NHS Direct National Health Service Trust
Annual Report & Accounts 2012/13

NHS Direct National Health Service Trust Annual Report & Accounts 2012/13

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Chair's statement

2012/13 was a major year of transition for the Trust and the entire NHS. The introduction of NHS 111 (111) is the biggest change to the urgent care system in many years and has happened in parallel with the abolition of Strategic Health Authorities and Primary Care Trusts, and the introduction of Clinical Commissioning Groups.

NHS 111, designed to provide one-stop signposting to face-to-face care, is very different from the Trust's national multichannel health assessment, advice and information service. NHS 111 is centrally defined but locally commissioned; procured on a competitive basis; telephone only; and relies on a different set of clinical content which is newly applied to urgent care.

The Trust faced a number of challenges in 2012/13:

- To provide a range of telephone, internet and mobile-based information, advice and guidance services for patients
- To prepare for the closure of the Trust's main service – the 0845 4647 service for which the Trust is known
- To prepare for the introduction of the new NHS 111 service

These activities are described in more detail in the body of this annual report.

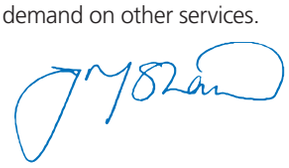
Such a significant series of changes were never going to be painless. The 0845 4647 service is expected to close in 2013 with a mix of emotions. We will be saying farewell to many colleagues who helped shape the service. We remain committed to continuing to provide a safe and excellent experience down to the last call. During the year the Trust worked to minimise 0845 decommissioning costs at every stage. This included active efforts to apply Cabinet Office Guidelines to reduce the number of frontline staff made redundant as a result of the transition to NHS 111. Due to difficulties enforcing the guidelines, only 12% of the Trust's frontline workforce transferred to other providers.

Remote and health self-care supported by clinical expertise is an increasingly important contributor to maintaining cost-effective heath services and meeting the changing needs of patients and the public. Instant mobile access to the internet/telephone services mean it is important that a reliable, trusted service is available. People increasingly want and need reliable health care advice where, when and how they want. The Trust continues to meet those needs whilst decommissioning 0845 4647. Delivering web and mobile app based services 24/7 allows us to contribute to fulfilling that demand, taking pressure off the rest of the NHS.

Our services remain popular with patients - we have exceeded our own challenging targets with over 5 million uses of the web and app, on top of 4 million calls to the 0845 service. We encourage feedback from patients, carers and health professionals. Users remain positive about our services. Surveys during the year showed a 92% satisfaction rate. We also achieved a drawing mark-up "net promoter" score of 78% amongst respondents saying that they would recomend the service to family and friends. We continue to receive 13 compliments per 100,000 calls, compared to fewer than 3 complaints. Every complaint is thoroughly investigated, with 96% resolved first time with the complainant. Most importantly, through robust systems of clinical governance and continued focus by the Board on quality issues, we remain committed to identifying problems quickly, tackling the root causes and improving the way we work to prevent them recurring.

Multichannel care will be an important part of the NHS of the future. Health and care services delivered by phone and web are safe, convenient and good value. Every 1% reduction in face-to-face care saves up to £200 million and the ability to provide affordable self-care advice over the phone or web can support this reduction safely and effectively. Research conducted on behalf of the Department of Health suggests that telehealth could save 20% of emergency admissions and 15% of visits to A&E.

The value of multichannel services has been recognised by NHS England, which has commissioned the Trust to deliver health information, dental assessment and online services with supporting nurse assessment. These services complement the telephone-only NHS 111 service. Multichannel services are a powerful tool against inequality by improving access for some disadvantaged populations. They also help to safeguard resources for more intensive support for those who need it most by encouraging people to self-care safely and confidently without using face-to-face resources. It is important that these services form part of any wider review of the NHS 111, as they play a key role in supporting the service and reducing the demand on other services.



Joanne Shaw
Chair, NHS Direct National Health Service Trust

Nick Chapman
Chief Executive's statement

2012/13 was a year of very significant change for the Trust, which faced the challenge of continuing to provide a range of services to patients, whilst simultaneously preparing for the closure of the Trust's main service – the 0845 4647 telephone advice and guidance service – and preparing for the new NHS 111 service.

In the light of the very significant challenges that the Trust faced, the Board took the step of revising the Trust's governance structure to ensure that the Trust's management was focused on tackling the simultaneous and potentially conflicting tasks that it faced. These governance changes are set out in the annual governance statement that can be found in the body of this annual report.

This statement highlights the main features of how the Trust tackled these challenges, with more detailed information set out in the main body of the report.

Providing a range of telephone, internet and mobile-based information, advice and guidance services for patients.

2012/13 was the last full year of the 0845 service prior to its replacement by the locally-commissioned NHS 111 service, planned by the Department of Health to take place at the end of March 2013. The Trust was committed to maintaining a very high standard of patient care in this last year of the service, whist also managing preparation for NHS 111, the close-down of the 0845 service and the great uncertainty which faced all staff and the organisation as a whole.

The national 0845 service maintained good access for patients, with 92.5% of calls answered in 60 seconds, and 96% of assessments for high priority patients commencing within 20 minutes. Quality indicators – patient satisfaction, complaints and incidents, and the quality of calls (based on expert call reviews) – were all good through the year. The service supported patients to care for themselves and make appropriate use of face-to-face NHS services, with 47% of patients not requiring onward referral to another NHS provider. The service handled 3.98m calls.

The Trust also provided other services to a significant number of patients:

- 12m website visits and 5m completed uses of the Trust's Health and Symptom checkers
- 3.1m calls to the NHS Appointments line for Choose and Book
- 547,000 calls to the NHS 111 pilot services run by the Trust

Preparing for the closure of the Trust's 0845 4647 Service

During 2012-13, the 0845 service accounted for the bulk of the Trust's activities and staff. During this financial year it was commissioned on behalf of the Department of Health and the NHS by the East of England SHA (EoE), itself due to be abolished at the end of 2012/13. The planning for the closure of the service was undertaken jointly between the Trust, Department of Health and EoE. This was inherently difficult and risky as it involved continuing to provide a high quality front line service for patients, whilst preparing for a change which would place at risk of redundancy substantial numbers of the Trust's staff. In preparation for these changes, the Trust agreed 5 high level principles with Department of Health and EoE:

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

The potential one-off cost of decommissioning the 0845 service was agreed with Department of Health in 2011/12 to be £144m, with the potential for over 2,500 staff redundancies and the closure of the Trust's 31 call centres spread throughout every part of England. The Trust focused on reducing the impact of the closure by being in a position to offer on-going employment and the retention of call centre sites, seeking continuing contracts for other services (such as the Trust's digital, 'click for nurse assessment', health information and dental assessment services), working with other providers of the 111 service to transfer front line staff in areas where the Trust was unsuccessful in 111 competitions, and in minimising decommissioning costs through the employment of temporary, agency and in-sourced staff rather than substantive staff.

The Trust reduced the financial and human impact of the closure of the 0845 service with costs in 2012/13 contained to £69.2m, placing 994 staff into the future Trust services, transferring 248 staff to other organisations. Following a three month consultation, 617 staff were made redundant as there were no suitable alternative employment options available for them. A further 693 staff were made redundant as they transferred to the Trust from other organisations under TUPE provisions.

The Trust focused on supporting staff through the process of change and preparing everyone as much as possible for their future, working on 111, in other services, redundancy or retirement. The 'Your Future' programme supported staff facing redundancy with practical assistance. This included, in planning and preparing staff to re-enter the job market, personal and career planning, considering self-employment, acquiring or brushing up on skills for face-to-face nursing roles. The scale of change that the Trust and its staff faced was unprecedented in recent decades for a front line NHS organisation.

Preparing for the introduction of the new NHS 111 service

The Trust participated in the Department of Health-led preparations for the new NHS 111 service. At the Department of Health's request it provided 111 pilot services in Luton, the East Midlands, and the North West. The cost and staffing structure of these pilots was based on a marginal cost of £13 per call – to cover front line staff salaries and other direct costs. The pilots were evaluated independently by the Department of Health, who appointed the University of Sheffield to undertake this work. This evaluation proved inconclusive and publication was delayed until after the majority of 111 procurements were concluded.

The new NHS 111 service was nationally specified but locally procured. The majority of local procurements were based on a maximum cost for the service that commissioners were willing to pay. The first NHS 111 service procurement was for the North East of England, and commissioners set the maximum cost of the service at £7.80 per call. This was extremely challenging for the Trust as it was far below the cost of the pilot 111 services that the Trust had experience of, and was substantially below the level of cost that the Trust had modelled as its future 111 service proposals. In the North East, the Trust submitted a non-compliant bid at a cost that exceeded the commissioner's specified maximum. The Trust's bid was declared non-compliant and the contract was awarded to another organisation. The substantial majority of other 111 procurements that followed the North East were conducted on the same terms, with maximum costs in the range £7 to £9 per call.

The Board decided in early 2012, to compete in the 111 market, based on re-modelled future costs informed by internal experimental 111 call handling pilots, and on remodelled low cost overhead and infrastructure costs. On the basis of this work, the Board came to the view that the Trust could bid on the basis of costs of £7 to £8, and the Trust proceeded with bids accordingly. The Trust was successful in being awarded eleven 111 contracts, covering 34% of England's population.

It is now clear that the Trust is not able to to provide the 111 service within this lower cost range, and that the 111 contracts that the Trust has entered into are financially unsustainable.

The Launch of 111 Services

During December (2012), January and February (2013) the Trust successfully launched the 111 services for Sutton and Merton, Somerset, Buckinghamshire, East London and City and South East London.

As the services for the West Midlands and the three areas in the North West went live on 21 March it became apparent that the capacity of the Trust's call centres was insufficient to handle the volume of calls by a significant margin.

The most significant issue was that calls took more than twice as long as expected. As a result the Trust's 111 services did not have sufficient front line capacity to handle all of the calls that it received, and calls had to be diverted back to GP out-of-hours organisations and to the 0845 service. In addition to call lengths, the other issues for the Trust at launch were the restrictions on capacity due to the ring-fencing of staff, the higher than expected referral of calls through to nurses, and the unavailability of staff not yet fully 'preceptored' and able to take live calls.

Patient safety remained paramount throughout this immediate period after launch, and decisive action was taken with local commissioners, and other NHS providers to overcome these problems and to provide a stable and satisfactory service.

The Trust's Board reviewed the safety of its NHS 111 services at its public meeting in April 2013. The conclusion reached at that stage was that whilst there had been a number of incidents there was no evidence that the calls handled by the Trust had directly led to patient harm nor that there was a higher incidence of adverse events than in the Trust's other services.

The Board of the Trust, NHS England and the NHS Trust Development Authority jointly commissioned an independent review of the root causes of the service failures at the Trust when it launched its NHS 111 services. At the time of writing, the actions arising from this independent report are being considered by the Chair of the Trust, NHS England and the NHS Trust Development Authority.

Also, the Trust is in discussion with local commissioners, NHS England and the NHS Trust Development Authority on continuing to provide safe and stable service for 2013/14 whilst a national review of the NHS 111 programme is undertaken, and revised arrangements for the provision of the Trust's 111 services are put in place.

Future Services

Whilst the future of the Trust's role in providing NHS 111 services is uncertain, the Trust has secured contracts to deliver a number of important new and retained services, including a digital health and advice service, incorporating the web and mobile based 'Health and Symptom Checkers' and associated service to enable patients using the checkers to 'click to speak to' a nurse or other advisors.

Personal message to staff

2012/13, and the first few weeks of 2013/14 have been a period of immense challenge and uncertainty for staff across the organisation. I would like to record this tribute to the resolve and determination of staff at every level, who maintained their focus on continuing to provide services to patients despite huge personal uncertainty. I would also like to express my gratitude to the families of members of staff who have supported them so well throughout this difficult period.

Nick Chapman
Chief Executive, NHS Direct National Health Service Trust
20 June 2013

Management commentary

Overview

The NHS Direct National Health Service Trust ("the Trust") provides remotely-delivered clinical care and services across a number of channels using its network of call centres and home workers. We work in partnership with commissioners to provide a key element of the urgent care pathway, helping patients achieve the best health outcomes through the services we deliver.

Our services

0845 4647

In line with the 2012/13 NHS Operating Framework, the national 0845 4647 telephone service is in the process of being decommissioned and replaced by the locally-commissioned NHS 111 service. However, the 0845 4647 service continues to operate in some areas of England as a contingency measure until NHS 111 services go live.

NHS 111

NHS 111 aims to make it easier for people to access healthcare services when they need medical help fast, but it's not a life-threatening situation. In future if people need to contact the NHS for urgent care there will only be three numbers: 999 for life-threatening emergencies, their GP practice, and 111.

NHS 111 provides a clinical assessment at the first point of contact without the need to call patients back. It directs people to the right NHS service, without the need for them to be re-triaged, transfers clinical assessment data to other providers and books appointments for patients where appropriate. NHS 111 works alongside the 999 emergency service to despatch an ambulance without delay and without the patient needing to repeat any information.

During the first half of 2012/13, the Trust bid for contracts to deliver the new NHS 111 service and successfully secured 11 contracts covering just over one third of England's population, in:

- Buckinghamshire
- Cornwall & Isles of Scilly
- East London and the City
- North Essex
- North West – Cumbria and Lancashire
- North West – Greater Manchester
- North West – Merseyside and Cheshire
- Somerset
- South East London
- Sutton & Merton
- West Midlands

In the second half of the year, we focused on the mobilisation of these new NHS 111 services, the first of which went live in Sutton and Merton in December 2012. By the end of 2012/13, Buckinghamshire, East London and the City, the North West, Somerset, South East London and West Midlands had also gone live.

In addition, the Trust has been commissioned to deliver the following national services to complement NHS 111:

- A digital health and advice service, including our web and mobile based 'Health and Symptom Checkers' which include the ability for patients to speak to an advisor. These services are accessed through NHS Choices (commissioned until March 2015).
- A complex health and medicines information service (commissioned until March 2014).
- A dental nurse assessment service (commissioned until March 2014).
- A national customer service telephone line to capture and publish patients' feedback and reviews of their experiences of using NHS services, and to direct customer service enquiries on behalf of patients and members of the public.

Long-term conditions

The Trust delivers services for telehealth and telecoaching where these are locally funded. We aim to offer cost-effective support for the Government to deliver their '3 million lives' campaign for patients with long-term conditions over the next five years.

Patient choice

We deliver The Appointments Line service for patients wishing to book their first hospital or clinical appointment through the NHS Choose and Book system. We will continue to deliver the service until the contract ends in November 2013.

National resilience

The Trust manages the National Pandemic Flu Service (NPFS) in dormancy, to ensure it can be quickly and effectively activated if required. This contract is due to end in April 2014.

Our network of contact centres

As part of the transition to delivering NHS 111 contracts and decommissioning the 0845 4647 service, a review of the Trust's estate portfolio has been undertaken. The strategic decision has been taken that, going forward, sites will work primarily on either NHS 111 or the portfolio of other services.

In the short term sites may be delivering a blend of services as the Trust continues to deliver the 0845 contingency. Delivering NHS 111 for approximately 34% of the country rather than the 0845 4647 service for the whole country means we will require fewer sites.

Six sites were decommissioned in preparation for this:

- Blackburn
- Chelmsford
- Derby
- Ferndown
- Ipswich
- Norwich

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

The external environment

2012/13 saw significant restructuring of the NHS as the Health and Social Care Act 2012 proposals were implemented. From 1 April 2013:

- NHS England (previously the NHS Commissioning Board) was formally established as an independent body, at arm's length to the Government and took up its full statutory duties and responsibilities.
- Public Health England was established as a new executive agency of the Department of Health.
- A total of 211 clinical commissioning groups became responsible for £65 billion of the £95 billion NHS commissioning budget.
- Health and wellbeing boards started being set up, where key leaders from the health and care system and Local Authorities collaborate to understand their community's needs, agree priorities and encourage commissioners to work in a more joined up way. This will help them develop solutions and offer services that can contribute to greater integration of care.

The revised regulatory regime for competition and procurement means commissioners are expected to look at a wider range of providers, balanced by the need to consider the interests of patients and the integration of services.

Our new commissioners are facing a number of pressing challenges:

- Cost pressures on the NHS are projected to grow at around 4% a year up to 2021/22. These arise from growing demand for healthcare to meet the needs of a population which is ageing, growing in size and experiencing more chronic disease.
- After decades of major funding increases, the NHS budget will increase by only 1.3% in real terms between 2010 and 2015. The NHS will need sustained and unprecedented increases in productivity to meet rising demand. There will be a premium on delivering services that manage demand more effectively, particularly by reducing avoidable demand on expensive face-to-face services and equipping more people to manage their own health and care needs.
- There is a renewed emphasis on the centrality of the patient. The NHS Mandate emphasises the importance of the patient experience and sets a priority to make rapid progress in measuring and understanding how people really feel about the care they receive; and taking action to address poor performance.
- Patients' expectations are growing in our increasingly 24 hour online world. People are using a wider range of accessible technology in their everyday lives and expect to do so for their health and care. Almost two thirds of the UK population search for health information online and almost half of those people are looking to self-diagnose.
- Health inequality is still a major issue. Multichannel services are a powerful tool against inequality by improving access for some disadvantaged populations and by safeguarding resources to deliver more intensive support for those who need it.

These challenges are leading commissioners to consider new and innovative ways to respond to patients' needs while delivering the care they require. There is a greater awareness of, and openness to, new channels such as online and the phone to complement face-to-face services. Department of Health research has suggested that using telehealth could result in a 20% reduction in emergency admissions, a 15% reduction in A&E visits and a 45% reduction in mortality. The NHS integrated customer platform, providing a single portal to the NHS core national data, is being launched to give patients control and choice and to take every opportunity to collect feedback.

Our vision and objectives

The Trust's business plan for 2011/12 to 2015/16, forecast a change in its operating environment driven by two major new policies: the introduction of a new NHS and wider care structure, including a focus on local, clinically-led competitive commissioning; and the introduction of NHS 111 alongside the decommissioning of the 0845 4647 service. The Trust set out its strategy to become a major provider of NHS 111 and to develop and deliver other services, while continuing to provide 0845 4647 safely and effectively.

The focus of the Trust over the past two years has been preparing for this new environment and securing its future. However, the landscape for the Trust has been fundamentally altered by the issues encountered in providing the new 111 services. At the time of writing the Trust is re-planning its 2013/14 goals and objectives. The Trust plans to publish in July a revised business plan, incorporating a revised service delivery plan for its NHS 111 and other services, a quality and safety plan, and a revised financial plan. The Trust has already notified the NHS Trust Development Authority that it is facing a substantial deficit in 2013/14. It will work with the Authority to manage this deficit in a way consistent with continuing to provide safe and stable services for patients throughout the year.

Our performance

The Board reviews performance on a regular monthly cycle, using a Board Scorecard which covers all significant aspects of the Trust's performance, including patient experience, quality and safety, access, productivity, volumes, outcomes, staff and finance (see Appendix B for detailed definitions of our key performance indicators).

Volumes and outcomes

The Trust's range of web and mobile health and symptom checkers continue to prove extremely popular in 2012/13, with over 5 million recorded uses, exceeding the target of 3.9 million. The number of patients using the 0845 4647 telephone service was slightly lower than expected at just under 4 million calls. We also answered 547,000 calls to the NHS 111 pilots we were leading on during 2012/13 and 3.1 million calls to The Appointments Line.

46.9% of calls to the 0845 4647 service were completed without the need for onward referral to other health services, exceeding our target of ≥43%. However, 34.7% of calls to the service required onward referral to urgent or emergency care. In the NHS 111 pilots, 24.5% of calls didn't require any onward referral, but 38.6% did need to be referred to urgent or emergency care.

Quality and productivity

In 2012/13, overall patient satisfaction and the quality and safety of our services remained strong. We exceeded all our performance targets in these areas.

Initial access to the 0845 4647 service and NHS 111 pilots – measured by the speed calls are answered and by abandonment rates – was also above target. We also exceeded our target for the speed at which urgent 0845 4647 calls were clinically assessed. However, we did not reach our targets for the time taken to clinically assess less urgent and non-urgent 0845 4647 calls. Similarly, in the NHS 111 pilots, the percentage of calls warm transferred to a clinical advisor was slightly below the ≥95% target set.

Staff

In 2012/13, reducing sickness absence remained a priority for the Trust. The Department of Health calendar year figure shows that overall sickness fell for the fourth year in a row from 14.6 days/WTE to 14.1 days. However, the targets set by the Board to reduce overall sickness to 13 days/WTE, and to reduce the number of staff on long-term sick leave were not achieved. Reducing sickness absence remains a priority for 2013/14.

On average, staffing levels for health advisors and nurse advisors was slightly below target during the year. This was due to the significant organisational changes taken place, including some staff transferring to other NHS 111 providers and new staff joining the Trust under TUPE-like arrangements

Finance

In 2012/13 the Trust faced a number of challenges as reported in the Chief Executive's statement to this report. The key impact of these challenges on the accounts for 2012/13 is the inclusion of decommissioning costs associated with the closure of the Trust's 0845 46 47 service.

The Trust has worked closely with the Department of Health and commissioners during 2012/13 to ensure that decommissioning costs have been minimised. This has been achieved through the transfer of staff to other 111 providers and the retention of staff by the Trust to run 111 and other services. Decommissioning costs of up to £79m have been agreed with the Department of Health and these costs will be funded in full by the Department through an increase in Public Dividend Capital during 2013/14 as the costs materialise. £69m of these decommissioning costs have been included in the accounts for 2012/13 with the remainder being included as a contingent liability.

The accounts also reflect an operating surplus of £378k which includes income from activities of £139m with associated operating expenses of £138m. Staffing costs were £92m or 67% of operating costs.

Cash and bank balances remained strong at £22m at the year end.

We invested £3.7m in capital assets including ICT, telephony infrastructure, premises , equipment and facilities improvements that have benefitted staff and patients.

Looking forward to 2013/14 the Trust has set a challenging financial plan to cover the costs of staff leaving the organisation or transitioning into new roles during the first quarter and costs required to meet the contracted 111 and other services for the year. Experience of the first month of running 111 services shows that the Trust will not be able to deliver the full contracted 111 volumes within this budget. During 2013/14 the Trust will be working closely with NHS England, local commissioners and the Trust Development Authority to agree how any deficit will be managed whilst continuing to provide safe and stable services. A note on this has also been included as a contingent liability.

Sustainability report

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

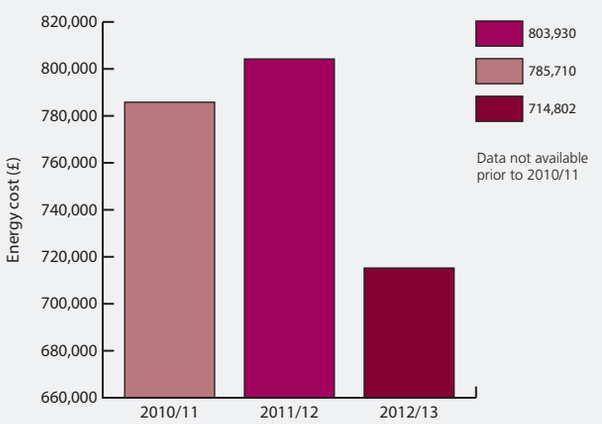
Our organisation has an up to date Sustainable Development Management Plan, although there are areas of work that require further attention.

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

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

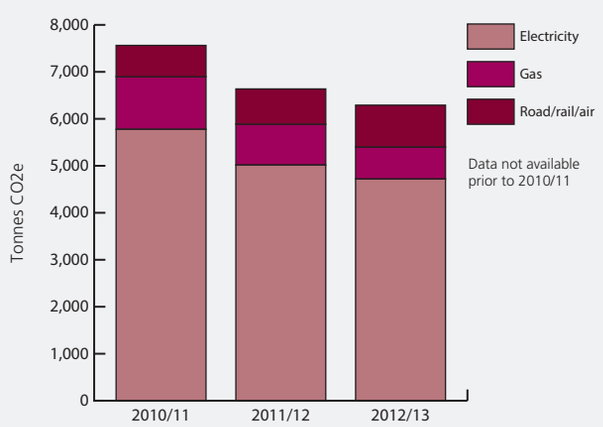
We continue to develop our capture of non-financial data, and a summary of the major areas where this has been done is as follows:

Expenditure on Energy



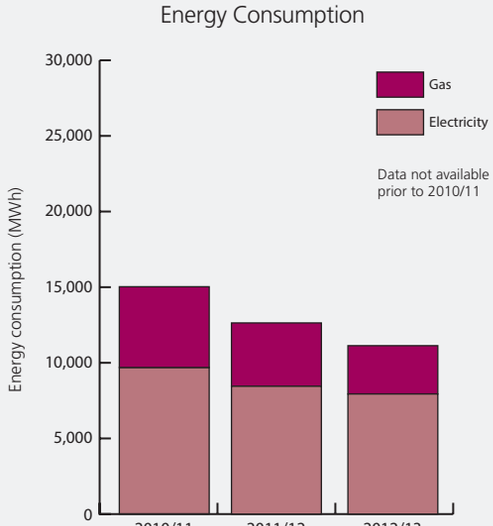
- The NHS aims to reduce its carbon footprint by 10% between 2009 and 2015. Reducing the amount of energy used in our organisation contributes to this goal.
- There is also a financial benefit which comes from reducing our energy bill. By reducing our energy costs by 11% in 2012/13, we have saved **£89,128**, the equivalent of 16 hip operations.

Carbon Emissions



- Our measured greenhouse gas emissions have reduced by 0,349 tonnes this year.
- During 2012/13 our total expenditure on business travel was £2,336,134.

Energy Consumption



- Our total energy consumption has fallen during the year, from 12,716 to 11,234 MWh.
- Our relative energy consumption has changed during the year, from 0.61 to 0.55 MWh/square metre.

Percentage of Waste Recycled

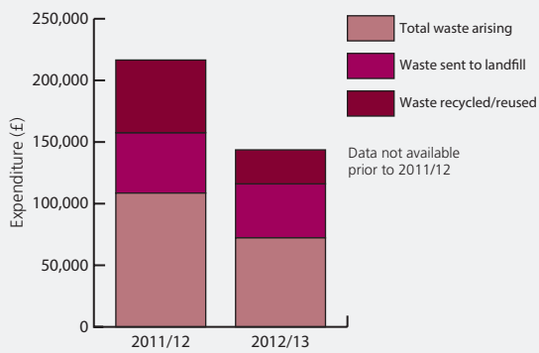
- We recover or recycle **124.66 tonnes** of waste, which is 38% of the total waste we produce.

Water consumption in cubic metres

- Our water consumption has increased by 1,193 cubic metres in the recent financial year.
- In 2012/13 we spent £34,992 on water.

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

Expenditure on waste



Our staff

In 2012/13, on average through the year 2,109 people (1,597 Whole Time Equivalents) were contracted to work on a permanent basis for the Trust.

98% of our substantive staff are contracted under the NHS Terms and Conditions of Service.

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

33% of our staff are registered with the Nursing & Midwifery Council (NMC), 71 employees are registered with the General Dental Council (GDC) and 5 employees are registered with the General Medical Council (GMC).

In addition to the nationally agreed Agenda for Change terms and conditions agreement, we have continued to offer our staff a range of benefits, including:

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

Organisational change – 'Our Future'

All employee related programmes and projects during 2012/13 have been focused on preparations for the fundamental changes to the organisation resulting from the decommissioning of the 0845 4647 telephone service and the mobilisation of NHS 111 and other nationally commissioned services which complement it.

By the end of July 2012, we were aware that the future organisation would be between a third and half of the size of the current organisation, that significant numbers of staff would transfer to other NHS 111 providers under TUPE-like arrangements, and that some staff would become redundant.

Improvements to staff rostering

During 2011/12 we consulted with front line staff on a radical restructuring of our rostering system. We needed to make it more streamlined and increase the proportion of staff available to answer calls in the out-of-hours and weekend period in preparation for delivering the new NHS 111 service. Changes to individual rosters were implemented on 1 April 2012 and although it has been a difficult exercise for staff who had enjoyed individual arrangements or a largely "in week" roster, it has significantly increased efficiency by shifting staff resources to the out-of-hours and weekend periods.

Staff consultation

A ninety day staff consultation on the implications of decommissioning 0845 4647 and related services and establishing NHS 111 and other commissioned services, began on 3 December 2012 and ended on 3 March 2013.

All employees who had not secured or been redeployed into a position in the future organisation were formally put at risk on 4 March 2013. The principal features of the consultation were:

- 41 Executive-led open forum meetings in December 2013 to launch the consultation
- 14 Collective Consultation Group meetings between management and staff side representatives from UNISON and RCN
- a dedicated 'Our Future' intranet site for staff
- over 600 questions answered through the "Frequently Asked Questions" email facility
- the early agreement of an appointments process for the future organisation, which enabled appointments to be made while the consultation was continuing
- a series of agreements in important employment policy areas, including mobility, pay protection and an appeals process.

Management and staff side representatives continued to meet weekly after the consultation, to address issues relating to the appointments process, transfers into and out of the Trust, and redundancies.

By the end of March 2013, all permanent employees of the Trust had been appointed to a post in the future organisation, been transferred to another provider of NHS 111, or been given notice of redundancy.

Other staff engagement activity

We are committed to ensuring that our staff have access to information about the Trust, important developments and the information they need to do their job. We also aim to give opportunities to provide feedback and ask questions where it really matters.

During the year we have continued to make use of our existing communications channels, including a weekly e-bulletin, a staff intranet and face-to-face meetings, as well as continuing to use virtual communications channels such as video and telephone conferencing to support communication over a widespread geography.

This year has been one of profound change for our organisation and so we have developed several additional mechanisms to support staff in engaging with the changes, helping them to have access to open and honest information that affects their futures. In addition to the Executive-led open forum meetings, dedicated 'Our Future' intranet site and frequently asked questions, we put in place a group of staff representatives, or Engagement Champions, who had direct access to the central change management teams. The Engagement Champions supported the organisation to more fully understand the issues and challenges facing staff during this difficult period.

Following the all staff consultation, we created an additional weekly update for all staff to help them navigate through the transition period, providing them with key information on decisions and events that would affect their future.

Colleague support programme

In anticipation of the changes taking place in 2013, we launched the Our Future colleague support programme in August 2012. Since then, together with our partners 10Eighty, we have offered the following services to employees:

- an online portal, accessible to all employees both at home and at work, containing current job search resources including a CV-builder tool, short videos, text and audio guides, interview skills guidance, access to current vacancy information and information on all major organisations
- support centres at our ten largest sites, where staff can get advice, information or access to a range of resources including a library of relevant reading material
- a helpline for employees who have queries about their job search or personal transition planning. It is staffed by career consultants, who are able to answer queries or signpost staff to suitable further support
- access to advice or coaching from an experienced career consultant
- access to an iPhone app, with links to career management reports and guidance
- a series of workshops covering topics from job search skills, personal strategies, networking, the recent developments of social media in recruitment, pensions and retirement, and becoming self employed
- specific workshops and specialist advice for clinicians

Staff survey

Due to the scale and nature of the changes being undertaken during the year, the Trust did not undertake a staff survey during 2012/13. The survey would have taken place during and in the lead-up to an all-staff consultation process, meaning staff may have had difficulty in engaging with the survey. It was agreed that action planning would also be challenging given the changing nature of the organisation. However, the outcomes from the past two years' staff surveys will be referred to as part of business planning for the coming year as the organisation moves towards its new form and structure.

Sickness absence

Over the last year we have implemented a 24/7 centralised reporting line for staff to provide notification of absence, whether this is due to sickness, carer's leave, compassionate leave or any other reason. Staff are also required to call the line on their return to work. This new system has improved the accuracy of our absence reporting information.

In addition, we have centralised the administration process around staff returning to work after absence. This takes the burden off line managers and ensures the necessary paperwork is completed in a consistent and timely manner.

During 2012/13, sickness levels have continued to fall and further measures are planned in 2013/14 to continue to improve sickness absence levels.

Equality and diversity

During the last year the Trust has complied with the specific duties under the Equality Act 2010 to publish equality information with regard to our staff and service provision. We have also undertaken Equality Impact Assessments and drawn up action plans for each major change to our service or working arrangements.

Significant progress has been made in ensuring that staff have completed mandatory training on equality and diversity - 84% of staff have completed this training. This has been facilitated by the development of an updated e-learning package.

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

As of the end of March 2013, 82 members of staff had a disability, which equates to 4.3% of the total staff employed (1929). This has remained the same as last year.

Health and safety

Roger Rawlinson, Human Resources and Transition Director is the Trust's Executive lead for health and safety.

The National Health & Safety Committee provides strategic health and safety direction to the Trust and is responsible for reviewing changes to legislation, commissioning annual audits, quality assuring our health and safety training and new policy development.

The Trust is continually seeking to improve our health and safety processes and procedures and within the past year has reviewed and rewritten ten of its health and safety policies. This has ensured compliance with latest legislation and external guidance. The Trust has achieved 100% compliance against the NHS Litigation Authority Standards following a recent assessment.

We have seen a decrease of over 50% in reported accidents over the past five years which reflects our commitment to providing a safe, secure and healthy environment for our staff.

The Trust is provided with occupational health services through an external agreement.

Security management

Over the past year, the Trust's two Local Security Management Specialists (LSMS) have continued to develop its security management functions and have ensured that reported incidents are investigated and followed through to their appropriate conclusion.

In 2012/13, we developed and implemented a standardised process for reporting and investigating abusive/inappropriate callers. Whilst this has resulted in an increase in reported incidents, the management of these has vastly improved ensuring affected staff received the support they require, as well as sanctions being taken against the offenders.

Counter fraud arrangements

Under the new NHS Standard Contract introduced in 2012/13, all organisations providing NHS services are required to have appropriate anti-fraud arrangements in place. In 2012, NHS Protect published 'Standards for Providers: Fraud, Bribery and Corruption' ("the Standards") to assist organisations with this process. It incorporates a requirement that the Trust employs or contracts a qualified person or persons to undertake the full range of anti-fraud work, and that it produces a risk-based workplan that details how it will approach anti-fraud and corruption work.

The Trust is committed to ensuring fraud, bribery and corruption does not proliferate within in the organisation. We are fully compliant with the directions issued by the Secretary of State in 1999, the NHS Standard Contract (2012) and the NHS Counter Fraud and Corruption Manual.

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

Throughout the past financial year we have continued to embed the counter fraud and anti-bribery culture, and work is undertaken against the Standards, comprising the area of Strategic Governance and the three key principles of Inform and Involve, Prevent and Deter, and Hold to Account.

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

Our patients

Patient experience

The overwhelming majority of our patients say they are very satisfied with the service they receive from us. In 2012/13, we surveyed around 9,000 patients who had used our 0845 4647 service and 92% were satisfied with the way their call was handled. Our Net Promoter Score – based on the question "On a scale of 0-10, how likely are you to recommend our service to your family and friends?" – was 78%, which is considered excellent.

Complaints and compliments

The Trust actively encourages patients, carers and health professionals from the wider NHS and social care to provide feedback on our services. In 2012/13 we received 2,897 items of feedback, which included 141 complaints from patients and service users of which 96% were resolved first time with the complainant. This represents less than three complaints for every 100,000 calls we received compared to 546 compliments, representing more than 13 for every 100,000 calls. Of the complaints we received, 94 (66.7%) were upheld where, following investigation, we agreed that they were founded and appropriate action was taken to make improvements to prevent the issues identified recurring.

The main area of concern expressed by complainants in 2012/13 related to the length of time patients had to wait for a nurse to call back. In response to this, we continued to implement a performance improvement plan that had been put in place at the end of 2011/12 to reduce the length of time callers have to wait for a nurse to call back during our busiest periods. We also routinely randomly review over 1% of all calls per month to the service to ensure that we can identify good practice and any potential areas for development for staff. During the year, three complaints were investigated by the Parliamentary and Health Service Ombudsman.

Patient and public involvement

In 2012/13, we carried out a programme of activities to engage with our patients, carers, public members and the general public as a whole. This included:

- web streaming of our Trust Board meetings
- engagement with patients and the public through social media, e.g. Twitter & Facebook
- surveys to support improvement in the experience and outcomes for our patients
- involving patients and the public in research, service evaluation and clinical audit projects
- seeking patients' and public views on the development of multichannel services, such as our health & symptom checkers
- involvement of public members in a range of groups and committees, including research and clinical audit

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

Our stakeholders

During the first half of 2012/13, the Trust was restricted in the amount of stakeholder engagement activity it could carry out due to the rules of the NHS 111 procurement process. However, by August 2013 the majority of NHS 111 contracts had been awarded and we began working closely with our commissioners to support the development and implementation of their stakeholder engagement strategies for the new NHS 111 services.

Five interim regional NHS 111 communications and engagement leads were recruited to support our regional teams during the development and implementation of the NHS 111 services. Stakeholder engagement activity initially focused on ensuring the views of commissioners, other providers and key health professional groups (e.g. GPs) were reflected in the service design. This was achieved through face-to-face meetings and workshops, together with site visits, where stakeholders could see first-hand how the NHS 111 service would be delivered.

Prior to the 'soft launch' of NHS 111 services, stakeholder engagement work expanded to include other key groups such as NHS staff, patient representative organisations, local authorities etc. Activity focused on raising awareness of the new service, explaining what it would mean for patients, and enlisting their support to promote NHS 111 when it went live. It was only at the 'full launch' of NHS 111 services that engagement with patients and the public began. This was to ensure that people with urgent health needs didn't try to access the service before it was available in their area. Activity is ongoing and includes local advertising, promotional leaflets delivered to every household in a local area, publicity in healthcare settings such as GPs surgeries and pharmacies, talks to community groups etc.

Public Interest and Governance

Non-Executive Directors' biographies

1. Joanne Shaw, Chair

Joanne was appointed as Chair of the Trust in January 2010. She has been acting Chair of the Trust since August 2008, providing leadership to the Board. As Chair, Joanne ensures that the Trust continues to lead the development of remote and digital health services to support users and the wider NHS. Joanne is also Chair of Datapharm Communications, which provides digital medicines information to the NHS, the pharmaceutical industry and the general public. She is a director of the British Board of Film Classification, Nuffield Health, and The Money Advice Service. Joanne's principal interests are partnerships between patients and health professionals and use of new communication channels for health and medicines. After serving on the management board of the Audit Commission, she became Director of Medicines Partnership, a Department of Health initiative to improve the use of medicines in the NHS. She previously worked internationally as a strategy consultant with the Boston Consulting Group.

2. Peter Catchpole

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

3. Trevor Jones

Trevor joined the Board on 1 April 2007 and is an accountant with 30 years' experience in the NHS. He is the former Head of the Scottish Executive Health Department and Chief Executive of NHS Scotland, working with Scottish Ministers to establish NHS 24 and to introduce the ban on smoking in public places. More recently he was Chief Executive of a Strategic Health Authority and a member of the NHS Leadership Forum advising the Secretary of State on health policy. He currently has a number of Non-Executive Director roles in both the public and private sectors.

4. Sue Hunt

Sue joined the Board on 1 April 2007. Sue currently holds an Appointed Trustee position at CfBT Education Trust, is a Board member of Notting Hill Housing Group and a Non-Executive Director of The Satellite Applications Catapult. She is a chartered accountant who spent nearly 20 years with global accountancy and business advisory firm KPMG. During that time she worked with a wide 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 providing due diligence services to investors in health related businesses and advising multiple Trusts on all aspects of their Foundation Trust application, either directly or on behalf of the Department of Health.

5. Tim Walton

Tim is an independent consultant and joined the board on 1 April 2007. He is also a Non-Executive Director at The Highways Agency and he has been a Non-Executive Director at Sourcerer Limited, BIS and Accent Group. He is a Fellow of the British Computer Society and a Chartered Engineer. Previously he held a number of executive roles in aerospace, engineering and technology sectors.

6. Luisa Dillner

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

7. Tim Heymann

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

8. Steve Duncan

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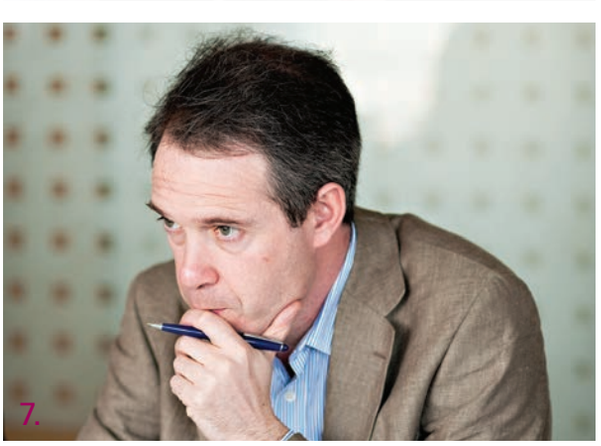
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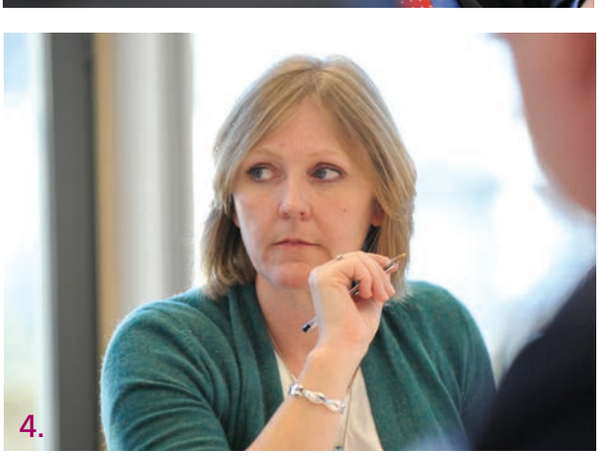
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Executive Directors' biographies

1. Nick Chapman, Chief Executive

Nick was appointed the Chief Executive of the Trust from 1 April 2009. Before joining the Trust he was the Department of Health's National Director for the 18-week target. He was also responsible within the National Programme for IT as SRO for the Choose and Book and PACS programmes. He joined the Department of Health on secondment from the NHS in 2005 to work on reducing cancer waits, elective waiting times, and in the implementation of patient choice and booking. Nick has practical experience leading and managing NHS organisations and of delivering and sustaining low waiting times. He joined the NHS in 1979 as a National Trainee in the South East. After a variety of administrative and managerial posts, he became Unit General Manager for Lewisham Hospital in 1987. He moved to Dorset in 1991 and spent the next 14 years as a Trust Chief Executive, first in West Dorset and then in Taunton, Somerset.

2. Trevor Smith, Managing Director

Trevor was appointed Managing Director from 1 January 2013, he resigned from the position on 4 June 2013. Prior to this he was Finance and Performance Director of the Trust for four years. Previous Finance Director roles include Barking, Havering and Redbridge NHS Trust, where he led the Financial Recovery Plan; Basildon and Thurrock University Hospital Foundation Trust, where he led the FT Financial Application and Assessment process; and Billericay, Brentwood and Wickford PCT. He was also the Acting Director of Finance at the Barking, Havering and Brentwood Community and Mental Health Trust supporting the successful dissolution and disaggregation of the Trust. Trevor joined the NHS in 1996 from local government.

3. Alan Bentall, Chief Information Officer

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

4. Jackie Dunn, Director of Finance

Jackie Dunn joined the Trust in 2008 as Deputy Director of Finance and became the Acting Director of Finance In January 2013. Jackie has 20 years experience within NHS Finance and she has held senior finance roles in a number of commissioner and provider organisations, the most recent being Deputy Director of Finance at Northampton General NHS Trust. Jackie moved into the NHS following a career in local government.

5. Keith Gait, Chief Operating Officer*

Keith Gait joined the Trust in August 2011 as Deputy Chief Operating Officer, taking up the role of Chief Operating Officer in December 2011. Keith has 18 years' experience in the customer service and contact centre field. He began his career as an advisor and is passionate about operations that recognise their people as well as their customers. Keith was Customer Service Director at Sainsbury's mobile and had a successful career with organisations such as Sitel and Barclaycard. He has completed performance improvement, strategic direction, outsourcing, and transformation programmes for a wide range of clients. Keith is the author of 101 Ways to Improve Customer Service, The Attrition Waterfall, and The Causes of Churn in the Broadband Industry. Keith is also a judge for the CCF European Call Centre Awards and the Customer Service Training Awards. He presented his research on 'The Unfaithful Customer' at the Call Centre Expo in September 2010. Keith has recently completed his MBA from Henley Business School.* Keith continued as Chief Operating Officer until 17 May 2013.

6. Patricia Hamilton, Clinical Director / Chief Nurse

Tricia has over 27 years of front line nursing experience in a variety of settings, including acute care, neuro-intensive care, and general surgery. Since joining the Trust in 1999 as a Nurse Advisor she has held a variety of senior positions at national and local level before becoming Clinical Director and Chief Nurse of the organisation in 2010. Along with ensuring the clinical safety, quality, and effectiveness of the Trust's services, Tricia's main area of interest is in exploring and developing technology to deliver safe and effective care remotely. She has overall responsibility for the Trust's pioneering online Health and Symptom Checkers that are now used by 4 million people annually. These have revolutionised healthcare, giving patients access to safe, clinically-validated advice and information wherever and whenever they need it, via the web or smartphone apps. Tricia is an advocate of remote care as a means of reducing pressure on high demand face-to-face health services, as well as empowering patients to become more informed and take charge of decisions about their own health.

7. Ruth Rankine, Director of Strategy & Planning

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

8. Roger Rawlinson, HR Director

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


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Information governance, risk and steering group

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

Summary of protected personal data related incidents formally reported to the Information Commissioner's office in 2012/13

Statement on information risk

The Trust formally reported one incident involving protected personal data to the Information Commissioner's Office in 2012/13.

The Trust will continue to monitor and assess its information risks in order to identify and address any weaknesses and ensure continuous improvement of its systems.

During 2012/13 the Senior Information Risk Owner (SIRO) and the Head of Information Security & Risk Management continued to champion information risk throughout the organisation at an operational level, through the implementation of the Information Risk Assessment & Management Strategy Plan & Programme. The SIRO and Head of Information Security & Risk Management also undertook refresher training courses for their roles, to help to ensure their responsibilities can be carried out effectively, and so that their knowledge and skills are kept up to date and in line with current requirements. The organisation also conducted a personal data flow mapping and risk assessment exercise to evaluate if the controls identified during 2011/12 are still effective and to identify and assess any potential new information risks. During 2013/14 the Trust will further develop the Risk Assessment & Management Strategy Plan & Programme to ensure the protection of information assets from a wide range of threats.

Date of incident (month)	Nature of incident	Nature of data involved	Number of people potentially affected	Notification steps
June 2012	Unauthorised access (53 patients) and subsequent loss of some patient information (18 patients) within Trust premises; safe haven fax policy was not followed	Personal data • Name • Address	53 Patients (unauthorised access) including 18 lost sets of patient information	• Information Commissioner's Office notified. • Implementation of paperless nhs.net system. • Reinforce staff understanding and application of supporting Information Governance Policies and Operating Procedures covering the use of fax machines and transfer of patient identifiable information. • Security Audits undertaken regularly and appropriately. • Undertake a review of Information Governance requirements for the future organisational design.

Further action on information risk

The Trust will continue to monitor and assess its information risks to identify and address any weaknesses and ensure continuous improvement of its systems.

Planned steps for the coming year include:

- continue the implementation of our rolling information risk assessment and management strategy plan and programme
- appointing and training additional information asset owners/administrators
- conduct privacy impact assessments on relevant projects
- review and revise key information governance, security and confidentiality policies

Summary of other protected personal data related incidents in 2012/13

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

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

Internal information governance audit

An information governance audit, utilising the centrally provided audit methodology developed by the Audit Commission, was included in the work plans of our internal auditors, to be carried out in support of the submission of the Information Governance toolkit v10 in March 2013. The purpose is to provide independent assurance of our returns, and enable the Trust to carry out any necessary remedial action during the course of 2013/14.

Information governance steering group

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

Better Payments practice code

	2012/13		2011/12	
	Number	£000	Number	£000
Total Non-NHS Trade Invoices Paid in the Year	17,148	78,709	17,207	67,181
Total Non-NHS Trade Invoices Paid Within Target	17,040	78,657	16,934	66,756
Percentage of Non-NHS Trade Invoices Paid Within Target	99.37%	99.93%	98.41%	99.37%
Total NHS Trade Invoices Paid in the Year	244	3,937	330	2,878
Total NHS Trade Invoices Paid Within Target	237	3,921	316	2,850
Percentage of NHS Trade Invoices Paid Within Target	97.13%	99.59%	95.76%	99.02%

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

Name of Auditor

These accounts have been audited by the Comptroller and Auditor General in accordance with the National Health Service Act 2006. The external auditor is responsible for reporting whether, in his opinion, the financial statements give a true and fair view of the state of affairs of the Authority's reported financial position, and whether the Trust has complied with relevant legislation and other requirements. The Trust incurred audit fees of £83,000. No other audit services were provided in this period.

Disclosure of relevant information

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

Directors' declaration of interest during 2012/13

Name	Interest Declared
Joanne Shaw	Nuffield Health – Non- Executive Governor The Money Advice Service – Director Council of Management of the British Board of Film Classification – Member Datapharm Communications Ltd – Chairman Dr Foster Ethics Committee – Member Vanguard Metropolitan Limited – Director
Trevor Jones	Womens' Royal Voluntary Service – Trustee WellChild – Trustee Tetbury Hospital Trust Ltd – Trustee
Tim Walton	Timothy Walton and Associates Limited – Director Highways Agency – Non-Executive Director
Sue Hunt	CfBT Education Trust – Appointed Trustee Notting Hill Housing Trust – Board member The Satellite Applications Catapult – Non-Executive Director
Peter Catchpole	General Dental Council – Lay Member British Association of Psychotherapy and Counselling Conduct Committee – Lay Member West Sussex County Council – County Councillor and Cabinet Member for Adult Services
Luisa Dillner	Head of New Product Development, British Medical Journal Publishing Group Limited
Tim Heymann	Medicine Today Limited – Directorship and Shareholder Imperial College Business School – Reader in Health Management Kingston Hospital NHS Trust – Consultant Physician
Steve Duncan	Sole Director of Aston West Lands Ltd – company providing consultancy in health care Advisor to Alliance Boots Non-Executive Chairman of Funeral Services Partnership
Nick Chapman	Spouse – self-employed consultant who does work from time to time with and for NHS bodies.
Trevor Smith	None declared
Alan Bentall	None declared
Jackie Dunn	None declared
Tricia Hamilton	Scholarship with Florence Nightingale Foundation to conclude June 2013
Keith Gait	None declared
Ruth Rankine	Carers First (charitable organisation), Tonbridge – Trustee
Roger Rawlinson	None declared

Remuneration report

Remuneration Committee

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

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

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

Remuneration policy and framework

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

The Remuneration Committee assessed the performance-related pay objectives of the Executive Directors for 2012/13 and made no recommendations for payments to the Board.

In 2012/13 the basic pay of those staff who are subject to the VSM pay framework was not uplifted, so remained frozen at the previous year's level. This decision was in line with a national instruction applying across the NHS.

The following Salaries and Allowances and Pension Benefits tables have been audited.

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

Name	Role	Start	Notice	Nature	Continuous Service Date
Nick Chapman	Chief Executive	01/04/2009	6 months	Permanent	25/11/1979
Trevor Smith	Managing Director	02/01/2009	6 months	Permanent	22/04/1996
Alan Bentall	Chief Information Officer	16/04/2010	3 months	Permanent	16/04/2010
Jackie Dunn	Director of Finance	30/06/2008	3 months	Fixed Term	01/07/1993
Keith Gait	Chief Operating Officer	01/07/2012	3 months	Permanent	01/07/2012
Patricia Hamilton	Clinical Director/Chief Nurse	01/09/1999	3 months	Permanent	01/10/1981
Roger Rawlinson	HR Director	01/09/2007	3 Months	Permanent	01/09/2003
Ruth Rankine	Director of Strategy & Planning	01/06/2010	3 Months	Permanent	01/06/2010

Salaries & Allowances

Name & Title	2012/13 Salary (bands of £5,000) £000	2012/13 Salary includes PRP awarded £000	2012/13 Other remuneration (bands of £5,000) £000	2012/13 Benefits in kind (rounded to nearest £00) £00	2011/12 Salary (bands of £5,000) £000	2011/12 Salary includes PRP awarded £000	2011/12 Other remuneration (bands of £5,000) £000	2011/12 Benefits in kind (rounded to nearest £00) £00
Nicholas Chapman Chief Executive	150–155	0	0	0	150-155	0	0	0
Trevor Smith Managing Director from 1/1/13	135-140	0	0	0	135-140	0-5	0	0
Roger Rawlinson Director of Human Resources	105–110	0	0	0	100-105	0-5	0	0
Ronnette Lucraft Chief Operating Officer to 16/12/11	0	0	0	0	90-95	0	0	0
Keith Gait Chief Operating Officer from 1/7/12	90–95	0	0	0	0	0	0	0
Ruth Rankine Director of Strategy & Planning from 1/6/10	110–115	0	0	0	110-115	0-5	0	0
Alan Bentall Chief Information Officer from 16/4/10	120-125	0	0	0	120-125	0-5	0	0
Patricia Hamilton Director of Nursing from 1/1/11	100–105	0	0	32	95-100	0	0	32
Brian Gaffney Director of Public Health left 31/07/2012	25–30	0	0	0	80-85	0	0	0
Jackie Dunn Acting Director of Finance and Performance from 1/1/13	25–30	0	0	0	0	0	0	0
Joanne Shaw (Non-Executive Chair)	35–40	0	0	2	35-40	0	0	3
Peter Catchpole (Non-Executive)	10–15	0	0	8	10-15	0	0	7
Trevor Jones (Non-Executive)	5–10	0	0	8	5-10	0	0	1
Tim Walton (Non-Executive)	5–10	0	0	16	5-10	0	0	26
Sue Hunt (Non-Executive)	5–10	0	0	8	5-10	0	0	11
Luisa Dillner (Non-Executive)	5–10	0	0	0	5-10	0	0	0
Tim Heymann (Non-Executive)	See below	0	0	1	0	0	0	1
Steve Duncan (Non-Executive) appointed 01/10/10	5–10	0	0	0	5-10	0	0	5

Trevor Smith resigned from the Trust on 4/6/13. Keith Gait continued to fulfill the role of Chief Operating Officer on an interim basis until 17/5/13.

Non-Executive Directors are required to attend Board and various committee meetings to fulfill their duties. The travel costs related to this of such attendance is borne by the Trust but is considered to be home to work by HMRC and therefore taxable. The amounts shown for benefits in kind reflect this for both years.

Amounts paid to third party organisations

	2012/13	2011/12
Tim Heymann (Non-Executive)	5-10	5-10
Keith Gait	55-60	70-75

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

Pension benefits

Name	Real increase in pension at age 60 (bands of £2,500) £000	Real increase in pension lump sum at age 60 (bands of £2,500) £000	Total accrued pension at at age 60 at 31 March 2013 (bands of £5,000) £000	Lump sum at age 60 related to accrued pension at 31 March 2013 (bands of £5,000) £000	Cash Equivalent Transfer Value at 31 March 2013 £000	Cash Equivalent Transfer Value at 31 March 2012 £000	Real increase in Cash Equivalent Transfer Value £000
Nicholas Chapman Chief Executive	0-(2.5)	(2.5)-(5.0)	60-65	185-190	1,295	1,220	12
Trevor Smith Managing Director	0–2.5	0–2.5	45–50	135-140	710	648	28
Roger Rawlinson Director of Human Resources	0–2.5	2.5–5	10–15	35-40	278	232	34
Ruth Rankine Director of Strategy & Planning	0–2.5	0	5–10	0	54	31	21
Alan Bentall Chief Information Officer	0–2.5	0	5-10	0	102	65	33
Patricia Hamilton Director of Nursing	0–(2.5)	0–(2.5)	35–40	105-110	650	610	8
Jackie Dunn Acting Director of Finance and Performance from 1/1/13	Refer to below note				636	0	
Ronnette Lucraft Chief Operating officer to 16/12/11	0	0	0.00	0	0	115	0

As Non-Executive members do not receive pensionable remuneration, there will be no entries in respect of pensions for Non-Executive members.
Prior year comparative data not available for Jackie Dunn as her appointment was from 1/1/13, therefore no increase in CETV has been calculated.
Jackie Dunn's pension reflects her service in the NHS so the figure given above is not merely pension earned from the appointment date shown above.

Salary Comparison to highest paid director

Reporting bodies are required to disclose the relationship between the remuneration of the highest-paid director in their organisation. The banded remuneration of the highest paid director in the Trust for the financial year 2012/13 was £150,000-£155,000 (2011/12: £150,000-155,000). This was 5.15 times (2011/12: 5.28) the median remuneration of the workforce, which was £25,000-£30,000 (2011/12: £25,000-£30,000).

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

Cash Equivalent Transfer Values

A Cash Equivalent Transfer (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member's accrued benefits and any contingent spouse's pension payable from the scheme. A CETV is a payment made by a pension scheme or arrangement to secure pension benefits in another pension scheme or arrangement when the member leaves a scheme and chooses to transfer the benefits accrued in their former scheme. The pension figures shown relate to the benefits that the individual has accrued as a consequence of their total membership of the scheme, not just their service in a senior capacity to which disclosure applies. The CETV figures and the other pension details include the value of any pension benefits in another scheme or arrangement which the individual has transferred to the NHS pension scheme. They also include any additional pension benefit accrued to the member as a result of their purchasing additional years of pension service in the scheme at their own cost. CETV's are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries.

Real Increase in CETV

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

Nick Chapman
Chief Executive

20 June 2013

NHS Direct National Health Service Trust Accounts 2012/13

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

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

The Accounting Officer for the Department of Health has appointed the Chief Executive of the NHS Direct National Health Service Trust as the Accounting Officer, with responsibility for preparing the Authority's accounts and for transmitting them to the Comptroller and Auditor General.

In preparing the accounts, the Board and Accounting Officer are required to:

- observe the accounts direction issued by the Secretary of State, including the relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis
- make judgments and estimates on a reasonable basis
- state whether applicable accounting standards have been followed, and disclose and explain any material departures in the financial statements
- prepare the financial statements on a going concern basis, unless it is inappropriate to presume that NHS Direct National Health Service Trust will continue in operation.

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

By order of the Board.

Disclosure of relevant information

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

Annual Governance statement

1. Introduction

1.1 The responsibilities of the Accountable Officer for the Trust are set out in the Accountable Officer Memorandum for Chief Executives of NHS Trusts. The Accountable Officer is responsible for maintaining a sound system of internal control within an organisation to support the achievement of the Trust's policies, aims and objectives as set by the Trust Board, whilst safeguarding the public funds and departmental assets assigned to the Trust. The Accountable Officer is also responsible for ensuring that the Trust is administered prudently and economically and that resources are applied efficiently and effectively to ensure the quality and safety of the service for patients and the welfare of staff members.

1.2 This statement gives the overview of the governance of the Trust; its performance, management of risk, state of its internal controls and an assessment of risks in the coming year. The Trust complies with The UK Corporate Governance Code as is appropriate to the type of organisation we are and has a well-functioning and mature system of integrated governance.

2. Context

2.1 2012/13 was a year of fundamental change for the Trust. The NHS Operating Framework for 2011/12 set out the Department of Health's (DH) decision to decommission the Trust's nationally commissioned 0845 4647 Service and to replace it with a new locally commissioned NHS 111 Service. The DH set the target for these service changes to be completed by April 2013. Operationally, the switchover date was set for 21st March 2013 in consultation with the DH national 111 team to avoid making the service change during the very busy Easter period, which spanned the year-end.

2.2 The 0845 4647 service and its associated activities represented the substantial majority of the Trust's activities and income in 2012/13. Therefore; preparation for the decommissioning of this service, competing for the right to provide local NHS 111 services, other non-111 services, and transitioning the organisation into a substantially leaner operating model has dominated the year's activities.

2.3 In consultation with the DH, the Trust concluded in September 2012 that it could remain a viable organisation as a result of three critical factors:

1. that the Trust had won a 34% market share of the NHS 111 Service, providing sufficient income for it to remain viable;
2. that the DH agreed to fund the costs of the transition and decommissioning of the 0845 4647 Service; and,
3. that the Trust could remain an NHS Trust until at least April 2014.

2.4 In December 2012, the NHS Commissioning Board (now NHS England) confirmed that it would commission the continuation of some national services from the Trust for 2013/14 and 2014/15. These services added approximately, a further 50% to the projected size of the future portfolio of contracts and income for the Trust.

3. Governance Structure

The Trust Board

3.1 The Trust Board is collectively responsible for the long-term success of the organisation and sets the overall strategic aims and objectives of the organisation. It is made-up of a Non-Executive Chairman, seven Non-Executive Directors (NEDs), the Chief Executive and seven Executive Directors of whom three are non-voting members.

3.2 The Trust Board receives regular performance and compliance reports from across key areas of the organisation, allowing it to make an assessment of its own effectiveness. It monitors key performance metrics through the use of a monthly 'Scorecard', including reviews of the quality and safety of its services and monitoring the value the organisation provides to patients and the wider NHS. All data submitted for inclusion in the Scorecard is quality-checked and approved by the relevant Executive from the business area, which provides it. Data is extracted from reports and cross-checked against outputs to help to ensure accuracy and consistency. The NEDs constructively challenge these performance reports and hold the Executive Directors to account. They also help the Executive Directors to develop proposals on strategy.

3.3 The Trust has over 19,700 public members that broadly represent the population of England and the Trust's service-users. Members receive a quarterly newsletter by post or email (according to their requirements) to keep them informed about new developments. Members are also invited to participate in specific working groups regarding the Trust's services and strategic direction. This allows the Trust Board to maintain a clear overview of stakeholder engagement.

3.4 The Trust Board regularly meets in public and met in regular session 11 times during 2012/13. Its proceedings are streamed live on the web and posted on YouTube, promoting openness and transparency within the organisation. It also communicates via Twitter. In addition, it was convened for two 'extraordinary meetings' to approve the Annual Report and Accounts 2011/12 and to approve bid submissions for future 111 Service Agreements. It held a strategy event in October 2012 to discuss the Trust's future and in addition, held two seminars; one to discuss its governance arrangements and the other to discuss the outcomes of the Robert Francis Inquiry Report. The latter led to the agreement of additional actions that may be required beyond those put in place in 2010 when it had reviewed the original 'Francis Report'. NEDs have each taken a specific interest in a major area of Trust activity and have engagement activities with staff and external stakeholders on which they report their findings and observations to the Trust Board.

3.5 Patient safety and experience form a key part of every Trust Board meeting Agenda. All Board members visit Contact Centres regularly to experience our services first hand and to speak to frontline, supervisory and support staff. Members also listen to voice recordings of calls to the services we deliver as well as being invited to observe internal reviews of our most serious incidents.

3.6 During 2012/13 there were changes made to the Trust Board membership to underpin the creation of the future organisation. It was proposed in December 2012 that the post of Chief Executive should be made redundant by July 2013 to be replaced by a Managing Director post appropriate to the new smaller organisation. Trevor Smith was appointed to this post in December 2012. In this post he reported to the Chairman of the Trust and the Future NHS Direct Trust Board Sub-Committee. His responsibility during the year was to bring the future NHS Direct organisation and the new 111 and other retained services into being.

3.7 Trevor Smith was replaced on the Trust Board as Director of Finance and Performance on an interim basis by Jackie Dunn. Dr Brian Gaffney left the Trust as Medical Director on 31st July 2012 and will be succeeded by Dr. Katherine Noble in 2013/14.

3.8 The Chairmen of the Board's Sub-Committees remained unchanged during the year. All Trust Board members have good attendance records at the Committees of which they are members. This is demonstrated in the table below:

Attendance for 2012/13

Board members	Trust Board (13 meetings)	Audit (4 meetings)	Finance (12 meetings)	Remuneration (2 meetings)	Clinical Governance (6 meetings)	Innovation (1 meeting)	ES,T&D** (6 meetings)	Future NHS Direct (6 meetings)
Alan Bentall*	12 of 13		12 of 12					5 of 6
Brian Gaffney	3 of 5				0 of 2			
Jackie Dunn	3 of 3						6 of 6	
Joanne Shaw	13 of 13 (C)							6 of 6 (C)
Keith Gait	7 of 13						3 of 6	
Luisa Dillner	9 of 13		6 of 12					6 of 6
Nick Chapman	13 of 13	3 of 4	9 of 12		5 of 6		6 of 6	
Peter Catchpole	12 of 13	4 of 4 (C)		2 of 2				6 of 6
Roger Rawlinson*	12 of 13					1 of 1	6 of 6	
Ruth Rankine*	12 of 13							5 of 6
Steve Duncan	11 of 13		11 of 12		3 of 6			6 of 6
Sue Hunt	12 of 13	4 of 4	12 of 12		6 of 6 (C)		6 of 6	6 of 6
Tim Heymann	13 of 13	2 of 4			6 of 6	1 of 1	6 of 6	
Tim Walton	13 of 13		12 of 12 (C)	2 of 2		1 of 1 (C)	6 of 6	
Trevor Jones	12 of 13	3 of 4		2 of 2 (C)	6 of 6		6 of 6 (C)	
Trevor Smith	13 of 13	1 of 2	11 of 12					6 of 6
Tricia Hamilton	11 of 13				5 of 6			5 of 6

			C	*	**
Member attendance for total number of meetings	Member attendance for period when active	Non-member in attendance	Chair	non-voting member	Existing Services, Transition & Decommissioning

3.9 The Trust Board has the appropriate balance of skills, experience and knowledge to enable them to discharge their responsibilities effectively. This includes a Registered Nurse as Clinical Director / Chief Nurse and a qualified Finance Director. In addition, the NEDs include two medical practitioners alongside colleagues with extensive experience in the private, not-for-profit and public sectors.

3.10 The Trust Board maintains an up-to-date Register of Interests, which formally records the declarations of interests made by its members. Any interest that arises during the course of a meeting is declared immediately and recorded in the Minutes of the meeting. This ensures that the Board acts in the best interests of the organisation and avoids situations where there may be a potential conflict of interest.

The Trust Board Sub-Committees

3.11 The Trust Board had five Sub-Committees. During October 2012 it created two further Board Sub-Committees, thereby building on the existing good foundation of governance within the Trust and providing the required management focus and scrutiny to steer through the fundamental changes to the organisation.

- Future NHS Direct
  This new Committee was responsible for overseeing the creation of the future NHS Direct Operating Model, including agreeing the terms and conditions of the Service Agreements to deliver new services, considering options for a new legal form and financial responsibility. The Managing Director was responsible for the Executive work overseen by this Committee.

- Existing Services, Transition & Decommissioning
  This new Committee was responsible for overseeing the final months of the 0845 4647 Service until June 2013 and other existing services. It was also responsible for the safe and cost-effective decommissioning and transition of the Trust's people, services and assets from their existing position to a future state; either to the future NHS Direct, another provider or an alternative future. The Chief Executive was responsible for the Executive work overseen by this Committee.

Audit Committee

3.12 The Audit Committee is a Sub-Committee of the Trust Board. Its membership is made-up of Non-Executive Directors. This allows the Trust Board to be independently assured about the effectiveness of the organisation's system of internal control. The Committee is assisted in this process by a function called Internal Audit, which carries out investigations and checks within the organisation. The Internal Audit Plan, carried out by our Internal Auditors, enables the Board to be assured that key internal controls and other matters relating to risk are regularly reviewed. This Committee regularly receives audit reports and progress reports on risk-related issues.

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

- reviewing in detail the Annual Report and Accounts for the Trust, including the Audit Completion Report from External Audit;
- considering the Audit Planning Reports from Internal Audit and the NHS Counter Fraud Service;

- assessing the Board Assurance Framework and ensuring that any highlighted risk areas were mitigated through reviews or other work-streams;
- considering the assurances on risk and control set out in Internal Audit's annual report and opinion, together with key assurance reported in individual reports.

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

Finance Committee

3.15 The Finance Committee is also a Sub-Committee of the Trust Board and is also responsible for providing additional assurance to the Board on financial matters. It provides effective governance and controls over spending and investment decisions, benefits realisation and scrutinises financial planning, management, performance and reporting. It considers investment proposals and responses to invitations to tender from NHS Commissioners and where appropriate makes recommendations for approval to the Trust Board. In addition, during 2012/13 the Committee undertook scrutiny of the substantial costs associated with the transition and decommissioning of the 0845 4647 Service.

Remuneration Committee

3.16 The Remuneration Committee is also a Sub-Committee of the Trust Board. Its remit is to make nominations, ensuring there is a formal, rigorous and transparent procedure for the appointment of new Executive Directors to the Trust Board. It sets the remuneration and terms-of-service for the Chief Executive and other Executive Directors, including salary uplifts and performance bonus payments where these apply. The Committee maintains an overview of all remuneration matters for staff in the Trust, and reports to the Trust Board. During 2012/13 it considered the substantial issues arising from the transition, decommissioning and future services activities. These included redundancy and retention bonus payments.

Clinical Governance Committee

3.17 The Clinical Governance Committee is also a Sub-Committee of the Trust Board. Its remit is to provide assurance on all aspects of clinical governance especially quality and patient safety. The Committee's key activities are:

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

Innovation Committee

3.18 The Innovation Committee is also a Sub-Committee of the Trust Board, which brings together a wide range of industry experts and interested parties both from the public, private, health and non-health sectors, to review the external environment and innovation in healthcare delivery, and to consider how the Trust can add value in the provision of remotely delivered services. The activities of this Committee were put on hold following their October 2012 meeting.

4. Accountable Officer Status

4.1 In December 2012, in view of the changes required to the the Trust's Operating Model, the Trust Board (following recommendations from the Remuneration Committee) approved the proposal that the Trust should make the post of Chief Executive redundant by July 2013 and to appoint a Managing Director from December 2012 to take forward the future NHS Direct. Trevor Smith was appointed to the role of Managing Director.

4.2 In February 2013, the Trust Board approved the formal change of Accountable Officer for the Trust, with Trevor Smith taking over the responsibility with effect from 1 April 2013.

4.3 In March 2013, the new 111 Services were mobilised. Performance problems encountered during this time were so poor that the Trust Board reversed their earlier decision and asked Nick Chapman to retain Accountable Officer responsibility for an interim period, with immediate effect, to focus on re-establishing a safe and stable service, with acceptable levels of performance.

5. Trust Performance

5.1 The Trust Board reviews performance on a regular monthly cycle, using a Board 'Scorecard', which covers all significant aspects of the Trust's performance. The Annualised Board Scorecard for 2012/13 is set out in the Appendices of this report.

5.2 Each performance area is scored using a metric, set at the start of the year by the Trust Board, and is rated red / amber / green according to whether performance is on target, slightly below target or well below target. The red rated areas of performance represent the greatest concerns for the Trust. In 2012/13, of the 28 performance metrics at Board level, 13 were 'green', 6 were 'amber' and 4 areas were 'red'. There are 5 areas where metrics set at the start of the year were either discontinued or became non-applicable as a result of changed circumstances.

5.3 Overall patient satisfaction and the quality and safety of the 0845 4647 Service remained strong. Patient feedback from regular monthly satisfaction surveys demonstrate that the level of satisfaction of patients with the services provided by the Trust is high. Satisfaction rates are consistently above 90% and net promoter scores are extremely high at around 78%.

5.4 Notwithstanding the general overall level of satisfaction, the Trust receives formal complaints at a rate of less than three per 100,000 calls. These complaints are individually investigated and appropriate open and honest responses are given to complainants. In addition, the Trust operates a system of national review of incidents judged as having the potential to give rise to serious harm. Each case is carefully scrutinised and where there are lessons to learn from complaints and untoward incidents where preventative action is required, this is put into effect without delay.

5.5 Financial performance during 2012/13 was closely monitored and remained on plan for the year; this included a detailed mid-year review of all budgets to ensure the Trust complied with its statutory duty to 'break-even'.

5.6 All calls to the Trust (including the Appointments Line) are recorded and the Trust has a robust process of reviewing a minimum of 1% of all calls to the service each month and for 2012/13 over 80% of all calls reviewed had an overall score of Excellent / Good. The clinical safety aspects of call reviews consistently scored above 80% and whilst the non-clinical aspects such as completing documentation did not score as highly, on average only 5% of all calls reviewed did not meet the required standard.

NHS 111 Service Mobilisation

5.7 The Trust encountered substantial operational difficulties immediately following the mobilisation of the 111 Service in the West Midlands and the North West on the 21st March 2013. At its meeting on the 25th March 2013 the Trust Board resolved that the Chief Executive should resume control of the Trust's 111 Service with immediate effect, and focus on three immediate priorities:

- stabilise the delivery of 111 services to ensure patient safety;
- establish the reasons for the failure of the services at launch;
- identify immediate lessons and implications for the future.

5.8 Soon after launch, in liaison with Commissioners and NHS England, diversions of 111 calls back to GP Out-Of-Hours Providers and to the 0845 Contingency Service were put in place. As a result overall, the volume of calls to the 111 services in the West Midlands and the North West were at around 30% of contracted volumes. Actions were also taken to maximise frontline staffing.

5.9 As a result of these actions the 111 services that the Trust mobilised were stabilised, with good access levels and very low abandonment rates, although other service levels had not achieved the contracted Key Performance Indicator rates. Following initial investigations the fundamental reasons for the service failures seen at launch were:

- call lengths that were very substantially greater than those planned for in the capacity plan;
- call routing restrictions which caused inefficiencies that restricted full utilisation of staff;
- poor 'roster fit' which did not optimise the utilisation of staff;
- some delays in getting staff fully trained, which were rectified within one week for Call Handlers and 2 weeks for Nurses;
- failures of assurance and governance, which allowed the services to be launched despite evidence strongly suggesting that they would fail.

6. Risk Management

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

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

- the Chief Executive has ultimate responsibility for risk implementation of the Board's policy and reporting requirements;
- the Managing Director independently reported risks relating to the future NHS Direct to the Future NHS Direct Trust Board Sub-Committee. These risk assessments were then also reported to the full Trust Board;
- all other Executive Directors are responsible for implementing risk policy at Directorate level and developing mitigation to manage the risks identified;
- the Clinical Director / Chief Nurse leads on the management of clinical risk in the Trust;
- the Chief Information Officer (CIO) is appointed by the Trust Board as the Senior Information Risk Owner and leads the management of information risk in the Trust through the Information Asset Owners;
- the Head of Corporate Governance is responsible for maintaining the Board Assurance Framework.

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

6.4 The Trust manages the risks to its principal objectives through its Board Assurance Framework (BAF). This identifies the assurance available to the Trust Board in relation to the achievement of its key priorities and strategic objectives and the effectiveness of the operation of key control processes. The Board is apprised on a bi-monthly basis of the gaps in control and assurance and the action being taken to address such gaps.

6.5 Incidents are managed using the Datix web-based Incident Management Software. Each incident is risk assessed, investigated (proportionate to the identified risk) and managed to completion. All frontline staff members are trained in identifying and reporting incidents. Supervisory and line management staff members are additionally trained in incident management.

6.6 Frontline staff members are supported by specialist back-office staff, such as Clinical Governance Leads, who have substantial experience and training in investigation management, including Root Cause Analysis, and experience in conducting investigations across multiple partners and collaborating with our Commissioners and delivery partners.

7. State of Internal Controls

7.1 The Trust's internal controls functioned well in most areas. With the exception of the new 111 Service, overall results indicate that risks are being identified and managed effectively. The evidence for 2012/13 is summarised below.

NHS Litigation Authority

7.2 The NHS Litigation Authority provides indemnity cover for legal claims against the NHS and assists the NHS with risk management. It sets standards for safe care and independently assesses NHS Providers of care, against these standards. The Trust achieved Level 1 of the NHS Litigation Authority Risk Management Standards in May 2012.

Care Quality Commission

7.3 The Care Quality Commission is the independent regulator of all health and social care services in England. Its role is to make sure that care provided meets national standards of quality and safety.

7.4 The Trust was not subject to any inspection by the Commission during 2012/13. It continued to achieve compliance with the standards required by registration throughout the year maintaining consistently high-levels of satisfaction and trust amongst our patients. Evidence of our continued registration is publicly available on the CQC website - www.cqc.org.uk – including reports of past routine unannounced inspections.

Information Governance Toolkit

7.5 The Information Governance Toolkit is a performance tool produced by the Department of Health. Complying with these standards helps to ensure the Trust meets its statutory obligations to manage data. The Trust successfully achieved compliance with 35 / 36 standards in version 10 of the Toolkit achieving an overall attainment of 86%. The standard the Trust was unsuccessful in achieving was mandatory training for all staff where we achieved 81% attainment out of a required 95%. This was primarily due to high staff turnover in the year.

Information Risk Management

7.6 The Trust formally reported one Information Governance Serious Untoward Incident to the Information Commissioner's Office during 2012/13. No formal enforcement action was taken on this occasion due to the particular facts of the case and the remedial measures carried out by the Trust.

Auditors

7.7 The Internal Audit services for the Trust are currently provided by Parkhill Internal Audit Services and External Audit by the National Audit Office. Both the Internal and External Auditors report independently to the Audit Committee.

The Head of Internal Audit Opinion 2012/13

7.8 The Internal Audit function planned a full programme of work. However, one area was subject to delay - forecasting and capacity planning - which in retrospect had greater significance than was raised at the time. The Auditors were able to provide the Audit Committee with adequate assurance or substantial assurance in every area that they looked at.

7.9 The purpose of the Head of Internal Audit Opinion is to contribute to the assurances available to the Accountable Officer and the Trust Board, which underpin the Board's own assessment of the effectiveness of the Trust's system of internal control. Overall, limited assurance was given by the Head of Internal Audit as a result of the delay to the forecasting and capacity planning audit.

External Audit

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

7.11 The National Audit Office's opinion for 2012/13 is an unqualified opinion based on the Trust as a 'going concern' but with an 'emphasis of matter' highlighting the fundamental uncertainty created by the performance and financial issues relating to 111 services provided by the Trust.

Clinical Audit, Service Evaluation and Quality Review

7.12 The Trust completed a full programme of clinical audit, service evaluation and quality reviews during 2012/13. The results of these audits, evaluations and reviews, together with the relevant follow-up management actions were presented to the Trust Board's Clinical Governance Committee. The overall results demonstrate that whilst there is the potential for improvement, the services provided by the Trust are safe and continue to operate within established professional and NHS standards.

8. Future Risks

8.1 The key strategic risks the Trust is facing for 2013/14 are identified in the table below. The Trust will keep these and other emerging risks under close review and have developed mitigating actions where possible.

8.2 As a result of the significant performance and financial issues relating to the 111 services, NHS England, the NHS Trust Development Authority, local commissioners and the Trust are reviewing the potential implications of these issues for the future of these Service Agreements. This introduces a 'fundamental uncertainty' for the Trust, which it is seeking to resolve as soon as possible.

Key Risk	Mitigation
Revised Planned 111 Service Delivery	Our Capacity Plan reflects requirements to meet service delivery levels on a daily basis
Deliver Digital and Other Services	We hold regular contract review meetings with our Commissioners
Financial Plan	We have regular budget performance review meetings to ensure expenditure is scrutinised
Safe, Quality Services	Call review procedures, complaints and feedback mechanisms and incident investigations help us to ensure patients will not be harmed
Engaging with the Public, Commissioners and Stakeholders	We hold regular engagement meetings with a wide range of stakeholders
Staff Morale	We hold regular engagement meetings and provide briefings to our staff to keep them fully informed of latest developments
Loss of key staff	We have a programme to support and retain staff
Retain Critical ICT Infrastructure	An ICT managed service procurement is underway
Unfunded Decommissioning Costs	We are working with NHS England and the NHS Trust Development Authority to minimise potential additional decommissioning costs

Accounting Officer: Nick Chapman

Nick Chapman
Chief Executive

Date: 20 June 2013

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 the NHS Direct NHS Trust (NHS Direct) for the year ended 31 March 2013 under the National Health Service Act 2006. The financial statements comprise: the Statements of Comprehensive Income, Financial Position, Cash Flows, Changes in Taxpayers' Equity; and the related notes. These financial statements have been prepared under the accounting policies set out within them. I have also audited the information in the Remuneration Report that is described in that report as having been audited.

Respective responsibilities of the Board, Accounting Officer and Auditor

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

Scope of the audit of the financial statements

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

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

Opinion on regularity

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

Opinion on financial statements

In my opinion:

- the financial statements give a true and fair view of the state of NHS Direct's affairs as at 31 March 2013 and of the net expenditure for the year then ended; and
- the financial statements have been properly prepared in accordance with the National Health Service Act 2006 and Secretary of State directions issued thereunder.

Opinion on other matters

In my opinion:

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

Emphasis of Matter

Without qualifying my opinion, I draw attention to the disclosures made in note 1.3.3 to the financial statements concerning the application of the going concern principle. The NHS Direct NHS Trust has prepared its 2012-13 financial statements on a going concern basis, but NHS Direct has disclosed its view that there is a fundamental uncertainty over the applicability of this basis in the longer term. Funding is in place to meet NHS Direct's cash requirements, however NHS Direct is currently in discussions with NHS England, the NHS Trust Development Authority and local commissioners about the future role of NHS Direct in the provision of NHS 111 services. Until the outcomes of these discussions are known and their impact on NHS Direct's future can be assessed, there remains a fundamental uncertainty over the applicability of the going concern basis for the preparation of NHS Direct's financial statements.

Matters on which I report by exception

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

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

Report

I have no observations to make on these financial statements.

Amyas C E Morse 2 July 2013

Comptroller and Auditor General

National Audit Office
157-197 Buckingham Palace Road
Victoria
London
SW1W 9SP

Annual accounts 2012/13

Statement of Comprehensive Income for year ended 31 March 2013

	Note	2012-13 Total £000	2012-13 Decommissioning £000	2012-13 BAU £000	2011-12 £000
Gross employee benefits	9.1	(130,054)	(37,581)	(92,473)	(91,443)
Other costs	7	(77,493)	(31,607)	(45,886)	(51,438)
Revenue from patient care activities	4	138,574	0	138,574	142,504
Other Operating revenue	5	632	0	632	1,297
Operating surplus/(deficit)		(68,341)	(69,188)	847	920
Investment revenue	12	59	0	59	54
Other gains and (losses)	13	0	0	0	(3)
Finance costs	14	0	0	0	0
Surplus/(deficit) for the financial year		(68,282)	(69,188)	906	971
Public dividend capital dividends payable		0	528	(528)	(483)
Retained surplus/(deficit) for the year		(68,282)	(68,660)	378	488
Other Comprehensive Income/(deficit)					
Impairments and reversals		(168)	0	0	0
Total comprehensive income/(deficit) for the year		(68,450)	0	0	488

Financial performance for the year

Retained surplus/(deficit) for the year	(68,282)	0	0	488
Decommissioning 0845 costs	69,188	0	0	0
Dividend credit due to Decommissioning activities	(528)	0	0	0
Adjusted retained surplus/(deficit)	378	0	0	488

The above adjustments relate to activities underpinning decommissioning of the 0845 service.
The costs are analysed below and more details provided on Note 7

Decommissioning Costs

Redundancy and Other Termination costs	33,579
Impairment of Non-Current Assets	19,076
Supplier Contracts - Exit Costs	7,724
Sites Decommissioning	1,709
Project Costs	7,100
Total decommissioning costs	69,188

PDC dividend: balance receivable/(payable) at 31 March 2013	548
PDC dividend: balance receivable/(payable) at 1 April 2012	70

The notes on pages 50 to 80 form part of this account.

Statement of financial position as at 31 March 2013

Non-current assets:	Note	31 March 2013 £000s	31 March 2012 £000s
Property, plant and equipment	15	8,030	9,657
Intangible assets	16	4,175	22,646
Trade and other receivables	20.1	0	0
Total non-current assets		12,205	32,303
Current assets:			
Trade and other receivables	20.1	5,295	5,602
Other current assets		0	0
Cash and cash equivalents		21,834	21,875
Total current assets		27,129	27,477
Non-current assets held for sale	22	0	0
Total current assets		27,129	27,477
Total assets		39,334	59,780
Current liabilities			
Trade and other payables	23	(40,852)	(15,038)
Other liabilities		0	0
Provisions	25	(21,708)	(2,038)
Borrowings		0	0
Other financial liabilities		0	0
Total current liabilities		(62,560)	(17,076)
Non-current assets plus/less net current assets/liabilities		(23,226)	42,704
Non-current liabilities			
Trade and other payables	23	(2,456)	(4,468)
Other liabilities		0	0
Provisions	25	(4,608)	(3,276)
Borrowings		0	0
Total non-current liabilities		(7,064)	(7,744)
Total Assets Employed/(Net liabilities)		(30,290)	34,960
Financed by: taxpayers' equity			
Public Dividend Capital		24,511	24,511
Retained earnings		(58,294)	9,988
Revaluation reserve		293	461
Other reserves	7	3,200	0
Total Taxpayers' Equity:		(30,290)	34,960

The notes on pages 50 to 82 form part of this account.
The financial statements on pages 46 to 49 were approved by the Board on 18 June 2013 and signed on its behalf by

Signed: Nick Chapman

Chief Executive
Date: 20 June 2013

Statement of changes in taxpayers' equity for the year ended 31 March 2013

	Public Dividend capital £000s	Retained earnings £000s	Revaluation reserve £000s	Other reserves £000s	Total reserves £000s
Balance at 1 April 2012	24,511	9,988	461	0	34,960
Changes in taxpayers' equity for 2012-13	0	0	0	0	0
Retained surplus/(deficit) for the year	0	(68,282)	0	0	(68,282)
Impairments and reversals	0	0	(168)	0	(168)
Initial Funding for 0845 decommissioning	0	0	0	3,200	3,200
Net recognised revenue/(expense) for the year	0	(68,282)	(168)	3,200	(65,250)
Balance at 31 March 2013	**24,511**	**(58,294)**	**293**	**3,200**	**(30,290)**
Balance at 1 April 2011	24,511	9,500	461	0	34,472
Changes in taxpayers' equity for the year ended 31 March 2012	0	0	0	0	0
Retained surplus/(deficit) for the year	0	488	0	0	488
Net gain / (loss) on revaluation of property, plant, equipment	0	0	0	0	0
Net gain / (loss) on revaluation of intangible assets	0	0	0	0	0
Net recognised revenue/(expense) for the year	0	488	0	0	488
Balance at 31 March 2012	**24,511**	**9,988**	**461**	**0**	**34,960**

Statement of cashflows for the year ended 31 March 2013

	Note	2012/13 £000s	2011/12 £000s
Cash Flows from Operating Activities			
Operating Surplus/(Deficit)		847	920
Decommissioning 0845 service	7	(69,188)	0
Depreciation and Amortisation	7	4,276	4,880
Impairments and Reversals	7	19,076	209
Dividend (Paid) / Refunded		(478)	(472)
(Increase)/Decrease in Trade and Other Receivables		308	(419)
(Increase)/Decrease in Other Current Assets		0	0
Increase/(Decrease) in Trade and Other Payables		25,911	(2,067)
(Increase)/Decrease in Other Current Liabilities		0	0
Provisions Utilised	25	(989)	(510)
Increase/(Decrease) in Provisions	25	21,991	3,903
Net Cash Inflow/(Outflow) from Operating Activities		1,754	6,444
Cash flows from investing activities			
Interest Received		59	54
(Payments) for Property, Plant and Equipment	15	(2,405)	(1,170)
(Payments) for Intangible Assets	16	(1,287)	(1,747)
Proceeds of disposal of assets held for sale (PPE)		143	0
Proceeds of disposal of assets held for sale (Intangible)		127	0
Net Cash Inflow/(Outflow) from Investing Activities		(3,363)	(2,863)
Net Cash Inflow/(Outflow) before Financing		(1,609)	3,581
Cash flows from Financing Activities			
Other Loans Repaid		(1,632)	(1,664)
Initial Funding for 0845 Decommissioning	7	3,200	0
Net Cash Inflow/(Outflow) from Financing Activities		1,568	(1,664)
Net increase/(decrease) in cash and cash equivalents		(41)	1,917
Cash and Cash Equivalents (and Bank Overdraft) at Beginning of the Period		21,875	19,958
Effect of Exchange Rate Changes in the Balance of Cash Held in Foreign Currencies		0	0
Cash and Cash Equivalents (and Bank Overdraft) at year end		21,834	21,875

Notes to the accounts

1 Accounting Policies

The Secretary of State for Health has directed that the financial statements of NHS Trusts shall meet the accounting requirements of the NHS Trusts Manual for Accounts, which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the 2012-13 NHS Trusts Manual for Accounts issued by the Department of Health. The accounting policies contained in that manual follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to the NHS, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the NHS Trusts Manual for Accounts permits a choice of accounting policy, the accounting policy which is judged to be most appropriate to the particular circumstances of the trust for the purpose of giving a true and fair view has been selected. The particular policies adopted by the Trust are described below. They have been applied consistently in dealing with items considered material in relation to the accounts.

1.1 Accounting convention

These accounts have been prepared under the historical cost convention modified to account for the revaluation of property, plant and equipment, intangible assets, inventories and certain financial assets and financial liabilities.

1.2 Acquisitions and discontinued operations

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

1.3 Critical accounting judgements and key sources of estimation uncertainty

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

1.3.1 Critical judgements in applying accounting policies

It is not considered that judgements made will have any significant impact under this requirement; but there have been a number of estimations as set out below, that management has made in the process of applying the Trust's accounting policies in relation to decommissioning.

1.3.2 Key sources of estimation uncertainty

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

As part of the rollout of the new NHS 111 telephony service the NHS Direct 0845 4647 telephony service provided by the Trust is being phased out. The Trust won eleven 111 contracts covering 34% of the population in England. To date, 9 of these contracts have been implemented and the Trust is answering approximately 30% of the contract volumes. The Trust continues to provide a contingency service using the 0845 4647 number, commissioned by NHS England. A contingency service is likely to be in place for most, if not all, of 2013/14 in some areas. NHS England have also commissioned the continuation of other services previously provided by NHS Direct (Digital Services including Health and Symptom Checkers, Complex Health and Medicines Enquiries, Dental Services) for between 12 and 24 months. The estimated cost of providing NHS 111 services is significantly lower than the previous 0845 4647 telephony service and this has therefore required a significant reduction in staff, sites and assets. These accounts reflect the impact of decommissioning the 0845 4647 telephony service during 2013 and beyond in the case of sites with longer leases.

Note 7 gives the detail of the amounts included in these accounts for the decommissioning costs under the headings detailed in the following paragraphs and totals £69.2m. The total cost of decommissioning will be met by the Department of Health.

Staff. Where staff have been given notice of redundancy at 31 March 2013, accruals have been made in respect of their redundancy entitlement. For other staff considered at risk of redundancy, provision has been made for this potential liability but may be subject to change

as the rundown in activity continues. Provision has been made for pay protection where staff have been appointed to new jobs below their current grade or at a grade higher than planned. Staff are also joining the Trust from Out of Hours providers whose contracts have been terminated as a result of the 111 contracts the Trust has won, so staff transfer under TUPE and provision has been made for termination of those staff who will not have a permanent role with the Trust in future.

Sites. A number of sites are closing and provision has been made for the continuing costs of occupying those sites until lease expiry and the dilapidation liability expected to arise on vacation. As some of these leases continue for some time, the precise amounts involved cannot be accurately determined at 31 March 2013 and there is the possibility of subletting in some cases.

Supplier contracts. Contracts will terminate or change as sites close and in addition the IT managed service is being redesigned to reflect the changed business, resulting in a break in the contract with the current supplier being exercised, effective at 30 November 2013. There are considerable costs associated with this change and provision has been made for these and other anticipated termination/change costs in the contracts with suppliers.

Assets. Assets used specifically in sites closing have been treated as fully impaired but as the closure programme continues, it is planned to review the specification and quality of these assets compared to those in the continuing sites and interchange accordingly, which will impact on which assets are eventually disposed of. Other assets particularly those used in IT and Telephony have been reviewed for use in the 111 service and impaired if not considered needed at this stage of service implementation.

As reported in the 2009-10 accounts, the Trust acquired a licence in perpetuity for the clinical content and content engine used in the Trust's activities on 25th May 2010 for £19,247,000. Although this is licenced in perpetuity the Trust decided to amortise the cost over 15 years. The introduction of the 111 telephony service using a different platform for providing advice and guidance to patients, results in this asset only being used in those services which are continuing for a limited period and thus its value has been impaired to that appropriate to its use in these.

Project Costs. There are significant costs associated with the above activities and ensuring a successful implementation of the future business model. This work is expected to continue throughout 2013 and provision has been made for these costs accordingly.

To the extent these significant decommissioning costs impact on cash requirements they are being funded by increasing the Trust's Public Dividend Capital. This funding will only be drawn down to meet costs as they arise. Once all costs have been finalised, should they be less than accruals and provisions held, the excess will be reflected in future years accounts as decommissioning adjustments, and if funding is unused it will be refunded through repayment of PDC.

1.3.3 Going Concern

With the loss incurred in the year through decommissioning costs, it is appropriate to consider whether these accounts should be prepared on a going concern basis. Also the initial performance under the two largest 111 contracts which started on 21 March 2013, has been significantly below that contracted and consequently the future of all the 111 contracts and funding available under them is being reviewed and discussed with local and national commissioners. It is clear from the work done so far that it is financially unsustainable for the Trust to continue to provide the 111 service within the agreed cost envelope.

The ongoing discussions are now aimed at agreeing a plan for the managed exit of NHS Direct from the 111 contracts; the preferred option is expected to be agreed in principle between NHS England and the Trust during July but it will then require approval by the Trust Development Authority and the Department of Health and the timescale for this is unknown. Additionally NHS England is due to have a review of its 111 services during the Autumn 2013 and the outcome of this review may have an impact on the services provided by the Trust.

Although the outcome of these reviews may not be known for some time, NHS England advise they require the Trust to continue operating its 111 contracts at current levels as part of the national rollout. If the funding negotiated to continue this work is such that the Trust incurs further losses in 2013-14, assurance has been obtained that the cash implications of this will be funded through additional Public Dividend Capital (PDC).

The Trust currently still provides the 0845 contingency service to those areas where 111 is not live and it is expected that this may continue to the end of March 2014. If the Trust is no longer a provider of 111 services by the end of March 2014, this will leave the Trust with a number of other services with a total value of under £30m. Further discussions will be required to agree whether the Trust can continue as a viable organisation running these services.

This means that there is a fundamental uncertainty over the future operations of the Trust and hence over the preparation of the accounts on a going concern basis. Although the Trust's operational result cannot be predicted with accuracy at this stage of the year, the assurances received on funding the Trust's cash requirements through PDC mean it is appropriate to prepare the accounts on a going concern basis.

1.4 Revenue

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

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

1.5 Employee Benefits

Short-term employee benefits

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

Retirement benefit costs

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

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

1.6 Other expenses

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

1.7 Property, plant and equipment

Recognition

Property, plant and equipment is capitalised if:

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

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

Valuation

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

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

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

An increase arising on revaluation is taken to the revaluation reserve except when it reverses an impairment for the same asset previously

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

Subsequent expenditure

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

1.8 Intangible assets

Recognition

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

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

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

Measurement

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

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

1.9 Depreciation, amortisation and impairments

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

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

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

A revaluation decrease that does not result from a loss of economic value or service potential is recognised as an impairment charged to the revaluation reserve to the extent that there is a balance on the reserve for the asset and, thereafter, to expenditure. Impairment losses that

arise from a clear consumption of economic benefit should be taken to expenditure. Where an impairment loss subsequently reverses, the carrying amount of the asset is increased to the revised estimate of the recoverable amount but capped at the amount that would have been determined had there been no initial impairment loss. The reversal of the impairment loss is credited to expenditure to the extent of the decrease previously charged there and thereafter to the revaluation reserve.

1.10 Non-current assets held for sale

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

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

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

1.11 Leases

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

The Trust as lessee

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

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

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

Where a lease is for land and buildings, the land and building components are separated and individually assessed as to whether they are operating or finance leases.

The Trust as lessor

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

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

1.12 Cash and cash equivalents

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

1.13 Provisions

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

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

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

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

1.14 Clinical negligence costs

The NHS Litigation Authority (NHSLA) operates a risk pooling scheme under which the Trust pays an annual contribution to the NHSLA which in return settles all clinical negligence claims. The contribution is charged to expenditure. Although the NHSLA is administratively responsible for all clinical negligence cases the legal liability remains with the Trust. The total value of clinical negligence provisions carried by the NHSLA on behalf of the Trust is disclosed at note 25.

1.15 Non-clinical risk pooling

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

1.16 Contingencies

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

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

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

1.17 Financial Instruments

Financial assets

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

Financial assets are initially recognised at fair value.

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

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

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

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

Financial liabilities

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

Financial liabilities are initially recognised at fair value.

Financial liabilities are classified as either financial liabilities 'at fair value through profit and loss' or other financial liabilities. The Trust only has financial liabilities within the other financial liabilities category. The Trust's financial liabilities comprise of creditors for goods and services received in the normal course of business and amounts due under long-term credit arrangements for the acquisition of equipment and intangible assets.

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

1.18 Value Added Tax

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

1.19 Foreign currencies

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

1.20 Public Dividend Capital (PDC) and PDC dividend

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

An annual charge, reflecting the cost of capital utilised by the Trust, is payable to the Department of Health as Public Dividend Capital dividend. The charge is calculated at the real rate set by HM Treasury (currently 3.5%) on the average carrying amount of all assets less liabilities, except for donated assets and cash balances with the Office of the Paymaster General. The average carrying amount of assets is calculated as a simple average of opening and closing relevant net assets.

1.21 Losses and Special Payments

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

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

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

The Treasury FReM does not require the following Standards and Interpretations to be applied in 2012-13. The application of the Standards as revised would not have a material impact on the accounts for 2012-13, were they applied in that year:

IAS 27	Separate Financial Statements - subject to consultation
IAS 28	Investments in Associates and Joint Ventures - subject to consultation
IFRS 9	Financial Instruments - subject to consultation

IFRS 10 Consolidated Financial Statements - subject to consultation
IFRS 11 Joint Arrangements - subject to consultation
IFRS 12 Disclosure of Interests in Other Entities - subject to consultation
IFRS 13 Fair Value Measurement - subject to consultation
IPSAS 32 Service Concession Arrangement - subject to consultation

2 Operating segments

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

NHS Direct NHS Trust only has one business segment and none of the customers referred to in note 4 account for more than 10% of income, other than the Core Service.

	2012/13 £000	2011/12 £000
Core Services	110,162	113,428
Choose & Book Appointments Line	6,373	6,388
Out of Hours Services	570	1,275
Dental Services	1,301	1,331
Long Term Conditions	1,568	3,450
Single Point of Access to NHS Services	5,103	5,439
Pandemic Flu & Fluline Service	4,385	4,387
Other Contestable Income	183	509
111 Income	8,929	6,298
	138,574	142,504

3 Income generation activities

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

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

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

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

Pandemic Flu and Fluline Service

During 2007/08 the Department of Health initiated the development of a Pandemic Flu advice and antiviral distribution system through NHS Direct. The system was to be available throughout the UK, funded by the Department of Health in England and the Devolved Health Authorities in Scotland, Wales and Northern Ireland. The Department of Health has contracted to reimburse the direct costs involved in this initiative and specific overheads involved in running this major project, with an overall revised budget of £71m for the system and keeping it in a state of readiness over its expected life of 5 years. The service has been extended for a further one year to April 2014.

The charges to the Devolved Health Authorities are subject to separate contracts.

Income from Department of Health in 2012/13 includes £3,793,914 (2011/12 £3,795,260) for reimbursement of costs incurred on the Pandemic Flu project, summarised below.

	2012-13 £000	2011-12 £000
Income from Department of Health for System Build and Maintenance	3,684	3,691
Income from the Devolved Authorities for Scotland, Wales and Northern Ireland	591	591
Costs		
Directly attributable costs	0	(5)
System Build costs	0	0
Dormancy Fees	(4,275)	(4,276)
External charges	0	(1)
Contribution to specified overheads including staff working on the project	0	0
Included within the above, contribution from the Devolved Health Authorities under the contracts referred to above	0	0
Income from Department of Health for delivery of Fluline service	110	104
External charges	1	3
Internal recharges	(85)	(83)
Contribution to specified overheads including staff working on the project	26	24

Dental Services	2012-13 £000	2011-12 £000
Income	1,301	1,331
Full cost	(1,520)	(1,361)
Surplus/(deficit)	(219)	(30)
Contribution	339	433

GP Out of Hours Services	2012-13 £000	2011-12 £000
Income	570	1,275
Full cost	(649)	(1,375)
Surplus/(deficit)	(79)	(100)
Contribution	112	264

Long Term Conditions	2012-13 £000	2011-12 £000
Income	1,803	3,450
Full cost	(1,758)	(3,441)
Surplus/(deficit)	45	9
Contribution	284	902

Single Point of Access to NHS Services	2012-13 £000	2011-12 £000
Income	5,103	5,439
Full cost	(6,247)	(6,671)
Surplus/(deficit)	(1,144)	(1,232)
Contribution	(325)	(269)

The overall service deficit has improved from last year, although the direct contribution has worsened slightly due to unavoidable increases in cost associated with services commissioned via a third party provider. The penalty payment under the terms of the core contract amounted to the loss of £325k (£269k for 11/12).

Choose & Book Appointments Line	2012-13 £000	2011-12 £000
Income	6,373	6,388
Full cost	(6,199)	(6,243)
Surplus/(deficit)	174	145
Contribution	1,944	1,741

111 Income	2012-13 £000	2011-12 £000
Income	8,929	6,298
Full cost	(12,226)	(8,775)
Surplus/(deficit)	(3,297)	(2,477)
Contribution	951	1,019

Core Services	2012-13 £000	2011-12 £000
Income	110,704	113,428
Full cost	(105,884)	(109,390)
Surplus/(deficit)	4,820	4,038

4 Revenue from patient care activities

	2012-13 £000s	2011-12 £000s
Strategic Health Authorities	116,626	122,254
NHS Trusts	0	11
Primary Care Trusts - non-tariff	16,770	12,515
NHS Foundation Trusts	199	174
Department of Health	4,332	3,797
Non-NHS	647	3,753
Total Revenue from patient care activities	138,574	142,504

5 Other operating revenue

	2012-13 £000s	2011-12 £000s
Education, training and research	232	686
Rental revenue from operating leases	205	166
Other revenue	195	445
Total Other Operating Revenue	632	1,297
Total operating revenue	139,206	143,801

6 Revenue

	2012-13 £000	2011-12 £000
From rendering of services	139,206	143,801
From sale of goods	0	0

7 Operating expenses (excluding employee benefits)

	2012-13 £000s	2011-12 £000s
Trust Chair and Non-Executive Directors	102	102
Supplies and services - general	83	88
Consultancy services	1,961	2,730
Establishment	2,209	2,178
Transport	1,375	1,407
Premises	6,999	7,998
Depreciation	1,902	2,412
Amortisation	2,374	2,468
Impairments and reversals of property, plant and equipment (see note (c))	0	209
Audit fees	83	53
Other auditor's remuneration (Internal Audit fees)	87	109
Clinical negligence	292	185
Education and Training	160	134
Telecommunications	4,618	5,299
Health Information	5,443	4,216
IT Contracts (a)	16,925	18,200
Other (b)	1,273	3,650
Total Operating expenses (excluding employee benefits and decommissioning costs)	45,886	51,438
Decommissioning Costs (c)	31,607	
Total Operating expenses (excluding employee benefits)	77,493	51,438
Employee benefits		
Employee benefits excluding Board members	91,395	89,011
Termination Benefits (see note (c))	0	1,360
Board members	1,078	1,072
	92,473	91,443
Decommissioning Costs (c)	37,581	0
Total employee benefits	130,054	91,443
Total operating expenses	207,547	142,881

Details of remuneration paid to Non-Executive Directors and the Senior Management Team are given in the Remuneration Report.

(a) IT contracts costs include £4,275,915 (2011/12 £4,276,534) in respect of Pandemic Flu and Fluline dormancy fees. CS computer contract included is £9,814,358 (2011/12 £10,706,381).

(b) Significant items included in Other Costs are: Employment tribunal costs £473,620 (2011-12 Nil), interpreting skills £155,500 (2011-12 £136,500), website development £139,930 (2011-12 Nil), patient surveys and public participation activities £34,775 (2011-12 £138,260), Dilapidations provision £Nil (2011-12: £2,588,000), costs in respect of potential performance fees Nil (2011-12 £554,000).

7 Operating expenses (Continued)

(c) Decommissioning Costs

Decommissioning costs will be funded by the Department of Health through an increase in Public Dividend Capital. An initial funding of £3.2m was provided in 12/13 and is accounted for within 'Other Reserves'.

		2012-13 £000s
Included within Operating expenses:		
Impairments of property, plant and equipment	1,819	
Impairments of intangible assets	17,257	
		19,076
Supplier Contracts - Exit Costs		7,724
Sites Decommissioning		1,709
Project Costs (excluding pay costs)		3,098
		31,607
Included within Employee benefits:		
Redundancy costs		26,855
Other Pay and termination costs		6,724
Project pay costs		4,002
		37,581
		69,188

8 Operating Leases

The Trust has 2 main types of operating leases:

- Car leases which are all for a period of 3 years
- Rental of premises for operational and administrative purposes

8.1 Trust as lessee

	Buildings £000s	2012-13 Other £000s	Total £000s	2011-12 Total £000s
Payments recognised as an expense				
Minimum lease payments	3,561	260	3,821	4,094
Contingent rents	0	0	0	0
Sub-lease payments	0	0	0	0
Total	3,561	260	3,821	4,094
Payable:				
No later than one year	2,785	135	2,920	3,988
Between one and five years	3,321	45	3,366	5,760
After five years	70	0	70	382
Total	6,176	180	6,356	10,130
Total future sublease payments expected to be received:			136	242

8.2 Trust as lessor

The Trust sublets 4 of the premises occupied

Recognised as income	2012-13 £000	2011-12 £000s
Rental revenue	205	166
Contingent rents	0	0
Total	205	166
Receivable:		
No later than one year	136	204
Between one and five years	0	38
After five years	0	0
Total	136	242

9 Employee benefits and staff numbers

9.1 Employee benefits

Employee Benefits - Gross and Net Expenditure	Total £000s	2012-13 Permanently employed £000s	Other £000s
Salaries and wages	85,849	54,169	31,680
Social security costs	4,435	4,398	37
Employer Contributions to NHS BSA - Pensions Division	6,476	6,422	54
Other employment benefits	6,724	6,724	0
Termination benefits	26,570	26,570	0
Total employee benefits	130,054	98,283	31,771
Included in the above is: Decommissioning costs (see note 7)	37,581		

Gross Employee Benefits & Net expenditure 2011-12	Total £000s	2011-12 Permanently employed £000s	Other £000s
Salaries and wages	77,885	62,538	15,347
Social security costs	4,842	4,841	1
Employer Contributions to NHS BSA - Pensions Division	7,481	7,452	29
Termination benefits	1,360	1,360	0
Total - including capitalised costs	91,568	76,191	15,377
Recognised as			
Employee costs capitalised	125		
Net Employee Benefits excluding capitalised costs	91,443		

9.2 Staff Numbers

Average Staff Numbers	Total Number	2012-13 Permanently employed Number	Other Number	2011-12 Total Number
Medical and dental	1	1	0	2
Ambulance staff	0	0	0	0
Administration and estates	1,486	1,018	468	1,383
Healthcare assistants and other support staff	0	0	0	0
Nursing, midwifery and health visiting staff	646	477	170	685
Nursing, midwifery and health visiting learners	0	0	0	0
Scientific, therapeutic and technical staff	43	43	0	62
Social Care Staff	0	0	0	0
Other	0	0	0	0
TOTAL	2,176	1,539	637	2,132

9.3 Staff Sickness absence and ill health retirements

	2012-13 Number	2011-12 Number
Total Days Lost	21,607	29,955
Total Staff Years	1,703	2,045
Average working Days Lost	12.69	14.65

The statistics shown above for sickness absence are for the calendar year 1 January to 31 December 2012, rather than the financial year, in accordance with instructions issued by the Department of Health.

	2012-13 Number	2011-12 Number
Number of persons retired early on ill health grounds	11	9
	£000s	£000s
Total additional pensions liabilities accrued in the year	798	826

9.4 Exit Packages agreed in 2012-13

	2012-13			2011-12		
Exit package cost band (including any special payment element)	*Number of compulsory redundancies	*Number of other departures agreed	Total number of exit packages by cost band	*Number of compulsory redundancies	*Number of other departures agreed	Total number of exit packages by cost band
	Number	Number	Number	Number	Number	Number
Less than £10,000	674	0	674	8	0	8
£10,001-£25,000	253	0	253	9	0	9
£25,001-£50,000	148	0	148	7	0	7
£50,001-£100,000	132	0	132	6	0	6
£100,001 - £150,000	10	0	10	0	0	0
£150,001 - £200,000	9	0	9	0	0	0
>£200,000	1	0	1	0	0	0
Total number of exit packages by type (total cost)	1,227	0	1,227	30	0	30
Total resource cost (£000s)	26,570	0	26,570	774	0	774

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

This disclosure reports the number and value of exit packages agreed during the year, and includes redundancy cost associated with staff transferred to the organisation under TUPE in relation to the decommissioning activities, as explained in note 1.3.2.

10 Pension costs

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

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

a) Full actuarial (funding) valuation
The purpose of this valuation is to assess the level of liability in respect of the benefits due under the scheme (taking into account its recent demographic experience), and to recommend the contribution rates to be paid by employers and scheme members. The last such valuation, which determined current contribution rates was undertaken as at 31 March 2004 and covered the period from 1 April 1999 to that date. The conclusion from the 2004 valuation was that the scheme had accumulated a notional deficit of £3.3 billion against the notional assets as at 31 March 2004.

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

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

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

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

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

The valuation of the scheme liability as at 31 March 2011, is based on detailed membership data as at 31 March 2008 (the latest midpoint) updated to 31 March 2011 with summary global member and accounting data.

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

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

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

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

Annual increases are applied to pension payments at rates defined by the Pensions (Increase) Act 1971, and are based on changes in retail prices in the twelve months ending 30 September in the previous calendar year.

Early payment of a pension, with enhancement, is available to members of the scheme who are permanently incapable of fulfilling their duties effectively through illness or infirmity. A death gratuity of twice final year's pensionable pay for death in service, and five times their annual pension for death after retirement is payable.

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

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

11 Better Payment Practice Code

11.1 Measure of compliance

	2012-13 Number	2012-13 £000s	2011-12 Number	2011-12 £000s
Non-NHS Payables				
Total Non-NHS Trade Invoices Paid in the Year	17,148	78,709	17,207	67,181
Total Non-NHS Trade Invoices Paid Within Target	17,040	78,657	16,934	66,756
Percentage of Non-NHS Trade Invoices Paid Within Target	99.37%	99.93%	98.41%	99.37%
NHS Payables				
Total NHS Trade Invoices Paid in the Year	244	3,937	330	2,878
Total NHS Trade Invoices Paid Within Target	237	3,921	316	2,850
Percentage of NHS Trade Invoices Paid Within Target	97.13%	99.59%	95.76%	99.02%

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

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

	2012-13 £000s	2011-12 £000s
Amounts included in finance costs from claims made under this legislation	0	0
Compensation paid to cover debt recovery costs under this legislation	0	0
Total	0	0

12 Investment Income

	2012-13 £000s	2011-12 £000s
Interest Income		
Bank interest	56	54
Other loans and receivables	3	0
Total investment income	59	54

13 Other Gains and Losses

	2012-13 £000s	2011-12 £000s
Gain/(Loss) on disposal of assets other than by sale (PPE)	0	(3)
Total	0	(3)

14 Finance costs

	2012-13 £000s	2011-12 £000s
Interest		
Interest on loans and overdrafts	0	0
Interest on late payment of commercial debt	0	0
Other interest expense	0	0
Total interest expense	0	0
Other finance costs	0	0
Total	0	0

15.1 Property, plant and equipment

2012-13	Land	Buildings excluding dwellings	Dwellings	Assets under construction & payments on account	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s
Cost or valuation:									
At 1 April 2012	556	11,625	0	714	1,980	0	7,840	2,292	25,007
Additions of Assets Under Construction	0	0	0	516	0	0	0	0	516
Additions Purchased	0	0	0	0	7	0	1,882	0	1,889
Additions Donated	0	0	0	0	0	0	0	0	0
Additions Government Granted	0	0	0	0	0	0	0	0	0
Additions Leased	0	0	0	0	0	0	0	0	0
Reclassifications	0	0	0	(596)	11	0	585	0	0
Reclassifications as Held for Sale and reversals	0	0	0	0	0	0	0	0	0
Disposals other than for sale	0	(3)	0	0	(9)	0	(131)	0	(143)
Upward revaluation/positive indexation	0	0	0	0	0	0	0	0	0
Impairments/negative indexation	0	(162)	0	0	(4)	0	0	(2)	(168)
Reversal of Impairments	0	0	0	0	0	0	0	0	0
Transfers to NHS Foundation Trust	0	0	0	0	0	0	0	0	0
Transfer (to)/from Other Public Sector bodies	0	0	0	0	0	0	0	0	0
At 31 March 2013	**556**	**11,460**	**0**	**634**	**1,985**	**0**	**10,176**	**2,290**	**27,101**
Depreciation									
At 1 April 2012	7	6,098	0	0	1,185	0	6,595	1,465	15,350
Reclassifications	0	0	0	0	0	0	0	0	0
Reclassifications as Held for Sale and reversals	0	0	0	0	0	0	0	0	0
Disposals other than for sale	0	0	0	0	0	0	0	0	0
Upward revaluation/positive indexation	0	0	0	0	0	0	0	0	0
Impairments	0	592	0	241	114	0	791	81	1,819
Reversal of Impairments	0	0	0	0	0	0	0	0	0
Charged During the Year	1	761	0	0	300	0	527	313	1,902
Transfers to NHS Foundation Trust	0	0	0	0	0	0	0	0	0
Transfer (to)/from Other Public Sector bodies	0	0	0	0	0	0	0	0	0
At 31 March 2013	**8**	**7,451**	**0**	**241**	**1,599**	**0**	**7,913**	**1,859**	**19,071**
Net Book Value at 31 March 2013	**548**	**4,009**	**0**	**393**	**386**	**0**	**2,263**	**431**	**8,030**
Purchased	548	4,009	0	393	386	0	2,263	431	8,030
Donated	0	0	0	0	0	0	0	0	0
Government Granted	0	0	0	0	0	0	0	0	0
Total at 31 March 2013	**548**	**4,009**	**0**	**393**	**386**	**0**	**2,263**	**431**	**8,030**

Asset financing:									
Owned	548	4,009	0	393	386	0	2,263	431	8,030
Held on finance lease	0	0	0	0	0	0	0	0	0
On-SOFP PFI contracts	0	0	0	0	0	0	0	0	0
PFI residual: interests	0	0	0	0	0	0	0	0	0
Total at 31 March 2013	**548**	**4,009**	**0**	**393**	**386**	**0**	**2,263**	**431**	**8,030**

Impairment charge of £1,819k relates to 0845 service decommissioning as shown on note 7. Disposals other than for sale relates to release of accruals re non-current assets no longer required.

Revaluation Reserve Balance for Property, Plant & Equipment

2012-13	Land	Buildings excluding dwellings	Dwellings	Assets under construction & payments on account	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s
At 1 April 2012	0	400	0	0	25	0	0	36	461
Movements	0	(162)	0	0	(4)	0	0	(2)	(168)
At 31 March 2013	**0**	**238**	**0**	**0**	**21**	**0**	**0**	**34**	**293**

Movement relates to impairment charge on non-current assets decommissioned.

Additions to Assets Under Construction in 2012-13

	£000s
Land	0
Buildings excl Dwellings	85
Dwellings	0
Plant & Machinery	431
Balance as at YTD	**516**

15.2 Property, plant and equipment prior-year

2011-12	Land	Buildings excluding dwellings	Dwellings	Assets under construction & payments on account	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s
Cost or valuation:									
At 1 April 2011	556	11,570	0	185	1,687	0	7,563	2,281	23,842
Additions - purchased	0	55	0	596	232	0	271	16	1,170
Additions - donated	0	0	0	0	0	0	0	0	0
Additions - government granted	0	0	0	0	0	0	0	0	0
Reclassifications	0	0	0	(67)	61	0	6	0	0
Reclassifications as Held for Sale and reversals	0	0	0	0	0	0	0	0	0
Disposals other than by sale	0	0	0	0	0	0	0	(5)	(5)
Revaluation & indexation gains	0	0	0	0	0	0	0	0	0
Impairments	0	0	0	0	0	0	0	0	0
Reversals of impairments	0	0	0	0	0	0	0	0	0
In-year transfers to/from NHS bodies	0	0	0	0	0	0	0	0	0
Transfer to NHS Foundation Trust	0	0	0	0	0	0	0	0	0
Cumulative dep netted off cost following revaluation	0	0	0	0	0	0	0	0	0
At 31 March 2012	**556**	**11,625**	**0**	**714**	**1,980**	**0**	**7,840**	**2,292**	**25,007**

Depreciation									
At 1 April 2011	7	5,338	0	0	851	0	5,396	1,140	12,732
Reclassifications	0	0	0	0	0	0	0	0	0
Reclassifications as Held for Sale and reversals	0	0	0	0	0	0	0	0	0
Disposals other than for sale	0	0	0	0	0	0	0	(2)	(2)
Upward revaluation/positive indexation	0	0	0	0	0	0	0	0	0
Impairments	0	0	0	0	0	0	208	0	208
Reversal of Impairments	0	0	0	0	0	0	0	0	0
Charged During the Year	0	760	0	0	334	0	991	327	2,412
Transfers to NHS Bodies	0	0	0	0	0	0	0	0	0
Transfer to NHS Foundation Trust	0	0	0	0	0	0	0	0	0
Cumulative dep netted off cost following revaluation	0	0	0	0	0	0	0	0	0
At 31 March 2012	**7**	**6,098**	**0**	**0**	**1,185**	**0**	**6,595**	**1,465**	**15,350**
Net book value at 31 March 2012	**549**	**5,527**	**0**	**714**	**795**	**0**	**1,245**	**827**	**9,657**
Purchased	549	5,527	0	714	795	0	1,245	827	9,657
Donated	0	0	0	0	0	0	0	0	0
Government Granted	0	0	0	0	0	0	0	0	0
Total at 31 March 2012	**549**	**5,527**	**0**	**714**	**795**	**0**	**1,245**	**827**	**9,657**
Asset financing:									
Owned	549	5,527	0	714	795	0	1,245	827	9,657
Held on finance lease	0	0	0	0	0	0	0	0	0
On-SOFP PFI contracts	0	0	0	0	0	0	0	0	0
PFI residual: interests	0	0	0	0	0	0	0	0	0
Total at 31 March 2012	**549**	**5,527**	**0**	**714**	**795**	**0**	**1,245**	**827**	**9,657**

15.3 Property, plant and equipment

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

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

The gross revalued amount of assets fully depreciated but still in use at 31 March 2013 is £3,745,962 (at 31 March 2012 £7,393,253)

At 2011-12	Min life (years)	Max life (years)
Long leasehold land	990	990
Buildings excluding dwellings - all leasehold	1	66
Plant & Machinery	3	9
Information Technology	1	5
Furniture & Fittings	1	10

16.1 Intangible non-current assets

2012/13	Software internally generated	Software purchased	Licences & trademarks	Assets under construction	Development expenditure	Total
	£000s	£000s	£000s	£000s	£000s	£000s
At 1 April 2012	0	5,718	19,445	2,002	323	27,488
Additions - purchased	0	0	0	1,287	0	1,287
Additions - internally generated	0	0	0	0	0	0
Additions - donated	0	0	0	0	0	0
Additions - government granted	0	0	0	0	0	0
Additions - leased	0	0	0	0	0	0
Reclassifications	0	185	0	(213)	28	0
Reclassified as Held for Sale and Reversals	0	0	0	0	0	0
Disposals other than by sale	0	(112)	(15)	0	0	(127)
Revaluation & indexation gains	0	0	0	0	0	0
Impairments charged to reserves	0	0	0	0	0	0
Reversal of impairments charged to reserves	0	0	0	0	0	0
Transfer to NHS Foundation Trust	0	0	0	0	0	0
Transfer (to)/from Other Public Sector bodies	0	0	0	0	0	0
At 31 March 2013	**0**	**5,791**	**19,430**	**3,076**	**351**	**28,648**
Amortisation						
At 1 April 2012	0	2,426	2,205	0	211	4,842
Reclassifications	0	0	0	0	0	0
Reclassified as Held for Sale and Reversals	0	0	0	0	0	0
Disposals other than by sale	0	0	0	0	0	0
Revaluation or indexation gains	0	0	0	0	0	0
Impairments charged to operating expenses	0	789	14,911	1,557	0	17,257
Reversal of impairments charged to operating expenses	0	0	0	0	0	0
Charged during the year	0	1,040	1,302	0	32	2,374
Transfer to NHS Foundation Trust	0	0	0	0	0	0
Transfer (to)/from Other Public Sector bodies	0	0	0	0	0	0
At 31 March 2013	**0**	**4,255**	**18,418**	**1,557**	**243**	**24,473**
Net Book Value at 31 March 2013	**0**	**1,536**	**1,012**	**1,519**	**108**	**4,175**
Net book value at 31 March 2013 comprises:						
Purchased	0	1,536	1,012	1,519	108	4,175
Donated	0	0	0	0	0	0
Government Granted	0	0	0	0	0	0
Total at 31 March 2013	**0**	**1,536**	**1,012**	**1,519**	**108**	**4,175**

Revaluation reserve balance for intangible non-current assets

	£000s	£000s	£000s	£000s	£000s	£000s
At 1 April 2012	0	0	0	0	0	0
Movements (specify)	0	0	0	0	0	0
At 31 March 2013	**0**	**0**	**0**	**0**	**0**	**0**

Impairment charge of £17,257k relates to 0845 service decommissioning as shown in note 7. Disposals other than for sale relates to release of accruals re non-current assets no longer required.

Additions to Assets Under Construction in 2012-13	£000s
Software developed	289
Software purchased	998
Balance as at YTD	1,287

16.2 Intangible non-current assets prior year

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

Net book value at 31 March 2012 comprises:						
Purchased	0	3,292	17,240	2,002	112	22,646
Donated	0	0	0	0	0	0
Government granted	0	0	0	0	0	0
Total at 31 March 2012	**0**	**3,292**	**17,240**	**2,002**	**112**	**22,646**

16.3 Intangible non-current assets

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

At 2012/13

	Min life (years)	Max life (years)
Computer Software purchased	1	5
Computer Software internally generated	3	5
Licenced Content	2	2
Development expenditure internally generated	3	5

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

The gross revalued amount of assets fully depreciated but still in use at 31 March 2013 is £1,653,953 (at 31 March 2012 £1,349,680)

17 Analysis of impairments and reversals recognised in 2012/13

	2012/13 Total
	£000s
Property, Plant and Equipment impairments and reversals taken to SoCI	
Loss resulting from decommissioning 0845 activities	1,819
Total charged to Departmental Expenditure Limit	**1,819**
Property, Plant and Equipment impairments and reversals charged to the revaluation reserve	
Loss resulting from decommissioning 0845 activities	168
Total impairments for PPE charged to reserves	**168**
Total Impairments of Property, Plant and Equipment	**1,987**
Intangible assets impairments and reversals charged to SoCI	
Loss resulting from decommissioning 0845 activities	17,257
Total charged to Departmental Expenditure Limit	**17,257**
Total Impairments of Intangibles	**17,257**
Total Impairments charged to Revaluation Reserve	168
Total Impairments charged to SoCI - DEL	19,076
Overall Total Impairments	**19,244**

Impairments of £168,000 charged to reserves relate to assets being decommissioned as a result of 0845 service decommissioining.

18 Capital commitments

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

	31 March 2013 £000s	31 March 2012 £000s
Property, plant and equipment	103	1,360
Intangible assets	28	132
Total	131	1,492

19 Intra-Government and other balances

	Current receivables £000s	Non-current receivables £000s	Current payables £000s	Non-current payables £000s
Balances with other Central Government Bodies	3,203	0	3,115	0
Balances with Local Authorities	0	0	0	0
Balances with NHS bodies outside the Departmental Group	0	0	0	0
Balances with NHS Trusts and Foundation Trusts	74	0	86	0
Balances with Public Corporations and Trading Funds	0	0	0	0
Balances with bodies external to government	2,018	0	37,651	2,456
At 31 March 2013	5,295	0	40,852	2,456
Prior period				
Balances with other Central Government Bodies	2,694	0	3,973	0
Balances with Local Authorities	0	0	70	0
Balances with NHS Trusts and Foundation Trusts	59	0	325	0
Balances with Public Corporations and Trading Funds	0	0	0	0
Balances with bodies external to government	2,849	0	10,670	4,468
At 31 March 2012	5,602	0	15,038	4,468

20.1 Trade and other receivables

	Current		Non-current	
	31 March 2013	31 March 2012	31 March 2013	31 March 2012
	£000	£000	£000	£000
NHS receivables - revenue	1,361	824	0	0
NHS receivables - capital	0	0	0	0
NHS prepayments and accrued income	94	661	0	0
Non-NHS receivables - revenue	277	810	0	0
Non-NHS receivables - capital	0	0	0	0
Non-NHS prepayments and accrued income	1,727	2,074	0	0
Provision for the impairment of receivables	(158)	(160)	0	0
VAT	1,806	1,268	0	0
Other receivables	188	125	0	0
Total	5,295	5,602	0	0
Total current and non current	5,295	5,602		
Included in NHS receivables are prepaid pension contributions	0	0		

The great majority of trade is with Primary Care Trusts, as commissioners for NHS patient care services. As Primary Care Trusts are funded by Government to buy NHS patient care services, no credit scoring of them is considered necessary.

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

20.2 Receivables past their due date but not impaired

	31 March 2013 £000s	31 March 2012 £000s
By up to three months	0	0
By three to six months	0	0
By more than six months	0	0
Total	0	0

20.3 Provision for impairment of receivables

	2012/13 £000s	2011/12 £000s
Balance at 1 April 2012	(160)	(216)
Amount written off during the year	2	56
Amount recovered during the year	0	0
(Increase)/decrease in receivables impaired	0	0
Balance at 31 March 2013	(158)	(160)

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

21 Cash and cash equivalents

	31 March 2013 £000s	31 March 2012 £000s
Opening balance	21,875	19,958
Net change in year	(41)	1,917
Closing balance	21,834	21,875
Made up of:		
Cash with Government Banking Service	21,834	21,875
Commercial banks	0	0
Cash in hand	0	0
Current investments	0	0
Cash and cash equivalents as in statement of financial position	21,834	21,875
Bank overdraft - Government Banking Service	0	0
Bank overdraft - Commercial banks	0	0
Cash and cash equivalents as in statement of cash flows	21,834	21,875

22 Non-current assets held for sale

There were no non-current assets held for sale at 31 March 2013.

23 Trade and other payables

	Current		Non-current	
	31 March 2013	31 March 2012	31 March 2013	31 March 2012
	£000s	£000s	£000s	£000s
Interest payable	0	0	0	0
NHS payables - revenue	434	62	0	0
NHS accruals and deferred income	1,086	1,860	0	0
Non-NHS payables - revenue	1,968	2,323	0	0
Non-NHS payables - capital	2,007	1,627	2,456	4,468
Non-NHS accruals and deferred income	34,144	7,644	0	0
Social security costs	590	713	0	0
Tax	611	799	0	0
Other	12	10	0	0
Total	40,852	15,038	2,456	4,468
Total payables (current and non-current)	43,308	19,506		
Included above:				
Outstanding Pension Contributions at the year end	798	864		

24 Deferred income

	Current		Non-current	
	31 March 2013	31 March 2012	31 March 2013	31 March 2012
	£000s	£000s	£000s	£000s
Opening balance at 1 April 2012	1,060	3,125	0	0
Deferred income addition	710	337	0	0
Transfer of deferred income	(699)	(2,402)	0	0
Current deferred income at 31 March 2013	1,071	1,060	0	0
Total deferred income (current and non-current)	1,071	1,060	0	0

25 Provisions

	Total £000s	Comprising: Pensions to Former Directors £000s	Pensions Relating to Other Staff £000s	Restructuring £000s	Other £000s	Redundancy £000s
Balance at 1 April 2012	5,314	0	761	1,231	3,322	0
Arising During the Year	23,858	0	32	9,564	960	13,302
Utilised During the Year	(989)	0	(30)	(908)	(51)	0
Reversed Unused	(1,867)	0	0	(323)	(1,544)	0
Unwinding of Discount	0	0	0	0	0	0
Change in Discount Rate	0	0	0	0	0	0
Transferred (to)/from other public sector bodies	0	0	0	0	0	0
Balance at 31 March 2013	**26,316**	**0**	**763**	**9,564**	**2,687**	**13,302**
Expected Timing of Cash Flows:						
No Later than One Year	21,708	0	36	8,806	1,989	10,877
Later than One Year and not later than Five Years	4,010	0	135	758	692	2,425
Later than Five Years	598	0	592	0	6	0

Amount Included in the Provisions of the NHS Litigation Authority in respect of Clinical Negligence Liabilities:	
As at 31 March 2013	14,919
As at 31 March 2012	9,941

Pensions relating to other staff relates to pensions payable to staff who are in receipt of this through permanent injury on the assumption it would continue to be paid until they are aged 80, discounted at 2.35% in line with Treasury guidance.

Restructuring provision relates to associated costs re the 0845 service decommissioning as explained in note 1.3.2.

Other provisions include dilapidation provision of £1,382,000 which is based on external surveyors assessment of dilapidation payments required on expiry of commercial property leases. The remainder of the provision relates to estimated amounts arising under Employment Tribunal cases, Employers liability insurance and retention payments to staff to execute a smooth 111 service.

Redundancy provision relates to the 0845 service decommissioning which has been approved by the Board and advised to staff affected being an estimate of the potential redundancy costs involved on implementation.

26 Contingencies

Contingent liabilities	31 March 2013 £000s	31 March 2012 £000s
Equal Pay	**0**	0
Other - Employment Liability	**25**	37
Contingent liabilities associated with decommissioning the 0845 service	**9,812**	0
Amounts Recoverable Against Contingent Liabilities	**0**	0
	9,837	37

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

The maximum total liability, previously estimated at £144m has now been revised to £79m after mitigation by the application of Cabinet Office Guidelines for front line staff transferred to successful bidders of 111 services, and other cost minimisation actions being implemented. £69m of these costs are recognised as accruals and provisions within these accounts while the remainder of £9.8m remain contingent liabilities. The Department of Health has agreed to fund the residual decommissioning costs by issuing additional PDC.

As the future of all the 111 contracts and funding available under them is being reviewed and discussed with local and national commissioners, the future of the organisation depends on the outcome of these reviews and the continued support the organisation gets from both NHS England and the Trust Development Authority. There remains, therefore, a further contingent liability in respect of decommissioning costs associated with the delivery of 111 services. This cannot be quantified until the outcome of the ongoing 111 review is known.

27 Events after the end of the reporting period

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

28 Financial risk management

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

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

Currency risk

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

Interest rate risk

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

Credit risk

Because the majority of the Trust's income comes from contracts with other public sector bodies, the Trust has low exposure to credit risk. The maximum exposures as at 31 March 2013 are in receivables from customers, as disclosed in the trade and other receivables note.

Liquidity risk

The Trust's 2012/13 operating costs are incurred under contracts with Primary Care Trusts, which are financed from resources voted annually by Parliament. The Trust funds its capital expenditure from funds obtained within its prudential borrowing limit. The cash costs of decommissioning the 0845 service reported in these accounts will be funded by the Department of Health by issuing additional PDC. The Trust is not, therefore, exposed to significant liquidity risks.

29 Related party transactions

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

The Department of Health is regarded as a related party. During the year 2012/13, the Trust has had a significant number of material transactions with the Department, and with other entities for which the Department is regarded as the parent Department. These entities are:

Strategic Health Authorities
NHS Foundation Trusts
NHS Litigation Authority

NHS Primary Care Trusts
NHS Trusts

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

Income	Income £'000	2012/13 Debtor £'000	Creditor £'000	Income £'000	2011/12 Debtor £'000	Creditor £'000
NHS Midlands and East (formerly East of England) Strategic Health Authority	116,989	649	0	122,622	0	731
Department of Health	4,514	16	431	4,430	9	517
Blackpool PCT	3,621	12	3	2,063	0	51
Calderdale PCT	5,103	0	429	5,439	41	0
East Lancashire Teaching PCT	13	0	4	338	0	0
Lincolnshire Teaching PCT	2,355	4	0	1181	682	0
Luton Teaching PCT	513	0	0	294	175	0
Manchester PCT	259	28	7	263	35	0
Nottingham City PCT	1,635	18	0	1,177	172	22
Stockport PCT	369	43	5	331	0	0
Warwickshire PCT	605	0	0	0	0	0

Expenditure	Expenditure £'000	Debtor £'000	Creditor £'000	Expenditure £'000	Debtor £'000	Creditor £'000
Imperial College Healthcare NHS Trust	208	0	44	327	0	17
NHS Litigation Authority	399	0	0	309	0	0
North West Ambulance Service NHS Trust	795	0	42	492	0	137
University Hospitals Of Leicester NHS Trust	352	0	0	385	0	0
Yorkshire Ambulance Service NHS Trust	447	9	0	753	0	76
NHS Pension Scheme	6,476	0	794	7,481	0	864
Nottinghamshire Healthcare NHS Trust	106	0	0	165	0	33

30 Losses and special payments

The total number of losses cases in 2012-13 and their total value was as follows:

	Total Value of Cases £s	Total Number of Cases
Losses	0	0
Special payments	363,156	47
Total losses and special payments	**363,156**	**47**

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

	Total Value of Cases £s	Total Number of Cases
Losses	0	0
Special payments	38,713	13
Total losses and special payments	**38,713**	**13**

31 Financial performance targets

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

31.1 Breakeven performance

	2007-08 £000s	2008-09 £000s	2009-10 £000s	2010-11 £000s	2011-12 £000s	2012-13 £000s
Turnover	144,381	161,566	191,036	149,606	143,801	139,206
Retained surplus/(deficit) for the year	5,062	467	949	2,733	488	(68,282)
Adjustment for:						
Timing/non-cash impacting distortions	0	0	0	0	0	0
Adjustments for impairments	0	0	0	0	0	19,076
Break-even in year position	5,062	467	949	2,733	488	(49,206)
Break-even cumulative position	5,062	5,529	6,478	9,211	9,699	(39,507)

	2007-08 %	2008-09 %	2009-10 %	2010-11 %	2011-12 %	2012-13 %
Materiality test (I.e. is it equal to or less than 0.5%):						
Break-even in-year position as a percentage of turnover	3.5%	0.3%	0.5%	1.8%	0.3%	-49.1%
Break-even cumulative position as a percentage of turnover	3.5%	3.4%	3.4%	6.2%	6.7%	-28.4%

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

The Trust has not met its break-even duty. However, this is due to costs associated with decommissioning the 0845 service, which will be separately funded by the Department of Health.

The operating surplus amounted to £378k, after adjusting for decommissioning costs of £69m and PDC dividend credit of £528k, as shown in the Statement of Comprehensive Income for the year.

31.2 Capital cost absorption rate

The dividend payable on public dividend capital is based on the actual (rather than forecast) average relevant net assets and therefore the actual capital cost absorption rate should be 3.5%. As the decommissioning costs are being funded by additional PDC post year end, the deficit for the year results on no dividend being payable for 2012-13.

31.3 External financing

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

	£000s	2012-13 £000s	2011-12 £000s
External financing limit		6,988	9,760
Cash flow financing	1,609	0	1,917
Finance leases taken out in the year	0	0	0
Other capital receipts	(3,200)	0	0
External financing requirement		(1,591)	1,917
Undershoot/(overshoot)		8,579	11,677

31.4 Capital resource limit

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

	2012-13 £000s	2011-12 £000s
Gross capital expenditure	3,692	2,917
Less: book value of assets disposed of	(270)	(3)
Less: capital grants	0	0
Less: donations towards the acquisition of non-current assets	0	0
Charge against the capital resource limit	3,422	2,914
Capital resource limit	5,985	9,164
(Over)/underspend against the capital resource limit	2,563	6,250

Appendices

Appendix A

Indicators of quality for 2012/13

During 2012/13 the 0845 4647 service closed in some areas of the country as the new NHS 111 services were launched and closed to the whole country in its national form on 21 March 2013. A contingency service continued to be available to a small proportion of the country to support those areas without an operational NHS 111 service.

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

Safety domain	Effectiveness domain	Patient experience domain
% incidents reviewed nationally that were judged as leading to harm to patients	% of calls resulting in onward referral to emergency and urgent health services	Patient satisfaction (%)
% urgent (P1) clinical assessments started in 20 minutes	% of calls completed within NHS Direct NHS Trust	Number of complaints per 10,000 calls
% less urgent clinical assessments (P2) started in 60 minutes	% of health and nurse advisors' time online spent talking with patients	% calls answered within 60 seconds
% non urgent clinical assessments (P3) started in 120 minutes	% call reviews achieving good or excellent	% complaints resolved first time

1. Safety

In 2012/13, NHS Direct achieved the following performance in indicators relating to patient safety:

Safety domain	2012/13 achievement	2012/13 target
% incidents for national review leading to harm*: standard achieved	0.3%	≤10%
% urgent (P1) clinical assessments started in 20 minutes: standard achieved	96%	≥95%
% less urgent clinical assessments (P2) started in 60 minutes: standard not achieved	92%	≥95%
% non urgent clinical assessments (P3) started in 120 minutes: standard not achieved	94%	≥95%

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

2. Clinical effectiveness

In 2012/13, NHS Direct achieved the following performance in indicators relating to clinical effectiveness:

Effectiveness domain	2012/13 achievement	2012/13 target
% call reviews achieving good or excellent: standard achieved	74%	≥60%
% Telephone contacts not requiring onward referral: standard achieved	46%	≥43%*

(*Throughout 2012/13 the urgency of patient need for callers to NHS Direct changed from month to month. Due to this changing level of need, the target for this area also changed each month to reflect this. The 46% achieved and target shown of 43% represent annualised figures)

3. Patient experience

In 2012/13, NHS Direct achieved the following level of quality for performance in indicators relating to patient experience:

Patient experience domain	2012/13 achievement	2012/13 target
Patient satisfaction (%): standard achieved	92%	≥90%
Number of complaints per 10,000 calls: standard achieved	0.25	≤1.0
% calls answered within 60 seconds: standard not achieved	90%	≥95%
% complaints resolved first time: standard achieved	96%	≥95%

Appendix B

Detailed definitions of key performance indicators

KPI Name	Purpose	Data Source	Definition	Calculation
Patient Satisfaction	To measure patients' perception of quality of our services	External monthly satisfaction survey	Patient perception of level of service being provided by NHS Direct.	% of respondents satisfied with NHSD service provided to them. Calculated from a range of factors most influential to user experience.
Number of Complaints	Indicates the quality of our service	Datix and regional complaints reporting	Number of complaints relating to clinical services per 10,000 calls.	Number of nationally handled complaints reported (for combined service) relating to clinical services) x 10,000 / Number of calls answered
Expert Call Review Scoring Good/ Excellent	Identifies the overall quality of calls, as per in-house quality assurance tool	Collated call reviews from front line managers and expert call review team	Percentage of random supervisory / peer call reviews undertaken for clinical services rating Good / Excellent.	(Total number of expert call reviews rating Good or Excellent / Total number of expert call reviews undertaken) x 100
% of Incidents Reported to National Review that have given rise to harm	Patient Safety	DATIX	The proportion of all reported National Incident for Review (NIR) through NHS Direct core or enhanced telephone services (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 National Incidents for Review reported in a month that led to harm ÷ Number of National Incident for Review reported in a month
0845 Time to Answer - within 60 seconds	Access measure	C&WW telephony system	Number of Combined Calls answered within 60 seconds following the message.	(Calls answered within 60 seconds / total calls answered) x 100
111 Time to Answer - within 60 seconds	Access measure	C&WW telephony system	Number of Combined Calls answered within 60 seconds following the message.	(Calls answered within 60 seconds / total calls answered) x 100
0845 Abandonment Rate	Access measure	C&WW telephony system	% of Combined calls abandoned after 30 seconds following the message and switching delay.	(Number of calls abandoned after application threshold / (number of calls abandoned after threshold + number of calls answered)) x 100

KPI Name	Purpose	Data Source	Definition	Calculation
111 Abandonment Rate	Access measure	C&WW telephony system	% of Combined calls abandoned after 30 seconds following the message and switching delay.	(Number of calls abandoned after application threshold / (number of calls abandoned after threshold + number of calls answered)) x 100
0845 Time to Clinical Assessment Urgent Calls - within 20 minutes	Identifies the speed of response to clinically urgent calls	Clinical Assessment System (CAS)	The proportion of urgent [P1 and D1] calls requiring clinical assessment where clinical assessment by a clinician is started within 20 minutes	Number of urgent [P1 & D1] calls starting clinical assessment within 20 minutes ÷ Number of urgent [P1 & D1] calls
0845 Time to Clinical Assessment Less Urgent - within 60 minutes	Identifies the speed of response to clinically less urgent calls	Clinical Assessment System (CAS)	Less urgent calls [P2 only] requiring clinical assessment, where clinical assessment is started by a clinician within 60 minutes	Number of less urgent [P2] calls starting clinical assessment within 60 minutes ÷ Number of less urgent clinical [P2] calls
0845 Time to Clinical Assessment Non Urgent Calls - within 120 minutes	Identifies the speed of response to clinically non urgent calls	Clinical Assessment System (CAS)	Non-urgent [P2, P3, D2, D3] calls requiring clinical assessment, where clinical assessment is started by a clinician within 120 minutes	Number of non-urgent [P2, P3, D2, D3] calls starting clinical assessment within 60 minutes ÷ Number of non-urgent [P2, P3, D2, D3] calls
111 % Transferred calls Warm Transferred to Clinical Advisor	Measures performance against contract	Clinical Assessment System (CAS)	Of the calls transferred to a Clinical Advisor what percentage were warm transferred	Number of calls transferred to a Clinical Advisor/Calls Warm Transferred to a Clinical Advisor
Time available for Patients	Productivity measure	C&WW telephony system & CCC	Measure not provided by OSC	Measure not provided by OSC
Rostering Efficiency Metric Composite Nas + Has)	Productivity measure	CCC	How accurately does the actual staffing levels fit the planned staffing levels	HA, NA Planned Staffing vs HA, NA Actual Staffing
Schedule Adherence (Composites Nas + Has)	Productivity measure	IRT	How accurately were the rotas adhered to	HA,NA planned schedules vs HA, NA actual adherence
0845 Core Contract Volumes	Measures performance against contract	C&WW telephony system	Number of calls answered for all services	0845 Answered Volumes

KPI Name	Purpose	Data Source	Definition	Calculation
111 Call Volumes	Measures performance against contract	C&WW telephony system	Numbers of called answered against the number of calls agreed as latest contract target	All 111 Calls Answered
Patient Choice (TAL)	Measures performance against contract	C&WW telephony system	Numbers of calls answered against the number of calls agreed as latest contract target	Number of TAL Calls Answered
HaSC Successes (All Channels)	Indicates success of web-based service	Urchin 7	Number of HaSC successes compared to contract plan	Number of Health and Symptoms Checker uses for the reporting period.
% Telephone Contacts not Requiring Onward Referral	Identifies the proportion of calls completed within NHS Direct i.e. those not requiring referral to any other NHS healthcare provider - this provides a proxy indicator for the impact of NHS Direct on the wider health economy	Clinical Assessment System (CAS)	Number of Core calls NHS Direct completes without onward referral	((Selfcare + Pharmacy + PCS Routine + HIS) for core service / (Core Service Symptomatic + HIS Calls)) x 100
111 Calls not Requiring onward Referral	Identifies the proportion of calls not requiring referral to any other NHS healthcare provider - this provides a proxy indicator for the impact of NHS Direct on the wider health economy	Pathways	Calculated using the number of dispositions set as self care, pharmacy, primary care services (PCS) routine and Health Information (HI)	Self care + Pharmacy + PCS Routine + HI ÷ Number of symptomatic calls
% Urgent and Emergency Onward Referrals	Value to Patients and NHS	Clinical Assessment System (CAS)	% of emergency and urgent referrals for Core calls only	(The number of calls referred to 999, A&E or PCS Urgent / Number of calls with clinical dispositions) x 100
111 Calls Requiring Onward or Urgent Emergency Referral	Measure Value to NHS	Pathways	Proportion of symptomatic calls referred to urgent & emergency care dispositions	999 + A&E + PCS urgent ÷ symptomatic calls
Total Sickness	Great Place to Work	HR Scorecard KPIs -2012/13	Gross number of days per WTE per year lost to sick leave	For all NHS Direct staff YTD Actual time spent off sick - WTE days (annualised) /7*5 / YTD Average number of WTE

KPI Name	Purpose	Data Source	Definition	Calculation
Number of People on Long Term Sick Leave	Great Place to Work	HR Scorecard KPIs -2012/13	Total number of people currently on long term sick leave	Continuous calendar days>28 & absence still open at end of the reporting month
Fullfilment of Budgeted Capacity Plan (NAs)	Corporate Effectiveness & Efficiency	CCC/Capacity Plan	Actual Staffing Levels vs Budgeted Staffing Levels	Actual WTE in place/Budgeted WTE in the contract
Fullfilment of Budgeted Capacity Plan (HAs)	Corporate Effectiveness & Efficiency	CCC/Capacity Plan	Actual Staffing Levels vs Budgeted Staffing Levels	Actual WTE in place/Budgeted WTE in the contract
Recurring Financial Balance (monthly run-rate)	Corporate Effectiveness & Efficiency	Finance	Year-to-date (Y-T-D) recurrent retained surplus variance as a proportion of actual Y-T-D turnover.	Y-T-D recurrent retained surplus variance as a proportion of actual Y-T-D turnover.
Department of Health Financial Health Index	Corporate Effectiveness & Efficiency	Finance	As defined by DH the aggregation of a range of financial measures specified to indicate financial health	Range of performance metrics covering actual financial results and including planning, forecasting, processes and balance sheet efficiency.