the continued improvement of services, infrastructure and facilities.

In 2010/11, the emphasis, momentum and drive for substantial efficiency improvements will escalate. The Trust must make more major improvements in its capability and capacity in order to deliver cost efficiencies and drive down operating costs. Best value, value for money, and sound financial planning and management will all be essential.

Funding reductions, combined with in-year cost pressures, mean a cost improvement programme of £20 million must be achieved in 2010/11. We must continue to rigorously examine our use of resources and explore all possible routes to deliver substantial ongoing cost reductions and productivity improvements. This must be done while not only maintaining, but also further improving, the quality of our patient care and user experience.

Continuously improving

We believe there is potential to drive greater benefits from our services. In 2009/10, we started work with East of England Strategic Health Authority to understand and quantify the value generated by different elements of our services. We will link this to our understanding of how different patients use our services so that we can target and promote those services most effectively.

We have developed our offering on the web and other platforms to improve access to our services, and the value they provide for commissioners, the wider NHS and patients.

In a pilot undertaken in 2008/09, we demonstrated that we had the technical capability for nurses to work from home safely and effectively. In 2009/10, we undertook two further pilots to establish whether homeworking could become part of a flexible employment model for the future.

The first involves nurses working extra hours at home, telephoning patients to undertake assessment and give advice. The second is a full-time homeworking pilot for nine of the ten nurses (one nurse opted to work at a different site) previously based at our Plymouth site, following a decision not to renew the lease on this site from March 2010. This model replicates the contact centre environment in nurses' homes.

These pilots will be evaluated in the first months of 2010/11. If successful, we believe that homeworking could be a key recruitment and retention tool for our nurses.

We will focus on developing and testing innovative approaches to providing remote care that address patients' and commissioners' needs efficiently.

Plymouth homeworking pilot

Following the closure of the Plymouth contact centre in March, eight nurse advisors and one clinical team leader transferred their base to their homes. All had previously expressed an interest in homeworking and were pleased to be given the opportunity to do so. They have been working from home since the middle of April.

In the months since the project was launched the team has been working hard on developing policies and procedures to ensure they are as effective at home as they would be in a contact centre environment.

The nurses find that having no travel time to work is a great benefit, particularly when working more unsociable shifts. Another benefit is that the working environment is much quieter with no background noise meaning nurses can fully focus on the calls they are dealing with.

Those nurses who might want to work extra hours have found that it is much easier because they can log on for a shorter period of time, and nurses who are available can cover shifts at relatively short notice if call volumes suddenly increase.

"I am really enjoying homeworking and my time available for patients has increased. The working environment is more relaxed and I have more free time in my day because I am home after my shift with no travelling. Family time has become more apparent and reduced family stress within my home."

Hayley Scott-Munden – homeworking nurse

Value to the NHS

The services we provide through our core service, over the phone and web, deliver real value to the NHS by ensuring more appropriate and efficient access to, and provision of, urgent care. The model we have developed for quantifying the value of our services centres on how they reduce unnecessary demand on urgent care services and save disruption to patients' lives, by advising patients to go to the right point of care at the right time.

Our research identifies that we recommend to around 49% of all our callers that they should go to a less urgent and lower cost point of care than they would have gone to if they had not sought our advice. A significant proportion of those callers — 75% — are advised that they can look after themselves without any need to access further care. We also reduce demand on urgent care services, and improve the patient's experience, by advising some patients to go to a more appropriate higher level point of care than they would have otherwise gone to. This saves them a visit that would have simply resulted in a referral on to the appropriate point.

We provide patients with advice and information, which means that they do not need to seek this advice from other health professionals, and it enables them to manage their symptoms more effectively if they have a repeat episode.

We recognise that, for a small proportion of patients who contact us about their symptoms but who otherwise would not have sought care from elsewhere in the NHS, we advise them to obtain care when their condition may have improved on its own without the need for treatment or a consultation with another healthcare professional. However, some of these patients' particular conditions may have worsened, and they could have required more costly attention without our advice.

Taken together, our services significantly reduce demand and stress on urgent care services across the country, and mean that services are accessed more efficiently than would have been the case if NHS Direct had not been available. In total, we estimate that our core services create an overall efficiency value to the NHS of £162 million, and save 3.6 million avoidable visits a year to different parts of the urgent and primary care services – that is an average of 24,000 visits per Primary Care Trust a year.

The other commissioned services we offer in certain areas (such as the GP and dental out of hours services and the handling of Category C ambulance calls) provide similar benefits in those areas in terms of reduced and more appropriate demand on urgent care services.

Urgent care partnership in Nottingham

We work in partnership with NEMS to provide an urgent primary care response which includes telephone advice, face-to-face consultations and home visits for a population of approximately 700,000. The service covers Nottingham City and the southern part of Nottinghamshire County Teaching Primary Care Trusts. We have worked as partners in the local community since 1999 and in a contractual partnership since 2006.

Callers ring their own GP surgery and the majority are automatically transferred to NHS Direct staff (the remaining patients are usually calling for an appointment and are advised to call back during opening hours). These patients are initially assessed by a health advisor and those that need an ambulance are passed directly to the ambulance service as part of their call. Patients deemed to have an urgent symptom are warm transferred to an NHS Direct nurse advisor for assessment. Patients with anticipatory care plans or specific conditions that are not amenable to telephone assessment or less urgent symptoms have their details passed via the electronic link to NEMS whose nurses and doctors make contact with the patients. Any callers who need health information are passed to our health information advisors.

Recent patient surveys undertaken by NEMS indicate that callers are very satisfied with the service – over 90% scored their telephone experiences as "excellent, very good or good".

NHS Direct and NEMS are working together with the Nottingham City 111 demonstrator site.

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

How we measure quality

In 2008/09, we worked with our staff and the public to develop new indicators to measure the quality of our telephone conversations with patients. In 2009/10, we implemented these measures by regularly monitoring the quality of calls, looking at elements of safety as well as levels of empathy shown by our staff. We also used feedback from patient satisfaction surveys to improve our services. We used Clinical Audit to monitor and improve the quality of our services, and our Quality Accounts for 2009/10 detail some of the audits we completed and the improvements we made as a result.

During 2010/11, we will develop new approaches to improving satisfaction and develop our staff, teams and services based on feedback from patients and users of our services.

Delivering an excellent patient experience

We believe that we provide a high quality service to our patients. We actively ask them what they think about our services through patient and public involvement, and we listen when patients tell us how to improve our services, through complaints and other feedback. We improve what we do on the basis of what we are told by other professionals and managers in the wider NHS, through our health professional feedback mechanisms.

In 2009/10, we listened to over 5,300 patients, members of the public and health professionals. From this, we made more than 3,000 improvements to our service. In 2010/11, we will be improving the way we measure and enhance patient experience, and we will provide new engagement opportunities.

Compliments

In 2009/10, we received almost twice as many compliments as complaints. When we receive a compliment from a member of the public or fellow health professional, it is reported directly to the member of staff who provided the service.

Complaints

Complaints from patients and service users are a valuable source of feedback. They can help us understand where we are doing well and where we could do better.

On 1 April 2009, new complaints regulations were introduced for the NHS and social care. The new regulations mean that we respond to the complainant in the way they would like us to (e.g. by phone or in writing) and agree this process with them. Most complaints are normally dealt with quickly over the telephone, involving the complainant in a discussion about the outcome of the investigation. Some complainants ask to receive a letter from us explaining the findings of our investigation. We agree a timescale to respond to the complainant and in 2009/10, responded within this timescale 91% of the time.

Outreach champions

In January 2009, we appointed nine members of front line staff to act as regional outreach champions for one day a week. Their role is to promote the appropriate use of NHS Direct's services among local communities by developing and maintaining relationships with local groups, such as voluntary and community groups, local businesses and schools. They are also a valuable feedback channel.

	Compliments		Complaints	
	Total compliments received	Compliments per 10,000 calls answered	Total formal complaints received	Formal complaints per 10,000 calls answered
2006/7	938	1.57	981	1.64
2007/8	1,800	2.15	551	0.99
2008/9	1,388	1.49	376	0.63
2009/10	878	0.92	460	0.48

Dealing with adverse incidents

When we get things wrong, we have robust systems to ensure that we learn quickly from these incidents. This process involves investigating and identifying a root cause for any adverse incidents. In 2009/10, there were 108 serious adverse incidents that were escalated for review by a team of clinicians within NHS Direct. Of these, only one led to actual harm to the patient, which is well within the 10% indicator agreed with our commissioners. We take all incidents and near misses very seriously.

In 2009/10, together with other NHS Trusts, we contributed to the wider learning of the NHS by reporting incidents to the National Patient Safety Agency through the National Reporting and Learning System (information about incidents is anonymised before sharing). When an incident relates to a patient's experience with more than one organisation, we contribute to joint reviews with the other agencies involved.

Stakeholder perceptions research

For the second year running, we commissioned independent research company Jigsaw Research to carry out research into stakeholders' opinions towards NHS Direct and our services. The study reflects our ongoing commitment to listen to and act upon the views expressed by our partners in developing our services.

Confidential interviews were held with senior representatives from over 200 NHS organisations, including Strategic Health Authorities, Primary Care Trusts, Acute Trusts, Mental Health Trusts and Ambulance Trusts. 66% rated our overall performance as good or better, up from 53% in 2009. Furthermore, the proportion rating the service as excellent or very good doubled from 13% last year to 27% this year.

We were keen to find out how well stakeholders feel we communicate with them about what we are doing as an organisation and about our future direction. Encouragingly, 59% of respondents rated our communications as good or excellent, up from 30% in 2009. However, the research showed that we need to improve communications with the medical profession who currently don't feel informed about what NHS Direct is doing.

The swine flu pandemic posed a significant challenge for all NHS organisations during the last 12 months. Almost three-quarters of stakeholders considered our telephone and online services to be effective in reassuring the public and reducing the burden on other parts of the NHS. 86% of respondents were aware that we had operated the National Pandemic Flu Service during the pandemic, and of these, 75% felt that we had done a good job.

As part of the research, in-depth, qualitative interviews were also conducted with representatives from a sample of national organisations, including the Department of Health and health charities.

Equality and diversity in service provision

As a public body, we have a statutory duty to actively promote equality in relation to race, disability and gender, and we have equality schemes for all these areas.

The National Operations Centre collects and analyses demographic data on calls received from patients and users of our services, and provides reports of usage by demographic breakdown across all regions. Further work will be undertaken to identify trends and issues that will be turned into equality and diversity objectives for 2010/11, and will increase our knowledge about the diversity of our patients.

The Language Line interpretation service is available for all users of our telephone services and we took 15,331 calls using the Line in 2009/10. The top five most requested languages were Arabic, Bengali, Polish, Punjabi and Urdu (not in order). Some of our web content is also available in multiple languages, and we provide health information in large print and Braille formats.

Patient and public involvement strategy

Our patient and public involvement strategy outlines how we will involve patients and the public in improving our services. We maintain a membership, which grew to over 19,000 in 2009/10, who support us (along with other members of the public) to improve our existing services and governance, and to develop new services.

We use a range of approaches to learn about patients' experiences of using NHS Direct, including satisfaction surveys, focus groups, mystery shopping, patient panels and involving members of the public in working groups. We work closely with the rest of the NHS, social care, voluntary sector and Local Involvement Networks (LINks) to improve our services. We report on what people have told us and also tell people what we have done to improve our services following their suggestions.

Year	Reported incidents by incident date	Incidents per 10,000 calls answered*	Serious incidents reviewed at national level	Reviews per 10,000 calls answered	Serious incidents leading to serious harm or death	Occurrences of serious harm or death per **1,000,000** calls answered*
2009/10	7,948	14.25	73	0.13	1	0.18

Services to meet local needs through our national infrastructure

Integration with other NHS services

As a national organisation, we are able to support local NHS organisations through our network of 32 contact centres across England. Wherever patients live, we provide consistent assessment and advice, and can refer them to the appropriate local services for treatment. Patients with dental pain will receive details of a local out of hours dentist and access to emergency care. If patients ring their GP surgery when it is closed, their call will often be transferred to a nurse at NHS Direct who will make a clinical assessment and, if the need is appropriate, arrange for a local on-call doctor to visit them. We can call an ambulance for the patient and ensure their safety by talking to them until it arrives.

Demand for ambulance services is growing year on year. This places regional ambulance services under increasing pressure, especially during winter. Of all emergency calls made to Ambulance Trusts, approximately one-third continue to be non-urgent 999 calls (often called Category C calls). Once a call has been identified by the Ambulance Trust as a low priority 999 call, our nurse advisors can provide further assessment. So far, we have managed over 75% of these calls, without them being returned to the ambulance service for an emergency response.

In the event of a local incident or health scare, we can run a telephone helpline on behalf of a local hospital or service. An example of this is the management of a patient information line for Mid Staffordshire NHS Foundation Trust following the publication of the Francis Report, which looked at standards of care at the Trust.

On a larger scale, we manage the West Yorkshire Urgent Care service, providing a single number for local people to call (see case study opposite).

We were a major part of the Department of Health's 'Choose Well' campaign which signposted patients to the most appropriate healthcare service. We worked closely with Primary Care Trusts to co-ordinate campaigns at a local level.

Some patients need regular care and treatment for their long-term conditions but visiting a GP is not always the easiest or best option for them. With advances in medical equipment and improvements in communication, it has become much more common for patients to take responsibility for self care in their own homes, supported by healthcare professionals via the telephone or internet, and alongside less regular face-to-face appointments. We are developing support services for people with long-term conditions, in partnership with local care providers, which will give patients more control and enable them to enjoy far less restrictive lifestyles, as well as generating valuable cost and time savings for the NHS.

Syndromic surveillance

Over the last ten years, NHS Direct and the Health Protection Agency (HPA) have developed a unique national syndromic surveillance system. The system is used to help health services with their day-to-day planning by monitoring seasonal illnesses. It also provides support both locally and nationally when there is a health scare or local incident, such as flooding or flu.

We provide the HPA with data on our calls, which it uses to track symptoms associated with seasonal illnesses such as flu and norovirus against a pre-determined base line. In the case of norovirus, if call volumes for vomiting exceed four per cent of the overall call volume two weeks in a row, this triggers a four-week warning of increased national activity. This helps Primary Care Trusts and Acute Trusts with their planning.

When dealing with more unpredictable health scares or incidents, surveillance can provide important insights about the impact on the local or national population. This can often be used to reassure the public and avoid widespread panic. At the initial stages of the swine flu pandemic, surveillance of NHS Direct's flu-related calls (alongside GP monitoring) provided a clear and accurate real-time picture of the situation. This information influenced the national response and quickly identified 'hot spots', helping with the local management of flu.

NHS Direct and the HPA are now looking at how syndromic surveillance could be used to assist London's health response to the Olympics in 2012.

West Yorkshire Urgent Care

Since its launch on 1 April 2009, West Yorkshire Urgent Care has provided advice, support and treatment to over 336,000 people living in West Yorkshire.

Callers to the service are assessed and advised over the telephone by either a nurse or GP. If necessary, a face-to-face appointment or home visit is then arranged. NHS Direct provides the telephone (or 'access and assess') side of the service with the treatment element provided by Care UK and Local Care Direct.

Research shows the patient experience is positive, with an overall satisfaction rate of more than 90% according to research conducted by IFF Research. This takes into account all aspects of the service, from initial telephone contact to face-to-face contact with the treatment provider.

West Yorkshire Urgent Care is commissioned by Wakefield District, Kirklees, Leeds, Calderdale and Bradford and Airedale Primary Care Trusts and covers over 2.1 million people.

Public Interest and Governance

Non Executive Directors' biographies

1. Joanne Shaw

Joanne has chaired NHS Direct since August 2008, having served on the Board since its inception in 2004. She is Chairman of Datapharm Communications, a leading provider of digital medicines information to the NHS, the pharmaceutical industry and the general public. She was recently appointed a director of the British Board of Film Classification. Until August 2008, she was a Trustee for the Long-Term Conditions Alliance and chaired the not-for-profit company behind 'Ask About Medicines', the independent campaign to increase people's involvement in decisions about their use of medicines.

Joanne has a strong interest in the use of new communication channels for health and medicines. In her professional roles and in writing for health publications, she is known for advocating partnership between patients and health professionals, and supporting people to make better informed choices about their health.

After serving on the management board of the Audit Commission, she became Director of Medicines Partnership, a Department of Health initiative to improve the use of medicines in the NHS. She previously worked internationally as a strategy consultant with the Boston Consulting Group.

2. Peter Catchpole

Peter joined the Board on 1 April 2004. He has worked as a senior executive in the NHS for over 30 years, 20 of those as a chief executive. He has also been a non-executive director for organisations in the not-for-profit and charity sectors. He is a County Councillor in West Sussex and is the Cabinet Member for Adult Services. He is a Fellow of the Faculty of Health at the University of Brighton. He also holds a number of appointments in the professional regulatory sector, and is an independent healthcare consultant and business advisor to the independent and private health sector.

3. Luisa Dillner

Luisa joined the Board in February 2010. She is Head of New Product Development at the BMJ Group where she has launched some of their most successful online products for doctors and consumers. Most recently she launched doc2doc, an online international global community for doctors and healthcare professionals. She trained in medicine at Bristol University and qualified as a surgeon before leaving the NHS to take up the post with the BMJ. Luisa also spent two years as Health Editor at the Guardian and has written three books and numerous health articles for consumer publications.

4. Tim Heymann

Tim joined the Board on 1 February 2010. He is a consultant physician and gastroenterologist at Kingston Hospital where he provides consultant-delivered services for the local population. At Imperial College Business School, he is a Reader in Health Management and has a particular interest in innovative approaches to delivering healthcare. He has worked for McKinsey & Company in strategic management consultancy and was a member of the government's Risk and Regulation Advisory Council. He has worked and taught in many developed and developing countries. He is a Fellow of the Royal College of Physicians and Higher Education Academy, chairs the Information Group of the British Society of Gastroenterology and is a medical advisor for the National Association for Colitis and Crohn's Disease.

5. Sue Hunt

Sue joined the Board on 1 April 2007. She is a chartered accountant who spent 18 years with global accountancy and business advisory firm KPMG, initially in the audit practice and subsequently providing transactions advice to clients involved in acquisitions and disposals. Sue was instrumental in setting up a multi-disciplinary healthcare group at KPMG, advising both public and private sector healthcare clients in the UK and internationally. She provided consultancy advice to the Department of Health and to individual applicant Trusts. Sue also holds an appointed Trustee position at CfBT Education Trust which delivers education services worldwide and is one of the top 50 charities in the UK. This allows her to follow her twin interests in both the health and education sectors.

6. Trevor Jones

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

7. Tim Walton

Tim joined the Board on 1 April 2007. He is also a non-executive director on the Capability and Operations Committee at the Department for Business, Innovation and Skills, and a non-executive director at Accent Group, where he chairs the Audit Committee, and at RS (Skipton) Limited. He is an independent business consultant in public and private sectors, concentrating on business transformation and exploitation of IT. His career has included executive and non-executive roles spanning operational, commercial, financial, e-business and IT assignments in civil and military aerospace, construction and design engineering. He is a Chartered Engineer and a Fellow of the BCS, The Chartered Institute for IT.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Executive Directors' biographies

1. Nick Chapman, Chief Executive

Nick took up post as Chief Executive of NHS Direct in April 2009. Prior to this, he was on secondment from the NHS to the Department of Health as the National Director for the 18-week programme, which aimed to improve waiting times for non-emergency hospital treatment. He was also Senior Responsible Officer for the Choose and Book programme and the PACS programme, which looked at digital storage of scans and x-rays. Nick has practical experience in leading and managing NHS organisations, and of delivering and sustaining low waiting times. He joined the NHS in 1979 as a national trainee in the South East. After a variety of administrative and managerial posts, he became Unit General Manager for Lewisham Hospital in 1987. He moved to Dorset in 1991 and spent the next 14 years as Chief Executive at NHS Trusts in West Dorset then Somerset.

2. Helen Young, Clinical Director/ Chief Nurse

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

3. Roger Rawlinson, Human Resources Director**

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

4. Ronnette Lucraft, Commercial Director; Chief Operating Officer (from January 2010)*

Ronnette joined the Board on 11 April 2007, with responsibility for business development, marketing and communications, and multi-channel integration. Ronnette has held senior management positions within the communications and new media industries at BT, Telewest and ntl (now Virgin Media). She has also worked with the NHS University (NHSU) and as an NHS LIFT Chief Executive, developing new healthcare facilities for south-west London's local health economy. She spent two years with Living Health, which led the way in providing television-based public healthcare services. As of January 2010, Ronnette took on the responsibilities of the Chief Operating Officer of NHS Direct.

5. Alan Bentall, Chief Information Officer**

Alan was appointed Chief Information Officer (CIO) in January 2010. He was seconded to the Trust as interim CIO in 2008 from the professional services firm Deloitte, where he was an Associate Partner in the Technology Integration Practice. Alan has over 25 years' experience in the software and telecommunications industry, more recently focusing on the delivery of major technology-enabled business change programmes in the public sector. He has held leading roles on assignments in many major central government departments and a selection of private businesses, including the Department for Work and Pensions, Her Majesty's Revenue and Customs, Ministry of Defence, Connecting for Health and Royal Mail Group. His career has also included roles as Operations Director at Praxis, a software and systems development company specialising in the development of business critical applications, and as head of ICT in a medical electronics company.

6. Trevor Smith, Finance Director

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

7. Ruth Rankine, Director of Strategy and Planning**

Ruth joined NHS Direct on 14 October 2007, on secondment from the Department of Health and was appointed Director of Strategy and Planning in December 2009. She is responsible for developing the Trust's medium-term strategy and business plan in addition to innovation, service development, marketing and communications. Her previous post in the Department of Health was Principal Private Secretary to the NHS Chief Executive and the Permanent Secretary. Prior to that, she was Director of Emergency Care for Leeds Acute NHS Trust and Leeds PCTs, and Programme Director for the GP contract negotiations, working for the NHS Confederation.

** The Chief Information Officer, Director of Strategy and Planning and the Human Resources Director are not voting members of the Trust Board.

* Paula Higson was Chief Operating Officer until January 2010.


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Information governance

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

Table 1: Summary of protected personal-data-related incidents formally reported to the Information Commissioner's Office in 2009/10

Date of incident (month)	Nature of incident	Nature of data involved	Number of people potentially affected	Notification steps
No Incidents	N/A	N/A	N/A	N/A
Further action on information risk	The Trust will continue to monitor and assess its information risks in light of the events noted above, in order to identify and address any weaknesses and ensure continuous improvement of its systems. Planned steps for the coming year include: • appointing and training the Information Asset Administrators • continuing the implementation of our rolling Information Security Risk Assessment and Management Programme • conducting privacy impact assessments on relevant projects.			

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

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

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

Information risk

During 2009/2010, we appointed a Head of Information Security and Risk Management to champion information risk throughout the organisation at an operational level. The executive management team endorsed this appointment. Our Senior Information Risk Owner (SIRO) also initiated the appointment of Information Asset Owners (IAOs) from the different business areas across the organisation, and the development of a documented Information Security Risk Assessment and Management Programme. The SIRO and Head of Information Security and Risk Management have undertaken bespoke training courses for their roles to ensure their responsibilities can be carried out effectively. The organisation also conducted a personal data flow mapping and risk assessment exercise to evaluate if the controls identified during 2008/2009 are still effective, and to identify and assess any potential new risks. During 2010/2011, we will appoint and train our Information Asset Administrators (IAAs) to support the IAOs in their role. NHS Direct also deployed a hard-disk encryption solution on its laptops.

Information governance steering group

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

Better Payment Practice Code

	2009/10		2008/09	
	Number	£000	Number	£000
Total non-NHS trade invoices paid in the year	30,741	95,535	31,068	70,649
Total non-NHS trade invoices paid within target	28,615	85,068	28,788	63,100
Percentage of non-NHS trade invoices paid within target	93%	89%	93%	89%
Total NHS trade invoices paid in the year	869	4,516	1,014	3,557
Total NHS trade invoices paid within target	797	3,649	869	2,686
Percentage of NHS trade invoices paid within target	92%	81%	86%	76%

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

Name of auditor

These accounts have been audited by the Comptroller and Auditor General in accordance with the National Health Service Act 2006. The external auditor is responsible for reporting whether, in his opinion, the financial statements give a true and fair view of the state of affairs of the Authority's reported financial position, and whether the Trust has complied with relevant legislation and other requirements. The Trust incurred audit fees of £102,500. No other audit services were provided in this period.

Disclosure of relevant information

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

Directors' declarations of interest during 2009/10

Name	Interest declared
Joanne Shaw	Datapharm Communications Ltd – chairman Council of Management of the British Board of Film Classification – member AAMW Limited – chairman Vanguard Metropolitan Limited – director Spouse is non-executive director at NHS London.
Trevor Jones	WRVS – Trustee WellChild – Trustee National Patient Safety Agency – non-executive director
Tim Walton	Accent Group – non-executive director Department for Business, Innovation and Skills – non-executive director Timothy Walton and Associates Limited – director RS (Skipton) Limited - chair
Sue Hunt	CfBT Education Trust – appointed Trustee
Peter Catchpole	General Dental Council – lay member Nursing and Midwives Conduct and Competence Committee – lay member General Medical Council Fitness to Practise Committee – associate member British Association of Psychotherapy and Counselling Conduct Committee – lay member West Sussex County Council – county councillor
Luisa Dillner	Head of New Product Development, British Medical Journal Publishing Group Limited
Tim Heymann	Medicine Today Limited – directorship and shareholder National Association for Colitis and Crohn's Disease (NACC) – medical advisor Imperial College Business School – Reader in Health Management Kingston Hospital NHS Trust – consultant physician
Nick Chapman	Spouse – self-employed consultant who works from time to time with and for NHS bodies.
Trevor Smith	Partner – part-time agency role with Audit and Security Management Services supplier.
Helen Young	Home James of London – directorship Dorothy House (Hospice) – trustee
Ronnette Lucraft	None declared
Alan Bentall	Employee of Deloitte MCS Ltd until 15 April 2010. Deloitte are in contractual relationships with NHS Direct.
Ruth Rankine	Carers FIRST (charitable organisation), Tonbridge - trustee
Roger Rawlinson	None declared
Brian Gaffney	GP in Northern Ireland (part-time)
Philip Baker	Director, National Institute for Health Research Biomedical Research Centre
Derek Newman	Trustee on the Board of the Croft House Settlement, Sheffield
Paula Higson	None declared

Remuneration Report

Remuneration Committee

The Remuneration Committee is a sub-committee of the Board to which it makes recommendations and is accountable. It is chaired by a non-executive director (Trevor Jones) and membership is made up of two further non-executive directors (Peter Catchpole and Tim Walton). The current terms of reference were amended and agreed by the Board on 22 September 2008.

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

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

Remuneration policy and framework

The executive remuneration policy is linked to the Very Senior Manager (VSM) Pay and Remuneration Framework issued by the Department of Health for Strategic Health Authorities and Primary Care Trusts.

The Remuneration Committee assessed the performance-related pay objectives of the executive directors for 2009/10 and made recommendations for payments to the Board. All bonus awards were under the threshold of 5% of the executive pay bill as required by the VSM pay framework.

In 2009/10, the basic pay of those staff who are subject to the VSM pay framework was uplifted by 1.5%, and no executive received an annual award of more than 7%. Both these decisions were in line with a letter from Sir David Nicholson received by the Chief Executive on 1 April 2009.

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

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

See tables below.

No executive directors receive any further allowances or compensation.

Executive Directors' Contracts and Notice Periods

Name	Role	Start	Notice	Nature	Continuous service date
Nick Chapman	Chief Executive	01/04/2009	6 months	Permanent	25/11/1979
Paula Higson	Chief Operating Officer to 11/01/10	01/05/2008	3 Months	Permanent	01/05/2008
Alan Bentall	IT Director (interim)	N/A	N/A	Interim	N/A
Helen Young	Director of Nursing	01/12/2004	6 Months	Permanent	11/08/1987
Trevor Smith	Finance Director	02/01/2009	3 Months	Permanent	22/04/1996
Ronnette Lucraft	Commercial Director to 10/01/2010 and Interim Chief Operating officer from 11/01/2010 to 16/03/2010, Chief Operating Officer from 17/03/2010	11/04/2007	3 Months	Permanent	11/04/2007
Roger Rawlinson	HR Director	01/09/2007	3 Months	Permanent	01/09/2003
Ruth Rankine	Director of Strategy & Planning (interim)	N/A	N/A	Interim	N/A

Salaries and Allowances

Name and title	2009-10		
Salary and Pension Entitlement of Senior Managers	Salary (bands of £5,000) £000	Other Remuneration (bands of £5,000) £000	Benefits in kind (Rounded to the nearest £00) £00
Nicholas Chapman, Chief Executive	150-155	0	0
Helen Young, Director of Nursing	110-115	0	0
Roger Rawlinson, HR Director	100-105	0	5
Ronnette Lucraft, Commercial Director to 10/01/2010 and Interim Chief Operating officer from 11/01/2010 to 16/03/2010, Chief Operating Officer from 17/03/2010	115-120	0	4
Paula Higson, Chief Operating Officer to 10/01/2010	105-110	0	0
Trevor Smith, Finance Director	135-140	0	3
Joanne Shaw (Non Executive Chair)	35-40	0	0
Peter Catchpole (Non Executive)	10-15	0	0
Trevor Jones (Non Executive)	5-10	0	1
Tim Walton (Non Executive)	5-10	0	0
Derek Newman (Non Executive), to 31/12/2009.	5-10	0	1
Sue Hunt (Non Executive)	5-10	0	0
Philip Baker (Non Executive), to 31/08/2009	0-5	0	0
Luisa Dillner from 1/2/2010	0-5	0	0
Tim Heyman from 1/2/2010	0-5	0	0

(Nicholas Chapman was awarded a performance related bonus of £3,660 but has declined it. Therefore it is not included in the salary figure above).

Following Paula Higson's resignation as Chief Operating Officer in January 2010, the Trust entered into a 2 year agreement from April 2010 to retain her skills and services for ongoing project work. The maximum value of this call-off contract is £264,375 including VAT.

	2008-9		
	Salary (bands of £5,000) £000	Other Remuneration (bands of £5,000) £000	Benefits in kind (Rounded to the nearest £00) £00
	0	0	0
	110-115	0	4
	100-105	0	11
	110-115	0	3
	130-135	0	0
	30-35	0	0
	25-30	0	1
	10-15	0	1
	5-10	0	2
	5-10	0	1
	5-10	0	1
	5-10	0	0
	5-10	0	0
	0	0	0
	0	0	0

Amounts paid to third party organisations

The costs shown for Alan Bentall and Ruth Rankine are the amounts paid by NHS Direct to external organisations for their services.

Name	Total Cost	2008-9
Alan Bentall - Interim Chief Information Officer	£280-285k	£140-145k
Ruth Rankine - Interim Director of Strategy and Planning - appointed from 1.7.2009	£110-115k	£Nil

Pension benefits

Pension Benefits Table

Name & title	Real increase in pension at age 60 (bands of £2,500) £000	Real increase in pension lump sum at aged 60 (bands of £2,500) £000	Total accrued pension at age 60 at 31 March 2010 (bands of £5,000) £000	Lump sum at age 60 related to accrued pension at 31 March 2010 (bands of £5,000) £000	Cash Equivalent Transfer Value at 31 March 2010 £000	Cash Equivalent Transfer Value at 31 March 2009 £000	Real increase in Cash Equivalent Transfer Value £000	Employer's contribution to stakeholder pension £00
Nicholas Chapman - Chief Executive	20-22.5	65-67.5	55-60	170-175	1,181	480	677	0
Paula Higson - Chief Operating Officer until January 2010	0-2.5	2.5-5	0-5	10-15	72	25	45	0
Ronnette Lucraft - Acting Chief Operating officer from January 2010	0-2.5	2.5-5	0-5	10-15	62	39	22	0
Trevor Smith - Director of Finance	0-(2.5)	(5)-(7.5)	35-40	105-110	560	529	5	0
Helen Young - Director of Nursing	0-2.5	0-2.5	30-35	90-95	429	386	24	0
Roger Rawlinson - Director of Human Resources	0-2.5	2.5-5	5-10	25-30	181	142	32	0

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

Cash Equivalent Transfer Value (CETV)

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 them purchasing additional years of pension service in the scheme at their own cost. CETVs are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries.

Real Increase in CETV

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

Our Quality Account

NHS Direct Quality Account 2009/10

Part 1

Statement on quality of services

NHS Direct is an NHS Trust with a national role to support patients by providing appropriate advice and guidance for people who contact us via the telephone and the internet. It is a fundamental objective for the trust that these services are safe and effective, and that our patients value the advice and guidance that we provide.

None of the national clinical audits, national confidential enquiries, or Care Quality Commission periodic reviews in 2009/10 were relevant to NHS Direct's service.

The Trust undertook a clinical audit programme of its own. While these audits provided evidence about where improvements could be made, the results also provided assurance that the service is meeting some essential standards.

During the year the Board received monthly reports on safety, effectiveness and patient satisfaction with the service, with key performance measured against standards agreed with our NHS commissioners. The detail of these key performance indicators and the levels attained during the year are set out in Part 3 of this Quality Account. In summary, the Trust performed well on its indicators of safety and clinical effectiveness. While we continued to have less than 1 formal complaint per 10,000 calls, our regular patient satisfaction ratings did not quite achieve our 95% target of being rated good or better. This was largely due to the additional volume of calls during the period of the swine flu pandemic, when too many patients had to wait longer than our standard of 60 seconds for their call to be answered. However, the responsiveness of the service was also affected by the fact that the Trust did not meet its own internal productivity target for increasing the proportion of front line staff time spent talking with patients.

NHS Direct continually strives to improve the quality of the service we provide, through understanding and acting on incidents, reviews and audits, and listening and responding to complaints and reflections from our patients and from other health professionals. The Board has agreed its standards and priorities for 2010/11. These include maintaining the standards already achieved, and to build on performance in areas requiring improvement. The highest priorities for improvement are: to raise the quality of calls so that at least 80% are scored as good or excellent using the Trust's objective call review process; to achieve prompt clinical assessment for less urgent patients; and to achieve consistent levels of patient satisfaction.

The Trust Board has endorsed the content of this Quality Account. To the best of my knowledge, the information contained in this Quality Account for NHS Direct for 2009/10 is accurate.

I hope that you find it informative. If you would like to tell us your views about this report or our services, please contact us on 0845 600 1866 or by email to members@nhsdirect.nhs.uk.

Nick Chapman
Chief Executive

Part 2

Schedule of Prescribed Information for 2009/10

1.0 During 2009/10, NHS Direct provided and/or subcontracted for 76 NHS services.
1.1 NHS Direct has reviewed all the data available on the quality of care in all 76 of these NHS services.
1.2 The income generated by the NHS services reviewed in 2009/10 represents 100 per cent of the total income generated from the provision of NHS services by NHS Direct for 2009/10.
2.0 During 2009/10, there were no national clinical audits or national confidential enquiries that covered the services NHS Direct provides*.
2.1 As there were no national clinical audits or national confidential enquiries applicable to NHS Direct the question as to NHS Direct's participation in such activities does not arise.
2.2 The national clinical audits and national confidential enquiries that NHS Direct was eligible to participate in during 2009/10 are as follows: 0*.
2.3 The national clinical audits and national confidential enquiries that NHS Direct participated in during 2009/10 are as follows: 0*.
2.4 The national clinical audits and national confidential enquiries that NHS Direct participated in, and for which data collection was completed during 2009/10, are listed below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry: 0*.
2.5 The reports of 0 national clinical audits were reviewed by the provider in 2009/10*.
2.6 NHS Direct intends to take the following actions to improve the quality of healthcare provided: None applicable*.

*None of the national clinical audits or national confidential enquiries were relevant to any of the services provided by NHS Direct during 2009/10.

2.7 The reports of three local clinical audits were reviewed by NHS Direct in 2009/10 and NHS Direct intends to take the following actions to improve the quality of healthcare provided:
2.7.1 Following the local clinical audit to measure standards of patient record keeping within NHS Direct, a year-long information governance campaign is being conducted to improve the quality of clinical record keeping. Each month, NHS Direct staff will focus on a different element of record keeping and practise for improvement.
2.7.2 The local clinical audit to measure the standards of practice of health advisors taking inbound calls from the public provided substantial assurance. Minor actions were identified through the audit to improve the clinical decision support software system used. We will also enhance the training for front line staff to ensure continued effective use of the updated system.
2.7.3 All NHS Direct front line staff participate in ongoing self, peer and supervisory audit of the safety, effectiveness and patient experience of the calls. This continuous call review audit identifies areas for individual learning and development and also provides valuable information to help us improve our systems, processes and training to support our staff.

3.0 The number of patients receiving NHS services provided or sub-contracted by NHS Direct in 2009/10 that were recruited during that period to participate in research, approved by a research ethics committee, was 887.
4.0 NHS Direct income in 2009/10 was not conditional on achieving quality improvement and innovation goals through the Commissioning for Quality and Innovation payment framework because this was not specified as a requirement by the commissioners of any of our services*.

*None of NHS Direct's commissioners required these conditions to be applied through CQUIN, but some services did have financial penalties associated with meeting key performance indicators.

5.0 NHS Direct is required to register with the Care Quality Commission (CQC) and its current registration status is unconditional. NHS Direct has the following conditions on registration: None.
5.1 The Care Quality Commission has not taken enforcement action against NHS Direct during 2009/10.
6.1 NHS Direct was not subject to periodic review by the CQC in 2009/10.
7.1 NHS Direct has not participated in any special reviews or investigations by the CQC during the reporting period*.

*None of the special reviews or investigations by the CQC were relevant to the services provided by NHS Direct in 2009/10

8.1 NHS Direct did not submit records during 2009/10 to the Secondary Uses Service for inclusion in the Hospital Episode Statistics, which are included in the latest published data*.

*None of the data collected by NHS Direct in 2009/10 was relevant to be submitted to the Secondary Uses Service for inclusion in the Hospital Episode Statistics.

9. NHS Direct's scores for 2009/10 for Information Quality and Records Management, assessed using the information governance toolkit, were 55% and 83%.
10. NHS Direct was not subject to the Payment by Results clinical coding audit during 2009/10 by the Audit Commission.

Board priorities for improvement in 2010/11

1. Call Quality
The quality of the calls that NHS Direct staff handle is critical to the safety and effectiveness of the service, and ultimately has a significant bearing on the levels of satisfaction that patients gain. The Board has set an improvement priority for call quality, to reach 80% of calls (based on a sample of 3 calls per advisor per month) scored as good or excellent. The aggregated call review scores will be reported to the Board each month.

The improvement will be generated though regular individual reviews with all front line staff, with individual development plans arising from the call review findings.

2. Prompt clinical assessment for less urgent patients
The swine flu pandemic posed significant challenges for NHS Direct in 2009/10. While we achieved the target of responding to more than 95% of our most urgent calls within 20 minutes and in spite of significant efforts on the part of our staff we did not achieve our target for clinical assessment of more than 95% of less urgent calls within 60 minutes (actual achievement was 90.6%). In 2010/11 we intend to achieve the target of more than 95% in both of these areas.

In 2009/10 we introduced new assessment tools for our staff to help increase the proportion of patients who our health advisors can safely and effectively give advice to. This will help us to continue to reduce the proportion of less urgent calls requiring assessment by a nurse allowing them to focus on the more urgent calls. We will also introduce a longest wait measure, which will ensure that as well as meeting the 95% target for commencing clinical assessment we will set a maximum time limit for all calls appropriate to their level of urgency. Our rolling recruitment plan and performance improvement plan will also ensure that we have the right number of nurses available at the right time to respond to the number of calls requiring clinical assessment.

3. Patient satisfaction
91% satisfaction was achieved in the context of a year in which NHS Direct experienced exceptionally high and sustained call volumes due to sickness and public anxiety caused by the swine flu outbreak. This pressure on the service meant that only 82.1% of calls were answered within 60 seconds. This was below the target of more than 95%. In spite of this we only received 0.83 complaints per 10,000 calls.

In 2010/11 we will pilot new measures for satisfaction that will enable us to be able to compare across different services we provide to allow us to prioritise areas for improvement. We will continue to focus improvement activities on the areas for greatest potential improvement in satisfaction. Our Performance Improvement Plan addresses many of these areas including the speed with which we answer calls.

4. Monitoring improvement
The Board receives monthly information on the actual performance against plan for each of these key indicators. This information is also provided to the East of England Strategic Health Authority, which is the commissioner for the core national service. In addition, this information, as it relates to other locally commissioned services, is also provided on a regular basis to those local commissioners.

Part 3

1. Indicators of quality for 2009/10

This section of this Quality Account relates to NHS Direct's core national service, which is available to the public in England, 24 hours a day, 365 days a year. This service is available via the phone on 0845 46 47 or on the internet through NHS Choices www.nhs.uk and NHS Direct's own website at www.nhsdirect.nhs.uk.

The table below contains the indicators of quality selected by the Trust Board and reviewed by it regularly during the year.

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

* See appendix for a detailed definition of these key performance indicators.

2. Safety

In 2009/10, NHS Direct achieved the following performance in indicators relating to patient safety:

Safety domain*	2009/10 achievement	2009/10 target
% incidents for national review leading to harm	1.4%: standard achieved	≤10%
% urgent (P1) clinical assessments started in 20 minutes	96.8%: standard achieved	≥95%
% less urgent clinical assessments (P2) started in 60 minutes	90.6%:standard not achieved	≥95%

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

3. Clinical effectiveness

In 2009/10, NHS Direct achieved the following performance in indicators relating to clinical effectiveness:

Effectiveness domain*	2009/10 achievement	2009/10 target
% of emergency and urgent referrals: standard achieved	24.6%: standard achieved	≤25%
% of callers with episode completed within NHS Direct: standard achieved	58%: standard achieved	≥50%
% of health and nurse advisors' time on line spent talking with patients: standard not achieved	69.5%: standard not achieved	≥75%

4. Patient satisfaction

In 2009/10, NHS Direct achieved the following level of quality for performance in indicators relating to patient experience:

Patient experience domain*	2009/10 achievement	2009/10 target
Patient satisfaction (%)	91%: standard not achieved	≥95%
Number of complaints per 10,000 calls	0.83: standard achieved	≤1.0
% calls answered within 60 seconds	82.1%: standard not achieved	≥95%

Part 4

1. Written statements by other bodies

1.1 East of England Strategic Health Authority

The following statement was provided by NHS East of England on 8 June 2010:

"As the commissioner on behalf of the NHS, for the National Core Service provided by NHS D, NHS East of England can confirm that the information contained in this Quality Account for the National Core Service is accurate and fairly interpreted. The priorities for improvement are representative and have also been agreed with us as the National Core Service commissioner and included in our contractual agreement for 2010/11, in particular, prompt clinical assessment for less urgent patients, a maximum time limit for all calls and the rolling recruitment and performance improvement plan to ensure that the right number of nurses are available at the right time to respond to the number of calls requiring clinical assessment."

1.2 Southwark Overview and Scrutiny Committee
The following statement was provided by Southwark Overview and Scrutiny Committee via Shelley Burke, Head of Scrutiny on 5 May 2010:

"Due to the 2010 Purdah period, during which councillor scrutiny work at Southwark effectively ceased, and as the 2010 QA timescale has precluded sufficient opportunity for Southwark OSC members to become informed to an appropriate level about NHS Direct's Services, it has not been viable for the Southwark OSC to review or comment on NHS Direct's 2010 Quality Accounts."

1.3 Southwark Local Involvement Network
The following statement was provided by Southwark Local Involvement Network on 21 May 2010:

"LINk Southwark would like to thank NHS Direct for providing a copy of their draft Quality Account 2009/10. However, the LINk Southwark does not have any comments to submit. The LINk looks forward to receiving the Quality Account for 2010/11 which will be presented to the LINk Members for comment."

1.4 Other Overview & Scrutiny Committees & Local Involvement Networks

All Overview and Scrutiny Committees in England were invited to receive a copy and comment on this Quality Account through the Centre for Public Scrutiny. Six other Overview and Scrutiny Committees received a copy of this Quality Account, but none provided any comment. Other Local Involvement Networks and patient representative groups were invited to receive a copy and comment on this Quality Account through National Voices, but none requested to receive a copy.

NHS Direct Accounts 2009/2010

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

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

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

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

By order of the Board

Statement on internal control

1. Scope of responsibility

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

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

2. The purpose of the system of internal control

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

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

The system of internal control has been in place in NHS Direct for the year ended 31 March 2010 and up to the date of approval of the annual report and accounts.

3. Capacity to handle risk

The Trust has continued during the course of the year (its third as an NHS Trust) to enhance its corporate risk and assurance register, which is firmly linked to the key objectives of the Trust. This document identifies and prioritises the key risks to the achievement of the objectives in the Trust's approved business plan and is subject to regular review and updating at the Board and Senior Management Team meetings, to reflect the changing nature of the risks the organisation faces in delivering its services to patients. Although I have overall responsibility, the management of risk is a key responsibility for all senior management in the organisation.

In 2009/10, the Trust's Corporate Governance Manual has been reviewed and agreed by the Audit Committee and Board and senior managers have been made aware of the importance of its contents.

In 2009/10, the Trust has updated its risk management policy to ensure that it provides sound guidance and support to staff in developing risk registers at the regional, department and directorate levels.

The corporate risk and assurance register is also subject to quarterly review by the Audit Committee, whose minutes are reported to the Board to provide assurance of the process.

4. The risk and control framework

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

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

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

The Trust also introduced a Performance Management Framework in 2009/10 with monthly review meetings for all directorates. Going forward formal Terms of Reference have been agreed for an Executive Management Board to meet each month to review in detail progress on all major Trust programmes, projects and performance areas. This commenced operation in June 2010 and has been informed by Internal Audit's review of programme management.

During 2009/2010, we appointed a Head of Information Security and Risk Management to champion information risk throughout the organisation at an operational level. The executive management team endorsed this appointment. Our Senior Information Risk Owner (SIRO) also initiated the appointment of Information Asset Owners (IAOs) from the different business areas across the organisation, and the development of a documented Information Security Risk Assessment and Management Programme. The SIRO and Head of

Information Security and Risk Management have undertaken bespoke training courses for their roles to ensure their responsibilities can be carried out effectively. The organisation also conducted a personal data flow mapping and risk assessment exercise to evaluate if the controls identified during 2008/2009 are still effective, and to identify and assess any potential new risks. During 2010/2011, we will appoint and train our Information Asset Administrators (IAAs) to support the IAOs in their role. NHS Direct also deployed a device encryption solution on its laptops.

The Trust is fully compliant with the core standards for better health, having achieved an excellent rating from the Care Quality Commission in 2009/10.

Our quality accounts include details of our performance against our priorities for quality improvement for 2009/10. We meet the statutory requirements for this publication.

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

Top-level control measures in respect of equality, diversity and human rights start ultimately at Board level from the Chief Executive, the HR Director and the non-executive director on the Trust Board who has explicit responsibility for equality and diversity.

The non-executive director is responsible for chairing the equality and diversity steering group, which is the next level of control that meets quarterly to approve and monitor progress on implementation of the equality and diversity annual objectives and action plan.

5. Review of effectiveness

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

The Head of Internal Audit's opinion for 2009/10 was: "Significant assurance can be given that there is a generally sound system of internal control, designed to meet the organisation's objectives, and that controls are generally being applied consistently. However, some weaknesses identified in the design and/or inconsistent application of controls put the achievement of particular objectives at risk." Internal Audit's review of the Trust's assurance framework concluded that it: "provides reasonable assurance that there is an effective system of internal control to manage the principal risks identified by the organisation."

Executive managers within the organisation, who have responsibility for the development and maintenance of the system of internal control, provide me with assurance. The Assurance Framework itself provides me with evidence that the effectiveness of controls (which manage the risks to the organisation achieving its principal objectives) have been reviewed. My review is also informed by our external auditors, the National Audit Office, internal auditors, Deloittes and our core standards self-assessment declaration for 2009/10.

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

There were two audits where internal audit raised some weaknesses in the design and application of controls, one relating to recruitment and training and the other to IT. In both cases a programme of action has been undertaken to address weaknesses and these have now been addressed.

In order to increase the awareness of good governance throughout the organisation the revised and reviewed Standing Financial Instructions and scheme of delegation is being drawn to the attention of all senior managers. This includes the importance and need to comply with procurement policies and regulations.

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

The Board

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

The Audit Committee

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

The Clinical Governance Committee

The Clinical Governance Committee is responsible for the oversight of the clinical governance of the Trust. It oversees the organisation's compliance with Standards for Better Health. A full self assessment was conducted on 2009/10 compliance with the Core Standards, and we have been able to declare full compliance, for the full year, with the standards for corporate and clinical governance.

The Investment Committee/Finance Committee

The Investment Committee was established in September 2008 to develop and implement a business case process for making investment decisions. It was established to provide more effective governance and controls over investment decisions and benefits realisation. The remit of the Committee has now been expanded to cover financial planning, management and reporting under revised terms of reference for a Finance Committee. These terms of reference maintain full Trust Board responsibilities for Finance.

The Information Governance Steering Group

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

Summary

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

- continued to develop and embed its assurance framework, and worked to embed its principles throughout the organisation
- reviewed, revised and re-launched its integrated risk management policy throughout the organisation, providing a consistent framework for the management of risk and supported by training for all senior managers
- held a risk management workshop for the Trust Board which has provided useful feedback to inform the development of the Trust's risk management strategy
- through the establishment of a new team (reporting directly to the Chief Executive and responsible for corporate governance), put integrated governance arrangements in place, ensuring that Board and executive activity is focused on the strategic development of the organisation, effectively managing risks and the delivery of NHS Direct's business plan
- addressed all areas of weakness identified by the internal auditor

Based on my review, I am not aware of any significant internal control problems. During 2010/11, the Trust will continue to strengthen its governance and control arrangements.

Nick Chapman
Accounting Officer
2 July 2010

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

I certify that I have audited the financial statements of NHS Direct National Health Service Trust for the year ended 31 March 2010 under the National Health Service Act 2006. These comprise the Statement of Comprehensive Income, the Statement of Financial Position, the Statement of Cash Flows, the Statement of Changes in Taxpayers' Equity and the related notes. These financial statements have been prepared under the accounting policies set out within them. I have also audited the information in the Remuneration Report that is described in that report as having been audited.

Respective responsibilities of the Accounting Officer and auditor

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

Scope of the Audit of the Financial Statements

An audit involves obtaining evidence about the amounts and disclosures in the financial statements sufficient to give reasonable assurance that the financial statements are free from material misstatement, whether caused by fraud or error. This includes an assessment of: whether the accounting policies are appropriate to the NHS Direct's circumstances and have been consistently applied and adequately disclosed; the reasonableness of significant accounting estimates made by the NHS Direct; and the overall presentation of the financial statements.

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

Opinion on Regularity

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

Opinion on financial statements

In my opinion:

- the financial statements give a true and fair view of the state of NHS Direct's affairs as at 31 March 2010 and of its surplus, changes in taxpayers' equity and cash flows for the year then ended; and
- the financial statements have been properly prepared in accordance with the National Health Service Act 2006 and directions issued thereunder by the Secretary of State with approval of HM Treasury.

Opinion on other matters

In my opinion:

- the part of the Remuneration Report to be audited has been properly prepared in accordance with the National Health Service Act 2006 and directions issued thereunder by the Secretary of State with approval of HM Treasury; and
- the information given in the Chairman's Statement, Chief Executive's Report and the Management Commentary included within the Annual Report for the financial year for which the financial statements are prepared is consistent with the financial statements.

Matters on which I report by exception

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

- adequate accounting records have not been kept; or
- the financial statements are not in agreement with the accounting records or returns; or
- I have not received all of the information and explanations I require for my audit; or
- the Statement on Internal Control does not reflect compliance with HM Treasury's guidance.

Report

I have no observations to make on these financial statements.

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

Date: 5th July 2010

Annual Accounts 2009/10

Statement of comprehensive income for the year ended 31 March 2010

	Note	2009/10 £000	2008/09 £000
Revenue			
Revenue from patient care activities	4	189,056	159,837
Other operating revenue	5	1,980	1,729
Operating expenses	7	(190,227)	(159,540)
Operating surplus/ (deficit)		**809**	**2,026**
Finance costs:			
Investment revenue	13	69	747
Other gains and (losses)	14		(7)
Finance costs	15	0	(11)
Surplus for the Financial Year		**878**	**2,755**
Public dividend capital dividends payable		**(430)**	(226)
Retained surplus/(deficit) for the year		**448**	**2,529**
Other comprehensive income			
Impairments and reversals		0	0
(Losses)/Gains on revaluations		(509)	392
Receipt of donated/government granted assets		0	0
Net gain/(loss) on other reserves (e.g. defined benefit pension scheme)		0	0
Net gains/(losses) on available for sale financial assets		0	0
Reclassification adjustments:			
- Transfers from donated and government grant reserves		0	0
- On disposal of available for sale financial assets		0	0
Total comprehensive income for the year		**(61)**	**2,921**

The notes on pages 62 to 88 form part of these accounts.

Statement of financial position as at 31 March 2010

	Note	31 March 2010 £000	31 March 2009 £000	1 April 2008 £000
Non-current assets				
Property, plant and equipment	16	**12,860**	15,020	13,933
Intangible assets	17	**2,810**	1,446	769
Trade and other receivables	20	**0**	0	0
Total non-current assets		**15,670**	16,466	14,702
Current assets				
Trade and other receivables	20	**18,666**	8,936	11,600
Cash and cash equivalents	21	**14,256**	24,779	19,161
		32,922	33,715	30,761
Non-current assets held for sale	22	**0**	0	0
Total current assets		**32,922**	33,715	30,761
Total assets		**48,592**	50,181	45,463
Current liabilities				
Trade and other payables	23	**(13,797)**	(12,716)	(12,930)
Provisions	24	**(2,250)**	(3,362)	(1,032)
Net current assets/(liabilities)		**16,875**	17,637	16,799
Total assets less current liabilities		**32,545**	34,103	31,501
Non-current liabilities				
Trade and other payables	23	**0**	0	0
Provisions	24	**(806)**	(2,303)	(2,622)
Total assets employed		**31,739**	31,800	28,879
Financed by taxpayers' equity:				
Public dividend capital		**24,511**	24,511	24,511
Retained earnings		**6,767**	6,319	3,790
Revaluation reserve		**461**	970	578
Total Taxpayers' Equity		**31,739**	31,800	28,879

The financial statements on pages 58 to 88 were approved by the Board on 14 June 2010 and signed on its behalf by:

Signed  (Chief Executive) date 2 July 2010

Statement of Changes in Taxpayers' Equity

	Public dividend capital (PDC)	Retained earnings	Revaluation reserve	Total
	£000	£000	£000	£000
Balance at 31 March 2008				
As previously stated under UK GAAP	24,513	5,062	578	30,153
Adjustments under IFRS:				
Holiday Pay Accrual	0	(1,284)	0	(1,284)
Prior Period Adjustment	(2)	12	0	10
Restated balance	**24,511**	**3,790**	**578**	**28,879**
Changes in taxpayers' equity for 2008-09				
Total Comprehensive Income for the year:				
Retained surplus/(deficit) for the year	0	2,529	0	2,529
Impairments and reversals	0	0	0	0
Indexation	0	0	392	392
Balance at 31 March 2009	**24,511**	**6,319**	**970**	**31,800**
Changes in taxpayers' equity for 2009-10				
Total Comprehensive Income for the year				
Retained surplus/(deficit) for the year	0	448	0	448
Loss on revaluation of long leasehold land and building	0	0	(509)	(509)
PDC repaid in year	0	0	0	0
Balance at 31 March 2010	**24,511**	**6,767**	**461**	**31,739**

Prior Period Adjustment. Expenditure of £11,449 in the year ended 31 March 2008 has been capitalised as an intangible asset, as explained in note 1.7. Presentational rounding difference on public dividend capital has been adjusted to bring into line with the underlying value .

Statement of cash flows for the year ended 31 March 2010

	Note	2009/10 £000	2008/09 £000
Cash flows from operating activities			
Operating surplus/(deficit)		809	2,026
Depreciation and amortisation		3,008	2,422
Impairments and reversals		12	0
Loss on revaluation of long leasehold land and building		501	0
Interest paid		0	(11)
Dividends paid		(430)	(226)
(Increase)/decrease in trade and other receivables		(9,728)	2,664
(Increase)/decrease in other current assets		0	0
Increase/(decrease) in trade and other payables		1,081	(214)
Increase/(decrease) in other current liabilities		0	0
Increase/(decrease) in provisions	24	(2,609)	2,011
Net cash inflow/(outflow) from operating activities		(7,356)	8,672
Cash flows from investing activities			
Interest received		69	747
(Payments) for property, plant and equipment	16	(1,340)	(2,858)
Proceeds from disposal of plant, property and equipment		0	0
(Payments) for intangible assets	17	(1,895)	(944)
Proceeds from disposal of intangible assets		0	0
Net cash inflow/(outflow) from investing activities		(3,166)	(3,055)
Net cash inflow/(outflow) before financing		(10,522)	5,617
Cash flows from financing activities			
Public dividend capital repaid		0	0
Net cash inflow/(outflow) from financing		0	0
Net increase/(decrease) in cash and cash equivalents		(10,522)	5,617
Cash (and) cash equivalents (and bank overdrafts) at the beginning of the financial year		24,778	19,161
Effect of exchange rate changes on the balance of cash held in foreign currencies		0	0
Cash (and) cash equivalents (and bank overdrafts) at the end of the financial year	21	14,256	24,778

Notes to the Accounts

1 Accounting policies

The Secretary of State for Health has directed that the financial statements of NHS Trusts shall meet the accounting requirements of the NHS Trusts Manual for Accounts, which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the 2009/10 NHS Trusts Manual for Accounts issued by the Department of Health. The accounting policies contained in that manual follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to the NHS, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the NHS Trusts Manual for Accounts permits a choice of accounting policy, the accounting policy which is judged to be most appropriate to the particular circumstances of the trust for the purpose of giving a true and fair view has been selected. The particular policies adopted by the trust are described below. They have been applied consistently in dealing with items considered material in relation to the accounts.

1.1 Accounting convention

These accounts have been prepared under the historical cost convention modified to account for the revaluation of property, plant and equipment.

1.2 Acquisitions and discontinued operations

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

1.3 Critical accounting judgements and key sources of estimation uncertainty

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

1.3.1 Critical judgements in applying accounting policies

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

1.3.2 Key sources of estimation uncertainty

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

The Trust is in the process of restructuring various support functions and consultations with staff are not fully concluded. The revised structures have been approved by the Trust Board and staff advised if they are at risk. Provision has been made for the likely redundancy costs to be incurred when the result of the staff consultations is implemented. In some cases this can be done with considerable accuracy as the particular staff affected are known. In others the actual staff who will eventually be redundant is less certain and probability factors have been applied to arrive at the total provision included in these accounts of £1,675,128. The range of outcomes to which probabilities have been applied are between £1,253,000 and £2,631,000.

1.4 Revenue

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

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

1.5 Expenditure

1.5.1 Employee benefits

Short-term employee benefits

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

Retirement benefit costs

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

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

1.5.2 Other expenses

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

1.6 Property, plant and equipment

Recognition

Property, plant and equipment is capitalised if:

- it is held for use in delivering services or for administrative purposes;
- it is probable that future economic benefits will flow to, or service potential will be supplied to, the trust;
- it is expected to be used for more than one financial year;
- the cost of the item can be measured reliably; and
- the item has cost of at least £5,000; or
- Collectively, a number of items have a cost of at least £5,000 and individually have a cost of more than £250, where the assets are functionally interdependent, they had broadly simultaneous purchase dates, are anticipated to have simultaneous disposal dates and are under single managerial control; or
- Items form part of the initial equipping and setting-up cost of a new building, ward or unit, irrespective of their individual or collective cost.

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

Valuation

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

Land and buildings used for the trust's services or for administrative purposes are stated in the statement of financial position at their revalued amounts, being the fair value at the date of revaluation less any subsequent depreciation.

Accumulated depreciation and impairment losses. Revaluations are performed with sufficient regularity to ensure that carrying amounts are not materially different from those that would be determined at the end of the reporting period. Fair values are determined as market value for existing use.

Until 31 March 2009, fixtures and equipment were carried at replacement cost, as assessed by indexation and depreciation of historic cost. From 1 April 2009 indexation has ceased. The carrying value of existing assets at that date will be written off over their remaining useful lives and new fixtures and equipment are carried at depreciated historic cost as this is not considered to be materially different from fair value.

An increase arising on revaluation is taken to the revaluation reserve except when it reverses an impairment for the same asset previously recognised in expenditure, in which case it is credited to expenditure to the extent of the decrease previously charged there. A revaluation decrease is recognised as an impairment charged to the revaluation reserve to the extent that there is a balance on the reserve for the asset and, thereafter, to expenditure. Gains and losses recognised in the revaluation reserve are reported as other comprehensive income in the Statement of Comprehensive Income.

Subsequent expenditure

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

1.7 Intangible assets

Recognition

Intangible assets are non-monetary assets without physical substance, which are capable of sale separately from the rest of the trust's business or which arise from contractual or other legal rights. They are recognised only when it is probable that future economic benefits will flow to, or service potential be provided to, the trust; where the cost of the asset can be measured reliably, and where the cost is at least £5000.

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

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

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

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

Prior Period Adjustment
In the course of the work to prepare the accounts under IFRS for 2008-9, expenditure on the corporate website and self assessment tools was identified, which could have been capitalised under UK GAPP and will be in future under IFRS. These costs have been transferred from income and expenditure to intangible assets as a prior year adjustment, effective from the date the assets were brought into use. The amount transferred was £826,308 on which depreciation of £36,503 has been provided. Of this total expenditure, £11, 449 relates to the year ended 31 March 2008, with no depreciation charged in that year.

Assets were identified which under both UK GAPP and IFRS would be more appropriately classified as intangible rather than tangible assets. Accordingly assets costing £1,241,115 with depreciation of £582,550 have been reclassified in these accounts.

1.8 Depreciation, amortisation and impairments

Property, plant and equipment under construction are not depreciated.

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

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

If there has been an impairment loss, the asset is written down to its recoverable amount, with the loss charged to the revaluation reserve to the extent that there is a balance on the reserve for the asset and, thereafter, to expenditure. Where an impairment loss subsequently reverses, the carrying amount of the asset is increased to the revised estimate of the recoverable amount but capped at the amount that would have been determined had there been no initial impairment loss. The reversal of the impairment loss is credited to expenditure to the extent of the decrease previously charged there and thereafter to the revaluation reserve.

1.9 Non-current assets held for sale

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

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

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

1.10 Leases

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

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

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

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

Where a lease is for land and buildings, the land and building components are separated. In April 2009 the International Accounting Standards Board reconsidered the treatment of Long Leasehold land as an operating lease. It decided that as from accounting periods beginning after 1st January 2010, this would change to a finance lease and early adoption of this change is permitted. The trust has adopted this change and its 999 year leasehold land is treated as a finance lease in these accounts. Leased buildings are assessed as to whether they are operating or finance leases.

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

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

1.11 Cash and cash equivalents

Cash is cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours. Cash equivalents are investments that mature in 3 months or less from the date of acquisition and that are readily convertible to known amounts of cash with insignificant risk of change in value.

1.12 Provisions

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

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

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

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

1.13 Clinical negligence costs

The NHS Litigation Authority (NHSLA) operates a risk pooling scheme under which the trust pays an annual contribution to the NHSLA which in return settles all clinical negligence claims. The contribution is charged to expenditure. Although the NHSLA is administratively responsible for all clinical negligence cases the legal liability remains with the trust. The total value of clinical negligence provisions carried by the NHSLA on behalf of the trust is disclosed at note 24.

1.14 Non-clinical risk pooling

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

1.15 Contingencies

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

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

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

1.16 Financial instruments

Financial assets

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

Financial assets are initially recognised at fair value.

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

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

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

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

Financial liabilities

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

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

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

1.17 Value Added Tax

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

1.18 Foreign currencies

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

1.19 Public Dividend Capital (PDC) and PDC dividend

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

An annual charge, reflecting the cost of capital utilised by the trust, is payable to the Department of Health as public dividend capital dividend. The charge is calculated at the real rate set by HM Treasury (currently 3.5%) on the average carrying amount of all assets less liabilities, except for donated assets and cash balances with the Office of the Paymaster General. The average carrying amount of assets is calculated as a simple average of opening and closing relevant net assets. A note to the accounts discloses the rate that the dividend represents as a percentage of the actual average carrying amount of assets less liabilities in the year. From 1 April 2009, the dividend payable is based on the actual average relevant net assets for the year instead of forecast amounts.

1.20 Losses and special payments

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

Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis, including losses which would have been made good through insurance cover had NHS trusts not been bearing their own risks (with insurance premiums then being included as normal revenue expenditure). However, the note on losses and special payments is compiled directly from the losses and compensations register which reports amounts on an accruals basis with the exception of provisions for future losses.

1.21 Accounting standards that have been issued but have not yet been adopted

All accounting standards issued by the IASB and IFRIC have been adopted to the extent included within guidance on preparation of these accounts from the Department of Health.

1.22 Accounting standards issued that have been adopted early

The change in treatment for leased land from an operating lease to a finance lease for accounting periods commencing after 1 January 2010 has been adopted in these accounts.

2. Operating segments

IFRS 8 requires NHS Trusts that have more than one business segment to report the Income, Surplus / (deficit) and Net Assets attributable to each segment.

NHS Direct NHS Trust only has one business segment and none of the customers referred to in note 3 account for more than 10% of income

Income from the various services provided by the trust is as follows

	2009/10 £000	2008/09 £000
Core Services	124,924	134,838
Choose & Book Appointments Line	7,540	7,146
Out of Hours Services	3,511	4,555
Dental Services	1,907	1,347
Long Term Conditions	3,453	2,820
Single Point of Access to NHS Services	6,329	0
Other Contestable Income	1,310	1,200
Department of Health	40,082	7,931
	189,056	159,837

During 2009-10 there was a contract variation of £2m as a result of an underspend of Strategic Development Investment; this includes investment for advertising not required given the wider pandemic flu publicity. In the financial year ended 31 March 2009, there was a £2.5m in year contract deduction for core services, as part of the transition in commissioning from Department of Health to East of England Strategic Health Authority.

3 Income generation activities

The Trust undertakes income generation activities with an aim of achieving profit, which is then used in patient care. The trust has a substantial investment in the national infrastructure necessary to provide the core service. It has historically undertaken other locally commissioned services in order to maximise the use of this infrastructure for patient care and to contribute towards its cost.

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

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

Pandemic Flu and Fluline Service

During 2007/08 the Department of Health initiated the development of a Pandemic Flu advice and antiviral distribution system through NHS Direct. The system to be available throughout the UK, funded by the Department of Health in England and the Devolved Health Authorities in Scotland, Wales and Northern Ireland. The Department of Health has contracted to reimburse the direct costs involved in this initiative and specific overheads involved in running this major project, with an overall budget of £48m for the system and keeping it in a state of readiness over its expected life of 5 years .

The charges to the Devolved Health Authorities are subject to separate contracts; these contracts had not been signed at 31 March 2010, although Northern Ireland signed on 2 April 2010. The financial information below is based on the assumption all contracts will be signed. If they are not, the impact on the Trust will be negligible as the current charges to the Department of Health will remain.

Following the outbreak of swine flu globally, the Department of Health placed a further contract to ensure systems were in place to meet this potential immediate demand.

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

Income from Department of Health in 2009/10 includes £36,326,897 (2008/09 £7,445,017) for reimbursement of costs incurred on the Pandemic Flu project, summarised below.

	2009/10 £000	2008/09 £000
Income from Department of Health for System Build and Maintenance	**32,590**	7,445
Income from the Devolved Authorities for Scotland, Wales and Northern Ireland	**3,230**	0
Costs		
Directly attributable costs	**(14,919)**	(590)
System Build costs	**(13,814)**	(2,303)
Dormancy Fees	**(3,761)**	0
External charges	**(2,867)**	(3,930)
Contribution to specified overheads including staff working on the project	**459**	622
Included within the above, contribution from the Devolved Health Authorities under the contracts referred to above	**13**	0
Income from Department of Health for delivery of Fluline service	**3,737**	0
External charges	**(943)**	0
Internal recharges	**(2,266)**	0
Contribution to specified overheads including staff working on the project	**528**	0

Dental Services	2009/10 £000	2008/09 £000
Income	1907	1360
Full cost	(3,359)	(3,998)
Surplus/(deficit)	(1,452)	(2,638)
Contribution	(111)	(907)

The failure to achieve a contribution for this service will be addressed when contracts are due for renewal.

GP Out of Hours Services	2009/10 £000	2008/09 £000
Income	3,511	4,574
Full cost	(4,094)	(5,943)
Surplus/(deficit)	(583)	(1,369)
Contribution	807	981

Long Term Conditions	2009/10 £000	2008/09 £00
Income	3,453	2,820
Full cost	(3,956)	(3,563)
Surplus/(deficit)	(503)	(743)
Contribution	886	623

Single Point of Access to NHS Services	2009/10 £000	2008/09 £000
Income	6,329	0
Full cost	(8,669)	0
Surplus/(deficit)	(2,340)	0
Contribution	(1,165)	0

These results reflect the initial start-up and one-off costs for the project involving new computer systems and transfer of staff from previous providers with a go-live date of 1 April 2009. A cost improvement and management plan to improve performance has been put in place for this 3 year contract.

The Appointments Line	2009/10 £000	2008/09 £000
Income	7,540	7,146
Full cost	(7,784)	(8,316)
Surplus/(deficit)	(244)	(1,170)
Contribution	1,668	1,142

As a result of the full cost allocation and apportionment across these services (as previously detailed) the surplus reported for the core service is

	2009/10 £000	2008/09 £000
Income	124,924	131,085
Full cost	(121,621)	(126,799)
Surplus/(deficit)	3,303	4,286

4 Revenue from patient care activities

	2009/10 £000	2008/09 £000
Strategic health authorities	132,433	141,919
NHS trusts	277	46
Primary care trusts	12,249	7,174
Foundation trusts	232	352
Local authorities	0	31
Department of Health	40,082	7,931
NHS other	1	0
Non-NHS:	3,782	0
Other	0	2,384
	189,056	159,837

5 Other operating revenue

	2009/10 £000	2008/09 £000
Education, training and research	149	0
Rental revenue	457	387
Other revenue	1,374	1,342
	1,980	1,729

6 Revenue

Revenue from the sale of goods is immaterial.

7 Operating expenses

	2009/10 £000	2008/09 £000
Directors' Costs	1,445	1,243
Staff costs	104,902	95,793
Consultancy services (c)	4,955	7,279
Supplies and services - general	170	183
Establishment expenses	3,217	5,812
Education & Training	597	1,090
Telecommunications	6,636	8,098
Premises	8,973	9,308
Transport	1,896	1,835
Depreciation and amortisation	3,008	2,422
IT contracts (e)	48,940	20,656
Audit fees (b)	102	108
Other audit fees	121	120
Contributions to the NHS Litigation Authority	154	215
Health Information services	3,684	1,244
Redundancy costs	1,460	1,890
Early retirement costs	(568)	855
Other (a)	34	1,388
Revaluation of long leasehold land in Nottingham (d)	501	0
	190,227	159,540

(a) Significant items included in Other Costs are: interpreting skills £388,419 (2008/09 £192,358), patient surveys and public participation activities £166,401 (2008/09 £302,275), personal injury claims £44,078 (2008/09 £441,077) and website development costs £210,068 (2008/09 £297,828. The figure for website development costs has been changed reflecting the prior year adjustments to capitalisation of intangibles). The reversal of the onerous lease provision for the Trust's former site in Cambridge of £1,035,800 is also included here, resulting in the comparatively small cost under this heading and accounting for the majority of the movement between years.
(b) Audit fees include £7,500 (2008/9 £7,500) for audit work completed in respect of the implementation of International Financial Reporting Standards in 2009/10.
(c) Consultancy costs include £2,955,957 (2008/09 £3,930,371) in respect of work done on the Pandemic Flu projects.
(d) The long leasehold land and buildings in Nottingham were revalued at 1 January 2010, resulting in a reduction in value of £1,010,298 of which £501,273 is included in operating expenses in respect of the land and the balance charged to revaluation reserve. Refer to note 16
(e) IT contracts costs include £30,105,998 (2008/9 £2,351,525) in respect of Pandemic Flu and Fluline system development costs and, associated dormancy fees charged to the Department of Health per note 3.

8 Operating leases

8.1 As lessee

The Trust has 2 main types of operating leases:

Car leases which are all for a period of 3 years

Rental of premises for operational and administrative purposes

Payments recognised as an expense	2009/10 £000	2008/09 £000
Minimum lease payments	4,301	4,529
Contingent rents	0	0
Sub-lease payments	0	0
	4,301	4,529

Total future minimum lease payments	2009/10 £000	2008/09 £000
Payable:		
Not later than one year	897	1,163
Between one and five years	1,722	1,933
After 5 years	1,258	1,236
Total	3,877	4,332

8.2 As lessor

The trust sublets 6 of the premises occupied

Rental Revenue	2009/10 £000	2008/09 £000
Minimum lease payments	457	387
Contingent rent	0	0
Other	0	0
Total rental revenue	457	387

Total future sublease payments expected to be received: £247,329 (2008/9 £349,189)

Total future minimum lease payments	2009/10 £000	2008/09 £000
Receivable:		
Not later than one year	113	209
Between one and five years	178	58
After 5 years	0	0
Total	291	267

9 Employee costs and numbers

9.1 Employee costs

	2009/10 Total	Permanently Employed	Other	2008/09 Total	Permanently Employed	Other
	£000	£000	£000	£000	£000	£000
Salaries and wages	90,950	79,069	11,881	84,325	76,459	7,866
Social Security Costs	5,925	5,925	0	5,580	5,580	0
Employer contributions to NHS Pension scheme	9,528	9,528	0	9,249	9,249	0
Other pension costs	0	0	0	0	0	0
Other post-employment benefits	0	0	0	0		0
Termination benefits	0	0	0	0	0	0
Employee benefits expense	106,403	94,522	11,881	99,154	91,288	7,866

9.2 Average number of people employed

	2009/10 Total Number	Permanently Employed Number	Other Number	Total Number	Permanently Employed Number	Other Number
Medical and dental	4	4	0	4	4	0
Administration and estates	1,881	1,582	299	1,677	1,456	221
Nursing, midwifery and health	979	902	77	1,001	1,001	0
visiting staff Scientific, therapeutic and technical staff	83	83	0	54	54	0
Other	5	5	0	6	6	0
Total	2,952	2,576	376	2,742	2,521	221
Of the above:						
Number of staff (WTE) engaged on capital projects	3			0		

9.3 Staff sickness absence

	2009/10 Number
Total days lost	42,482
Total staff years	2,490
Average working days lost	17.1
Total staff employed in period (headcount)	3,447
Total staff employed in period with no absence (headcount)	871
Percentage staff with no sick leave	25.3%

The statistics shown above for sickness absence are for the calendar year 1 Jan 2010 to 31 December 2010, rather than the financial year in accordance with instructions issued by the Department of Health

9.4 Management Costs	2009/10 £000	2008/09 £000
Management costs	24,496	25,780
Income	150,250	152,941
Management Costs as a percentage of income	16.3%	16.9%

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

10 Pension costs

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

The scheme is subject to a full actuarial valuation every four years (until 2004, every five years) and an accounting valuation every year. An outline of these follows:

a) Full actuarial (funding) valuation

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

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

b) Accounting valuation

A valuation of the scheme liability is carried out annually by the scheme actuary as at the end of the reporting period by updating the results of the full actuarial valuation.

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

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

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

c) Scheme provisions

The scheme is a "final salary" scheme. Annual pensions are normally based on 1/80th of the best of the last 3 years pensionable pay for each year of service. A lump sum normally equivalent to 3 years pension is payable on retirement. Annual increases are applied to pension payments at rates defined by the Pensions (Increase) Act 1971, and are based on changes in retail prices in the twelve months ending 30 September in the previous calendar year. On death, a pension of 50% of the member's pension is normally payable to the surviving spouse.

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

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

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

11 Retirements due to ill-health

During 2009/10 there were 9 (2008/09, 12) early retirements from the NHS Trust agreed on the grounds of ill-health. The estimated additional pension liabilities of these ill-health retirements will be £572,790 (2008/09: £740,998). The cost of these ill-health retirements will be borne by the NHS Business Services Authority - Pensions Division.

12 Better Payment Practice Code

12.1 Better Payment Practice Code - measure of compliance

	2009/10 Number	2009/10 £000	2008/09 Number	2008/09 £000
Total Non-NHS trade invoices paid in the year	30,741	95,535	31,068	70,649
Total Non NHS trade invoices paid within target	28,615	85,068	28,788	63,100
Percentage of Non-NHS trade invoices paid within target	93%	89%	93%	89%
Total NHS trade invoices paid in the year	869	4,516	1,014	3,557
Total NHS trade invoices paid within target	797	3,649	869	2,686
Percentage of NHS trade invoices paid within target	92%	81%	86%	76%

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

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

	2009/10 £000	2008/09 £000
Amounts included in finance costs from claims made under this legislation	0	0
Compensation paid to cover debt recovery costs under this legislation	0	0
Total	0	0

13 Investment revenue

	2009/10 £000	2008/09 £000
Interest revenue: Bank accounts	69	747
Total	69	747

14 Other gains and losses

	2009/10 £000	2008/09 £000
Gain/(loss) on disposal of property, plant and equipment	(13)	(7)
Gain/(loss) on disposal of intangible assets	0	0
Total	(13)	(7)

The loss in year arose on plant at the Southall site which closed and has been charged to the provision for this closure

15 Finance costs

	2009/10 £000	2008/09 £000
Interest on late payment of commercial debt	0	0
Other interest expense	0	11
Total interest expense	0	11
Other finance costs	0	0
Total	0	11

16 Property, plant and equipment

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

Prior year

2008/09	Long leasehold land £000	Buildings excluding dwellings £000	Assets under construction £000	Plant and machinery £000	Information technology £000	Furniture & fittings £000	Total £000
Cost or valuation at 1 April 2008	1,114	10,925	488	684	5,523	1,160	19,894
Additions purchased	0	517	872	346	710	413	2,858
Reclassifications	0	180	(488)	44	146	119	1
Reclassified as held for sale	0	0	0	0	(58)	0	(58)
Disposals other than by sale		(8)			(28)	(10)	(46)
Indexation	48	462	0	18	0	30	558
At 31 March 2009	**1,162**	**12,076**	**872**	**1,092**	**6,293**	**1,712**	**23,207**
Depreciation at 1 April 2008	0	3,535	0	127	1,794	505	5,961
Reclassifications	0	0	0	0	0	0	0
Reclassified as held for sale	0	0	0	0	(58)	0	(58)
Disposals other than by sale	0	(7)	0	0	(28)	(2)	(37)
Indexation	0	150	0	3	0	13	166
Charged during the year	5	660	0	185	1,143	162	2,155
Depreciation at 31 March 2009	**5**	**4,338**	**0**	**315**	**2,851**	**678**	**8,187**
Net book value							
Purchased	1,157	7,738	872	777	3,442	1,034	15,020
Total at 31 March 2009	**1,157**	**7,738**	**872**	**777**	**3,442**	**1,034**	**15,020**
Total at 31 March 2008	**1,114**	**7,390**	**488**	**557**	**3,729**	**655**	**13,933**
Asset financing							
Owned	1,157	7,738	872	777	3,442	1,034	15,020
Finance leased	0	0	0	0	0	0	0
Total 31 March 2009	**1,157**	**7,738**	**872**	**777**	**3,442**	**1,034**	**15,020**

16 Property, plant and equipment (cont.)

The long leasehold land and building occupied by the Trust in Nottingham were revalued at 1 January 2010 but applied to the net book value as at 31 March 2010. The valuation was undertaken by DVS the commercial arm of the Valuation Office Agency. The valuation has been carried out in accordance with the requirements of IAS 16, specifically the amount for which an asset could be exchanged between knowledgeable willing parties in an arm's-length transaction . The fair value of land and buildings is usually determined from market based evidence by appraisal undertaken by a professionally qualified valuer. These principles have been applied to this valuation
The impact of the revaluation is as follows:

	Land £000	Buildings £000
Net book value at 31 March 2010	1,156	3,404
Valuation in accordance with above note	550	3,000
Change in value	606	404
Charged to revaluation reserve	105	404
Charged to operating expenses	501	0

The long lease in Nottingham expires on 30 December 2991 and the value of the land is being amortised over this period. The building on that land is being depreciated over 66 years representing an approximation of its useful economic life.

The economic lives of fixed assets for those still subject to depreciation range from:	Min Life (years)	Max Life (years)
Long leasehold land	990	990
Buildings excluding dwellings - all leasehold	4	71
Plant & machinery	4	9
Information technology	5	5
Furniture & fittings	4	10

The gross revalued amount of assets fully depreciated but still in use is £2,630,185

At 2008-9	Min Life (years)	Max Life (years)
Long leasehold land	990	990
Buildings excluding dwellings - all leasehold	4	71
Plant & machinery	4	9
Information technology	3	5
Furniture & fittings	4	10

17 Intangible assets

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

Prior year

2008/09	Computer software - purchased £000	Computer software - internally generated £000	Assets under Construction £000	Development expenditure (internally generated) £000	Total £000
Gross cost at 1 April 2008	1,123	0	0	0	1,123
Additions purchased	135	290	124	82	631
Additions internally generated	0	117	82	114	313
Additions donated	0	0	0	0	0
Additions government granted	0	0	0	0	0
Reclassifications	0	0	0	0	0
Reclassified as held for sale	0	0	0	0	0
Disposals other than by sale	0	0	0	0	0
Revaluation	0	0	0	0	0
Impairments	0	0	0	0	0
Reversals of impairments	0	0	0	0	0
Gross cost at 31 March 2009	**1,258**	**407**	**206**	**196**	**2,067**
Amortisation at 1 April 2008	354	0	0	0	354
Reclassifications	0	0	0	0	0
Reclassifications as held for sale	0	0	0	0	0
Disposals other than by sale	0	0	0	0	0
Revaluation	0	0	0	0	0
Impairments	0	0	0	0	0
Reversal of impairments	0	0	0	0	0
Charged during the year	232	19	0	16	267
Amortisation at 31 March 2009	**586**	**19**	**0**	**16**	**621**
Net book value					
Purchased	672	388	206	180	1,446
Total at 31 March 2009	**672**	**388**	**206**	**180**	**1,446**
Total at 31 March 2008	769	0	0	0	769

Prior Period Adjustment. As explained in note 1.7 expenditure previously charged in the income and expenditure account has been capitalised. Thus expenditure of £826,308 is included within purchases shown above and on which depreciation of £36,503 has been charged. In addition assets costing £1,241,115 with cumulative depreciation of £582,550 at 31st March 2009 have been transferred from tangible to intangible assets

17 Intangible assets

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

	Min Life (years)	Max Life (years)
Computer Software purchased	2	5
Computer Software internally generated	3	3
Development expenditure internally generated	3	3

18 Impairments

Following the nature of intangible assets referred to in Note 17, impairments have been considered but not deemed necessary at 31 March 2010.

19 Capital commitments

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

	31 March 2010 £000	31 March 2009 £000
Property, plant and equipment	128	0
Intangible assets	588	0
Total	716	0

20 Trade and other receivables

20.1 Trade and other receivables

	Current			Non-current		
	31 March 2010 £000	31 March 2009 £000	31 March 2008 £000	31 March 2010 £000	31 March 2009 £000	31 March 2008 £000
NHS receivables	3,715	1,018	2,947	0	0	0
Other trade receivables	4,382	1,277	963	0	0	0
VAT	1,239	1,270	1,699	0	0	0
Accrued income	4,086	655	422	0	0	0
Provision for the impairment of receivables	(240)	(292)	0	0	0	0
Prepayments other	5,484	5,008	5,569	0	0	0
Total	18,666	8,936	11,599	0	0	0

The great majority of trade is with strategic health and primary care trusts, as commissioners for NHS patient care services. As these trusts are funded by government to buy NHS patient care services, no credit scoring of them is considered necessary.

Other trade of significance is with big pharmaceutical companies, which have satisfactory credit ratings.

20.2 Receivables past their due date but not impaired

	31 March 2010 £000	31 March 2009 £000
By up to three months	2,573	143
By three to six months	28	46
By more than six months	371	193
Total	2,972	382

20.3 Provision for impairment of receivables

	31 March 2010 £000	31 March 2009 £000
Balance at 1 April	292	0
Amount written off during the year	(89)	0
Amount recovered during the year	(21)	0
(Increase)/decrease in receivables impaired	58	292
Balance at 31 March	240	292

The provision relates to salary overpayments to former staff deemed irrecoverable

21 Cash and cash equivalents

	31 March 2010 £000	31 March 2009 £000	31 March 2008 £000
Balance at 1 April	24,778	19,161	16,111
Net change in year	(10,522)	5,617	3,050
Balance at 31 March	**14,256**	24,778	19,161
Made up of			
Cash with Office of HM Paymaster General	14,256	24,778	19,161
Commercial banks and cash in hand	0	0	0
Current investments	0	0	0
Cash and cash equivalents as in statement of financial position	14,256	24,778	19,161
Bank overdraft - Office of HM Paymaster General	0	0	0
Bank overdraft - Commercial banks	0	0	0
Cash and cash equivalents as in statement of cash flows	14,256	24,778	19,161

22 Non-current assets held for sale

There were no non-current assets held for sale at 31 March 2010

23 Trade and other payables

There were no non-current assets held for sale at 31 March 2010

	Current			Non-current		
	31 March 2010 £000	31 March 2009 £000	31 March 2008 £000	31 March 2010 £000	31 March 2009 £000	31 March 2008 £000
Interest payable	0	0	0	0	0	0
NHS payables	657	826	209	0	0	0
Other trade payables - revenue	2388	2,300	1,877	0	0	0
Other trade payables - capital	0	0	0	0	0	0
Tax and social security costs	1785	1,695	1,775	0	0	0
VAT	0	0	0	0	0	0
Accruals	7858	7,433	7,903	0	0	0
Deferred income	1109	462	1,166	0	0	0
Other	0	0	0	0	0	0
Total	13,797	12,716	12,930	0	0	0

Other payables include:

Outstanding pensions contributions at 31 March 2010 £1,138,032 (2008/9 £1,086,618).

24 Provisions

	Current			Non-current		
	31 March 2010 £000	31 March 2009 £000	31 March 2008 £000	31 March 2010 £000	31 March 2009 £000	31 March 2008 £000
Pensions relating to former directors	**0**	0	0	0	**0**	
Pensions relating to other staff	**34**	33	16	806	**800**	408
Legal claims	**0**	0	0	0	**0**	
Restructurings	**1,675**	2,909	0	0	**0**	
Other (specify)	**541**	420	1,016	0	**1,503**	2,214
Total	**2,250**	3,362	1,032	806	**2,303**	2,622

Other provisions include the vat due on contracts where the price is vat inclusive £394,015 (31 March 2009 £169,000),

	Pensions relating to former directors £000	Pensions relating to other staff £000	Legal £000	Restructurings £000	Other £000	Total £000
At 1 April 2009	0	833	0	2,909	1,923	**5,665**
Arising during the year	0	44	0	1,675	297	**2,016**
Used during the year	0	-37	0	-2,028	-623	**-2,688**
Reversed unused	0	0	0	-881	-1,056	**-1,937**
Unwinding of discount	0	0	0	0	0	**0**
At 31 March 2010	0	840	0	1,675	541	**3,056**
Expected timing of cash flows: In the remainder of the spending review						
Period to 31 March 2011	0	34	0	1,675	541	**2,250**
Between 1 April 2011 and 31 March 2016	0	158	0	0	0	**158**
Between 1 April 2016 and 31 March 2021	0	142	0	0	0	**142**
Thereafter	0	506	0	0	0	**506**

Details of the estimates made in arriving at the restructuring provision are given in note 1.3.2

£323,747 is included in the provisions of the NHS Litigation Authority at 31 March 2010 in respect of clinical negligence liabilities of the trust (31March 2009 £388,921).

25 Contingent liabilities

	2009/10 £000	2008/09 £000
Equal pay cases	**0**	0
Other (specify)	**22**	23
Total	**22**	23

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

26 Financial instruments

Disclosure

IFRS 7 provides an option to exclude from the interest-rate risk and fair values disclosures financial assets and liabilities which are due within one year and this option has been applied to this note.

Financial risk management

Financial reporting standard IFRS 7 requires disclosure of the role that financial instruments have had during the period in creating or changing the risks a body faces in undertaking its activities. Because of the continuing service provider relationship that the Trust has with the Strategic Health authority and the way both are financed, the Trust is not exposed to the degree of financial risk faced by business entities. Also financial instruments play a much more limited role in creating or changing risk than would be typical of listed companies, to which the financial reporting standards mainly apply. The Trust has limited powers to borrow or invest surplus funds and financial assets and liabilities are generated by day-to-day operational activities rather than being held to change the risks facing the Trust in undertaking its activities.

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

Currency risk

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

Interest rate risk

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

Credit risk

Because the majority of the Trust's income comes from contracts with other public sector bodies, the trust has low exposure to credit risk. The maximum exposures as at 31 March 2010 are in receivables from customers, as disclosed in the Trade and other receivables note.

Liquidity risk

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

27 Events after the reporting period

In Note 1.3.2, the Trust drew attention to the restructurings taking place to improve efficiency and reduce the cost base in recognition of the reduced income available for core activities in 2010-11 from East of England SHA. These continue and will result in additional costs not provided for in these accounts, as the processes were not sufficiently advanced at 31 March 2010 to facilitate their inclusion.

On 25th May 2010 a contract was signed with CS solutions for a licence in perpetuity in respect of the clinical content and the content engine used in the Trust's activities. The amount payable to CS Solutions is £19,247,000 to be paid by instalments over the period to 30 November 2015. The amount to be paid in the financial year 2010-11 is £11,612,248, which can be accommodated within the Trust's existing cash resources. This intangible asset will be depreciated over 15 years and reduce the Trust's operating costs by circa £5m per annum over the capital repayment period.

28 Financial performance targets

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

28.1 Breakeven performance

	2007/08 £000	2008/09 £000	**2009/10 £000**
Turnover	144,381	161,566	191,036
Retained surplus/(deficit) for the year	5,062	467	448
Break-even cumulative position	5,062	5,529	5,977
	2007/08 %	**2008/09 %**	**2009/10 %**
Materiality test (I.e. is it equal to or less than 0.5%):			
Break-even in-year position as a percentage of turnover	3.5%	0.3%	0.2%
Break-even cumulative position as a percentage of turnover	3.5%	3.4%	3.1%

The amounts in the above tables in respect of financial years 2007/08 to 2008/09 inclusive have not been restated to IFRS and remain on a UK GAAP basis.

28.2 Capital cost absorption rate

For 2008/09 the trust was required to absorb the cost of capital at a rate of 3.5% of forecast average relevant net assets. The rate is calculated as the percentage that dividends paid on public dividend capital, totalling £226,000, bears to the actual average relevant net assets of £8,626,597, that is 2.6% (2007/08 1.8%)

The dividend of £226,000 is an agreed amount for the year based on capital charge estimates submitted in December 2007. The actual dividend payment based on 3.5% of net relevant assets would have been £301,931.

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

28.3 External financing

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

	2009/10 £000	2008/09 £000
External financing limit	**6,217**	4,443
Cash flow financing	**10,522**	(5,617)
Finance leases taken out in the year	**0**	0
Other capital receipts	**0**	0
External financing requirement	**0**	0
Undershoot/(overshoot)	**(4,305)**	10,060

28.4 Capital resource limit

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

	2009/10 £000	2008/09 £000
Gross capital expenditure	**3,235**	2,988
Less: book value of assets disposed of	**(13)**	(8)
Charge against the capital resource limit	**3,222**	2,980
Capital resource limit	**5,891**	4,000
(Over)/Underspend against the capital resource limit	**2,669**	1,020

29 Related party transactions

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

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

Strategic Health Authorities
Primary Care Trusts
NHS Trusts
NHS Foundation Trusts
NHS Litigation Authority
NHS Professionals
NHS Purchasing and Supply Agency
NHS Institute of Innovation and Improvement

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

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

	2009/10 £000			2008/09 £000		
Income in nature	**Income**	Debtor	Creditor	Income	Debtor	Creditor
East of England Strategic Health Authority	**102,386**	293	0	141,919	0	66
Department of Health	**31,054**	5,932	0	9,245	189	0
Calderdale PCT	**4,598**	0	0	278	0	0
Nottingham City PCT	**522**	399	0	448	216	0
East Lancashire PCT	**376**	0	0	493	0	0
Stockport PCT	**298**	28	0	520	0	0
South East Essex PCT	**293**	24	0	354	100	0
Hillingdon PCT	**273**	30	0	367	28	0
Bury PCT	**252**	56	0	323	0	0
Hounslow PCT	**250**	28	0	342	0	0
Expenditure in nature	Expenditure	Debtor	Creditor	Expenditure	Debtor	Creditor
Yorkshire Ambulance Service NHS Trust	379	0	0	354	0	4
University Hospitals of Leicester NHS Trust	297	0	0	555	0	555
Nottinghamshire Healthcare NHS Trust	267	0	7	314	0	13
NHS Professionals	244	0	266	0	0	0

30 Intra-Government and other balances

	Current receivables £000	Non-current receivables £000	Current payables £000	Non-current payables £000
Balances with other Central Government Bodies	8,195	0	3,154	0
Balances with Local Authorities	0	0	0	0
Balances with NHS Trusts and Foundation Trusts	100	0	123	0
Balances with Public Corporations and Trading Funds	0	0	0	0
Intra Government balances	8,295	0	3,277	0
Balances with bodies external to Government	10,371	0	10,520	0
At 31 March 2010	**18,666**	0	**13,797**	0
Balances with other Central Government Bodies	2,183	0	2,992	0
Balances with Local Authorities	23	0	0	0
Balances with NHS Trusts and Foundation Trusts	105	0	616	0
Balances with Public Corporations and Trading Funds	0	0	0	0
Intra Government balances	2,311	0	3,608	0
Balances with bodies external to Government	6,625	0	9,108	0
At 31 March 2009	**8,936**	0	**12,716**	0

31 Losses and special payments

There were 16 cases of losses and special payments (2008/9 26 cases) totalling £77,504 paid during 2009-10 (2008/9 £203,932)

32 Transition to IFRS

	Retained earnings £000	Revaluation reserve £000
Taxpayers' equity at 31 March 2009 under UK GAAP:	**5,529**	**970**
Adjustments for IFRS changes:	0	0
Private finance initiative	0	0
Leases	0	0
Intangible assets capitalised net of depreciation	0	0
Adjustments for prior year changes:		
Intangible assets capitalised net of depreciation	778	0
Prior period adjustment	12	0
Adjustments for:		
Impairments recognised on transition	0	0
UK GAAP errors	0	0
Taxpayers' equity at 1 April 2009 under IFRS:	**6,319**	**970**

	£000	
Surplus/(deficit) for 2008/09 under UK GAAP	**467**	**0**
Adjustments for:		
Private finance initiative	0	0
Leases	0	0
Holiday pay accrual made in 2007-8	1,284	0
Intangible assets capitalised net of depreciation in the year ended 31 March 2009	778	0
Surplus/(deficit) for 2008/09 under IFRS	**2,529**	

The UK GAAP 2008/09 cash flow statement included net movements in liquid resources of £5,617 This net movement is included in the bottom line cash and cash equivalents figure in the 2009/10 statement of cash flows under IFRS.

Appendix
Key Performance Indicators - Detailed Disclosure Requirements

KPI name	Purpose	Definition and calculation method
Patient/user satisfaction	To measure patients' perception of quality of our services	Patient perception of level of service being provided by NHS Direct. % of respondents satisfied with NHS Direct service provided to them.
Standards for Better Health compliance	To ensure our services are of a safe and fit standard	Self assessment of compliance against Care Quality Commission Standards for Better Health, verified by internal audit. Based on internal quarterly and annual self-assessment process, verified by internal audit.
Incidents and complaints		**50:50 weighting of KPIs below:**
Number of complaints relating to clinical services per 10,000 calls	Indicates the quality of our service	Number of complaints relating to clinical services per 10,000 calls. Calculated using: Number of nationally handled complaints reported (for combined service) relating to clinical services x 10,000 ÷ Number of calls answered.
Serious incidents leading to harm	Indicates quality and safety of service	Serious incidents leading to harm. Number of serious incidents leading to unexpected or unintended serious patient harm or death as a % of total serious incidents (Monthly – 12-month average).
Appropriate prioritisation of calls		**Based on internal quarterly and annual self-assessment process, verified by internal audit.**
% urgent calls started within 20 minutes	Identifies the speed of response to clinically urgent calls	The percentage of urgent calls (i.e. those with clinical priorities P0, P1 and D1) where triage by a clinician is started within 20 minutes. Calculated using: Number of urgent clinical calls (P0,P1 and D1) started within 20 minutes ÷ Number of urgent clinical calls (P0,P1 and D1) requiring clinical assessment.
% less urgent calls started within 60 minutes	Identifies the speed of response to clinically less urgent calls	The percentage of less-urgent calls (i.e. those with clinical priorities P2) where triage by a clinician is started within 60 minutes. Calculated using: Number of urgent clinical calls (P2) started within 60 minutes ÷ Number of urgent clinical calls (P2) requiring clinical assessment.

Target	Data source
≥95%	External monthly satisfaction survey (IFF Research)
0 standards at risk of being non-compliant	Internal assessment results and internal audit report
<1	Datix & regional complaints reporting
<10%	National Peer Review Outcome Report Log
≥95%	CAS (Clinical Assessment Service)
≥95%	CAS (Clinical Assessment Service)

KPI name	Purpose	Definition and calculation method
% non-urgent calls started within 120 minutes	Identifies the speed of response to clinically non-urgent calls	The percentage of non-urgent calls (i.e. those with clinical priorities P2, P3, D2, P3) where triage by a clinician is started within 120 minutes. Calculated using: Number of non-urgent clinical calls (P2, P3, D2, P3) started within 120 minutes ÷ Number of non-urgent clinical calls (P2, P3, D2, P3) requiring clinical assessment.
YTD contract performance KPI penalties	Measures performance against contract	Financial penalties incurred YTD on the major NHS Direct contracts - Core, WYUC, TAL. Aggregation of all financial penalties incurred/total potential financial penalties on those defined contracts.
Calls answered vs. latest contract target (volume)	Measures performance against contract	Number of calls answered against the number of calls agreed as latest contract target (Core, WYUC, TAL, East Lancashire OOH, Stockport Dental). Number of calls answered compared to latest contract target.
Web usage (volume) total		**80:20 weighting of KPIs below:**
SAT usage	Indicates success of web-based service	Number of SAT visits compared to phased contract plan
Online enquiries	Indicates success of web-based service	Number of online enquiries compared to phased contract plan.
Completed within NHS Direct	Identifies the proportion of calls completed within NHS Direct i.e. those not requiring referral to any other NHS healthcare provider – this provides a proxy indicator for the impact of NHS Direct on the wider health economy	The percentage of calls NHS Direct completes without onward referral. Calculated using the number of dispositions set as self care, pharmacy, primary care service (PCS) routine and health information with formulae: (Self-care + Pharmacy + PCS Routine + HIS) ÷ Number of calls for combined service.
Growth in the volume of non-core services purchased by commissioners	Measure of income from contracts outside the core contract	Income generated by enhanced contracts (all contracts other than core) compared to planned income target. The income generated by enhanced contracts (including flu) compared to planned income target/planned income target.
Stakeholder perception annual survey	Measures key stakeholders' perception of our service	Stakeholder perception of level of service being provided by NHS Direct. % of respondents rating NHS Direct's overall performance as good or excellent.

Target	Data source
≥95%	CAS (Clinical Assessment Service)
<5%	
≥ 9.6m	Symposium
≥ Contract plan target	CAS (Clinical Assessment Service)
≥ Contract plan target	CAS (Clinical Assessment Service)
≥50%	CAS (Clinical Assessment Service)
≥0%	Accounts
≥60%	Annual stakeholder perception research carried out by Jigsaw Research

KPI name	Purpose	Definition and calculation method
Front line staff attrition leaving within one year	Measure of staff turnover	Nurse advisors (NA), Health Advisors (HA), Dental Nurse Advisors (DNA) and Health Information Advisors (HIA) starters head count (12 month rolling) who have left with <1yr service ÷ NA, HA, DNA and HIA starters head count (12 month rolling).
Staff sickness		**50:50 weighting of KPIs below:**
Gross number of days per whole time equivalent (WTE) per year lost to sick leave	Measure of staff sickness	For all NHS Direct staff year to date (YTD) actual time spent off sick - WTE days (annualised) ÷ YTD average number of WTE.
% of staff with less than five days sick leave	Measure of staff sickness	Current in post with >1yr service and with <5 working days sick leave in 12-month period / Current in post with >1yr service.
Staff satisfaction annual survey	Measure of staff views	Average % rating of annual staff satisfaction surveys.
Time with patients	Productivity measure	Actual staff time (hours speaking with the caller + call wrap + call follow up + call postal work + call research + call child protection + safeguarding adults) with patients compared to the total time employed (IRT logged on hours + total planned absences (CCC) + total changed absences (CCC) – scheduled breaks (IRT) - for NA, HA, DNA and HIA.
Monthly recurrent expenditure run-rate	Measure of rate of expenditure	Actual expenditure run-rate (excluding non-recurring items) compared to planned run-rate. (Current actual expenditure run-rate (excluding non-recurring items) - planned run-rate)/Planned run-rate.
Department of Health (DH) Financial Health Index	DH measure of financial health	As defined by DH, the aggregation of a range of financial measures specified to indicate financial health. Range of performance metrics covering actual financial results and including planning, forecasting, processes and balance sheet efficiency.

Target	Data source
<10%	Electronic staff record
<10	Electronic staff record
≥75%	Electronic staff record
≥70%	Staff opinion survey
≥60%	CCC, IRT and Symposium
-2.5% to +2.5%	Accounts
≥2.5	Accounts

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