NHS Direct

NHS Direct Annual Report & Accounts 2007/08
A Year of Success

Contents

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A Year of Success

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02

We're

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here.

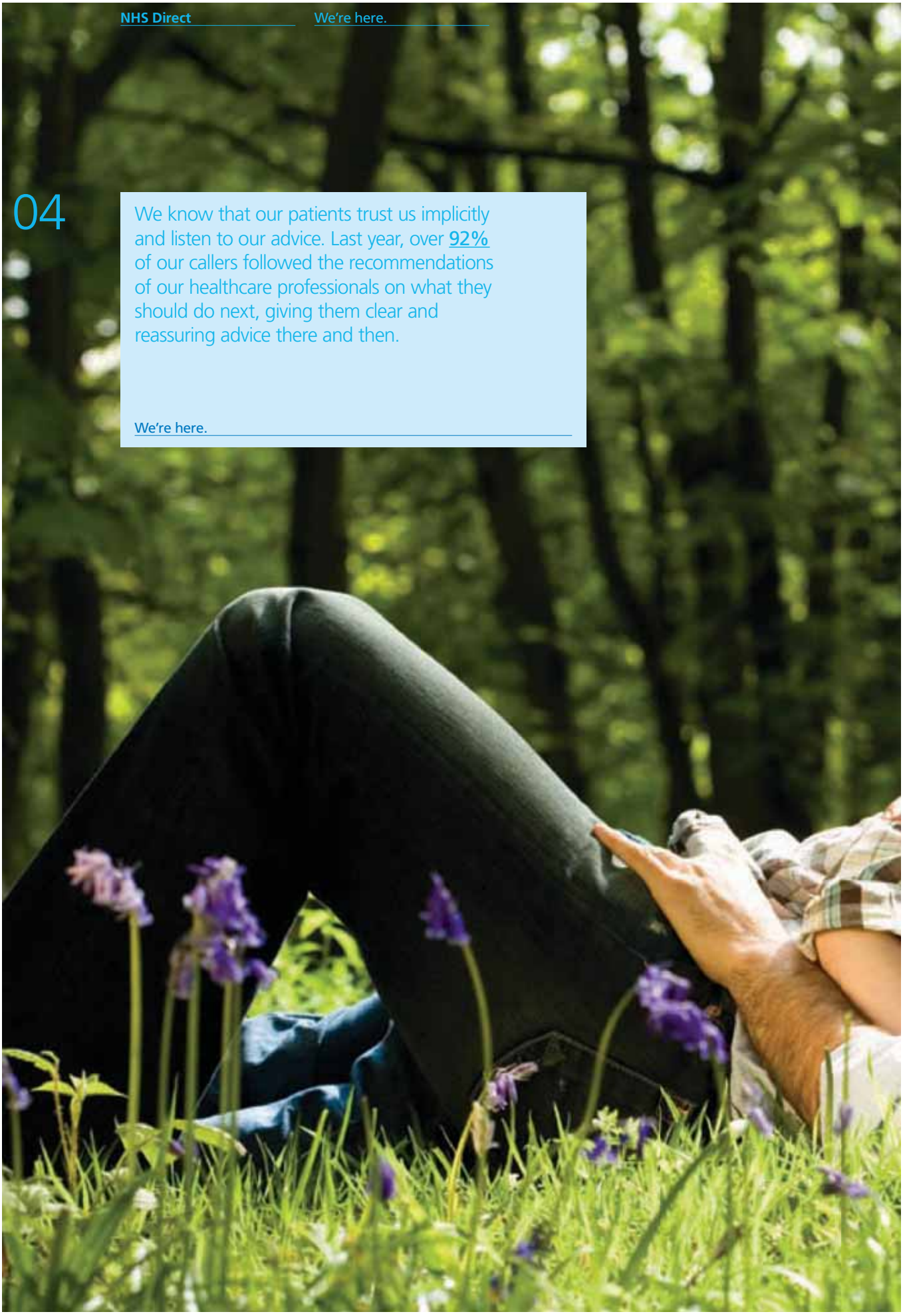
To make a difference to the lives of people in England 24 hours a day. We're always here for them whenever they have health worries, and we have the knowledge and experience to give them real help and reassurance.

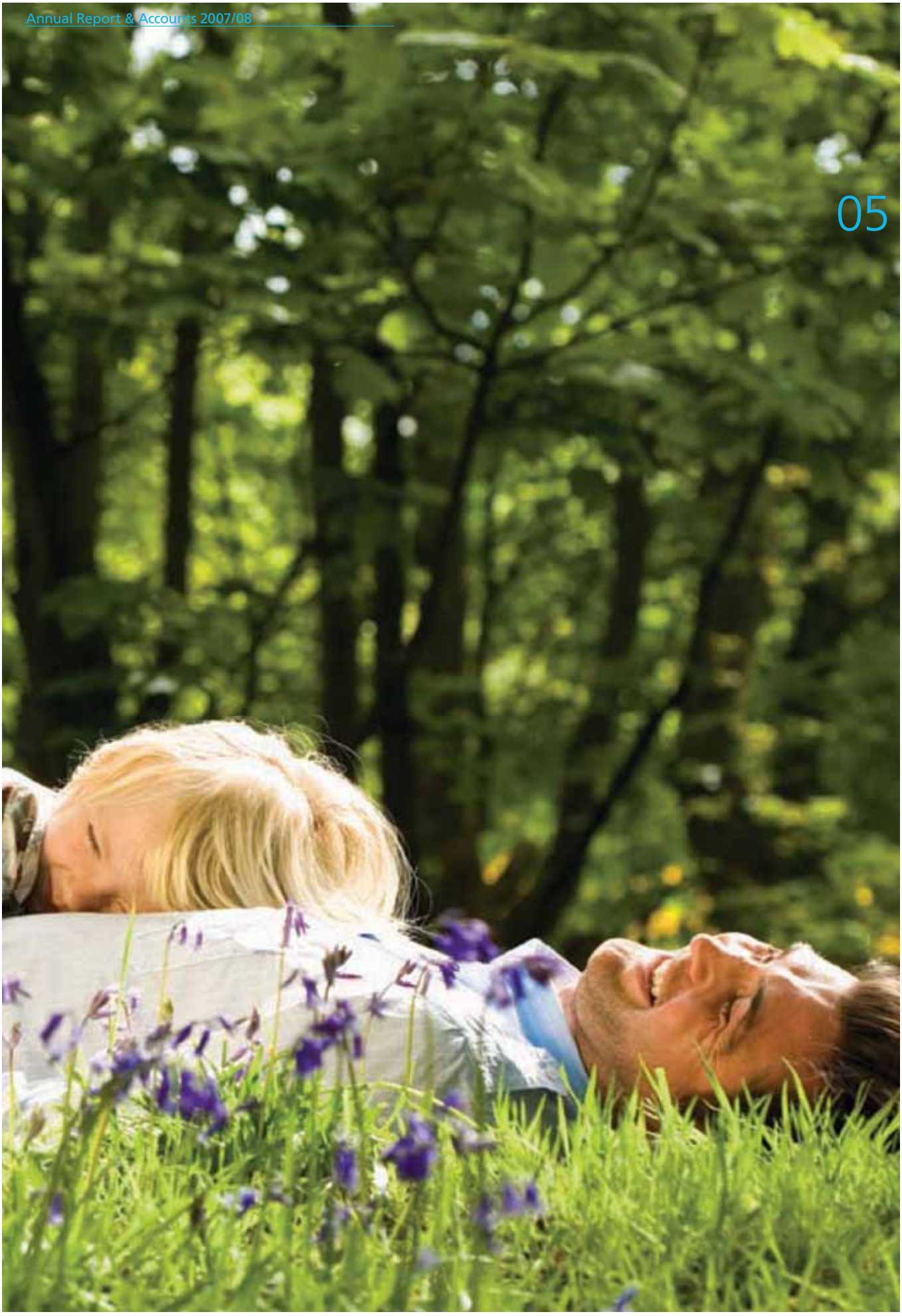
This makes us unique.

04

We know that our patients trust us implicitly and listen to our advice. Last year, over **92%** of our callers followed the recommendations of our healthcare professionals on what they should do next, giving them clear and reassuring advice there and then.

We're here.





06 Chairman's Statement

I joined NHS Direct as Chairman when it first became independent of the Department of Health nearly five years ago. It was an organisation already delivering a first class service to the community. Those who had built the organisation, based on the skills of nurses, had been committed to quality advice and clinical excellence.

But the new Board recognised that we lacked the operational structure needed to deliver the expanding services we wanted for the future. NHS Direct had grown fast and needed a much stronger underpinning for finance, systems, people management and estates. So in my last statement as Chairman I am proud to report that over those years we have built on the early foundations and, with a combination of skilled and ambitious planning and the commitment of all the staff, have succeeded in creating a truly world class organisation. Wherever I go, the service that NHS Direct provides is now recognised as the international benchmark.

Our programme of restructuring and transformation has been completed successfully. New internal systems, training programmes and improved performance have enabled us to achieve new, more ambitious performance targets month after month. In the speed of answering the phone, the level of abandonment and time to assess calls – as will be seen later in the Operational Performance section of this Report – we are hitting targets that would be seen as first class in any private sector organisation. In January 2008 we handled the highest number of incoming calls in the history of the organisation.

Market research shows that over 95% of callers are satisfied with the quality and reliability of advice from our health advisors and nurses. There is huge confidence in the reliability of the advice we give, which is a credit to our staff.

We can be proud that this reflects the benefits we are deriving from the process of linking, with high class systems, our staff and our users – whether patients or those seeking advice. It is the proof that we are delivering the services that are needed out in the community and that they are being delivered to an exceptionally high and consistent standard.

At the same time, our internet site goes from strength to strength. Five years ago we had 3,972,487 website visits in one year. By 2008, that number has risen dramatically to 30,772,894 – a tenfold increase.

At the end of the year 2007/08, after years of major investment in new equipment, infrastructures and training, NHS Direct was in good financial health. For the fourth year in succession we have been in financial surplus and all financial targets have been achieved. We returned a large sum of unspent budget to the Department of Health.

A national newspaper described us in an editorial as a "national treasure". I have every confidence that the Board and executive team now in place can support our staff at every level so that we may continue to grow in quality, scale and value to the community of which we are a part.

David Edmonds
Chairman

08 Chief Executive's Report

I became Chief Executive of NHS Direct in July 2007 and would not wish to take personal credit for the many successes of the organisation over the last financial year. However, I am extremely proud of the achievements of our staff and I am pleased that in this annual report we have a chance to put those on record.

Achieving a high level of operational performance has over the years been difficult for NHS Direct. However in 2007/08 with improved technology, but also a huge commitment from staff across the organisation, we achieved all our operational targets and will maintain them consistently going forward.

For our patients this means that the phone gets answered quickly and, where it is necessary, they get nurse advice within the agreed time. I would like to pay tribute to Ed Lester, my predecessor as Chief Executive, and Dr Mike Sadler who as Chief Operating Officer (and Acting Chief Executive in the first quarter of 2007/08) led much of the work that enabled the organisation to achieve its targets.

In striving to achieve operational targets, particularly on access times, it can be easy to overlook the quality of the service that is provided. This has not been the case in NHS Direct. Delivering the right, high quality patient experience is at the centre of our operation. Every time I visit one of our contact centres and observe our staff going about their daily work, I am hugely impressed by the professionalism that they show and the empathy that they achieve with patients in a very short time.

It is important, however, to remember that NHS Direct is not just the telephone service. In the last year our website had over 30 million unique visits and our digital TV services reached into over 18 million households. Increasingly we see these technologies converging and one of our challenges for the future is to understand how we meet the needs of patients in an increasingly multimedia environment.

One of the reasons I applied to join NHS Direct is that I passionately believe that there is huge potential to use communication technology to improve the care that patients receive from the NHS. One of our priorities, therefore, is to develop new services which we can offer to primary care trusts and other parts of the NHS to help them better meet the needs of their patients. The Birmingham OwnHealth scheme has been a great example of this and we will strive to provide more of these 'enhanced' services in the future, whilst ensuring that our 'core' service is of the highest quality.

I am very proud that we are an NHS organisation and part of a comprehensive health service to the citizens of England. Looking to the future our priority will be to work more closely with the NHS, particularly in localities, and to be better integrated with other NHS services. To this end, I have made it a priority of my first year to visit other NHS organisations to understand how they deliver care to their patients, to explain what we do, and to explore how we can do it better together in the future. I am very grateful to the many organisations that have been keen to work in partnership with us.

Over the course of 2007/08 we have been progressing our application to become an NHS Foundation Trust. Our public consultation was well received and NHS Direct received hundreds of positive responses from the community and the NHS. I am also delighted that by the end of the year 10,000 members of the public had signed up to be members of NHS Direct.

Looking forward, the priorities for NHS Direct are, briefly stated:

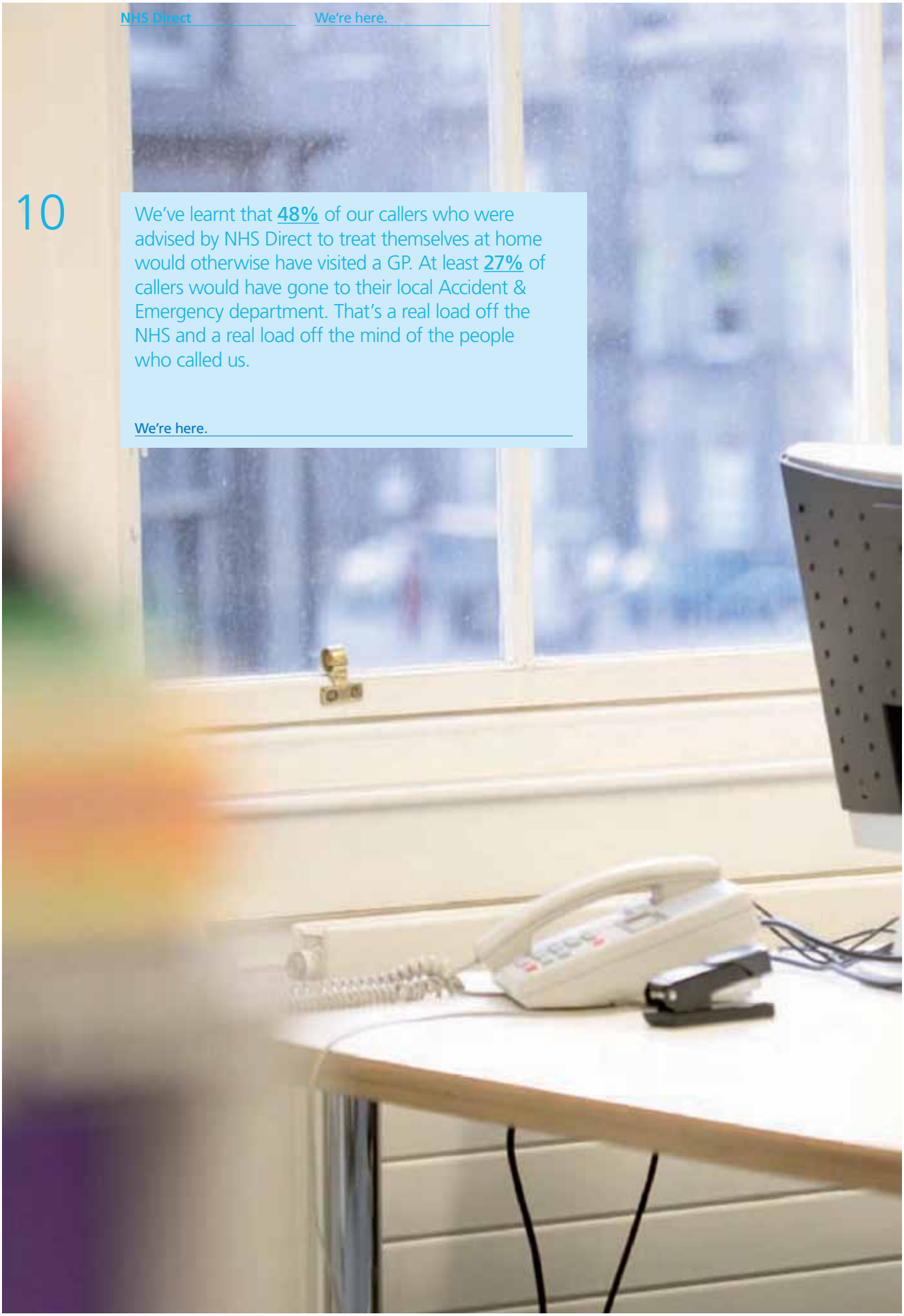
- Building on the 'core' service we provide for the Department of Health by maintaining the operating targets, by improving the quality and by moving to a contract which would be fit for a Foundation Trust environment.
- Developing more 'enhanced' services and providing them to more customers.
- Working more closely with other NHS organisations and integrating our services better with theirs.
- Being at the forefront of the application of new technologies to healthcare.
- Being a well run, high performing, organisation fit for a Foundation Trust environment.

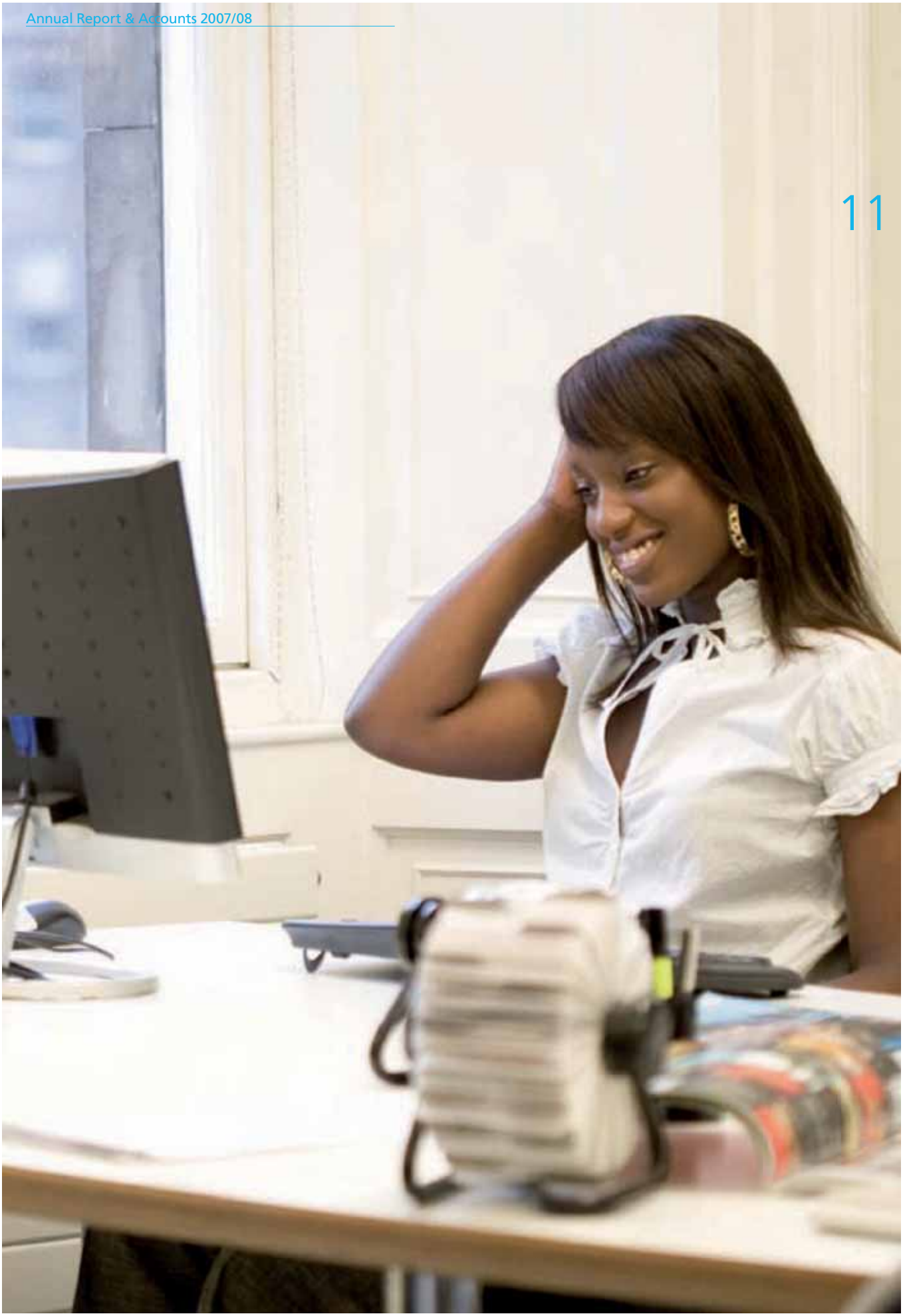
One person who will not be with us for the journey to come is David Edmonds our outgoing Chairman. David has been with NHS Direct for nearly 5 years and has been instrumental in creating the successful organisation we see today. He leaves us to become Chairman of both the Legal Services Board and Wincanton plc and we will be sorry to lose him. I am personally very grateful to him for the support and encouragement he has given me in my first year.

I would like to conclude by thanking our staff. The last two years in NHS Direct have not always been easy – achieving the operational targets while maintaining very high quality standards has required is a huge commitment from everyone. I am always struck by the enthusiasm and professionalism that our staff bring to their work. I know that this is hugely appreciated by our patients and this is part of what makes being Chief Executive of NHS Direct such a privilege.

Matt Tee
Chief Executive

We've learnt that **48%** of our callers who were advised by NHS Direct to treat themselves at home would otherwise have visited a GP. At least **27%** of callers would have gone to their local Accident & Emergency department. That's a real load off the NHS and a real load off the mind of the people who called us.





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Operational Performance

To attain best in class levels of operating efficiency allowing us to offer value for money to our customers.

Over the year, our transformation to a truly national organisation was successfully completed. The installation of new systems, technology and training has led to a seamless national service which has met all performance targets.

How we performed

NHS Direct delivers a high quality health information and advice service. We aim to make a difference to the lives of people in England 24 hours a day, 365 days a year. We're here for them whenever they have health worries and we have the knowledge and experience to give them real help and reassurance.

During 2007/08 access to our services has been very good, and we are highly regarded by our users for the service we provide. We are also demonstrably easing the demands on other NHS services.

The ability to deliver a service to every patient in their own home when they need it is at the core of what we do. This local delivery is supported by a national operations model that enables us to deliver efficient and cost-effective services.

In 2007/08 we achieved high standards of performance

- 93% of all calls were answered within 60 seconds, and less than 2% of calls were abandoned after more than 30 seconds of waiting
- 98% of the most urgent calls received a nurse assessment within 20 minutes, and 98% of callers with less urgent needs received the advice they needed within one hour
- Of those callers with non-urgent needs, 99% received a call-back within four hours
- By the end of the year, almost 50% of all calls were completed within NHS Direct without the need for onward referral to another healthcare professional
- Emergency and urgent referrals reduced from 32.2% to 25.4% of all calls over the year
- Our patients appreciate the fact that they can call on us at any time for information, advice and guidance. Last year we took almost 5 million calls on our 0845 number.
- We started the year with 1.7 million unique visits to our website and saw monthly visits rise to nearly 3.5 million in March 2008. In total we had 30,772,894 visits to the website in the 12 months in the 2007/08 financial year. This is a tenfold increase in the five years since 2002, powerful witness to the effectiveness and popularity of this valuable service.

Life on-line

2007/08 saw a marked increase in the use of the NHS Direct website. This growth continued in addition to the development of NHS Choices, for which NHS Direct is a key knowledge partner, having provided the bulk of the health information that was available on NHS Choices at its launch, and having worked closely with the NHS Choices team throughout the year.

The most popular parts of our website continued to be our Health Encyclopaedia and Common Health Questions. Both were updated and expanded based on feedback from our contact centres. Our ever popular Self Help Guide was reviewed and new pathways added. We also introduced some new Health Zones which brought together content from across our website and clustered it into topic areas which we know are popular. These included topics such as pregnancy, travel health, medicines, and emergency contraception. User feedback has been very positive.

We also made some changes to our Digital TV service which is available to over 18 million homes, moving to the Teletext service on Freeview, with the potential to be seen by many more viewers.

Reaping the benefits of a national service

Meeting and exceeding our performance targets has been the result of a huge, organisation-wide effort involving all of our staff. Optimal use of staff resources was helped by the introduction of the National Virtual Telephone System. This was the outcome of a strategy developed in 2005 for a Virtual Contact Centre based on a single, national telephony infrastructure, new integrated clinical support system with single national patient database and a new resilient network infrastructure. Using BT and Clinical Solutions as our supply partners, the system serves 37 locations, as well as providing real-time voice recording and archiving. NHS Direct completed the implementation of this new Virtual Contact Centre and underpinning technology by June 2007 as planned.

This world class infrastructure enables calls from any part of the country to be routed instantly (and invisibly to the caller) to the next available operator countrywide, resulting in a seamless service for patients and better balancing of workload.

The use of national workflow co-ordinators and scheduling schemes has enabled our staff to increase the proportion of time they spend responding to the needs of our patients. While this placed huge pressure on the training and development team, new and existing staff and the system generally, our successful results show that it was worthwhile.

To cement and recognise these improvements we are working towards accreditation under the Customer Contact Association Accreditation Scheme, an internationally recognised quality mark for public- and private-sector contact centres.

"I had a great experience with NHS Direct. I woke up one night with a very painful cricked neck. So painful I couldn't sleep. I considered going to A&E but wasn't sure if I was up to driving. So I called NHS Direct for advice. They told me to take some painkillers and lie in a hot bath. It worked! 30 minutes later I was back in bed and asleep rather than sitting in a waiting room."

Marc Owen
Service user

Service Performance April 2007 to March 2008

	Apr 2007	May 2007	Jun 2007	Jul 2007	Aug 2007	Sept 2007	Oct 2007	Nov 2007	Dec 2007	Jan 2008	Feb 2008	Mar 2008	Total
Calls answered in 60 seconds	76%	87%	98%	96%	96%	95%	95%	95%	89%	98%	96%	94%	**93%**
Calls abandoned after 30 seconds	6%	3%	1%	1%	1%	1%	1%	1%	3%	0%	1%	1%	**2%**
Urgent calls started in 20 minutes	97%	98%	98%	98%	98%	98%	98%	98%	98%	99%	99%	98%	**98%**
Less urgent calls started in 60 minutes	97%	99%	100%	100%	99%	100%	99%	100%	93%	99%	97%	95%	**98%**
Non urgent calls started in 240 minutes	98%	99%	100%	100%	100%	100%	99%	100%	99%	99%	99%	99%	**99%**
Calls completed within NHS Direct	45.0%	46.1%	48.4%	48.9%	48.4%	47.3%	48.3%	47.8%	46.4%	51.1%	50.9%	48.2% (end of year position)	**48.2%**
Emergency and urgent referrals	32.2%	30.4%	28.7%	28.3%	27.5%	28.7%	28.8%	29.1%	27.3%	26.8%	25.4%	25.4% (end of year position)	**25.4%**
Online contacts	1,705k	1,855k	1,774k	1,894k	2,293k	2,359k	2,875k	2,953k	2,652k	3,642k	3,294k	3,478k	**30,773k**

Notes

Urgent calls – clinical calls with Priority P1, D1 (dental) or PO (unprioritised)
Less urgent calls – clinical calls with Priority P2
Non Urgent calls – clinical calls with Priority P3, D2 or D3

"I woke up very early one morning with an excruciating pain in one leg. The first thing that crossed my mind was the possibility of Deep Vein Thrombosis. In something of a panic I phoned NHS Direct. The person I was put through to was most helpful. They took a run-down of my symptoms and were reassuring that it was probably not DVT. More importantly they were able to tell me what symptoms I should be looking for that would suggest DVT. It was a very good way of checking symptoms and reassuring myself, without having to bother a GP with what was probably just a rather severe attack of cramp."

Ann Fincher-O'Brien, Croydon
Service user

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Financial Performance

To generate a surplus for re-investment.

For the fourth year in succession NHS Direct has achieved its financial targets. In 2007/08 the Trust has generated a surplus of £5.1m.

The table below summarises the financial performance for 2007/08 and provides comparative information for the previous financial year.

	2007/08	2006/07
	£000	£000
Operating Income	144,381	147,889
Expenditure	(141,265)	(145,549)
Non-operating items	1,946	(11)
Retained Surplus	5,062	2,329

At the beginning of the financial year the Trust set a budget for 2007/08 with a targeted surplus of £765k after allowing for a first dividend on Public Dividend Capital of £168k. The actual surplus for the year is therefore a favourable variance of £4,297k over budget.

Included in Operating Income is £5.5m of year-end flexibility in respect of income returned by NHS Direct to the Department of Health in 2006/07.

Included in the Retained Surplus is interest receivable of £2,121k.

Income and expenditure

In 2007/08 the organisation generated income of £126.8m from its contract with the Department of Health to provide telephone, online and interactive digital television service. This was supplemented with additional income from a variety of commissioned services by Primary Care Trusts covering for instance out of hours medical and dental services.

This income was used to finance the costs of the organisation which are summarised in the table below:

	2007/08	2006/07
Operating costs	£000	£000
Salary and wages	89,102	90,803
Telecoms and information technology	26,675	26,578
Overheads	25,304	19,512
Organisational Change costs	184	8,656
Gross Operating Costs	141,265	145,549

Included in Overheads for the current year above is a charge of £1.935 million in respect of an onerous lease at the Trust's former site in Cambridge.

In addition to achieving a surplus at the end of year, the Trust made the planned savings of £8.5m that were incorporated into the balanced budget for the year through a variety of recurrent and non recurrent measures. Both the surplus and savings were achieved against the background of excellent service performance delivered during the year.

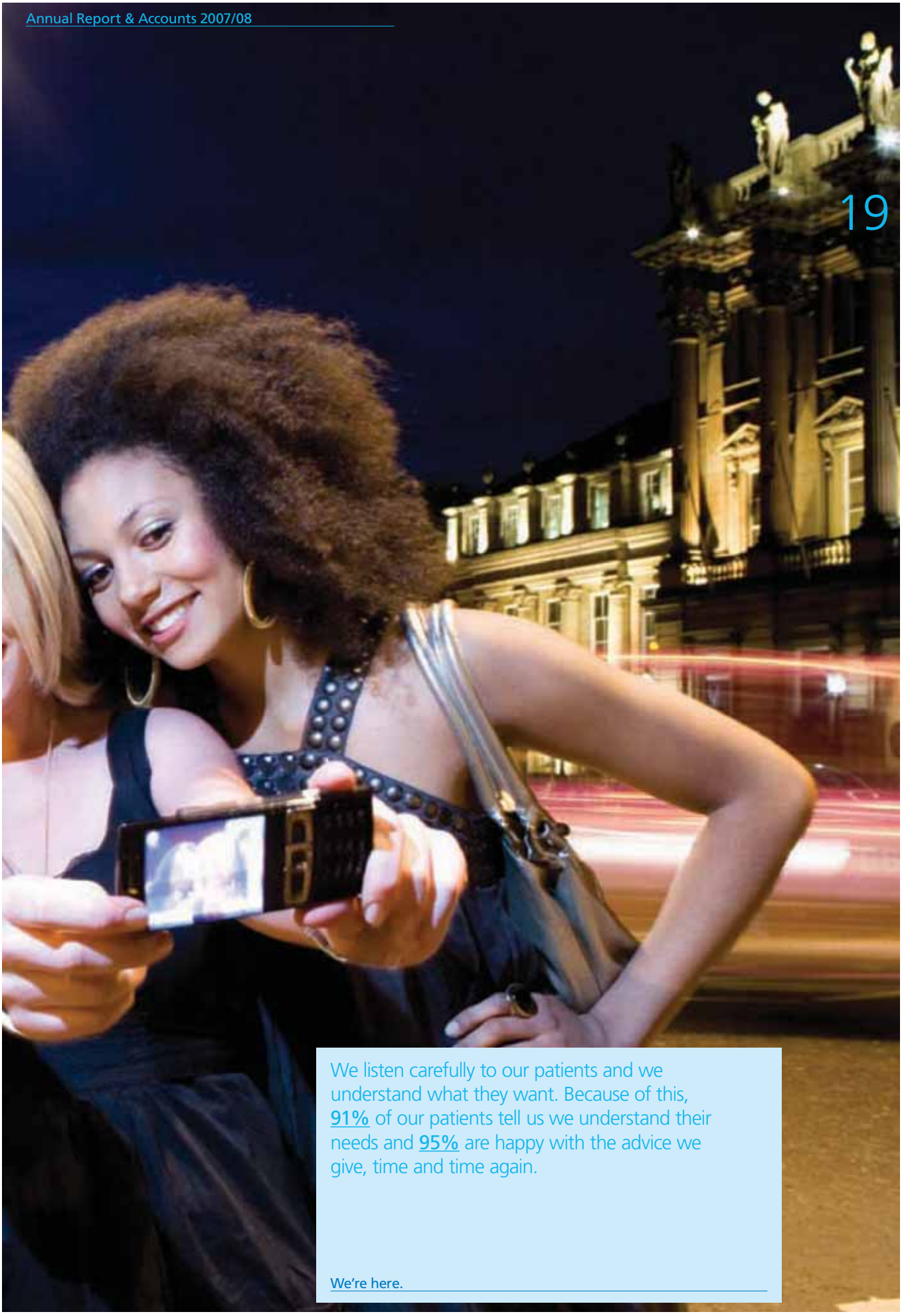
Balance Sheet and Working Capital

Net current assets at the year-end were £5m higher than in 2006/07. This increase is consistent with the income and expenditure surplus achieved. There was a net reduction in Provisions over the year of £16k. Within this net movement the significant elements are the reduction in the provision for Agenda for Change arrears, the creation of a new provision in respect of an onerous lease, and the re-classification from Creditors of a provision in respect of a possible amount of VAT repayable to HM Revenue and Customs.

Of the Agenda for Change provision at 31 March 2007 of £2,557k, £1,319k was utilised and the balance of £1,238k released unused. The new element of provision is £1,935k in respect of an onerous lease at the Trust's former Cambridge site. The provision for possible VAT repayable is set at £971k.

The Trust's Bank balance at 31 March 2008 was £19,161k, an increase of £3,050k over the year.

In summary at the year end the Trust was in good financial health with a sound working capital position to operate from in 2008/09.



We listen carefully to our patients and we understand what they want. Because of this, **91%** of our patients tell us we understand their needs and **95%** are happy with the advice we give, time and time again.

We're here.

20 Management Commentary

User Experience

To continually improve user experience, driven by their needs to generate professional and appropriate responses.

The opinions which our users and the general public hold of us are critically important. We value their feedback and use this to inform the development of our services. We take a variety of steps to measure these opinions, and this year the results were enormously positive

Appropriate referrals

In February 2008 we commissioned IFF Research to undertake a large scale independent evaluation of 4,554 users to explore the appropriateness and timeliness of NHS Direct referrals. The findings were encouraging. Headline findings were the following:

- 73% would either have gone to their GP (44%) or attended A&E (29%) if they had not been able to phone NHS Direct
- The speed with which NHS Direct can be contacted, compared to booking an appointment with a GP or other health provider, was one of the main reasons for satisfaction
- 93% of respondents felt that our referral process was efficient
- 93% said NHS Direct "helped me deal with the issue I was calling about", while only 6% said calling NHS Direct was a waste of time
- Of the callers who followed the advice given by NHS Direct, 95% were satisfied

Whilst findings from this research were encouraging, we will continue to focus on improving our referral pathways to satisfy the needs of users and become better integrated with the rest of the NHS.

Attitudinal Research

In November 2007, we commissioned Continental Research to measure national awareness, usage and attitudes towards our service amongst adults in England.

The results showed that:

- Spontaneous awareness of the NHS Direct telephone service is second only to GPs and higher than pharmacists
- Total awareness of the NHS Direct telephone service after prompting is 79%
- 82% of those who have used our telephone service say they got the information they were looking for, and 98% of them acted on it
- 53% of adults are either likely or very likely to use our telephone service in future, rising to 86% amongst those who have used the service before

Quality of Service

In April 2008, the Picker Institute undertook a survey of users of NHS Direct's core telephone service, similar to the Healthcare Commission surveys used by NHS acute trusts, primary care trusts and ambulance trusts. The findings of this survey were consistent with the IFF Research and Continental Research surveys above:

- 98% were happy with the time we took to answer the phone
- Over 90% were satisfied with the quality of service they received from the health advisor, or from the nurse if referred
- 91% felt that we definitely understood their needs
- 89% said the main reason for their call was dealt with satisfactorily, and 94% would definitely use us again
- 95% rated the advice and/or information we provided as excellent, very good or good

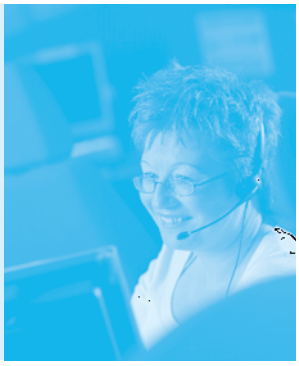
We were particularly pleased that the attributes which people most regularly associated with NHS Direct were:

- Staff involve the caller, and focus their full attention on them
- Staff are professional and efficient
- Staff are friendly and caring
- The service is trustworthy and reliable

"Because you don't have contact with the patient, you have to develop acute critical thinking skills, which I found very challenging and rewarding.

NHS Direct opened up a lot of avenues and built my confidence. For me it opened up the opportunity to train other staff, as I had a managerial role."

Carol Tandridge
Nurse Advisor, Caterham



Compliments and Complaints

We see compliments and complaints as valuable feedback to help us improve our service to patients. A key part of this is ensuring a timely response to all issues raised about our services. We have a 21-day target for responding to formal complaints, with a focus on speedy local informal resolution wherever possible to provide a better experience for the complainant. We also measure our performance against the target for the rest of the NHS of 95% responses to complaints being sent within 25 days. Last year we achieved 98.9% in 21 days against a target of 95% and we achieved 100% against the 25 day target.

	COMPLAINTS		COMPLIMENTS	
	Total Formal Complaints received	Complaints per 10,000 calls answered	Total Compliments received	Compliments per 10,000 calls answered
2006/07	981	1.64	938	1.57
2007/08	551	0.99	1800	2.15

In 2007/08 we received a third fewer complaints than in the previous year, and recorded over three times as many compliments as complaints.

"NHS Direct has brought me many challenging scenarios over the years not least the new telephony infrastructure completed over the last year. This has brought great benefits to our patients by routing calls to the next available health advisor improving access to all our services.

Building on the knowledge from my past NHS career has allowed me to gain a perspective on how the new technology impacts on the user and by working closely with the ICT Directorate to implement these changes. Further challenges have been bought about with the new technology as we have worked up robust business continuity processes to cover any major failures in the technology which we are pleased to say are rare."

David Oxley
National Operations Support

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Clinical Governance

To empower people to make informed decisions/ choices and improve overall health outcomes.

The wellbeing of our patients is our main priority. We constantly review and improve our standards to help deliver a safe and effective service – which is reflected in our very high levels of customer satisfaction.

Focus on safety and quality

NHS Direct remains focused on improving our patients' experience through a safe and effective service. We are continually learning, and are developing our people and systems to ensure that a high-quality patient experience remains at the heart of our service. We have a multidisciplinary team who make up our National Clinical Governance Committee which is responsible for the co-ordination of all activities relating to patient safety and quality.

Standards for Better Health

A key focus of this year has been ensuring that the service provided by NHS Direct continues to meet the Department of Health's Standards for Better Health. These standards, introduced in 2004, specify the level of quality which all NHS organisations in England are expected to meet in terms of:

- Safety
- Clinical and cost-effectiveness
- Governance
- Patient focus
- Accessible and responsive care
- Care environment and amenities
- Public health

In 2007/08, NHS Direct agreed the core standards against which NHS Direct would be assessed. These varied standards received approval from the Secretary of State in January 2008. This is the first time NHS Direct as a national organisation has been reviewed this way.

In April 2007, we undertook an assessment of compliance with the standards, validated by our auditors. This led to a declaration of compliance with all standards throughout the year to the Healthcare Commission, with the exception of the following two areas, which we are working to address in 2008/09:

- standard C7e (healthcare organisations challenge discrimination, promote equality and respect human rights)
- standard C21 (healthcare services are provided in environments which promote effective care and optimise health outcomes by being well designed and well maintained with cleanliness levels in clinical and non-clinical areas that meet the national specification for clean NHS premises).

Dealing with adverse incidents

NHS Direct's adverse incident management policy was reviewed and updated in 2007/08, including an upgrade to the database management system used for the reporting, logging and investigation of incidents. To be fully implemented in 2008/09, the revised policy sets out how the service will respond to, and learn from, any adverse incidents resulting from NHS Direct advice, including our approach to openness with patients in the most serious of incidents. Incidents are always thoroughly investigated and are subject to peer review. This year, our incident reporting system was linked to the National Patient Safety Agency's National Reporting and Learning System, ensuring that learning from our incidents will contribute to wider NHS learning.

Number of incidents

In 2007/08, 98 incidents were escalated for review by a team of clinicians within NHS Direct. Of these five led to actual harm to the patient, which is well within the 10% indicator limit agreed with the Department of Health for the year. This is an adverse incident rate of 0.18 per 10,000 calls, compared to a figure of 0.29 in 2006/07.

Incidents			
Escalated For National Review			
Total		Rate per 10,000 calls	
2006/07	2007/08	2006/07	2007/08
165	107	0.29	0.18

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Innovations and Partnership Working

To achieve pre-eminence in chosen areas of e-health through integrating our multi-channel capabilities.

Our joint services with NHS partners and commissioners continue to break new ground and to offer valued services to patients. These may support an existing service, or provide a special facility to meet a specific local need. Either way, they bring marked improvements to the health of those for whom we care. Also they offer a variety of different career opportunities for many of our staff.

A new model for out-of-hours

NHS Direct provides the 'access and assess' element of GP out-of-hours services for over 12% of the population. We receive, assess and prioritise all calls made to locally commissioned out-of-hours services as required. Callers are assessed by NHS Direct nurses according to their priority, and referred to the relevant out-of-hours provider or external service as appropriate.

NHS Direct provides this service with Harmoni for over 30% of Londoners. During the year, we successfully piloted a new model of service for London, whereby the highest priority calls were passed to Harmoni GPs for immediate assessment, whilst NHS Direct nurses dealt with the less urgent calls as well as health information.

Richmond & Twickenham Primary Care Trust acknowledges the quality of our service, and has extended its contract with NHS Direct: *"We have been working with NHS Direct for a number of years now and were recently involved in piloting a new service model for out-of-hours care. We have been pleased with the new model, which allows urgent out-of-hours callers to be assessed directly by a GP, and we have entered into a three-year arrangement with NHS Direct on this basis."*

Out-of-Hours relief for teeth

NHS Direct has been commissioned by over 90 primary care trusts to support patient access to dental services, particularly out of hours. Calls are received via dedicated telephone numbers which are advertised locally, and NHS Direct advisors use tailored dental streaming protocols to prioritise and stream calls based on the severity of the presenting symptoms.

The system enables health advisors to distinguish between calls requiring emergency attention (normally less than 1%) and urgent dental problems requiring a more detailed assessment. Those patients requiring further assessment are referred to the dental provider.

NHS Direct, in collaboration with the Rocky Lane Dental Practice (Salford), provides emergency out-of-hours dental cover to a consortium of primary care trusts across the Manchester area. As part of this winning team, NHS Direct was pleased to receive the award for Best Dental Team in the North West at the Dentistry Awards, 2007.

NHS Direct leads the way with FluLine

As a key component of the Department of Health Pandemic Flu strategy, NHS Direct has been commissioned to design, build and deliver the FluLine service. This will provide symptomatic patients rapid access to an initial assessment, advice, triage, and, where appropriate, authorisation of antiviral medicine treatment.

In the event of a pandemic, FluLine will provide a multi-channel response over the web, automated telephony and through call handlers in out-sourced contact centres. FluLine will use a nationally agreed clinical algorithm to assess if patients are eligible for antiviral medicine and if they need to be referred to a healthcare professional for further assessment and care.

FluLine builds on our expertise of running large scale health contact centres, of developing clinical algorithms with involvement of a wide range of health professionals and of delivering services over multiple channels. In the event of a flu pandemic the FluLine service will be central to the protection of public health and supporting the rest of the NHS

Prizewinning OwnHealth in Birmingham

Birmingham OwnHealth is an innovative collaboration between Birmingham East & North (BEN) Primary Care Trust, NHS Direct and Pfizer Health Solutions. It enables people with particular long-term conditions to receive regular telephone-based coaching from highly experienced care managers. It both complements and integrates with existing local healthcare activities to make self-care a reality for people living with long-term conditions, and is the UK's first large-scale telephone-based care-management service.

A review of the service after 18 months of operation found an encouraging set of outcomes. Members of OwnHealth:

- Found the service accessible and easy to use
- Felt more confident in their ability to self-manage
- Showed changes in their diet, exercise and smoking habits
- Had improved cholesterol, blood glucose and blood pressure control
- Were getting better at taking medication as indicated
- Reported fewer symptoms and decreased their demand for healthcare resources.

This has led to the service being further developed with the intention to roll it out to all of the people in the BEN PCT area – eventually benefiting over 40,000 people. Smaller scale programmes are also in place for the people within the Heart of Birmingham, South of Birmingham, and Walsall PCT areas.

In July 2007, Birmingham OwnHealth won the Healthcare Partnership Award at the national Communique Awards, which celebrate the best in medical education and PR within the health sector. NHS Direct and Pfizer Health Solutions won the BEN PCT annual award for Best Partners. In February 2008 the service won the regional round in the 'Inequalities in Health' category of the NHS Health & Social Care award, and is shortlisted for the national award.

Getting the right information

In 2006/07 the Department of Health commissioned a number of pilot schemes to test the feasibility of Information Prescriptions. NHS Direct was an integral part of the pilots, including a pharmacist-led scheme at Evelina's Children's Hospital, part of Guys & St Thomas' Foundation Trust.

Parents and carers were offered a consultation which included a discussion regarding information needs with a pharmacist when they collected their child's medication. The Information Prescription was sent to NHS Direct who then provided the relevant information by email or post.

One parent commented: *"The information provided helped me know what to do when my daughter had an asthma attack. As a result, I was able to cope at home rather than go to the hospital."*

Since becoming a member of the Birmingham OwnHealth programme, Mr Singh pictured here meeting his Care Manager, Joanne Devaney says:
"Birmingham OwnHealth has changed my life.
My visits to my GP are not as often and, with my Care Manager's support I have started to walk a little further everyday and I am enjoying the exercise. I am taking my medication on time every day and I have changed the things I eat so that I am more healthy."

Mr Singh

Urgent repeat prescriptions

A three way collaboration in the Nottingham area between the local Out-of-Hours (OOH) service Nottingham Emergency Medical Services (NEMS), NHS Direct and Boots aims to provide a better patient service and reduce the number of unnecessary requests in the OOH period. NHS Direct takes all repeat prescription calls to NEMS, establishes that the caller needs no further clinical assessment, and offers a call-back from a local Boots pharmacist within the hour. The patients who have used the service have reported appreciation for its convenience and efficiency, and discussions are underway to test the service in other areas.

Encouraging attendance at outpatient clinics

A service run by NHS Direct for Northumbria Healthcare NHS Foundation Trust outpatients department has halved missed appointments in just five weeks by making reminder calls to patients.

As each appointment attended generates income for the Trust, finances have improved since the service began and patient satisfaction has increased. The Trust has been so impressed with the outcomes achieved that the service has been expanded to cover more clinics.

Building partnerships with ambulance trusts

NHS Direct in consultation with ambulance trusts identified that the patient pathway for callers with non-life-threatening conditions could be improved, thereby freeing up ambulance service capacity to respond to life-threatening situations.

Building on many years of close working with Great Western Ambulance Service and North West Ambulance Service, NHS Direct has been working with South Western Ambulance Service to develop an improved patient pathway, which might be suitable for Ambulance Trusts across England.

Patients calling 999 are assessed in the usual way by ambulance dispatch staff, using their prioritisation system. If the primary call symptoms indicate that the patient does not need an ambulance and would be better served with an assessment by an NHS Direct Nurse Advisor, then the new system enables the electronic transfer of the patient details to NHS Direct for follow up.

Focus on Research

As a knowledge-driven organisation, NHS Direct is developing a much broader programme of research activity, based on five priority areas:

1. Advice & referral: impact on the health services
2. Long-term conditions
3. Health promotion & self-care
4. New media & multi-channel services
5. Public health surveillance & response

In creating a programme of research to address our priority areas, we have developed partnerships with the following institutions:

Academic	Institution
Dr John Powell	University of Warwick
Professor Chris Salisbury	Primary Care Research Unit, University of Bristol
Dr Gillian Smith	Health Protection Agency
Professor Derek Bell	Imperial College, London
Professor Julius Weinberg and Dr Patty Kostkova	City University, London
Dr Peter Bath and colleagues	Information Studies, University of Sheffield
Professor Caroline Watkins	University of Central Lancashire
Dr Marina Jirotka	Oxford University
Dr Paul Ferrand	University of Plymouth

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We're rightly proud of our service. And our patients tell us why – **98%** were happy with the time it took to answer the phone over **90%** were happy with the quality of the service – two of the biggest bones of contention with a contact centre service.

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Engaging with our public

To understand our customers and work to fulfil their needs through developing services that utilise national capabilities at a local level.

A brand new look

We recognise how important it is to be, and to be seen to be, a friendly, accessible, professional and modern organisation and service. Our brand identity can support us in achieving this.

NHS Direct's current brand identity has remained largely unchanged since it was developed in 2002. However, both the organisation and the service have moved on considerably over the past six years. A new brand identity was needed to reflect these changes and also to show that we are fit for the future.

We appointed Thompson, a Leeds-based specialist branding agency, to develop our new brand identity. After consulting with a wide range of stakeholders and staff, Thompson distilled NHS Direct's qualities down to a single idea: that we're everywhere. This led to a creative development process, resulting in the core proposition that "We're here", which is central to the new brand identity for NHS Direct.

We will be using our new brand identity throughout our communications, internally, to the public, with our colleagues in the wider NHS, as well as all our other stakeholders and partners.

Providing information to and consulting with employees

NHS Direct retains close involvement with staff side representatives from accredited trade unions through a network of local and regional joint partnership forums. They link into the National Joint Partnership Forum, which is the joint negotiating body for the organisation. NHS Direct also has regular regional conferences for all members of staff, an annual staff survey and a monthly team brief. As part of the consultation in preparation for the application to become a Foundation Trust, staff meetings were held at every site.

Hearing our stakeholders

NHS Direct is keen to interact with as many stakeholders as possible to ensure that we can keep our service relevant and integrated to the broader NHS. To this end we attended and addressed a number of conferences and exhibitions throughout 2007, to increase our visibility and people's understanding of our core services.

This included hosting a lively National Stakeholder Conference in February 2008. The event was chaired by John Carvel, Social Affairs Editor of The Guardian, and took place at the King's Fund, London.

A wide range of delegates attended, including chief executives from national charities, public organisations and professional bodies. There were speeches from Dr David Colin-Thome, National Clinical Director for Primary Care at the Department of Health, and senior members of our team, as well as workshops so that we could hear as many views as possible. In order to involve as many people as possible, we broadcast the whole event over the web. The film of the event can still be accessed on our website, at www.nhsdirect.nhs.uk/foundationtrust

We also hosted ten Working Better Together events in which stakeholders and commissioners took an active part. We shared our future plans and learned more about the issues and challenges facing our NHS colleagues, with a view to finding effective joint solutions.

Launching our PPI strategy

Representatives from the voluntary sector attended the launch of our patient and public involvement (PPI) strategy. NHS Direct recognises the importance of engaging effectively with patients, carers and the public in order to design, develop, improve and govern our services, and this was the first step in that journey. Those attending the launch event were keen to help NHS Direct work alongside a wide range of communities and patient groups in order to take the service forward.

Welcoming visitors

Due to its success and world-wide renown, NHS Direct is often contacted by Ministers and health professionals from overseas looking to create similar services in their countries. During the year NHS Direct hosted visitors from the World Health Organisation, China, Australia, Japan, Sweden, Norway, Portugal and Canada. At the same time, we regularly welcome UK health professionals to our centres, such as nurses, GPs and paramedics, in order to further facilitate joint working throughout the NHS.

NHS Foundation Trust

NHS Foundation Trusts (FTs) are at the cutting edge of the Government's commitment to the decentralisation of public services and the creation of a patient-led NHS. They are a new type of NHS trust created to devolve decision-making from central government control to local organisations and communities so they are more responsive to the needs and wishes of their local people. The introduction of NHS Foundation Trusts represents a profound change in the history of the NHS and the way in which NHS services are managed and provided.

NHS Foundation Trusts have flexibilities to better shape the services they provide around the needs and priorities of their users. NHS Foundation Trusts remain firmly part of the NHS and exist to provide and develop healthcare services for NHS patients in a way that is consistent with NHS standards and principles – free care, based on need not ability to pay.

Much of what we intend to do in the future fits well in a Foundation Trust environment. We are keen to have a membership and to be more accountable to our users and the public. We will be well governed and well managed and work in a more commercial way developing new products for our customers to help them improve health and healthcare for their populations. Lord Warner, then the Minister for Health, announced that we should become an NHS Trust in April 2007 and then work to apply for NHS Foundation Trust status.

Over the last year we have been working towards FT and have:

- Appointed a new Chief Executive to lead the organisation
- Put in place new Non-Executive Directors with commercial expertise and attracted strong Executive Directors from private and public sectors who demonstrate the skills required for a well governed organisation
- Launched a Board development programme to ensure we have a Board of Directors that is fit-for-purpose
- Undertaken a public consultation exercise, with over 500 written responses and feedback from nearly 3000 people who attended 175 meetings
- Recruited nearly over 10,000 public members and 3,300 staff members
- Delivered against all our key national targets including year on year surpluses
- Strengthened our corporate governance arrangements through several key appointments
- Improved our partnership working with the NHS, demonstrable through the success of our locally commissioned services
- With the Department, commissioned a review of our commissioning and service delivery models

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Organisational Profile

NHS Direct is the unique multi-channel provider of health information and advice to the population of England.

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Overview

NHS Direct is the unique multi-channel provider of health information and advice to the population of England. Using telephone, internet and digital TV we provide a national service working from a small head office in London and a nine region operational structure generally coterminous with Strategic Health Authority boundaries. NHS Direct became an NHS Trust on 1 April 2007.

Estate

Our service delivery is virtual, provided through 36 call centres. Our headquarters building is at Riverside House in London, we successfully re-located from our previous headquarters building at Old Street during March 2008.

Head Office
01 Riverside House

Yorkshire and the Humber
02 Hull
03 Sheffield
04 Wakefield

North East
05 Newcastle
06 Stockton-on-Tees

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

West Midlands
13 Stafford
14 Dudley

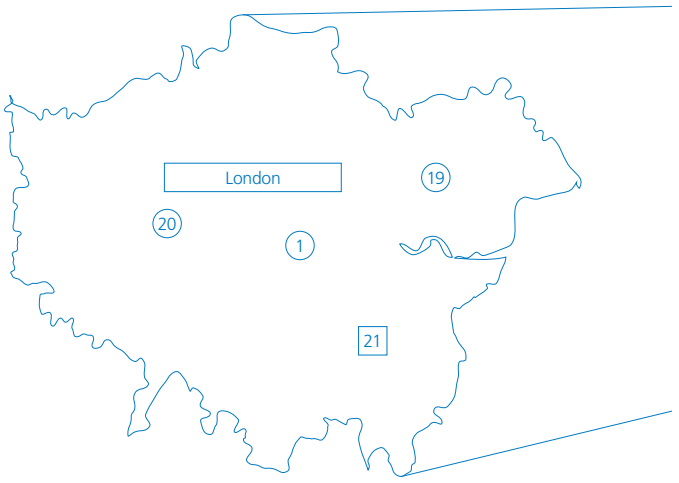
East Midlands
15 Nottingham
16 Derby
17 Chesterfield
18 Mansfield

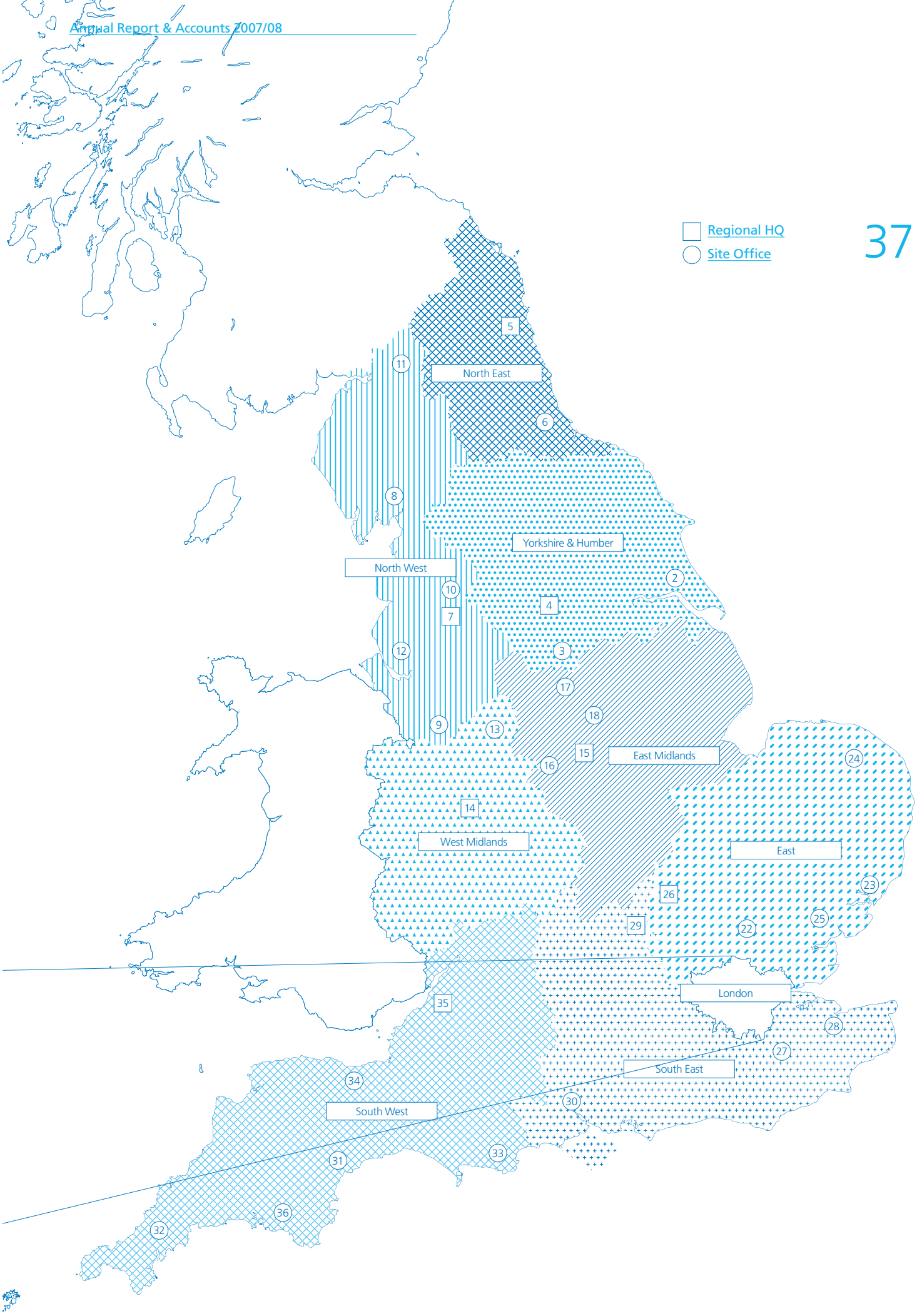
London
19 Illford
20 Southall
21 Beckenham

East
22 Stevenage
23 Ipswich
24 Norwich
25 Chelmsford
26 Bedford

South East
27 Caterham
28 Chatham
29 Milton Keynes
30 Southampton

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




Regional HQ
Site Office
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Yorkshire & Humber
North West
East Midlands
West Midlands
East
London
South East
South West
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Core Services

Our core service is the provision of health information and advice, delivered to the public in England through the telephone, the web and our own digital TV channel. These three channels are available 24 hours a day 365 days a year.

Calls

- clinical advice and referral for callers with symptomatic conditions
- information about diseases, conditions and treatments, medicines, health and social care organisations and healthy lifestyle information
- support for national and local health scares or major incidents
- 24/7 translation/interpretation services into over 100 languages
- textphone service for the deaf or hard of hearing

Website

- Health Encyclopaedia giving information about diseases, conditions, treatments
- a practical interactive self help guide and a frequently asked question section
- information about health care organisations – via link to NHS.uk
- On-line enquiries service for non-symptomatic issues
- links to other accredited on-line sources of information
- access to a range of patient information leaflets in multiple languages
- "Mind and Body" magazine containing the latest health news

Digital TV Service

- DTT (Freeview) via teletext on channel 100.
- 18.7m homes on digital satellite (SKY) via the interactive services menu providing:
  - information about a range of diseases, conditions and treatments as well as frequently asked health questions
  - healthy lifestyle information
  - seasonal features on topical health news
  - information about health care organisations – via link to NHS.uk (requires a telephone call) or SMS text message.
  - information regarding using NHS services.

Enhanced services

Our non core services are won in a competitive environment. Our customers are generally other NHS organisations and the Department of Health. Currently we provide the following services:

The Choose and Book Appointments Line offers patients the opportunity to book a hospital appointment at a hospital and a time to suit them.

Out-of-Hours (OOH) services are delivered when GP surgeries are closed between 18:30 and 08:00 Monday to Friday, weekends and Bank Holidays.

Dental services are provided in the same manner as OOH GP services.

We also provide the following services:

- Long Term Conditions Management
- The National Care Records Service
- Non Urgent Category C ambulance calls
- Pre and post operative care

Valuing Staff

NHS Direct employs over 3,000 staff, who work in the following roles:

1. Regional Operations

Post Title	WTE	Headcount
Regional Director	9.00	9
Regional Head of Operations	9.00	9
Regional Director of Nursing	9.00	9
Service Delivery Manager	32.40	33
Clinical Team Leader	154.48	177
Team Leader	138.94	159
Nurse Advisor	848.90	1218
Health Advisor	658.05	925
Total	**1859.77**	**2539**

2. Health Information

Post Title	WTE	Headcount
Health Information Managers	5.35	6
Health Information Team Leader	14.17	16
Health Information Advisor	123.37	156
Total	**142.89**	**178**

3. National Directorates

Post Title	WTE	Headcount
Commercial	12.80	13
Clinical	104.72	122
Human Resources	53.29	62
ICT	49.60	50
Finance	29.44	36
Operations	102.76	112
Executive Board	8.00	8.00
Chief Executive's Office	9.20	10
Total	**369.81**	**413**

In the year since it completed its Transformation Programme and became an NHS Trust in April 2007, NHS Direct has been improving in its role as an effective employer.

2007 Staff Survey

NHS Direct's first comprehensive Staff Survey was undertaken in August 2007. It attracted an outstanding response rate and, in the light of the recently completed Transformation Programme, conveyed a number of positive messages about the organisation. There were also a significant number of areas of concern, however, which have led to the development of a National Staff Survey Action Plan, and also informed NHS Direct's first HR strategy, both of which were developed in partnership with staff side colleagues, and were endorsed by the Board and by the National Joint Partnership Forum in January 2008.

Career Progression

The Staff Survey revealed that NHS Direct's relatively high attrition rate is due in part to a lack of opportunities for career progression in the organisation. As a result, we are undertaking pilot projects on the introduction of a new level of nurse adviser, on home teleconsultation, and on the development of rotations between NHS Direct contact centres and local NHS trusts.

Training & Development

NHS Direct's clinical induction and development training is excellent:– we run a safe service with few clinically related complaints. Opportunities for development for aspiring and existing managers have been patchy, however, so the Board has agreed to invest significantly in regional Education, Training and Development Leads, as well as a senior national role for non-clinical training and management development, so that we are able to nurture our talented staff up through the organisation.

Equality & Diversity

There has been a lot of very useful Equality and Diversity activity in NHS Direct during its first ten years. An organisation-wide Equality and Diversity Strategy was agreed at the December 2007 Board Meeting, which established an Equality & Diversity Steering Group, and a Race Equality Scheme was agreed by the National Joint Partnership Forum and the Board in March 2008. An action plan for 2008/09 will deliver an Equality Impact Assessment system, diversity awareness training for all staff, and a Single Equality Scheme, as well as regional activity through the Improving Working Lives teams.

Internal Processes

As a former special health authority, NHS Direct was in the last wave of trusts to adopt the NHS wide HR and payroll system, the Electronic Staff Record, in March 2008. The project enabled NHS Direct to cleanse and update much of its employee data, and has led to a second phase of the project, which will develop the best possible internal processes for a virtual contact centre organisation.

The business impact on the environment

NHS Direct had more than 40 million contacts from people's homes in 2007/08, through the telephone, the internet and digital TV, which is a ten-fold increase in five years, and we now have verified data that demonstrates that 73 per cent of NHS Direct telephone callers would have gone to their GP or to a hospital's accident and emergency department if they had not been able to call for advice.

We are not only helping to take the pressure off GP surgeries and emergency departments by advising people how best to treat themselves at home, therefore, but we are demonstrably saving millions of car journeys every year.

Internally, the transformation programme in 2006/07 reduced the number of sites and increased the cost effectiveness of the organisation. We now have video-conferencing facilities in each of our major regional centres and at twenty one sites in all, and teleconferencing facilities in all of our sites. NHS Direct's Travel Expenses Policy specifically requires colleagues who organise meetings to consider teleconferencing or video-conferencing, and we have introduced a "Cycle to Work Scheme".

Key Stakeholders

During 2007/08 NHS Direct's core service was commissioned by the Department of Health.

Minister of State for Health Services
Andrew Burnham MP (to June 07)
Ben Bradshaw MP (from June 07)

NHS Chief Executive
David Nicholson

Local commissioners within the primary, acute and social care markets are also key stakeholders, and one of our 08/09 corporate objectives is to build closer working relationships with these stakeholders. We will do this not only to increase the level of contestable services we win, and thereby make a contribution to overheads, but also to ensure that we have a regular dialogue regarding how our national core services support their local aims.

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

- CAS Services Ltd – for application and managed services
- BT – for telephony and network services
- Adastra Software Ltd – technology solutions for Out of Hours links

My role is to develop and maintain a framework for Information Governance, and to ensure that the organisation understands and complies with its statutory obligations. This is a demanding but rewarding role that has allowed me to develop several new skills. I have to provide sound advice and guidance to my colleagues; therefore I have fostered key relationships across all Directorates to increase awareness of Data Protection and Information Security.

Sarah Feal
Information Governance & Security Officer

Local services through a national network

A key focus for NHS Direct over the past year has been to develop a better understanding of our commissioners' needs and to relate more locally to the health economy in which we serve. We are keen to adapt our core service to be more locally integrated, and to develop our portfolio of enhanced services.

To this end we have a team of Regional Directors and Business Development professionals. They combine their in depth knowledge of the region they work in, with a comprehensive understanding of how our core capabilities of world class telephony, technical links, knowledge management and clinical safety can assist with local priorities. Our portfolio consists of service offers which can meet the needs of commissioners of primary care, long term conditions and the acute hospital sector.

Our service development process ensures that we make the most of our core capabilities to address commissioner identified issues whilst challenging norms to ensure that patient outcomes are robust, resilient and innovative.

If you would like to learn more about our portfolio of enhanced services and how these can be developed into individual products to meet your needs, please make contact with your local Head of Business Development.

Regional Directors

Region	Regional Director	Base Site	Telephone	E-mail
East	Richard Winter	Bedford	01234 848504	richard.winter@nhsdirect.nhs.uk
East Midlands	Nigel Nice	Nottingham	0115 948 9302	nigel.nice@nhsdirect.nhs.uk
London	Steven Wibberley (on secondment)	Beckenham	020 8676 3100	steven.wibberley@nhsdirect.nhs.uk
	Richard Winter (interim)			
North East	Tom McAneney	Newcastle	0191 238 1117	tom.mcaneney@nhsdirect.nhs.uk
North West	Jill Stringer	Middlebrook	01204 478701	jill.stringer@nhsdirect.nhs.uk
South East	Mike Daly	Milton Keynes	01908 259813	mike.day@nhsdirect.nhs.uk
South West	Gill Stewart	Bristol	01454 452505	gill.stewart@nhsdirect.nhs.uk
West Midlands	Pam Bradbury	Dudley	01384 473816	pam.bradbury@nhsdirect.nhs.uk
Yorkshire & Humber	Nicola Williams	Wakefield	01924 877909	nicola.williams@nhsdirect.nhs.uk

Heads of business development

Region	Head	Base Site	Telephone	E-mail
East	Monica Finn	Bedford	01234 848 516	monica.finn@nhsdirect.nhs.uk
East Midlands	Helen Thompson	Nottingham	0115 948 9340	helen.thompson@nhsdirect.nhs.uk
London	Donna Patten	Beckenham	020 8676 3100	donna.patten@nhsdirect.nhs.uk
North East	Chris Dawson	Newcastle	0191 238 1137	chris.dawson@nhsdirect.nhs.uk
North West	Kathy Agrebi	Middlebrook	01204 478715	kathy.agrebi@nhsdirect.nhs.uk
South East	Katherine Pitts	Caterham	01883 334803	katherine.pitts@nhsdirect.nhs.uk
South West	Caroline Pike	Bristol	01454 452501	caroline.pike@nhsdirect.nhs.uk
West Midlands	Anthony Nicholls	Dudley	01384 473830	anthony.nicholls@nhsdirect.nhs.uk
Yorkshire & Humber	Linda Nuttall	Wakefield	01924 877927	linda.nuttall@nhsdirect.nhs.uk

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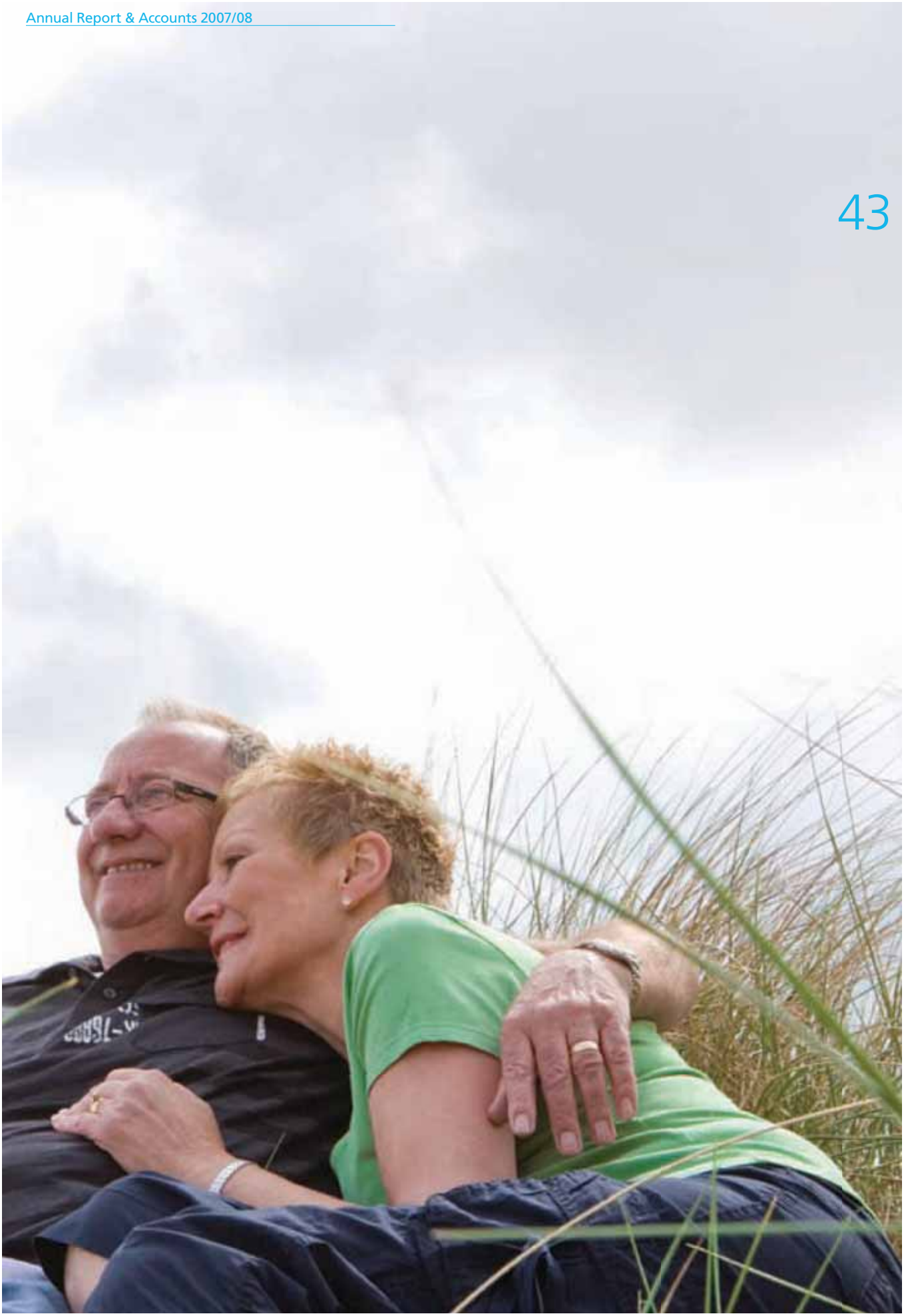
We can be contacted anytime, anywhere in England, 365 days of the year. We know this is the main reason that 95% of our patients rate our care and service very highly and were satisfied with our efficient service.



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Plans for the Future

NHS Direct's vision is to be the national healthline. We provide expert health advice, information and reassurance using world class telephone, website and digital TV services. We aim to be the NHS' provider of choice for telephone and digitally delivered health services.

We will increase our contribution to the delivery of local health and social care services through the provision of a range of telephone and digital based services which are integrated with the wider NHS. We want to be a valued partner in the delivery of high quality health and social care and to be seen as a central part of the health and social care services.

Our strategic goals for the next five years are:

Growth

To increase revenues from contestable markets and grow core service contract volumes.

Financial Health

To generate a surplus for re-investment.

Efficiency

To attain best in class levels of operating efficiency allowing us to offer value for money to our customers.

Customer Focus

To understand our customers and work to fulfil their needs through developing services that utilise national capabilities at a local level.

User Experience

To continuously improve user experience, driven by their needs to generate professional and appropriate responses.

Talent

To develop the skills and knowledge of the organisation and build staff commitment.

E-Health Leadership

To achieve pre-eminence in chosen areas of e-health through integrating our multi-channel capabilities.

Health Improvement

To empower people to make informed decisions /choices and improve overall health outcomes.

Our 2008/09 corporate objectives have been designed to help us move towards achieving these longer term strategic goals and are:

NHS Direct will:

– Deliver all of the following Key Performance Indicators (KPIs) agreed with Department of Health over the plan period.

Measure	Department of Health Target
Number of complaints per 10,000 calls	< 1
% Incidents for National Review leading to harm	≤ 10%
Abandonment Rate	≤ 5%
% Calls Answered within 60 Seconds	≥ 95%
% of Urgent P1, D1, & P0 Calls Starting Clinical Assessment within 20 Minutes	≥ 95%
% of Non-urgent P2 Calls Starting Clinical Assessment within 60 Minutes	≥ 95%
% of Non-urgent P2, P3, D2 & D3 Calls Starting Clinical Assessment within 120 Minutes	≥ 95%
% Emergency and Urgent Referrals	≤ 25%
% of calls completed within NHS Direct	≥ 60% (target end of March 2009)
0845 46 47 Answered Calls per annum	≥ 5 million
% of time the welcome message is played	≥ 95%

More details of these Key performance Indicators are given at Appendix A.

– Ensure delivery against the requirements of Standards for Better Health.
– Agree with Department of Health (DoH) new KPI's for Health Information.
– Agree with DoH the scope and engagement of the joint Review of Commissioning.
– Develop the Board and organisational capability to ensure a successful submission to become a Foundation Trust.
– Operate an effective financial control and performance management environment to ensure delivery of the 08/09 budget.
– Engage with the Tender for NHS Choices to ensure successful delivery of both NHS Direct and NHS Choices key requirements.
– Review and implement a channel optimisation strategy that meets user requirements and delivers corporate efficiencies.
– Review contestable market opportunities and ensure capture of new business to meet the financial targets.
– Develop an effective engagement strategy that meets the requirements of the NHS and public.
– Develop effective Home Working pilots to evaluate operational benefits.
– Reduce sickness and attrition to agreed levels.
– Develop corporate governance, performance and Board reporting in line with Monitor guidance and best practice.

Trends and factors that could impact the future of NHS Direct

As part of our preparation of our Business Plan for 2008/09, the Directors undertook a PEST (Political, Economic, Social and Technical) analysis to assess potential future impacts on our business which included consideration of possible transformational government initiatives, such as single non-emergency access number; social trends in relation to e-health, demographic changes and developments in new technology.

The External Environment

Our contract with the Department of Health gives us annual funding for the core service.

There are currently no competitors in health with a national infrastructure and experience of providing protocol based advice and information over the telephone, internet and television.

A possible move to a single number for non-emergency access to healthcare, as suggested by Lord Darzi in his report, has significant implications for NHS Direct.

The market for enhanced services is highly competitive. The out-of-hours market has several significant private sector players and the ambulance services are keen to handle more of the telephone front end of these services.

Non-Executive & Executive Directors' Biographies

Non-Executive Directors' Biographies

David Edmonds, Chair

David Edmonds has been Chair of NHS Direct since it was set up as a Special Health Authority on 1 April 2004. Following a career in the senior civil service, he became Chief Executive of the Housing Corporation before spending seven years in the City and five years as the UK's telecommunications regulator. He currently sits as a Non-Executive Director on a number of plc and public-sector boards.

Philip Baker

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

Peter Catchpole

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

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 KMPG, both as a Consultant and Director. During that time she worked with a range of clients from the public and private sectors, both in the UK and internationally. Sue was instrumental in establishing a multi-disciplinary healthcare group at KPMG and advised numerous trusts on all aspects of their Foundation Trust application process, either directly or on behalf of the Department of Health NHS Foundation Trust Implementation Unit (NHSFTU).

Trevor Jones

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

Derek Newman

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

Joanne Shaw

Joanne joined the Board on 1 April 2004. She holds the posts of Chair of Datapharm Communications (since April 2006), Vice-Chair of NHS Direct and Chair of Ask About Medicines, and is a Trustee of the Long-Term Medical Conditions Alliance. Her previous roles have included Director of the Task Force on Medicines Partnership and Director of Performance Development at the Audit Commission. She has also worked internationally as a Management Consultant in the private sector.

Tim Walton

Tim joined the Board on 1 April 2007. He is an independent consultant and Non-Executive Director with BERR and the Accent Group. He was also a Non-Executive Director of Sourcerer Ltd 1998-2002. His executive career has included Chief Information Officer roles with CLM, the Olympic Delivery Authority delivery partner for London2012 and Arup Group and was Director of e-business at Rolls Royce Group Plc. Other assignments have included roles spanning operational, commercial, financial, e-business and IT in civil and military aerospace, construction and design engineering. A Fellow of the British Computer Society and a Chartered Engineer, Tim has been a member of various steering boards for industry initiatives and is also a guest speaker at Warwick and Oxford MBA Courses.

Executive Directors' Biographies

Matt Tee
Chief Executive

Matt joined NHS Direct on 2 July 2007 from the Department of Health, where he was the Director General of Communications. Previously, Matt had worked as Director of Business Development at health information specialists Dr Foster. He has a long history in the health sector, and has held board Communications Director roles at the Commission for Health Improvement and at Guy's and St Thomas' hospitals. Matt was also Director of News at the Department for Trade and &Industry.

Ed Lester
Chief Executive

to 4 May 2007.
Ed joined the NHS Direct Board on 1 April 2004 from Mobility Finance Ltd, where he was Chief Executive for nine years. Prior to that he held several senior management positions in banking and the oil industry. Ed left the Board of NHS Direct on May 4, 2007.

Murray Bain
Director of Information & Communications Technology (ICT)*

Murray joined the Executive Management Team on 1 April 2004 and is responsible for the smooth running of our ICT* infrastructure. After a background in local government finance and later IT management at St Albans City and District Council, he joined NHS Direct in 1999 as IT Telecoms Manager at the Bedfordshire and Hertfordshire contact centre before spending two years as national ICT Advisor. He leaves the organisation on 30 June 2008.

Paula Higson
Chief Operating Officer

Paula Higson joined NHS Direct as Chief Operating Officer on 1 May 2008, with responsibility for ensuring the effective and efficient delivery of NHS Direct services. She has 10 years' experience of working at board level in public service organisations; most recently, she was Senior Director for Managed Migration for the UK Border Agency, where she led the programme for the launch of the points-based system.

Ronnette Lucraft
Commercial Director

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

Mike Pack
Director of Finance

Mike Pack joined the Board on 10 April 2007. He is a Chartered Accountant and has over 20 years' experience of financial management at director level in the private sector. He has worked in blue-chip businesses within the retail, hospitality and business service sectors. Since moving into the public sector in 2004, he has held Finance Director roles at the DCA and a special health authority. He leaves NHS Direct on 30 June 2008.

Roger Rawlinson
Human Resources Director

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

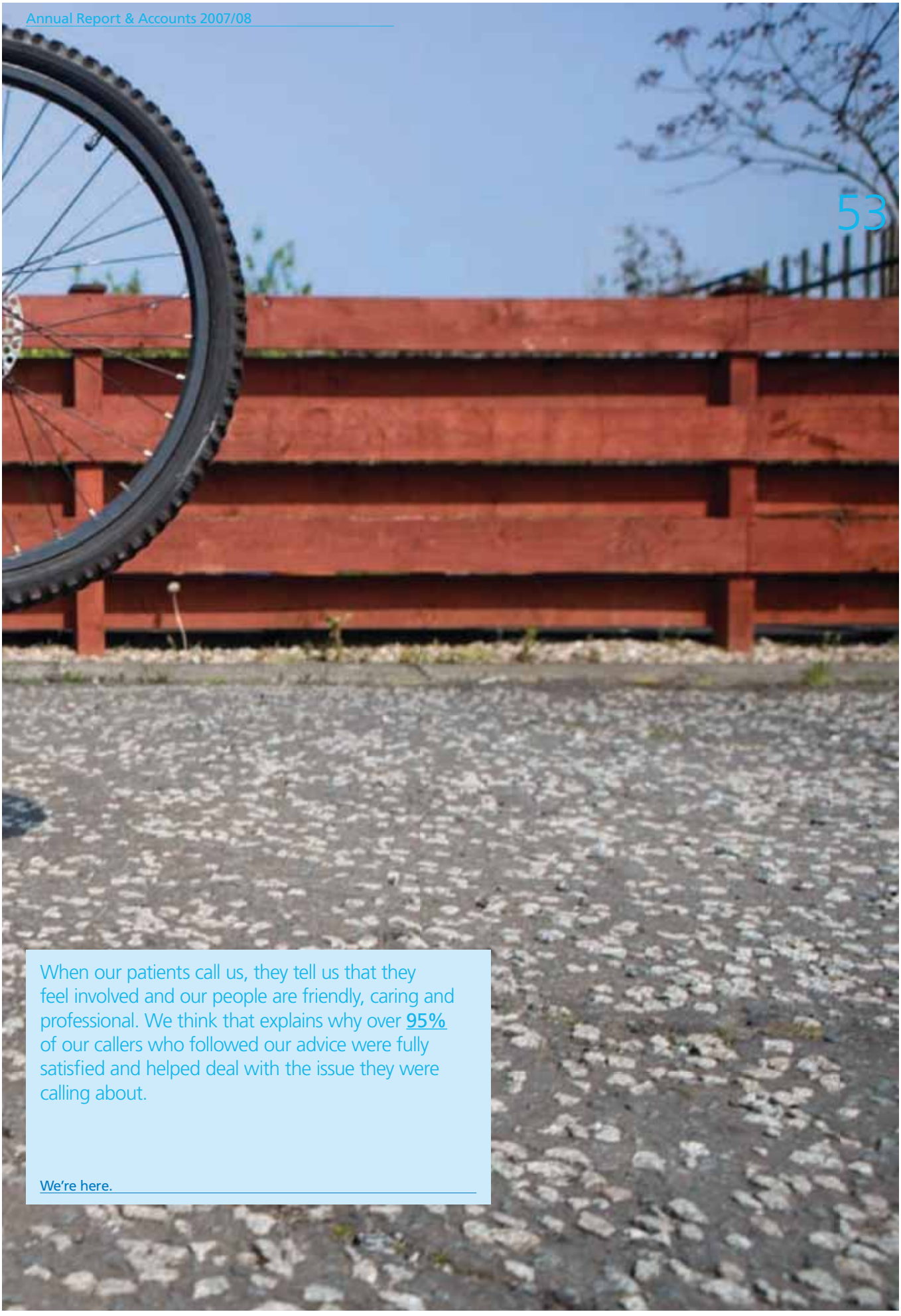
Dr Mike Sadler
Chief Operating Officer

to 29 February 2008 (Acting Chief Executive 4 May 2007 to 30 June 2007)
Dr Mike Sadler joined the NHS Direct Board on 15 November 2004. This was his second spell at NHS Direct, having been between 2000 and 2003 the local Medical Director for NHS Direct Hampshire and Isle of Wight, and the National Medical Advisor to NHS Direct Online. He began his medical career in general practice before moving into public health, eventually working as Deputy Director of Public Health medicine at Portsmouth and South East Hampshire Health Authority. In 2003 he was the National Medical Director of Primecare. Returning to NHS Direct in 2004 as Medical Director he brought a wealth of clinical and managerial experience until January 2006, when he became Chief Operating Officer. Mike left NHS Direct on 29 February 2008.

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 Executive Clinical Director/ Chief Nurse of NHS Direct. She is responsible for ensuring safe, effective and evidence-based clinical services for our patients and users, as well as being the clinical professional lead for NHS Direct. Helen has held a number of executive and senior management and lead nurse/midwifery positions in large Acute, Mental Health and Community NHS Trusts, including 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.

*The Director for ICT and the Human Resources Director are not members of the Trust Board.



When our patients call us, they tell us that they feel involved and our people are friendly, caring and professional. We think that explains why over **95%** of our callers who followed our advice were fully satisfied and helped deal with the issue they were calling about.

We're here.

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History and statutory background

NHS Direct was established on 1 April 2004 as a Special Health Authority under the NHS Direct (Establishment and Constitution) Order 2004, (Statutory Instrument 569).

NHS Direct Special Health Authority assumed the roles previously undertaken by the Department of Health and 22 host NHS organisations. NHS Direct is part of the National Health Service. It is a national organisation established to provide to the public, via multi-channel services, health-related information and advice.

On 1 April 2007 NHS Direct changed its organisational status and became an NHS Trust under The NHS Direct NHS Trust (Establishment) Order 2007 No. 478. Its operating framework, including standing orders and standing financial instructions, is set out in its Corporate Governance Framework Document. A Board was established comprising a Chair, seven Non-Executive Directors and five Executive Directors.

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

The Trust Board has established the following Sub-Committees:

The Audit Committee

Members
Peter Catchpole (Chair), Sue Hunt, Trevor Jones, Tim Walton and Director of Finance

Risk Committee

Members
Derek Newman (Chair), Philip Baker, Peter Catchpole, Tim Walton and Clinical Director/Chief Nurse

Clinical Governance Committee

Members
Philip Baker (Chair), Trevor Jones, Joanne Shaw and Clinical Director/Chief Nurse

Remuneration Committee

Members
Trevor Jones (Chair), Tim Walton and Peter Catchpole

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 2007/08

Date of incident (month)	Nature of incident	Nature data of involved	Number of people potentially affected	Notification steps
N/A	N/A	N/A	N/A	N/A
Further	NHS Direct has not formally reported any action on protected personal data related incidents information to the Information Commissioner's Office risk in 2007/08. NHS Direct will continue to monitor and assess its information risks in order to identify and address any weaknesses and ensure continuous improvement of its systems. Planned steps for the coming year include: – Device Encryption, Content Encryption and Port Control – Revised Confidentiality Policy – New Corporate Induction Programme – New Information Security Event Reporting and Management Policy – Role based Information Governance training			

Table 2

Summary of other protected personal data related incidents in 2007/08

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 organisation 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 Government premises	0
II	Loss of inadequately protected electronic equipment, devices or paper documents from outside secured Government premises	1
III	Insecure disposal of inadequately protected electronic equipment, devices or paper documents	0
IV	Unauthorised disclosure	2
V	Other	0

There were no protected personal data related incidents, under any category, formally reported to the Information Commissioner' Office during 2004/5, 2005/6 or 2006/7.

The Statement on Internal Control includes details of an irretrievable deletion of voice recordings in 2007.

There were no other protected personal data related incidents, under any category during 2004/5, 2005/6 or 2006/7.

Equal opportunities

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

Policy in relation to disabled employees

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

Better Payments Practice Code

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

Name of auditor

The accounts have been audited by the Comptroller and Auditor General in accordance with the National Health 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 £100,000 for 2007/08. No other audit services were provided during this period.

Pensions

Past and present employees are covered by the provisions of the NHS Pension Scheme. A detailed explanation of how pension liabilities are treated in the Accounts of the organisation can be found in Note 1.9 under Accounting Policies in the annual accounts and also under the Remuneration Report within this annual report.

Disclosure of relevant information

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

Matt Tee
Accounting Officer

Directors' declarations of interests

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

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

Matt Tee
– 53,000 (0.45%) shares in Dr Foster

Philip Baker
– Director of the National Institute for Health Research Biomedical Research Centre
– Practising consultant obstetrician at St Mary's Hospital, Manchester

Murray Bain*
– None declared

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

Paula Higson
– None declared

Sue Hunt
– None declared

Ed Lester
– Director, Casa Toscana Ltd
– Director, Placepass Ltd

Ronnette Lucraft
– Director, More Than This Ltd

Trevor Jones
– Non-Executive Director, National Patient Safety Agency
– Non-Executive Director, Sport England South West
– Non-Executive Director, Pinnacle Staffing Group plc
– Trustee of Wellchild Charity

Derek Newman
– Trustee on the board of the Croft House Settlement, Sheffield

Mike Pack
– None declared

Roger Rawlinson*
– None declared

Mike Sadler
– None declared

Joanne Shaw
– Trustee of Long Term Conditions Alliance
– Director, Vanguard Metropolitan Ltd
– Director, AAMW Ltd
– Chairman, Datapharm Communications Ltd

Tim Walton
– Director of Tim Walton and Associates Ltd
– Non-Executive Director of Accent Group
– Non-Executive Director of BERR

Helen Young
– Director, Home James of London
– Trustee and named individual of Dorothy House Hospice

*Murray Bain and Roger Rawlinson are Directors of NHS Direct but are not members of the Trust Board

Remuneration Report 2007/08

Composition & roles of the committee

During 2007/08, the remuneration committee comprised Trevor Jones, Tim Walton and Peter Catchpole, all of whom are independent Non-Executive Directors. The committee met five times during the year and was chaired by Trevor Jones. The terms of reference for the remuneration committee are available on request.

The committee makes recommendations to the board of the trust, within the formal terms of reference, on the policy and framework of executive remuneration and its overall cost to the trust. The committee is also responsible for the implementation of remuneration policy and the specific remuneration arrangements for all Executive Directors and also advises on other senior employees. The committee has access to advice from the Director of Human Resources and the Chief Executive.

Remuneration policy & framework

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

The remuneration committee assessed the performance-related pay objectives of the Executive Directors for 2007/08, and made recommendations for payments to the board.

In 2007/08, the increase in the annual pay bill for Executive Directors was contained within an overall uplift of 1.3% as requested by the Department of Health. This resulted in a phased payment of a 1% increase from April 2007 and a further 1.2% from November 2007.

The following tables have been audited.

Contracts & notice periods

The duration of contracts and notice periods, by executive role, are as follows:

	Role	Start	Notice	Nature	Continuous Service Starts
Ed Lester	Chief Executive (to 04/05/07)	01/03/04	6 months	Permanent	01/03/04
Matt Tee	Chief Executive	02/07/07	6 months	Permanent	01/07/07
Mike Sadler	Chief Operating Officer (to 29/02/08)	15/11/04	6 months	Permanent	07/12/81
Murray Bain	Director of ICT	01/09/99	6 months	Permanent	10/03/70
Michael Munt	Director of Finance and Estates (to 30/04/07)	20/09/04	6 months	Permanent	20/09/04
Helen Young	Clinical Director	01/12/04	6 months	Permanent	11/08/87
John Mockler	Director of Human Resources (to 31/08/07)	26/02/07	n/a	Interim	n/a
Mike Pack	Director of Finance and Estates (from 01/05/07)	01/05/07	3 months	Permanent	10/04/07
Roger Rawlinson	Director of Human Resources (from 01/09/07)	01/09/07	3 months	Permanent	01/09/07
Ronnette Lucraft	Commercial Director (from 11/04/07)	11/04/07	3 months	Permanent	11/04/07

The remuneration relating to all Directors in post during 2007/08 (together with the comparative information for 2006/07) is detailed on the tables below which identify the salary, other payments, allowance and pension benefits applicable to both Executives and Non-Executive Directors of the trust and are subject to audit.

Salaries and allowances

Name and title	2007/08			2006/07		
	Salary (bands of £5,000)	Other Remuneration (bands of £5,000)	Benefits in kind (Rounded to the nearest £00)	Salary (bands of £5,000)	Other Remuneration (bands of £5,000)	Benefits in kind (Rounded to the nearest £00)
	£000	£000	£00	£000	£000	£00
David Edmonds, (Chair)	35-40	0	1	30-35	0	0
Joanne Shaw, (Non Executive)	5-10	0	0	5-10	0	0
Peter Catchpole, (Non Executive)	10-15	0	0	10-15	0	0
Derek Newman, (Non Executive)	5-10	0	1	5-10	0	0
Susan Hunt, (Non Executive) (from 01/04/07)	5-10	0	1	n/a	n/a	n/a
Philip Baker, (Non Executive) (from 01/04/07)	5-10	0	0	n/a	n/a	n/a
Trevor Jones, (Non-Executive) (from 01/04/07)	5-10	0	1	n/a	n/a	n/a
Tim Walton, (Non Executive) (from 01/04/07)	5-10	0	1	n/a	n/a	n/a
Ed Lester, Chief Executive (to 04/05/07)	70-75	0	0	165-170	0	1
Matt Tee, Chief Executive (from 02/07/07)	115-120	0	0	n/a	n/a	n/a
Mike Sadler, Chief Operating Officer (to 29/02/08)	120-125	0	0	115-120	0	8
Murray Bain, Director of ICT	100-105	0	3	95-100	0	2
Helen Young, Clinical Director	115-120	0	0	95-100	0	0
Michael Munt, Director of Finance and Estates (to 30/04/07)	10-15	0	0	105-110	0	1
John Mockler, Director of Human Resources (to 31/08/07)	50-55	0	0	5-10	0	0
Mike Pack, Director of Finance and Estates (from 01/05/07)	115-120	0	3	n/a	n/a	n/a
Roger Rawlinson, Director of Human Resources (from 01/09/07)	55-60	0	0	n/a	n/a	n/a
Ronnette Lucraft, Commercial Director (from 11/04/07)	105-110	0	2	n/a	n/a	n/a

Pension Benefits

Name and title	Real increase in pension at age 60 (bands of £2,500)	Lump sum at age 60 related to real increase in pension (bands of £2,500)	Total accrued pension at age 60 at 31 March 2008 (bands of £5,000)	Lump sum at age 60 related to accrued pension at 31 March 2008 (bands of £5,000)	Cash Equivalent Transfer Value at 31 March 2008	Cash Equivalent Transfer Value at 31 March 2007	Real increase in Cash Equivalent Transfer Value	Employer's contri-bution to stake holder pension
	£000	£000	£000	£000	£000	£000	£000	£000
Ed Lester, Chief Executive	0-2.5	0-2.5	0-5	10-15	91	75	14	0
Matt Tee, Chief Executive	2.5-5	7.5-10	10-15	35-40	170	141	26	0
Mike Sadler, Chief Operating Officer	2.5-5	12.5-15	30-35	90-95	479	359	111	0
Murray Bain, Director of ICT	0-2.5	5-7.5	45-50	145-150	785	720	47	0
Helen Young, Clinical Director	2.5-5	12.5-15	25-30	80-85	294	235	53	0
Michael Munt, Director of Finance and Estates	0	0	0-5	5-10	59	57	1	0
Mike Pack, Director of Finance and Estates	0-2.5	2.5-5	0-5	0-5	25	0	25	0
Roger Rawlinson, Director of Human Resources	0-2.5	2.5-5	0-5	15-20	88	68	19	0
Ronnette Lucraft, Commercial Director	0-2.5	2.5-5	0-5	0-5	15	0	15	0

As Non-Executive Members do not receive pensionable remuneration, there are no entries in respect of pensions for Non-Executive Members.

John Mockler was not a pensionable employee of the trust.

Cash equivalent transfer values

A cash equivalent transfer value (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. It is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a given date.

The benefits valued are the member's accrued benefits and any contingent spouse's pension payable from the scheme. The pension figures shown relate to the benefits which the individual has accrued as a consequence of their total membership of the pension scheme, not just their service in a senior capacity to which disclosure applies. The CETV figures and other pension details include the value of any pension benefits in another scheme or arrangement which the individual has transferred to the NHS pension scheme. They also include any additional pension benefit accrued to the member as a result of their purchasing additional years of pension service in the scheme at their own cost. CETVs are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries.

Real Increase in CETV

This reflects the increase in CETV effectively funded by the employer. It takes account of the increase in accrued pension due to inflation 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.

Matt Tee
Chief Executive, 7 July 2008

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Annual Accounts

Statement of The Board's and Chief Executive's Responsibilities

Under the National Health Service Act 2006 and directions made thereunder by the Secretary of State with the approval of 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 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; and
- 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 2007/08

Scope of responsibility

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

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

The purpose of the system of internal control

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

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

The system of internal control has been in place in NHS Direct for the whole year ended 31 March 2008 and up to the date of approval of the Annual Report and Accounts.

Capacity to handle risk

The Trust has continued during the course of the year, its first as an NHS Trust, to enhance its assurance framework, which is now solidly based on the key objectives and principal risks set out in the organisation's approved Business Plan covering both strategic and operational risks. The framework is the subject of regular review and updating to reflect the changing nature of the risks the organisation faces in delivering its services to patients. This overarching control mechanism is underpinned at a detailed level by a corporate risk register that is the subject of regular review by the Risk Committee.

All committees report directly to the Trust Board, where minutes of meetings are considered and key issues identified, thereby ensuring that all Board members are appropriately apprised of the key issues. Although I have overall responsibility the management of risk is a key responsibility for all senior management in the organisation.

The Trust continues to develop its control processes through a range of mechanisms including clinical supervision and individual and peer review, performance monitoring and continuing education and development.

The risk and control framework

The Trust has a controls assurance framework which sets out the principal risks to delivery of its key targets and objectives. The risks to achieving these objectives have been identified and appropriate actions are in place to address the identified shortcomings. These actions are reflected at a detailed level in the corporate risk register that is the subject of regular review by the Risk Committee.

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

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

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 programme. Executive managers within the organisation who have responsibility for the development and maintenance of the system of internal control provide me with assurance. The assurance framework itself provides me with evidence that the effectiveness of controls that manage the risks to the organisation's achievement of its principal objectives have been reviewed. My review is also informed by assurances from other sources, which include internal and external audit, the counter fraud service and user and staff surveys.

The opinion from the Head of Internal Audit was that 'significant assurance can be given that there is a generally sound system of internal control designed to meet the organisation's objectives, and that controls are generally being applied consistently. However, some weakness in the design and inconsistent application of controls put the achievement of particular objectives at risk. We were satisfied that an Assurance Framework has been established which is designed and implemented to meet the requirements of the 2007/08

Statement on Internal Control and provides reasonable assurance that there is an effective system of internal control to manage the principal risks identified by the organisation'.

I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the Board, which has been informed by the audit committee, the risk and clinical governance committees. A plan to address any weaknesses that might exist and to ensure continuous improvement of the system is in place.

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

The Board

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

The Audit Committee

The internal audit plan enables the Board to be reassured that the key internal controls and other matters relating to risk are regularly reviewed. It receives internal and external audit reports and progress reports on risk-related issues, whilst also providing to the Board an overview of the effectiveness of the assurance arrangements based on the work of the risk and clinical governance committees.

Risk Committee

The committee is responsible for assessing the risks to the organisation in terms of the likelihood and impact on achieving its strategic, business and operational objectives, whilst also reviewing and assessing the effectiveness of existing and potential control and assurance systems.

Clinical Governance Committee

The committee is responsible for oversight of clinical governance of the Trust. It oversees the organisation's compliance with Standards for Better Health. A full self-assessment was conducted on 2007/08 compliance with the Core Standards. In addition a more in-depth review was commissioned from our internal auditors to provide a rigorous appraisal of the organisation's own internal assessment with a rating of Substantial Assurance.

Information Governance Steering Group

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

Significant Control Issues

NHS Direct maintains a full patient record of each patient interaction. This record includes:
– The demographic details of the patient;
– A log of the assessment process used and the decision path taken;
– The final advice given to the patient; and
– A voice recording of the telephone call for support purposes.

NHS Direct works to a standard that all records are archived and kept securely for between 2 and 26 years (in accordance with NHS guidelines).

As a result of reports from clinicians that certain voice recordings appeared to be unavailable, an audit was commissioned internally which identified that the content of certain calls could not be found. During subsequent investigations the supplier identified that an error had been made in the initial configuration of the archiving process. This has meant that approximately 2 million of the earliest voice recordings taken during calendar year 2007 have been irretrievably deleted. A full audit by the supplier was commissioned to confirm the precise extent of the deletion of voice recording and is ongoing. The error has been corrected and the three primary elements of the patient record remain securely held within NHS Direct.

No patient has been or could be harmed as a result of the deletion of these voice recordings. Controls over the archiving process have been tightened to ensure that this type of error cannot re-occur.

Summary

The organisation has continued to address previously identified and new control weaknesses and has maintained its previous significant progress in its first year as an NHS Trust. In particular it has:
– Continued to develop and embed its assurance framework, while recognising that further work is necessary to cascade the principles throughout the organisation
– Has further developed and strengthened payroll processes to support the implementation of the new Electronic Staff Record (ESR) Human Resources and Payroll system, which went live on 1 April 2008
– established a new team responsible for corporate governance and performance management reporting directly to the Chief Executive. This is designed to strengthen and co-ordinate the Trust's efforts in these areas. This team will 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 the NHS Direct business plan.

It is acknowledged that work remains ongoing as the NHS Trust seeks to strengthen its governance arrangements.

Matt Tee
Accounting Officer, 7 July 2008

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

I certify that I have audited the financial statements of NHS Direct NHS Trust (NHS Direct) for the year ended 31 March 2008 under the National Health Service Act 2006.

These comprise the Income and Expenditure Account, the Balance Sheet, the Cash Flow Statement and Statement of Total Recognised Gains and Losses and the related notes. These financial statements have been prepared under the accounting policies set out within them. I have also audited the information in the Remuneration Report that is described in that report as having been audited.

Respective responsibilities of the Board, Chief Executive and auditor

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

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

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

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

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

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

Basis of audit opinions

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

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

Opinions

In my opinion:

- the financial statements give a true and fair view, in accordance with the National Health Service Act 2006, and directions made thereunder by the Secretary of State with the approval of HM Treasury, of the state of NHS Direct's affairs as at 31 March 2008 and of its surplus, total recognised gains and losses and cash flows for the year then ended;
- the financial statements and the part of the Remuneration Report to be audited have been properly prepared in accordance with the National Health Service Act 2006, and directions made thereunder by the Secretary of State with the approval of HM Treasury; and
- information, which comprises the management commentary and the public interest disclosures, included within the Annual Report, is consistent with the financial statements.

Opinion on Regularity

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

Report

I have no observations to make on these financial statements.

T J Burr
Comptroller and Auditor General
National Audit Office
151 Buckingham Palace Road
Victoria
London
SWIW 9SS

11 July 2008

Income and Expenditure Account for the year ended 31 March 2008

	Note	2007/08 £000	2006/07 £000
Income from activities	3	**144,046**	147,465
Other operating income	4	**335**	424
Operating expenses	5	**(141,265)**	(145,549)
Operating Surplus		**3,116**	2,340
Profit/(loss) on disposal of fixed assets	8	**(3)**	(11)
Surplus Before Interest		**3,113**	2,329
Interest receivable	9	**2,121**	0
Interest payable	9	**(4)**	0
Surplus For The Financial Year		**5,230**	2,329
Public Dividend Capital dividends payable		**(168)**	0
Retained Surplus For The Year		**5,062**	2,329

The notes on pages 76 to 91 form part of these accounts.
All income and expenditure is derived from continuing operations.

Balance Sheet as at 31 March 2008

	Note	31 March 2008 £000	31 March 2007 £000
Fixed Assets			
Tangible assets	10	**14,691**	12,905
		14,691	12,905
Current Assets			
Debtors	11	**11,601**	14,604
Cash at bank and in hand		**19,161**	16,111
		30,762	30,715
Creditors: Amounts falling due within one year	12	**(11,646)**	(16,339)
Net Current Assets		**19,116**	14,376
Total Assets Less Current Liabilities		**33,807**	27,281
Provisions For Liabilities And Charges	13	**(3,654)**	(3,670)
Total Assets Employed		**30,153**	23,611
Financed By:			
Taxpayers' Equity			
Public dividend capital	19	**24,513**	0
Revaluation reserve	14	**578**	0
Capital Reserve	14	**0**	13,613
Income and expenditure reserve	14	**5,062**	9,998
Total Taxpayers' Equity		**30,153**	23,611

The notes on pages 76 to 91 form part of these accounts.

The financial statements on pages 72 to 91 were approved by the Board on 23 June 2008 and signed on its behalf by:

Signed.....(Chief Executive) date 7 July 2008

Statement of Total Recognised Gains and Losses for the year ended 31 March 2008

	2007/08 £000	2006/07 £000
Surplus for the financial year before dividend payments	5,230	2,329
Unrealised surplus on fixed asset indexation	578	539
Total recognised gains and losses for the financial year	5,808	2,868

The notes on pages 76 to 91 form part of these accounts.

Cash Flow Statement for the year ended 31 March 2008

	Note	2007/08 £000	2006/07 £000
Operating Activities			
Net cash inflow/(outflow) from operating activities	15	2,922	(10,302)
Returns On Investments And Servicing Of Finance:			
Interest received		1,962	0
Interest paid		(4)	0
Net cash inflow/(outflow) from returns on investments and servicing of finance		1,958	0
Capital Expenditure			
(Payments) to acquire tangible fixed assets		(2,564)	(10,002)
Receipts from sale of tangible fixed assets		0	0
Net cash inflow/(outflow) from capital expenditure		(2,564)	(10,002)
Dividends Paid		(168)	0
Net cash inflow/(outflow) before financing		2,148	(20,304)
Financing			
Public dividend capital received		902	0
Capital Funding		0	15,818
Net cash inflow/(outflow) from financing		902	15,818
Increase/(decrease) in cash		3,050	(4,486)

The notes on pages 76 to 91 form part of these 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 Trust Manual for Accounts which shall be agreed with HM Treasury. The accounting policies contained in that manual follow UK generally accepted accounting practice and HM Treasury's Government Financial Reporting Manual to the extent that they are meaningful and appropriate to the NHS. The accounting policies have been applied consistently in dealing with items considered material in relation to the accounts.

1.1 Accounting convention

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

1.2 Acquisitions and discontinued operations

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

1.3 Income Recognition

Income is accounted for applying the accruals convention. The main source of income for the Trust is from income from call centres commissioned from the Department of Health and centrally funded through the East of England Strategic Health Authority. Income is recognised in the period in which services are provided. Where income is received for a specific activity which is to be delivered in the following financial year, that income is deferred.

1.4 Intangible fixed assets

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

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

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

1.5 Tangible fixed assets

Capitalisation

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

– individually have a cost of at least £5,000; or
– collectively have a cost of at least £5,000 and individually have a cost of more than £250, where the assets are functionally interdependent, they had broadly simultaneous purchase dates, are anticipated to have simultaneous disposal dates and are under single managerial control; or
– form part of the initial equipping and setting-up cost of a new building or unit irrespective of their individual or collective cost.

Valuation

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

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

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

The valuations are carried out primarily on the basis of Depreciated Replacement Cost for specialised operational property and Existing Use Value for non-specialised operational property. The value of land for existing use purposes is assessed at Existing Use Value. For non-operational properties including surplus land, the valuations are carried out at Open Market Value. Additional alternative Open Market Value figures have only been supplied for operational assets scheduled for imminent closure and subsequent disposal.

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

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

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

Depreciation, amortisation and impairments

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

Assets in the course of construction and residual interests in off-balance sheet PFI contract assets are not depreciated until the asset is brought into use or reverts to the Trust, respectively. Buildings, installations and fittings are depreciated on their current value over the estimated remaining life of the asset as advised by the District Valuer. Leaseholds are depreciated over the primary lease term.

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

Where, under Financial Reporting Standard 11, a fixed asset impairment is charged to the Income and Expenditure Account, offsetting income may be paid by the Trust's main commissioner using funding provided by the NHS Bank.

1.6 Stocks and work-in-progress

Stocks and work-in-progress are valued at the lower of cost and net realisable value. This is considered to be a reasonable approximation to current cost due to the high turnover of stocks. Work-in-progress comprises goods in intermediate stages of production. Partially completed contracts for patient services are not accounted for as work-in-progress.

1.7 Research and development

Expenditure on research is not capitalised. Expenditure on development is capitalised if it meets the following criteria:

– there is a clearly defined project;
– the related expenditure is separately identifiable;

the outcome of the project has been assessed with reasonable certainty as to:

– its technical feasibility
– its resulting in a product or service which will eventually be brought into use;
– adequate resources exist, or are reasonably expected to be available, to enable the project to be completed and to provide any consequential increases in working capital.

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

Fixed assets acquired for use in research and development are amortised over the life of the associated project.

1.8 Provisions

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

1.9 Pensions

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. As a consequence it is not possible for the NHS Trust to identify its share of the underlying scheme assets and liabilities. Therefore the scheme is accounted for as a defined contribution scheme and the cost of the scheme is equal to the contributions payable to the scheme for the accounting period.

The Scheme is subject to a full actuarial investigation every four years. The main purpose of which 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 investigation, on the conclusions of which scheme contribution rates are currently based, had an effective date of 31 March 2004 and covered the period from 1 April 1999 to that date. Between the full actuarial valuations, the Government Actuary provides an annual update of the scheme liabilities for FRS17 purposes. The latest assessment of the liabilities of the Scheme is contained in the Scheme Actuary report, which forms part of the NHS Pension Scheme (England and Wales) Resource Account, published annually. These accounts can be viewed on the Business Service Authority – Pensions Division website at www.nhspa.gov.uk Copies can also be obtained from The Stationery Office.

The conclusion of the 2004 investigation was that the scheme had accumulated a notional deficit of £3.3 billion against the notional assets as at 31 March 2004. This is after making some allowance for the one-off effects of pay modernisation, but before taking into account any of the scheme changes which come into effect on 1 April 2008. Taking into account the changes in the benefit and contribution structure effective from 1 April 2008, employer contributions could

continue at the existing rate of 14% of pensionable pay. On advice from the actuary, scheme contributions may be varied from time to time to reflect changes in the scheme's liabilities. Up to 31 March 2008 employees paid contributions at the rate of 6% (manual staff 5%) of their pensionable pay. From 1 April 2008, employees will pay contributions according to a tiered scale from 5% up to 8.5% of their pensionable pay.

1.10 Value Added Tax

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

1.11 Foreign Exchange

Transactions that are denominated in a foreign currency are translated into sterling at the exchange rate ruling on the dates of the transactions. Resulting exchange gains and losses are taken to the Income and Expenditure Account.

1.12 Leases

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

1.13 Public Dividend Capital (PDC) and PDC Dividend

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

1.14 Losses and Special Payments

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

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

1.15 Accounting Treatment for the first year

NHS Direct NHS Trust was established under Statutory Instrument number 478 on 1 April 2007. At this time Public Dividend Capital was issued to cover the value of the historic accumulated reserves held by NHS Direct Special Health Authority prior to its abolition on 31 March 2007. Interest became payable on funds held in the Trust's bank account on 1 April 2007.

Changes in the presentation of these accounts, particularly in Taxpayer's Equity in the Balance Sheet, and Note 3, Income from Activities, Note 4, Other Operating Income, Note 6.4, Management Costs, Note 19, Movements in Public Dividend Capital, Note 20, Financial Performance Targets derive from this change in status.

2 Segmental Analysis

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

3 Income from Activities

	2007/08 £000	2006/07 £000
Core Services	**126,798**	129,603
Choose & Book Appointments Line	**6,032**	4,394
Out of Hours Services	**5,283**	8,076
Other Contestable Income	**3,901**	3,684
Department of Health	**1,684**	0
Other	**348**	110
Release of Capital Grant from Capital Reserve	**0**	1,598
	144,046	147,465

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

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

The release of Capital grant in 2006/07 derived from the accounting treatment appropriate to a Special Health Authority. There is no equivalent for the NHS Trust in 2007/08.

4 Other Operating Income

	2007/08 £000	2006/07 £000
Rental Income	**335**	424
Other Income	**335**	424

5 Operating Expenses

5.1 Operating expenses comprise:

	2007/08 £000	2006/07 £000
Services from other NHS Trusts	153	374
Services from other NHS bodies	51	4
Directors' Costs	1,051	1,269
Staff costs	88,051	89,534
Consultancy services (c)	3,627	1,787
Supplies and services - general	107	108
Establishment expenses	4,763	3,813
Telecommunications	7,467	7,947
Premises	10,244	9,210
Transport	194	182
Depreciation and amortisation	1,998	1,587
IT contracts	19,208	18,631
Capital charges interest	0	103
Audit fees (b)	100	110
Internal audit fees	110	76
Contribution to the NHS Litigation Authority	187	90
Health Information services	210	202
Redundancy costs	184	5,203
Early retirement costs	0	3,453
Other (a)	3,560	1,866
	141,265	145,549

(a) Significant items included in Other are: interpreting skills £185,432 (2006/07 £137,658), personal injury claims £101,338 (2006/07 £210,704). Other items include staff training and occupational health. Also included in Other Expenses is the cost of providing for an onerous lease at the Trust's former Cambridge site – £1,935,000

(b) The Trust did not make any payments to Auditors for non audit work.

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

5.2 Operating leases

5.2.1 Operating expenses include:

	2007/08 £000	2006/07 £000
Hire of plant and machinery	148	86
Other operating lease rentals	4,102	3,832
	4,250	3,918

5.2.2 Annual commitments under non – cancellable operating leases are:

	2007/08 £000	2006/07 £000
Land and buildings		
Operating leases which expire:		
Within 1 year	1,132	1,482
Between 1 and 5 years	299	133
After 5 years	2,671	2,217
	4,102	3,832

	2007/08 £000	2006/07 £000
Other leases		
Operating leases which expire:		
Within 1 year	24	4
Between 1 and 5 years	124	82
	148	86

6 Staff costs and numbers

6.1 Staff costs

	2007/08			2006/07
	Total	Permanently Employed	Other	
	£000	£000	£000	£000
Salaries and wages	**75,225**	68,828	6,397	75,909
Social Security Costs	**5,046**	5,046	0	5,859
Employer contributions to NHS Pension Scheme	**8,831**	8,831	0	9,035
	89,102	**82,705**	**6,397**	**90,803**

6.2 Average number of persons employed

	2007/08			2006/07
	Total	Permanently Employed	Other	
	Number	Number	Number	Number
Medical and dental	**5**	5	0	6
Administration and estates*	**1,504**	1,263	241	1,493
Nursing, midwifery and health visiting staff	**1,054**	1,054	0	1,282
Scientific, therapeutic and technical staff	**35**	35	0	21
Other	**0**	0	0	6
Total	**2,598**	**2,357**	**241**	**2,808**

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

6.3 Employee benefits

	2007/08 £000	2006/07 £000
Car lease and fuel	108	185

6.4 Management costs

	2007/08 £000	2006/07 £000
Management costs	23,852	N/A
Income	144,381	N/A
Management costs as a percentage of income	16.5%	N/A

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

6.5 Retirements due to ill-health

During 2007/08 there were 9 (2006/07, 11) early retirements from the NHS Trust on the grounds of ill-health. The estimated additional pension liabilities of these ill-health retirements will be £435,631 (£739,661). The cost of these ill-health retirements will be borne by the NHS Business Services Authority – Pensions Division.

7 Better Payment Practice Code

7.1 Better Payment Practice Code – measure of compliance

	2007/08 Number	2007/08 £000
Total Non-NHS trade invoices paid in the year	27,102	56,961
Total Non NHS trade invoices paid within target	22,512	51,066
Percentage of Non-NHS trade invoices paid within target	83%	90%
Total NHS trade invoices paid in the year	885	10,152
Total NHS trade invoices paid within target	671	9,539
Percentage of NHS trade invoices paid within target	76%	94%

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

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

	2007/08 £000	2006/07 £000
Amounts included within Interest Payable (Note 9) arising from claims made under this legislation	0	0
Compensation paid to cover debt recovery costs under this legislation	0	0

8 Profit/(Loss) on Disposal of Fixed Assets

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

	2007/08 £000	2006/07 £000
(Loss) on disposal of land and buildings	0	(3)
(Loss) on disposal of plant and equipment	0	(8)
(Loss) on disposal of fixtures and fittings	(3)	0
	(3)	(11)

9 Interest Receivable and Payable

9.1 Interest Receivable

As an NHS Trust NHS Direct has earned interest on surplus funds invested since 1 April 2007

	2007/08 £000	2006/07 £000
Interest receivable	2121	0

9.2 Interest Payable

	2007/08 £000	2006/07 £000
Interest payable	4	0

10 Fixed Assets

10.1 Intangible fixed assets

There were no intangible fixed assets at the balance sheet date, (31 March 2007–nil).

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

	Land	Non residential Buildings	Assets under construction and payments on account*	Plant and machinery	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000
Cost or valuation at 1 April 2007	1,057	9,034	462	402	6,107	1,034	18,096
Additions purchased	0	1,446	488	272	896*	108	3,210
Impairments	0	0	0	0	0	0	0
Reclassifications	0	85	(462)	0	377	0	0
Indexation	57	752	0	11	0	28	848
Disposals	0	(392)	0	(1)	(745)	(10)	(1,148)
Cost or Valuation at 31 March 2008	**1,114**	**10,925**	**488**	**684**	**6,635**	**1,160**	**21,006**
Depreciation at 1 April 2007	0	3,106	0	26	1,687	372	5,191
Charged during the year	0	562	0	101	1,205	130	1,998
Impairments	0	0	0	0	0	0	0
Reversal of Impairments	0	0	0	0	0	0	0
Reclassifications	0	0	0	0	0	0	0
Indexation	0	259	0	1	0	10	270
Disposals	0	(392)	0	(1)	(744)	(7)	(1,144)
Depreciation at 31 March 2008	**0**	**3,535**	**0**	**127**	**2,148**	**505**	**6,315**
Net book value – Total at 1 April 2007	**1,057**	**5,928**	**462**	**376**	**4,420**	**662**	**12,905**
– Total at 31 March 2008	1,114	7,390	488	557	4,487	655	14,691

* Included in the figure for IT additions is an amount of £775k. This represents VAT which was assumed to be recoverable at last year end, but for which recovery has subsequently been disallowed by HM Revenue and Customs.

The net book value of assets held under finance leases and hire purchase contracts at the balance sheet date are as follows:

31 March 2007	£0
31 March 2008	**£0**

The total amount of depreciation charged to the income and expenditure in respect of assets held under finance leases and hire purchase contracts:

31 March 2007	£0
31 March 2008	**£0**

10.3 Net book value of land and buildings

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

	31 March 2008 £000	31 March 2007 £000
Freehold	3,366	3,151
Long leasehold	4,009	2,748
Short leasehold	16	28
Long leasehold land	1,114	1,057
Total	8,505	6,984

11 Debtors

11.1 Amounts falling due within one year

	31 March 2008 £000	31 March 2007 £000
NHS debtors	1,055	1,993
Department of Health	1,892	3,848
Other prepayments and accrued income	5,990	6,552
Recoverable VAT	1,699	1,555
Other debtors	965	656
Total	11,601	14,604

11.2 Amounts falling due after more than one year

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

12 Creditors

Creditors at the balance sheet date are made up of:

12.1 Amounts falling due within one year

	31 March 2008 £000	31 March 2007 £000
NHS Creditors	1,272	1,846
NHS Capital Creditors	0	129
Tax	958	1,069
Social Security	817	881
Other Creditors	814	1,179
Accruals	6,619	10,650
Deferred Income	1,166	585
	11,646	16,339

12.2 Amounts falling due after more than one year:

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

13 Provisions for liabilities and charges

	Pensions relating to former staff £000	Other £000	Total £000
At 1 April 2007	301	3,369	**3,670**
Arising during the year	141	3,086	**3,227**
Utilised during the year	(18)	(1,629)	**(1,647)**
Reversed unused	0	(1,596)	**(1,596)**
Unwinding of discount	0	0	**0**
At 31 March 2008	**424**	**3,230**	**3,654**
Expected timing of cashflows:			
Within one year	16	1,016	**1,032**
Between one and five years	60	536	**596**
After five years	348	1,678	**2,026**

Other provisions include £74,395 (31 March 2007 £58,222) to cover LTPS claims outstanding at the year end and £223,391 (31 March 2007 £648,189) in respect of Employment Tribunal Claims, and £971k (31 March 2007 £0) in respect of a possible amount of VAT repayable.

Also included in Other Provisions is an amount of £1,935,000 provided in respect of an onerous lease at the Trust's former site in Cambridge.

£419,067 is included in the provisions of the NHS Litigation Authority at 31 March 2008 in respect of clinical negligence liabilities of the NHS Trust (31 March 2007 £122,964).

14 Movements on Reserves

Movements on reserves in the year comprised the following:

	Capital Reserve £000	Revaluation Reserve £000	Income and Expenditure Reserve £000	Total £000
At 1 April 2007	13,613	0	9,998	**23,611**
Transferred to Public Dividend Capital	(13,613)	0	(9,998)	**(23,611)**
At 1 April 2007 as restated	0	0	0	**0**
Transfer from the income and expenditure account	0	0	5,062	**5,062**
Surplus/(deficit) on other revaluations/indexation of fixed/current assets	0	578	0	**578**
At 31 March 2008	**0**	**578**	**5,062**	**5,640**

15 Note to the Cash flow Statement

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

	2007/08 £000	2006/07 £000
Total operating surplus	3,116	2,340
Depreciation and amortisation charge	1,998	1,587
Fixed asset impairments and reversals	0	0
Capital charges interest	0	103
Transfer from the capital reserve	0	(1,598)
(Increase)/decrease in debtors	3,162	(6,369)
Increase/(decrease) in creditors	(4,564)	2,220
Increase/(decrease) in provisions	(790)	(8,585)
Net cash inflow from operating activities	**2,922**	(10,302)

16 Capital Commitments

There were no commitments under capital expenditure contracts at 31 March 2008 (31 March 2007 £417,700).

There was no capital expenditure approved but not contracted at the balance sheet date (31 March 2007 £0).

17 Post Balance Sheet Events

The financial statements on pages 72 to 91 were authorised for issue on 11 July 2008 by the Chief Executive and Accounting Officer.

18 Contingencies

	2007/08 £000	2006/07 £000
Contingent Liabilities	26	28

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

19 Movements in Public Dividend Capital

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

20 Financial Performance Targets

20.1 Capital Cost Absorption Rate.

The Trust is required to absorb the cost of capital at a rate of **3.5%** of average relevant net assets. The rate is calculated as the percentage that dividends paid on Public Dividend Capital, totalling **£168,000**, bears to the average relevant net assets of **£9,245,500**, that is **1.8%**.

The variance from 3.5% arises because the capital charge forecast used to determine the dividend assumed lower net relevant assets of £4,807,000. Factors in the higher net relevant assets now reported are the higher than budgeted surplus and that the forecast assumed that loans of £4 million would be required under the revised NHS Trust capital regime to fund capital expenditure. These were not required owing to the Trust's healthy cash position throughout 2007/08.

20.2 External financing

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

	2007/08 £000
External financing limit	902
External financing requirement	(2,148)
Undershoot	3,050

20.3 Capital Resource Limit

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

	2007/08 £000
Gross capital expenditure	3,210
Less: book value of assets disposed of	(4)
Charge against the capital resource limit	3,206
Capital resource limit	9,102
Underspend against the capital resource limit	5,896

21 Related Party Transactions

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

During the year none of the Board Members or members of the key management staff or parties related to them has undertaken any material transactions with the Trust.

The Department of Health is regarded as a related party. During the year the Trust has had a significant number of material transactions with the Department, and with other entities for which the Department is regarded as the parent Department. The Trust had material transactions with the following organisations exceeding £250,000 in value:

	£'000s
Income in Nature	
East of England Strategic Health Authority	132,067
Department of Health	1,892
Kirklees PCT	527
East Lancashire PCT	481
Ealing PCT	479
Stockport PCT	363
Hounslow PCT	335
Hillingdon PCT	332
Bury PCT	321
Harrow PCT	302
Blackburn with Darwen PCT	298
South East Essex PCT	285
Heart of Birmingham Teaching PCT	278
Calderdale PCT	268
Expenditure in Nature	
Yorkshire Ambulance Service NHS Trust	606
University Hospitals of Leicester NHS Trust	535
West Midlands Ambulance Service NHS Trust	410
Nottinghamshire Healthcare NHS Trust	278

22 Financial Instruments

FRS 13, Derivatives and Other Financial Instruments, requires disclosure of the role that financial instruments have had during the period in creating or changing the risks an entity faces in undertaking its activities. Because of the way NHS Trusts 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 the listed companies to which FRS 13 mainly applies. The Trust has limited powers to borrow or invest surplus funds and financial assets and liabilities are generated by day-to-day operational activities.

Liquidity Risk

The Trust's income is set each year by the Department of Health in relation to an agreed business plan. The Trust finances its capital expenditure from its own internal resources, which can be supplemented by loans from the Department. The Trust is therefore not exposed to significant liquidity risks.

Interest-rate Risk

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

Foreign Currency Risk

The Trust has no foreign income or expenditure.

Fair Values

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

23 Intra-Government and Other Balances

	Debtors: amounts falling due within one year	Debtors: amounts falling due after more than one year	Creditors: amounts falling due within one year	Creditors: amounts falling due after more than one year
	£000	£000	£000	£000
Balances with other Central Government Bodies	2,930	0	1,775	0
Balances with Local Authorities	120	0	97	0
Balances with NHS Trusts and Foundation Trusts	1,128	0	2,416	0
Balances with Public Corporations and Trading Funds	591	0	1,072	0
Balances with bodies external to government	6,832	0	6,286	0
At 31 March 2008	**11,601**	**0**	**11,646**	**0**
Balances with other Central Government Bodies	7,392	0	3,250	0
Balances with Local Authorities	8	0	60	0
Balances with NHS Trusts and Foundation Trusts	1,489	0	2,762	0
Balances with Public Corporations and Trading Funds	0	0	0	0
Balances with bodies external to government	5,715	0	10,267	0
At 31 March 2007	14,604	0	16,339	0

24 Losses and Special Payments

There were 29 cases of Losses and Special payments (2006/07: 8 cases) totalling £347,914 (2006/07: £22,665) paid during 2007/08.

Of the above payments, 16 cases totalling £315,971 had been provided for in the 2006/07 accounts. On an accruals basis the charge to Income and Expenditure Account in 2007/08 is £64,087.

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Appendix A
Definitions of our Key Performance Indicators

Appendix A
Definitions of our Key Performance Indicators

	% calls answered in 60 seconds	% calls abandoned after 30 seconds	% less urgent calls commencing clinical assessment in 60 minutes	% non-urgent (P2) calls commencing clinical assessment in 60 minutes
Definition and calculation method	The percentage of calls answered within 60 seconds following the end of any message played and calculated using: (Number of calls answered within 60 seconds following any message played) ÷ (Total number of calls answered)	The percentage of calls abandoned after 30 seconds following any message played and calculated using: (Number of calls abandoned 30 seconds after any message) ÷ (Number of calls abandoned 30 seconds after any message) + (Number of calls answered)	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 & D1]) started within 20 minutes) ÷ (Number of urgent clinical calls [P0, P1 & D1])	The percentage of less urgent calls (i.e. those with clinical priority P2) requiring clinical assessment, where triage is started by a clinician within 60 minutes and calculated using: (Number of non-urgent clinical calls [P2] started within 60 minutes) ÷ (Number of non-urgent clinical calls [P2])

% Non-urgent calls commencing Clinical Assessment in 240 minutes	% Completed within NHS Direct	% of Emergency & Urgent referrals	Number of complaints per 10 thousand calls	% Incident for National Review leading to harm	0845 46 47 Answered Calls per annum
The percentage of non-urgent calls (i.e. those with clinical priorities P2, P3, D2 and D3) requiring clinical assessment, where triage is started by a clinician in 240 minutes. Calculated using: (Number of non-urgent clinical calls [P2, P3, D2 & D3] started within 240 minutes) ÷ (Number of non-urgent clinical calls [P2, P3, D2 & D3])	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: (Self-care + Pharmacy + PCS Routine + Health Information) ÷ (Symptomatic Calls + Health Information Calls) Symptomatic calls are calls of a symptomatic nature where a clinical outcome has been advised	The percentage of emergency and urgent referrals for GP OOH and 0845 calls only. Calculated using: (Number of calls referred to 999, A&E or PCS Urgent) ÷ Symptomatic calls	The measure is for formal complaints that are defined as a complaint requiring a written response. The measure is expressed per ten thousand calls. (The number of reported complaints) ÷ (The number of calls answered) ÷ 10,000	The proportion of all reported Incidents for National Review (IFNR) through NHS Direct core or enhanced telephone services including online and DiTV (excluding TAL) where an NHS Direct failing had the potential to have led or contributed, or did lead or contribute, to serious harm or death, or serious loss or damage, to patients or staff, contractors or visitors. Number of Incident for National Review reported year to date that lead to harm ÷ The number of Incident for National Review reported year to date	The number of calls ringing 0845 46 47 that are answered by a person.

Appendix A

Definitions of our Key Performance Indicators continued…

	% Calls answered within 60 seconds	% Abandonment Rate	% Urgent calls commencing Clinical Assessment in 20 minutes	% Non-urgent (P2) calls commencing Clinical Assessment in 60 minutes
Target	greater or equal to 95%	less than or equal to 5%	greater than or equal to 95%	greater than or equal to 95%
Purpose	To confirm that patients are able to access our service within a timely manner. In line with Department of Health (DoH) Out of Hours (OOH) provider quality standards, benefit of the measure is to understand the service provided to patients/callers. Cross referenced to DoH Standards for Better Health: Domain – Accessible and Responsive Care C18 and C19	To identify proportion of callers/patients who are unable to access our service within a timely manner. In line with DoH OOH provider quality standards benefit of measure is to understand demand for the service. Cross referenced to DOH Standards for Better Health: Domains – Accessible and responsive Care C18 and C19 and Public Health C24.	Identifies speed of response to clinically urgent calls. Benefit associated with clinical safety/ quality and patient access in line with DoH OOH provider quality standards. Cross referenced to DoH Standards for Better Health: Domain – Accessible and responsive Care C18 and C19.	Identifies speed of response to clinically less urgent calls. Benefit associated with clinical safety/ quality and patient access. In line with DoH OOH provider quality standards. Cross referenced to DoH Standards for Better Health: Domain – Accessible and Responsive Care C18 and C19.
Data Source	Telephony system (BT Symposium)	Telephony system (BT Symposium)	CAS (Clinical Assessment System)	CAS (Clinical Assessment System)
Future Targets	NA	NA	NA	NA

	% Non-urgent calls commencing Clinical Assessment in 240 minutes	% Completed within NHS Direct	% of Emergency & Urgent referrals	Number of complaints per 10 thousand calls	% Incident for National Review leading to harm	0845 46 47 Answered Calls per annum
	greater than or equal to 95%	greater than or equal to 50%	less than or equal to 25%	less than or equal to 1	less than or equal to 10% per annum	greater than or equal to 5 million for the year
	Identifies speed of response to clinically non-urgent calls. Benefit associated with clinical safety/ quality and patient access. In line with DoH OOH provider quality standards. Historically all non-urgent calls had the same target, with no distinction on priority, which is reflected in the inclusion of P2 calls in this measure and also the non-urgent P2 in 60 measure. Cross referenced to DoH Standards for Better Health: Domain – Accessible and responsive Care C18 and C19.	Identifies the proportion of calls completed within NHS Direct i.e. those that do not require referral to any other NHS healthcare provider. This provides a proxy indicator for the impact of NHS Direct on the wider health economy. Cross referenced to DOH Standards for Better Health: Domains – Public Health C22, C23, and C24 and Accessible and responsive Care C18.	Proxy measure for the impact of NHS Direct dispositions on health economy stakeholders. Cross referenced to DOH Standards for Better Health: Domains – Public Health C22 and C24 and Accessible and Responsive Care D11	To monitor complaints and respond to them in line with the NHS Complaints Regulations 2004 and to learn from these complaints where appropriate. Cross referenced to DoH Standards for Better Health: Domains– Safety C1 and D1, Patient Focus C14 and D8 and Accessible and Responsive Care C17	A Incident for National Review is: "any occurrence, or "near miss", that led to or could have led to unintended or unexpected serious harm or death, or serious loss or damage to patients; or staff, contractors and visitors (whilst on NHS Direct premises); or the organisation (particularly where this would be expected to attract adverse legal or media attention)." It is a requirement in the NHS that these incidents are reported and acted on. Learning from adverse incidents is also an important part of a learning culture Cross referenced to DoH Standards for Better Health: Domains – Safety C1 and D2 and Accessible and Responsive Care C17	Indicator of the usage of the 0845 46 47 service, linking to patient access and growth of the service. Cross referenced to DoH Standards for Better Health: Domains – Public Health C22 and C24 and Accessible and Responsive Care C18 and C19
	CAS (Clinical Assessment System)	CAS (Clinical Assessment System)	CAS (Clinical Assessment System)	National Risk Database (DATIX)	National Risk Database (DATIX)	CAS (Clinical Assessment System)
	From April 2008 this measure will use a reduced time period of 120 minutes rather than 240 minutes to improve the clinical safety and service to patients.	NA	NA	NA	This was a new measure introduced April 2007 to replace number of Serious Adverse Incidents per ten thousand calls.	NA

Appendix A

Definitions of our Key Performance Indicators continued…

	% Calls answered within 60 seconds	% Abandonment Rate	% Urgent calls commencing Clinical Assessment in 20 minutes	% Non-urgent (P2) calls commencing Clinical Assessment in 60 minutes
Last Years' Benchmark	60% March 2007	11% March 2007.	96% March 2007.	84% March 2007

% Non-urgent calls commencing Clinical Assessment in 240 minutes	% Completed within NHS Direct*	% of Emergency & Urgent referrals	Number of complaints per 10 thousand calls	% Incident for National Review leading to harm	0845 46 47 Answered Calls per annum
97% March 2007.	Not Available. New calculation introduced from May 2007	32% March 2007	2.3 March 2007	NA	4.9 million calls answered in 2007/2008

*Calculation of this measure changed in May 2007 to bring the definition and measurement into line with other telephony providers, and more accurately reflect actual advice given. Calls completed with Self-care advice, but with a 'worsening' instruction to contact their PCS if the condition changes, were previously calculated as a PCS referral, out of line with other providers. This has now been amended in this calculation. The Clinical Governance Team conducted a review of final clinical dispositions to underpin this work. A new target is proposed for March 2009 of greater than or equal to 60%.

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